SOCIAL + BEHAVIOUR CHANGE

Goal Area 1

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Every child, including adolescents, survives and thrives, with access to nutritious diets, quality primary health care, nurturing practices and essential supplies

Compendium of SBC Best Practices

Key social and behaviour change (SBC) strategies, achievements and lessons learned

Access the individual case studies by clicking on each item below:

- UNICEF Bolivia Supports Behaviour Change Activities to Promote COVID-19 Vaccine Uptake
- UNICEF Brazil Uses Social Listening to Improve Adherence to Routine Child Immunization During the COVID-19 Pandemic
- UNICEF Colombia Engages Local Media Outlets to Reach Migrants with COVID-19 Messages
- UNICEF Guatemala Supports Ministry of Health to Develop Community Based Approach to Increase COVID-19 Vaccine Uptake
- UNICEF Gains Insight into Social Influences on Diet and Nutrition Behaviours in Colombia, Guatemala and Mexico
- UNICEF Malaysia Engages Youth Through Digital Social Spaces
- UNICEF Pacific Supports Micronesia Red Cross Society Youth in the Fight Against COVID-19 in the Federation States of Micronesia
- UNICEF Bulgaria's 'How are you really? Tell me' Campaign Supports Psychological Resilience Among Adolescents
- UNICEF Georgia Supports Testing SMS Reminders to Motivate HPV Vaccination
- UNICEF MENA Explores Integrating COVID-19 Vaccine with Other Services in Iraq and Syria
- UNICEF Sudan Uses Social Listening to Promote COVID-19 Vaccine Equity
- UNICEF Bangladesh Supports Information Feedback Centers that Provide Rohingya Refugees in Cox's Bazar, Bangladesh with Critical Information and Services
- UNICEF Bhutan Engages Scouts and Youth Volunteers to Disseminate COVID-19 Lifesaving Message
- UNICEF Nepal Uses Social and Behaviour Change Strategies to Provide Life-Saving Support to Nepalese in the Aftermath of Devastating Earthquakes
- UNICEF Nepal Helps to Improve the Safety of Female Community Health Volunteers Using Human Centred Design
- UNICEF Ghana Facilitates Social and Behaviour Change Research and Message Dissemination
- UNICEF Ghana Supports the Use of Human Centred Design to Improve COVID-19 Vaccination Uptake and Consistent Handwashing Among Health Workers at Vaccination Sites
- UNICEF Sierra Leone Uses U-Report Platform to Prevent a Cholera Outbreak and Facilitate Cash Transfers Among Mudslide Victims in Freetown

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UNICEF Bolivia Supports Behaviour Change Activities to Promote COVID-19 Vaccine Uptake

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

UNICEF Bolivia supported evidence generation, communication, and social mobilization activities to motivate COVID-19 vaccine uptake, including street theatre and community-based sports activities. The COVID-19 vaccination programme established a strategic partnership with the Bolivian Aviation and National Police forces that allowed for the distribution and security of the vaccine, and hired individuals without health experience to perform vaccine pre-registration and support data-entry and reporting, allowing health workers to focus primarily on vaccination.

UNICEF Bolivia worked proactively with the press and used designated speakers to spread messages to improve the demand for and acceptance of vaccination. The large decrease in COVID-19 patients can be attributed to the actions and initiatives taken to increase the vaccination rate in the country. By August 2022, at least 62 per cent of the Bolivian population had been vaccinated. At least 113 students were immunized with their first dose as a result of seeing the school-based theatre play.

Context

Latin America and the Caribbean countries suffered from the pandemic because of their lack of economic and human resources and their weakness in successfully implementing political, economic, social, and scientific measures to combat the disease. In early March 2020, Bolivia had its first COVID-19 case, and on 26 March 2020, the country had its first COVID-19 fatality. In July 2020, the country was in a dire situation due to a lack of available space in hospitals, a shortage of diagnostic tests, and even a lack of medical oxygen. Even with a comparatively smaller population than its neighbours, Bolivia had one of the highest pandemic-related mortality rates in the region. By 3 November 2022, there were a total of 1,109,529 cases of COVID-19 in the country and 22,239 deaths, due in part to the fact that Bolivia's economy relies on workers in the informal sector who could not work remotely. [1,2]

Strategic approach

UNICEF Bolivia supported evidence generation, communication, and social mobilization to motivate positive behavioural change toward COVID-19 vaccination through the use of street theatre and sports activities in community spaces in rural and suburban communities. These activities were reinforced with radio spots in native languages, videos that circulated on Tik Tok with the support of influencers (mainly young people), audio-visual micro-documentaries for video debates in communities and educational units, and a guide on quick answers about Covid-19 and the vaccine, aimed at health personnel.

UNICEF, the Bolivia Ministry of Health and Sports, and the Expanded Programme on Immunization promoted community participation activities to raise awareness among school-aged children about the importance of getting vaccinated against COVID-19. A group of local artists created and performed an entertaining play containing key messages about COVID-19 and the importance of vaccines aimed at young people in public schools. As part of the play, the artists asked the young audience members questions and corrected myths and misconceptions about the vaccine.

Key achievements

The large decrease in COVID-19 patients can be attributed to the actions and initiatives taken to increase the vaccination rate in the country. As of 21 August 2022, at least 62 per cent of the Bolivian population had been vaccinated (14,862,375 COVID-19 vaccination doses) – including 800,000 first doses and 564,447 second doses for 12 children aged 5 to 11 years.[3]

The theatre play initiative provided an excellent example of how to use entertainment-education to promote vaccination and disease prevention. At least 113 students were immunized with their first dose as a result of seeing the theatre play. In August 2022, a "best practices" reference guide on COVID-19 vaccination was published by GAVI, UNICEF, and WHO that highlighted key strategic areas of intervention in Bolivia:

- **Governance, Planning and Coordination:** The ministerial office mobilized resources to ensure adequate financial resources to implement planned activities and implemented cost-saving measures to optimize the use of funds;
- **Service Delivery and Integration:** Special measures were taken to schedule vaccinations for the indigenous population, representing native and rural indigenous nations or populations living in areas that are difficult to access and have communication and intercultural barriers;
- **Partnership:** The COVID-19 vaccination programme established a strategic partnership with the Bolivian Aviation and National Police forces that allowed for the distribution and security of the vaccine;
- **Human Resources Management and Training:** Hired individuals without health experience to perform pre-registration and to support data entry and reporting, allowing health workers to focus primarily on vaccination;
- **Proactive Engagement with the Media:** Worked proactively with the press and used designated speakers to spread messages to improve the demand for and acceptance of vaccination.

62%

of population vaccinated as of August 21, 2022

AT LEAST 113 STUDENTS

immunized with their first dose as a result of seeing the school-based theatre play

Lessons learned

1. The use of face-to-face and interactive activities (e.g., street theatre and sports activities) in community spaces can allow for the collection of evidence on existing barriers to vaccine uptake while promoting the COVID-19 vaccine.

2. Beliefs and perceptions about COVID-19 vaccination side-effects can be quickly turned around through community activities (e.g., in schools, markets and meeting places) that generate positive discussions among community members.

3. Health personnel were, and continue to be, a crucial primary reference for people to learn about COVID-19 vaccines, their effects, and their efficiency; they are essential for spreading positive messages to patients in health centres and through social networks, mass media, and mobilization actions.

4. The promotion of the COVID-19 vaccine can generate adherence to the regular vaccination schedule for girls and boys.

Recommendations

1. It is essential to coordinate at the local level with municipal governments, education and health personnel, and community authorities, promoting the appropriation of the strategy so that the implementation phase has the participation and commitment of these groups and the population.

2. Coordinating with churches and groups that are reluctant to be vaccinated but have not been very active in their resistance is essential; behaviour change messages can turn these groups into vaccine supporters.

Endnotes

1 United Nations Children's Fund, UNICEF Latin America and the Caribbean: The best practices in Social and Behavior Change (SBC), UNICEF, December 2022.

2 Penafiel et al., 'Pandemia COVID-19: Situación política - económica y consecuencias sanitarias en América Latina' , 2020, <https://ojs.unemi.edu.ec/index.php/ cienciaunemi/article/view/1118>.

3 PLD Al Día, 'Actualidad pandemia Covid-19', 8 August 2022, <https://pldaldia.com/portada/actualidad-pandemia-covid-19-546/>.

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UNICEF Brazil Uses Social Listening to Improve Adherence to Routine Child Immunization During the COVID-19 Pandemic

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
November 2020 to December 2022

Duration
Two years

Budget
US$5,000

During the COVID-19 pandemic, public uncertainty about adhering to routine childhood immunization led to a decrease in the rate of childhood immunizations in Brazil. There was an infodemic of confusing information, misinformation, and disinformation surrounding all immunizations. UNICEF Brazil used social listening data from the Data for Good Project (Meta), Public Good Projects (PGP), and the Yale Institute for Global Health, to confirm the root causes of hesitancy to continue child immunizations during the pandemic among parents and caregivers. This data provided behavioural insights into the main barriers to vaccination, namely concerns about safety and efficacy. These findings were used to inform the design and implementation of a social and behaviour change (SBC) and community engagement (CE) intervention. Digital platforms were used to provide correct information about routine childhood immunization, improve people's perceptions of vaccines, and promote staying on schedule with routine childhood immunization.

Context

Between 3 January 2020 and 1 February 2023, Brazil has had more than 36.8 million confirmed cases of COVID-19, and almost 700,000 related deaths.[1] COVID-19 misinformation and disinformation about the vaccines led Brazilians to distrust the vaccine and hesitate to get vaccinated. Historically, anti-vaccination discourse has been low in Brazil. The Brazilian government's negative stance on COVID-19 vaccines, however, contributed to the population's distrust and low uptake of the vaccine. While the COVID-19 vaccine was approved for children 5—11 years old on 16 December 2021, by the *Agência Nacional de Vigilância Sanitária* – Anvisa (Health Surveillance National Agency), the delivery of the vaccines was postponed pending final approval by the government who called into question the safety and efficacy of the vaccines. The vaccination of children in the 5—11 year age group only began on 14 January 2022.[2]

Prior to 2015, Brazil had high rates of routine immunization coverage. Since 2015, the immunization rates in Brazil have been backsliding. The pandemic contributed to the worsening of this vaccination trend. For example, from 2019 to 2021, 1.6 million Brazilian children did not receive their first DTP vaccination; another 700,000 received the first or second dose, but did not receive the third dose, leaving a total of 2.4 million children unimmunized against DTP. The data is similar for the polio vaccine – between 2019 and 2021, 1.6 million children did not receive their first dose of protection against polio. A UNICEF study conducted in 2019 and 2020 showed that parents did not have their children under five vaccinated out of fear of adverse reactions, the possible lack of vaccines in health facilities, limited access to health services, a perception that the risk of eradicated diseases is low, and a lack of information, time, and resources.[3] Health systems weakened and compromized child routine immunization activities. Since vaccination rates have fallen, Brazil has experienced outbreaks of vaccine-preventable diseases. Boosting vaccination rates is critical for stopping the transmission of disease in Brazil, restoring immunization programmes, and implementing catch up efforts to reach children who missed vaccinations during the pandemic.

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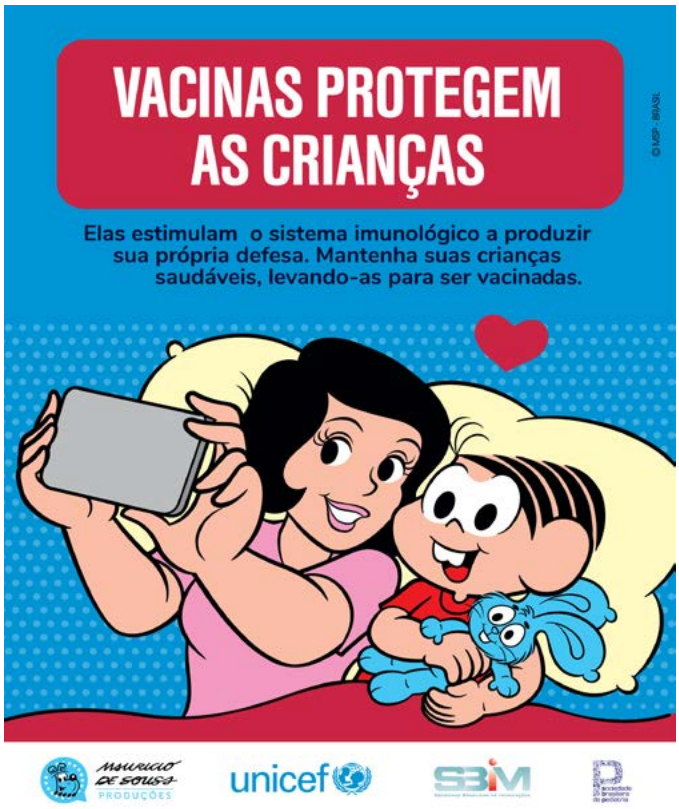
Strategic approach

UNICEF Brazil used social listening research to identify the key barriers to adhering to routine child immunizations in the country. One social listening study was conducted that focused on routine immunization, including COVID vaccination in one arm, and excluding COVID in another arm of the study. The study showed that there were 78,000 mentions of routine immunization on six web-based platforms (Google, Facebook, Instagram, Twitter, YouTube and Telegram). Another similar social listening study conducted by Meta using the tool Crowdtangle (as part of the Data for Good Project) de-identified and analysed Facebook posts about routine immunization. Meta found that women were 33 per cent more likely to post about vaccines and immunization than men, and that men and women over 35 years old were more likely to post about vaccines. The findings pointed to the need to create content that would engage men and younger (18—24 years) audiences.

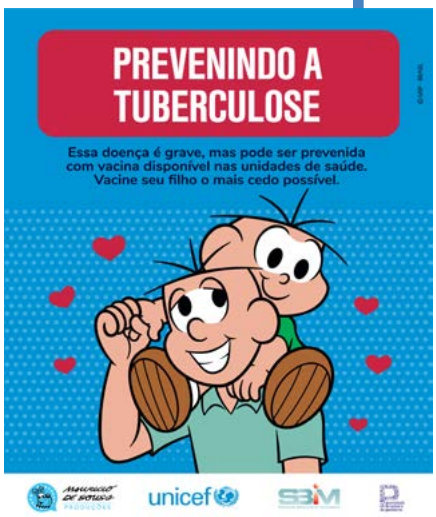


The results from this research were also used to guide in-person focus groups discussion (FGDs) in the Amazon, Semi-Arid regions, and Rio de Janeiro City, to test and create tailored messages. The FGDs were conducted with especially vulnerable populations (e.g., indigenous people; migrants; people living in underserved settings) and with health professionals. By merging the online and offline information, UNICEF and its partners developed audience-driven strategies, including communication campaigns and youth engagement activities to promote vaccine uptake and reduce hesitancy.

Tailored social and behaviour change (SBC) and community engagement (CE) campaign ads were created to motivate parents and caregivers in urban centres (including migrants, refugees, and indigenous populations) to keep their children up to date with their immunizations, called "Up-to-

date vaccinations, even in the pandemic". The ads used the popular cartoon "Monica and Friends" to deliver the messages. The overarching theme of the campaign was that, in addition to COVID-19, there are other risks from diseases for which vaccines provide protection. UNICEF and Meta conducted a digital Brand Lift[4] study with two messaging themes (efficacy versus safety) and two message framings (emotional versus rational) to determine the most effective ads for addressing hesitancy around routine immunization in Brazil. The campaign ads were tested over a two-week period with people 18 years and older. Viewers of the campaign were divided into two groups, a test group (those that saw the ads), and a control group (those that did not see the ads). Two thousand users in each group were randomly surveyed during the testing period to determine if the campaigns produced a positive influence, or a "lift" in responses to post-campaign survey questions about vaccination.[5]

Three posters were created as part of the campaign. Each poster aimed to make specialists and the general public aware of the importance of adhering to a child's vaccination schedule. UNICEF supported the Brazilian Society of Immunizations (SBIM) and the Brazilian Society of Paediatrics (SBP) to develop and disseminate a digital booklet for doctors, nurses, and other health professionals and managers, entitled "Covid-19 Pandemic: What changes in the routine of immunizations." This booklet contained information about the importance of continuing routine vaccination during the pandemic and was delivered via a free webinar. Insights from the social listening activity were also used by the UNICEF Brazil country office to tailor community engagement strategies across technical areas.



Key achievements

The UNICEF campaigns reached a total of more than 32 million people across Brazil.[6] Findings from the Brand Lift study showed that there was a statistically significant lift in ad recall, indicating that the content was engaging and memorable; the efficacy-focused campaign messages and the rational approach framing improved the perceptions of vaccine effectiveness in preventing disease. New campaign materials were developed based on the findings from the Brand Lift study.

Based on campaign reach data, at least 223,000 people were impacted by the campaign. That is, they improved their perception of routine immunization as an effective means for preventing disease in their children. The majority (95 per cent) of those exposed to the campaign agreed that it is important to vaccinate their child, and 77 per cent agreed that vaccines are safe.

AT LEAST 223,000 PEOPLE

95% of those exposed to the campaign agreed that it is important to vaccinate their child

77% agreed that vaccines are safe

Lessons learned & Recommendations[7]

1. **Use familiar content.** Content depicting popular characters from "Monica and Friends" produced a stronger ad recall indicating that the content was engaging, especially for younger adults, and was successful in promoting childhood immunizations as being effective for preventing disease. However, it is important to conduct more testing to determine to what degree the illustrations and/or messages captured the intended audience's attention.

2. **Choose rational over emotional.** The "rational" campaign ads outperformed the "emotional" campaign, suggesting that rational messages (i.e., authoritative framing with facts and information) may be the preferred tone of messaging for future ads to motivate parents/caregivers to have their children vaccinated.

3. **Provide answers to common questions.** Campaigns aimed at addressing vaccine safety should focus on addressing the specific concerns and questions that parents have about that vaccine. Testing should be done to determine exactly which messages are effective in addressing concerns.

4. **Communicate the what and the why.** Reminding parents about vaccine-preventable diseases like polio and measles can be an effective strategy to help parents understand why completing routine childhood immunizations is important.

Endnotes

1 World Health Organization, 'Brazil Situation', WHO, <https://covid19.who.int/region/amro/country/br>.

2 Fernandez M., Matta G., Paiva E., 'COVID-19, vaccine hesitancy and child vaccination: Challenges from Brazil. The Lancet Regional Health: Americas, The Lancet, 2022, <www.thelancet.com/journals/lanam/article/PIIS2667-193X(22)00063-1/fulltext>.

3 United Nations Children Fund, 'Building confidence to continue routine immunization during COVID-19: UNICEF Brazil Insights for Impact Project with Meta', UNICEF Brazil.

4 A Brand Lift Study measures an ads' impact on the perception of a brand (in this case, the UNICEF brand). Using metrics such as ad recall, brand awareness, and consideration (rather than traditional metrics such as clicks, impressions, or views), Brand Lift can help align a campaign with the programme goals.

5 "Lift" is a statistically significant result with a 90 per cent likelihood of replication if the same study was repeated. Achieving lift as a result of a digital campaign is a significant accomplishment because it provides a powerful opportunity for influencing complex vaccine decision making at a low cost per person reached.

6 United Nations Children Fund, 'Building confidence to continue routine immunization during COVID-19: UNICEF Brazil Insights for Impact Project with Meta', UNICEF Brazil.

7 Ibid.

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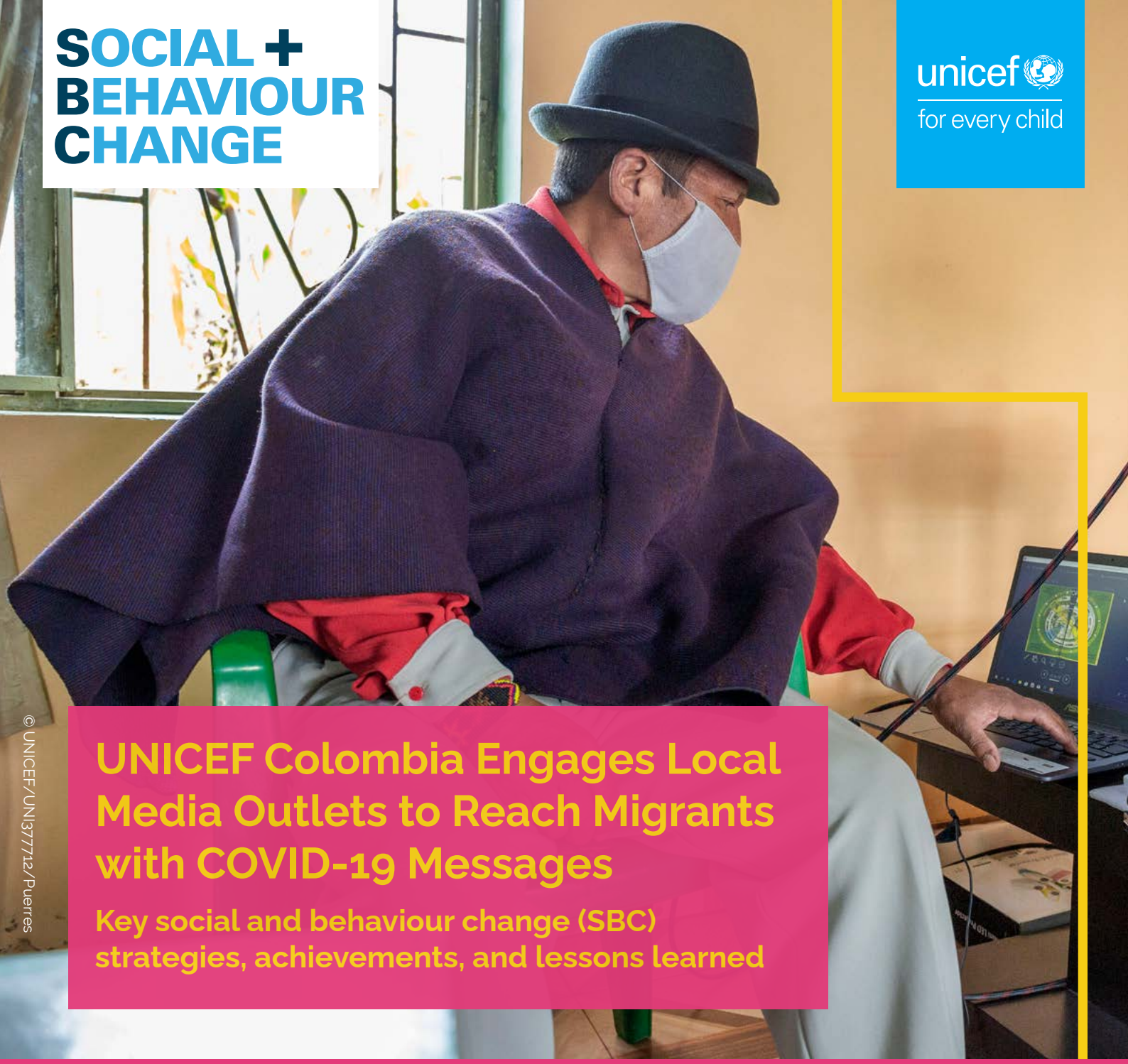

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UNICEF Colombia Engages Local Media Outlets to Reach Migrants with COVID-19 Messages

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

In 2020, the migrant situation was exacerbated by the COVID-19 pandemic. UNICEF Colombia conducted an open call to communication platforms, including radio stations, to facilitate the delivery of accurate information about COVID-19 to members of migrant populations, especially those in hard-to-reach areas. UNICEF field coordinators worked with the media producers to create and disseminate accurate programme content. UNICEF Colombia implemented this migrant-oriented risk communication and community engagement strategy in 17 of 32 departments of the country, which complemented the Ministry of Education (MoE) COVID-19 campaign at the national level. At least 400,000 migrants were reached with important pandemic-related messages every two weeks.

Context

The Venezuela migrant crisis began in 2015. Since then, migrant flow into Colombia has increased. In 2020, there were about two million migrants in the country, of which only one million were considered to have regular migrant status. The migrant crisis was exacerbated by the COVID-19 pandemic. By June 2020, there were more than 34,000 confirmed cases of COVID-19 in Colombia. Communities where migrants were living, known as "host" communities, faced conflict, increased poverty, and lack of access to essential services. A lack of Internet access, especially among migrants on the move and in rural areas, made it difficult to reach those populations with information about the pandemic. More than half of Colombia's 1,103 municipalities, however, had media platforms able to disseminate information at the centre or national levels. More than half of these media platforms were not producing local news for local consumption.

Strategic approach

Communication through media platforms has been an effective means for promoting local empowerment and allows communities to produce information about their specific development priorities and beliefs. In 2020, UNICEF Colombia conducted an open call to various communication platforms, including radio stations, to facilitate the delivery of accurate information about the pandemic to caregivers, teachers, community members, and migrant populations. UNICEF field coordinators worked with the media producers to create and disseminate accurate programme content about COVID-19. UNICEF Colombia's local and national editorial board, consisting of community media producers, mobilizers, and UNICEF Field Coordinators, worked to identify rumours and misinformation about COVID-19 that each media outlet would address in the content created for the migrant populations. Each media platform also has a feedback mechanism in place through which people can engage, voice their concerns, and ask questions about COVID-19.

The UNICEF Colombia team reached out to its existing network of local and community non-profit organizations, teachers and adolescent leaders to serve as mobilizers. UNICEF Colombia also engaged indigenous leaders and national indigenous organizations in order to expand reach.

UNICEF Colombia implemented this migrant-oriented risk communication and community engagement strategy in 17 of 32 departments of the country. This effort also served to support the Ministry of Education (MoE) COVID-19 campaign at the national level; the MoE coordinated national media allies while UNICEF Colombia coordinated local, community media, ensuring greater reach across the country, especially in areas without adequate Internet or television services.

Key achievements

- The strategy of engaging local media outlets to disseminate COVID-19 messages to reach hard-to-reach migrant populations enabled UNICEF Colombia to reach 400,000 people every two weeks.

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400,000

reached people every two weeks

Migrant-oriented communication and community engagement strategy implemented in 17 departments

COVID-19 messaging reached hard-to-reach migrant populations by engaging local media outlets

Lessons learned & Recommendations

1. The messages shared through local media outlets should be adapted to reflect the concerns and priorities of the affected populations.
2. Alternative platforms need to be found for areas that lack adequate internet access

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UNICEF Guatemala Supports Ministry of Health to Develop Community Based Approach to Increase COVID-19 Vaccine Uptake

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

UNICEF Guatemala supported the use of a guide on Community Participation to Promote COVID-19 Vaccination (developed by WHO and UNICEF) as an orientation tool for risk communication, community engagement, and civil society organizations, and for community leaders/influencers, local media, and other stakeholders responsible for carrying out COVID-19 vaccine activities. The guide was transformed into an online course for health personnel at the municipal level and staff of municipality offices. By 2022, the Guatemala Ministry of Health adopted the guide and community-based approach for promoting community participation in health; the approach was translated into a framework with technical input from UNICEF and the Association for the Advancement of Social Sciences (AVANCSO). At least 80 communities in 25 municipalities, in collaboration with the Ministry of Health, used the guide to develop their basic community health plans. Community trust in health services increased.

Context

When a nationwide mass media campaign failed to motivate Guatemalans to get the COVID-19 vaccine during the pandemic, the Guatemala Ministry of Health developed the Communication and Social Mobilization Plan to motivate people to get vaccinated against COVID-19.


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Strategic approach

To address the challenge of low vaccination uptake during the COVID-19 pandemic, UNICEF Guatemala supported the Ministry of Public Health and Social Assistance (MSPAS)/Department of Health Promotion and Education (PROEDUSA) in designing community-based participatory activities based on community listening and dialogue to understand the key concerns about the vaccine. First, the Pan American Health Organization (PAHO) conducted a qualitative anthropological study to identify factors of low vaccination coverage in various health areas. This study highlighted that religious groups were telling people that believing in the vaccine was to "distrust the power of God"; and that indigenous peoples' approach to health and the western approach of the Ministry of Health were divergent, and indigenous communities were not connected to health facilities.

A guide on Community Participation to Promote COVID-19 Vaccination developed by WHO and UNICEF, was disseminated by UNICEF Guatemala to health coordinators, health district staff, and personnel at the Municipal Women's Directorates (DMM) and the Municipal Offices for the Protection of Children and Adolescents (OMPNA). The guide served as an orientation tool for risk communication, community engagement, and civil society organizations, and for community leaders/influencers, local media, and other stakeholders responsible for carrying out COVID-19 vaccine activities. The guide was adapted to the local reality and transformed into an online course. UNICEF together with PROEDUSA/MSPAS and Peace Corps volunteers set up the online course on community participation in COVID-19 vaccination for health personnel at the municipal level and staff of municipality offices (Oficina Municipal de la Niñez y la Adolescencia, OMPNA). Online participants shared information about why Guatemalans were not getting vaccinated against COVID-19 in their municipalities; a common refrain was that many people distrusted the health system because of its limited resources and capacity. Course participants also conveyed that people felt that since the coverage of health centres was concentrated in urban areas, COVID-19 must mostly affect people from the capital and cities (85.6 per cent) and foreigners and those who travel a lot (62.5 per cent).[1] The UNICEF U-Report system was also used to collect information about COVID-19-related rumours through online surveys.[2] If internet access was an issue for the online survey, the questionnaire was administered via telephone and the responses recorded on an online form by the person that administered the questionnaire. These data were analysed by the Guatemala Ministry of Health, which developed appropriate correct clarifications that were sent to communities, especially frontline workers.

Key achievements

- By 2022, the Guatemala Ministry of Health adopted the guide and community-based approach for promoting community participation in health; the approach was translated into a framework with technical input from UNICEF and the Association for the Advancement of Social Sciences (AVANCSO);
- More than 1,000 rumours were collected and addressed with correct information disseminated through social networks;
- At least 80 communities in 25 municipalities, in collaboration with the Ministry of Health, used the guide to develop their basic community health plans;
- Local media in 25 municipalities with the lowest COVID-19 vaccination coverage committed to and engaged in disseminating messages to encourage community members to participate in health activities;
- Community trust in health services increased.

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MORE THAN 1,000

rumours collected and addressed

80 COMMUNITIES

used the guide to develop their basic community health plans

LOCAL MEDIA IN 25 MUNICIPALITIES

committed to and engaged in disseminating messages

Lessons learned

1. During the pandemic, training had to take place virtually. The online course with the support of volunteer tutors was facilitated through Moodle (yocomunico.org). In some areas, however, participants did not have stable connections for synchronous tutoring sessions, so sessions had to be conducted via cell phone calls.
2. The COVID-19 pandemic shed light on the need to work within different social contexts, promoting dialogue to empower communities and strengthen the health system.
3. Community trust and involvement from the beginning of an intervention are key to ensuring vaccine acceptance.
4. Engaging communities requires approaches that include the culture and language of the communities themselves.
5. Developing alliances with local media helps to create an enabling environment that favors community commitment and participation in health.
6. For community engagement plans to be successful, the response must be evidence-based and ensure a well-coordinated approach that is supported by community mobilization influencers and other members of civil society.

Recommendations

1. Improve the government's capacity to use and analyze SBC data;
2. Adopt the community monitoring system used by the Nutrition section – based on Lot Quality Assurance Sampling (LQAS) that surveys only 19 mothers per community to know if mothers in the community know and practice basic actions for child health and nutrition – for SBC activities.

Endnotes

1 United Nations Children's Fund, UNICEF Latin America and the Caribbean: The best practices in social and behaviour change (SBC), UNICEF, Panama City, 2022.

2 U-Report is a social messaging tool and data collection system developed by UNICEF to improve citizen engagement, inform leaders, and foster positive change. The programme sends SMS polls and alerts to its participants, collecting real-time responses, and subsequently publishes gathered data.

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UNICEF Gains Insight into Social Influences on Diet and Nutrition Behaviours in Colombia, Guatemala and Mexico

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
November 2021 to June 2022

Duration
Seven months

Budget
US$166,332

UNICEF's Latin America and Caribbean Regional Office (LACRO) commissioned MAGENTA, an LTA provider of Social and Behaviour Change (SBC) services to UNICEF, to conduct research and provide insights on social norms related to diet and body size in Colombia, Guatemala, and Mexico. MAGENTA conducted a scoping literature review, focus group discussions with adolescents and adults, and key informant interviews with stakeholders from public, private, and civil society organizations in the three countries. They gathered information about decision-making processes, preferences, practices and expectations around foods, beverages, and body size. The findings will be used to develop UNICEFs regional and country programmes for the prevention of obesity.

Context

Latin America has among the highest rates of overweight and obesity in the world. The adult prevalence of obesity in Latin America is around 23 per cent, adult overweight is above 50 per cent, and childhood obesity and overweight is about 30 per cent for children aged 5—19 years and about 7.5 per cent in children under five years of age.[1,2] As economies in Latin America develop and become more globalized, people across the region are increasingly transitioning away from traditional diets of plants, whole grains, legumes, meat, and fish, and are moving toward diets rich in processed sugar, fat, oil, and refined grains that are increasingly available and accessible. Current lifestyles also include less physical activity.[3]

These transitions are occurring more rapidly in urban settings; rural settings are catching up as mozre ultra-processed food enters the rural food system. The burden of malnutrition-related overweight is borne disproportionately by lower socio-economic individuals, families, and communities. The changes in diet and physical activity are contributing to an epidemic of nutrition-related non-communicable diseases in the region. By 2030, more than 80 per cent of deaths in Latin America will be attributed to non-communicable diseases.[4]

To understand the drivers of the nutrition transition and its effects of the populations in Latin America, UNICEF commissioned a study on the social norms around dietary habits and body image in Colombia, Guatemala, and Mexico. These countries were selected as representative of the region because of their culinary diversity (rooted in Mesoamerican, Spanish, and African traditions), and the progress of the double burden of malnutrition they are experiencing. Each country is at a different state of the nutrition transition, with Mexico being the most advanced, followed by Colombia and Guatemala respectively.[5]

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Strategic approach[6]

MAGENTA conducted qualitative research using the Behaviour Drivers Model (BDM) as a framework. The study aimed to understand participants' nutritional experiences through the lens of their norms in their communities and homes, how and why they made food-related decisions, and to contextualize these finding within the conditions of the environments where they lived.

MAGENTA identified relevant key stakeholders in consultations with UNICEF, a local data collection partner, and local nutrition focused organizations. The selection of stakeholders was purposive, that is, each stakeholder was selected based on the type of information that they could provide as it related to the BDM. Study participants were selected from both rural and urban areas in two to three regions of each country. The findings from the study represent a snapshot of the nutritional experiences of people experiencing financial scarcity and, often, food insecurity, as opposed to a comprehensive ethnographic account of the nutritional experiences of every population in each country.


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Key insights

- Cognitive biases, emotion, and self-efficacy play a role in determining what and how a person eats. For example, many people in Colombia and Mexico used a rule of thumb to distinguish "healthy" from "unhealthy" foods: in Colombia, they distinguished between "natural" (healthy) and "artificial" (unhealthy), and in Mexico they distinguished between "homemade" (healthy) and store-bought (unhealthy). This rule of thumb contributed to a salience bias, where the low nutrition in some foods was less apparent when they used this rule of thumb.
- Low self-efficacy (i.e., belief in one's ability to reach a specific goal) demotivates individuals to take charge of their health.
- Ambivalent health interest and attitudes contribute to low motivation to make health changes.
- Social influence of adults informs children's food and health interests and attitudes.
- Participants in all three country studies shared similar attitudes about body image and size. Most participants considered smaller bodies to be a sign of health in both men and women, which differed from the typical body sizes that they saw in their communities.
- Limited road infrastructure in rural areas hinders organizations' transporting of perishable foods in and out of the areas, affecting the ability of people to change their diet-related behaviours.
- Limited pedestrian infrastructure in rural and urban areas hinders people's ability to walk and exercise regularly.
- Limited regulation of ultra-processed foods increases their availability, affordability, and variety.
- Community dynamics encourage eating out for recreation and celebration, only discussing health topics at home.
- Gender norms assign meal preparation and serving to women and girls.
- Men make decisions about going going out to eat.

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gathered information about decision-making processes, preferences, practices and expectations around foods, beverages, and body size.

The research found that many people in Colombia and Mexico used a rule of thumb to distinguish "healthy" from "unhealthy" foods.

The study revealed that limited regulation of ultra-processed foods increases their availability, affordability, and variety.

Lessons learned & Recommendations

1. Develop governing instruments to regulate exposure and access to ultra-processed foods and beverages and expand food policy initiatives.
2. Create and promote built infrastructure that facilitates health-forward decisions.
3. Increase interest, positive associations, and cultural identification with nutritionally rich foods.
4. Increase individual's self-efficacy to support their health through initiatives aimed at building capability and motivation to include health-forward habits.
5. Foster public discourses and community dynamics that promote nutrition-forward and body neutral conversations around health.
6. Promote gender equality and increase men and adolescent boy's engagement in meal preparation and in creating healthy habits early and often at home.

Endnotes

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4 Ibid.

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6 For details on the study approach see: Santamaria A, O'Sullivan O, Bonvecchio Areas, A, Cunningham S-J (July 2022). Understanding social norms that drive diet behaviors and body image in Latin America. UNICEF/MAGENTA; https://static1.squarespace.com/static/61751a56593c762f6c492e6b/t/633f29141da0440e45863482/1665083696032/Understanding+Social+Norms+That+Drive+Diet+Behaviours+and+Body+Image+in+Latin+America.pdf

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UNICEF Malaysia Engages Youth Through Digital Social Spaces

Key social and behaviour change (SBC) strategies, achievements and lessons learned

Brief summary

Dates of Activity
Phase 1: May to December 2020
Phase 2: July 2021 to July 2022

Duration
Two years

Budget
US$158,000

UNICEF Malaysia used the U-Report platform to create a dedicated online social space on the Telegram channel, called KitaConnect (We Connect), where users could receive regular and correct information and updates on COVID-19, and on mental health and psychosocial well-being. The platform enabled users to provide real-time feedback about their concerns related to the virus and connect with other youth via participatory activities and challenges. Through KitaConnect, UNICEF could link users to appropriate services and resources to address their needs. The platform provided a way to combat COVID-19 misinformation and alleviate fear and anxiety among youth. As of December 2022, KitaConnect successfully engaged more than 703,547 young people through online sessions, messages, polls, social media posts, and challenges. Almost all users (97 per cent) said that they learned something new from engaging with the platform. Based on popular feedback and demand from participants, KitaConnect burgeoned into a youth-driven and youth-centric platform where users could share their enthusiasm about meaningful causes, discuss topics that matter to their lives, and learn soft skills in communication, self-development, stress management and goal setting.

Context

The daily lives of Malaysian youth (10 to 25 years) were disrupted because of the COVID-19 pandemic. At the height of the pandemic, schools closed and there were inherent difficulties with remote learning. Youth were cut off from directly interacting with their peers and had limited spaces where they could express their feelings related to the pandemic situation. The education, mental health and psychosocial wellbeing of young people were compromised, and access to accurate COVID-19 information and services was limited. Online engagement was one of the few ways that youth could interact. Malaysia's internet penetration was about 90 per cent.

Strategic approach

In 2020, UNICEF Malaysia partnered with Childline Foundation and Project I.D. to develop KitaConnect, a dedicated online social space on the Telegram channel of the U-Report platform. The platform served as an online social space to disseminate regular and correct information and updates related to COVID-19.[1] KitaConnect also served as an open platform for young people to express their anxiety about the pandemic, connect to other youth for peer support, and receive messages on mental health and psychosocial well-being. Activists and influencers also volunteered as peer-leaders to motivate the youth and demonstrate ways to contribute to their society. Through KitaConnect, participants received SMS polls and alerts. Their responses were collected in real-time and published, giving rise to a sense of empowerment among young participants to engage with and speak out on issues that mattered to them.

The programme was implemented in two phases: phase one, from May to December 2020, (US$20,000) and phase two, from July 2021 to July 2022 (US$138,000). During Phase one, the partners created a workplan for the KitaConnect program and conducted a needs assessment of youth and adolescents in Malaysia to development the platform activities. The needs assessment focused on collecting information to ensure the accurate representation of the diverse KitaConnect target demographic (i.e., ethnicity, gender, disability status, socio-economic background, and locality), and to identify topics of interest among youth across Malaysia. UNICEF and their Malaysian partners developed a 12-month curriculum to accompany the KitaConnect programme (incorporating digital activities and events that build skills in youth), delivered and managed the platform, and conducted monitoring and evaluation activities to determine the effects of KitaConnect on young people in Malaysia. UNICEF Malaysia engaged civil society, private sector, and influencer partners to promote wellbeing among the U-report platform users.

UNICEF Malaysia commissioned an assessment of the KitaConnect activity at the end of phase one. A survey was conducted to determine the rate of participation on the platform, and to understand the overall experience of KitaConnect users (i.e., did the platform serve the key needs of the users). A total of 99 individuals responded to the survey, 62 per cent of whom were active users, 75 per cent were female, and at least seven per cent self-identified as a Person with Disabilities. The feedback and demand from KitaConnect users from phase one were so strong that the KitaConnect transitioned from an emergency response communication activity in 2021, into a youth-driven and youth-centric platform, where users could share their enthusiasm about meaningful causes, discuss topics that matter to their lives, and learn soft skills in communication, self-development, stress management and goal setting.

In phase two of the programme, the curriculum was reviewed and refined based on insights from the end-of- phase one assessment. The curriculum was scaled up, focusing on three key pillars: Motivation (including mental health and psychosocial support), Learning, and Social and Civic Engagement. More and diverse innovative platforms were used to engage young people (e.g., workshops, Instagram Live sessions, post-session activities on Discord).[2] An online community was established to support peer to peer engagement beyond the workshop sessions. Twenty-four youth facilitators ("KitaConnect Champions") were recruited and upskilled as @KitaConnect Champions to facilitate and moderate @KitaConnect sessions. The key KitaConnect intitiatives included eleven workshops, seven Instagram Live sessions, four youth chats, eleven supplementary Discord engagements, and an @KitaConnect micro-site that featured key highlights and young people's content from the programme.

Key achievements

As of December 2022, 703,547 Malaysian youth were engaged via KitaConnect Instagram, Facebook, and Discord activities. More than 783 young people between the ages of 13 and 25 from all 14 Malaysian states (72 per cent female, and 10 per cent people with disabilities) participated in KitaConnect sessions via workshops, Zoom youth chats, Gather.town, and Instagram Live sessions. The activity that generated the most interest were the online workshops. The top three topic areas of interest among active users were "youth mental health," "education," and "gender equality." Almost all the survey respondents (97 per cent) said that they had learned something new from *KitaConnect* messages and/or online sessions. Most users (89 per cent) agreed that they had enhanced their understanding of mental health issues as a result of interacting with the KitaConnect activities. Ninety-seven per cent of the survey respondents that engaged on the platform said that the online sessions helped them to change their perceptions about an issue, and 95 per cent agreed that KitaConnect inspired them to contribute to a social cause. The majority of platform users wanted more workshops and activities (e.g., webinars with influential people). Only 11 per cent of users said that they encountered any problems using KitaConnect.

With more Internet users moving to Telegram (mostly due to security concerns with WhatsApp), the KitaConnect platform may likely see an increase in total active users. UNICEF will be transitioning KitaConnect from being an emergency response communication channel that focused on COVID-19, to becoming a key youth online engagement programme under UNICEF's Adolescent Development and Participation Programme. The aim is to build the skills of young people to maximize their mental and psychosocial wellbeing, support their learning, and be civically engaged in their communities.

703,547 MALAYSIAN YOUTH

engaged in the first phase

89% of users reported an enhanced understanding of mental health issues

95% of users agreed that KitaConnect inspired them to contribute to a social cause

Lessons learned

1. **Let the youth take the lead!** KitaConnect made a successful transition from a COVID-19 related platform to a youth-engagement platform because it encouraged youth to select topics of interest to them and decide on the skillsets they wanted to learn. The discussions were facilitated by youth to feel that they were in a safe space to speak out.

2. **A strong foundation builds a strong platform.** The use of data supported and strengthened the KitaConnect activity. The survey feedback helped to shape the platform. Using 24 youth facilitators (champions) that had previous experience as peer engagement workers meant that the champions did not start from zero capability and required less capacity building training; they were more confident and competent to lead a youth-centric programme.

3. **Be creative in using different platforms to reach out.** New communication platforms are introduced frequently, and youth are attracted to new things. KitaConnect started from Telegram, but also used U-Report, Instagram, Zoom and Gather.town to maximize each platform's features. To help youth with low internet connection, resources were shared by Telegram in advance so the participants would not lose track even when the connection breaks mid-session.

Recommendations[3]

1. Implement surveys after each KitaConnect activity to collect feedback for the continuous improvement in planning future activities, and comments that can aid with planning of content and logistics.
2. Continue KitaConnect activities with a more intensified use of online workshops and varied topics.
3. Host more online sessions and with differing times (e.g., weekends) to accommodate various schedules of interested individuals.
4. Implement targeted surveys to understand the needs of Persons with Disabilities and East Malaysians to ensure future sessions include their interests and concerns.
5. Promote and organize events which foster inclusion, particularly in the challenges to enable and encourage Persons with Disabilities to attend.
6. Allocate more slots led by young people, such as peer-to-peer sessions.
7. Combine two or three related topics in one activity to attract different demographics and allow them to interact.
8. Provide the opportunity for users to directly interact with entities who are influential or experts in a field and from diverse backgrounds.
9. Design activities that promote explicit learning and offer fun rewards/prizes at the same time.
10. UNICEF and partners should explore a more hybrid approach to delivering skills-building and engagement programmes now that movement restrictions due to COVID-19 have been lifted.

Endnotes

1 U-Report is a social messaging tool and data collection system developed by UNICEF to improve citizen engagement, inform leaders, and foster positive change.

2 The Discord server is a virtual social platform created exclusively for the KitaConnect community. Participants can stay connected with each other beyond the sessions via youth-led discussions and activities. Discord was chosen as it emerged as the most commonly used social platform among young people.

