

# A Behavioural Playbook for Public Health Responses

Learning from the  
MENA experience, preparing  
for the future



THE  
BEHAVIOURAL  
INSIGHTS  
TEAM



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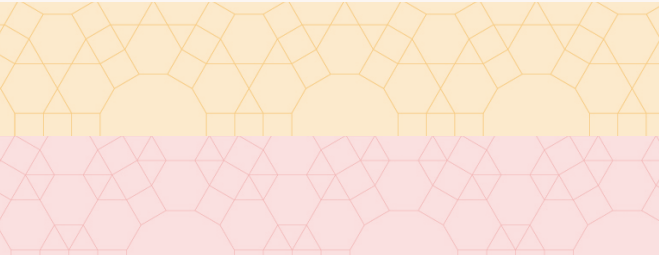


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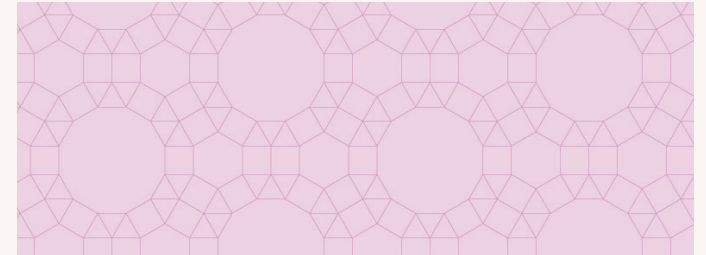
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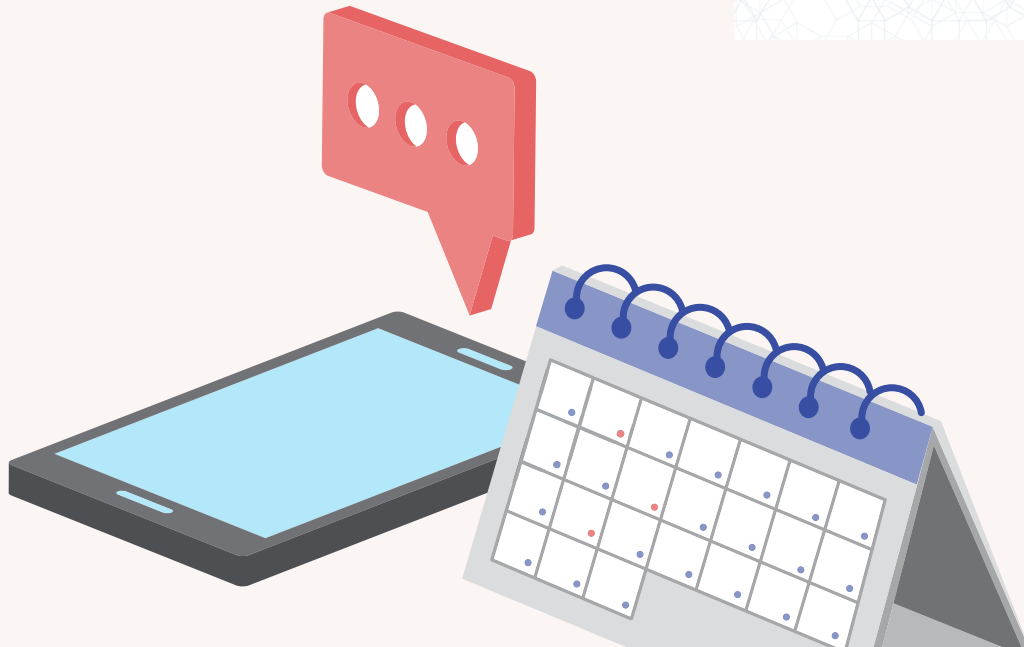
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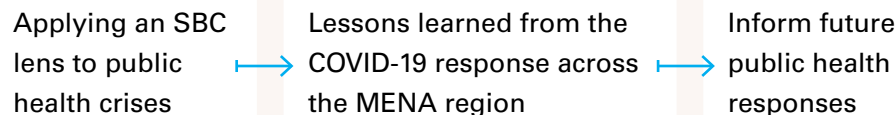


# Introduction

## What is the Behavioural Playbook for Public Health Response?

Effective public health responses require a comprehensive range of policy solutions, including epidemiological and behavioural data, specific expertise in community engagement as well as social and behaviour change strategies, investment in healthcare systems, a well-trained and well-equipped workforce, reliable supply chains and coordinated public health and social measures.

This playbook focuses on Social and Behaviour Change (SBC) solutions to public health crises, drawing upon promising SBC initiatives that were deployed during the COVID-19 pandemic within the Middle East and North Africa (MENA). The playbook has been created as a resource for practitioners within UNICEF and beyond, distilling lessons learned from the MENA region to shape more effective strategies for future responses to epidemics, pandemics and other types of health crises - using an SBC lens.



Effective public health responses also rest on a strong foundation of 'preparedness', which tends to be organised as a cycle of continuous activities rather than having a beginning and end point per se.

As a complement to this foundation, this playbook is structured along **four general phases of response to a public health crisis:**

- Phase 1: Emergence of the Virus
- Phase 2: Continuous Adaptation
- Phase 3: Vaccine Rollout
- Phase 4: Recovery and Integration

We also address **two cross-cutting themes** that span across the response phases follow the sections on the four phases:

- Social and Behavioural Data
- Economic and Social support

One of the unique features of the MENA region is the co-existence of low-, middle- and high-income countries, as well as fragile and conflict-affected states and sub-regions. While much of the experience and response to COVID-19 was common across the region, some distinctions were evident across these categories of countries, such as varying trust in government institutions, ability to swiftly mobilise resources and reach communities.

The SBC approach to the response in the MENA region was guided by the Regional Framework for Risk Communication and Community Engagement, which consisted of four interlinked pillars (i) localising, (ii) evidence (iii) capacity building and (iv) coordination. Accordingly, this playbook reflects the strategies and activities recommended in that framework, elaborated by case studies and additional insights gleaned from practical experience.

Within each section of the playbook, we **learn from the past** by revisiting the progression of the COVID-19 pandemic within the region, highlighting common response measures as well as differing timeframes across countries. We then explore the relevant pain points emerging from MENA, with an emphasis on the distinct behavioural challenges faced by individuals, communities, and systems at each phase of the pandemic. We **prepare for the future** by exploring behavioural solutions and case studies. Given the unprecedented scale and impact of the COVID-19 pandemic, it is crucial that we distil the knowledge acquired during this time for future use. By concentrating on MENA, this resource provides a contextualised view of the behavioural challenges and innovative solutions for public health responses.

This framework is intended as a guide for future public health crises, however we recognise that it is only one of several and that other frameworks or approaches may be more appropriate in particular contexts. We also make an important acknowledgment that Phase 3 of this playbook will be most applicable to future vaccine-preventable crises, whereas other sections will have wider relevance. Lastly, in an effort to avoid repetition, we have only highlighted pain points and solutions in the sections where they are most acute and relevant but acknowledge that overlaps exist across the phases.

## How should I use this playbook?

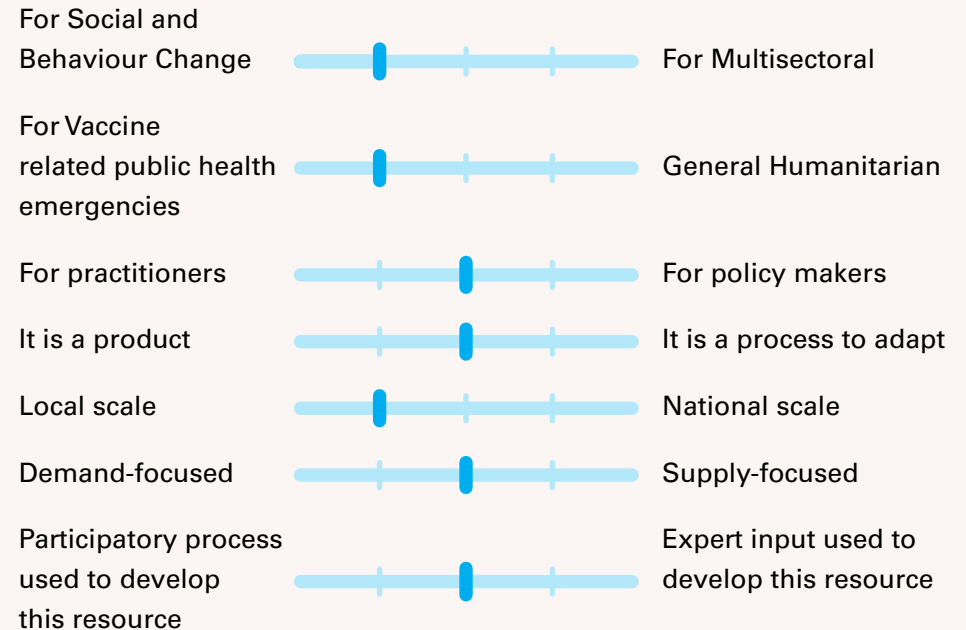
Consider this playbook as a source of inspiration. This playbook can be used without prior SBC knowledge. A glossary of key terms is included. You will also find case studies detailing the SBC principles in practice, which we hope will further inspire reflection on best practice and the importance of evaluation.

While this playbook aims to capture a range of principles and ideas across the MENA region, it is not exhaustive. We acknowledge that MENA region is richly diverse, with significant cultural, social, and economic heterogeneity across and within its countries. We suggest that as readers peruse this playbook, they bear in mind the importance of local contextualisation and adaptation.

## How was this playbook created?

The SBC team from the UNICEF MENA Regional Office initiated this playbook with support from The Behavioural Insights Team (BIT) in collaboration with 10+ UNICEF Country Offices from across MENA and a cadre of independent experts and academics. We collected data from reports, publications, and internal UNICEF documents, as well as from expert consultations and a literature review.

## About this resource



# Overview of the social and behavioural response framework

In this guide, we conceptualise the response to a public health crisis into four phases of health-related response. Inspired by the events of the COVID-19 pandemic as experienced in the MENA region, this social and behavioural response framework provides an overview of pain points and possible solutions for each phase, highlighting the use of [behavioural insights](#).

<b>Phase 1: Emergence of the Virus</b>	<b>Phase 2: Continuous Adaptation</b>	<b>Phase 3: Vaccine Rollout</b>	<b>Phase 4: Recovery and Integration</b>
Immediate response to contain infections and provide immediate guidance and reassurance to the public	Continuous adaptation of response measures to control infections and address prolonged impacts of disruption	Distribution and rollout of vaccines, as they became available in different countries at different times	Slowdown of infections with increasing focus on integrating the response into routine health services

## Social and Behavioural Data

Availability and access to timely and accurate information to inform decision-making

### Pain Points

Availability and access of timely and accurate information to better understand public attitudes, beliefs or perceptions and develop effective interventions.

### Potential Solutions

Mechanisms or systems set up to better understand pain points for specific populations or communities. For example, social listening and surveys.

## Economic and Social Support

Implications of public health crisis on broader societal wellbeing, such as poverty, unemployment, gender equity, and education

### Pain Points

Factors impacting broader well being, such as poverty and unemployment, inequality, gender, education, stability and security.

### Potential Solutions

Interventions or programmes that provide social and economic assistance. For example: unemployment benefits, mental health services, digital learning programs.

