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Compendium of SBC Best Practices

Middle East and Northern Africa Region

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Foreword

UNICEF's work in the Middle East and North Africa (MENA) region covers a heterogenous span of 20 high to middle income countries, fragile states, and countries in conflict or protracted crises. The region is geo-politically significant with its long and chequered history, resources, as well as rich socio-cultural traditions and multi-religious influences.

Cutting across this context, live 193 million children under eighteen who account for approximately 36 percent of the region's population. 50 million of these, constituting 30 percent of the global population of children, require humanitarian assistance. The Children's Climate Risk Index shows that more than 82 million children in MENA face high or extremely high climate risks. This number is expected to increase to 98 million by 2050.

The region also faces the highest youth unemployment rates in the world; deeply entrenched gender divides and harmful social practices; stagnating health and nutrition outcomes amidst frequent disease outbreaks and a triple nutrition burden; eroding social services linked largely to armed conflicts; forced displacements and migration; natural disasters, and economic shocks. 85 percent of children aged two to fourteen years have experienced violent discipline, and close to half of adolescents aged 13 to 15 years, have been bullied.

Against this challenging backdrop and utilizing regional child rights data, UNICEF has prioritized six areas of focus for accelerated action. These include : strengthening primary health care; prevention and treatment of malnutrition; skills, learning and employability; climate crises with a focus on water scarcity; ending violence against children; and strengthening national social protection systems.

Social and behaviour change, and community engagement (SBC-CE) approaches undergird the design and delivery of programme responses across all these areas. Large-scale emergencies have required increasing attention to social listening and community engagement for the practice of life-saving behaviours and trust building, particularly among highly vulnerable and displaced populations. Norms-based approaches using behavioural analyses, public engagement and dialogue, and policy and service workforce improvements have been central to discarding harmful practices and the uptake of social services.

The MENA case studies in this compendium are dedicated to the children and youth of this rich and diverse region. They aim to demonstrate the power and potential of applying evidence-based and inclusive SBC-CE approaches across diverse contexts to improve the health and social wellbeing of children, youth, and their families. Most importantly, they bear testimony to the courage, commitment, creativity and perseverance of UNICEF partners and staff on ground to empower communities for lasting social and behaviour change. We hope you enjoy reading and learning from them.

On behalf of the UNICEF MENA SBC-CE team,

Neha Kapil
Regional Advisor, SBC-CE
UNICEF MENA Regional Office
Amman, Jordan

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

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

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

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

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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

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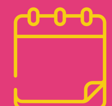
Brief summary



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 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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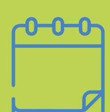
UNICEF Lebanon Uses Social Mobilization to Motivate Transformational Change for Children and Women through QUDWA Strategy

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

Brief summary



Dates of Activity
June 2020 - present

Duration
Seven years

Budget
US$1.8 million

QUDWA (Arabic for 'role model') is a national social and behaviour change (SBC) initiative to prevent child marriage, child labour and violence against girls, boys and women in Lebanon. QUDWA is comprised of mass and social media edutainment, community engagement and capacity building activities that support the creation of a conducive and protective environment where children and families can feel safe and thrive. The aim is to give communities ownership to uphold children's rights themselves, and to create individual and community social responsibility to act against violence. QUDWA initiatives have contributed to an increase in the engagement of child protection promoters in communities; these promoters have become co-investors in prevention efforts in the eight governorates of Lebanon.

Context

QUDWA was developed by UNICEF and the Ministry of Social Affairs (MoSA) as part of Lebanon's Strategic Plan (2020-2027) for the Protection of Women and Children. The Strategic Plan focuses on strengthening MoSA's leadership and regulatory role in the field of child protection and protection against gender-based violence, while ensuring the necessary coordination and integration between the public and private sectors, including civil society. The aim of QUDWA is to translate the Strategic Plan into practices that ensure the delivery of comprehensive and quality services for target groups and strengthen the national system for the prevention and response to child protection violations and gender-based violence. The QUDWA strategy is designed to address the root causes of harmful practices against Lebanese girls, boys and women (e.g., child labour, child marriage), and encourage behaviours and norms that promote wellbeing, dignity and equality. The QUDWA programme was launched in 2020 and rolled out to all eight governorates of Lebanon in 2021.

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Strategic approach

In 2020, QUDWA was implemented as a pilot intervention in selected areas of the country in collaboration with dedicated partners.[1] The activities were implemented by 13 UNICEF Child Protection (CP) partners that worked around the clock to address harmful practices and key CP issues. UNICEF Lebanon provided capacity building opportunities to CP workers, regardless of whether they partnered with QUDWA, that motivated them to adopt the QUDWA approach. By 2022, the QUDWA strategy was rolled out by partners across Lebanon's eight governorates.

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The QUDWA programme activities were tailored to reach specific audiences. The QUDWA activities include:

- **Bakir:** A 22-episode television series about a Lebanese family dealing with familiar struggles of daily life. The characters depict the hardships that lead to violence against girls, boys, and women, child marriage, and child labour. The series aired in March 2022 in prime time on LBC TV, followed by Al Jadeed in April, and MTV in September.
- **My Father's House:** A short drama featuring a Lebanese family trying to make ends meet and raise their children. The episode depicts the everyday challenges that families and children encounter and is intended to spark reflection and dialogue around social norms and common caregiving behaviours that may or may not be healthy for children. This drama was integrated into the caregiver's toolbox and used by partners in the outdoor cinema initiative (see below).
- **Community theatre:** Volunteers are trained to be agents of social change by engaging audiences in participatory theatre performances. The aim is to stimulate dialogue around the key QUDWA focal areas of child marriage, child labour, and domestic violence.
- **Puppet shows:** A set of QUDWA characters were developed with corresponding scripts and role-plays about child marriage, child labour and violence, appropriate for children and families. Discussions guidelines were created for frontline workers and communities to help initiate healthy and constructive dialogues about these topics.
- **Comic books:** A series of illustrated comic books were developed to engage children in contextualized storytelling that reflect Lebanon's community dynamics and social norms. The aim is to broaden the perception of what girls and boys can do and be.

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- **Interfaith documentaries:** A series of documentaries featuring interfaith teams of religious leaders highlighting successful initiatives to prevent and reduce violence against boys, girls and women, child marriage and child labour within their communities.
- **Community engagement:** Community 'safe spaces' were created where girls and boys can socialize with peers, engage in sports, and play before and after school, and on weekends. These spaces also serve as places where adults and families can meet to de-stress and exchange experiences. QUDWA also mobilized such key community influencers and socially networked individuals as barbers, beauticians, and religious leaders, to play a proactive role in preventing harmful practices against children and women. The influencers were trained to recognize signs of harm and provide referrals to services.
- **Capacity building:** Capacity building activities were conducted for UNICEF partners, UN agencies, local stakeholders and the Child Protection sector. Programme managers, team leaders and frontline workers were engaged to ensure that all practitioners involved in the implementation of the QUDWA strategy were aware of and able to apply the concepts, approaches and tools. Training-of-trainers (TOT) sessions and on-the-job coaching were provided to those that wanted to engage with QUDWA. A National QUDWA Task Force was set up and led to a rapid scale up of QUDWA initiatives throughout Lebanon.

- **Caregivers Toolbox:** The toolbox includes: shareable audible memes aimed at men; a human sized model of a child with removable Velcro patches to facilitate discussions about the seen and unseen effects of violence on the body; a Velcro timeline to help children and adolescents understand life stages, key milestones, and healthy development; a series of 3-7 minute videos about brain development and the importance of early childhood stimulation; 24 flashcards depicting scenes to prompt discussions about child marriage, child labour, healthy communication in families and avoiding violent discipline ; role-play scripts to encourage, for example, discussions about key milestones in teenagers' development and challenges caregivers may face while raising teenagers; colouring books to encourage parent-child play and development; a Trivia game; eight reusable wipe-clean posters; a playmat and sticker book that helps children learn about their bodies and their development cycle; an interactive journal to motivate adolescents to discuss their goals and mental health with caregivers; a board game about child marriage with information steps to reach a finish line.
- **Religious Leaders Engagement:** As part of the QUDWA Strategy, UNICEF Lebanon organized six participatory roundtable discussions with religious leaders throughout Lebanon. The purpose was to reflect on the role of religious leaders in promoting protective environments for women and children in the country. Attendees emphasized the importance of their sermons as platforms for dialogue around child marriage, child labour, and child disciplining methods. The roundtables were followed up with individual meetings with religious leaders and a general meeting to gather all interested parties in advocating for children's rights as part of a QUDWA RL network.

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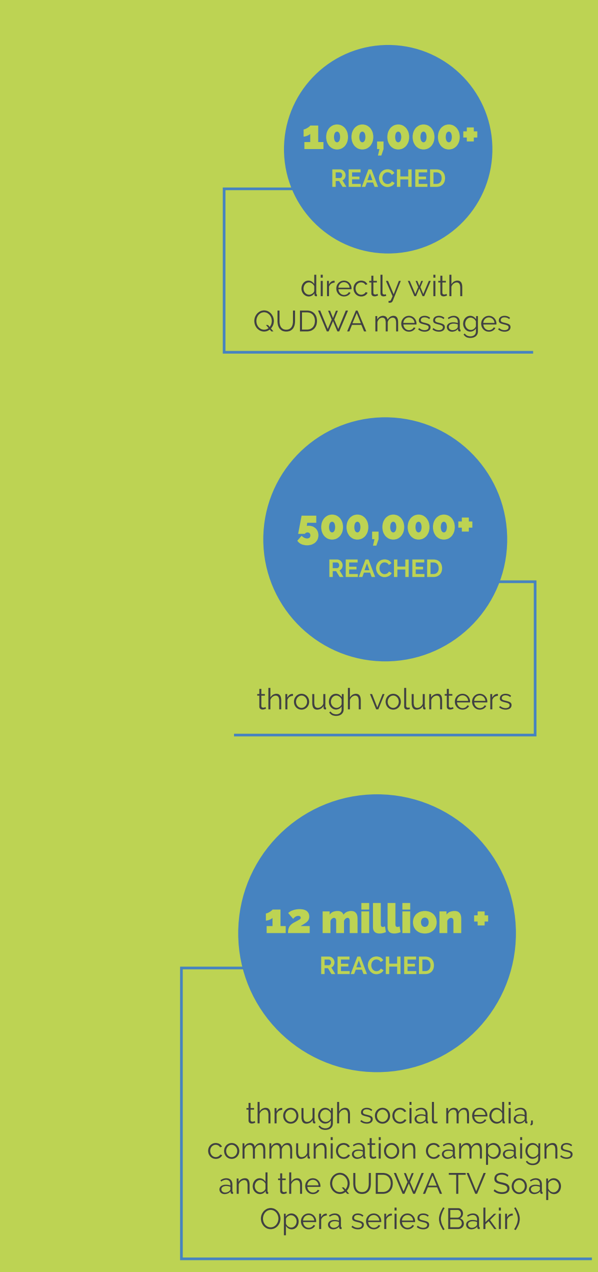
Key achievements

QUDWA initiatives have reached the most vulnerable populations in Lebanon, enabling open discussions about sensitive topics. The key to the success of QUDWA is the sense of ownership it gives communities to act in ways that uphold children's rights. The social mobilization and community engagement initiatives are leading to the development of grassroots community-based networks (including caregivers, taxi drivers, pharmacists, religious leaders, barbers/beauticians, activities, mayors, business owners, and others), empowered to speak up on cases of violence around them and refer them to UNICEF-supported services.

