

Lessons Learned from the **RCCE Response to COVID-19** in the Eastern and Southern Africa Region





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Acronyms

BeSD	Behavioural and Social Drivers of Vaccination
CATI	Computer Assisted Telephone Interviewing
CO	(UNICEF) Country Office
CRA	Community Rapid Assessment
CSO	Civil Society Organisation
ESAR	Eastern and Southern Africa Region
ESARO	(UNICEF) Eastern and Southern Africa Regional Office
EVD	Ebola Virus Disease
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
IoGT	Internet of Good Things
IEC	Information, Education and Communication
IRCK	Inter-Religious Council of Kenya
IVR	Interactive Voice Relay
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interview
LTA	Long-Term Agreement
MOH	Ministry of Health
PCA	Partnership Cooperative Agreement
PHE	Public Health Emergency
PHSM	Public Health and Social Measures
PPE	Personal Protective Equipment
RCCE	Risk Communication and Community Engagement
SBC	Social and Behaviour Change
TWG	Technical Working Group
WASH	Water, Sanitation and Hygiene

Acknowledgements

This Lessons Learned from the RCCE Response to COVID-19 in the Eastern and Southern Africa Region review was developed through a consultative process that engaged a large number of stakeholders from nine countries in the Eastern and Southern Africa Region (ESAR), including Botswana, Ethiopia, Kenya, Madagascar, Mozambique, Rwanda, South Africa, South Sudan and Uganda. Stakeholders participated in online key informant interviews (KIIs) and focus group discussions (FGDs) via Microsoft Teams in March and April 2022. UNICEF wishes to acknowledge the contribution of all participants.

UNICEF ESAR's contributions to COVID-19 response in a nutshell



bolstering
demand for
COVID-19 vaccines



providing technical
support to governments
and partners rolling out of
PHSM and Back-to-School
campaigns



strengthening
social listening
capacities via
digital and social
media



generating and **promoting**
the utilization of SBC data



promoting innovative
approaches to transition
between face-to-face community
engagement and virtual, two-way
communications

1

Executive Summary

Objective

The United Nations Children’s Fund (UNICEF) conducted this Risk Communication and Community Engagement (RCCE) review to identify and document how UNICEF Country Offices (COs) in ESAR supported RCCE responses to COVID-19.¹

Spanning the period from early 2020 to mid-2022, the review builds on previous efforts to take stock of the RCCE response, including through global and regional real-time assessments, the regional compendium of lessons learned and other country-specific efforts. The review focuses on the elements of RCCE-related emergency preparedness that best positioned UNICEF COs at the onset of the COVID-19 pandemic and those that enabled countries to optimize response efforts. The resulting recommendations highlight the need to sustain and leverage these efforts to reinforce the humanitarian-development nexus and improve responses to current and future public health emergencies (PHEs).

Findings from the review, intended for internal audiences, were presented and discussed at the 21–23 June 2022 Regional Social and Behaviour Change (SBC) Network and Learning Meeting in Nairobi, Kenya. SBC leads from ESAR COs have subsequently provided feedback, all of which is incorporated herein.

Background

The first known case of COVID-19 in Africa was confirmed in Egypt on 14 February 2020² and by late May health officials across ESAR had confirmed cases, with reports of widespread community transmission despite limited testing capacity.³ Prior to the widespread availability of biomedical innovations, such as COVID-19 tests, vaccines and treatments, RCCE was key to limiting the spread of the virus. Lifesaving information on preventive measures was widely disseminated across ESAR to promote the adoption of protective behaviours in accordance with new evidence and national guidelines on Public Health and Social Measures (PHSM). With the availability of COVID-19 vaccines beginning in early 2021, RCCE strategies expanded to support vaccine demand and uptake.

1 Risk communication refers to: ‘...the real-time exchange of information, advice and opinions between experts, community leaders, or officials and the people who are at risk...Effective risk communication allows people most at risk to understand and adopt protective behaviours. It allows authorities and experts to listen to and address people’s concerns and needs so that the advice they provide is relevant, trusted and acceptable.’ See World Health Organization, *Communicating Risk in Public Health Emergencies: A WHO guideline for emergency risk communication (ERC) policy and practice*, WHO, Geneva, 2017. In addition, Community Engagement refers to ‘...working with traditional, community, civil society, government, and opinion groups and leaders; and expanding collective or group roles in addressing the issues that affect their lives. Community engagement empowers social groups and social networks, builds upon local strengths and capacities, and improves local participation, ownership, adaptation and communication...’ See United Nations Children’s Fund, *Minimum Quality Standards and Indicators in Community Engagement*, UNICEF, August 2019.

2 Africa Identifies First Case of Coronavirus Disease: Statement by the Director of Africa CDC. Retrieved from [here](#) on 9 Nov 2022.

3 Southern and Eastern Africa COVID-19 Digest, OCHA, 29 May 2020. Retrieved from [here](#) on 9 Nov 2022.

From the onset of the COVID-19 pandemic, UNICEF played a critical role in the implementation of RCCE activities across ESAR. UNICEF's contributions included: co-leading partner coordination mechanisms at the regional and country levels, including mechanisms to bolster demand for COVID-19 vaccines; providing technical support to governments and partners in the roll out of PHSM and Back-to-School campaigns; strengthening social listening capacities via digital and social media and through community feedback platforms; generating and promoting the utilization of SBC data to inform country and regional RCCE responses; and promoting innovative approaches to transition between face-to-face community engagement and virtual, two-way communications.

The onset of COVID-19 transformed how UNICEF and partners engaged with communities. Initial uncertainties, particularly regarding modes of transmission, vulnerable populations and the lack of personal protective equipment (PPE), combined with PHSM imposed by national governments, compelled UNICEF to rapidly adopt new approaches to engaging communities across all programme sectors, especially RCCE. The rapid augmentation of existing tools and platforms and development of new innovations were critical to collect SBC data, reach communities at scale, engage community members through two-way communication and provide evidence to guide programme adaptations to the new operating environment.

In January 2020, UNICEF's Eastern and Southern Africa Regional Office (ESARO) hosted a regional review and a stocktaking meeting on key lessons learned during the Ebola Virus Disease (EVD) preparedness and response. The meeting report includes operational recommendations for sustaining and expanding preparedness efforts to strengthen future responses⁴.

The recommendations include:

- Systematically collect, analyse and present community feedback to ensure concerns implicating other pillars are addressed;
- Develop a community feedback toolkit that can be adapted to different country contexts;
- Consider health workers and support staff as priority audiences in community engagement interventions for PHEs;
- Ensure social science research is incorporated into RCCE preparedness efforts to understand the unique contextual and social dynamics and inform the response; and
- Establish/strengthen a regional coordination mechanism for RCCE and strengthen cross-border collaboration and coordination to ensure harmonization of responses.

Several factors presented opportunities to develop innovative approaches to deepening community engagement in public health responses, including the rapid scale up in investment, particularly following the arrival of COVID-19 vaccines; the extended nature and magnitude of the response; and the timing of the COVID-19 pandemic, which began immediately after the regional lessons learned exercises for EVD.

As the regional response to COVID-19 continues against the backdrop of new and recurring PHEs, including EVD, cholera, monkeypox, polio and drought, the consolidation and leveraging of these advances is urgently needed to ensure countries maintain capacity to prepare for and respond to future emergencies. Building on the main lessons learned by UNICEF's SBC teams in ESAR, this report identifies recommendations to catalyse the investments made during COVID-19 to strengthen RCCE/SBC platforms, sustain innovative approaches in social and behavioural data collection and use and enhance accountability to affected communities.

⁴ RCCE for Ebola Virus Disease Preparedness and Response: Lessons Learnt and Recommendations from Burundi, Rwanda, South Sudan, Tanzania and Uganda. Retrieved from [here](#) on 9 Nov 2022.

Methodology

To frame the development of the semi-structured interviews and FGD questionnaires in accordance with the areas of focus, UNICEF conducted an initial desk review of lessons learned from previous outbreak responses and other COVID-19 response reviews.

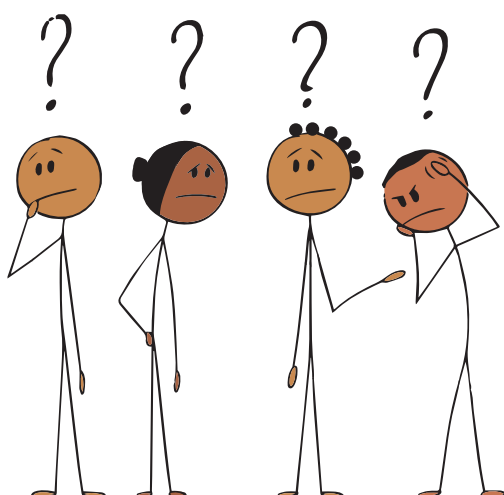
Fifty-six respondents – comprising staff from UNICEF COs, civil society organisations (CSOs) and non-governmental organisations (NGOs), as well as RCCE pillar leads from national Ministries of Health (MOHs) – in nine ESAR countries, including Botswana, Ethiopia, Kenya, Madagascar, Mozambique, Rwanda, South Africa, South Sudan and Uganda, participated in online KIIs and FGDs via Microsoft Teams in March and April 2022.

