ESAR

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Compendium of SBC Best Practices

Eastern and Southern Africa

Foreword

For decades, the Social and Behaviour Change (SBC) Section of the UNICEF Eastern and Southern Africa Regional Office (ESARO) has been at the forefront of the SBC field, offering oversight, guidance, and technical support to 21 UNICEF Country Offices in the region. Working in collaboration with Health, Nutrition, HIV/AIDS, Water, Sanitation and Hygiene (WASH), Education, Child Protection, and Social Protection sectors, the SBC-ESAR team has empowered communities, enhanced services, and fostered positive social and behavioral change for children and communities in the region.

Drawing on invaluable insights gained by UNICEF's SBC teams in ESAR, these case studies encompass a range of SBC-related topics and present recommendations to sustain innovative SBC approaches. Our aim is to inspire practitioners to address global challenges and propel the SBC agenda towards more community-led and people-centered frameworks, thus contributing to the Sustainable Development Goals (SDGs). The journey continues!

Siddartha Shrestha

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ESAR

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

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

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

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SOCIAL + BEHAVIOUR CHANGE

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UNICEF Mozambique Addresses Root Causes of Child Marriage

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

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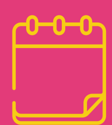
Brief summary



Dates of Activity
2015 to present

Durationof Field Research
April 2016
to June 2017

Budget
US$120,0000

Context

Child marriage and teenage pregnancy remain major child protection issues in Mozambique. More than half of all girls are married before their 18th birthday, and about 14 per cent are married before they turn 15 years old. The northern provinces have the highest rates of child marriage among female aged between 20 and 24. Signs of puberty are regarded as an important biological and social landmark for determining the maturity of girls for marriage. Socio-cultural practices and beliefs about children's readiness for marriage after their traditional initiation rites,

contribute to high levels of child marriage. Bearing children at an early age is also a social burden which falls more on girls than on boys.

In July 2014, the Government of Mozambique launched a national campaign to prevent and combat child marriage at provincial level, and in December 2015 the first National Strategy to Prevent and Eliminate Child Marriage (2015—2019) was approved, headed by the Ministry of Gender, Children and Social Welfare. As part of the national Strategy development process, formative research to understand the root causes of child marriage was conducted by UNICEF in Mozambique from April 2016 to June 2017. The formative research findings together with data from the SBC and social norms survey done in 2020—2022 is informing the Child Marriage programme which is part of the third National Action Plan for Children slated to be approved in 2023.

Strategic approach[1]

The first activity of the formative research undertaking was to conduct a literature review of existing publications on child marriage, the strategies used to deal with child marriage, studies which analyzed social and gender norms and the social and economic barriers that foster child marriage at the community and institutional levels in Mozambique, in order to amass an evidence-base on which to build a national strategy to prevent and eliminate child marriage.

Field-level formative research was conducted to understand the underlying drivers, motivations, social-cultural, legal and economic reasons for marrying girls soon after puberty, and how girls feel about early marriage. A total of 86 in-depth interviews and 40 focus group discussions (FGDs) were conducted in four provinces, Manica, Nampula, Tete and Zambézia, with a total sample size of 406 individuals. Questions about positive deviance were purposively included in the data collection in order to determine existing solutions to eliminating child marriage. The interviews and FGDs were conducted in the language chosen by the interviewees. The research team included two local research assistants (two for each province and district) who supported the main researcher in conducting the interviews and FGDs.

The research results were triangulated, and the formative research report findings were discussed during a validation workshop attended by UNICEF and partners. Findings from this research were used to develop the national social and behaviour change strategy for eliminating child marriage in Mozambique.

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Key achievements

The research findings showed that the factors that contribute to the perpetuation of child marriage are numerous, multidimensional, and complex. For example, once a girl has her first period, she is considered a woman ready for marriage and having children –there is no "adolescent" period. There is a common perception that late marriage implies wasted opportunities related to having children so early marriage (at first signs of puberty) is considered ideal. Social pressure as well as self-determination and social prestige also perpetuate child marriage. Gaps in knowledge about the legal framework, attitudes and practices rooted in cultural traditions, unequal gender relations, poor and unequal access to information, education, and health services, and poverty are key to sustaining the practice of child marriage.

The research gave rise to specific recommendations for eliminating child marriage, namely provided more, correct, and easy-to-understand information about puberty, not as a marker of marriage eligibility, but as a time in a young woman's life that necessitates a period of growth toward biological and psychological maturity and readiness for marriage. More information is needed among the population of Mozambique to help shift the notion that a woman's fertility and fecundity are short-lived and limited, and change social norms (including shame, honor, blessings, prestige, etc.) that create pressures for a girl to be married early. The research findings uncovered positive deviants that perceived later marriage as a way to avoid the risks associated with child marriage, like complications during childbirth among physically immature girls. These positive deviants contributed to the development of a strategy to profile and highlight families of girls that do not marry before the age of 18 years.

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The research findings were used to develop an integrated package of SBC approaches and interventions, using community dialogues as a core intervention beginning in 2018. The focus of the activities was on access to protection, health and education and other basic services. UNICEF established a partnership with *N'weti*, a national non-governmental organization, to address gender and health issues. UNICEF also supported the Government to develop a national multimedia campaign to address child marriage, with the participation of high-level figures including the Minister of Gender, Children and Social Action, the First Lady, the chair of the Interfaith Council of Religions in Mozambique, teachers, and other stakeholders. In addition, UNICEF developed storylines about child marriage and initiation rites as part of a long-running national edutainment radio drama *Ouro Negro* and for community theatre, that kick-started the community dialogues to address gender and social norms around child marriage in target districts.

The engagement and discussions generated at societal level between 2017 and 2019 might have been hampered by the wake of Cyclone Idai in 2019, recent military conflict and the impact of COVID-19 prevention measures, including school closures, that led to an increase in teenage pregnancies, increased household poverty and families turning to coping mechanisms including child marriage.

Still, the combined advocacy efforts of UNICEF, UNFPA and civil society organizations led to the approval, in 2019, of a new law against child marriage. The research findings also informed a mentorship programme led by UNFPA under the Rapariga Biz UN Joint Programme for Adolescent Sexual Reproductive Health and Rights (ASRHR) and inform the social and behaviour change programmes led by UNICEF. Together with the Ministry of Education and in coordination with the Ministry of Health, the Ministry of Gender and Social Action, the police and civil society organizations, UNICEF also developed a school-based mechanism to report and refer cases of violence and child marriage and provide access to legal and protection services.

and

40 FOCUS GROUP DISCUSSIONS (FGDS)

were conducted
IN FOUR PROVINCES
with a total of

406 INDIVIDUALS

The research gave rise to specific recommendations for eliminating child marriage.

The findings uncovered positive deviants that perceived later marriage as a way to avoid the risks associated with child marriage.

Lessons learned

1 The formative research was instrumental for understanding the reasons given for marrying before the age of 18, who girls marry, and reasons for not marrying. The research highlighted such factors as social prestige and pressure related to initiation rites and honour, and economic reasons, for marrying early, and potential complications in pregnancy and childbirth, and the importance for a girl continuing her studies as reasons for not marrying. To engage with community gatekeepers in charge of the initiation rites, UNICEF and civil society organization have promoted several consultations at national, provincial and local levels but this requires a long term-programming to ensure sustainable social change.

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Recommendations

1 UNICEF should invest in a deeper understanding of the interaction between gender and social norms, and how to reach 'critical mass' of champions required to trigger social norms change at scale to end child marriage.

2 UNICEF and its partners should continue to strategically ensure more systematic engagement of gatekeepers in charge of the initiation rites, as well as men and boys in preventing gender-based violence.

3 More investment is needed to strengthen and expand adolescent-friendly services.

Endnotes

1 The full formative research report can be found at: https://www.unicef.org/mozambique/media/4931/file/Publication%20Communication%20for%20Development%20Strategy%20for%20the%20Prevention%20and%20Elimination%20of%20Child%20Marriages.pdf.

