SOCIAL + BEHAVIOUR CHANGE

WCAR

unicef
for every child

Compendium of SBC Best Practices

West and Central Africa Region

Foreword

What can volunteer community leaders in Maiduguri Nigeria learn from health workers promoting nutrition in Burkina Faso? What insights can we gain from the culture-based approach to social change in Niger and the way young leaders combat cholera transmission in Sierra Leone? What can child rights advocates and others reading these case studies learn from each set of committed community members and leaders represented in these pages?

Let us find out.

We may find a tip, an inspiration, or a new set of questions about social and behaviour change for child rights.

We are pleased to present cases from UNICEF's work with governments and civil society to promote social and behaviour change in Burkina Faso, Ghana, Nigeria, Niger, and Sierra Leone.

These cases illustrate our child rights work in the West and Central Africa Region, building on the rich and diverse histories and cultural foundations found in each of the 24 countries of the region. Innovators, musicians, political theorists, entrepreneurs, artists, civil servants, and religious leaders add to a rich tapestry of engaged civic actors and leaders, including children and adolescents, who promote social change in the region.

We are grateful for the contributions of Social and Behaviour Change colleagues from the region, recounting collaborations with their talented counterparts supporting child rights outcomes in health, nutrition, protection, education, and water, sanitation, and hygiene (WASH).

We welcome any suggestions you might care to offer (click here to share), and invite you to check out additional resources on social and behaviour change, compiled and co-created with colleagues and partners across the region.

Karen Greiner, Regional Advisor,
Social and Behaviour Change,
West and Central Africa Regional Office.

WCAR

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

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

- UNICEF Nigeria Supports Volunteer Community Mobilizers to Help Eradicate Polio
- UNICEF Leads Social Mobilization and Community Engagement Central to the Ebola Response in West Africa
- UNICEF Ghana Supports Social Mobilization Activities to Increase COVID-19 Vaccination Coverage Among the Fulani Population
- UNICEF Sierra Leone Uses U-Report Platform to Prevent a Cholera Outbreak and Facilitate Cash Transfers Among Mudslide Victims in Freetown
- UNICEF Burkina Faso Assesses Scale-Up of Optimal Infant and Young Child Feeding Practices in Two Health Districts
- UNICEF Ghana Facilitates Social and Behaviour Change Research and Message Dissemination
- UNICEF Ghana Helps Prevent Outbreaks and through Digital Platform Agoo
- UNICEF Niger Supports Girls and Youth Empowerment Through Skills-Building Platform and Community Hubs
- UNICEF Ghana Supports the Use of Human Centred Design to Improve COVID-19 Vaccination Uptake and Consistent Handwashing Among Health Workers at Vaccination Sites
- UNICEF Niger Helps to Strengthen Community Engagement Using the Niyya Da Alkawali Approach

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

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

- UNICEF Highlights Gender-Focused Immunization Demand Programmes in Six Countries
- UNICEF Launches Initiative to Improve Social Norms Measurement and Programming

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

© UNICEF/UN0557418/Esiebo

UNICEF Nigeria Supports Volunteer Community Mobilizers to Help Eradicate Polio

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

Brief summary

Dates of Activity
2012 to 2021

Duration
11 years

Budget
US$8,052,194

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

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

Context

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

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

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

Strategic approach

Creating a Cadre of VCMs

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

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

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

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

Digitizing Nigeria's Health Information System

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

Key achievements

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

© UNICUNICEF/Nigeria/2021/Kaalu

MORE THAN 20,000

volunteers trained

500,000 CHILDREN

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

Lesson learned

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

Recommendations

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

Endnotes

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

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

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

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

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

© UNICEF/UN175705/Ryeng

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

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

Brief summary

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

Context

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

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

© UNICEF/UNI176799/Ryeng

Strategic approach

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

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

© UNICEF/UN|176921/Nesbitt

© UNICEEUN|17692|Nesbitt

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

Key achievements

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

53
survey respondants

MORE THAN 90
expert discussions

UNICEF USED C4D
expertise and tools to share Ebola knowledge

© UNICEF/UNI176936/Nesbitt

Lessons learned & Recommendations

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

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

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

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

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

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

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

Endnotes

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

2 World Health Organization, 'Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa', WHO, Geneva, 8 August 2014, <https://www.who.int/news/item/08-08-2014-statement-on-the-1st-meeting-of-the-ihr-emergency-committee-on-the-2014-ebola-outbreak-in-west-africa>.