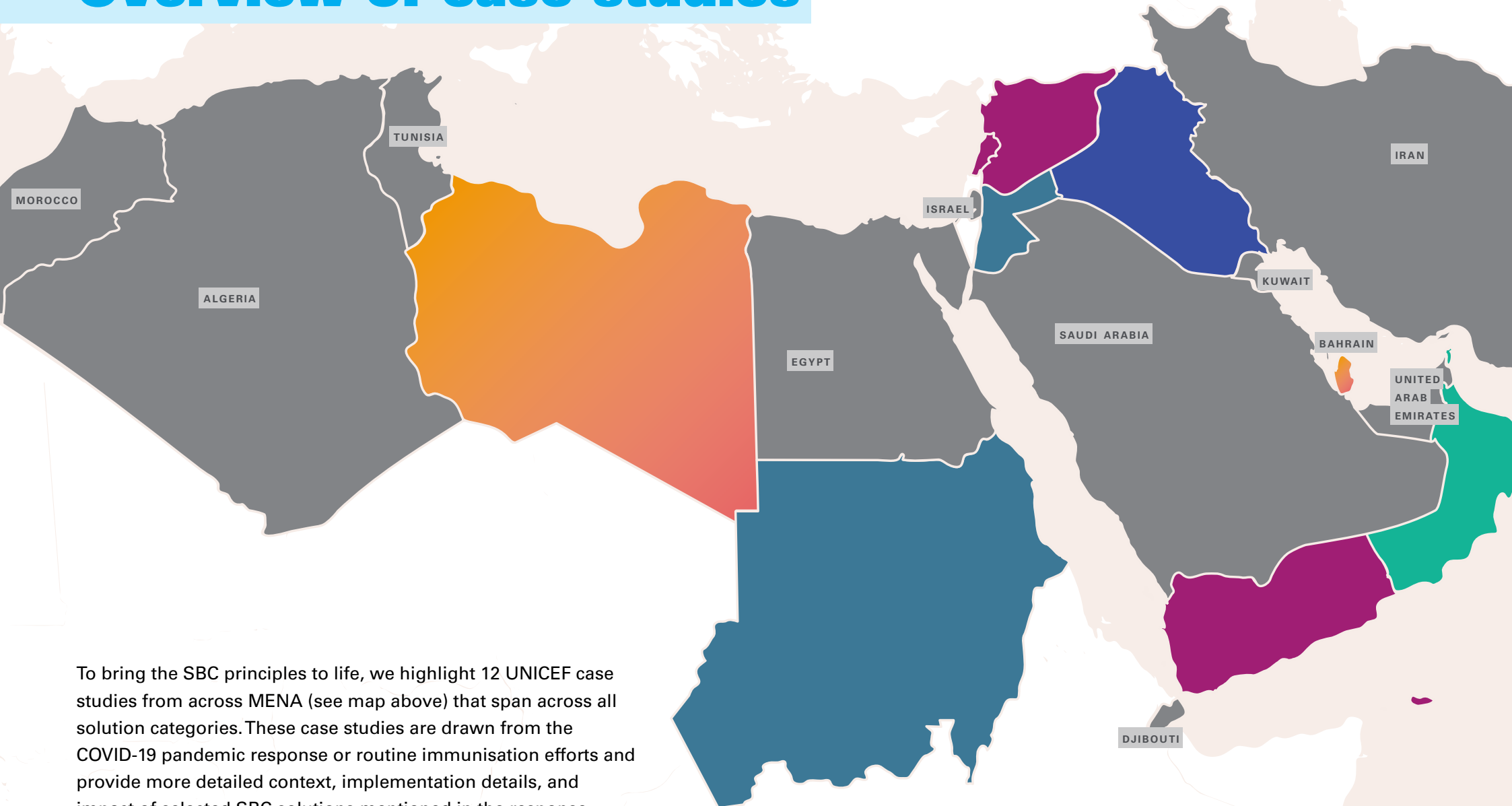
Within each phase of response, we further segment public health pain points and solutions by the Individual, Social and Community, and Systems levels, which draws inspiration from the [Social-Ecological Model](#) and [Behavioural Drivers Model](#). For each level, the pain points correspond with behaviourally-informed solutions.

LEVEL	<b>Individual</b> ●	<b>Social/Community</b> ●	<b>Systems</b> ●
PAIN POINTS	Attitudes, beliefs, perceptions and intentions held by an individual that affect their health or that of others.	Factors that often subconsciously influence behaviour, including culture, religion and norms, that affect the health of citizens.	Any hassle factors or practical issues on the supply and systems side that affect the health of citizens.
SOLUTIONS	Interventions or programmes that address individual level pain points. For example: targeted messaging campaigns, reminders to attend vaccination.	Interventions or programmes that address community level pain points, social networks or social influence. For example: community-based dialogue, peer support groups, working with online influencers, religious influencers or community mobilisers to improve trust.	Interventions or programmes that address systems level pain points. For example: public signs, mobile vaccination, flexible vaccination hours, training and upskilling of health workers or service bundling.




















# Overview of case studies



To bring the SBC principles to life, we highlight 12 UNICEF case studies from across MENA (see map above) that span across all solution categories. These case studies are drawn from the COVID-19 pandemic response or routine immunisation efforts and provide more detailed context, implementation details, and impact of selected SBC solutions mentioned in the response framework.

PHASE	COUNTRY AND CASE STUDY	LEVEL	SBC COMPONENTS
Phase 1 and 2		Individual	• - Tailored risk communication
		Social/Community	•  - Trusted messengers
Phase 3		Individual	• - Trusted messengers
		Social/Community	•  - Reminders
		Social/Community Systems	  - Education campaigns
		Social/Community Systems	  - Reminders
Phase 4		Social/Community	• - Education campaigns
		Social/Community	•  - Trusted messengers
		Individual	• - Reminders
		Social/Community	•  - Education campaigns
Social and Behavioural Data		Social/Community Systems	  - Peer dialogue
		Social/Community Systems	  - Service bundling
		Social/Community Systems	  - Relatable messengers
Economic and Social Support		Social/Community Systems	  - Research surveys
		Social and behavioural data	- Social listening, Sentiment analysis
		Social and behavioural data	- Research survey, Segmentation, Personas
Economic and Social Support		Economic and social support	- Digital learning programmes
		Economic and social support	- Social proof
		Economic and social support	- Tailored social media campaigns
		Economic and social support	- Social protection

# Phase 1: Emergence of the Virus

Phase 1 of the COVID-19 pandemic was marked by the emergence of the virus. Government and public health bodies conducted initial observation of cases and began to implement responses to contain infections and provide immediate guidance and reassurance to the public.

**How Phase 1 transpired over the COVID-19 pandemic in MENA**

## PHASE 1: Emergence of the Virus

### APPROXIMATE TIME FRAME IN MENA

January 2020 - March 2020

**WHO pandemic classification:**

Spread of virus across countries

### PROGRESSION OF THE VIRUS IN MENA

The virus emerged outside the region and cases began clustering in hotspots

Infections began to spread internationally, with the first known case arriving in MENA in late January 2020

By mid-March, Iran had become a regional epicentre for the virus

### RESPONSE MEASURES IN MENA

Coordination mechanisms established, including human resources and rosters, strategy development and technical guidance

Daily epidemiological updates were available, with open access dashboards created in most countries; social and behavioural data were not yet widely available

Governments began to provide guidance on recommended public health safety measures (PHSM); controversy over wearing masks continued

Movement restrictions (e.g. curfews, travel restrictions) imposed in most countries

Religious sites (e.g., Mecca and Medina), large public events and schools were interrupted, cancelled or shut down

Health services began to mobilise resources and source PPE and medicines that held promise for marginalised communities

PHASE 1: **Pain Points****INDIVIDUAL**

**Low trust in governments:** In certain countries, there was widespread distrust and scepticism towards governmental institutions, their policies and messages, stemming from perceived corruption and political instability.

**Present bias related to fear and uncertainty:** The threat to health posed by the virus, as well as uncertainty about how to protect oneself and others, drove present bias (the tendency to prioritise short-term interests over long-term interests).

**Low risk perception:** Reliable information about COVID-19 was hard to discern, not everyone perceived COVID-19 as a significant personal risk or followed recommended guidelines.

**Misinformation eroding trust in public health guidance:** High uncertainty and constantly changing conditions within countries, fed misinformation and occasionally lead to hazardous behaviours (e.g, ethanol consumption).

**Language and literacy barriers:** In a region with a diverse set of languages and varying literacy rates, effective communication of COVID-19 guidelines posed a significant challenge, especially among key groups such as those living in remote areas, economically disadvantaged populations, and refugee and migrant groups.

**SOCIAL/  
COMMUNITY**

**Social norms and cultural/religious practices:** While the support of religious leaders was a significant and positive factor in addressing COVID-19, some negative voices were active. Some cultural and religious practices like closed gatherings (e.g. weddings, funerals) or communal prayer posed an increased risk of virus spread. Governments struggled to balance competing priorities of cultural significance and epidemiological safety.

**SYSTEMS LEVEL**

**Uncertainty:** Research and practical experience brought new information on a daily basis. Conflicting messaging and misalignment among global, national, and local health entities led to a lack of consistent information and guidance for citizens, resulting in confusion for institutions such as schools and businesses. Interruptions to vaccine supply also eroded trust in authorities and allowed space for conspiracies to foment.

**Displacement and conflict:** Large numbers of displaced people, instability and ongoing conflict within MENA, made the implementation of public health measures such as social distancing and quarantine significantly more difficult to implement.

**Middle East Respiratory Syndrome (MERS) availability heuristic:** Previous experience with MERS (2012) may have led institutions and individuals to make false assumptions about the COVID-19 virus.

## Phase 2: Continuous Adaptation

In Phase 2, continuous adjustments to response measures were needed to control infections and address prolonged impacts of disruption.

While Phase 1 of public health crises is typically marked by uncertainty and panic management, Phase 2 is marked by prolonged disruption and fatigue. While these two phases have different pain points, the type of SBC solutions to address these challenges are similar in nature and as such, they appear together in this playbook.

### How Phase 2 transpired over the COVID-19 pandemic in MENA

## PHASE 2: Continuous Adaptation

### APPROXIMATE TIME FRAME IN MENA

April 2020 - September 2021

#### WHO pandemic classification:

Phases 5-6—Rapid global spread of the virus and active government response

### PROGRESSION OF THE VIRUS IN MENA

Virus spread rapidly within the region, particularly amongst high-density living settings such as refugee camps

Infection rates increased, fell and rose again over the 16-month period

The prospect of effective COVID-19 vaccines grew, along with questions about the emerging vaccines

### RESPONSE MEASURES IN MENA

Strengthening of the linkage between SBC and the broader response mechanism, intensifying technical support to countries

Increased information and prospects for effective vaccines (but not yet available)

Strong community engagement with religious and other community leaders, and social influencers

Governments took more stringent measures (e.g., lockdowns, business closures) to control the spread of infections

As infection rates fell and rose and the pandemic wore on, governments experimented with different combinations of restrictions to balance competing economic, epidemiological and wellbeing priorities

Testing was widely available quickly, but expensive, invasive, and often inconvenient

Mask mandates were recommended and widely used

Almost all countries implemented economic measures, including cash transfers to support families and businesses

Health worker capacity-building efforts implemented at scale

Social and behavioural data collected in most countries, also increasingly involving social media monitoring

## INDIVIDUAL

**Pandemic fatigue:** Prolonged periods of restrictions led to complacency, lack of motivation, and resistance towards health guidelines, contributing to pandemic fatigue. Cognitive overload: Large volumes of constantly changing information, as well as increasing attempts to deliberately mislead, made it challenging for citizens to keep up with the details of changing regulations, leading to confusion and disengagement.

**Decreasing or lack of trust in government by some:** Trust in government fluctuated during the pandemic, however time series data from the region showed that those who were positive about COVID-19 vaccines had more trust in governments, and especially health workers. However, trust in the government wavered when people were suspicious of vaccines and frustrated about policy decisions, communication and the impact of restrictions.

**Contextual illiteracy:** Despite guidance, some people did not wear masks correctly and did not change masks, or people struggled to estimate two metres in everyday scenarios for social distancing.

## SOCIAL/ COMMUNITY

**Social norms and cultural/religious practices:** While the support of religious leaders was a significant and positive factor in addressing COVID-19, strong cultural and religious norms around important large gatherings such as the Haj, Ramadan in Islamic communities, funerals, weddings) conflicted with social distancing rules, creating a barrier to adherence.

**Avoidance behaviour:** In many countries, people avoided seeking testing or reporting symptoms to avoid quarantine and other restrictions. In addition, stigmatisation of those infected or suspected to be infected with COVID-19, discouraged people from seeking testing or reporting symptoms.

**Gender inequalities and norms:** Traditional gender roles in the MENA region impacted women's experience of the pandemic. For example, women tend to have restricted movement, less engagement in formal employment, more caregiver responsibility for children, the elderly, and sick relatives. In turn, women tended to have less information about COVID-19 and were more concerned about certain vaccine misinformation – related to reproductive health and fertility, also exacerbated by the lack of access to health services.

## SYSTEMS LEVEL

**Overwhelming pressure on healthcare systems and capacity** to cope with COVID-19, provide routine care and build capacity to manage the promise of effective vaccines, particularly in conflict-affected areas, weak health systems and lower-income countries.

**Pre-existing stresses on communities:** the region has a large informal economy, with many people relying on piece work and day by day income. Low income families and vulnerable populations such as refugees also tend to have less space and more people per household. Challenges such as gender-based violence were also reportedly exacerbated by COVID-19 restrictions. Lock downs severely affected these already stressed households.