SOCIAL + BEHAVIOUR CHANGE

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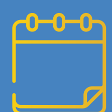
UNICEF Ethiopia Overcomes COVID-19 Vaccine Hesitancy Among Health Workers

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

Brief summary



Dates of Activity
April to November 2021

Duration
Eight months

Budget
US$37,800

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

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Context

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

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

Strategic approach

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

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

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

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

Key achievements

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

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372,025 HEALTH WORKERS

were vaccinated against COVID-19

UNICEF Ethiopia

supported in-person training for 25,159 healthcare workers

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

Lessons learned

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

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

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

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

Recommendations

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

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

Endnotes

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

SOCIAL + BEHAVIOUR CHANGE

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

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

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Brief summary

Dates of Activity
July 2017 - December 2023

Duration
6.5 years

Budget
US$43 million

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

Context

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

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

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Strategic approach

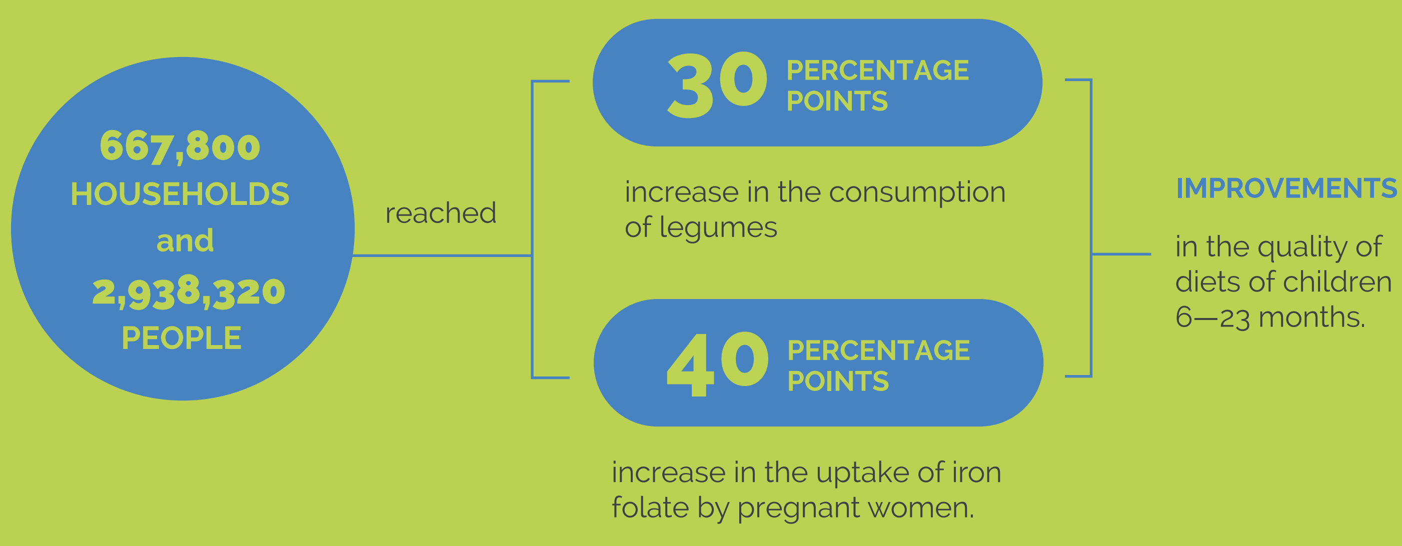
The *Afikepo* nutrition programme, implemented by UNICEF and the FAO in collaboration with the Government of Malawi, was a multi-sectoral effort that integrated agriculture, health, and nutrition activities to address the problem of food and nutrition insecurity and malnutrition. The project aimed to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

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

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

Key achievements

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



Lessons learned

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

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

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

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

Recommendations

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

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

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

Endnotes

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

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

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

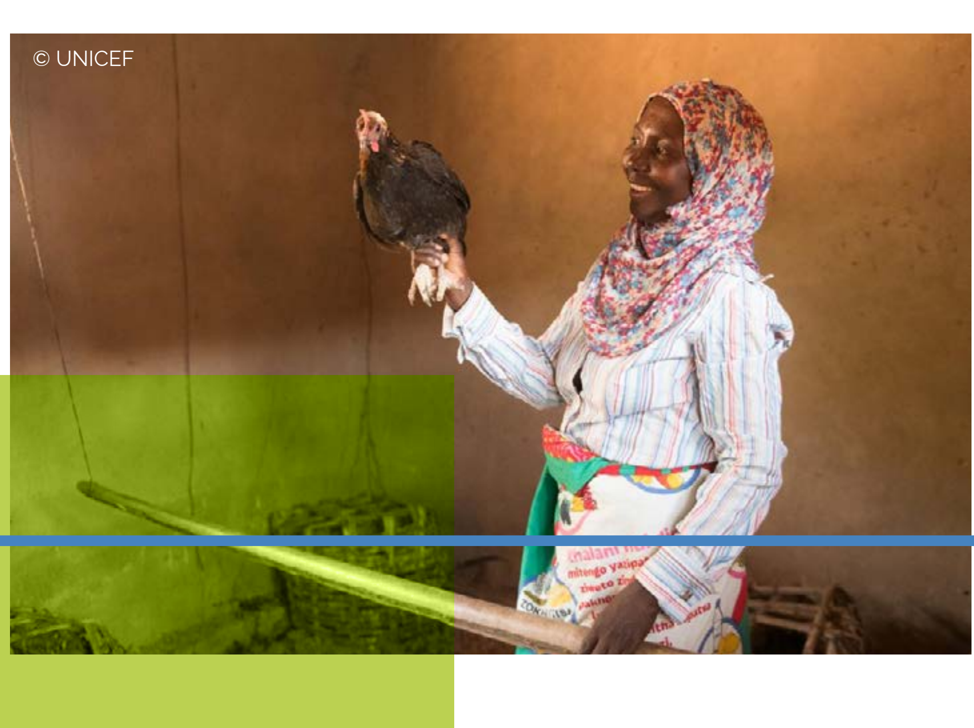
4 Mussa R., A matching decomposition of the rural-urban difference in Malnutrition in Malawi, Health Econ Rev, pp 4-11.

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

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

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

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



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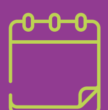
UNICEF Rwanda Partners with Rwanda Red Cross Society to Address COVID-19 Rumours and Misinformation

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

Brief summary



Dates of Activity
July 2020 to December 2021

Duration
18 months

Budget
US$148,503,390

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

Context

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

Strategic approach

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

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

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

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

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

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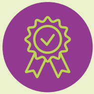

Key achievements

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

Lessons learned & Recommendations

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

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

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

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

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

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

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Endnotes

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

SOCIAL + BEHAVIOUR CHANGE

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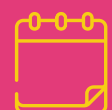
UNICEF Ethiopia Connects with Adolescents to Change Behaviours and Increase Agency

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

Brief summary



Dates of Activity
November 2019 to 2022

Duration
Three years

Budget
US$1,133,025.23

UNICEF Ethiopia in partnership with Girl Effect, a creative non-profit building youth brands and mobile platforms to empower girls, implementing a healthy lifestyle campaign targeting adolescents in Ethiopia. The *Yegna* (meaning "Ours" in Amharic) campaign encourages positive behaviour change and increased agency for girls by tackling real-life challenges through a TV drama, radio programmes, digital channels, music, and school-based clubs. *Yegna* is rooted in Ethiopian culture, and was created after listening to the challenges faced by thousands of Ethiopian girls in their everyday lives. Key messages focused on improving nutritional status, menstrual health and hygiene, sexual and reproductive health, access to and use of health services, and building self-esteem and agency, among adolescent girls. At the height of the COVID-19 pandemic, the *Yegna* drama series was used to provide adolescents with relevant messages about COVID-19 prevention.[1] Since its first national television broadcast in 2019, the *Yegna* drama has become a household name in Ethiopia, captivating an audience of about 10 million. Seventy-eight per cent of viewers of the *Yegna* TV drama said that they learned something new from the show; 42 per cent said that they changed their behaviour as a result of watching the show.

Context

Undernutrition and poor dietary diversity affect large swaths of the adolescent and youth population in Ethiopia. Findings from a UNICEF-supported baseline study on adolescent nutrition, menstrual hygiene management, and utilization of adolescent-friendly health services in Ethiopia showed that about 83 per cent of girls consumed foods from less than five food groups and only 50 per cent consume animal-source foods. Norms around when and how often boys and girls eat showed that girls eat less food, less frequently, and have fewer options to eat a variety of foods, compared to boys who have greater access to food outside of the home. The study findings also highlighted that taboos around menstruation and menstrual hygiene management have restricted girls' mobility and caused shame and embarrassment. Many girls felt the need to manage their periods at home, depriving them of their education, and of the confidence to manage menstruation wherever they are. Girls felt that they could not adequately communicate with their teachers when they were having difficulty managing menstruation at school. Menstruation also signals a girl's readiness for marriage and childbearing in Ethiopian culture. Girls have little agency around when or who they marry. A girl that refuses marriage risks shame and ostracization from her family and community.[2]

The availability of quality youth-friendly health services has been a pressing issue throughout Ethiopia. The baseline study supported by UNICEF suggested that girls felt poorly treated by health care providers and health service facility staff, had low satisfaction with health service accessibility and health facility conditions, and perceived a lack of privacy and confidentiality related to their care.