3 United Nations Children's Fund, 'UNICEF Situation Reports: Guinea, Liberia, Sierra Leone', UNICEF, New York, 29 February 2016.

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

© UNICEF/UN328480/QUARMYNE

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

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

Brief summary

Dates of Activity
March to July 2022

Duration
5 months

Budget
US$22,600

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

Context

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

Strategic approach

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

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

© UNICEF/UN085634/QUARMYNE

Key achievements

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

31 community-based quality improvement volunteers trained

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

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

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

© UNICEF/UN781482/ASSELIN

Lessons learned & Recommendations

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

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

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

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

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

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

SOCIAL + BEHAVIOUR CHANGE

unicef for every child

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

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

Brief summary

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

Context

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

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

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

© UNICEF/UN076070/James

Strategic approach

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

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

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

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

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

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

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

Key achievements

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

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

78,628 HOUSEHOLD VISITS were conducted by community mobilizers

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

Lessons learned & Recommendations

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

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

Endnotes

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

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

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

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

Brief summary

Dates of Activity
X

Duration
X

Budget
X

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

Context

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

Strategic approach

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

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

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

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

Key achievements

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

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

Lessons Learned

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

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

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

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

Recommendations

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

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

Endnotes

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

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

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

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

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

© UNICEF/UN0259707/Dsongh

UNICEF Ghana Facilitates Social and Behaviour Change Research and Message Dissemination

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

Brief summary

Dates of Activity
2015 to present

Duration
Ongoing

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

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

Context

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

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

Strategic approach

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

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

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

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

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

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

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

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

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

Key achievements

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

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

OVER
nine million calls
have received and
4.5 million people
supported

Talking Book programme reached
94,793 PEOPLE

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

Lessons learned

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

Recommendations

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

Endnotes

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

© UNICEF/UN043 1322/Annankra

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

© UNICEF/UN0231639/Dejongh

UNICEF Ghana Helps Prevent Outbreaks and through Digital Platform Agoo

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

Brief summary

In 2015, UNICEF Ghana partnered with the Government of Ghana and the private sector to create Agoo, a mobile-based communication platform to provide Ghanaian cell-phone users with access to information about cholera prevention, through a call center with trained agents, Interactive Voice Response (IVR), and/or technology, and short message service (SMS). The platform gained popularity among young people through its promotion on mass media and the mobilization of senior high school students. Due to its success, Agoo was transitioned to become a more interactive tool to create demand for information around WASH, education, health, nutrition, and child protection issues. The Agoo platform has evolved into an information hub used by adolescents and young people; more than 85 per cent of Agoo users are under 25 years of age, with the majority of them being in senior high school.

Context

Since the 1980s, Ghana has experienced sporadic outbreaks of cholera. From 2014 to early 2015, the country experienced the deadliest cholera outbreak in its history, with about 28,922 cases reported, including 243 deaths. The outbreak was widespread, with 130 out of 216 districts across 10 affected regions. Though children suffered during the outbreak, the most affected age group was between 20 and 49 years, which represented about 70 per cent of all reported cholera cases.

The risk factors for cholera outbreaks in Ghana include poor hygiene and environmental sanitation, especially in crowded urban settlements with lack of potable water, poor drainage systems and improper disposal of both solid and liquid waste. In 2014, only 14 per cent of households in Ghana had access to improved toilets that were not shared with other households. Another 21 per cent of households practiced open defecation. Handwashing with soap, which is proven to be the most cost-effective way of reducing infectious disease, was not practiced by many Ghanaians; only 53 per cent of Ghanaians washed their hands with soap.[1]

Strategic approach

In 2015, UNICEF partnered with the Government of Ghana and the private sector to create *Agoo*, a mobile-based communication platform.[2] Agoo is a service partnership between UNICEF Ghana and the country's largest mobile phone network, MTN. Under this arrangement, MTN provides free airtime worth US$1 million to its customers to access information on Agoo. Customers can dial a toll-free service on 5100, while other mobile users also access information by calling 0540118999 for a small charge. Ghanaians were already using mobile phones thanks to affordable phone models and good network coverage. The Agoo platform gave literate and non-literate Ghanaians access to information about cholera prevention through a call center with trained agents, Interactive Voice Response (IVR)[3] technology, and/or and short message service (SMS).

Initially, the focus of Agoo information was on the promotion of handwashing with soap as a first line of defense against cholera. Messages about Ebola prevention (similar to cholera prevention) were also made available. Ghanaians could access this information in any of the seven commonly spoken languages in the country (English, Twi, Dagbani, Hausa, Ga, Frafra, and Ewe), at their convenience on their mobile phone. The platform included a real-time dashboard to track user statistics on which topics and messages users selected and how long they listened to them.

