SOCIAL AND BEHAVIOUR CHANGE (SBC) STRATEGY FOR ROUTINE IMMUNISATION IN RWANDA 2021-2026

LIST OF ABBREVIATIONS

AAP: Accountability to Affected Populations

AEFI: Adverse Events Following Immunisation

BBC: British Broadcasting Organisation

cMYP: Comprehensive Multi Year Plan

CHW: Community Health Worker

CRBP: Child Rights and Business Principles

CSO: Civil Society Organisation

ECD: Early Childhood Development

FBO: Faith Based Organisation

HCD: Human Centred Design

HPV: Human papillomavirus

IFRC: International Federation of Red Cross

IPC: Interpersonal Communication

IoGT: Internet of Good Things

IZU: Inshuti z'Umuryango (Friends of Famliy)

KAPB: Knowledge, Attitudes, Practices and Behaviours

MCV: Meningococcal Conjugate Vacine

MIGEPROF: Ministry of Gender and Family Promotion

MSC: Most Significant Change

NCC: National Children's Council

NCDA: National Children's Development Agency

NCPD: National Council for Persons with Disabilities

NGO: Non-Governmental Organisations

NWC: National Women's Council

RBC: Rwanda Biomedical Centre

RCCE: Risk Communication and Community Engagement

RHCC: Rwanda Health Communication Centre

SBC: Social and Behaviour Change

SEM: Socio-Ecological Model

SMART: Specific, Measurable, Achievable, Relevant, Timebound

SMS: Short Message Service

UNICEF: United Nations Children's Fund

WHO: World Health Organisation

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EXECUTIVE SUMMARY

Rwanda has a very successful immunisation programme that has achieved *very high levels of immunisation* of around 95 per cent, way ahead of many other African countries. A strategic and comprehensive Multi-Year Plan (cMYP 2017-21) was put in place by the Government of Rwanda, to maintain this high-performance level of the programme and to close the remaining equity gaps.

Despite the achieved successes, variances in immunisation outcomes were observed between some of the districts. It was felt that these could be related to knowledge, attitudes, practices and behaviours of the parents/primary caregivers and community leaders, regarding vaccination. However, this also pointed to the need for greater immunisation equity across different parts of the country.

To provide an evidence base and an understanding of the barriers and enablers towards achieving complete immunisation coverage, a *Knowledge, Attitudes, Practices and Behaviours (KAPB) study was commissioned in 2019* by the Ministry of Health (MoH)/Rwanda Biomedical Centre (RBC) with support from UNICEF and Rwanda Health Communication Centre (RHCC). This forms the basis of the development of this five-year Social and Behaviour Change (SBC) strategy for immunisation in Rwanda, along with a two-year Action Plan to guide implementation of the strategy.

This strategy has been developed following a *systematic process* of reviewing the evidence base and identifying issues, gaps, barriers and enablers; based on that setting communication objectives; using a theoretical framework to analyse the levels and points of intervention; identifying and analysing participant groups, message development; identifying appropriate communication channels and materials to be developed to reach these participant groups; monitoring and evaluation and developing an implementation plan.

A desk review of documents was conducted and forms the evidence base of this strategy. Some of the major findings of this review include the following:

- The KAPB study found *that knowledge regarding what is immunisation, its' benefits and the different vaccines is quite high, with more women than men being knowledgeable*, as they are the primary caregivers and interact more with health workers.

- The Coverage and Equity Assessment of Immunisation conducted in Rwanda in 2021, commented that "There is a considerable gap between the caregiver's knowledge about immunisation and the vaccine coverage of their children. It appears that the immunisation programme has focused more on increasing coverage rather than increasing knowledge of the benefits of immunisation. This reflects a need to improve communication activities to sustain immunisation coverage and increase demand. Communication efforts should be designed towards heightened awareness of the risk of vaccine preventable diseases, to be more effective".

- The Coverage and Equity Assessment found that *age appropriate vaccinations* were lower than basic vaccinations, although it was higher in higher wealth quintiles.

- The KAPB study indicated that some myths and rumours about immunisation could be linked to religious beliefs. The studies also indicated that *risk perception of their children contracting vaccine preventable diseases* among caregivers is quite low.

- Although there is mostly no difference in vaccination coverage between boys and girls, the KAPB study and the Coverage and Equity Assessment both indicated several gender issues in Rwanda, which have implications for immunisation. Women are the primary caregivers of young children and immunisation is considered 'women's work' by men. However, *cultural values that restrict women's mobility and interactions outside the home, lack of income generating opportunities and decision making, reduce their self-efficacy to be able to take their children for immunisation without the support of the men in the family and other family members*.

- *Distance to health facilities, transportation costs* (which can be quite high for caregivers living in hard to reach areas) and *opportunity costs*, such as loss of wages due to long wait times at health centers, act as barriers to access for immunisation for many caregivers. Therefore, advocacy is required to expand the reach of immunisation through *outreach sessions, opening new health centers in remote areas and special campaigns for missed children. In addition, immunisation services should be adapted to women's needs, for example, vaccinating children in markets where women go. In view of financial constraints of families, exacerbated by the COVID-19 pandemic, other measures, such as conditional cash transfers to caregivers to cover transport costs, could also be considered.*

- Several issues, which need to be addressed, both through communication as well as through more customized service delivery, are primarily linked to the *mobility of populations* for work and other reasons. This imposes time constraints on caregivers, as they must work, as well as commute. To address this issue, offering vaccination services where caregivers go with their children, such as bus stops, could also be considered.

- The KAPB study found that *children with disabilities* have poorer access to immunisation as their caregivers tend to hide them due to *the prevailing stigma in the community.*

- The Coverage and Equity Assessment found *significant disparities in vaccination equity between regions and districts,* with the *Northern Province* having lower coverage of both basic and age-appropriate vaccinations. Therefore, a more intensive and focused approach will be required in some areas, based on *microplanning*. To promote equity, it is important to ensure that women and caregivers, particularly from marginalized groups and caregivers of children with disabilities, are included in the microplanning process, so that is it inclusive and addresses their concerns and offers solutions.

- Most caregivers in the KAPB study indicated that the health care workers carrying out immunisation were *knowledgeable* and that they *trusted the quality of vaccines*. However, according to the Coverage and Equity Assessment, perceptions of quality of service varied by region. The KAPB study found that there is widespread use of *traditional remedies* to deal with side effects. Therefore, it must be ensured that *caregivers are appropriately counseled* to expect and to manage the side effects of certain vaccinations. *Capacity building,* particularly of the community health workers, in community engagement approaches and interpersonal communication would be required.

- The KAPB study found that the most widely used and preferred communication channel to reach caregivers is *interpersonal communication through community health workers and health workers at the health facility.* This is followed by *Umuganda (community events)* and lastly *radio and mobile phones.* The use of *social media has also been suggested to address myths and misconceptions.*

- The KAPB study found that most caregivers felt that the *COVID-19 pandemic* had no impact on immunisation. However, five per cent of caregivers believed that caregivers were not able to immunise their children due to the pandemic.

Communication objectives have been developed for the SBC strategy, based on the understanding provided by the desk review, on the issues, gaps, barriers, and enablers. These include closing the gaps in *knowledge* among female caregivers, fathers of children 0-5 years, other older family members and religious and community leaders, *increasing positive attitudes* of caregivers, fathers, mothers, mothers-in-law, other older family members, religious and community leaders towards immunisation, addressing *gender norms* towards immunisation and increasing the *role of fathers*, as well as increasing *self-efficacy of female caregivers* to take their children for immunisation.

The communication objectives also include *advocacy issues*, such as advocating for *increasing access* to immunisation for urban poor and hard to reach areas, ensuring adequate budget for SBC for immunisation and advocating with the *media* to carry positive stories on immunisation in the media.

This also includes the need to improve service experience of caregivers not only through reinforcement of interpersonal communication by the health worker, but also strengthening the social accountability mechanisms, to ensure that services are accountable to the communities they serve.

The communication objectives also include the *private sector* to ensure that the children of their employees are fully immunized, partner and use their networks and influence to support immunisation.

Finally, the communication objectives include improving *interpersonal communication skills of community health workers and health workers at health centers*, as well as their *motivation* levels through social recognition.

A *theoretical framework* has been developed and applied for the SBC strategy, based on the *Socio-Ecological Model (SEM) and the Journey to Health and Immunisation*, which focuses on the journey of the caregiver and the service provider, as they go through the steps of (*1) knowledge, awareness and belief; (2) intent; (3) preparation, cost and effort; (4) point of service; (5) experience of care and (6) after service*.

The *barriers and enablers* to immunisation, both for the caregiver and the healthcare worker, have been identified at each stage. The SEM has been used additionally, as it helps to analyze the *layers of influence* on the caregiver and the health care worker, as well as other participant groups, and the different levels – *individual, interpersonal, community, organisational and policy,* at which interventions are required. It also helps to identify the *participant groups* at each level. Evidence indicates that programmes with *interventions at multiple levels* are more likely to succeed, as they address family, community, social norms, and systemic barriers as well as individual behaviours.

Based on the above analysis, *participant groups* have been identified and categorized into *primary participant groups* (those whose behaviours we need to directly address), *secondary participant groups* (those who can influence the primary group) *and tertiary participants* (those who will affect the secondary groups).

The primary groups have been identified as *mothers and fathers of children 0-5 years and health care workers*, the secondary groups comprise *other family members, neighbours, community members, religious and community leaders and men's, women's, and youth groups.* The tertiary groups include *health system functionaries and administrators, policy makers, the media and the private sector.* These correspond to the *micro, meso and macro levels of the SEM.*

Messages have been developed for each of the major groups. The messages are the content of what we need to communicate to each of the participant groups, not the actual words to be used in communication materials and activities, which will be developed by the creative agency contracted to develop communication materials. They have been articulated from the perspective of the participant groups for whom they are intended and contain a *benefit* for changing their behaviour from the perspective of the participants, based on the understanding from the analysis of barriers and enablers of behaviour and social change identified.

Communication channels available in Rwanda have been analysed for their relevance and suitability for SBC on immunisation, using the parameters of their *reach in participant groups, cost, and appropriateness* in terms of the content to be communicated. Rwanda has several communication channels that could potentially be used for SBC for immunisation. In addition, the available channels include several *community-based platforms*, unique to Rwanda, which could be used for communication on immunisation. The primary one is *Umuganda*, or the community coming together once a month to help each other in infrastructural and other projects. This was also mentioned in the KAPB study as being an effective channel of communication. The most preferred channel indicated by caregivers in the KAPB study, as mentioned above, was *interpersonal communication* through community health workers and health workers at health centers. Additional *communication channels* include *mass media, such as TV and radio, social media like Facebook, Instagram, Twitter, IoGT and WhatsApp tree.*

Communication materials to be developed, such as TV, radio spots and programmes in different formats, including TV and radio dramas, print materials, such as a flip chart, brochures, leaflets, posters, banners and job aids have also been identified for each participant group.

This SBC strategy focuses on community engagement as an approach to behaviour and social change, which places *communities at the center of the process*, so that they have *ownership* of it. This will be done through a process of

dialogue and discussion with communities, facilitated by the community health worker, together with other field workers.

UNICEF has developed *Minimum Quality Standards and Indicators for Community Engagement,* which focus on empowerment and ownership, participation, two-way communication, adaptability, and localization, and building local capacity. These minimum standards have been described in Chapter 7.

The *steps* in implementing a community engagement process have also been detailed, beginning with *start-up meetings, community-led assessment,* going on to *participatory analysis of the findings, identifying problems and problem sorting, developing an action plan, implementation, and monitoring.*

These steps have been adapted for development of a *Risk Communication and Community Engagement (RCCE*) plan to prepare for and mitigate the impact of disease outbreaks in Chapter 8, which also details the *role of community engagement at various stages of an outbreak or humanitarian crisis*, to ensure that key concerns of affected populations, as well as rumours and misinformation are addressed, and the approach is participatory in nature. The key participant groups in a RCCE plan and their primary concerns have been identified. The role of community engagement at each phase of an emergency – *preparation, the initial phase, maintenance, and resolution -* has been identified. The need for and ways to build *trust and credibility* with the affected populations during an outbreak or a humanitarian crisis have also been described.

Accountability to Affected Populations (AAP), is a key element of any RCCE or humanitarian crisis strategy and plan. The three pillars of AAP *– information provision, participation, and complaints and feedback mechanisms* and required actions are also detailed.

A *monitoring and evaluation plan* has been developed. This includes *implementation monitoring* to check, on an ongoing basis whether implementation is taking place as planned, to what extent, reasons for shortfalls, if any, and the quality of implementation through mass media as well as community engagement. It also includes *behavioural monitoring* that will look for early signs of behaviour change, which will be done through *qualitative and participative methods*, which have been described, including focus groups, interviews, Most Significant Change, and participatory photography/video.

Monitoring indicators have been identified. It has been proposed that *evaluation* should be carried out at the end of five years of implementation of the strategy, through a *follow up qualitative and quantitative KAPB study*, using the one finalized in 2020 as a baseline. *Evaluation indicators* have been identified, which have been derived from the communication objectives identified at the beginning of the strategy development process, to assess whether those objectives have been achieved, and to what extent. However, baselines are not available for all the proposed indicators. The follow up KAPB study should also provide *diagnostics* of the factors that have enabled progress or lack of it, to be used as the basis for planning of the next phase of the SBC strategy development / modification and implementation.