**Planning fallacy:** To start, there was no early warning system, and institutions initially underestimated the resources needed to combat the pandemic effectively, including physical resources such as Personal Protective Equipment. Masks were also in short supply, contributing in part to a policy of not recommending their use for the general public. As the virus started to spread rapidly, health officials and the general public found themselves in a situation of scarcity, which also impacted behaviour. Low- and middle-income countries were disproportionately impacted by testing capacity constraints.

## INDIVIDUAL

### Selective and tailored risk communications to build trust:

- Segmentation of different audiences and design interventions accordingly – for example use ‘personas’ to highlight different characteristics and interventions. This could include oral communication for low literacy populations, language-adapted materials, graphics with demographic representation of target audience, and culturally-sensitive communication.
- Selective communication, prioritising key behaviours with largest impact on transmission to avoid cognitive overload, for example hand washing and mask-wearing.

#### CASE STUDY

### Empowerment, self-care and wellbeing:

- Communications that emphasises self-efficacy eg. what you *can* do to protect yourself, or to manage stress and mental health, especially in already stressed environments, such as conflict-affected areas

## SOCIAL/ COMMUNITY

### Peer dialogue:

- Hotlines or peer support groups to address health-related enquiries.
- Virtual community gatherings for religious or significant events to encourage safe social distancing

### Use of trusted messengers:

- Leadership figures (such as religious, community and/or political leaders) role-modelling key public health safety measures (such as mask-wearing).
- Using the voice of trusted messengers from public health, religious or cultural communities to disseminate accurate public health information and dispel myths.
- Using female messengers to address gender-specific concerns.
- Limiting the engagement of politicians where trust is very low, and carefully selecting appropriate and trusted messengers to avoid backfiring due to political affiliations or public mistrust

#### CASE STUDY

## SYSTEMS LEVEL

### Policy changes and mandates

- Adaptations to policies and introduction of mandates requiring, and enforcing, certain public health and social measures eg. masks, social distancing, banning mass gatherings, and limitations on movement (“lock-downs”)

### Healthcare workers support

- ‘Soft skills’ training as well as clinical skills for vaccination, to enhance health worker self efficacy, as well as improve public interaction with health workers and overall experience of health services.
- Gratitude campaigns and “thank-a-thons” to address health worker burnout.

### Establish feedback mechanisms

- Where public feedback is available, systems act on the information to improve services, and build trust

### Public signage

- Posts, signage, and markers for social distance guidelines (e.g., arrows on elevators, social bubbles in parks).

### Health officials decision-making

- Standardised PHSM classification for lockdown phases and criteria for movement between phases to manage citizen expectations; create alignment between entities, and set clear decision criteria.

## QATAR

## Health guidelines in migrant languages

LEVEL: Individual

Social/Community

SBC SOLUTIONS:

Tailored risk communication

Trusted messengers

## Target audience

Migrant workers in Qatar, who were vulnerable to COVID-19, and also the majority of the population

## Overview

A health communication campaign was conducted to disseminate key public health information in the languages of migrant workers. The campaign was launched by the Ministry of Public Health (MoPH) in collaboration with many stakeholders – ranging from government ministries, local NGOs, community and religious leaders, media outlets, and employers.

In addition to diverse language options, the campaign used multiple channels and formats to reach out to migrant workers effectively, such as printed posters and fliers with graphic prompts, targeted radio stations and broadcasts, and social media posts. SMS messages, hotline services, webinars, and face-to-face interactions, including through workplaces, were also deployed. Importantly, the approach leveraged the existing resources and networks of the stakeholders to adapt the messages to the linguistic and cultural diversity of migrant workers.

## Bilingual COVID-19 awareness pamphlet for migrant workers (Bengali and English)

সংক্রমণ থেকে নিজেকে এবং অন্যদেরকে রক্ষা করুন।  
PROTECT YOURSELF AND OTHERS FROM INFECTION

কিভাবে সংক্রমণ থেকে নিজেকে এবং অন্যদেরকে রক্ষা করবেন।  
How to protect yourself and others from infection:

Wash your hands regularly with soap and water or use a hand sanitizer  
নিয়মিতভাবে সাবান পানি অথবা স্যানিটাইজার দিয়ে হাত ধোঁত করুন।

Avoid touching your eyes, nose and mouth with your hands  
হাত দিয়ে চোখ, নাক ও মুখ স্পর্শ করা থেকে বিরত থাকুন।

Avoid close contact with anyone showing symptoms of respiratory illness  
শ্বাসকষ্ট জনিত অসুস্থ লোকের সংস্পর্শ যাওয়া থেকে বিরত থাকুন।

Cover your mouth and nose when you sneeze, and dispose of used tissues  
হাঁচি দেয়ার সময় মুখ ও নাক ঢাকুন এবং ব্যবহৃত টিস্যু যথাস্থানে ফেলুন।

If you experience symptoms including cough, sneezing, and fever, limit your contact with other people  
যদি আপনার কাশি, হাঁচি ও জ্বর অনুভূত হয়, তখন অন্যের সাথে আপনার চলাচল সীমিত করে ফেলুন।

Ministry of Public Health  
Hamad Medical Corporation  
Qatar Red Crescent

For more info, on novel coronavirus (COVID-19) visit [www.moph.gov.qa](http://www.moph.gov.qa) or call 16000





## Social and Behaviour Change (SBC) solutions

This campaign leveraged SBC solutions to target both individual and community pain points, using selective and tailored risk communications and the messenger effect.

In deploying selective and tailored risk communications, the approach:

- **Utilised local channels:** Using specific radio stations familiar to migrants, to deliver oral messages in migrant languages, taking into account low literacy levels or limited access to internet or mobile phones.
- **Adapted to migrant languages:** The materials were adapted into more than nine languages. Positive behaviours such as wearing masks, washing hands, maintaining physical distance, avoiding gatherings, and seeking medical help when needed were clearly articulated in simple terms and graphically represented.

In using the messenger effect, the approach:

- **Engaged a variety of local leaders:** Community leaders from different cultures and neighbourhoods were recruited to deliver key messages in their respective language. Notably, the challenges and difficulties faced by migrant workers during the pandemic were continually acknowledged and empathy and appreciation were expressed for their contributions to society.

### List of local leaders and languages covered

Community leaders using migrant languages.

	Date Posted	Community	Language
1	April3	Ex-Chairman, United Filipino Organizations in Qatar	Tagalog
2	April3	Urdu radio, 107 FM	Urdu & Hindi
3	April3	President, Indian Cultural Centre Doha	Malayalam
4	April3	President, Qatar Tamil Toastmasters	Tamil
5	April3	Sri Lankan community	Sinhalese
6	April3	Nepali community	Nepali
7	April3	President, The Bangladesh Community-Qatar	Bengali
8	April4	Pakistani Community leader	Urdu
9	April4	President, Indian Community Benevolent Forum	Malayalam
10	April4	General secretary, Indian Sports Centre Doha	Hindi & Urdu
11	April4	Joint secretary, Rajini Makkal Mandaram	Tamil
12	April4	Director, Toastmasters District 116	English

## RESULTS

Key informant interviews with community leaders suggested that the approach contributed to an increased sense of acceptability and compliance to health advisories, specifically through addressing cultural and religious sensitivities. The use of multilingual communication also created a sense of inclusion and recognition for the migrant workers and their languages. Finally, the selection of media outlets familiar to, and trusted by the target audience – such as radio, social media, websites, and print materials, as well as workplaces – increased the reach and impact of health messages.

## LESSONS LEARNED

The inclusive COVID-19 policy set a strong foundation for engagement with migrant workers. Further, tailoring health communications to reflect the linguistic and cultural diversity of a country's population is important. In Qatar, this approach not only enhanced message acceptance and adaptability but also fostered a sense of inclusion and recognition among migrant workers.

# LIBYA Trusted public health messengers

LEVEL: Individual

Social/Community

SBC SOLUTION:

Trusted messengers

## Target audience

The target audience of the initiative was young adult Libyan social media users of both sexes, especially those who consume, and share information related to COVID-19 and vaccination. The largest age group targeted was 25-34, comprising 42% of the Facebook audience base and 50% of the Instagram audience base. See more detail below:

Channel	Facebook followers 1,268k	Instagram followers 46k
Age	18-24: 15.9% 25-34: 42.4% 35-44: 27.9%	18-24: 24.1% 25-34: 50% 35-44: 19.1%
Gender	Women: 41% Men: 59%	Women: 42.6% Men: 57.4%
Top Cities	Tripoli, Libya 39.8% Benghazi, Libya 12.4%	Tripoli, Libya 40.5% Benghazi, Libya 10.4%
Top Countries	Libya 86.6% Egypt 2.6% Tunisia 1.8%	Libya 68.9% Egypt 1% Tunisia 0.8%

## Overview

The initiative was a collaboration between El Kul, a Libyan online platform that produces and shares engaging content on social media, and BBC Media Action, a UK-based international NGO that supports media development and communication for social change. The initiative aimed to use findings from social listening to produce and disseminate content that addressed the gaps and challenges in the information environment. This included fact-checking videos, myth-busting graphics, and stories of COVID-19 survivors. In particular, trusted messengers, such as public health figures, were consistently involved in disseminating important health-related and public safety information.

## Social and Behaviour Change (SBC) solutions

The Messenger effect: The key messenger, “Dr Tarek”, consistently appeared to address these in online sessions, acting as a reliable messenger that people could trust and approach for key information.

### Screenshot of video with Dr. Tarek



Date: 26.08.2021

<https://bit.ly/3BDx0Vh>

An informative / scientific video with Dr. Tarek answering people questions (in response to previous post where the audience were asked to send their questions and concerns to be answered by a specialist).

Reach: 107.397

Engagement: 464

**Main attitudes, opinions, and emotions:** The audience were interested in the provided information and shared their questions and concerns to make sure they are getting the right answer from a trusted resource (the doctor).



## RESULTS



Research conducted by BBC Media Action showed that El Kul's daily content reached over 1.7 million adult Libyans, or approximately 25% of the adult population. The initiative helped address the pain points of misinformation and mistrust in the context of the COVID-19 pandemic. The research also showed that the audience found El Kul's content to be balanced, covering issues that were important to their lives, and discussion-worthy, with over half of the audience members discussing the content with family, friends, and others.

More detailed reach and engagement measures of the initiative:

- The initiative analysed over 10,000 posts and comments from March to June 2020 on Facebook and Twitter related to COVID-19 and vaccination.
- The initiative produced over 100 content pieces, based on these posts, on various topics related to COVID-19 and vaccination, such as symptoms, prevention measures and treatment options.
- The content reached over 1.7 million people on Facebook and Twitter, generating over 300,000 views, 40,000 likes, 10,000 shares, and 5,000 comments.

## LESSONS LEARNED



'Dr. Tarek', represents a consistent and trusted figure who helped to share key information, address specific concerns, and answer broader questions from the public. Using an existing local trusted platform such as El Kul also helped lend credibility and trust among the target audience. In addition, the two-way communication that the platform facilitated allowed for clarification of key concerns of the audience and more tailored responses.

## Phase 3: Vaccine Rollout

Phase 3 is marked by the distribution and rollout of vaccines; however, the global vaccine shortage, large differences in economic development, the strength of systems and political stability across MENA along with other factors, affected access across and within countries.

**How Phase 3 transpired over the COVID-19 pandemic in MENA**

### PHASE 3: Vaccine Rollout

#### APPROXIMATE TIME FRAME IN MENA

Early access group (mostly high-income countries)<sup>1</sup>: Jan 2021 - Dec 2021

Mid access group (mostly low-/middle-income countries)<sup>2</sup>: May 2021 - April 2022

Late access group (mainly low-income countries)<sup>3</sup>: Sept 2021 - Dec 2022

#### WHO pandemic classification:

*Post-Peak*

Distribution and administration of vaccines

#### PROGRESSION OF THE VIRUS IN MENA -->

Infection rates dropped (as countries began large-scale vaccination programmes) as variants continued to emerge (e.g., Omicron in late 2021)

#### RESPONSE MEASURES IN MENA

High income countries launched vaccination programmes early, approving and directly procuring as vaccines became available; however the timing and volume of vaccine supply was suboptimal in middle and lower income countries respectively

Focus on improving vaccine acceptance and combat misinformation, especially among marginalised communities and for women; with strong community engagement with religious and other community leaders, and women's groups Strong epidemiological, social and behavioural data were made available, including social media and social listening

<sup>1</sup> This included countries such as Bahrain, Egypt, Israel, Kuwait, Oman, Qatar, Saudi Arabia, Turkey and the UAE.