The platform gained popularity among young people through its promotion on mass media and the mobilization of senior high school students. UNICEF collaborated with the Ghana Education Service and a pool of 16 implementing NGOs to mobilize and educate more than 400,000 high school students (96 per cent of the high school population in Ghana) in response to the cholera outbreak. Each school received buckets and soap for handwashing as well as banners, posters and Agoo wristbands. More than 200,000 students voluntarily registered their phone numbers with the Agoo service. In the event of subsequent cholera or other outbreaks, their numbers can be used to distribute essential information in affected areas.

UNICEF also engaged eight well-known Ghanaian singers representing different languages and regions of the country to produce an edutainment music video called Wash Wana Our Hands.[4] The catchy song and dance music features the gesture of handwashing as a choreographic element, and lyrics that promoted the importance of clean hands (for both cholera and Ebola prevention). The call to action, "Call Agoo to know more" is repeated throughout the music video, with the number prominently displayed on screen.

Due to its success, at the end of the cholera outbreak in 2015, UNICEF, together with other partners, transitioned the platform to become a more interactive tool to create demand for information around WASH, education, health, nutrition and child protection issues. The platform has since been linked to UNICEF's youth engagement platform, U-Report, to widen its reach and strengthen feedback loops to those who are responsible for policies and actions related to adolescents.

Key achievements

- Agoo has become one of the most interactive voice services in Ghana, with a daily call volume averaging 2,575 calls. In November 2018, nearly two million calls were received on the Agoo platform from over 460,000 individuals.
- The Agoo platform has evolved into an information hub used by adolescents and young people. More than 85 per cent of Agoo users are under 25 years of age, with the majority of them being in senior high school.
- Based on a survey conducted by VIAMO[5] in February 2018, Agoo users have reported changes in attitudes and practices and have adopted some key behaviours such as preventing child marriage (12 per cent), avoiding open defecation (10 per cent), using long lasting insecticidal nets (7 per cent) and practicing handwashing (7 per cent) over the base line period of September 2017.
- According to an IVR-based user satisfaction survey in 2017, 78 per cent of users expressed that they would recommend the *Agoo* service to their friends and family.

85%

of Agoo users are under 25 years of age

78%

of users would recommend Agoo to their friends and family

12%

of Agoo users reported changes in attitudes around child marriage

Lessons learned & Recommendations

1. The Agoo platform has proven to be a valuable tool, especially for reaching young people. It is limited only by the population's access to mobile phones. As a platform using mobile phones, it has a competitive edge over mainstream mass media channels in the following ways:

   - **Cost efficiency:** No costs are incurred for printing, delivery and buying media time for outreach;
   - **Speed:** Key messages are sent within seconds to all subscribers with the click of a button;
   - **Targeting:** Messages are sent to targeted population groups from the database of users who have registered their phone numbers with the service
   - **Scalability:** There are no limits on the project's scale and it can be linked innovatively to other platforms such as the mobile-phone-based U-Report;
   - **Flexibility:** It sends a variety of messages to adolescents that are tailored to their programming needs;
   - **Measurability:** It collects user data on the duration of calls and choice of topics in real time.

2. The sustainability of *Agoo* as a free service depends on the willingness of the mobile network provider (MTN) to extend its memorandum of understanding with UNICEF. Once the MoU ends, UNICEF and the Government of Ghana will have to solicit private sector funds.

3. New participatory content incorporated into the Agoo platform such as interactive games and a link to a gender hotline counseling service can expand this approach.

© UNICEF/UN09754/Ademuyiwa

Endnotes

1 Ghana Statistical Service (GSS), Ghana Health Service (GHS), ICF International, 2015, and Ghana Demographic and Health Survey, 2014.

2 *Agoo* is a word used across regions and languages in Ghana to announce someone's presence when entering a house, a fitting name for a multilingual service that provides life-saving information to Ghanaians.

3 IVR is a technology that enables customers to interact with a company's host system via a telephone keypad, allowing users choice in the selection of topics and a private channel for learning about sensitive topics.

4 The Wash Wana Our Hands video can be seen at https://youtu.be/rGjkZPyiD3g.

5 Viamo is global technology enterprise that uses digital technology, data science, and mobile platforms to create scalable campaigns with immediate feedback.