Yegna is a media platform using music, radio, and digital channels, where storytelling is used to support in-school and out-of-school girls ages 10 to 19 years on their individual and collective journeys to adulthood. Girl Effect, a global NGO specializing in communication for adolescents, launched *Yegna* in Ethiopia in 2012. Since its launch, *Yegna* has become an authentically Ethiopian youth brand, including branded merchandise. The original campaign consisted of a radio drama, radio talk show, and music, all in Amharic (Ethiopia's national language). The content was produced by an all-female cast, and focused on the lives of five teenage girls with a strong friendship bond and a music band. The girls portrayed the typical challenges Ethiopian girls faced, and then produced music to help share their experiences. The intended audience for *Yegna* was girls ages 13 to 15 years old, but soon gained a wider following in Ethiopian communities. The first music single from the campaign received the national "Best Single of the Year Award". In 2019, *Yegna* introduced a gender-mixed cast and developed a new TV drama entitled "*Yegna* – The Story of All of Us", that continues to be nationally broadcast in multiple languages.

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Strategic approach

In 2019, the *Yegna* TV drama was first broadcast on national television, gaining popularity among urban audiences. Viewers were able to watch the episodes in three languages: Amharic, Afan Ormo and Tigrigna. The aim was to improve knowledge, perceptions and outcomes for nutrition, menstrual health and hygiene, and sexual and reproductive health; improve access to and use of health and nutrition-related goods and services; and to build the self-esteem and agency of adolescent girls. The drama included messages on menstruation, puberty, gender-based violence, gender equality and girls' empowerment, and other topics designed to motivate discussions between parents and children. Each subsequent *Yegna* series reinforced the key messages, added new messages (e.g., nutrition challenges among teenage mothers; cervical cancer, HPV, and the HPV vaccine) and used monitoring data to refine the messages and delivery mode (e.g., shortening episode length from one hour to 30 minutes in 2020). The *Yegna* drama series was also uploaded on a Yegna YouTube channel where adolescents could engage in online conversations about the drama series.

Ethiopian adolescents in rural areas did not have access to the *Yegna* TV drama. To address this gap, UNICEF and Girl Effect created the Yegna Rural Schools Programme, an educational initiative bringing the TV show to adolescents aged 13-15 studying in Ethiopia's rural regions and providing them with knowledge to help them with decision-making about critical issues at this pivotal time in their development. UNICEF purchased solar projectors to show shortened clips of the series in school clubs, targeting 28 schools in two regions. Teachers and principals were trained, and the initiative was launched in schools in the Oromia and Amhara regions. After watching an episode, talking guides led students and teachers through discussion about the content and the topic(s) highlighted in the show. These discussions were supplemented by fact sheets for discussion with parents. The rural schools programme created safe spaces where students could discuss topics featured in the series, from nutrition, to menstrual hygiene management, to toxic masculinity. A second phase of the programme was launched in 2022, in 13 schools of the Oromia region, building on the impact from the first year. A total of 1,170 students participated in the second phase.

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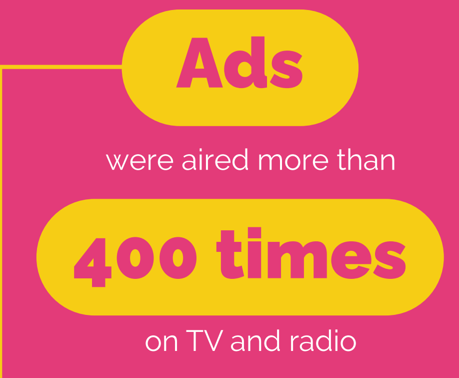
In November 2020, UNICEF Ethiopia supported a baseline study to determine what messages the *Yegna* activities could disseminate to reduce COVID-19 mortality and morbidity.[3] The baseline research also included questions about other topic areas relevant to the core intended audience of adolescent girls (e.g., menstrual hygiene, gender-based violence, mental health, and nutrition). Findings from the research showed that while 99 per cent of respondents knew about COVID-19 and methods for preventing the disease, only 37 per cent practiced regular hand washing, and only 40 per cent wore facemasks. The baseline assessment also revealed that more than half of the adolescent respondents (55 per cent) assumed that eating processed snack foods is healthy. The research highlighted the need to promote the adoption of key COVID-19 prevention behaviours, to increase the number of parents and children willing to return to school, and to enhance knowledge in the areas of nutrition, violence against women and menstrual hygiene management.

In 2020, UNICEF Ethiopia supported the development of a 20-week *Yegna COVID-19* campaign consisting of 20 public service announcements (PSAs) using the *Yegna* mixed-gender cast. The PSAs were broadcast weekly in three languages (Amharic, Afan Oromo, & Tigirigna), on both national and regional radio. From December 2020 to May 2021, video advertisements were created and broadcast on five TV stations, four radio stations, and via social media. The ads featured *Yegna* characters (influencers) that discussed the importance of not eating processed food (including fast food), menstrual hygiene and creating sanitary pads, excitement and anxiety of returning to school in COVID-19 times, and the importance of handwashing and regular physical exercise. The ads were aired more than 400 times on TV and radio. *Yegna* billboards showing *Yegna* characters with message about COVID-19 prevention (e.g., wear face masks and wash hands frequently), nutrition, menstrual hygiene, mental health, and not being fearful to report GBV, were placed in major cities of Ethiopia: Addis Ababa, Adama, Hawassa, Bahirdar. The aim of the *Yegna* campaign was to reach an audience of at least 15 million. Various social media channels were used to disseminate *Yegna COCID-19* campaign messagesincluding a *Yegna* YouTube channel, Telegram, and the UNICEF Ethiopia official Facebook page.

Key achievements[5]

Over the past three years, *Yegna* activities have reached 500,000 adolescents throughout Ethiopia and built a vast and loyal fan base. The TV drama has become a household name throughout the country, reaching almost 10 million viewers. Each *Yegna episode on the YouTube channel was viewed by* 200,000 to 650,000 viewers. Some of the achievements of the programme include:

- Forty-two per cent of viewers said that they changed their behaviour as a result of watching the show.
- More than 1,300 adolescents in Oromia and Amhara have taken part in the rural school-based *Yegna* programme.
- Fifty-two per cent of participants in Oromia that participated in the *Yegna* rural school programme talked to at least one family member using the programme's factsheets and manuals on the topics covered in the drama.[4]
- Students found the Yegna club was especially relevant for receiving new knowledge that helped them in their day-to-day life and that they felt would help them with their future success.
- Parents and teachers noted positive changes in the children who attended the rural school programme.
- Awareness and knowledge about cervical cancer and the HPV vaccine was higher among viewers compared to non-viewers of the *Yegna* TV drama.
- Those exposed to the *Yegna* in My Head campaign were more cautious about COVID-19 prevention. Hand washing and mask wearing increased over time.
- The frequency of eating processed foods and eating a more diverse diet changed for the better. Those exposed to the *Yegna* campaign were more likely to know that eating processed snacks is unhealthy and they reported eating less processed food.
- Those exposed to the *Yegna* campaign were more likely to know about producing reusable pads at home and using disposable or reusable pads interchangeably.



Lesson learned

1 Conducting baseline research to understand the intended audiences' awareness, knowledge, perceptions, behaviours and norms associated with the health topics of interest is key to developing culturally and age-appropriate messages to motivate behaviour change.

2 Using edutainment/storytelling and characters played by famous Ethiopian actors that appealed to adolescents, made the Yegna TV programme more attractive and effective in captivating the attention of Ethiopian adolescents and motivating the desired change.

3 Using the existing *Yegna* brand was instrumental in enabling UNICEF to rapidly reach a wide audience with the key health messages based on evidence from the intended audience.

Recommendations

1 Ensure that the intended audience (in this case, adolescents) are actively engaged from the planning phase of the programme through to the evaluation in order to ensure greater engagement and ownership of the messaging

2 When designing a similar programme for adolescents, engage parents, caregivers, and teachers that play an important role in shaping the development and future of young people.

3 Use technology/social media to engage adolescents and motivate them to participate in online discussions and/or activities.

Endnotes

1 Funding support for this campaign comes from Global Affairs Canada.

2 Cader R., Eager R., Tenaw E., Cornelius A., *UNICEF Ethiopia adolescent nutrtion-WASH-education joint programme evaluation*, 3 June 2020.

