

# Real time assessment (RTA) UNICEF's ongoing response to COVID-19 in eastern and southern Africa

## COVID-19 vaccine demand promotion

Key insights from qualitative research in Ethiopia,  
Rwanda, South Africa and South Sudan



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## Preface

The United Nations Children's Fund (UNICEF) Eastern and Southern Africa Regional Office (ESARO) commissioned Oxford Policy Management (OPM) to carry out a Real-Time Assessment (RTA) of UNICEF's response to COVID-19 in countries in the region.

Three reports were produced in this phase, Phase II, of the RTA. The reports covered three thematic areas: COVID-19 vaccine supply; COVID-19 vaccine demand promotion; and education, specifically the safe return to school. This report outlines the findings from the study on COVID-19 vaccine demand promotion. Drawing on the qualitative data gathered during the course of 31 interviews with key informants in the four focal countries (Ethiopia, Rwanda, South Africa, and South Sudan) and from UNICEF ESARO, the report shares the key findings, emerging themes, and lessons to be learned.

The RTA team includes the following members: Jayne Webster (Team Leader), Emma Jones (Project Director), Bilal Hakeem (RTA Coordinator), Kandi Shejavali (Monitoring and Evaluation (M&E) Expert), Lauren Mueenuddin (M&E Expert), Kate Gooding (health sector specialist), Sourovi De (education specialist), Elizabeth Harrop (gender and communications for development (C4D) specialist), Vimal Kumar (cold chain specialist) and Nicola Wiafe (Research Analyst). Kandi Shejavali conducted the interviews and drafted this report in collaboration with Emma Jones and Elizabeth Harrop, with review and inputs from Jayne Webster.

We are grateful to the numerous UNICEF staff whose guidance and contributions were invaluable to the research:

- UNICEF ESARO's Evaluation Section, specifically Urs Nagel, Bikul Tulachan, and Yasmin Almeida, for their invaluable collaboration and guidance on the conceptualisation, design, and technical delivery of the RTA work.
- ESARO C4D/RCCE section staff provided guidance in defining the research questions and in co-creating the recommendations: Natalie Fol and Helena Ballester Bon.
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We reserve our deepest gratitude for the UNICEF staff, implementation partners, and frontline workers who participated in this study. We appreciate the time they took to share their feedback, and we especially appreciate the important C4D/RCCE work that they so passionately and creatively carry out on an ongoing basis.

## Executive summary

This real time assessment (RTA) of UNICEF support to COVID-19 vaccine demand promotion in the eastern and southern African region (ESAR) is based on qualitative research in four countries: Ethiopia, Rwanda, South Africa, and South Sudan. The aim is to support UNICEF's reflection on its ongoing work on COVID-19 vaccine demand promotion (success factors and challenges) and to draw lessons.

The assessment is based on a review of documents, and interviews with 31 respondents across the four focal countries: UNICEF CO staff (4), partners (17) and frontline workers (9) and 3 C4D staff from UNICEF's Eastern and Southern Africa Regional Office (ESARO) No direct beneficiaries were interviewed. The interviews were conducted from June to July 2021. Focused on COVID-19 vaccine demand promotion, the study addressed questions related to UNICEF partnerships and fund mobilisation; data collection tools and the use of data; community engagement and social mobilisation; and UNICEF operational and programmatic modalities.

## Key Findings

The key findings summarised below were common to all four countries unless otherwise specified. However, we identify where an issue was emphasised more in specific countries. It should be noted that the research did not reach saturation point, so an issue not being reported in a country does not necessarily mean that it was not resonant.

### Partnerships and fund mobilisation

Across the locations, strong partnerships (especially through the TWGs, and with CSOs and CBOs) were seen as a cornerstone of the achievements to date. Strong TWG partnerships have promoted coherence and the harmonisation of key messages, which has lessened the risk of disjointed or contradictory approaches. UNICEF COs were widely appreciated for their active, responsive leadership role in the TWGs, and for their ability to quickly source expertise and funds for the vaccine demand promotion effort. The latter was enabled by the COs' access to **accelerated funding and standby agreements**. However, some government partners (especially in Rwanda and South Sudan) would like to be on a more equal footing with UNICEF in regard to **involvement in UNICEF's budget decisions and keeping supplies on their sites**, to enable them to respond directly and independently to emerging issues. Some partners and frontline workers expressed the need for more funding and **appropriate transport to reach remote populations**. The inadequacy of transportation is a structural barrier that cannot be addressed by UNICEF but might be an issue for increased UNICEF advocacy towards governments and/or other relevant stakeholders. Two key issues were widely proposed as strategic adaptations regarding partnerships and fund mobilisation, in all four countries.

- **Need for longer-term partnerships and funding for C4D work**, including COVID-19 vaccine demand promotion, to align with the long-term nature of behavioural change.
- **Build sub-national capacity for all components of the vaccine demand promotion work**. Embedding technical assistance in sub-national government structures was widely proposed as a preferred approach to this.

## Data collection

UNICEF COs have also played a key role in supporting the collection of data to inform C4D/RCCE on COVID-19 vaccine demand promotion. Respondents widely perceived that in-person community-based data collection tools were the most effective, as they provided more nuanced information, enhanced understanding of feedback, and built trust. Yet, the need for multiple sources of information was widely appreciated: Online tools were faster and required less human resources and provided more ongoing information. Key lessons learned were the benefits of:

- **Data collection tools that also enable immediate engagement on issues** raised and training frontline workers to be able do this.
- **Targeted tools to understand vaccine hesitancy among health workers.** These were used in Ethiopia, Ethiopia and South Africa, with the largest number of respondents in the latter).
- **Pre-testing tools and ensuring sufficient time is allocated to training fieldworkers,** despite the need for fast roll-out in emergencies.

A key challenge was the **inadequate contextualisation of tools** that were developed outside of the focal countries (reported in all four countries), due to difficulties with contextualising the tools.

## Use of the data to inform plans and action

In all four countries, the data is being used to inform and adjust COVID-19 vaccine demand promotion plans and interventions, and UNICEF has played a leadership role in this. The key enablers have been **strong TWG coordination, a learning and adaption approach, and UNICEF guidance** on how to use the data in the development of action plans. **Making use of existing community feedback mechanisms and local organisations** to implement community-based data collection was another widely perceived success factor. This was because such organisations know the communities and are able to communicate with them effectively; and have a network of people in place to support data collection which enabled highly valued face-to-face interaction and trust building.

Respondents in all four countries perceived good attention to inclusion, including through peer engagements (led by women's, youth, faith and disability groups and key influencers), and in mass communications. In the latter, the main focus so far has been broad coverage and using different languages and pictures to make the communications materials accessible and relatable. In Ethiopia and South Africa especially, this process was **strengthened by the sub-national contextualisation of messages**. The KAP and social listening data have identified notable hesitancy problems among specific social groups (e.g. religious communities) which informed targeted engagements. Yet, while the **survey data is amenable to disaggregation there was limited mention of it being used to craft *different* messages** for different social groups. Many respondents felt that 'the core messages are the same for everyone'. However, most respondents also saw the **need for better use of the data, including to inform differentiated approaches**. The key challenges have been inadequate financial and human resources to comprehensively translate findings into plans and action (most emphasised in Ethiopia and Rwanda), the sheer amount of misinformation and disinformation, and fast-evolving developments in vaccine supply.



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*Key lessons learned:*

- For C4D work in emergencies: there are benefits to **acting fast on data insights (rather than waiting for 'perfect information')** while anticipating later adaptation (South Sudan).
- **Tone of messages matters:** some messages were seen as patronising, so they were revised to convey ownership and collective effort (Rwanda and South Africa)

*Key challenges (also conveyed as required adaptations moving forward):*

- **Much of the data is at national level, while localised action is needed** (most mentioned in South Africa and Rwanda) and would be supported by geographically disaggregated data and sub-national capacity building.
- **Need for more clarity and specificity in messages**, going beyond 'building demand' to provide comprehensive information about the vaccines and to explain when and how to access the vaccination – especially where the vaccine modality is different to previous campaigns.

## Community engagement and social mobilisation

The COs have provided technical and financial support to numerous activities, including community mobilisation, hotlines, media events, social media, info-dramas and capacity building for government partners, key influencers and journalists. In all four countries, the COs' emphasis on **collaborating with local CSOs and influencers, who are integrated into community contexts and ongoing community mobilisation efforts, were widely seen as central to success and supported trust-building**. Survey questions on how best to reach citizens helped to identify appropriate communication channels. **Direct community engagements (meetings, peer influencing, engaging religious leaders) were perceived as more effective than indirect mass communications**, in all four countries. Yet, use of multiple channels and mass communications were crucial for broadening reach. **Community radio was seen as the most effective channel for mass communications**, as messages could be localised; it provided a platform for local influencers; citizens could call in to ask questions; and it enabled some reach into hard-to-reach and insecure areas. Yet, across the countries, respondents emphasised the need to intensify the vaccine demand promotion work. Respondents also made the following suggestions regarding adaptations moving forward:

- **Further multiply communication channels to reach additional social groups.** Suggestions included: dissemination in everyday spaces (Rwanda) and adaptations to better reach youth (South Africa), and remote or conflict areas (Ethiopia and South Sudan).
- **A longer term, holistic approach, and integration of COVID-19 vaccine demand promotion into wider behavioural change interventions in health and beyond.** There has been some misalignment with other health promotion campaigns (South Sudan, Ethiopia). Partners said that this is already on the agenda in Rwanda.
- Poverty was widely reported as the key barrier to the effectiveness of the vaccine demand promotion work, as many poor beneficiaries are more concerned about a lack of food and water, etc. **Due to this, respondents articulated the need to consider citizens' 'whole lives' in demand promotion activities, such as providing information on other services.**

## Operational and programmatic modalities

It was perceived that UNICEF has effectively built on existing partnerships and capacities in the COVID-19 vaccine demand promotion. Readiness was also supported by experiences of previous crises (particularly in Rwanda and South Sudan) such as Ebola. In regard to what was done

differently in this response, respondents perceived that the vaccine related C4D/RCCE campaign was more quickly developed and implemented; there was better coordination (across more sectors and new partnerships); more intensive engagement and a more hands-on approach; and improved and simplified communications materials. Various UNICEF internal platforms have been used to showcase COVID-19 vaccine demand promotion work. ESARO C4D team support and leadership in this was appreciated by C4D CO staff. Timely technical assistance from UNICEF regional and headquarters was also useful, including the sharing of peer experiences. Suggested adaptations moving forward:

- **C4D/RCCE would benefit from having its own budget lines**, to raise the profile of achievements and challenges.
- **Establish more long-term supplier agreements** at country level, to enable faster CO access to technical assistance.
- **Ongoing documentation of the response**, to enable C4D lesson learning and visibility.

## Summary of key recommendations

This section first summarises the key emerging issues that were prioritised by key informants in the focal countries; and then the prioritised action points developed by the ESARO C4D/RCCE team. The latter were developed following a workshop on the RTA findings in which the emerging issues were discussed.

### *Issues to consider in ongoing COVID-19 vaccine demand promotion (short term)*

- Partners emphasised the need to reinforce data collection and to scale-up the implementation of targeted tools such as those to understand vaccine hesitancy among health workers.
- There is a widely perceived need for sub-national government capacity building on all areas of the response.
- There is potential to strengthen targeting by using disaggregated data (sex, location, etc).
- Key messages should include information on when and where vaccinations will take place.
- Further multiply communications channels, to reach additional social groups. For example, some respondents suggested greater use of everyday spaces, such as taxi parks, and engaging more local radio and TV stations. In South Africa, where social media penetration is higher, respondents suggested more expansive and diverse social media work to reach youth.
- Consider advocacy to governments to increase funding for vehicles appropriate for reaching remote areas (all four countries but most mentioned in Rwanda and South Sudan).
- As poverty is a major barrier to the effectiveness of the demand promotion, consider providing information on other services to beneficiaries, and further integration with other services (health, nutrition, etc). The latter would also strengthen the alignment of communications.
- Pursue ongoing documentation of the response, to enable C4D lesson learning and visibility.

### *Longer term issues to consider – for wider C4D initiatives*

- Further develop a longer-term, holistic approach to C4D, and longer-term partnerships.
- Data collection tools developed outside of the country can be difficult to adapt.
- Put in place more long-term agreements at the country level, for the supply of C4D services.

### ***Game changers that should be sustained or replicated***

- Use of existing community feedback mechanisms, and collaboration with local CSOs and key influencers who are integrated into community contexts and ongoing community mobilisation efforts. Such approaches helped to build trust.
- Close partner collaboration (through RCCE country platforms) in data review and efforts to harmonise key SBBC interventions.
- Accelerated funding and standby agreements were widely perceived as key enablers.

### **Prioritised action points**

Following a workshop to discuss the RTA findings, the ESARO and CO C4D focal staff liaised to agree the priority action points. These are outlined below.