© UNICEF/Ghana

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

UNICEF Niger Supports Girls and Youth Empowerment Through Skills-Building Platform and Community Hubs

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

Brief summary

Dates of Activity
January-December 2022

Duration
12 months

Budget
655,327 USD

As part of the UNICEF 2019-2021 Country Programme, UNICEF Niger supported social and behavioural change interventions for youth and adolescents, including activities to change social norms that are harmful to girls and young mothers (e.g., arranged marriages). UNICEF Niger developed a digital mapping platform, installed on the Ministry of Youth and Sports server, that facilitated the registration of 5,315 youth-based associations in eight regions. The UNICEF Niger team set up 11 connectivity hubs equipped with 21 laptops and 22 desktops where adolescents and young people could build capacity and skills and co-create social innovations to improve self-efficacy, transform negative social and gender norms and contribute to positive change in their communities. A national community-based approach was also implemented, Niya Da Alkaweli (Love and Promise), based on 16 norms and standards of quality community engagement, in four regions. About 2,200 adolescents and young people (986 girls and women) from 948 villages in the four regions were trained in community profiling, causal analysis, group problem-solving and facilitation of community assessments, and dialogues and planning of youth-led community engagement initiatives.

Context

In 2022, the population of Niger was 26.2 million, 47 per cent of whom were under the age of 14 years.[1] The majority (83%) of the population live in rural areas.[2] Patriarchal and hierarchical gender relations are the norm in the country's seven regions. Women and young people have little involvement in family decisions, which limits their access to social and economic services, hinders their survival and development, and affects their ability to adapt to crises and shocks.[3]

Niger has one of the highest prevalence of child marriage in the world. At least 85 per cent of women aged 20-24 in rural areas were married by the age of 18, compared to 43 per cent in urban areas.[4,5] An estimated 28 per cent of girls are married before the age of 15. Child marriage is driven by gender inequality and the belief that women and girls are inferior to men and boys. Cultural norms give married girls a certain level of respect within society that they could not achieve if they were unmarried.[6] As part of the UNICEF 2019-2021 Country Programme, UNICEF Niger supported social and behavioural change interventions for youth and adolescents, including activities to change social norms that are harmful to girls and young mothers, for example, arranged marriages. UNICEF supported youth and adolescent civic engagement through empowerment and participation in inclusive and accessible spaces that ensured adolescents and youth (especially the most vulnerable) were accounted for and heard.

Since 2021, Niger's security challenges have displaced more than 3.7 million people (including two million children), exacerbated poverty, increased food insecurity, and created a situation of insufficient opportunities for young people. In May 2022, 759 primary schools and 34 secondary schools were closed nationwide due to the security situation, affecting more than 68,000 children, 48 per cent of whom were girls.[7] Only 27 per cent of females 15-19 years are literate, compared to 50 per cent of boys in the same age group.[8] Many girls drop out of school or are excluded due to an unsafe environment, placing them at higher risk of marrying young due to limited alternative options.[9]

© UNICEF/Islamane

Strategic approach

In 2022, UNICEF Niger initiated an inclusive youth movement to support programmatic priorities including the promotion of positive social and gender norms; climate action; promotion of peace and social cohesion; and generation of demand for basic social services (e.g., immunization, entrepreneurship). To support this youth movement, UNICEF Niger developed a digital mapping platform, installed on the Ministry of Youth and Sports server that facilitated the registration of 5,315 youth-based associations in eight regions.

The UNICEF Niger team set up 11 connectivity hubs equipped with 21 laptops and 22 desktops. The connectivity hubs are spaces where adolescents and young people can build capacity and skills (e.g., entrepreneurship, advocacy, leadership, non-violent conflict management), reflect on relevant issues, engage in decision-making with others, and by co-creating social innovations to improve self-efficacy, transform negative social and gender norms and contribute to positive change in their communities. In 2022, a national community-based approach, *Niya Da Alkaweli* (Love and Promise), based on 16 norms and standards of quality community engagement, was also implemented in four regions (Maradi, Zinder, Diffa and Tahoua). Almost 2,200 adolescents and young people (986 girls and women) from 948 villages in the four regions were trained in community profiling, causal analysis, group problem-solving and facilitation of community assessments, and dialogues and planning of youth-led community engagement initiatives.