<sup>2</sup> This included countries such as Algeria, Jordan, Lebanon, Morocco, Tunisia, and the West Bank and Gaza.

<sup>3</sup> This included countries such as Iran, Iraq, Libya, Mauritania, Sudan, Syria and Yemen.

## PHASE 3: Pain Points

### INDIVIDUAL

#### Confirmation or Consistency Bias and polarised vaccine acceptance

Adverse events following immunisation (AEFI), misinformation, and politicisation disproportionately affected those who were already hesitant about COVID-19 vaccination, leading to distorted perceptions of vaccine safety and benefits.

#### Anchoring Bias and sporadic release of vaccine safety research

Vaccine trials did not initially include tests for children and for pregnant women, leading to misplaced fear that vaccines were unsafe for these groups, which persisted even after trials were completed and these groups were included in vaccination recommendations.

#### Low risk perception

Complacency, desensitisation and underestimation of risk of being infected emerged with successive waves of COVID-19; At the same time, confidence in the benefits of the vaccines wavered as new variants emerged.

### SOCIAL/ COMMUNITY

#### Social norms and cultural/religious practices

Perception emerged amongst some communities that vaccination contradicts religious beliefs, by violating the prohibitions against taking life, violating dietary laws (e.g., non-halal-based vaccine), or interfering with the natural order by not letting events take their course.

#### Gender inequalities and norms

Men tended to have better initial access to vaccination in some countries, possibly due to their greater mobility and engagement with formal employment with incentives for vaccination.

### SYSTEMS LEVEL

#### Vaccine supply affected by poor infrastructure, conflict and instability

Difficulty reaching remote and vulnerable communities with vaccines due to lack of cold chain, electricity / fuel, digital technology and high operational cost. Difficulty reaching remote and vulnerable communities in countries with conflict and political instability.

#### Insufficient human resources

Limited supply of trained health workers to implement vaccination programmes, and support other functions such as maternal and child health services.



## PHASE 3: Potential Solutions

### INDIVIDUAL

#### Reminders

- Physical cards / SMS reminders for initial and subsequent appointments.

#### CASE STUDIES

#### Behavioural informed education programs and campaigns

- Behavioural insights and cognitive biases incorporation into programs.
- Pre-bunking and myth-busting communications to address misinformation regarding vaccines (e.g., side effects, risk to vulnerable populations such as elderly, pregnant women or children).
- Edutainment (educational entertainment) to weave vaccine messages into broader stories.
- Door-to-door visits to hear individual level concerns and deliver a personalised educational response (two-way communication).

#### CASE STUDIES

### SOCIAL/COMMUNITY



#### Peer dialogue to build trust amongst the community

- Community-based dialogue to explore underlying social norms and beliefs affecting vaccine uptake.
- Hotlines or peer support groups to address vaccine concerns.

#### CASE STUDIES

#### Use of messengers to create trust in vaccines

- Religious, community and/or political leaders as vaccination champions and key messengers.
- Careful matching of influencers (e.g., health experts, celebrities, politicians) to specific subpopulations, with special consideration of required for political leaders in the region.

#### CASE STUDIES

#### Social proof

- Making vaccination visible eg. stickers for those who have received vaccines.
- Vaccination stories from community members / local influencers.
- Highlighting how similar people are adopting positive behaviours.

## PHASE 3: Potential Solutions

# SYSTEMS LEVEL



### Policy changes and mandates

- Adaptations to policies and introduction of mandates requiring, and enforcing, certain public health and social measures; eg. Vaccine passports as a prerequisite for access to travel and transport, workplaces, events and other public spaces

### Healthcare workers support

- Recruiting and/or upskilling additional and existing healthcare workers through purpose-driven recruitment messages, including soft skills eg. Motivational interviewing.

### Increasing vaccination access points

- Mobile or pop-up vaccination sites
- Vaccination drives to workplaces, mosques, churches and other places of worship.

### Enhanced vaccination service experience

- Flexible / extended opening hours for vaccination centres.
- Vaccination reservation / booking system to avoid long waiting times.
- Women-only vaccination sites to combat prevailing gender norms.

### CASE STUDY



## LEBANON

## Behaviourally-informed pamphlets

LEVEL: Individual

• Social/Community

SBC SOLUTIONS:

Reminders

Education campaigns

## Target audience

Parents/caregivers with children who had not completed their childhood immunisation vaccination schedules.

## Overview

Following weeks of extensive fieldwork, several challenges were identified, including some that have strong behavioural roots, such as: a) lack of trust among Lebanese caregivers in the quality of services and vaccines provided by healthcare centres; b) a strong belief among Lebanese caregivers that they are entitled to receive better vaccination services than those being offered to non-Lebanese; c) the adverse influence of peers who may have had a negative experience at a healthcare centre; d) neglect and forgetfulness leading to an intention-action gap; and e) lack of awareness that others are using the service. To offset these challenges, a behaviourally-informed leaflet with five nudges was designed.


## Social and Behaviour Change (SBC) solutions

Parents received a paper-based reminder, incorporating several other behavioural solutions:

- **Social endorsement / social norms:** Statements indicating social support for the vaccination programme by others
- **Commitment / active choice:** Non-binding parental commitment to vaccinate their children
- **Implementation intention:** A calendar where parents would specify the date and location of their child's vaccination to help them plan
- **The Messenger effect:** Assurance of the vaccine's quality and effectiveness by the Ministry of Public Health

## Pamphlet prototype

MoPH / UNICEF logos



More than 90,000 children have been vaccinated for FREE in PHCs or dispensaries through this activity!

**Your neighbors are protecting their children by vaccinating them ... when will you?**

I promise to vaccinate my children at the PHCs or dispensaries

Write names of children here

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_


DECEMBER 2018						
SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	--					

Place the address and working hours of the preferred PHC or dispensary

We will follow up with you to find out more about your experience

The MoPH guarantees the quality and effectiveness of the free vaccinations offered by PHCs and dispensaries

For more information or complaints, please call the MOPH on 1214






## RESULTS



The pamphlet resulted in a 6.8% increase in the number of households vaccinating at least one child. The majority of the children reached were Syrian nationals (73.2%), while Lebanese children comprised most of the remaining sample (24.2%). Additional insights and associations between household characteristics and uptake of vaccination were also explored. For instance, nationality played an important role: non-Lebanese households were significantly more likely to vaccinate at least one child (18.2% vs Lebanese households: 13.8%). Also, the child's gender was not a significant predictor of vaccination uptake.

## LESSONS LEARNED



Behaviour change is more likely where several strategies are implemented simultaneously. Results may be enhanced further by combining this innovation with other strategies. In addition, while a pre-post test design was applied here, adding a comparison group may provide a more thorough understanding of the value of this and other interventions.

# YEMEN Faith-based engagement

LEVEL: Social/Community



Systems



SBC SOLUTIONS:

Reminders

Trusted messengers

## Target audience



The general population of Marib governorate, including internally displaced persons (IDPs) who had sought refuge in the area.

## Overview



In the midst of the ongoing conflict and the challenges faced by Yemen's healthcare system, the initiative aimed to address low COVID-19 vaccination coverage among the local communities in Marib governorate. Through partnership with the Ministry of Religious Guidance, Ministry of Health and the Risk Communication and Community Engagement (RCCE) Working Group, UNICEF's SBC team supported partners to roll out training and mobilise religious leaders in Marib. A total of 55 religious leaders, comprising 30 Imams (males) and 25 Morshydats (females), were selected and deployed across mosques, IDP centres, and villages. This programme leveraged the influential role of religious leaders in the community to promote COVID-19 vaccination.

## Social and Behaviour Change (SBC) solutions



The programme incorporated various solutions to effectively improve vaccination acceptance and ease of access. These strategies included:

- **Community engagement:** Imams and Morshydats incorporated positive vaccination messages into their lessons after daily prayers, community gatherings (separate male and female) inside their homes and community-based dialogue sessions.
- **Messenger effects:** By leveraging local religious leaders, targeting both men and women, the vaccination messages were disseminated in a more powerful and trusted channel.
- **Mobile vaccination:** This programme also directly brought vaccination services to mosques to reduce physical barriers to vaccination and greatly enhance ease of access.

### Religious leaders delivering sermons that address lack of awareness and misinformation about the vaccination



Imam Abdulrahman delivering a session after Assir (afternoon) Prayer encouraging the community to take the C19 vaccine, using himself as an example of those who have received 2 doses of vaccine.

Photo by: Ziad Al-Ray – Head of Health Education Center Marib. Location: Marib Al-Madyna (central Marib). Al-Fathah Mosque

Date: December 15 2022. Name of the Imam: Sheikh Abdulrahman Mohammed Hassan



## RESULTS



The involvement of religious leaders in promoting COVID-19 vaccination yielded positive results. Following their engagement, the number of people vaccinated significantly increased in the targeted areas. During the initial round of vaccination in December 2022, 954 individuals were vaccinated. However, after the intervention and increased community engagement by religious leaders, the number of vaccinated individuals rose to 1,642 in the same five villages during the subsequent round in March 2023.

## LESSONS LEARNED



Engagement of religious leaders played an essential role in addressing rumours and misconceptions, particularly those stemming from religious beliefs. Furthermore, training religious leaders created a sustainable source of community engagement, as religious leaders incorporated public health messages while performing their routine work, with little direct support needed from UNICEF after training.

## SYRIA

## Demand generation for teachers and healthcare workers

LEVEL: Individual

• Social/Community

SBC SOLUTIONS:

Education campaigns

Trusted messengers

## Target audience



Teachers, students and healthcare workers across several Syrian directorates.

### UNICEF and WHO master training workshop for 17 trainers on RCCE COVID-19 vaccination



Partners participating in a capacity-building workshop on RCCE COVAX in Damascus.

Credit: UNICEF/Syria/2022

## Overview



By March 2022, COVID-19 vaccine uptake in Syria had slowed due to a number of reasons. In response, UNICEF kicked off a range of demand generation activities, including some engaging teachers, students and healthcare workers. UNICEF, the Ministry of Health and School Health Department linked to the Ministry of Education launched a COVID-19 health programme in schools. This involved 36 trainings for 934 health educators to engage teachers and carry out demand generation initiatives for teachers and students in 4,760 schools in 14 governorates. UNICEF deployed mobile teams to rural communities to visit schools with low vaccination coverage to engage with teachers and students about the importance of vaccination. In addition, UNICEF and WHO facilitated training sessions for health workers of UNHCR and its partners in 110 community centres across Syria to encourage vaccination uptake. These sessions had the particular purpose of increasing vaccine acceptance directly and tackling misinformation, especially among healthcare workers across all governorates.

### Social and Behaviour Change (SBC) solutions



- Education campaigns: Mobile teams conducted school visits, delivered communications campaigns, and conducted trainings to combat misinformation and increase vaccine acceptance.
- Use of messengers: By changing the beliefs of teachers and healthcare workers, these individuals were then able to have a continuous effect on those around them to further increase



## RESULTS



Although many of these measures were not evaluated individually, we can comment on the collective reach of the broader demand generation campaign, which also included religious-based messaging, social listening, and mass vaccination events. In March 2022, a total of 358,781 people were reached through COVID-19 messaging on prevention and access to services alone. In total, approximately 390,913 were engaged with through these activities.

## LESSONS LEARNED



While demand generation campaigns typically target individual community members or religious and community leaders, it is also important to consider other individuals who hold influential roles in communities (e.g., teachers and healthcare workers). These individuals can then create a ripple effect for vaccine demand. The investments made in strengthening community engagement networks during COVID-19 can also be mainstreamed to support other programs, such as cholera prevention and routine immunisation.

# YEMEN

## Comprehensive vaccine uptake strategy

LEVEL: Individual

• Social/Community

SBC SOLUTIONS:

Reminders

Education campaigns

Trusted messengers

### Target audience



General population of Yemen, though especially vulnerable groups such as refugees, migrants, muhamasheen (a marginalised social group), and people with disabilities.

### Overview



The initiative was a comprehensive community engagement strategy that used both online and offline channels to raise awareness, address misinformation and stigma, and promote preventive behaviours related to COVID-19. The strategy included:

- Mass media campaigns across 44 radio stations, 18 TV networks, a Ramadan drama series and Yemeni musicians that used informative and persuasive messages.
- Roving public announcement vehicles, outdoor advertisements as well as private sector engagement to promote COVID-19 messages on packaging that used catchy slogans and visuals.
- Religious centres such as mosques that made announcements after daily prayers, using religious references and appeals to social responsibility.