- Embed SBC/ RCCE dedicated human resources in national and subnational governments to strengthen demand promotion skills and sustain delivery.
- Reinforce and/or scale-up time-series disaggregated SBC data collection, to inform targeted, pro-equity and gender-sensitive SBC planning and interventions
- Leverage existing community-based platforms (e.g. youth and women networks, faith-based organizations) to support trust building interventions.
- Advocate for the integration of COVID-19 vaccine demand into ongoing SBC/RCCE interventions to avoid vertical programming.
- Preparedness: Establish long-term partnerships and secure specific RCCE funding prior to emergencies to ensure adequate preparedness and reinforce the emergency-development nexus
- Internal: Ensure that SBC/RCCE is included in all response planning and reporting formats with specific objectives, interventions and budget lines to strengthen accountabilities
- Internal: Sustain ongoing efforts to document the response to enable SBC lessons learning and visibility

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## List of abbreviations

BeSD	behavioural and social drivers (survey)
C4D	communication for development
CBO	community-based organisation
CSO	civil society organisation
CO	country office (UNICEF)
COVID-19	coronavirus disease 2019
CRA	community rapid assessment
ESAR	eastern and southern Africa region
ESARO	Eastern and Southern Africa Regional Office (of UNICEF)
FBO	faith-based organisation
GBV	gender-based violence
IEC	information, education and communication
INGO	international non-governmental organisation
KII	key informant interview
NGO	non-governmental organisation
OPM	Oxford Policy Management
PPE	personal protective equipment
RCCE	risk communication and community engagement
RTA	real-time assessment
TWG	technical working group
UN	United Nations
WHO	World Health Organisation



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## Table of Contents

<b>1</b>	<b><i>Introduction</i></b> .....	<b>1</b>
1.1	Background to the study on COVID-19 demand promotion.....	1
1.2	Intervention contexts: situating the four focal countries .....	1
1.3	Study scope, approach and questions .....	3
<b>2</b>	<b><i>Partnerships and fund mobilisation</i></b> .....	<b>6</b>
2.1	Partnerships: what worked well.....	7
2.2	Fund mobilisation: what worked well.....	8
2.3	Areas for improvement in partnerships and fund mobilisation .....	8
<b>3</b>	<b><i>Data collection tools</i></b> .....	<b>10</b>
3.1	What mechanisms are in place to collect and analyse data? .....	10
3.2	Perceived effectiveness of the data collection mechanisms.....	11
3.3	Challenges and perceived areas for improvement .....	12
<b>4</b>	<b><i>How has the data been used?</i></b> .....	<b>14</b>
4.1	Processes for data use and planning .....	14
4.2	Are workplans and interventions aligned with the findings?.....	14
4.3	Is the data sufficiently disaggregated to inform inclusive approaches?.....	16
4.4	Key challenges of translating findings into use and action.....	18
<b>5</b>	<b><i>Community engagement and social mobilisation</i></b> .....	<b>21</b>
5.1	What support is UNICEF providing?.....	21
5.2	Community engagement: success factors and lessons learnt .....	21
5.3	Dissemination of communications materials: success factors .....	23
5.4	Disseminating communications materials: lessons learnt and possible adaptations.....	24
5.5	Perceived effectiveness of the demand promotion overall.....	25
5.6	What risks were anticipated and mitigation strategies .....	27
<b>6</b>	<b><i>Operational and programmatic modalities</i></b> .....	<b>30</b>
6.1	Have UNICEF reporting systems supported the visibility of the demand promotion? ..	30
6.2	Was UNICEF able to build on existing capacity / resources? .....	30
6.3	What was done differently in this RCCE response? .....	30
6.4	Suggested adaptations moving forward .....	31
<b>7</b>	<b><i>Conclusions and recommendations</i></b> .....	<b>32</b>
	<i>Annex A</i> <i>References</i> .....	<i>34</i>
	<i>Annex B</i> <i>Interviewees</i> .....	<i>36</i>
	<i>Annex C</i> <i>Data collection tools</i> .....	<i>37</i>

# 1 Introduction

As of September 2021, over 4.6 million people globally have died from COVID-19.<sup>1</sup> The pandemic has upended people's lives across the globe, and the effects on economies, livelihoods and service provision are exacerbating poverty,<sup>2</sup> vulnerability and inequity (Robertson et al 2020).

This real time assessment (RTA) was commissioned by the UNICEF Eastern and Southern Africa Regional Office (ESARO) **to support UNICEF reflection on its COVID-19 response to date, including success factors, challenges and lessons learned.** The RTA has been implemented in two phases:

*Phase I (research undertaken from October to December 2020)* had a broad multi-sectoral basis. It included a light-touch regional analysis and deep dives in six countries (South Africa, Somalia, Uganda, Kenya, Madagascar and Namibia).

*Phase II (research undertaken from June to September 2021)* has a more discrete focus on three thematic areas and four focal countries (Rwanda, South Africa, South Sudan and Ethiopia). This responded to UNICEF staff reflections on Phase 1, which highlighted preference for more in-depth analysis. Phase II assesses UNICEF's response to COVID-19 in three thematic areas, encompassing the work of four UNICEF programmes:

- COVID-19 vaccine supply (UNICEF Supply and Health EPI teams)
- COVID-19 vaccine demand promotion (C4D) – **the focus of this report**
- Education - specifically the safe return to school

The thematic focus for Phase II was defined by the RTA Steering Committee. As described in the RTA Phase II inception report, the focus and questions for each thematic study were agreed through a series of engagements with the focal ESAR programme teams (regional and country offices), with support from the ESARO Evaluation Team. The focal countries were also identified in collaboration with the regional programme teams and the UNICEF Deputy Regional Director. The focal countries were a 'best fit' of the four programme team preferences, based on factors such as progress with programme roll out, country contexts (e.g. conflict, economic development, and effective vaccine management rating), and UNICEF's role in country coordination structures.

## 1.1 Background to the study on COVID-19 demand promotion

Mistrust in government, doubts about vaccine safety and efficacy, rumours and misinformation as well as questions about access have led to behaviours that do not prevent COVID-19 transmission and drive vaccine hesitancy or refusal. UNICEF's COVID-19 risk communication and communication engagement (RCCE) strategy aims to promote knowledge of COVID-19, sustain preventive behaviours to reduce transmission and increase vaccine demand and uptake.

## 1.2 Intervention contexts: situating the four focal countries

In ESAR, since the beginning of the pandemic, there have been 4,740,722 confirmed COVID-19 cases and 124,191 deaths. There is considerable country variation, however.<sup>3</sup> Of the four focal countries, South Africa has had the highest number of cases (2,882,630) by a substantial margin, followed by Ethiopia (332,961), Rwanda (95,257), and South Sudan (11,814). **Figure 1** shows the

<sup>1</sup> WHO Coronavirus Disease (COVID-19) Dashboard: <https://covid19.who.int/>

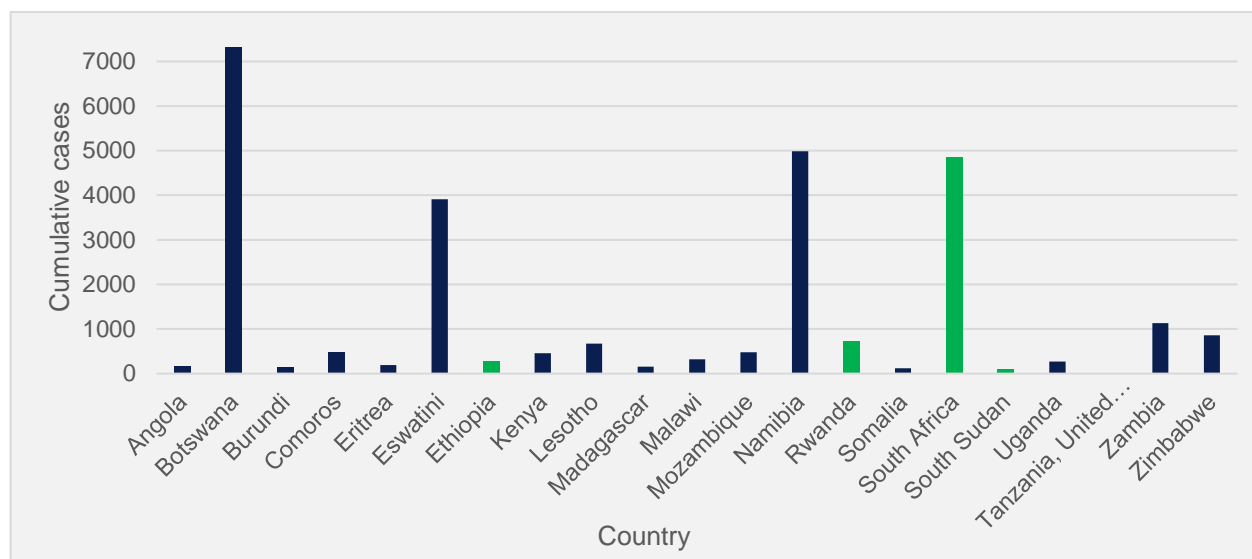
<sup>2</sup> World Bank: <https://www.worldbank.org/en/topic/poverty/overview>

<sup>3</sup> WHO COVID-19 Dashboard: <https://covid19.who.int/> [Accessed 21<sup>st</sup> September 2021].

cumulative number of COVID-19 cases per 100,000 population in the four focus countries (green bars) compared to the wider east and southern Africa region.

Figure 1 shows that, among the four focal countries, South Africa has also had the highest cumulative number of cases per 100,000 population, although bordering nations (Botswana and Namibia) have had higher case rates. Rwanda has had more cases per 100,000 population than Ethiopia, while South Sudan has had the fewest. The number of deaths per 100,000 population in the four countries follows the same pattern.<sup>3</sup>

**Figure 1 Cumulative number of COVID-19 cases per 100,000 population<sup>3</sup>**



The four countries also differ in terms of pre-COVID-19 immunization coverage, and the factors affecting this variation may be relevant to COVID-19 vaccine uptake. Notably, in Rwanda in 2019, 98% of children had completed three doses of the vaccine against diphtheria, tetanus and pertussis (DTP3); compared to less than 50% in South Sudan (Table 1).

**Table 1 Comparison of country characteristics<sup>1</sup>**

	Population <sup>4</sup>	Land area (sq. km)	Income classification <sup>5</sup>	Poverty headcount ration at \$1.90 a day (2011 PP) (% of population)	Fragile and conflict affected context? <sup>6</sup>	Number of languages spoken	DTP3 coverage (2019) (%) <sup>7</sup>
<b>Ethiopia</b>	114,963,583	1,129,300	Low-income	30.8	Yes	93	68
<b>Rwanda</b>	12,952,210	24,670	Low-income	56.5	No	6	98
<b>South Africa</b>	59,309,690	1,213,090	Upper middle income	18.7	No	52	85
<b>South Sudan</b>	11,194,730	631,928	Low income	76.4	Yes	74	49

<sup>4</sup> World Bank (2021). <https://data.worldbank.org/> [Accessed: 21<sup>st</sup> September 2021]

<sup>5</sup> World Bank (2021). World Bank Country and Lending Groups. <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>

<sup>6</sup> The World Bank. 2021. Classification of Fragile and Conflict-Affected Situations. <https://www.worldbank.org/en/topic/fragilityconflictviolence/brief/harmonized-list-of-fragile-situations> [Accessed: 21<sup>st</sup> September 2021]

<sup>7</sup> UNICEF (2021), Immunization coverage by antigen (country, regional, and global trends). <https://data.unicef.org/topic/child-health/immunization/>; [accessed: 21<sup>st</sup> September 2021]

Table 1 also shows that the four focal countries differ in terms of key contextual factors which may affect the implementation of COVID-19 demand promotion interventions.

- Ethiopia's population is far larger than the other three countries.
- Ethiopia, South Africa and South Sudan have highly diverse populations. For example, 93 languages are spoken in Ethiopia,<sup>8</sup> although there are far fewer official languages.<sup>9</sup>
- Rwanda is a smaller country in terms of population and land mass, and there is much less linguistic diversity. However, the majority of the population reside in remote hilly areas.
- South Africa is classified as an upper middle-income country, while Ethiopia, Rwanda and South Sudan are low-income, with the proportion of the population below the poverty line varying from 31% in Ethiopia to 76% in South Sudan.
- In Ethiopia and South Sudan, both classified as fragile and conflict-affected states, the COVID-19 pandemic further complicates complex humanitarian situations. In both countries, civil conflict has led to a lack of basic services and infrastructure, population displacement, insecurity, and restricted movement.

### 1.3 Study scope, approach and questions

**Scope:** The RTA provides a relatively light-touch assessment, based on review of available documentation and a limited number of key informant interviews (KIIs) in the four focal countries. This design recognises the need for real time learning and reflection in an unchartered and fluid context in which programme adaptations may be needed. As UNICEF support interventions are being rolled out in the evolving COVID-19 context, the RTA aims to inform what is working, challenges and possible adaptations, whilst recognising their non-static nature.