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5 United Nations Children's Fund, 'Yegna in My Head: Baseline and post-wave consolidated report', UNICEF, October 2021.

SOCIAL + BEHAVIOUR CHANGE

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UNICEF Ethiopia Helps Break the Silence of Menstrual Hygiene Management

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

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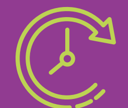
Brief summary

Dates of Activity
August 2016
to December 2020



Duration
3.5 years

Budget
US$2.5 million

Girls across Ethiopia face social, cultural and economic barriers related to menstruation that inhibits their right to dignity, and often prevents their right to education because of inadequate menstrual hygiene education, insufficient WASH facilities in schools, bullying from their fellow students and poor access to sanitary materials. UNICEF Ethiopia's Water, Sanitation and Hygiene (WASH) Programme recognize that menstrual hygiene management (MHM) is an important aspect of eliminating inequalities in WASH services access, and that MHM contributes to reducing early marriage through improving girls' school attendance, performance and school completion. UNICEF Ethiopia designed and supported the implementation of a pilot menstrual hygiene management (MHM) programme in six regions of Ethiopia between August 2016 and December 2020. The aim of the programme was to break the silence on MHM and empower adolescent girls to stay in school during menstruation. An endline study of the pilot showed that access to sanitary materials during menstruation was associated with fewer school absences.

Context

In 2017, there were about 17.9 million adolescent girls in Ethiopia between the ages of 10—24, representing more than one third (34 per cent) of the country's total population.[1] Findings from a 2016 national WASH KAP baseline survey in Ethiopia showed that 70 per cent of adolescent girls knew that menstruation is a natural process that occurred when a girl reached puberty. Most girls, however, are unprepared for managing their menses. Fifty-two per cent of adolescent girls never received information about menstrual hygiene; only 22 per cent of mothers said that they talked with their daughter about menstruation before she started menstruating. Less than half of girls in the baseline study (42 per cent) knew that homemade menstrual cloth and reusable pads/underwear needs to be washed with soap and water.[2]

In Ethiopia, the natural process of menstruation is strongly associated with shame and silence. A pervasive myth about menstruation is that it is an indicator of the beginning of sexual activity. In traditional, rural communities this myth can be extremely damaging and potentially dangerous for adolescent girls since it is related to belief that menstruation is a sign of maturity that signifies that a girl is ready to be married. Girls that attend school experience harassment and teasing from their classmates, especially boys, leading to missed days of school during their period, and, in many cases, school drop-out. Teachers and school officials are of little help since most are unaware of the significance of this problem. WASH infrastructure in schools is in generally poor state, with over half of girls (56 per cent) reporting there is never access to water in schools. MHM centers created for girls tend to go unused because girls prefer not to be identified as having their period by using the centers, and, in some cases, require asking a male teacher for a key to use those facilities.[3]

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Strategic approach

UNICEF Ethiopia commissioned two baseline surveys between 2016 and 2017 (led by Ethiopian research teams) to inform and guide the design of the MHM pilot programme, as well as to develop the monitoring framework and indicators to measure progress and guide the final evaluation. Until the UNICEF baseline, there had never been a detailed national survey on menstruation in Ethiopia, only small-scale studies have taken place, and only for some regions. There was also almost no evidence that looked at the attitudes and beliefs about menstruation among Ethiopian men and boys. UNICEF also organized a national Knowledge, Attitudes and Practices (KAP) survey in early 2017 to establish baseline data for UNICEF's WASH country programme strategy.

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The UNICEF Ethiopia WASH unit translated the baseline findings into a pilot MHM programme entitled Breaking the Silence on Menstrual Hygiene Management.[4] The aim of the programme was to ensure the safety, dignity, and empowerment of adolescent girls while contributing to the retention of adolescent girls in schools at the critical time of menstruation. Specifically, the key objectives of the programme were to achieve 80 per cent of adolescent girls in selected schools practicing appropriate MHM, and reducing by 80 per cent the number of girls that are absent from, or drop out of, the target schools. The pilot activities were implemented in 47 schools located in six regions of the country: Afar, Southern Nations, Nationalities and Peoples (SNNP), Oromia, Amhara, Somalia, and Gambella, between August 2016 and December 2020.

In collaboration with UNICEF, the Ethiopia Ministry of Health developed a national MHM guide designed to address the topic of MHM in schools, communities and workplaces, as well as in emergencies. On 15 February 2017, UNICEF launched community- and school- focused MHM training of trainers (ToT) workshops for a total of 240 staff of the regional health and education bureaus in Oromia, Amhara, Gambella, Afar, SNNP and Somali regions. The ToT workshop established coordination between the education and health sectors and equipped focal persons with global, national and regional menstruation facts. It also introduced participants to the MHM package of services: SBC activities concerning menstruation, establishing safe spaces to enable girls to receive peer support, counselling, and emergency kits as well as improved WASH facilities and supply of MHH kits.[5]

The pilot programme consisted of an advocacy component and a proof-of concept component to test various sanitary pad products, marketing and distribution service options. UNICEF Ethiopia engaged in advocacy and dialogue with key higher-level stakeholders to promote the MHM agenda, and to influence adolescent girls and women friendly WASH programming by government and its partners. The advocacy activities included:

- Nationwide promotion of acceptable quality standards for local production of reusable sanitary pads;
- Nationwide revision and validation of institutional WASH design and construction manual to include provision of safe, private and MHM friendly WASH facilities in schools;
- Nationwide integration of MHM in the Health Extension Program (HEP);
- Adoption of the National MHM guidelines jointly by the Ministry of Health (MoH) and Ministry of Education (MoE); and
- Linkage with regional/global best practices and knowledge base.[6]

The programme worked in partnership with the One WASH national programme signatory Ministries of Water, Health and Education, and their respective line offices. UNICEF also collaborated with Non-Governmental Organizations (NGOs) to share/learn knowledge and practices on MHM, engaged specialty expertise from regional/global market to work on quality standards and regulation mechanisms, and partnered with local media companies (public and private) to sensitize stakeholders.

The key activities for the proof-of-concept testing were:

- Creating access to water, sanitation and waste disposal infrastructure in schools (MHM friendly WASH facilities and safe spaces);
- Capacity building for local production of sanitary pads in schools and communities (business viability assessment for local production and sale of reusable pads, supply of materials and equipment for local production of pads, and linkage/partnership with private sector to access key inputs for local production of quality and safe pads);
- Social behavioural change interventions. The intervention activities included providing girls and boys with pre- and post-menarche information to ensure they were prepared and informed about menstruation. Boys and young men were encouraged to understand the importance of menstrual hygiene, and to support girls and women during their menstruation. Boys participated in school-based activities, particularly through clubs and mini-media, and acted as role models and influencers for their peers; their aim was to persuade other boys to stop teasing girls during their period. Community meetings were held to discuss and de-stigmatize and dispel myths and misconceptions about

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menstruation, and to raise awareness about the need to support girls and women instead of excluding them during their menstrual cycle. Opinion leaders (namely religious and clan leaders) were also engaged to support menstrual hygiene management;

- Monitoring and Evaluation (M&E) and Knowledge Management, i.e., knowledge management and sharing among sector actors, including linkage to regional/global partnerships and service agreements with specialized consulting firms; baseline/end-line surveys, interim evaluation and monitoring.[7]

The sanitary pad supply chain component of the programme established women's groups to produce reusable sanitary pads and provides support to local manufacturers through partnerships to improve the production, packaging, distribution and use of sanitary pad products in target regions. On the manufacturing end, partner companies were engaged in backward integration of the production of raw materials such as absorbents and liners. On the sales end, pharmaceutical and family planning outlets, such as pharmacies, drug stores and clinics, were utilized at local and regional levels to bring the improved products to communities.

An endline evaluation study was conducted in 2020 to understand changes in knowledge, attitudes, and practices around menstrual hygiene management among schoolgirls and boys resulting from the MHM pilot activities. The study used a cross-sectional, mixed-methods approach, with data collected from primary and secondary sources (structured interviews, in-depth interviews, focus group discussions case stories, observation and document review).