3 Recommendations are based on findings from the UNICEF KitaConnect Assessment Report (April 2021).

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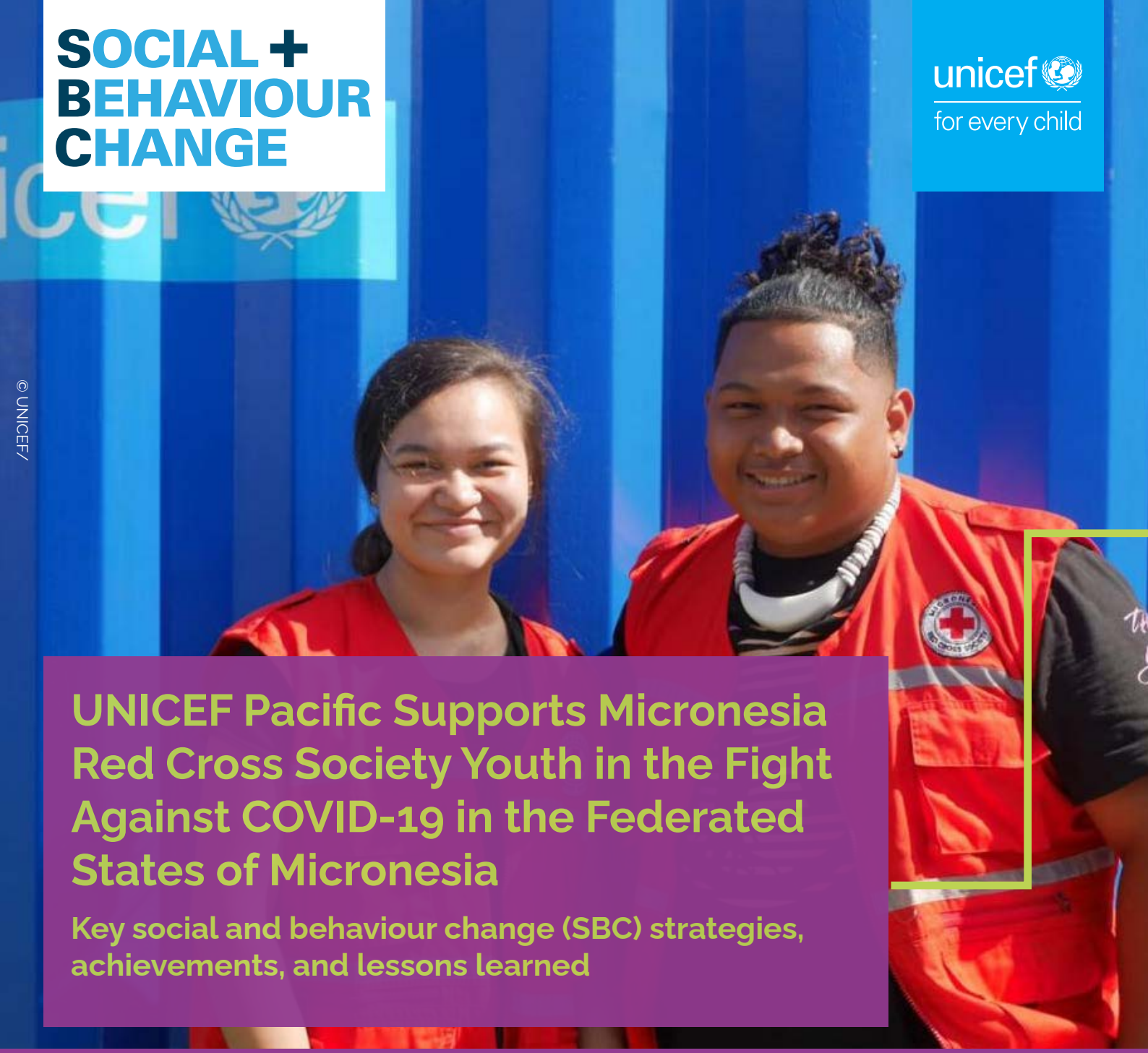

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UNICEF Pacific Supports Micronesia Red Cross Society Youth in the Fight Against COVID-19 in the Federated States of Micronesia

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

UNICEF Pacific Social and Behaviour Change (SBC) Team trained more than 400 Micronesia Red Cross Society (MRCS) youth volunteers on COVID-19 Risk Communication and Community Engagement (RCCE). The aim of this intervention was to resource young people to become risk communicators and community mobilizers to reach isolated island communities with correct information about COVID-19, how to prevent being infected, and to motivate uptake of the COVID-19 vaccine. The trained MRCS youth volunteers, together with trained health workers, implemented a COVID-19 sensitization campaign across four island states (Pohnpei, Chuuk, Yap, Kosrae), consisting of about 607 islands with a combined area of 702 square kilometres. In Pohnpei alone, youth volunteers engaged more than 20,000 people from 3,000 households in dialogues on COVID-19 preventive behaviours as well as the importance of vaccination.

Context

The first cases of COVID-19 in the Federated States of Micronesia (FSM) were reported in July 2022, more than two years after the declaration of the pandemic in March 2020. Prior to February 2022, FSM maintained a strict border control regime, with only essential supplies and goods being allowed into FSM. In this low-prevalence context, where most people did not perceive COVID-19 as an immediate threat, the FSM population questioned why they should get vaccinated or boosted against COVID-19. The FSM COVID-19 RCCE strategy was largely focused on preventing a potential COVID-19 outbreak by getting the most-at-risk individuals vaccinated and boosted so that they would be protected when the borders eventually opened, and the likelihood of community transmission increased. The strategy also focused on getting the general population to understand the importance of being vaccinated against COVID-19 so that life could return to normal as soon as possible.

Strategic approach

The UNICEF Pacific SBC team implemented a multi-pronged strategic approach to COVID-19 prevention, including youth volunteer training; house-to-house COVID-19 awareness raising visits with distribution of supplies; mobilization of communities to develop their own COVID-19 response action plans; and data collection and research. Workshops were conducted to train 400 hundred Micronesia Red Cross Society (MRCS) youth volunteers and public health personnel on RCCE for COVID-19. The aim was to equip the volunteers with relevant and correct information about COVID-19, including how to recognize the signs and symptoms, modes of transmission, and preventive behaviours, including vaccination. The training addressed interpersonal communication skills and SBC methods for conducting effective community engagement and dialogues to empower and motivate individuals to practice prevention and get vaccinated. A field-level mentorship component was included in the training; the UNICEF SBC team supervised and supported the trainees on conducting effective dialogues in communities. Youth volunteers were also trained on data collection with a mobile application. They collected social-level data (e.g., perceptions on COVID-19 and routine vaccines; willingness to accept the vaccines if offered; awareness about COVID-19; preferred channels for receiving information; and access to hygiene supplies) that the government used for COVID-19 preparedness and response planning.

The community- and household- level sensitization campaign focused on educating adults and children about COVID-19 preparedness, prevention, and control practices. The young volunteers conducted hygiene and hand-washing demonstration sessions, engaged community members in discussions about their risk perception, conducted community discussions aided by flipcharts and flyers, and helped communities develop COVID-19 action plans.

Key achievements

- UNICEF Pacific trained and supported more than 400 MRCS youth volunteers on COVID-19 RCCE.
- In Pohnpei State, the second most populated state, more than 3,000 households were engaged and sensitized, accounting for a reach of more than 20,000 people with about 8,000 children.
- The RCCE efforts resulted in a significant rise in demand for COVID-19 vaccines and contributed to an increase in vaccination coverage from 47 per cent in July 2021 to 76 per cent in November 2021.
- A long-term result among communities that participated in the RCCE initiative for COVID-19 has been better preparedness for future disease outbreaks, and a greater overall sense of resilience and adaptation.

MORE THAN **400**

MRCS youth volunteers trained on COVID-19 RCCE

Increase in vaccination coverage from

47% IN JULY 2021

to

76% IN NOVEMBER 2021

MORE THAN **3,000**

households were engaged and sensitized in Pohnpei State

Lessons learned & Recommendations

1 **Community ownership can lead to changes in health practices.** The youth encouraged active participation from community members in the sensitization sessions, which helped foster community ownership and adoption of safe hygiene practices and behaviours.

2 **Evidence generation through social data collection is critical to understanding the knowledge gaps, barriers and motivators related to the adoption of disease prevention practices.** The data collected by youth helped the Ministry of Health, UNICEF, MRCS, and other partners to understand community members' COVID-19-related knowledge, attitudes, intentions, and practices, and what would or would not motivate uptake of the vaccine. The data was also instrumental in making changes in health service delivery, for example, altering vaccination days or times to suit communities and/or population segments.

3 **Teaching youth to collect data can give them valuable skills in social research** that are applicable to other areas of their lives, and to future outbreaks or pandemics.

4 **Effective partnerships and joint coordination are essential for conducting health campaigns, especially in geographically challenging locations**. UNICEF Pacific's partnership with the local Red Cross combined UNICEF's expertise in SBC with MRCS's experience in emergency response, geographical reach, and large cadres of youth volunteers to achieve extended reach of critical messages.

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UNICEF Bulgaria's 'How are you really? Tell me' Campaign Supports Psychological Resilience Among Adolescents

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
10 October 2022 – present

Duration
Ongoing

Budget
US$ 180,000

On 10 October 2022, World Mental Health Day, UNICEF Bulgaria launched its first free-of-charge online self-care and mental health platform for adolescents. The virtual UNICEF Room was created within the Tell Me mobile app. The purpose of the UNICEF Room is to help young people develop psychological resilience, build mental health literacy skills to deal with adverse events, and to better understand themselves and what they want. The platform's information portal is also useful for parents of teenagers who want to learn how to emotionally support their child. A broader social and behaviour change (SBC) campaign, 'How are you really? Tell me', was developed to motivate adolescents to practice self-care, strengthen their own mental health, and help others to strengthen theirs. In the last quarter of 2022, almost two million people were exposed to the Facebook and Instagram messages and YouTube videos. Through clicks, views and video launches, the mobile app had about 8,000 unique downloads and users.
In its second phase, UNICEF Bulgaria and its business and CSO partners aim to launch online counseling via the Tell Me app.

Context

Fifty per cent of all mental health disorders start by age 14, and 75 per cent by age 24.[1] UNICEF data shows that one in five deaths among 15- to 19-year-olds in the European Union is caused by intentional self-harm.[2] Suicide is the second most prevalent cause of death for adolescents of the same age in Europe. At least 11 per cent of girls and boys in Bulgaria aged 10—19 are diagnosed with a mental disorder each year.[3] Mental health is a sensitive topic and most Bulgarian youth (63 per cent) do not seek professional help because they feel that to do so is shameful and/or they do not know where to look for help. Thirty-three per cent turn to negative coping strategies (e.g., smoking, drinking, aggression) and 17 per cent do not know whom to turn to for help. At least 10 per cent of Bulgarian youth cannot pay for the services. Only 13 per cent of adolescents use positive coping strategies to cope with mental health distress (e.g., sports, art). Almost half of all children in Bulgaria have experienced or witnessed some type of violence by the time they are 18 years old; emotional violence is the most common form (50 per cent), along with physical violence (31 per cent), sexual abuse (16 per cent), and neglect (11 per cent).[4]

Bulgarian adolescents, like adolescents around the world, are faced with such challenging situations as bullying at school and domestic violence. They have questions about their career path, first intimate relationships, and about navigating the intergenerational gap between themselves and their parents. The COVID-19 pandemic and war in neighboring Ukraine have heightened typical adolescent conditions such as **fear, anxiety, depression, and panic attacks**. At least one third of Bulgarian children resort to harmful practices as a coping mechanism.[5] UNICEF Bulgaria identified the urgent need to address the mental health needs of adolescents in Bulgaria and break the silence caused by stigma and shame that prevent them from accessing help.

Strategic approach

UNICEF Bulgaria used the social ecological model (SEM) as a framework to guide the development of mental health interventions at multiple levels (e.g., advocacy, organizational/service delivery, community, interpersonal, and individual). Evidence-based research from in-country studies contributed to the development of strengthened mental health components of the Government's National Health Strategy 2021-2030 (e.g., the addition of a digital service delivery approach), and the Ministry of Health's National Mental Health Strategy 2021-2030 (that focused on adolescent-centered services), and led to the establishment of a Mental Health Council – a specialized multi-stakeholder body to the Council of Ministers to ensure a more holistic approach to mental health issues in line with Bulgaria's Recovery and Resilience Plan developed in response to the COVID-19 pandemic. UNICEF Bulgaria collaborated with WHO Bulgaria and other key stakeholders, including the National Centre for Public Health and Analyses (a think-tank of the Ministry of Health), the NGO Foundation Global Initiative in Psychiatry, and the Patients' Portal information platform, to establish a mental health advocacy coalition in Bulgaria.

A landscape analysis of online and offline services oriented toward adolescent mental health in Bulgaria was conducted to take stock of, and provide recommendations for, interventions that would address any gaps in the information and services currently being offered to youth. Adolescent-led participatory research activities engaged youth (especially those from vulnerable backgrounds) in an exploration of their mental health needs, conditions, expectations. The evidence-based review was conducted to determine what interventions address mental health concerns for Bulgarian adolescents in a timely, unprejudiced, and easy-to-access manner. The findings showed that there were no digital mental health services for adolescents.

The behavioural insights gained from the adolescents were used to inform the design of specific interventions. UNICEF, in partnership with a Bulgarian start-up company, designed the 'UNICEF Room' within the 'Tell Me' app. Access to the platform is free for all young people between 14 and 24 years of age and their parents. Inside the 'UNICEF Room' adolescents and their parents can find information, exercises, and coping strategies to increasing health literacy, self-efficacy, and self-care.[6] The content is based on the principles of cognitive behavioural therapy (CBT) that helps an individual learn how to identify and change destructive or disturbing thought patterns that have a negative influence on their behaviour and emotions. The aim of the app is to break the stigma associated with mental health and promote self-help and help-seeking behaviours. The online platform will be expanded to provide e-counseling and serve as a model to be scaled up by the Ministry of Health and other stakeholders as part of a plan to modernize telemedicine in Bulgaria.

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Based on recommendations from the research, UNICEF Bulgaria supported the development of a social and behaviour change (SBC) campaign, 'How are you really? Tell me,' aimed at motivating adolescents to practice self-care, strengthen their own mental health, and help others to strengthen theirs. The campaign promotes self-efficacy and agency of change among adolescents, and community engagement and social mobilization in support of mental health wellbeing. The campaign activities include:

1. **Public campaign**: The 'Beyond the smiles. How are you really?' campaign aimed to destigmatize and normalize conversations about mental health and help-seeking behaviours, and to generate support (political and financial) for adolescent mental health services in Bulgaria. The campaign attracted roughly US$180 000 in individual pledges and corporate donations, which were used to create new content, market a new mobile app, and generate behavioural insights about youth mental health issues using U-Report polls and conducting mapping studies.

2. **Postbox for fairytales**: Youth from across the country were invited to share their experiences with COVID-19 isolation by writing essays and poetry and submitting their entries to a national contest that attracted about 250 youth authors. Ten contest finalists were selected whose stories reflected first-hand experiences with depression, anxiety, domestic violence, eating and sleeping disorders, and suicidal thoughts. Celebrities were engaged to read the winning essays via video streaming as a way of raising public awareness about the mental health state of adolescents and about the importance of de-stigmatizing mental health and seeking help.

3. **Podcast series**: The "Inside Out" monthly podcast series with Teen Station (a youth media network) was co-created by youth, for youth, and provided a unique glimpse into the lives and mental health of adolescents. This series will be scaled up in schools across Bulgaria to serve as basis for open dialogue, collaboration between teenagers, teachers, parents, psychologists on the topics that concern young people in the country.

4. **Immersive installation**: Giant spaces in urban environments and other interactive experiences were created to stimulate individual and collective reflections on trauma (e.g., COVID-19 pandemic, conflict, violence). Young artists (illustrators, musicians, poets, filmmakers) were invited to reflect on their own struggles with anxiety, depression, burnout, and other issues, and to use their talent to convey those messages to the general public. Visitors to the installations were able to immerse themselves in the mental health world of the young artists through music, illustrations, and poetry. Media coverage of the installations heightened attention for this activity. A series of video stories about the young artists is planned and will be screened at community events as dialogue-starters.

Key achievements

- The 'UNICEF room' reached 239,874 people and yielded 7,394 downloads and users on World Mental Health Day (October 2022);
- In October 2022 (Mental Health Month), 1,000 people visited the immersive installation;
- The 'Inside Out' podcast series reached 69,326 people and engaged 2,439 via the new youth-led mental health podcast series 'Inside Out' launched during European Mental Health week;
- In the last quarter of 2022, almost two million people were exposed to the Facebook and Instagram messages and YouTube videos through clicks, views and video launches. The YouTube video on anxiety and stress was viewed 21,608 times;
- The mobile app had about 8,000 unique downloads and users;
- UNICEF Bulgaria influenced the design of the National Health Strategy and National Mental Health Strategy which, for the first time, provided digital mental health and psychosocial support services (MHPSS) and youth-friendly care;
- US$180,000 was raised by UNICEF for mental health and psychosocial support (MHPSS) programming in a 12-month period.

8,000 unique downloads and users

US$180,000 raised by UNICEF for mental health and psychosocial support (MHPSS) programming

'UNICEF room' REACHED **239,874 people** on World Mental Health Day

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Lessons learned

1. Conducting behavioural insight and other applied research is crucial for developing quality mental health and psychosocial support programming;
2. It is important to use human-centred design and co-create interventions with representative members of the intended audiences (e.g., adolescents living with mental health issues or conditions)
3. It is important to use a mix of SBC approaches (e.g., advocacy, community engagement, digital apps) to motivate change regarding adolescent mental health, and to normalize psychosocial support for adolescents;
4. Digital solutions (e.g., the 'Tell Me' app) are essential for reaching youth audiences with critical and possibly life-saving mental health information;
5. It is critical to review the evidence of the effectiveness of SBC interventions to determine whether they merit continuation and sustainability.

Recommendations

1. MHPSS programming should involve multiple sectors (e.g., Child Protection, Education, Adolescent Development and Participation, Health) to be most effective;
2. Use social and behaviour change (SBC) approaches to address the self-stigma and normative stigma associated with mental health among adolescents, at multiple levels of the social ecological (SEM) model;
3. Ensure political and financial commitments for adolescent mental health and psychosocial support is in place to implement and sustain key activities.

Endnotes

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UNICEF Georgia Supports Testing SMS Reminders to Motivate HPV Vaccination Uptake

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
2022 to 2023

Duration
Six months

Budget
US$14,000

The HPV vaccine was added to Georgia's national vaccination schedule in 2019. In 2020, the coverage rate among females was 22 per cent for all doses of the vaccine.[1] Human centered design research was conducted to understand the reasons for the low uptake of the HPV vaccine. The behavioural insights from the research suggested that using SMS reminders might increase HPV immunization coverage in the country. A randomized controlled trial was conducted to test four versions of SMS reminder messages to determine which would be most effective in motivating caregivers to bring girls 10—12 years old for the HPV vaccine. The findings from the trial pointed to one message that had the largest positive effect on eligible girls receiving their first dose of the HPV vaccine, relative to the control group. The selected behavioural-insight informed SMS reminder message was mainstreamed as part of Georgia's national system and delivered to caregivers of eligible girls.

Context

Human papillomavirus (HPV) infection is a well-established cause of cervical cancer, and there is growing evidence of HPV being a relevant factor in other cancers. Vaccines against HPV have been in use for 15 years. In 2017, Georgia first piloted the HPV vaccine in three cities, Tbilisi, Kutaisi and Batumi. In 2019, the HPV vaccine was added to the national vaccination schedule. By 2020, the HPV vaccine coverage rate was 19 per cent for the first dose and 22 per cent for the second dose.[2] In 2021, there were 327 new cases of cervical cancer, and 204 deaths from the disease. Georgia has approximately 1.7 million women ages 15 years and older who are at risk for developing cervical cancer. Cervical cancer ranks as the fifth most frequent cancer among women in Georgia and the third most frequent cancer among women 15—44 years of age.[3]

Strategic approach

Between 2020 and 2021, UNICEF Georgia, in collaboration with national health authorities conducted human centered design (HCD) research to understand the reasons for the low uptake of the HPV vaccine. The behavioural insights from the research suggested that using SMS reminders might increase HPV immunization coverage in the country. In 2022, UNICEF Georgia supported a randomized controlled trial (RCT) to test four tailored versions of an SMS message designed to increase uptake of the first dose of the HPV vaccine among Georgian girls 10 to 12 years old. The UNICEF Behavioural Insights Team, in collaboration with the National Centers for Disease Control and Public Health in Georgia, and the Information Technology Agency, Georgia, designed four versions of HPV messages to be tested: (1) Short SMS and no additional information; (2) Short SMS and link to a cervical cancer website (NCDC); (3) SMS, plus link to NCDC, plus a behavioural insight (BI) informed "reserved for her" message; (4) SMS and link to NCDC, plus a BI-informed safety message. These messages were compared to no intervention (i.e., no SMS reminder). The specific SMS messages were:

1. "As per national immunization calendar your daughter is due her free human papilloma virus vaccine, which will protect her against


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cervical cancer. Contact your family doctor today to arrange an appointment."

2. "As per national immunization calendar your daughter is due her free human papilloma virus vaccine, which will protect her against cervical cancer. Contact your family doctor today to arrange an appointment. More information on the official NCDC website."

3. "As per national immunization calendar your daughter is due her free human papilloma virus vaccine, which will protect her against cervical cancer. Her vaccine is reserved at the policlinic. Contact your family doctor today to arrange an appointment. More information on the official NCDC website."

4. "As per national immunization calendar your daughter is due her free human papilloma virus vaccine, which will protect her against cervical cancer. The vaccine has been given safely to more than 118 million girls worldwide. Contact your family doctor today to arrange an appointment. More information on the official NCDC website."

The estimated test pool of girls 10-12 years old that had not received any doses of the HPV vaccine, and whose caregiver's mobile number was in the e-health system, was approximately 50,000. The average number of caregivers associated with a girl was two, and the mean number of individual SMS messages sent to the caregivers was also two. The primary analysis sought to answer the research question of whether each of the designed BI-informed SMS reminders increased the uptake of HPV vaccination among eligible girls, compared to no reminder. The hypothesis was that SMS reminders would increase uptake of HPV vaccination. The trial lasted three months, from September to November 2022. The primary outcome measure was first dose HPV vaccination status 60 days after receiving the SMS reminder.

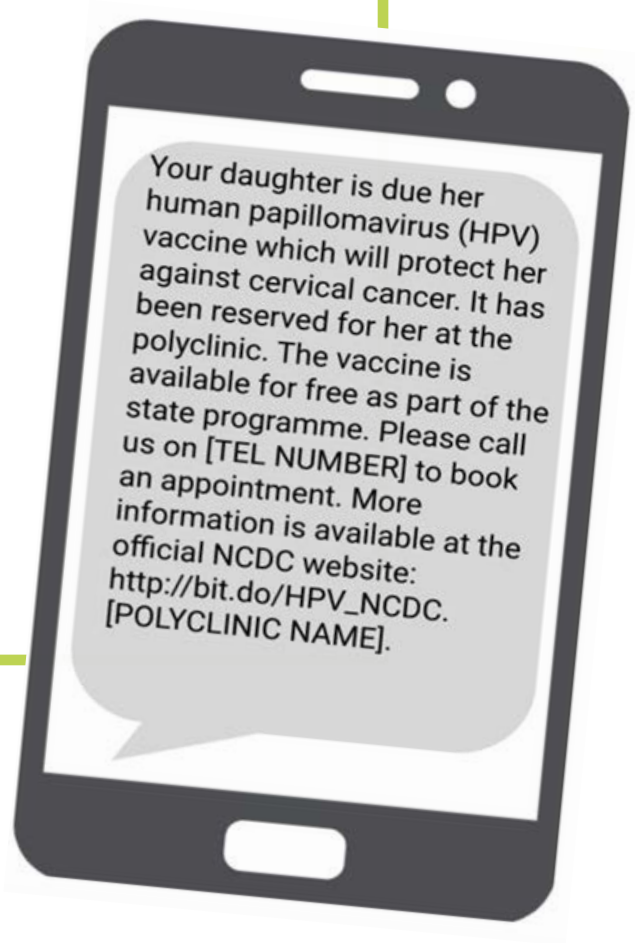
The study results indicated that version three of the SMS reminder ("Reserved for her" framing and the NCDC link) had the largest positive effect on eligible girls receiving their first dose

of the HPV vaccine, relative to the control group. The intervention achieved a 58 per cent relative increase in vaccination compared to the control (no SMS) group, at a cost of only US$0.15 per additional vaccination. The researchers estimated that if all caregivers in the trial had received this most effective message, 488 more girls may have been vaccinated in addition to the 2,077 that received the HPV vaccine during the trial. A secondary analysis of the data indicated that age, total number of SMS reminders sent to a girl's caregiver(s), and region also had a statistically significant impact on HPV vaccination.[4,5]

The researchers recommended that the version three message should be delivered to caregivers of the control group of 10—12 year old girls, and those still unvaccinated from the other RCT groups (i.e., the caregivers of all girls in the sample who have not yet received the HPV vaccine), and caregivers of future cohorts of 10—12 year olds, as they become newly eligible for the HPV vaccine (i.e., on their 10th birthday). UNICEF advocated with the Georgian government to include the SMS message as part of the e-health reminder system.

Key achievements

In 2022, the selected BI-informed SMS reminder message (version three) was mainstreamed as part of the national health system (NCDC) and delivered to caregivers of eligible girls. The HPV vaccine information on the NCDC website was updated, and a list of health facilities that provide the vaccine was added.



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58%

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50,000

girls 10—12 years old that had not received any doses of the HPV vaccine were reached

UNICEF advocated with the Georgian government to include the

SMS MESSAGE

as part of the e-health reminder system

Lessons learned & Recommendations

1. **Obtain and maintain an up-to-date and accurate set of caregiver contact details for SMS-based interventions.** The more valid caregiver contact numbers that the NCDC database had for each girl, the more likely she was to receive the vaccine.

2. **Tailor SMS reminders.** The study findings showed that it is important to test variations of key messages to determine which type of message will be most effective in motivating the intended audience to practice the intended behaviour.

3. **Address more than one key barrier to vaccination.** The SMS reminders were designed to directly address only one of the key barriers to uptake of the HPV vaccine among 10—12 year-olds in Georgia. Uptake of the vaccine could be further improved by policies or interventions that address other barriers, such as caregiver concerns about vaccine quality, inconvenient appointment times, and clinicians lacking both the necessary information and motivation to encourage uptake.

4. **Include more groups in SMS reminders.** There were no reminders for caregivers of girls 13—18 years old. SMS reminders should be sent to caregivers of girls in this age group.

5. **New SMS reminders should be tested** to find new messages that would boost uptake of the vaccine. The "Reserved" message should be used as part of the NCDC alert systems; it should be evaluated against existing NCDC messages to build evidence for the effectiveness of this type of framing for other childhood vaccinations.

Endnotes

1 The HPV vaccine was not introduced or available for males in Georgia.

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4 UNICEF Behavioral Insights Team, *Design and test of SMS reminders to increase demand for HPV immunisation in Georgia: Final report, January 2023.*

5 For the full set of results for this study, see: UNICEF Behavioral Insights Team (January 2023). Design and test of SMS reminders to increase demand for HPV immunisation in Georgia: Final report, January 2023.

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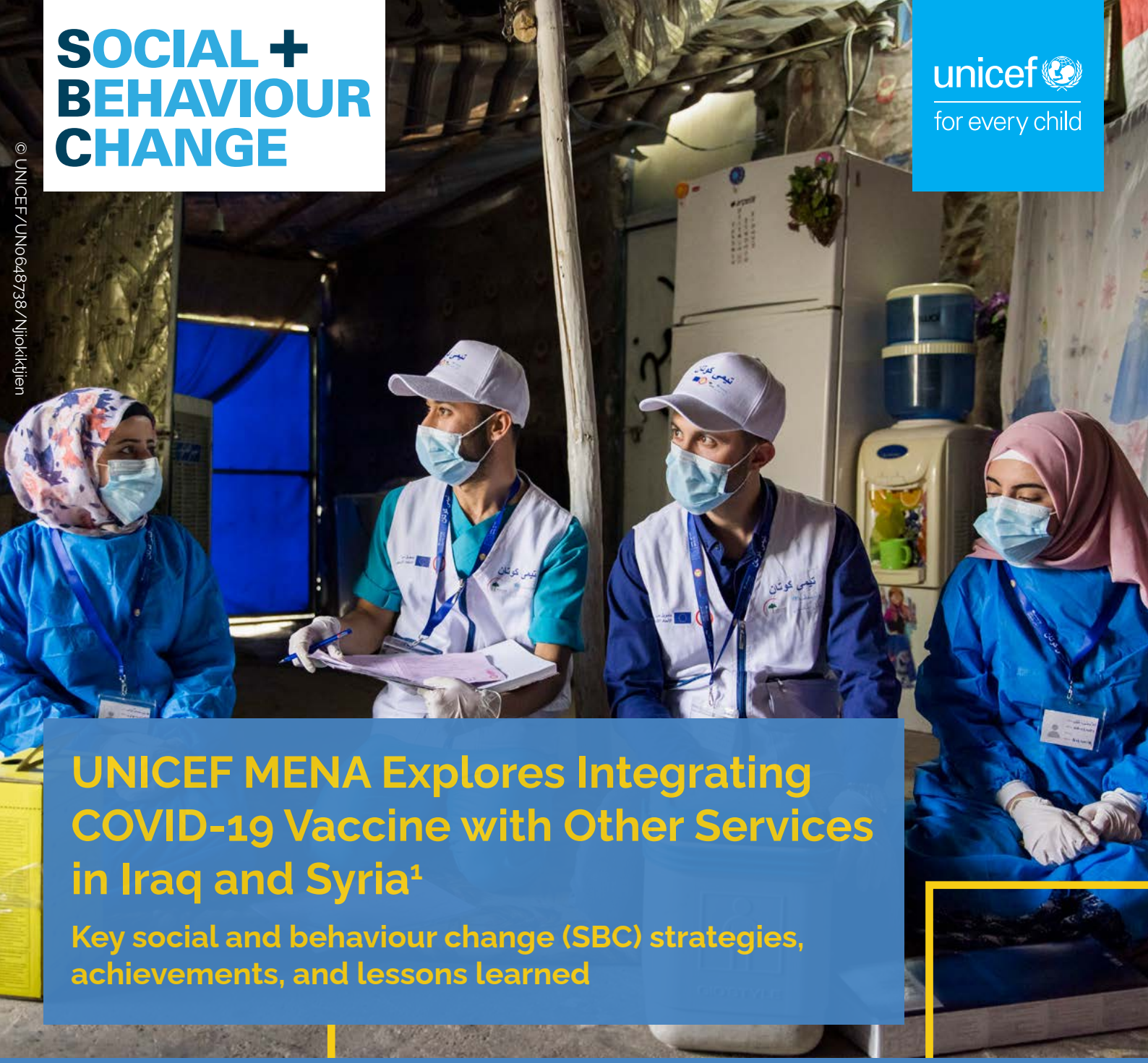

UNICEF MENA Explores Integrating COVID-19 Vaccine with Other Services in Iraq and Syria[1]

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

To increase COVID-19 vaccination rates, UNICEF MENA tested integrating COVID-19 vaccination into other types of health care services (e.g., primary health care; chronic disease care; maternal and newborn health care; WASH, education). Iraq integrated COVID-19 vaccination with routine child immunisation through mobile outreach initiatives and implemented the Intensification of Integrated Immunisation Services (3iS) campaign in all Departments of Health in Iraq and in 94 per cent of districts across the country. In Syria, COVID-19 vaccination was integrated with routine immunisation, the School Health Programme, Back-to-School campaign, and Children with Disabilities Programme. Insights from a review of the integration approaches showed that models of integration should be tailored to a specific group, location, and context.

Context

MENA is a region of multiple, protracted, and large-scale crises. At the end of 2021, the region was home to 16 million forcibly displaced and stateless people, many of whom live in vulnerable and hard-to-reach settings.[2] Many countries experience ongoing violence and fragile governance, and there are shortages of medical equipment and physicians, WASH services, and health infrastructure. People grapple with hunger, unemployment, poverty, and other immediate threats daily, meaning that COVID-19 and the COVID-19 vaccination are not at the top of their list of priorities or concerns.

To increase COVID-19 vaccination rates, there is a need to make the process as effortless as possible, bringing COVID-19 vaccines directly to people across the region. Countries in the MENA region are beginning to integrate COVID-19 vaccination with other services. This integration is mostly occurring with routine immunisation (RI) for children. There are limited documented examples of integration with other services. Iraq integrated COVID-19 vaccination with routine child immunisation through mobile outreach initiatives. In Syria, COVID-19 vaccination was integrated with routine immunisation, the School Health Programme, Back-to-School campaign, and Children with Disabilities Programme.

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Strategic approach

Iraq

In February 2022, UNICEF Iraq initiated the Intensification of Integrated Immunization Services (3iS) campaign. The five key objectives of the campaign were to (1) accelerate control of COVID-19 by improving COVID-19 vaccine uptake, particularly among hard-to-reach groups; (2) reduce the probability of VPD resurgences; (3) bridge coverage gaps and reach children who had not received a single dose of routine vaccines; (4) raise public awareness about the risks of COVID-19 and other diseases; and (5) strengthen ties between health systems and communities.[3] The campaign had a national framework, timeline, and reporting channels so the impact can be measured across the whole health system, but with a bottom-up microplanning approach. The campaign was implemented in all Departments of Health in Iraq, and in 94 per cent of districts across the country. It covers 1,320 sites in 1,064 Primary Health Care Centres (PHCCs), with around 7,000 visits per month nationwide.

One outreach team was created for each of the selected PHCCs. Each team consisted of six members: one RI vaccinator, one COVID-19 vaccinator, two logbook registrars, one IT officer, and one health promoter or community mobiliser. Teams carried all routine antigens and three types of COVID-19 vaccine and were trained on their use. Often, the teams incorporated people with experience working on national polio and measles campaigns. These teams visited specific communities with a mobile clinic or set up a vaccination point in a village 'health house,' shrine, or public park. The community mobiliser then walked through the locality talking to families about vaccination, answering their queries, attempting to build trust, and encouraging them to visit the mobile clinic. The teams visited schools, universities, shopping centres, and other key local sites. Sometimes, the community mobiliser went house-to-house, identifying unvaccinated people and talking to them about routine and COVID-19 vaccination before the vaccination team visited the house. The community mobilisers and other team members were familiar with the context of the local area and know the community leaders and other influencers. They involved community leaders, both male and female, religious leaders, and health workers in awareness sessions and encouraged them to talk to their neighbours about vaccination. The community mobilisers were trained on interpersonal communication and key messages, which they delivered using culturally specific job aids (videos, flip charts, and interactive materials).

Different approaches were used for different settings and population groups. For example, IDP and refugee camps usually had established, well-frequented clinics run by community health workers, which offered nutrition, maternal and newborn health, and immunisation services. A COVID-19 vaccination team was added to the clinic. The community mobiliser went tent-to-tent making people aware of the COVID-19 vaccination services available at the clinic. Women were sometimes reached through home visits, since they were less likely than men to be accessible outside the home. Teams connected with local people to find out how to reach women that did not have children. Most teams had at least one female vaccinator dedicated to work with women. In remote and hard-to-reach areas, the team communicated with the local population beforehand about when and where they would be arriving, or alerted caregivers listed on their database via SMS or phone. Some villages had permanent health houses where two health workers were stationed. The health workers informed the population that a vaccination team would be arriving, and the outreach team set up their clinic in the health house on arrival.

The Ministry of Health (MoH) and Department of Health (DoH) in each area carried out monitoring and supervision at national, provincial, district, and local levels, sometimes accompanied by UNICEF and WHO staff. The campaign had its own data submission channel. At the end of each month, it was possible to see exactly how many people had been vaccinated through the campaign and how many through service delivery at health facilities. Although the campaign was national, partners working on the campaign described an approach that is bottom-up and flexible, with input from the service points whose personnel were familiar with the needs of the local population. DoH managers had decision-making capacity about the approach taken in their province, which allowed them to use MoH and DoH statistics to decide which localities or population groups to target and how. Teams may engage with women's groups, religious leaders, medical students' groups, or youth groups as entry points, depending on the demographics and needs of each locality.

Syria

In Syria, COVID-19 vaccination was integrated with routine immunisation, the School Health Programme, Back-to-School campaign, and Children with Disabilities Programme. It was also integrated with Risk Communication and Community Engagement (RCCE) interventions relating to both COVID-19 and routine immunisation. Mobile vaccination teams paired with implementing partner health promotion teams (such as Syrian Arab Red Crescent – SARC) and Directorate of Health communications teams to deliver both awareness activities and vaccines to people where they need them. This approach was successful in some governorates (e.g. Deir ez-Zor), where most of the people involved in the awareness activities subsequently chose to get vaccinated. The teams conducted household visits and community dialogues involving healthcare professionals and influential people, and people had the option to be vaccinated immediately after the dialogues.[4]

Evidence collected through Knowledge, Attitude and Practice (KAP) studies, social listening exercises, and community engagement mapping exercises was used to tailor interventions to different locations and population groups based on their situation and needs. For example, in Homs, a group of medical and science undergraduate students known as 'hakeem (doctor) teams' engaged in science-based dialogues on the importance of COVID-19 and routine vaccination, working to build trust among high-risk groups including health workers, the elderly, refugees, and people with comorbidities. In Northeast Syria, governorate-specific demand generation strategies were used to counter misinformation and confusing health guidance. This included engaging religious leaders from mosques and churches, working with women, especially in camps populated by people of various nationalities, and featuring community influencers in social media videos and campaigns.

The integration of RCCE teams with vaccination teams resulted in an increase in demand for COVID-19 vaccines, particularly in Al-Hasakah governorate. The process was facilitated by strong coordination between UN agencies, NGOs, camp management and directorates of health.[5] Challenges to integration included a preference among the population for certain vaccines, such as Astra Zeneca, which were not always available, low prioritisation of COVID-19 vaccination among communities, limited resources, including health workers, health infrastructure, electricity and water, and logistical challenges of ensuring availability of, delivering, and storing both COVID-19 vaccines and routine childhood vaccines, as they cannot use the same cold chain. An additional challenge was the extremely low uptake of COVID-19 vaccines among health workers, who are highly influential on the population.[6] Challenges differed according to the context of each governorate. For example, in Homs there was constant movement of people in border areas, in Northeast Syria people are dispersed in small, sporadic villages, and in Deir ez-Zor, sandstorms hampered campaign days.[7]

Key achievements

Iraq

In February 2022, 207,276 COVID-19 vaccines and 381,585 routine vaccines were administered through the 3iS campaign in Iraq.[8] Between February and May 2022, the percentage of COVID-19 vaccines administered through the 3iS campaign averaged monthly 20.5 per cent of all doses administered in the country, indicating that the campaign was not insignificant on a national scale.[9] The 3iS campaign also made a strong contribution to improving RI coverage. For example, the percentage of children vaccinated through the campaign as compared to through other strategies in February 2022 was 27 per cent for OPV3, 20 per cent for Penta1, 30 per cent for Penta3, and 37 per cent for MMR1.20. Despite the apparent overall success of the 3iS campaign, partners have noted that it seems to have been somewhat less successful for COVID-19 vaccination than for RI.

Vaccines administered through the

3iS CAMPAIGN

averaged monthly

20.5%

of all doses administered in the Iraq

The campaign was implemented in all Departments of Health in Iraq, and in

94%

of districts across the country

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Lessons learned & Recommendations

Models of integration should be tailored to a specific group, location, and context.

Iraq

1. The Iraqi MoH, with support from UNICEF, should develop and implement a new, multiyear strategy that focuses on full, long-term programme integration and strengthening health systems. As well as including the COVID-19 vaccine annually in the RI plan under the EPI department, the strategy should move beyond immunisation to incorporate other interventions, including primary health care services such as antenatal care (ANC), postnatal care (PNC), non-communicable disease (NCD) control, and nutrition.

2. Community mobilisation should be a cornerstone of integration efforts in Iraq, using the role of the community mobiliser to create links between communities and the various services available to them, while at the same time building trust and gathering evidence needed to create better interventions in the future.

3. Digitalisation and the electronic reporting of doses given, and eventually the establishment of individual electronic health records, should be incorporated into the approach. Digitalised communications with community members using mobile phone messaging and applications will build on nascent approaches already being introduced.

4. Programme design should consider the context of each location and population group, bearing in mind needs, preferences, and barriers. For example, PHC services such as ANC, delivery care, and PNC are better attended in KRI than in South-Central Iraq. Students in one study in Mosul, Ninawa have been found to prefer to receive awareness through teachers and school-organised campaigns.

Syria

1. Mobile teams should work to raise awareness not only about immunisation, but also about nutrition, education, WASH, and child protection.

2. Integrate COVID-19 vaccination with other planned campaigns (e.g., Measles and Rubella Campaigns).

3. Plan future demand generation interventions that integrate COVID-19 vaccination, routine immunisation, and polio immunisation.

Endnotes

1 Social Science in Humanitarian Action Platform, 'Key Considerations for Integrating COVID-19 Vaccination Services: Insights from Iraq and Syria for the Men Region', SSHAP,<https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/17631/Key%20Considerations_Integrate%20COVID_19%20Vaccination%20MENA%20Insights%20Iraq_Syria.pdf>.

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3 Rahi, A., Hipgrave, D., Al-Mossawi, F., & Kadhim, K., 'Update on Routine and COVID-19 Immunization in Iraq', 2022.

4 Iraqi Ministry of Health, UNICEF, UNHCR, UNFPA Syria, UNDP, & UNRWA, 'Risk Communication and Community Engagement: The need of the hour', 2022, <https://reliefweb.int/report/syrian-arab-republic/risk-communication-and-community-engagement-need-hour>.

5 Ibid.

6 United Nations Human Rights Council, 'Middle East and North Africa. Global Report 2022', UNHCR, 2022, <http://reporting.unhcr.org/mena>.

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UNICEF Sudan Uses Social Listening to Promote COVID-19 Vaccine Equity

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

UNICEF Sudan used social listening to gather data about gender-based perceptions of the COVID-19 vaccine. This data was used to develop tailored COVID-19 vaccine promotion messages disseminated via social media and during community engagement activities such as group meetings and home visits by health promoters. The social media campaign included testimony and advice from medical experts such as gynaecologists. TV and radio messages focusing on pregnant and lactating women were also broadcast. A factsheet for women was developed, pre-tested and disseminated. Vaccines were delivered in fixed sites such as health facilities, temporary or mobile sites such as mosques, and through outreach services in hard-to-reach areas and frequently visited spaces such as marketplaces. Real-time monitoring and feedback from online and offline sources allowed for ongoing analysis and data on gender-related barriers. Social listening enabled a sound understanding of the needs of both women and men in information and demand creation and service delivery and became a valuable tool to learn, adapt and improve programming to overcome gender disparities in information dissemination, feedback and monitoring.

Context

Sudan was the first country in the Middle East and North Africa (MENA) region to receive the COVID-19 vaccine through the COVAX initiative. Vaccine rollout began in March 2021. Health workers, the elderly and those with underlying conditions were the first to receive vaccines. UNICEF Sudan and its partners supported the rollout nationwide, including for refugees and migrants. Initially vaccination was offered at primary health centres in Khartoum State and then expanded gradually across all 18 states. Both women and men feared the side effects of the COVID-19 vaccine and conspiracy theories, such as claims that the Western world was trying to reduce fertility rates, circulated through communities.

Miscommunication over government criteria for vaccine eligibility caused confusion among, for example, pregnant women and lactating mothers who were eligible but did not know it because it was not communicated clearly to all vaccinators. An initial round of COVID-19 vaccine promotion messages from Sudan's Federal Ministry of Health (FMoH), supported by UNICEF, did not address women's need for gender-specific information about effects of the vaccine on their reproductive health. Social listening[1] on COVID-19 reporting, rumour tracking dashboards, the frequently asked questions on the FMoH website, and feedback from field-based teams, revealed that women were concerned primarily about their fertility, the health of their unborn babies, and the safety of the vaccine during menstruation, pregnancy, and lactation. Men were also concerned about fertility.

Social listening is part of the UNICEF Voice and Space Initiative (VASI), an inclusion platform that promotes the voices of marginalized groups. VASI aims to create an integrated evidence generation and feedback system using community and digital engagement tools to make rights-holders aware of their rights and engage them in the change process. VASI works in conjunction with other digital (online) and community engagement (offline) tools such as Community Voice, U-Report and Rapid-Pro, and integrates Accountability for Affected Populations, risk communication and community engagement (RCCE), community-based feedback and monitoring.

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Strategic approach

The intervention drew on data captured through the Talkwalker application which UNICEF Sudan has been using since August 2021. UNICEF Sudan partnered with the Ministry of Health to coordinate the social listening component. Key words and topics (e.g., COVID-19, handwashing, and face masks) featuring on social media feeds were entered into the system and tracked, generating a dashboard that was monitored weekly. Findings from the Talkwalker dashboard were shared on a monthly basis at national technical committee and coordination meetings. Social listening informed gender-responsive messaging, provided a space for women and men's concerns to be voiced, addressed vaccine hesitancy and resulted in enhanced female engagement on social media. The intervention focused on understanding gender-specific barriers and rapidly responding to them to promote vaccine equity. Women were able to share their questions and fears and receive accurate information.

To address both women's and men's concerns, UNICEF Sudan launched a social media campaign. The social media posts were designed based on insights from social listening. Four gender-oriented messages were produced and disseminated via Facebook, Twitter, and Instagram accounts. The first set of messages emphasized vaccine safety during pregnancy, reiterated that there is no scientific proof that the vaccine adversely affects women, reassured women that they can have healthy babies and stressed that the antibodies in the vaccine do not affect fertility. Messages also emphasized that the vaccine is safe during menstruation and there is no need to delay vaccination due to menstruation or lactation. The social media campaign included testimony and advice from medical experts such as gynaecologists. TV and radio messages focusing on pregnant and lactating women were also broadcast. A factsheet for women was developed, pre-tested and disseminated.

Community engagement activities such as group meetings and home visits by health promoters (mostly female) aimed to reach those left out of the social media campaigns and to reinforce messages for those who may have limited internet access. Orientation sessions for women were also conducted at the health centres and in communities. The male engagement component of the outreach strategy leveraged the social influence of religious leaders such as Bushara Abdallah Bushara from North Darfur, for disseminating messages about vaccine safety and addressing rumours and misinformation. The religious leaders stressed that the Ministry of Health would not promote something that is not safe and reassured their congregations that vaccines were not forbidden by Islamic law (haram).

In January 2022, vaccines were delivered in fixed sites such as health facilities, temporary or mobile sites such as mosques and through outreach services in hard-to-reach areas and frequently visited spaces such as marketplaces. The local Expanded Programmed on Immunization (EPI) team decided whether to mobilise a male or female vaccinator depending on the location and acceptability of male vaccinators. Female vaccinators were well accepted by their communities and their families were used to them traveling to remote places and working for long hours. Female vaccinators rotated remote visits among themselves, so they do not have to be away from their families for extended periods. Families were more accepting of male vaccinators if they spoke the local language and belonged to the community.

The real-time monitoring and feedback from online and offline sources allowed for ongoing analysis and data on gender-related barriers. Social listening enabled a sound understanding of the needsof both women and men in information and demand creation and service delivery and became a valuable tool to learn, adapt and improve programming to overcome gender disparities in information dissemination, feedback and monitoring.

Key achievements

- As part of COVID-19 RCCE efforts, UNICEF and partners reached over 16 million people through a variety of platforms.
- More than 90 per cent of participants in a survey conducted by UNICEF Sudan demonstrated sufficient knowledge about symptoms, transmission of, and precautions against COVID-19.[2]
- Vaccine coverage increased from six per cent to 12 per cent of the target of vaccinating 20 per cent of the population by June 2022.
- Data from the Sudan dashboard on social listening (Talkwalker) showed an increase of 144 per cent in overall engagement during the campaign, with sharp rises in female engagement after gender-responsive messaging. In August 2021 engagement was 31 per cent female, 69 per cent male. Following the gender-oriented social media campaigns from September to October 2021 and from January to February 2022, female engagement increased to over 40 per cent.

INCREASE OF 144% in overall engagement during the campaign

Following the gender-oriented social media campaigns, female engagement increased to **OVER 40%**

MORE THAN 90% of participants demonstrated sufficient knowledge about symptoms, transmission of, and precautions against COVID-19

Lessons learned

1. **Social listening enabled the campaign to provide tailored and gender-sensitive information to women.** Rapid real-time feedback and the large-scale tracking of feedback and data from the state to the federal level can be time consuming and opportunities for timely adaptations or improvements may be missed. Without social media, this scale of coverage and feedback would be resource-intensive.

2. **Having disaggregated data on gender, age, education, disability, ethnicity, geographical location and socio-economic status of social media users would help to better tailor key messages.** Social media engagement favours those who are literate and have access to social media and technology. Disaggregated data on gender, age, education, disability, ethnicity, geographical location and socio-economic status were unavailable in Sudan.

3. **Building the capacity of national partners to institutionalise and scale up social listening is required to sustain momentum and provide longitudinal data on a regular basis.** Strengthening systems for real-time feedback to be generated and analysed can improve programmes and enhance community engagement.

Recommendations

1. Integrate the offline and online listening and add the same level of rigour and systematic tracking for the offline component.

2. Use social listening to provide more insights on multiple dimensions of women's lives in order to address specific gender norms and harmful practices, and tailor messages that meet women's needs.