Specific achievements from this initiative include:

1. QUDWA initiatives have contributed to an increase in the engagement of child protection promoters in communities. These promoters have become co-investors in prevention efforts in the eight governorates of Lebanon.
2. More than 800 QUDWA activities have been implemented.
3. Over 500 frontline workers and volunteers have been trained to carry out QUDWA activities.
4. More than 100,000 individuals have been reached directly with QUDWA messages, and over 500,000 reached through volunteers.
5. Over 12 million people have been reached through social media engagement, communication campaigns and the QUDWA TV Soap Opera series (Bakir).
6. More than 134 religious leaders from various sects participated in roundtable discussions about strengthening and taking a more active role in addressing child marriage, child labour, and violent disciplinary methods. Religious leaders unanimously agreed to follow up with in-depth workshops to generate content to support their efforts in addressing harmful practices. In June 2023, an interfaith network was established on children's rights, creating opportunities to address harmful practices and negative social norms at scale and through the sectarian sector.

There has been increasing interest across different partners to increase investments in prevention efforts based on the QUDWA approach. Some partners have established SBC committees within their institutions to develop and implement similar initiatives across different programmatic interventions, while others are identifying dedicated focal points for SBCC.



Lessons learned

1 **Investment in capacity building is pivotal to ensuring impactful interventions.** Focusing on capacity building of QUDWA frontline workers ensured that they understood the strategy and their role in implementing it, which in turn helped to scale up activities. Engaging and training frontline workers on the QUDWA strategy led to exceeding the projected target of people reached by 49 per cent with the same financial resources, thus bringing in greater cost efficiency, higher reach and more impactful results for children and women.

2 **Investing in initiatives that focus on community empowerment yields returns:** The mobilization of many QUDWA role models led to a sharp increase in the identification and referral of CP and gender-based violence (GBV) cases. QUDWA prevention efforts need to be complemented with an equal scale up of CP and GBV services which is currently advocated for with donors.

3 **Working with religious leaders is key to strengthening child protection efforts.** Lebanon is a multi-theistic society and religious leaders tend to have a major influence on families and communities. Working closely with religious leaders and community influencers ensures that key messages reach families, especially the most vulnerable.

Recommendations

1 Invest in sustainable community driven interventions for children and women that enable them to be proactive about addressing violence.

2 Solicit buy in and ownership from child protection partners. Provide capacity building activities that enable communities to take the lead on interventions.

3 Invest in programmes that focus on increasing social responsibility of individuals within a community to amplify the result of changing traditional behaviours and social norms regarding children and women.

Endnotes

1 Examples of the QUDWA activities can be seen at https://www.unicef.org/lebanon/qudwa.

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UNICEF Jordan Transforms the Lives of Vulnerable Children and Adolescents

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

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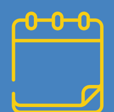
Brief summary



Dates of Activity
2015 – present

Duration
9 years (ongoing)

Budget
US$20 million (annually)

UNICEF Jordan's Makani ('My space' in Arabic) programme is an integrated set of interventions that aim to promote the well-being of the most vulnerable youth in Jordan, and support them in achieving their full physical, cognitive, social, and emotional potential. Children and adolescents benefit from the age-appropriate and gender-responsive integrated package of services, including learning readiness, learning support, community-based child protection services and skills building programmes (including digital skills). Parents can access early childhood development and parenting programmes tailored for different age groups. Makani facilitators can refer children and families to specialized services as needed. Children who attended Makani centres were 50 per cent more likely to be enrolled in school and showed better learning outcomes when compared to similar groups not attending Makani and demonstrated better results in relation to social connectedness, self-confidence, awareness of violence and well-being. These skills-building interventions have resulted in stronger social connections and overall better outcomes for youth participating in the Makani programme compared to those that do not participate.[1]

Context

Approximately 54 per cent of Jordan's population is under the age of 24 years. This population faces a series of challenges including poverty, lack of quality education, high unemployment rates, and inadequate child protection and social services. The Kingdom of Jordan hosts one of the largest refugee populations in the world per capita, with over 1.3 million Syrians (both registered and unregistered).[2] Of the 660,605 registered Syrian refugees (April 2023), almost half (49 per cent) are children.[3] In addition, more than two million registered Palestinian refugees live in Jordan, as well as smaller groups from Iraq, Yemen, Sudan, Somalia and other countries.[4]

Jordanian classrooms are generally overcrowded and leave schoolteachers with little time to provide individual attention to students that require help with their lessons. Non-Jordanian children have a higher out-of-school rate than Jordanian children. Syrian children account for the largest proportion of children that do not attend school.[5] Adolescent girls and those with disabilities are particularly vulnerable populations that face the risk of early-marriage, experience restricted mobility, and are most likely to drop out of school. In 2020, 57 per cent of vulnerable hard-to-reach communities (e.g., those living in informal tent settlements - ITS) reported that no child was attending formal education, either because they lacked the funds to afford related costs, did not have access to transportation to school, the family moved, or the child was working for money.[6]

The COVID-19 pandemic strained an already fragile economy in Jordan. It affected economic growth, heightened existing vulnerabilities, and increased unemployment and poverty rates. Extended pandemic-related school closures resulted in inequitable access to quality online learning. Varying levels of parental support for children's learning further exacerbated gendered inequalities among Jordanian youth.

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Strategic approach

To address the needs of vulnerable children in Jordan, and in response to the Syrian crisis and the government's No Lost Generation (NLG) initiative, UNICEF Jordan developed the Makani programme in 2015. Makani is a comprehensive approach to the provision of gender equitable services to vulnerable refugee and Jordanian children that integrates learning support, community-based child protection services, early childhood development (ECD), parenting programmes, youth participation, and skills development programmes into one space. The programme's inclusive life-cycle approach makes it possible to address the complex needs of the most vulnerable and marginalized children (e.g., the Dom, ITS children), young people, and their caregivers.[7],[8]

The Makani programme's primary objective is to strengthen the resilience and social cohesion of vulnerable children, adolescents and youth in Jordan by improving their learning opportunities, social skills and psychosocial health. The goal is to enable Jordanian youth to realize their potential, transition to productive adulthood, and positively engage in community life. Child protection messages are integrated into all Makani activities, including community outreach awareness sessions. The Makani programme supports activities through a network of 136 centres in all of Jordan's governorates, Syrian refugee camps, and ITS. The activities include:

- **Learning support services:** Providing vulnerable children and youth with quality accelerated lessons in Arabic, mathematics, and reading recovery.
- **Skills building:** Providing sessions on digital literacy, financial literacy, communication, critical thinking, processing emotions, awareness about violence, gender equality, building resilience, and other transferable life-skills.

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- **Unstructured recreational time and sports activities.** The social time spent with peers at the Makani centres helps youth build social skills and facilitate developing positive relationships. By actively engaging in their communities through youth-led initiatives and meaningful volunteering opportunities, adolescents and youth acquire skills and information that help shape their personalities, develop their practical experiences, boost their confidence, enable their healthy adaptation to new situations, and increase their future employment opportunities.
- **Early Childhood Development (ECD) and better parenting sessions:** These sessions equip parents and caregivers with skills to support their children to achieve their full potential, including how to provide positive discipline, stimulate early learning, and increase parent-child bonding.
- **Community outreach:** Makani community committees, comprised of youth, women, community leaders and influencers, have been trained to identify and refer vulnerable youth to Makani Centres where the youth can receive appropriate assistance.
- **Climate Action Clubs:** In 2020, Makani Centers established Climate Action Clubs to raise awareness about climate change and its associated risks, to encourage youth-led environmental initiatives in the communities. Makani also invested in equipping 48 Makani Centres with solar panels to generate electricity, promote sustainable infrastructure, and reduce emissions.
- **Cash transfers:** In 2020, the Makani programme leveraged strategic linkages with Jordan's social protection system in collaboration with the Ministry of Social Development (MOSD) and the National Aid Fund (NAF), through the Cash Plus initiative, which complements financial aid with Makani's integrated services in line with UNICEF's global Cash Plus initiatives and global best practices.

During the COVID-19 pandemic, the Makani programme leveraged their network of families and communities to rapidly respond to the crisis by shifting all centre activities to online platforms. To address the digital divide, Makani centres provided vulnerable children tablets and internet connectivity. In the aftermath of the pandemic, the Makani centres adapted the programme content and material to help youth make up for any learning loss.

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The programme continues to benefit from its robust near-real-time monitoring system, called Bayanati ('My Data' in Arabic). The quality data provided by this system supports evidence-based performance monitoring, adaptive programming and allows for the adjustment of the programme design to better serve the most vulnerable children.

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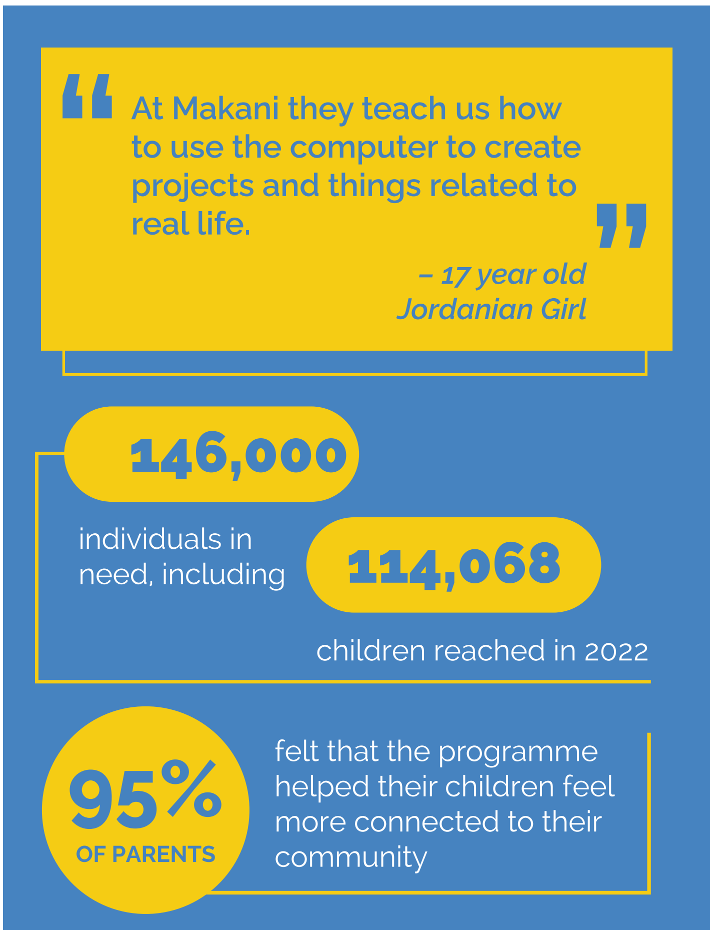
Key achievements