An implementation plan has been developed, which details the *steps and actions to be taken, those responsible for them and the proposed timelines.*

INTRODUCTION

Background

Rwanda has a very successful immunisation programme that has achieved very high levels of immunisation of around 95 per cent, way ahead of many other African countries. A strategic and comprehensive Multi-Year Plan (cMYP 2017-21) was put in place by the Government of Rwanda, to maintain this high-performance level of the programme and to close the remaining gaps.

Despite the achieved successes, variances in immunisation outcomes were observed between some of the districts. It was felt that these could be related to knowledge, attitudes, practices and behaviours of the parents/primary caregivers and community leaders, regarding vaccination. However, this also pointed to the need for greater immunisation equity across different parts of the country.

In addition, the COVID-19 pandemic contributed to disruption of access to some essential health services like HPV immunisation, and its negative effects are still being fully understood.

The Government of Rwanda, with technical support from UNICEF and other development partners, is working to improve the effectiveness of immunisation efforts and maintain a high immunisation coverage. This work is guided by identifying and addressing socio-cultural, administrative, and legal barriers and behavioural drivers for achieving high and equitable vaccines uptake. To provide an evidence base and an understanding of the barriers and enablers towards achieving complete immunisation coverage, a *Knowledge, Attitudes, Practices and Behaviours (KAPB) study* was commissioned in 2019 by the Ministry of Health (MoH)/Rwanda Biomedical Centre with support from UNICEF and Rwanda Health Communication Centre. This forms the basis of the development of this five-year Social and Behaviour Change strategy for immunisation in Rwanda, along with a two-year Action Plan to guide implementation of the strategy.

Developing an SBC Strategy: A systematic process

As the figure below indicates, developing an SBC strategy is a *systematic process*.

It begins with an *analysis of the situation* with regard to the issue for which the strategy is being developed, in this case immunisation, including the socio-economic, cultural, behavioural and political context, particularly focusing on the barriers and enablers to achieving the desired behaviours and goals. This also includes a *review of existing evidence* – studies, reviews, documentation of existing interventions, as well as field visits, consultations etc.

In the case of the development of this strategy, this analysis has been conducted based on the desk review, as consultations and field visits were not possible due to the COVID-19 pandemic. This could be considered a limitation of this strategy. Based on this analysis, *communication objectives* have been articulated. Ideally, they should be SMART – Specific, Measurable, Achievable, Relevant and Timebound, so that they can easily be modified as indicators for monitoring and evaluation, although this may not always be possible.

This is followed by identification, analysis and prioritisation of different *participant groups* (or target audiences) to be included in the strategy, and categorising them as primary – those whom we wish to directly influence, secondary – those who will influence the primary participants and tertiary – those who influence the secondary participants. These correspond to the micro (individual, family, community), meso (civil society, institutional) and macro (policy, national, international) of the Socio-Ecological Model described later in this strategy. It may not be possible to communicate with all participant groups given resource and time constraints, so they may also need to be prioritised, so that the groups that are key to the achievement of the SBC strategy's communication objectives can be identified.

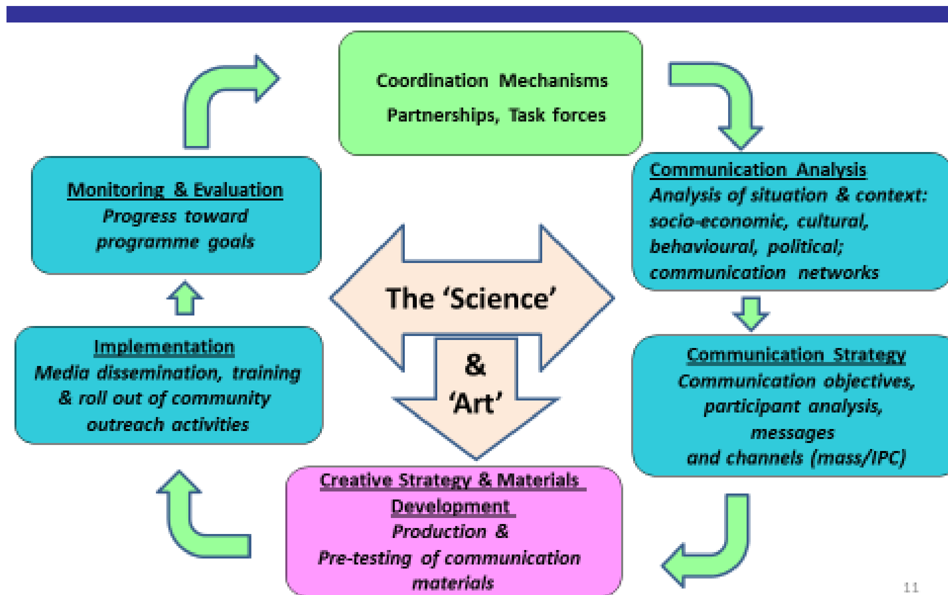


Figure 1: Developing an SBC Strategy - A Systematic Process

Based on this analysis and categorisation of participant groups, *key messages are developed* for each group. These are not the actual lines in creative materials, but the content of the message that needs to be communicated to each participant group to achieve the communication objectives. Each message should contain a benefit as perceived by the participant groups for whom it is intended. *Communication channels available are then analysed*, based on their ability to reach key participant groups, their cost and suitability for the content.

Next, a *creative strategy and communication materials are developed* for each recommended channel and participant group, and pre-tested and modified if required, based on the feedback from the pre-test.

An *Implementation plan* is developed in consultation with the implementing partners, identifying roles and responsibilities and timelines. Implementation begins with dissemination of materials/media placement, training of field workers and other implementing partners and roll out of community engagement and outreach activities.

The final stage is development of a *monitoring and evaluation plan*, based on pre-identified indicators. Monitoring will include implementation monitoring of the implementation plan, as well as behavioural monitoring, which looks for *early signs of behaviour change*. Evaluation after a defined period of implementation of the strategy (minimum 3-5 years), will indicate whether the communication objectives have been achieved and to what extent, and identify challenges and facilitating factors. Ideally mixed methods should be used, including quantitative, qualitative, and participatory processes. The entire process should ideally be as participative as possible, with engagement of key stakeholders.

Principles underlying the development of the SBC strategy

This strategy has been developed keeping certain principles in mind:

- *Evidence-based:* As indicated above, all SBC strategies should be based on an analysis of the situation.
- *Inclusive:* It includes all marginalised groups, including those living in hard to reach and urban poor areas, women, and children with disabilities.
- *Participative:* The limitation to this process in the development of this SBC strategy has been mentioned above. However, it has been developed on the assumption that UNICEF Rwanda and Ministry of Health

will engage all stakeholders in the dissemination, development of the creative materials, implementation, and monitoring and evaluation of the strategy.

- *Contextualised:* It has been customised to the Rwandan context based on the understanding from the desk review and interactions with UNICEF Rwanda.
- *Theory-based*: All effective SBC strategies should be based on a theory so that there is a clear understanding of how the behaviour change is sought to be achieved.

1. SITUATION ANALYSIS

As mentioned above, the desk review and interactions with UNICEF Rwanda have formed the basis of the situation analysis and evidence base for the development of this SBC strategy. A detailed desk review of various documents including the KAPB study and the Coverage and Equity Assessment was undertaken, which led to the following conclusions:

- ***Knowledge regarding immunisation:*** The KAPB study found *that knowledge regarding what is immunisation, its benefits and the different vaccines is quite high, with more women than men being knowledgeable*, as they are the primary caregivers and interact more with health workers. Knowledge levels of fathers will also have to be improved through the strategy, as they need to be engaged to support the mothers to take their children for immunisation. The KAPB study and the Coverage and Equity studies have indicated the need for increasing knowledge levels about immunisation. While there is a need to increase knowledge among caregivers about the date, time and place of vaccination, where to go for reliable information on immunisation and how to manage AEFI, there is also a need to increase knowledge among both mothers, fathers and family members, as well as religious and community leaders, about the benefits of immunisation and address other drivers, such as increasing the role of fathers in their children's health and immunisation, increasing self- efficacy of mothers to take their children for immunisation, and advocating for improving access to immunisation services, particularly for families in urban poor and hard to reach areas.
- ***Age-appropriate vaccinations:*** According to the Coverage and Equity Assessment***,*** *age-appropriate vaccination levels are much lower (84.4 per cent) than basic vaccinations,* indicating either knowledge gaps of when vaccinations are due, forgetting about it (particularly in the long six-month gap between MCV1 and MCV2), distance to health facilities, competing priorities etc., resulting in children not receiving timely vaccinations. A reminder system through mobile phones may be useful, to remind caregivers when the next dose of vaccination for their child is due. Age-appropriate vaccinations were also higher among more educated mothers and those from higher wealth quintiles, indicating that knowledge does play a role in ensuring timely vaccinations for children. However, *knowledge alone will not ensure behaviour change and higher immunisation coverage*, as indicated by the Journey to Health and Immunisation Model and the HCD approach described later in this strategy, and appropriate interventions will be required to address other barriers.
- ***Gap between coverage and demand:*** The KAPB study and the Coverage and Equity Assessment indicated that demand for immunisation, as expressed by caregivers, is lower than actual immunisation levels. The cause of this is not clear from the documents reviewed. There are also some indications of *myths linked to religious beliefs*. Therefore, communication strategies should be more *focused on the barriers and motivators of immunisation and on reducing misinterpretations and negative beliefs*. The KAPB study also found *low risk perception among caregivers, about vaccine preventable diseases*. While risk perception does need to be increased through the communication strategy, it needs to be done in a way that does not generate a negative response, where people do not accept the message and disregard it. This has happened in several instances in many countries on health issues, including HIV, where 'scare tactics' only served to turn people off the issue.
- ***Gender issues in immunisation:*** According to the Coverage and Equity Assessment, *while there is no overall gender gap in immunisation coverage in Rwanda, coverage of zero dose polio among boys is significantly lower*

compared to girls. This could be due to some cultural reason which is not known and needs further investigation. The KAPB study and the Coverage and Equity Assessment both indicated a number of gender issues in Rwanda, which have implications for immunisation. Women are the primary caregivers of young children and immunisation is considered 'women's work' by men. However, *cultural values that restrict women's mobility and interactions outside the home, lack of income generating opportunities and decision making, reduce their self-efficacy* to be able to take their children for immunisation without the support of the men in the family and other family members. As mentioned above, the knowledge levels of men about immunisation are lower than for women. Fathers need to be engaged so that they are motivated to take responsibility for their children's health, including immunisation. This will require the use of *gender and social norms approaches*, which may already be planned as part of a broader approach to address gender issues for ECD and other programmes.

- ***Religious leaders:*** As mentioned above, the KAPB study indicated that some myths and rumours about immunisation could be perpetuated by religious beliefs. Therefore, they also need to be engaged as participants in the SBC strategy, to ensure that they have correct knowledge about and positive attitudes towards immunisation and to motivate religious leaders to encourage community members, including men, to take their children for immunisation, rather than be the source of myths and misinformation. In fact, with a little capacity building, they could become *valuable resources in the community engagement process, as people place a lot of trust in them.* Religious leaders could also help in addressing the *gender issues* mentioned above, as most of them would be men and trusted and listened to by other men in the community.
- ***Increasing access to immunisation:*** *Distance to health facilities, transportation costs* (which can be quite high for caregivers living in hard to reach areas) and *opportunity costs, such as loss of wages due to long wait times at health centers*, act as barriers to access for immunisation for many caregivers. Therefore, advocacy is required to expand the reach of immunisation through *outreach sessions, opening new health centers in remote areas and special campaigns for missed children.* Immunisation services could also be offered in places where mothers congregate, such as markets and religious shrines. There are also some suggestions of subsidies/financial support for transport costs, which should be examined for feasibility and sustainability. *Integration of services*, such as distribution of mosquito nets, growth monitoring and nutrition services with immunisation, has been suggested to make access easier and more meaningful for families, particularly those who are hard to reach.
- ***Urban areas:*** There are *disparities in coverage between urban and rural areas, both for basic and age-appropriate vaccinations,* although the KAPB study found no association between knowledge and attitudes of caregivers and their wealth status or their location i.e. urban or rural. Perceptions and attitudes may also differ in different parts of a large urbanized centers like Kigali.

  Urban areas have several issues which need to be addressed, both through communication as well as through more customized service delivery, as the primary challenge seems to be the *mobility of populations* for work and other reasons. The reasons for zero dose children with highly educated, relatively economically better off mothers in Kigali needs to be better understood before it can be addressed through communication. *Advocacy for more outreach services with flexible timings may be required. Reminders to caregivers about the date, time and place of upcoming immunisation sessions would also be useful*. More intensive and focused approaches would be required in urban areas, to understand the needs of caregivers and families and to reassure them so that they can access services. Service providers also may not be adapted to the profile of people living in urban poor settings, and therefore caregivers may not feel welcome in bringing their children for immunisation. This should be addressed through training, orientation, and job aids, specific to urban poor settings.