3. Social listening and social media could be used to promote broader behaviour change initiatives and gender transformation by triggering conversations around gender equality and challenging inequitable norms.

Endnotes

1 Social listening, also referred to as social media listening, is the process of identifying and assessing what is being said about a topic, product or brand on the internet.

2 United Nations Children's Fund, *Health Annual Report.* UNICEF Sudan 2021, <www.unicef.org/sudan/media/8526/file/UNICEF%20Sudan-Health-%20Report%20(2021).pdf>.

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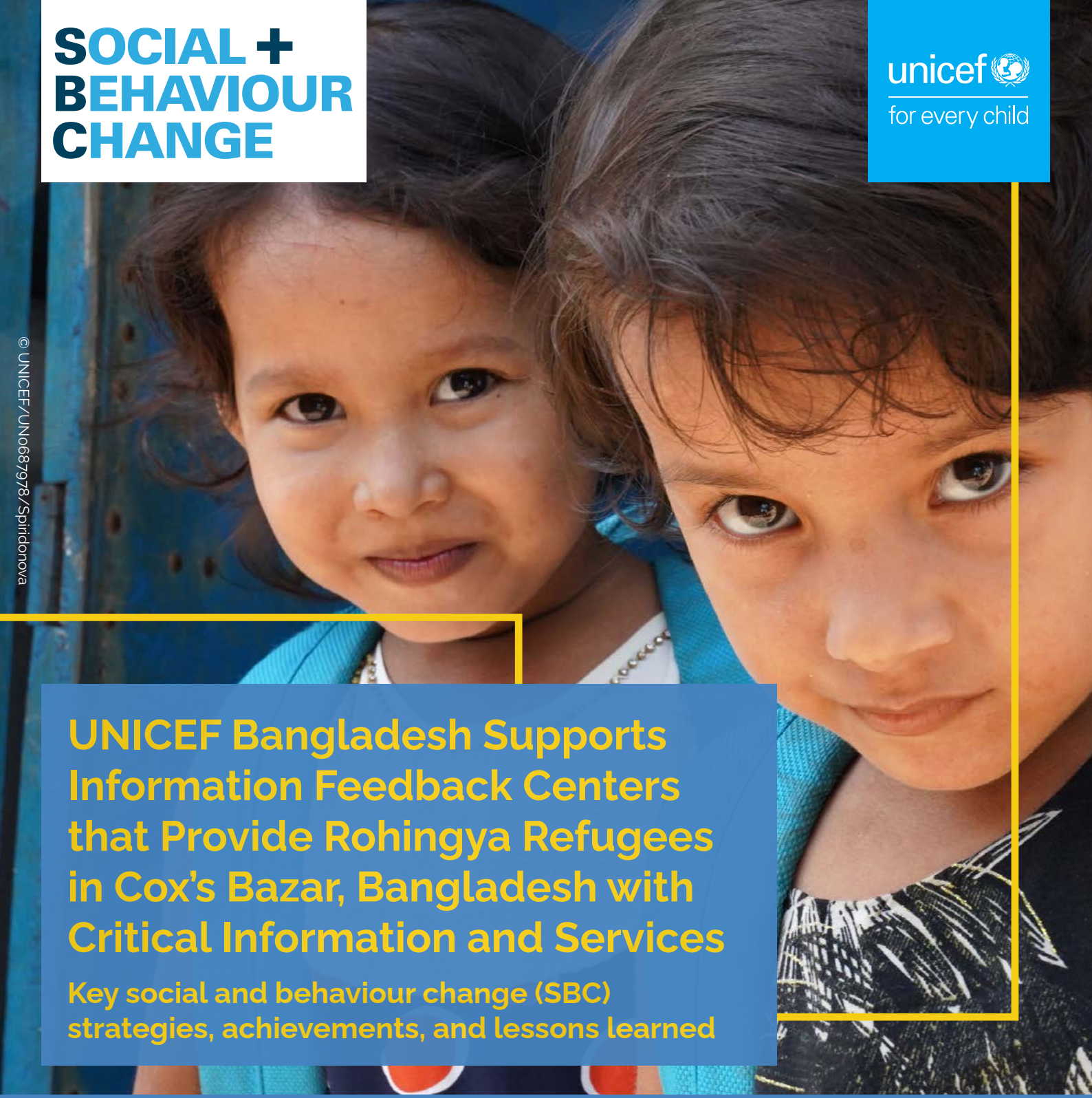

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UNICEF Bangladesh Supports Information Feedback Centers that Provide Rohingya Refugees in Cox's Bazar, Bangladesh with Critical Information and Services

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

In close partnership with local NGOs, UNICEF Bangladesh established information and feedback centres (IFCs) in key locations throughout refugee camps and host communities in Cox's Bazar to serve Rohingya refugees from Myanmar. IFCs provide information and referral to available services, and receive and respond to community complaints, feedback and queries (CFQs) via two-way, face-to-face interactions with community members. Community volunteers provide outreach and dialogue. UNICEF Bangladesh also supports satellite activities that serve to provide correct and timely information to the Rohingya population. The IFCs have proven to be a good way to achieve accountability to vulnerable populations and respond to UNICEFs commitment to supporting accountability to affected populations.

Context

In August 2017, 740,000 Rohingya people, including 400,000 children, fled from violence in Myanmar into Bangladesh.[1,2] They live in temporary shelters in highly congested refugee camps in Cox's Bazar, one of the poorest and most disaster-prone districts in Bangladesh. Annual cycles of heavy monsoon and cyclones pose substantial risks to both Rohingya refugees and host communities. The Rohingya rely entirely on humanitarian assistance for protection, food, water, shelter, and health. While basic services have been provided to them, children still face disease outbreaks, malnutrition, inadequate educational opportunities, and the risks related to neglect, exploitation and violence, and child labour. Girls and women are at particular risk of sexual and other gender-based violence in the camps. Twenty-three per cent of girls and 57 per cent of women feel unsafe when using latrines. Over 40 per cent of children under five years are stunted. Unaccompanied and separated children are at high risk of trafficking, early marriage, and sexual exploitation.[3]

Thirty-nine per cent of children and 97 per cent of adolescent refugees, lack access to education.[4] Girls are often kept out of school by parents trying to keep them safe. Older children and adolescents who are deprived of opportunities to learn or make a living are at real risk of becoming a 'lost generation,' ready prey to traffickers and those who would exploit them for political or other ends.[5]

Together with government and other humanitarian partners, UNICEF immediately responded to provide life-saving assistance and protection to the newly arrived Rohingya children and their families, also taking a lead role in health, nutrition, water, sanitation, and hygiene (WASH), child protection, and education. The majority of the newly arrived Rohingya refugees, however, were not aware of the humanitarian services available, and frontline workers and service providers had difficulty reaching out and making referrals in the camps and makeshift settlements. Refugees seeking accurate and timely information about their situation and surroundings did not know which sources were credible, and did not feel heard when they reported that the aid they were receiving was insufficient. There was no feedback mechanism to record complaints about aid, sexual harassment, and other injustices in the settlements.[6]

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Strategic approach

To respond to the needs of the Rohingya in Cox's Bazar, UNICEF and partners (e.g., NGO PULSE) established information and feedback centres (IFCs) in critical locations across the camps. The IFCs improve accountability to the refugee population and provide a two-way information flow through face-to-face interactions with community members. At the IFCs, Rohingya are able to learn about emergency preparedness, gender equality and safe environments for women and girls, file complaints, and obtain answers to any pressing questions, and receive referrals to services. IFC staff conduct sessions to demonstrate and practice positive behaviours. Public service announcements are initiated from the IFCs about, for example, nutrition action weeks, vaccination campaigns, and cyclone preparedness. The centres have become 'safe spaces' where vulnerable individuals could go for protection.


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The learning centres provide early education to children ages 4 to 6 years, and non-formal basic education to children ages 6 to 14 years. There are three shifts in each learning centre, with each shift accommodating 35 children. Children learn English, Math, Burmese, Science, Arts and Anthems. Children receive psychosocial counselling and are taught hygiene and life skills. The children are given books, pens, colouring pencils, school bags and other educational materials.

The first two centres were formed in September 2017, during the first weeks of the crisis, and began providing life-saving information and on-site referral for urgent services, including nutrition, WASH, medical help, hygiene behaviours, vaccination campaigns, and child and newborn care. As the crisis worsened within the camps, UNICEF supported new IFCs in order to increase referral capacity. By June 2019, 20 IFCs were established, linked to a network of 300 community mobilisers (volunteers) from Rohingya and host communities in Cox's Bazar.[7] The community mobilisers include 120 Model Mothers, 120 Model Youth Mobilisers, who conduct outreach and collect information within their community, for example convening community dialogue sessions. Each IFC has 13 Model Mothers and 12 Model Youth Mobiliser. These volunteers receive training in interpersonal communication, capacity building, and a communication package.[8] The mobilisers are each expected to contact 15 families per day for engagement and consultation. An average of three to five family members participate during an interpersonal communication session, which lasts approximately 20–35 minutes, depending on the nature of the messages or dialogue and the demonstration required.[9]

The IFC staff, known as information service providers (ISPs), keep logbooks (now digitised via Open Data Kit using tablets and available

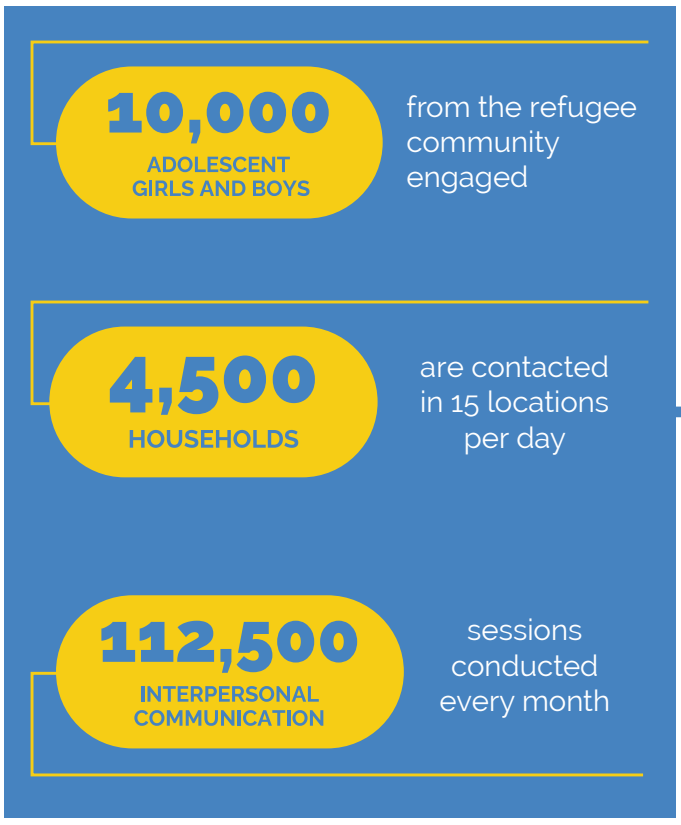
on a dashboard) to document the feedback received from the refugee population, as well as maintain sociodemographic information about the community. Standard operating procedures (SOPs) were developed by UNICEF to facilitate follow-up in response to the feedback. Complaints that cannot be addressed on site by service providers or site management focal points are elevated to the relevant supervisor of the respective agency at Cox's Bazar. The feedback loop is closed once the response is communicated back to the community. Community members are informed in all cases.[10]

UNICEF Bangladesh supported satellite activities that also served to provide correct and timely information to the Rohingya population. For example, conducting outreach with local leaders and religious leaders through various advocacy meetings, creating a community mobilisation network of community mobilisation volunteers (CMVs), conducting community dialogues, youth engagement activities, radio distribution, interactive popular theatre shows, community consultation meetings, radio listener clubs and radio programming.

Key achievements

As of May 2019, UNICEF has established 20 IFCs across 4 host communities and 16 camps located in the Rohingya settlements. As of October 2019, the IFCs provided collected about 120,000 individual complaints, queries, and feedback, with a response rate of nearly 100 per cent, significantly improving the responsiveness of service delivery. An estimated 4,500 households are contacted in 15 locations per day, per site, with 112,500 interpersonal communication sessions conducted every month (equivalent to 25 working days). A mapping system has been developed to avoid duplication of messaging and to facilitate tracking and monitoring by the mobilisers. The IFCs and outreach workers have increased trust and responsiveness with Rohingya refugees in Cox's Bazar.[11,12]

Model Mothers and Model Youth Mobilizers have reached 100,000 households with critical information and resources. An estimated 10,000 adolescent girls and boys from the refugee community have been engaged as change agents to provide life-saving information and referrals to services. Another 3,000 adolescent girls and boys from the host communities were similarly engaged. Over 70,000 CFQs were synthesised and forwarded to Sector colleagues to support their interventions across Health, WASH, Nutrition, Child Protection, and Education. The majority of CFQs were health-related. The digitisation has enabled these sectors to access the information in a timely manner.[13]



Lessons learned[14,15]

1. The IFCs have proven to be an effective way to achieve accountability to vulnerable populations and respond to UNICEFs commitment to supporting Accountability to Affected Populations.

2. Engaging communities in face-to-face dialogue is especially important when, like the Rohingya, the population has a high level of illiteracy and there is no written script for the language. Development of user-friendly, image-focused behaviour change materials has enabled the Model Mothers and youth volunteers to engage communities in dialogues.

3. Regular capacity-building for the ISPs that staffed the IFCs, including training on interpersonal communication and the prevention of sexual exploitation and abuse (PSEA), among other topics, has enabled more robust programming and quality assurance.

4. Promoting the use of IFCs through outreach workers within communities is essential to their success.

5. IFC staff need to build strong relationships with camp service providers. Investments must be made early on for systematic recruitment and training of IFC staff. This is essential to the quality of IFCs and service referrals.

6. Standardisation of response systems is essential to maintaining the quality of information dissemination and service referrals across all IFCs.

7. Staffing the IFCs with volunteers and outreach workers who are from the community themselves greatly increases credibility, acceptance and trust of information and service referrals. Recruitment strategies must be carefully considered, accounting for gender and the local sociocultural milieu of the refugees. For example, in Cox's Bazar the majority of the volunteer mobilisers and outreach workers are female. This can sometimes create pushback in the community where women are not allowed in certain spaces, or men find themselves without jobs. Similarly, if female adolescents are recruited, their safety and security need to be carefully considered.

8. The use of multiple communication devices and creative tools, such as tablet computers, wind-up radio sets, information leaflets, and visual materials, are an effective component of the IFC response.

9. Digitising CFQs and feedback collected at IFCs facilitates rapid data entry and retention and improves analysis and information sharing, thereby increasing the efficiency of the response at multiple levels. Such an initiative also introduces new challenges and priorities related to risk management and data protection, which needs to be addressed by appropriate data security and oversight mechanisms.

10. The success of the IFCs should be gauged by actions taken by responders and service providers to modify their strategies, delivery mechanisms or supplies based on feedback received from the communities. Closing the loop on the CFQs is essential and requires that the data generated through the digital databank is routinely fed back to responders who make decisions and provide services.

Recommendations

1. Instantaneous and broad dissemination of digitised information and data to other sectors/clusters for a more timely and efficient response remains a key challenge to be addressed. Consultative efforts should be made at the start for building ownership and action from other agencies and sectors/clusters.

2. Surveys and other data collections tools should be used as feedback mechanisms to further strengthen accountability to the affected population and assess the community's satisfaction with the services delivered by IFCs.

3. Consolidating the approach of different agencies in the use of a common agreed-upon mechanism for data collection and analysis would greatly enhance both coordination and the humanitarian response.

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1 United Nations High Commissioner for Refugees, 'Refugee Response in Bangladesh', UNHCR, 30 September 2019, <https://data2.unhcr.org/en/situations/myanmar_refugees>.

2 United Nations Children's Fund, *Rohingya emergency response: Information feedback centres strengthen community feedback mechanisms*, UNICEF Bangladesh, 2017, <https://aa9276f9-f487-45a2-a3e7-8f4a61a0745d.usrfiles.com/ugd/aa9276_874631420f584b0f899db09c463161ba.pdf>.

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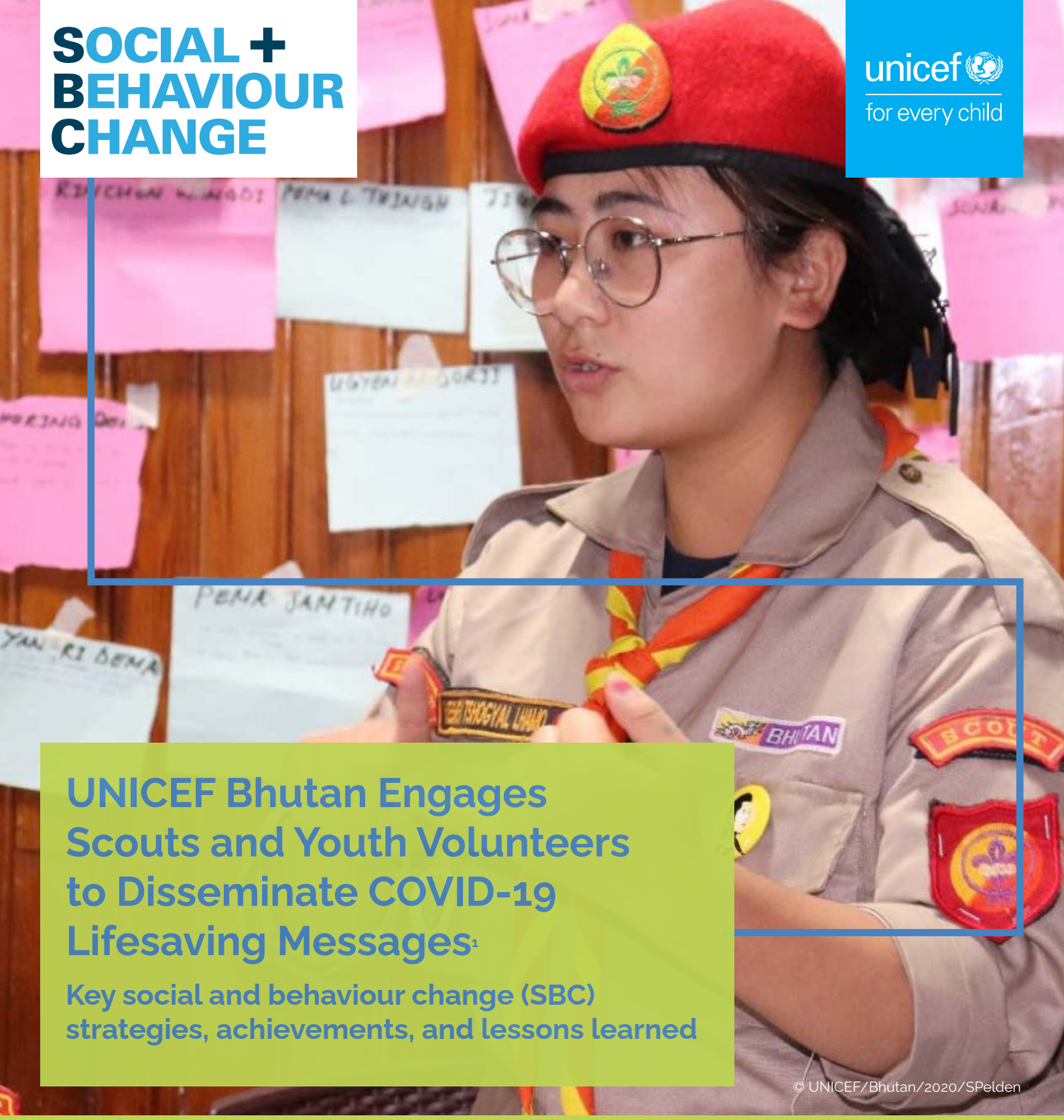

UNICEF Bhutan Engages Scouts and Youth Volunteers to Disseminate COVID-19 Lifesaving Messages[1]

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

UNICEF Bhutan, in collaboration with the Ministry of Health, supported leveraging more than 800 leadership scouts and youth volunteers in 17 districts to play a catalytic role in supporting their communities during the COVID-19 pandemic. The country's Risk Communication and Community Engagement (RCCE) response to the pandemic focused on engaging scouts and youth volunteers to raise awareness about the disease and disseminate messages on how to prevent becoming infected within schools, in communities, and as patrols in marketplaces. The scout leaders reached an estimated 8,000 young people across the target districts.

Context

In March 2020, the first COVID-19 case was detected in Bhutan. With a total of 863 confirmed cases by December 2020. While Bhutan's Covid-19 infection rate did not have a severe impact on the health system as compared to other countries, social vulnerabilities and economic losses were felt across different sectors and communities. Since Bhutan has a significantly young population, with sixty per cent being below the age of 25 years, the country's Risk Communication and Community Engagement (RCCE) response focused on leveraging the positive enthusiasm and drive of young people to accelerate community-based interventions to help solve some of the pressing challenges brought forth by the pandemic.

The RCCE response, led by the Bhutan Scouts Association (BSA) of the Ministry of Education and supported by UNICEF and the Ministry of Health, focused on collective youth-based community action. This response prioritised leveraging and building a network of inspiring young change makers and volunteers to help tackle the secondary impacts of the pandemic, such as mental health, economic stress, social stigma, gender-based violence, child protection issues, and socio-political strain. There were about 1,700 scout leaders and 59,000 scout members within the BSA structure across 20 districts in Bhutan.

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Strategic approach

From the outset, Bhutan's RCCE strategy was informed by evidence emerging from a Rapid Pulse Survey and U-Report data. The survey was designed to gain deeper insights into Bhutan's remote communities' perceptions. The main objectives of the survey were to assess the reach and clarity of COVID-19 prevention messages in remote communities and evaluate knowledge levels related to preventive measures. The survey findings indicated that while communities had sufficient access to COVID-19 messaging and information, there was a need for personalized engagement and interaction to address concerns, narrow the informational gap, and translate the knowledge to actionable community responses. The U-Report data allowed for an understanding of the deeper impacts of the pandemic on young people and children, especially vis-à-vis their home-schooling journey during the initial lockdown.

The Government of Bhutan's partnership with young scouts through the Bhutan Scout Association (BSA) was facilitated by UNICEF Bhutan and stood out for its uniqueness, and for accelerating community outreach in remote areas across the region. UNICEF partnered with the Ministry of Health and Department of Youth and Sports to engage and empower adolescents as change-makers and leaders for creating awareness about such emerging pandemic-related issues as domestic violence, sexual harassment, and mental health, in their communities. The young scouts were oriented on how to effectively and empathetically engage with their communities, disseminate critical information on COVID-19 prevention behaviours (e.g., social distancing, hand washing, cough etiquette, and quarantine/isolation), and develop social innovation projects, in a two-day session in June 2020. This training enabled and empowered scouts to develop tailored interventions for their communities.

Following the training, scout leaders developed and implemented community-based COVID-19 related activities. For example, in remote areas of southern Bhutan, scout leaders volunteered as teachers in villages that had no access to online learning. As part of the scouting "community service" activities, scout leaders and scouts also volunteered to deliver essential medicines to peoples' homes during lockdown. In Thimphu, scout leaders helped raise awareness at markets about the Druk Trace App, also standing at the front gate of the market and reminding shoppers about social distancing. Scouts patrolled the markets to ensure COVID-19 protocols were being followed. All scouts encouraged community members to appreciate and have gratitude for the frontline workers that were sacrificing themselves for the sake of the Bhutanese people.

The scouts were supported with psychosocial materials and trained to use digital media to supplement their community engagement efforts. WhatsApp and Messenger groups were established for scout leaders and scout secretaries to facilitate communication, feedback, and response. The BSA maintained an official Facebook page and website for information sharing and updates. The BSA also produced a short video (with transcriptions in local dialects) on handwashing and social distancing that was broadcast on national television and shared on the BSA's social media platforms.

Key achievements

- More than 800 leadership scouts and youth volunteers in 17 districts were engaged and participated in the national response efforts playing a catalytic role in supporting their communities.
- The scout leaders reached an estimated 8,000 young people across selected districts.
- The scout intervention was instrumental in supporting the Ministry of Health's objectives of instilling youth-led collective social responsibility and inspiring wider community-level change in remote areas during the pandemic.

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800
leadership scouts and youth volunteers engaged

8,000
young people reached

Scouts across
17
DISTRICTS
participated in national response efforts

Lessons learned

1 **Leveraging youth to reach communities with lifesaving messages can be achieved through existing networks:** Bhutan's scout-led community engagement intervention during the pandemic reflected the compassion, commitment, and enthusiasm of young people to drive social action during crisis. Their engagement showed that catalysing youth networks to be the driving force that shape advocacy and social change initiatives can impact communities.

2 **Youth can be empowered to develop self-directed activities and solutions to health-related challenges:** Training youth to design, develop, and implement RCCE interventions enhanced their civic engagement and help to build resilient, forward-looking young communities.

Recommendations

1 Positioning young people at the epicentre of the RCCE response not just as beneficiaries but as active contributors to meaningful change by involving them as partners and vocal change agents can be instrumental in helping communities find solutions to problems that are impacting them.

2 Formal structures and systems should be developed and regularised to enable sustainable co-working inter-sectoral partnerships with youth-based networks and groups to maximise impact and drive national efforts during COVID-19 recovery and future pandemics.

Endnotes

1 Based on a case produced by the United Nations Children's Fund (UNICEF) Regional Office for South Asia (ROSA).

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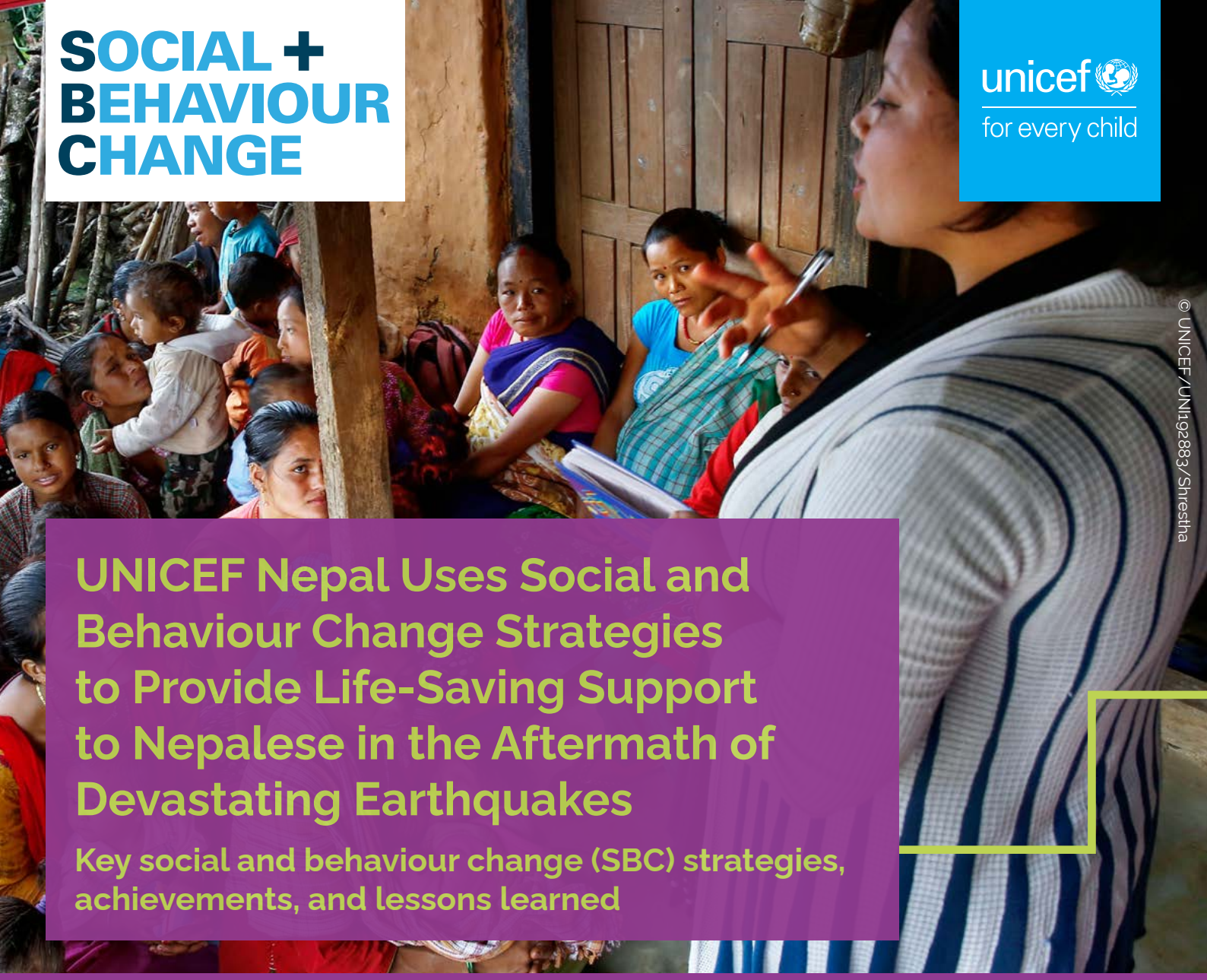

UNICEF Nepal Uses Social and Behaviour Change Strategies to Provide Life-Saving Support to Nepalese in the Aftermath of Devastating Earthquakes

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

In April and May, 2015 devastating earthquakes struck Nepal, killing 9,000 people and injuring more than 100,000 others. A majority of the houses were damaged or fully destroyed, and people, were forced to move to safe spaces or live in makeshift shelters. Much of the healthcare, community, and telecommunication infrastructure were also destroyed. Subsequent landslides blocked major roads and highways, hampering relief agencies and authorities from delivering aid to affected populations. UNICEF Nepal's Communication for Development (C4D) team responded by initiating information dissemination activities via remaining functioning media channels, and collecting feedback on the immediate needs of affected populations. Using social and behaviour change communication strategies, UNICEF Nepal mobilized communities and presented edutainment shows and outreach activities to deliver life-saving messages. During the recovery phase following the earthquakes, the UNICEF Nepal team developed the capacity of civil society organizations to promote positive behaviours with regard to emergency preparedness, preventing human trafficking, and disaster risk reduction. The information, coordination, and feedback mechanisms supported by UNICEF Nepal resulted in building more resilient communities and strengthening the accountability of government and the international community.

Context

The Himalayan region is one of the most seismically active in the world, yet large earthquakes are a relatively rare occurrence. The Gorkha Earthquake in Nepal, with a magnitude of 7.6, occurred on 25 April 2015. Its epicenter was about 47 miles northwest of the capital, Kathmandu. It was followed by more than 300 aftershocks. Around 9,000 people were killed, more than half of whom (55 per cent) were female. At least 100,000 people were injured. Over 500,000 houses were destroyed and another 269,000 damaged, which included historical and cultural monuments. Key infrastructure was also destroyed, as were livelihoods, especially in the agriculture and tourism sectors.[1] On May 12 2015, a magnitude 7.3 aftershock killed more than 100 people and injured nearly 1,900.[2] In total, more than eight million people were affected, and about 2.8 million people were displaced. The earthquakes produced landslides that devastated rural villages and some of the densely populated areas in Kathmandu.[3]

The Nepalese government declared a state of emergency and called on the international community for aide. According to the Post Disaster Needs Assessment by the UN, World Bank and the EU the total value of the damages and losses of the disaster was estimated at US$7.1 billion, while the estimated needs for recovery were US$ 6.7 billion.[4]

Strategic approach

UNICEF Nepal's response in the immediate aftermath of the earthquakes was to engage media channels that were still functional to disseminate life-saving messages, collect feedback on the needs and concerns of affected populations, and provide on-air psychosocial counselling (through call-in radio broadcasts). In the short-term, UNICEF supported the distribution of tents, generators, portable audio recorders, telephone hybrids, laptops and radio receivers, and training for local technicians on repairing damaged radio sets. The long-term plan consisted of training community radio stations on strengthening their disaster risk reduction programming and emergency preparedness response. An initial Communities Working Group (CWC) was established to coordinate communication efforts among relief and UN agencies, international and national non-governmental organizations, media organizations, and community radio operators.[5,6]

A survey of children conducted in the immediate aftermath of the seismic events pointed to the need for psychosocial support to address feelings of loss, fear, grief and sadness. UNICEF Nepal supported the *Bhandai Sundai* (Talking-Listening) radio programme aimed at children, women, and families that did not otherwise have access to direct counselling services.[7] The radio programme was also used to promote a Back to School campaign (e.g., modeling how teachers and administrators should act with children in their first days back to school), Nutrition Week, and the Cash Transfer scheme for earthquake affected families. The success of the *Bhandai*

Sundai programme led to the spin-off *Bhandai Sundai Gaon Gaon Ma* (Talking-Listening in Villages), a traveling edutainment show hosted by popular Nepali celebrities who delivered messages about health, nutrition, sanitation, hygiene, and child protection.[8,9] Partnerships with Radio Nepal and with the Association of Community Radio Broadcasters Nepal enabled community members to call in and provide feedback to humanitarian responders about their needs and concerns.

UNICEF Nepal also partnered with *Yuwalaya*, a youth-led organization with an existing district-based network. Hundreds of youth volunteers mobilized communities to facilitate face-to-face discussions and distribute communication materials and essential rehabilitation supplies. These efforts helped to build resilience in communities and strengthen the accountability of government and the international community.

During the recovery phase following the earthquakes, the UNICEF Nepal C4D team supported the Promoting, Recovery and Resilience Among Earthquake-Affected Communities programme, comprised of (1) capacity building activities for civil society organizations (CSOs), community groups, and youth, and (2) broadcasting an edutainment radio drama series, *Milan Chowk* (the name of an imaginary village in Nepal). Individuals from the key organizations and youth networks were trained to disseminate critical information, track community perceptions and needs, and develop community action plans, and create mechanisms for community feedback and accountability by those in responsible positions. The messages delivered by these groups included ways to prepare for future disasters, and how to prevent human trafficking. Wherever possible and relevant, the messaging was entrenched in ongoing programmes.[10] The radio drama, broadcast weekly in 20-minute segments, provided messages on maternal and child health, nutrition, hygiene, and disaster risk reduction. The content was supplemented by local content in local languages produced by 16 community radio stations in priority districts.

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A third-party end-user monitoring system (DARA) was engaged to assess the effectiveness of the humanitarian response and provide periodic reports on the performance of UNICEF emergency programmes, including the social and behaviour change communication initiatives.[11] DARA staff visited nine districts in Nepal and conducted over 150 key informant interviews, 30 group discussions, and observations of assistance at health centers, learning centres, shelters, homes and other locales.

Key achievements

- Outreach activities conducted by CSOs, community groups, and youth reached over 57,000 people, preparing them for future disasters.

57,000 PEOPLE

reached to prepare them for future disasters

DARA staff

visited nine districts in Nepal and conducted over 150 key informant interviews and 30 group discussions

16 COMMUNITY RADIO STATIONS

in priority districts supplemented with local content

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Lessons learned[12]

1. Earthquake and other disaster response initiatives should have a clear theory of change as a framework for guiding activities. No clear theory of change underpinned UNICEF's initial response in Nepal, which undoubtedly contributed to the lack of integration of early recovery activities into the response and a gap in planning from late August until February 2016.[13]

2. Coordination and feedback mechanisms are necessary for community engagement and increased accountability. The CWC, in collaboration with the government, took a key role in providing situation updates, supporting community engagement and disseminating critical and timely life-saving messages right from the onset of the emergency. The close collaboration with all involved stakeholders, as well as the presence of established mechanisms, helped to ensure accountability to the affected population.

3. Involving young people from local communities in the outreach activities not only ensures appropriateness and acceptance of messages, but also increases identification and creates a sense of ownership.

4. Partnerships with the national broadcasters and broadcasting associations helped ensure accountability to affected populations by providing communities with a channel for feedback to humanitarian responders about their concerns and needs.

5. Providing communities with local language and geographically-appropriate content as part of the *Milan Chowk* radio drama broadcast fostered community participation and ownership of the drama series, increasing its effectiveness.

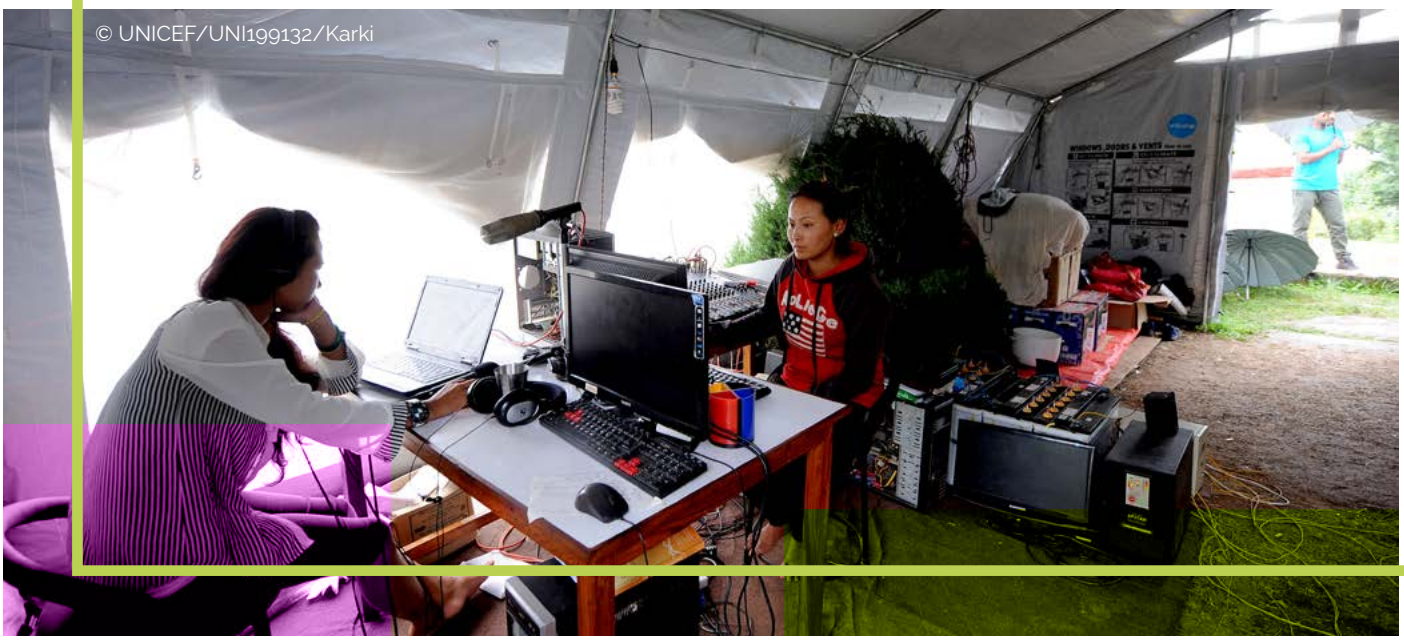
6. Generating audience feedback for media content through interviews with people from the community and group discussions led to more in-depth understanding of how the radio drama series was received and understood by the intended audiences.

7. Using radio programmes to provide psychosocial counselling benefitted those who did not have direct access to counselling services.

8. Funding for specific social and behaviour change communication activities is vital for reaching affected and vulnerable populations.

Recommendations

1. Formulate a theory of change to guide disaster risk reduction initiatives.
2. Strengthen preparedness measures, including the required training on emergency procedures and preparedness and contingency plans.
3. Increase community participation in programme design and implementation.
4. Strengthen data collection, monitoring and evaluation, and the use of data to develop and refine activities.
5. Ensure adequate planning processes and frameworks in future emergencies, including strengthening guidance on early recovery and resilience, and transition planning from emergency response to recovery activities.
6. Improve timeliness of overall emergency response, including expanding cash-based programmes to expedite procurement and identifying strategic warehousing opportunities for emergency response.



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5 United Nations Children's Fund, *Nepal earthquake 2015: Engaging communities to build resilience and accountability mechanisms*, UNICEF Nepal, <https://app.box.com/s/ol86kvo5d71de6x6a5iwdurypsfncpjh>.

6 The CWC was later further divided into four subgroups: Messages and Materials, Community Mobilization, Radio, and Monitoring and Evaluation.

7 Radio is a very popular medium among all wealth segments of the Nepalese population.

8 United Nations Children's Fund, *Nepal earthquake 2015: Engaging communities to build resilience and accountability mechanisms*, UNICEF Nepal, <https://app.box.com/s/ol86kvo5d71de6x6a5iwdurypsfncpjh>.

9 The edutainment shows included comedians, magicians, singers and other performing artists, like Ani Choying Drolma, Jeetu Nepal, Kaliprasad Baskota, Komal Oli,Deepak Raj Giri and Deepashree Niraula.

10 United Nations Children's Fund, *Nepal earthquake 2015: Engaging communities to build resilience and accountability mechanisms*, UNICEF Nepal, <https://app.box.com/s/ol86kvo5d71de6x6a5iwdurypsfncpjh>.

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12 The lessons learned are based on those noted in the following source unless otherwise notes: United Nations Children's Fund, *Nepal earthquake 2015: Engaging communities to build resilience and accountability mechanisms*, UNICEF Nepal, <https://app.box.com/s/ol86kvo5d71de6x6a5iwdurypsfncpjh>.

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UNICEF Nepal Helps to Improve the Safety of Female Community Health Volunteers Using Human Centred Design

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

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Brief summary

UNICEF Nepal provided training in four provinces to understand underlying issues contributing to low vaccination rates in certain Nepalese communities. Following a training to build capacity in using human centred design (HCD), a field team in Kathmandu conducted research to understand why the Chepang community had immunization coverage rates below 70 per cent. The findings from the study pointed to the fear of female community health volunteers (FCHV), key persons responsible for reminding families to go for their vaccinations, to travel alone in certain areas as an underlying reason for low vaccination rates. The solution that presented itself from the findings was to engage money lenders (community influentials) in ensuring the safe passage of FCHV in their communities.

Context

Female community health volunteers (FCHV) in Nepal are tasked with reminding families to attend vaccination appointments. They have a long-standing practice of accompanying family members to health facilities to get vaccinated. This practice has been an effective strategy for increasing vaccination rates. The FCHV, however, felt unsafe travelling alone from house to house in certain areas. This issue was impacting immunization coverage and rates in communities in areas that were perceived by FCHV as unsafe.

Strategic approach

UNICEF Nepal supported human centred design (HCD) training in four provinces. Within each province, the focus was on communities with immunization coverage below 70 per cent.

In Kathmandu, the Chepang community, an indigenous ethnic minority group living in an urban slum was prioritised for investigating the reasons for low vaccination rates. During the training, participants travelled to Chepang, and, using the HCD systems-view mindset from the training, the field team set out to understand the journey to vaccination from the perspective of the people directly or indirectly involved (e.g., pastors, teachers, parents/caregivers, vaccinators, health section chief, female community health volunteers (FCHV), ward chairperson). Using visual discussion cards and other creative discussion tools, the field team asked:

- What habits, routines, and responsibilities make up a typical day for a female community health volunteer (FCHV)?
- Who are the most trusted and influential actors in the community?
- What are the biggest barriers keeping health workers from providing quality health services?
- How are health practices and services perceived in the community?
- What is the relationship between health workers and families attending the clinic?

The findings from this inquiry revealed that FCHV felt at-risk travelling alone from house to house to remind families to visit the clinic for vaccinations. The field team also learned that money lenders, not community leaders, had the most influence in the community, and these money lenders saw themselves (and wanted to be seen) as the protectors of the community. The solution seemed to lie in engaging the money lenders in maintaining the safety of the FCHV. As successful, well-connected members of the community, money lenders had access to such resources as motorbike transportation that could provide FCHV with safe passage. They could also advocate for FCHV at local meetings and in places where community leaders gather to generate broader community support and awareness for their activities and well-being. In return, the health sector would recognise money lenders for their service and positive impact.

Key achievements

- Through the process of seeking to understand broader community dynamics, the team discovered that money lenders, not local leaders, have the most influence in the community.


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UNICEF Nepal supported

HUMAN CENTRED DESIGN (HCD)

training in four provinces

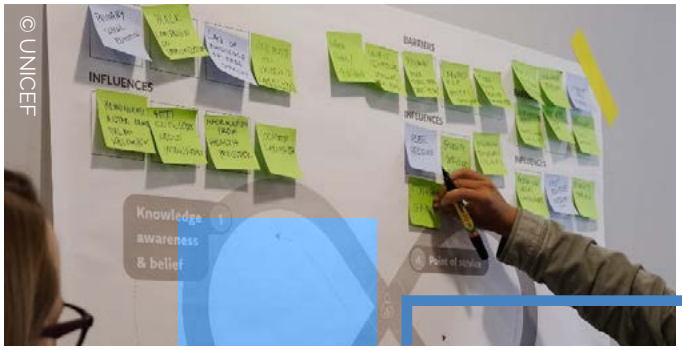
The field team used visual discussion cards and other creative discussion tools

The field team learned that money lenders had the most influence in the community

Lessons learned & Recommendations

1. Money lenders can be given the opportunity to participate in local health committees so that they can help address safety concerns, become involved in social causes in the community, and advocate for FCHVs in exchange for recognition of their impact.

2. The idea to leverage the influence and resources of money lenders, a previously untapped population in the community, to address the safety concerns of FCHV, could only have been discovered by letting go of a narrow focus on immunization and seeking to understand the broader dynamics within the community using a human centred perspective.



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UNICEF Ghana Facilitates Social and Behaviour Change Research and Message Dissemination

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
2015 to present

Duration
Ongoing

Budget
Free airtime to UNICEF worth US$1 million through MTN Telecommunications renewable every two years

UNICEF Ghana is collaborating with partners to use MessageWorks, a platform that consists of five key technology-enabled solutions, to rapidly conduct research and collect health-related information, disseminate social and behaviour change health, finance and other information to Ghanaians, provide micro-remote trainings to healthcare workers across Ghana, and make sexual and reproductive health counseling services accessible at low or no cost. Information collected about people's knowledge, perceptions, attitudes, and practices are used to create intervention prototypes and conduct message testing toward developing more effective social and behaviour change (SBC) interventions. To date, the technologies have reached many millions of users and provided UNICEF Ghana and their partners with feedback that is being used to improve the platforms and the resulting social and behaviour change interventions.

Context

Creating effective social and behaviour change interventions requires input from the intended populations (human-centred design). Information about individual and community barriers, drivers, social determinants, beliefs, biases, perceptions, and current practices has to be collected, analyzed, and translated into appropriate messages and activities. Once the interventions are created, there need to be accessible communication channels for the intended populations to engage with the messages. While at least 17 million internet users in Ghana (53 per cent of population) are able to access information about emergencies, health, education and child protection, millions of other Ghanaian people still lack access to quality and credible information. In some instances, this lack of information can be life threatening. In others it constrains social and economic growth.[1] For health care workers that work long and strenuous hours, it can be a challenge finding time to absorb new lessons (e.g., how to address COVID-19 vaccine hesitancy), especially those in remote locations for whom it is an effort to seek out or attend trainings.

With support from a local telecommunications company, MTN, Ghanaians without previous access to technology-based information channels have been able to access critical information for free. This partnership, along with other local partnerships, has allowed UNICEF Ghana to leverage several web-based platforms to conduct audience research, and to reach audiences, especially the most vulnerable, with life-saving information.

Strategic approach

UNICEF Ghana is leveraging five key technology-based solutions to enable widespread access to health and other important information to Ghanaians:

1. **SMS, audio platforms**, and low-data online platforms have been made available through VIAMO, a technology partner and UNICEF LTA holder. VIAMO maintains a database of 486,565, people across Ghana. They use Interactive Voice Response (IVR) technology to send social and behaviour change messages and audio content at low or no cost. This system allows for rapid development of content in the six most widely spoken Ghanaian languages. The audio content is especially suitable for persons that are illiterate. Ghana's largest telecom company, MTN, provides UNICEF with US$1 million worth of airtime every two years, enabling those without internet access to receive critical information for free and in the comfort of their homes.