The majority of respondents comprised UNICEF CO staff focusing on SBC/RCCE during the COVID-19 response, including SBC and Communication and Emergency Specialists, as well as Deputy Representatives and country staff from programme sectors.⁵ Focal points from key implementing partners and governments in the region also contributed.

The key findings emerging from these KIIs and FGDs were presented to UNICEF SBC leads from all ESAR country offices in the region; their comments and feedback are incorporated herein.

Overview of Key Findings and Lessons Learned

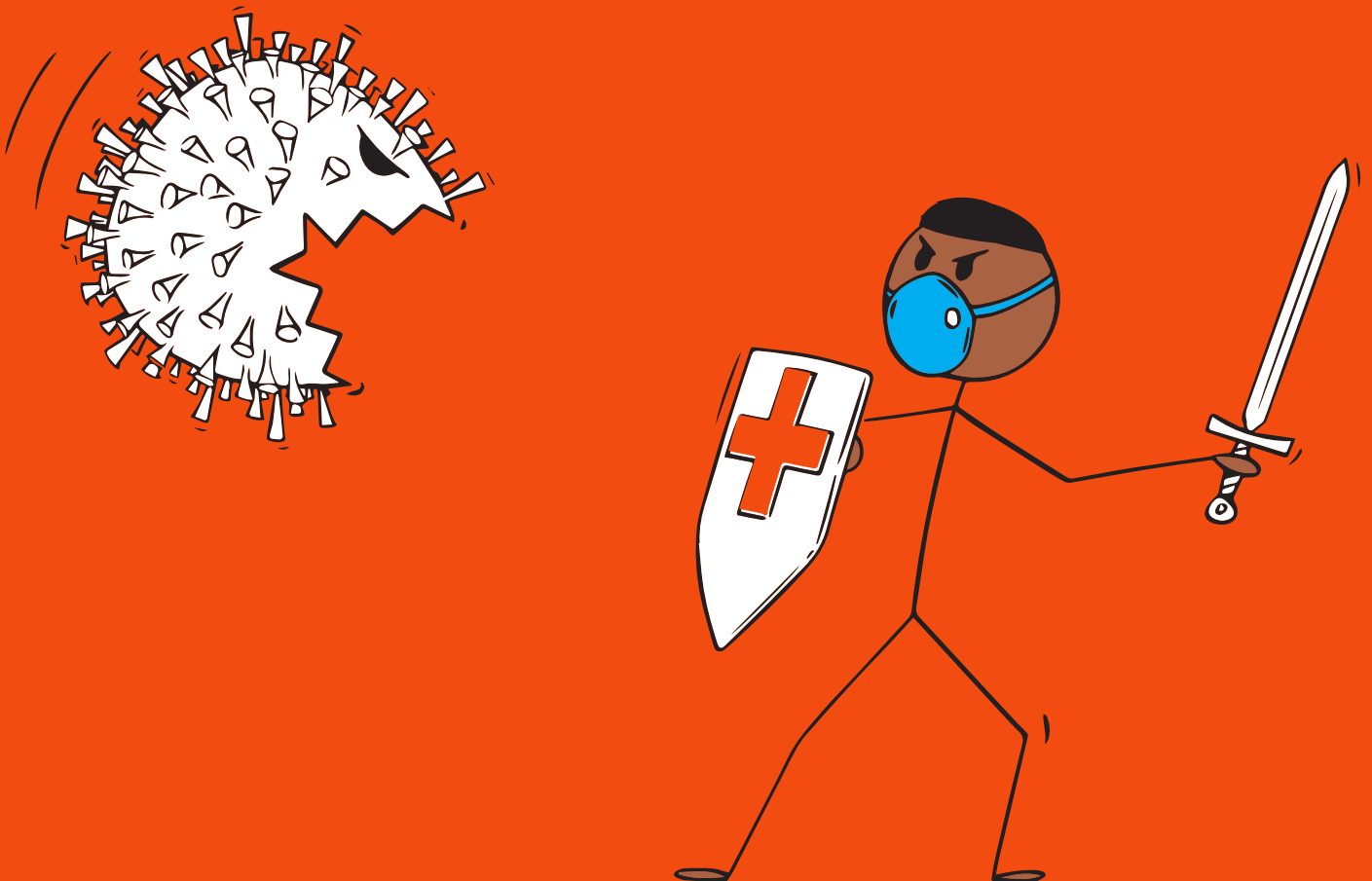
Seven key lessons learned emerged from analysing the data collected from the KIIs and FGDs, as well as the feedback received from UNICEF SBC leads at the June 2022 Network meeting. The lessons learned have been grouped into categories: 1) those that UNICEF COs and partners should consider framing preparedness for future responses and 2) those that should be scaled up during emergency responses.



⁵ See Appendix B for a list of KII and FGD respondents.

Lesson # 1

Exposure to prior outbreaks and experience in outbreak response enabled more effective RCCE preparedness and response to the COVID-19.



i) Emergency Preparedness: Capitalise and build on existing expertise, mechanisms and partnerships

UNICEF has significant expertise in RCCE preparedness and response to PHEs in the region, particularly in countries that have experienced multiple emergencies in recent years. These countries had pre-existing coordination mechanisms and operational modalities, including long-term partnerships with implementing partners and governments, enabling them to rapidly scale up during the COVID-19 RCCE response.

Lesson # 1: Exposure to prior outbreaks and experience in outbreak response enabled more effective RCCE preparedness and response to the COVID-19.

Countries with recent and recurring experience with outbreaks had RCCE coordination mechanisms and technical expertise to facilitate efficient and harmonized responses. Middle income countries that had less frequent or no experience responding to PHEs were less prepared to support RCCE responses than lower income countries prone to health outbreaks and natural hazards.

Lesson # 2: Capitalizing on institutional coordination, leadership and existing RCCE technical committees enabled greater coordination capacity, optimization of resources and harmonization of public messages, as well as a clearer division of labour among partners.

Building on existing relationships and in recognition of its RCCE expertise, UNICEF co-led the RCCE response with national MOHs, strengthening government coordination and leadership through weekly meetings of RCCE Technical Working Groups (TWGs) and the development of national communications strategies. The COVID-19 response elevated RCCE as a critical pillar in the World Health Organization (WHO) Strategic Response Plan and coordination structures at the regional and country levels, ensuring RCCE had dedicated workstreams and sub-groups.

Lesson # 3: Existing long-term partnerships with key implementing partners facilitated rapid responses at national and subnational levels.

Efficient and timely RCCE responses require partnerships to be in place prior to an emergency response, ensuring a reservoir of skills and expertise that can be quickly mobilized to bolster partners' and UNICEF's capacity. These standby partnerships should include diverse entities, such as government agencies, NGOs, the media, youth networks, faith-based organizations (FBOs) and private sector organizations. In addition to ensuring standby workforce capacity, these partnerships provide structures and platforms to facilitate community engagement even when PHSM restrict movement.

ii) Emergency Response: Capturing social and behavioural data for data-driven, community-centred responses

Effective RCCE responses rely on social and behavioural data to inform and adjust interventions and tailor messages for specific audiences. In an effort to rapidly disseminate lifesaving information at scale, the initial focus of the COVID-19 RCCE response in ESAR relied primarily on one-way risk communication. However, as the pandemic evolved, the importance of engaging communities to monitor adoption of and barriers to adoption of recommended preventive measures, while also identifying emerging trends in online and offline

conversations, primarily at the community level, increased. Significant investments had to be made over a very short timeframe to reinforce existing social and behavioural data collection methodologies and establish social listening mechanisms. Countries that had previous experience using digital platforms, such as U-Report, Internet of Good Things [IoGT], among others, to collect SBC data and engage communities were better able to respond to the evolving demands of the response.

Lesson # 4: Risk Communication should go hand in hand with Community Engagement to build trust and ensure risk communication is responsive in addressing community perceptions.

Risk Communication enabled rapid, at-scale reach through one-way communication in the initial phases of the response, though two-way community engagement was jointly needed to ensure a tailored response, informed by community concerns and perspectives and grounded in trust. As the pandemic progressed, travel and movement restrictions eased and data related to COVID-19 disease transmission, as well as PPE, became more readily available, allowing more traditional forms of community engagement through networks of volunteers, community health workers and CSOs to recommence.

Lesson # 5: Establishing community feedback systems to monitor trends in online and offline conversations enabled real-time tracking of perceptions and concerns about COVID-19 and vaccines.