Since 2017, Niger has been holding a five-day conference called the "Forum national pour l'autonomisation de la femme et des jeunes" (National forum for the empowerment of women and youth, or FONAF), a platform for showcasing and amplifying girls' experience and skills. This forum is attended by regional authorities, UN Women representatives, youth entrepreneurs from regions throughout Niger, and more than 500 exhibitors (e.g., a vegetable dying business, a pureed tomato enterprise, and a local spice dealer). In 2022, UNICEF supported the empowerment of young girls through capacity building on agri-food processing to allow young girls to develop their business and train their peers. During the 6th FONAF in 2022, young girls who received training during the 5th forum in 2021 shared their transformational journeys. The women shared their challenges marketing local products and were able to discuss solutions and strategies with decision makers and received support and advice from girls of the 2021 cohort. For example, in rural areas, households have vegetable gardens used for their daily subsistence, but most people have no refrigerator. The trained youth developed the idea of teaching female youth to process and conserve tomatoes as pureed or peeled to avoid waste and enable them to preserve their produce for 20 months without needing a fridge, and to save money and preserve the environment at the same time.

At the national level, UNICEF Niger supported the participatory development and the validation of the National Youth Policy and operational plan through a validation workshop. At the institutional level, The UNICEF country office supported the creation and operationalization of 13 frameworks to guide the coordination of activities for and with youth and adolescents (including those with disabilities) and monitoring implemented by youth movements. Niger also supported capacity building among local authorities and within communities (including religious leaders, local media, and local NGOs) to create an environment conducive to inter-generational dialogue, participation and engagement of adolescents and young people in community life, and to increase social accountability and social cohesion.

Key achievements

- At least 5,315 youth and sports associations were registered on the digital mapping platform which remains functional on the Ministry of Youth server.
- UNICEF supported 303 associations working to promote citizenship, culture of peace and youth leadership.
- With UNICEF's support, 15,586 girls and boys participated in the skills development, empowerment, civic engagement and/or employment training led by the Ministry of Youth with support from UNICEF. At least 6,395 youth (35 per cent girls) were trained on advocacy techniques, leadership, associative life and prevention and management of conflict through the associations.
- Over 7,000 young people and adolescents (30 per cent girls) developed various skills under the leadership of the Ministry of Youth.
- 360 individuals (women, youth, religious and traditional leaders, elected officials, refugees and people with disabilities) reported having developed the capacity to host community debates and dialogues.
- UNICEF's support to the FONAF contributed to empowering young women and girls, recognizing their value within the communities, and fostering women and girls' autonomy and self-efficacy; 237 young girls were trained specifically in agribusiness and vegetable dyeing.
- UNICEF supported 32 training sessions for youth and adolescents in simplified accounting and literacy in collaboration with regional youth directorates. 47 girls successfully completed the literacy and basic accounting training. Out of these 47, thirty girls from Gaffati, Koleram, Jirataoua and Doguerawa villages actively marketed their products.
- The youth entrepreneurship model has strengthened citizen engagement and motivated decision makers to support financing micro, small, and medium-size enterprises in Niger.
- 13 coordination and accountability frameworks were co-created with young people at the municipal level that reinforce the culture of including the voices of youth and adolescents in local governance.
- UNICEF supported the development and the validation of the National Youth Policy and action plan through a validation workshop.

5,315

youth and sports associations were registered on the digital mapping platform

7,000 +

young people and adolescents participated in skills-development trainings

237

young girls were trained specifically in agribusiness

Lessons Learned

1. Young people's entrepreneurship can be an important lever for change, especially among young females.
2. As a result of UNICEF's support to the FONAF, girls' interest in entrepreneurship increased; many are successfully creating and managing micro-enterprises in Niger and changing the power dynamics in their family and in the community.
3. Girls that participate in entrepreneurial activities were regarded as role models by their peers and were able to share their experience with neighboring communities.
4. Girls' economic empowerment can be leveraged to abandon harmful practices such as child marriage and gender-based violence; parents that value a girl's productivity will allows her to delay marriage.
5. The trainings created a critical mass of young people and adolescents with the self-efficacy to act as leaders and contribute for social and gender norms transformation in their communities.
6. The establishment of coordination frameworks at the municipal developed with and for young people reinforced the culture of including the voices of adolescents and young people in decision-making and community development.