2. **Agoo** is a proprietary on-demand local-language IVR portal designed to provide relevant information on finance, employability, entrepreneurship, health (especially sexual health), COVID-19 prevention, digital and online safety and more. The portal is operated by VIAMO for UNICEF Ghana. UNICEF Ghana and VIAMO engaged youth friendly partners, including Girl Guides Ghana, Boy Scouts, the Ghana Education Service, Curious Minds, Amplio Ghana, Savanna Signatures, Ghana Health Service, and Theatre for Social Change, through content co-creation workshops to determine how best to reach more young people through Agoo. This portal helps break the barriers (e.g., stigma) that young people face with regard to accessing information and services through in-person contact points.

Through Agoo, young people have a chance to participate in important dialogues that are relevant to their communities and help bring about change. MTN subscribers can access this portal via a short code (5100) for free to listen to life-saving information designed to empower them to make better decisions.

3. **AgooSHE+** is a helpline that provides an enabling environment for young people to access information and services on reproductive health, and gives them the opportunity to directly interact with professional life counsellors in the areas of health, sexual and reproductive health rights, and social services. This service started as a sexual and reproductive health helpline, and has since been scaled up to include other key emerging topics, such as financial literacy, mental health and wellbeing, digital safety, and entrepreneurship and employability, which remain critically important to Ghanaian youth.

4. **Talking Book** is an easy to use, handheld mobile audio device that runs on rechargeable battery power. At their convenience, listeners with limited access to information due to poverty, geographic location, low literacy, lack of electricity

or internet, are able to access and share key pre-recorded messages on health, agriculture, education, nutrition and more, in their local languages. The content, usually in the form of songs, dramas, interviews, and endorsements, is developed by local partners that are able to tailor messages depending on the cultural context. The messages are jointly produced by the beneficiary communities and programme designers through co-creation sessions. This device also allows listeners to record, providing organizations with relevant feedback that can inform their programme delivery. In collaboration with UNICEF Ghana, Amplio and Ghana Health Service, Talking Books delivered relevant information on COVID-19 to the most vulnerable areas in the Upper West Region while allowing community health workers to maintain social distancing during the COVID-19 pandemic.

5. **The Internet of Good Things (IoGT)** is a UNICEF-led initiative that hosts mobile-packaged content designed to make lifesaving and life-improving information available for free, even on low-end devices. IoGT is helping communities and frontline workers access educational information at the point of care. Topics and issues on Internet of Good Things include maternal health, hygiene, emergency information on diseases such as Yellow fever, climate change, polio and cholera, HIV and sexual health advice for adolescents, Internet safety, positive parenting techniques and more. With its multimedia elements and two-way communication features, the IoGT platform can also be used to capture feedback and local best practices from communities through polls and survey functionalities.

The content for each key technology-based activity is co-created with in-country partners, and based on research conducted using the platforms. For example, an interactive mobile phone survey was conducted to explore factors that influence polio vaccine uptake among Ghanaian mothers with children under the age of five years. Key findings from the study showed that the primary barrier to polio vaccination is fear of side effects, followed by perceptions that polio is not a dangerous disease, and that the key drivers of polio vaccine uptake are awareness of polio paralysis, perceptions of the vaccine as safe and supported by healthcare workers. These findings were used to provide platform users with messages about the vaccine's safety. The platforms were also used to test message types (e.g., altruism versus fear). The platform content is regularly updated and is easily scaled as a result of leveraging pre-recorded messages and training courses. Given the tight timelines to activate critical interventions, especially in emergency response situations, these technology-based solutions have proven invaluable for improving access to information for all Ghanaians.

Key achievements

- To date, over nine million calls have been received and 4.5 million people have been supported by the Agoo platform. In 2021 as many as 1,112,989 calls were received from 174,548 callers during the year, indicating high repeat usage rates with each caller calling more than six times over the course of the year.
- In 2021 the Agoo SHE+ call centre enabled 2,162 adolescents to receive counselling services.
- The Talking Book programme reached 94,793 people in Tolon, Karaga and Jirapa districts in Northern Ghana with social and behaviour change messages. A new listenership model of using the hand-held device in Child Welfare Clinics and ANC sessions in five CHPS Zones in Jirapa Municipality yielded an increase in CHPS attendance in ANC and CWC sessions by 14 per cent in 2019. It also motivated caregivers to stay longer for health promotion education, increased uptake of Vitamin A supplementation by 29 per cent in three out of five selected CHPS Zones, and increased participation of men in CWS sessions (45 per cent). Technical support on IPC skills training to Ghana Health Service in 14 accelerated WASH districts helped reach 571,152 caregivers with hand washing messages.
- On average, the Internet of Good Things in Ghana is visited by over 11,500 people every month, helping to bridge the digital divide and increase access to critical information.

By disseminating behaviour change messages across all five technology platforms, UNICEF Ghana enables scalability of interventions and accessibility to critical information to over 3.3 million Ghanaians annually.

OVER
nine million calls
have received and
4.5 million people
supported

Talking Book programme reached
94,793 PEOPLE

11,500 VISITORS
to the Internet of Good Things in Ghana every month

Lessons learned

1. Technology solutions like AgooSHE+ and IoGT remove the pressure of face-to-face interactions and, provide more assurance of confidentiality to users, especially adolescents.
2. Collaboration between private sector, NGOs, academic institutions, and government partners, and participatory co-creation of the technology-based content, ensures that it is highly relevant to the audience.
3. Technology-based platforms designed for information dissemination may also be used to gather quantitative research insights that assist in designing, testing, and tracking progress among the intended audience.
4. Audio technology is an important communication medium for reaching individuals that are not literate.
5. Linking technology platforms together and scaling content across multiple channels can help to maximize the reach of key messages.
6. The powerful pairing of storytelling and gamification can lead to significant user engagement, and boost the promotion and uptake of positive behaviours.

Recommendations

1. Integrate the MessageWorks key technologies with government and other communication platforms to enhance interoperability and system strengthening.
2. Continue collaborations with universities to conduct rapid research, experimentation, and testing, to sustain the gains made in behaviour change via MessageWorks since its inception in 2015.
3. Integrate existing technology platforms (e.g., WhatsApp chatbot, Cranky Uncle) into MessageWorks to enhance digitalization of SBC interventions.
4. Conduct more co-creation sessions to develop new content and trainings for MessageWorks key technologies.

Endnotes

1 United Nations Children's Foundation, 'UNICEF Ghana launches Internet of Good Things 2.0', UNICEF Ghana, 13 June 2022, <www.unicef.org/ghana/press-releases/unicef-ghana-launches-internet-good-things-20>.

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UNICEF Ghana Supports the Use of Human Centred Design to Improve COVID-19 Vaccination Uptake and Consistent Handwashing Among Health Workers at Vaccination Sites

Key social and behaviour change (SBC) strategies, achievements and lessons learned

Brief summary

Given the urgency needed to respond to the growing COVID-19 pandemic, unpacking and understanding the behavioural factors that contributed to delaying acceptance or refusal of the COVID-19 vaccine(s) required a shift in design strategies from the traditional social and behaviour change (SBC) approaches. The Ministry of Health, Ghana and UNICEF Ghana immediately turned to the Human Centred Design (HCD) approach to develop behavioural interventions for rolling out the COVID-19 vaccination while concurrently addressing handwashing practice for frontline health workers in the Greater Kumasi metropolitan area.

Context

In February 2022, a huge disparity existed between COVID-19 vaccine supply and coverage in Ghana. While the country had enough vaccine to inoculate 88 per cent of its eligible population with at least one dose, uptake was dismally low. Approximately half of the country's available vaccines were administered to about 16 per cent of the target population.

One of the hardest hit areas during the pandemic was Ghana's Greater Kumasi metropolitan area, the country's second largest city and historic capital of the Ashanti Empire.[1] According to a pre-COVID-19 vaccination survey conducted in that area, about 55 per cent of Ashanti region residents expressed an intention to get vaccinated against COVID-19 and to wash their hands regularly to prevent the spread of the disease. The rates of COVID-19 vaccination and regular handwashing, however, remained low. The Ministry of Health's Ghana Health Service (GHS), UNICEF, and Common Thread formed a collaboration to address low COVID-19 vaccine up take and handwashing.

Strategic approach

Over a three-day period, national-level and regional- level stakeholders from Ghana Health Services, UNICEF, implementing partners, and civil society organizations received theoretical and practical skills-building training in the human centred design (HCD) approach, including an initial introduction to behavioural design, rapid inquiry exercised in three locations, and a co-design workshop using the rapid inquiry findings. As part of the rapid inquiry exercises, Ghana Health Service staff, UNICEF staff, and implementing partners completed a full day of observations and conversations with vaccinators and people receiving their COVID-19 vaccines at three vaccination sites in Kumasi. Blending classroom learning, hands-on data collection, and co-design work to develop a final intervention helped to improve the participants' understanding and application of the approach.

The rapid inquiry exercises helped to identify a key reason that Ghanaians in the Greater Kumasi metropolitan area were not going for the COVID-19 vaccine, namely that they were "vaccine opportunistic," that is, they did not have any particular hesitancy about being vaccinated, but were not urgently or actively seeking out vaccination. In the health facilities, health workers knew the importance of hand washing with soap under running water as well as the frequency of the practice, yet they tended to rely more on hand sanitizer. The rapid inquiry observations highlighted that mobile or static vaccination sites did not have any signs, posters, murals, or other indications that vaccines were available. Most people learned about vaccine availability from radio announcements or word of mouth. Within vaccination sites, the process for vaccination was typically not indicated using any kind of visual cues. People relied on health worker instructions to guide them through the process.

These findings led to two conclusions that informed the design of contextually relevant solutions: (1) Create opportunities for "vaccine opportunistic" people to easily get vaccinated; and (2) create "wayfinding" materials to direct people to convenient vaccination sites, and to remind health workers to wash their hands with soap in line with COVID-19 stipulated guidelines. The aim was to reduce friction so that as little effort as possible was required from community members to get vaccinated. For health workers, there was an opportunity to use visual reminders placed within their immediate environment to remind them not only to wash their hands regularly between patients, but also to ensure their workstations were set up for handwashing at the beginning of each vaccination session.

Prototypes or wayfinding materials were created and tested with community members and frontline health workers to ensure that the materials were appropriately tailored to the intended populations. The focus of the prototyping was to use prompts to increase vaccination, especially among market women whose daily hassle of buying and selling made it difficult for them to get vaccinated and to seek other routine services. Once the key tenets of the wayfinding approach were established, iteration and scale up followed. Health facilities offering COVID-19 vaccination were provided with guidelines for using the wayfinding material (e.g., "Place branded signs outside each static or mobile vaccination site indicating the type of vaccines available, the days/hours of availability, and the approximate time needed to get a vaccine"; "Equip mobile and static vaccination sites with handwashing materials, including clean water from working taps, soap, tissues/serviettes, and hand sanitizer").

Key achievements

- Applying a behavioural design to develop community-driven solutions for improving health service delivery received interest from stakeholders in the Ghana Health Services (GHS). The Health Promotion Division (HPD) is actively discussing with UNICEF plans for cascading the training to staff at regional and district levels;
- Data from Ghana Health Services – Expanded Programme on Immunization (EPI) covering the intervention period from February to November 2022 showed the percentage of fully vaccinated people in Ashanti (Kumasi region) increased from 24.6 to 35.4 per cent.[2]
- Results from applying HCD to COVID-19 challenges in Ghana aroused interest in other sectors. For example, HCD is now being applied in the water, sanitation and hygiene (WASH) sector. To this end, a national training of trainers on HCD was conducted with 48 participants from the government, non-governmental organization (NGO) partners and the UNICEF WASH team to co-create solutions to accelerate the construction of sustainable latrines to end open defecation in rural communities in Ghana.
- Early-stage interest was expressed by UNICEF's Social Policy and Inclusion team following their annual review with government partners. In the new country programme (2023–2027), the Social Policy and Inclusion team identified HCD as an effective leveller to capture ideas and co-create solutions around promotional materials on programmes like Livelihood Empowerment Against Poverty (LEAP), a government social cash transfer programme meant to empower poor and vulnerable people to access health and social services.

48
PARTICIPANTS

from government, NGO and UNICEF WASH participated in training of trainers

Fully vaccinated people in Ashanti
(KUMASI REGION)

increased from

24.6% to **35.4%**

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Lessons learned

1. **Prototyping and listening to feedback on materials helped to improve messages and appeal.** Feedback showed a clear preference for a green and yellow colour scheme. Based on feedback, there were further areas identified for adaptation, including translation of the messaging into Twi (or other local languages, as appropriate) and adapting the hairstyle and clothing of the woman portrayed depending on the particular community in which the sign is placed.

2. **Wayfinding materials should include the particulars of the vaccination site, especially their opening hours.** Signage should indicate key vaccination information (e.g., time, requirements, availability, hotline or phone number) to guide people to the site and set appropriate expectations for the process, especially if they are required to return for a subsequent vaccination.

3. **Wayfinding materials should be placed in public spaces and directly outside of static health facility sites.** It is important to make information about the place of vaccination service highly visible to the intended population.

4. **Wayfinding materials about handwashing for health workers should be clear, attention-grabbing, and appropriately placed.** Signs should identify the need for handwashing with clean water and soap for safety reasons in a manner that appeals to, and captures the attention of busy health workers; the materials should be appropriate for mobile and/or static sites.

5. **Wayfinding materials will not be effective without supporting infrastructure**. Vaccination sites need to be equipped with the necessary accommodations for handwashing to enable regular hand hygiene.

Recommendations

1. Support the capacity building of Health Promotion Officers across Ghana to improve their skills on how to apply HCD for designing community-based interventions in order to institutionalize HCD in government implementing agencies.

2. As part of the UNICEF Regional Office's Social and Behaviour Change agenda, UNICEF Ghana should continue to work with Common Thread to implement other HCD projects in Ghana.

3. Form a Technical Working Group for Behaviour Science/HCD implementation to promote sustainability.

Endnotes

1 Acheampong et al, 'Examining Vaccine Hesitancy in Sub-Saharan Africa: A Survey of the Knowledge and Attitudes among Adults to Receive COVID-19 Vaccines in Ghana', MDPI, 2021, <https://www.mdpi.com/2076-393X/9/8/814>.

2 Wayfinding may have contributed to this increase. It is however not solely attributable to the change witnessed. Further analysis is needed to provide an accurate estimate of Wayfinding on immunization uptake.

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UNICEF Sierra Leone Uses U-Report Platform to Prevent a Cholera Outbreak and Facilitate Cash Transfers Among Mudslide Victims in Freetown[1]

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

In August 2017, UNICEF Sierra Leone responded to the needs of displaced families affected by flooding and mudslides in Sierra Leone's capital, Freetown, by providing safe drinking water, sanitation, delivering supplies (including medicine, tents, and gloves) per the government's request, and providing psychosocial support to affected individuals and families. UNICEF Sierra Leone used the U-Report social messaging platform to communicate with crisis-affected populations, including them in the design and delivery of humanitarian assistance. No cholera outbreak was reported. The U-Report system put into place by UNICEF continues to be used for other emergency events.

Context

Sierra Leone remains among the world's poorest countries, ranking 179 out of 188 countries in the Human Development Index in 2016. Flooding in Sierra Leone is commonplace during the annual rainy season and occurs throughout the country with varying impacts. The primary causes of flooding are a combination of the tropical rains, coastal degradation, aggregate stone mining, deforestation, and unplanned urbanization that cause blocked drainage systems in major towns.

On 14 Augus 2017 heavy rains pelted the slopes of Sugar Loaf mountain in Freetown. Chronic deforestations had left the slopes bare, causing boulders to roll and mud to flow into housing settlements, crushing homes and engulfing communities in red mud. More than 500 people died as a result, and an estimated 1,500 households were seriously affected. Thousands were left homeless; displaced people were housed in temporary shelters. The disaster left people deeply shocked and traumatized.

Cholera and other outbreaks are common in the wake of such disasters. In 2014-2015, during Sierra Leone's Ebola epidemic (causing 13,500 cases and almost 4,000 deaths), UNICEF first set up U-Report, a free social messaging tool that is both an information delivery system as well as a platform for community engagement, to inform the population about the disease and effective prevention measures. Following the 2017 mudslides, the UNICEF Sierra Leone Communication for Development (C4D) team collaborated with U-Report to deliver cholera prevention messages, and inform affected individuals and families about entitlements and unconditional cash transfer disbursements made available through the United Kingdom's Department for International Development (DFID).

Strategic approach

The UNICEF U-Report platform, available via SMS, Facebook and Twitter, was used to issue messages to, and gather information from, people in affected areas. U-Report polls to assess the situation for immediate planning purposes were conducted within 24 hours of the mudslides. The poll results showed that at least 72 per cent of U-Report users were without safe drinking water. The polls also showed that only a minority of those with disrupted water supplies could receive trucked water (largely due to inaccessibility), thwarting UNICEF's initial planned response to truck in water supplies. Another poll revealed that 51 per cent of the 75,000 U-Report users could not identify the signs of cholera, 67 per cent did not know how to treat it, and 62 per cent did not know how to prevent the disease. These electronic polls facilitated rapid assessments of the situation and reporting to officials involved in responding to the mudslide victims. The data were translated into advocacy, social mobilization, and behaviour change messages. The messages were delivered via television, radio programmes with call-in shows, and during town hall or community meetings.

The National Communication and Social Mobilization Pillar (NCSMP), comprised of governmental and international non-governmental organizations and co-chaired by UNICEF, provided financial and technical support for communication and social mobilization activities. Key messages on cholera and flooding contained in the existing UNICEF 2017 Emergency Message Guide, were extracted and used to convey the importance of cholera prevention and safety measures following a flood. Related messages on breastfeeding, handwashing, rain harvesting, child protection, malaria preventions the use of Oral Rehydration Salts (ORS), and psychosocial care were added to the key messages during community mobilization activities.

More than 500 Community Health Workers (CHWs) were engaged and trained using the Emergency Message Guide, to go door-to-door to deliver key cholera, flood and mudslide prevention messages to families in their communities. The guide was also distributed to radio stations to help radio hosts facilitate discussion programmes about the

disaster. Orientation events for key community stakeholders were held to update them on the situation while also encouraging them to take actions that protected the victims in their communities from further exploitation.

A key message orientation session was organized for religious leaders. At the time of the floods, UNICEF C4D had an active Program Cooperation Agreement with the Inter-Religious Council of Sierra Leone that facilitated the mobilization of 80 religious leaders from churches and mosques in Freetown. All non-governmental organizations and school officials in Freetown were also oriented to the key messages. The C4D team worked closely with the WASH Sector to ensure that all behaviour change messages included information about water chlorination and water harvesting.

The cash transfers were delivered by the local mobile phone company, ORANGE, using an existing mobile money cash transfer platform called ORANGE Mobile Money. During the enrollment and distribution days, all the verified programme beneficiaries who had received a mobile phone and Subscriber Identity Module (SIM) card were registered for U-Report on their new phones, with the help of volunteers. In support of the Humanitarian and Early Recovery Cash Transfers to mudslide and flood victims, U-Report was used to assess both programme operations and impact and also to serve as an information tool for beneficiaries. The transfers were disbursed in four installments, with all activities closely monitored by the National Commission for Social Action (NaCSA), the Anti-Corruption Commission, the Social Protection Secretariat, UNICEF and other partners.

U-Report was used for monitoring and evaluating the recovery efforts in the aftermath of the mudslides. Information was gathered on the number of families engaged, their areas of concern, and issues related to the delivery of services. The data were amassed and submitted for analyses at the end of each day to help inform C4D activities in a timely manner.

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Key achievements

- Within 24 hours of the event, the UNICEF Sierra Leone Country Office (CO) was in direct communication with affected communities about their water supply and general conditions through U-Report.
- Orientation sessions were held with 500 community health workers, 150 local councillors, ward councillors and tribal heads, 300 teachers in affected areas, 150 drivers who were union members, other trade union members, okada and tricycle riders, 150 boat owners, street vendors and food handlers, and members of Parent Support Groups.
- The C4D team activities contributed to the prevention of a cholera outbreak following the flooding and mudslides.
- By the end of the initial response, 78,628 household visits were conducted by community mobilizers. Of these, 39,412 mothers of under-five children were visited repeatedly and engaged, and 3,222 children were screened for various infections including 151 suspected cholera cases who were referred for further screening and medical advice.
- Between September and March 2018, cash transfers were provided to 1,885 households in affected communities through NaCSA supported by UNICEF. The cash transfers had the desired outcome of helping the target households recover from the disaster, aiding them in accessing basic services and meeting basic needs. The cash transfers also enabled families to invest in longer-term recovery through investments in livelihoods, ultimately building their resilience to future shocks.
- The U-Report approach used for the 2017 mudslide event in Sierra Leone is being used for other emergency, humanitarian and development work in Sierra Leone. Just before the onset of the rainy season in May 2018, C4D supported the Freetown City Council in conducting awareness-raising activities in 35 flood prone areas in the capital city. All 75 Ward Councillors in the Western Area were given an orientation of these activities and critical information about flood mitigation.

Orientation sessions were held with **500** COMMUNITY HEALTH WORKERS

78,628 HOUSEHOLD VISITS were conducted by community mobilizers

Cash transfers were provided to **1,885** HOUSEHOLDS in affected communities

Lessons learned & Recommendations

1 U-Report has proven to be highly useful in engaging directly with populations in an emergency aid situation to provide information to affected populations and to gather real-time data from them. The information generated through U-Report led to informed course corrections on planned interventions.

2 A spinoff from the 2017 Sierra Leone disaster was the creation of emergency focal points and committees in all 190 chiefdoms across the country. Focal points were trained using the Emergency Message Guide to identify and work on a plan to curb the occurrence of likely hazards in their localities.

Endnotes

1 United Nations Children's Fund, *Sierra Leone mudslide response 2017: Using digital platforms to place affected populations at the heart of the response*, UNICEF Sierra Leone, <https://www.unicef.org/innovation/media/8611/file/Sierra%20Leone%20Mudslide%20Case%20Study.pdf>.

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UNICEF Ethiopia Overcomes COVID-19 Vaccine Hesitancy Among Health Workers

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

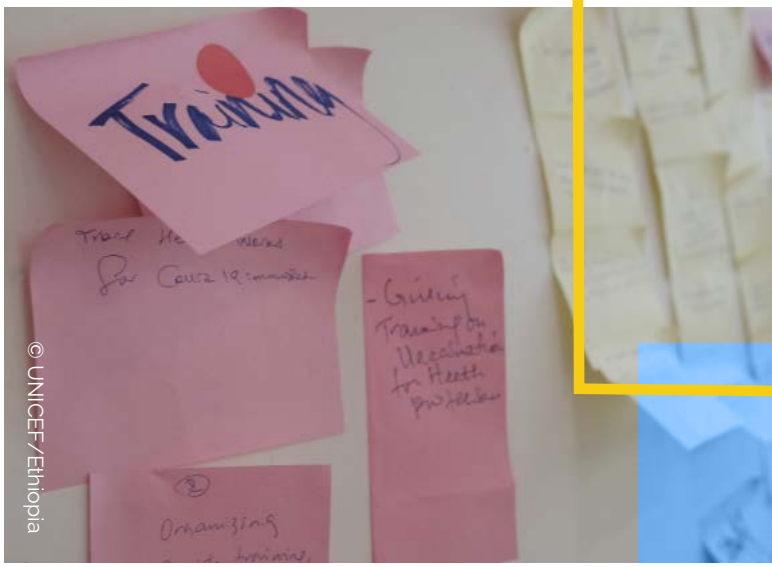
Brief summary

Dates of Activity
April to November 2021

Duration
Eight months

Budget
US$37,800

UNICEF Ethiopia conducted an in-depth qualitative assessment to determine the reasons that healthcare workers were not getting their COVID-19 vaccinations. The assessments showed that the newness and rush to development of the vaccine, as well as questions about its effectiveness, were key reasons for their vaccine hesitancy. Based on the findings, UNICEF Ethiopia supported in-person training of healthcare workers and advocacy with medical professional associations to facilitate interactive discussion with health staff. These efforts contributed to some 372,025 health workers being vaccinated against COVID-19.



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Context

Ethiopia introduced COVID-19 vaccination in mid-March 2021. By the beginning of August 2021, more than two million Ethiopians (less than two per cent of the total population) had received a first dose of the COVID-19 vaccine. In September 2021, more than 332,000 COVID-19 cases were diagnosed, resulting in 5,115 deaths.

While demand for the COVID-19 vaccine was high among many population groups, it was reported as low among health workers. Coverage among health workers varied across the country's regions, the lowest being in Sidama (65 per cent), with further variation across zonal/woreda levels within the same region.

Strategic approach

In April 2021, the UNICEF Ethiopia Country Office (ECO) supported a small-scale rapid qualitative assessment in the Southern Nations, Nationalities & Peoples' (SNNP) Region and Sidama Region to understand the reasons why uptake was low. The assessment participants included five healthcare workers, an orthodox religious leader, and four people aged 55 and older with a co-morbidity or older than 65 years. Four of the five health workers were COVID-19 vaccine hesitant, and one decided to delay vaccination. The assessment used the Behaviour and Social Drivers (BeSD) framework to understand the reasons for low uptake. The BeSD of vaccination are the beliefs and experiences specific to vaccination that are potentially modifiable to increase vaccine uptake. The assessments showed that the newness, and the rush to development of the vaccine, as well as questions about its effectiveness were key reasons for the COVID-19 vaccine hesitancy.

In August 2021, the findings from the rapid assessment were presented to health workers (doctors, nurses, health extension workers, EPI officers, and public health officers) at two ideation workshops, one in Awasa, Sidama region, and one in Dalla, SNNP region.[1] The aim of the workshops was to develop activities to boost COVID-19 vaccination among healthcare workers.

The ideation sessions focused on four key issues: (1) How to promote trust in COVID-19 vaccines among health workers; (2) how to effectively address COVID-19 vaccine-related questions from health workers; (3) how to support health workers to prevent COVID-19; and (4) how to promote COVID-19 vaccination acceptance and uptake among healthcare workers.

The ideation sessions resulted in a set of solutions for helping healthcare workers to overcome their vaccine hesitancy, and to improving vaccine uptake among healthcare workers. The solutions included training healthcare workers and health extension workers in the benefits and advantages of COVID-19 vaccination; holding staff discussions with healthcare workers to provide a space for them to express their concerns; engaging such *influencers* as senior physicians and religious leaders to encourage vaccination; and providing healthcare workers with sufficient personal protective equipment to keep them safe. UNICEF Ethiopia supported in-person training for 25,159 healthcare workers. The influencers conducted advocacy sessions with medical professional associations in the form of face-to-face meetings where they made presentations and allowed for Q&A sessions.

Key achievements

At least 372,025 health workers were vaccinated against COVID-19 following the ECO efforts to understand the underlying issues for the initial hesitancy, and the resulting training and advocacy activities.

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372,025 HEALTH WORKERS

were vaccinated against COVID-19

UNICEF Ethiopia

supported in-person training for 25,159 healthcare workers

The ideation sessions resulted in solutions to help healthcare workers to overcome their vaccine hesitancy

Lessons learned

1. The BeSD method was useful for determining the key underlying reasons for COVID-19 vaccine hesitancy among healthcare workers. This approach enabled the ECO team to collect information directly from vaccine-hesitant individuals as rapidly as possible given the urgency of the situation.

2. Ideation sessions, which are part of the human centred design approach. were key to rapidly developing recommendations for how to address the reasons for COVID-19 vaccine hesitancy uncovered in the rapid assessment. Having a set of recommendations enabled the ECO team to advocate for support from medical professional associations.

3. Engaging healthcare workers in face-to-face discussions about the introduction of a new vaccine is essential to garnering their approval and support for vaccine uptake (for themselves and the people they serve). In-persons discussions about the vaccine and their reasons for hesitancy gave healthcare workers a safe-space for working through the issues that initially kept them from accepting the COVID-19 vaccine.

4. Engaging or partnering with influencers such as inter-faith organizations and health professional associations is important for gaining confidence among vaccine-hesitant individuals.

Recommendations

1. Include the intended audience for the social and behaviour change activities in the co-creation of the solutions to the problem being addressed. In this case, healthcare workers participated in the ideation sessions and were able to contribute based on their own beliefs and experiences.

2. Create safe-spaces where individuals can feel comfortable raising their concerns and questions about vaccines, and where they feel listened-to and heard, to obtain useful information that leads to tailored and effective interventions.

Endnotes

1 An ideation workshop is a collaborative workshop to help groups of people work with research insights in order to draw out a broad range of potential solutions.

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UNICEF Ethiopia Supports Human Centred Design Training to Make Disease Prevention a Normative Community Practice[1]

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

In April 2021, UNICEF Ethiopia supported a four-day workshop to build capacity using the human centred design (HCD) approach for developing tailored demand-generation interventions to increase immunization uptake. Participants from this training applied the HCD methodology to understand issues related to low child immunization uptake and maternal and newborn health issues. The training was operationalized as field research studies that yielded insights into key issues, which led to ideas for solutions, and eventually, actual solutions.

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Context

In Ethiopia, reaching zero dose and under-immunized families across vast geographies, languages and cultures requires tailored diagnoses and adapted interventions.

Strategic approach

In April 2021, UNICEF Ethiopia supported a four-day workshop to build capacity using the human centred design (HCD) approach for developing tailored demand-generation interventions to increase immunization uptake. Thirty representatives from eight provinces attended the workshop remotely. Throughout the training, HCD methodologies and tools were introduced to help stakeholders master community-focused opportunity identification and creative problem-solving.

In preparation for the training, HCD rapid inquiry methods were applied in the Oromia region to demand and supply-side Expanded Programme of Immunization (EPI)/Maternal, Newborn and Child Health (MNCH) services. After an orientation and collaborative session to finalize research materials, a local team conducted interviews with 13 caregivers, 10 fathers, nine healthcare workers, and eight community leaders to uncover local insights. Synthesized findings were shared with participants during the workshop. Having on-the-ground examples, quotes and perspectives allowed remote participants to understand the importance of hearing voices from the local communities and health workers. It also provided real, local data to practice synthesis, idea generation and prototyping methods during the training.

Following the training, field research using the HCD methodology was conducted. For example, an HCD-oriented assessment was conducted with 40 participants living in two slum areas in a peri-urban section of Adama in the Oromia region. In those areas, families perceived health services as a last-resort, worst-case option for sick children that could not be cured using home remedies. In order to change this perception and norm, tailored solutions were required. The field researchers used "creative prompts" to elicit underlying associated with low immunization


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coverage and MNCH care. Healthcare workers were prompted to discuss what motivates them to practice compassionate care. This prompt elicited responses that highlighted their struggles to complete their daily EPI/MNCH tasks, limiting interpersonal communication with families and leaving parents/caregivers feeling intimidated by the health facility experience. Community leaders that participated in the Oromia field study highlighted the need to align health services with community needs and practices, including making services available at times that are convenient for community members, and providing reminders for services. Most fathers that were asked about immunizing their child did not know when immunization services should be used, or when mothers and children need to go for postpartum care; due to gender norms, fathers were not included by healthcare workers or community leaders in mother or child health activities.

The creative prompts yielded hundreds of ideas for addressing the specific issues that were raised during the HCD-oriented field research. The proposed solutions went beyond suggesting that community members be provided with information about EPI/MNCH, and addressed all members of the community.

Key achievements

- UNICEF Ethiopia SBC representatives from the different regions within Ethiopia have been using the HCD approach to design key interventions for immunization and health as well as child protection, water and sanitation. For example, in Oromia, a UNICEF SBC field consultant trained local teams of HCW to apply the methods. Findings from rapid inquiry were used to enlighten and inspire idea generation sessions held with the community, including both health workers and caregivers. Prototypes of the most promising ideas were developed and tested with representative samples of Oromia communities.
- The UNICEF Ethiopia SBC team included HCD in their technical assistance workplans. Trainings were held in three regions with the highest number of zero-dose children.

HCD-oriented

assessment was conducted with 40 participants living in two slum areas

Trainings were held in three regions with the highest number of zero-dose children

Interviews with

13 CAREGIVERS
10 FATHERS
9 HEALTHCARE WORKERS
8 COMMUNITY LEADERS

were conducted to uncover local insights

Lessons learned & Recommendations

1. The on-the-ground examples, quotes, and perspectives allowed remote participants to understand the importance of hearing voices from local communities and health workers. It also provided real, local data to practice synthesis, idea generation and prototyping methods during the training.
2. The training should be given to health professionals in order to address challenges in their communities from various perspectives.

Endnotes

1 Based on United Nations Children's Fund, Ethiopia, HCD Scale-up Final Report, <https://drive.google.com/file/d/10X8V8DZ8hAhqtF24ClxP03hocGVdogk3/view?pli=1>.

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UNICEF Malawi Helps Improve Community-Level Nutrition and Health-Related Indicators

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

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Brief summary

Dates of Activity
July 2017 - December 2023

Duration
6.5 years

Budget
US$43 million

A child's nutritional status reflects their overall health and development, and the household, community, and national investment in family health. The Community Behaviour Tracking Tool (CBTT) was used as part of the multi-year *Afikepo* nutrition programme in 10 districts of Malawi to enable communities to track health and nutrition issues in their area and take corrective measures as necessary.[1] The tool helped households to increase and diversify their intake of safe and nutritious foods and improved the nutritional status of Malawian women of childbearing, adolescent girls, and infant and young children. Results from the community behaviour tracking data showed an overall increase in the percentage of pregnant women that took iron folate tablets and consumed animal source foods and legumes. There were also improvements in the quality of diets of children 6—23 months.

Context

Malnutrition, in all its forms, affects a child's cognitive ability, lowers their immunity, makes them vulnerable to infections, and impacts their well-being over their lifespan. Malnutrition, especially stunting (low height-for-age), has remained a major public health challenge in Malawi, and is a major contributor to preventable child deaths. At least 39 per cent of girls and 42 per cent of boys less than five years old are stunted.[2] Stunting is indicative of chronic malnutrition and can occur within the first 1000 days of life if a child is not fed an age-appropriate diet. Sixty-four per cent of Malawian children under six months are exclusively breastfed, and only 60 per cent of new mothers breastfed within an hour after delivery, despite that 98 per cent of women give birth at a health facility. Only nine per cent of Malawian children between six and 23 months meet the minimum standards of an acceptable diet. Only 17 per cent of children meet the minimum standard for dietary diversity, and just 37 per cent achieve the minimum meal frequency.[3]

There is a persistent rural-urban malnutrition gap in Malawi, with the prevalence of malnutrition being higher in the rural areas than in the urban areas.[4] The 2019 Malawi Multi Indicator Cluster Survey (MICS) found that over 29 per cent of children in urban settings are stunted compared to about 36 per cent in rural settings.[5] Despite a significant drop in stunting by 11 per cent from 2012 to 2019, infant and young child feeding practices remain a challenge.

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Strategic approach

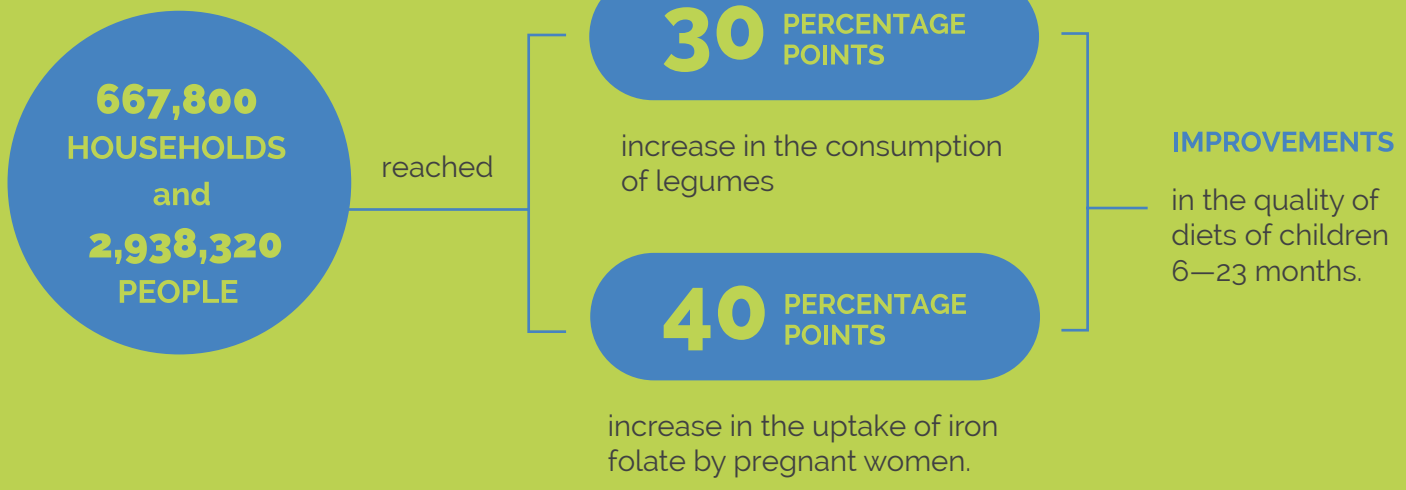
The *Afikepo* nutrition programme, implemented by UNICEF and the FAO in collaboration with the Government of Malawi, was a multi-sectoral effort that integrated agriculture, health, and nutrition activities to address the problem of food and nutrition insecurity and malnutrition. The project aimed to enhance household nutritional status in ten districts through the implementation of interventions that increased availability, access, and consumption of diversified foods at the household level, especially among women of childbearing age, adolescent girls, infant and young children.[6]

Afikepo activities were implemented through a care group model – a nutrition and health strategy that brings together a group of 8—12 community-based volunteers who meet regularly with Health Promoters that discuss nutrition and health, and provide training, supervision, and support. Each care group is led by a cluster leader who is selected from among the group members. A cluster is comprised of 8—12 households that are close together. The cluster leaders were responsible for passing nutrition information and providing nutrition counselling to the households in their community; they used the Scaling Up Nutrition (SUN) package to teach community members how to grow nutritious food, and about the importance of diversified and age-appropriate infant and child feeding practices. These practices were replicated by community members in their households. There was a total of 6,678 care groups across 10 districts in Malawi, with an average of 81 care groups across 82 Traditional Authority areas (an administrative unit in the district local governance structure). Community-based facilitators (CBFs) and community outreach groups (COGs) were trained and mentored to support community cluster and care group members at each of the *Afikepo* project sites. The CBFs (frontline workers, care group promoters and lead farmers) were responsible for identifying, training and supervising the COG leaders that provided outreach services at the household level. The care group model was designed to promote community ownership of the interventions and sustainability of the desired nutrition and health outcomes by setting a set of shared goals and creating a sense of identity and solidarity in the care group.

Cluster leaders were provided with the Community Behaviour Tracking Tool (CBTT), a nutrition monitoring and evaluation tool used as an early detection system for malnutrition cases. The CBTT contains nutritional indicators to track the progress communities are making in nutrition-related behaviour change for children, pregnant women, breastfeeding mothers, and adolescent girls. Besides, it helps to monitor the nutrition status of children under five using the Middle Upper Circumference Tape (MUAC). Data from the Care groups were collected monthly using the CBTT and upload online through Kobo platform. The data are consolidated over a period of three months and used to engage community leaders, households, frontline workers and care-groups in dialogues to discuss corrective measures for low performing indicators. Progress could be measured by comparing data from one quarter to previous quarters, and group decisions could be made about addressing specific gaps or issues. For example, if the CBTT numbers showed that very few people in a community were eating beans or nuts because it was a lean year for those staples, the community would develop an action plan recommending that, going forward, the community should store adequate beans to feed their family year-round. This message would be disseminated by the cluster leaders and care promoters through visits to households that were lagging in bean and nut consumption, and through a care group meeting to share the information with the community as a whole.

Key achievements

- The aim of the project was to reach 675, 000 households targeting under-five children, pregnant women, lactating women and adolescents in the 10 project sites. To date, the project has reached a total of 667,800 households (99 per cent of the target), and an estimated 2,938,320 individuals.
- A UNICEF Knowledge, Attitudes and Practices (KAP) study of the *Afikepo* project in 2022 showed that there were improvements in infant and child feeding practices (including breastfeeding practices) compared to 2018 baseline figures.[7] In some communities, for example, the use of the CBTT contributed to an increase in the consumption of legumes to 70 per cent, compared to only 30 per cent before the tool was employed. The uptake of iron-folate by pregnant women increased to almost 100 per cent from 60 per cent, in almost all areas. In some districts the data showed improvements in the quality of diets of children 6—23 months.[8]
- Early identification of low performing indicators combined with the capacity to discuss solutions as a community, empowered the communities to make the changes they deemed necessary.



Lessons learned

1. **The CBTT was instrumental in exposing nutrition bottlenecks in communities and rapidly finzding solutions that worked best for the community.** The skills gained through the CBTT monitoring empowered communities to take control of nutrition-related health deficiencies in children that were previously going undetected and generated social accountability and dialogue on nutrition issues.

2. **For the CBTT to have effects, there needs to be a pool of well-trained and committed community volunteers and front-line workers to support its use.** Incentives and/or income generating activities should be provided to the pool of volunteers to keep them motivated.

3. **Involvement of local leaders was critical to the *Afikepo* project implementation.** The leaders played an important role in mobilizing communities to understand the nutrition challenges and collectively identify solutions.

4. **Community dialogues** were essential for providing community members with the opportunity to problem-solve and take ownership of the change they wanted to see.

Recommendations

1. Continue to invest in volunteer training. Since CBT data is collected by volunteers, it is important to continuously invest in refresher trainings to ensure quality data collection and analysis.

2. Empower community volunteers to initiate dialogue sessions on their own.

3. Increase access to iron-folate tablets to help generate (almost) real time data to improve district level decision making.

Endnotes

1 Afikepi is a Chichewa name that translates as "let them [the children] develop to their full potential".

2 UNICEF Malawi, The nutrition program in Malawi, 2017.

3 Malawi National Statistical Office, 'Multiple Indicator Cluster Survey 2019-20 Survey Findings Report', December 2021, <https://washdata.org/sites/default/files/2022-02/Malawi%202019-20%20MICS.pdf>.

4 Mussa R., A matching decomposition of the rural-urban difference in Malnutrition in Malawi, Health Econ Rev, pp 4-11.

5 Malawi National Statistical Office, 'Multiple Indicator Cluster Survey 2019-20 Survey Findings Report', December 2021, <https://washdata.org/sites/default/files/2022-02/Malawi%202019-20%20MICS.pdf>.

6 The districts are Chitipa, Karonga, Nkhatabay, Mzimba, Kasungu, Nkhotakota, Salima, Chiradzulu, Thyolo and Mulanje.

7 UNICEF, FAO, EU, 'Knowledge, Attitude and Practices Survey (KAP) towards maternal, adolescent, infant and young child nutrition and care practices, water and sanitation and nutrition-sensitive agriculture: Report for the Afikepo Nutrition Programme and Nutrition-sensitive Agriculture component in Malawi;', July 2022', <https://www.unicef.org/malawi/media/4571/file/Report%20For%20The%20Afikepo%20Nutrition%20Programme%20and%20Nutrition-sensitive%20Agriculture%20component%20in%20Malawi.pdf>.

8 UNICEF Malawi, 'Tracking tool brings new lease of life: Community behavior tracking tool', January 25, 2023, <https://www.unicef.org/malawi/stories/tracking-tool-brings-new-lease-life>.

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UNICEF Rwanda Partners with Rwanda Red Cross Society to Address COVID-19 Rumours and Misinformation

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
July 2020 to December 2021

Duration
18 months

Budget
US$148,503,390

Between July 2020 and December 2021, UNICEF Rwanda, in partnership with the Rwanda Red Cross Society (RRCS), implemented a community-level social listening and feedback activity to track rumours about COVID-19. The aim of the joint activity was to develop interventions to address the Rwandan populations' misconceptions relazated to the COVID-19 virus, and to increase trust in the COVID-19 vaccines. UNICEF Rwanda and the RRCS developed a training module on COVID-19 for RRCS volunteers that went into communities with megaphones for disseminating correct COVID-19 information and promoting the vaccine, and with smartphone-loaded forms to collect data about rumours and misinformation that kept Rwandans from practicing preventive behaviours and getting vaccinated. In total, 476 RRCS volunteers (including 60 Trainer of Trainers) were identified and trained to deliver correct COVID-19 information, promote disease prevention, and record feedback and rumours from the community members where they served. The work of the volunteers, in tandem with the support of radio messages broadcast of five radio stations throughout the country, resulted in an overall increase in correct knowledge about COVID-19 and greater adherence to COVID-19 preventive measures (e.g., mask-wearing) over time. Trust in COVID-19 vaccines increased from 60 per cent in December 2020 to 89 per cent by June 2021.

Context

In Rwanda, the first case of COVID-19 was declared by the Ministry of Health on 14 March 2020. A national crisis committee of key Ministries was nominated to handle the pandemic response, chaired by the Prime Minister. The committee gathered a COVID-19 Joint Task Force to coordinate implementation of the preparedness and response plan just as the first cases were emerging. As the virus spread across the country, so too did rumours and misinformation about the disease and the newly developed vaccine. From the outset, UNICEF Rwanda, supported the Government of Rwanda and partnered with the Rwanda Red Cross Society (RRCS) to promote COVID-19 preventive practices and uptake of the newly developed vaccine. The activities used to reach the population of Rwanda included social mobilization, community feedback, and trust-building interventions aimed at increasing awareness about the virus, countering rumours and misinformation circulating about the virus and vaccine, and ensuring vaccine uptake.

Strategic approach

UNICEF and RRCS jointly developed a COVID-19 community engagement training module to strengthen the capacity of RRCS volunteers to deliver correct information about COVID-19 and motivate vaccine uptake. UNICEF Rwanda provided financial and technical support for training 60 Trainer-of-Trainers (two per district) to ensure cascade training and supportive supervision of the sector-based volunteers that worked hand-in-hand with the RRCS district Coordination Team. A total of 416 sector-level RRCS volunteers were trained in interpersonal communication and community engagement skills to enable them to effectively engage Rwandans, provide information about social distancing, mask-wearing and other COVID-19 preventive practices, and address stigma associated with the disease. The volunteers also learned how to obtain and address pandemic-related feedback and questions from community members, and to track and report rumours about the disease, the government's response to the pandemic, and the vaccine. UNICEF leveraged a WhatsApp Tree and the Internet of Good Things (IoGT), a UNICEF global online platform, to support the volunteer activities. The WhatsApp Tree group was created for all Red Cross volunteers from the sector level to the national level to facilitate the exchange of information/feedback and identify rumours. Local authorities were also added to the WhatsApp Tree group. Content about COVID-19 prevention and vaccine uptake were uploaded to the IoGT platform, and volunteers were orientated on its use and navigation during training-of-trainers (TOTs) of Red Cross supervisors/coordinators at the district level. Following the orientation, the trained Red Cross coordinators instructed Red Cross volunteers at the sector level on how to use


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IoGT, which was utilized by volunteers to obtain updated information on COIVD-19 prevention and vaccines.

UNICEF Rwanda and the RRCS established a community-level data collection and rumour tracking mechanism using the RRCS network of community volunteers. Equipped with a megaphone, pre-recorded messages about COVID-19, and KOBO-enabled smartphones for data collection, the 416 volunteers disseminated COVID-19 prevention messages and simultaneously collected data about the virus and vaccine uptake using a feedback form and rumour-tracking form from an average of 8.5 households per volunteer on a bi-weekly basis. The findings were analysed regularly and shared with key stakeholders at the local and national levels, including UNICEF Rwanda and the Rwanda Health Communication Centre (RHCC). The data was used to develop appropriate messages to address the key rumours and misconceptions related to COVID-19. The RRCS representative in each district shared the findings during monthly command post meetings organized by local authorities so that appropriate actions would be taken locally. The data collected through the RRCS mechanism was complemented by three rounds of Community Rapid Assessments (3,045 respondents in total) using the Behavioural and Social Drivers model between December 2020 and June 2021.