Online (digital and social media) and offline community feedback emerged as critical components of the RCCE response during the COVID-19 pandemic. Social listening provided insight into recurring trends in online conversations that had potential to negatively impact response efforts, enabling response actors to adapt the respond as needed. Social listening also enabled the rapid identification of online trends that would later emerge through offline community feedback. Triangulation of data collected via online and offline community feedback mechanisms enabled inputs on key trends in community perceptions to be captured across a broader range of communities, including those with limited or no digital access. In some countries, however, the use of online and community feedback data was sub-optimal due to limited capacity to adapt the response regularly based on evolving trends.

Lesson # 6: Traditional data collection mechanisms may be inadequate for dynamic emergency responses which require rapid,

innovative and cost-effective data collection methodologies.

Limited funding and the urgent need to understand the dynamics in community perceptions and drivers of non-compliance with recommended practices and uptake of COVID-19 vaccines prompted the collection of social and behavioural data through a range of platforms. Data collection occurred through the expansion of existing platforms, collaboration with vendors through easily activated long-term agreements (LTAs), the development of new approaches and triangulation of research conducted by other partners. As of April 2022, UNICEF had supported 105 data collection exercises related to COVID-19 in ESAR countries. Additional investments in capacity building for further development of data visualisation tools, such as user-friendly dashboards, summary reports highlighting key actionable findings and data syntheses to triangulate across data sources remain critical.

Lesson # 7: Availability of human, financial and technical resources for RCCE interventions catalysed the COVID-19 response and provided a strong foundation for future emergency preparedness and response across the humanitarian-development nexus.

The COVID-19 pandemic witnessed an overwhelming response in terms of the availability of RCCE resources, particularly in comparison to previous outbreaks, catalysing a rapid surge in UNICEF technical and strategic capacity. The pandemic also highlighted the criticality of social and behaviour data to inform and adjust interventions. Despite these investments, government institutions across ESAR continue to lack RCCE capacity—both in terms of technical skills-set and financial resources.

As the COVID-19 response begins to transition towards recovery, it will be vital to continue to build on these investments in technical capacity throughout the region, while also ensuring lessons learned from previous outbreaks continue to frame RCCE and SBC responses across the emergency response, preparedness and development nexuses.

Main recommendations

The following 10 recommendations, organised into four specific domains, are an urgent call to action to ensure the momentum and progress achieved during the COVID-19 response are not lost but rather sustained and strengthened as the region responds to the emergency and development needs arising from multiple existing and emerging PHEs.

Domain 1: Sustain investment in national and subnational SBC coordination systems to reinforce preparedness and capacity to timely respond to emergencies

- **Recommendation #1:** Support governments to sustain functional coordination mechanisms that can be rapidly activated, with a focus on both national and subnational levels.
- **Recommendation #2:** Invest in RCCE preparedness for rapid, agile emergency response, with a focus on reinforcing RCCE partner capacities to engage in interagency RCCE programming using harmonized tools and approaches at the national and subnational levels.

Domain 2: Sustain long-term partnerships and foster new alliances to complement existing capacities

- **Recommendation #3:** Build on achievements made during the COVID-19 response to ensure continued institutionalized agreement and working arrangements with efficient partners and platforms aiming to reach people at scale.
- **Recommendation #4:** Sustain partnerships with trusted and credible community organizations that can be easily deployed to support community engagement through stand-by partnership cooperative agreements (PCAs), national LTAs and rosters.

Domain 3: Sustain data collection, visualization and use to inform and adjust interventions

- **Recommendation #5:** Support the establishment and/or strengthening of inter-agency or UNICEF social listening systems and capacity to monitor online and offline community conversations and feedback at the national and subnational levels.
- **Recommendation #6:** Continue to strengthen existing and develop new approaches to social and behavioural data collection to improve speed, cost-effectiveness and reach, especially among marginalised and vulnerable populations.
- **Recommendation #7:** Promote data-driven, community-centred SBC approaches in development and emergency preparedness programming to ensure capacity for rapid scale up during emergency responses, including ensuring that technical capacity, structures, guidance and tools to understand community perceptions are in place.

Domain 4: Sustain advocacy and fundraising efforts to strengthen the SBC/RCC agenda

- **Recommendation #8:** Continue to advocate internally in UNICEF and externally with donors, UN agencies and governments to strengthen RCCE for PHE preparedness and response through sustained investments in capacity building and flexible resources.
- **Recommendation #9:** Ensure internal UNICEF processes and formats for planning, budgeting and reporting on emergency preparedness and response include space for SBC/RCCE strategies, activities and funding requirements.
- **Recommendation #10:** Invest in documentation, evidence review and publication of SBC/RCCE contributions.

Lesson # 2

Capitalizing on institutional coordination, leadership and existing RCCE technical committees enabled greater coordination capacity, optimization of resources and harmonization of public messages, as well as a clearer division of labour among partners.



2

Methodology

This report was developed through a combination of a desk review of lessons learned during COVID-19 and other outbreak responses and a series of KIIs and FGDs. The ESARO SBC team coordinated with the consultant to validate initial analysis and findings emerging from the KIIs and FGDs. Thereafter, SBC focal points at all ESAR COs had an opportunity to provide comments and feedback, all of which is incorporated herein.

2.1 Desk review

The desk review focused on key regional and global efforts to take stock of the COVID-19 RCCE response, including through global and regional real-time assessments, the regional compendium of lessons learned and other country-specific efforts. Findings from the desk review informed the KII and FGD questionnaire design, intended to assess the investments required to ensure an efficient RCCE response to COVID-19, considering the critical role of

capacity building, coordination and institutional communication in emergency preparedness. Specifically, the analysis focused on the following areas: coordination, social listening, social and behavioural data, risk communication versus community engagement, demand for vaccines, resources, sustainability and response challenges and/or failures.

2.2 KIIs and FGDs

Cumulatively, fifty-six respondents – comprising staff from UNICEF COs, CSOs and NGOs, as well as RCCE pillar leads from national MOHs – in nine ESAR countries, including Botswana, Ethiopia, Kenya, Madagascar, Mozambique, Rwanda, South Africa, South Sudan and Uganda participated in the KIIs and FGDs.

The majority of respondents (n = 38) comprised UNICEF CO staff focusing on SBC/RCCE during the COVID-19 response; these staff included members of the Communication, Emergency and SBC teams, as well as programmatic staff and Deputy Representatives. Additionally, 14 respondents from CSOs, NGO partners and national governments participated in the KIIs and FGDs, including members of: the Botswana Red Cross Society, the Rwanda Red Cross, the Uganda Red Cross Society, the Social Communication Institute of Mozambique, WHO/Uganda and the MOHs in Ethiopia, Mozambique, Uganda and Rwanda.

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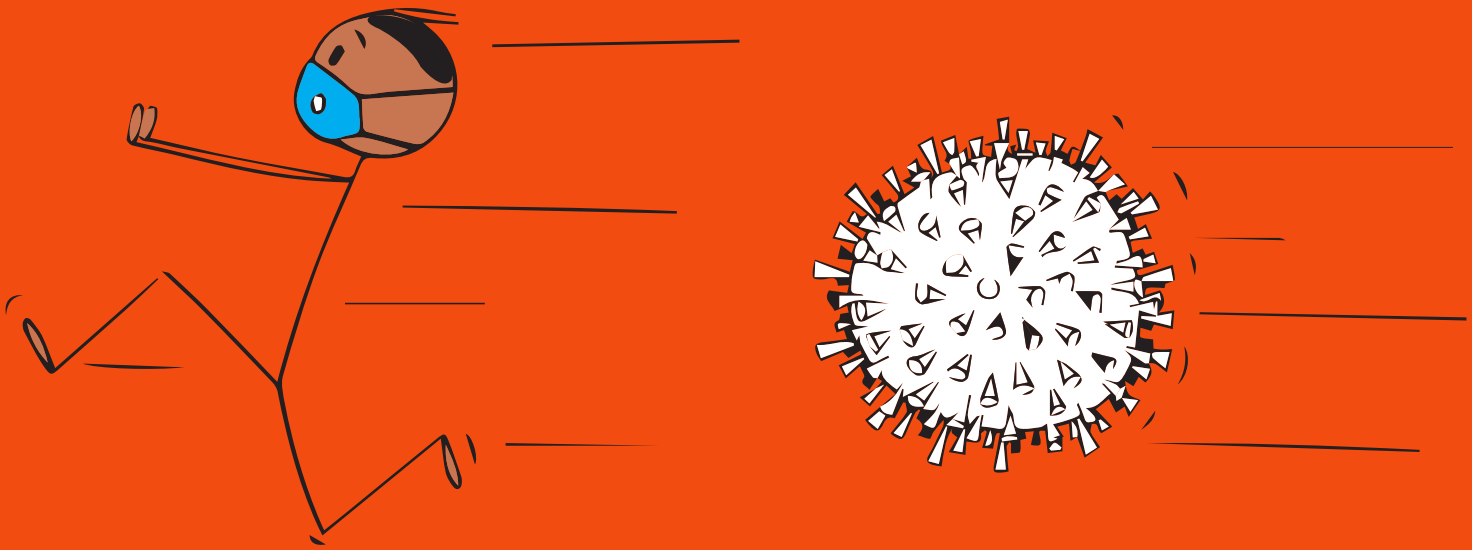
Findings from the desk review and interviews

Seven key lessons learned emerged from the data collected via the KIIs and FGDs, as well as feedback from the SBC focal points at the June 2022 Network meeting. These lessons learned have been grouped into two categories: 1) those that UNICEF COs and partners should consider framing preparedness for future responses and 2) those that should be scaled up during an emergency response.



