Compendium of SBC Best Practices

South Asia Region

Foreword

South Asia is the home for 650 million children, ¼ of all world's children and 30% of the world's adolescents. Despite remarkable progress in the past two decades, South Asia continues to experience high numbers of newborn, child and adolescent deaths. Children in South Asia face inter-generational challenges, such as lack of access to health services, child marriage, learning crisis, open defecation, and climate change. These challenges involve intricate interplays of environmental, social, and behavioural dynamics. Social and Behaviour Change (SBC) responds to the immediate and future needs of children in South Asia by ensuring that policies and programmes are informed by behavioural and social datas and designed in collaboration with local communities.

In South Asia, an alarming estimated of 3 million children remains not fully vaccinated.i To boost immunization uptake, the regional team has developed the Vaccine Demand Strategy Builder. This tool was designed through a blend of practical, on-the-ground experience involving continuous iteration, field testing, and community feedback, with rigorous academic standards. Measles regional coverage still falls below the key target.ii In the midst of the COVID-19 pandemic, Bangladesh's initiatives for community engagement for Measles and Rubella vaccination emphasized the need for multi-sectoral approaches to ensure no child is left behind. In the process of eradication of Polio, Pakistan successfully confronted misinformation and navigated complex social dynamics through the effective use of data .

In response to the COVID-19 pandemic, Bhutan achieved commendable health outcomes through effective Risk Communication and Community Engagement strategies by collaboration and engagement with various stakeholders, particularly Scouts and youth volunteers. Meanwhile, India's "Dur Se Namaste" Drama series applied edutainment approaches with the potential of television and YouTube to educate prevention measures, healthy-seeking behaviours and mental health among youth and adolescents.

Bhutan created a supportive, nurturing and enabling social environment for children and adolescents to grow and develop, with the social and gender norms approach to end the violence against children. In the UNICEF-supported Information Feedback Centers in Cox's Bazar, Bangladesh, the most vulnerable and marginalized populations have gained access to life-saving advice and improved services through the feedback and accountability mechanisms and systems.

Nepal, a nation thrived from devastating earthquakes and public health emergency like cholera and dengue, demonstrates the local resilience through capacity development and systems strengthening. The Human-Center Design approach for Frontline Community Health Volunteers in Nepal further illustrated the power of innovation in ensuring the safety and well-being of children, families, and communities.

The experiences collected in SAR demonstrate the complexity of drivers around the critical challenges and the key role SBC plays in addressing them.

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SBC Regional Advisor, South Asia

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

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

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SOCIAL + BEHAVIOUR CHANGE

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UNICEF Bhutan Raises Awareness About Violence Against Children

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

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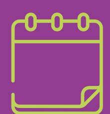
Brief summary



Dates of Activity
July 2022 – January 2023

Duration
6 months

Budget
US$600,000

In July 2022, Bhutan launched a six-month multi-sectoral pilot campaign to raise awareness about the prevalence of violence against children (VAC), and to address barriers preventing children and young people from utilizing child protection services. The campaign was led by the National Commission for Women and Children and implemented by a consortium of 17 governmental and non-governmental agencies through January 2023. The campaign co-occurred with the COVID-19 pandemic, so messages about COVID-19 prevention were included with the VAC campaign messages. The campaign activities reached at least 200,000 people in the three pilot districts, double the number of the intended target. At least 50,000 community influencers were trained and mobilised, and more than 395,000 people engaged with social media. Overall, the campaign yielded positive outcomes regarding improved knowledge, awareness, and perceptions of violence against children, but also highlighted the need for further efforts to address reporting barriers and promote positive discipline practices.

Context

Family structures in Bhutan are changing due to separation, divorce, stress, and violence. The traditional layers of protection provided by families and communities have been weakened. Normative practices that place children at risk for violence, for example child marriage and corporal punishment, persist throughout the nation. These social and cultural factors have contributed to an increase in incidents of violence against children in Bhutan over time, from 168 in 2018, to 970 in 2022.[1] The COVID-19 pandemic from 2020 onward has exacerbated acts of violence against children.

About six out of ten Bhutanese children between 13 and 17 years old have experienced at least one incident of physical violence. Parents, teachers, adult caregivers and peers are among the common perpetrators of violence. Peer violence is endemic. At least 12 per cent of children experience sexual violence and almost 50 per cent of children report experiencing emotional violence. Verbal sexual harassment and neglect are commonly experienced by girls as well as boys. Children's exposure to pornography and access to internet also makes them vulnerable to online abuse. In the past four to five years, a child or young person in Bhutan experienced violence every 42 hours. Child labor and substance abuse among children and adolescents is also a critical concern in the nation.[2]

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Neglect is the highest reported form of VAC reported (34 per cent), followed by emotional violence at 26 per cent and physical violence at 22 per cent. Sixty-eight per cent of the total reported cases were among girls and women. Since the start of the COVID-19 pandemic in 2020, helplines in Bhutan saw an increase in the number of children and young people seeking mental health support services. In 2021, 1,067 children and young people sought counselling services for various mental health related issues, of which 598 were female, and more than 45 per cent were adolescents between 15 and 17 years old.[3]

Research on violence against children in Bhutan has shown that children and young people rarely disclose or report violence to adults or authorities. Although Bhutan's Child Care and Protection Act contains provisions pertaining to different forms of physical, sexual and emotional violence, as well as sexual harassment, usually only cases of physical battery and assault resulting in significant injury, and cases of child molestation and rape, are ever reported to the police. Non-consensual sexual touching, verbal sexual harassment and corporal punishment are generally considered an annoyance rather than a crime to be reported by adults or children.[4]

Strategic approach

In July 2022, UNICEF Bhutan supported the launch of a six-month multi-sectoral and multi-pronged pilot campaign, *Rangge Buzhi, Rangee Norbu (Our Children, Our Wealth)*, to raise awareness about violence against children (VAC) in three districts – *Thimphu, Trashigang and Samtse*. The campaign included messages to motivate children, parents, and caregivers to seek services for VAC, to promote the importance of children's mental wellbeing, and to promote COVID-19 preventive measures. The campaign was led by the National Commission for Women and Children, and implemented by a consortium of 17 governmental and non-governmental agencies.[5] Schools, health workers, sports associations, civil society and religious organizations, and youth volunteers were engaged at the community level. Media outlets were also engaged to spread the word about ending VAC in Bhutan.

The campaign consisted of four phases, each with a distinctive theme. The first phase focused on messages that defined VAC, mental health, and psychosocial support, and highlighted how VAC and poor mental health can impact a child's wellbeing, especially during such challenging times as the COVID-19 pandemic. The second phase was centered on sexual violence. Phase three identified the harmful effects of physical violence by peers. The last phase highlighted the damage to children from online abuse. Each phase provided messages on how the specific type of violence affects children, and suggested actions that children, parents/caregivers, service providers and others can take to prevent and respond to the various type of VAC. A signature tune was created and used with all campaign materials to help the audiences identify the campaign.

The campaign was comprised of several social and behaviour change (SBC) activities for audiences at multiple social ecological levels (e.g., individual, community, and societal/institutional), and included the following outputs:

Individual Level Outputs

- Five thousand copies of an illustrated handbook (in English and *Dzongkha*) on ending violence against children were disseminated to schoolteachers, local leaders, religious leaders, social workers, media persons and other community influencers;
- Videos on sexual violence, peer violence, and positive/non-violent child discipline, were disseminated via mass media (aired on BBS

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the national radio and TV station) and shared on Facebook pages of collaborating partners including UNICEF social media sites.

Community Level Outputs

- Mobilization through faith-based organizations and religious leaders' networks to promote kindness, harmony and social cohesion, and to address COVID-19 and its shadow issues of VAC.

- Mobilization using community serving organization (CSO) and their networks. Three CSOs (RENEW, *Nazhoen Lamtoen, Tarayana*) conducted consultation and discussions with district officials and local government officials. Following the district level consultations, the CSOs conducted discussions with other influential people at the community level consisting of local leaders, community-based support service volunteers, youth volunteers, counsellors and community representatives and mobilized them to engage communities and families in their locality.

- Mobilization through schoolteachers, scouts, and youth volunteers. Bhutan's Ministry of Education and Skills Development's Department of Education and Programme Scouts and Sports Division carried out engagement session with scouts, schoolteachers, students and young people in 161 schools and youth centres in *Thimpu, Trashigang, Samtse*.

- Mobilization through disabled people's organizations (DPOs). Two DPOs (*Ability Bhutan Society* and *Draktsho*) engaged children with disabilities and their parents/caregivers to discuss and increase awareness about the risks of VAC and mental health, and how to seek support services;

Societal/Institutional Level Outputs

- A video with the Deputy Chief of Police of the Royal Bhutan Police Department discussing sexual harassment and abuse as a social system issue that needs to be addressed through coordinated societal efforts, and the need for reporting cases of abuse was disseminated through social media platforms as part of online advocacy that was held simultaneously with the SBC activities.

- Mobilization of the Bhutan Football Federation (BFF). The BFF launched the campaign as part of the 2022 national football championship matches. The BFF conducted sessions with players and officials and discussed how players could raise awareness about preventing and responding to VAC, promoting child mental health, and promoting and modelling COVID-19 preventive behaviours. The BFF involved local celebrities and popular sports personalities in advocating for children's safety and wellbeing. All players and match officials made a public pledge to fight to end VAC.

- World Children's Day events where the Government announced the roll out of an anti-bullying campaign in schools for the 2023 academic year and amplified VAC messages.

- Advocacy through mainstream media. Bhutan Broadcasting Service (the national TV and radio station) and *Kuensel* (the national print media) disseminated messages to raise public awareness about children's safety and wellbeing using various media formats (e.g., panel discussions; expert interviews, info blocks, teasers, radio dramas, jingles, docufilms, TV spots).

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Key achievements

The campaign activities reach at least 200,000 people in the three pilot districts, double the number of the intended target. At least 50,000 community influencers were trained and mobilized, and more than 395,000 people were reached via social media. Specific achievements included:

- The three CSOs engaged and mobilized about 13,000 community influencers in the three districts. The initiative also contributed to local leaders and volunteers at the community level setting up social media groups and child well-being committees to discuss children's issues. Some local leaders have made decision to incorporate child wellbeing as an agenda in their regular community development meeting. Likewise, the CSO partners have incorporated promotion of child wellbeing as part of their community engagement programmes.
- More than 29,000 students, schoolteachers and young people were engaged in the discussion and mobilized to reach other students and young people.
- The BFF has incorporated child wellbeing as part of their child safety training programme;.
- A UNICEF and BFF exhibition football match on World Children's Day (20 November 2022) was broadcasted live on the national TV and social media sites of BFF and UNICEF. More than 500 people were present at the event and more than 200,000 people were reach through the social media.
- More than 350 religious leaders from different faiths were engaged and mobilized to engage families and communities in three districts.
- About 250 children with disabilities, their parents and care givers were made aware of risks of violence and mental health on children and how to seek support services to prevent and respond to their concerns;
- BBS developed and aired more than 40 radio programmes in four languages (*Dzongkha*, English, *Nepali* and *Tsangla*), including panel discussions; expert interviews; info blocks; teasers; radio dramas; jingles on the types of violence and consequences on child development and how to prevent and respond and seek support services.

- BBS TV developed and aired a 24 television programmes, including panel discussions, expert interviews, dramas, documentary films, TV spots and other entertainment-education programmes.
- On print media, Kuensel, the national newspaper published a special issue on VAC in August 2022. Kuensel also produced 10 short videos on different topics of violence and disseminated it on their social media channels.
- All the BBS programmes were re-shared on BBS social media sites.
- Helplines recorded a three-fold increase in calls during the campaign.
- Social media garnered more than 54 million impressions (the total number of times social media browsers were shown the campaign content); more than 395,000 users engaged with the social media content;
    - More children acknowledged the ability to report incidents of violence (85 per cent in March 2023 compared to 79 per cent in November 2022).
- Bhutanese people exposed to the campaign identified children with disabilities, children from lower-income or broken families, orphans, the LGBT+ community, and those vulnerable to mental health issues, as being at risk of violence.
- An experience sharing workshop was organized for Government, CSOs, UN and other stakeholders to share the lessons learnt from the campaign to amplify the need for strengthening joint multi-sectoral programming and mainstreaming SBC. Each implementing partner share their achievements, challenges and lessons learnt. More than 50 participants representing various agencies; two Honourable Members of the Parliament and UN RC's office attended the workshop.

Campaign activities reached at least **200,000 PEOPLE** in the three pilot districts

AT LEAST 50,000 community influencers were trained and mobilized

MORE THAN 54 million social media impressions

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Lessons Learned & Recommendations

1. The campaign assessment revealed the need for effective reporting mechanisms and education efforts to address barriers to reporting VAC incidents; there was a persistent lack of knowledge about where to report cases violence, and fear of dealing with law enforcement and legal issues.

2. The campaign activities should be expanded beyond the three pilot districts to a nation-wide campaign.

3. The campaign messages should go beyond increasing awareness (although awareness about child protection policies still need improvement), to changing attitudes and practices (which take more time and repetition of messages).

4. UNCIEF Bhutan should continue to strengthen cross-sector, multi-stakeholder partnerships, and include new partners (e.g., with LGBTQIA+, Wangsel Institute of Deaf, Pema Secretariat and popular social media influencers), and continue to build the capacities of partners to support activities to eliminate VAC.

5. UNICEF Bhutan and partners should focus on the most vulnerable children, i.e., those at heightened risk of violence (e.g., effeminate boys, masculine girls, children with disabilities) and those that suffer significant harm.

6. Linkages should be created between violence against children (VAC) and violence against women (VAW) since the risk factors for perpetuating violence can be similar (e.g., alcohol use), and the violence can co-occur in the same space (e.g., at home).