© UNICEF/Islamane

Recommendations

1. The Ministry of Youth should prioritize the operationalization of the National Youth policy and action plan.
2. The Ministry of Youth should promote the digital mapping platform to grow the number of youth and youth associations registered to accelerate the spread of a youth-led social movement for social and behavior change.
3. The Ministry of Youth should strengthen initiatives or policies that focus on providing young women entrepreneurs in rural community with access to credit, vocational training, and literacy opportunities in collaboration with other relevant sectors.
4. The Ministry of Commerce and Industry should promote local consumption to boost the sales and the profitability of young women entrepreneurs.
5. The Ministry of Commerce and Industry to facilitate funding opportunities for startups and small and medium-sized enterprises and made accessible to young women entrepreneurs.
6. The Ministry of Commerce and Industry should further support young women entrepreneurs through agricultural and entrepreneurial public policies at the institutional level (e.g., abolition or reduction of the business tax for the first five years in business), and by creating pathways for young entrepreneurs to access appropriate local expertise, resources and support.
7. The Ministry of Commerce and Industry should incorporate the use of digital/ICT-based platforms and prioritize the digital transformation in business strategy and development. A digital mapping of the initiatives can contribute to greater visibility and influence of public policies supportive of girls' entrepreneurship.

© UNICEF

Endnotes

1 United Nations Department of Economic and Social Affairs, World population prospects 2019, <https://population.un.org/wpp>

2 World Bank, World development indicators.

3 United Nations Children's Fund (UNICEF) Niger, Gender Programmatic Review, 2021.

4 World Bank (2023). Niger: Data, <https://data.worldbank.org/country/NE>

5 Girls not Brides, Niger, <https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regions-and-countries/niger/>

6 Girls not Brides, Niger, <https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regions-and-countries/niger>

7 UNICEF Niger, Niger: Situation Report, August 5, 2022, <https://www.unicef.org/media/125581/file/Niger-Humanitarian-SitRep-June-2022.pdf>

8 Direction Générale de la Statistique et de la Prospective (DGSP) et ICF International (2012): Enquête démographique et de santé et à indicateurs multiples (EDS-MICS) 2012.

9 Girls not Brides, Niger, <https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regions-and-countries/niger>

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

© UNICEF/UNI342088/

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

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

Brief summary

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

Context

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

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

Strategic approach

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

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

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

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

Key achievements

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

48
PARTICIPANTS

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

Fully vaccinated people in Ashanti
(KUMASI REGION)

increased from

24.6% to **35.4%**

© UNICEF/UN0431325/Annankra

Lessons learned

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

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

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

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

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

Recommendations

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

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

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

Endnotes

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

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

© UNICEF/UNI342092/

SOCIAL + BEHAVIOUR CHANGE

© UNICEF/UN0209724/Gilbertson VII Photo

unicef for every child

UNICEF Niger Helps to Strengthen Community Engagement Using the *Niyya Da Alkawali* Approach

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

Brief summary

Dates of Activity
March 2021 to December 2022

Duration
22 months

Budget
US$1,744,797

Niyya Da Alkawali (also called INDA) is an integrated community participatory approach that is based on 16 standards of quality community engagement. This approach was used in four regions of Niger to improve the capacity of communities to develop action plans to improve the quality and sustainability of community engagement efforts. The overall aim for implementing INDA was to enhance household and community resilience. Approximately 2,228 community members were trained to use INDA tools for developing participatory community action plans. Almost 300 multisectoral community action plans were developed and implemented in the villages. The INDA supported villages were able to demonstrate their capacity to manage projects, which enabled them to organize such activities as combatting silting by spraying in villages in the commune of Mainé Soroa and constructing classrooms in the village of Guidan Oumarou in the commune of Kornaka. Several awareness raising sessions were organized to promote social cohesion and peaceful co-existence in the villages of Baderi, Kateillari, and Soukoudou in the commune of Mainé Soroa.

Context

Niger has one of the fastest growing and youngest populations in the world and is affected by chronic, recurrent and sudden emergencies, which are compounded by multi-dimensional vulnerabilities, climatic shocks and population displacements. In 2010, the Government of Niger prioritized local self-governance to support the provision of quality basic services, foster social cohesion and promote socio-economic development. Decentralization as an organizing principle was enshrined in the country's constitution. Many local authorities, however, did not have the financial resources, human resources, or management skills to properly manage development activities (e.g., WASH, nutrition, or education projects; health services). As such, villages and regions are often not able to assure the provision of efficient and effective public services, resulting in mistrust by citizens of local representatives.

Strategic approach

UNICEF Niger has been focusing on building the capacity of local authorities around decentralization efforts and integrated community-based approaches. INDA was implemented in 13 communes across four regions (Tahoua, Zinder, Diffa and Maradi), and facilitated by 52 national NGOs under the leadership of local administrative and municipal authorities. This approach was used to create networks of community groups within a village. The spokespersons of the community groups were brought together to form a *Wakilan Gari* ("village committee"), that served as the gateway for all development and emergency actions for the village. The *Wakilan Gari* members served as volunteers.