UNICEF Rwanda and the RRCS, in collaboration with the Ministry of Health, local authorities, and influencers, enlisted five radio stations (KT radio, Radio Salus, RC Rubavu, Radio Huguka, and Isangano Radio) to produce and air a weekly 30-minute radio show with messages based on the findings from the community feedback collected by the volunteers. The first fifteen minutes of each radio show discussed critical COVID-19 issues, facilitated by health experts and experts from other relevant sectors (e.g., Water, Sanitation and Hygiene (WASH), Education, Child Protection). The remaining 15 minutes was allocated for answering listener questions with the aim of debunking COVID-19 rumours and misconceptions, and while promoting trust for COVID-19 vaccines among the Rwandan population.

UNICEF Rwanda provided the necessary support for documenting the success stories and lessons learned, leveraging videographers, photographers, and writers, and working together with RRCS communication staff. Human interest stories were identified on a regular basis and posted on the UNICEF website.[1]

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Key achievements

- From November 2021 to March 2022, over three million people (48 per cent male, 52 per cent female) across Rwanda were reached through community engagement and mass media with necessary information to protect themselves and their families from COVID-19 and promote the recommended preventive behaviours among family and friends; 247,952 people gained the knowledge and skills to address key rumours and misconceptions about COVID -19 that were identified during the project cycle.
- In total, 476 RRCS volunteers (including 60 ToTs) were identified and trained to deliver correct COVID-19 information, promote disease prevention, and record feedback and rumours from the community members where they served.
- There was an overall increase in correct knowledge about COVID-19. For example, in March 2022, 17 per cent of rapid assessment respondents believed that COVID-19 was a political mechanism for reducing the number of people on the earth, compared to 22 per cent in September 2021.
- Communities increased their adherence to COVID-19 preventive measures over time. In October 2020, 42 per cent of respondents said that they wore a face mask, compared to 52 per cent in April 2021.
- Trust in COVID-19 vaccines increased from 60 per cent in December 2020 to 89 per cent by June 2021.
- Some of the data obtained through the UNICEF Rwanda and RRCS partnership informed Rwanda's national "Back to School" campaign implemented jointly with the Rwanda Basic Education Board.
- The COVID-19 communication content from this activity was adapted for dissemination through the Internet of Good Things.

Trust in COVID-19 vaccines increased from

60%
IN DECEMBER 2020

to

89%
BY JUNE 2021

OVER
3,000,000
people across Rwanda were reached

476
RRCS volunteers were identified and trained

Lessons learned & Recommendations

1. When community feedback is collected, programmatic responses are expected. It is crucial to manage expectations and maintain transparent communication with the communities from whom feedback is collected.

2. Sustaining data collection about rumours and misinformation at the community level requires dedicated coordination between the government, development partners, and civil society organizations.

3. Active volunteer engagement is essential for liaising with the target population and addressing rumours and misinformation. Additional approaches should be considered, including involving community-level opinion leaders, social media influencers, and others who could address misconceptions and change the narrative.

4. Radio remains the most trusted and available information channel in Rwanda and should be leveraged to increase the reach of risk communication and community engagement messages.

5. Data visualization and presentation were limited due to the high volumes of information and a lack of human resource capacity to process and share findings in a concise and clear manner. Discussions are ongoing with Rwanda Health Communication Centre (RHCC) on how to address this challenge.

6. A human-centred design (HCD) approach to developing interventions requires an understanding of the people for whom the intervention is being designed. The UNICEF partnership with RRCS, whose community research component is well-defined, opened the space for the application of HCD and enabled the development of appropriate training and data collection.

Endnotes

1 For an example of a UNICEF human interest story see: https://www.unicef.org/rwanda/stories/frontlines-battle-against-covid-19-misinformation, and https://www.youtube.com/watch?v=RjGBlvo1lBs&list=PLYaKipQFMMmsiYJNxvAjxoq15P4Ktmq8y&index=2

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UNICEF Rwanda Helps Communities Address Immunization Demand-Related Challenges with Human-Centred Design

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Human-Centred Design (HCD) is a participatory social and behaviour change (SBC) approach and technique that puts people and communities at the centre of all stages of the programme development, implementation and assessment process. HCD has long played a central role in UNICEF's work. A key challenge to applying this approach in UNICEF's Eastern and Southern Africa region (ESAR) has been the limited capacity to use HCD among UNICEF office staff and partners. In July 2022, UNICEF Rwanda conducted two workshops for 50 participants (UNICEF and partners) to increase capacity to use the HCD approach. The training content focused on COVID-19 vaccine uptake and included practical demonstrations of how to apply HCD. These workshops resulted in a number of solutions for improving COVID-19 vaccine uptake. The participants are continuing to spread their knowledge of HCD with members of other groups with whom they work (e.g., technical working groups).

Context

The COVID-19 pandemic in Rwanda lead to increased unemployment, loss of productive livelihood, and lead to stigma and discrimination of survivors. Access to personal protective gear was also limited.[1] In early 2022, COVID-19 cases and deaths in Rwanda spiked.[2]

Strategic approach

In 2022, the UNICEF ESARO SBC section conducted HCD training in four countries: Botswana, Malawi, Kenya, and Zambia. Following this training, the UNICEF Rwanda SBC team, with technical support from the UNICEF ESARO SBC section, organised two back-to-back HCD workshops in Rwanda's Western and Northern provinces. The focus of the workshops was on COVID-19 vaccine uptake and used information and tools available at the UNICEF HCD for Health homepage. The workshops brought together 50 participants from government, civil society, faith-based organizations, organizations of people with disabilities and private sector actors/ creative agencies. The trainings were delivered by the UNICEF Rwanda and ESARO SBC teams and included practical demonstrations on the HCD approach. The HCD methods taught included persona building (personas might be health workers, teachers, mothers, fathers, faith-based leaders, adolescents); journey mapping; community research/rapid inquiry; synthesis; Idea generation; and prototyping. Both workshops reached the 'idea generation' stage and generated feasible solutions for various personas (e.g., creating job aids about COVID-19 for teachers). These solutions were then taken through the piloting and iteration stages.

Key achievements

- Both Rwanda HCD workshops were highly appreciated by participants and UNICEF partners. The HCD approach was fully embraced by all UNICEF staff and partner participants.
- The head of the Rwanda Health Communication Centre who participated in one of the workshops committed to applying the approach.
- Several civil society partner participants reported that they started applying HCD in their work for COVID-19 vaccine uptake, youth engagement, and other areas.
- Many of the beneficiaries of the two trainings were also active members of different technical working groups through which they promoted HCD as an effective approach for improving health outcomes.

The head of the Rwanda Health Communication Centre committed to applying the **HCD APPROACH**

Two back-to-back **HCD WORKSHOPS** organized in Rwanda's Western and Northern provinces

The **HCD APPROACH** was fully embraced by all UNICEF staff and partner participants


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Lessons learned & Recommendations

1. **Planning the training**: Liaise with the UNICEF regional office for support and send out invitations early. Arrange for the community research stage early. Plan for logistics and contingencies carefully.

2. **Location for training**: Select a comfortable location for the training that supports a conducive and engaging work environment.

3. **Select diverse participants**: A diverse group of participants (e.g., Ministry of Health, civil society, faith-based, persons with disabilities, and private sector/creative agencies) makes it possible to look at challenges and solutions from different angles.

4. **Training facilitation**: Keep people motivated, united, and engaged through smaller group work, energisers, competitions, and social activities. Maintain a sense of joint ownership of the purpose and solutions.

5. **Training documentation**: Documentation (written and audio/visual) of every step of the journey is a critical step to continue advocating for HCD application and resource mobilization. Clear documentation of the process at the sub-national level is also critical for accountability. Soliciting feedback about the HCD approach from various stakeholders adds value.

6. **Conducting community research**: It is essential to make sure community research participants feel safe and comfortable to share their views openly and understand their rights as research participants. Remuneration for community members' time and effort is key. The expectations of community members should be managed in terms of which solutions could be implemented immediately, based on the prioritization of the key objectives, available funds, time, human and other resources.

7. **Safeguarding data collected during training**: It is essential to agree within the group that the sensitive data obtained during the community research part of the training will not be shared beyond the workshop participants and will only be used for refining the solutions. It is critical that all data collected be anonymised.

8. **Maintain the momentum**: The HCD workshops triggered a lot of interest within and outside UNICEF (e.g., among programme colleagues, USAID, UNHCR, WHO). Given this interest it was important to organize a series of follow-up sessions in Kigali to keep the momentum of HCD going. It is key to assign responsible UNICEF and partner organizations' staff who will continue leading the way for HCD.'

Endnotes

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UNICEF Rwanda Supports an Ethnographic Study to Understand Behavioural Drivers of Suboptimal Maternal and Child Feeding Practices[1]

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

In Rwanda, suboptimal maternal and child feeding practices have persisted despite high knowledge about beneficial nutrition among mothers. To understand why programmes are slow to improve nutrition and stunting rates in Rwanda, UNICEF Rwanda supported an ethnographic household-level study to understand the behavioural drivers of nutrition practices, and to determine what could be done to drive the "last-mile behaviour change" to better nutrition outcomes. The study found that poverty and poor harvests were the two most important constraints on providing nutritious diets to mothers and children. Behaviour governing food choices (i.e., decisions to buy large quantities of less nutritious foodstuffs instead of smaller quantities of nutritious foods) was identified as an underlying cause of poor diets, and by extension, suboptimal nutrition outcomes. Another key finding was that knowledge and behaviour are not necessarily codependent, that is, even if material requirements are met and knowledge levels are high, a given behaviour may not have reached a point where it is normative. Recommendations for addressing the issues highlighted in the study included providing counselling and education to caregivers on nutrition prioritisation and decision-making, motivating communities to adopt the prioritisation of healthy nutrition practices for mothers and children, supporting economic empowerment activities, and providing social protection cash benefits to economically constrained households.

Context

Poor maternal nutrition during pregnancy and lactation can adversely affect mothers and children.[2,3] Stunting rates among under five-year-olds in Rwanda remain stubbornly high (33 per cent), as does childhood anaemia (37 per cent) and anaemia among pregnant women (25 per cent). Intensive communication and education campaigns have provided caregivers with high levels of knowledge about best practices in Maternal, Infant and Young Child Nutrition (MIYCN), but this knowledge has not translated into the improved decision-making about nutrition and changes in diets that could contribute to reducing stunting.

Patterns of chronic child undernutrition in Rwanda are at least partly linked to inadequate diets. According to the composite minimum acceptable diet indicator (which captures diversity and meal frequency), only 22 per cent of Rwandese children aged 6-23 months are fed a minimum acceptable diet.[4] The majority (62 per cent) of children 6–23 months ate a diet that was below minimum dietary diversity (i.e., they ate from less than four food groups).[5] Only 18.6 per cent of Rwandan children aged 6–23 months had consumed meat, poultry, or fish and 7.7 per cent had consumed eggs in the day or night preceding the recall.[6] Suboptimal nutrition was also reflected in inadequate nutrient intake that was below the age-specific recommendations.[7] Research in Rwanda has confirmed that suboptimal feeding practices have multiple drivers, including cultural beliefs and taboos, poverty, low maternal education, and the unavailability of nutritious foods.[8]

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Strategic approach

UNICEF Rwanda supported an ethnographic research study with a deep and broad scope to understand household drivers for why suboptimal nutrition persists among pregnant and lactating women, as well as young children, when mothers are generally knowledgeable about nutrition. The findings from the study would be used to tailor social and behaviour change communication interventions designed to reduce malnutrition in these groups. A Focused Ethnographic Studies (FES) approach based on a four-module protocol was used to carry out a household case study of 30 households, one in each of Rwanda's 30 districts.[9] Each module focused on a different research area (e.g., WASH; food selection, preparation, diet, childcare, and hygiene beliefs and practices; barriers and drivers of behaviour change in nutrition practices; barriers and drivers of behaviour change in handwashing practices). Interviews were conducted with household members, and observations were made of the physical house, its facilities, food storage, preparation, and consumption, and of family members' activities.

Each of the six field researchers spent between four and five days in close contact with one study household, arriving at the home at dawn, observing meal preparation and feeding, asking questions about observed practices, and remaining with the family until nightfall. Over the course of this period, fieldworkers applied each module to a selection of household respondents; this set of respondents always included the primary caregiver (in all study households, this was a woman), as well as heads of household (in most cases a male co-resident partner). Indepth interviews and recall exercises were carried out with 30 primary caregivers, while the ranking exercise in Module 3 was implemented with 60 participants in total. Observations were carried out more broadly and opportunistically, both in the household and in places where foods were acquired (e.g., farms and markets).

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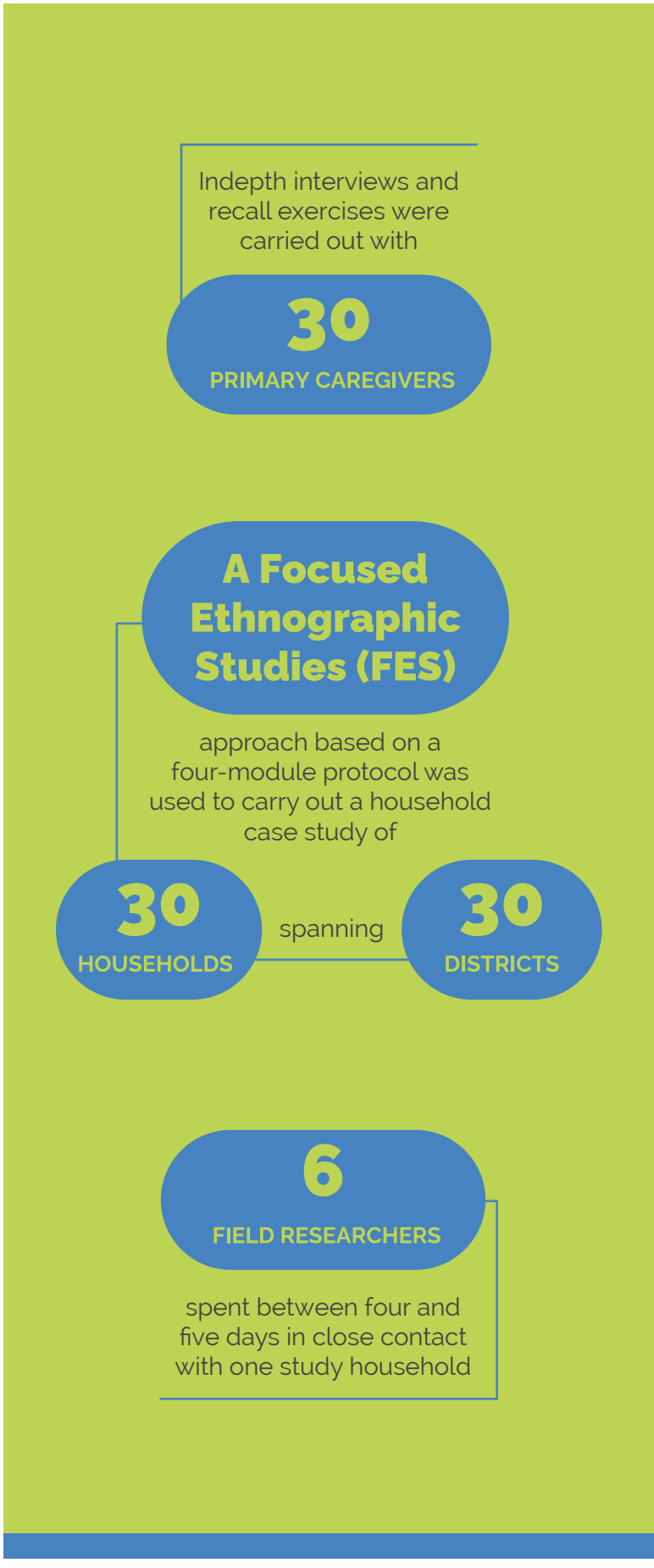
Key achievements

The key achievement of this study is that it highlighted important findings about why high knowledge about optimal nutrition fails to translate into optimal diets for mothers, infants, and children, namely:

1. Poverty and poor harvests were identified as the two most important constraints on providing nutritious diets (i.e., the immediate cause of poor mother, infant, and young child nutrition). While knowledge of how to construct a nutritious meal was part of the cultural repertoire of most of the women in the study, having the economic freedom and broader capability to put this into practice independently of behaviourally informed prioritisation and decisionmaking was less common.
2. Behaviour governing food choices and decisions to buy large quantities of less nutritious foodstuffs instead of smaller quantities of nutritious foods was identified as an underlying cause of poor diets, and by extension, suboptimal nutrition outcomes.
3. Beliefs about specific foods dictate the types of foods fed to young children. Study participants suggested that young children should not consume hard food (e.g., green banana, taro, sweet potato, hard cassava) because they are low in vitamins when prepared separately from other types of food and can cause stunting. While this belief is, to some degree, a folk taxonomy, it is undeniably grounded in some scientific truths insofar as an excess of these foods may displace other foods, including those rich in micronutrients in the diet.
4. Knowledge and behaviour are not necessarily codependent; even if material requirements are met and knowledge levels are high, a given behaviour may not have reached a point where it is normative.



Lesson learned

The study findings revealed gaps in the knowledge-capability-practice chain resulting from decisions and prioritisations taken by caregivers. Driving "last mile" behaviour change requires knowledge, changes in attitude at the individual/household level, shifts in social norms at the cultural/community level, and strengthened economic capacity for poorer households.

Recommendations

The authors proposed a three-pronged approach to improve nutrition outcomes among Rwandan mothers, infants, and young children:

1. **Individual level:** Support, strengthen, and launch SBC activities where necessary to address attitude-mentality changes. Provide counselling, dialogue, and education for caregivers of young children that focuses on prioritisation and decision-making, not on more knowledge about nutrition (which is already high).

2. **Community level:** Support, strengthen, and launch community and social mobilisation activities to prioritise the adoption of better mother/child nutrition practices as a community norm.

3. **Economic capacity:** Support, strengthen, and launch economic empowerment activities (e.g., nutrition-sensitive agricultural extension sessions to increase and diversify foodstuffs; social protection cash benefits), especially for more resource-constrained households.

Endnotes

1 Birungi A., Koita Y., Roopnaraine T., Matsiko E., Umugwaneza M., 'Behavioral drivers of suboptimal maternal and child feeding practices in Rwanda: An anthropological study', *Maternal & Child Nutrition*, 2021, <https://onlinelibrary.wiley.com/doi/epdf/10.1111/mcn.13420>.

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6 National Institute of Statistics of Rwanda, Ministry of Health, ICFInternational, 'Rwanda Demographic and Health Survey', Rockville, 2020.

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8 Birungi A., Koita Y., Roopnaraine T., Matsiko E., Umugwaneza M., 'Behavioral drivers of suboptimal maternal and child feeding practices in Rwanda: An anthropological study', *Maternal & Child Nutrition, 2021*, <https://onlinelibrary.wiley.com/doi/epdf/10.1111/mcn.13420>.

9 The FES approach is ideal for situations where the benefits of ethnographic approaches are required, but time and resource constraints preclude the implementation of a longterm, ethnographic study protocol.

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UNICEF South Sudan Supports Strategy to Reach Hard-to-Reach Populations with Cholera Prevention Information

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

South Sudan has suffered from perennial cholera outbreaks with devastating effects on the health, well-being, and socio-economic status of the people. A large-scale cholera outbreak affected South Sudan from June 2016 to December 2017, resulting in 20,438 cases and 436 deaths in one third of all counties. The UNICEF South Sudan Country Office (SSCO) commissioned a KAP study in 2016 to identify key behavioural and communication factors for consideration in planning social and behaviour change interventions. Based on the study findings, the SSCO social and behaviour change (SBC) team designed a response plan that targeted areas with active cholera transmission whose populations were outside the reach of conventional communication and community engagement approaches, mainly among cattle camps. The two key platforms used for education and risk communication were community/household engagement and mass media. A total of 1,912,187 people in 362,615 households were reached in affected areas. An additional 2,173,381 people were reached with key cholera messages through the various interpersonal communication efforts, while 2.4 million people were reached through mass media messages.

Context

In South Sudan, only about 50 per cent of the population has access to improved drinking water sources, and open defecation is practiced by approximately 65 per cent of the population. Drought has led to serious water and food shortages in the country, forcing people, especially cattle herders, to gather around the fewer remaining water points, rendering them more vulnerable to disease. A majority of the population believe that clear water is safe when, in fact, it can be contaminated with fecal particles and parasites that cause cholera and other diseases. Open defecation and drinking water from unsafe sources (e.g., swamps or rivers) have contributed to cholera outbreaks throughout the country.

A large-scale 16-month long cholera outbreak affected South Sudan from June 2016 to December 2017, resulting in 20,438 cases and 436 deaths in one third of all counties. Children under 19 years of age constituted almost 60 per cent of the total cholera cases during this outbreak. The most affected populations included communities in landing sites and towns along the Nile River, cattle camp dwellers and populations living on islands with limited access to basic social services. Many were internally displaced persons (IDPs) who living with inadequate access to water, sanitation and hygiene (WASH) facilities.

Pastoral communities represent a significant portion of the South Sudan population. Most of their camp settlements are located in scattered, isolated and remote swampy areas with very limited accessibility especially during rainy seasons. These communities frequently shift location depending on the availability of pasture and water for the animals they are tending. Due to the temporary nature of the settlements and the community's long-held traditions, the practice of open defecation is widespread. A common practice is the consumption of unsafe and untreated swamp or river water which is often shared with the animals. Their culture of not burying the dead contributes to a conducive environment for transmission of cholera bacteria as the bodies decompose directly into the rivers and swamps. The majority of this population are not functionally literate, and they prefer receiving information from their peers. For this reason, they are often missed by mainstream strategic community mobilization interventions for hygiene promotion and cholera prevention.

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Strategic approach

The UNICEF South Sudan Country Office (SSCO) commissioned a KAP study in 2016 to identify key behavioural and communication factors for consideration in planning social and behaviour change interventions; a baseline study supported by the Integrated Community Mobilization Network (ICMN) collected key family knowledge and practices data from 400 households that complemented the KAP study. Based on the study findings, the SSCO SBC team designed a response plan that targeted areas with active cholera transmission whose populations were outside the reach of conventional communication and community engagement approaches, mainly among cattle camps. The plan focused on emergency interventions during cholera outbreaks and preparedness activities during the inter-epidemic period. The overall objective was to control and prevent cholera transmission among affected and at-risk populations (including cattle camp, IDP and fishing communities) by increasing risk perception and knowledge of prevention and treatment of the disease.

The two key platforms used for education and risk communication were community/household engagement and mass media. The ICMN was key to enabling effective community engagement. The ICMN's 2,506-member network of trained community mobilizers had a presence in six cholera-affected states and worked under seven implementing partners. The ICMN supported community engagement through peers and two-way conversation with households and people with direct contact with households (e.g., water and food vendors; traditional, religious, youth and women leaders; community forums and institutions such as schools, health facilities, worship centers and markets). Community mobilizers engaged with communities at the household level, conducted school orientation sessions, and held community and religious leader's meetings as well as community engagement sessions at market and water points. Local mass mobilization was also intensified using traditional drama and musical performances.

Radio platforms were leveraged to strengthen risk communication. A total of 32 radio channels broadcasted jingles, talk shows, and spot ads to alert listeners to the risk of cholera, and to educate communities on the prevention and treatment of the disease, in nine widely spoken local languages. A hotline service was set up in collaboration with the private mobile operator Vivacell to provide cholera counselling to callers. The radio broadcasts were complemented by traditional media and megaphone announcements at the community level to increase reach and impact.

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A cattle camp strategy was developed to engage mobile populations. This strategy involved identifying and engaging opinion leaders (gate keepers) among the cattle communities, working with them to track the migrant community, and ensuring their active involvement in all mobilization activities. Other activities included the training and establishment of rapid response teams at the national, state and county level, micro-planning using social maps, and community surveillance.

Standardized communication materials (e.g., wall charts and booklets) were designed to inform and mobilize communities during oral cholera vaccine campaigns and placed in communities, Oral Rehydration Points, Cholera Treatment Units/Centers, health facilities, schools and other key locations. The materials were highly pictorial, and easy to understand and use for education sessions.

UNICEF contributed to the response by leveraging cross-sectoral synergies among the Health, SBC and WASH sectors. At the national level, UNICEF acted as co-chair for a social mobilization and communication working group. This group coordinated community engagement interventions in collaboration with the Government, key stakeholders and humanitarian clusters, and communication with community working groups to promote and sustain optimal social and behavioural outcomes. UNICEF also worked with 32 radio channels across the country to develop standardized key messages and communication materials, through formalized long-term agreements (LTAs) with audio production, promotion and printing services. Under the joint supportive supervision of the WASH, Health and SBC sectors, the UNICEF teams conducted visits to all the supported cholera hotspots during which technical support and guidance were provided for the implementing partners and communities on effective prevention and control of the outbreak. Regular situation reports (Sitreps) using a standardized reporting format were collected, collated and shared with WHO and the National Emergency and Response Forum on a weekly basis.

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Key achievements

- The strategic and integrated focus of the cholera response enabled the promotion of two-way communication interventions covering 74 out of 80 counties in all ten states across the country.
- A total of 1,912,187 people in 362,615 households were reached in affected areas. An additional 2,173,381 people were reached with key cholera messages through the various interpersonal communication efforts, while 2.4 million people were reached through mass media messages.
- The phone hotline was accessed by 2,000 people to either bring attention to suspected cases or to receive cholera prevention information.
- Of 5,640 cases of cholera, 5,468 (97 per cent) were treated in health facilities. As per patients' discharge records, most of these patients indicated that they became aware of cholera prevention and treatment strategies from house-to-house visits, community meetings and radio messages. Other reported sources of information include printed materials and the cholera hotline. Focus group discussions conducted by partners, spot interviews done during roadshows, and observations found that food vendors in Juba (the capital of South Sudan) and other cholera hotspots exhibited positive hygienic behaviour in their business locations as a result of exposure the cholera messages.
- As a result of the interventions, no cholera cases were reported between December 2017 and April 2019.

74 OUT OF **80** COUNTIES

in all 10 states across the country covered

1,912,187 PEOPLE

in 362,615 households were reached in affected areas

The phone hotline was accessed by

2,000 PEOPLE

Lessons learned & Recommendations

1 **The strategic response to the cholera outbreak can be used to promote other important health and child rights issues.** In South Sudan, the cholera outbreak response strategy has been leveraged in other disease prevention strategies such as the rift valley fever, malaria and Hepatitis E, and outbreaks. It has also been used to promote children's rights, with a key focus on child survival, birth notification, and education and hygiene promotion activities.

2 **Community interventions can reach populations that are beyond what government structures can reach**. In South Sudan, government structures are weak at the subnational level, and lacking beyond the county level. Community-level interventions that include networks of local partners can extend the reach of messages and increase their impact because they are perceived as coming from 'peers'.

3 **Having an overarching body to support community mobilization is key to achieving the greatest amount of contact with the intended population.** The ICMN enable large numbers of community mobilizers to engage communities and households through sustained and locally adapted communication approaches.

4 **Using radio, traditional media, and creating highly pictorial communication materials is essential to reaching non-literate populations.** In the context of South Sudan, and especially among mobile and displaced population where the literacy level is particularly low, access to radio and picture-based outreach and education materials is appropriate and necessary for engaging the intended audiences.

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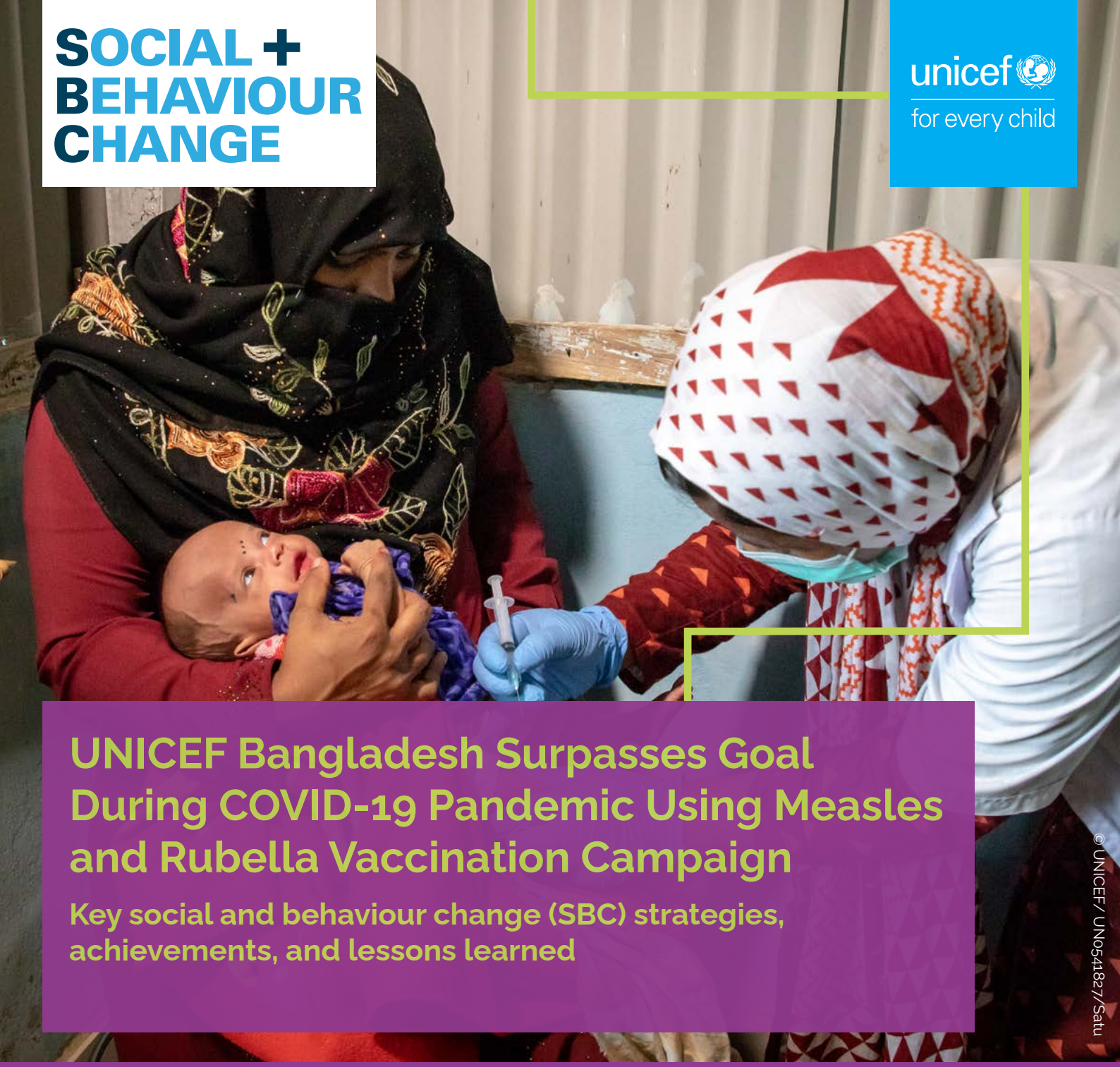

UNICEF Bangladesh Surpasses Goal During COVID-19 Pandemic Using Measles and Rubella Vaccination Campaign

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
December 2020 to February 2021

Duration
Six Weeks

Budget
US$12 million

UNICEF Bangladesh, in collaboration with the Bangladesh Ministry of Health and Family Welfare (MOHFW) Extended Immunization Programme (EPI) and other partners, supported the implementation of a vaccination campaign to ensure that parents and caregivers retained confidence in childhood immunizations during the COVID-19 pandemic, and that children between the ages of nine months and nine years old kept up with their measles and rubella vaccination (MRV) schedules. The campaign reached 36.6 million children in all 64 districts of the country, including children that were missed in one or all previous MRV opportunities.

Context

Before 2000, less than 75 per cent of children in Bangladesh received their routine first dose of measles-containing vaccine (MCV1) and measles was a major cause of child death. From 2000 to 2016, after increasing MCV1 coverage, implementing three supplementary immunization activities (SIAs), introducing the rubella vaccine (the MRV) in 2012, and adding a second dose of measles vaccine for children aged 15 months as part of the country's routine immunization protocol, the estimated MCV1 coverage increased from 74 to 94 per cent. MCV2 coverage increased from 35 per cent in 2013 to 93 per cent in 2016. By 2016, confirmed measles incidence in Bangladesh decreased by 84 per cent, from 40 per million population to six per million population.[1],[2]

In 2003, Bangladesh instituted laboratory-supported case-based surveillance for suspected measles cases using 143 active and 625 passive surveillance sites in all 64 districts of the country. This system was adapted from the existing acute flaccid paralysis surveillance system for polio detection. Surveillance for measles and rubella was integrated with vaccine preventable disease (VPD) surveillance in 2003 and congenital rubella syndrome (CRS) surveillance in 2012. Aggregated measles cases continue to be reported by all health facilities through the National Health Management Information System (NHMIH) and have been reported annually through the WHO/UNICEF Joint Reporting Form (JRF) since 2000. The difference in number of cases reported annually by these two parallel systems has decreased since 2013.

The government of Bangladesh set a goal to eliminate measles and rubella by 2020. A national vaccination coverage survey conducted in 2015 found that the most common reasons for a child not being vaccinated or only partially vaccinated were that caregivers were too busy with other priorities or did not remember to bring the child for vaccination, and/or they lacked information about when to bring the child for vaccination. These findings indicated the need for intensified social mobilization activities to strengthen routine immunization (RI).[3] MRV catch-up campaigns were implemented throughout Bangladesh. However, Bangladesh had a total of 2,136 confirmed cases in 2018 and 5,266 in 2019.[4]

In March 2020, at the time of the COVID-19 pandemic, the government of Bangladesh imposed a mass quarantine to control the outbreak of the virus. Adherence to the quarantine, and orders to avoid crowded places like vaccination centers, disrupted the RI and EPI programmes, resulting in many children missing lifesaving routine vaccinations. As the EPI programme in Bangladesh began to rebound, there was an urgent need to renew the commitment to improving MRV access and uptake and restoring RI services to (at least) pre-COVID-19 achievements.

Strategic approach

The government of Bangladesh's revised target for complete elimination of circulating measles and rubella virus is by the year 2023. UNICEF Bangladesh, in collaboration with the Bangladesh Ministry of Health and Family Welfare (MOHFW) Extended Immunization Programme (EPI) and other partners, supported the implementation of an MRV campaign to ensure that parents and caregivers retained confidence in childhood immunizations during the COVID-19 pandemic, and that children between the ages of nine months and nine years old kept up with their measles and rubella vaccination (MRV) schedules. UNICEF supported the development of a social and behaviour change communication (SBCC) strategy to identify key audiences (especially high-risk groups) and guide the campaign activities.[5] The campaign was spread over six weeks (instead of the usual three weeks), between 12 December 12 2020 and 3 February 2021, to avoid crowding at vaccination sites and reduce the risk of COVID-19 infection. The duration the campaign was somewhat flexible during the pandemic. In some hard-to-reach areas, the campaign continued beyond the planned timeframe to ensure that all key populations were reached. The key populations for the campaign included urban mothers and caregivers living in slums, garment workers and employers, hard-to-reach populations in cities, tea garden labourers and owners, caregivers in Haor and marshy lands, ethnic communities, children, adolescents and youth, both in-school and out-of-school, local community leaders and faith-based leaders.

Since the pandemic restricted in-person communication, Bangladesh's robust community network (including health systems, local government institutes, faith leaders, voluntary groups, and school-systems) was not able to play its usual role in engaging community members and motivating them to have their children vaccinated. The UNICEF SBC team pivoted to relying on mass and social media.

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Based on previous successes with mass media, the team created television and radio public service announcements, talk shows, songs, booklets, newspaper articles and advertisements, outdoor media (e.g., large posters, billboards), and used megaphones to make announcements in communities without calling people to gather. Community-radio networks were activated to provide key messages about staying up-to-date with MRV. Celebrities were recruited to promote MRV. The slogan for the campaign was "O loving children come, it's time to get vaccinated," a line that echoes a famous children's lullaby. The slogan was pretested with children, parents/caregivers, and health workers, and found to be reassuring. The mass media message and materials were also delivered via social media (e.g., Facebook) and shared through a synched content calendar to ensure wider audiences were reached with the most up-to-date messages.

A committed force of over 50,000 vaccinators were employed to deliver the vaccines into children's arms. They carried the cold-packed vaccine vials to hard-to-reach areas of the country to vaccinate the most vulnerable children, all the while maintaining COVID-19 safety protocols.

UNICEF invested in strengthening the cold chain capacity in Bangladesh, installing cold rooms and procure refrigeration equipment, cold boxes, and vaccine carriers, while also developing logistics management information systems and training for health workers for the 2020 MRV campaign. The Central Medical Store Department (CMSD) serves as the unit for facilitating the custom clearing of the vaccines, while the Central EPI Store at EPI-HQ under the MOH is responsible for storing the vaccines at the central level and in maintaining the required temperature.[6] This newly implemented cold-chain best-practice eliminated what used to be a substantial barrier to achieving full immunization coverage in the country.

Online tools were developed to create micro-plans and facilitate real-time monitoring of campaign activities through a dedicated server within the District Health Information System 2 (DHIS2). This system enabled team members from the lowest administrative unit to the national level to upload data in a timely manner. An android-based mobile App was created to disseminate the micro-plan templates, report on the "vaccination sessions" through which the micro-plans were created, provide supportive supervision, facilitate household visit scheduling, and strengthening Rapid Convenience Monitoring of the campaign activities reported on a real-time dashboard. A risk communication plan was developed to help the campaign team to address vaccination misinformation, disinformation, rumors, and adverse events following immunization (AEFI).[7]

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Key achievements

- The government of Bangladesh protected its children from measles and rubella throughout the COVID-19 pandemic. At least 36.6 million children between the ages of nine months and nine years old were vaccinated against measles and rubella during the UNICEF-supported 2020 MRV Campaign. This achievement surpassed the target of 34 million children (i.e., 104 per cent of the target was reached). The campaign reached 64 districts and 12 city corporations, including 484 Upazilas, 111 municipalities, and 48 zones.
- The UNICEF Bangladesh MRV campaign page on Facebook was followed by more than 10.5 million FB users. The theme song reached more than 300,000 people, and the PSA reached about 500,000.

OVER 50,000
vaccinators were employed

AT LEAST 36.6 million
children vaccinated

PSA reached about
500,000 PEOPLE

Lessons learned

1. Gathering evidence about social norms influencing behaviour change related to MRV was crucial for developing the campaign interventions.
2. Having a clear strategic framework template, an easily navigable implementation plan, and a process for campaign partners to follow made it possible to quickly transform MR materials for the pandemic context, and helped partners deliver on the ground through virtual orientations.
3. A specific Guideline for Crisis and Emergency Risk Communication (CERC) and Addressing Vaccine Hesitancy helped address issues of AEFI arise during the campaign.

Recommendations

1. Future campaigns should consider developing or using an existing character (cartoon or otherwise) to serve as a mascot that can be associated with childhood vaccination in Bangladesh and be used to promote childhood vaccinations throughout the country.

2. The social media assets created for this campaign were mostly hosted by UNICEF Bangladesh. The capacity of partners in social media listening needs to be further strengthened so that they are capable of promoting campaign messages.

3. There are at least 30,000 zero-dose children under one year old in Bangladesh. Zero-dose children have not received any vaccinations, including for measles and rubella and future campaigns should address these children.

Endnotes

1 Khanal S., Bohara R., Chacko S., Sharifuzzaman M., Shamsuzzaman M., Goodson J.L. et al., 'Progress toward measles elimination – Bangladesh, 2000-2016', *Morbidity and Mortality Weekly Report*, vol. 66, no. 28, pp. 753-757, 2017.

2 Supplementary Immunization Activities (SIAs) are immunization campaigns, typically implemented for two targeted age ranges. An initial, nationwide catch-up SIA targets all children aged nine months to 14 years; a periodic follow-up SIAs then targets all children born since the last SIA and are generally conducted every 2–4 years. The goal of a follow-up SIA is to eliminate any measles susceptibility that has accumulated in recent birth cohorts and to protect children who did not respond to the first dose of measles vaccine.

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UNICEF Pakistan Develops Social and Behaviour Change Interventions to End Polio in Karachi

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
August 2020 to present

Duration
Ongoing

Budget
US$45,000 for community engagement activities (staffing and external comm's budget are not included)

Pakistan is one of three remaining polio-endemic countries in the world, along with Afghanistan and Nigeria. To eliminate polio completely, every child in every household must be vaccinated. UNICEF Pakistan supported challenge mapping research in Karachi (capital of Sindh province) to profile cases of polio vaccine refusals, determine the key bottlenecks of the under-immunized population, and engage community members using tailored social and behaviour change (SBC) activities in mapping and co-creating solutions to address polio-vaccine resistance. The community engagement activities resulted in a 70 per cent decline in the rate of polio vaccination refusals in Karachi between August 2020 and August 2022.

Context

Since the launch of the Pakistan's Polio Eradication Programme in 1994, there has been a 99 per cent decline in polio cases in Pakistan.[1] In Sindh province, wild polio virus (WPV) cases declined from 12 in 2015 to only one in 2018. In 2019 and 2020, however, the number of cases jumped to 30 and 22 respectively. The number of circulating vaccine-derived polioviruses (cVDPV2) in Sindh was 45 in 2020.[2] Thousands of Pakistani children are still missing out on the polio vaccine. Many of these children live in remote, fragile, and conflict-affected areas, and many are part of migrant or refugee populations, which makes reaching them with vaccines very difficult. Misinformation about polio vaccines, especially during the COVID-19 pandemic when immunization campaigns were interrupted, also hampered the eradication of this disease.

Karachi is the largest city in Pakistan, with approximately 17 million people belonging to different communities and tribes that struggle to maintain their cultural and historic identity while surviving amidst difficult socio-economic circumstances, poor civil and health systems, and a barrage of political conspiracies that result in low trust in the government and their programmes, including polio vaccination. Most Pashtun communities lie on the fringes of Karachi city.

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Strategic approach

UNICEF Pakistan supported a household-level challenge mapping study of parents in Karachi (Sindh province) that refused the polio vaccine for their children ages one to five years old.[3] This study allowed the researchers to identify the language, tribe, caste, clan, religion, and socioeconomic status of families with the highest refusal rates, their reasons for refusal, as well as tribal leaders/ influencers within Pashtun communities.

The highest refusal rates came from Urdu and Pashto speakers, and families living either in slums or in "posh" areas. More than 150,000 children went unvaccinated for polio. The majority of parents in the study refused to have their child vaccinated because they believed the vaccine should be administered by a doctor, or they did not trust the polio vaccine and/or the Pakistani government that supported the polio vaccination activities. Some parents harboured misconceptions that the polio prevention programme was a Western conspiracy against Muslims and contained ingredients forbidden by Islamic law. Cultural misconceptions about the dangers of vaccinating a newborn also circulated within the Pashtun population. A majority of parents said that their child missed the vaccine because they had diarrhoea, fever, or a seasonal disease at the time of the vaccination campaign. Parents in "posh" areas were reluctant to let their child get multiple doses of the polio vaccine. The findings from the study with parents were used to identify refusal clusters on a map of Karachi.

A set of tailored social and behaviour change (SBC) interventions were co-created with community members to decrease the number of polio vaccination refusals. Polio micro-plans were developed at the community level to engage the community and heighten ownership of, and accountability for, increasing polio vaccination among children within the community. Each area had about 1,000—1,200 children targeted to receive a polio vaccine. Areas with more than 10 per cent vaccine refusal rates were the priority for SBC interventions. The key SBC activities included:

1. **Advocacy with key stockholders:** High level engagement with key political, religious, and tribal leaders was initiated to create an enabling environment for polio vaccination activities.
2. **Integrated service delivery:** A specific action plan was developed and engaged other sections of UNICEF to focus more on integrated service delivery and sensitization of communities around key family health care practices.
3. **Training Frontline Workers (FLWs):** Capacity-building sessions were conducted with FLWs to improve their interpersonal communication (IPC) skills.
4. **Community engagement sessions with tribal elders and community members:** Interpersonal communication was used to motivate tribal elders to support polio vaccination, and to engage Pashtun community members to have their children vaccinated against polio. Pashtun AS and SM identified elderly female Pashtun "mother figures" (*Moor*) in the community who served as influencers for female caregivers.
5. **Religious school engagement**: Key messages were disseminated through Madrassahs (boys-only Islamic religious schools for elementary and higher learning) and religious gatherings.
6. **Mass media:** Local media outlets were approached to broadcast videos made by a UNICEF videographer in Pakistan, with positive messages about polio vaccination delivered by such influencers as tribal leaders, political leaders, the Pakistan Medical Association, individual doctors, the Pakistan Islamic Medical Association, UNICEF partners, UNICEF's Area Supervisors, Polio Team, and other stakeholders.

Key achievements

- At least 19 polio vaccination campaigns were implemented between 2020 and 2022.
- At least 100 videos with messages from UNICEF staff and key stakeholders about the benefits of polio vaccination have been created by UNICEF and broadcast via local media.
- More than 80 Frontline Workers were trained in IPC and are attached to their home community.
- The rate of polio vaccination refusals in Karachi declined by about 70 per cent between August 2020 and August 2022.
- Overall coverage of polio vaccination improved to where more than 98 per cent of eligible children were vaccinated in each supplemental immunization activity.
- Systematic engagement of key tribal, political, and religious leadership led to more than 1,500 key leaders actively supporting polio vaccination and other integrated services.
- Community engagement efforts led to a major boost in community trust; polio vaccinators were able to move through hostile areas without law enforcement.
- The number of females that participated in community engagement sessions about polio vaccination increased.
- Targeted and area specific interventions helped to reduce resistance to polio vaccination.
- Strong alliances were developed with community-based organizations.
- No polio virus was found in humans or the environment in most parts of the Sindh province since the intervention began in 2020.

MORE THAN **80**

Frontline Workers were trained

70%

decline in the rate of polio vaccination refusals

AT LEAST **19**

polio vaccination campaigns were implemented

Lessons learned

1. Gathering behavioural insights and challenge mapping are key to understanding polio vaccination refusals as a first step toward developing activities to change attitudes and behaviours regarding the polio vaccine.

2. Involving community members (especially community/opinion leaders) in the planning, implementation, and monitoring of SBC activities, helps to create ownership of the activities and lowers resistance to polio vaccination uptake activities. Continuous community listening helps to identify and address on-the-ground challenges to polio vaccination interventions.

3. Integrated service delivery can revitalize community engagement, build confidence and trust within the community, and make the community feel heard. Even when communities did not have positive experiences with the health service delivery system, this trust was not eroded. Need-based partnerships and alliance-building with public and private partners requires goal-driven activities and an action plan for efficient execution.

Recommendations

1. Continue to use a systematic, real-time approach to collecting social data from households (parents/caregivers) to identify and understand the underlying causes of polio vaccine refusals.

2. Intensify the integrated services approach, specifically in slum pockets of Karachi, including strengthening EPI and basic health and nutrition services to improve the community's trust in the health system.

3. Employ systematic advocacy at the policy level to achieve better integration of SBC, EPI, and overall integrated service delivery, and greater sustainability of results.

Endnotes

1 Pakistan Polio Eradication Programme, 'Pakistan Polio Eradication Initiative: Working towards a polio-free Pakistan for every child', <www.endpolio.com.pk/images/reports/PPEI%20Brochure%20English.pdf>.

2 Pakistan Polio Eradication Programme, 'Polio Free Pakistan for Every Child', <www.endpolio.com.pk/polioin-pakistan/polio-cases-in-provinces>.