**Respondent sample:** The RTA of UNICEF's support to COVID-19 vaccination demand promotion is based on 7-8 KIIs in each of the four countries (31 overall). These focused on UNICEF CO C4D staff (4), partners (17) and frontline workers (9), in addition a group interview was conducted with several ESARO C4D staff; Annex B provides a more detailed breakdown. The respondents were purposively sampled based on their roles in the COVID-19 vaccine demand promotion.

**Interviews and analysis:** All respondents were sent a statement on research ethics ahead of the interview, and all provided informed consent at the beginning of the interview. The C4D interviews were undertaken from June to July 2021, using semi-structured interview guides (see **Annex C**). The interviews were recorded. The interview data were analysed using a framework based on the study sub-themes, and successes and challenges within these.

**The intended audience** of the study are the ESAR C4D teams at the regional and country-levels. The report identifies findings that were common across the four countries, and thus may be applicable to wider ESAR. It also identifies country-specific innovations, successes and challenges, which may be applicable to ESAR countries with similar contexts.

#### Limitations:

<sup>8</sup> Eberhard, David M et al (eds.). 2021. *Ethnologue: Languages of the World*. Twenty-fourth edition. Dallas, Texas: SIL International. <http://www.ethnologue.com>. [Accessed: 21<sup>st</sup> September 2021]

<sup>9</sup> Shaban A. 2020. One to five: Ethiopia gets four new federal working languages. Africanews. Online: <https://www.africanews.com/2020/03/04/one-to-five-ethiopia-gets-four-new-federal-working-languages/> [Accessed: 21<sup>st</sup> September 2021]

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- As the RTA is relatively light touch and entailed a small number of KIIs, we have not captured a broad range of perspectives and the research did not reach saturation point. Additionally, it did not include interviews with final beneficiaries. These factors affect the depth of analysis.
  - The report highlights the countries in which specific successes and challenges were mentioned by interviewees. However, **if the issue was not mentioned in a country, it does not mean that the issue was not resonant there**. As may be expected with a small sample, the issues raised by respondents varied even within countries.
  - There are limitations to the transferability of the findings to other countries.
  - As the COVID-19 response work is ongoing, the assessment does not make judgements on the impact and coverage of the COVID-19 response.

## Focal questions for the C4D study

**High level questions:** How are UNICEF COs supporting the collection, analysis and use of information to promote COVID-19 vaccine demand and uptake and to reduce hesitancy? What lessons have been learned and are there good practices or game changers that emerged from the COVID-19 vaccine-related RCCE response which should be sustained and/or reinforced?

### Sub-questions:

1. **Partnerships and funding:** How is UNICEF working with partners on C4D/RCCE work on COVID-19 vaccination, and supporting fund mobilisation? What are the perceived successes and challenges of UNICEF's role? What are the lessons learned?
2. **Data collection tools:** What mechanisms are in place or were established from the onset of the response to collect rumours, mis/disinformation, perceptions, misconceptions, concerns, fears, and complaints? What data collection tools are most effective for informing demand related efforts and what could be improved?
3. **Use of data:** How have UNICEF COs, governments and partners used the data collected through social listening mechanisms (online and offline), surveys and polls to inform and adjust the demand efforts to promote uptake of COVID-19 vaccines? Were the data disaggregated sufficiently to inform gender sensitive and inclusive approaches? Are key interventions aligned with findings, and what was UNICEF's role in promoting this? What are the difficulties of translating findings into use and action? How does UNICEF support the development of related IEC materials using the data gathered?
4. **Community engagement and the dissemination of IEC materials:** How is UNICEF supporting community engagement work (with non-governmental organisations – CSOs, CBOs, FBOs –, key influencers, and other actors) and the dissemination of IEC materials to promote demand for and uptake of COVID-19 vaccines? How effective are these interventions, and what are the lessons learned? What risks to effective communications and community response were anticipated during planning and which were not? What mitigation strategies were put in place?
5. **Operational and programmatic modalities:** What was done differently in this C4D/RCCE response, both from a programmatic and an operational perspective? How well was UNICEF able to build on existing partnerships, capacities, and resources to effectively respond from the onset of the crisis? How well have UNICEF reporting systems supported visibility of RCCE achievements and challenges?





# Research findings



## 2 Partnerships and fund mobilisation

In all four countries, UNICEF played a leadership role in the national Technical Working Groups (TWGs) and related sub-national TWGs, often being the co-chair alongside the government lead. Through this, UNICEF was widely recognised as playing a lead role in country-wide efforts to reduce vaccine hesitancy and encourage uptake. In all four countries, the TWGs were the main entry point for UNICEF's partnerships, including the extension of technical and financial support.

In South Africa, however, it took time for UNICEF to develop a leadership role in COVID-19 demand promotion work. SACO had no C4D staff prior to the COVID-19 crisis and it was not actively engaged in RCCE. While SACO engaged C4D consultants in the early stages of the pandemic, it took three-months for the team to get into the relevant national TWG. SACO now has a C4D section and related human and financial resources, but the team is comprised of consultants who are not fully integrated into the staff structure. Yet, aside from this, there was no notable difference in descriptions of UNICEF's leadership role in the South Africa TWG.

### 2.1 Partnerships: what worked well

The vast majority of sampled partners and frontline workers expressed extensive praise for UNICEF's leadership and partnership in the COVID-19 response. They also felt that the strong partnerships developed through the TWGs had been central to the successes achieved in vaccine demand promotion. The key perceived successes and success factors were as follows.

- **UNICEF's active and responsive presence on the national TWGs** was highlighted in all four countries and appreciated for providing effective leadership in the process of ongoing learning, and helping government be more effective. Particularly in Rwanda, UNICEF's credibility within government was described as a key enabler for stronger collaboration. In all four countries, UNICEF was also widely praised for 'taking initiative' and 'relentless' work in a difficult situation in which everyone was learning.
- **Effective coordination and harmonisation of partner work** was widely reported as supporting coherent and thus more effective messaging (highlighted especially in South Africa and Sudan). For example, in South Sudan, all partners used harmonised training materials which UNICEF supported.
- **Working in strong implementation partnership which helped partners and frontline workers to feel accompanied and heard.** This was highlighted particularly in Rwanda and South Africa, where respondents widely reported that UNICEF did not just provide technical and financial support, but also partnered in implementation.
- **UNICEF's support to embed technical assistance in government structures** to enable closer, ongoing support (highlighted in Ethiopia in particular). This has positively impacted on other areas highlighted in this section.

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*"In our region [subnational], all COVID-19 vaccination promotion activities were co-led by UNICEF. While vaccines are now out of stock, UNICEF's efforts and work with other partners has increased acceptance and reduced hesitancy.*  
**(Frontline worker, South Sudan)**

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*"UNICEF ensured that whatever feedback they receive from us, they shared it in the various platforms. That encouraged the CBOs as they saw that the information was really being used."* **(Partner, South Africa)**

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*What I like about UNICEF is that they don't just give you money and then go. They engage."*  
**(Partner, Rwanda)**

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## 2.2 Fund mobilisation: what worked well

Respondents in all four countries felt that UNICEF had provided good support to mobilising funds for the demand promotion effort. Numerous cases were reported of **UNICEF responding flexibly and quickly to funding needs that arose**, especially in South Africa and Ethiopia. CO C4D staff appreciated the support of CO leadership and UNICEF regional and global offices in this regard.

While partners and frontline workers had limited visibility of how UNICEF had raised funds, some noted the benefit of UNICEF's **access to accelerated funding**, with support from the UNICEF regional office. A partner in Rwanda also emphasised the **benefit of standby agreements**, as they 'didn't have to go through a long process of developing MOUs'. UNICEF strategic partnerships with the private sector (South Africa and Rwanda) enabled the mobilisation of some additional funds for vaccine demand promotion, such as Unilever funding for a media event in South Africa. In Ethiopia, UNICEF stepped in to meet a funding gap, when expected World Bank funding for the printing of materials was delayed.

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*"Sometimes UNICEF didn't have the funds right away, but they would source it within a week or two. They know how to raise funds."* (Partner, South Sudan)

*"UNICEF almost always came through with the funds when needed"* (Partner, South Africa).

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*"If UNICEF hadn't taken the lead when the World Bank funding was delayed, we wouldn't have been able to print the materials and distribute them on time... UNICEF also sourced funds for face-to-face meetings when these were needed. UNICEF has that capacity and willingness to respond."* (Partner, Ethiopia)

## 2.3 Areas for improvement in partnerships and fund mobilisation

In all four countries, numerous partners and frontline workers emphasised that **the collaboration on C4D, and within that vaccination demand promotion, needs to be longer term and to have commensurate financing**. They related this to the long-term nature of behaviour change, and to the appearance of the same socio-cultural norms as barriers in different sectoral initiatives. This reiterates the need for a longer term intersectoral approach, which is central to UNICEF's C4D strategic vision (UNICEF 2017).

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*"Behaviour change is a long-term process and connects to other issues, so you need long-term planning and partnerships. The COVID interventions we introduce can be helpful in other areas. UNICEF needs long-term strategies so that our impact is greater when specific issues arise."* (Partner, Rwanda)

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**Inadequate capacity at subnational level was a widely noted challenge** which was seen to mediate the overall effectiveness of the response, including data collection, the use of data to inform interventions, community mobilisation and the dissemination of communications materials. Some partners (especially in Ethiopia and South Sudan) felt that UNICEF could consider more support at sub-national level – and specifically embedded technical assistance. **Capacity gaps were also noted in national government** and identified as an area for UNICEF support, including building government capacity in strategies for fund mobilisation (Rwanda).

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*"In previous communications work, there was technical support at sub-national level. But currently UNICEF has only committed one technical assistant. We need this also at local level: someone there to facilitate, coordinate and to improve collaboration with UNICEF field offices."* (Frontline worker, Ethiopia)

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**Partners also identified specific infrastructure challenges to which they felt UNICEF might grant more funding and support.** For example, some partners and frontline workers in Rwanda and South Sudan expressed the need for more funding and appropriate vehicles to reach remote areas. Weak internet connection in sub-national areas of South Sudan also impinged on the effectiveness of coordination meetings. **These are structural barriers that can only be addressed by governments but might be issues for increased UNICEF advocacy.**

#### **Gaps in government ownership:**

- Some government partners (especially in South Sudan and Rwanda) felt that UNICEF should **consider providing direct funding to government, although this beyond the scope of the C4D section.** Some perceived the limited or lack of direct funding as a lack of trust in them. Challenges which they related to the lack of direct funding were an inability to respond directly and independently to emerging issues.
- Similarly, some partners noted that they were **not involved in UNICEF's funding decisions** and alluded to feeling disempowered in that regard.
- A parallel issue raised in Rwanda and South Sudan was a **sensed need for UNICEF to enable NGO and government partners to hold RCCE materials on their sites,** so that they can respond more independently and feel ownership.

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*"We should be more involved in planning the budgets. There may be weak trust in the ministry to handle the money, but we should be involved and know what money is coming from where."*  
**(Partner, South Sudan)**

*"UNICEF should support organisation's capacity to respond more independently. I am talking about basic materials and response equipment. UNICEF has that, but if partners have that capacity, they could respond without having to go through UNICEF."* **(Partner, Rwanda)**

*"As much as we are working in partnership, there's still a gap in ownership, in terms of keeping the materials with us. So when a partner asks for materials, we don't have to run to UNICEF."* **(Partner, South Sudan)**

*"It would be helpful if there were direct funding for this department, so we don't have to involve UNICEF all the time. Our capacity has been built already."* **(Partner, South Africa)**

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## 3 Data collection tools

UNICEF COs are supporting governments to collect data on perceptions, rumours, fears and mis/disinformation about COVID-19 and related vaccines. In the four focal countries, UNICEF has provided technical and funding support to: (a) develop, contextualise and translate data collection tools; (b) train data collectors and support data collection; (c) support data compilation and analysis; and (d) build partner capacity for data collection, analysis and use.

### 3.1 What mechanisms are in place to collect and analyse data?

Various mechanisms are being used to gather the data. These include online and offline social listening mechanisms, and other sources of insights such as *behavioural and social drivers* (BeSD) surveys and *community rapid assessments* (CRAs). As shown in **Table 2**, different mechanisms have been used in the sampled countries. Regarding social listening, the table uses the categories provided in Sommariva et al (2021).