- SMS and voice messages that provided timely and accurate information and reminders to the subscribers.
- Social media announcements that used interactive and engaging content such as videos, graphics and quizzes to attract attention and generate feedback.
- Megaphone and mobile vans that used loud and clear messages to reach people around mosques and residential areas.
- Door-to-door efforts that allowed for higher quality two-way interaction which was critical as vaccines became available



Marib Aisha Mohammed, a midwife and also a Morshydah (female religious leaders), having counselling session with women on vaccines. Photo by: Health Education Centre – Marib, 10 June 2023, Marib governorate

### Social and Behaviour Change (SBC) solutions



Various channels and SBC techniques were used to inform, persuade, and motivate the target audience to adopt preventive behaviours such as wearing masks, washing hands, and accepting vaccination. These included:

- **Reminders:** Regular SMS and voice messages were sent to those who subscribed, that helped people stay informed of the latest official health information.
- **Education campaigns:** A drama series in the form of edutainment modelled desirable social norms, behaviours and outcomes through relatable characters and scenarios that reflected the common values and beliefs of the Yemeni population.
- **Use of messengers:** This included religious leaders, celebrities and community volunteers who acted as trusted sources of information for different segments of the population



## RESULTS



Over 13.5 million people successfully subscribed through SMS and voice messages and over 8 million viewed social media announcements. The Ramadan drama series reached more than 2.5 million viewers on YouTube and 1.3 million on Facebook. Social media platforms together reached over 8 million views and 7 million people via megaphone with 13.5 million followers currently subscribed and consistently receiving SMS and voice messages.

## LESSONS LEARNED



By utilising a blend of online and offline channels - including mass media, religious centres, social media, SMS, and face-to-face interactions - the campaign was able to reach a vast audience, disseminating accurate health information at scale. The efforts also highlighted the effectiveness of edutainment in changing behaviour. The drama series allowed public health messages to be infused into a broader story, therefore reducing “pandemic fatigue” and making messages more relatable and persuasive for the population.

## Phase 4: Recovery and Integration

Phase 4 denotes a period marked by a slowdown in infectious spread due to collective preventative measures and increased vaccination coverage. This phase transitions into integrated crisis response into routine health services. While the virus threat diminishes, the challenge of restoring normalcy and reinforcing health infrastructure gains prominence.

**How Phase 4 transpired over the COVID-19 pandemic in MENA**

### PHASE 4: Recovery and Integration

#### APPROXIMATE TIME FRAME IN MENA

Early access group (mostly high-income countries)<sup>4</sup>: Jan 2022 - ongoing

Mid access group (mostly middle-/low-income countries)<sup>5</sup>: May 2022 - ongoing

Late access group (mostly low-income countries)<sup>6</sup>: Jan 2023 – ongoing

##### **WHO pandemic classification:**

*WHO Phase Post-Peak to Post-Pandemic*

New case count begins to decline and control measures are lifted

#### PROGRESSION OF THE VIRUS IN MENA -->

Successful vaccination programmes begin to show results, with lower case numbers seen in many countries

In some countries case numbers rise with new infections / reinfections in response to easing of restrictions, but symptoms are not as severe

Testing rates and uptake of vaccination slows significantly as risk perception of COVID-19 falls

WHO declares a close to the public health 'emergency,' however managing COVID-19 is still a global priority

#### RESPONSE MEASURES IN MENA

Coordination efforts turning to re-strategising, capturing lessons learned and integration of COVID-19 into routine immunisation services

Public health safety measures (PHSM) gradually easing, sometimes in stages, with greater privileges offered to the vaccinated compared to unvaccinated groups

Integration of COVID-19 services into Primary Health Care (PHC) practices and routine immunisation

Increase in community outreach to those not yet vaccinated (e.g., community outreach)

Catch-up programs to address backsliding in several health indicators, e.g., routine childhood vaccination

Increasing access to rapid self-tests

<sup>4</sup> This included countries such as Bahrain, Egypt, Israel, Kuwait, Oman, Qatar, Saudi Arabia, Turkey and the UAE.

<sup>5</sup> This included countries such as Algeria, Jordan, Morocco, Lebanon, Tunisia, and the West Bank and Gaza.

<sup>6</sup> This included countries such as Iran, Iraq, Libya, Mauritania, Sudan, Syria and Yemen



PHASE 4: **Pain Points****INDIVIDUAL****Spillover of dampened vaccine acceptance**

Decrease in vaccine acceptance following COVID-19 could dampen demand for routine immunisation and other health services due to mistrust and/or misinformation.

**Risk compensation**

As vaccination coverage improves and lockdown measures are lifted, citizens may overcompensate for lower perceived risk with behaviours that could be risky to their health (e.g., not wearing a mask at large indoor gatherings, not washing or sanitising hands).

**SOCIAL/  
COMMUNITY****Settling into new norms**

Uncertainty around what the prevailing public health social norms should be, in absence of government mandates (e.g., attendance at social gatherings when unwell).

**New training for health and community members**

The necessity to rapidly develop and novel training programs for healthcare professionals and community members. This includes understanding new safety protocols and handling unique patient care challenges after the pandemic.

**SYSTEMS LEVEL****Returning to non-pandemic health services**

Backslide in routine immunisation and other healthcare services (e.g., routine check-ups) due to diverted health systems capacity during the pandemic.

**Health worker burnout**

High rates of burnout and mental health challenges amongst healthcare workers.

**Ongoing reliable and adequate supply of vaccines**

Ensuring a consistent and sufficient supply of vaccines to meet the demands of the population. This includes challenges related to procurement, distribution, storage, and administration, as well as addressing potential supply chain disruptions and equitable access across different regions and communities.

PHASE 4: **Potential Solutions****INDIVIDUAL****Ongoing communications for PHSM, vaccine uptake and diagnostic testing**

- Continued communications for adherence to public health and safety measures for individual benefit.
- Benefit-framing messages to encourage uptake of routine immunisation / other health services.

**SOCIAL/  
COMMUNITY****Guidance on new norms**

- Partnering with local cultural and religious institutions (e.g., mosques, community councils) or employers to reinforce guidance from health officials and help set local public health norms

**Peer dialogue**

- Local, community-based dialogue to promote uptake of routine immunisation, diagnostic testing and other health services/adherence to public health and safety measures.

**CASE STUDY****SYSTEMS LEVEL****Healthcare workers support**

- Recovery support and mental health services to health workers

**Services bundling and integration**

- Evidence-based, coordinated integration of COVID-19 vaccination systems with routine immunisation systems and other healthcare services.
- Bundling of vaccination services with other social protection services (e.g., food, cash transfers).

**CASE STUDY****New approaches to health outreach**

- Integrated teams, including local skilled community engagement workers and community dialogue.
- Relatable messengers, e.g. female staff to engage with female patients.

**CASE STUDY**

# IRAQ COVID-19 integration and bundling with routine immunisation

LEVEL: Social/Community



Systems



SBC SOLUTIONS:

Peer dialogue

Service bundling

Relatable messengers

## Target audience



Underserved and vulnerable populations, especially those living in remote locations and informal settlements.

## Overview



The 3iS programme (Intensifying Integrated Immunisation) was launched in February 2022 and continued until the end of the year. (A further campaign was delivered for one quarter in 2023, starting in March. It aimed to increase uptake of both COVID-19 vaccination and routine immunisation (RI) by addressing access- and convenience-related barriers, and building trust through community outreach and engagement.

The initiative involved a dedicated outreach team for every priority community across 1,321 primary health care centres (PHCs) in Iraq. The outreach strategies include mobile clinic or pop-up vaccination points linked to PHCs, as well as school visits, shopping centres and other local gathering sites, as well as some house-to-house visits. Each outreach team included vaccinators as well as community mobilisers whose role was to build trust in the vaccination services. Often on foot, and equipped with training in communication about vaccination as well as culturally-specific videos and flip charts, community mobilisers worked across their communities over a one year period

## Social and Behaviour Change (SBC) solutions



- **Peer dialogue:** Each vaccination team included a 'community mobiliser' who was a person familiar with the local area and who had trusted relationships with community members. These mobilisers listened to the concerns of local people, provided accurate information about the vaccine, and helped to improve vaccine acceptance through an interpersonal approach that was responsive to individual concerns and needs.
- **Service bundling and integration:** The 3iS programme aimed to reduce access- and convenience-related barriers by outreach offering both routine immunisations and COVID-19 vaccinations together. This involved deploying mobile vaccination teams to hard-to-reach areas and setting up pop-up vaccination centres in convenient locations like marketplaces, community centres, and places of worship.
- **New approaches to health outreach:** Notably, each outreach team included at least one female vaccinator, to help address the needs and concerns related to vaccination specific to women



## RESULTS



The programme increased routine vaccination dramatically nationwide, and also saw a modest increase in COVID-19 vaccination:

- By March 2022, the programme had administered 4.4million vaccinations in total. Coverage rates for Penta3 and MMR1 vaccines were 17% and 27% higher respectively, reaching 98% and 99% coverage, compared to March 2021.
- WHO-UNICEF coverage estimates for 2022 indicate that the number of zero dose children decreased from over 150,000 to less than 12,000 in Iraq.
- The program accounted for approximately 20% of all COVID-19 doses administered nationally and 20-40% of routine immunisation doses.
- The data demonstrated a significant increase in vaccination coverage, especially in hard-to-reach populations such as those in conflict-affected areas, refugees, and internally displaced persons.
- Qualitative data from community feedback and interviews with healthcare providers and community mobilisers, revealed positive changes in community attitudes towards the vaccine.
- Community members showed increased trust and acceptance of the vaccine.

## LESSONS LEARNED



- Bottom-up planning, facilitated through detailed data analysis, helps to identify and target the most vulnerable populations and enables the teams to reach the previously unreached.
- Outreach plus facility-based services, with SBC value-add, helps to reach previously underserved populations, and can identify new entry points and service adaptations, and builds public trust.
- Gender-sensitive adjustments – such as female vaccinators and community mobilisers who are known and trusted by the communities they serve.
- Integration of services is viable where additions are made to existing services that are already working well and are trusted. Strategic partnerships including but beyond health are also a key success factor, eg. faith-based, youth and women's organisations.

# Social and Behavioural Data

Social and behavioural data collection and monitoring is applicable across all phases of the response, as it provides vital insights into public sentiment, behaviour patterns, and the efficacy of health measures. These insights enable more targeted, and therefore effective strategies to be devised and adjusted throughout each stage of the response. This section identifies some of the key pain points related to the use of social and behavioural data, and also makes suggestions regarding data collection, analysis and use during the pandemic

## SOCIAL AND BEHAVIOURAL DATA: **Pain Points**

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### **Understanding of public sentiment**

Knowledge gaps in current and evolving public sentiment and behaviours, impacting public health strategies.

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### **Identifying misconceptions**

Limited knowledge of prevailing public misconceptions or role of misinformation, hindering the effectiveness of public health communication.

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### **Addressing diverse needs**

One-size-fits-all approach by public health bodies and practitioners, which may not adequately address the diverse needs and attitudes of different population segments in public health interventions.

## SOCIAL AND BEHAVIOURAL DATA: **Potential Solutions**

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### **Qualitative and Quantitative research**

Based on behavioural theories, behavioural research typically includes knowledge, attitudes and behaviours gathered using face to face methods, phone, CATI (computer-assisted telephone interviewing), or mobile web channels, either one-time or a time series.

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### **Segmentation**

Triangulation of multiple data sources and behavioural analysis by segmenting different psychographic, attitudinal, and/or behavioural subgroups to better target and tailor solutions.

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### **Persona Analysis**

Based on actual data, hypothetical characters, or “personas,” that represent different groups of people and behaviours are developed to help to adjust interventions to allow for more relevant and effective interventions.

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#### **CASE STUDY**

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### **Social listening**

Real time monitoring and analysis of public conversations, particularly on social media, to gain insights into community sentiments, trends, and needs, to inform behaviour change strategies; eg. Talkwalker social listening platform

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#### **CASE STUDY**

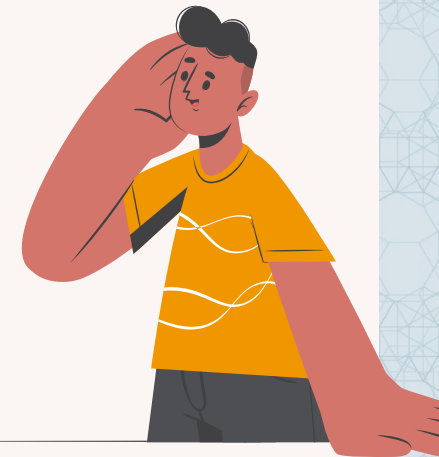
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### **Sentiment analysis**

Application of natural language processing techniques to identify, extract, and categorise sentiment from text data, often used in social listening to understand public attitudes and perceptions.