7. The initiative contributed to improved understanding and commitment among government, non-government and UN agencies how complex issues like violence and mental health can be addressed as a whole society through joint multisectoral collaboration that complements one another for efficiency.

8. Funding for such initiative is a limitation for smaller countries. UNICEF regional SBC support was instrumental in implementing the campaign. Such regional support to smaller countries must continue.

Endnotes

1 United Nations Children's Fund, 'Results report: *Rangge* Buzhi, Rangee Norbu – Our Children, Our Wealth, a multisectoral social and behaviour change campaign to address violence against children', UNICEF Bhutan, 22 January 2023.

2 United Nations Children's Fund, 'Protection…For every child', UNICEF Bhutan, <www.unicef.org/bhutan/protection-%E2%80%A6-every-child>.

3 United Nations Children's Fund, 'Results report: *Rangge* Buzhi, Rangee Norbu – Our Children, Our Wealth, a multisectoral social and behaviour change campaign to address violence against children', UNICEF Bhutan, 22 January 2023.

4 United Nations Children's Fund, *Research on violence against children in Bhutan: A report*. National Commission for Women and Children, Royal Government of Bhutan and UNICEF Bhutan, 2016, <www.unicef.org/bhutan/media/341/file/Research%20on%20Violence%20Against%20Children%20in%20Bhutan.pdf>.

5 The agencies involved in the Campaign are National Commission for Women and Children; Ministry of Education, Ministry of Health, Department of Information Technology and Telecom, MoIC, *Dratshang Lhentshog*, Council for Religious Affairs in Bhutan, Royal Bhutan Police, *Tarayana* Foundation, RENEW, *Nazhoen Lamtoen*, Ability Bhutan Society, *Draktsho*, Bhutan Nun Foundation, Bhutan Broadcasting Service and UNICEF.

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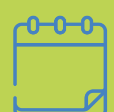
UNICEF India Promotes Healthy COVID-19 Related Behaviours to Youth

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

Brief summary



Dates of Activity
August 2022 to January 2023

Duration
18 weeks

Budget
US$700,000 (approx.)

On 14 August 2022, the U.S. Agency for International Development (USAID) and UNICEF launched an 18-part television and YouTube series, entitled *Duur Se Namaste* ("Greetings from a distance" or DSN). This fictional edutainment soap opera highlighted the challenges for children and young people living in the "new normal" world. The characters promoted COVID-19 vaccination and the need to continue practicing preventive behaviours and provided tips for managing the mental health challenges of youth in a post-pandemic India.[1] The show was broadcast from 14 August 2022 to 15 January 2023. It has been viewed by about seven million television viewers, and by 3.8 million YouTube users. Most viewers found the soap opera informative and discussed the key messages with others.

Context

Many families have experienced a pervasive sense of loss due to COVID-19, including the loss of loved ones, social networks, jobs, and financial security. These feelings have impacted the quality of relationships among parents, children and siblings, and the education and mental well-being of children. In March 2020, schools across India were closed to curb the spread of COVID-19. Two years without being in a classroom, and without physical interaction with people outside their homes, has resulted in children losing the behaviours, and skills for engaging in public life. Many have lost their attention spans from over-exposure to digital devices.

Strategic approach

Duur Se Namaste is a television soap opera designed to address the effects of COVID-19 on children, by providing them with coping tools and modelling healthy behaviours as they readjust to their usual daily activities. The first episode of the Duur Se Namaste drama series aired on *Doordarshan* (India's public service television broadcaster) in a primetime slot on 14 August 2022. The show was broadcast every Sunday from 11 AM to noon, with repeat telecasts on Saturdays from six to seven PM. The soap opera format is familiar to Indian audiences. The main characters conveyed key COVID-19 related messages, including the importance of COVID-19 vaccination and combating vaccine hesitancy. Caregiver and other role-model characters portrayed such healthy behaviours and practices as psychosocial support for children and facilitating children's return to classrooms.

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The show was also made available on the *Duur Se Namaste* YouTube channel. This digital component enabled audience to continue their engagement with the programme and characters through the U-Report chatbot, and reinforcing the messages and starting conversations to keep children healthy and thriving.[2]

An endline assessment was conducted through U-Report and complemented by telephone surveys conducted with the audience by on-the-ground outreach teams. Implementing partners across India collected telephone numbers of viewers with their consent to participate in telephone surveys about DSN. A random sample was selected from the lists of potential participants. They were asked to provide feedback on the show and assessed for their engagement and recall of messages. The

data collection activities started in January 2023, after the broadcast of the show on television. Telephone surveys were conducted in two phases; phase one data was collected after the broadcast of Episode 16, and phase two data was collected after the broadcast of Episode 32. The respondents hailed from the Hindi speaking states where the outreach took place. The mean age of the respondent was 21 years. There was almost equal representation of men and women in the respondent pool.

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Key achievements

- To date, Duur Se Namaste has been seen by at least seven million *Doordarshan* viewers and more than 3.8 million YouTube users.
- 63 per cent of the soap opera's viewers said that they watched the series because they found it informative, and 64 per cent said that they discussed the edutainment drama with others.
- There have been about 84,000 unique viewers of the soap opera on the YouTube channel.
- The endline evaluation showed that the ratings given for the quality of DSN were higher than those of any other comparable show in India. More than 70 per cent of the respondents felt that DSN is more realistic, motivating, and educational than other serials, while around 53 per cent said it is more entertaining.
- 72 per cent of the respondents reported gaining new information from the serial. The endline respondents showed a marked improvement in their understanding of crucial information related to COVID-19. Respondents were also more aware of the impact of the COVID-19 lockdown on children. Significantly more endline respondents talked about healthy food, exercising, and washing hands as ways of keeping themselves healthy post-COVID-19, and were also able to identify symptoms of mental stress.

have seen *Duur Se Namaste.*

63% of the viewers found it informative

64% of viewers said that they discussed the edutainment drama with others

Lessons learned & Recommendations

The broadcast of the series on television and YouTube ended in January 2023. The monitoring and evaluation activities showed that it was possible to monitor people's response, obtain feedback and gage viewers' recall of messages in real time through YouTube and U-Report. This immediate feedback allowed for quick tweaks to the messaging on digital platforms. The main learning, as from previous edutainment initiatives, is that edutainment worked to increase knowledge about COVID-19 prevention. Specific lessons learned include:

1. **Binge-watching versus appointment viewing:** Adaptations must be made for young viewers whose television habits differ from those of many adults who are more familiar with appointment television. Appointment viewing meant that the viewer was invested and interested in the content because they chose to tune in, and then at regular intervals return to that content. Youth are more engaged with their mobile devices. As smartphone penetration increased and data charges plummeted, viewing habits in India have shifted to binge watching on various platforms. The crowded digital environment requires a different approach to edutainment, where content is both user-friendly and released all at once (as opposed to staggered release for appointment television) to keep youth engaged.

2. **Building relationships takes time:** Monitoring results for DSN showed that engaged viewers made the characters and the storylines a part of their lives. When viewers were asked if they discuss the show, its themes, and the characters with a friend, the percentage of respondents who answered in the affirmative rose through the four rounds of concurrent monitoring, from 69 per cent in the first round to 70 per cent in the fourth and final round. Discussion with a spouse increased from 23 per cent in the first round, to 28 per cent in the fourth round. Edutainment is most effective when the programme content sparks discussions with others. Although viewers were able to build relationships with the characters in just 36 episodes, more episodes would be ideal for enabling viewers to fully connect with the themes and move toward actual behaviour and social norm change.

3. **Recall with messaging:** Viewers tend to pick up only those messages that were personally relevant to them at that moment in time. DSN had multiple health promotion messages, including on COVID-19, mental health, nutrition, gender equality, and others. U-Report and qualitative assessments of viewers showed that their message recall shifted as the story progressed. For instance, episode 9—16 had a story arc on mental health among adults and the corresponding concurrent monitoring round had questions pertaining to it. In that concurrent monitoring round, message recall on mental health was high, and then fell in the subsequent round when the story had progressed. Another example is that the recall of caring for pregnant women with COVID-19 was poor across rounds, even though it was given a lot of air-time being a major plot point in the show. This could be because viewers did not find the information to be personally relevant. It is not only important to tailor health promotion messages to the specific needs and interests of the viewers but also to repeat key messages in creative ways throughout multiple episodes to reinforce their importance and increase information retention.

4. The new media and entertainment landscape with the proliferation of entertainment options makes Edutainment for health promotion a challenge. A cluttered environment calls for innovative solutions to reach out to the viewer through a mix of traditional and new media, digital and interpersonal campaigns.

Endnotes

1 UNICEF, 'UNICEF and the Ministry of Health launch the "Kindness is Contagious" campaign in Viet Nam', May 2020, <www.unicef.org/vietnam/stories/unicef-and-ministry-health-launch-kindness-contagious-campaign-viet-nam>

2 U-Report is a social messaging tool and data collection system developed by UNICEF to improve citizen engagement, inform leaders, and foster positive change. The programme sends SMS polls and alerts to its participants, collecting real-time responses, and subsequently publishes gathered data.

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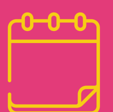
UNICEF ROSA Delivers Demand Strategy Builder Package to Help Countries Increase Vaccine Uptake

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

Brief summary



Dates of Activity
2020—2021

Duration
15 months

Budget
Unavailable

UNICEFs Regional Office of South Asia (ROSA) supported the development of the Demand Strategy Builder, a package of practical, highly illustrated tools to guide health programme managers and implementers in using a human-centered design approach to develop evidence-based sub-national level strategies that promote vaccine uptake.

The package is designed to guide users through a step-by-step process that enables them to look at immunization from a parent/caregiver's perspective, and to design activities and programmes that remove the barriers that prevent children from being immunized.

Context

At least six million children are unvaccinated or under-vaccinated in the eight highest-risk countries in South and Southeast Asia. Reasons for low demand for vaccines include lack of knowledge about vaccines or number of doses required, widespread misinformation about vaccine side-effects, and vaccine recalls leading to distrust of the product. In Indonesia, a 2018 measles vaccination campaign targeting 70 million children was derailed by religious groups that withdrew their support. In Nepal, ineffective messaging about the need for a second dose of measles vaccine resulted in a decrease in immunization rates from 90 to 70 per cent.[1] During the COVID-19 pandemic, vaccine confidence was eroded and demand for childhood vaccinations declined. Childhood vaccination schedules were disrupted due to stay-at-home measures, intense demands on health systems, the diversion of immunization resources to COVID-19 vaccination and health worker shortages.

To understand and address the most pressing reasons for low vaccine uptake, UNICEF has been scaling up the use of the Human Centered Design (HCD) approach for developing tailored demand strategies to increase vaccine uptake of in selected countries. HCD is a problem-solving method that puts real people at the center of the development process, generating a clearer understanding of the problem from the perspective of the population of interest, and enabling the development of specifically tailored materials, products and services that resonate with their needs. Since 2020, UNICEF has been supporting Ministries of Health in South Sudan, Zimbabwe, Madagascar, Indonesia, Ethiopia, Mozambique, Somalia, Myanmar, Afghanistan and Pakistan, to use the HCD approach to develop tailored, context-specific demand generating strategies.

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Strategic approach

UNICEF ROSA worked with Common Thread, a social and behaviour design agency, to create the Demand Strategy Builder package.[2] The Package was designed to address global principles and be applied across sectors in South Asia, Southeast Asia and the Pacific, but can be used by anyone who finds it useful. It was designed for health, communication and/or behaviour change professionals working at sub-national levels, although the primary user may vary from country to country. Each primary use will be supported by managers and champions at national, regional and/or global levels.

Common Thread talked to UNICEF, WHO, and government sub-national immunization and behavioural managers across South and Southeast Asia to understand what they needed and wanted from the proposed package. The key takeaways were that nobody wanted "another manual," and no one was interested in theory.[3] Common Thread then researched the specific reasons for low vaccination uptake in the region. The findings from this research helped to define the problem from the parent/caregiver perspective and learn what health workers and managers needed to remove the barriers and clear the way for keep children up to date with their vaccines.

The package development was guided by a Steering Committee that provided feedback at each phase of the development process (initial insights, problem identification workshop, field insights, and solution design workshop).[4] UNICEF's regional, country, and sub-national immunization and communication officers provided key inputs to Common Thread. The development of the package took 15 months to complete, from initial draft, to field-testing, to revisions and finalization.

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The Demand Strategy Builder takes managers through key moments in an immersive experience to design a behavioural strategy and map out an action plan. Throughout each moment, field practitioners are provided with visual guidance (using as little text as possible), instructions for undertaking guided visits to communities, and gamification through cards and role play. A human-centered design (HCD)-inspired research phase in the middle of the process makes sure assumptions are challenged and human connections are made. The Package contains posters to guide workshop activities. This includes a binder, "independent planning moment" cards, and a USB stick or webpage containing in-depth instructions, workshop scripts, and resources/readings and a box of participant cards. The first step in the strategy-building process, which can be done alone or with a small group, is to use independent planning cards, a digital workbook, the binder, and post-it notes to develop a hypothesis for the vaccine demand challenge, and to assess any existing strategies and plans. This step leads into the first of two workshops, divided into eight modules, to engage the design group in gaining a deeper understanding and confirmation of the demand challenge (e.g., the people, places, specific barriers, and data). The aim is to achieve group consensus on the core demand challenges. Prior to the second workshop, a small group(s) of planners use another set of independent planning tools to decide which HCD methods and tools they will use to collect missing data relevant to the problem(s) they identified. The second workshop is structured to help the group finalize their strategy. A mix of materials from the first workshop (e.g., posters, participant cards, digital workbook) is used throughout six modules to help the participants review and finalize the demand strategy.