- ***Children with disabilities:*** The KAPB study found that children with disabilities have poorer access to immunisation as their caregivers tend to hide them due to *the prevailing stigma in the community.* This needs to be addressed through community engagement involving religious and community leaders. There could already be other communication interventions being implemented to address this issue, as it does not apply only to immunisation, and is a barrier to access for all services for children with disabilities. Immunisation could be integrated into such communication interventions and should also be a focus of community health workers interactions with caregivers on immunisation.
- ***Regional/district-specific approaches:*** The Coverage and Equity Assessment found *significant disparities in vaccination equity between regions and districts,* with the Northern Province having lower coverage of both basic and age-appropriate vaccinations. There are also differences between districts in the perceptions of caregivers about the need for immunisation and its benefits. Therefore, a more intensive approach will be required in some areas. The precise areas should be identified through *updating micro plans with the engagement of communities,* as part of the implementation of the RED/REC approach.
- ***Community health workers, health service providers:*** *Capacity building, particularly of the community health workers, in community engagement approaches and interpersonal communication* would be required. Most caregivers in the KAPB study indicated that the health care workers carrying out immunisation were knowledgeable and that they trusted the quality of vaccines. However, according to the Coverage and Equity Assessment, perceptions of quality of service varied by region. Although the KAPB study and other documents indicate that health education sessions are supposed to be held prior to immunisation sessions, it is not clear whether they are in fact routinely held and *whether caregivers are counseled to expect some side effects from certain vaccines, as well as how to manage them.* The KAPB study found that there is widespread use of traditional remedies to deal with side effects. Therefore, it must be ensured that *caregivers are appropriately counseled to expect and to manage the side effects of certain vaccinations*. Fear of side effects has been found to be a significant reason for vaccine hesitancy in many countries. The documents reviewed do not throw any light on the level of motivation of the community health workers and health service providers. However, some *motivational approaches to acknowledge their contribution may be helpful*, as indicated by the Journey to Health and Immunisation Framework described later.
- ***COVID-19/Outbreaks:*** The KAPB study found that most of the caregivers felt that the COVID-19 pandemic had no impact on immunisation. However, 5 per cent of caregivers believed that caregivers were not able to immunize their children because of COVID-19. Some of them were also concerned about the *overcrowding at some of the health centers*, making social distancing infeasible, and the long wait times, exposing them to infection. This needs to be addressed *through more outreach sessions and reassuring caregivers and families about the safety of taking their children for immunisation*. As the Immunisation Agenda 2030 states, and the vaccination programmes for COVID-19, HPV and other new vaccines has also shown, in the future the immunisation programme in all countries will need to adapt to *immunizing all age groups, rather than focusing only on children,* as has been done traditionally. There is not much information available about HPV vaccination in the documents reviewed. The KAPB study mentions that although there was some hesitancy initially, it is no longer there.
- ***Communication channels:*** The KAPB study found that the most widely used and preferred communication channel to reach caregivers is *interpersonal communication through community health workers and health workers at the health facility.* This is followed by *Umuganda (community events)* and lastly *radio and mobile phones.* The use of *social media has also been suggested to address myths and misconceptions.* A review of available and appropriate channels for immunisation has been included later in this strategy.

2. COMMUNICATION OBJECTIVES

Communication objectives, as distinct from programme objectives, state *what is sought to be achieved through communication.* Communication cannot address all the barriers, such as increasing access in hard to reach or urban areas, although it can advocate with government and other partners for it, but access is also affected by many other factors. The attempt here is to make as many of the communication objectives as possible SMART – Specific, Measurable, Achievable, Relevant and Time bound, but this may not be possible for all objectives, where baselines are not available. These are, nevertheless, key issues to be addressed through communication. It has also been kept in mind that while communication objectives should include all the key issues to be addressed by the strategy, they should also not be too many as it may not be feasible to address all of them at the same time. The following communication objectives have been proposed for the communication objectives:

Knowledge

- Increase knowledge of male and female caregivers, fathers and grandmothers of children 0-5 years, living in rural and urban areas, about immunisation, including
    - How many times the child needs to be taken to the vaccination centre within the first two years of birth
    - Benefits of immunisation
    - Where and when they can get their children vaccinated
    - Where to get reliable information about immunisation
    - How to manage side effects of some vaccines

Risk perception

- Increase perception of male and female caregivers and fathers of children 0-5 years that their children are at risk of contracting vaccine preventable diseases if they are not immunized against them.

Attitudes and beliefs

- Increase positive attitudes of female and male caregivers, fathers, and grandmothers of children 0-5 years toward immunisation (think it's a good idea).
- Increase female and male caregivers, father and grandmothers of children 0-5 years believing that
    - All children should be fully immunized
    - Vaccines are an effective way to protect their children, themselves, and others in the community from diseases
    - Vaccines are safe and effective, and the benefits of immunisation outweigh the risks of side effects
    - Vaccines are a priority for their children's health
    - That they should also take their children with disabilities for immunisation
- Reduce belief of female and male caregivers, fathers, and grandmothers of children 0-5 years, in traditional medicines to cure side effects of immunisation and their usage
- Increase positive attitudes of traditional healers towards immunisation.
- Reduce vaccine hesitancy/refusal among caregivers

Gender

- Increase positive attitudes of spouses/co-parents towards immunisation (think it's a good idea)
- Increase fathers of children 0-5 years taking their children for immunisation/supporting their wives to do so
- Change attitude among fathers, families, and the community that immunisation is the mother's responsibility

- Increase self-efficacy of female caregivers of children 0-5 years to be able to take the decision to immunize their children and to be able to take them to the service point for vaccination.

Social norms

- Increase the social expectation that the reference networks of caregivers and fathers of children 0-5 years expect them to immunize their children
- Establish social norm that all parents are expected to immunize their children, including those with disabilities.
- Encourage caregivers who have had a positive experience with getting their children immunized, to share their experiences with others.

Religious and community leaders

- Increase knowledge and positive attitude of religious and community leaders about immunisation
- Encourage religious leaders, and those from umbrella organizations, particularly from low immunisation coverage districts, to publicly support immunisation and encourage parents, particularly from marginalized groups, to take all their children for immunisation, including those with disabilities
- Encourage community leaders to publicly support immunisation and encourage parents to take their children for immunisation, including those with disabilities.

Health workers

- Increase community health workers and health workers at health centres trained in interpersonal communication skills and community engagement
- Emphasise to community health workers and health workers at service centres, the importance of counselling of caregivers about benefits of certain vaccines and AEFI.
- Increase motivation of health workers through public recognition at local events
- Motivate community health workers to remind caregivers about their next vaccination visit through home visits, SMS, WhatsApp trees, phone calls etc.
- Encourage community health workers to promote immunisation within their communities and ensure that they have the means to do so.
- Improve attitudes of health workers towards caregivers from vulnerable groups and children with disabilities, and to encourage them to bring their children for immunisation.

Microplanning and community engagement

- Involve local communities, particularly those from vulnerable groups, and women, in microplanning
- Encourage community health workers to use community-based mechanisms to organize open discussions with the community on immunisation
- Institute social accountability systems to engage communities in improving service quality
- Encourage communities to support each other to address competing priories of caregivers, so that they can take their children for immunisation

Advocacy

- Advocate with government authorities to increase access to immunisation services through
    - Increasing health centres in hard to reach areas
    - Flexible timings in urban areas
    - Increasing outreach sessions
- Advocate for sufficient budget for SBC plan implementation
- Advocate with media for increasing positive stories about immunisation in media and build their capacity for this purpose.

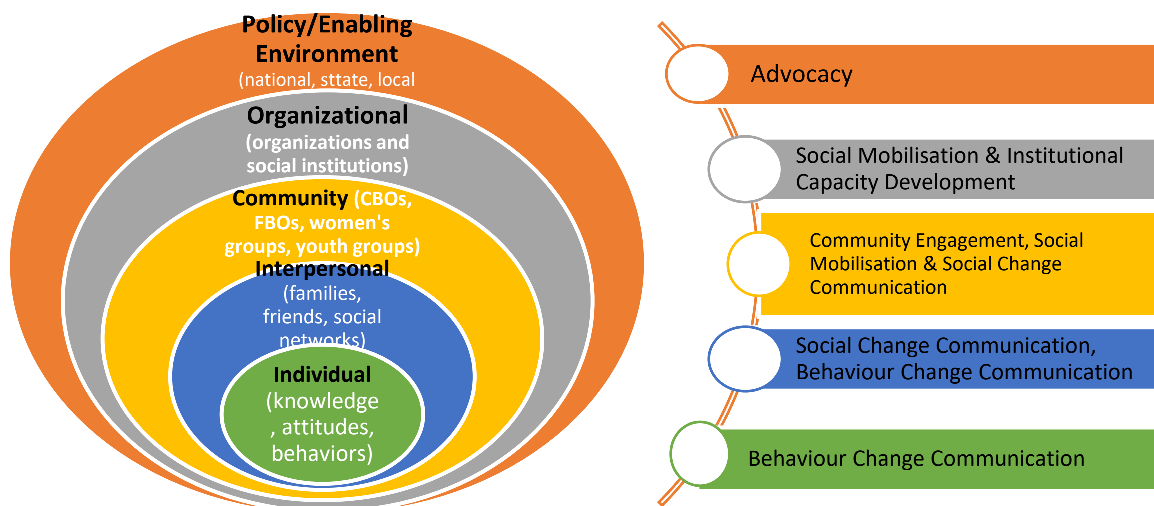
- Advocate with private sector to ensure all children of employees are fully immunised, provide resources and use their networks to promote and support immunisation.

3. THEORETICAL FRAMEWORK

Socio-ecological Model (SEM)

The socio-ecological model has been used as one of the theoretical frameworks on which this SBC strategy is based. The underlying assumption of the SEM is that *individual behaviour and collective action* are shaped by the *social structures and environment* (including regulation and policy as well as physical environments), in which people as individuals and as a society find themselves. These are governed by *social norms and cultural beliefs* within formal and informal networks of interpersonal relations. When *multiple levels of influence* (policy, legislation, organisational, community, interpersonal, individual) are addressed simultaneously, or in a *synergistic manner*, behaviour and social changes are more likely to be successful and sustained.

Figure 2: The Socio-ecological Model and Communication Approaches



The *SEM is in fact a simple analytical tool* to help diagnose problems and design programmes that consider relevant *interpersonal, cultural, behavioural, and political variables* that influence individual and community decision-making. The SEM recognizes that most challenges to human development and well-being are interrelated and can rarely be addressed on a single level. People's ability and willingness to adopt healthy and protective behaviours - individually and collectively - are shaped by an interplay of determinants at the individual, family, community, policy and social level, or layers of influence.

Such analysis helps in identifying and prioritizing the *key participant groups* we need to include in our SBC strategy, to change behaviours. It also helps to detect those most *marginalised and at risk of being missed* and allows for tailor made communication and engagement strategies, as well as a mix of social and behavioural change communication approaches that is most likely to work. This means defining social and behavioural outcomes and interventions that engage people not just as individuals, but also as family members and community members, as media consumers, and as the recipients of services.

Applying the SEM, SBC uses a combination of *six key approaches* in promoting behaviour and social changes in terms of impact, scale, and sustainability. The approaches are: *(1) Behaviour Change Communication (BCC) at the individual level (2) Communication for Social Change (CFSC) at the interpersonal level (3) Community Engagement*

at the community level (4) Social Mobilisation at the community and the organisational levels (5) Institutional Capacity-Building at the organisational level and (6) Advocacy at the policy level. Together, these six strategic approaches aim to shift attitudes and social norms at the individual, household, community, institutional, and societal levels to promote cultural behaviours and collective practices consistent with a complete human rights approach.

As can be seen from the above, the SBC strategy for immunisation in Rwanda, will therefore have to work at different levels of the SEM:

Individual: The strategy will address all the issues mentioned above about knowledge, attitudes, beliefs, and behaviours of both the caregiver and the healthcare worker.

Family: This will include the fathers of the children and other family members such as mothers and mothers-in-law, and other older family members, who may have either gender related attitudes, or be influenced by myths and rumours about vaccination and consulting traditional healers to cure side effects.

Community: This will include religious and community leaders and other local influencers, to ensure that they have correct knowledge and positive attitudes and beliefs about immunisation, end myths and rumours, reduce stigma towards vulnerable groups and children with disabilities, and be motivated to become advocates for immunisation all children.

Governance and health systems: Advocacy will be required to ensure that issues related to increasing access through more health centres in hard to reach areas, increasing outreach sessions based on microplanning, flexible timings, particularly in urban areas, and overcrowding and long wait times at health centres are addressed.

Private sector: The private sector is growing rapidly in Rwanda and employs many people. Therefore, it can play a large role in ensuring that children of all their employees' families are fully immunized, by holding immunisation sessions within their facilities in coordination with health authorities and using their networks for advocating for immunisation and resources. In addition, they can be a potential source for resource mobilization, to reduce dependence of the immunisation programme in Rwanda on external funding.

Media environment: Advocacy will also be required with mass media, such as radio and TV and print media, to ensure that they carry positive stories about immunisation, including the rights of vulnerable groups and children with disabilities to immunisation and other services, become our partners in the fight against vaccine preventable diseases and do not sensationalise any incidents of AEFI. Therefore, a continuous strategy of engagement and advocacy with media always will be required, not just when there is a crisis to be managed.