3 A challenge map clearly communicates insights gained from fieldwork and pinpoints specific challenges using pictures of and quotations from users, as well as an explanatory text that addresses a problem, barrier or theme.

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UNICEF Leads Social Mobilization and Community Engagement Central to the Ebola Response in West Africa[1]

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

In July 2014, UNICEF was asked to co-lead, in coordination with WHO and the ministries of health of Ebola affected countries (e.g., Guinea, Liberia, Sierra Leone), the communication and social mobilization component—which UNICEF referred to as communication for development (C4D)—of the Ebola response. For the first time in an emergency setting, C4D was formally incorporated into each country's national response, alongside more typical components such as supplies and logistics, surveillance, and clinical care. A post-outbreak assessment of the social mobilization and community engagement response yielded key lessons learned, including the importance of investing in trusted local community members to facilitate community entrance and engagement, and balancing centralized mechanisms to promote consistency and quality with decentralized programming for flexibility and adaptation to local needs.

Context

In December 2013, an outbreak of Ebola Virus Disease (EVD) began in West Africa, spreading through Guinea, Liberia, and Sierra Leone. In July 2014, the World Health Organization (WHO) declared the outbreak a "Public Health Emergency of International Concern."[2] By March 2016, when the Emergency Committee on Ebola convened by WHO concluded that the outbreak no longer constituted a public health emergency, a total of 28,616 confirmed, probable, and suspected cases had been reported, more than 11,310 people had died and 23,588 children had lost one or both parents or their primary care-giver.[3] An initial underestimation of the scope of the outbreak contributed to delays in funding, which in turn contributed to a slow start to the response.

Once the response hit the ground, it was initially focused on containing EVD and establishing the supply-side pillars related to surveillance, logistics, and, in particular, burials. Communities had been managing their own risks, but the formal response at that time paid little attention to working within community structures and did not acknowledge traditional community coping strategies and influences on behaviour. Rumours and misconceptions circulated widely because community members mistrusted messaging from formal communication channels. These poor community linkages and poor quality of services undermined community confidence, effective social mobilization, and ultimately the response itself. As the outbreak progressed beyond initial projections, and given the limitations of clinical approaches and weak local systems, pressure increased for community engagement and social mobilization to be central to changing behaviour to prevent and control the outbreak.

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Strategic approach

For the first time in emergency contexts, social mobilization and community engagement was included as a "cluster system" (also known as a "pillar") in the three most affected countries (Guinea, Liberia, Sierra Leone), representing a key area of focus for the response. These cluster systems were led by the ministries of health and their corresponding technical units with support from United Nations (UN) agencies and civil society organizations. The main function of the social mobilization and community engagement pillar was to coordinate efforts and design a strategy to focus on key behaviours, including measuring and reporting on key performance indicators. UNICEF was designated as co-lead for this pillar with government and civil society counterparts in each of the countries, while working closely with many other partners.

Although variations existed among the three countries, the other pillars commonly included media and communication, epidemiology/surveillance, case management/contact tracing, infection control, laboratories, burials, logistics/supplies, psychosocial support and child protection, and other sectors such as water and sanitation, HIV/AIDS, health, nutrition, and education. UNICEF used its communication for development (C4D) expertise and tools to share Ebola knowledge and social norms.

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In 2015, an assessment was conducted to identify lessons learned from the Ebola response in West Africa, with a particular focus on the C4D contributions. The assessment included a literature review of relevant documents from UNICEF and partner agencies; structured expert discussions with more than 90 UNICEF and civil society participants across West and Central Africa; an online survey, implemented between July 2014 and April 2015, with individuals who worked on Ebola with governments, the UN or any partner organization in any of the three countries; and confirmatory key informant interviews with UNICEF and UN Mission for Ebola Emergency Response (UNMEER) senior advisory to discuss draft lessons learned. The draft lessons learned were also presented at the International Summit on Social and Behaviour Change Communication in Ethiopia in February 2016. In both the interviews and at the summit, partners provided positive and confirmatory feedback on the validity of the lessons.

Key achievements

- A total of 53 respondents from UNICEF, UNMEER, NGOs, government, and civil society organizations completed the survey.
- Survey respondents pointed to the key challenging elements during the Ebola response (e.g., coordinating community engagement efforts; working with survivors; developing community engagement indicators or monitoring and evaluation issues).

53
survey respondants

MORE THAN 90
expert discussions

UNICEF USED C4D
expertise and tools to share Ebola knowledge

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Lessons learned & Recommendations

1. Establish a comprehensive strategy that focuses on key behaviours, places communities at the centre during all phases of the response and facilitates decentralization with high-quality C4D programming integrated across sectors.

2. Establish solid C4D leadership at all levels with the necessary authority to coordinate partners.

3. Invest in trusted local community members as mobilizers and strengthen broader community systems for long-term resilience. Identify key influencers and channels of communication with strong reach and relevance while considering more specialized communication for specific sub-groups.

4. As the patterns of the epidemic change over time, continually adapt messages and strategies that are most relevant to communities' understanding of the health issue, to their information needs, and to what is most likely to prevent and control infections.

5. Invest in strategic partnerships to achieve short- and long-term goals, starting with communities themselves, to build strategies, skills, and other resources that are most relevant to community understanding of the health issue and to controlling the outbreak.

6. Establish and support a network of local and international professionals with capacity in C4D, including both management and technical skills, who can be deployed rapidly and remain in place for significant amounts of time to supplement national systems.

7. Establish clear C4D process and impact indicators and an accessible harmonized data platform for monitoring, and strive for innovations in real-time data analysis and rapid feedback to communities and authorities to inform decision making.

Endnotes

1 Gillespie A.M., Obregon R., El Asawi R., Richey C., Manoncourt E., Joshi K., Naqvi S., Pouye A., Safi N., Chitnis K., Quereshi S., 'Social mobilization and community engagement central to the Ebola response in West Africa: Lessons learned for future public health emergencies', *Global Health: Science and Practice*, vol. 4, 2016, pp. 626—644.

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UNICEF China Motivates Children to Change Their Food Habits

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
May to June 2022

Duration
One month

Budget
US$582,000

During National Nutrition Week in May 2022, UNICEF China launched a month-long #KnowYourFood campaign. A mock convenience store was unveiled in Chengdu, Enshi, and Weiha cities. The mock store was created to simulate the retail food environment that children are experiencing every day. Instead of selling snacks and drinks, the store provides "shoppers" with nutritional information about the food and beverage items. These stores offered a creative approach to helping children and parents become informed consumers and make healthier choices about what they eat and drink. School-based nutrition sessions for children, adolescents, and parents were also conducted during the month-long campaign. The aim of the campaign was to empower children and young people to make informed, healthy choices about their diet through improved nutrition literacy. An assessment following the campaign showed that 81 per cent learned new information from the campaign, including the importance of eating more vegetables, getting more exercise, and getting enough sleep.

Context

Child overweight and obesity rates in China have increased rapidly in the past decades. In 2020, about 10 per cent of children below the age of six years had an overweight or obesity problem. The prevalence of overweight and obesity among children aged 6—17, reached 19 per cent in 2020.[1] The increase in overweight and obesity is being driven by a changing food environment with readily available cheap, ultra-processed food and sugar-sweetened beverages, combined with aggressive marketing that targets children and young people. Convenience stores near schools or in communities expose children to foods high in fat, sugar, and salt. Without action, the threat of childhood obesity could have severe short-term and long-term consequences for children's psychological development, as well as increasing the risks of obesity and associated health problems in adulthood.

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Strategic approach

To help children and young people understand the potential health hazards of ultra-processed snacks, UNICEF China launched the #KnowYourFood edutainment campaign. The centerpiece of the campaign was a pop-up convenience store filled with mock-ups of the most popular pre-packaged foods that children and young adults typically purchase (e.g., potato chips, puff foods, and sugar-filled drinks). Unlike a regular store, the pop-up store did not sell snacks and drinks; instead, it offered "customers" information on the ingredients and potential health impacts of the snacks and drinks.

Large cartoons made the mock store youth friendly. Easy-to-understand food labels showed the added sugars, salt, and fat contents of each item. Interactive features, for example, a self-checkout scanner machine, allowed children to scan an item and receive a printed "receipt" with nutrition information that they could use as a bookmark. During their visit to the pop-up store, children participated in various interactive games to gain nutrition literacy through fun and play (e.g., solving puzzles). At the end of the tour, children waved to the exit camera with their special takeaways from the store in hand (e.g., puzzles in the shape of a pack of potato chips), and more importantly, knowledge to make healthier food choices.

The campaign included a digital presence across six popular social media platforms (Weibo, WeChat, Douyin, Kuaishou, Bilibili, Xinhua), with a virtual 3D version of the convenience store, short videos, and games. UNICEF China published 201 social media posts related to the campaign. In collaboration with the Kwai short video platform, the #KnowYourFood campaign also featured interactive experiments to create an immersive learning experience for children so that they can understand the science behind food. Dr. David Evans, a chemistry professor from the Beijing University of Chemical Technology and video blogger on Kwai, joined UNICEF to produce science experiment videos to explore the ingredients of some of the most popular snacks and sugar-sweetened drinks (known as "Dr. Dai's Lab"). Popular sports figures and influencers with the China Athletics Association also helped amplify the messages of the campaign and shared with children and young people the importance of nutrition literacy for their health.

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To further expand the reach of the campaign, and to encourage children to make changes, UNICEF worked with nutrition and education experts to develop teaching materials to promote healthy diets for primary and secondary school students. The "nutrition sessions" were offered to students, parents and caregivers, so that students and their families can change their consumption behaviours and improve students' diets and nutrition. Children were encouraged to take a one-week nutrition challenge and given a worksheet to record the foods that they consumed in one week. The sessions were implemented in 10,516 primary schools and 6,426 middle schools in 30 provinces/regions.

UNICEF China supported an assessment of activities to determine the impact of the mock convenience stores, social media engagements, and school-based nutrition sessions. The RE-AIM model was used as a guide for the assessment that asked about the Reach, Effectiveness, Adoption, Implementation, and Maintenance of the activities and behaviour changes. Data was collected by tracking online social media page views and interactions, and using an online survey posted on the campaign home page that collected 3,825 responses from 32 provinces/regions. Students and parents attending nutrition sessions were asked to complete questionnaires after the sessions and again seven days later. Questionnaires were completed by 2,830 students and 2,599 parents after the nutrition sessions. Focus group discussions were conducted with selected students and their parents that had attended nutrition sessions to gain a deeper understanding of how the nutrition sessions influenced their food-related behaviours and choices.

Key achievements

- The most popular social media activity of the #KnowYourFood campaign was "Dr. Dai's Lab," with more than 77 million views.
- The #KnowYourFood campaign that spread across five social media platforms yielded at least 291,000 interactions (e.g., likes, forwards, favorites, reviews). More than 3,500 user reviews were published, 97 per cent of which were positive.
- Eighty-one per cent of the online survey respondents said that the learned new information from the campaign (91 per cent learned that they should be eating more vegetables, 89 per cent learned they should get more exercise, and 87 per cent learned they should be getting enough sleep);
- At least 95 per cent of the online survey respondents said that they were willing to share information about the campaign with others.
- The school-based nutrition sessions reached 13 million children and adolescents and six million parents. Almost all students (93 per cent), parents (92 per cent), and teachers (97 per cent) found the sessions useful, educational, and inspiring. At least 66 of children were able to complete the one-week nutrition campaign challenge.
- Seven days after the school-based nutrition sessions, a questionnaire completed by 3,189 students on their health behaviours during the past week showed that 78 per cent of students improved their slevep habits, 77 per cent exercised more, and 68 per cent reduced their consumption of sugar-sweetened beverages. The questionnaire also found that students who had rated the nutrition sessions as very inspiring and instructive, were more likely to report positive behaviour changes seven days later.

sessions were implemented in

10,516
PRIMARY SCHOOLS

and

6,426
MIDDLE SCHOOLS

in 30 provinces/regions

MORE THAN 3,500

user reviews were published,

97%

of which were positive

68%
OF STUDENTS

reduced their consumption of sugar-sweetened beverages

Lessons learned & Recommendations

1. The food and beverage industries have an oversized presence in Chinese mass and online media – large potential for conflict of interest.
2. Partnering with government to amplify the campaign, using "National Nutrition Week", was good, but technocrats are fearful of taking on business.
3. Advocacy campaigns aligned with activities on the ground are hard to coordinate, but they can help us to amplify impact.
4. Campaigns need to be sustained; building on assets and ideas.

Endnotes

1 UNICEF China Country Office, '#KnowYourFood, Empowering children and young people to make healthier food choices', <https://www.unicef.cn/en/know-your-food>

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UNICEF Strengthens Immunization Campaigns in Europe and Central Asia

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
October 2020 to November 2022

Duration
Two years

Budget
Unknown

UNICEF Europe and Central Asia Regional Office (ECARO), in partnership with UNICEF country offices and the London School of Hygiene and Tropical Medicine's Vaccine Confidence Project (VCP), implemented a social media listening initiative in 15 ECAR countries. The aim was to identify and track immunization and COVID-19-related conversations, topics of interest, rumours and misinformation, to understand the impact of social media on caregivers' attitudes, beliefs, trust, immunization intention and vaccine uptake.

The findings from this initiative informed country level decision-making and programming, including the development of evidence-based social media campaigns to improve vaccination coverage rates, and contributed to the development of a social media listening and engagement toolkit to support those involved in communicating about and delivering routine immunization programmes. It was the first social listening initiative in the region.

Context

Despite a considerable investment in vaccine supply and delivery in the past decades, many children in Europe and Central Asia still miss out on basic childhood vaccines. Routine vaccine coverage rates continue to vary substantially between and within countries, from as high as 99 per cent to as low as 50 per cent.[1] More than 70 per cent of the region's unvaccinated infants are from middle income countries, with Ukraine presenting the lowest coverage rate and the greatest challenge. Children from ethnic and vulnerable groups (e.g., Roma, refugees, and migrants) are all lagging in basic immunizations.[2] Some countries also lack adequate monitoring of vaccine coverage that is essential to understanding and addressing any gaps.

Vaccine hesitancy is a growing concern in the region. Parents exposed to myths, misinformation, and disinformation about immunization in the media or on social media are less likely to trust vaccines. Decreases in donor support for immunization, increased costs and shortages of vaccines on the global market, and reforms that have affected the structure and financing of immunization programmes in some countries have contributed to outbreaks of vaccine-preventable diseases.[3] At least 500,000 children in the region are not protected against measles.[4]

Organizations promoting vaccination often face significant challenges in monitoring and communicating effectively through social media. These challenges can include a lack of resources, lack of access to specialist skills and software, online misinformation, and organized anti-vaccine disinformation campaigns.[5] These problems are often compounded by a lack of data around the effectiveness of different kinds of digital intervention, making it difficult for organizations promoting vaccination to develop evidence-based communication strategies or to make informed decisions about how best to allocate scarce resources. In the context of the COVID-19 pandemic, there was a growing awareness among public health organizations of the need to build institutional capacity to monitor social media, and to design, implement and evaluate social media interventions.[6]

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Strategic approach

Social media monitoring is a means for tracking conversations about a selected topic across social media platforms. In 2020, UNICEF launched a regional initiative with its research partner, the Vaccine Confidence Project (VCP) at the London School of Hygiene and Tropical Medicine to map the social media landscape in Europe and Central Asia (ECA) and to develop a set of social media monitoring and engagement tools. The key aim of the two-year initiative was to strengthen UNICEF's and governments' capacities to design, implement and evaluate evidence-based social media interventions around vaccination. In practice, the initiative focused primarily on former Eastern Bloc countries, where vaccine confidence often is relatively low, and where institutional capacity tends to be most constrained.[7] Originally conceived prior to the COVID-19 pandemic, and with a focus on routine childhood immunization, the initiative had to adapt to the pandemic context by expanding its focus to include the novel coronavirus, and shifting to online, virtual collaboration and distance-learning methodologies and platforms.

During the planning phase, the UNICEF ECA Regional Office in Geneva invited participation from UNICEF country offices throughout the region. The countries that opted to take part were: Albania, Armenia, Bosnia and Herzegovina, France, Georgia, Kazakhstan, Kosovo, Kyrgyzstan, Moldova, Montenegro, North Macedonia, Romania, Serbia, Tajikistan, Turkey and Uzbekistan. UNICEF country offices in the participating countries were asked to identify additional relevant local stakeholders to take part (e.g., Public Health Institutes and Ministries of Health).

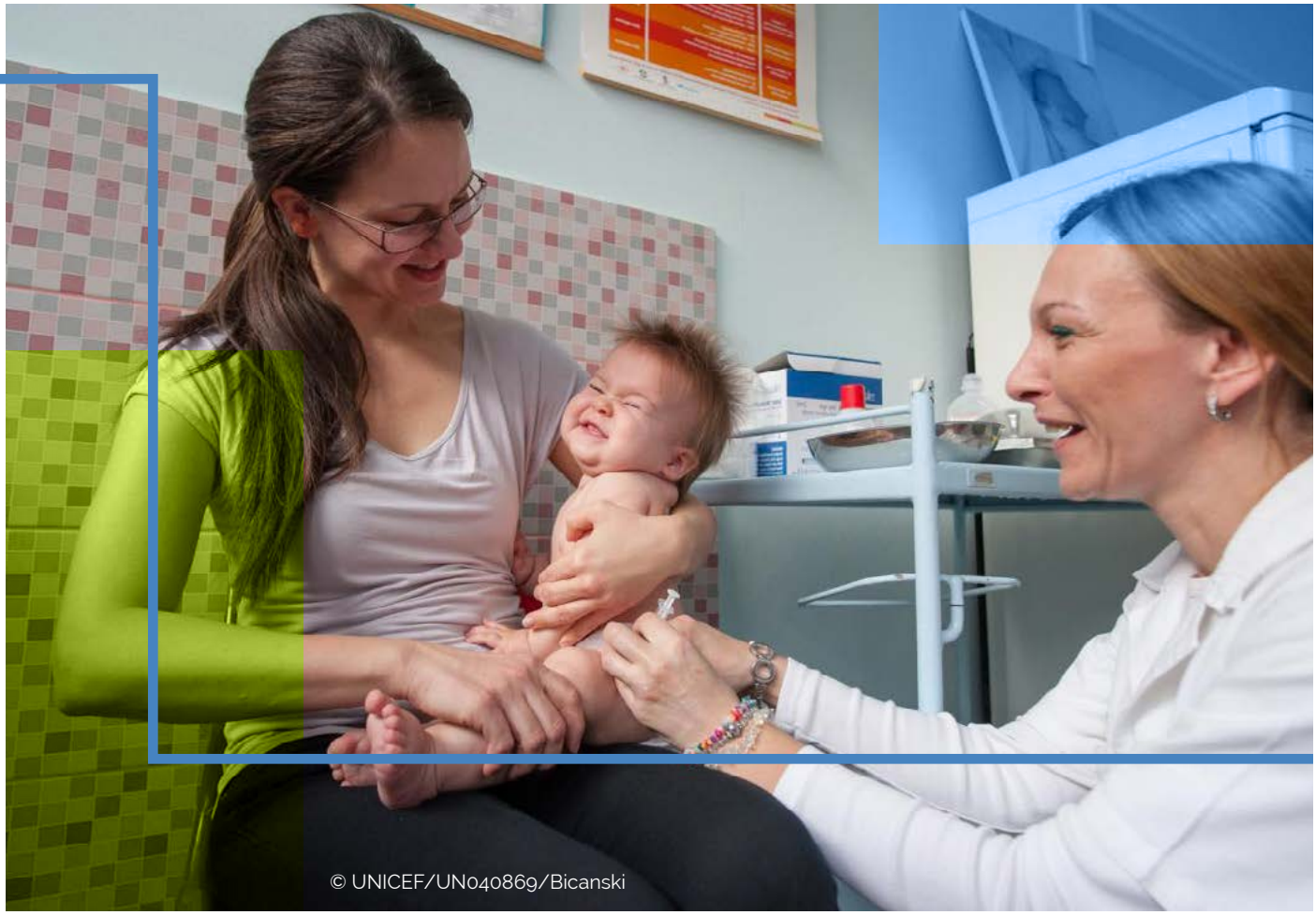
The formative research phase of the initiative began in October 2020. UNICEF country teams and regional stakeholders responded to surveys and participated in online workshops to share their experiences and insights. These learnings served as a baseline for knowledge and capacity related to social media monitoring and engagement, helped to map existing social listening activities, and pointed to appropriate online communication channels. At least 43 per cent of participants at a February 2021 online workshop said that their organization was conducting social media monitoring. Sixty-five per cent of those organizations were using specialized software tools while 25 per cent were monitoring social media feeds. Ten per cent had designated a third party to conduct the monitoring and data analysis. The data collected from the workshop participants suggested that there was a need to develop knowledge and skills around how to use social media monitoring software or how to select the most appropriate tool for the specific need and context.

The social media monitoring phase was implemented between October 2020 and October 2021. COVID-19 vaccine programmes were underway in many countries throughout the ECA region. The monitoring focused on identifying the key platforms, pages, and groups for online discussions about vaccines and COVID-19. Of particular interest was the tone and sentiment of the discussions, and the sociodemographic makeup, attitudes, and behaviours of the participants of the online conversations. The monitoring criteria were selected based on expert knowledge and translated into search terms (in multiple languages) and updated as appropriate over time. The main software tool used was YouScan, a social media monitoring service headquartered in Kiev, Ukraine, which has the ability to perform sentiment analysis of social media posts in both Latin and Cyrillic script, and in various regional languages including Kazakh, Russian and Armenian. Additional software tools included

CrowdTangle, a proprietary tool from Meta with the capability to monitor Facebook and Instagram in multiple languages; Meltwater, a media monitoring tool which provides unlimited access to Twitter data; and Audiense, an audience analysis and segmentation tool. Monthly regional and country-specific reports were generated and shared with the UNICEF regional office and country teams. Overall, the findings showed that online chatter centred on COVID-19 vaccines, and not on routine childhood immunization.

The insights generated through social media listening were used by UNICEF ECARO to support the design of a toolkit that illustrates how to develop a social media listening system and use the findings to develop, implement, monitor, and evaluate social media campaigns. The toolkit explains how to draft tailored messages that debunk myths and misinformation, incorporate testing into the social media campaign, and provides examples, guidelines and resources.

The creative concept for the campaign highlighted vaccines as "silent protectors." The messages and the visual content were created by Real Chemistry (an AI-driven service provider) using an iterative process. The core theme of the campaign was that vaccines provide parents with peace of mind about keeping their children safe from unforeseen diseases. The campaign was launched on Facebook and Instagram, the most popular online sites across the region. Capacity building workshops were conducted in March and April 2021 to train stakeholders on how to set up social media monitoring systems, monitor rumours and misinformation, and translate digital data into public health social media campaigns.



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Key achievements

- The social listening insights informed the development of communication messages for the public (e.g., debunking myths and misinformation) and for health professionals (in the form of FAQs).
- Several countries have created their own social listening mechanisms (e.g., Ukraine, Uzbekistan, Moldova, Kosovo).

MONTHLY REGIONAL AND COUNTRY-SPECIFIC REPORTS

were generated and shared with UNICEF regional office and country teams

Online chatter centred on

COVID-19 VACCINES

and not on routine childhood immunization

Lessons learned & Recommendations

1. Online comments and discussions about vaccines, including the specific language people use, and the responses generated by that language, can offer important insights into the most effective ways to communicate about vaccines.

2. Insights from social media monitoring can highlight trends in public discourse on vaccines/ immunization, especially related to trust, endorsements, mis- or dis-information, and conspiracy theories.

Endnotes

1 Vaccine Confidence Project, 'Building confidence in routine immunization', 2022, <www.vaccineconfidence.org/our-work/projects/building-confidence-in-routine-immunisation/>.

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UNICEF Myanmar Creates Interactive Accountability to Affected Populations Dashboard to Improve Programme Interventions

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
April 2021 to present

Duration
Ongoing

Budget
US$400,000

UNICEF Myanmar's Social and Behaviour Change (SBC) Unit launched an interactive Accountability to Affected Populations (AAP) dashboard to facilitate the consolidation of feedback and inputs regularly collected from community members by UNICEF field offices (FOs) and implementing partners (IPs) through community feedback mechanisms and as part of their field monitoring and outreach activities. The aim of the dashboard is to provide programme planners with user-friendly disaggregated data to inform and strengthen programme activities. The dashboard is powered by Microsoft's Power Business Intelligence (BI) reporting software.

Context

Prior to 2021, there was no systematic approach or strategy to implement AAP in UNICEF Myanmar, despite some initiatives at the sectoral level. In 2021, an AAP indicator was integrated into the Humanitarian Action for Children (HAC) and the responsibility for reporting on AAP was assigned to the SBC unit. This task was followed by institutionalizing community feedback mechanisms and systematizing the process for collecting feedback from communities through UNICEF's IPs. The main impetus for developing the dashboard was the need to collate and analyse information being received from implementing partners from various states and regions.


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Strategic approach

To design the AAP dashboard, UNICEF Myanmar conducted consultations with field office (FO) staff and implementing partners (IPs) to determine the types of data that would be most useful for informing their programme activities. In April 2021, UNICEF FO and IP staff began amassing monitoring and outreach feedback and inputs through activities such as focus group discussions, satisfaction surveys, individual interviews, post distribution monitoring, and group meetings, as well as through dedicated suggestion boxes and hotlines. The feedback was (and continues to be) recorded by IPs in a Microsoft Excel template, converted into an online data collection application on Kobo Connect, and uploaded automatically when a device (e.g., smart phone) is connected. Of particular importance is the feature that Kobo Connect does not require constant internet access, which ensures that field workers in conflict zones and areas with limited or no internet access can submit their data without delay. Further, this process ensures that data can be uploaded from any location even if it is remote. The UNICEF Myanmar SBC Unit has access to the data once it is uploaded on Kobo Connect.

The data on the AAP dashboard can be disaggregated by sector (e.g., Education, WASH, Child Protection), age, gender, and location of respondents. Users of the dashboard can also see the modality used for collecting community feedback (e.g., field visit report, suggestion box, phone call, etc.). The feedback is analysed by the UNICEF Myanmar SBC Unit on a quarterly basis and is communicated to the programme sections who, in turn, use the same to refine sector-specific priorities and activities.

The AAP dashboard has three sections:

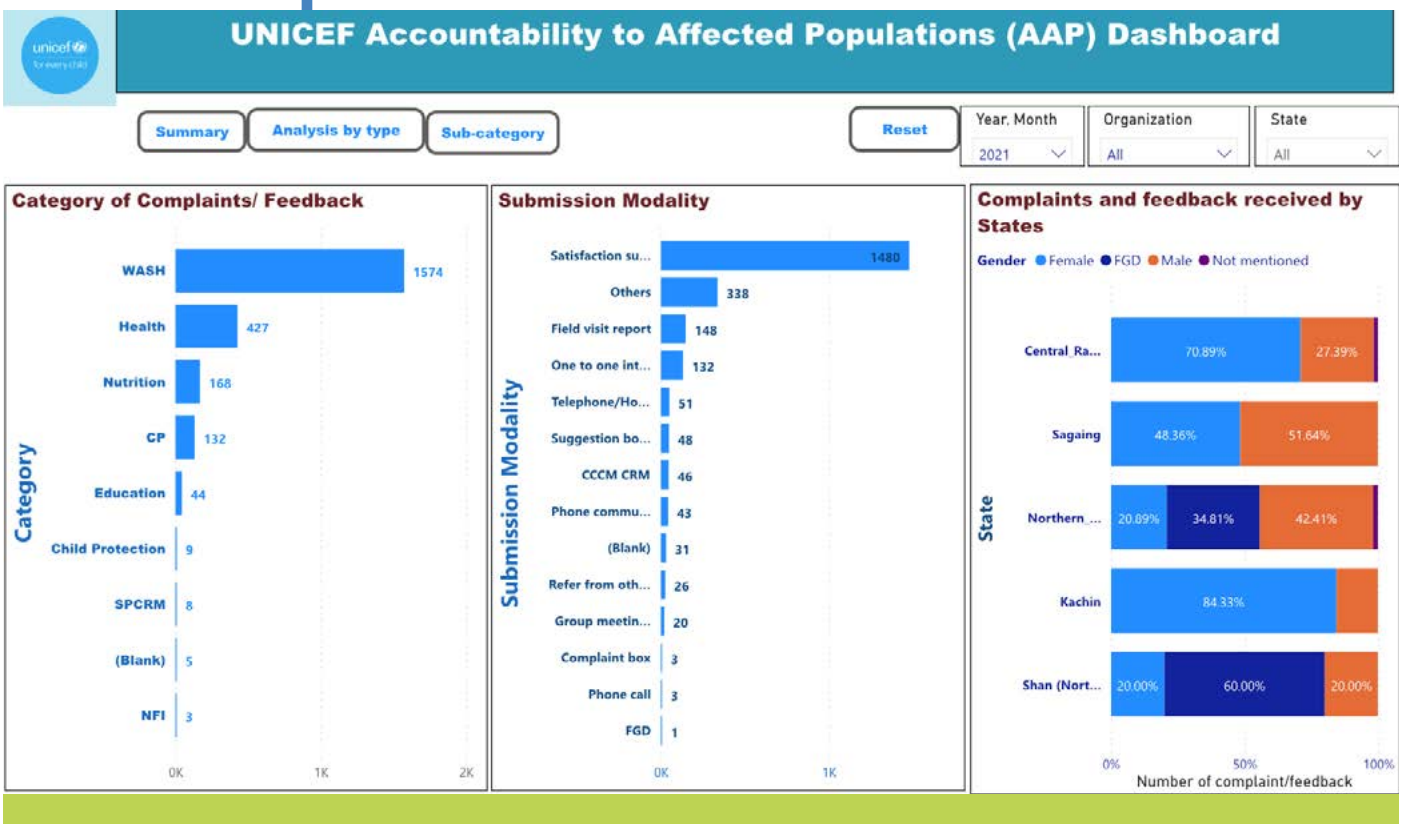
- **Summary section:** The first section of the dashboard provides an overview of the number of feedback inputs received per month, their status with respect to action

taken, and an age, gender and location (e.g., village, IDP camp) disaggregated status of feedback received. For example, between January and September 2022, 3,290 submissions were received, of which 61 per cent were from females and 61 per cent were from individuals 19—34 years old; 45 per cent of the submissions were from the new displacement sites, and the maximum number of submissions were from the Central Rakhine area (2,116).

- **Disaggregated data:** The second section presents data disaggregated by sector, submission modality, and location (and gender at each location). The analysis of the submissions for January to September 2022, for example, showed that the majority of submissions were related to WASH (1,761) followed by health (833), education (310) and nutrition (214). Most of the feedback came from satisfaction surveys conducted by IPs.
- **Analysis of services/interventions:** This section presents comments from affected populations about the services/interventions provided to them through UNICEF and IPs.

A 19-member AAP Taskforce was established by the UNICEF Myanmar country office to ensure that the dashboard feedback and inputs received from the affected persons were used to inform programme activities. The Taskforce members are designated focal persons from UNICEF programme sections, monitoring and evaluation section, and FOs. The UNICEF Myanmar SBC Unit also conducts regular orientation and/or training sessions on AAP for programme sections, FOs and IPs.

In May 2023, UNICEF Myanmar launched an e-course on AAP in the local language on the Talent Learning Management Server (LMS) platform. The course consists of five modules: (i) Introduction to Accountability to Affected Populations, (ii) Integrating AAP in our Work, (iii) Strengthening AAP in the Programme Cycle, (iv) AAP in Action, and (v) Partnership and Collaboration. It is designed for self-paced learning and includes interactive elements such as videos, exercises, and quizzes. A certificate of completion is provided upon finishing all modules and final quizzes. This course is currently open to UNICEF partners, including frontline workers and volunteers, as well as civil society organizations (CSOs) and community-based organizations (CBOs).



Key achievements

- The AAP dashboard has enabled systematic and regular collation and analysis of feedback received from affected populations and has enabled recording feedback from the most marginalized populations residing in remote locations.
- Under this initiative, community feedback mechanisms have been institutionalized in partner organizations where there previously were none, and strengthened in organizations where they were not so robust.
- The dashboard has made it easier for the SBC unit to inform/ advocate with UNICEF programme sections and management for speedy response and redressal as well as any course corrections required.
- The dashboard has been used an advocacy tool within UNICEF, its IPs and other stakeholders.

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A 19-member AAP Taskforce

was established

Community feedback mechanisms have been institutionalized in partner organizations

The course includes interactive elements such as videos, exercises, and quizzes

Lessons learned

1. Convincing implementing partners to adopt AAP indicators requires advocacy and time, especially when the innovation (in this case AAP indicators) were new and previously not a part of programme documents. Partners working on protection issues find it difficult to report on AAP due to the sensitive nature of the interventions such as case management of child issues.

2. Even though the AAP dashboard is useful and powerful, awareness and capacity building of UNICEF staff as well as partners on AAP needs to be undertaken on a regular basis to ensure that AAP is mainstreamed.

Recommendations

1. Institutionalize a mechanism for online submission of community feedback in real time.

2. Train and build capacity among stakeholders, including internal stakeholders (UNICEF staff and FOs), Implementing Partners (staff, community workers and volunteers).

3. Conduct regular consultations with all stakeholders at every phase of dashboard development to ensure regular reporting is received from partners, endorsed, and supported by different sectors.

4. Establishing a mechanism for tracking actions taken or changes made in programmatic activities as a response to the feedback received will go a long way in closing the accountability loop.

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UNICEF Nigeria Supports Volunteer Community Mobilizers to Help Eradicate Polio

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
2012 to 2021

Duration
11 years

Budget
US$8,052,194

Nigeria's Volunteer Community Mobiliser (VCM) programme aimed to increase polio immunizations in eight high-risk states in an effort to eradicate wild and circulating vaccine-derived polio virus (WPV and cVDV2) in the country. More than 20,000 volunteers were trained to work with, and facilitate the work of, vaccination teams.

Together, these teams covered settlements across Nigeria's high-risk states, reaching more than five million children under-five with the polio vaccine. The result was that polio was eliminated in areas with VCMs much earlier than in areas where VCMs were not deployed.

Context

Northern Nigeria, where Western medicine and immunization programmes have been treated with suspicion, has presented a persistent challenge to Nigeria's efforts to eradicate polio. In 2016, the Northern states were the epicentre of the wild poliovirus outbreak. To raise polio immunization coverage, the Polio Eradication Initiative (PEI) in Nigeria created a cadre of Volunteer Community Mobilizers (VCMs) through the CORE Group Polio Project (CGPP). Two thousand one hundred thirty VCMs were deployed in 31 participating local government areas in the five CGPP implementing states beginning in 2014, and tasked with increasing awareness, understanding and acceptance of polio immunization.

Nigeria was declared wild polio-free in 2020. The last wild polio virus case was in Borno state (a previously inaccessible area) in 2016. An aggressive year-round vaccination campaign throughout the country helped to ensure that no child under-five was without a vaccination. The delivery of vaccinations to every household required collaborations between various state governments and international partners. Thousands of volunteer mobilizers and vaccinators were engaged and trained, and vaccine logistics systems were overhauled in several states in the country. Religious and traditional leaders, trusted members of their communities, were engaged to improve acceptance of vaccination, resulting in improved vaccination of children across almost all communities in the country.

Although the country is officially wild polio-free, it remains important to sustain the rates of both routine and supplemental immunization and reinforcement of epidemiological surveillance. The extensive, efficient and effective networks of trained volunteers created to end polio are being leveraged to ensure that Nigeria's children remain polio-free.

Strategic approach

Creating a Cadre of VCMs

Approximately 20,000 Volunteer Community Mobilizers (VCMs), typically adult women in the community, were at the center of Nigeria's polio eradication programme. VCMs worked alongside teams that performed vaccinations. The VCMs were known to the community, perceived as trustworthy, spoke the local language, knew the local norms and customs, and could therefore facilitate access to households for the vaccinators. They were typically assigned 150 to 300 households in their community. VCMs received comprehensive training on the importance of the Polio Eradication Initiative (PEI), routine immunization, Acute Flaccid Paralysis (AFP) surveillance, social mobilization and community engagement, use of behaviour change communication tools, and interpersonal communication skills. VCMs were given pink hijabs to identify them as community workers.

The VCMs introduced the vaccination team to the household, kept records of who was missing or who refused a vaccine, and was responsible for notifying community leaders about community members that refused to be vaccinated. They used behaviour change materials (e.g., banners, posters, stickers, wrist bands, fliers, t-shirts) to provide information about polio vaccination and motivate uptake of the vaccine. They also worked with health facilities to identify missed children and escorted those children to the facility for immunization and connected non-compliant parents with health facility personnel. The close case-by case follow-up of missed vaccinations ensured that no child was left behind.

The VCMs also capitalized on community events (e.g., community health camps or campaigns) and cultural activities (e.g., *Suna* Immunization) to raise awareness about the importance of polio vaccination as well as routine immunization. [1,2]

The expansive networks of the trained VCMs enabled them to reach previously un-reached communities to eradicate polio from Nigeria. The VCM network was deployed in some of the hardest to reach, conflict-affected, urban poor, and remote rural areas and played a significant role in reaching zero-dose, under-served, and displaced children and families.

Digitizing Nigeria's Health Information System

The digitization of the health information systems used to track immunizations was central to the success of ending polio in Nigeria. The prior system of manual record-keeping in paper-based registries contributed to delays in vital information reaching healthcare and health management decision-makers, and in thousands of children missing their vaccinations. VCMs were trained to use the new Open Data Kit (ODK) system to collect detailed information on newborns, mothers and children-five.[3] The VCMs used ODK to register every child that missed their vaccination during a polio campaign and assigned people to follow-up until the child was vaccinated. ODK enabled VCMs to track routine immunization defaulters, conduct house-to-house awareness-raising visits, organize community dialogues on immunization and work with community influencers to address the concerns of vaccine-hesitant parents. This type of real-time data reporting also enabled decision-makers to forecast vaccine supply needs, resulting in greater efficiency of the entire immunization programme.

Key achievements

In 2016, the Polio outbreak in Nigeria was effectively stopped in areas where VCMs were deployed. This result happened 3—4 years earlier than in states that were not covered by VCMs. These community workers contributed significantly to reducing the number of households that rejected polio immunization, had unvaccinated children, were non-compliant, and the number of polio cases. In VCM-covered areas of Nigeria, the per cent of children 12—23 months who had never been vaccinated against polio (zero-dose) dropped from 45 per cent in 2014 to 1.4 per cent in 2017. The per cent of children 12—23 months who had received at least one dose of the polio vaccine increased from 55 per cent in 2014 to 99 per cent in 2017. Each year, about 500,000 children living in high-risk and hard-to-reach locations are reached by VCMs, with little to no turnover in women workers.[4]

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MORE THAN 20,000

volunteers trained

500,000 CHILDREN

living in high-risk and hard-to-reach locations are reached each year

Lesson learned

1. Involving trusted local women to motivate and track immunization within a community is an efficient and effective means gaining access to household to vaccinate children.
2. Teaming VCMs with local influencers (e.g., religious leaders) for community events or activities can help to increase trust in immunization programmes.
3. Tasking VCMs with household tracking of vaccinated and unvaccinated children decreases the number of children that go unvaccinated.
4. Linking VCMs with health facilities helps the VCMs to identify unvaccinated children and follow-up with the family.
5. The investment in VCMs can be leveraged to address other health behaviour changes.
6. Digitizing the health information system makes the process of tracking household vaccination status more efficient for recording vaccine uptake, missed children, and supply-side planning.

Recommendations

1. Continue to use VCMs to strengthen the routine immunization system and to improve immunization coverage and the primary health-care system.
2. Leverage the investment in VCMs to go beyond polio to provide health education, data collection, active disease surveillance and home visits for hard-to-reach populations for other health initiatives.
3. Documents, including publication and adoption of polio best practices, contribute both to the legacy of polio eradication and to faster attainment of targets and objectives for other priority health programmes.
4. Keep high level advocacy to institutionalize VCM approach through the budget line supporting community health programme from a national to an operational level.

Endnotes

1 The traditional 7th day naming ceremony, also known as *Suna* Immunization, is an activity during which a VCM immunizes the newborn child and other children younger than five years. This traditional ceremony is organized by the family that invites relatives, friends, and well-wishers. The VCM, with the support of her supervisor (the VWS), collects oral polio vaccine from the health facility and joins the family in the celebration. During the ceremony, the newborn receives the birth dose of OPV as do the other young children who are in attendance.

2 Ijeoma Duru J., Usman S., Adeosun O., Stamidis K.V., Bologna L., 'Contributions of Volunteer Community Mobilizers to polio eradication in Nigeria: The experiences of non-governmental and civil society organizations', *Am J Trop Med Hyg*, vol. 10, 2019, pp. 74—84.

3 ODK is an open-source software for collecting, managing and using real-time data in resource-constrained environments.

4 Ijeoma Duru J., Usman S., Adeosun O., Stamidis K.V., Bologna L., 'Contributions of Volunteer Community Mobilizers to polio eradication in Nigeria: The experiences of non-governmental and civil society organizations', *Am J Trop Med Hyg*, vol. 10, 2019, pp. 74—84.

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UNICEF Ghana Supports Social Mobilization Activities to Increase COVID-19 Vaccination Coverage Among the Fulani Population

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
March to July 2022

Duration
5 months

Budget
US$22,600

Vaccinations generally come with risks and benefits that need to be communicated to the potential beneficiaries. Vaccine hesitancy is a behaviour influenced by such factors as knowledge, perceptions, attitudes, confidence and convenience. Trust in the effectiveness and safety of the vaccine, and the health delivery system through which it is delivered, are key to an individual's or family's decision to be vaccinated. UNICEF Ghana's Social and Behaviour Change (SBC) unit supported civil society organizations to engage and motivate the Fulani population in the upper east and upper west regions to accept and obtain COVID-19 vaccinations.

Context

COVID-19 vaccination coverage among the Fulani people in the upper east and upper west regions of Ghana has presented a significant challenge to containing the COVID-19 pandemic. Vaccine hesitancy among this group has been fueled by myths, misconceptions and inappropriate vaccine promotion targeting, resulting in disproportionately low uptake and coverage.

Strategic approach

The Social and Behaviour Change (SBC) unit of the UNICEF Ghana Office engaged RISE-Ghana and other civil society organizations (CSOs) to promote vaccine confidence among the Fulani through social mobilization and media activities. The SBC unit conducted a series of capacity building, technical support, and planning sessions with the CSOs to increase their capacity to understand and respond to local context-specific drivers of vaccine hesitancy, demand and uptake. The CSOs conducted focus group discussions (FGDs) and rapid assessments with members of the Fulani population to determine their knowledge about the COVID-19 vaccine, and the myths, misinformation and disinformation circulating within their spheres of social influence (e.g., wives, butchers, traditional and religious leaders).

The findings from the rapid assessments were translated into SBC activities to engage the vaccine-hesitant population with correct information about the COVID-19 vaccine and motivate uptake of the vaccine. Activities implemented from March to July 2022 included training 31 community-based quality improvement volunteers to conduct house-to-house campaigns, holding focus groups discussions to inform human centered responses, designing and placing social and behaviour change materials (e.g., wall murals) in key locations, training Fulani leaders to mobilize local listeners and lead local weekly radio discussions in their dialect, and developing and airing daily radio-jingles three times per day over a three month period on local community stations and at lorry parks. The messages were co-created with health workers and community members. Because the Fulani migrate in groups, the UNICEF Ghana SBC team gave the clan leaders radio schedules to form listener groups among shepherds and other community members who then self-mobilized to monitor and join radio programmes as listeners and callers. For the first time ever, the Fulani people had an opportunity to act as resource persons and panelists to call-in radio shows and were overjoyed to receive useful information in their own language, from their own people. Routine monitoring was conducted, and human-interest stories were collected.

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Key achievements

The SBC interventions were successful in motivating members of Fulani communities to obtain COVID-19 vaccination. The radio programmes yielded high levels of listenership. At least 200,000 people across the two regions listened to the key messages in the radio programmes. More than 800 people belonged to listener groups, and the radio stations received 215 questions during call-in sessions. Approximately 30 callers to the radio stations attributed their decision to be vaccinated to hearing the appeal in their own language.

31 community-based quality improvement volunteers trained

AT LEAST 200,000 people across the two regions listened to the radio programmes

radio stations received **215 QUESTIONS** during call-in sessions

DAILY radio-jingle developed and aired on local stations over a three month period

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Lessons learned & Recommendations

1. **Ensure vaccination schedules fit with the migratory patterns of the intended population:** It is important to consider the local community calendars of the intended population, in this case the Fulani. As one FGD participant noted, immunization coverage among the Fulani was low because the health workers visited the Fulani communities when it was convenient for the health workers, which was not necessarily convenient for the community members.

2. **In resource-poor communities and highly conservative settings using peer influence and working in groups is effective.** This lesson is premised on the fact that people influence others and that behaviours can be infectious. Identifying and equipping local champions and mobilizing groups to listen and discuss new information through radio and community-based platforms can be easily replicated in similar low resource settings.

3. **Messages need to be communicated by trusted sources:** It is important that messages are delivered by individuals, groups, or sources that are perceived to be trustworthy and respected by community members. The community health workers that were trusted and accepted by the Fulani, and who took the time to visit and listen to Fulani peoples' concerns about the COVID-19 vaccine were most effective in motivating vaccine uptake.

4. **Involve community leaders from the outset:** As with many minority groups, the Fulani are a close-knit community prone to *group-think* and/or *group-act*. It is critical to gain the support of the community leaders from the outset of an intervention in order to ensure that the community members will buy in to the proposed activity and adopt the desired practice.

5. **Language is important:** Few Fulani had previously heard their language spoken on Ghanaian radio. Hearing the Fulani language on the radio was instrumental in engaging Fulani community members to attend to the broadcast messages and go for COVID-19 vaccination.

6. **Leverage local resources:** To ensure meaningful and active participation in the radio programmes, Fulani listener groups were formed to listen to and discuss the programme content. Word of mouth adverts were used to mobilize and inform communities about radio schedules and location to go and listen by visiting various homestead and farms.