Since its inception, the Makani programme has continued to evolve. It has increased collaboration between organizations working in short-term humanitarian aid and long-term international development, and expanded its vulnerability-based targeting approach to include all vulnerable communities in Jordan, with a particular focus on girls and women, children with disabilities, and marginalized groups. In 2022, the Makani programme reached over 146,000 individuals in need, including 114,068 children (55 per cent girls; 19 per cent in refugee camps; two per cent children with disabilities). Specific achievements include:[9],[10]

- Children who attended Makani centres were 50 per cent more likely to be enrolled in school and showed better learning outcomes when compared to similar groups not attending Makani.
- Eighty-nine per cent of children who attended Makani centres demonstrated a positive increase in post-test scores compared to pre-test scores in Arabic and Math.
- Children attending Makani centres demonstrated better results in relation to social connectedness, self-confidence, awareness of violence and well-being.
- Adolescents and youth participating in Makani were 38 per cent more likely to hold a leadership position in school. Forty-one per cent were more likely to control their own finances and were twice as likely to play a sport than those not enrolled in Makani.
- Girls who participated in Makani activities reported improved learning and understanding of what constitutes violence and how child marriage can be harmful. Thirty per cent of Makani girls were more likely to know where to seek support if they experienced violence, and more likely to have a trusted friend.
- Adolescents who participate in Makani were 70 per cent more likely to have worked with others to solve a community problem through volunteer initiatives than non-Makani participants. Seventy per cent volunteer on a regular basis in the community and 81 per cent believe in their ability to contribute to the development of their community.
- Ninety-two per cent of adolescents felt more secure in their community as a result of attending Makani centres.
- Ninety-seven per cent of parents and caregivers demonstrated better awareness of how to discipline their children after attending the better parenting sessions offered at the Makani centres.
- About 95 per cent of parents felt that the programme helped their children feel more connected to their community.



Lesson learned

1. Leveraging synergies with other UNICEF, government, and partner programmes enabled greater reach and impact.

2. Strengthening the national capacities of the implementing partners (e.g., the Ministry of Social Development) enhanced the quality, ownership and accountability of the Makani interventions, which is critical to sustaining and institutionalizing the programme.

3. Efforts to reach specific vulnerable groups (e.g., children with disabilities) were critical to ensuring that all youth in Jordan succeed in school and achieve their potential throughout their lifespan.

4. Integrating gender equality into programme activities raised awareness, supported access to education, and has the potential to transform societies.

5. Maintaining an evidence-based approach to assessing Makani activities' relevance, consistency, efficacy, efficiency, impact, and viability, is critical for refining the overall programme.

Recommendations

1. **Strengthen referral mechanisms for youth:** Strengthen the referral mechanisms that link youth to post-programme opportunities that include education and career guidance tailored to local realities, and that help vulnerable youth generate income, which the Makani programme is teaching them how to use more efficiently (e.g., Technical and Vocational Education and Training).

2. **Systematically embed gender awareness into all activities:** Integrate learning about discriminatory gender norms into the broader Makani curriculum so that girls' and boys' exposure to gender equal ideas and practices is not dependent on the interests of individual facilitators or limited to particular days (such as Women's Day).

3. **Increase support for youth in the most vulnerable and marginalized communities:** Foster Arabic language skills in the early grades and build parents' and children's educational aspirations. Where secondary schools are not easily accessible, provide transportation vouchers to ensure uptake of education services.

4. **Continue supporting and expanding Cash Plus initiatives.** Provide transfers to more adolescents and guarantee support through to the end of secondary school.

5. **Continue institutionalization efforts for programme sustainability:** Expand national capacity building activities to empower governmental and non-governmental partners to sustain the Makani approach in the longer term, with the aim of assuming responsibility for the programme implementation.

Endnotes

1 Presler-Marshall, E., Jones, N., Małachowska, A., Oakley, E., *UNICEF Jordan's Makani Programme: supporting students, building resilience'. Policy brief. London: Gender and Adolescence: Global Evidence*, 2022.

2 The Brookings Institution, 'Syrian refugees in Jordan: A decade and counting', Brookings, 2022, <https://www.brookings.edu/articles/syrian-refugees-in-jordan-a-decade-and-counting/>.

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5 United Nations Children's Fund, *Jordan Country report on out-of-school children*, UNICEF, 2020, <www.unicef.org/jordan/media/5501/file/OSC-Report-EN.pd>.

6 United Nations Chidlren's Fund, *Final report: Summative Impact Evaluation of the UNICEF Jordan Makani Programme*, UNICEF Jordan, 5 May 2022, <https://www.unicef.org/jordan/media/11671/file/Makani%20summative%20impact%20evaluation_English.pdf>.

7 The word Dom is used to describe a specific ethnic group from Middle East, North Africa and Eastern Anatolia Region/Turkey. This group is a marginalized minority in Jordan.

8 United Nations Children's Fund, *Jordan Country report on out-of-school children*, UNICEF, 2020, <www.unicef.org/jordan/media/5501/file/OSC-Report-EN.pd>.

9 Jones N., Baird S., Presler-Marshall E., Małachowska A., Kilburn K., Abu Hamad B., et al., 'Adolescent well-being in Jordan: exploring gendered capabilities, contexts, and change strategies: A synthesis report on GAGE Jordan baseline findings', Gender and Adolescence: Global Evidence, October 2019, <www.gage.odi.org/wp-content/uploads/2019/10/Adolescent-Well-Being-In-Jordan-Exploring-Gendered-Capabilities-Contexts-And-Change-Strategies.pdf>.

10 United Nations Children's Fund, *Final report: Summative Impact Evaluation of the UNICEF Jordan Makani Programme*, UNICEFR Jordan, 5 May 2022, <https://www.unicef.org/jordan/media/11671/file/Makani%20summative%20impact%20evaluation_English.pdf>.

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SOCIAL + BEHAVIOUR CHANGE

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UNICEF Palestine Supports the Development of an SBC Strategy for Children with Developmental Delays and Disabilities

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

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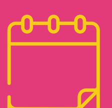
Brief summary



Dates of Activity
2019-2022

Duration
2 months to develop the strategy

Budget
Unknown

Children with developmental delays and disabilities in the State of Palestine are often severely marginalized and subjected to stigma and discrimination from those around them. UNICEF Palestine conducted a mixed-methods baseline knowledge, attitudes, beliefs and practices (KABP) study of children with developmental delays and disabilities, their parents/caregivers, community members, and service providers. The study results were used to inform the design of a multi-year SBC strategy for the State of Palestine. The strategy activities aimed to promote early childhood development behaviours, increase demand for services among parents and caregivers of children with developmental delays and disabilities, and provide parents and caregivers with the knowledge and skills they need to address stigma and discrimination.

Context

A study of people with disabilities in Palestine showed that Jenin (in the West Bank) had the highest reported percentage (4.1 per cent), followed by the district of Hebron in the southern West Bank (3.6 per cent). The Gaza governate in the Gaza Strip reported that 2.3 per cent of their children were living with disabilities. At least half of the people living with disabilities in Palestine had mobility issues. Health services in Gaza and the West Bank are generally insufficient to meet the needs of the population, especially the needs of children with disabilities.[1]

Palestinian parents and caregivers of children with developmental delays and disabilities face many barriers when seeking services for their child. Many residents of Gaza and the West Bank are unemployed and have lower levels of education. They often struggle with transporting their children to receive services due to a lack of funding for assistive devices such as wheelchairs, or an inability to pay for transportation services. Once a parent arrives at a facility with their child, they may find that those services are not available, or may be too expensive for the parents to afford. Many parents and caregivers often do not know where to go to seek information and services for their child. Stigma and discrimination toward children, and parents of children, with developmental delays and disabilities, self-stigmatization and religious and/or cultural beliefs that associate disabilities with a lack of faith, can also be reasons for not seeking assistance or services.[2] In 2016, a situation and services assessment for people with disabilities in Palestine concluded that reducing stigma and discrimination is key to improving access to services.[3]

Strategic approach

The aim of the KABP study was to understand the ways in which children with developmental delays and disabilities, parents and caregivers, service providers, and community members perceived the issue of stigma toward children with developmental delays and disabilities. The study also measured knowledge of positive parenting practices among parents or caregivers and practitioners, and how knowledge and attitudes are practiced in caregiving, parenting, and day-to-day interactions with disabled children.

The study consisted of (1) a quantitative study, representative of the entire population of Gaza and the three governates of Hebron, Jericho, and Nablus in the West Bank; (2) a qualitative study that included focus group discussions (FGDs) and key informant interviews (KIIs) with parents or caregivers/guardians, extended family members, community members, leaders, service providers, and policymakers in both Gaza and the West Bank; and (3) participatory activities that were conducted with youth ages 10—15 years with developmental delays and disabilities in both Gaza and the West Bank, and parents/caregivers in each region. The design of the study was based on a review of literature, including key reports on the situation of children with developmental delays and disabilities in Palestine. Three key concepts from the Theory of Planned Behaviour (i.e., attitudes, normative expectations, and self-efficacy) were used to guide the design of the quantitative survey instrument and the qualitative inquiry. Findings from the study were used to develop an SBC strategy.[4]

Key achievements

- The study findings were used to develop a cross-sectoral and innovative approach to working with children, families and providers, and support for policy and programming in Palestine.
- The Palestine KABP study received a 'Best of UNICEF Research 2021' for its high potential for impact to benefit children.

The Palestine KABP study received a

'Best of UNICEF Research 2021'

Participatory activities that were conducted with youth ages 10—15 years with developmental delays

Lessons learned & Recommendations

1. When using the participatory inquiry method, it is important to ensure that the facilities used for activities support a multitude of disability profiles.

2. Include a specific question or set of questions about actual behavioural intention to confront stigma and discrimination in the quantitative research tool. While intention was assessed, in part, using qualitative inquiry, it may be useful to create a specific survey question category for intention.

3. It is important to ensure that the registries used for sample selection include all possible communities, especially small communities. Some communities in the West Bank and Gaza were not well represented in the KABP study because there were not listed as communities in the sampling frame. The excluded communities may present different findings than neighbouring villages, refugee camps, or cities.

4. The research instruments were complex and largely suitable for parents and not children. Although there may be complications trying to conduct research with children, it is important to understand their perspective. The participatory activities came close to capturing the view of children and their parents or caregivers.

5. Keep FGDs to a respectful and manageable timeframe. The FGDs for the KABP study incorporated questions for a social network analysis. Although the network discussions yielded useful insights into the perceptions of parents and caregivers with regard to their support systems, not all FGD facilitators were able to complete those questions due to time constraints.

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Endnotes

1 Carlson A., Lungu C., *Report: Baseline knowledge, attitudes, beliefs and practices (KABP) study in support of a C4D strategy for early childhood development and children with developmental delays and disabilities for Palestine*, UNICEF Palestine, Jerusalem, 18 September 2019.