**Table 2: Data collection mechanisms in the four focal countries**

**Key:** ✓ mechanism used in the country. \* Mechanism newly introduced during the COVID-19 pandemic

Data collection mechanism	Ethiopia	Rwanda	South Africa	South Sudan
<b>Social listening – digital</b>				
Search trends	✓	-	✓	-
Social media content (posts, comments)	✓	✓	✓	✓*
Digital news articles	✓	✓	✓	✓
WhatsApp groups	-	✓	✓	✓*
U-Report	-	-	-	-
<b>Social listening – offline (although responses may be captured digitally)</b>				
In-person community engagement (population and community leaders)	✓	✓ (Captured using KoBo Toolbox)	✓	✓ (Captured manually and via Google form)
Remote community engagement (hotlines/call centers, radio call-in shows)	✓	✓	✓	✓
Broadcast media (TV, radio)	✓	-	-	✓
Reports from command posts	-	✓	-	-
<b>Surveys, polls, and other studies</b>				
Behavioral and Social Drivers (BeSD) survey	✓* General population & health workers. Captured by VIAMO	-	✓ (Health workers)	✓* Health workers (Captured via IoT)
KAP data collection through a Community Rapid Assessment (CRA)	✓ National (via mobiles/ RDD)	✓ National (mobile)	✓ National (via mobiles)	✓ National (face-to-face)
Other surveys/ follow up - research	✓	-	-	-

Data collection mechanism	Ethiopia	Rwanda	South Africa	South Sudan
	(Qualitative/ face-to-face)			

Some of the data collection mechanisms were new, as shown by the stars in Table 2. The BeSD survey was new in all three countries where it was undertaken. **In other cases, existing mechanisms were adapted or scaled up** for the purpose of COVID-19 vaccine-related risk communications work. For example, in Ethiopia, all data collection activities except BeSD had been in use previously. Meanwhile in South Sudan, the use of hotlines and of online Google forms to capture community feedback was scaled up.

### 3.2 Perceived effectiveness of the data collection mechanisms

Partners and many CO C4D staff in Rwanda, South Africa and South Sudan<sup>10</sup> felt that the **most effective tools for informing COVID-19 vaccine demand promotion work were in-person, community-based tools** that were COVID-19-specific (but not necessarily COVID-19 vaccine-specific) and gathered qualitative information. The perceived advantages of face-to-face community-level data collection included: **(a)** obtaining nuanced information; **(b)** building trust; **(c)** enhanced understanding of respondent feedback; and **(d)** reaching people without phones or outside of network range, thus helping to ensure inclusion; Additionally, **(e)** the community engagement enabled parallel and immediate vaccine demand promotion messaging.

Related to this, **making use of existing community feedback mechanisms and local organisations to implement community-based data collection was a widely perceived success factor**. This was because such organisations know the communities and are able to communicate with them effectively; and have a network of people in place to support data collection which enabled highly valued face-to-face interaction.

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*"[Organisation] has a wide network of volunteers around the country. The best thing was that the volunteers were from communities. So, they weren't strangers asking questions. They understood the community...and that level of trust is important for data validity."* **(Partner, Rwanda)**

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**However, in-person community-based data collection efforts were also the most labour- and time-intensive** and required the hiring and training of enumerators under tight time constraints. In Rwanda and South Sudan, refresher training helped to address data quality and community engagement concerns. In addition, in all four focal countries, in-person community-based data collection efforts were most likely to be negatively affected by COVID-19 containment measures, such as curfews and lockdowns.

Most respondents felt that **online data collection tools, that gather mostly quantitative data, make up for what offline community-based tools lack in terms of speed and ease-of-implementation**. However, many noted that online mechanisms do not typically elicit information that is as nuanced as the qualitative information gathered from other data collection modalities. In all four countries, UNICEF CO C4D staff and their partners (in government, other UN agencies and NGOs) were attuned to these trade-offs. Indeed, most respondents emphasised that **complementary data from multiple sources are needed**, so that the advantages of one can make up for the drawbacks of another.

<sup>10</sup> In response to this question, Ethiopia respondents spoke of various mechanisms, with emphasis on community engagement but also the hotline, media monitoring and social listening.

Another notable finding regarding data collection mechanisms, this time specific to Ethiopia and South Africa,<sup>11</sup> was that **tools targeted at healthcare workers were extremely useful** - not only for informing follow-up C4D/RCCE work, but also for guiding its implementation. This was because healthcare workers are key influencers in promoting demand for vaccines; yet the data showed that they have significant hesitancy about the vaccine. Among the four countries, only Rwanda did not undertake the BeSD specifically with health workers. In Ethiopia especially, partners emphasised the **need for additional research to understand healthcare workers' perceptions** and for UNICEF's support and guidance on this.

*"UNICEF is currently supporting assessment, but we need research on vaccine hesitancy."* (Frontline worker, Ethiopia)

Across the four countries, UNICEF CO and partners also referred to the **usefulness of tools (offline or online) that allow for immediate engagement on issues raised**. For example, hotlines were seen not only as a means for learning about social perceptions but also for instantly responding to these perceptions and providing accurate information and other resources. Hotline workers were specifically trained to be able to do this. This immediate engagement was also done during in-person community-based data collection endeavours.

*"Some of the concerns were responded to right away during the data collection in communities."* (Frontline worker, Ethiopia)



Rwanda Red Cross data collector interviewing a store owner in Kimironko, about her perceptions of COVID-19 and the vaccination

Photo credit: UNICEF/2021/Carmina Ndahiro



South African social mobilizers researching citizen perceptions on COVID vaccination and educating them at the same time

Photo credit: © UNICEF South Africa 2021)

### 3.3 Challenges and perceived areas for improvement

Despite the perceived value of the mechanisms for gathering data on COVID-19 vaccine-related perceptions, informants also highlighted the need for improvement.

- **Interviewees in all four countries emphasised the importance of adequately contextualising tools, particularly those that originated from outside of the country or had been repurposed to gather COVID-19 vaccine-specific data.** A common perception was that externally developed data collection tools were not adequately adapted to context and such adaptation can be difficult. In South Africa, for example, the process of contextualizing and translating CRA questions was complex. One key informant speculated that one reason for this may have been that the translation function was located outside the country or that the service provider may have been stretched.

<sup>11</sup> Although the BeSD was also undertaken with health workers in South Sudan, respondents did not refer to it in analysis of the most useful data collection mechanisms. This does not infer that it was not useful, however.

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- In some cases, notably in Rwanda, the **tools were too long** and had to be revised to reduce enumerator and respondent fatigue.
  - South Sudan respondents said that the **data collection documentation was 'bulky'**, making it difficult for enumerators to get around.
  - In South Sudan, frontline workers articulated the need to **take more account of the coverage and quality of network infrastructure** in the country. For example, CRA data transmission required internet connection and network coverage in rural areas was inadequate, so the opportunity for real-time feedback was not fully realized. In South Sudan, **respondents also articulated the need for better technology for data collection**, such as to capture incoming calls to the hotline. Meanwhile, several **South Africa interviewees perceived that technology could have been used more** in fieldwork, which may reflect South Africa's stronger communications infrastructure.
  - In all four countries, respondents highlighted the need to **strengthen government data collection capacity, especially at sub-national level, including on the BeSD**. This is health systems strengthening work beyond the scope of the UNICEF C4D team.
  - **A key lesson learnt was the need to pre-test data collection instruments**. In Rwanda, enumerators provided critical feedback that helped to improve the tools and their alignment to the context.
  - Despite time pressures, **sufficient time must be dedicated to training field workers** and to refresher training.
  - UNICEF CO and partner respondents in Rwanda noted that data collection efforts pay **inadequate attention to mental health/ psychosocial issues/ needs**. Feedback from interviewees in all four countries, particularly frontline workers, also indicated that the broader context of beneficiaries' lives needs attention if C4D/RCCE efforts are to be effective.
  - Some partners saw the need to reinforce data collection, by undertaking it more regularly - in order to keep pace with the evolving context.

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*"Volunteer feedback also shaped the questionnaire. They said it was too long. Our lesson learned is that we must consider people at the grassroots, including enumerators, when designing a questionnaire." (Partner, Rwanda)*

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*"In poor communities, volunteers come across people without water; without food. ... Beyond livelihood issues, there is a need for psychosocial support, which we don't talk about much. So that for me is the issue. We collect this information, but we need to try to respond to the issues that concern people." (Partner, Rwanda)*

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## 4 How has the data been used?

To promote effective use of the data, UNICEF provided technical and financial support to various key activities, such as data analysis, developing workplans and messages, and designing and producing communications materials and products.

### 4.1 Processes for data use and planning

Interviewees in all four countries confirmed that the information collected on rumours, perceptions and behaviours are being used to inform and adjust vaccine demand promotion efforts. The process for this was similar in all four focal countries and can generally be described as follows:

- The relevant government-led national TWGs in each country have convened regularly to review the data generated through the social listening mechanisms (online and offline), surveys and polls.
- The TWGs have developed messages to address the perceptions reflected in the data. These messages are tailored, as necessary, to different sub-populations.
- Workplans and related activities to diffuse the messages are developed and updated.
- Related communications materials and content are developed and produced.
- Messages and materials have been distributed among partners for their follow-up action.

In all four countries, UNICEF played a leadership role in this process, especially through the TWGs. The **regularity of TWG meetings was perceived as useful**. For example, in South Africa, the TWG meetings are held weekly, which has enabled ongoing reflection on the insights emerging from the data, and development or refinement of key messages and dissemination plans. The data were also used to update the overarching C4D/RCCE strategies and to inform broader planning.

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*“On Mondays, we have a TWG stream called Content Development that uses the findings to develop messages, which we send to our partners. For ourselves, we also include the messages in the Minister’s speeches and on social media platforms. We translate the messages into local languages and tailor them for different groups like people with disabilities.”*  
**(Partner, South Africa)**

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### 4.2 Are workplans and interventions aligned with the findings?

In all four countries, respondents explained that the data has been key to informing the development of messages and communications materials and channels, mentioning a **strong alignment between the data insights and interventions**. For example, where data reflected vaccine hesitancy based on religious beliefs, interventions targeted at religious communities were planned and undertaken, including engaging religious leaders as key influencers (Ethiopia and South Sudan). Another example was the use of survey data on which information sources community members rely on, in determining communications channels for the vaccine demand promotion (all four countries). In Rwanda, messages transmitted through info-dramas reflected the life conditions and situations faced by audience members, based on evidence collected during content creators’ extended stays with the target communities. Furthermore, frontline workers who had been involved in both data collection and later community

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*“Our communications strategy is changing all the time, based on new information coming in, the social listening data, and also what is happening on the ground and the government’s priorities.”*  
**(Partner, South Africa)**

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engagement activities, reported that the messages reflected the key issues raised during the community-based data collection (Rwanda and South Africa).

**Respondent descriptions of the process suggested good adaption and flexibility** in response to new issues raised by the data and wider changes such as vaccine rollout plans. In some cases, the entire communications approach (not just specific messages) was reframed to respond to the data and other COVID-19-related developments. In Rwanda, for example, UNICEF supported the Ministry of Health to use the findings in revision of the *National Contingency Plan for COVID-19 Prevention and Vaccine Confidence*. **The ongoing nature of community feedback has been useful for informing the adaption of messages.** For example, in both Rwanda and South Africa, the feedback highlighted that the initial messaging was perceived as 'patronising' (Box 1).

#### **Box 1: Revising messages in response to feedback**

In Rwanda, when the social listening and community survey data showed that people were experiencing message fatigue, officials started to incorporate COVID-19 messages into social communications on other themes. Additionally, community feedback highlighted that campaign's 'Think Twice' tagline was perceived as 'patronising' and 'instructive'. In response, the TWG developed an alternative framing ('*Shindohoka*') which conveyed ownership and collective effort and was thus different in appeal and tone to the original messages. It did so by shaping the messaging in such a way that it called on members of the target audience to do their part in preventing the spread of COVID-19 rather than communicating instructions on how to behave.

The South Africa TWG similarly responded to feedback that the messaging was 'preachy', and moved toward a more beneficiary-centred, differentiated approach to messaging. Revised communication materials focused on community members sharing advice (rather than authority figures giving instructions).

**Partners in all four countries reported that, through its leadership role in TWGs, UNICEF played an important role in such adaption and alignment** between data insights and workplans. However, as the TWGs were perceived as 'strong partnerships', none of the interviewees were able to single out UNICEF's 'unique contribution'. Indeed, working in partnership to reflect on the findings and develop messages, with UNICEF playing a notably active role, was highlighted as a driver of success in ensuring that demand promotion interventions align with what is happening on the ground.

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*"The TWG was actively involved in reflecting on and assessing the insights from different surveys, to understand vaccine hesitancy from different points of view... UNICEF is part of this team; and has helped us to see how all these different bits of information fit together into something that can be turned into an action plan."* **(Partner, Rwanda)**

*"The TWGs worked in a participatory way, by bring together a small group to brainstorm the tipping points to change".* **(Partner, Ethiopia)**

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Other success factors included:

- **Acting fast:** In Ethiopia, for example, UNICEF and its partners did not wait to have a perfect set of information about rumours, (mis)perceptions and vaccine rollout timelines. Instead, they proceeded based on the information they had. However, one interviewee pointed out: *"the challenge, on the flip side, was having to update the materials."*
- **A learning and adaption approach: ongoing revision of messages.** According to one Ethiopia respondent, twenty-seven messages have been revised so far. South Africa and South Sudan informants also referred to an ongoing reframing of messages.