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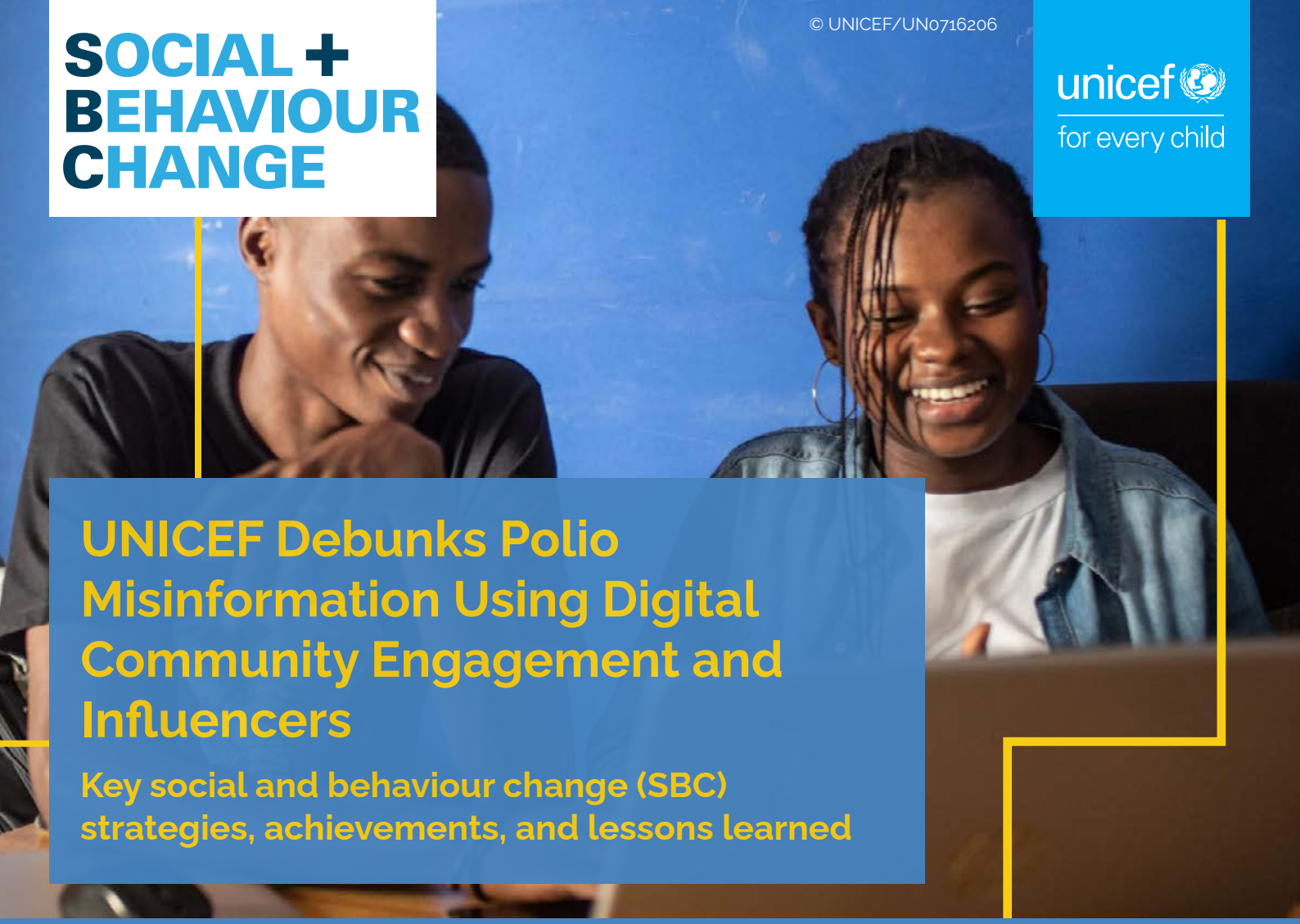

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UNICEF Debunks Polio Misinformation Using Digital Community Engagement and Influencers

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
April 2022 to April 2023

Duration
12 months

Budget
US$2.5 million

Online misinformation about the safety and effectiveness of vaccines is one of the major challenges to reaching every child in the final stages of the global effort to eradicate polio. In 2021, UNICEF and the Public Good Projects (PGP) launched the Digital Community Engagement Unit (DCEU), a first-of-its-kind model aimed at engaging and mobilising communities online to build trust and drive the demand for polio vaccines. In 2023, DCEU was renamed 'Digital Community Engagement' (DCE) to better represent that broader collection of digital engagement strategies instead of a specific team. DCE, an integral part of the UNICEF Polio Social Behaviour Change strategy, helps UNICEF county offices monitor online conversations about polio and immunisation, and effectively respond to misinformation through accurate and timely information about vaccines. DCE trains country office teams to engage communities using online platforms, manage online vaccine misinformation, and build a network of volunteer digital social mobilisers (DSMs) to act as the 'trusted voice' about vaccines in their communities. Within six months of its initiation, DCE demonstrated up to 22 per cent increase in virus risk perception, 16 per cent more confidence in vaccine safety, and recruited more than 77,000 volunteer DSMs to amplify the key messages.[1]

Context

Polio, the deadly viral disease once the leading cause of paralysis among children worldwide is very close to being eradicated. Since establishing the Global Polio Eradication Initiative in 1988, the number of children affected by polio has reduced by 99 per cent. To eliminate polio, every child in every household must be vaccinated. Thousands of children, however, are still missing out on the polio vaccine. Over the past couple of years, there have been unforeseen disruptions to polio vaccination campaigns. The COVID-19 pandemic, for example, forced countries to temporarily suspend vaccinations, leaving many children unprotected against poliovirus. The COVID-19 pandemic also brought with it a myriad of misinformation and disinformation about vaccines, and an uptick in general vaccine hesitancy among parents and caregivers. This hesitancy also affected the polio programme globally.

Strategic approach

DCE conducted two cross-sectional online surveys among the general population across seven countries (Togo, Nigeria, Pakistan, Zambia, Somalia, Mozambique and Egypt) to identify knowledge, attitudes, and behaviours related to key polio messages, including perceptions about vaccine safety, efficacy, and polio risk, likelihood of vaccinating children, recommending the vaccine to others, and sharing information on the vaccine. Surveys were conducted in English across all countries, with additional French language surveys collected in Togo. The findings were used to develop messages with correct information about polio and polio vaccines for country offices and DSMs to disseminate.

Digital Community Engagement (DCE)

In 2021, the UNICEF Polio team partnered with Public Good Projects (PGP), a public health non-profit agency, to manage online misinformation in polio outbreak, endemic, and at-risk countries. DCE monitors multiple social listening platforms (e.g., Facebook, YouTube, Instagram, Twitter) to uncover public perceptions about vaccines, and monitor the spread of facts and disinformation. Based on the data collected, DCE and country teams jointly create appropriate messaging and online content to debunk vaccine myths and rumours and build trust with accurate and timely information.

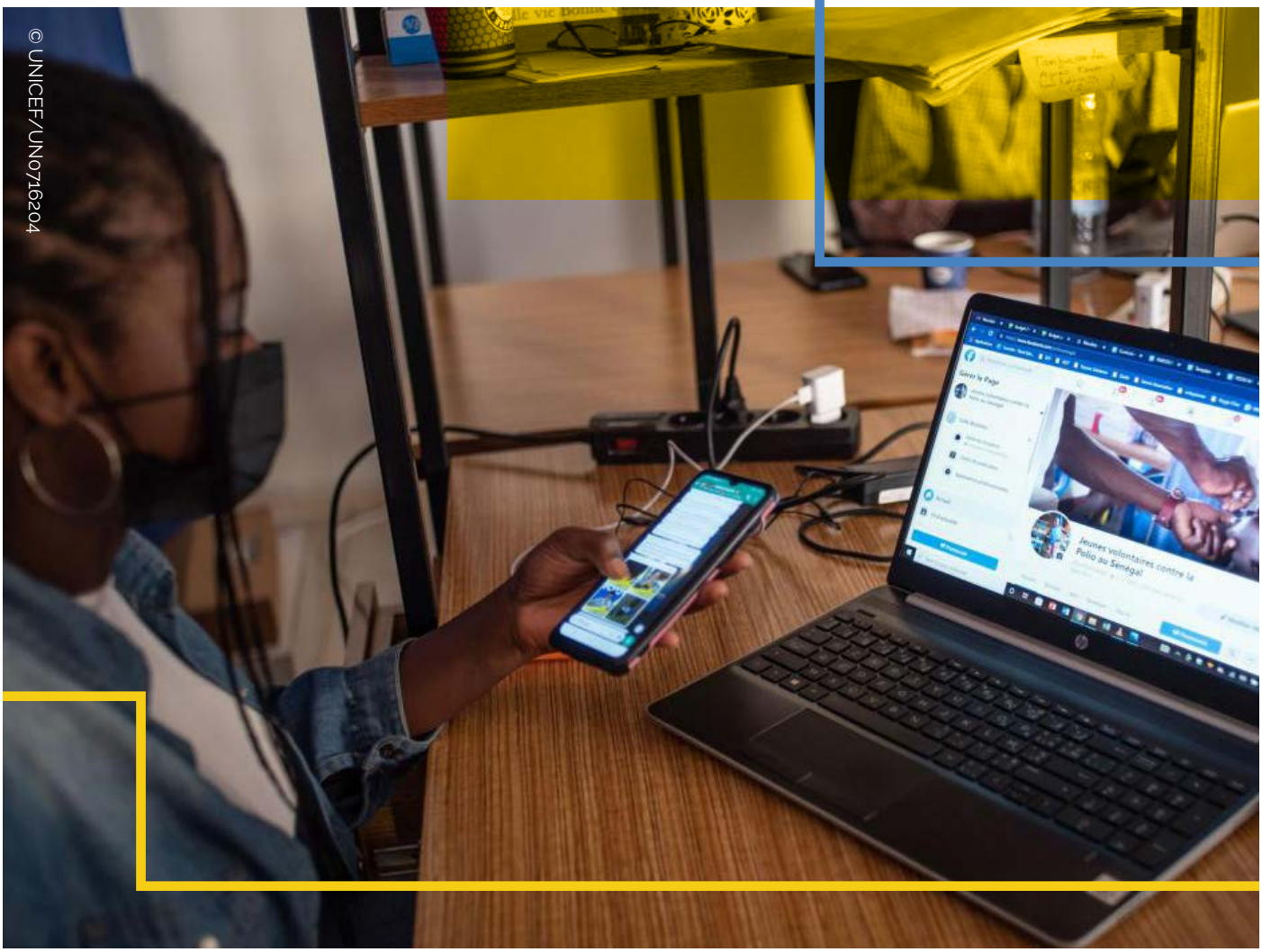
DCE supports UNICEF country offices by providing tools and training (e.g., monthly webinars and videos); online social listening activities; a message bank for responding to specific misinformation in digital content; editable paid digital advertising to expand the reach of accurate information to targeted audiences; and by engaging Digital Social Mobilisers (DSMs) to spread the word about polio vaccine uptake. DCE also circulates a weekly newsletter with current vaccination information, common misinformation, and incoming questions about vaccinations that polio vaccination teams can use to refine their strategic approach and respond more effectively to community information needs.

Digital Social Mobilisers (DSMs) and the *uInfluence* network

DSMs are volunteer social media micro-influencers that use social media channels to reshare science-based messages designed by DCE to help answer common questions about

vaccines in an easy-to-understand manner, report misinformation, and direct other social media users to trusted sources of information. DSMs make up the *uInfluence* network, the UNICEF Polio Team's digital social mobilisation network of more than 77,000 influencers in 200 countries as of May 2023.

A *uInfluence* campaign to counter misinformation about polio vaccination was launched using Instagram and Facebook. The campaign utilised paid digital advertising to attract DSMs in 17 countries and distribute accurate information about polio vaccination. The campaign reached 66 million people. DSMs received "drip emails"(i.e., periodic emails sent to people that engaged with the social media content) with key messages such as "Senior doctors at WHO and local ministries of health have confirmed that the polio vaccine does not cause polio disease," or "Multiple doses of the polio vaccine are needed to protect children from polio." DSMs amplified these messages through Facebook posts, Instagram stories, in-feed posts, and user-generated content using the #uInfluence tag. Call-to-action (CTA) emails were sent to DSMs in all UNICEF regions. Each email contained a title (e.g., "You've got this"), a brief message to the DSM (e.g., "To help you fight misinformation and share factual polio information online, here are a few reminders and resources"), and 2—3 key evidence-based messages about the polio vaccine. The campaign concluded in March 2023. A post-campaign survey was conducted 17 March to 21 April 2023. DCE also conducted a one-time, online cross-sectional survey of DCE newsletter recipients between 22 March to 14 April 2023, in English and French.



Key achievements

DCE demonstrated up to 22 per cent increase in virus risk perception, and 16 per cent more confidence in vaccine safety.[2] The survey findings about DCE activities showed further successes in three key areas: DCE effect on DSMs; positive outcomes of the *uInfluence* campaign; and the usefulness of DCE newsletter. Following are key findings for each of these areas:

Key findings about the DSMs include:

- DCE recruited more than 77,000 volunteer social media influencers to amplify the key messages;
- The programme positively impacted DSMs' vaccine communication and advocacy efforts by enhancing their ability to combat misinformation. More DSMs said that they knew how to recognise polio misinformation when they see it (from 73 per cent at baseline to 79 per cent at endline), and that they know where to find reliable facts to share about polio (66 per cent at baseline compared to 72 per cent at endline);
- The follow-up survey revealed improvements in knowledge and attitudes towards polio and vaccines, particularly in the importance of multiple vaccine doses; there was a significant increase in the number of DSMs who believed that multiple doses are needed for the polio vaccine to be most effective;
- The majority of DSMs are satisfied with the information and materials received from uInfluence, believe that uInfluence help them have a positive impact on their community, and would recommend uInfluence to a friend.

The key findings about the *uInfluence* campaign include:

- Campaign awareness had a positive impact on polio and vaccine knowledge i.e., the need for multiple doses of the polio vaccine to be effective, perception of the vaccine as safe, belief that polio is still a risk, and understanding that the polio vaccine is the only way to protect a child against polio;
- The campaign was highly successful in impacting knowledge that multiple doses of the polio vaccines are needed;
- In general, there was a high self-reported willingness to vaccinate one's own children, recommend that others vaccinate their children, and those who were aware of the campaign were more willing to share or post information online about the polio vaccine.

Key achievements

The key findings about DCE activities among newsletter recipients include:

- Almost all of the 46 respondents (96 per cent) found that DCE was informative to their work, and over 80 per cent said they were satisfied with the support provided by DCE and would likely participate in the DCE activities in the future;
- Ninety-four per cent of respondents agreed that the DCEU has increased their confidence in fighting polio misinformation;
- Ninety-eight per cent of respondents stated that the weekly newsletters were most useful to them, followed by the training videos and message bank 94 per cent, and editable digital ads (89 per cent);
- At least 76 per cent of newsletter recipients used the message bank at least one time.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MORE THAN **77,000** volunteer social media influencers recruited

94% of respondents increased their confidence in fighting polio misinformation

96% found that DCE was informative to their work

Lessons learned

1. **Digital mobilisation and micro-Influencing are effective:** The use of Digital Social Mobilisers (DSMs) and the uInfluence network significantly amplified the reach of accurate vaccine information. Leveraging individuals with smaller, more engaged social media followings (micro-influencers) promises to effectively combat misinformation.

2. **Real-time data and feedback improve response:** Social listening tools and surveys provided real-time insights into public sentiment and misinformation trends. This data was invaluable for quickly countering misinformation with factual information, adjusting strategies as needed, and measuring the impact of various initiatives.

3. **Multi-platform engagement expands reach:** Engaging with audiences across multiple digital platforms maximised visibility and allowed for diverse strategies in information dissemination. It also catered to the varied media consumption habits of different demographic groups.

4. **Community trust is vital:** The willingness of community members to receive and share information was largely based on trust. Utilising DSMs who were already part of their communities leveraged existing trust relationships, making messages more credible and persuasive.

Recommendations

1. **Expand uInfluence network:** Given the success of DSMs and uInfluence network, it is planned to expand this initiative, recruiting more DSMs across more regions, and providing them with the necessary training and resources.

2. **Enhance real-time monitoring capabilities:** Investing in advanced social listening tools and in-country social listening data analysis capability can help to identify more locally relevant insights that can be used to counter emerging misinformation quickly.

3. **Implement regular impact assessments:** Conduct regular and systematic evaluations of the various project sub-initiatives to understand their impact better, identify areas for improvement, and adjust strategies accordingly.

4. **Prepare for future health campaigns:** Use the infrastructure, partnerships, and lessons learned from this initiative to prepare for future public health misinformation challenges beyond polio. This proactive and integrated approach will be invaluable for post-polio GPEI investment sustainability.

Endnotes

1 United Nations Children's Fund, Digital Community Engagement Unit: Program introduction, UNICEF/ Public Goods Project, UNICEF, New York, 5 July 2022.

2 Ibid.

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UNICEF Shapes Risk Communication and Community Engagement Strategies in Twelve Countries

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
August 2020 to July 2021

Duration
12 months in ESAR

Budget
US$500,000 in ESAR

Between 2020 and 2021, UNICEF supported the Community Rapid Assessment (CRA) initiative in 12 countries across the South Asia and East and Southern Africa regions (SAR and ESAR respectively). The CRAs provided each country office with data on the populations' COVID-19 related perceptions, determinants of behaviours, current behaviours, barriers and access to information, level of trust, vaccine acceptance, coping strategies, and evolving needs during the COVID-19 pandemic. This data was used to inform the social and behaviour change risk communication and community engagement (RCCE) response to COVID-19, challenge the concept of community influencers, track the uptake of preventive behaviours, prepare the introduction of COVID-19 vaccines, and advocate for school reopening.

Context

Risk communication and community engagement (RCCE) are important strategies for reinforcing behaviours and strengthening trust and social cohesion in emergency and outbreak situations. While UNICEF has long been a leader in RCCE, the organization has experienced a systemic lack of social and behavioural data, as well as evidence that can be used to inform policy and programmes at the national and regional levels. One-off knowledge, attitudes, and practices (KAP) studies and surveys are common and contribute to initial inputs or baseline benchmarks for programmes. Few long-term data collection and analysis activities, however, are supported to continuously feed into programme design and messaging for ever-changing populations. Lessons learned from the Ebola outbreak in West Africa in 2014-2015 showed that RCCE strategies cannot follow a cookie-cutter approach, but should prioritize the engagement of local communities, be evidence-based (making use of robust data on the knowledge, attitudes, and practices of specific communities), and track with how these practices evolve over time.[1]

In 2020, UNICEF launched the Community Rapid Assessment (CRA) initiative. This initiative was designed around the UNICEF Behavioural Drivers Model (BDM), a framework that shows the key determinants that affect people's behaviours.[2]

The aim was to collect longitudinal data that would inform COVID-19 responses across populations. Between March 2020 and mid-2021, countries across South Asia and East and Southern Africa experienced several deadly waves of COVID-19. COVID-19 vaccination was introduced progressively and at small scale in early 2021. The pandemic was stressing health systems and disrupting essential health services.

The situation necessitated the adoption of individual and collective behaviours to reduce transmission (the focus of the risk communication and community engagement efforts) and the promotion of vaccine uptake. Effective management of the pandemic depended on communication; encouraging people to get vaccinated against the virus; improving people's knowledge, attitudes, beliefs, perceptions, and preventive behaviours about the virus; and the effective engagement of communities and local organizations, networks, and influencers during the pandemic, especially during surge periods.

The UNICEF CRA data was used by programme planners and governments to develop RCCE prevention and mitigation strategies, and interventions to motivate vaccine uptake. The national RCCE working groups, co-chaired by the ministries of health and UNICEF COs, mobilized the groups into action.

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Strategic approach

The CRA initiative was piloted in four countries in South Asia (Afghanistan, India, Nepal, and Pakistan), and in eight countries in East and Southern Africa (Angola, Ethiopia, Kenya, Madagascar, Rwanda, South Africa, South Sudan, and Uganda) between mid-2020 to mid-2021. Three rounds of data collection were conducted from September to July 2021 (every three to four months). Each round of data collection consisted of a random sample of 1,000 respondents in each of the selected countries. There were more than 48,000 CRA respondents across the two regions (6,000 per country in SAR and 3,000 per country in ESAR).

A third-party agency, VIAMO, was engaged to collect the data and conduct the data analyses and visualization, in collaboration with UNICEF staff. The survey questions focused on people's COVID-19 related (risk) perceptions and behaviours, drivers and barriers, vaccine acceptance, coping strategies, trust in institutions, community groups and communication channels, and evolving needs. The surveys were administered using Interactive Voice Response (IVR) and random-digit dialling (RDD). The data was disaggregated by sex, age, and location.

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The data analysis looked at associations between outcomes of interest (e.g., behavioural practices) and a set of respondent characteristics (e.g., age, education, gender, rural/urban dweller). In some countries, the surveys achieved national coverage, while in others, they were repeated in selected states or households. The data was made available via a global dashboard supported by the Harvard Humanitarian Initiative and Statistics Without Borders and published in the Chance Journal and the American Statistical Journal. The Harvard Humanitarian Initiative published real-time indicators between each round of data collection for public awareness.

Data was discussed at national and sub-national RCCE working group meetings and used to refine the national RCCE responses in each region. For example, in the East and Southern Africa Region (ESAR), the data challenged the assumption that engaging traditional and religious leaders would yield the best outcome for vaccine uptake; respondents to the surveys stated that youth and women-led groups would be more trusted networks at the community level for promoting adherence to preventive practices.

The UNICEF CRA data helped to unpack the factors that influenced individual willingness to get the COVID-19 vaccine, send their children back to school, and other individual and collective behaviours associated with COVID-19 prevention and mitigation.

The data was used to develop COVID-19 RCCE strategies and activities. CRA data was regularly shared by COs participating in this exercise with their national RCCE counterparts, through the established RCCE National coordination mechanisms.

Key achievements

- In the South Asia Region (SAR), over 1.1 billion people were reached through the COVID-19 RCCE response (including the four CRA countries – Pakistan, Nepal, Afghanistan, and India).
- At least 300,000 people were engaged on COVID-19 RCCE activities, and 21 million shared concerns through feedback mechanisms.
- In the East and Southern Africa Region (ESAR), over 160 million people were reached with lifesaving and preventive messages in the eight selected CRA countries (Angola, Ethiopia, Kenya, Madagascar, Rwanda, South Africa, South Sudan, and Uganda).
- The CRA data collected in 2020 and early 2021 were disseminated internally (to UNICEF) and externally through webinars and presentations at the national RCCE Working Group meetings chaired by the Ministry of Health and co-chaired by UNICEF in the South Asia Region (SAR).
- The UNICEF HQ Evaluation Office published a report of findings from ESAR's baseline (first round) CRA data collected in 2020 in the first three countries.[1] The report was used to revise the RCCE plans for 2021 in Kenya, Madagascar, and South Sudan, and shared with Senior Management at UNICEF (HQ, ESARO and COs) and with partners.

MORE THAN 48,000

CRA respondents across the two regions

OVER 1.1 billion

people were reached through the COVID-19 RCCE response in the South Asia Region (SAR)

21 million

shared concerns through feedback mechanisms


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Lessons learned

1. Designing effective, people-centred Risk Communication and Community Engagement strategies requires an understanding of the drivers of behaviour, which are not always integrated in monitoring and evaluation systems.

2. Different demographic groups require tailored RCCE approaches that leverage trusted community influencers and appropriate communication channels. The CRA real-time findings provided critical information to multiple sectors of UNICEF's work. The CRA's data disaggregation, analyses and feedback strengthened UNICEF's ability to deliver tailored approaches, especially for vulnerable populations.

3. In a rapidly changing environment, baseline and time series data harvested through CRA provided valuable insights in multiple programme areas, including Social Protection, Child Protection and Education, contributing to enhanced preparedness for future crises.

4. Phone-based surveys allowed for rapid and affordable data collection. They also bypass literacy issues and can be delivered in local languages. This data collection has limitations, especially in countries with low mobile phone ownership (and low ownership by women), which could result in the underrepresentation of vulnerable groups.

5. The CRA's core innovation lies in its ability to gather real-time and trending data in places where there is deep mobile phone penetration, reaching rural populations that can be otherwise difficult to reach through household surveys, especially considering the significant limitations in terms of mobility and safety of frontline workers and researchers posed by COVID-19.

Recommendations

1. With further investment, this modality of producing and using representative, time-series, population-sourced data to complement ongoing UNICEF data collection linked to service delivery can be enhanced. The systems in which they are embedded can be strengthened and, ultimately, the interventions that UNICEF and governments implement in targeted areas can be strengthened and assessed over time.

Endnotes

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UNICEF Highlights Gender-Focused Immunization Demand Programmes in Six Countries

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
December 2021 to May 2022

Duration
6 months

Budget
Unknown

The UNICEF Headquarters Immunization Unit/ Health Section supported the development of case studies in six countries (Liberia, Mozambique, Pakistan, Rwanda, Sudan, and Yemen) that highlight the importance of integrating gender in immunization demand. Each of the case studies provide a description of the context and background for the programme, the intervention approaches, and how gender considerations were included in the design and implementation of the immunization demand efforts. Each case highlights the key achievements of the programme, and summarizes the lessons learned from implementing various approaches.

Context

Immunization is a cost-effective way to prevent childhood morbidity and mortality and reduce health-care costs and inequities.[1] Gender is a critical determinant of vaccination uptake. Gender norms and expectations result in differences between how women, men, girls and boys know about, seek and access health services and resources. Immunization, decision-making and uptake are also influenced by gender. As primary caregivers, women bear the responsibility of ensuring childhood vaccination, but their lower status within the household often restricts them from making health-related decisions for themselves or their children. Completing or receiving vaccinations, understanding the importance of vaccination, having the ability to make vaccine-related decisions and use health services impacts the health of women and families for generations, as well as national health outcomes.[2]

Gender-responsive programmes to promote and expand immunization uptake require an understanding of how gender norms, roles and relationships impact vaccination. The UNICEF compendium of cases studies from six countries (Liberia, Mozambique, Pakistan, Rwanda, Sudan, and Yemen) showcases immunization demand generation programmes with explicit gender focused activities, both stand-alone and integrated into a package of essential services, led by UNICEF country offices.

Strategic approach

The case studies in the UNICEF compendium were developed to provide examples of how demand generation using social and behaviour change (SBC) approaches can reduce gender inequities in immunization as well as transform norms and power structures that limit women's mobility, voice, decision-making and control over health decisions. Each of the case studies provides a description of the context and background (i.e., underlying need) for the programme, the intervention, and how gender considerations were included in the design and implementation of the immunization demand efforts. Each case highlights the key achievements of the programme, and summarizes the lessons learned from implementing various approaches. Although the interventions focus on demand generation, the supply and services aspects are closely linked. Similarly, while the focus is on immunization, the interventions relate to broader public health issues. Intervention effectiveness and impact are not assessed in these case studies.

The six case studies in the UNICEF compendium include:[3]

Country	Approach	Key gender-related changes	Level of gender integration
Liberia	Gender and equity-focused urban outreach campaign	Male engagement Recruitment of female vaccinators and mobilizers	Responsive
Mozambique	Promoting male engagement for integrated health practices	Male engagement Joint decision-making Sharing of household responsibilities	Transformative
Pakistan	Social listening to promote female digital engagement	Female digital engagement Acceptance of female health workers	Responsive
Rwanda	Entertainment-education to address gender norms	Gender socialization Male engagement in child rearing	Transformative
Sudan	Social listening for vaccine equity during COVID-19	Female engagement Informed decision-making	Responsive
Yemen	Mobilizing mothers to promote essential family practices	Women as change agents Informed decision-making Income generation/skill building	Transformative

A combination of primary and secondary research was used to generate the case studies. The primary research involved consultations with selected country offices from December 2021 to May 2022. The purpose was to understand promising practices that have integrated gender considerations in the design, implementation and monitoring of immunization demand generation efforts. A list of questions was developed to guide the consultations.

The consultations provided information on the context, programme/intervention design and implementation, positive experiences or what worked well and challenges or what did not work as well. Secondary sources include national surveys, peer-reviewed articles, reports, guidelines and resources produced by UNICEF and partners. The consultation process was implemented in three stages:

- Survey the situation and understand the immunization demand generation efforts with a gender component. Identify a specific programme for the case study.
- Deeper look to gain a better understanding of the selected case including the gender barriers, intervention design to respond to the barriers, scope and coverage, contribution to gender equality and key achievements. Discuss follow-up interviews and timeline.
- Capture community voices and understand the experiences and perspectives of programme participants, community mobilizers or influencers and community health volunteers/workers/ vaccinators.[4]

The compendium of case studies is intended for health, SBC, and gender practitioners, and anyone responsible for planning, implementing, managing or leading immunization programmes (e.g., government officials, civil society and community-based organizations, international development practitioners, and humanitarian aid workers).[5]


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Key achievements

The six case-study examples of integrating gender into vaccine demand programmes help to highlight the role that social and behaviour change plays in helping to understand and address social and normative gender barriers, and addressing misinformation, fears, and rumours around immunization.

APPLYING A **gender focus** is key to ensuring greater impact

6 CASE-STUDY examples of integrating gender into vaccine demand programmes

Lessons learned & Recommendations

1. Applying a gender focus is key to ensuring a more positive experience for women and girls, men and boys, and gender-diverse groups.
2. It is important to recognize that gender includes women, men, girls and boys and the diversity within these groups as well as those who do not identify with or conform to binary notions of gender.
3. Addressing gender-related barriers to immunization not only leads to equitable coverage but contributes to gender equality and empowers women to access and claim health services. Healthier women can contribute to the well-being and development of their families, communities and countries.
4. Planning interventions that contribute to immunization coverage as well as shifts in gender norms requires robust gender analysis, strategic planning, and evidence-based design and adaptations. A common drawback noted across the six case studies is the lack of data that assess gender-related shifts linked to immunization interventions.

Endnotes

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UNICEF Malaysia Uses COVID-19 Message Experiment Results to Design Risk Communication and Community Engagement Campaigns

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
April 29 to June 2021

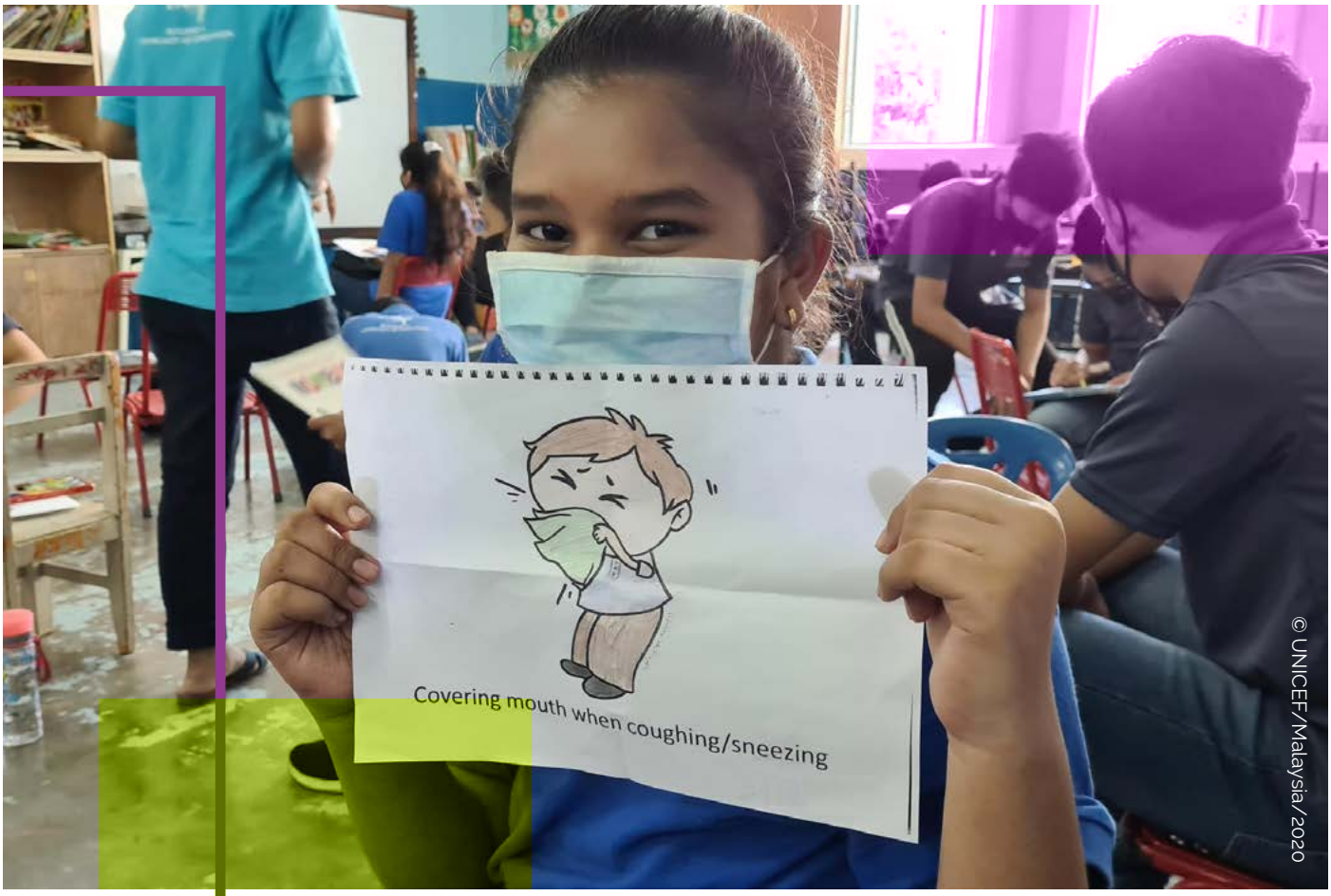
Duration
Two months

Budget
US$25,000

The rapid dvevelopment of the COVID-19 vaccine raised questions about its safety among Malaysians, leading to vaccine hesitancy. UNICEF Malaysia supported a randomized controlled trial to test seven persuasive messages about vaccine safety to determine which would motivate Malaysians to accept the COVID-19 vaccine. The study showed that addressing vaccine safety concerns using persuasive messages is appealing to individuals that are being nudged to recommend the COVID-19 vaccine to people with pre-existing health conditions. Findings from the study were used to inform COVID-19 risk communication and community engagement (RCCE) campaigns supported by the Ministry of Health Malaysia.

Context

In February 2021, Malaysia initiated a mass COVID-19 vaccination programme, first vaccinating frontline workers, followed by high-risk groups (e.g., people 60 years and older), people with disabilities, and individuals with underlying chronic conditions. By April 2021, the vaccine was being offered to all Malaysians on a first-come basis. In August 2021 there were almost 1.3 million cases of COVID-19 in Malaysia, and 11,162 deaths from the disease.[1] Despite strong evidence that COVID-19 vaccines reduced the odds of disease severity and mortality, many Malaysians were hesitant about being vaccinated.[2],[3] In general, vaccine hesitancy is affected by attitudinal and behavioural factors (e.g., perceived risk, convenience). In the case of COVID-19 vaccination, subjective norms (being influenced by others), perceived behavioural control, and concern about the safety and costs associated with the vaccine explained, in large part, COVID-19 vaccine hesitancy among Malaysians.[4],[5],[6] Widespread reports about side-effects and other misinformation led to negative perceptions of the newly derived vaccine. Endorsement of conspiracy beliefs was also associated with COVID-19 vaccine hesitancy.[7] The lack of confidence in the vaccine led many Malaysians to adopt a 'wait-and-see' attitude, that is, they would wait to see if the COVID-19 vaccine turned out to be safe before being vaccinated.



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Strategic approach

UNICEF Malaysia supported a randomized controlled trial study with 5,784 Malaysians to learn whether persuasive messages focusing on vaccine safety influenced an individual's intention to be vaccinated against COVID-19, and to recommend the vaccine to healthy adults, the elderly (aged 60 and older), and people with pre-existing health conditions.[8] The researchers compared various single COVID-19 safety messages with a control message, hypothesizing that exposure to a single safety message would do significantly more to improve intentions to be vaccinated among individuals who were initially hesitant to accept or recommend the vaccine compared to the control message. They then studied the effects of exposing participants to two persuasive safety messages in an effort to mimic a real-world environment where people are exposed to multiple messages. The researchers also hypothesized that exposure to two persuasive messages would create higher positive shifts in intent among hesitant individuals, that is, a higher "dose" of messages (i.e., being exposed to more than one message) would be more effective in motivating vaccine uptake and recommending the vaccine to others than exposure to one message.

The study participants were randomly allocated into 14 experimental arms and exposed to one or two messages that promoted individuals to get their COVID-19 vaccination. Each experimental message was framed in a different way, for example, one message would address safety, while another would address side effects. The control message simply read "Get the COVID-19 vaccine. It's safe and effective!" Each participant was asked to read the messages. Outcome measures were assessed as intent to both take the vaccine and recommend it to healthy adults, the elderly, and people with pre-existing health conditions, before and after message exposure. Changes in intent were modelled and the average marginal effects were estimated based on changes in the predicted probability of responding with a positive intent for each of the four outcomes.[9]

At baseline, at least 80 per cent of participants said that they would recommend the COVID-19 vaccine to healthy adults (only 20 per cent were "hesitant"). None of the persuasive experimental messages improved vaccination intentions or improved recommendations to healthy or older individuals, with some showing signs of backfiring. The researchers stated that the negative results may have been due to the limited effect of providing brief textual messages that failed to capture the attention and sound convincing, or that addressing vaccine safety may not be the most appropriate angle for reaching a hesitant minority of individuals. Some messages did, however, lead to improving recommendations to people with pre-existing health conditions. The results also showed that vaccine recommendation intentions to others did not necessarily reflect on one's own intention


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to get vaccinated. The researchers suggested that delivering messages through more engaging media might have yielded better results.

Results from this study were used to inform COVID-19 messages as part of a larger healthy lifestyle campaign supported by the Malaysia Ministry of Health (MoH). A media buy plan was developed to create more awareness and reach of key messages through social media, Google Display Network, YouTube ads, TikTok, Telegram, and KOL activation from August 2022 to January 2023. The campaign included content related to raising awareness about leading a healthier lifestyle. The audience most interested in the MoH Google ads were in the 25—44 age group. Animated posts that reflected everyday scenarios, used casual, simple and comic messaging, and were in the local language (Malay), were relatable and the most engaging. Educational content performed best overall across all platforms, suggesting that the population is eager to learn and open to new information.

Campaign reached

951,344
INDIVIDUALS

10,731

engaged across MoH social media and digital platforms

Key achievements

The campaign reached 951,344 individuals and engaged 10,731 across MoH social media and digital platforms.

Lessons learned

1. Despite safety being a reason for COVID-19 vaccine hesitancy among Malaysians, crafting messages that focus solely on this attribute did not significantly improve personal vaccination intent or vaccine recommendation, except for people with pre-existing health conditions.

2. Persuasive messages that emphasize safety should be used when promoting recommendations of novel health interventions to individuals with pre-existing health conditions, especially if the intervention is initially perceived as potentially harmful to them.

3. For emergency contexts, a more rapid study may be more appropriate to inform the development of campaigns. The experiment took about one year to be completed by which time Malaysia had achieved a 90 per cent vaccination rate. While some lessons could still be applied to inform the healthy lifestyle campaign, it was not directly related.

Recommendations

1. Conduct more in-depth qualitative research based on theoretical frameworks to gain a firmer understanding on how persuasive messages affect individual perceptions about COVID-19 vaccination.

2. Conduct more research to understand the science behind individuals recommending healthcare interventions to others.

3. Include more educational and "light-hearted" lifestyle content in campaigns to engage the intended audiences.

Endnotes

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UNICEF MENARO Conducts Time-Series Surveys to Understand COVID-19 Knowledge, Attitudes, and Practices in 23 Middle East and North African Countries

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
Round one 20 May to 30 July 2021, round two 30 September to 2 December 2021, and round three 20 May to 9 August 2022

Duration
1 year

Budget
Unknown

Between June 2021 and June 2022, a times-series survey of knowledge, attitudes, and practices (KAP) related to key COVID-19 social and behaviour change (SBC) indicators was implemented. The survey was conducted simultaneously in 23 countries across the Middle East and North African region and repeated at three points in time over the one-year period.[1] The first of the three surveys was conducted jointly by UNICEF MENARO and WHO EMRO (Eastern Mediterranean Regional office), and thereafter by UNICEF MENARO. The data from these surveys established a standardized baseline for COVID-19 SBC data collection and served as a point of triangulation for national and sub-national level data. The data was used to directly inform programme decisions (e.g., audience segmentation) and develop tailored responses.

Context

Throughout 2021, people in the Middle East and North Africa (MENA) region experienced almost 16 million confirmed cases of COVID-19 and 279,000 deaths from the virus by December 2021. The Islamic Republic of Iran had the highest number of confirmed cases and deaths in the region.

The region is unique in that it is home to low-, middle- and high-incomes countries experiencing varying economic and social conditions and health systems. The high-income Gulf countries were able to purchase a range of COVID-19 vaccines in adequate supply for their total populations as soon as they were available, while supplies to middle- and low-income countries tended to arrive later and in batches that were not sufficient for the total populations. The percentage of vaccinated population varied significantly from country to country, with high-income countries (e.g., United Arab Emirates) having the highest vaccination rate and low-income countries (e.g., Yemen, Sudan, and Syria) having some of the lowest rates in the world.[2] Direct and indirect effects of the COVID-19 pandemic, as well as instability and protracted humanitarian situations in Yemen, Iraq, Libya, Sudan, and Syria, continued to have an impact on the lives and well-being of the region's most vulnerable children.

In 2021, UNICEF prioritized assisting national partners in responding to the immediate effects of the COVID-19 pandemic while simultaneously building capacity to address the long-term effects of the virus on children throughout the MENA region. UNICEF MENA played a significant role in the areas of coordination, surveillance, laboratory capacity, clinical management, infection prevention and control, risk communication and community engagement, and research.

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Strategic approach

From June 2021 to June 2022, UNICEF conducted a cross-sectional KAP survey in 23 countries in the Middle East and North Africa (MENA) region to understand risk perceptions and other factors associated with COVID-19 vaccine uptake, and practices related to COVID-19 prevention and vaccination, among adults 18 years and older.[3] The aim of this research was to identify strategies, community solutions, approaches, preferred communication channels, and trusted sources of information on COVID-19. The survey instrument was based on a WHO conceptual framework specific to immunization and focused on behavioural and social drivers associated with vaccination summarized as: thinking and feeling (e.g., perceived disease risk and vaccine confidence); social processes (e.g., social norms); motivation (e.g., intention to get vaccinated), and systems and practical issues (e.g., availability, affordability, access, service quality).

Three rounds of data were collected. Round one took place from 20 May to 30 July 2021, round two took place from 30 September to 2 December 2021, and round three took place from 20 May to 9 August 2022.

Random digit dialling (RDD) probability sampling was used to create a computer-generated randomized sampling frame from which to select respondents for computer-assisted telephone interviews (CATI) and Mobile Web (MW) surveys. Recruitment for MW surveys relied on user recruitment on social media (e.g., Facebook, Twitter) and messaging applications (e.g., WhatsApp). MW survey inputs were sent directly to data processing, whereas the data from the CATI method required enumerators and administration of the surveys. For the first two rounds of data, the CATI method was used in all 23 countries. In round three, the data from respondents in the Gulf Cooperation Committee (GCC) countries of Kingdom of Bahrain, the State of Kuwait, the Sultanate of Oman, the State of Qatar, the Kingdom of Saudi Arabia, and the United Arab Emirates were collected via Mobile Web, while CATI surveys were used in the other 17 countries.[4] The survey instruments in rounds two and three varied slightly, given the changing context of the COVID-19 pandemic and the need to adjust some of the questions. In round three for example, respondents were asked about their willingness to receive a second dose or booster of the COVID-19 vaccine, whereas only one dose was recommended at the time of round one.

The data was analysed and weighted by country population size and sex to produce regional descriptive statistics. Comparisons with service delivery data on vaccination uptake suggested that the survey sample for round three was biased toward people who were already vaccinated with at least one dose. The data was used to develop archetypes based on suggested trends for categories of vaccination status or intention (i.e., vaccinated; not yet vaccinated but intending to be vaccinated; undecided; and unvaccinated with no intent).[5] These archetypes were intended to describe distinct sub-populations for the purposes of creating social and behaviour change interventions to increase COVID-19 vaccine uptake.


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Key achievements

The data obtained from the three rounds of surveys in the MENA region were instrumental in reframing vaccine hesitancy as a continuum of vaccine "acceptance," shaping the design of multiple responses to address vaccine acceptance based on the different personas identified from the data and understanding the social norms associated with vaccine acceptance.

The study findings pointed to several interventions to improve COVID-19 vaccine uptake, including:

- Addressing attitudes of health workers by increasing their engagement with healthcare facility senior management/leadership on vaccination benefits and the importance of vaccinations;
- Improving working conditions for healthcare workers (HCWs);
- Conducting health education/educational seminars for all relevant personnel in health facilities and hospitals;
- Implementing vaccination campaigns for healthcare workers (HCWs) with a formal "Opt Out" policy (i.e., HCWs would have to sign a form saying they are declining the vaccine and understand the risks of non-vaccination to themselves and others);
- Providing letters, emails, or telephone call reminders for individuals to get vaccinated;
- Issuing incentives for vaccination (e.g., refreshments, raffles, lottery tickets, and cash prizes);
- Integrating compliance/non-compliance into routine healthcare employee performance reviews;
- Developing tailored messages for specific personas or sub-groups that address their specific concerns or barriers;
- Partnering with community service organizations (CSOs) and other agencies to support educational outreach and vaccination registration.

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Cross-sectional knowledge, attitudes, and practices survey in

23 COUNTRIES

in the MENA region

3 ROUNDS

of data collected

Lessons learned & Recommendations

1 Data triangulation provides a more balanced picture of a situation than any single data collection measure alone. This research was part of a wider data strategy that included national and sub-national quantitative and qualitative studies, social listening, and a range of online and offline feedback mechanisms (e.g., hotlines). While the regional study took more time to produce, the randomized sample had the advantage of providing a stronger sense of the relative importance of different constructs over time, whereas social media tended to be more biased towards strong opinions (either negative or positive) but has 'real time' advantage. Future studies should use multiple methods to enable data triangulation.

2 Knowing the intended audience's reasons and stage of the decision-making process for vaccine uptake is essential for developing effective strategies to motivate uptake. The data showed that different segments of the population were at different stages in their decision-making process regarding vaccine uptake. The majority of the region reported that they intended to be vaccinated, and only a small proportion reported unwillingness to be vaccinated; their concerns and reasoning varied considerably. This study informed different strategies to address different segments of the population, resulting in multiple localized responses rather than a 'one size fits all' intervention.

Endnotes

1 Nikoloski Z, Bain R, Elzalabany MK, Hanna P, Aynsley TR, Samhouri D, Menchini L, Kapil N, Gillespie A. Modelling COVID-19 vaccination status and adherence to public health and social measures, Eastern Mediterranean Region and Algeria. Bull World Health Organ. 2023 Feb 1;101(2):111-120. doi: 10.2471/BLT.22.288655. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9874377/pdf/BLT.22.288655.pdf>.

2 United Nations Children's Fund, *UNICEF Middle East and North Africa: Humanitarian situation report*, UNICEF, December 2021, <www.unicef.org/media/118566/file/MENARO-Humanitarian-Situation-Report-December-2021.pdf>.

3 The 23 countries included the Islamic Republic of Afghanistan, the People's Democratic Republic of Algeria, the Kingdom of Bahrain, the Republic of Djibouti, the Arab Republic of Egypt, the Islamic Republic of Iran, the Republic of Iraq, the Hashemite Kingdom of Jordan, the State of Kuwait, the Republic of Lebanon, Libya, the Kingdom of Morocco, the Sultanate of Oman, the Islamic Republic of Pakistan, the State of Palestine, the State of Qatar, the Kingdom of Saudi Arabia, the Federal Republic of Somalia, the Republic of the Sudan, the Syrian Arab Republic, the Republic of Tunisia, United Arab Emirates, and the Republic of Yemen.

4 United Nations Children's Frund, *UNICEF MENA regional survey: COVID-19 knowledge, attitudes, & practices: Vaccine acceptance and public health and social measures, Round 3 regional report*, UNICEF, 2022.