The Demand Strategy Builder Package was pre-tested in a couple of countries to determine its usability and scalability across countries before it was finalized. Findings from the pretests were used to refine the Package for great ease of use.

Key achievements

The package has been disseminated among Steering Committee members, to UNICEF Afghanistan, and more recently to the GAVI Secretariat.[5] UNICEF MENA has reached out to the ROSA team to explore and pilot and adapted version of the Demand Strategy Builder suitable to MENA country contexts. The aim is to position the Strategy Builder Package as a global tool.

Development of the package took

15 MONTHS

The package takes managers through key moments in an immersive experience to design a behavioural strategy and map out an action plan

Lessons learned & Recommendations

1 **Adapt the content to suit the context.** The Package content is applicable to multiple regional and country contexts. Each region and/or country should pilot the Package and adapt the content so that it is palatable to the intended populations, without foregoing its intended objectives.

2 **Build capacity for using the Package**. Conduct Master Trainer sessions to create a cadre of trainers that can cascade the training and ensure deep and wide dissemination and use of the Package.

3 **Build a community of practice** to support the roll-out of the Package. Create a network of experts and motivate peer learning and sharing of local content and resources.

4 **Form a Task Force** (with MoH as the Convenor) to ensure that the Package is reaching its intended users, monitor its intended use and any novel uses or unintended consequences, and guide any refinements to the Package as necessary.

5 Countries that would like to adopt the Package should ensure that there are earmarked funds for conducting the appropriate training necessary to create knowledgeable users of the package.

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Endnotes

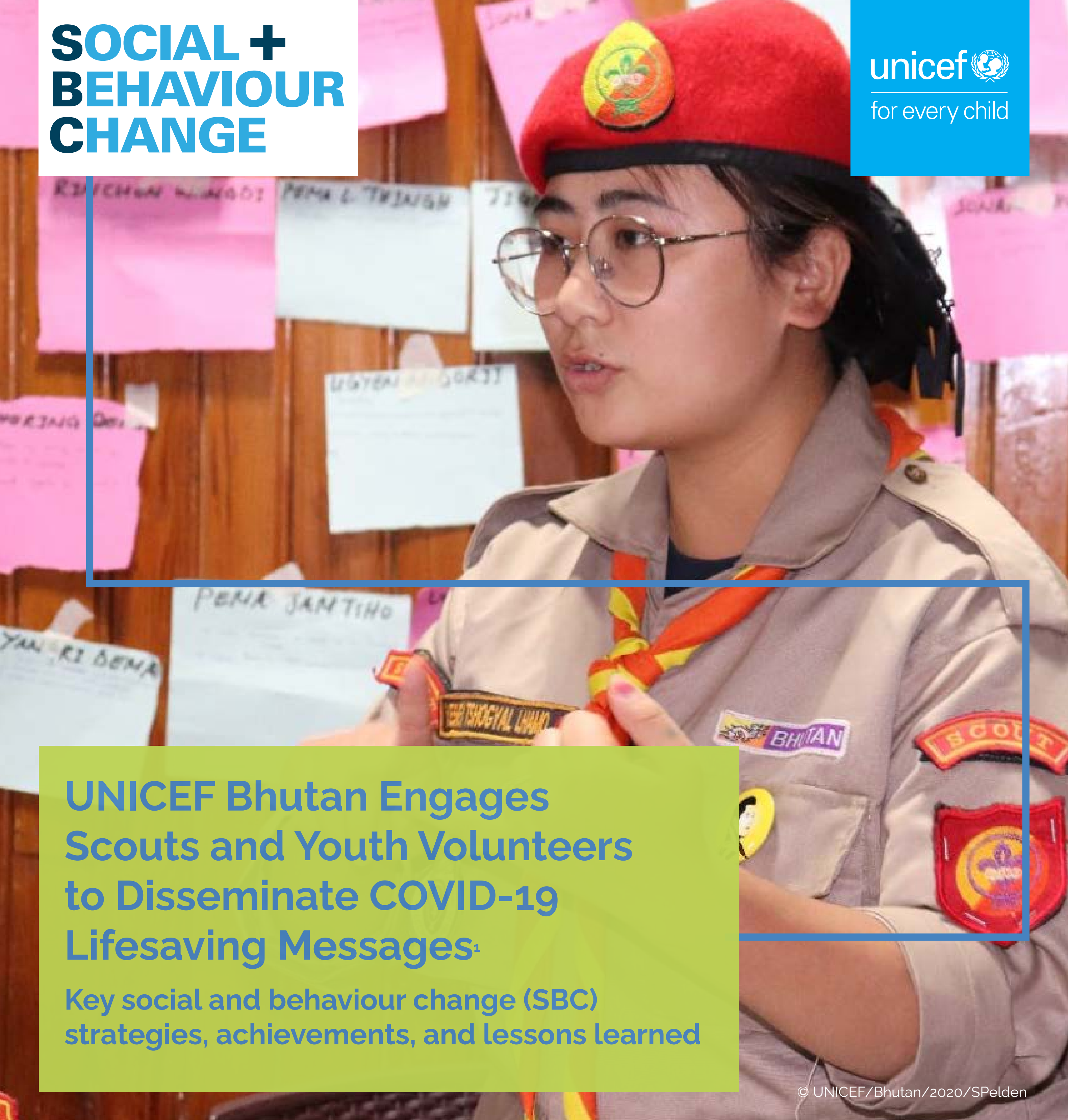
1 Common Good, 'South and Southeast Asia: Reimagining the vaccination guidebook', 2021, <https://gocommonthread.com/work/south-and-east-asia/>.

2 Common Thread was contracted by GAVI, the Vaccine Alliance.

3 Common Good, 'South and Southeast Asia: Reimagining the vaccination guidebook', 2021, <https://gocommonthread.com/work/south-and-east-asia/>.

4 The Steering Committee included individuals from the World Health Organization in EMRO and SEARO, UNICEF's Regional Office for East Asia and Pacific Office, and UNICEF and WHO Headquarters.

5 GAVI, the Vaccine Alliance, is an independent public-private partnership and multilateral funding mechanism that aims to expand global access to and use of vaccines, particularly among vulnerable children.



UNICEF Bhutan Engages Scouts and Youth Volunteers to Disseminate COVID-19 Lifesaving Messages[1]

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

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Brief summary

UNICEF Bhutan, in collaboration with the Ministry of Health, supported leveraging more than 800 leadership scouts and youth volunteers in 17 districts to play a catalytic role in supporting their communities during the COVID-19 pandemic. The country's Risk Communication and Community Engagement (RCCE) response to the pandemic focused on engaging scouts and youth volunteers to raise awareness about the disease and disseminate messages on how to prevent becoming infected within schools, in communities, and as patrols in marketplaces. The scout leaders reached an estimated 8,000 young people across the target districts.

Context

In March 2020, the first COVID-19 case was detected in Bhutan. With a total of 863 confirmed cases by December 2020. While Bhutan's Covid-19 infection rate did not have a severe impact on the health system as compared to other countries, social vulnerabilities and economic losses were felt across different sectors and communities. Since Bhutan has a significantly young population, with sixty per cent being below the age of 25 years, the country's Risk Communication and Community Engagement (RCCE) response focused on leveraging the positive enthusiasm and drive of young people to accelerate community-based interventions to help solve some of the pressing challenges brought forth by the pandemic.

The RCCE response, led by the Bhutan Scouts Association (BSA) of the Ministry of Education and supported by UNICEF and the Ministry of Health, focused on collective youth-based community action. This response prioritised leveraging and building a network of inspiring young change makers and volunteers to help tackle the secondary impacts of the pandemic, such as mental health, economic stress, social stigma, gender-based violence, child protection issues, and socio-political strain. There were about 1,700 scout leaders and 59,000 scout members within the BSA structure across 20 districts in Bhutan.

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Strategic approach

From the outset, Bhutan's RCCE strategy was informed by evidence emerging from a Rapid Pulse Survey and U-Report data. The survey was designed to gain deeper insights into Bhutan's remote communities' perceptions. The main objectives of the survey were to assess the reach and clarity of COVID-19 prevention messages in remote communities and evaluate knowledge levels related to preventive measures. The survey findings indicated that while communities had sufficient access to COVID-19 messaging and information, there was a need for personalized engagement and interaction to address concerns, narrow the informational gap, and translate the knowledge to actionable community responses. The U-Report data allowed for an understanding of the deeper impacts of the pandemic on young people and children, especially vis-à-vis their home-schooling journey during the initial lockdown.

The Government of Bhutan's partnership with young scouts through the Bhutan Scout Association (BSA) was facilitated by UNICEF Bhutan and stood out for its uniqueness, and for accelerating community outreach in remote areas across the region. UNICEF partnered with the Ministry of Health and Department of Youth and Sports to engage and empower adolescents as change-makers and leaders for creating awareness about such emerging pandemic-related issues as domestic violence, sexual harassment, and mental health, in their communities. The young scouts were oriented on how to effectively and empathetically engage with their communities, disseminate critical information on COVID-19 prevention behaviours (e.g., social distancing, hand washing, cough etiquette, and quarantine/isolation), and develop social innovation projects, in a two-day session in June 2020. This training enabled and empowered scouts to develop tailored interventions for their communities.

Following the training, scout leaders developed and implemented community-based COVID-19 related activities. For example, in remote areas of southern Bhutan, scout leaders volunteered as teachers in villages that had no access to online learning. As part of the scouting "community service" activities, scout leaders and scouts also volunteered to deliver essential medicines to peoples' homes during lockdown. In Thimphu, scout leaders helped raise awareness at markets about the Druk Trace App, also standing at the front gate of the market and reminding shoppers about social distancing. Scouts patrolled the markets to ensure COVID-19 protocols were being followed. All scouts encouraged community members to appreciate and have gratitude for the frontline workers that were sacrificing themselves for the sake of the Bhutanese people.

The scouts were supported with psychosocial materials and trained to use digital media to supplement their community engagement efforts. WhatsApp and Messenger groups were established for scout leaders and scout secretaries to facilitate communication, feedback, and response. The BSA maintained an official Facebook page and website for information sharing and updates. The BSA also produced a short video (with transcriptions in local dialects) on handwashing and social distancing that was broadcast on national television and shared on the BSA's social media platforms.

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Key achievements

- More than 800 leadership scouts and youth volunteers in 17 districts were engaged and participated in the national response efforts playing a catalytic role in supporting their communities.
- The scout leaders reached an estimated 8,000 young people across selected districts.
- The scout intervention was instrumental in supporting the Ministry of Health's objectives of instilling youth-led collective social responsibility and inspiring wider community-level change in remote areas during the pandemic.

800
leadership scouts and youth volunteers engaged

8,000
young people reached

Scouts across
17
DISTRICTS
participated in national response efforts

Lessons learned

1 **Leveraging youth to reach communities with lifesaving messages can be achieved through existing networks:** Bhutan's scout-led community engagement intervention during the pandemic reflected the compassion, commitment, and enthusiasm of young people to drive social action during crisis. Their engagement showed that catalysing youth networks to be the driving force that shape advocacy and social change initiatives can impact communities.

2 **Youth can be empowered to develop self-directed activities and solutions to health-related challenges:** Training youth to design, develop, and implement RCCE interventions enhanced their civic engagement and help to build resilient, forward-looking young communities.

Recommendations

1 Positioning young people at the epicentre of the RCCE response not just as beneficiaries but as active contributors to meaningful change by involving them as partners and vocal change agents can be instrumental in helping communities find solutions to problems that are impacting them.

2 Formal structures and systems should be developed and regularised to enable sustainable co-working inter-sectoral partnerships with youth-based networks and groups to maximise impact and drive national efforts during COVID-19 recovery and future pandemics.

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Endnotes

1 Based on a case produced by the United Nations Children's Fund (UNICEF) Regional Office for South Asia (ROSA).

SOCIAL + BEHAVIOUR CHANGE

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UNICEF Bangladesh Surpasses Goal During COVID-19 Pandemic Using Measles and Rubella Vaccination Campaign

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

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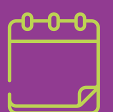
Brief summary



Dates of Activity
December 2020 to February 2021

Duration
Six Weeks

Budget
US$12 million

UNICEF Bangladesh, in collaboration with the Bangladesh Ministry of Health and Family Welfare (MOHFW) Extended Immunization Programme (EPI) and other partners, supported the implementation of a vaccination campaign to ensure that parents and caregivers retained confidence in childhood immunizations during the COVID-19 pandemic, and that children between the ages of nine months and nine years old kept up with their measles and rubella vaccination (MRV) schedules. The campaign reached 36.6 million children in all 64 districts of the country, including children that were missed in one or all previous MRV opportunities.

Context

Before 2000, less than 75 per cent of children in Bangladesh received their routine first dose of measles-containing vaccine (MCV1) and measles was a major cause of child death. From 2000 to 2016, after increasing MCV1 coverage, implementing three supplementary immunization activities (SIAs), introducing the rubella vaccine (the MRV) in 2012, and adding a second dose of measles vaccine for children aged 15 months as part of the country's routine immunization protocol, the estimated MCV1 coverage increased from 74 to 94 per cent. MCV2 coverage increased from 35 per cent in 2013 to 93 per cent in 2016. By 2016, confirmed measles incidence in Bangladesh decreased by 84 per cent, from 40 per million population to six per million population.[1,2]

In 2003, Bangladesh instituted laboratory-supported case-based surveillance for suspected measles cases using 143 active and 625 passive surveillance sites in all 64 districts of the country. This system was adapted from the existing acute flaccid paralysis surveillance system for polio detection. Surveillance for measles and rubella was integrated with vaccine preventable disease (VPD) surveillance in 2003 and congenital rubella syndrome (CRS) surveillance in 2012. Aggregated measles cases continue to be reported by all health facilities through the National Health Management Information System (NHMIH) and have been reported annually through the WHO/UNICEF Joint Reporting Form (JRF) since 2000. The difference in number of cases reported annually by these two parallel systems has decreased since 2013.