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Key achievements[8]

The pilot programme activities played an important role in improving access to facilities and hygiene materials for MHM at schools. Girls gained access to quality sanitary pads for free, safe places for changing pads, rest, and consultations, access to water and latrine facilities. Key achievements from this programme include:

- The percentage of girls who ever heard about MHM increased from 48 per cent in 2016 (the time of the pilot programme baseline) to 95 per cent at endline in 2020.
- The percentage of girls that knew menstruation is a natural process that occurred when a girl reached puberty increased to from 70 per cent in 2016 to 93 per cent in 2020.
- The use of disposable and reusable sanitary pads increased from 50 per cent and 3 per cent respectively at baseline, to 80 per cent that prefer disposable sanitary pads and 15 per cent who prefer reusable sanitary pads at endline.
- Girls' practice in washing reusable menstrual materials with water and soap increased from 77 per cent at baseline to 99 per cent at endline.
- At least 90 per cent of the girls at endline said sanitary pads are available at their school for free. This is a significant increase from 19 per cent in the 2016.
- Seventy-two per cent of girls said that they used school safe spaces or rooms during menstruation. Among those who use the safe spaces or rooms, 78 per cent used the facilities for rest and 71 per cent for changing sanitary pads. Twenty-one per cent used the safe spaces or rooms for consultation.
- Forty-two per cent of the girls at endline said water is always available at school for menstrual hygiene, a significantly increased from 16 per cent in the 2016.
- Although there was no statistically significant difference from baseline to endline of the percentage of girls that missed school during menstruation, the most cited reason was too much pain as opposed to teasing or other shaming reasons.
- Qualitative study participants (girls and boys) reported improved knowledge and attitude change related to MHM within the school community and the general community. Female FGD participants confirmed that boys have stopped teasing them about menstruation at school. Boys who participated in FGDs claimed that they abandoned teasing menstruating girls due to the awareness raising education programme. Those boys said they were more supportive of girls when they were menstruating, by, for example, sharing their notes if the girls missed classes, or, if they saw menstrual blood stains on a girl's clothes, they would offer her their cloth to cover it and help her to go to the safe space/room.

AT LEAST **90%** OF THE GIRLS

at endline said sanitary pads are available at their school for free

72% OF THE GIRLS

said that they used school safe spaces or rooms during menstruation

42% OF THE GIRLS

said water is always available at school for menstrual hygiene, a significantly increased from 16 per cent in the 2016

Lessons learned

1. Awareness creation activities about menstruation among schoolboys is important for creating positive attitudes toward menstruation, and helps to prevent boys from teasing menstruating girls, reducing girl's school absenteeism due to fear of teasing. Engaging boys and men in the discussion around menstruation can help break the taboo and create a supportive environment for girls and women.

2. Providing pre and post menstrual information for both girls and boys, as well as parents, can help to dispel misconceptions and empower them with knowledge.

3. Conducting community discussions and awareness-raising campaigns on menstrual hygiene can help to break the silence and encourage open communication about menstruation.

4. Engaging community members such as religious leaders and local leaders in breaking the silence around menstruation can be an effective approach in promoting behaviour change and addressing cultural taboos. By involving these influential community figures, it can help to increase the acceptance and uptake of menstrual hygiene practices, as well as generate support for the social and behaviour change interventions.

5. Availability of safe spaces for girls to change pads, rest, and consult with others about their menstrual hygiene is essential at schools. Girls found the safe spaces necessary for managing their menstrual hygiene, and used the facilities for the intended purpose. The construction of safe spaces needs to consider the number of girls in the school to ensure the rooms' adequacy and proper site selection to safeguard privacy.

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Recommendations

1. Similar MHM interventions should also address the cultural and religious vtaboos and beliefs that impede girls from social and religious activities during menstruation.

2. Explore the use of technology, such as mobile apps or interactive messaging platforms, to increase access to information and education around menstrual hygiene, especially in areas with limited access to health services.

3. Enhance male teachers' participation so that they are more comfortable discussing or teaching about menstruation.

4. Foster partnerships with private sector entities to increase access to affordable and quality sanitary products, especially for low-income communities.

5. Future school MHM programmes should focus not only on the construction of WASH facilities but also on ensuring uninterrupted water supply by installing adequate water stworage containers, proper use, and periodic maintenance of latrines, and improving the hygiene of latrines.

6. Integrate menstrual hygiene management education in school curriculums to ensure that children and adolescents understand the importance of menstrual hygiene practices and receive accurate and reliable information.

7. Consider the number of girls in the school in determining the size of safe spaces and appropriate site selection to locate the facilities in areas that ensure the privacy of girls.

8. To enhance inclusive MHH by engaging children and people with disabilities and to ensure that MHH interventions reach the most vulnerable communities, i.e., Children with disabilities and MHH in humanitarian situations.

9. Besides providing sanitary pads to schools, similar future programmes should also focus on implementing a system to locally produce sanitary materials (e.g., supporting schools to produce locally made sanitary materials) by providing seed money, tools, and training to teachers.

10. Develop community-based peer education and mentoring programmes where older girls and women act as mentors to younger girls, providing support, information, and practical advice on menstrual hygiene.

11. Conduct advocacy with education offices and schools to allocate budgets to produce reusable sanitary pads.

12. Create a monitoring and evaluation system at the school to measure MHH's contribution to adolescent girls' education, including absenteeism and dropout due to menstruation.

Endnotes

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4 The programme was funded by the Embassy of the Kingdom of the Netherlands.

5 Kalkidian Gugsa, 'UNICEF Ethiopia: Menstrual hygiene management programme kicked off with a training of trainers in Oromia and Somali regions', February 2017, <https://unicefethiopia.wordpress.com/2017/03/30/menstrual-hygiene-management-programme-kicked-off-with-a-training-of-trainers-in-oromia-and-somali-regions/>.

6 United Nations Children's Fund, Endline KAP survey on menstrual hygiene management among schoolgirls and boys in 6 regions of Ethiopia (Afar, Gambella, Somali, Oromia, Amhara, and SNNP): Evaluation report. Addis Ababa, Ethiopia: DAB Development Research and Training PLC, UNICEF Ethiopia, 2020, p. 3.

7 United Nations Children's Fund, Endline KAP survey on menstrual hygiene management among schoolgirls and boys in 6 regions of Ethiopia (Afar, Gambella, Somali, Oromia, Amhara, and SNNP): Evaluation report. Addis Ababa, Ethiopia: DAB Development Research and Training PLC, UNICEF Ethiopia, 2020, p. 3—4.

8 For a full account of the key achievements, see UNICEF Ethiopia (2020). Endline KAP survey on menstrual hygiene management among schoolgirls and boys in 6 regions of Ethiopia (Afar, Gambella, Somali, Oromia, Amhara, and SNNP): Evaluation report. Addis Ababa, Ethiopia: DAB Development Research and Training PLC.

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

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

Brief summary

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

Context

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

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

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

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Strategic approach

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

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

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

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

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

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

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Key achievements

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

74 OUT OF **80** COUNTIES

in all 10 states across the country covered

1,912,187 PEOPLE

in 362,615 households were reached in affected areas

The phone hotline was accessed by

2,000 PEOPLE

Lessons learned & Recommendations

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

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

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

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

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UNICEF Somalia Supports Communities Care Model to Eliminate Female Genital Mutilation

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

Brief summary

UNICEF Somalia supported the integration of activities to eliminate female genital mutilation (FGM) into wider programmes that primarily focus on gender-based violence, such as the Communities Care: Transforming Lives and Preventing Violence Programme (CC Programme), which began in Somalia in 2013. The aim of the CC programme has been to engage and support communities to tackle gender-based violence (GBV) by changing individual behaviours, collective practices and widely held beliefs that contribute to violence against women and girls and limit the ability of survivors to seek support and assistance. When the CC Programme first began, discussions on sensitive issues, such as FGM and child marriage, were met with resistance. However, because the programme focuses on building relationships over time, rooted in community-led dialogue and the local identification of needs, priorities and solutions, the approaches taken are contextually appropriate, locally owned and locally supported. Community dialogues have provided opportunities to discuss societal expectations and norms, health concerns related to FGM, as well as the roles and responsibilities of different people Integrated programming has allowed for wider multi-sector engagement and the enhancement of coordination across a range of different stakeholders.

Context

Female genital mutilation (FGM) involves altering or injuring the female external genitalia for non-medical reasons. The practice poses serious risks to the health and wellbeing of girls and women and is widely recognised as a human rights violation. Although government and political actors have demonstrated a commitment to promote FGM bills and policy at the federal and Somaliland government levels,, the practice remains widespread throughout the country. The recent Somali Demographic and Health Survey (2020) showed an FGM prevalence rate of 99 per cent. Sexual and gender-based violence against women and girls, including gang rapes, forced marriages and FGM are considered significant concerns across all federal states of Somalia.[1] The massive effort needed to reduce the practice is made more challenging by weak governmental authority amidst long-standing conflict, political instability and resource scarcity. Despite the federal government's efforts to strengthen child protection systems at all levels, governance and practice differ from region to region, and the practice of FGM is deeply embedded in social norms and practices within communities.