- **Integrating questions on preferred communication channels into the surveys** and community data collection (Ethiopia) enabled responsiveness in this regard too.
- **UNICEF guidance on how to use the data in development of action plans.** Several Ethiopia and South Africa partners appreciated that UNICEF had provided such tools.

### 4.3 Is the data sufficiently disaggregated to inform inclusion=?

In all four countries, respondents felt that great effort is being made to tailor the demand promotion interventions to different population groups, although many also felt that this could be strengthened. The large focus so far (in all four countries) has been on ensuring broad coverage, including hard-to-reach areas and different linguistic groups, and making the communications materials relatable for key identity groups.

- *All four countries have published communications materials in different languages, while printed materials include pictorial messages which are widely perceived as improving accessibility*
- *Community engagements to promote vaccine uptake* have included a focus on hard-to-reach populations; and community sub-groups - through engagement with women's groups, youth groups, religious leaders, representatives of people with disabilities.
- *Posters have been reproduced with different pictures* - of women, people with disabilities and different ethnic groups, etc. In Ethiopia, posters have also been produced to target people with comorbidities, internally displaced persons, healthcare workers and the elderly. More broadly, across the four countries, the use of ordinary people in communications materials were widely seen as a success factor.
- *Research on everyday life to make communications products more relatable:* This was done in Rwanda, where content creators spent several days living with families in target communities and used these experiences to integrate cultural and lifestyle aspects into the messaging, for example storytelling in radio drama productions. Several partners felt that this process of gaining in-depth understanding of community member's perceptions and concerns promoted more appropriate messaging, and info-dramas and characters which community members could relate to, while subtly absorbing the C4D/RCCE messaging.
- *Integrating questions on preferred communication channels into the surveys* and community-based data collection. This enabled the identification of appropriate communication channels

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*"I think our work is targeting almost everyone in the community: we have someone who manages inclusion, who goes to groups of people with disabilities. We also collect data in a gender-sensitive way by holding community meetings with women; and we ask community members how we can best do the messaging and what channels to use."*  
**(Frontline worker, South Sudan)**

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The interviews in all four countries suggested that while KAP data has been used to inform targeting to some degree and it is amenable to disaggregation, **use of survey data to inform different messages for specific identity groups (e.g. women) has been more limited.** OPM review of UNICEF CO weekly reports on the data also suggested that the main focus has been on identifying notable rumours and hesitancy issues, with very limited disaggregation of these by location or social group. Indeed, many respondents, in all four countries, felt that ‘the core messages are the same for everyone’. Instead, the tailoring of communications has been largely informed by prior knowledge of population differences (e.g. language).

*“The KAP survey showed rumours were circulating based on beliefs, like Christian beliefs, and we immediately understood that we needed to engage religious leaders.”*  
**(Partner, Rwanda)**

However, the **KAP, BeSD and social listening data have identified notable hesitancy problems and mis/disinformation circulating among particular groups**, particularly religious communities - which highlighted the need for targeted engagement. This was done largely by identifying appropriate messengers, such as faith leaders and engagement with faith groups.

**In some cases, other data (such as health systems information) has been reviewed to identify lower vaccine uptake in geographical areas or among women, which led to targeted C4D follow up research to understand the barriers.** In South Sudan, for example, focus group discussions were held to find out why vaccination uptake was low among women. This revealed that many women were too busy with income generating activities, and a misperception that COVID-19 vaccine rollout would use the same modality as other immunisation campaigns, which were delivered closer to home. Follow-up research was also helpful in Ethiopia, to better understand health workers’ hesitancy about the vaccines, which was hindering demand promotion work. Some informants (especially in Ethiopia) identified the need for more follow-up research to better understand key issues arising from the surveys.



FGDs with women in Juba, South Sudan

Photo credit: © UNICEF South Sudan

**In Ethiopia and South Africa, the tailoring of messages to promote inclusion has been enabled by some decentralisation and localisation of message development:**

- In Ethiopia, a partner explained: *“We never disseminate from the national level in the same language, rather we develop the message and then we let the regions contextualize it.”*
- In South Africa, all respondents lauded ‘UNICEF truck’ initiative, particularly as the video content is tailored to the communities through which the truck passes, including showcasing people from that community (see Section 5.2).

**Despite the efforts described above, the extent of targeting was identified as a key area for improvement by informants, especially in Ethiopia, Rwanda and South Africa. That this was less noted in South Sudan does not necessarily mean that the issue is less resonant. One informant in South Africa felt that the data is largely 'national level' and lacks localised information (see the quote to the right). However, the main issue was perceived as making better use of the data to inform more targeted and differentiated approaches.**

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*"[We have to consider how to] adapt our information to specific groups. We don't have uniform issues in different parts of the country." (Partner, Rwanda)*

*"UNICEF isn't able to get more localized information... Almost all the reports are at national level...and we respond in national media and social media. But we're realising the need for more local targeting. Adaption has to be much more localised because there are different issues in different communities. Just putting out another WhatsApp media graphic is nice but is not actually responding to where the problems lie. ... A more nuanced, localised media response would be useful." (Partner, South Africa)*

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#### 4.4 Key challenges of translating findings into use and action

While respondents explained that the data has been used to inform interventions, many respondents, including CO C4D staff, felt that RCCE data are not being used to its fullest extent. One explained: *"We feel like the RCCE data is not fully utilised. In our work with government, we're not doing enough to address the feedback and rumours"* (CO C4D staff). Key informants in all four countries referred to challenges with translating the findings into workplans and action.

**Insufficient data analysis was affected by capacity gaps.** This was most prominently mentioned in Rwanda but also in the other three countries. Inadequate national and especially sub-national capacities were a reoccurring theme in all components of this study and is a key area in which partners and frontline workers would like more UNICEF support. Referring to the CRA tool design and data analysis, some informants in South Africa felt that the lead role played by organisations outside of the country did not support the development of in-country analytical capacity, and they would have appreciated the opportunity for such learning and a framework for how to do this. Some Rwanda informants spoke of the need for capacity building in data visualisation. Such visualisation was perceived as particularly important for district level data to make it more accessible and visible to officials and partners at that level, alongside building their capacity to analyse and use the data to develop more targeted and tailored messages.

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*"The main challenge is that RCCE task forces have low financial and technical capacity to translate findings into action."*

**(Partner, Rwanda)**

*'What UNICEF should be doing differently is to financially support data visualisation at district level, to make the data more visible and accessible. We need data at district level.'* **(Partner, Rwanda)**

*"The main challenge was budget shortage, at both national and sub-national levels. The plan was rolled out, but it was difficult to translate findings into action due to the budget shortage".* **(Partner, Ethiopia)**

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**Inadequate resourcing** was also widely cited as a barrier to translating findings into plans and action, most notably in Ethiopia and Rwanda.



**The sheer amount of misinformation and disinformation, and the fast-evolving developments regarding COVID-19 vaccines, presented challenges** for translating findings into action. This was mentioned in all four countries. In some cases, messaging had to be amended when the vaccine rollout schedule changed. In South Africa, international reports of severe side-effects from the Johnson & Johnson vaccine led to a temporary halt in demand promotion. **In all four countries, slow bureaucratic processes for message approval exacerbated the challenges of adapting in a fast-changing context.**

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*"It's difficult to counter what the population is experiencing. There's too much noise. There's a lot of negativities with the vaccine, and it's not helped by the near expiration of vaccines, the Johnson & Johnson issue, the rumours. (Partner, South Africa)*

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**As the campaigns progressed in Ethiopia and Rwanda, there were challenges with demand for the vaccine outstripping supply and developing strategies to manage this.** Key informants in these countries indicated that the dissonance between 'messages and vaccine supply fed into new rumours and dis/misinformation. Government partners and frontline workers felt ill-equipped to manage this situation, and development of associated strategies was a key area identified for more UNICEF support.

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*"The first challenge was addressing vaccine hesitancy. Now demand has been created and is high, whereas supply is limited. ... So people are asking questions. We were telling people to get vaccinated, but now what will we say? ... So I would ask UNICEF what tools should we use? What should we do? Stop demand creation?" (Partner, Ethiopia)*

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**Another challenge, in all four countries, were community perceptions that the messages have been contradictory.** A specific confusion has been the need to wear a mask even after vaccination, which has cast additional doubts on the vaccine's efficacy. A common approach to addressing this has been training community mobilizers to be prepared to repeat and reinforce the messages.

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*"When you say, 'you need to continue to mask up and sanitise even after vaccination', that makes people say the vaccines aren't effective after all. ... It's a challenge." (Partner, Rwanda)*

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**The diversity of populations posed challenges for planning demand promotion and required more effort to tailor and translate messages and communications materials,** via translations, culturally appropriate pictures, etc. This was most mentioned in South Sudan and South Africa, but less in Rwanda - perhaps due to its smaller size and lesser linguistic diversity. As a partner in South Sudan explained: *"At the field level, the main challenge is the language. We find that most materials must be translated into the local language, which is costly. The way of overcoming is transforming the information into pictures. Then the next challenge is getting immediate feedback, as the approval chain is at national level."*

**Finally, there were specific challenges with translating findings into action in regard to addressing perceptions based on religious beliefs.** These beliefs have been highly difficult to counter, especially when the leaders of faith-based organisations (FBOs) held those beliefs too. For example, in South Sudan and Ethiopia, associations between the Covid-19 vaccine and the number 666 were problematic among Christians (as 666 is perceived to denote 'evil'). In South Sudan, this problem was exacerbated by an inappropriate vaccine hotline number (6666). In both cases, **UNICEF, as a key member of the TWGs, contributed to strategies to counter the misperceptions.** In South Sudan, UNICEF supported establishment of a dedicated hotline for



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FBOs. This is an example of UNICEF's flexible / fast response funding which partners appreciated (see section 2.2).

## 5 Community engagement and social mobilisation

### 5.1 What support is UNICEF providing?

In each of the focal countries, the UNICEF COs is providing technical and financial support to community engagement, in collaboration with civil society organisations (CSOs), community-based organisations (CBOs), faith-based organisations (FBOs) and key influencers. In South Africa and Rwanda, this is also being done in collaboration with the private sector. Specific UNICEF financial and technical support provided in the four countries has included:

- *Funding the work of community mobilizers*, including training and provision of personal protective equipment.
- *Financial and technical support to training key influencers*, such as journalists, media houses, community leaders, and leaders of FBOs, youth and women's organisations.
- *Capacity strengthening* for government partners and supporting development of training guides.
- *Funding hotlines* that community members can use to ask questions, share their concerns and complaints about COVID-19 vaccines, and receive evidence-based information.
- *Funding and supporting media events* aimed at promoting COVID-19 vaccine demand.
- *Supporting the design of radio jingles*, social media and television info-campaigns, and funding airtime for radio and TV messaging.
- *Dissemination of communications materials through other channels*, such as through info-dramas (Rwanda) and a truck that goes from community to community in South Africa.
- Limited support to light equipment.

Through its leadership role in the TWGs, some CO C4D staff explained that UNICEF '*pretty much set the agenda*' in much of the community engagement work and the dissemination of communications materials.

### 5.2 Community engagement: success factors and lessons learnt

In all four countries, partners appreciated UNICEF's support to building the capacity of local organisations to undertake COVID-19 demand promotion activities. Regarding approaches, a widely perceived positive was UNICEF's emphasis on collaborating with key influencers and local organisations which are integrated into community contexts and ongoing community mobilisation efforts. This was widely perceived as **positioning community leaders and frontline workers as 'the driving force of the communication'** and to build trust and promote vaccine uptake. The approach also made use of existing UNICEF and partner networks of C4D mobilisers who had experience of RCCE work on other issues. These approaches are central to the UNICEF C4D strategic vision (UNICEF 2017) and UNICEF's COVID-19 overarching strategy (UNICEF 2020). The findings highlight the benefits of such approaches.

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*"UNICEF has increased technical capacity of community-based platforms, CSOs, FBOs, and journalists on COVID-19 recommended behaviours and confidence."*  
(Partner, Rwanda)

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*"If it wasn't for UNICEF, we wouldn't have done as much community engagement."*  
(Partner South Africa)

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Various elements of the approach were appreciated by respondents in all four countries:

- **Truly engaging the community**, even in the selection of community mobilisers (Rwanda) and in how the messaging was to be done.
- **Using existing community engagement infrastructures**. For example, in South Sudan, a church hotline used for peacebuilding was adopted as a channel for promoting COVID-19 vaccination. An interviewee in Ethiopia noted that using existing infrastructure had the advantage of generating a significant impact at minimum cost. However, some Ethiopian respondents felt that more use might be made of health extension workers.
- **UNICEF's collaboration with FBOs and convening events in which religious leaders were vaccinated in public**. This was emphasized as an influential intervention in all four countries, most especially in Ethiopia.