2 Ibid.

3 Jones N., Abu Hamad B., Kifah Odeh K., Pereznieto P., Al Ghaib OA., Georgia Plank G., Presler-Marshall E., Shaheen M., *Every child counts: Understanding the needs and perspectives of children with disabilities in the State of Palestine*, UNICEF Palestine, Jerusalem, 2016.

4 The final report from this study can be accessed at www.unicef.org/sop/media/1666/file/KAP%20REPORT%20FINAL.pdf.

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UNICEF Egypt Supports Positive Parenting and Girls' Empowerment Programmes to Promote Children's Rights

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

Brief summary

Dates of Activity
2018 to present

Duration
ongoing

Budget
US$5,000,000

UNICEF Egypt is implementing a comprehensive social and behaviour change (SBC) programme that focuses on the root causes of behaviours related to poor child development outcomes and gender discrimination. As part of this larger work, the UNICEF Egypt SBC team has been supporting two national-level evidence-based SBC programmes and *Dawwie* (the National Girls' Empowerment Initiative), with the aim of ensuring that children reach their full potential and achieve gender equity.[1] To date, these SBC programmes have been integrated into national institutions and have gradually been implemented to scale by different partners in Egypt. UNICEF's Positive Parenting Programme has provided training on positive parenting behaviour for at least 10,000 service providers, engaged 1.5 million community members in face-to-face parenting-related interventions and enabled 15 million people to engage with positive parenting content online. The *Dawwie* community engagement programme has reached more than 33 million people and actively engaged 4 million. More than 450,000 individuals have been engaged through *Dawwie's* face-to-face activities, including skills building opportunities focusing on digital literacy, storytelling circles, intergenerational dialogues, and community events such as viewing clubs,

sport tournaments and dialogue with policy makers. More than 46 per cent of the 75,000 girls and boys aged 10—24 years old that have completed the Dawwie digital literacy training have demonstrated an increased understanding of gender equality and agency. Dawwie has also been instrumental in catalysing intersectoral attention on the specific needs of girls, political support and coordination.

Context

Most children ages 1 to 14 years in Egypt (81 per cent) are exposed to violent disciplining methods.[2] Ninety-one per cent are subjected to various forms of psychological violence, and at least 78 per cent experience physical punishment.[3] At least 6 per cent of children 5—17 years perform child labour.[4] Gender inequality has also been a long-standing issue in Egypt. Entrenched social norms and attitudes, economic pressures, and structural forces are key factors that contribute to maintaining the status quo of ender inequality in Egypt.

UNICEF Egypt is focused on addressing the key drivers of poor child development outcomes, including poor parenting and gender discrimination against girls. The UNICEF SBC team used the Social Ecological Model (SEM) as its foundational framework for developing an integrated SBC programme including individual-level behaviour change interventions, social support activities, and coordination mechanisms for institutional level ownership and implementation at scale. Two key initiatives being managed by the UNICEF Egypt SBC team, in close coordination with relevant UNICEF and government sectors, are (1) a positive parenting programme, and (2) a girls' empowerment programme. The two programmes are complemented by the systematic engagement of Faith Based Organizations, and by the SBC system strengthening work.

The UNICEF SBC team has been focusing on mainstreaming SBC indicators on positive parenting and girls' empowerment within the national M&E framework (in partnership with Ministry of Social Solidarity and Ministry of Planning and Economic Development), strengthening the use of RapidPro as tool to monitor the adoption of behaviours, supporting the development of a Media and Children's Rights Code of Conduct in collaboration with the Supreme Council of Media Regulation and SBC capacity building for key institutional partners. UNICEF Egypt's goal is to mainstream the integrated SBC model at the institutional level to reduce overall acceptance for practices that are harmful for children and to accelerate the adoption of behaviours promoting children's rights.

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Strategic approach

In 2019, UNICEF supported a formative research study to understand knowledge, attitudes, practices and social norms shaping parenting practices among Egyptian caregivers, and to identify best national and international practices. The study consisted of a systematic review of literature on positive parenting, and a knowledge, attitudes, and practices (KAP) survey of 10,000 households. The survey findings showed that violent disciplinary practices were prevalent among Egyptian parents, participation in early childhood education was low, there were gendered inequalities within the family structure, and knowledge about positive parenting was low. The findings were used to develop the national Parenting Programme on positive parenting tailored to the Egyptian context, and integrated with the national cash transfer programme, *Takaful and Karama*, under the leadership of Ministry of Social Solidarity.

The Parenting Programme has been supported by an ecosystem of interventions including community engagement through viewing clubs and toy making festivals, the use of digital and social media platforms to engage parents, media advocacy, and content co-creation with the private sector with one of the largest media networks for a TV drama on positive parenting to model the desired parenting behaviours. The Parenting Programme focuses on engaging parents to adopt behaviours related to positive parenting and on providing support in the areas of health and nutrition, learning/cognition, social/emotional, and protection for children ages 0—18 months. The support is provided through service providers that regularly engage with parents of children in this age group. UNICEF Egypt supported the development of parenting programmes for alternative care, gender transformative parenting, and parenting for children with disabilities that were subsequently integrated into the annual workplans of the Ministry of Social Solidarity (MoSS), Minstry of Health and Population (MoHP) and Ministry of Youth and Sports (MoYS). UNICEF Egypt also supported the digitalization of Parenting Programme components for easy access on Internet of Good Things (IoGT) and Learning Passport (in alignment with Egypt's digital transformation strategy). Additionally, to mitigate the negative impact of the COVID-19 pandemic, UNICEF Egypt worked with the Government of Egypt and other partners to engage youth networks and influencers, including media networks and private sector, in community engagement activities to support children's and families' resilience during COVID-19. By decree of Egypt's Prime Minister, and given the inter-ministerial nature of the programme, a National Committee for Positive Parenting was established in 2022.

In 2019, UNICEF also supported the Government of Egypt to launch *Dawwie* (meaning "loud voice with an impact and echo"), the first national girls' empowerment initiative. The aim of *Dawwie* is to promote girls' voices and facilitate their access to skills and essential services. *Dawwie* engages adolescent girls and boys in online and face-to-face activities that help them express themselves, accept diversity and equality, and foster engagement from their families and communities, leading to changes in the way society sees and talks about girls. *Dawwie* is comprised digital literacy skills development opportunities, storytelling (*Dawwie* Circles), community dialogue facilitated by viewing clubs, participatory theatrical performances, sports activities, intergenerational dialogue session between boys and girls and their parents, and opportunities to interact with decisionmakers at national and local levels. The initiative is led by the National Council for Childhood and Motherhood (NCCM) in partnership with National Council for Women (NCW), with technical support from UNICEF, and many other partners. In 2022, this Initiative was placed under the auspices of the First Lady of Egypt and has been implemented in over 21 governorates.

Key achievements

UNICEF Egypt's positive parenting programme activities have been adopted by, and integrated into, national institutions and initiatives, and are being scaled up by various partners. For example, the girls' empowerment programme is driving the National Investment Framework on Girls in Egypt, an accountability framework led by the National Council for Women and the National Council for Childhood and Motherhood.

- At least 10,000 service providers have been trained on positive parenting behaviour change strategies to date.
- At least 10,000 volunteers were trained and active in community engagement on positive parenting during COVID-19.
- More than 500,000 parents participated in face-to-face positive parenting programme activities between 2020 and 2022.
- 1.5 million community members engaged in face-to-face parenting related interventions.
- 15 million people accessed positive parenting content online with and engagement rate between 7 and 9 per cent.
- *Dawwie* activities have reached more than 33 million people, and actively engaged 4 million to date; More than 450,000 individuals have been engaged through face-to-face activities;
- More than 46 per cent of the 75,000 girls and boys aged 10—24 years old that have completed the *Dawwie* digital literacy training have demonstrated an increased understanding of gender equality and agency.

Provided training on positive parenting behaviour for

AT LEAST

10,000

service providers

ENGAGED

1.5 million

community members in face-to-face parenting-related interventions

ENABLED

15 million

people to engage with positive parenting content online

Lessons learned

1. Designing an integrated SBC programme has been instrumental for mobilizing flexible medium-term financial resources for thematic interventions essential to planning and sustaining social and behavioural change interventions at scale.

2. Building cross-sectorial ownership of behavioural change interventions requires time and dedication. Planning for co-designing and trust building is essential to accelerate implementation for positive impacts.

3. Investing in coordination among relevant stakeholders is essential to implementing programmes at scale. The cross-sectorial nature of behavioural change intervention requires systematic and strategic coordination to leverage existing dynamics, opportunities and investments.

4. The possibility to engage and support institutional partners with the use of tech-based solutions such as RapidPro has been instrumental to create the space for longitudinal evidence generation opportunities and to introduce and to initiate the process to introduce SBC indicators within the institutional M&E system. This paves the way for sustainability and scale of the designed SBC programmes. How to systematically analyse and use the evidence generated remains an area of improvement.

Recommendations

1. Shift the planning focus from the materials to be produced to the processes that facilitate positive behaviour change.

2. Increase the visibility of activities to reach wider audiences and motivate change in the entire Egyptian population.

3. Invest more in overall programme coordination to facilitate the diffusion of positive parenting knowledge, attitudes, practices and social norms.

4. Indirect modalities to address sensitive behaviours, such as violence and harmful practices, come often with greater transformative value. Focusing on the positive rather than negative narrative is essential to drive the change.

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Endnotes

1 Positive parenting promotes a parenting style that is proactive, empathetic and mutually respectful, thereby helping to build stronger and healthier relations between parents and children.

2 United Nations Children's Fund, 'Egypt fast facts', UNICEF, 2022.

3 World Economic Forum, 'Insight Report: Global Gender Gap Report 2020', WEF, 2020, <www3.weforum.org/docs/WEF_GGGR_2020.pdf>.

4 United Nations Children's Fund, 'Egypt fast facts', UNICEF, 2022.

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UNICEF Jordan Supports Creating Happy Homes through the Parenting Programme

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

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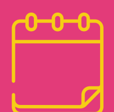
Brief summary



Dates of Activity
2018 to present

Duration
Five years

Budget
US$3 million

The Parenting Program is a low-cost programme aimed at enhancing positive parent-child relationships and changing negative parenting practices, with a primary focus on ending corporal punishment as a disciplinary method. The Parenting Program offers guidance to parents through different stages of the child's life, from newborn to 18 years of age. From 2018 to 2023, the Parenting Programme has reached more than 200,000 parents and caregivers throughout Jordan. At least 90 per cent of participants attended every session in the programme. Pre- and post- training assessments suggested that 95 per cent of the targeted population showed improved knowledge of positive parenting practices. The Parenting Programme has contributed to the creation of safe support groups for mothers and connected mothers to existing referral services as cash assistance and child protection.

Context

Early childhood (from birth to age eight) is a critical period during which children's brains are developed. The quality of a child's early experiences depends on the care provided to them by their parents or caregivers.

Young developing children need healthcare, nutrition, protection from harm, a sense of security, opportunities for learning, and responsive caregiving (e.g., talking, singing and playing). Parenting practices, especially disciplinary responses, can affect a child's behaviour, and their psychological and social well-being. Disciplining children (i.e., the process of teaching them the values and normative behaviours of their social system) is one of the most important yet difficult responsibilities of parenting.