Each municipality worked with a local NGO to hold workshops to build the capacity of 2,228 members of *Wakilan Gari* to be leaders in directing the development cycle for local projects, and to transfer their knowledge and expertise to volunteers in their villages. Fifteen traditional leaders have also been trained to accompany the roll out of the INDA. Two thousand one hundred forty-eight young people part of the *Wakilan Gari* were also trained on community engagement approaches. UNICEF Niger supported the development of training modules and materials for the Niyya Da Alkawali initiative (e.g., tools for participatory planning).

Sixty-five staff from 52 local NGOs have received capacity building in community participatory approaches. The INDA training guide used by facilitators to build capacity for managing and sustaining community interventions was tailored to the Niger context by, for example, including local proverbs to help explain community engagement norms. The NGOs have organized monitoring field trips to support communities.

The *Wakilan Gari* members carried out community diagnoses, inclusive participatory planning, and supported the local development cycle for the community project. The community interventions were adapted to meet the needs of communities in conflict areas that are prone to attacks (e.g., Diffa).

In December 2022, an online training module containing the steps for implementing the integrated community-based approach and the fundamental standards for quality community engagement for village committee members and community engagement platforms, was developed in six languages (French, Hausa, Kanouri, Tamashek, Peul and Toubou) and disseminated using Interactive Voice Response (IVR) technology.

© UNICEF/UN0209708/Gilbertson VII Photo

Key achievements

- Since 2021, the Niyya Da Alkawali community engagement strengthening programme was carried out through a partnership with 13 selected NGOs (coached by a national NGO) and 13 tripartite agreements signed between NGOs and municipalities. The partnerships have led to the establishment and training of 942 village platforms and 948 village committees (*Wakilan gari*).
- All 948 village committees have developed action plans. Action plans that have been implemented include spraying to combat silting in several villages in the commune of Mainé Soroa (Doumawa, Konkondou, N'gabidare, Chankol, Bacha, Baderi and Katiellari), and constructing classrooms in the village of Guidan Oumarou (commune of Kornaka). Several awareness raising sessions were organized to promote social cohesion and peaceful coexistence, in the villages of Baderi, Kateillari, and Soukoudou in the commune of Mainé Soroa.
- Forty-two monitoring missions of local NGOs and village committees were carried out by the NGOs to galvanize these core community groups to coordinate and carry out the activities. This approach helped municipalities benefit from a meaningful participatory programme, and to establish real ownership of the community-building responsibilities assigned to them through Niger's decentralization reform.


© UNICEF

948 VILLAGE COMMITTEES
have developed action plans

42 MONITORING MISSIONS
of local NGOs and village committees were carried out

65 STAFF
from

52 LOCAL NGOS
have received capacity building in community participatory approaches

Lessons learned

1. **It is essential to give the vulnerable a voice:** The INDA contributed to building resilience by leveraging human and social resources and community structures. The application of norms and standards for community engagement made the voice of the most vulnerable heard. The legitimacy, representativeness and effectiveness of community leadership led to results in this first phase of the Niyya Da Alkawali pilot project. INDA/ACPi has enabled communities to become aware of the importance of collective analysis of their own situations and their ability to solve many of their problems through the implementation of endogenous initiatives.

2. **Raising community self-esteem is critical to success:** This approach fostered self-esteem and self-confidence for communities to gain mastery of their own lives. Dialogues, coaching and peer support have given local communities greater capacities for diagnosing and prioritizing their problems, and planning for change.

3. **Adapting core standards to local cultures motivates ownership:** The adaptation of the core standards for quality community engagement to local cultures (e.g., using local proverbs) facilitated community ownership.

4. **Commitment from leaders is critical:** The commitment of some mayors from the 13 selected communes who recognized the added value of the approach enabled bottom-up planning and better representation of villages.

5. **Coordination and sharing information enables more efficient implementation:** The establishment of a regional-level system for coordinating and sharing information with implementing NGOs and development and emergency actors, was essential to implementing the activities.

6. **Improving integration of the community activities:** The improved integration of the Community Early Warning and Emergency Response Systems, food security committees, nutrition committees, education committees and child protection committees into the list of village committee members allowed for better responses to community interests in a holistic way, through inter-sectorial programming and linkages with systems, national programmes and policies and government.