Lesson # 3

Existing long-term partnerships with key implementing partners facilitated rapid responses at national and subnational levels.



i) Emergency Preparedness: Capitalize and build on existing expertise, mechanisms and partnerships

UNICEF has significant expertise in RCCE preparedness for and response to PHEs in the region, particularly in countries that have experienced multiple emergencies in recent years. With established coordination mechanisms and operational modalities, including long-term partnerships with implementing partners and governments capable of scaling up during the COVID-19 RCCE response, these countries were especially well positioned to respond to COVID-19.

Lesson # 1: Exposure to prior outbreaks and experience in outbreak response enabled more effective RCCE preparedness for and response to COVID-19.

For RCCE to be effective, coordination mechanisms must be in place to facilitate efficient and harmonized responses. UNICEF has supported RCCE responses in multiple disease outbreaks and other emergencies in ESAR countries in recent years. Respondents from UNICEF, national governments and implementing partners all reported feeling unprepared for a PHE of the magnitude of COVID-19. However, countries like Rwanda, Uganda, Ethiopia and Madagascar, which had experience preparing for outbreaks such as EVD, Marburg virus, plague and cholera, among others, exhibited better preparedness and response to the COVID-19 pandemic.

Previous experience with disease outbreaks had the greatest impact on the level of preparedness of a country, as exemplified by Uganda's experiences with EVD, though regional differences existed. Western Uganda, for example, was notably more prepared to respond to the COVID-19 pandemic than other parts of the country given the region's experience dealing with EVD outbreaks at the country's border with the Democratic Republic of Congo.

In addition, countries with pre-existing mechanisms and partnerships had a greater degree of preparedness than those without such structures. This was the case in Ethiopia, which responds to seasonal cholera outbreaks in some regions, as well as recurring measles and polio outbreaks. Since 2019, Ethiopia has had a health-related TWG, including a UNICEF-co-led RCCE component, and had previously developed an RCCE plan, enabling the country to respond rapidly to the arrival of COVID-19. Similarly, the Government of Madagascar had an established coordination mechanism for epidemics and other crises following the 2017–2018 plague outbreak in the country. The mechanism was adapted during the COVID-19 pandemic, centralizing former coordination entities into a single, federal structure with the UNICEF-supported national communication commission. Epidemiological surveillance and risk communication were conducted by governors at the subnational level.

By comparison, middle income countries, such as Botswana and South Africa, reported being less prepared than several lower income countries with PHE experiences. Botswana was prepared to respond to natural disasters, such as drought conditions and floods, but not for PHEs. When COVID-19 reached its peak transmission in the country, the Government of Botswana became acutely aware of their lack of preparedness.

Lesson # 2: Capitalizing on institutional coordination, leadership and existing RCCE technical committees enabled greater coordination capacity, optimization of resources, harmonization of public messages and a clear division of labour among partners.

Effective coordination of RCCE interventions enables alignment among partners, resulting in reduced duplication of efforts and ensuring harmonization of communications. Government leadership in the coordination of COVID-19 responses was visible across all countries.

Overall strategic and operational direction was provided to implementing partners through the government led national RCCE TWGs. Building on existing relationships and in recognition of its RCCE expertise, UNICEF became the partner of choice for co-leading the RCCE response in countries across ESAR from the onset of the pandemic, strengthening government coordination and leadership through weekly meetings of RCCE TWGs and development of national communications strategies and key messaging.

The inclusion of RCCE as a pillar, along with others like case management, surveillance and logistics, in the WHO Strategic Response architecture enabled the development of a clear and dedicated workstream for RCCE at regional and national levels. This was especially critical during the early phases of the pandemic before vaccine availability. RCCE pillar subgroups provided forums to exchange information and best practices; coordinate response activities; and provide technical guidance to partners on the collection and utilization of social and behavioural data and community feedback. The RCCE pillar also supported other pillars by collecting and sharing community feedback and social listening data and tailoring risk communication interventions in line with the evolving epidemiological situation.

The analysis found that pre-existing RCCE coordination mechanisms, intended to ensure optimal use of resources, harmonization of public messages and a clear division of labour among implementing partners, were prevalent both in Eastern and Southern African countries. The overall response to COVID-19 in Kenya was led by a coordination committee reporting directly to the Office of the Kenyan President. In Mozambique, the MOH activated a coordination group, which played an active role in the RCCE response. During the early stages of the pandemic, the group convened virtual meetings with implementing partners to exchange information and avoid a duplication of efforts. In addition, the group facilitated the dissemination of prevention messaging and coordination of

activities related to the COVID-19 vaccine at the national and municipal levels.

In Botswana, strong coordination among the MOH, districts, communities and implementing partners enabled the development of a national communication strategy. The country's RCCE committee was inclusive of all RCCE stakeholders and met more frequently throughout the pandemic, contributing to improved multisectoral coordination. In Uganda, UNICEF served as the RCCE convenor, working closely with the MOH, WHO, CSOs and the Government of Uganda's Public Health Education Division to promote positive SBC. This involved chairing national communication plan meetings on a weekly basis and providing strategic direction throughout the crisis.

Although there were many good examples of strong national-level coordination, these examples were not always replicated at the subnational level. National RCCE strategies and approaches were not always contextualized at subnational level resulting in RCCE activities that were not optimized or fit for purpose.

Challenges around coordination, attributed to the rapid influx of donors and lack of clarity over who was leading RCCE efforts, resulted in confusion and overlapping activities in some geographical areas while others remained underserved. In Ethiopia, for example, the national government and UNICEF developed two separate communication strategies in response to COVID-19, generating confusion among partners, including UNICEF, as to which strategy to contribute to.

Delays in UNICEF's initial response in some countries, including in Madagascar and Rwanda, also resulted in delayed implementation of RCCE interventions. In South Sudan, a number of RCCE working groups existed in parallel, contributing to challenges in harmonizing messages across working groups and implementing partners, disseminating accurate information, tracking rumours and providing feedback.

Lesson # 3: Existing long-term partnerships with key implementing partners facilitated rapid responses at the national and subnational levels.

In order to improve efficiency and predictability of RCCE responses, standby partnerships should be established with diverse entities, including government agencies, NGOs, the media, youth networks, FBOs, and private sector organizations, whose specific expertise, structures and capacities complement those of UNICEF. When available, these partnerships enabled a standby capacity of human resources, structures and platforms to facilitate community engagement, with capacity for rapid activation and deployment during emergencies.

From the onset of the pandemic, PHSM, including lockdowns, quarantines and travel restrictions, limited travel both within urban areas and to rural areas. In order to reach communities with RCCE interventions on PHSM and eventually vaccinations, UNICEF leveraged existing partnership agreements with NGOs and community networks at national and sub national levels. Some examples included in South Sudan, where UNICEF-led RCCE at the state level provided technical advice and capacity building to CSOs, while leveraging community mobilizer networks at the subnational, county, payam and boma levels; South Africa, where UNICEF relied heavily on its key partnership with World Vision to promote handwashing in communities with limited water availability; and Uganda, where implementing partners produced and disseminated information, education, and communication (IEC) materials and prevention messages via radio in 30 local languages.

Partnerships with religious leaders, radio stations, youth leaders and other key influencers also facilitated implementation of RCCE interventions. In Madagascar, UNICEF supported national-level coordination, working to remove barriers to prevention measures,

mobilize communities and engage religious leaders. The way the junior reporter club in Madagascar engaged CSOs, influencers and sport champions were recognized as a best practice. However, engagement with the private sector was identified by many COs as needing improvement in future responses.

UNICEF/Kenya launched a new vaccination drive in partnership with the Inter-Religious Council of Kenya (IRCK) and MOH which included opening more than 280 places of worship – including churches, mosques and temples – as vaccination centres, facilitating the vaccination of congregations immediately following sermons on the subject. At the end of the launch, which was held at the Christian Student Leadership Centre, several religious leaders got vaccinated on live television, publicly showing their commitment to the campaign.