Forty per cent of Jordan's population is under 18 years old. A survey conducted in Jordan in 2019 showed that 76 per cent of Jordanian children were subjected to psychological punishment, 59 per cent were subjected to corporal punishment, and 13 per cent were subjected to severe physical punishment.[1] Most cases of punishment are unreported. While corporal punishment is prohibited in schools under the School Discipline Regulation, there is no explicit prohibition of corporal punishment in the home, in early childhood care facilities, and in day care for older children. Article 62 of the Jordanian Criminal Code allows discipline "within what is permitted by general custom," which describes a normative acceptance of violent disciplinary practices. Article 62 does not consider the psychological damage caused by the parents to their children which can be more severe than corporal punishment.

During the COVID-19 lockdown in Jordan, physical violence against children increased in 65 per cent of households. The most vulnerable children were the most affected by the pandemic; an increase in poverty rates among vulnerable families increased negative coping methods among parents, leading to an increase in punishment for their children.[2]

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Strategic approach

The Better Parenting Program (BPP) was first launched in Jordan in 1996. Since that time, the activities have been revised to improve the programme within an evolving Jordanian context. In 2019, UNICEF Jordan conducted an extensive, in-depth participatory review of the BPP with a range of national partners and revised the programme to align it with recent scientific developments in the field of early childhood development and positive parenting programmes, and with changes in the country context (e.g., an increase in the number of refugees). The revamped programme, Our Happy Home, incorporates significant scientific advances in parenting for children ages 0—18 years and builds on the lessons learnt from the implementation of the parenting programme over the years. The revised Parenting Program was adapted to the changing context of Jordan to better address the harmful social norm of using violent discipline with children at home.

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The Parenting Program is guided by a theory of change that explicitly lays out the theoretical linkages between programme approaches and inputs, parental knowledge and behavioural outcomes, and child protection and developmental outcomes. The programme is delivered separately for parents and caregivers of children ages 0—9 years (Early Childhood Development), and one for parents and caregivers of children aged 10—18 years. Given that most pre-school aged children are cared for at home and do not attend formal early childhood education services, the goal of the Parenting Program is to empower parents to provide a nurturing, stimulating and protective environment at home. The programme is designed to be low-cost and easily delivered by trained non-professionals. It aims to improve positive parent-child relationships and interactions, which is an essential requirement for ensuring that children thrive and reach their full potential, from early childhood through adolescence. In addition to the programme goals, parents specify individual goals they would like to achieve through the Parenting Program. This goal-setting is done through an exercise in which parents list their best parenting practices as well as practices they would like to change or skills they would like to acquire. These lists are turned into goals that are reviewed mid-programme and at the end of programme to assess if the goals were met.

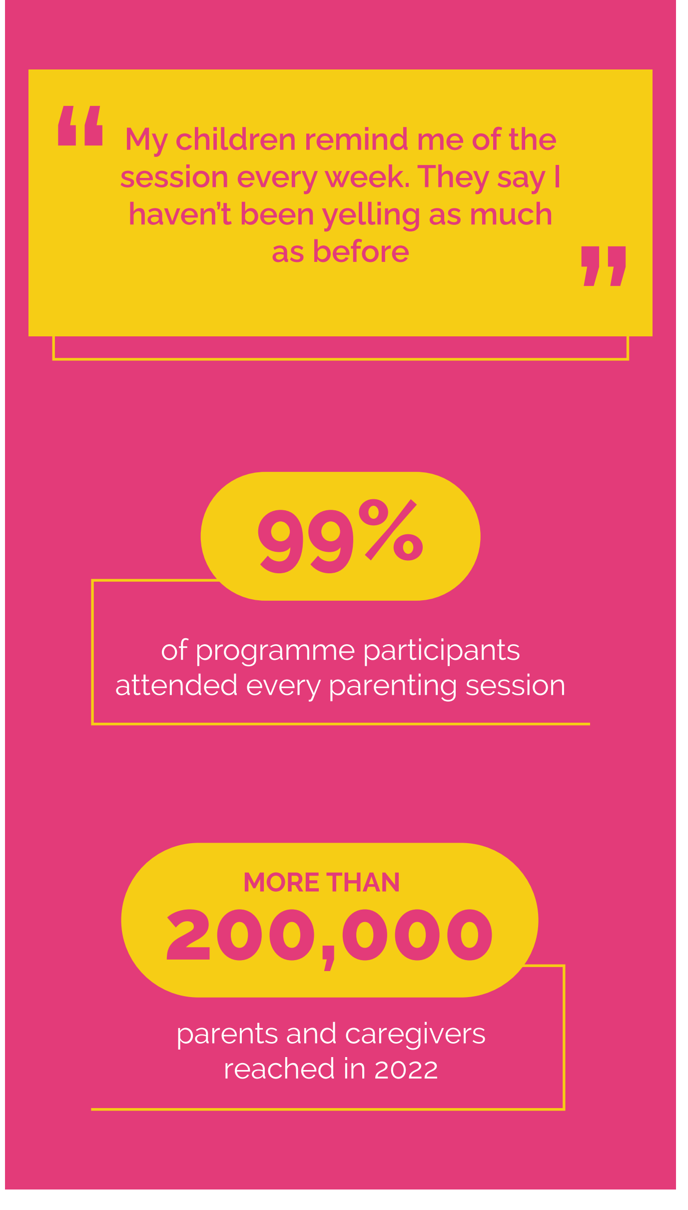
The current Parenting Program is implemented through Parent Groups that bring up to 15 parents together for a progressive series of thirteen structured, interactive, and participatory sessions. The parenting programme cycle is three months (12 weeks); participants attend a two-hour session per week. Parents are supported to adopt effective communication skills and apply positive, non-violent discipline with their children. The programme curriculum addresses several themes related to childcare and upbringing, for example, the importance of play, child protection, exploration, positive discipline, parent child communication and interaction, creating safe

thriving environments, protecting children, child and adolescent developmental stages and needs, gender roles and stereotypes, and more. The facilitator presents a situation each session to start the discussion among the group, and then facilitates the content of the session including engaging parents with group work.

The Parenting Program has been successful at integrating a "buddy system" to reinforce sessions and encourage participants to work together to support each other in between sessions. The programme includes raising awareness among parents about the need for self-care. In each session, time is spent at the end to promote the importance of self-care and focus on participants' own well-being as one of the main contributory factors to successful outcomes. A home practice is added to be implemented between sessions, for participants to practice new concepts and techniques through home-based homework assignments, which supports involving fathers in the programme's insights and benefits.

Key achievements

- The Parenting Program is implemented nationwide and has grown into a national network of partners.
- In 2022, the Parenting Program reached more than 200,000 parents and caregivers throughout Jordan.
- Ninety per cent of programme participants attended every parenting session.
- Ninety-five per cent of the targeted population showed improved knowledge about positive parenting practices.
- Ninety per cent of the participants reported that the programme contributed to their improved mental well-being, and that they found safe space in this programme.
- The buddy system created through the programme has raised awareness about the various self-care practices mothers and fathers can use.
- Engaging religious organizations and obtaining support from various government ministries has significantly added value to the programme and contributed to its reach and impacts.



- The Parenting Programme has created a solid referral mechanism for mothers to consult on other areas related to learning and social protection.
- The programme yielded indirect positive outcomes in terms of gender equality in areas such as intimate partner violence (IPV) and violence against women (VAW). For example, one woman participant said: "Not only has my relationship with my children improved, but also my relationship with my husband. I feel happier, calmer, and less burdened by issues with my children, resulting in a positive effect on my marriage." The unintended ripple effect demonstrates the potential for programmes to create broader positive impacts on gender equality beyond their initial scope.

Lessons learned & Recommendations

1. **Expand the Parenting Programme to digital platforms**: The Parenting Programme was delivered via digital platforms during the COVID-19 pandemic shutdowns, and suspended once in-person activities resumed. The programme should be permanently expanded to include digital platforms to ensure those who cannot attend parent groups in person, can attend interactive sessions online. This is particularly relevant for women, who are restricted by gender norms within their communities.
2. **Step up efforts to break gender-normative parenting**: There remains a need to improve parents' understanding that positive parenting is not gender-specific and that parents should protect and advocate equally and equitably for their male and female children.
3. **Increase fathers' involvement in positive parenting**: To date, the programme has mainly targeted mothers. Structural adjustments to the programme and flexible implementation modalities can be made to ensure a higher level of fathers' participation.
4. **Develop and implement more effective and efficient qualitative tools** to better track the behaviour change resulting from parent involvement in the programme.
5. **Implement national positive parenting campaigns** (using the UNICEF parenting website, TV series, social media) during 'Parenting Month' in Jordan to raise awareness about positive parenting.
6. **Embrace a gender transformative approach** within the programme by strengthening content and facilitation methodologies on gender modules (i.e., increase content about harmful gender norms, roles and relations, and how to redistribute power, resources, and services more equally).
7. **Broaden the approach of the Parenting Programme** to include community engagement, family dialogues, and collaboration with local institutes, to widen the reach and ensure sustainability.

Endnotes

1 'Study: 81% of children in Jordan were subjected to violent punishment', Roya News, 17 June 2019, <https://en.royanews.tv/news/17823/Study--81--of-children-in-Jordan-were-subjected-to-violent-punishment>.

2 United Nations Children's Fund, 'UNICEF study highlights plight of children and youth in Jordan during COVID-19', UNICEF Jordan, 25 August 2020, <www.unicef.org/jordan/press-releases/unicef-study-highlights-plight-children-and-youth-jordan-during-covid-19>.

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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.

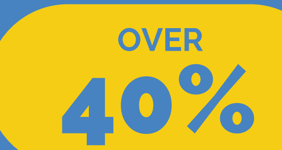
The real-time monitoring and feedback from online and offline sources allowed for ongoing analysis and data on gender-related barriers. Social listening enabled a sound understanding of the needsof both women and men in information and demand creation and service delivery and became a valuable tool to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



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>.

SOCIAL + BEHAVIOUR CHANGE

unicef for every child

UNICEF Lebanon Tackles Disability Stigma

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

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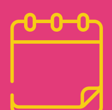
Brief summary



Dates of Activity
2019 - ongoing

Duration
3.5 years

Budget
US$2.5 million

In 2021, the UNICEF Lebanon country office supported a revised disability inclusion approach that encouraged specialized disability organizations to build networks with formal public and private schools and non-formal education organizations. The approach ensured that children with moderate disabilities were partially or fully integrated in inclusive learning, while still receiving rehabilitation services at the specialized disability organization. As an immediate impact of the newly adapted disability strategy, by January 2022 at least 53 out of the 486 Children With Disabilities (CWDs) with severe to moderate disabilities were integrated fully into formal and non-formal inclusive education, while still receiving rehabilitation services from specialized organizations. About 250,000 people were reached with messages about inclusivity through Social and Behaviour Change (SBC) activities supported by UNICEF Lebanon and implemented by partner organizations.