The government of Bangladesh set a goal to eliminate measles and rubella by 2020. A national vaccination coverage survey conducted in 2015 found that the most common reasons for a child not being vaccinated or only partially vaccinated were that caregivers were too busy with other priorities or did not remember to bring the child for vaccination, and/or they lacked information about when to bring the child for vaccination. These findings indicated the need for intensified social mobilization activities to strengthen routine immunization (RI).[3] MRV catch-up campaigns were implemented throughout Bangladesh. However, Bangladesh had a total of 2,136 confirmed cases in 2018 and 5,266 in 2019.[4]

In March 2020, at the time of the COVID-19 pandemic, the government of Bangladesh imposed a mass quarantine to control the outbreak of the virus. Adherence to the quarantine, and orders to avoid crowded places like vaccination centers, disrupted the RI and EPI programmes, resulting in many children missing lifesaving routine vaccinations. As the EPI programme in Bangladesh began to rebound, there was an urgent need to renew the commitment to improving MRV access and uptake and restoring RI services to (at least) pre-COVID-19 achievements.

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Strategic approach

The government of Bangladesh's revised target for complete elimination of circulating measles and rubella virus is by the year 2023. UNICEF Bangladesh, in collaboration with the Bangladesh Ministry of Health and Family Welfare (MOHFW) Extended Immunization Programme (EPI) and other partners, supported the implementation of an MRV campaign to ensure that parents and caregivers retained confidence in childhood immunizations during the COVID-19 pandemic, and that children between the ages of nine months and nine years old kept up with their measles and rubella vaccination (MRV) schedules. UNICEF supported the development of a social and behaviour change communication (SBCC) strategy to identify key audiences (especially high-risk groups) and guide the campaign activities.[5] The campaign was spread over six weeks (instead of the usual three weeks), between 12 December 12 2020 and 3 February 2021, to avoid crowding at vaccination sites and reduce the risk of COVID-19 infection. The duration the campaign was somewhat flexible during the pandemic. In some hard-to-reach areas, the campaign continued beyond the planned timeframe to ensure that all key populations were reached. The key populations for the campaign included urban mothers and caregivers living in slums, garment workers and employers, hard-to-reach populations in cities, tea garden labourers and owners, caregivers in Haor and marshy lands, ethnic communities, children, adolescents and youth, both in-school and out-of-school, local community leaders and faith-based leaders.

Since the pandemic restricted in-person communication, Bangladesh's robust community network (including health systems, local government institutes, faith leaders, voluntary groups, and school-systems) was not able to play its usual role in engaging community members and motivating them to have their children vaccinated. The UNICEF SBC team pivoted to relying on mass and social media.

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Based on previous successes with mass media, the team created television and radio public service announcements, talk shows, songs, booklets, newspaper articles and advertisements, outdoor media (e.g., large posters, billboards), and used megaphones to make announcements in communities without calling people to gather. Community-radio networks were activated to provide key messages about staying up-to-date with MRV. Celebrities were recruited to promote MRV. The slogan for the campaign was "O loving children come, it's time to get vaccinated," a line that echoes a famous children's lullaby. The slogan was pretested with children, parents/ caregivers, and health workers, and found to be reassuring. The mass media message and materials were also delivered via social media (e.g., Facebook) and shared through a synched content calendar to ensure wider audiences were reached with the most up-to-date messages.

A committed force of over 50,000 vaccinators were employed to deliver the vaccines into children's arms. They carried the cold-packed vaccine vials to hard-to-reach areas of the country to vaccinate the most vulnerable children, all the while maintaining COVID-19 safety protocols.

UNICEF invested in strengthening the cold chain capacity in Bangladesh, installing cold rooms and procure refrigeration equipment, cold boxes, and vaccine carriers, while also developing logistics management information systems and training for health workers for the 2020 MRV campaign. The Central Medical Store Department (CMSD) serves as the unit for facilitating the custom clearing of the vaccines, while the Central EPI Store at EPI-HQ under the MOH is responsible for storing the vaccines at the central level and in maintaining the required temperature.[6] This newly implemented cold-chain best-practice eliminated what used to be a substantial barrier to achieving full immunization coverage in the country.

Online tools were developed to create micro-plans and facilitate real-time monitoring of campaign activities through a dedicated server within the District Health Information System 2 (DHIS2). This system enabled team members from the lowest administrative unit to the national level to upload data in a timely manner. An android-based mobile App was created to disseminate the micro-plan templates, report on the "vaccination sessions" through which the micro-plans were created, provide supportive supervision, facilitate household visit scheduling, and strengthening Rapid Convenience Monitoring of the campaign activities reported on a real-time dashboard. A risk communication plan was developed to help the campaign team to address vaccination misinformation, disinformation, rumors, and adverse events following immunization (AEFI).[7]

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Key achievements

- The government of Bangladesh protected its children from measles and rubella throughout the COVID-19 pandemic. At least 36.6 million children between the ages of nine months and nine years old were vaccinated against measles and rubella during the UNICEF-supported 2020 MRV Campaign. This achievement surpassed the target of 34 million children (i.e., 104 per cent of the target was reached). The campaign reached 64 districts and 12 city corporations, including 484 Upazilas, 111 municipalities, and 48 zones.
- The UNICEF Bangladesh MRV campaign page on Facebook was followed by more than 10.5 million FB users. The theme song reached more than 300,000 people, and the PSA reached about 500,000.

OVER **50,000** vaccinators were employed

AT LEAST **36.6 million** children vaccinated

PSA reached about **500,000** PEOPLE

Lessons learned

1 Gathering evidence about social norms influencing behaviour change related to MRV was crucial for developing the campaign interventions.

2 Having a clear strategic framework template, an easily navigable implementation plan, and a process for campaign partners to follow made it possible to quickly transform MR materials for the pandemic context, and helped partners deliver on the ground through virtual orientations.

3 A specific Guideline for Crisis and Emergency Risk Communication (CERC) and Addressing Vaccine Hesitancy helped address issues of AEFI arise during the campaign.

Recommendations

1 Future campaigns should consider developing or using an existing character (cartoon or otherwise) to serve as a mascot that can be associated with childhood vaccination in Bangladesh and be used to promote childhood vaccinations throughout the country.

2 The social media assets created for this campaign were mostly hosted by UNICEF Bangladesh. The capacity of partners in social media listening needs to be further strengthened so that they are capable of promoting campaign messages.

3 There are at least 30,000 zero-dose children under one year old in Bangladesh. Zero-dose children have not received any vaccinations, including for measles and rubella and future campaigns should address these children.

Endnotes

1 Khanal S., Bohara R., Chacko S., Sharifuzzaman M., Shamsuzzaman M., Goodson J.L. et al., 'Progress toward measles elimination – Bangladesh, 2000-2016', *Morbidity and Mortality Weekly Report*, vol. 66, no. 28, pp. 753-757, 2017.

2 Supplementary Immunization Activities (SIAs) are immunization campaigns, typically implemented for two targeted age ranges. An initial, nationwide catch-up SIA targets all children aged nine months to 14 years; a periodic follow-up SIAs then targets all children born since the last SIA and are generally conducted every 2–4 years. The goal of a follow-up SIA is to eliminate any measles susceptibility that has accumulated in recent birth cohorts and to protect children who did not respond to the first dose of measles vaccine.

3 Khanal S., Bohara R., Chacko S., Sharifuzzaman M., Shamsuzzaman M., Goodson J.L. et al., 'Progress toward measles elimination – Bangladesh, 2000-2016', *Morbidity and Mortality Weekly Report*, vol. 66, no. 28, pp. 753-757, 2017.

4 United Nations Children's Fund, *Measles & rubella vaccination 2020: Capturing the action*, UNICEF Bangladesh, Dhaka, 2021.

5 Hassan B., Gupta D., Rehman S.M., Adhikary J.M., *Social and Behaviour Change Communication (SBCC) Strategy for Improving Routine Immunization and Measles-Rubella (MR) Campaign Coverage 2018-2019*, UNICEF, 2019.

6 United Nations Children's Fund, *Measles & rubella vaccination 2020: Capturing the action*, UNICEF Dhaka, 2021.

7 Government of Bangladesh, 'Measles Rubella Vaccination Campaign 2020: Guideline for the crisis and emergency risk communication (CERC) and addressing the vaccine hesitancy', Dhaka, 2020.

SOCIAL + BEHAVIOUR CHANGE

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UNICEF Nepal Helps to Improve the Safety of Female Community Health Volunteers Using Human Centred Design

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

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Brief summary

UNICEF Nepal provided training in four provinces to understand underlying issues contributing to low vaccination rates in certain Nepalese communities. Following a training to build capacity in using human centred design (HCD), a field team in Kathmandu conducted research to understand why the Chepang community had immunization coverage rates below 70 per cent. The findings from the study pointed to the fear of female community health volunteers (FCHV), key persons responsible for reminding families to go for their vaccinations, to travel alone in certain areas as an underlying reason for low vaccination rates. The solution that presented itself from the findings was to engage money lenders (community influentials) in ensuring the safe passage of FCHV in their communities.

Context

Female community health volunteers (FCHV) in Nepal are tasked with reminding families to attend vaccination appointments. They have a long-standing practice of accompanying family members to health facilities to get vaccinated. This practice has been an effective strategy for increasing vaccination rates. The FCHV, however, felt unsafe travelling alone from house to house in certain areas. This issue was impacting immunization coverage and rates in communities in areas that were perceived by FCHV as unsafe.

Strategic approach

UNICEF Nepal supported human centred design (HCD) training in four provinces. Within each province, the focus was on communities with immunization coverage below 70 per cent.

In Kathmandu, the Chepang community, an indigenous ethnic minority group living in an urban slum was prioritised for investigating the reasons for low vaccination rates. During the training, participants travelled to Chepang, and, using the HCD systems-view mindset from the training, the field team set out to understand the journey to vaccination from the perspective of the people directly or indirectly involved (e.g., pastors, teachers, parents/caregivers, vaccinators, health section chief, female community health volunteers (FCHV), ward chairperson). Using visual discussion cards and other creative discussion tools, the field team asked:

- What habits, routines, and responsibilities make up a typical day for a female community health volunteer (FCHV)?
- Who are the most trusted and influential actors in the community?
- What are the biggest barriers keeping health workers from providing quality health services?
- How are health practices and services perceived in the community?
- What is the relationship between health workers and families attending the clinic?

The findings from this inquiry revealed that FCHV felt at-risk travelling alone from house to house to remind families to visit the clinic for vaccinations. The field team also learned that money lenders, not community leaders, had the most influence in the community, and these money lenders saw themselves (and wanted to be seen) as the protectors of the community. The solution seemed to lie in engaging the money lenders in maintaining the safety of the FCHV. As successful, well-connected members of the community, money lenders had access to such resources as motorbike transportation that could provide FCHV with safe passage. They could also advocate for FCHV at local meetings and in places where community leaders gather to generate broader community support and awareness for their activities and well-being. In return, the health sector would recognise money lenders for their service and positive impact.

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Key achievements

- Through the process of seeking to understand broader community dynamics, the team discovered that money lenders, not local leaders, have the most influence in the community.

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UNICEF Nepal supported

HUMAN CENTRED DESIGN (HCD)

training in four provinces

The field team used visual discussion cards and other creative discussion tools

The field team learned that money lenders had the most influence in the community

Lessons learned & Recommendations

1 Money lenders can be given the opportunity to participate in local health committees so that they can help address safety concerns, become involved in social causes in the community, and advocate for FCHVs in exchange for recognition of their impact.

2 The idea to leverage the influence and resources of money lenders, a previously untapped population in the community, to address the safety concerns of FCHV, could only have been discovered by letting go of a narrow focus on immunization and seeking to understand the broader dynamics within the community using a human centred perspective.

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UNICEF Nepal Supports Innovative Youth-Led Social Mobilization Initiatives to Prevent Acute Gastroenteritis and Cholera in Kathmandu Valley

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

Brief summary

UNICEF Nepal, in partnership with *Yuwalaya*, a youth-led organization, designed and implemented an innovative six-month social mobilization initiative to improve the hygiene practices of people living in the urban slums of Kathmandu Valley and eliminate cholera outbreaks. The interventions included capacity building among youth organizations, a campaign involving infotainment activities such as flash mobs, forum theatre, wall comics, slam poetry, community mobilization and discussions, and public hearings with district-level public officials. More than 34,000 people were directly reached with key messages in 29 hot-spot areas in two metropolitan cities and five municipalities of the Kathmandu Valley. Eight hundred young people were reached with trainings by youth and strengthened their skills to discuss key sanitation and hygiene messages with their communities and families. Apart from increasing knowledge on safe water and hygienic practices, young people who designed, led, and implemented these initiatives, developed key life skills such as self-confidence in public speaking, expressing emotions, critical and creative thinking, and influencing people.

Context

Cholera is endemic in various parts of Nepal, including the Kathmandu Valley. A large earthquake in Kathmandu Valley (in 2015) resulted in partial water scarcity. Many people still live in unhygienic conditions with limited access to safe drinking water and sanitation facilities.

People living in slums have difficulty adopting safe water, sanitation and hygienic practices despite their knowledge on their importance. During the monsoons, cholera poses the threat of reaching epidemic proportions.