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#### **CASE STUDY**



# JORDAN Phone survey for missed appointments

LEVEL: Social and Behavioural Data

SBC SOLUTION: Research surveys

## Target audience

500 Jordanian individuals, randomly selected, who had recently missed a vaccination appointment.

## Overview

To better address barriers to vaccination, a phone survey was conducted in Jordan under the auspices of the Government of Jordan. The purpose of this survey was to understand the reasons behind missed vaccination appointments.

## Social and Behaviour Change (SBC) solutions

- **Phone survey:** Gathering feedback from the public through a phone survey allowed the Jordanian government to quickly and efficiently identify the factors contributing to missed appointments and the level of acceptance in COVID-19 vaccines among the target population.

## RESULTS

The survey found that the main reasons for missed appointments were related to infection from COVID-19 itself or other illness, as well as access challenges such as lack of transportation. Fear of adverse events following immunisation (AEFI) and low vaccine acceptance were also factors influencing the likelihood of vaccination, but not as significant as previously thought. The survey found that vaccine acceptance was significantly related to higher educational level and occupation, with higher levels of acceptance among health-sector employees.

Overall, 60% of those who had recently missed an appointment stated that they would get vaccinated if they had a second chance, compared to 13.9% who did not want to get vaccinated and 13.7% who were unsure. The results highlighted the need for a way to reschedule missed appointments, as well as giving a sense of the higher than expected rate of vaccine acceptance among the general population, and the need to tailor solutions accordingly.

## LESSONS LEARNED

Timely data collection changed survey respondents' point of view on vaccine hesitancy. In fact, the majority were willing to be vaccinated, but were held back by factors that the system was able to address.

# SUDAN

## Social listening for gender equity

LEVEL: Social and Behavioural Data

SBC SOLUTIONS: Social listening

Sentiment analysis

### Target audience

Women and girls in Sudan, as field research and social listening revealed that women and girls faced a unique set of obstacles hindering their COVID-19 vaccination uptake.

### Overview

The initiative, led by UNICEF in partnership with the Ministry of Health, sought to address gender disparity in COVID-19 vaccination uptake in Sudan. Social listening was instrumental in capturing public response, identifying gender-based differences, and allowing immediate adjustments to communication strategies. Using the Talkwalker application, keywords and topics related to COVID-19 were monitored, creating a valuable database for strategizing vaccine promotion efforts

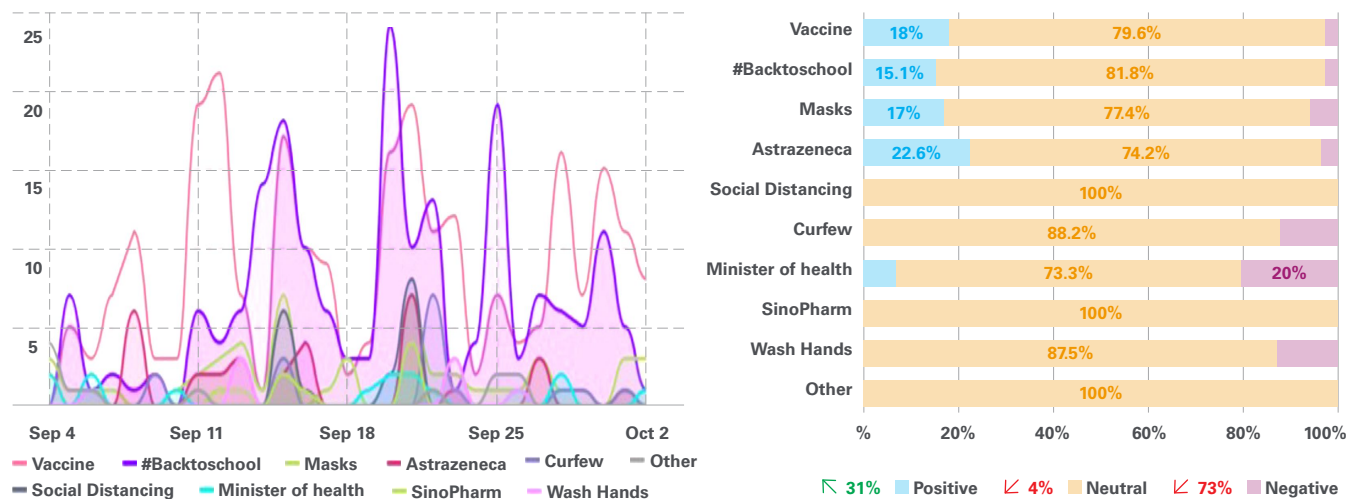


### Social and Behaviour Change (SBC) solutions



- Social listening:** Talkwalker allowed the Ministry of Health and UNICEF to monitor dialogue on social media platforms in relation to key concepts (such as vaccines, lockdown, Ministry of Health, and social distancing). It mapped out how frequently these terms were being discussed, on which channels, and in what type of context.
- Sentiment analysis:** Talkwalker also used natural language processing to categorise the sentiment associated with key concepts being discussed in social media. For example, in the screenshot captured below, there was nearly 22% negative sentiment and 78% neutral sentiment in contexts where the term “curfew” appeared.

Extract from Talkwalker Dashboard exploring sentiment, by topics (snapshot from 2021)





To leverage the data captured from Talkwaker, UNICEF then developed gender-oriented messages to further address women's vaccination concerns. These messages were inspired by challenges surfacing from the social listening and were backed by testimonies and advice from healthcare professionals, aiming to address fears and barriers hindering women's vaccine uptake. These efforts were complemented by nationwide community engagement activities such as community dialogue by community leaders and home visits by trained health promoters – who were mostly female – to reach those left out of the social media campaigns and to reinforce messages for those who may have limited internet access.

## RESULTS



The COVID-19 response yielded significant results in Sudan. The gender-oriented social media and in-person campaigns were associated with a 9% increase in the national vaccination rate among women (from 31% before the campaigns, to 40% during the campaigns). Although it is not possible to solely attribute this increase to the campaigns, social listening played a pivotal role in this broader response: not only providing a basis for gender-responsive messaging but also creating a dedicated space where women's concerns could be freely voiced and addressed. This approach was instrumental in enhancing female engagement on social media, a key conduit for distributing vaccination-related information. Moreover, data from the campaign period revealed a 144% increase in women's engagement. Notably, female engagement, which had lagged, rose sharply following the introduction of gender-responsive messaging. This rise indicates the potential of tailored communication strategies in bridging gender disparities in health initiatives

## LESSONS LEARNED



Social listening and sentiment analysis can be powerful, responsive, and live-time data collection tools to identify the barriers and status of any public health problem. They can not only inform the design of interventions but also serve as powerful feedback mechanisms to monitor and assess the impact of interventions once deployed.

# MULTIPLE COUNTRIES

## Time series survey on behavioural data

LEVEL:

Social and Behavioural Data

SBC SOLUTIONS:

Research survey

Segmentation

### Target audience



Adults aged 18 and over across 23 countries in MENA.

### Overview

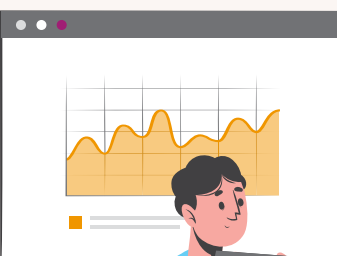


Between June 2021 and June 2022, UNICEF conducted time-series surveys across all 23 countries of the WHO Eastern Mediterranean Region and UNICEF MENARO. The cross sectional surveys explored knowledge, attitudes and practices (KAP) related to risk perceptions, COVID-19 vaccine uptake, and related preventive practices among adults aged 18 years and older.

### Social and Behaviour Change (SBC) solutions



- **Cross-sectional survey:** Using a randomised sample, the data was collected in three rounds with computer-assisted telephone interviews (CATI) and Mobile Web surveys, which allowed for comparison among countries over time.
- **Segmentation:** Based on the data, personas were developed representing the status or intention of the respondents to be vaccinated – for example, identifying characteristics of those who were already vaccinated, willing to be vaccinated, unsure, or not willing to be vaccinated. Different interventions were then recommended based on these personas



## RESULTS



The study made recommendations for interventions that could further improve COVID-19 vaccination uptake in the region, including:

- Increasing engagement by leadership in healthcare facilities with staff on vaccination benefits and the importance of vaccinations for healthcare workers (HCWs) and patients
- Conducting education 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., free lunches, 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 emphasise the benefits of vaccination and the disadvantages of not getting the COVID-19 vaccine(s)
- Partnering with community service organisations (CSOs) and other agencies to support educational outreach and vaccine registration.
- Partnering with community service organisations (CSOs) and other agencies to support educational outreach and vaccine registration.

## LESSONS LEARNED

The findings of the research reframed the thinking about vaccine ‘hesitancy’, moving instead to a continuum of vaccine “acceptance”. The data identified specific personas, enabling the design of multiple tailored responses to address vaccine acceptance. This research effort shows the value of tracking behavioural data over time, to monitor ongoing changes and to inform public health response and demonstrated the value of a region-wide approach to data collection, especially when triangulated with local data.

# Economic and Social Support <sup>7</sup>

This section explores the far-reaching implications of a public health crisis, highlighting how such events ripple through all facets of societal wellbeing, from poverty to unemployment to gender equity to education. The repercussions of a health crisis extend beyond physical health, often creating profound social, economic, and psychological effects and exacerbating pre-existing inequalities. These broader impacts are observable across all phases of the response, emphasising the importance of comprehensive strategies that address not just the immediate health crisis but also its wider and enduring societal consequences.

## ECONOMIC AND SOCIAL SUPPORT: Pain Points

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### **Economic instability**

Many individuals faced unemployment and financial insecurity as businesses started to close or reduce operations, exacerbating uncertainty.

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### **Education disruption**

In many countries, schools closed during the pandemic, disrupting education leading to widespread learning loss, disproportionately affecting children from lower-income families, who also had less access to online learning resources.

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### **Financial insecurity**

Many people in the region depend on the informal economy for their livelihood, which was severely affected by lockdown measures, leading to increased financial insecurity.

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### **Food insecurity**

With the breakdown of supply chains and the loss of income, more families faced food insecurity.

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### **Negative impact on women and girls**

COVID-19 exacerbated gender disparities in the region, with increased risks of gender-based violence, interrupted access to reproductive health services, and increased burden of unpaid care and domestic work.

<sup>7</sup> For a more comprehensive view of social protection measures during COVID-19 in MENA, please refer to: <https://www.unicef.org/mena/reports/social-protection-responses-covid-19-mena-design-implementation-and-child-sensitivity>

## ECONOMIC AND SOCIAL SUPPORT: **Potential Solutions**

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### **Digital learning programs**

E-learning materials and internet data packages  
eg. [The Learning Passport](#).

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#### **CASE STUDY**

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### **Social media campaigns**

Tailored campaigns targeting key populations, such as parents, and other primary carers, to spread positive behaviours and create a sense of community.

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#### **CASE STUDY**

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### **Cash transfers and social protection**

[Conditional or unconditional cash transfers](#) to support those vulnerable or economically disadvantaged, sometimes bundled or integrated with other services.

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#### **CASE STUDY**

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### **Food parcels or vouchers**

Food, or food vouchers, to support families who faced food insecurity.

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### **Gender protection programmes**

Increased provision of hotlines, gender-based violence services and social protection programmes to ensure the well-being of girls and women.

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### **Mental health support**

Expansion of hotlines and mental health services, especially for vulnerable groups (e.g., children, women) and critical response staff (e.g., frontline health workers).



# MULTIPLE COUNTRIES Digital education delivery

LEVEL:

Economic and social support

SBC SOLUTION:

Digital learning programmes

Social proof

## Target audience



Children and youth across MENA, with limited or no access to education

## Overview



The Learning Passport is designed to close the learning poverty gap, through an online mobile tech platform enabling high quality and flexible learning. Specifically, it aims to mitigate learning loss and ensure continuity of education for children and youth during periods of disruption. Throughout the COVID-19 pandemic, it was rapidly scaled across the globe as a consequence of measures such as lockdowns and social distancing. Within MENA, access to the Learning Passport was given to Sudanese refugees in Egypt by organisations such as the UNHCR.