*"It's those on ground, local organisations who have been most effective because they are engaging people directly.... that's what's brought about a huge change."*

**(Frontline worker, South Africa)**

*"The strategy of going house-to-house and involving the community in the selection of community mobilizers - this is one of the first things that helped us get trust in the community. They are respected and welcomed by the community. That's one of the best things I've seen."*

**(Frontline worker, South Sudan)**



Prominent national-level religious leaders in Ethiopia getting vaccinated at events with high media coverage as part of building trust in and acceptance of COVID-19 vaccines among community members

Photo credit: © Ministry of Health, Ethiopia/April 2021

- **Promoting inclusion by engaging 'identity group peer influencers.'** In South Sudan, women's leaders and volunteers were recruited and trained to engage other women, and there was similar peer engagement among people with disabilities and youth.
- **Campaign truck:** In South Africa, a very widely lauded innovation was a UNICEF supported truck which is driven around communities to share key COVID-19 vaccine demand promotion messages. In regard to what worked, respondents were particularly impressed that the truck intervention has tailored messages to different communities, including videos which showcase people from that community – which has been enabled by an initial period of community engagement.

*"The UNICEF Truck is playing a huge role; it is so easy that way. I wish that UNICEF would have more trucks."*  
**(Frontline worker, South Africa)**



### 5.3 Dissemination of communications materials: success factors

Respondents in all four countries perceived that **survey questions on 'how can we best reach you' were useful** for informing the dissemination modalities. For example, respondents in several countries reported that radio emerged as a preferred communication channel.

*"We asked community members how we can best do the messaging, what channels to use, and how they can support us."* **(Frontline worker, South Sudan)**

**Accordingly, in all four countries, the use of radio (especially community radio) was widely perceived as the most appropriate channel for mass communications.** Explanations of this focused on two factors. Firstly, as it has enabled the localisation of communications and a channel for citizens to call in and ask questions. It has also provided a platform for local radio hosts, community leaders and influencers to share messages in locally appropriate terms and languages.

*"When we started to improvise by going into radio stations and doing interviews, that's where it started working the most as people could call in and get clarity right there"*  
**(Frontline worker, South Sudan)**

Secondly, radio was perceived as enabling reach into areas and populations that have been harder to visit directly, due to remoteness, topography or conflict. In this regard, radio



communications were perceived as especially important in South Sudan, as a route to reaching internally displaced people and those in conflict areas; although informants also noted that reaching this segment of the population remains a challenge.

**Integrating messages into popular communications was also perceived as appropriate and effective.** This was particularly emphasised in Rwanda, where the sampled frontline workers perceived that the COVID-19 informational radio drama has been 'extremely popular' and has contributed to vaccine uptake.

A UNICEF-funded community mobilizer in Juba, South Sudan, sharing COVID-19 prevention messages and distributing IEC materials.



Photo credit: © UNICEF South Sudan

#### 5.4 Disseminating communications materials: lessons learnt and possible adaptations

While the communications materials were generally perceived as well-designed and useful within the overall demand promotion effort, some challenges were also raised.

Reflecting on which areas of UNICEF support were most effective, **some frontline workers felt that printed materials (posters and pamphlets) were less effective and efficient than verbal communications** via community engagement and radio. This opinion was mostly raised in South Africa and South Sudan. For example, a frontline worker in South Africa felt that printed communications materials, particularly pamphlets, were a 'wasted expenditure' as they are very quickly thrown away', while use of alternative 'modern methods' would help to reach youth. This may be more relevant in South Africa, given its more advanced communications infrastructure. In South Sudan, respondents explained that, driven by poverty, some community members have pulled down larger communications materials to use in their home. However, none of the South Sudan respondents suggested that such materials should no longer be produced.

*"Let's move away from distributing pamphlets, which are kind of a wasted expenditure. We need to move with the times, use modern alternatives, especially if we want to target youth, who are important because they influence other people."*

**(Frontline worker, South Africa)**



**In South Africa and Rwanda, lessons were learnt about the tone of messaging.** In both countries, as explained in Section 4.2, community feedback highlighted that some of the initial messages were perceived as 'patronising' and 'too instructive' or 'preachy' – such as the Rwandan '*Think Twice*' tagline. In response, the TWG developed an alternative framing ('*Shindohoka*') to convey ownership and collective effort. Similarly, in South Africa the messages were revised to emphasise a more 'beneficiary-centred', differentiated approach to messaging.

Although repeating messages was widely seen as necessary to engender behaviour change, interviewees also noted the **need to be cognisant of message fatigue and to develop strategies to mitigate this.** In Rwanda, in response to data showing that people were experiencing message fatigue, the TWG made the decision to incorporate COVID-19 messages into social communications on other themes.

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*"People tired of hearing the same thing over and over again, and nothing changing. In the meantime, the containment measures create problems for their survival."* (Interviewee, Rwanda)

*"When it came to tracking complaints, people mainly raised the complaint of only hearing about COVID-19."* (Frontline worker, South Sudan)

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Respondents in Rwanda and South Sudan highlighted a lesson learnt regarding the **need for more clarity and specificity in messages (practical knowledge)– going beyond 'building demand' to also explain when and how to access the vaccination, and to revise this in line with vaccine roll out.** This issue related partly to problems with vaccine supply, and the challenges of supply modalities being worked out in parallel to the development of the demand promotion materials. Yet, more broadly, Rwanda respondents emphasized that the COVID-19 vaccine modality is different to previous vaccination campaigns; and explaining this should have been central to the communications. In Rwanda, some citizens have mistakenly gone to health centres for the vaccination; while some have arrived at the right location, but the vaccine was not yet being provided to their age group. Similarly in South Sudan, the vaccination modality is different to previous campaigns such as polio, and frontline workers believed that women's low uptake may be affected by expectations that the vaccination would be done close to their homes.

## 5.5 Perceived effectiveness of the demand promotion overall

While a South Sudan respondent referred to KAP data which inferred that a large proportion of the population has been reached, respondents largely provided their personal views about the effectiveness of the demand promotion effort, based on observations and the ongoing feedback they have received. Notably, many respondents, across the countries, felt that there have been **strong outcomes from the demand promotion work, in regard to the number of people turning up for vaccination. Yet, most also felt that there is still work to be done** and challenges to address.

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*'It has resulted in massive uptake of the vaccine. Rumours have been mitigated and it has brought understanding. People are now asking when they will be vaccinated.'* (Partner, South Africa)

*"I have no doubt that the impact of the interventions has been felt by the target population. But there's a lot more to be done. ... There were those who had the opportunity, but they didn't come. It's something we need to continue addressing."* (Partner, Rwanda)

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In all four countries, across respondent categories, **direct community engagements (e.g. community meetings, peer influencing, and the engagement of local religious leaders) were perceived as more effective than indirect mass communications.** Yet, as noted for data collection methods, mass communications were seen as crucial for broadening reach. Among these, the more localised mass communications, such as community radio, were widely perceived as the most effective.

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*“The interpersonal contact, while it needs to respect social distancing, was more important to us compared to radio, TV...”*  
(Partner, Rwanda)

*“It’s those on ground, local organisations who ...have been most effective because they have been engaging people directly.... and that’s what’s brought about a huge change.”* (Frontline worker, South Africa)

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The use of **multiple channels to engage community members was appreciated by most interviewees.** Feedback in all four focal countries highlighted the wide diversity of channels used, from going door-to-door to megaphones to theatre, printed posters and pamphlets, to hotlines, radio shows and social media. This aligns with UNICEF's C4D strategic agenda (UNICEF 2017) to promote innovation and multiplicity in communications approaches.

On the other hand, **some interviewees felt that there needed to be a stronger focus on strategically using a wider set of communication channels, to reach additional social groups.** For example, a partner in Rwanda felt strongly that the communications should include **channels that leverage on the everyday spaces in which people live their lives**, such as airing messages through radio and public address systems in markets and places where people wait for taxis. This was described as targeting a different population to those who use social media. Similarly, **in South Africa, frontline workers felt that there has not been enough focus on engaging youth** – and saw this as a priority group ‘as it is youth who are infecting the elderly at home’. However, youth were described as a focus in South Sudan, where they were engaged as peer influencers. Meanwhile, respondents in Ethiopia and South Sudan emphasised the **challenges of reaching marginalised groups, remote populations, and especially people in conflict zones.**

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*“We’ve realized that we need to use a more comprehensive set of communications channels. We need to use social media, but that only reaches a portion of the population. So, we’d like UNICEF to consider more use of traditional media (radio, TV). Also, a broadcasting system that plays messages in markets and car parks, where people wait for taxis.”* (Partner, Rwanda)

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A broader issue raised by many partners, across the four countries, was the **need for a longer term, holistic approach, and the integration of COVID-19 vaccine demand promotion into wider behavioural change interventions.** As noted above, the Rwandan TWG has made the decision to do so, by integrating COVID-19 messages into other C4D campaigns.

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*“When COVID it started, we said “stay home”. Yet we kept saying “seek treatment for malaria within 24 hrs”. The messages were contradictory. They should have explained that health workers are wearing masks; it’s safe to go to health centres for treatment.”*  
(Partner, Rwanda)

- Some partners in South Sudan and Ethiopia identified **specific challenges with a lack of alignment with parallel health promotion campaigns** (e.g. malaria) and a perceived over-emphasis on COVID-19.

*‘Communications tools should be integrated with routine activities...so while we were telling people what to do about COVID-19, we should also tell them to ‘bring your kids for routine vaccination, sleep under nets’.*  
(Partner, South Sudan)

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- A related point on the need for more holistic messaging was the need to **incorporate more comprehensive information about the vaccine**:

*‘UNICEF messages should tell people more about the vaccine itself: its good and bad effects; what effect it might have on their bodies; and clear information that the vaccine improves your immunity and the intensity of the symptoms, but doesn’t prevent the disease entirely,’ (Frontline worker, Ethiopia)*

- Similarly, some respondents asserted that the demand promotion response **should consider community members ‘whole lives’**, such as arming community mobilisers with information that would enable them to refer people to appropriate services for their other needs (i.e., non-COVID-19, non-health-related issues).

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*“In some places, people expect much more than we can give. You clearly see people have bigger needs: food, water.’ People have much bigger expectations and they feel what we’re doing is not enough. So that’s a challenge.” (Partner, South Sudan)*

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Across the countries, partners and frontline workers also emphasised the **need to intensify the COVID-19 demand promotion work**. Funding is inevitably a barrier to this and moreover, COVID-19 has reduced some partner’s access to funds. For example, a South Sudan frontline worker reported that COVID-19 has redirected donor resources, leading to a reduction in their grant, with knock on effects regarding the number of community mobilisers they can engage. This affected the intensity of the demand promotion effort. **This is beyond the scope of the UNICEF C4D team.**

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*“With campaigns of this nature, there’s a need for a second and third coat after the first coat has been applied.... The truck is here now, then away for weeks, and when we come back it’s like we have to start from scratch. Maybe it’s a question of resources?” (Partner, South Africa)*

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*“Changing perceptions is a process; it needs time. We need to meet the same people over and over again.” (Partner, South Sudan)*

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**Poverty was widely noted as a major barrier to the effectiveness of the demand promotion work.** Frontline workers, in all four countries spoke of the challenges of promoting vaccination to people experiencing severe poverty concerns. While this is beyond UNICEF’s sphere of influence in the COVID-19 vaccine demand promotion, some more operational challenges were raised. For example, a partner in South Africa explained that the mode of vaccination registration was inaccessible to some citizens: *“there was a challenge with getting people to register online for the vaccination. People don’t necessarily have a phone or may have a phone but not the know-how.”*

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*“A major challenge is that you have to provide vaccine information to hopeless people. If someone is hungry and you come to them with COVID-19 messages, it doesn’t work.” (Frontline worker, Rwanda)*

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## 5.6 What risks were anticipated and mitigation strategies

Two notable risks to effective communications and community response were anticipated in all four focal countries during the initial planning:

- The **ongoing evolution of the COVID-19 situation created uncertainty** and risks in regard to the relevance of messages. So, in all four countries, it was anticipated that messages and materials would need ongoing review and revision.

- With multiple actors involved, there was a **risk that the COVID-19 vaccine demand promotion messaging could come across as disjointed** or conflicting.

These risks have been mitigated through the strong partnerships developed through the TWG structures, and ongoing work to collectively analyse feedback data and harmonise key messages.



A Red Cross volunteers sharing COVID-19 prevention messages by megaphone, Gatsata community, Rwanda

*Photo credit:* © UNICEF/2021/Carmina Ndahiro

**The risks of not reaching marginalised groups were also taken into account in the initial planning.** A key mitigation strategy, used in all four countries, has been use of multiple communications channels.