Countries with strong HIV/AIDS community-based programmes were able to leverage those structures for the RCCE response through the trained home-based care network and networks of community health workers. In Botswana, COVID-19 response activities focused on providing technical support to the MOH, while concurrently working with the Botswana Red Cross Society to reach communities and ensure continuity of activities for children. UNICEF supported COVID-19 prevention and response activities, including the development of a home-based care network, training for community health workers and the provision of soap and hydroalcoholic solution, as well as hand washing promotion trainings, for schools and health clinics.

Most countries reported engaging with the national Red Cross Society to reach communities with RCCE activities through their network of volunteers. In Ethiopia, UNICEF staff suggested: “civil society organizations made UNICEF’s job easier. An LTA with key implementing partners should be foreseen.”

ii) Emergency Response: Capturing social and behavioural data for data-driven, community-centred responses

Effective RCCE emergency responses rely on social and behavioural data to inform and adjust interventions and tailor messages for specific audiences. The initial emphasis on one-way risk communication, urgently needed to provide lifesaving information at scale, lacked community engagement. As the pandemic progressed it became only more crucial to monitor the level of acceptance of the recommended preventive measures, to understand the main barriers and concerns limiting their adoption, and to capture the trending concerns emerging from both online and offline community conversations. The pandemic prompted significant investments in this field within a relatively short timeframe, augmenting the collection, dissemination and utilization of social and behavioural data.

Lesson # 4: Risk Communication should go hand in hand with Community Engagement to build trust and ensure risk communication is responsive in addressing community perceptions.

Risk communication allows faster at-scale reach through one-way communication in the initial phases of a response, but should eventually be complemented with two-way community engagement to ensure the response is informed by community views, concerns and perspectives and builds trust. Risk communication interventions at the onset of COVID-19 were critical for providing and updating information on the disease and PHSM instituted to curb transmission, including raising community risk perceptions as a strategy to encourage compliance with PHSM. Initially, one-way risk communication allowed rapid dissemination of lifesaving information on a heretofore unknown disease in an environment of restricted access and movement. In countries like South Africa, which have significant internet penetration, social media platforms, such as TikTok and Facebook, were leveraged to disseminate messages. Utilizing different channels in different countries, UNICEF was able to reach million people in ESAR with COVID-19 prevention messages in 2020 and 2021.

The significant reach of UNICEF's risk communication interventions – which included disseminating COVID-19 prevention messages to 268 million people in 2020 and 70 million people in 2021 – can be juxtaposed against the number of people UNICEF mobilized through its community engagement activities – 33.2 million people in 2020 and 0.5 million people in 2021. This gap in community engagement became more marked as perceptions about the disease and its severity evolved and trust declined, resulting in hesitancy to adhere to PHSM, including uptake of vaccines. Community engagement was more resource intensive, relying on networks of volunteers, community health workers and civil society organisations, many of whom would traditionally use face-to-face meetings, such as household visits and community dialogues, to collect information about community perceptions. However, the importance of community engagement in ensuring that vulnerable communities had access to services was noted by respondents: “we cannot cover as much population with community engagement interventions as we can with risk communication, but we can balance out our approaches and ensure that the concerns of community members from different socio-economic backgrounds and geographies are covered through risk communication.”

As the pandemic progressed, travel and movement restrictions eased, while knowledge of disease transmission and availability of PPE increased, allowing community engagement to recommence. By leveraging existing relationships with NGOs, CSOs, FBOs and inter-faith networks, critical two-way interventions, such as providing accurate information, addressing rumours and reinforcing trust and social support, could be augmented. The engagement of grassroots organizations, including those focused on women, youth, persons affected by HIV, older persons and religion, enabled feedback from marginalised and vulnerable communities to inform UNICEF's risk communication interventions. UNICEF's reliance on mobilizing volunteer networks for RCCE, however, presented potential sustainability issues.

Lesson # 4

Risk Communication should go hand in hand with Community Engagement to build trust and ensure risk communication is responsive in addressing community perceptions.



UNICEF partnerships with national Red Cross and Red Crescent Societies enabled the collection of community feedback and insight via networks of volunteers. In Ethiopia, risk communication was the predominant form of intervention at the start of the pandemic as public health measures rendered community engagement difficult, though digital platforms eventually resolved some challenges. Later in the pandemic, Ethiopia Red Cross Society volunteers, equipped with PPE, were able to recommence some forms of community engagement.

UNICEF/Rwanda focused on strengthening community engagement through its partnership with the Rwandan Red Cross; activities included dissemination of IEC materials, tracking of rumours and gathering of feedback through house-to-house visits, prioritizing the most disadvantaged households through work with the Umbrella of Organizations of Persons with Disabilities. UNICEF/Rwanda also supported radio stations to roll out programming at car parks and markets, engaging youth volunteers who were seen as the most trusted community actors during the COVID-19 response and utilizing insights from community feedback. According to one stakeholder: “We had to rely on mass media a lot to ensure better reach. To the extent possible, mass media interventions were informed by our work at [the] community level in terms of addressing community concerns, identifying the right influencers to feature on television and in radio shows and audio-visual materials.”

Mozambique also prioritized the implementation of risk communication in the early stages of the pandemic when community engagement was severely constrained. UNICEF supported the training of community health committees which played a significant role in the resumption of community engagement interventions, in addition to leveraging implementing partners at the community level. As one stakeholder noted, “community engagement needs proper structures. Some implementing partners [were] already on the ground working on other issues like TB, HIV and WASH tried to sensitize [communities to] COVID-19 preventive measures... under the guidance of the MOH.”

In some countries, such as South Sudan and Uganda, low literacy rates combined with limited access to the internet and mobile phones presented significant challenges to risk communication. Radio coverage is not universal in South Sudan, where many households own a single radio, often the property of the man of the household, limiting its utility in transmitting critical messages to all members of a household.

The arrival and widespread administration of the COVID-19 vaccines presented several challenges, including related to logistics, service delivery capacities and vaccine hesitancy. In terms of RCCE, the promotion of vaccine uptake required a significant, coordinated effort to help clarify the differences between the available vaccines and evolving messages related to their dosages.

In Mozambique, risk communication messages focused on the importance of taking the COVID-19 vaccine, its safety and efficacy. Social media influencers were engaged to disseminate messages related to the availability of vaccines including eligibility, vaccination site locations and open hours.

In South Sudan, vaccine hesitancy was observed among lactating mothers, prompting specific engagement on the safety of vaccines for pregnant and lactating women through an integrated communication framework involving religious leaders and traditional chiefs, as well as significant advocacy efforts to counter misconceptions and myths. As a result, a majority of leaders got vaccinated and became ambassadors encouraging vaccine uptake among other people.

In South Africa, response actors localized RCCE content to target areas where misconceptions were particularly high. Likewise, messages needed to address the varying rumours about each vaccine and confusion related to vaccine dosage. Issues surrounding dosage also affected Botswana, requiring greater flexibility in messaging. One key informant noted: “at [the] beginning, [it was a] one dose vaccine, then

two doses were needed and then a third dose/booster was recommended. People were made to feel, each time, that they were immunized and protected from COVID-19... The [confusion caused vaccine] uptake [to] became lower.”

Lesson # 5: Establishing community feedback systems to monitor trends in online and offline conversations enabled real-time tracking of perceptions and concerns about COVID-19 and vaccines.

New and innovative information and communication technologies were crucial to the monitoring of rumours and misinformation and the development of targeted messages to address trending rumours, concerns and questions. Online (digital and social media) and offline social listening and community feedback have emerged as critical components of an effective RCCE response. In addition to the offline community feedback collected at the community level, online feedback gathered through social listening allowed response actors to address recurring trends in online conversations with potential to negatively impact response efforts. Social listening also enabled rapid identification of online trends that would later emerge from offline community feedback.

Social listening in the context of COVID-19 was a learning process for most countries as there were no systematic mechanisms for collecting such information at the start of the pandemic. Though social media platforms had been utilized to disseminate information at scale among digitally connected populations, prior to the onset of the pandemic there had been almost no investment in social listening mechanisms due to the limited availability of internet services for the majority of the population in ESAR. During COVID-19, however, it became clear that the online content reaching a relatively small number of people in connected countries was contributing to the rapid spread rumours and mis/disinformation across the entire region.

During the pandemic, UNICEF was able to leverage LTAs established with UNICEF/Global, such as with Talkwalker, as well as analysis of online trends from digital and social media, to

provide countries with periodic reports, establish country-level dashboards and train CO staff and partners in social listening and infodemic management.