The platform was created through a partnership between UNICEF, Microsoft, and the University of Cambridge. Depending on the country and context, it offers localised and tailored content for each child. Notably, the Learning Passport also supports the social and emotional learning of

children and youth by offering courses on topics such as resilience, coping skills, and well-being.

Although the platform was primarily aimed at children, it also contained resources that parents, teachers and other caregivers could access to help them through the pandemic.

### Example of Learning Passport dashboard

The screenshot shows the Learning Passport dashboard interface. At the top, there is a search bar and navigation tabs for 'My Courses' and 'Course Library'. Below this, there are several filter buttons for different course categories: 'All courses', '01. Demo Courses', 'British Council - LearnEnglish Kids', 'British Council TeachingEnglish - Secondary', 'CK-12 Physical Science Grade 6-8 (EN)', 'Khan Academy (EN)', and 'UNICEF Uganda English'. A specific filter for 'UNICEF Uganda Science' is selected. The main content area displays a grid of course cards, each with a thumbnail image, a title, and a progress indicator. The cards shown are:

- 01. Area builder (60% Complete)
- 02. Place value (25% Complete)
- 04. Grammar and vocabulary (11% Complete)
- 02. Intermediate B1 (6% Complete)
- 02. Matter and Change (1% Complete)
- Grade 4.02. Addition, subtraction, and estimation (6% Complete)
- 05. Primary four - Shopping (0% Complete)
- 01. Primary Four - Plant Life (0% Complete)



## Social and Behaviour Change (SBC) solutions



The Learning Passport was not only delivered digitally to improve access but also incorporated a range of SBC techniques in its design, including:

- **Social proof:** The platform encourages positive behaviours and practices among learners, teachers, and parents. The platform showcases testimonials and stories from children who have benefited from the Learning Passport, creating a sense of belonging.
- **Personalised feedback:** Recognition is provided to users who complete courses or modules, creating a sense of achievement and motivation.
- **Reminders:** Notifications help users stay on track with their learning goals and deadlines.

## RESULTS



Within MENA, data is not available in relation to the impact of the Learning Passport. More broadly, however, it has achieved remarkable results and outcomes in reaching and supporting millions of learners, teachers, and parents around the world during the COVID-19 pandemic. Some highlights:

- The Learning Passport has reached more than two million users across more than 20 countries globally since its launch in 2020.
- The Learning Passport has enabled over 90 percent of users to continue their education during school closures caused by the pandemic.
- The Learning Passport has improved the learning outcomes and well-being of users by increasing their knowledge, skills, confidence, and motivation.
- The Learning Passport has also more broadly improved capacity building of teachers and educators by offering training courses, guidance, and tools.

## LESSONS LEARNED



Digital or alternative delivery solutions to traditional services can only work where the infrastructure and pre-training is available, so that in moments of crises they can be rapidly scaled and used widely. The Learning Passport is a good example of children with online access being able to continue accessing education through online, technological tools during disruption.

## OMAN

## Campaign for positive parenting

LEVEL: Economic and social support

SBC SOLUTION: Tailored social media campaigns

## Target audience

Parents and caregivers of children in Oman.

## Overview

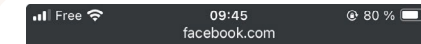
Parents4Parents was a social media campaign launched by UNICEF Oman in May 2020, at the height of the lockdown in Oman due to COVID-19. The initiative aimed to shed light on positive parenting practices with a focus on topics such as motivating children to continue studying online, managing stress and anxiety, ensuring safety and hygiene, and supporting children with disabilities. It involved parents from diverse backgrounds sharing short video clips directed towards other parents providing encouragement and tips during the COVID-19 response and recovery phases.

The campaign used social media platforms such as Facebook, Twitter, Instagram, and LinkedIn to reach a wide audience of parents and caregivers in Oman. The campaign was part of UNICEF's global initiative to support parents and families during the COVID-19 pandemic, which also included providing online resources, guidance, and tools on positive parenting.

## Social and Behaviour Change (SBC) solutions

The campaign incorporated shared video clips from parents reflecting on their experiences, spread across various social media platforms. These clips were then shared using a designated hashtag to encourage conversation and community building. It further leveraged principles such as:

- **Social proof:** As part of the social media campaign, parents and caregivers were invited to join the conversation by posting their own video clips using the hashtag #Parents4Parents and #ForOmansChildren. This engagement was an application of 'social proof', where people are influenced by the actions of others. The campaign aimed to create a virtual community of parents and caregivers, supporting each other, and exchanging advice to cope with the challenges of parenting during the COVID-19 situation.
- **Edutainment:** The initiative followed an 'edutainment' approach – the purposeful design and implementation of a media message to both entertain and educate. This approach was aimed at increasing audience knowledge about an issue, fostering favourable attitudes, shifting social norms, and ultimately, changing behaviour



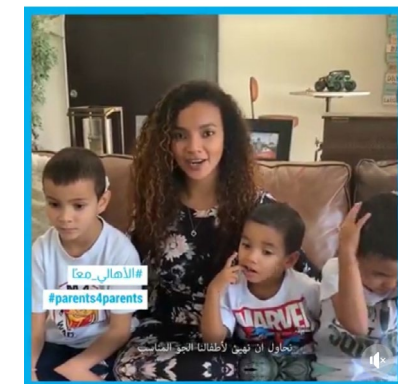
UNICEF Oman · Follow  
28 May 2020 ·

Home schooling. Work. Staying Active. How do parents balance it all while we #StayHome? Nasra Grimley shares her experience of finding the perfect routine to balance family life while working and staying safe at home. How do you manage? Share your story with us!  
[#parents4parents](#)

يونيسف عمان #يونيسف لكل\_طفل\_الحياة  
صحتي\_في\_البيت #صحي\_في\_البيت\_عمان  
اللحظات\_الأولى\_مهمة #خليك\_باليبيت  
\_خليك\_باليبيت\_عمان #خليك\_بأمان #خليك  
بأمان\_عمان #عمان\_تواجه\_كورونا  
فعاليات\_الحجر\_المنزلي #التباعد\_الاجتماعي  
كورونا\_عمان #عمان #كوفيد19 #فيروس\_كورونا  
عمان

#UNICEFOman #UNICEF #HealthyAtHome  
#FunAtHome #EarlyMomentsMatter  
#EarlyMomentsMatterOman #StayHome  
#StayHomeOman #StaySafe #StaySafeOman  
#COVID19 #Muscat #Oman #muscatmums

UNICEF  
UNICEF MENA - [يونيسف الشرق الأوسط و شمال إفريقيا](#)



9 likes 48 views



## RESULTS



The Parents4Parents campaign was successful in reaching a large number of parents and caregivers in Oman through social media platforms. According to UNICEF Oman, it generated more than 1.5 million impressions, 500,000 views, and 10,000 engagements on Facebook, Twitter, Instagram, and LinkedIn. The campaign also received positive feedback from the participants and the audience, who appreciated the practical tips and the peer-to-peer support provided by the campaign. The campaign helped raise awareness and knowledge on positive parenting practices among parents and caregivers in Oman, particularly in a time where the COVID-19 pandemic may have distracted.

## LESSONS LEARNED



Emergencies can also be opportunities to introduce new ideas. UNICEF identified that familiarity of positive parenting as a concept is not widespread in Oman, so the concept itself had to be elaborated as well as the strategies within the approach

# MULTIPLE COUNTRIES Social Protection Measures to Mitigating the Impact of COVID-19

LEVEL: Economic and social support

SBC SOLUTION: Social protection

## Target audience



Vulnerable groups, especially children and women in the MENA region, severely impacted by the pandemic fallout, including school closures, disruption of essential services, and increased risk of domestic abuse against children and women.

## Overview



The COVID-19 pandemic unleashed unprecedented socio-economic challenges worldwide, disproportionately affecting vulnerable populations. Children in the MENA region were among the severely impacted, with school closures, disruption of essential services and increased risk of domestic abuse. To mitigate these effects, social protection measures were implemented by governments and humanitarian agencies in the region. This case study assesses the design and implementation of social assistance responses undertaken by governments in the MENA region to mitigate these effects on children. This included the nine countries with humanitarian situations (Iran, Iraq, Jordan, Libya, Lebanon, State of Palestine (SoP), Sudan, Syria, and Yemen).

In 2020, estimations indicated that over 12 million children could have fallen into multidimensional poverty due to the pandemic. School closures affected around 110 million children's education and approximately 51,000 children under five were at risk of death due to disrupted health and nutrition services. [Reports](#) suggested that domestic abuse against children and women surged during the pandemic. Social protection was fundamental to mitigating many of these deeper effects and protecting families. It promoted children's well-being and reduced the negative impacts of the economic shocks on them, taking into account their needs and vulnerabilities.

## Social and Behaviour Change (SBC) solutions



Governments in the MENA region implemented over 158 social assistance interventions, of which 77 are subsidies and cash transfers, indicating a focus on immediate relief. The benefit values varied considerably, with most interventions offering one-off transfers for an average of two months. The coverage and vertical expansions of the interventions took less time than the global average for implementation. Rapid responses were seen in countries like Morocco and Jordan. About 64 of the 158 social assistance interventions targeted children, especially those in socio-economic vulnerability. Few explicitly addressed children with disabilities, newborns, and forcibly displaced children. There was evidence that some of the interventions supported access to nutrition and education. However, there was a need for programs to ensure regular access to nutritious food and incentivize school attendance, particularly for girls. SBC focused on enhancing acceptance and quality of social protection services



## RESULTS



Social protection interventions during the pandemic reportedly covered populations in the MENA region from >2% in Egypt to over 70% in Morocco. The services supported families child safety and well-being, reinforcing social protection services as an important core element of any response to the deep impact of public health emergencies and humanitarian situations.

## LESSONS LEARNED



During the pandemic social protection was expanded in various ways by all countries in the region, and to some extent demonstrated the potential beyond emergencies per se, for mitigating the impact of stressors on families. While often utilised to mitigate poverty and economic stress, the need to address a much wide range of challenges was revealed during the pandemic. In this regard, there is scope for further alignment of social protection (and cash in particular) with positive behavioural outcomes, without necessarily imposing strict conditions.

# Conclusion

## Learning from the past

This playbook is intended for practitioners and policy makers, and seeks to highlight the role of social and behaviour change as an adjunct to existing tools that support preparedness for future public health emergencies - and vaccine preventable emergencies in particular. To that end, institutionalising meaningful engagement at the interface of health, development, and humanitarian action is an ongoing priority. Past efforts against influenza<sup>8</sup>, EVD,<sup>9</sup> and the COVID-19 pandemic<sup>10</sup> showed that community engagement positively impacted the uptake of public health and social measures as well as the prevention of disease transmission. Engaging communities in early warning systems enhanced system efficiency, especially where human and financial resources were limited.<sup>11</sup> Overall, community engagement contributes to health systems strengthening and building community resilience.<sup>12</sup>

UNICEF is a leading organisation with one of the largest institutional workforces in SBC and community engagement-related functions in the region. With unprecedented levels of funding for SBC, the COVID-19 pandemic enabled expansive implementation and rapid accumulation of experience, which has since been the subject of a great deal of reflection and evaluation. The reflections presented in this playbook are largely based on that documentation and the insights drawn from the network of government partners and practitioners involved in the response.

While much of the COVID-19 pandemic experience was common across the MENA region, some marked distinctions arose among countries. Conflict,

instability, limited resources and fluctuations in public trust created complex barriers to an efficient response, particularly in low income countries. The COVID-19 pandemic left deep and lasting impacts in MENA, exacerbating inequalities, causing backslides in health-seeking behaviour and public health outcomes from which the region is still recovering. However, it has also catalysed an unprecedented global effort to reshape our approach to public health crises to be more holistic and community-centric.

Formal evaluations and the experience of UNICEF offices and key partners in MENA region reflected in this playbook suggest that the COVID-19 pandemic shifted the perspective of many governments and partners on the utility of SBC in public health emergencies. Let us consider just three of these shifts:

Firstly, SBC has been typically applied to demand side challenges prior to the pandemic, whereas its potential for improving service delivery and systems performance emerged more clearly during the pandemic. As a result, authorities and policy makers have a more sophisticated understanding of SBC, and community engagement in particular, as a more complex and necessary process, rather than an afterthought. As such, the legitimacy of SBC as a key element of the architecture of public health emergency responses and coordination has been reinforced.