In this context, the UNFPA-UNICEF Joint Programme was launched in Somalia in 2008 in a collaborative effort with the Ministry of Labour and Social Affairs and various non-governmental organizations. To date, work related to FGM has been integrated into wider programmatic efforts such as those aimed at combatting gender-based violence (GBV). Embedding FGM into wider programming can be considered a promising practice in the Somalia context because it offers a less confrontational way of engaging communities and stakeholders on a very sensitive issue within the wider context of GBV, and, given that Somalia is a heavily resource-constrained environment, an integrated programming approach provides an opportunity to improve the appropriateness and sustainability of different interventions. By merging those programmes that have shorter funding timelines with others that have multi-year funding, it has been possible to build rapport with communities over time, an essential prerequisite to meaningful and lasting engagement and change.

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Strategic approach

With support from UNICEF and UNFPA, a new national strategy was developed to inform efforts to combat FGM. The key pillars of the strategy included:

- A strong rights-based approach and high-level advocacy: human rights, women's rights, children's rights, and national policy and legislation.
- Maximizing the role of religious leaders, religious terminology, and religious and spiritual beliefs, as 72% of women believe that FGM is a religious requirement (DHS 2020).
- Addressing the medicalization of FGM and capitalize on the role of the MOH, the health sector, and health workers in the provision, prevention and treatment of FGM.
- Change the narrative and re-focus the message on Zero Tolerance of FGM given that there has been no reduction in overall prevalence.
- Accelerating community education, awareness raising and engagement to change social norms.
- Highlighting the importance of documentation and regular monitoring and evaluation to demonstrate programmatic and advocacy impacts over time.

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The programmatic efforts were integrated into wider programmes that primarily focus on GBV, such as the *Communities Care: Transforming Lives and Preventing Violence Programme* (CC Programme), which began in Somalia in 2013. The aim of the CC programme has been to engage and support communities to tackle GBV by changing individual behaviours, collective practices and widely held beliefs that contribute to violence against women and girls and limit the ability of survivors to seek support and assistance. When the CC Programme first began, discussions on sensitive issues, such as FGM and child marriage, were met with resistance. However, because the programme focuses on building relationships over time, rooted in community-led dialogue and the local identification of needs, priorities and solutions, the approaches taken are contextually appropriate, locally owned and locally supported. This is also the reason why taboo topics like FGM and Child Marriage could be discussed.[2]

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In 2013, Over a 15-week period, trained local facilitators brought together diverse groups of community members of all ages with different partners across multiple sectors (e.g., health, education) to discuss and reflect on their shared values, beliefs and aspirations. This approach provided a platform for communities to identify their own priorities which ultimately informed the programme design in each respective location. As the programme progressed, communities identified their priority needs, building on the discussions and exploring the social norms in their community that tolerate GBV, including FGM, and silence those who experience it. Dialogue was grounded in the everyday realities of women and girls in the community and stimulated discussion about what is relevant, their priorities, and what was important in their particular context. It localized shared ideals and values and enabled community members to work together to identify the collective actions needed to transform harmful social norms and practices. Linked to ongoing community level dialogue has been the identification of 'champions for change'. These 'champions' are usually identified in the course of community discussions and engagement both within the CC programme and through the work of the Community Based Child Protection Committees. These individuals usually include elders, religious leaders, adolescents (girls and boys), mothers, fathers, local authorities and others.

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Considering the high prevalence of women who believes it's a religious requirement, faith leaders play a significant role in shaping everyday life at the community level and can play a critical role in the elimination of FGM. While 99 per cent of Somalis are Sunni Muslims, organizations working with religious leaders highlighted the need to contextualize differences in federal and non-federal religious groupings in the development of advocacy and dialogue (depending on the type of Sunni Islam practiced). This differentiation had implications for how to engage various Imams and Sheikhs, both in terms of their secular beliefs and approaches to governance.

The Ministry of Health (MoH) worked with midwifery training schools to de-medicalize FGM.[3] The medicalization of FGM was increasing in parts of Somalia (including Somaliland), especially in urban centres, and amongst the diaspora. This challenge highlighted the need to diversify messaging and approaches to combatting the practice, rather than the more historically-dominant method of focusing primarily on the health risks associated with traditional cutting techniques. The MoH developed modules on the anti-medicalization of FGM in the national midwifery curriculum.

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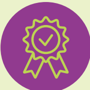

Key achievements

- The Community Care evaluation performed in 2018 demonstrated shifts in gender unequitable norms.
- Integrated programming has allowed for wider multi-sector engagement and the enhancement of coordination across a range of different stakeholders, such as girls and boys, caregivers, elders, religious leaders, and service providers in the areas of health, education, police and others. This way of working is consistent with a 'systems strengthening' approach to child protection as opposed to an 'issue-based' approach, in which individual issues are addressed in isolation from each other and the broader social and economic context in which they are manifested.
- Community dialogues have provided opportunities to discuss societal expectations and norms, health concerns related to FGM, as well as the roles and responsibilities of different people, including girls, boys, caregivers, teachers, religious leaders and authorities and the role of religion in keeping girls and women safe and protected.

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Diverse groups

OF COMMUNITY MEMBERS

of all ages brought together to discuss and reflect on shared values and aspirations over a 15-week period

Integrated programming has allowed for wider multi-sector engagement

Community dialogues have provided opportunities to discuss societal expectations and norms

Lessons learned & Recommendations

1 There is value in taking a holistic approach to addressing FGM, both in terms of the framing of the issue as one that requires multi-sectoral collaboration, and the implementation of a broad range of programmatic approaches, for example, addressing the social norms. These combined efforts offer the most promise in terms of relevance and sustainability.

2 The need to contextualize approaches to addressing FGM is paramount. Although some efforts may be required at an overarching 'national' level, for example in policy and legislation, the Communities Care Programme demonstrated that different regions and communities may have different approaches to how they engage in dialogue and with whom. The flexibility of the model ensured that the programme was contextually relevant and appropriate and also increased a sense of ownership within families and communities.

3 Strongly linked to contextualization is the need to diversify approaches to FGM. In the past, programmes and messaging have been overly reliant on imported programmes insufficiently rooted in local realities or unable to adjust as necessary over time. Working with communities and supporting dialogue on sensitive issues requires taking an iterative approach that can be adapted over time.

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Endnotes

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3 Medicalization is the situation in which health care professionals carry out FGM, whether in a health facility or at home or elsewhere, often using surgical tools, anesthetics, and antiseptics in the hope of mitigating immediate complications.

UNICEF Uganda Supports a WhatsApp Coordination Mechanism to Prevent Cross-Border Female Genital Mutilation between Uganda and Kenya

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

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Brief summary

Stopping cross-border female genital mutilation (FGM) is a rising priority for the Ugandan government. One widely identified area requiring improvement was information sharing, coordination of activities, and referral services for girls and women who are at risk of, or need support after, undergoing FGM. In April 2020, UNICEF Uganda supported the creation of a WhatsApp based coordination and communication mechanism on cross-border FGM between bordering districts in Uganda and Kenya, called the *Kenya Uganda anti-FGM Forum*. Local sub-county chiefs became administrators of the new WhatsApp group.

Administrators on both sides of the border moderate the platform. During the peak of the COVID-19 lockdown in March-June 2020, this platform was the only way for people to communicate with each other to understand what was happening to girls and young women who had left their communities and could not be traced. Between April and October 2020, the use of this collaborative WhatsApp platform enabled a total of 37 girls between the ages of 11-16 years to be intercepted in Kenya and returned to Uganda, without undergoing FGM, by the Kenyan authorities.[1]

Context

Female genital mutilation (FGM) involves altering or injuring the female external genitalia for non-medical reasons. The practice can pose serious risks to the health and wellbeing of girls and women and is widely recognised as a human rights violation. Uganda has the lowest rate of FGM in east Africa. In 2016, the national prevalence of the practice among girls and women 15-49 years was 0.32 per cent, a decline from 0.64 per cent reported in 2006.[2,3] These overall low rates mask significant variations in incidence across geographic regions and ethnic groups. The vast majority of FGM takes place in the regions of Karamoja and Sebei, where overall prevalence is reported to be 26.7 per cent.[4] Prevalence rates in some sub-counties are as high as 67.3 per cent (e.g., Tapac, Moroto District).