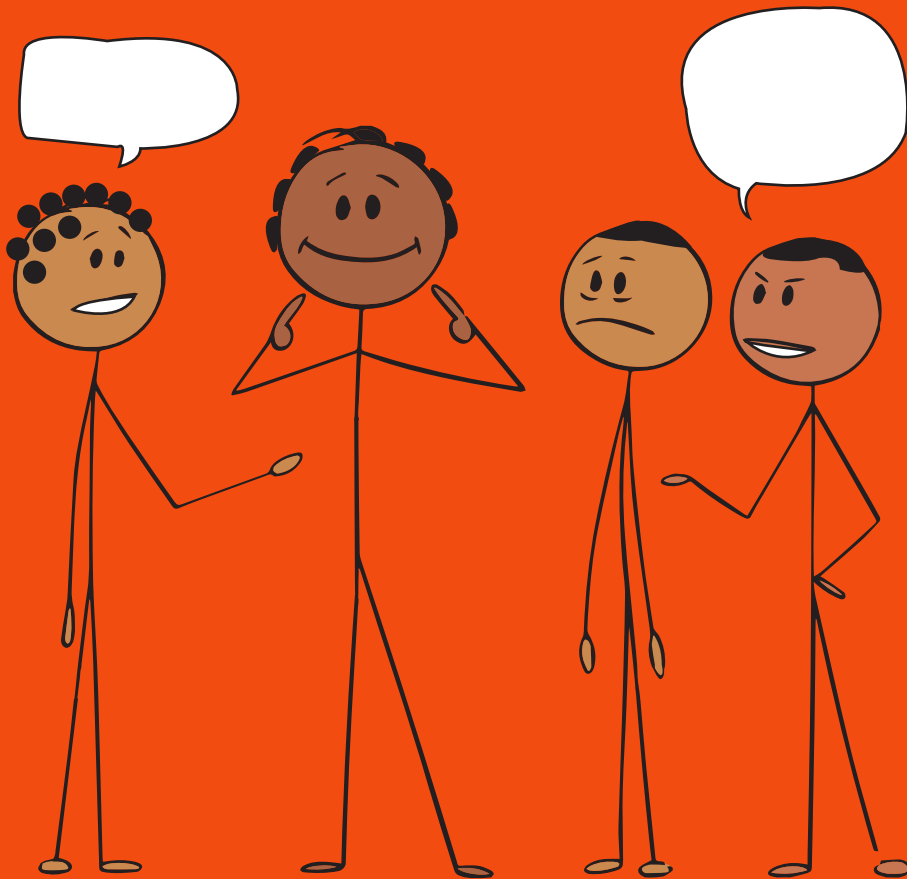
UNICEF also provided support on leveraging and expanding existing digital platforms, such as U-Report and loGT. In Ethiopia, for example, this support included developing a toll-free hotline/call-centre; a Community Rapid Assessment (CRA)/random digit dial survey; and support to the media monitoring unit of the Ethiopian Public Health Institute. Some countries also had social listening consultants seconded to the MOH to support activities.

In most countries across ESA, national governments managed hotlines and social media activities with UNICEF support. In Uganda, social listening enabled the development of weekly and monthly summary reports on rumour tracking which were reviewed in district level meetings in an attempt to provide recommendations on how to adapt response activities per the feedback. In Rwanda, UNICEF relied on online social listening tools and, in partnership with the Rwanda Red Cross, supported the creation of a rumour tracking and feedback mechanism, compiling and disseminating findings to inform RCCE interventions on a regular basis. The mechanism also helped measure the extent to which community members were adhering to recommended public health measures, as well as individual readiness for COVID-19 vaccines.

Mozambique utilized two widely available hotlines offering live calls and SMS group chats to collect community feedback data, including on individual beliefs and the spread of rumours. In Kenya, UNICEF-supported radio programmes through Africa’s Voices Foundation integrated SMS messaging to engage audience members and obtain feedback on various topics related to COVID-19. In Botswana, information was collected from national newspapers and consolidated into daily summary reports used to inform RCCE activities. In addition, volunteers from the Botswana Red Cross Society collected and documented community feedback. UNICEF’s role in promoting social listening

Lesson # 5

Establishing community feedback systems to monitor trends in online and offline conversations enabled real-time tracking of perceptions and concerns about COVID-19 and vaccines.



in Botswana was strengthened through the placement of a social listening consultant at the Botswana MOH.

Most countries across ESA were challenged by the volume of data collected, which highlighted the need to develop and share concise, visual formats of the data. Triangulation of online and offline community feedback enabled inputs on key trends in community perceptions to be captured across a broad range of communities, including those with limited or no digital access. Online and offline data, collected from a range of channels including hotlines, media monitoring, SMS messaging prompts and feedback collected by CSOs and volunteers, was analysed for key trends and reviewed through RCCE TWGs and dynamic listening sub working groups. Coordination around the review process engaged different response partners and enabled the development of operational recommendations to address key concerns, questions and to counter rumours.

The benefits of social listening for rapidly tracking changing trends in community perceptions, monitoring rumours and contributing to the adaptation of RCCE and other interventions during emergency responses are clear. Sustaining initial investments to further develop tools and capacity, including for the triangulation with offline data, improved analysis and visualisation of data and expanded capacity to monitor digital spaces, will be a critical element of current and future emergency preparedness and response.

Lesson # 6: Traditional data collection mechanisms may be inadequate for dynamic emergency responses which require rapid, innovative and cost-effective data collection methodologies.

The disruptions in movement and other restrictions occasioned by the pandemic meant that collection of reliable data using conventional methods, such as labour-intensive, face-to-face Knowledge, Attitudes and Practices (KAP) surveys were not possible in the majority of countries. All countries reported the near absence of behavioural data to inform the RCCE response in the early stages of the pandemic;

such data was critical given the dynamic situation and imposition of PHSM.

Limited funding and the urgent need to understand the dynamics in community perceptions and drivers of non-compliance with recommended practices and COVID-19 vaccines prompted the collection of social and behavioural data through a range of platforms. Data collection occurred through the expansion of existing platforms, such as U-Report and the loGT; the development of new approaches, such as implementing time-series data collection through CRAs deployed through interactive voice recorded messages and computer assisted telephone interview approaches; and the triangulation of data collected via Facebook. As of April 2022, UNICEF had supported 105 data collection exercises related to COVID-19 in ESAR countries.

COVID-19 was seen as an opportunity to inform improved methods of behavioural data collection moving forward, giving precedence to tools and platforms able to collect multiform and multisectoral data. In Botswana, the government utilized UNICEF's U-Report platform to collect data at the community level, complementing a rapid assessment conducted by the MOH and data collected during household visits by Red Cross Society volunteers. In Uganda, platforms such as U-Report, helped to conduct KAP studies, bolstering community data collected by the Ugandan Red Cross Society. In South Africa, U-Report facilitated government and implementing partners' access to behavioural data. Key informants in Rwanda and South Africa noted that integrated mechanisms for behavioural data collection comprising multisector data, such as data on hand washing, nutrition and school reopening, were more effective than collecting data only for COVID-19.

UNICEF/Rwanda conducted three rounds of CRAs using the behavioural and social drivers (BeSD) framework – a model to facilitate data collection on drivers and barriers to COVID-19 vaccine uptake by measuring factors that are fluid and have capacity for change, including how people feel, what social norms and processes exist and how such norms and

Lesson # 6

Traditional data collection mechanisms may be inadequate for dynamic emergency responses which require rapid, innovative and cost-effective data collection methodologies.



processes affect individual motivations and barriers to behavioural change. The CRA methodology was used in seven other countries in ESA region as per the CRA report.⁶

In low-income countries, such as South Sudan, which have limited capacity to monitor social media, UNICEF was able to collect social and behavioural data by conducting a CRA through its network of social mobilisers. UNICEF also conducted a health care worker perception survey, gathering data from regular community feedback hotlines and radio talks, as well as varied stakeholders to understand the negative perceptions of COVID-19 vaccines held by many health care workers.

In Mozambique, UNICEF worked with IPSOS, a multinational market research and consulting firm, and the World Bank to conduct a time-series rapid assessment – the MOZ Pulse – with over 7,000 people. The assessment helped gather national data on compliance with COVID-19 prevention measures and social drivers; a subsequent study was carried out following the arrival of the COVID-19 vaccines to assess vaccine acceptance.

Coordinating with other partners to promote deployment of the same or similar data collection tools, such as the UNICEF-WHO BeSD module, allowed response actors to track data across time and countries and reduce the duplication of data collection efforts. In Kenya, the government established a mechanism for data collection via the National Bureau of Statistics, while concurrently providing financing for several national studies. UNICEF and other key stakeholders provided technical assistance for the studies, particularly with regards to defining the study questions.

Utilization of new approaches and platforms enabled data collection to inform the response, albeit with a new set of challenges. Many countries reported a data backlog, with limited capacity to analyse the data fast enough to

inform the evolving situation, let alone adapt interventions based on emerging findings. Further, many countries in ESAR lacked capacity at the national level to visualize RCCE data in user-friendly dashboards. Investing in capacity building related to data visualisation through user-friendly dashboards, summary reports highlighting key actionable findings and data syntheses to triangulate different data sources remains critical.

Lesson # 7: Availability of human, financial and technical resources for RCCE interventions catalysed the COVID-19 response and provided a strong foundation for future emergency preparedness and response across the humanitarian-development nexus.