In 2017, 75 per cent of respondents in Lebanon thought that children with intellectual disabilities should not be integrated into society (25 per cent for physical disabilities). The underpinning behavioural and attitude change was therefore deemed as a necessary step to create an enabling environment for people with disabilities. In 2018, UNICEF developed a Social and Behaviour Change Communication (SBCC) strategy that is based on the socio-ecological

model and that equips key stakeholders with essential tools to promote positive attitudes and behaviours on inclusion. Every education partnership that provides services to children with disabilities (CWD) has a Social and Behaviour Change (SBC) component embedded. Since 2019, educations partners have been developing and rolling out SBC plans, leading to the transformation of the SBCC strategy into an SBC through the addition of a conceptual framework. In 2022, more than 100 SBC initiatives nationwide in collaboration with 132 local entities engaging more than 9,000 people on disability inclusion were conducted. SBC initiatives have been diverse in nature and speak to all levels of the Socio-Ecological Model (SEM), engaging children with disabilities themselves, their parents and peers, service providers, communities, local authorities and more! A pre-post quantitative assessment of SBC initiatives have shown an increase in positive attitudes towards inclusion in children without disabilities and caregivers of children with and without disabilities. Qualitative tools of assessment have also captured changes in knowledge, attitudes and behaviours.

Context

UNICEF believes in the right of children with disabilities to be included in society and in inclusive quality education. The UNICEF Lebanon Country Office (LCO) committed in its Country Programme Document to mainstream the needs of children and youth with disabilities (CWDs) across programme outcomes. The main objective was to ensure that barriers to inclusion of CWDs in society were addressed and that CWDs had equitable access to basic services and needs. In 2017, the LCO partnered with five specialized disability organizations that provide rehabilitation, special education and parental engagement services to 400 refugee children with moderate to severe disabilities. For children with milder disabilities, UNICEF LCO worked with non-formal education partners to ensure the inclusion of CWDs in non-formal education, and with the Ministry of Education and Higher Education (MEHE) to increase the accessibly of CWDs in the public schools through the MEHE inclusive pilot schools.[1] In 2021, UNICEF shifted its disability inclusion approach with specialized disability organizations by implementing more inclusive modalities. The new strategy's objective is to improve the access of children with moderate disabilities to inclusive learning. Throughout the whole process, the underpinning behavioural and attitude change was deemed as a necessary step to create an enabling environment for people with disabilities. Therefore, every partnership on disability inclusion had an SBC component.

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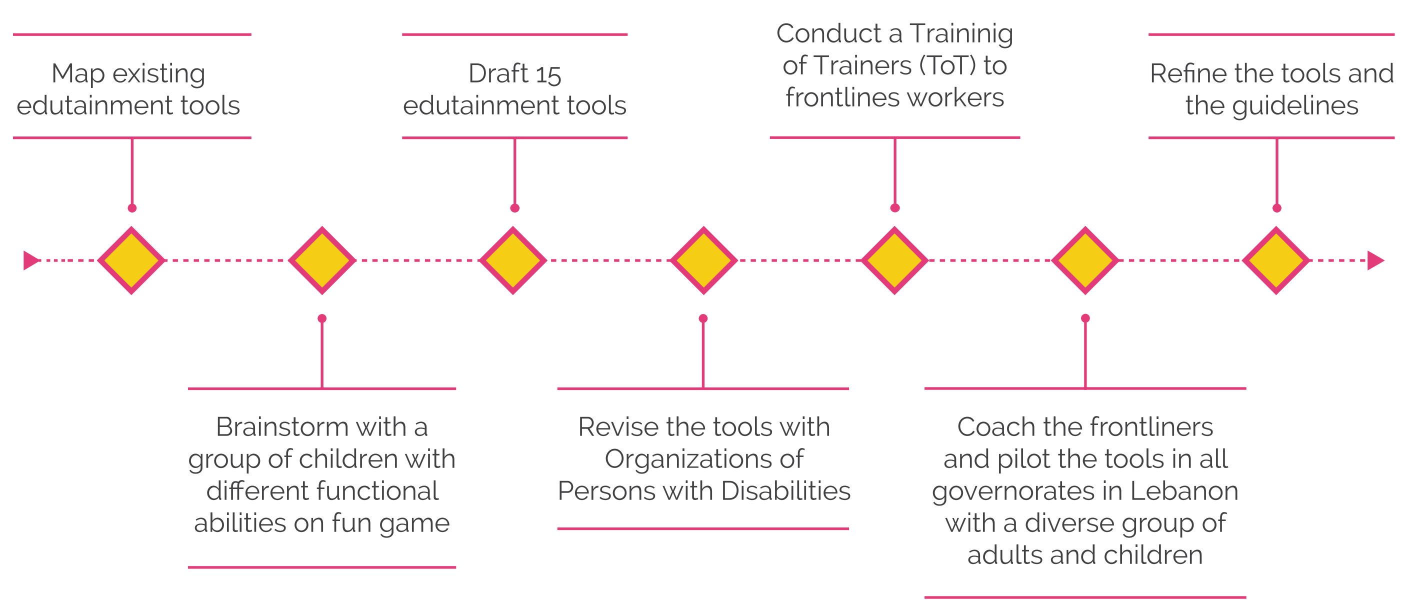
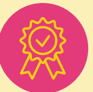
Strategic approach

Community engagement: In 2022, all partners were trained in the Community Engagement (CE) curriculum and were coached to develop community plans. Partners then engaged community members to identify problems and use available resources to plan and implement solutions on disability inclusion. Examples of initiatives conducted include the development of an inclusive garden and the building of a path to one of the biggest public beaches in Lebanon. Partners usually start with CE and use the community plans as a roadmap to design and implement capacity building, social mobilization and edutainment. Several of the identified problems from the community members that are highlighted in the community engagement include the lack of capacity of local institutions to include CWD, hence limiting the social inclusion of CWD. Therefore, employing a bottom-up approach, partners provide that capacity building local institutions such as social development centres, recreational centres, sports and summer clubs, theater clubs, scouts etc. to be able to be inclusive in their services. Partners refer children with disabilities to these services and provide coaching to the service providers. This results in continuous long-term positive social inclusion of CWD.

Social mobilization: Making inclusion everyone's business is key to SBC. Hence, partners conduct different social mobilization initiatives such as getting people together to conduct a street parade, conduct an inter-university competition on the best video for inclusion and train volunteers from the community and universities to co-implement community-based activities.

Edutainment: To move away from the traditional-style awareness sessions, education-entertainment formats are used to engage the community in creative and fun inclusive activities, increasing awareness and inclusive interactions in a gradual, natural, and subtle way. These types of activities are scarce, hence UNICEF developed 15 edutainment tools to be used by frontliner workers. A guide is being finalized and the participatory process was as follows:





Key achievements[2]

A pre-post quantitative assessment of SBC initiatives has shown an increase in positive attitudes towards inclusion in children without disabilities and caregivers of children with and without disabilities. This has become a standard monitoring tool in the form of pre-post test on KOBO that all partners use in every activity they do. This data is directly inputted into two attitudinal indicators in the RWP monitoring plan. Sixteen innovative inclusive edutainment tools have been developed that frontliners can use to promote positive attitudes towards disability inclusion. Most Significant Change M&E tool has been piloted and captures important changes in knowledge, attitude and practices. The third layer of selection is at the community level where only at the end of the programme, all the stories that were chosen by the second layer go back to the community for them to select the story they found most significant.

250,000

people were reached with messages about inclusivity

> I finally saw my son happy because this activity made gave him an opportunity in life where he felt valuable and that he has an important role to play.
>
> *-Lebanese mother from Beddawi*

> The sessions and the guidance we took gave me great courage to stop the bullying.
>
> *-44-year-old Palestinian woman living in Saida*

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Lessons learned

1. Not all partners are ready to do SBC for disability inclusion. They need to show commitment and interest in SBC. Then, training is needed.
2. In-hand resources and guidance are needed. The CE curriculum and training was very useful as it unified our understanding of the CE process. Unified template was also very useful.
3. Unified key intervention guidelines were needed and provided partners with options for SBC activities. However, we need to keep space for the partners to innovate and pilot-test.
4. Small scale trial and error is okay.

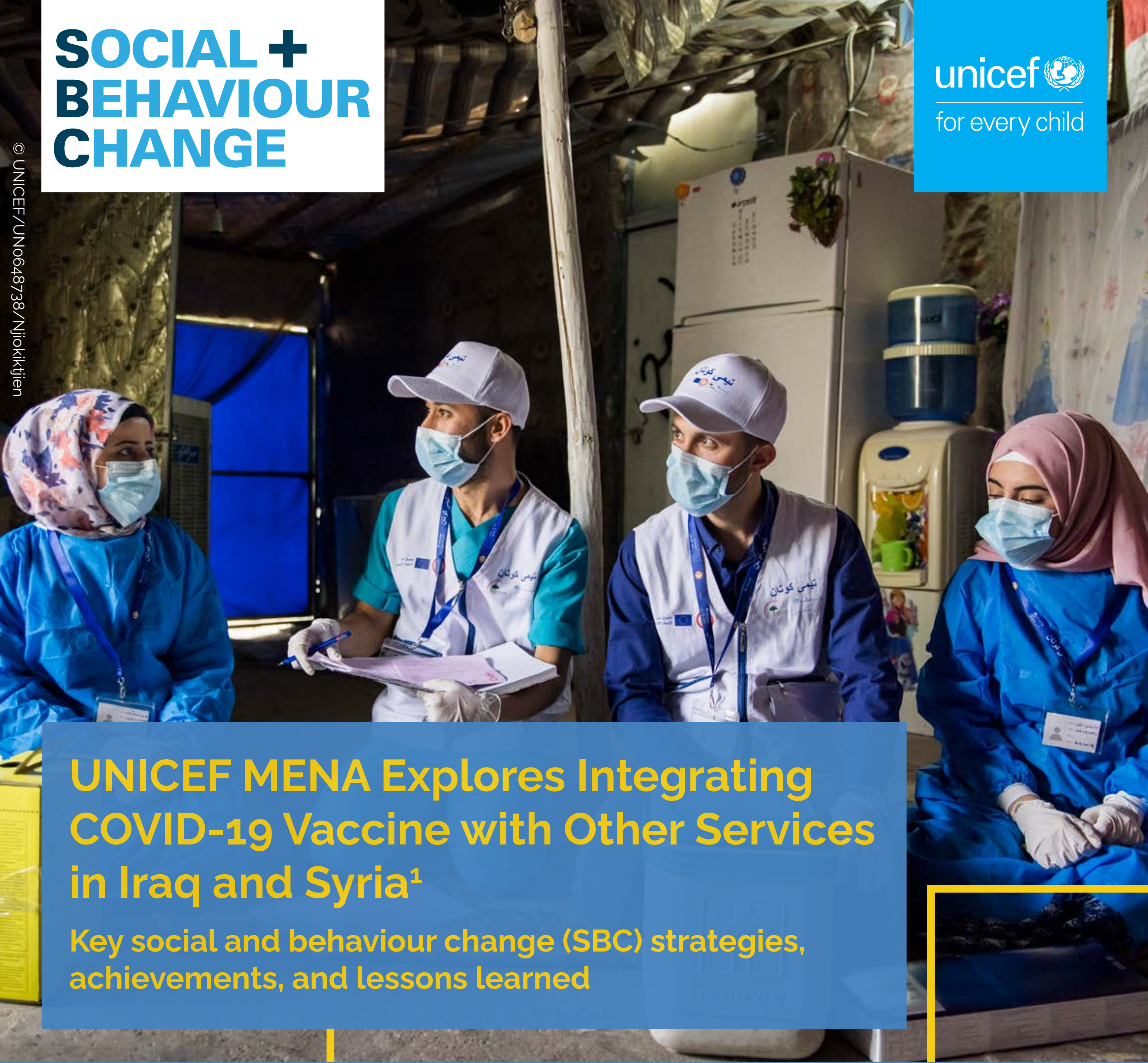
Recommendations

1. Continue implementing and strengthening SBC for disability inclusion.
2. Ensure that the network of specialized disability partners continue to provide work efficiently and effectively with formal schools and non-formal education organizations, and with the whole community, to integrate children with moderate disabilities in inclusive education.
3. Incorporate an SBC component for partner organizations to complement the special services and create an enabling environment for inclusion of CWDs in communities.
4. Specifically address barriers and needs of girls with disabilities who are more vulnerable to violence and child marriage.