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Strategic approach

A baseline survey of prevalent knowledge, attitudes and practices (KAP) was conducted to understand people's water, sanitation, hygiene and treatment seeking behaviours for acute gastroenteritis and cholera. Sixty-four young people received training on data collection to carry out the KAP survey. A questionnaire, containing 50 questions was developed by UNICEF Nepal and pre-tested by *Yuwalaya* (a youth-led non-profit, non-governmental organization in Nepal) for finalization. Young enumerators went door to door to collect data from 1,601 households. This method of collecting data built the capacity of young people to objectively assess the situation of sanitation and hygiene, as well as measure the difference that their work made in their communities.

The findings were used by UNICEF Nepal and *Yuwalaya*, in close consultation with the District Public Health Offices (DPHO) of Kathmandu, Lalitpur and Bhaktapur, to design a six-month programme to increase the adoption of safe water and sanitary and hygienic practices among families and communities in Kathmandu Valley. The programme was based on the Social Ecological Model (SEM) and incorporated corresponding communication approaches, namely advocacy, capacity building, and outreach/interpersonal communication.[1]

Between June and November 2017, during the pre-monsoon and monsoon seasons, various trainings and innovative youth-led activities were carried out in 29 areas identified as hot-spots for cholera in the two metropolitan cities of Kathmandu and Lalitpur, and five municipalities of *Chandragari, Godawari, Kirtipur, Mahalaxmi* and *Suryabinayak*. The key activities included:

1. **Strengthening the capacity of youth organizations**: By coordinating with the local youth clubs, adolescents and youth from the identified hotspot areas were selected for a training on Communication and Social Mobilization Skills. A one-day training was conducted for 141 youth where they acquired basic skills linked to social mobilization, and refined their knowledge on the prevention of water-borne diseases.
2. **Community-level discussions**: Thirty youth clubs and various local stakeholders (e.g., ward representatives, Female Community Health Volunteers (FCHVs), women's groups and local youth) held community discussions to promote the use of safe drinking water and hygiene practices in intervention areas, and to advocate for a clean and healthy environment.
3. **Events**: Youth clubs contributed to various events during the World Environment Day, International Youth Day, Children's Day and World Toilet Day, emphasising that access to safe drinking water and hygiene is crucial for a healthy community and the right of every child. The youth contributions included 130 wall comics, 20 flash mobs, 24 participatory forum theatre presentations, slam-poetry sessions (with 123 slam poets), and "miking" (walking or traveling through settlements while spreading messages using a microphone). Mascots were used to attract crowds for performances and presentations in public spaces.
4. **Public hearings**: Public hearings were held at DPHO where youth presented sanitation and hygiene issues through slam poetry and theatre performances, and the presentation of wall comics.
5. **Endline survey:** An endline survey was conducted to determine the effects of the campaign on prevalent knowledge, attitudes and practices (KAP) regarding water, sanitation, hygiene and treatment seeking behaviours.

Key achievements

- One hundred forty-one youth were trained in interpersonal communication and social mobilization. Twenty-nine community discussions and sanitation campaigns were coordinated and implemented by youth clubs in 29 wards. Sixty-four of these 141 youth were also trained in conducting household surveys on knowledge, attitudes and practices (KAP).
- Thirty-four thousand three hundred fifty-one people were directly reached with key messages in 29 hot-spot areas in two metropolitan cities and five municipalities of the Kathmandu Valley.
- Eight hundred young people were reached with trainings by youth trainers and strengthened their skills to discuss key sanitation and hygiene messages with their communities and families.
- Apart from increasing knowledge on safe water and hygienic practices, young people who designed, led and implemented these initiatives, developed key life skills like self-confidence in public speaking, expressing emotions, critical and creative thinking, and influencing people.
- Thirty youth clubs strengthened their collaboration with local stakeholders; 16 youth, including eleven community facilitators, two field supervisors and three reporting associates, took the lead in ensuring a direct link between local youth clubs, their ward representatives and relevant health facilities
- Ninety-four public events around safe water, sanitation and hygiene promotion were implemented by 30 youth groups.
- Nine public hearings involving the District Public Health Offices, were implemented in hot spot areas in all seven municipalities.
- No cholera outbreak in Kathmandu Valley in 2017, as compared to 186 cases in 2016.

94
PUBLIC EVENTS
around safe water, sanitation and hygiene promotion were implemented by 30 youth groups

9
PUBLIC HEARINGS
were implemented in hot spot areas in all seven municipalities

141
YOUTH
were trained in interpersonal communication and social mobilization

Lessons learned & Recommendations

1. Public services (safe water supply and functional sewage systems) need to be improved to ensure that people living in urban slums are able to translate their high levels of knowledge and positive attitudes about sanitation and hygiene into practice.

2. Youth-led activities, using networks of youth clubs and supported by appropriate training, can be a cost-effective way to reach communities with relevant messages about water, sanitation, and hygiene.

3. Community engagement (especially involving youth) will likely increase project reach, efficiency and sustainability, and should be applied to all relevant projects.

4. Innovative activities such as slam poetry, flash mobs and wall comics could be used as part of other projects to tackle social norms and change behaviours.

Endnotes

1 The Social Ecological Model (SEM) posits that individual behaviour is determined by multiple levels of influence (individual, interpersonal, community, institutional/organizational, societal), hence the need to intervene at all levels in order to promote behaviour change.

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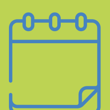
UNICEF Pakistan Develops Social and Behaviour Change Interventions to End Polio in Karachi

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

Brief summary



Dates of Activity
August 2020 to present

Duration
Ongoing

Budget
US$45,000 for community engagement activities (staffing and external comm's budget are not included)

Pakistan is one of three remaining polio-endemic countries in the world, along with Afghanistan and Nigeria. To eliminate polio completely, every child in every household must be vaccinated. UNICEF Pakistan supported challenge mapping research in Karachi (capital of Sindh province) to profile cases of polio vaccine refusals, determine the key bottlenecks of the under-immunized population, and engage community members using tailored social and behaviour change (SBC) activities in mapping and co-creating solutions to address polio-vaccine resistance. The community engagement activities resulted in a 70 per cent decline in the rate of polio vaccination refusals in Karachi between August 2020 and August 2022.

Context

Since the launch of the Pakistan's Polio Eradication Programme in 1994, there has been a 99 per cent decline in polio cases in Pakistan.[1] In Sindh province, wild polio virus (WPV) cases declined from 12 in 2015 to only one in 2018. In 2019 and 2020, however, the number of cases jumped to 30 and 22 respectively. The number of circulating vaccine-derived polioviruses (cVDPV2) in Sindh was 45 in 2020.[2] Thousands of Pakistani children are still missing out on the polio vaccine. Many of these children live in remote, fragile, and conflict-affected areas, and many are part of migrant or refugee populations, which makes reaching them with vaccines very difficult. Misinformation about polio vaccines, especially during the COVID-19 pandemic when immunization campaigns were interrupted, also hampered the eradication of this disease.

Karachi is the largest city in Pakistan, with approximately 17 million people belonging to different communities and tribes that struggle to maintain their cultural and historic identity while surviving amidst difficult socio-economic circumstances, poor civil and health systems, and a barrage of political conspiracies that result in low trust in the government and their programmes, including polio vaccination. Most Pashtun communities lie on the fringes of Karachi city.

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Strategic approach

UNICEF Pakistan supported a household-level challenge mapping study of parents in Karachi (Sindh province) that refused the polio vaccine for their children ages one to five years old.[3] This study allowed the researchers to identify the language, tribe, caste, clan, religion, and socioeconomic status of families with the highest refusal rates, their reasons for refusal, as well as tribal leaders/ influencers within Pashtun communities.

The highest refusal rates came from Urdu and Pashto speakers, and families living either in slums or in "posh" areas. More than 150,000 children went unvaccinated for polio. The majority of parents in the study refused to have their child vaccinated because they believed the vaccine should be administered by a doctor, or they did not trust the polio vaccine and/or the Pakistani government that supported the polio vaccination activities. Some parents harboured misconceptions that the polio prevention programme was a Western conspiracy against Muslims and contained ingredients forbidden by Islamic law. Cultural misconceptions about the dangers of vaccinating a newborn also circulated within the Pashtun population. A majority of parents said that their child missed the vaccine because they had diarrhoea, fever, or a seasonal disease at the time of the vaccination campaign. Parents in "posh" areas were reluctant to let their child get multiple doses of the polio vaccine. The findings from the study with parents were used to identify refusal clusters on a map of Karachi.

A set of tailored social and behaviour change (SBC) interventions were co-created with community members to decrease the number of polio vaccination refusals. Polio micro-plans were developed at the community level to engage the community and heighten ownership of, and accountability for, increasing polio vaccination among children within the community. Each area had about 1,000—1,200 children targeted to receive a polio vaccine. Areas with more than 10 per cent vaccine refusal rates were the priority for SBC interventions. The key SBC activities included:

1. **Advocacy with key stockholders:** High level engagement with key political, religious, and tribal leaders was initiated to create an enabling environment for polio vaccination activities.
2. **Integrated service delivery:** A specific action plan was developed and engaged other sections of UNICEF to focus more on integrated service delivery and sensitization of communities around key family health care practices.
3. **Training Frontline Workers (FLWs):** Capacity-building sessions were conducted with FLWs to improve their interpersonal communication (IPC) skills.
4. **Community engagement sessions with tribal elders and community members:** Interpersonal communication was used to motivate tribal elders to support polio vaccination, and to engage Pashtun community members to have their children vaccinated against polio. Pashtun AS and SM identified elderly female Pashtun "mother figures" (*Moor*) in the community who served as influencers for female caregivers.
5. **Religious school engagement**: Key messages were disseminated through Madrassahs (boys-only Islamic religious schools for elementary and higher learning) and religious gatherings.
6. **Mass media:** Local media outlets were approached to broadcast videos made by a UNICEF videographer in Pakistan, with positive messages about polio vaccination delivered by such influencers as tribal leaders, political leaders, the Pakistan Medical Association, individual doctors, the Pakistan Islamic Medical Association, UNICEF partners, UNICEF's Area Supervisors, Polio Team, and other stakeholders.

Key achievements

- At least 19 polio vaccination campaigns were implemented between 2020 and 2022.
- At least 100 videos with messages from UNICEF staff and key stakeholders about the benefits of polio vaccination have been created by UNICEF and broadcast via local media.
- More than 80 Frontline Workers were trained in IPC and are attached to their home community.
- The rate of polio vaccination refusals in Karachi declined by about 70 per cent between August 2020 and August 2022.
- Overall coverage of polio vaccination improved to where more than 98 per cent of eligible children were vaccinated in each supplemental immunization activity.
- Systematic engagement of key tribal, political, and religious leadership led to more than 1,500 key leaders actively supporting polio vaccination and other integrated services.
- Community engagement efforts led to a major boost in community trust; polio vaccinators were able to move through hostile areas without law enforcement.
- The number of females that participated in community engagement sessions about polio vaccination increased.
- Targeted and area specific interventions helped to reduce resistance to polio vaccination.
- Strong alliances were developed with community-based organizations.
- No polio virus was found in humans or the environment in most parts of the Sindh province since the intervention began in 2020.

MORE THAN
80
Frontline Workers were trained

70%
decline in the rate of polio vaccination refusals

AT LEAST
19
polio vaccination campaigns were implemented

Lessons learned

1 Gathering behavioural insights and challenge mapping are key to understanding polio vaccination refusals as a first step toward developing activities to change attitudes and behaviours regarding the polio vaccine.

2 Involving community members (especially community/opinion leaders) in the planning, implementation, and monitoring of SBC activities, helps to create ownership of the activities and lowers resistance to polio vaccination uptake activities. Continuous community listening helps to identify and address on-the-ground challenges to polio vaccination interventions.

3 Integrated service delivery can revitalize community engagement, build confidence and trust within the community, and make the community feel heard. Even when communities did not have positive experiences with the health service delivery system, this trust was not eroded. Need-based partnerships and alliance-building with public and private partners requires goal-driven activities and an action plan for efficient execution.

Recommendations

1 Continue to use a systematic, real-time approach to collecting social data from households (parents/caregivers) to identify and understand the underlying causes of polio vaccine refusals.

2 Intensify the integrated services approach, specifically in slum pockets of Karachi, including strengthening EPI and basic health and nutrition services to improve the community's trust in the health system.

3 Employ systematic advocacy at the policy level to achieve better integration of SBC, EPI, and overall integrated service delivery, and greater sustainability of results.

Endnotes

1 Pakistan Polio Eradication Programme, 'Pakistan Polio Eradication Initiative: Working towards a polio-free Pakistan for every child', <www.endpolio.com.pk/images/reports/PPEI%20Brochure%20English.pdf>.

2 Pakistan Polio Eradication Programme, 'Polio Free Pakistan for Every Child', <www.endpolio.com.pk/polioin-pakistan/polio-cases-in-provinces>.

3 A challenge map clearly communicates insights gained from fieldwork and pinpoints specific challenges using pictures of and quotations from users, as well as an explanatory text that addresses a problem, barrier or theme.

UNICEF Nepal Uses Social and Behaviour Change Strategies to Provide Life-Saving Support to Nepalese in the Aftermath of Devastating Earthquakes

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

Brief summary

In April and May, 2015 devastating earthquakes struck Nepal, killing 9,000 people and injuring more than 100,000 others. A majority of the houses were damaged or fully destroyed, and people, were forced to move to safe spaces or live in makeshift shelters. Much of the healthcare, community, and telecommunication infrastructure were also destroyed. Subsequent landslides blocked major roads and highways, hampering relief agencies and authorities from delivering aid to affected populations. UNICEF Nepal's Communication for Development (C4D) team responded by initiating information dissemination activities via remaining functioning media channels, and collecting feedback on the immediate needs of affected populations. Using social and behaviour change communication strategies, UNICEF Nepal mobilized communities and presented edutainment shows and outreach activities to deliver life-saving messages. During the recovery phase following the earthquakes, the UNICEF Nepal team developed the capacity of civil society organizations to promote positive behaviours with regard to emergency preparedness, preventing human trafficking, and disaster risk reduction. The information, coordination, and feedback mechanisms supported by UNICEF Nepal resulted in building more resilient communities and strengthening the accountability of government and the international community.