The participant groups at each level and the issues to be addressed and the communication for each one are indicated in the table below:

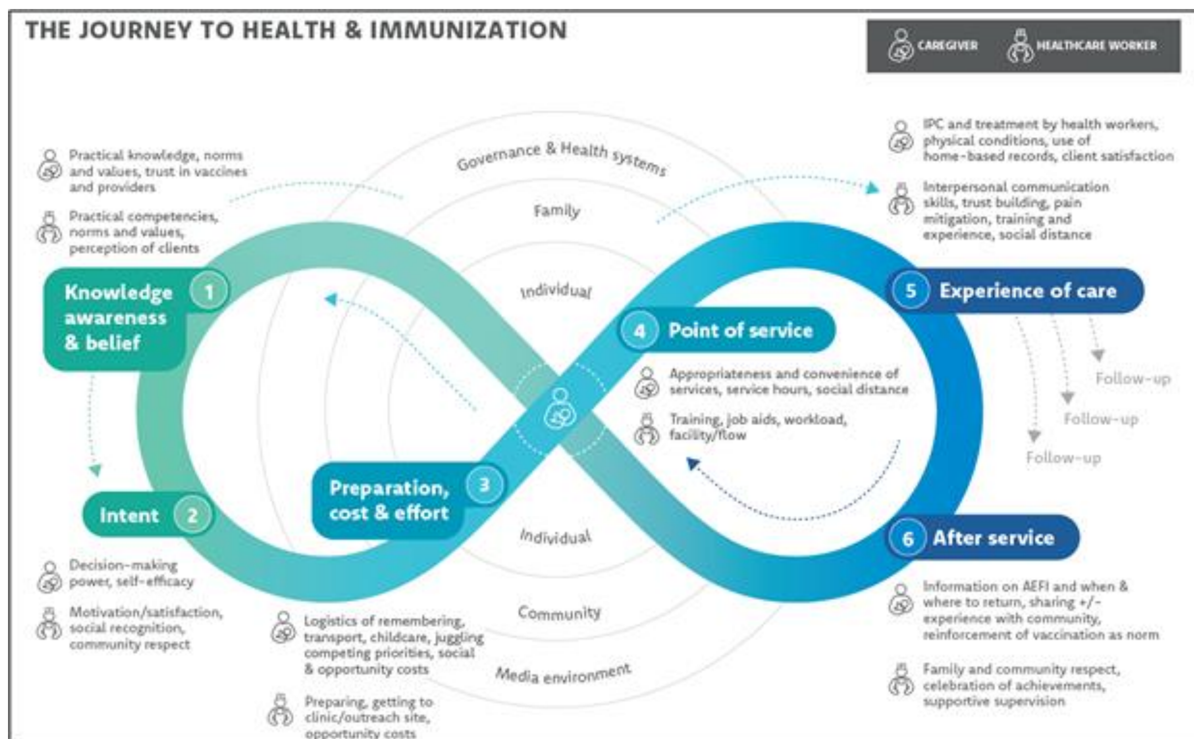
Another framework called the Journey to Health and Immunisation has been developed based on the Socio-Ecological model, which is more specific to health and immunisation issues.

Journey to Health and Immunisation

The Journey to Health and Immunisation is based on the socio-ecological model and includes elements of behavioural science and Human Centred Design (HCD). The framework places the child and the caregiver at the centre, covering the demand-supply loop using a life-cycle approach, from the pre-conception to the reproductive age of the child. It follows the journey of the caregiver and the healthcare worker through the stages of (1) knowledge, awareness and beliefs (2) intent (3) preparation, cost and effort (4) the experience at the point of service (5) experience of care (6) after service. This SBC strategy addresses the gaps and barriers at each stage of the journey, and builds on the enabling factors at the individual, family, community, media environment and governance and health system levels.

This model is presented in the figure below:

Figure 3: Journey to Health and Immunisation



Stage 1: Knowledge, awareness, and belief

Caregivers: The gaps in comprehensive knowledge among caregivers, particularly men, have been highlighted in the situation analysis above. As it indicates, knowledge of the benefits of immunisation needs reinforcement. However, as the HCD approach emphasises, knowledge alone does not lead to behaviour change, as there are other barriers, such as distance to facilities, transportation costs and lack of family support that stand in the way. There are also myths and rumours regarding vaccination among some communities, some of which seem to be connected to religious leaders. Therefore, they need to be engaged as well, so that they can become advocates for immunisation, rather than adding to vaccine hesitancy. They could in fact become powerful advocates for immunisation, as the community members trust them. In Rwanda as elsewhere, mothers are the primary caregivers of young children, and therefore immunisation is also seen as the mother's responsibility, by the fathers and other family members. Mothers often find it difficult to ensure timely immunisation for their children, without the support of their husbands. According to the KAPB study, mothers generally trust vaccines and service providers and find them knowledgeable. However, it does not mention whether and to what extent they are counselled to expect and manage side effects of vaccination, as the KAPB study indicates a high usage of traditional medicines for this purpose.

Healthcare workers: As mentioned above, health care workers seem to have the practical knowledge required for immunisation, although it is not known how regularly they receive refresher training, as new antigens are added to the immunisation schedule. The current COVID-19 pandemic has also, likely, impacted capacity building of healthcare workers. In addition, they may need capacity building in counselling and interpersonal communication as well as supporting them having a caring and service-oriented attitude. There is also a mention in the Coverage

and Equity Assessment of healthcare workers themselves being affected by gender norms, although this needs better understanding.

Stage 2: Intent

Caregivers: Although many theories/models of behaviour have suggested that intent is a strong predictor of behaviour change (for example, the stages of change or Transtheoretical model), the HCD approach in fact posits the opposite, presumably due to the barriers that stand in the way between intent and actual behaviour change. The KAPB study makes it clear that mothers often do not have the decision making power or self-efficacy to take their children for immunisation on their own. On the other hand, according to the KAPB study, men believe that immunisation is “women’s work”. Therefore, men need to be actively engaged as part of the SBC strategy, so that they also take responsibility for their children’s health, including immunisation. Since this issue affects all aspects of children’s health and development, it should ideally be part of an integrated Early Childhood Development (ECD) approach, which is being implemented in Rwanda. Gender and social norms take time and sustained effort to change, and therefore this needs to be part of a medium/long term approach.

Healthcare workers: There is not much information available from the documents about the motivation levels of healthcare workers and their standing in the community. However, some form of social recognition will help to increase their motivation, as well as respect in the communities in which they work. This could be in the form of non-monetary recognition of their services at local public events.

Stage 3: Preparation, cost, and effort

Caregivers: Distance to the health centre and cost of transportation are barriers for around 22 per cent of caregivers, according to the KAPB study. Given distances and wait times at health centres, opportunity costs of losing wages for female caregivers as well as for men, are also a barrier. In addition, women have competing priorities, such as looking after other children and housework. As has been mentioned earlier, urban areas have problems, with mobile populations and often both parents working, for which a more flexible approach in timings of health centres and service provision may be required.

Healthcare workers: Not much information is available from the documents on the effort required on the part of healthcare workers in preparing for the immunisation session, reaching the vaccination site and opportunity costs to them. While integrating immunisation with other services, which has been suggested, such as growth monitoring and distribution of mosquito nets, would be beneficial for caregivers, it may require more preparation and effort on the part of healthcare workers to coordinate. The same is true of outreach sessions, which are required to increase coverage in urban and hard to reach areas but will take extra effort on the part of healthcare workers. Compensation and motivation of healthcare workers for this extra effort need to be considered.

Stage 4: Point of service

Caregivers: Issues related to appropriateness of service and service hours have already been mentioned. The KAPB study and the Coverage and Equity Assessment have found long wait times and overcrowding at some health centres to be a barrier. This is a particular concern from the point of view of social distancing required during the COVID-19 pandemic.

Healthcare workers: Issues related to training of healthcare workers on interpersonal communication and counselling caregivers, particularly on the management of side effects, have already been mentioned. In addition, it needs to be ensured that they have appropriate job aids to perform their jobs effectively, that there is enough staff to manage the workload and the workflow in the facility is efficiently managed. Not all of these issues can be directly addressed by communication, but those that can be advocated for with health authorities, other stakeholders and policy makers.

Stage 5: Experience of care

Caregivers: The issues of caregivers about their experience of care, have also already been mentioned above. According to the KAPB study, most caregivers appeared to be satisfied overall with the quality of service received. However, the Coverage and Equity Assessment had mentioned that perceptions regarding quality of service varied across districts. Therefore, this requires a more nuanced approach and should be a part of micro planning. Urban areas and hard to reach areas are again a matter of concern as far as the caregiver's experience of care is concerned.

Healthcare workers: The issues as far as the healthcare workers are concerned are the same as those mentioned in stage 5 of point of service. These relate to interpersonal communication and skills and attitudes of healthcare workers that inspire trust from caregivers, mitigation of any pain at the time of vaccination and counselling regarding side effects, as well as whether they are trained and experienced in all aspects of immunisation, including counselling, and follow COVID appropriate norms in terms of masking and social distancing. Healthcare workers are usually very busy during immunisation sessions and delivery of other services, so it is challenging for them to find time to reassure and counsel caregivers, who naturally have many fears about their children's health during and after vaccination. However, it is also a question of attitude and patience in dealing with the natural fears of caregivers, and this must be inculcated through training, to be an integral part of service delivery.

Stage 6: After service

Caregivers: According to the Journey to Health and Immunisation model, this includes receiving information on AEFI and when/where to return, sharing positive and negative experience with the community by caregivers and reinforcement of vaccination as a norm. The caregivers who have taken their children for immunisation can become our spokespersons in the community, by sharing positive experiences and encouraging their friends and neighbours to also do likewise. However, if they have had a negative experience, this could also do a lot of damage to the programme, as they will share these negative experiences within the community and discourage others from getting their children immunised. AEFI also leads to a lot of myths and rumours about vaccination and its benefits, and appropriate steps need to be taken to guard against this. Therefore, the experience of the caregivers at the point of service is critical in ensuring that they and others bring their children for immunisation in the future.

Healthcare workers: If the caregivers' experience at the point of service has been positive, it will also lead to healthcare workers receiving family and community respect. Their achievements should be celebrated, as has been mentioned, through recognition and non-monetary awards at public events. Supportive supervision would also encourage them to perform better.

Table 1: Participant Groups and SBC barriers at each Level of the SEM

Level	Communication Approach	Participant Group	SBC Barriers
Individual	Behaviour Change Communication	Female caregivers of children 0-5 years, including those from marginalized groups	Increase knowledge about benefits about immunisation, how to manage AEFI, where and when to go for vaccination, number of times a child needs to be taken for immunisation in the first two years etc.; increase risk perception of their children contracting vaccine preventable diseases; increase positive attitudes and beliefs towards immunisation including efficacy and safety of vaccines and remove fear of AEFI; reduce belief and practice of taking

			traditional medicines to cure side effects; increase self-efficacy to take decision to immunize all children, including those with disabilities for immunisation and to discuss this with husbands.
		Fathers of children 0-5 years	Emphasize role in children's health, including immunisation and that it is "women's work"; increase number of fathers taking their children for immunisation/supporting their wives to do so, including those with disabilities; Increase knowledge about benefits of immunisation, how to manage AEFI, where and when to go for vaccination, number of times a child needs to be taken for immunisation in the first two years etc.; increase risk perception of their children contracting vaccine preventable diseases: increase positive attitudes and beliefs towards immunisation, including vaccine safety and efficacy; remove fear of AEFI; reduce belief in and usage of traditional medicines to cure side effects of immunisation;
		Community health workers, health workers at health centres	Improve interpersonal communication skills; increase positive attitudes towards caregivers, including those from vulnerable groups and children with disabilities, as well as service and care orientation; emphasize importance of counselling caregivers about benefits of immunisation and AEFI and its management; motivate to conduct community engagement sessions on immunisation and engage community members, particularly women and those from disadvantaged groups in microplanning and developing and implementing social accountability mechanisms; motivate them through social recognition at local public events
Interpersonal	Behaviour change communication, social change communication	Mothers-in-law, mothers	Increase knowledge about benefits of immunisation and how to manage AEFI, where and when to go for vaccination, number of times a child needs to be taken for immunisation
		Older male family members	
		Friends, neighbours, colleagues	

			in the first two years etc.; increase risk perception of their children contracting vaccine preventable diseases; increase positive attitudes and beliefs towards immunisation, including efficacy and safety of vaccines and remove fear of AEFI; reduce belief and practice of taking traditional medicines to cure side effects; change gender norms about men's and women's roles in child health and child rearing, particularly immunisation and that it is "women's work"; change attitudes about rights of children from vulnerable groups and those with disabilities to services, including to immunisation and other services
Community	Community engagement, social change communication and social mobilisation	Women's/mother's groups, Mothers Union groups, men's groups, youth groups/clubs, community volunteers (Inshuti z'Umuryango), traditional healers	Increase theirs and community knowledge about benefits of immunisation, immunisation and how to manage AEFI, where and when to go for vaccination, number of times a child needs to be taken for immunisation in the first two years etc.; increase risk perception of children contracting vaccine preventable diseases; increase positive attitudes and beliefs towards immunisation including efficacy and safety of vaccines and remove fear of AEFI; reduce belief and practice of taking traditional medicines to cure side effects; emphasize role in encouraging al caregivers, including those from vulnerable groups, to take their children for immunisation, including those with disabilities, ending myths and rumours, developing positive attitudes of community members towards immunisation, increasing role of fathers in immunisation; encourage community members to support each other to manage competing priorities so that caregivers can take children for immunisation during service hours; recognize contribution of community health workers at local public events