The COVID-19 pandemic generated an overwhelming response in terms of RCCE resources available, particularly in contrast to previous outbreaks. Although these resources were instrumental in developing strong and dynamic context analyses and enabled promotion of RCCE technical support and partnerships to implement RCCE interventions, many of the resources had short grant periods, restrictions on expenditure and burdensome reporting requirements.

For most country offices, including those in Kenya and Rwanda, the COVID-19 pandemic provided an opportunity to learn how to put money to best use. Per one key informant, “this means that country offices shouldn’t continue doing business as usual but keep on improving [the] allocation of funds toward SBC and RCCE, continue building [the] capacity of partners and increase counterparts’ and donors’ trust in UNICEF.” In Southern African countries, like Botswana, with small COs that normally struggle to mobilize resources, UNICEF was able to support the national government with skills development and other capacity-building efforts.

⁶ Undertaking the Community Rapid Assessments in the COVID-19 Context Report: Experience of UNICEF in 8 countries of the Eastern and Southern Africa Region. Retrieved from [here](#) on 9 Nov 2022.

The rapid allocation of funding during emergency situations presents significant challenges. Local capacity to fund interventions is often weak, and the availability of specialists within national governments is insufficient. As an example, the Government of Uganda made significant efforts to raise funds for COVID-19 response programming, however late disbursements resulted in delays in interventions which were particularly problematic as funding often arrived with strict deadlines and restrictions on how it could be spent.

The availability of financial, material and human resources has a direct impact on the sustainability of RCCE programming by evolving UNICEF's tools, platforms and approaches. In Ethiopia, UNICEF observed increased sustainability of programming when capacity building activities were integrated within development programmes, rather than emergency programmes. Similarly, UNICEF/Ethiopia noted greater effectiveness of continuous evidence generation than sporadic assessments. In Madagascar, the COVID-19 response has contributed to increased sustainability by introducing multiform and multisectoral data collection techniques and continuing to capitalize on institutional coordination and leadership, as well as mechanisms and tools.

According to UNICEF/Mozambique's SBC team, the notion of sustainability during an outbreak response is merely hypothetical as the expectation is that emergency interventions will be implemented over the short-term. Nonetheless, it is possible to conceive of sustainability differently, considering the long-term utility and adaptability of mechanisms and trainings. For example, had coordination mechanisms existed prior to the COVID-19 crisis, they could have reinforced social listening and the rapid mobilization of resources for RCCE.

Critical for future robust emergency preparedness and response in the region are more stable financial and human resources to build strategic and technical expertise, particularly given UNICEF's role in co-leading

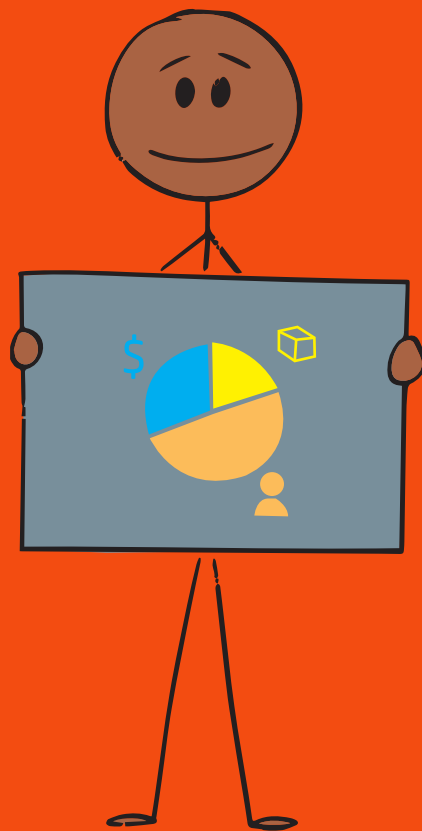
RCCE responses at regional and country levels. One respondent emphasized "we could think differently, upon reflection, for more stable resources and structures, starting from other grants related to COVID-19. We could be very well positioned for RCCE among pillars of the response. RCCE components are not always seen like other components of response with same priority."

Mobilization of RCCE funding for the COVID-19 response was effective, in part due to the pandemic's global nature, however UNICEF will need to identify ways to mobilize resources more effectively at the local and/or country level. Country offices are considering different approaches to maintaining resourcing levels to support RCCE strengthening through advocating with donors to ensure RCCE activities are included in both response and development planning. UNICEF/Madagascar has advocated for RCCE to be included in the basket fund of donors' contribution to the government. The amount of money allocated for SBC activities is significantly less than other, more traditional operational areas of UNICEF, such as education, maternal and child health and water, sanitation, and hygiene (WASH).

The massive investment in RCCE related to COVID-19 in ESAR countries catalysed a rapid surge in UNICEF technical and strategic capacity for risk communication and community engagement activities. Investments in RCCE also highlighted the importance of collecting social and behavioural evidence to inform and adjust interventions. This momentum around coordination with government; collaboration with implementing partners and CSOs; and the innovative collection, analysis, visualization and utilization of social data for evidence-based, community-centred approaches must not be lost. As efforts related to COVID-19 move towards recovery, it will be vital to build on these investments in technical capacity across the region and to ensure lessons learned from previous outbreaks, including COVID-19, continue to frame RCCE and SBC responses across the emergency response, preparedness and development nexuses.

Lesson # 7

Availability of human, financial and technical resources for RCCE interventions catalysed the COVID-19 response and provided a strong foundation for future emergency preparedness and response across the humanitarian-development nexus.



4

Recommendations

The following 10 recommendations, organised into four specific domains, are an urgent call to action to ensure the momentum and progress achieved during the COVID-19 response are not lost but rather sustained and strengthened as the region responds to the emergency and development needs arising from multiple existing and emerging PHEs. The recommendations cut across the humanitarian-development nexus and aim to ensure the progress achieved during the RCCE preparedness and responses to EVD and COVID-19 are sustained and leveraged to support development interventions, increase resilience among communities and contribute to greater preparation for future shocks.



1

Sustain investment in national and subnational SBC coordination systems to reinforce preparedness and capacity to timely respond to emergencies



2

Sustain long-term partnerships and foster new alliances to complement existing capacities



3

Sustain data collection, visualization and use to inform and adjust interventions



4

Sustain advocacy and fundraising efforts to strengthen the SBC/RCC agenda

Domain 1: Sustain investment in national and subnational SBC coordination systems to reinforce preparedness and capacity to timely respond to emergencies

- **Recommendation #1:** Support governments to sustain functional coordination mechanisms that can be rapidly activated, with a focus on both national and subnational levels.
- **Recommendation #2:** Invest in RCCE preparedness for rapid, agile emergency response, with a focus on reinforcing RCCE partner capacities to engage in interagency RCCE programming using harmonized tools and approaches at the national and subnational levels.

Domain 2: Sustain long-term partnerships and foster new alliances to complement existing capacities

- **Recommendation #3:** Build on achievements made during the COVID-19 response to ensure continued institutional agreement and working arrangements with efficient partners and platforms, including media – digital, social and traditional – and other platforms aiming to reach people at scale.
- **Recommendation #4:** Sustain partnerships with trusted and credible community organizations that can be easily deployed to support community engagement through stand-by PCAs, national LTAs and rosters.

Domain 3: Sustain data collection, visualization and use to inform and adjust interventions

- **Recommendation #5:** Support the establishment and/or strengthening of inter-agency or UNICEF social listening systems and capacity to monitor online and offline community conversations and feedback

at the national and subnational level. This includes strengthening data collection through a variety of partners and channels, data analysis and visualization and supporting partners to utilize the data to adapt response activities per feedback.

- **Recommendation #6:** Continue to strengthen existing and develop new approaches to social and behavioural data collection to improve speed, cost-effectiveness and reach, especially among marginalised and vulnerable populations. Investment in time-series data collection and analysis should be systematically included in cost plans for both emergency preparedness and response.
- **Recommendation #7:** Promote data-driven, community-centred SBC approaches in development and emergency preparedness programming to ensure capacity for rapid scale up during emergency responses, including ensuring that technical capacity, structures, guidance and tools to understand community perceptions are in place.

Domain 4: Sustain advocacy and fundraising efforts to strengthen the SBC/RCC agenda

- **Recommendation #8:** Continue to advocate with donors, UN agencies and governments to strengthen RCCE for PHE preparedness and response through sustained investments in capacity building and flexible resources.
- **Recommendation #9:** Ensure internal UNICEF processes and formats for planning, budgeting and reporting on emergency preparedness and response include space for SBC/RCCE strategies, activities and funding requirements.
- **Recommendation #10:** Invest in documentation, evidence review and publication of SBC/RCCE contributions.

Appendices

Appendix A.

KII and FGD Informant Guide

Please read verbatim:

[“Hello.”] My name is _____. Thank you for agreeing to participate in this discussion today. I want to let you know that the information you share today is confidential. That is, we will not share anything said during the discussion today with anyone outside this room.