**“It is well understood that even the best solutions in the world don’t work if the public rejects them.”**

Secondly, the pandemic demonstrated the wide range of factors that affect decisions, including, but well beyond information alone – and that perceptions, motivations and public sentiment are not necessarily predictable and can change quickly. With communities facing unprecedented uncertainty and misinformation, public trust in the messenger, as well as in the solutions, emerged as a powerful factor in the success of the response.<sup>13</sup>

<sup>8</sup> WHO (2009). *Pandemic influenza preparedness and response: a WHO guidance document*. World Health Organization.

<sup>9</sup> WHO (2017). *WHO community engagement framework for quality, people-centred and resilient health services*. Geneva: World Health Organization; (WHO/HIS/SDS/2017.15). Licence: CC BY-NC-SA 3.0 IGO.

<sup>10</sup> Burgess, R. A., Osborne, R. H., Yongabi, K. A., Greenhalgh, T., Gurdasani, D., Kang, G., ... & McKee, M. (2021). The COVID-19 vaccines rush: participatory community engagement matters more than ever. *The Lancet*, 397(10268), 8-10.

<sup>11</sup> Sufri, S., Dwirahmadi, F., Phung, D., & Rutherford, S. (2020). A systematic review of community engagement (CE) in disaster early warning systems (EWSs). *Progress in Disaster Science*, 5, 100058.

<sup>12</sup> Frimpong, S. O., & Paintsil, E. (2023). Community engagement in Ebola outbreaks in sub-Saharan Africa and implications for COVID-19 control: A scoping review. *International Journal of Infectious Diseases*, 126, 182-192.

<sup>13</sup> Szreter, S., & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International journal of epidemiology*, 33(4), 650-667.

**“Trust is a shared resource that enables networks of people to do collectively what individual actors cannot”.<sup>14</sup>**

A recent study of 177 countries reported that higher levels of trust in government and also interpersonal trust had a large and statistically significant association with fewer COVID-19 infections.<sup>15</sup> Other studies have previously shown that trust and compliance with public health guidance are also correlated.<sup>16, 17, 18, 19</sup> Furthermore, the authors hypothesised that if all countries improved interpersonal trust to the same level as Denmark (the 75th percentile of measured countries), 40-3% fewer global infections would have occurred. To this end, this study also recommends greater investment in risk communication and community engagement strategies. Furthermore the authors suggest that to the extent that such measures modify key risks, a reduction in mortality as well as prevention of infections is possible.

Thirdly, the value that behavioural data brings before (including as part of early warning systems), during and after public health emergencies is much clearer. All countries of the region collected behavioural data sets and were able to triangulate these data with epidemiological data during the pandemic to inform the response. As a result, the role of information and misinformation is better understood in the context of emotional and psychological factors that also affect decision-making. Equally, the strong influence of situational and social factors is also more recognised. In

addition, countries increasingly utilised behavioural theory to guide monitoring and evaluation efforts, as well as overall intervention design.

## What to expect in the future

The complexity, duration and intensity of future public health crises is unlikely to ease in the near future; more likely they will be exacerbated by climate change, conflict and economic and political instability, linked to several on-going large-scale emergencies (e. earthquakes, floods, drought) across the region. Recurring disease outbreaks, natural disasters and humanitarian crises have high health, economic and social costs and add pressure to fragile health systems. As an established component of public health responses, SBC - and community engagement in particular – are powerful tools to address disruptions to health care, to address misinformation and to strengthen positive social norms, thus making a critical contribution to building trust, resilience and social cohesion.<sup>20</sup>

Entrenched gender inequities across the region persist, although some encouraging signs of attention to the status of women exist in terms of revised laws and policies. Nevertheless, there is still a need for ongoing support to translate these efforts into practice and make a deep impact on social norms – particularly to address important barriers to women’s access to information, services and other support.

Capacities and resources across MENA are unevenly spread, and challenges vary, requiring localised, differentiated approaches to the optimal application and integration of SBC in national programmes and policy – while simultaneously considering the interconnectedness of communities and indeed nations. The experience of the COVID-19 pandemic has sensitised governments in the region to the flow-on effects of policies and the need to adapt to their local contexts, rather than applying global guidance generically. For example, the concept of ‘isolating’ at home is very different

<sup>14</sup> Bollyky, T. J., Hulland, E. N., Barber, R. M., Collins, J. K., Kiernan, S., Moses, M., ... & Dieleman, J. L. (2022). Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021. *The Lancet*, 399(10334), 1489-1512. [https://doi.org/10.1016/S0140-6736\(22\)00172-6](https://doi.org/10.1016/S0140-6736(22)00172-6)

<sup>15</sup> *ibid.*

<sup>16</sup> Prati, G., Pietrantonio, L., & Zani, B. (2011). Compliance with recommendations for pandemic influenza H1N1 2009: the role of trust and personal beliefs. *Health education research*, 26(5), 761-769.

<sup>17</sup> Van der Weerd, W., Timmermans, D. R., Beaujean, D. J., Oudhoff, J., & Van Steenberg, J. E. (2011). Monitoring the level of government trust, risk perception and intention of the general public to adopt protective measures during the influenza A (H1N1) pandemic in the Netherlands. *BMC public health*, 11(1), 1-12.

<sup>18</sup> Gilles, I., Bangert, A., Clémence, A., Green, E. G., Krings, F., Staerklé, C., & Wagner-Egger, P. (2011). Trust in medical organizations predicts pandemic (H1N1) 2009 vaccination behavior and perceived efficacy of protection measures in the Swiss public. *European journal of epidemiology*, 26, 203-210.

<sup>19</sup> Bargain, O., & Aminjonov, U. (2020). Trust and compliance to public health policies in times of COVID-19. *Journal of public economics*, 192, 104316.

<sup>20</sup> See for instance, [WHO guidance](#), [Compass tools](#) or [COVID-19 Communication Network](#)

for high density living situations such as camps for IDPs, compared to a relatively affluent family in the high income countries of the region. Similarly, the 'cost' of staying at home if you feel unwell are much higher for a (non-salaried) day labourer who needs to work each day to feed a family. As such the concept of 'bundling' services with cash and other social support is likely to be more effective and efficient on both fronts than offering either alone.

There is some evidence to suggest that future responses will need to rely more heavily on home-based and community-led solutions.<sup>21</sup> A more comprehensive COVID-19 response would put greater emphasis on limiting contact with treatment facilities and increasing outreach and community capacity to respond. For example, increasing access to home-based self-testing, virtual platforms for case management, community- and home-based prevention and care services such as local management and distribution of test kits, vaccines, and multi-month dispensing of treatments. Strong preparedness of community systems would allow for greater local control and reduce reliance on imposing mandates.

The pandemic experience also demonstrated the value of the dual-track approach of fixed sites alongside outreach. In the latter phase of the pandemic, outreach proved to be a very useful approach as families sought local trusted sources of information to clarify complex concepts and misinformation. The cost of integration of services and outreach is often cited as a key barrier. Experience in the region suggested that much of the cost is associated with the outreach component; however where a number of services are integrated, the cost per family reached per service reduces considerably. Such efforts will rely on strong, institutionalised community engagement 'systems', rather than ad hoc spontaneous community activity or generic policies. Inviting a wider range of multi-sectoral partners will also help to tackle the indirect impact of public health threats and pre-existing stressors, such as gender inequity and discrimination, poverty, conflict and instability, and climate change.

<sup>21</sup> Inzaule, S. C., Ondo, P., Loembe, M. M., Tebeje, Y. K., Ouma, A. E. O., & Nkengasong, J. N. (2021). COVID-19 and indirect health implications in Africa: Impact, mitigation measures, and lessons learned for improved disease control. *PLoS Medicine*, 18(6), e1003666.; Ozili, P. (2020). COVID-19 in Africa: socio-economic impact, policy response and opportunities. *International Journal of Sociology and Social Policy*, 42(3/4), 177-200.

Strengthening and leveraging SBC tools will be valuable for all countries, and critical for low-income countries, which suffer most from shocks. In those contexts in particular, strengthening local community systems will be instrumental in building public trust and accountability in larger systems, and minimising the spread of misinformation. To this end, strengthening genuine partnership with key influencers in the region will continue to be central to community engagement. While faith remains a strong influence across the region, greater attention to segmentation and tailoring to specific sub-groups is needed – for women, young people, displaced people, those living with disabilities and other marginalised groups - as well as sharpening expertise regarding working with on- and off-line preferences and synergies. Expanding direct access to more digital and technological solutions, will be especially important for women and girls, as well as for low income, remote, rural and displaced communities.

UNICEF's Core Commitments for Children guide<sup>22</sup> the overall approach to humanitarian action, indicating the key elements that need to be in place. Localisation and implementing community engagement for behaviour and social change in collaboration with national and local actors are two of the core commitments, among others, that are highly relevant to SBC, and detailed Community Engagement Minimum Standards<sup>23</sup> are available to support consistent, harmonised and coherent implementation across sectors. In addition, a wide range of resources were developed to support SBC within the COVID-19 response specifically, which are also relevant to future public health emergencies generally.<sup>24</sup>

<sup>22</sup> Core commitments for children humanitarian action, United Nations Children's Fund (UNICEF), 2020, <https://www.unicef.org/emergencies/core-commitments-children>

<sup>23</sup> Minimum Quality Standards and Indicators for Community Engagement, United Nations Children's Fund (UNICEF), 2020, <https://www.unicef.org/mena/reports/community-engagement-standards>

<sup>24</sup> IFRC, UNICEF, WHO 2022 [Risk communication and community engagement \(RCCE\) readiness and response to the 2019 novel coronavirus \(2019-nCoV\)](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/risk-communication) (who.int)

# Glossary

## Key SBC terms used:

### Community-based dialogue

Participatory process that facilitates inclusive conversations within community groups to enhance understanding and action on a particular issue or subject.

### Commitment device

A strategic tool to help individuals bind themselves to a future course of action that aims to counteract innate human tendencies such as procrastination and limited cognitive capacity.

### Edutainment

Educational entertainment which is a method of presenting educational content in an entertaining manner to promote both learning and behaviour change.

### Implementation intentions

Plans that specify the 'when', 'where', and 'how' of a behaviour, to help individuals perform the intended behaviour. A type of commitment device (see above).

### Messenger effect

Using the credibility, relatability, or status of an individual to enhance the impact of how the message is perceived by recipients. Within MENA countries, this is often used with religious leaders (also see: religious influence).

### Misinformation

Incorrect or misleading information, spread unintentionally, leading to false beliefs or misconceptions.

### Disinformation

Deliberately false or misleading information, shared with the aim to deceive, potentially undermining trust in health institutions.

### Personalisation

Tailoring of services or messages to fit the unique needs, concerns, and contexts of individuals, aiming to enhance the relevance, engagement, and effectiveness in behaviour change initiatives.

### Present bias

The human tendency in decision making to prioritise the present over the future, often leading to worse outcomes over time.

### Reducing friction

Simplifying processes and removing barriers in order to facilitate ease of use or participation, thereby increasing the likelihood of the target behaviour.

### Religious influence

Leveraging the impact of religious leaders, beliefs, or institutions to shift individuals' attitudes and behaviours.

### Reminders

Mechanisms, such as messages or cues at timely moments, used to prompt individuals to perform a target behaviour.

### Social norms

Rules and perceptions of acceptable and expected behaviours within a group or society, which significantly influence individual attitudes and actions.

### Social proof

Psychological phenomenon where individuals mirror the actions or opinions of others, particularly others they view as similar to themselves.

## Key research and monitoring terms used:

### Feedback mechanisms

Processes or tools used to gather and analyse data at various stages of a research study or project, allowing for real-time adjustments and improvements based on the collected information.

### Segmentation

The process of categorising a population or audience into groups based on shared characteristics, such as demographics, behaviours, or attitudes, to better understand and address their specific needs or perspectives.

### Sentiment analysis

A technique that uses computer algorithms to interpret and categorise people's emotions and opinions from text data, often used to understand public attitudes and perceptions on different topics.

### Social listening

Monitoring and analysing public conversations, particularly on social media, to gain insights into community sentiments, trends, and needs, to inform behaviour change strategies.

### Persona Analysis

Development of hypothetical characters, or "personas," that represent different groups of people within a targeted demographic or behaviour set. These personas help in tailoring strategies to meet specific needs and expectations, allowing for more relevant and effective interventions.