		FBOs, Inter-faith Council, religious leaders, community leaders	Increase knowledge about benefits of immunisation, immunisation and how to manage AEFI, where and when to go for vaccination, number of times a child needs to be taken for immunisation in the first two years etc.; increase risk perception of unimmunized children contracting vaccine preventable diseases; increase positive attitudes and beliefs towards immunisation; strengthen belief in efficacy and safety of vaccines; emphasize key role in influencing caregivers to vaccinate their children, increasing involvement of fathers in children's health, including immunisation, increasing collective self-efficacy of female caregivers to take their children for immunisation, ending myths and rumours about immunisation, reassuring them about AEFI and how to manage it, encouraging community members not to give their children traditional medicines to manage AEFI; motivate to promote immunisation within their communities and other fora, such as religious gatherings and events; include immunisation In their sermons and when they meet community members.
Organisational	Social mobilisation, Institutional capacity development	Health care system, district and national administration	Increase participation of community members, including women and those from vulnerable groups in development of micro-plans; institute social accountability mechanisms to receive community feedback to improve service quality and care; improve service quality and experience of care
		Media	Increase knowledge about benefits of immunisation how to manage AEFI, where and when and when to go for vaccination, number of times a child needs to be taken for immunisation in the first two years etc.; increase risk perception of children contracting vaccine preventable diseases; increase positive attitudes and beliefs towards immunisation including

			safety and efficacy of vaccines; motivate to carry content supporting immunisation, particularly about role models/'positive deviants' who have immunized all their children and are willing to advocate for it, need to vaccinate all children, including those with disabilities and not to sensationalize AEFI; carry positive stories about role of health workers in immunisation, ending myths and rumours; motivate to use their networks to support immunisation
		Private sector	Increase knowledge about benefits of immunisation how to manage AEFI, where and when to go for vaccination, number of times a child needs to be taken for immunisation in the first two years etc.; increase risk perception of their and their employees' children contracting vaccine preventable diseases; increase positive attitudes and beliefs towards immunisation including efficacy and safety of vaccines and remove fear of AEFI; ensure all employees immunize children, including those with disabilities; emphasise father's role in immunisation; advocate with employees not to give traditional medicines to their children to manage AEFI; arrange outreach sessions; encourage private sector companies to promote immunisation through their networks; resource mobilization
Policy	Advocacy	Government line ministries, provincial and district administration, lawmakers	Community-led advocacy, at community level to from the community level, to district and provincial administration and ensure social accountability mechanisms to improve service quality and experience of service; advocacy by partners and stakeholders at the national and provincial levels, to highlight issues of access/other barriers, need to improve quality and experience of care; ensure adequate funding for immunisation programme, including SBC strategy implementation.

4. MESSAGE DEVELOPMENT AND PARTICIPANT GROUPS

Rwanda cultural and family context

In Rwanda, the mother is seen as the *guardian of the child* and bears all the responsibility for the child's welfare, while the *father's role* is seen mostly as a provider. The grandmother may help the mother but does not bear any obligation for the child's welfare. Most of the time the mother also must bear the burden of cultivating the fields or looking after the livestock. She has *very little decision-making power*. Husbands are reported to be highly influential in decision making related to childcare, with mothers-in-law, grandmothers, aunties, and sisters influencing childcare practices within the household. Most trusted for advice on childcare are *husbands, mothers-in-law, grandmothers and CHWs. Local and national leaders* are also listened to and highly respected. *School teachers, along with religious leaders, opinion leaders and other authority figures* are all perceived as extremely influential in motivating parents to adopt correct maternal and child health practices.

Messages have been developed for the various participant groups. These are not the lines or actual words to be used in the materials to be developed by a professional creative agency contracted by UNICEF, Rwanda, but the content of what needs to be communicated to each group, which would then be crafted into the actual words, visuals and ideas. Ideally, the messages should contain not only what 'we' would like to 'tell' the participant groups or what we would like them to 'do' in a didactic manner, but also contain a benefit from the perspective of that group, which motivates them to change their behaviour. Sample messages for the key participant groups are given below:

Mothers/female caregivers of children 0-5 years

- *Benefit:* Your child will be healthy and be *protected from many life-threatening diseases* if you ensure that s/he gets all the vaccinations in time, that the government is providing *free of cost* at health centres.
- *Knowledge:* The CHW/health care provider at the health centre will tell you where and when to take your child for immunisation, how to manage side effects like fever that some vaccines can cause and how many times you need to take your child for immunisation in the first two years from birth.. You can also see this for yourself at https://rw.goodinternet.org/. There is no data charge to access this site. Read the information available there and and ensure they are given *in time so that your child in protected* from all those diseases.
- *Risk perception:* If you do not fully vaccinate your child s/he could contract several diseases which can be prevented by vaccination. That will lead to a lot of *cost and additional work for you and your family* in looking after a sick child.
- *Self-efficacy:* Have the confidence to discuss the importance of immunisation for your child with your husband, so that he can *help you take your child for immunisation*. The community health worker will help you to talk to your husband, if necessary.
- *Vaccine safety and efficacy:* Vaccines are effective, *safe and guaranteed by the government*. If you have questions/concerns, please talk to the healthcare worker.
- *Managing side effects:* Some vaccines can cause mild side effects, like fever for a few days. It is *nothing to worry about*. Ask your local health centre/health care worker for some medicine/paracetamol so that you can manage that.
- *Children with disabilities:* All children, including those with disabilities should be vaccinated, so that they are protected from several serious diseases like measles and diphtheria and do not spread them to you and others. In the community. Talk to your community health worker and your husband and other family members about it. This may mean a little effort for you but could be even more *difficult and expensive for you* if the child gets any of these diseases.

Fathers of children 0-5 years

- *Benefits of immunisation:* Ensuring your child is fully vaccinated will *protect him/her from many life-threatening diseases,* such as measles and diphtheria. If you do not do so, the child could get these diseases which will mean more *effort and cost* in taking the child for treatment.
- *Knowledge:* Read the information provided by the heath care worker or available at https://rw.goodinternet.org/ on your mobile phone, *without paying any data charges*, to know how many times your child should be taken for immunisation in the first two years from birth, and ensure they are *given in time* so that your child in protected from all those diseases.
- *Vaccine safety:* Vaccines are effective and *safe and guaranteed by the government*. If you have questions, please talk to the health worker about it or look at the information on https://rw.goodinternet.org/ *free of cost*
- *Side effects:* Some vaccines can cause mild side effects like fever for a few days. It is *nothing to worry about*. Ask your local health centre/health care worker for some medicine/paracetamol so that you can manage that.
- *Children with disabilities:* All children, including those with disabilities should be vaccinated so that they are protected from several serious diseases, like measles and diphtheria, and do not spread them to you, your family, and others in the community. This may mean a little effort for you but could be even more *difficult and expensive* for you if the child gets any of these diseases.
- *Responsibility of fathers:* The health of your child is not "women's work". It is *your responsibility* too. Your wife may *need your help* in taking your child for immunisation and m find it difficult without your support.

Community health workers (CHWs) and healthcare providers at health centres

- *Knowledge:* To supplement the knowledge you receive in trainings, there are resources available for you to refresh your knowledge at https://rw.goodinternet.org/. There is no data charge to access this site. Read the resources there to *keep yourself updated* so that you can answer any questions the community members may have and gain their *respect*.
- *Attitude towards caregivers:* Mothers and fathers who bring their children for vaccination are naturally anxious about their children getting vaccinated and its side effects. Even though you are busy during vaccination sessions, as the *knowledgeable person* you are able to reassure them and tell them what to do if a child gets fever. That is an important part of your job.
- *Motivation:* You are providing a very *valuable service* to the community and the country and saving lives of so many children by ensuring they are fully vaccinated. Your hard work is very *much appreciated*. Engage religious and community leaders and other community members to promote immunisation in their communities.
- *Right to quality services*: It is the *right of every person and child*, including those from marginalized groups, who comes to the health centre to receive quality service and of every child to be fully immunized, including children with disabilities.

Grandmothers, Grandfathers, other older family members.

- *Knowledge/risk:* If your grandchild is fully vaccinated, s/he will be *protected from many life threatening diseases*, such as measles and diphtheria. While some of these vaccines may not have been there when you were young, we are fortunate that today children can be protected from these diseases. The community health worker and the health workers at the health centre will tell you where and when to take your child for immunisation, and how many times they need to be taken for vaccination in the first two years from birth.
- *Vaccine safety:* Some people may question the efficacy of vaccines and their safety, and say other things about them, but all vaccines have been *tested and are safe*. This is *guaranteed by the Government of Rwanda*. So, don't worry about your grandchild's health after being vaccinated.

- *Side effects:* Some vaccines could cause minor side effects, like fever, for a few days. This is nothing to worry about and *easily treated* with medicines given by the healthcare worker.
- *Children with disabilities:* If there are children with disabilities in your family, they need to be *protected from these life-threatening disease*s as well, otherwise *their lives and that of others in the family* are at risk.
- *Family/husband's support:* Your daughter/daughter-in-law *needs your and her husband's support* to ensure your grandchild is fully vaccinated and *protected from life threatening diseases*. Encourage your son/son-in-law to help her take the child for immunisation as she may find it difficult on her own and to help her manage other household tasks so that she can take the child for immunisation.

Religious/community leaders

- *Knowledge/risk:* Vaccines *protect children in your community from life threatening diseases*. If all children are not fully vaccinated, they are at risk of getting these diseases and spreading them to others. You can get more information about vaccines from the healthcare worker or on your mobile phone from https://rw.goodinternet.org/, without data charges, such as where and when caregivers should take their children for immunisation, and how many times the child should be taken for immunisation in the first two years after birth. Spread this information in your community and encourage parents to take their children for immunisation.
- *Vaccine safety:* All vaccines have been *tested by the government and are safe and effective*. There could be some myths and rumours about them, but these are not true. Thousands of children in Rwanda have already been vaccinated and are fine. You should reassure parents in your community about this.
- *Side effects:* Some vaccines may cause fever for a couple of days. This is nothing to worry about and can *easily be managed* with medicine/paracetamol given by the health worker.
- *Role:* You are a *person of great influence in your community*. *People listen to you*. So it is also your responsibility to use that influence to encourage parents, including fathers who may think it is the mother's responsibility, to take their children for all the immunisations. The health of the children is the responsibility of both the mother and the father. Discuss this in *religious sermons and at other church and community gatherings and events*.
- *Children with disabilities:* Some parents hide children with disabilities and do not take them for immunisation as they fear social stigma. These children are at *risk of contracting life-threatening diseases and spreading them to others* they encounter. You have an important role in encouraging and reassuring parents to ensure that their children with disabilities are fully vaccinated.

5. COMMNUNICATION CHANNELS

Channel Analysis

Available channels of communication in Rwanda and their suitability for communication with the identified participant groups on immunisation, are analysed below.

Desk Review

According to the KAPB study, the most preferred channel of communication for caregivers is *interpersonal communication.* This takes place through community health workers and health workers at the health facility. They represent a vital channel of communication with caregivers and the community. However, they may need capacity building in interpersonal communication, counselling, and community engagement. Community events or *Umuganda* were the next most preferred channel, according to the study. This was followed by *radio and mobile phones.* The Comprehensive Multi-Year Plan (cMYP) for Vaccine Preventable Diseases Program 2017-21 for Rwanda, also mentions *public and private radios, announcements on radio and in churches, newspapers and print materials like brochures, posters, leaflets*, which have been/were proposed to be used for communication with

caregivers and others on immunisation. The use of *social media* has also been suggested by the KAPB strategy, to address myths and rumours.

Mass media

According to the Rwanda Demographic and Health Survey 2014-15, *radio is the most widespread and frequently used communication channel in Rwanda, with more than half the population (55 per cent) owning a radio*. Radio programmes are also listened to on mobile phones, which are owned by 60 per cent of the population. On average, 79 per cent of men and 62 per cent of women listen to radio at least once a week. There have been several popular programmes on radio, including talk shows, serial dramas such as Urunana and Umuhoza. Urunana is a radio drama on safe pregnancy, which has been broadcast on BBC and Radio Rwanda for 20 years and has been effective in increasing knowledge and improving safe pregnancy practices, including partners accompanying expectant mothers for antenatal checks. Radio spots on health issues have also been broadcast on radio.

Access to television is limited (10 per cent), but *29 per cent of men and 16 per cent of women say they watch TV at least once a week*. This indicates that there is a high level of community TV viewing, which is bound to increase with the country's rapid electrification. Mass media can be used for *entertainment education*, as indicated above, through engaging, interactive soap operas. Such approaches encourage *dialogue and reflection* among the viewers/listeners and *create credibility and sustain interest* in discussion on health issues, which otherwise may not be of much interest to community members, and ultimately leads to behaviour change. This can also be a powerful way to *change social and gender norms*, which act as barriers to immunisation and to create more positive ones, by role modelling *'positive deviants'* as characters.