Recommendations

1. Support the development of the national programme for strengthening community and citizen engagement (PRCC) by the Ministry of Land Use and Community Development.
2. Integrate the *Niya Da Alkawali* community-based model (including communal development plans) into the decentralization scheme (systems, programmes, and governance) at national, regional and local levels.
3. Establish institutional framework and coordination platforms(s) at the national, regional, and communal levels of the PRCC.
4. Create a partnership with the National Association of Religious and Traditional Leaders to support the coordinated diffusion of a social movement for the transformation of social and gender norms.
5. Strengthen community systems and the implementation of public policies conducive to community engagement through the National Agency of Development Volunteers (ANVD) of Niger.
6. Organize quadripartite community meetings between the different actors involved in the implementation of INDA (e.g., *Wakilan Gari*, NGOs, community health workers and relays, and technical service representatives at the local level) to monitor action plan progress.
7. Build capacity within village committees to improve their communication techniques, and to set up an inclusive accountability framework for meetings organized by municipalities to gather complaints and provide feedback and build on the lessons learned.

© UNICEF/UNI329721/Haro

SOCIAL + BEHAVIOUR CHANGE

unicef
for every child

© UNICEF/UN183373/Tanya Bindra

UNICEF Highlights Gender-Focused Immunization Demand Programmes in Six Countries

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

Brief summary

Dates of Activity
December 2021 to May 2022

Duration
6 months

Budget
Unknown

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

Context

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

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

Strategic approach

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

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

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

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

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

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

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


© UNICEF/ UN0533098


© UNICEF/ UNI206123/Claudio Fauvrelle

Key achievements

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

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

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

Lessons learned & Recommendations

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

Endnotes

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.

SOCIAL + BEHAVIOUR CHANGE

© UNICEF Sierra Leone/2016/Mason

unicef for every child

UNICEF Launches Initiative to Improve Social Norms Measurement and Programming

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

Brief summary

Dates of Activity
December 2019 – January 2023

Duration
3 years

Budget
Unavailable

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

Context

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

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

Strategic approach

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

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

© UNICEF/Lebanon

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

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

Key achievements

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

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

The studies focused on

CAREGIVERS AGES 18-49

to understand social norms around selected key child protection issues.

Lessons Learned

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

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

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

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

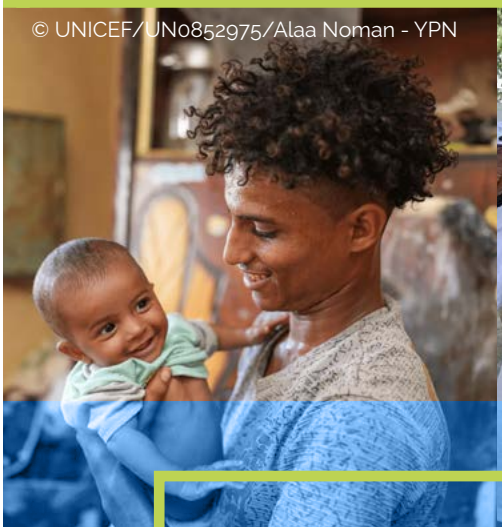
5. **Conduct follow-up research**: Qualitative follow-up research can support the exploration of seemingly contradictory quantitative findings and unpack the extent to which social desirability bias may have been present during quantitative data collection.

© UNICEF/UN0612296/Noman

© UNICEF Sudan/Noorani/2019

Recommendations

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


© UNICEF/UN0852975/Alaa Noman - YPN

© UNICEF/UNI4398271

unicef
for every child

SOCIAL + BEHAVIOUR CHANGE

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

In the West and Central Africa Region, we would like to express our gratitude for the efforts of country office colleagues and their government counterparts who contributed ideas and insights for this compendium. We acknowledge also the strong leadership of communities for the promotion and defense of child rights - Their creativity and resourcefulness are inspiring and essential. Nothing about us without us.

Special thanks to Raissa Edwige Vanian, Fatouma Ali Goudal and Abdou Ali (Niger), Elizabeth Onitolo, Claude Monj and Soterine Tsanga (Nigeria), Iddi Iddrisu, Momoka Ishida and Charity Nikoi (Ghana), Maryam Abdu (Sierra Leone), Charles Tayo Jiofack (Burkina Faso), Johary Randimbivololona (RO), Juan Andres Gil (RO), Etienne Kilian Reussner (RO), Karen Greiner (RO), Audrey Franchi (HQ) and Vincent Petit (HQ).

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

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