A combination of social, cultural, and economic factors, as well as traditional and/or religious beliefs motivate the practice in different families, communities and regions. These include beliefs about female cleanliness, purity and modesty and the importance of premarital virginity and marital fidelity.[5] Widely considered to be a necessary rite of passage into womanhood, FGM is often a prerequisite for marriage and is perceived as a way to overcome poverty in contexts where there are limited educational, economic and social protection opportunities for women.[6,7] The girls and women most likely to experience FGM are those who are very poor, about to be married or recently married, reside in rural areas, and/or have mothers who were themselves cut.[8] The high value placed on FGM means that girls and women experiencetremendous social and familial pressure to be cut; those who do not undergo FGM confront considerable stigma and ill-treatment.[9]

Uganda has been part of the UNFPA-UNICEF Joint Programme to Eliminate FGM since 2009 and recently completed its third phase (2018-2021). The Joint Programme aims for Uganda to be FGM-free by 2030 through a coordinated and multi-sectoral approach to FGM prevention. Part of this work involves using community-led approaches such as dialogues among adolescents and the use of role models. Community-to-community conversations, both in Uganda and across the border with Kenya, are also undertaken in order to build understanding about how to put an end to cross-border FGM.

In 2010 the practice of FGM was made illegal in Uganda, criminalizing those who cut, or attempt to cut girls or women, and those who seek to procure FGM on their own or others' behalf. This law has driven the practice underground. The threat of being apprehended has led Ugandan women to travel across the border to Kenya for FGM, where the practice is more affordable and of better quality than in Uganda.[10] In March 2020, the COVID-19 pandemic led to an increase in the number of Ugandan girls and young women crossing into Kenya to undergo FGM. Stopping cross-border FGM is a rising priority for the Ugandan government. One widely identified area requiring improvement was information sharing, coordination of activities and initiatives, and referral services for girls and women who are at risk of, or need support after, undergoing FGM.

Strategic approach

In April 2020, UNICEF Uganda supported the creation of a WhatsApp based coordination and communication mechanism on cross-border FGM between Moroto, Bukwo and Amudat Districts in Uganda and four neighbouring districts in Kenya (Alale, Kacheliba, Kongelai and Kapenguria). Maroto District took the lead, alongside the District Commissioner from West Pokot, in Kenya. Local sub-county chiefs became administrators of the new WhatsApp group, called the *Kenya Uganda anti-FGM Forum*. Administrators on both sides of the border moderate the platform. Membership in the WhatsApp group is diverse, including Community Development Officers and District Probation and Social Welfare Officers, village chiefs, and others. There are currently three sub-groups, one per district.

During the peak of the COVID-19 lockdown in March-June 2020, this platform was the only way for people to communicate with each other to understand what was happening to girls and young women who had left their communities and could not be traced. Community volunteers sought insights from families, friends and others and then provided local surveillance to inform members of the platform in other districts and across the border of the girls' who were going to undergo FGM, their planned travel route and any contacts that they might have at their destination and along the way. Surveillance volunteers along the route tipped off the local authorities so that girls could be stopped, provided with support, counselling, and any necessary medical care.

Communication was then made with the district authorities on the Uganda side the girls concerned were taken to a border point to meet a Probation and Social Welfare Officer, who then accompanied them to one of a few temporary rescue centres set up to provide interim care to girls fleeing FGM. All were provided with the opportunity to attend nearby primary schools, and provided with psychosocial counselling and connections to vocational and livelihood opportunities. They were also introduced to social workers and role models from the community in an effort to encourage them to see a different future for themselves – a future without FGM.

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Key achievements

- Between April and October 2020, the use of this collaborative WhatsApp platform enabled a total of 37 girls between the ages of 11-16 years to be intercepted in Kenya and returned to Uganda, uncut, by the Kenyan authorities.[11] The majority chose to remain at the rescue centre for an interim period, while outreach to their families was undertaken. Six girls chose to be immediately reunified with their parents and caregivers; five ran away from the centre (and efforts were made to establish why they did so, and what happened to them since).
- The platform continues to provide a surveillance function and to share information about FGM, and about other child protection threats and safety concerns, including child marriage.

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Use of this collaborative WhatsApp platform enabled a total of

37 girls
BETWEEN THE AGES OF 11-16 YEARS

to be intercepted in Kenya and returned to Uganda wihtout undergoing FGM

The platform continues to provide a surveillance function and to share information about FGM

Lessons learned & Recommendations

1 **It is important to coordinate interventions aimed at ending FGM and child marriage.** The WhatsApp platform can be used as an effective child protection surveillance tool.

2 **Approaches led by the discrict and administered and/or coordinated by the chiefs organizing these efforts are an essential and effective component of anti-FGM and anti-child marriage efforts.** Creating a community surveillance system and training its members strengthens their capacity to intervene in FGM cases and increases the likelihood of the abandonment of FGM and other child protection concerns, including child marriage.

Endnotes

1 Jjuuko D., Nakibuuka Mbonye P. 'Uganda-Kenya cross-border partnership rescues girls from female genital mutilation during COVID-19: Countries unite to keep girls uncut', UNICEF, 24 September 20202, <www.unicef.org/uganda/stories/uganda-kenya-cross-border-partnership-rescues-girls-female-genital-mutilation-during-covid>.

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

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

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Brief summary

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

Context

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

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

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Strategic approach

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

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

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Key achievements

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

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

Indepth interviews and recall exercises were carried out with

30 PRIMARY CAREGIVERS

A Focused Ethnographic Studies (FES)

approach based on a four-module protocol was used to carry out a household case study of

30 HOUSEHOLDS spanning **30** DISTRICTS

6 FIELD RESEARCHERS

spent between four and five days in close contact with one study household

Lesson learned

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

Recommendations

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

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

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

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

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Endnotes

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

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5 Uwiringiyimana, V., Ocke, M.C., Amer, S., Veldkamp, A., 'Predictors of stunting with particular focus on complementary feeding practices: Acrosssectional study in the Northern Province of Rwanda', *Nutrition*, vol. 60, 2018, pp. 11 - 18.

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

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

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

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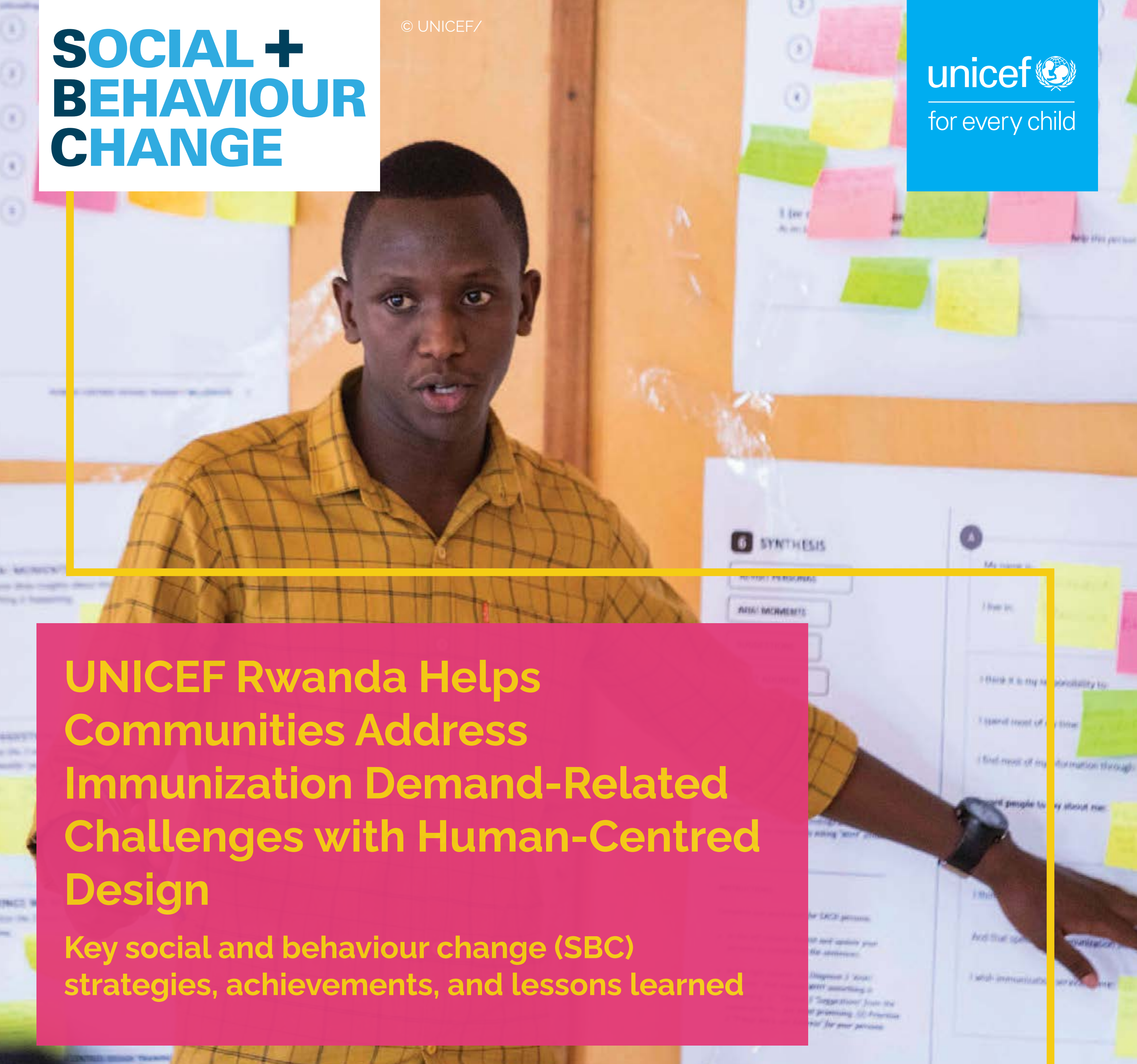