Mobile phones

As mentioned earlier, 60 per cent of the population in Rwanda owned a mobile phone, according to the 2014-15 RDHS. Although this would be higher in urban areas, by now this would be much higher. SMS has been used in several African countries to communicate on health issues. In Rwanda it has been used to *monitor maternal and child health*. Reports are sent by CHWs to the health facility and information replicated by a central server is accessed by health providers and decision makers at the ministerial level, which fosters accountability in health services. SMS can also be used to remind community health workers about upcoming immunisation sessions and as a reminder medium for caregivers on when their child's vaccinations are due. However, it should be borne in mind that SMS needs to be paid for and could be expensive, unless it is possible to negotiate agreements with the service providers.

SMS can be used to disseminate information on immunisation and obtain feedback. *U-Report* is a programme to *engage and interact with young people* who enrol in the programme, called U-Reporters, on a variety of issues that are of interest and relevance to them, such as discrimination and child marriage. It is currently being implemented in 68 countries around the world, including many in Africa. In many countries, including in Africa, it has been very successful and has generated many U-Reporters, who provide *valuable inputs and feedback for programmes and also ensure social accountability*. If there are a significant number of U-Reporters in Rwanda, this is a potential communication channel for immunisation and can also be used to *obtain feedback on any problems that may exist on the ground, including those related to access and myths and rumours*. U-Report is now available as a *chatbot* which has been successfully used in many countries to disseminate accurate information on the COVID-19 pandemic and answer queries. *ICT platforms using voice messaging or call-in services* can create interactive opportunities where people can use their own basic mobile phones to proactively retrieve information in the *local language*. Such interactive form of messaging allows people to make decisions regarding their health and other topics. The call-in service can cover several topics including health, gender, child protection etc. In a *series of "listen, then choose" steps, callers can use their phones to select from among hundreds of recorded voice messages*. These can include immunisation.

Internet of Good things

The Internet of Good Things (IoGT) is a *mobile-ready website* that enables access to educational and lifesaving information. IOGT is available for *free, without data charges,* for the Airtel subscribes in Rwanda at https://rw.goodinternet.org/. However, it should be borne I mind that Airtel may not the primary mobile phone service provider in Rwanda, which appears to be MTN.

IOGT's users include *frontline workers, educators, parents, caregivers, youths, and adolescents*. The IoGT site is managed by the UNICEF Country Office in Rwanda and contains *localised content in English and Kinyarwanda*. This includes content on *maternal health, ECD, immunisation, parenting, hygiene, emergency information on diseases, HIV and sexual health advice for adolescents, and internet safety*. In response to COVID-19, IoGT content now includes information on how to prevent and identify symptoms of *COVID-19*, clinical guidelines for frontline health workers, and support for mitigating the secondary impacts of COVID-19, including Gender Based Violence (GBV) resources, anti-stigma messaging, and positive parenting strategies.

By connecting to the Internet of Good Things, children, adolescents, mothers, fathers, other family members, health trainers, caregivers and communities can gain access to *localised, updated, quality content at their point of care and directly on their mobile phone at any time*.

In addition, IOGT offers the following features:

Provision of Professional Resources: IoGT can be used to enable *free access to digital versions of training materials, clinical guidelines,* education benchmarks and curriculum tools for teachers, *health care workers, faith leaders, traditional leaders, and community agents of behaviour change*. It can also include *streaming video and PDF downloads.*

Job Aids hosted on IoGT can assist frontline workers, teachers and other stakeholders with quick references to guide both their work and to refer patients, students and the public to resources and services.

Polls and Surveys available on IoGT can be used to capture *knowledge and attitudes among frontline workers and teachers, community members and public at large* to better inform content development and training.

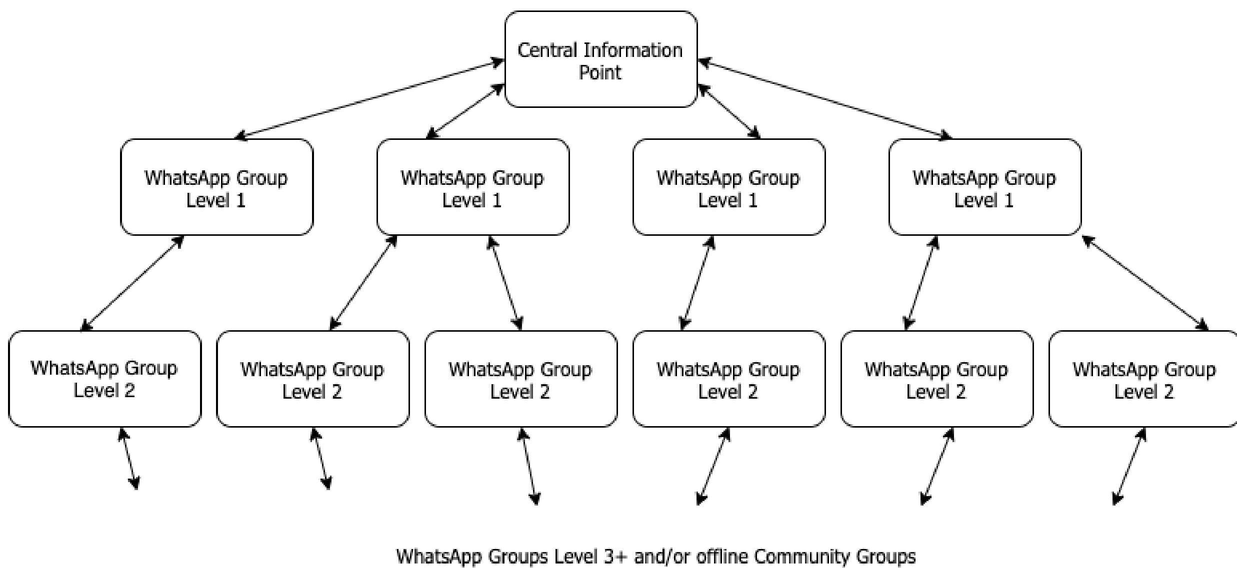
IoGT therefore represents a useful potential channel of communication with CHWs, health service providers at health facilities, caregivers with mobile phones, religious and community leaders and others.

WhatsApp Trees

Globally, messaging Apps like WhatsApp have proven useful in supporting the *cascaded information flow to and from UNICEF and partners via established groups* – these are often called "WhatsApp Trees". These trees build on traditional 'communication tree models' which were designed to speed up the delivery of information through phone calls from one central point via community members. This tool can be useful in fulfilling UNICEF's commitment to *Accountability to Affected People (AAP)*, including the principles of participation and inclusion; communication and transparency; feedback and response; and organisational learning and adaptation. If appropriately adopted and correctly established, "WhatsApp Trees" can provide support across these four commitments.

A "WhatsApp Tree" aims to cascade information from and to a centralized point (one) to several groups (many) to dispersed users (even more).

Figure 4: WhatsApp Tree



Developing and sharing information: "WhatsApp trees" can enable *UNICEF and partners to share text-based information, images, audio, and video.* Low/no-text content may be preferable for specific groups with lower literacy levels and audio/visual content may be more accessible for persons with disabilities. Conducting an information and communications needs assessment will help in identifying the preferred content type across the diversity of a community. Although it is entirely possible to share audio, video, and image, it is important to understand if there are barriers to accessing this content. Individuals may be unwilling or unable to access certain multimedia content due to *data consumption and cost implications*. Such communication tools would be particularly useful during *outbreaks, addressing myths and misinformation, information about new vaccine introductions and the benefits of immunisation.*

Building trust and triangulating information: When sharing content, it is important to ensure that the *information shared states the source* (i.e. from UNICEF Rwanda) and can be triangulated against other channels to help build trust. For example**,** sharing consistent information across the WhatsApp Trees, the Internet of Good Things (https://rw.goodinternet.org/) and cross referencing with www.unicef.org/rwanda/. Ensuring consistency with information being shared offline is also important.

Social media

Other social media, such as *Facebook, Instagram, Twitter* and other social media channels should also be used, particularly to reach *young people*, among whom usage of these platforms would be higher, *service providers, administrators and policy makers for advocacy* on ensuring easy, affordable access to immunisation. All social media can be a useful channel to *share stories of role models/'positive deviants'*, particularly of men who have been actively engaged in their children's health and development, including immunisation, to *create new social norms* around father's involvement in bringing up their children.

Theatre for development

Theatre for development is a live entertainment education format that can be a very *powerful medium to engage communities* and has been found to be very effective in many countries, to *stimulate and engage communities* in a *facilitated dialogue* on a particular issue. This format can be used to complement entertainment education approaches on mass media, using trained street theatre actors or community members who have been trained for this purpose. They can also be engaged in *developing the storyline* in a participative way. Using *interactive*

methodologies, members of the audience can even be invited to act out a small part to take the storyline in the direction in which they feel appropriate, followed by a facilitated discussion.

Religious denominations and networks

According to the National SBC strategy for ending violence against children, *most Rwandans are religious*. According to the 2012 census, 44 per cent of the resident population of Rwanda are Catholics, followed by Protestants (38 per cent) and Adventists (12 per cent). Muslims represent 2 per cent of the resident population. *Religious leaders,* although independent from government, play an *important role* in forming and guiding social norms and individual behaviours. They also serve as an important *source of information, especially for the rural population*, where diversity of communication channels is limited. According to the Rwanda Audience Survey 2009, 72.8 percent of the population obtained information through the church channels. In the case of immunisation, as has been mentioned earlier, they are a key participant group, as it would be vital to make them positive spokespersons of immunisation, rather than be the source of misinformation. There are also community groups which are part of church activities, such as *mothers' union groups*, which *bring together 20 mothers in a faith-based group.* This would be a useful channel of communication for immunisation.

Cultural events and word of mouth

Rwanda has a rich tradition of *religious culture and music*. Experience from other African countries indicates that for health promotion messages to be successful, they must *resonate with local popular culture*. *Traditional songs, dances, storytelling, poems, and proverbs* are popular channels of communication in Rwanda. Traditional proverbs have been successfully linked with health themes through radio shows and village theatre. Used strategically, word of mouth is the communication channel most likely to reach individuals, families and communities at *community gatherings, administrative and religious meetings etc., through one on one communication, such as peer to peer counselling in school clubs or community networks etc.* The *culture of reading* is spreading throughout Rwanda, even in the rural areas mainly through literacy interventions. Decentralised structures are well organised and information networks are being developed.

Community based forums

In addition to mass media, Rwanda also has several community-based forums which can be used for communicating with community members on immunisation, as well as other issues:

Umugoroba w'Ababyeyi (Parent's gathering)

This is a *village gathering which brings together parents, both men and women*. Young men and women who do not have children are sometimes invited to join the gathering, and occasionally children, if subjects of relevance to them are being discussed. According to the strategy document of the programme, it aims to provide a platform where *parents can discuss and address their socio-economic concerns for sustainable development*. It has been successful in resolving family issues, improving health and nutrition, and reducing domestic violence. Village Committees of the National Women's Council (NWC) in collaboration with the Women's Executive Committees are responsible for overseeing Umugoroba w'Ababyeyi's activities. The National Women's Council highlights the achievements of this forum in its quarterly report submitted to the Ministry of Gender and Family Promotion (MIGEPROF).

Umuganda (Community work)

The word Umuganda can be translated as 'coming together for a common purpose to achieve an outcome'. In traditional Rwandan culture, members of the community would call upon their families, friends, and neighbours to help them complete a difficult task. As part of the effort to reconstruct Rwanda and nurture a national identity, the government drew on traditional practices to enrich and adapt development programmes to the country's need and context. The result is a set of home-grown solutions – culturally owned practices translated into

sustainable development programmes. One of these solutions is Umuganda. Modern day Umuganda can be described as a *community service (umunsi w'umuganda)*. *On the last Saturday of each month Rwandans 18-65 years old come together for three hours in the morning to do a variety of public works*. This often includes infrastructure development and environmental protection. Participation in Umuganda is usually supervised by a manager or *Umudugudu chairperson* who oversees the effectiveness and efficiency of community participation. This can be an effective communication channel for health issues, including immunisation.

Inshuti z'Umuryango

Intrinsic to Rwandan culture is the belief that *children belong not only to the biological parents but also to the extended family and community.* This promotes the positive value of 'treating every child as your own'. *Two people, one man and one woman, are selected in each village to prevent and respond to violence, abuse, exploitation, neglect, abandonment, and other child protection risks in their village.* Although the focus of this programme is on child protection, it could also be used as a mechanism to promote and follow up on immunisation. This informal cadre was established in 2015 by the National Children's Council NCC (now the NCDA) and is an integral part of the child protection system in Rwanda. It works together with professional social workers and psychologists at district level. Their main responsibilities are to *conduct home visits, identify any concerns regarding child protection, make referrals to professionals and other service providers and sensitise households on positive parenting and child friendly practices.*

They report to local and authorities and professional social workers and psychologists in districts and work with other sectors, including community health workers and ECD caregivers to ensure that children and families receive holistic services. Immunisation is also one of these services, and therefore the Inshuti z'Umuryango could help in *coordinating outreach sessions and ensuring that caregivers are able to take their children for immunisation*. This would entail some *training of these IZUs and other community groups* so that they can effectively perform this role.

Mother care groups

Mother care groups are groups of women from the community. *Each group looks after 10-15 families with children under five years or pregnant women and make periodic home visits under the leadership of the village CHW.* They would be another useful channel of communication for immunisation and helping mothers overcome vaccine hesitancy and other barriers. They would also need some *training in motivating caregivers* to ensure their children are fully immunised and in addressing myths and rumours.