Context

The Himalayan region is one of the most seismically active in the world, yet large earthquakes are a relatively rare occurrence. The Gorkha Earthquake in Nepal, with a magnitude of 7.6, occurred on 25 April 2015. Its epicenter was about 47 miles northwest of the capital, Kathmandu. It was followed by more than 300 aftershocks. Around 9,000 people were killed, more than half of whom (55 per cent) were female. At least 100,000 people were injured. Over 500,000 houses were destroyed and another 269,000 damaged, which included historical and cultural monuments. Key infrastructure was also destroyed, as were livelihoods, especially in the agriculture and tourism sectors.[1] On May 12 2015, a magnitude 7.3 aftershock killed more than 100 people and injured nearly 1,900.[2] In total, more than eight million people were affected, and about 2.8 million people were displaced. The earthquakes produced landslides that devastated rural villages and some of the densely populated areas in Kathmandu.[3]

The Nepalese government declared a state of emergency and called on the international community for aide. According to the Post Disaster Needs Assessment by the UN, World Bank and the EU the total value of the damages and losses of the disaster was estimated at US$7.1 billion, while the estimated needs for recovery were US$ 6.7 billion.[4]

Strategic approach

UNICEF Nepal's response in the immediate aftermath of the earthquakes was to engage media channels that were still functional to disseminate life-saving messages, collect feedback on the needs and concerns of affected populations, and provide on-air psychosocial counselling (through call-in radio broadcasts). In the short-term, UNICEF supported the distribution of tents, generators, portable audio recorders, telephone hybrids, laptops and radio receivers, and training for local technicians on repairing damaged radio sets. The long-term plan consisted of training community radio stations on strengthening their disaster risk reduction programming and emergency preparedness response. An initial Communities Working Group (CWC) was established to coordinate communication efforts among relief and UN agencies, international and national non-governmental organizations, media organizations, and community radio operators.[5,6]

A survey of children conducted in the immediate aftermath of the seismic events pointed to the need for psychosocial support to address feelings of loss, fear, grief and sadness. UNICEF Nepal supported the *Bhandai Sundai* (Talking-Listening) radio programme aimed at children, women, and families that did not otherwise have access to direct counselling services.[7] The radio programme was also used to promote a Back to School campaign (e.g., modeling how teachers and administrators should act with children in their first days back to school), Nutrition Week, and the Cash Transfer scheme for earthquake affected families. The success of the *Bhandai*

Sundai programme led to the spin-off *Bhandai Sundai Gaon Gaon Ma* (Talking-Listening in Villages), a traveling edutainment show hosted by popular Nepali celebrities who delivered messages about health, nutrition, sanitation, hygiene, and child protection.[8,9] Partnerships with Radio Nepal and with the Association of Community Radio Broadcasters Nepal enabled community members to call in and provide feedback to humanitarian responders about their needs and concerns.

UNICEF Nepal also partnered with *Yuwalaya*, a youth-led organization with an existing district-based network. Hundreds of youth volunteers mobilized communities to facilitate face-to-face discussions and distribute communication materials and essential rehabilitation supplies. These efforts helped to build resilience in communities and strengthen the accountability of government and the international community.

During the recovery phase following the earthquakes, the UNICEF Nepal C4D team supported the Promoting, Recovery and Resilience Among Earthquake-Affected Communities programme, comprised of (1) capacity building activities for civil society organizations (CSOs), community groups, and youth, and (2) broadcasting an edutainment radio drama series, *Milan Chowk* (the name of an imaginary village in Nepal). Individuals from the key organizations and youth networks were trained to disseminate critical information, track community perceptions and needs, and develop community action plans, and create mechanisms for community feedback and accountability by those in responsible positions. The messages delivered by these groups included ways to prepare for future disasters, and how to prevent human trafficking. Wherever possible and relevant, the messaging was entrenched in ongoing programmes.[10] The radio drama, broadcast weekly in 20-minute segments, provided messages on maternal and child health, nutrition, hygiene, and disaster risk reduction. The content was supplemented by local content in local languages produced by 16 community radio stations in priority districts.

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A third-party end-user monitoring system (DARA) was engaged to assess the effectiveness of the humanitarian response and provide periodic reports on the performance of UNICEF emergency programmes, including the social and behaviour change communication initiatives.[11] DARA staff visited nine districts in Nepal and conducted over 150 key informant interviews, 30 group discussions, and observations of assistance at health centers, learning centres, shelters, homes and other locales.

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Key achievements

- Outreach activities conducted by CSOs, community groups, and youth reached over 57,000 people, preparing them for future disasters.

57,000 PEOPLE

reached to prepare them for future disasters

DARA staff

visited nine districts in Nepal and conducted over 150 key informant interviews and 30 group discussions

16 COMMUNITY RADIO STATIONS

in priority districts supplemented with local content

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Lessons learned[12]

1. Earthquake and other disaster response initiatives should have a clear theory of change as a framework for guiding activities. No clear theory of change underpinned UNICEF's initial response in Nepal, which undoubtedly contributed to the lack of integration of early recovery activities into the response and a gap in planning from late August until February 2016.[13]

2. Coordination and feedback mechanisms are necessary for community engagement and increased accountability. The CWC, in collaboration with the government, took a key role in providing situation updates, supporting community engagement and disseminating critical and timely life-saving messages right from the onset of the emergency. The close collaboration with all involved stakeholders, as well as the presence of established mechanisms, helped to ensure accountability to the affected population.

3. Involving young people from local communities in the outreach activities not only ensures appropriateness and acceptance of messages, but also increases identification and creates a sense of ownership.

4. Partnerships with the national broadcasters and broadcasting associations helped ensure accountability to affected populations by providing communities with a channel for feedback to humanitarian responders about their concerns and needs.

5. Providing communities with local language and geographically-appropriate content as part of the *Milan Chowk* radio drama broadcast fostered community participation and ownership of the drama series, increasing its effectiveness.

6. Generating audience feedback for media content through interviews with people from the community and group discussions led to more in-depth understanding of how the radio drama series was received and understood by the intended audiences.

7. Using radio programmes to provide psychosocial counselling benefitted those who did not have direct access to counselling services.

8. Funding for specific social and behaviour change communication activities is vital for reaching affected and vulnerable populations.

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Recommendations

1. Formulate a theory of change to guide disaster risk reduction initiatives.
2. Strengthen preparedness measures, including the required training on emergency procedures and preparedness and contingency plans.
3. Increase community participation in programme design and implementation.
4. Strengthen data collection, monitoring and evaluation, and the use of data to develop and refine activities.
5. Ensure adequate planning processes and frameworks in future emergencies, including strengthening guidance on early recovery and resilience, and transition planning from emergency response to recovery activities.
6. Improve timeliness of overall emergency response, including expanding cash-based programmes to expedite procurement and identifying strategic warehousing opportunities for emergency response.

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Endnotes

1 United Nations Office for Disaster Risk Reduction, *Nepal: Gorkha earthquake* 2015, UNDRR, 2020,

<www.preventionweb.net/collections/nepal-gorkha-earthquake-2015>.

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3 Ibid.

4 United Nations Office for Disaster Risk Reduction, *Nepal: Gorkha earthquake* 2015, UNDRR, 2020, <www.preventionweb.net/collections/nepal-gorkha-earthquake-2015>.

5 United Nations Children's Fund, *Nepal earthquake 2015: Engaging communities to build resilience and accountability mechanisms*, UNICEF Nepal, <https://app.box.com/s/ol86kvo5d71de6x6a5iwdurypsfncpjh>.

6 The CWC was later further divided into four subgroups: Messages and Materials, Community Mobilization, Radio, and Monitoring and Evaluation.

7 Radio is a very popular medium among all wealth segments of the Nepalese population.

8 United Nations Children's Fund, *Nepal earthquake 2015: Engaging communities to build resilience and accountability mechanisms*, UNICEF Nepal, <https://app.box.com/s/ol86kvo5d71de6x6a5iwdurypsfncpjh>.

9 The edutainment shows included comedians, magicians, singers and other performing artists, like Ani Choying Drolma, Jeetu Nepal, Kaliprasad Baskota, Komal Oli,Deepak Raj Giri and Deepashree Niraula.

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UNICEF Bangladesh Supports Information Feedback Centers that Provide Rohingya Refugees in Cox's Bazar, Bangladesh with Critical Information and Services

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

Brief summary

In close partnership with local NGOs, UNICEF Bangladesh established information and feedback centres (IFCs) in key locations throughout refugee camps and host communities in Cox's Bazar to serve Rohingya refugees from Myanmar. IFCs provide information and referral to available services, and receive and respond to community complaints, feedback and queries (CFQs) via two-way, face-to-face interactions with community members. Community volunteers provide outreach and dialogue. UNICEF Bangladesh also supports satellite activities that serve to provide correct and timely information to the Rohingya population. The IFCs have proven to be a good way to achieve accountability to vulnerable populations and respond to UNICEFs commitment to supporting accountability to affected populations.

Context

In August 2017, 740,000 Rohingya people, including 400,000 children, fled from violence in Myanmar into Bangladesh.[1,2] They live in temporary shelters in highly congested refugee camps in Cox's Bazar, one of the poorest and most disaster-prone districts in Bangladesh. Annual cycles of heavy monsoon and cyclones pose substantial risks to both Rohingya refugees and host communities. The Rohingya rely entirely on humanitarian assistance for protection, food, water, shelter, and health. While basic services have been provided to them, children still face disease outbreaks, malnutrition, inadequate educational opportunities, and the risks related to neglect, exploitation and violence, and child labour. Girls and women are at particular risk of sexual and other gender-based violence in the camps. Twenty-three per cent of girls and 57 per cent of women feel unsafe when using latrines. Over 40 per cent of children under five years are stunted. Unaccompanied and separated children are at high risk of trafficking, early marriage, and sexual exploitation.[3]

Thirty-nine per cent of children and 97 per cent of adolescent refugees, lack access to education.[4] Girls are often kept out of school by parents trying to keep them safe. Older children and adolescents who are deprived of opportunities to learn or make a living are at real risk of becoming a 'lost generation,' ready prey to traffickers and those who would exploit them for political or other ends.[5]

Together with government and other humanitarian partners, UNICEF immediately responded to provide life-saving assistance and protection to the newly arrived Rohingya children and their families, also taking a lead role in health, nutrition, water, sanitation, and hygiene (WASH), child protection, and education. The majority of the newly arrived Rohingya refugees, however, were not aware of the humanitarian services available, and frontline workers and service providers had difficulty reaching out and making referrals in the camps and makeshift settlements. Refugees seeking accurate and timely information about their situation and surroundings did not know which sources were credible, and did not feel heard when they reported that the aid they were receiving was insufficient. There was no feedback mechanism to record complaints about aid, sexual harassment, and other injustices in the settlements.[6]

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Strategic approach

To respond to the needs of the Rohingya in Cox's Bazar, UNICEF and partners (e.g., NGO PULSE) established information and feedback centres (IFCs) in critical locations across the camps. The IFCs improve accountability to the refugee population and provide a two-way information flow through face-to-face interactions with community members. At the IFCs, Rohingya are able to learn about emergency preparedness, gender equality and safe environments for women and girls, file complaints, and obtain answers to any pressing questions, and receive referrals to services. IFC staff conduct sessions to demonstrate and practice positive behaviours. Public service announcements are initiated from the IFCs about, for example, nutrition action weeks, vaccination campaigns, and cyclone preparedness. The centres have become 'safe spaces' where vulnerable individuals could go for protection.

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The learning centres provide early education to children ages 4 to 6 years, and non-formal basic education to children ages 6 to 14 years. There are three shifts in each learning centre, with each shift accommodating 35 children. Children learn English, Math, Burmese, Science, Arts and Anthems. Children receive psychosocial counselling and are taught hygiene and life skills. The children are given books, pens, colouring pencils, school bags and other educational materials.