5 Ibid.

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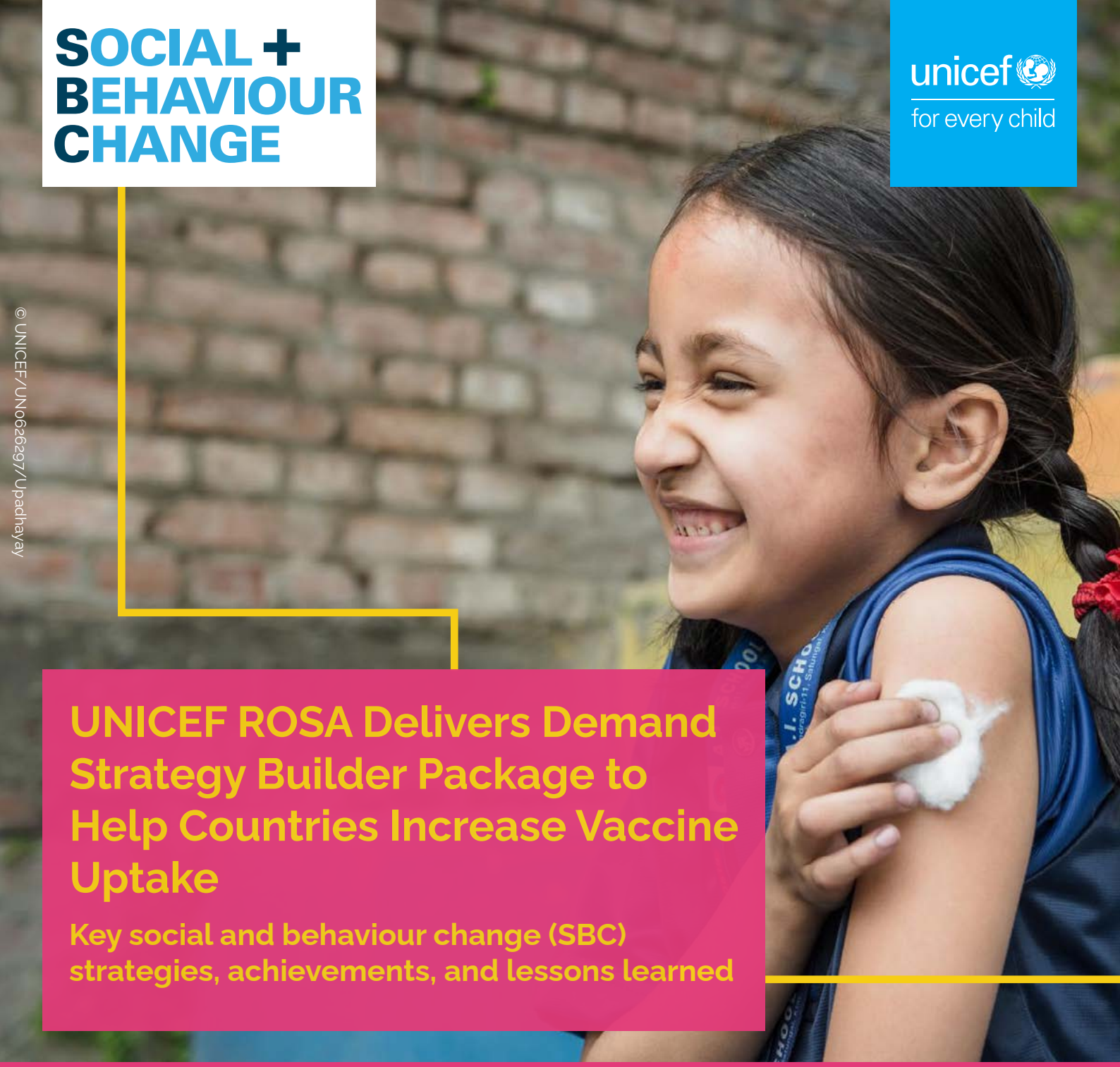

UNICEF ROSA Delivers Demand Strategy Builder Package to Help Countries Increase Vaccine Uptake

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
2020—2021

Duration
15 months

Budget
Unavailable

UNICEFs Regional Office of South Asia (ROSA) supported the development of the Demand Strategy Builder, a package of practical, highly illustrated tools to guide health programme managers and implementers in using a human-centered design approach to develop evidence-based sub-national level strategies that promote vaccine uptake.

The package is designed to guide users through a step-by-step process that enables them to look at immunization from a parent/caregiver's perspective, and to design activities and programmes that remove the barriers that prevent children from being immunized.

Context

At least six million children are unvaccinated or under-vaccinated in the eight highest-risk countries in South and Southeast Asia. Reasons for low demand for vaccines include lack of knowledge about vaccines or number of doses required, widespread misinformation about vaccine side-effects, and vaccine recalls leading to distrust of the product. In Indonesia, a 2018 measles vaccination campaign targeting 70 million children was derailed by religious groups that withdrew their support. In Nepal, ineffective messaging about the need for a second dose of measles vaccine resulted in a decrease in immunization rates from 90 to 70 per cent.[1] During the COVID-19 pandemic, vaccine confidence was eroded and demand for childhood vaccinations declined. Childhood vaccination schedules were disrupted due to stay-at-home measures, intense demands on health systems, the diversion of immunization resources to COVID-19 vaccination and health worker shortages.

To understand and address the most pressing reasons for low vaccine uptake, UNICEF has been scaling up the use of the Human Centered Design (HCD) approach for developing tailored demand strategies to increase vaccine uptake of in selected countries. HCD is a problem-solving method that puts real people at the center of the development process, generating a clearer understanding of the problem from the perspective of the population of interest, and enabling the development of specifically tailored materials, products and services that resonate with their needs. Since 2020, UNICEF has been supporting Ministries of Health in South Sudan, Zimbabwe, Madagascar, Indonesia, Ethiopia, Mozambique, Somalia, Myanmar, Afghanistan and Pakistan, to use the HCD approach to develop tailored, context-specific demand generating strategies.

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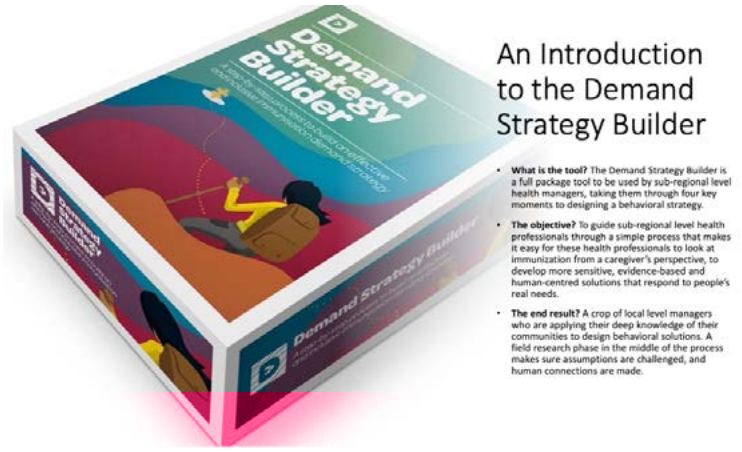
Strategic approach

UNICEF ROSA worked with Common Thread, a social and behaviour design agency, to create the Demand Strategy Builder package.[2] The Package was designed to address global principles and be applied across sectors in South Asia, Southeast Asia and the Pacific, but can be used by anyone who finds it useful. It was designed for health, communication and/or behaviour change professionals working at sub-national levels, although the primary user may vary from country to country. Each primary use will be supported by managers and champions at national, regional and/or global levels.



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Common Thread talked to UNICEF, WHO, and government sub-national immunization and behavioural managers across South and Southeast Asia to understand what they needed and wanted from the proposed package. The key takeaways were that nobody wanted "another manual," and no one was interested in theory.[3] Common Thread then researched the specific reasons for low vaccination uptake in the region. The findings from this research helped to define the problem from the parent/caregiver perspective and learn what health workers and managers needed to remove the barriers and clear the way for keep children up to date with their vaccines.

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The package development was guided by a Steering Committee that provided feedback at each phase of the development process (initial insights, problem identification workshop, field insights, and solution design workshop).[4] UNICEF's regional, country, and sub-national immunization and communication officers provided key inputs to Common Thread. The development of the package took 15 months to complete, from initial draft, to field-testing, to revisions and finalization.

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The Demand Strategy Builder takes managers through key moments in an immersive experience to design a behavioural strategy and map out an action plan. Throughout each moment, field practitioners are provided with visual guidance (using as little text as possible), instructions for undertaking guided visits to communities, and gamification through cards and role play. A human-centered design (HCD)-inspired research phase in the middle of the process makes sure assumptions are challenged and human connections are made. The Package contains posters to guide workshop activities. This includes a binder, "independent planning moment" cards, and a USB stick or webpage containing in-depth instructions, workshop scripts, and resources/readings and a box of participant cards. The first step in the strategy-building process, which can be done alone or with a small group, is to use independent planning cards, a digital workbook, the binder, and post-it notes to develop a hypothesis for the vaccine demand challenge, and to assess any existing strategies and plans. This step leads into the first of two workshops, divided into eight modules, to engage the design group in gaining a deeper understanding and confirmation of the demand challenge (e.g., the people, places, specific barriers, and data). The aim is to achieve group consensus on the core demand challenges.

Prior to the second workshop, a small group(s) of planners use another set of independent planning tools to decide which HCD methods and tools they will use to collect missing data relevant to the problem(s) they identified. The second workshop is structured to help the group finalize their strategy. A mix of materials from the first workshop (e.g., posters, participant cards, digital workbook) is used throughout six modules to help the participants review and finalize the demand strategy.

The Demand Strategy Builder Package was pre-tested in a couple of countries to determine its usability and scalability across countries before it was finalized. Findings from the pretests were used to refine the Package for great ease of use.

Key achievements

The package has been disseminated among Steering Committee members, to UNICEF Afghanistan, and more recently to the GAVI Secretariat.[5] UNICEF MENA has reached out to the ROSA team to explore and pilot and adapted version of the Demand Strategy Builder suitable to MENA country contexts. The aim is to position the Strategy Builder Package as a global tool.

Development of the package took

15 MONTHS

The package takes managers through key moments in an immersive experience to design a behavioural strategy and map out an action plan

Lessons learned & Recommendations

1. **Adapt the content to suit the context.** The Package content is applicable to multiple regional and country contexts. Each region and/or country should pilot the Package and adapt the content so that it is palatable to the intended populations, without foregoing its intended objectives.

2. **Build capacity for using the Package**. Conduct Master Trainer sessions to create a cadre of trainers that can cascade the training and ensure deep and wide dissemination and use of the Package.

3. **Build a community of practice** to support the roll-out of the Package. Create a network of experts and motivate peer learning and sharing of local content and resources.

4. **Form a Task Force** (with MoH as the Convenor) to ensure that the Package is reaching its intended users, monitor its intended use and any novel uses or unintended consequences, and guide any refinements to the Package as necessary.

5. Countries that would like to adopt the Package should ensure that there are earmarked funds for conducting the appropriate training necessary to create knowledgeable users of the package.

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Endnotes

1 Common Good, 'South and Southeast Asia: Reimagining the vaccination guidebook', 2021, <https://gocommonthread.com/work/south-and-east-asia/>.

2 Common Thread was contracted by GAVI, the Vaccine Alliance.

3 Common Good, 'South and Southeast Asia: Reimagining the vaccination guidebook', 2021, <https://gocommonthread.com/work/south-and-east-asia/>.

4 The Steering Committee included individuals from the World Health Organization in EMRO and SEARO, UNICEF's Regional Office for East Asia and Pacific Office, and UNICEF and WHO Headquarters.

5 GAVI, the Vaccine Alliance, is an independent public-private partnership and multilateral funding mechanism that aims to expand global access to and use of vaccines, particularly among vulnerable children.

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UNICEF Poland Reaches Out to Ukrainian Refugee Families with Vaccination Campaign

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
March 2022 to present

Duration
Ongoing

Budget
US$2.5 million

The UNICEF Refugee Response Office (RRO) in Poland launched a national campaign to promote vaccination uptake by Ukrainian refugees that arrived in Poland since the war in Ukraine began on 24 February 2022. At least 4,380,000 people were exposed to vaccination promotion messages through the outdoor campaign advertisements (e.g., billboards, bus stop and metro station ads), information posted on the SPILNO digital platform and through social media.

Context

Since the beginning of the war in Ukraine on 24 February 2022, millions of Ukrainians have sought refuge in Europe. Poland has welcomed most refugee women and children seeking temporary protection (between 1.5 and 2.0 million individuals).[1] About 90 per cent of Ukrainian refugees registered by the Polish government are women and children. This mother-and-child displacement crisis is exerting extraordinary pressure on Poland's public and healthcare services. Polish legislation states that refugees from Ukraine have free access to all health services in Poland which includes routine immunization services for children. Vaccinations are essential to protecting both Ukrainian and Polish children and families against preventable diseases.

Low immunization rates in Ukraine mean that refugees are at risk of vaccine-preventable diseases. Before the war, Ukraine was already at a high risk of a polio outbreak, with only 55 per cent of Ukrainian children vaccinated against the disease. In 2018, only 78 per cent of Ukrainian children were vaccinated against measles, which resulted in 47,000 measles cases, the largest outbreak in Europe. The low vaccination coverage and uptake among Ukrainian children in Poland could lead to disease outbreaks. All children should be protected from vaccine preventable diseases no matter where they live. UNICEF is promoting the safety of immunization and its importance to children's health in Poland and ensuring there are sufficient supplies of critical vaccinations.[2]

Strategic approach

The UNICEF Refugee Response Office in Poland was established in March 2022 to help strengthen the Polish systems already delivering essential services and protection to refugee children and families from Ukraine. The RRO in Poland has been partnering with the central government, including the Ministries of Health, Education, Justice, and Family, the 12 municipalities hosting around 75 per cent of refugees from Ukraine, and with NGOs and CSOs, to fill key gaps in government service provision. The ERO is focused on preventing disease outbreaks, helping refugees gain access to health care and promoting exclusive breastfeeding. Protecting Ukrainian refugee children in Poland remains a critical pillar of UNICEF's immediate humanitarian response.

UNICEF RRO Poland used a human centred design approach to understand issues related to

low vaccine uptake among Ukrainian refugees. Between December 2022 and February 2023, the RRO (Social and Behaviour Change Office), in collaboration with the Institute of Mother and Child Foundation, conducted a cross-sectional study among Ukrainian mothers from vulnerable refugee families. They were asked to fill in an online, self-administered questionnaire about their awareness and knowledge regarding child immunization, and about access to essential services (e.g., education, health, protection from violence and mental health support). Research among health workers was conducted to understand their perspectives on vaccine uptake among Polish refugees. Social listening research was also conducted to learn about vaccine hesitancy and mis- or dis-information among Ukrainian refugees in Poland.

The HCD findings highlighted key barriers to vaccination: legal, administrative, and technical; lack of awareness, knowledge, and information; individual access; personal, social, cultural and religious beliefs and norms; affordability of the vaccine; convenience of getting vaccines. Ukrainian mothers had concerns about the safety of vaccines that affected their likelihood of ensuring routine immunization for their children. Based on the findings from the initial research,


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UNICEF Poland's Emergency Response team designed and launched a multi-media campaign to motivate vaccination uptake among Ukrainian refugees in Poland. Specifically, the campaign consisted of:

- Ten articles with practical information and recommendations about accessing aid in Poland. These were accessible to Ukrainian refugee families on the SPILNO digital platform.[3]
- Lectures for medical professionals to provide them with key information about immunizations for Ukrainian refugee children.
- Five webinars presented by doctors about vaccinations for refugee children, including a psychologist who presented on how to communicate with Ukrainian refugee families.
- A Help Desk platform was created and implemented from September 2022 to January 2023, where parents/caregivers could call and receive expert advice on vaccination.
- A Website (www.szczepieniaua.pl) aimed at Ukrainian mothers, with live chat and information from Ukrainian and Polish healthcare specialists.
- Five films highlighting the importance and safety of child vaccinations, delivered by Ukrainian doctors, nurses, and psychologists, to motivate mothers to have their children immunized.
- YouTube videos to motivate vaccine uptake among Ukrainian refugee families.
- Print materials (e.g., posters, flyers) that were posted on city lamp posts.
- A brochure on childhood Immunization for doctors.

The UNICEF RRO monitored the Website and social media channels using SPILNO to ensure that the messages were being disseminated as intended.

Key achievements

- At least 400,000 people were exposed to vaccination promotion messages through the outdoor campaign advertisements (e.g., billboards, bus stop and metro station ads).
- The information posted on the SPILNO digital platform was viewed by at least 15,000 SPILNO users.[4] An additional 22,344 people were reached through social media.[5]
- More than 1,500 healthcare workers were reached through the lectures and webinars.
- The Help Desk was accessed 4,300 times, and there were 550 live chats inquiries.

4,380,000

people exposed to vaccination promotion messages

5
WEBINARS

presented by doctors about vaccinations for refugee children

5
FILMS

highlighting the importance and safety of child vaccinations

Lessons learned

1. The use of HCD research was instrumental for developing targeted interventions and activities for Ukrainian refugee parents/caregivers.
2. It is important to engage experienced local partners that have trusted ties with the population of interest.
3. Engaging medical professionals to deliver messages about immunization for children gave credibility to the messages among the intended audience of parents/caregivers.
4. Using multiple channels to reach parents/caregivers and healthcare providers with key messages about immunizing Ukrainian refugee children helped to ensure that greater numbers of the intended audiences were reached.
5. Avoid working in silos. The UNICEF RRO staff ensured that their objectives were aligned with other sections from the earliest stage of the activity.

Recommendations

1. Revisit the needs of healthcare workers and Ukrainian caregivers. Given that Poland is almost two-years into the Ukrainian refugee crisis, it is important to engage in research to re-examine how child immunization knowledge, attitudes, behaviours (i.e, vaccine uptake) and norms have changed since the beginning of the crisis, and to review and revised existing materials and/or develop other appropriate social and behaviour change materials.

2. Share insights and lessons learned about addressing immunization among refugee populations with relevant stakeholders and national-level institutions.

3. Continue to monitor ongoing activities aimed at increasing child immunization uptake among Ukrainian refugees in Poland and support an evaluation of the overall activity.

Endnotes

1 United Nations Children's Fund, Emergency response progress report Poland: A detailed overview of the UNICEF Emergency Response Office in Poland's work for children and families fleeing war in Ukraine, UNICEF Europe and Central Asia, November 2022, <www.unicef.org/eca/reports/emergency-response-progress-report-poland>.

2 Ibid.

3 SPILNO is a participatory digital democracy platform for citizens, organizations and local governments. It was created to improve communication of active citizens, acceleration of ideas, initiatives, implementation of socially important projects (https://spilnoinpl.org/).

4 SPILNO is a participatory digital democracy platform for citizens, organizations and local governments. It was created to improve communication of active citizens, acceleration of ideas, initiatives, implementation of socially important projects (https://spilnoinpl.org/). This platform provided up-to-date and lifesaving information in Ukrainian for parents, youth and children in Poland. The portal collates the latest verified information from trusted sources on legal matters, financial assistance, health, education and mental health support.

5 United Nations Children's Fund, Ukraine Situation: Refugee Response in Neighboring Countries. Humanitarian Situation Report No.16-2022, UNICEF Europe and Central Asia Region, <www.unicef.org/media/127491/file/ECAR-Refugee-Humanitarian-SitRep-06-September-2022.pdf>.


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UNICEF Burkina Faso Assesses Scale-Up of Optimal Infant and Young Child Feeding Practices in Two Health Districts

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
X

Duration
X

Budget
X

UNICEF Burkina Faso, in collaboration with Nudge Lebanon, Busara Centre for Behavioural Economics and the Ministry of Health, conducted baseline research to determine the barriers and enabling factors associated with the uptake of antenatal care (ANC) and multiple micronutrients supplementation (MMS). The findings from the research were used to develop a pregnancy calendar for mothers to remind them about ANC visits and taking MMS, and a pocket guide for healthcare providers with semi-scripted responses to frequently asked questions about ANC and MMS to help them communicate effectively with clients and motivate them to attend regular ANC and take MMS as prescribed. The calendar and pocket guide were piloted in two health districts, Yako and Ziniaré. A cluster randomized control trial was conducted to assess the impact of using both interventions.

Context

More than 70 per cent of pregnant women in Burkina Faso suffer from anaemia, a driver of infant mortality, malnutrition and developmental deficiencies.[1] In 2014, at the outset of the government's initiative to improve infant health (in 2014) the infant and child mortality rate was 82 per cent[2]. At least 25 per cent of children under five years of age.[3] Burkina Faso's Infant and Young Child Feeding (IYCF) Practices Plan 2013-2025, developed by local and international partners, aims to scale up the promotion of optimal infant and young child feeding practices. In collaboration with UNICEF, the Ministry of Health has implemented the replacement of current iron and folic acid (IFA) supplementation with multiple micronutrients supplementation (MMS) and is piloting its effectiveness in the two health districts of Yako and Ziniaré. Pregnant women are expected to consume MMS tablets daily during their pregnancy and for 42 days after delivery. MMS tablets are distributed for free to pregnant women at their antenatal care (ANC) visits. However, many women do not attend ANC visits, especially early in their pregnancy, due to a variety of structural and behavioural barriers.

Strategic approach

Nudge Lebanon[4] collaborated with UNICEF and Busara Centre for Behavioural Economics to conduct research to identify barriers and enabling factors for ANC and MMS uptake, and to promote adequate and timely attendance to ANC visits and motivate uptake of MMS. The research findings led Nudge Lebanon to design two behavioural interventions: (1) a calendar for pregnant women to remind them of their ANC appointments and keep track of their MMS uptake; and (2) a pocket guide for healthcare workers summarizing behaviourally informed messages to convey to pregnant women about MMS uptake and ANC visits.

The calendar was designed based on findings from ideation workshops and behavioural mapping exercises. The content was also aligned with information provided during community mobilization sessions. The calendar includes 11 months and uses visual depictions of the stages of the pregnancy journey, from receiving the news about pregnancy to 42 days after delivery. Each page provides the specific target behaviours for ANC and MMS and includes a self-tracking activity section for daily MMS consumption and monthly attendance at health centres for picking up the mother's MMS supply and ANC check-ups. The calendar also provides information on how to take MMS and about community support groups that mothers can attend. The rollout plan for the pregnancy calendars was divided into four phases: training, supply, distribution, and feedback. The training was conducted by Busara and Nudge Lebanon via online sessions. Busara field officers provided in-person field-level follow-up. UNICEF and implementing partners handled the logistics of planning the sessions and inviting the trainees. The training sessions introduced the pregnancy calendars to Community Health Workers (CHWs) who interact directly with pregnant women. Following the training, the CHWs receive a supply of calendars for distribution during community mobilization activities with pregnant women across selected villages. The distribution was monitored to assess the supply, reach and use of the calendars, and to collect qualitative feedback from the field.

Health workers received training on how to address common concerns and misperceptions about ANC and MMS with their clients. A pocket guide summarizing the key strategies for communicating with clients about ANC and MMS was distributed to the trained health workers that staff the ANC health centres. This tool aims to help ANC staff better communicate important ANC and MMS information to pregnant women and effectively answer their most common concerns. The pocket guide includes: a semi-structured script of key messages on the importance of maternal nutrition and consumption of MMS supplements and calls to action; a reflective section to think of how to communicate the key messages in the local language (Moore); answers to FAQs about maternal health and MMS tablets; useful tips in the form of dos and don'ts that address miscommunication; positive feedback to healthcare workers highlighting their contribution to raising a healthy generation; and commitment devices to enhance the engagement and use of the pocket guide. The guide also includes additional features to enhance its day-to-day utility, for example, a monthly calendar and additional empty pages for notes.

The impact of the pregnancy calendar and pocket guide was assessed using a cluster randomized control trial (RCT) in randomly selected health centres that offer maternal healthcare services (including ANC and MMS tablets) in two health districts, Yako and Ziniaré. Working in close partnership with UNICEF, partners, and relevant governmental entities, the status of implementation was monitored, and outcomes were recurrently assessed. At the end of the experimental period, outcomes between women who received the interventions and those who did not were compared. This information was used to develop recommendations and write policy briefs.

Key achievements

- UNICEF, in collaboration with Nudge Lebanon and Busara Centre for Behavioural Economics, was successful in using qualitative methods to identify barriers and enablers to maternal health among pregnant women in the study areas.
- The research constituted a baseline of what pregnant women already know about maternal care and nutrition and provided an analysis of how this knowledge affects behaviours around ANC appointments and MMS tablet adoption.
- Finding from the research were used to develop behavioural maps that demonstrated the socio-behavioural journey of pregnant women attending ANC appointments and consuming MMS tablets.
- The findings were used to design and conduct behavioural experiments using a calendar and pocket guide to increase ANC attendance and MMS tablet consumption by pregnant women.

> "Many women did not go to school. If you hand me a sheet and ask me to write my name, I wouldn't know what to write. Often you see the information but it's written in French. Even if someone sends you something you have to call someone else to come read and translate into Moore for you. Really it limits our access to information"
>
> *Women, FGD*

Lessons Learned

1. For most pregnant women, their husbands and mothers-in-law are the primary decision-makers of their pregnancy routines.

2. A lack of knowledge among husbands and household members about the benefits of attending ANC reinforces the misconception that pregnancy does not require hospital care as it is not an illness, and/or that, previously, women had normal deliveries without visiting ANC centres.

3. ANC appointment attendance and consumption of MMS tablets involves multi-layered decision-making through several stages and milestones, and each decision and stage needs to be focused on individually.

4. ANC attendance and MMS consumption are interdependent behaviours where the success of one may be correlated to the success of the other. Regular ANC attendance may lead to the probability of higher consumption rates of MMS and vice versa.

Recommendations

1. For women to overcome their individual barriers to attending ANC visits, it is imperative for their local ecosystem (i.e., household and community) to foster acceptance and promote ANC visits.

2. Community health workers, community leaders and local women support groups are influential advocates for bridging the gap between the pregnant household and the ANC health centres.

Endnotes

1 Nudge Lebanon (ND). Implementation plan and experimental protocol: Improving prenatal nutrition among pregnant women in Burkina Faso.

2 Government of Burkina Faso, *Burkina Faso Enquête Multisectorielle Continue 2014*, 2014, <https://microdata.worldbank.org/index.php/catalog/2538>

3 United Nations Office for the Coordination of Humanitarian Affairs (OCHA), *Enquête Nutritionnelle Nationale 2020*. SMART 2020. <https://ghdx.healthdata.org/record/burkina-faso-national-nutrition-survey-2020>

4 Nudge Lebanon is a nongovernmental and non-profit initiative working to apply behavioural insights to policy challenges, using rigorous experimental approaches and tools typically used in the field of behavioural economics, such as randomized controlled trials.

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UNICEF Montenegro Uses Behavioural Insights to Develop Social and Behaviour Change Messages for Parents Receiving Government Child Allowances

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
2021 - 2023

Duration
3. years

Budget
USD$75,000

UNICEF Montenegro conducted behavioural insights research to determine how best to deliver social and behaviour change messages to parents about using government cash allowances to enrol their children in preschool and improve their children's diets. Research was conducted to understand how parents were currently using their cash allowances. The findings were used to develop brochures and posters to raise awareness about the benefits of enrolling children in preschool, about how to improved children's nutrition, and to nudge parents to act. The materials were pretested and revised according to feedback from parents. In the current and final phase of the project, UNICEF Montenegro is testing selected interventions in municipalities with the lowest pre-school enrolment rates.

Context

Up to a third of Montenegrin children face significant monetary poverty, making them one of the most deprived population groups in the country.[1] About 46 percent of children (0-17 years old) live at risk of poverty or social exclusion.[2] Poverty is particularly widespread and concerning among such vulnerable populations as Roma and Egyptian children. To address this issue, the Commission for Child Rights of the Montenegro. National Government, with support from UNICEF, proposed implementing child allowances, namely:

- A universal (unconditional) child allowance first for age groups 0-6 years and then expanded (in 2022) for all underaged (<18) children; and
- A Family Material Support (FMS) based child allowance for vulnerable children (conditional on school attendance).

UNICEF Montenegro initiated a behavioural insights (BI) approach to determine the best use of the child allowances by parents and caregivers to promote early childhood development (ECD) and early childhood education (ECE) outcomes.

Strategic approach

The behavioural insights project began with data and evidence gathering initiatives, including an Expenditure Survey and Beneficiary Assessment. The aim of the assessment was to explore and understand how child allowances are currently used by Montenegro families. The data suggested that government funds were not necessarily being used by parents in a way the best served the child. Specific desirable behaviours were identified, for example, enrolling the child in kindergarten, utilizing child allowance funds for child nutrition, enrolling the child in extra-curricular activities, and saving child allowance money for the child's future. The project team documented the findings and wrote a case study based on key findings from the initial phases of the project. The findings were used to develop a behavioural map and identify potential social and behaviour change (SBC) approaches.

SBC was a new concept for the UNICEF Montenegro country office. In order to familiarize the staff with SBC, a series of internal meetings were held, and external meetings and a day-long workshop were conducted with all relevant social and child protection stakeholders (including representatives from the Ministry of Labour and Social Welfare and Ministry of Education) and educational institutions. The workshop introduced the BI process to participants and presented the two proposed interventions: (1) Using social norms to encourage parents to spend child allowances for the well-being of their child in ways that are consistent with their community (in-group); and (2) sending time-based messages to parents encourage the use the child allowances for child-specific needs. Workshop participants identified a need for diverse communication channels to reach both general and vulnerable populations. The UNICEF team held focus group discussions with social workers, beneficiaries (parents receiving child allowance) and preschools, as well as individual meetings with stakeholders (e.g., Ministry for Labor and Social Welfare Director, Head of the Center for Social Work) to gather feedback on the proposed interventions, especially on messages about increasing awareness about early childhood development goals.

In the second phase of the project, a communication strategy was developed, and SBC interventions were tested. A brochure and posters with messages for parents about the benefits of enrolling their children in preschool using the government cash allowance and improving child nutrition were pretested through two online focus group discussions with parents. Changes to the SBC materials were made based on the feedback from parents. All the project documents included recommendations for future policy and programme design in the area of social policy and poverty reduction, and for how to implement a nation-wide scale-up of evidence-based SBC interventions to ensure positive outcomes for children.

In the current and final phase of the project, UNICEF Montenegro is testing selected interventions in municipalities with the lowest pre-school enrolment rates. The interventions focus on nudging parents to use their child allowance as the main funding source for preschool education for their children.

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Key achievements

- UNICEF Montenegro implemented several rounds of expenditure surveys to create an evidence-base for developing behavioural interventions to improve early childhood development.
- UNICEF Montenegro improved cross-sectoral communication about the Government of Montenegro's child allowance programme by including Government line ministries and social and protection institutions in the identification of SBC interventions.
- The BI project served as an SBC capacity-building intervention for the UNICEF country office, that is, it helped to orient office staff on SBC and positioned SBC as an integrated approach that can unite various sectors.

> "As for kindergarten, I have a wonderful experience! Both my sons started at one year old. That first period was a bit of screaming, and banging, like with the others... and after 2 - 3 years, you can really see the difference between children attending kindergarten and those who are looked after by grandparents. The first ones are more independent and more self-confident. A 5-year-old child will come to the playground and say "Let's play" without any hesitation."

Lessons Learned

1. High qualitative and quantitative data collection and analysis, using data collected through stakeholder interviews and beneficiary assessment and expenditure surveys, were instrumental in informing behavioural insights (BI) interventions to promote the optimal use of child allowances.
2. The evidence showed that cash transfers to parents and families alone do not alter parenting practices or improve early childhood development, and suggested that application of SBC approaches is recommended.

Recommendations

1. During the final phase of this BI project, randomized groups of parents have been created for comparison purposes. One group of parents will receive a child allowance and SBC messages to guide them on how best to use the money for their children; the second group will receive the allowance without the messaging. The primary outcome of interest will be the use of allowance money for enrolling the children in preschool.
2. Additional research and investments are needed to better understand complementarities between cash allowances, demand-side behavioural change interventions, and supply-side interventions improving the quality-of-service provision or various direct interventions targeting children or parents.

Endnotes

1 Carraro A, Gavrilovic M, Novkovic M, Stanisic S, Smolovic D, (2020). Multidimensional Child Poverty in Montenegro – Understanding the complex realities of children in poverty using a mixed-methods approach. UNICEF Office of Research – Innocenti and UNICEF Montenegro.

2 Monstat (2022). Survey on income and living conditions (EU-SILC) – preliminary data: https://www.monstat.org/uploads/files/SILC/2021/RELEASE_Survey_on_Income_and_Living_Conditions_EU-SILC_2021.pdf

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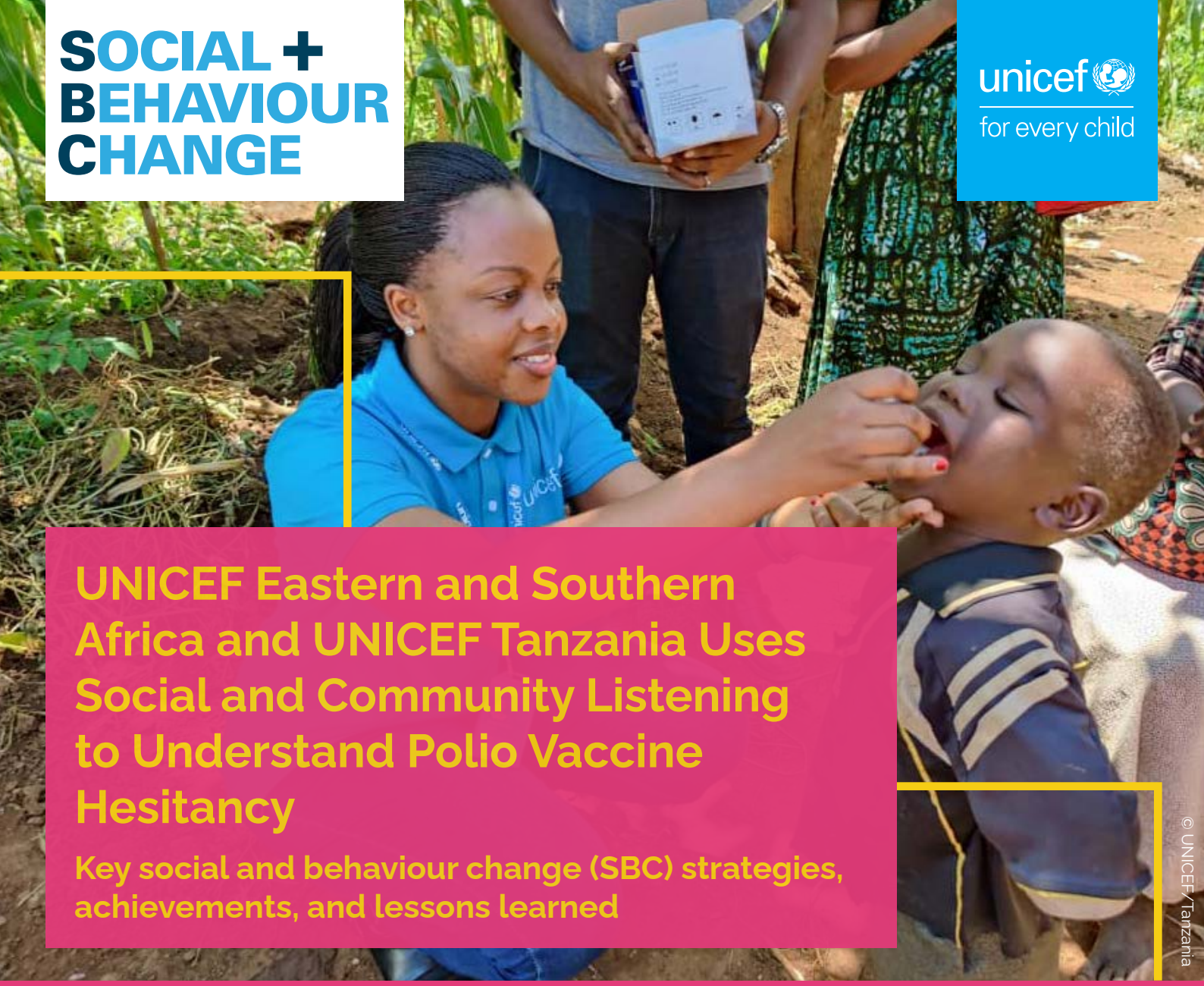

UNICEF Eastern and Southern Africa and UNICEF Tanzania Uses Social and Community Listening to Understand Polio Vaccine Hesitancy

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

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Brief summary

Dates of Activity
October 2023

Duration
48 hours

Budget
$8,000 (estimate)

Social and community listening (SCL) tracks questions, concerns, rumours (unverified information) and false information (misinformation and disinformation) shared by community members on social media, through media, via call-centres, and during primary research. The goal for SCL is to generate insights that can inform evidence-based programmatic action and is an essential component of risk communication and community engagement strategies. UNICEF Tanzania used SCL tools and approaches to identify polio vaccine related misinformation on social media. The team then used Premise, a commercially available tool to conduct a 48-hour rapid and remote mobile phone app-based survey to deepen their understanding of the polio misinformation and underlying behavioural concerns. The rapid survey showed that despite successful polio communication efforts in the country, more than half of respondents expressed concerns about potential polio vaccine side effects. The SCL survey findings led to specific recommendations for activities that would address community concerns about the polio vaccine.

Context

Polio is a vaccine preventable viral disease that causes permanent paralysis and can lead to death. It mostly affects children under the ages of five years and polio vaccine is the only way to protect children from this deadly disease. Since the 1980s, there has been a 99 per cent reduction in polio cases globally thanks to the efforts of the Global Polio Eradication Initiative (GPEI), a consortium of partners including UNICEF and WHO. Polio is deemed a global health emergency, and the world has never been closer to eradicating this virus as it is now.

Misinformation has always affected polio vaccination, but the spread and breadth of polio vaccine related misinformation has increased with greater access to social media, and after wider vaccine hesitancy in the wake of the COVID-19 vaccine introduction. Vaccine misinformation can erode trust in public health systems, cause communities to refuse vaccines, lead to loss of lives, and undo billions of dollars invested in polio eradication. Social and community listening (SCL) is the process of collecting and analysing publicly available information from online, offline, and on-ground sources. SCL is an upstream social and behaviour change (SBC) data source that supplements primary research and provides teams with rapid community level insights that inform behaviour change action.

Strategic approach

To understand the breadth of polio vaccine hesitancy, UNICEF Tanzania sought to identify vaccine hesitancy narratives circulating amongst the public prior to the launch of the September 2023 national polio vaccination campaign. An SCL Validation Survey was conducted in the first week of October 2023. The survey was conducted using a commercially available tool called Premise that delivered rapid and remote surveys via a mobile phone app and a screened panel of respondents. Premise rewards or incentivizes respondents to answer survey questions or complete data collection tasks such as photographing a health facility. It allows geographically targeted surveys with standard or custom sampling methods, including representative, quota, or convenience sampling, and post- stratification weighting. These capabilities were essential to the survey to ensure that data could be swiftly collected from various parts of the country, given the public health emergency status of the polio programme.

The SCL survey received 400 valid responses in a 48-hour window. A majority (287) of these responses were in English, while the rest (133) were in Kiswahili. The rejection rate of collected responses was four per cent. Key findings from the SCL survey showed that the most recent polio communication campaign appeared to be successful, with 87 per cent of the respondents being aware of the vaccination campaign


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and 92 per cent aware of the polio vaccine. Eighty-eight per cent of the survey participants indicated that their intent to vaccinate was positively influenced by the information they encountered on social media. About 26 per cent of respondents self-reported active engagement in posting or reposting about polio. The respondents applauded on-ground polio eradication operations; 93 per cent of the people that were aware of the polio campaign found the vaccination process seamless, and 95 per cent felt that the vaccination teams were adequately skilled.

Despite the campaign's success, only 58 per cent of respondents held a very positive perception of vaccines, and 61 per cent expressed concerns about potential side effects of the polio vaccine. The primary concerns were related to fever and pain post-vaccination. Twenty-three per cent of the participants had come across misinformation which suggested that polio vaccine has potential risks. Social media was highlighted as the leading channel for such misinformation, with 37 per cent of respondents encountering false narratives in the past two weeks.

The information gathered through this type of social listening was translated into recommendations for strategies to address concerns and questions about polio vaccines and control the rumours that inhibited vaccine uptake.

Key achievements

- The SCL validation survey provided valuable insights into the Tanzanian public's perceptions of the polio vaccine and the vaccination campaign. While the campaign achieved significant success in many areas, addressing misinformation and vaccine safety concerns was crucial to ensuring ongoing vaccine acceptance.
- UNICEF Tanzania identified SCL-based strategies to bolster public trust and improve the efficiency of future vaccination campaigns.

400

surveys conducted in English and Kiswahili via a mobile phone app

87%

of respondents were aware of the vaccination campaign

92%

of respondents were aware of the polio vaccine

Lessons Learned

1. Validation can be powerful: Validating SCL insights is a powerful tool to highlight community voices and demonstrate the need for on-ground SBC action or programme modification.

2. Validation surveys can demystify misinformation: SCL insights can highlight potential misinformation narratives, and validation surveys can delve deeper into specific behavioural concerns that emerge from misinformation.

3. Rapid surveys are a core SCL function: Swift access to data collection from a wide and geographically targeted sample bolsters confidence in SCL insights and recommendations.

4. SCL and Digital Engagement are intertwined: A majority of SCL data is collected through online platforms and closely integrating SCL with Digital Engagement could bolster the outcomes for both.

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Recommendations

1. Educational content: Create short TikTok style videos that demystify common vaccine side effects and emphasize their mild, temporary nature to reassure the public and mitigate concerns.

2. Testimonials and endorsements: Use testimonials from trusted community figures, healthcare professionals, and other known individuals that have been vaccinated to motivate others to be vaccinated.

3. Digital engagement: In response to the misinformation spreading online, implement a vaccine specific digital engagement strategy that promptly addresses false narratives.

4. Expert-led initiatives: Host online Q&A and live-stream sessions with health professionals who can provide real-time solutions and ease public anxieties.

5. Leverage influencers: Given the influence of social media, collaborating with influencers can amplify the reach of information.

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UNICEF Yemen Combats Cholera and COVID-19 through Health Behaviour Monitoring System

Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary

Dates of Activity
2018 to present

Duration
Ongoing

Budget
Unknown

Context

The conflict in Yemen, ongoing since 2015, has resulted in multiple humanitarian crises including malnutrition, food insecurity, severe economic crisis, as well as disease outbreaks and epidemics. Yemen has experienced some of worst cholera outbreaks in the world. Between 2016 and 2021, 2.54 million suspected cholera cases have been registered in Yemen, with almost 4,000 associated deaths across the country. Children under the age of five continue to represent more than a quarter of all suspected cholera cases.[1] The outbreaks are associated with Yemen's damaged water, sanitation, and health infrastructure, as well as low adoption of key hygiene and sanitation practices at the household level, crucial for preventing the spread of cholera and other diseases. In 2020, the cholera situation was compounded by the COVID-19 pandemic. The healthcare system in the country was already crippled, struggling to deal with casualties of violence, malnutrition, and other disease outbreaks.

As part of the humanitarian response to the various public health emergencies in Yemen, the UNICEF Yemen SBC section has been leading the development and implementation of Risk Communication and Community Engagement (RCCE) strategies to respond to the outbreaks. Effective RCCE strategies rely on collecting social and behavioural data to understand people's knowledge, attitudes, risk perception, and practices related to a specific health emergency. This data is important for understanding the key drivers and barriers of behaviours that determine the adoption of positive preventive practices. Establishing and maintaining a system to collect this essential data has been critical to combating cholera and other diseases in Yemen.

Strategic approach

In 2018, recognising the critical need for collecting social and behavioural data to guide the development and implementation of outbreak responses, UNICEF Yemen established a comprehensive system for collecting timely and accurate data on public health emergencies, including a series of knowledge, attitudes, and practices (KAP) assessments carried out in periodic rounds to track shifts in KAP over time, and to assess the effectiveness of RCCE efforts. These quantitative assessments are complemented with qualitative social listening approaches (e.g., online social listening using platforms like *Talkwalker*; in-person focus group discussions rumour tracking; hotlines) to identify the root causes and drivers of negative (non-protective) practices.

Between 2018 and 2019, UNICEF Yemen conducted three rounds of a Cholera Behaviour Indicators Monitoring study with 9,800 households and 1,200 food vendors across 98 high-risk cholera districts, to monitor the adoption of key cholera preventive practices, including handwashing with soap, water safety, excreta disposal, food safety, and management of diarrhoea. In 2020, when the COVID-19 pandemic reached Yemen, UNICEF Yemen adapted the established Cholera Behaviour Indicators Monitoring protocols and tools to generate data on COVID-19 to guide the development and implementation of the UN-led COVID-19 RCCE strategic response to the pandemic. Since 2020, five rounds of assessments on COVID-19 KAP and vaccines have been conducted, with

about 1,500 participants from all governorates in Yemen in each round. UNICEF Yemen also developed a tracking tool to monitor rumours and misconceptions about COVID-19, COVID-19 vaccines, and immunisation overall. The tool allows individuals and volunteers to share information about COVID-19 related rumours circulating in their communities via smartphone. UNICEF Yemen trained medical doctors and midwives to track and respond to rumours and misconceptions.

UNICEF Yemen utilised online social listening tools to monitor social media conversations related to COVID-19 and COVID-19 vaccine. The social listening tool *Talkwalker* was used to track and analyse trends, sentiments, misinformation, and key themes in social media conversations that include COVID-19 and COVID-19 vaccines. The UNICEF team also utilised data from COVID-19 hotlines and call-in radio programmes to gain further insights into the most frequent queries and concerns Yemenis had related to the pandemic. These data are continuously being collected, triangulated and shared with Yemen's COVID-19 response coordination mechanisms, including the National Steering Committee, the Technical COVID-19 Deployment Committee, and the RCCE Working Group, to support decision making about the use of national resources. Drill-down and trend analyses of the data were also conducted to identify behavioural gaps at the governorate and district levels. This approach enabled UNICEF to take further focused actions and develop better-tailored messages to address the specific needs and concerns of different communities.

Key achievements

The Behaviour Indicators Monitoring System established by UNICEF Yemen has been instrumental in providing a comprehensive view of public knowledge, perceptions, attitudes, and behaviours related to public health emergencies, especially during the height of the COVID-19 pandemic. The information generated from the multiple components of the system has enabled UNICEF Yemen to regularly review and revise its response strategies, RCCE messages, and interventions to address the gaps identified. Being able to triangulate the data with demographic and RCCE interventions data has helped to ensure the effective utilisation of the findings. This approach has allowed for a more nuanced understanding of the factors influencing public perceptions and behaviours related to public health emergencies and helped to identify areas where targeted interventions were needed.

The data generated from COVID-19 hotlines, radio call-in programmes, and online social listening were particularly useful for understanding the information needs and concerns of people throughout Yemen. The rumour tracking mechanisms implemented by UNICEF played a key role in responding to COVID-19 related rumours and misconceptions. These tools have enabled UNICEF to quickly identify and respond to misinformation and rumours related to COVID-19 and COVID-19 vaccines which is an integral part of the RCCE strategy.

5
ROUNDS

of assessments on COVID-19 KAP and vaccines conducted since 2020

1,500
PARTICIPANTS

from all governorates in Yemen in each assessment round

Lessons learned & Recommendations

1. Timely collection of social and behavioural data during the initial stages of a public health emergency is critical to developing and implementing effective RCCE strategies, informing the response efforts, and guiding the development of tailored communication and messaging strategies.

2. Triangulating data from multiple sources, including periodic KAP assessments, social listening tools, and rumour tracking mechanisms can provide a more comprehensive and nuanced understanding of public perceptions and behaviours related to public health emergencies.

3. Tailoring communication and messaging strategies to the specific needs and concerns of different contexts and communities is critical to building trust and confidence in the response efforts.

4. Addressing rumours and misinformation related to public health emergencies is critical to building trust and confidence in RCCE efforts.

5. Engaging stakeholders (e.g., partners, donors, senior management, relevant UNICEF programmes and counterparts) on the findings of the social and behavioural data is key for coordinated and collective actions.

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Endnotes

1 World Health Organization, 'Cholera situation in Yemen, April 2021', Reliefweb, 9 January 2022, <https://reliefweb.int/report/yemen/cholera-situation-yemen-april-2021>.

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The Compendium of SBC Best Practices has been jointly developed by the Country Offices, the Regional Office, the HQ SBC Team and PCI Media.

Thanks to the amazing SBC and programme country teams for the contributions

The compendium is available electronically and can be downloaded from https://www.sbcguidance.org and https://unicef.sharepoint.com/sites/PG-SBC

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