Institutional platforms

ECD Centres

In ECD Centres parents of children 0-6 years are engaged on issues of early childhood development, including health and development. This would include immunisation.

Youth friendly centres

Health education is provided to young people at *youth resource centres*, which offer young people the opportunity to participate in *sports, cultural dance, and other fun activities*. This channel offers an opportunity for discussion between boys and girls and their parents about healthy behaviours based on informed choices. In collaboration with the National Youth Council this channel can be used for messages on immunisation as well.

Itorero (National Itorero Commission)

This is a Rwandan civic education institution which aims to teach all Rwandese to maintain their traditional culture through their *values of national unity, social solidarity, patriotism, integrity, bravery, tolerance, the dos and don'ts of society etc.* Through this platform, Rwandans are also *informed of government policies* and programmes, which

strengthens community ownership and promotes their role in implementing these social-economic development programmes. Civic education is organised by the 'Iterero ry Iguhugu' institution under the National Itorero Commission. This forum could also be used to communicate the benefits of immunisation to caregivers. There is apparently also a radio drama on Itorero that is being broadcast.

Private sector

The private sector in Rwanda in *growing rapidly*. The private sector *employs many people, and the workforce is mostly young, including many young parents* with whom it could be possible to communicate on immunisation and motivate them to ensure that their children and those of others they know are fully immunised. The *management and owners of the companies* would also be key stakeholders to be co-opted into the strategy for immunisation. MIGEPROF, in partnership with UNICEF, in advancing its partnership with the private sector to advance child rights, brought the *Child Rights and Business Principles (CRBP)* initiative. Capacity building interventions will be carried out to raise awareness of CRBP, targeting business sectors which affect the lives of women and children, including the *tea sector, the ICT sector and leisure and tourism*, and messages on immunisation can be incorporated into this Potential partnerships with the private sector, could also lead to *domestic opportunities for resource mobilisation* to reduce the dependence on foreign funding for the immunisation programme, including implementation of the SBC strategy.

Proposed Communication channels

Based on this communication channel analysis, the proposed channels for each participant group, the issues/messages to be communicated to each one and the materials to be developed are summarised in the table below:

Table 2: Proposed Communication Channels by Participant Group

Participant Group	Communication Channels	Issues/Messages to be communicated	Materials to be developed
Female caregivers of children 0-5 years old	Television, radio – spots and entertainment education content	• Benefits of immunisation • Risks of not immunising children • Where and when to take children for vaccination • How many times to take their children for immunisation before the age of two years. • Address myths, rumours, misinformation • Where to get reliable information on immunisation • Counsel to expect and manage side effects • Increase self-efficacy to discuss immunisation with husbands to get their support and take children for timely immunisation	TV, radio spots; TV, radio content – soap operas role modelling 'positive deviants', interactive talk/discussion shows, phone-in programmes, magazine format shows, through training and co-creation workshops for TV, radio content developers
	Mobile phones – SMS if partnerships can be negotiated with mobile service providers, IoGT, WhatsApp trees, other social media platforms (facebook, twitter, Instagram etc.)		SMS messages, updated content on IOGT and other social media
	IPC through CHWs, healthcare workers at health facilities		Flip chart, leaflets to take away, short film to show at health centres if possible
	Umuganda, Umugoroba w'Ababyeyi (Parent's gathering), Inshuti z'Umuryango		Banners, songs about immunisation, audio messages to played over a public announcement system

	Community theatre, songs, dance, proverbs; local festivals and events		Scripts for plays, songs, stall at community events with banners and print materials
	Mother care groups, Mother's groups/unions		Training/orientation on immunisation, leaflets
	Church networks, religious leaders		Talking points with references to religious texts
	ECD centres		Posters, leaflets, flip chart
Fathers of children 0-5 years	TV, radio	• Benefits of immunisation • Risks of not immunizing children • Where and when to take children for vaccination • Where to get reliable information on immunisation • How many times to take their children for immunisation before the age of two years. • Address myths, rumours, misinformation • Counsel to expect and manage side effects • Emphasize role of fathers in their children's health and motivate to take children for timely immunisation/support their partners to do so.	Same as above, include content on role and responsibilities of fathers
	Mobile phones – SMS if partnerships can be negotiated with mobile service providers, IoGT, WhatsApp trees, other social media platforms (Facebook, twitter, Instagram etc.)		Same as above, include content on role and responsibilities of fathers
	IPC through CHWs, healthcare providers at health facilities		Same as above, include content on role and responsibilities of fathers
	Umuganda, Umugoroba w'Ababyeyi (Parent's gathering), Inshuti z'Umuryango		Same as above, include content on role and responsibilities of fathers
	Community theatre, songs, dance, proverbs, local festivals and events		Same as above, include content on role and responsibilities of fathers
	Men's community groups, clubs		Talking points, job aides for facilitators/leaders on responsibilities of fathers
	Church networks, religious leaders		Same as above, include content on role and responsibilities of fathers

	ECD centres		Same as above, include content on role and responsibilities of fathers
CHWs, health workers at health centres	Training sessions	• Comprehensive and up-to-date knowledge on all aspects of immunisation so that they can speak authoritatively and with confidence to caregivers and communities. • Need to improve interpersonal communication skills • Need to counsel and reassure parents and families about the efficacy and safety of vaccines, as well as side effects and how to manage them • Inculcate service orientation • Need for community engagement, including women and those from marginalized groups and in microplanning to identify missed children • Emphasis role of fathers in their children's immunisation. • Social recognition to motivate health workers to organize community engagement sessions on immunisation in the community, and ensure all children in their community are immunized	Training manual on IPC skills/counselling to be included in regular trainings if special training not possible. Training to be interactive and human centred; job aids for IPC and counselling of caregivers
	Meetings		Presentation, talking points for supervisors
	TV. radio		Same as above. Include role modelling of health workers to motivate
	Mobile phones - SMS, IOGT, WhatsApp trees, other social media platforms (Facebook, Instagram, twitter etc.)		Specific updated content for healthcare providers – refresher knowledge, IPC/counselling tips, digital versions of training materials, clinical guidelines on management of AEFIs and outbreaks. Database of CHWs and healthcare providers at health centres
Mothers-in-law, mothers, fathers-in-law, fathers, other older family members, neighbours, other community members	TV, radio	• Benefits of immunisation • Risk of not immunizing • Safety and efficacy of vaccines • How many times to take their children for immunisation before the age of two years. • Date, time and place of immunisation sessions being held	Same as above, include need for family support
	Umuganda		Same as above, include need for family and community support, particularly to manage competing

		• Where to get reliable information on immunisation. • Address myths, rumours, misinformation • Counsel to expect and manage side effects • Support caregivers to take children for timely immunisation, help with competing priorities. • Emphasize role and responsibility of fathers in their children's immunisation and health.	priorities of caregivers
	Community theatre, stories, songs, dance, proverbs, local festivals and events		Same as above, include need for family and community support
	Religious leaders/church groups/networks		Same as above, include need for family and community support
	Mobile phones - SMS, IoGT, WhatsApp trees, other social media platforms (Facebook, Instagram, twitter etc.)		Same as above, include need for family support
Religious and community leaders	Gatherings/meetings of religious leaders, Associations of religious leaders/denominations, such as the Rwanda Interfaith Council for Health	• Benefits of immunisation/risks of not immunizing • How many times to take their children for immunisation before the age of two years. • Date, time, and place of immunisation sessions being held • Where to get reliable information on immunisation • Safety and efficacy of vaccines and how to manage AEFI/side effects • Role in motivating all families, particularly those from vulnerable groups, to immunize all their children, including those with disabilities, addressing myths/misinformation/rumours • Motivate to include immunisation in sermons at other fora, such as religious gatherings and events	Presentation, short film, Job aids/talking points/leaflets with content relating to religious texts
	Individual /group meetings		Job aids/talking points with reference to religious texts
	TV, radio		Same as above, include role of religious leaders
	Mobile phones - SMS, IoGT, WhatsApp trees, other social media platforms (Facebook, Instagram, twitter etc.)		Same as above, include role of religious leaders
	Training/orientation sessions		Training manual/module
National, provincial, district administration, policy makers, private sector	Meetings, workshops	• Ensure equitable access to immunisation services through additional health centres in hard to reach areas, more outreach sessions in specific	Presentations, print materials - policy briefs, leaflets, brochures
	Mobile phones - SMS, IOGT, WhatsApp trees, other social media		Same as above

	platforms (Facebook, Instagram, twitter etc.)	areas, flexible timings in urban areas • Emphasize need to engage fathers and address myths and misinformation • Emphasize need for microplanning and engaging marginalized groups and women in the process • Mobilize religious and community leaders to advocate for immunisation in their communities • Ensure adequate budget for SBC strategy implementation	
	TV, radio		Same as above
Media and influencers	Workshops, one on one discussions	• Benefits of immunisation/risks of not immunizing • How many times to take children for immunisation before the age of two years. • Date, time and place of immunisation sessions being held • Where to get reliable information on immunisation • Safety and efficacy of vaccines • Side effects of some vaccines and how to manage them. • Emphasize need to engage fathers • Address myths and misinformation • Motivate to carry positive stories and not sensationalise cases of AEFI.	Presentations, Media pack, short film

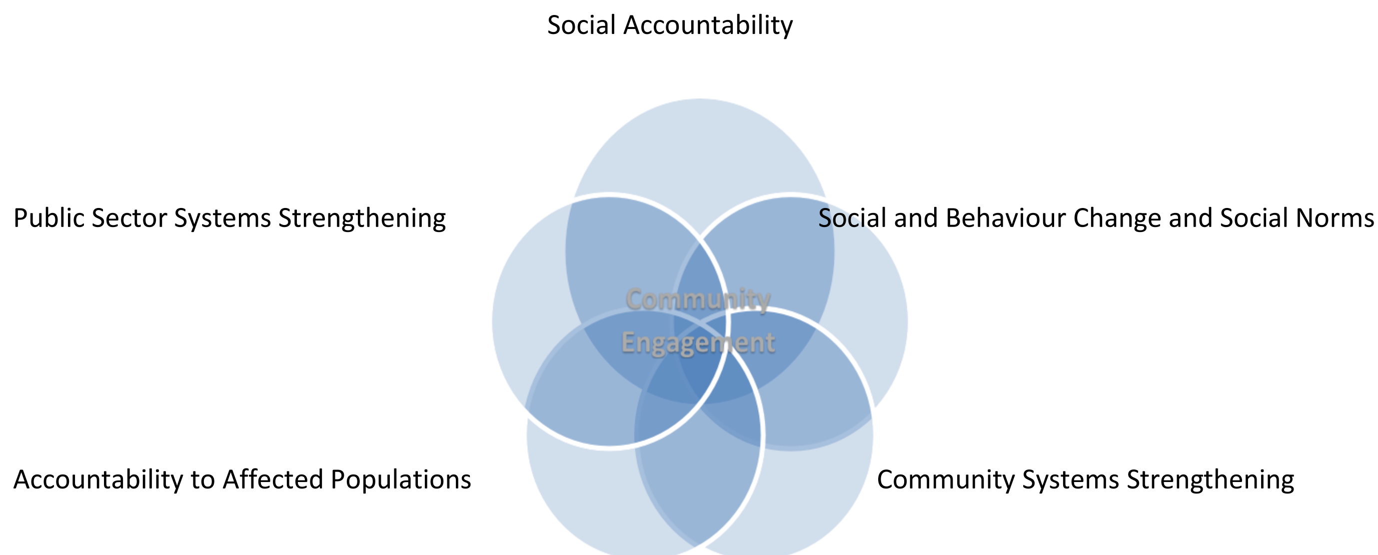
6. COMMUNITY ENGAGEMENT

Community Engagement is a key strategy for engaging communities on an issue of concern to them and bring about behaviour and social change with community ownership. It is a strategy for working with traditional, community, civil society, government, and opinion groups and leaders; and *expanding collective or group roles* in addressing the issues that affect their lives. Community engagement *empowers social groups* and social networks, *builds upon local strengths and capacities*, and improves local participation, *ownership, adaptation, and communication*.

Minimum Quality Standards and Indicators for Community Engagement were developed by UNICEF Communication for Development (C4D) HQ in 2019. The purpose of these is to *establish a common language* among all stakeholders for defining *community engagement principles, key actions, goals, and benchmarks*. They provide guidance for gender-sensitive community engagement in development and humanitarian contexts, across all sectors. These standards support direct implementation of community engagement by establishing the *principles and parameters* for communities to plan, take action and be heard in all matters affecting them. They are meant to serve as a guide for stakeholders in establishing an *enabling environment* for robust community engagement practice. The standards do not presuppose that community engagement requires external interventions, nor that specific or prescribed community engagement approaches are always optimal in all contexts. The standards reflect a consensus on the growing recognition of *the social determinants of development* and the importance of community-level action, leadership, and ownership in all aspects of policy, research, and practice.

Community engagement sits at the intersection of five global objectives: *public sector systems strengthening; accountability to affected populations (AAP); social accountability; social and behavioural change & social norms; and community systems strengthening*. The figure below illustrates the intersectional nature of community engagement practice.