Endnotes

1 United Nations Children's Fund, UNICEF Lebanon: Specialized Disabillity Organizations, UNICEF Lebanon, <www.unicef.org/lebanon/media/8486/file>.

2 Ibid.



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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>.

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

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>.

7 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>.

8 Al-Mossawi, F., 'Best practices on COVID-19 vaccination and strategies with Intensification of Integrated Immunuization Services', IIS, 2022.

9 Ibid.

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SOCIAL + BEHAVIOUR CHANGE

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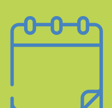
UNICEF Oman Develops Social and Behaviour Change Strategy to Address Early Childhood Development, Inclusion of Children with Disabilities and Violence Against Children

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

Brief summary



Dates of Activity
2020 to 2021

Duration
18 Months

Budget
Unknown

UNICEF Oman, in collaboration with the Sultanate of Oman Ministries of Education, Health, and Social Development, supported formative research to inform the development of a social and behaviour change (SBC) communication strategy for three programme areas: Integrated early childhood development (ECD), inclusion of children with disabilities (CWD), and violence against children (VAC). A comprehensive desk review was conducted to provide information on what is already known about these areas in the Omani context. Qualitative studies were conducted to identify perceptions and attitudes on ECD, CWD, and VAC prior to developing the strategy. UNICEF Oman delivered a joint cross-sectoral SBC strategy for the Government of Oman and formed an SBC Taskforce to oversee and achieve the SBC activities in the strategy workplan. Social and behaviour change indicators were embedded into administrative data systems in three government ministries. UNICEF Oman also supported the launch of mass campaigns with Government of Oman.

Context

Early childhood development programmes are one of the most cost-effective ways to set the right foundation for children's health and education to increase skills, abilities and productivity of children. Integrated Early Childhood Development (IECD) is essential for all children to achieve their full potential. Children who do not receive adequate "nurturing care' (e.g., health, nutrition, early development, learning opportunities, care and protection) tend to have lowered cognitive, language and psychosocial outcomes which translates to lowered academic achievement in primary school. The 2014 Oman Multiple Indicator Cluster Survey (MICS) showed that only 25 per cent of children under-five have three or more children's books. The percentage of children ages 36—59 months who are developmentally on track in at least three of the four domains (literacy-numeracy, physical, social-emotional, and learning) is 68 per cent.[1] While early childhood education services in Oman have expanded rapidly in recent years, participation in early childhood development programmes, particularly in nurseries and day care, is still relatively low, despite strong public commitment and widespread acknowledgement of the importance of a good start in life for social and economic development. Early childhood development services, such as kindergartens and nurseries, are mostly provided through the private sector and tend to be limited in remote areas. Enrolment in ECE for 3—5 year-olds was reported at 50 per cent during the 2017/18 school year.[2]

Inclusion of children with disabilities in preschools is limited.[3] According to a formative research study conducted in 2019 on perceptions around inclusion, parents of children with disabilities were concerned about the well-being of their children in school, given the stigma and discrimination that their children might face. Parents of children without disabilities and young people themselves expressed reservations on the benefits of inclusion and described their interaction with CWD as evoking pity or discomfort, with some even saying that CWD are "not normal." Some parents refused to have their children in inclusive classes with CWD.[4]

Violence against children is outlawed in all settings, including schools, by the Child Law of 2014. Yet, a significant proportion of children and young people are exposed to violence in schools, communities and families. Limited availability of recent prevalence data makes it difficult to gain a more complete understanding of the many dimensions and extent of this issue.

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Strategic approach

UNICEF Oman worked with the Programme Management Group (PMG) and the Social and Behavioural Change Communication (SBCC) Task Force, comprised of officials from the ministries of information, education, health, social development as well as the National Centre for Statistics and Information, on the development of a strategy to address ECD, inclusion of CWD and VAC. A formative research study was conducted to inform and guide the design and delivery of the strategy, beginning with a comprehensive desk review to provide information on what is already known about these areas in the Omani context. The review highlighted additional areas where information was missing, and these gaps also informed and guided the research inquiry and development of a qualitative study research protocol that focused on:

1. Obtaining a deeper understanding of knowledge and practices related to ECD/ECE, inclusion of children with disabilities, and violence against children and identifying any myths and cultural beliefs that influence caregiver behaviours.
2. Identifying common practices associated with child development, upbringing, and care in early years and exploring reasons behind low exclusive breastfeeding rates and early initiation of complementary feeding, and factors that contribute to resistance to exclusive breastfeeding.
3. Exploring the perceptions of the community on ECD and obtaining a better understanding of early schooling perceptions.
4. Exploring infrastructural, social, and cultural challenges to inclusion of children with disabilities.

Exploring knowledge and attitudes on positive disciplinary measures, identifying potential entry points and platforms for implementing a positive parenting programme, and exploring credible sources of information ECD/ECE, inclusion, and positive discipline.[5]

A strategy document was developed based on findings from the formative research. The overall communication goals of the strategy were to:

1. Contribute to the scaling up and strengthening of Oman's IECD and positive parenting interventions.
2. Contribute to the acceptance, scaling up and strengthening of inclusion of children with disabilities in the education system.
3. Contribute to improving awareness of parents/caregivers, teachers, communities and to foster an environment that will eliminate and stop violence against children in households and schools.

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Strategic approach

Activities were planned on three levels: policy, service delivery and interpersonal. At the policy level, advocacy and high-level engagement activities were planned with senior officials, decision makers and media. At the service delivery level, activities aimed to enhance the capacity of health providers and educators on IECD, inter-personal communication (IPC), nutrition, ECE and early stimulation. A wide range of interpersonal level activities were planned, including:

- A national communication campaign on IECD targeting caretakers of children between 0—8 years, EVAC, and inclusion of CWD targeting caregivers between 0—18 years and influencers.
- Social mobilization activities in priority zones through identification and capacity building of local partners and NGOs.
- Awareness raising activities at pre-schools and schools.
- Celebrating International days in relation to IECD, EVAC, and CWDs.
- Engaging religious institutions to promote IECD, Nutrition, and preschool education.
- Research, monitoring and evaluation.
- Management and coordination.

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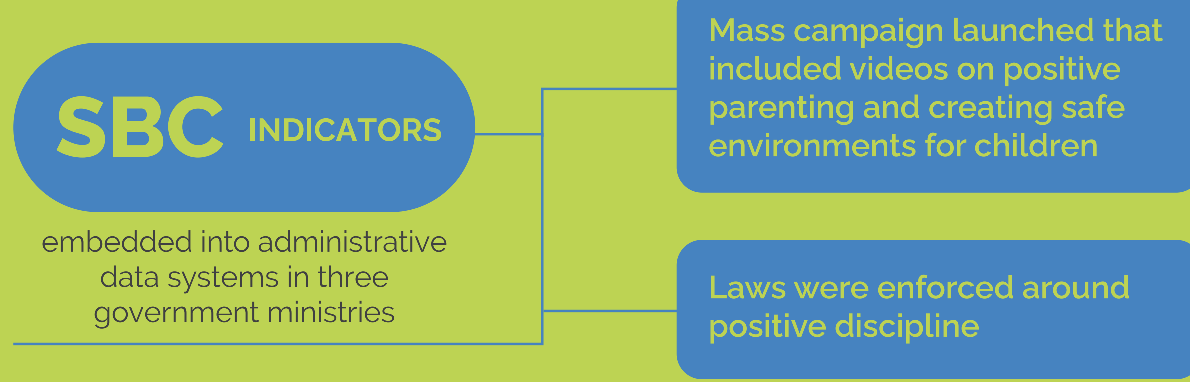
Key achievements

- UNICEF Oman delivered a joint cross-sectoral SBC strategy for the Government of Oman.
- UNICEF Oman formed an SBC Taskforce to oversee and achieve the SBC activities in the strategy workplan.
- Social and behaviour change indicators were embedded into administrative data systems in three government ministries.
- UNICEF Oman developed a training-of-trainers curriculum on how to counsel caregivers on IECD and nutrition and developed job aides and digital tools for health providers.
- UNICEF Oman supported the launch of a mass campaign (*Our Children, Our Priority)* with the Government of Oman, including videos on positive parenting and creating safe environments for children.
- Nutrition protocols and child feeding practices were developed and/or updated.
- Manuals for handling reported cases of violence, bullying and cyberbullying were updated.
- Advocacy was conducted for ensuring the opening of additional inclusive preschools and ensuring quality preschool education.
- Laws were enforced around positive discipline.
- Training for media personnel was conducted to highlight the importance of IECD and positive discipline for the future of Omani children.
- Capacity building sessions were conducted to train Health, Education, and Social Development focal points at the ministry level to communicate with the media about IECD, EVAC and inclusion.



Lessons learned

1 A key challenge was getting the SBC Taskforce to implement SBC strategy activities. It may be necessary to create a higher-level governing structure to strengthen the implementation mechanism.

Recommendations

1 Generate more data to serve as evidence to improve the strategy.

2 Advocate for various ministry sectors to include more social indicators into their administrative data systems.

3 Add community engagement and community mobilization components to round out the strategy (it was missing from the initial strategy).

Endnotes

1 M&D Consulting, *Oman Social and Behaviour Change Communication Strategy 2021-2024*, UNICEF Oman, 2021.

2 Ibid.

3 Ibid.

4 M&D Consulting, 'Formative Research to Support Development of a C4D Programme with the Aim of Enhancing Practices in IIECD, Protection from Violence and Inclusion of Children with Disabilities', 2019.

5 Ibid.

UNICEF Yemen Combats Cholera and COVID-19 through Health Behaviour Monitoring System

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

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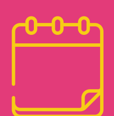
Brief summary



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.