**Also taken into account in the planning was the risk of distrust in the messenger.** Approaches to mitigate this risk included asking community members, during data collection, about their preferred information channels, and responding to this in the channels used. It was also addressed by the focus (in all four countries) on working through existing community networks and influencers, and community radio and faith leaders. Specific examples included the use of local community voices in the ‘UNICEF Truck’ initiative in South Africa and the mobilisation and training of peer influencers (youth, PWD, etc) in South Sudan (see section 5.2).

*“So, we felt that the only way to get people to understand this wasn’t a rich person’s disease was to show people from the targeted communities telling those stories.”*

**(Partner, South Africa)**

**Some major risks that were *not* anticipated included:**

- The high degree of **vaccine hesitancy among healthcare workers** (Ethiopia and South Africa).
- **Longer than expected contracting timelines** to bring service providers and technical support on board (Ethiopia and Rwanda);
- **Community sensitivity to the tone of the messaging**, i.e., the need to avoid patronising or disempowering messaging (Rwanda and South Africa).

- The **disruption to the campaign caused by COVID-19 containment measures**, most notably school closures (all four focal countries).



## 6 Operational and programmatic modalities

### 6.1 Have UNICEF reporting systems supported the visibility of vaccine demand promotion work?

**CO C4D staff reflections on the visibility of vaccine demand promotion work in UNICEF internal systems were positive and similar across the four countries.** They referred to various internal platforms that have been used to showcase COVID-19 vaccine demand promotion work: situation reports, annual reports, donor reports, and regional newsletters. CO staff appreciated the ESARO C4D team's support and leadership in showcasing C4D/RCCE successes in UNICEF's reporting systems. They also noted that it was helpful to receive timely technical assistance from UNICEF regional and global offices, including peer experiences. However, one CO respondent suggested that it **would be useful for C4D/RCCE to have its own line item in budgets** to help raise the profile of achievements and challenges.

### 6.2 Was UNICEF able to build on existing capacity / resources?

**In all four countries, partner and CO feedback suggested that UNICEF has effectively built on existing national-level partnerships and capacities** to strengthen the response. As noted above, partnerships were deepened and coordination strengthened, which necessitated drawing on different capacities. **Readiness was also supported by experiences of previous crises** (particularly in Rwanda and South Sudan) such as Ebola. However, as outlined in section 5, interviewees felt that **much more should be done at the sub-national level** to ensure an effective response. Problematic resource gaps were also cited (see section 2.3) and UNICEF CO staff suggested an increased use of **long-term supplier agreements** in order to address the challenges and effects of lengthy consultant recruitment processes.

### 6.3 What was done differently in this RCCE response?

Respondents highlighted the following programmatic and operational differences in UNICEF's C4D work in the COVID-19 response compared to earlier programmes. It should be noted that respondents' reflections were often broader than the C4D work on vaccination demand promotion *per se*.

- **Better coordination** was widely noted, in regard to both coordinating across more sectors and new partnerships (Rwanda, South Africa, South Sudan).
- **More intensive engagement and a more hands-on approach** were noted in all four countries. For example, it was reported that UNICEF has invested more in training frontline workers for the COVID-19 vaccine demand promotion effort.
- **Respondents felt that communications materials and other resources were improved**, compared to earlier C4D campaigns (all four countries). For example, communications materials were described as simplified and include more pictorial content, which was perceived as beneficial.

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*“UNICEF is doing this campaign differently. They have worked closely with local C4D specialists like me to build our capacity. This is new. It requires a lot of evidence – so also more engagement, resources and social listening, and a greater sense of urgency.” (Frontline worker, Ethiopia)*

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*“UNICEF has improved their communication materials. They are simplified and include more pictures than before.” (Partner, South Sudan)*

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- **The C4D campaign was also widely described as more quickly developed and implemented compared to previous C4D work** (all four countries). This included South Sudan, where the campaign was compared to Ebola and other emergency responses. Most respondents felt that the speed and incorporation of COVID-19 containment measures (e.g. social distancing, PPE) was managed well and did not negatively impact on quality. Indeed, UNICEF was widely appreciated for its capacity to **quickly adapt programming and operations** to COVID-19 containment measures without losing pace on implementation and oversight.

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*“UNICEF has adapted effectively. For example, when COVID-19 started, we had already planned activities in communities. We needed immediate discussions to reach the same audience. So we decided on radio sketches, to reach the audience in their homes. UNICEF was quick in taking this decision and agreeing on what we should do.” (Partner, Rwanda).*

*UNICEF supported ongoing changes to plans as the situation evolved.” (Partner, South Africa)*

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- **Some frontline workers reported, however, that community members were sensitive to the different channels used in the vaccination demand promotion compared to earlier messaging.** This was mostly related to non-COVID-19 related campaigns. Yet, in South Sudan, a frontline worker reported community members were questioning why the text messaging used in the COVID-19 prevention communications was no longer happening for COVID-19 vaccinations.

## 6.4 Suggested adaptations moving forward

A UNICEF CO respondent suggested that **documenting the response on an ongoing basis** would be useful for understanding what was done and how well it worked; and would enable UNICEF to draw on the lessons for subsequent programming and C4D visibility within and outside of UNICEF.

Some CO staff felt that the **integration of C4D/RCCE funding with sector spending limits its visibility and the ability to track results.**

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*“A challenge is that we don’t know how much funding is allocated to C4D, as it’s all integrated into sector programming. Yet, it’s important to show the achievements and effectiveness of C4D specifically, as partners and some donors are only slowly understanding the importance of RCCE. We’ve been advocating for C4D to have its own line item.” (UNICEF CO C4D staff)*

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Some respondents felt that UNICEF should consider putting **additional long-term supplier agreements in place at the country level**, to enable quick engagement of relevant expertise, as some COs struggled to get C4D consultants onboard on time.

As explained in several sections of the report, there is a widely perceived need to **embed technical advisors at sub-national level**, to build capacity there as well.

Some respondents suggested the **integration of social listening into wider C4D interventions** to strengthen implementation rollout and health service delivery.

## 7 Conclusions and recommendations

This section summarises the key areas that may be relevant for UNICEF support moving forward and includes the UNICEF C4D team's inputs and prioritised action points. The section includes challenges and suggested adaptations, as well as success factors or game changers emerging from the COVID-19 vaccine demand promotion work that could be sustained and/or reinforced.

### Issues to consider in COVID-19 vaccine demand promotion (short term)

- **Many partners emphasised the need to reinforce data collection (to create time-series data) and to scale-up the implementation of targeted tools** such as those to understand vaccine hesitancy among health workers. The ESARO UNICEF C4D section noted that targeted tools were developed for many ESAR countries but have not always been implemented or implemented at scale, largely due to a lack of funding.
- **There is potential to strengthen targeting through use of disaggregated data.** In the four sampled countries, KAP data has been used to inform targeting to some degree; yet use of survey data to inform differentiated approaches for specific social groups has been more limited.
- **There is a need for clearer specificity and clarity in communications, going beyond 'building demand' to include information on when and where** vaccination will take place (especially where the vaccine modality is different to previous campaigns).
- Given that poverty is a key barrier to the effectiveness of COVID-19 vaccine demand promotion work, UNICEF might consider **providing information on other services to beneficiaries, or further integration with other services** (health, nutrition, etc).
- **Further multiply communications channels**, to reach additional social groups.
- **Consider building the capacity of sub-national government actors on all areas of the response. Some partners proposed that this be done through embedded technical assistance** at the sub-national level (replicating a widely perceived success factor at national level). The UNICEF ESARO C4D team also noted that embedding technical assistance at sub-national was a documented good practice at the regional level in 2020.
- **Advocacy to governments to increase funding and adequate transport** to reach remote populations.
- **The need for more long-term supplier agreements at country level** was prioritised by several CO C4D staff, to enable faster engagement of relevant expertise.
- **Pursue more ongoing documentation of the response**, to enable C4D lesson learning and visibility

### Key issues to consider for future C4D initiatives (longer term)

*Good practices and game changers that could be reinforced and replicated in future emergencies:*

- **Use of existing community feedback mechanisms and working with local organisations and influencers who are already integrated into community contexts** and ongoing mobilisation efforts. These were widely noted success factors for both data collection and community engagement. Such approaches helped to build trust.

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- **Data collection tools that also enabled immediate engagement on issues** raised, and training frontline workers to be able do this.
  - **Survey questions on how best to reach citizens** helped to identify appropriate communication channels.
  - **Close partner collaboration** (through RCCE country platforms) in data review and in efforts to harmonise SBBC interventions.
  - **Direct community engagements were perceived as more effective than indirect mass communications.** Yet, use of multiple channels and mass communications were crucial for broadening reach. **Community radio was seen as the most effective channel for mass communications**, as messages could be localised; it provided a platform for local influencers; citizens could call in to ask questions; and it enabled some reach into hard-to-reach and insecure areas.

*Lessons learned and suggested adaptations:*

- **The need to pre-test data C4D collection tools and to allocate sufficient time to train fieldworkers**, even during emergency response work.
- **Data collection tools developed outside of the country were commonly seen as inadequately contextualised** and key informants noted that adaptation can be difficult. Some also felt that opportunities for capacity building were lost by developing tools outside of the country.
- **Consider longer-term partnerships, and further develop a longer-term, holistic approach** to align with the long-term nature of behavioural change.

## Prioritised action points

Following a workshop to discuss the RTA findings, the ESARO and CO C4D focal staff liaised to agree the priority action points. These are outlined below.

- Embed SBC/ RCCE dedicated human resources in national and subnational governments to strengthen demand promotion skills and sustain delivery.
- Reinforce and/or scale-up time-series disaggregated SBC data collection, to inform targeted, pro-equity and gender-sensitive SBC planning and interventions.
- Leverage existing community-based platforms (e.g. youth and women networks, faith-based organizations) to support trust building interventions.
- Advocate for the integration of COVID-19 vaccine demand into ongoing SBC/RCCE interventions to avoid vertical programming.
- Establish long-term partnerships and secure specific RCCE funding prior to emergencies to ensure adequate preparedness and reinforce the emergency-development nexus.
- Internal: Ensure that SBC/RCCE is included in all response planning and reporting formats with specific objectives, interventions and budget lines to strengthen accountabilities
- Internal: Sustain ongoing efforts to document the response to enable SBC lessons learning and visibility.

## Annex A      References

*In addition to reviewing various internal UNICEF documents related to COVID-19 vaccine-related C4D/RCCE activities, the following references were consulted.*

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## Annex B Interviewees

Key: \* multiple ESARO C4D staff were present in the interview.

Interviewees by organisational category	
<b>UNICEF staff</b>	<b>5</b>
Country office staff	4
Regional office staff	1*
<b>UNICEF partners</b>	<b>17</b>
Government staff	4
Bilateral (foreign government) staff	1
NGO/INGO	10
UN Agency	2
<b>Frontline workers</b>	<b>9</b>
Government staff	3
NGO/INGO	5
Private sector	1
UN Agency	0
<b>TOTAL</b>	<b>31</b>

Interviews per country	
Ethiopia	7
Rwanda	7
South Africa	8
South Sudan	8
Regional	1*
<b>TOTAL</b>	<b>31</b>

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## **Annex C      Data collection tools**

This annex contains the following sub-sections:

- C1. Standard research ethics protocols (generic)
- C2: KII guide: UNICEF CO
- C3. KII guide: partners
- C4. KII guide: frontline workers

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## C1. Standard research ethics protocols (generic)

Both written and verbal consent protocols were communicated to the interviewees.

### Written informed consent document (provided ahead of each interview)

#### Background to the RTA

UNICEF ESARO has contracted Oxford Policy Management (OPM) to undertake a Real Time Assessment (RTA) of UNICEF's ongoing response to COVID-19 in ESAR.

- Phase I of the RTA had a broad multisectoral focus, with deep dives in six countries.
- Phase II of the RTA will provide a more detailed analysis of three programme areas: **(a)** COVID-19 vaccine supply (Health EPI and Supply) and **(b)** demand promotion (C4D); and **(b)** education – the safe return to school. The focal countries for RTA Phase II are Rwanda, South Sudan, South Africa, and Ethiopia

The aim of the RTA is to support the UNICEF ESARO and Country Offices to reflect on the COVID-19 response to date, with a view to understanding the success factors, challenges lessons learned and possible adaptations moving forward.

#### Invitation to participate

We would like to interview you as key personnel working on C4D in one of the focal countries. Your feedback will help to inform the cross-country analysis and to identify lessons that will help to inform UNICEF approaches and guidance moving forward.

**The objective of the interview** is to understand UNICEF's role in interventions undertaken in response to COVID-19, and the lessons learned. The attached *Question Guide* outlines the issues that we would like to explore with you in the interview.

**Participation is voluntary:** Your input is valuable and will support UNICEF lesson learning, but participation in this interview is entirely voluntary. Whether or not you participate will have no consequence on any aspect of your relationship with UNICEF. Please be aware that even if you initially agree to participate in this interview, you may stop participating at any time. You may also skip any specific question that you do not wish to answer.