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UNICEF Rwanda Helps Communities Address Immunization Demand-Related Challenges with Human-Centred Design

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

Brief summary

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

Context

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

Strategic approach

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

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Key achievements

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

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

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

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

Lessons learned & Recommendations

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

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

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

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

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

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

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

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

Endnotes

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2 World Health Organization, 'How home-based care eased Rwanda's COVID-19 response', WHO African Region, 19 April 2022, <www.afro.who.int/news/how-home-based-care-eased-rwandas-covid-19-response>.

SOCIAL + BEHAVIOUR CHANGE

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

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

Brief summary

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

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Context

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

Strategic approach

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

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

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

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

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

Key achievements

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

HCD-oriented assessment was conducted with 40 participants living in two slum areas

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

Interviews with

13 CAREGIVERS
10 FATHERS
9 HEALTHCARE WORKERS
8 COMMUNITY LEADERS

were conducted to uncover local insights

Lessons learned & Recommendations

1. The on-the-ground examples, quotes, and perspectives allowed remote participants to understand the importance of hearing voices from local communities and health workers. It also provided real, local data to practice synthesis, idea generation and prototyping methods during the training.

2. The training should be given to health professionals in order to address challenges in their communities from various perspectives.

Endnotes

1 Based on United Nations Children's Fund, Ethiopia, HCD Scale-up Final Report, <https://drive.google.com/file/d/1oX8V8DZ8hAhqtF24ClxP03hocGVdogk3/view?pli=1>.

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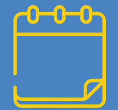
UNICEF Highlights Gender-Focused Immunization Demand Programmes in Six Countries

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

Brief summary



Dates of Activity
December 2021 to May 2022

Duration
6 months

Budget
Unknown

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

Context

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

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

Strategic approach

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

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

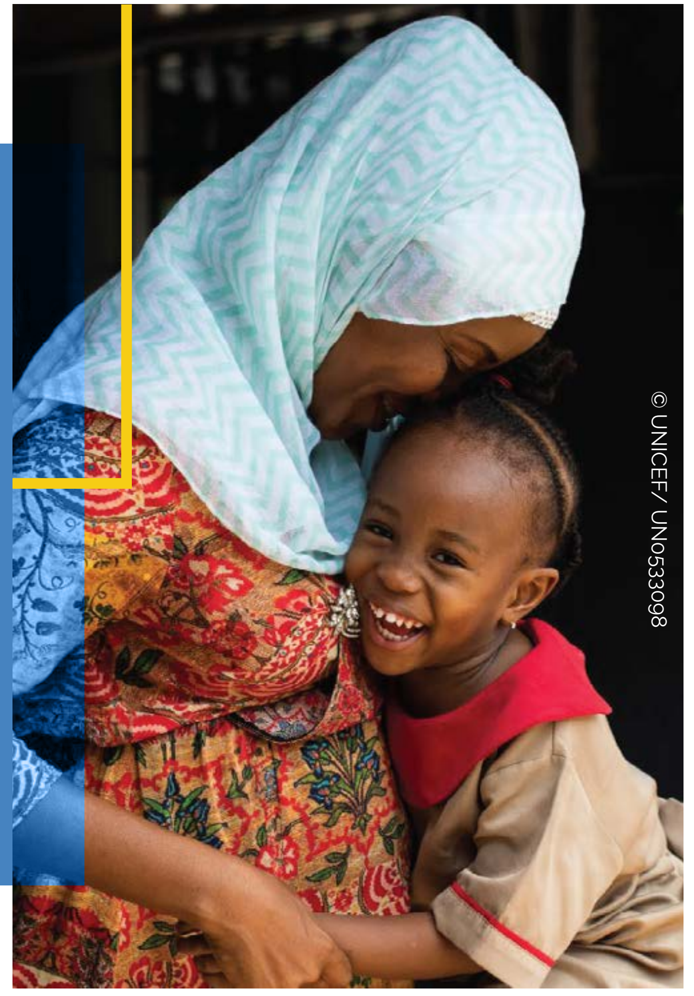
Country	Approach	Key gender-related changes	Level of gender integration
Liberia	Gender and equity-focused urban outreach campaign	Male engagement Recruitment of female vaccinators and mobilizers	Responsive
Mozambique	Promoting male engagement for integrated health practices	Male engagement Joint decision-making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

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

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

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

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

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

is key to ensuring greater impact

examples of integrating gender into vaccine demand programmes

Lessons learned & Recommendations

1. Applying a gender focus is key to ensuring a more positive experience for women and girls, men and boys, and gender-diverse groups.

2. It is important to recognize that gender includes women, men, girls and boys and the diversity within these groups as well as those who do not identify with or conform to binary notions of gender.

3. Addressing gender-related barriers to immunization not only leads to equitable coverage but contributes to gender equality and empowers women to access and claim health services. Healthier women can contribute to the well-being and development of their families, communities and countries.

4. Planning interventions that contribute to immunization coverage as well as shifts in gender norms requires robust gender analysis, strategic planning, and evidence-based design and adaptations. A common drawback noted across the six case studies is the lack of data that assess gender-related shifts linked to immunization interventions.

Endnotes

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

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

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

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

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

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

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

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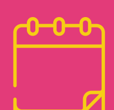
Brief summary



Dates of Activity
October 2023

Duration
48 hours

Budget
$8,000 (estimate)

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

Context

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

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

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Strategic approach

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

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

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

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

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

Key achievements

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

surveys conducted in English and Kiswahili via a mobile phone app

of respondents were aware of the vaccination campaign

of respondents were aware of the polio vaccine

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Lessons Learned

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

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

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

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

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Recommendations

1. Educational content: Create short TikTok style videos that demystify common vaccine side effects and emphasize their mild, temporary nature to reassure the public and mitigate concerns.

2. Testimonials and endorsements: Use testimonials from trusted community figures, healthcare professionals, and other known individuals that have been vaccinated to motivate others to be vaccinated.

3. Digital engagement: In response to the misinformation spreading online, implement a vaccine specific digital engagement strategy that promptly addresses false narratives.

4. Expert-led initiatives: Host online Q&A and live-stream sessions with health professionals who can provide real-time solutions and ease public anxieties.

5. Leverage influencers: Given the influence of social media, collaborating with influencers can amplify the reach of information.

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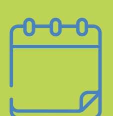
UNICEF Shapes Risk Communication and Community Engagement Strategies in Twelve Countries

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

Brief summary



Dates of Activity
August 2020 to July 2021

Duration
12 months in ESAR

Budget
US$500,000 in ESAR

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

Context

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

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

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

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

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

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Strategic approach

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

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

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

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

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

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

Key achievements

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

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Lessons learned

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

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

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

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

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

Recommendations

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

Endnotes

1 United Nations Children's Fund, 'Evaluation of UNICEF's Response to the Ebola Outbreak in West Africa, 2014-2015', UNICEF, New York, 2016.

2 United Nations Children's Fund, COVID-19 Behavioral Drivers and Patterns: A longitudinal assessment from the South Asia region: Findings from Afghanistan, India, Nepal, and Pakistan, November 2021, <www.unicef.org/rosa/media/16941/file/Final%20report%20-%20COVID-19%20Behavioural%20Drivers%20and%20Patterns:%20%20A%20longitudinal%20assessment%20from%20the%20South%20Asia%20region%20(November%202021).pdf>.

The Compendium of SBC Best Practices has been jointly developed by the Country Offices, the Regional Office, the HQ SBC Team and PCI Media.

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

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