The first two centres were formed in September 2017, during the first weeks of the crisis, and began providing life-saving information and on-site referral for urgent services, including nutrition, WASH, medical help, hygiene behaviours, vaccination campaigns, and child and newborn care. As the crisis worsened within the camps, UNICEF supported new IFCs in order to increase referral capacity. By June 2019, 20 IFCs were established, linked to a network of 300 community mobilisers (volunteers) from Rohingya and host communities in Cox's Bazar.[7] The community mobilisers include 120 Model Mothers, 120 Model Youth Mobilisers, who conduct outreach and collect information within their community, for example convening community dialogue sessions. Each IFC has 13 Model Mothers and 12 Model Youth Mobiliser. These volunteers receive training in interpersonal communication, capacity building, and a communication package.[8] The mobilisers are each expected to contact 15 families per day for engagement and consultation. An average of three to five family members participate during an interpersonal communication session, which lasts approximately 20–35 minutes, depending on the nature of the messages or dialogue and the demonstration required.[9]

The IFC staff, known as information service providers (ISPs), keep logbooks (now digitised via Open Data Kit using tablets and available

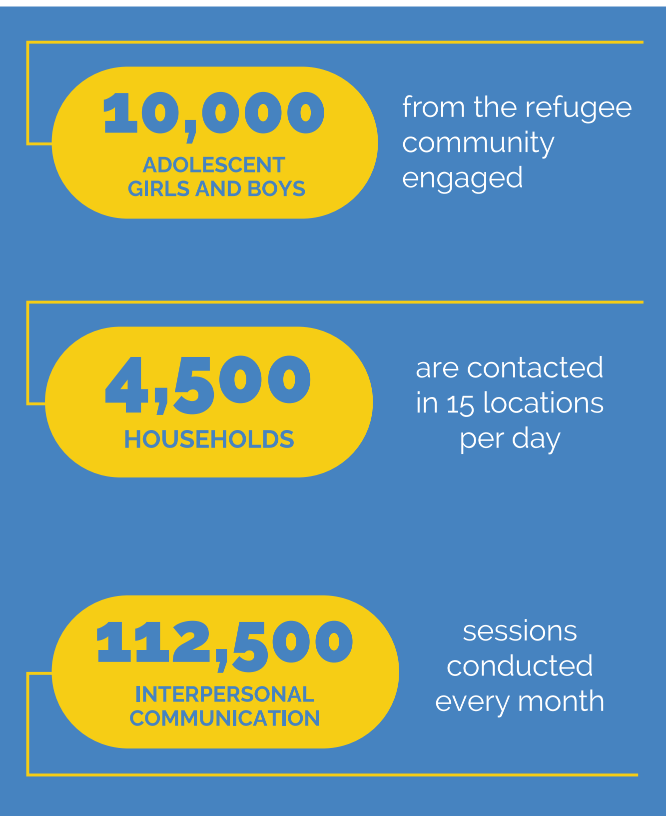
on a dashboard) to document the feedback received from the refugee population, as well as maintain sociodemographic information about the community. Standard operating procedures (SOPs) were developed by UNICEF to facilitate follow-up in response to the feedback. Complaints that cannot be addressed on site by service providers or site management focal points are elevated to the relevant supervisor of the respective agency at Cox's Bazar. The feedback loop is closed once the response is communicated back to the community. Community members are informed in all cases.[10]

UNICEF Bangladesh supported satellite activities that also served to provide correct and timely information to the Rohingya population. For example, conducting outreach with local leaders and religious leaders through various advocacy meetings, creating a community mobilisation network of community mobilisation volunteers (CMVs), conducting community dialogues, youth engagement activities, radio distribution, interactive popular theatre shows, community consultation meetings, radio listener clubs and radio programming.

Key achievements

As of May 2019, UNICEF has established 20 IFCs across 4 host communities and 16 camps located in the Rohingya settlements. As of October 2019, the IFCs provided collected about 120,000 individual complaints, queries, and feedback, with a response rate of nearly 100 per cent, significantly improving the responsiveness of service delivery. An estimated 4,500 households are contacted in 15 locations per day, per site, with 112,500 interpersonal communication sessions conducted every month (equivalent to 25 working days). A mapping system has been developed to avoid duplication of messaging and to facilitate tracking and monitoring by the mobilisers. The IFCs and outreach workers have increased trust and responsiveness with Rohingya refugees in Cox's Bazar.[11,12]

Model Mothers and Model Youth Mobilizers have reached 100,000 households with critical information and resources. An estimated 10,000 adolescent girls and boys from the refugee community have been engaged as change agents to provide life-saving information and referrals to services. Another 3,000 adolescent girls and boys from the host communities were similarly engaged. Over 70,000 CFQs were synthesised and forwarded to Sector colleagues to support their interventions across Health, WASH, Nutrition, Child Protection, and Education. The majority of CFQs were health-related. The digitisation has enabled these sectors to access the information in a timely manner.[13]



Lessons learned[14,15]

1. The IFCs have proven to be an effective way to achieve accountability to vulnerable populations and respond to UNICEFs commitment to supporting Accountability to Affected Populations.

2. Engaging communities in face-to-face dialogue is especially important when, like the Rohingya, the population has a high level of illiteracy and there is no written script for the language. Development of user-friendly, image-focused behaviour change materials has enabled the Model Mothers and youth volunteers to engage communities in dialogues.

3. Regular capacity-building for the ISPs that staffed the IFCs, including training on interpersonal communication and the prevention of sexual exploitation and abuse (PSEA), among other topics, has enabled more robust programming and quality assurance.

4. Promoting the use of IFCs through outreach workers within communities is essential to their success.

5. IFC staff need to build strong relationships with camp service providers. Investments must be made early on for systematic recruitment and training of IFC staff. This is essential to the quality of IFCs and service referrals.

6. Standardisation of response systems is essential to maintaining the quality of information dissemination and service referrals across all IFCs.

7. Staffing the IFCs with volunteers and outreach workers who are from the community themselves greatly increases credibility, acceptance and trust of information and service referrals. Recruitment strategies must be carefully considered, accounting for gender and the local sociocultural milieu of the refugees. For example, in Cox's Bazar the majority of the volunteer mobilisers and outreach workers are female. This can sometimes create pushback in the community where women are not allowed in certain spaces, or men find themselves without jobs. Similarly, if female adolescents are recruited, their safety and security need to be carefully considered.

8. The use of multiple communication devices and creative tools, such as tablet computers, wind-up radio sets, information leaflets, and visual materials, are an effective component of the IFC response.

9. Digitising CFQs and feedback collected at IFCs facilitates rapid data entry and retention and improves analysis and information sharing, thereby increasing the efficiency of the response at multiple levels. Such an initiative also introduces new challenges and priorities related to risk management and data protection, which needs to be addressed by appropriate data security and oversight mechanisms.

10. The success of the IFCs should be gauged by actions taken by responders and service providers to modify their strategies, delivery mechanisms or supplies based on feedback received from the communities. Closing the loop on the CFQs is essential and requires that the data generated through the digital databank is routinely fed back to responders who make decisions and provide services.

Recommendations

1 Instantaneous and broad dissemination of digitised information and data to other sectors/clusters for a more timely and efficient response remains a key challenge to be addressed. Consultative efforts should be made at the start for building ownership and action from other agencies and sectors/clusters.

2 Surveys and other data collections tools should be used as feedback mechanisms to further strengthen accountability to the affected population and assess the community's satisfaction with the services delivered by IFCs.

3 Consolidating the approach of different agencies in the use of a common agreed-upon mechanism for data collection and analysis would greatly enhance both coordination and the humanitarian response.

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SOCIAL + BEHAVIOUR CHANGE

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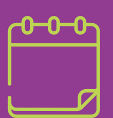
UNICEF Afghanistan Develops New Social and Behaviour Change Integrated Strategy

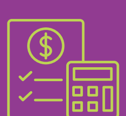
Key social and behaviour change (SBC) strategies, achievements, and lessons learned

Brief summary



Dates of Activity
2022-23

Duration
August 2022 to April 2023



Budget
USD91,000 (HQ)
USD150,000 (CO)

Context

Afghanistan remains one of the most complicated operations in the South Asia region. Prior to August 2021, the decades-long conflict in Afghanistan, combined with institutional weaknesses and sociocultural norms created a challenging context in which to support children's rights and health. After August 2021, healthcare programmes and humanitarian work became increasingly difficult to implement. Because of the brain drain, the UNICEF Afghanistan office lost many staff, SBC section alone lost four members out of five; in addition, there was no Chief in the office and no SBC specialist until April 2022. Other emergency situations (e.g., Cholera and Measles outbreaks, Acute Watery Diarroeha) and natural disasters (e.g., earthquakes and floods) increased the vulnerability of children and women and added pressure on the overall country office response

In August 2022, UNICEF Afghanistan developed an integrated Social and Behaviour Change (SBC) country strategy. The country office utilized SBC guidance documents and frameworks provided by UNICEF HQ, and received technical support from UNICEF South Asia Regional Office and UNICEF HQ teams. The strategy was used to build SBC capacity within the country office, and partners.

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Strategic approach

The UNICEF Afghanistan SBC team hired an international company through the global Long Term Agreement (LTA) to support the development of the strategy. The strategy was co-created in consultation with all UNICEF programme sections and selected number of participants from key NGO partners. Representatives from each UNICEF section and partners participated in a five-day workshop to finalize the details of the strategy and develop a theory of change for 2023 to 2025. The SBC strategy development process began with creating cross-sectoral guidance documents on SBC evidence generation, community engagement and accountability to affected people, and an SBC emergency toolkit with special modules (e.g., how to conduct rapid assessments; mobilizing SBC responses) for use in emergency settings. UNICEF Afghanistan allocated some of its own resources to roll out the strategy by cascading trainings at the sub-national level; staff in 15 international and national non-governmental organizations (NGOs) and Afghans from various community structures (e.g., Community Health Workers, school management Shura members, religious leaders) that work with UNICEF on community engagement activities were trained in SBC and accountability. The strategy was used to build the capacity of the UNICEF SBC and other sector staff (e.g., WASH, Nutrition), UNICEF implementing partners (international and national NGOs), and stakeholders from key departments of DFA ministries.

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The newly developed strategy supported overall SBC programme planning and implementation in Afghanistan. The SBC team adopted an integrated approach to deliver community engagement, respond to emergencies, and improve Accountability to Affected People (AAP), and established Complaints and Feedback Mechanisms (CFMs) across the country. The SBC team worked with program sections to identify key priorities and then developed focused sectoral strategies to address the priorities. The SBC activities have been operationalized by local partners and amplified by community members through various community structures, including safe spaces where women and adolescent girls can share their feedback, concerns, and complaints. The SBC toolkit for emergency situations helped to ensure timely and appropriate responses during recent earthquakes and Cholera/Acute Watery Diarrhoea (AWD) outbreaks, and for managing an influx of Afghan returnees.

UNICEF Afghanistan used the SBC approach to support Community Systems Strengthening (CSS), new community engagement activities,

and scaling up ongoing initiatives. Investments were made in leveraging partnerships with community structures, for example, the TAAVON (a religious leaders' network that grew from 500 members in 2022 to about 7,000 members in 2023). A training module on Child Rights in Islam was developed to help religious leaders understand children's rights using religious examples for familiarity. The religious leaders have since assisted with access to previously hard-to-access districts and facilitated engagement with communities. A partnership was also formed with QAHRAMANAN (a youth network of about 5,000 members) to support their civic engagement, and at the same time leverage their support to wider SBC areas of work. A limited amount from the 7% set-aside funds was used to strengthen Grandmothers Groups (GMGs). Grandmothers are influential at the household level and respected throughout the country. They can move around freely, and are in a position to help women overcome restrictions placed on them. Grandmothers helped not only in influencing recommended practices at household level, but also in overcoming the issues of restrictions on women and Maharam's cost. In collaboration with program sections, the SBC team contributed to the capacity building of Community Health Workers, School Management Shuras, and Community Development Councils.

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Key achievements

- The development and endorsement of the integrated SBC strategy plus the integrated system documents (evidence generation, community engagement, and SBC in emergency toolkit).
- Training for key partners on the strategy. A total of 82 UNICEF and partner participants were trained on the integrated SBC approach. Some of those partners cascaded the training at the sub-national level, reaching more groups and investing in the community structures.
- UNICEF Afghanistan mobilized additional resources to roll out the SBC strategy at the national- and sub-national levels. The SBC team also put into practice some of the assets developed as part of this strategy, for example, implementing the SBC emergency toolkit during the earthquakes, and the Cholera and Measles outbreaks.

82
PARTNERS TRAINED
on the integrated SBC approach

Cascaded trainings at the sub-national level

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Lessons Learned

1. Designing an integrated SBC strategy for community engagement and accountability requires a robust situation analysis to understand the key issues to be addressed.
2. Engaging multiple UNICEF sectors and selected partners in the co-creation of an integrated SBC strategy is challenging (in terms of time), yet instrumental to ensuring that all parties understand the added value of SBC.
3. Having a newly formed and talented UNICEF SBC team in post-2021 Afghanistan facilitated the shift from C4D to SBC and the adoption of an integrated SBC strategy.
4. Explaining "integrated SBC" to staff, partners and stakeholders with varying backgrounds and basic knowledge of SBC requires persistent and repetitive efforts. Creating an understanding of the "value added" of integrated SBC, especially for community engagement and accountability activities, and especially in challenging environments, entailed significant effort.
5. When working in a constrained, complex, and unpredictable environment (e.g., restrictions on women's movement; bans on education for females and female employment; shrinking physical spaces in which to work), requires staff to be adaptable and agile in how SBC programmes are implemented. The community service organizations (CSOs) in Afghanistan have limited SBC capacity, which required the SBC team to work that much harder to ensure quality programming. The external agency responsible for developing the SBC strategy was unable to travel to Afghanistan to deliver the training on the strategy due to their stand on bans for female humanitarian workers, which negatively impacted the quality of the training.
6. The UNICEF Afghanistan team manages an extensive program that, in addition to SBC, covers AAP, youth and young people engagement, and community systems strengthening. The integration of SBC across UNICEF sections helped that SBC does not get lost in programme development and implementation across sectors.
7. The UNICEF office in Afghanistan was able to leverage the 7% set-aside funds to invest in existing and established community structures which has proven to be very effective in overall programme planning, implementation and monitoring.

Recommendations

1. Continue scaling up the implementation of the strategy in 2024 and beyond.
2. Train more partners on the SBC strategy.