**Mode and duration of interview:** the interview will be conducted remotely, using Microsoft teams, Skype or Zoom. The requested duration of the interview is 1 hour.

**Interview recording:** The interviewer will take written notes of your feedback. If you consent, the interview will also be recorded. The purpose of the recording is to strengthen accuracy in the documentation of your feedback and to enable oversight of the research. Please be aware that your consent to digitally record the interview is entirely voluntary and at your discretion. Even if you initially consent to the recording, you can withdraw this consent at any point in the interview.

**Confidentiality:** Your responses (interview notes and recording) will be kept confidential and anonymous. No one except the RTA Assessment Team<sup>12</sup> will have access to them. After the RTA is complete, the interview notes and recording will be destroyed. Identifying information will not be disclosed in the way that we report our findings.

**Expectation:** It is hoped that you would read the *Question Guide* in advance of the interview (if you have time), so you are able to prepare your thoughts.

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<sup>12</sup> The RTA Assessment Team is made up of Oxford Policy Management and UNICEF evaluation staff.

## **Interviewer information**

**Name and contact details of interviewer:** The interview will be conducted by [*name and email address*] who is a member of the RTA assessment team led by Oxford Policy Management (OPM).

**Reporting concerns:** If you have any concerns about the interview, conduct of the interviewer, or any other concerns related to the research, please contact Emma Jones (OPM Project Manager): [emma.jones@opml.co.uk](mailto:emma.jones@opml.co.uk) Details on OPM safeguarding and whistleblowing policy is available at:

<https://www.opml.co.uk/about-us/organisational-policies-reporting#whistleblowing>

## **Verbal informed consent (provided at the start of each interview)**

Thank you for making yourself available for the interview today.

My name is [full name of researcher], and I am a member of the Assessment Team engaged by UNICEF ESARO to undertake a real-time assessment of the support the country offices in the region have provided to the COVID-19 response.

The objective of this interview is to understand UNICEF's role in interventions undertaken in response to COVID-19, and the lessons learned. The *Question Guide* shared earlier outlines the issues that I would like to explore with you in the interview.

Your feedback will help to inform the cross-country analysis and to identify lessons that will help to inform UNICEF approaches and guidance moving forward.

Your input is valuable, but participation in this interview is entirely voluntary. Whether or not you participate will have no consequence on any aspect of your relationship with UNICEF. Please be aware that even if you initially agree to participate in this interview, you may stop participating at any time. You may also skip any specific question that you do not wish to answer.

Your responses will be kept confidential and anonymous. No one except the Assessment Team (OPM researchers and UNICEF evaluation staff) will have access to them.

The interview should take approximately 1 hour.

With that introduction, unless you have any questions at this point, I'd like to request your explicit consent for participation in, and the recording of, this interview. Do you agree to participate in this interview, given the stipulations I just laid out?



## C2. KII guide: UNICEF CO

### C4D: Question guide for UNICEF CO (C4D staff)

#### 1. DATA COLLECTION TOOLS

Questions will be tailored to the country, based on the review of UNICEF documents.

*I understand from our document review that your country office and its partners used specific online and offline social listening mechanisms and other sources of insights such as polls and surveys to gather information on rumours, mis/disinformation, perceptions, misconceptions, concerns, fears, and complaints about COVID-19 vaccines.*

- 1.1 Did any of the tools **build on pre-existing mechanisms and/or platforms (such as U-Report or loGT)** in [country]? What were the benefits or challenges of this?
- 1.2 Which data collection tools (e.g., BeSD, CRA surveys, social listening) have been **most effective** for informing the demand related efforts? Why do you think that was the case?
- 1.3 What could be **improved** about the tools to make them more effective for informing COVID-19 vaccine demand work?
- 1.4 What methods worked well to **capture the perceptions of women and other individuals/groups who are marginalized** or harder to reach (e.g., due to age, location, disability, or cultural-religious beliefs etc)? What were the challenges of gathering the perceptions of such groups?

#### 2. USE OF DATA

- 2.1 How has UNICEF **used the data** to inform and adjust the efforts to promote demand for and uptake of COVID-19 vaccines?
- 2.2 What **role did the CO play in aligning** government risk communication and community engagement plans, and the specific interventions under each plan, with the findings (from the social listening mechanisms and other sources of insights)? Are they well aligned? What are the lessons learned from this?
- 2.3 What have been the **difficulties of translating findings** (from the social listening mechanisms and other sources of insights) into use and action?
- 2.4 Are the **data sufficiently disaggregated to inform gender-sensitive and inclusive approaches**; and what has worked well or been a key challenge in this regard? (e.g., *the targeting and inclusion of people marginalized by their gender, age, area of residence (urban/rural), disabilities and religious beliefs*)

#### 3. COMMUNITY ENGAGEMENT AND DEVELOPMENT AND DISSEMINATION OF IEC MATERIALS

- 3.1 How is UNICEF supporting the community engagement work with community-based platforms, CSOs, faith-based organizations and key influencers and the development and dissemination of IEC materials to promote demand for and uptake of COVID-19 vaccines? What is working well and what are the challenges and lessons?
- 3.2 What are the good practices and lessons learned in regard to **UNICEF support to community engagement and the development and dissemination of IEC materials**, to promote demand and uptake of COVID-19 vaccines?
- 3.3 Thinking now of your country office's overall RCCE/C4D efforts to reduce hesitancy and promote demand for and uptake of the COVID-19 vaccine (i.e., not just in terms of working with key influencers and supporting IEC materials), what **risks to effective communications and community engagement response** were anticipated during planning and which were not?

**3.4** What **mitigation strategies** were put in place to address the anticipated risks, and what are the lessons learned?

#### **4. PARTNERSHIPS AND FUND MOBILIZATION**

**4.1** Regarding RCCE/C4D, how well was the CO able to **build on existing partnerships and develop new partnerships** to effectively respond from the onset of the crisis? What is working well, and what are the challenges and lessons learned?

**4.2** Regarding RCCE/C4D, how well was the CO able to **mobilise funds** to effectively respond from the onset of the crisis? What are the **lessons learned in regard to mobilising funds** for RCCE/C4D work on COVID-19 vaccination: what worked well and what might be done differently in the future?

#### **5. OPERATIONAL AND PROGRAMMATIC MODALITIES**

**5.1** In terms of programmatic and operational modalities, what was **done differently** in this RCCE response and what are the lessons learned for future initiatives?

**5.2** How well have UNICEF reporting systems supported the visibility of C4D/RCCE achievements and challenges?

#### **6. CLOSING**

**6.1** Is there anything else you'd like to add?

## C3. KII guide: partners

### C4D: Question guide for partners

#### 1. DATA COLLECTION TOOLS

I understand from our document review (or from our interview with the UNICEF CO) that specific online and offline social listening mechanisms<sup>13</sup> and other sources of insights<sup>14</sup> such as polls and surveys were used in [name country] to gather information on rumours, mis/disinformation, perceptions, misconceptions, concerns, fears, and complaints about COVID-19 vaccines.

**1.1 Which of the tools have been most useful** for understanding social perceptions and informing follow-up action to reduce vaccine hesitancy and promote demand for COVID-19 vaccination, **and why?**

**1.2 Have any of the tools been less useful? What could be improved** about the tools to make them more effective in informing or refining follow-up action?

#### 2. USE OF DATA

**2.1 How have the findings from these tools been used** both by government and by development partners to inform and refine plans and interventions aiming to promote demand and uptake of COVID-19 vaccines?

**2.2 What role did UNICEF play** to help align the findings with plans and interventions (i.e., risk communication and community engagement plans, and the specific interventions under each plan)? What additional support would be useful to enable use of the findings from these tools?

**2.3 What have been the main challenges** in [name country] in translating the findings into action?

**2.4 Is the data sufficiently disaggregated** to ensure that follow-up actions were gender-sensitive and inclusive? What worked well in this regard? What are the gaps and what should be done differently moving forward?

#### 3. COMMUNITY ENGAGEMENT AND DEVELOPMENT AND DISSEMINATION OF IEC MATERIALS

**3.1 How is UNICEF supporting the community engagement work** with community-based platforms, CSOs, faith-based organizations and key influencers and the development and dissemination of IEC materials to promote demand for and uptake of COVID-19 vaccines? What might UNICEF do differently in this regard?

**3.2 What has been most useful in regard to UNICEF support to community engagement and development and dissemination of IEC materials,** to promote demand and uptake of COVID-19 vaccines? What might UNICEF do differently in this regard?

**3.3 How effective** do you think UNICEF's overall support to communications and community engagement efforts has been *so far* in reducing hesitancy and promoting demand for and uptake of COVID-19 vaccines, **and why?**

#### 4. PARTNERSHIPS AND FUND MOBILIZATION

**4.1 Overall, what has worked well in terms of UNICEF's partnership with government and with entities such as yours on communications and community engagement work? And in related fund mobilization? What has**

<sup>13</sup> Social listening means 'the tracking, analysis, and synthesis of community inputs both digital and offline. Social listening identifies questions and queries, as well as concerns, complaints, and suggestions shared by communities. This approach can help identify rumors—information that has not been verified—and false information (misinformation and disinformation). Data from social listening in the context of the COVID-19 pandemic, triangulated with other sources of insights such as primary research data, can contribute to social and behavioral sciences evidence, which in turn provides a holistic understanding of the dynamics of disease outbreak and a more effective response.' (Sommariva et al, 2021). Sources of information for social listening include news, WhatsApp groups, social media, U-Report, and data from community leaders.

<sup>14</sup> For example, primary research such as polls and surveys (BeSD, CRA, and others).

worked less well in regard to UNICEF partnership with government and fund mobilization on COVID-19 RCCE/C4D?

**5. OPERATIONAL AND PROGRAMMATIC MODALITIES**

**5.1** From your perspective, what did UNICEF do differently (programmatically and operationally) to support this response versus how they supported previous, non-COVID-19-related, communications and community engagement work? What were the positives of this? What were the challenges?

**6. CLOSING**

**6.1** Is there anything else you'd like to add?

## C4. KII guide: frontline workers

C4D: Question guide for frontline workers
<b>1. DATA COLLECTION TOOLS</b>
<p>1.1 If you were involved in collecting data from community members to find out the what mis/disinformation, perceptions, misconceptions, concerns, fears, and complaints they have about COVID-19 vaccines, were the findings of the data collection exercises shared with you?</p> <p>1.2 If so, how useful was it to receive the findings?</p>
<b>2. USE OF DATA</b>
<p>2.1 Do you know whether the COVID-19 vaccine demand promotion effort you are implementing are <b>based on knowledge</b> about the population's perceptions, misconceptions, and concerns about COVID-19 vaccines? Were community engagement and communications efforts adapted based on findings from data collection exercises looking into the rumours, mis/disinformation, perceptions, misconceptions, concerns, fears, and complaints community members have about COVID-19 vaccines?</p> <p>2.2 Do you think that the community engagement and awareness-raising work around the COVID-19 vaccines <b>is sufficiently targeted</b> to address the perceptions of women and other individuals/groups who are marginalized or harder to reach (e.g., due to their location, age, disability, cultural-religious beliefs, etc)? What worked well in this regard? What are the gaps and what should be done differently moving forward?</p> <p>2.3 What <b>challenges have you faced in responding</b> to the population's perceptions, misconceptions, and concerns about the COVID-19 vaccine?</p>
<b>3. COMMUNITY ENGAGEMENT AND DEVELOPMENT AND DISSEMINATION OF IEC MATERIALS</b>
<p>3.1 How is UNICEF supporting the community engagement work with community-based platforms, CSOs, faith-based organizations and key influencers and the development and dissemination of IEC materials to promote demand for and uptake of COVID-19 vaccines? What might UNICEF do differently in this regard?</p> <p>3.2 What has been most useful in regard to <b>UNICEF support to community engagement and dissemination of IEC materials</b>, to promote demand and uptake of COVID-19 vaccines? What might UNICEF do differently in this regard?</p> <p>3.3 <b>How effective</b> do you think UNICEF's overall support to communications and community engagement efforts has been so <i>far</i> in reducing hesitancy and promoting demand for and uptake of COVID-19 vaccines, <b>and why</b>?</p>
<b>4. PARTNERSHIPS AND FUND MOBILIZATION</b>
N/A for frontline workers
<b>5. OPERATIONAL AND PROGRAMMATIC MODALITIES</b>
<p>Question will be tailored based on feedback from UNICEF CO staff on whether the targeted frontline workers would be aware.</p> <p>5.1 From your perspective, <b>what is UNICEF doing differently (programmatically and operationally) to support</b> this response versus how they supported previous, non-COVID-19-related, communications and community engagement work, if you happen to know? What are the positives of this? What are the challenges?</p>
<b>6. CLOSING</b>
6.1 Is there anything else you'd like to add?



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