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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

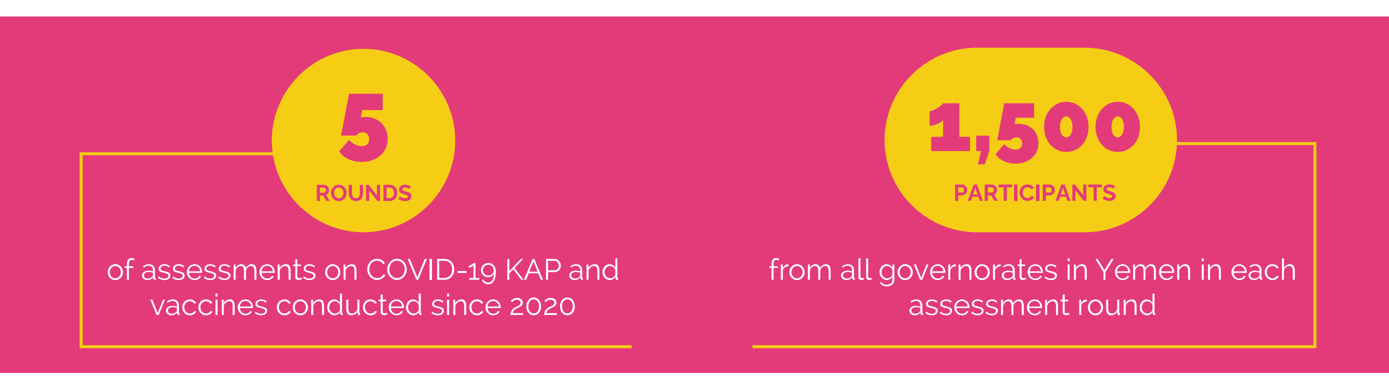
about 1,500 participants from all governorates in Yemen in each round. UNICEF Yemen also developed a tracking tool to monitor rumours and misconceptions about COVID-19, COVID-19 vaccines, and immunisation overall. The tool allows individuals and volunteers to share information about COVID-19 related 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.



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>.

SOCIAL + BEHAVIOUR CHANGE

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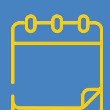
UNICEF Highlights Gender-Focused Immunization Demand Programmes in Six Countries

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]

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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.

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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.

is key to ensuring greater impact

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

1 Nandi A., and Shet A., 'Why vaccines matter: understanding the broader health, economic, and child development benefits of routine vaccination', *Human Vaccines & Immunotherapeutics*, vol. no. 8, 2020, pp. 1900-1904.

2 United Nations Children's Fund, From coverage to empowerment: Integrating gender in immunization demand. Promising practices from six countries, UNICEF, New York, 2022.

3 For the full compendium report see: https://demandhub.org/from-coverage-to-empowerment-integrating-gender-in-immunization-demand/

4 United Nations Children's Fund, *From coverage to empowerment: Integrating gender in immunization demand. Promising practices from six countries*, UNICEF, New York, 2022, p. 4.

5 United Nations Children's Fund, *From coverage to empowerment: Integrating gender in immunization demand. Promising practices from six countries*, UNICEF, New York, 2022, p. 4.

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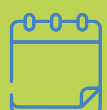
UNICEF Launches Initiative to Improve Social Norms Measurement and Programming

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

Brief summary



Dates of Activity
December 2019 – January 2023

Duration
3 years

Budget
Unavailable

For UNICEF's Child Protection (CP) Section, promoting positive social norms is now widely recognized as a key strategy to address the elimination of harmful practices (e.g., violence against children) and improving caregiving practices. There remains, however, limited robust information about how norms motivate action among various behavioural drivers, hindering the ability of programme implementers to show rigorous evidence of change. Similarly, there are also limited field tested tools related to measuring changes on these drivers and related social norms which compounds the capacity to measure such change. Measuring shifts in social and behavioural norms is a UNICEF priority underlying the development of evidence-based social and behaviour change (SBC) programmes to strengthen both its programming as well as the capacity across the sector. A series of multi-year mixed-methods studies encompassing population-based surveys, anthropological and field observation qualitative research on different child protection topics were conducted across nine countries that resulted in the development of validated research tools and guides to measure social and behavioural norm change. This also included conducted developing grounded study findings in Child Discipline. Child Marriage, Sexual Violence, Intimate Partner Violence, Child Labour, Female Genital Mutilation, Child Feeding, and Xenophobia.

Context

The issue of measuring social and behavioural norms is particularly acute when examining discriminatory norms and social determinants that are at the root of harmful practices perpetuated across generations, such as child marriage, teenage pregnancy, female genital mutilation (FGM), child labour, violence, and poor education. Underlying such practices are a complex set of social and behavioural drivers that exist at the individual level (attitudes, beliefs, agency), the group level (community dynamics, social influences, norms), and within the broader enabling environment (government entities, structural barriers).

A significant number of UNICEF Country Offices across regions expressed the need for innovative and accessible guidance and tools that can provide programmatic and concrete ways of planning, delivering, and tracking progress while acknowledging the complexity of human behaviour at multiple levels (i.e., bridging complex theories with the reality of the field). To support country offices, UNICEF HQ invested in developing a strengthened conceptual and programmatic approach to measuring positive social and behaviour change, including launching the *Cross-Regional Social Norms Change Initiative on Harmful Practices* to develop a set of monitoring tools focused on social and behaviour change. The aim of this initiative was to move away from relying on basic prevalence data and anecdotal evidence toward obtaining an in-depth understanding of why people do what they do and put concrete values on the social and behavioural drivers.

Strategic approach

Building on work initiated in 2015 by the UNICEF West and Central Africa Regional Office (WCARO) to measure social norms related to CP in Senegal, the UNICEF Social and Behaviour Change (SBC) and CP teams in the Middle East and North Africa Regional Office (MENARO) partnered with UNICEF HQ and nine country offices (Djibouti, Lebanon, Jordan, Mozambique, Senegal, Sierra Leone, Sudan, Yemen and Zimbabwe) to develop a set of monitoring tools focused on social and behaviour change around child marriage, FGM and violent discipline. In December 2019, *Ipsos* (a global market research firm) was commissioned by UNICEF MENARO SBC to design:

- A conceptual framework on the drivers of SBC that is the theoretical basis for other tools;
- A practical guide for social norms programming; and

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- A monitoring toolkit on social and behavioural drivers of CP issues, including a) indicators for drivers of Child Marriage (CM), Child Discipline (CD), and FGM; b) questionnaires on CM, CD and FGM, in English, Arabic and French designed to be administered to caregivers of children; c) qualitative instruments (focus group discussion (FGD) and key informant interview (KII) guides); and d) a guidance tool on the use of the toolkit, including articulation between qualitative and quantitative research, and adaption of the questionnaires to specific contexts.
- Provide research findings and selected programmatic insights based on the results of the studies for integration for UNICEF country offices.

Ipsos conducted a desk review as a foundation for the tools and guidance development, and used cognitive and pilot testing to ensure that the tools were valid, appropriate, and easy-to-use. The research team largely targeted caregivers ages 18-49 by specific geographies and/or sociodemographic groups to understand social norms around the selected key child protection issues. In most circumstances, the Ipsos team used computer-aided in-person interviewing (CAPI) methodology to collect data on tablets and phones which had numerous advantages over traditional pen-and-paper methods including built-in logic, GPS, validity/consistency checks, and reduced data processing. For the qualitative aspect, in field observation and anthropological studies were conducted on selected areas of identified countries.

Key achievements

- Ipsos, in collaboration with UNICEF SBC teams at global regional level, successfully concluded the mixed-methods studies across the participating nine countries which is currently leading into the development of field tested and validated programme monitoring and population surveys research tools and guides to measure social and behavioural norm change.
- Several UNICEF country offices across the three regions are now interested in conducting surveys on these topics (CM, CD and FGM), as well as on additional Child Protection topics such as Sexual Violence, Domestic Violence, Child Labour, and Xenophobia, following the same approach.
- A UNICEF Workshop on Behavioural Surveys was held in Dubai, UAE on February 6th-10th 2023 to chart the path forward on the measurement, research, and evidence efforts in the area. This included the review and discussion of survey findings and programmatic insights with the participating countries staff, identifying ways to use the research findings and workshop outcomes for programme strengthening, and to chart next steps for advocacy and dissemination with policymakers and key stakeholders.

Nine countries conducted a series of multi-year mixed-methods studies

The studies focused on

CAREGIVERS AGES 18-49

to understand social norms around selected key child protection issues.

Lessons Learned

1 **Conduct formative research**: Where program goals are nascent, formative research (often qualitative) is critical in ensuring the usefulness of indicator tracking.

2 **Streamline survey instruments**: Shorter survey instruments will reduce survey fatigue and improve respondent experiences.

3 **Conduct a formal pilot**: The formal pilot period for each survey instrument (n=90 for most) was critical not only for finalizing the questionnaire, but also for ensuring enumerator familiarity with research design and fieldwork plans, as well as comfort with sensitive topics and specific wording to measure challenging concepts. This phase is also key in finalizing customized quality assurance processes.

4 **Include participant-centered informed consent processes**: Collecting data from people residing in areas impacted by fragility, conflict, and violence is critical in developing an understanding of their lives and improving conditions in communities; however, these same environmental challenges also significantly impact the collection of these data. Enforcing an institutionally required conventional informed consent process (e.g., a signed document) can create barriers to participation among certain populations (e.g., low literacy; high distrust of perceived authority), leading to data that inaccurately represents populations of interest. In-depth understanding of the target population and research context is critical, which demands the involvement of local experts with extensive experience both in research ethics and in the needs of the community.

5 **Conduct follow-up research**: Qualitative follow-up research can support the exploration of seemingly contradictory quantitative findings and unpack the extent to which social desirability bias may have been present during quantitative data collection.

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Recommendations

1. Continue to refine the tools and guides to be more comprehensive and advanced, field-oriented and user-friendly.
2. Conduct additional analyses that focuses on contradictions and what they tell us about people (e.g. intention/action gap, biases, norms) or the collection mechanisms (sequencing, prompts, etc.)
3. Orient UNICEF Planning, Monitoring and Evaluation (PM&E) on the newly developed tools and methodologies.
4. Engage PM&E colleagues in participating country offices as partners to help translate the data.
5. Conduct internal advocacy to increase other sectors' ownership of the SBC tools, methodologies, and data.
6. Advocate for SBC data usage across different levels within UNICEF.
7. UNICEF HQ should assess the separate costing of qualitative and quantitative research components within the study and develop a brief costing tool that covers full implementation (including report writing, translation, etc.).
8. UNICEF regional offices and HQ should create a minimum bank of indicators that countries can use
9. UNICEF HQ should provide support on how to design country data strategies to get more rapid data.
10. Consider how rapid tools such as U-Report and the CRAs (Community Rapid Assessments) can be utilized for data collection as well as social mobilization.
11. Orient UNICEF LTA research entities on BDM and new SBC tools and methodologies.

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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.

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The compendium is available electronically and can be downloaded from https://www.sbcguidance.org and https://unicef.sharepoint.com/sites/PG-SBC

For more information please contact: **sbc@unicef.org**