SOCIAL + BEHAVIOUR CHANGE

unicef for every child

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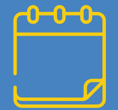
UNICEF Highlights Gender-Focused Immunization Demand Programmes in Six Countries

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

Brief summary



Dates of Activity
December 2021 to May 2022

Duration
6 months

Budget
Unknown

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

Context

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

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

Strategic approach

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

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

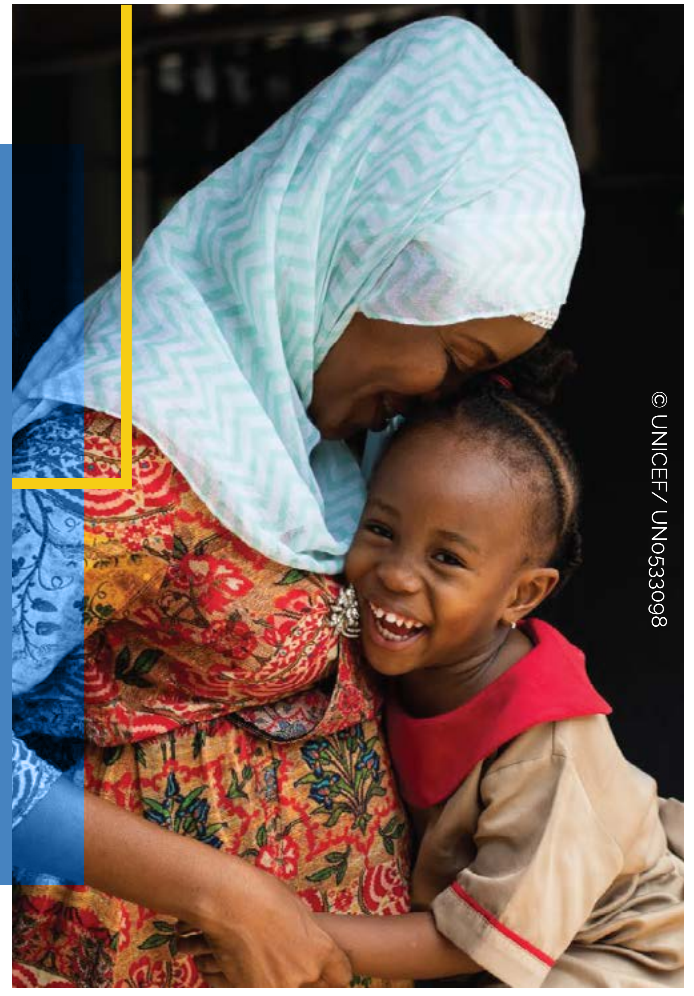
Country	Approach	Key gender-related changes	Level of gender integration
Liberia	Gender and equity-focused urban outreach campaign	Male engagement Recruitment of female vaccinators and mobilizers	Responsive
Mozambique	Promoting male engagement for integrated health practices	Male engagement Joint decision-making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

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

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

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

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

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

is key to ensuring greater impact

examples of integrating gender into vaccine demand programmes

Lessons learned & Recommendations

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

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

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

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

Endnotes

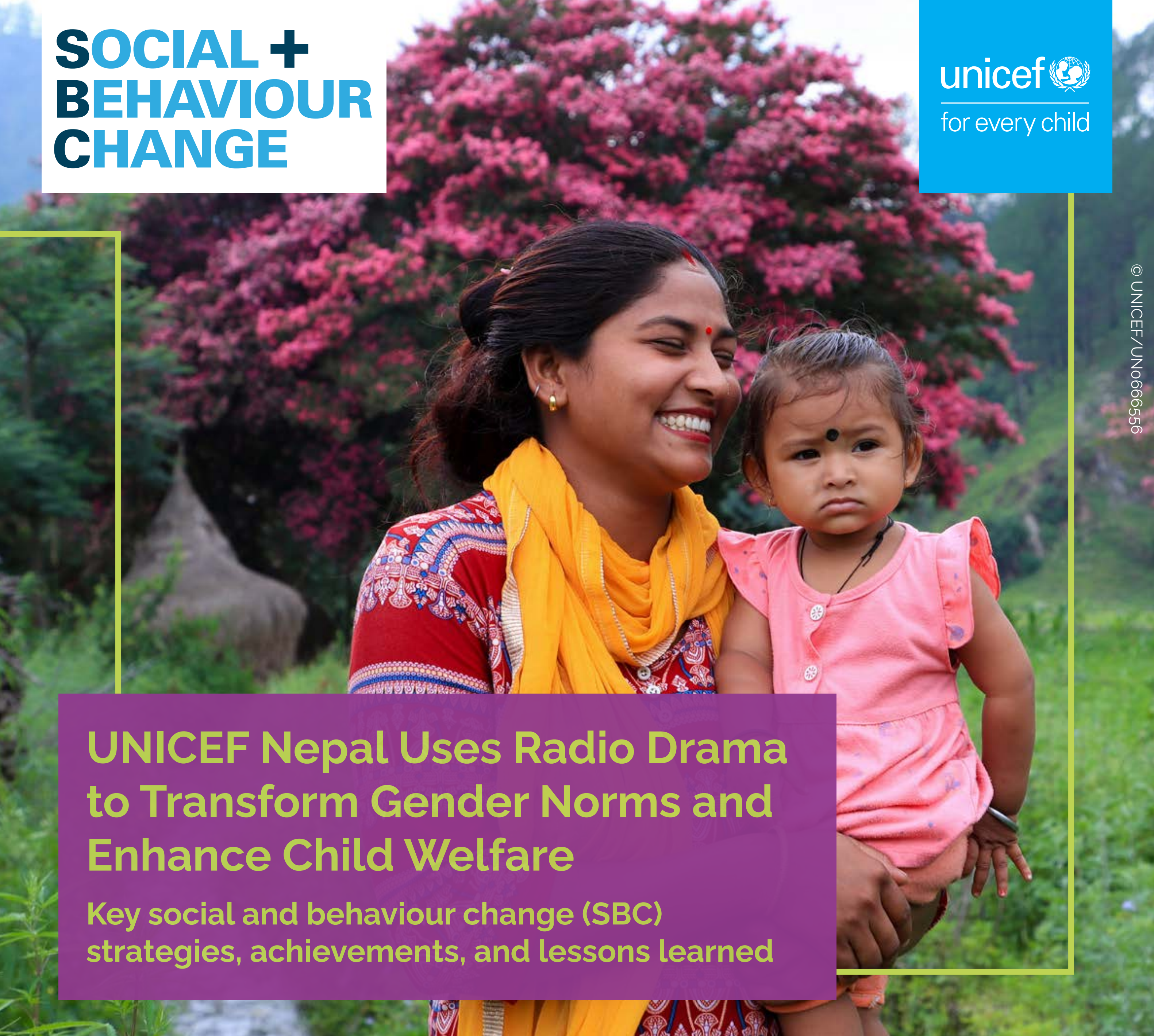
1. Nandi A., and Shet A., 'Why vaccines matter: understanding the broader health, economic, and child development benefits of routine vaccination', *Human Vaccines & Immunotherapeutics*, vol. no. 8, 2020, pp. 1900-1904.

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

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

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

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



UNICEF Nepal Uses Radio Drama to Transform Gender Norms and Enhance Child Welfare

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

Brief summary

An entertaining fictional radio series, *Rope Guna Fal* ("You Reap What You Sow"), engaged an estimated 325,026 Nepalis every week between 2021 and 2022, at a cost of only US$0.91 per listener. Funded by UNICEF and The Kendeda Fund and produced in partnership with Antenna Foundation Nepal and Population Media Centre, the 104-episode story motivated social, behavioural, and normative change toward reducing and eliminating child marriage, improving adolescent sexual and reproductive health, and strengthening parenting skills to improve child well-being. All listeners surveyed agreed or somewhat agreed that their knowledge increased from listening to the radio drama. Ninety per cent of listeners reported a change in attitude, awareness of new issues, and reflection on social norms. Eighty-nine per cent of listeners reported a new behaviour change or maintenance of a recently changed behaviour.

Context

The Nepalese government has implemented various programmes and policies aimed at improving parenting education, child marriage, and adolescent sexual and reproductive health (ASRH), including providing sex education in schools, increasing access to family planning services and information, and working to reduce stigma and discrimination. Cultural norms and traditional practices related to parenting, child marriage, and ASRH, however, pose significant barriers to improvement. The *Rope Guna Fal* ("You Reap What You Sow") radio drama series was created to bolster the Nepalese government efforts.

Strategic approach

UNICEF Nepal, in partnership with The Kendeda Fund, Antenna Foundation Nepal (AFN) and Population Media Center (PMC)-Nepal sponsored and developed the radio drama series *Rope Guna Fal* to challenge traditional gender norms and serve as an educational platform for parents and adolescents. A stages-of-change model was used as the foundation for developing the radio programme. The 104-episode series was broadcast two times per week throughout Nepal (with a focus on Karnali, Lumbini, and Sudur Paschim provinces) from September 2021 to September 2022, on Radio Nepal and 100 local radio stations. It was available through Facebook, YouTube, Hamro Patro, and 3-2-1 social media platforms. Episodes were also made available to hard-to-reach audiences (who were subscribers of Nepal Telecom) through the VIAMO toll-free instant voice response system, "Suchana ko Sansar".[1]

The key themes of the radio programme included parenting education, child marriage, and adolescent sexual and reproductive health. The themes were selected based on local needs. The primary intended audiences for the drama were adolescents and young people ages 13 to 24 years, and parents ages 25 to 45 years. The series was also designed to appeal to grandparents, guardian, and other caregivers. The characters served as role models to the *Rope Guna Fal* audience. Each episode closed with a quiz for audiences, with prizes (e.g., a recharge of Rs. 200 on the listener's mobile phone, courtesy of AFN) for those who got the answers right. This strategy was designed to motivate listeners to tune in and to reward them for their knowledge of the topic(s) at hand.

A cross-sectional quantitative survey was administered to a representative sample of individuals ages 14—49 who live within the broadcast area in all seven provinces of Nepal, from 14 October to 5 November 5 2022. Validation exercises were conducted throughout to test the accuracy and precision of survey data. Data collection in some areas was not possible due to landslides. The *Rope Guna Fal* assessment included a series of questions to assess the degree to which listeners felt they (1) became aware of new social issues, (2) gained knowledge, (3) changed their attitudes, (4) reflected on social norms in their community, (5) were inspired to change behaviour, and (6) were motivated to maintain changes they made.

Key achievements

- *Rope Guna Fal* engaged an estimated 325,026 Nepalis each week, with an average cost of only US$0.91 per listener.
- 100 per cent of listeners agreed or somewhat agreed their knowledge increased from listening to the radio drama.
- 90 per cent of listeners reported a change in attitude, awareness of new issues, and reflection on social norms.
- 89 per cent of listeners reported a new behaviour change or maintenance of a recently changed behaviour.
- More than half (54.5 per cent) of listeners told their friends and family about the show and discussed the issues it raised with them.
- Almost all listeners (95.5 per cent) said that they intend to stop child marriage in their family and community, compared to 78.9 per cent of non-listeners.
- Listeners were more than four times more likely than non-listeners to agree that their community expects them to support girls' completing their education before marriage.
- 93 per cent of listeners thought that husbands must care for pregnant women/ new mothers compared to 84 per cent of non-listeners (an important shift towards increased male involvement in parenting amongst listeners).
- Listeners were nearly four times more likely than non-listeners to report that they have taken actions to discourage child marriage.
- 83 per cent of listeners said that they have tried to improve child learning and development in their home compared to 69 per cent of non-listeners.

325,026
Nepalis engaged each week

cost of only
US$0.91
per listener

the
104-episode
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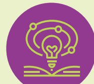

Lessons learned & Recommendations

1 Using radio as a channel for disseminating important information is critical for raising awareness, changing attitudes and motivating behaviour change in areas where radio dramas are known and liked, and where other media channels are hard to access. Always conduct a media landscape analysis prior to developing a radio drama to understand what other similar programmes or activities are being implemented prior to, or concurrently with, your intended radio intervention. Knowing what programmes may be competing with or complementing your radio messages will help to understand the audience's recall and reactions.

2 Conducting robust data collection activities is critical for monitoring activities and creating an evidence-base for understanding the effects behaviour and social norm change over time. For situations where listenership is less than 10 per cent, it may be wise to use a matched case-control study design, and to use radio call-in data, social media data, and other sources to identify a sample of "case" listeners to interview. Then enumerators could interview in the community to identify demographically matched non-listeners (the controls).

3 Collect qualitative data (e.g., interviews or focus group discussions) as part of an intentional mixed-methods assessment design. Findings from qualitative methods can help to contextualize and better understand why and how listeners responded to their *Rope Guna Fal* drama.

Endnotes

1 VIAMO is a global social enterprise that specializes in mobile engagement and Information and Communication Technology for Development.

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for every child

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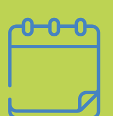
UNICEF Shapes Risk Communication and Community Engagement Strategies in Twelve Countries

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

Brief summary



Dates of Activity
August 2020 to July 2021

Duration
12 months in ESAR

Budget
US$500,000 in ESAR

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

Context

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

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

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

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

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

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Strategic approach

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

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

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

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

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

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

Key achievements

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

MORE THAN
48,000
CRA respondents across the two regions

OVER
1.1 billion
people were reached through the COVID-19 RCCE response in the South Asia Region (SAR)

21 million
shared concerns through feedback mechanisms

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Lessons learned

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

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

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

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

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

Recommendations

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

Endnotes

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

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

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

Thanks to the amazing SBC and programme country teams for the contributions:

Special thanks to Tobgye Tobgye (Bhutan), Tamara Abu Sham and Alka Malhotra (India), Mohammad Badrul Hassan, Bridget Job-Johnson, Armm Kamal and Sanjit Kumar Das (Bangladesh), the SBC colleagues in Nepal, Tommi Laulajainen, Jahanuddin, Julianne Birungi and Sheeba Afghani (Pakistan), Ibrahim Elsheikh (Afghanistan), Shreya Singh (Nepal), Tasmia Bashar (RO), Dorina Andreev-jitaru (RO) Xiaohan Ma (RO), Audrey Franchi (HQ) and Vincent Petit (HQ).

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