Definition of RCCE. Risk communication is **communication intended to supply audience members with the information they need to make informed, independent judgements about risks to health, safety and the environment.**

Community Engagement is **the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting the well-being of those people.** It is a powerful vehicle for bringing about environmental and behavioural changes.

We are interested to hear about your thoughts, feelings and experiences regarding UNICEF’s RCCE response to COVID-19 in your country and community. We also want to hear your opinions, preferences and recommendations for how best to support vaccine demand in your country. You do not have to answer questions if you do not want to.

I want to remind you that the information shared during the discussion today is confidential. What you will say will not be connected back to you, though the information gathered during this discussion will be combined with that from other discussions and shared with ESARO’s SBC Section and UNICEF COs, implementation partners and counterparts to improve RCCE services.

Your participation in this study is completely voluntary. You may withdraw (stop taking part) from the study at any time, including before, during or after the interview. If you withdraw from the study, we will not collect any further information from you for research purposes and any information collected from you before your withdrawal may be discarded if you wish. If you withdraw from the study, your decision to withdraw will not be shared with anyone. If you decide to withdraw during the FGD itself, other members of the focus group may note your decision, but all participants will be encouraged not to share the contents of the discussion or any other observations from the focus group with anyone outside the study. No-one will know who said what, when things were said or where things were said. There are no ‘right’ or ‘wrong’ answers. We are interested in your experiences and lessons learned, and in what you think and feel. Please feel free to ask me any questions if something is unclear.

Do you have any questions before we begin?

Introduction of participants

Do you consent to participate to the study? YES NO

Introduction Question

Presentation of participants, overview of country context documentation and how involved.

a. Emergency Preparedness: RCCE Preparedness and implications for COVID-19

a.1.1 Do you think that UNICEF, Governments, partners, etc. were ready and well prepared for the COVID-19 pandemic?

- YES
- NO
- SOMEHOW
- DON'T KNOW
- OTHER (explain)

a.1.2 Describe how you were prepared, in general, and with regards to RCCE? Do you work alone or synchronized?.....

Probe: UNICEF; Government; implementing partners

If so, by which means or trainings?.....

What were the main gaps?.....

a.2.1 Could you describe some of the lessons learned from previous RCCE responses to outbreaks? In your view, how were those lessons learned applied to the COVID-19 pandemic?.....

a.2.2 In your view, were these lessons learned applied and translated into a stronger level of preparedness to respond to COVID-19?.....

a.2.3 Have you missed any learning from previous experiences that were not put in place?

b. Emergency response: RCCE response to COVID-19

b.1.1 Let's talk about coordination. What is your overall assessment of the coordination mechanisms established for the RCCE response to COVID-19? In terms of leadership and operationalization: timeliness, effectiveness, structure, avoiding duplication, linkages/translation/replication at regional, national and subnational levels.

b.1.2 How were the linkages between the national and subnational level?.....

b.1.3 Was there a recognized ability to be considered as a convener for the RCCE response to COVID-19?

b.1.3 What is the main lesson learned from RCCE coordination during COVID-19?.....

b.1.4 What are the main lessons learned regarding coordination during the COVID-19 response? (up to 3)

- b.2.1 How were the linkages and operational modalities between the regional, national and subnational responses?
- b.3.1 Social listening has emerged as a crucial area of work. How was this undertaken in your country office?
- b.3.2 Based on the above description, what would you say have been the main lesson learned from the social listening efforts?
- b.3.3 What should be sustained? Why and how? Priorities of UNICEF and other organizations at the national coordination level?
- b.4.1 What mechanism was put in place to collect social and behavioural data to inform the COVID-19 response?
- b.4.2 What in your view have been the main lesson learned related to social behavioural data and implications for response efforts?
- b.4.3 What should be sustained? And how? What about Community Feedback Mechanisms?
- b.5.1 How did the COVID-19 response build on the existing systems, structures and platforms?
- b.5.2 What have we learned? What was missing? What was put in place thanks to COVID-19? What systems should be sustained beyond COVID-19? And how?
- b.6.1 The COVID-19 response has been associated with greater availability of resources (human, financial, tools, etc.) to support response efforts than in previous outbreaks. What role have these resources played in the implementation of the RCCE response?
- b.7.1 Community engagement is crucial to building trust and ensuring community buy in. In your view, to what extent were community engagement and related principles deployed for the COVID-19 RCCE response? Could you share some examples?
- b.7.2 How did it compare with risk communication? Are there any major lessons learned from this? To what extent was community engagement a part of the COVID-19 response, in comparison to risk communication?
- b.8.1 Based on your overall assessment of the RCCE response to COVID-19, what would you say was done less well?
- b.8.2 What would you do differently if faced with similar circumstances or outbreaks in the future?
- b.8.3 Is there anything else you would like to add that was not covered by the previous questions?

THANK YOU!

APPENDIX B.

List of Participants in COVID-19 RCCE Lessons Learned Exercise

UNICEF/Botswana	Joseph Segodi, SBC Officer
	Sulah Sekisambu Kaggwa, Consultant
	Tswelelo Yvonne Morgan, Health & Nutrition Specialist
	Alexandra Illmer, Deputy Representative
UNICEF/Ethiopia	Rachana Sharma, SBC Manager
	Hnin Su Mon, SBC Specialist
	Andinet Challa, SBC Specialist
	Tesfaye Simireta, SBC Specialist
UNICEF/Madagascar	Awa Ouattara Guedegbe, Chief SBC
	Herisoa Razafindraibe, SBC Specialist
	Chancy Mauluka, Emergency SBC Specialist
	Luthecia Andrianarivo, SBC Change Officer
UNICEF/Mozambique	Ketan Chitnis, Chief SBC
	Angelo Ghelardi, SBC Specialist
	Aida Mahomed, SBC Specialist
	Marçal Monteiro, SBC Consultant
	Sharmina Sultana, Maternal & Child Health Specialist
UNICEF/Kenya	Akiko Sakaedani Petrovic, SBC Manager
	Roselyn Mutemi-Wangahu, SBC Specialist
	John Obisa, SBC Specialist
UNICEF/Rwanda	Maksim Fazlitdinov, SBC Specialist
	Redempter Batete, SBC/Gender Specialist
	Justin Rutayisire, SBC Specialist
	Jean Claude Rukundo, SBC Contractor
	Denise Ilibagiza, Health Specialist
UNICEF/South Africa	Toby Fricker, Chief of Communications & Partnership
	Janine Simon-Meyer, RCCE/SBC Consultant
	Pumla Ntlabati, RCCE/SBC Consultant
	Dan Harford, Communications/RCCE Consultant
UNICEF/South Sudan	Aping Kuluel Machuol, SBC Officer
	Atem Agot Deng, SBC Specialist
	Joshua Brown Afatio, SBC Officer
	Rufus Eshuchi, SBC Manager OIC

UNICEF/Uganda	Mandi Chikombero, Chief SBC
	Douglas Lubowa Sebba, SBC Specialist - Emergencies
	Miriam Lwanga, SBC Specialist
	Agnes Barongo, SBC Specialist
	Paul Semakula, WASH Specialist
	Patrick Banura, Immunization Officer
UNICEF/Somalia	Shah Jamal Akhlaque, Chief SBC
UNICEF ESARO	Natalie Fol, Regional SBC Adviser
	Charles Nelson Kakaire, SBC Specialist
	Helena Ballester Bon, SBC Specialist
	Massimiliano Sani, SBC Specialist
	Sergiy Prokhorov, SBC Specialist
KEY INFORMANTS	CSOs
	Josiane Umutoniwase, former Coordinator, Rwanda Red Cross Society
	Arnold Ezama, Community Epidemic & Pandemic Preparedness Programme Officer, Ugandan Red Cross Society
	Isabel Epajja, Health Officer, Ugandan Red Cross Society
	Patrick Bengana, Monitoring & Evaluation Officer, Ugandan Red Cross Society
	Neo Mogowa, Health & Care Coordinator, Botswana Red Cross Society
	Tshepho Garethata, Programme Manager, Botswana Red Cross Society
	Private Sector
	Kenneth Mulondo, Social Inclusion & Behaviour, DreamLine Products
	UN
	Benjamin Sensasi, Health Promotion Officer, WHO/Uganda
	Government
	Melaku Abebe, Ethiopia Public Health Institute-Seconded RCCE Lead, Ethiopia MOH
	Julien Niyingabira, Head of Rwanda Health Communication Centre
	Avelino Siteo, Instituto de Comunicacao Social, Mozambique
	Laurinda Angela, MOH Health Promotion Department, Mozambique
	Elisa Mavili, Communication Focal Point on Expanded Programme on Immunization, Mozambique MOH
	Kabanda Richard, Acting Commissioner for Health Promotion, Education and Health Communication, Uganda MOH

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