Figure 5: Inter-sectoral Nature of Community Engagement



A summary of the Minimum quality standards for community engagement is given in the table below:

Table 3: Summary of Minimum Standards for Community Engagement[1]

Part A: Core Community Engagement Standards
1. Participation
2. Empowerment and Ownership
3. Inclusion
4. Two-way Communication
5. Adaptability and Localisation
6. Building on Local Capacity

Part B: Standards Supporting Implementation
7. Informed Design
8. Planning and Preparation
9. Managing Activities
10. Monitoring, Evaluation, and Learning

Part C: Standards Supporting Coordination and Integration
11. Government Leadership
12. Partner Coordination
13. Integration

A brief description of each of these standards is given in the table below:

Table 4: Description of Minimum Standards for Community Engagement

Part A: Core Community Engagement Standards	Description
1. Participation	*Communities assess their own needs and participate* in the analysis, planning, design, implementation, monitoring and evaluation of governance, development, and humanitarian initiatives. Community views and needs are given due weight in all aspects of policy, planning, research, and practice.
2. Empowerment and Ownership	Communities have opportunities to *own and feel empowered* by community engagement processes. Empowerment is both a process and an outcome of community engagement and participatory practice.
3. Inclusion	Community members and groups that are *under-represented, disadvantaged, vulnerable, and marginalised* are identified, supported, and ensured of a role and a voice in all aspects of community engagement. This includes discriminated, deprived, and disadvantaged groups such as poor households, persons with disabilities, adolescents and youth, the elderly, children, ethnic and linguistic minorities, indigenous communities, religious minorities, LGBTI community members, women, and. Safety considerations should be taken into account in implementation of this standard.

[1]Minimum Quality Standards and Indicators for Community engagement, C4D NYHQ, 2019

4. Two-way communication	Communities give and receive clear, appropriate and accurate information through *two-way communication* pathways on a regular and predictable basis in order to ensure access to information and participation
5. Adaptability and Localization	Community engagement approaches are developed based on *local contexts*. They are able to be flexible and responsive to local populations' needs, conditions, and concerns. Adaptable and localized community engagement approaches ensure that community engagement processes are able to adapt to new circumstances, deal with sudden or anticipated changes, and respond to uncertainty.
6. Building on Local Capacity	Community engagement should *build on the existing skills and resources* of communities and the local groups and organizations that serve them.
Part B: Standards Supporting Implementation	**Description**
7. Informed Design	Informed design is a project design approach that ensures that community engagement initiatives are *contextually appropriate.* It is comprised of contextual analysis, alignment with international standards and principles, and results in the capacity to be responsive to information gained during consultation with communities and governments.
8. Planning and Preparation	*Planning and preparation are undertaken collaboratively with communities* in advance of implementation activities. This includes initial engagement with communities, partner identification, and participatory assessment. It involves the direct participation of community members in identifying *key community groups, individual leaders and potential leaders,* determining community priorities, and appropriate mechanisms for resolving issues.
9. Managing Activities	Managing activities involves *community participatory approaches* that focus on reaching agreement on *activities, resources required, roles and responsibilities*, and establishing a timeline for implementation. It encompasses providing *capacity, training, and the execution of planned activities* in collaboration with communities. Additionally, it is associated with the *mobilization of networks*, communications, systems, and feedback mechanisms identified through informed design and participatory planning efforts.
10. Monitoring, Evaluation and Learning	Monitoring, evaluation and learning processes involve communities in designing monitoring and evaluation frameworks, *identifying indicators, undertaking data collection, analysis, and validation of findings*. The data collected during monitoring and evaluation *belongs to local and communities* first and foremost, as well as national and local governments.

Part C: Standards Supporting Coordination and Integration	**Description**
11. Government Leadership	Implementing agencies recognize that *national governments have the primary responsibility* to respect, fulfil, and protect the rights of the population. Governments can facilitate processes through which community engagement efforts are *coordinated and integrated* with relevant government agencies, and work in a manner that is consistent with national policies and strategies. Government should develop policy and advance mechanisms for coordinating community engagement activities.
12. Partner Coordination	Partners utilizng community engagement approaches should *coordinate their activities with other response partners and coordination structures*. In the absence of government policy or strategy specifically guiding engagement with communities, work to ensure intra-agency coordination to increase quality, accountability, harmonization, and optimization. Partners should take appropriate steps to conduct *risk analysis and risk mitigation* to ensure that coordination efforts do not result in risk to safety, discrimination, or targeting of vulnerable populations by government or other actors.
13. Integration	Community engagement should be *integrated and harmonized* within the development and humanitarian architecture in any given context. At programmatic level, community engagement should be *mainstreamed across all sectors* to ensure participation and to improve effectiveness.

Steps in community engagement

The key to community engagement is bringing community members together with technical specialists, partners, local leadership, and social networks to work collectively on priority areas chosen by the community. *Health care workers and other field workers will need to facilitate an inclusive and transparent process* so that all these diverse actors can participate fully, and all opinions are heard before the community takes decisions about a development plan. Health care workers and other field workers should *facilitate meetings of community members and selected leaders,* while they learn to assess, problem-solve, plan and act collectively. The steps to implement this process are described below:

Figure 6: Steps in Community Engagement[2]

Step 1: Start-up Meetings

Initial start-up meetings with local leaders (it will take *more than one meeting*) are important to discuss the issue of immunisation and any other issues that may be included, introduce the community engagement approach, build trust, and clarify objectives, methods and expected outcomes. These meetings should also devote time for community health workers and other field workers, supervisors and local administration to *listen to the community* describe its past experiences with immunisation and other development programmes (which shape their expectations), and to learn how leaders and members of the community could participate. Community leaders have probably had many such meetings with representatives of government and other development organisations, so initial contact with listening and exchanging information is important to customise methodology and to clarify expectations of costs, benefits and outcomes.

Step 2: Community led Assessment

The next step in community engagement is to *coordinate and help affected community members lead assessments* in their neighbourhood. Following the initial start-up meetings, community members would have already identified which local conditions are of *priority concern*. While working with the community focal point(s) and the implementing partner, a decision needs to be made as to *how to organise the assessment*. Field workers could assemble selected community members and appropriate technical specialists to participate in the assessment.

It must be ensured that assessment is objective and transparent, so that community members expose weaknesses and gaps as well as strengths and what is working well. Participation in this kind of *assessment increases local knowledge* and begins the process of *building trust* among community members. It is also important to identify any *marginalised groups, families or individuals* that face special constraints or have been ignored in the immunisation related activities, including those living in hard to reach areas and those with children with

[2] Community Engagement Field Manual for use by Frontline Workers in Lebanon

disabilities. Community health workers and other field level workers need to find ways to *include and support their participation* so that they are equally active as other community members in the assessment activity. Only through active involvement will their views have any impact in planning and decision-making. Groups of people who are often left out of the process are *women, youth, the elderly, those with disabilities and members of different religious groups.*

Step 3: Identifying problems and problem sorting

This step entails reviewing the results of the assessment in a community meeting and discussing the strengths, weaknesses opportunities and threats *(SWOT)* are acting as *barriers and enablers* to the entire community immunising their children. To better understand reasons for barriers to complete immunisation, the group should discuss the *root causes* of deficiencies so that appropriate activities are targeted at the cause. This could be undertaken through a root cause analysis of *immediate causes, underlying causes, and root causes.*

Step 4: Action Planning

In a community meeting the group should identify what *barriers* they will address, what *activities* they will implement, who will be *responsible* for each activity, what *resources* are necessary to implement the activity, who will *access* these resources, what are *outcome indicators*, and the *time line*. While discussing resources, it should be kept in mind that besides financial resources, many *material resources* can be found locally to help with the community's projects. These could be venues for meetings/outreach sessions, transport vehicles etc. or community members who could be *potential partners* for the activity, such as those who have the required knowledge, access to appropriate authorities, required materials, service providers of other programmes (for example, education, WASH) who could be useful to the process. Success in finding these kinds of resources is an important beginning to the engagement process.

Ideally, the Action Plan should be limited to just a few *activities.* Not all problems can be solved at once and groups often stop participating if they don't see progress or success. The community focal point or group rapporteur should share the *group Action Plan* with other community groups, leadership and immunisation officers through the communication channels chosen by the group.

Step 5: Implementation and Monitoring

Implementation

When the various community groups have decided on the activities to implement, when partners have agreed to participate, and when responsibilities and resources have been identified and recorded in the Action Plan, implementation begins. During the months that follow, the role of the *community health worker* is to *facilitate and coordinate* the community's efforts to carry out the activities they have planned. This means *repeated meetings* of the community group to see if they have followed up with partners and community members about their commitments to the activity, checked that schedules of various actors are synchronised, verified the availability of supplies, worked on necessary forms and permissions critical to implementation and so on. The community health worker's role is more as a *facilitator*, using communication skills and information sharing to encourage community members to cooperate during implementation. The community health worker and/or a designated community member will be the liaison between implemented activities, partners, local leaders and immunisation officers. The aim is to keep them *informed and supportive* of the activities that community members have designed.

Step 6: Monitoring

- Monitoring is *measurements taken periodically during implementation* - sometimes weekly, monthly or each time a community group meets.

- What is measured by monitoring (monitoring indicators) focuses more on the *process* being followed and *immediate outcomes*. Evaluation focuses more on long term results, such as increase in immunisation levels.
- Monitoring provides a *'snapshot'* of the project's implementation, so the number of monitoring indicators should be *few and easy to collect.*
- Monitoring community-based projects should be *led by community members* themselves. With the help of the community health worker, they should design a *monitoring plan* that focuses on the specific activities of their group.
- The community group's *monitoring indicators and methods* should come from the activities listed in the Action Plan. The link between an activity and a monitoring indicator should be clear.
- Since monitoring indicators are measured easily by community members, the *data should also be easy to collect, compile and use*. A regular activity during implementation, then, is for community members to *review and discuss* monitoring results and modify ongoing activities according to the findings.

7. RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)

What is risk communication?

According to the WHO, risk communication is a *two-way and multi-directional communication and engagement process with affected populations*, so that they can take informed decisions to protect themselves and their families. Risk communication and Community engagement is an essential component of an outbreak management plan or a disaster a risk management and action plan, which includes the *prevention, preparedness, mitigation, and response phases*. This includes effectively engaging with the *public, communities, local partners, and other stakeholders* to help prepare and protect individuals, families and the public's health and welfare.

Key Steps in developing an RCCE Action Plan

The steps involved in developing an RCCE plan are similar to that involved in developing a community engagement plan described earlier, with a focus on identifying and mitigating risks of outbreaks and other humanitarian crises.

Step 1: Assess and collect

The first step is to collect existing information and conduct *rapid qualitative and/or quantitative assessments*, to learn about the communities: *knowledge, attitudes and perceptions* about the *risks faced by the community, most at risk populations, communication patterns and channels, language, religions, influencers, health services and situation.* Vulnerabilities and deprivations that render people at risk of disease outbreaks often overlap. Therefore, RCCE would be more efficient if it integrates relevant sectors. This would then be analysed by the team, so that they have a good understanding of the situation.

Step 2: Coordinate

The next step is to use existing *coordination mechanisms* or create new ones, to engage with RCCE counterparts in partner organisations at all levels of the response: *local, regional, and national*. These include health authorities, ministries, and agencies of other government sectors, international organisations (WHO, UNICEF, IFRC, other INGOs), NGOs, academia etc. An *up to date contact list of all partners and their focal points* should be developed and maintained. Regular contact with all partners will help *avoid duplication and identify possible gaps* in the RCCE response.

Step 3: Define

Define and prioritise key risk communication and community engagement objectives with the team and partners. This should be in relation to an early warning system which the community is part of and should lead to early actions to reduce outbreak risks by taking preventive action, ensuring adequate health infrastructure and supplies of medicines and other requirements. They should be *reviewed regularly* to ensure they are responding to local level priorities as the crisis evolves. Focus must be on the *most vulnerable and marginalised groups*, social assets, and facilities.

Step 4: identify key participants and influencers

These include policy makers, influential bloggers or other social media leaders, local leaders, women and youth groups, religious and elder's groups, local and international NGOs, health experts, volunteers and people who have been affected by the outbreak or at risk. Social media influencers are particularly important in getting information out fast in a simple manner and *addressing misinformation and rumours* about the outbreak. Inclusive participation of all social, gender, ethnic, livelihood and age groups should be ensured. Participants and influencers should be matched with

channels that reach them. The plan can be used to *strengthen social cohesion* through internal dialogue and joint/collective action by all community members and the local administration.

Step 5: Develop RCCE strategy

Based on the results of the qualitative analysis, the defined key objectives, and participants, an RCCE strategy should be developed that fits into the country's overall outbreak response strategy. It should be adapted to the local context i.e. focus on messages that are tailored to the national and local context, reflecting key participants' questions, perceptions, beliefs, and practices.

Define and prioritise *key objectives* with the team and partners in alignment with the overall objectives of the risk management plan. RCCE should include messages and actions which aim at promoting *risk prevention and mitigation as well as response*. They should be reviewed regularly with partners and team to ensure they are responding to evolving priorities. Work with the different technical groups of the response to ensure *alignment, coordination, and internal dialogue* between the RCCE leadership/field staff and other response teams.

Actions/activities should be defined and described that will contribute to achieving the RCCE objectives. Develop *messages and materials* to communicate messages and health communication steps and situation updates in line with the government's message guide. Messages and materials should be tailored to reflect participant perceptions and knowledge at the level to which the RCCE materials are targeted (national, regional, and local).

While defining the list of activities tailored to the country, simultaneously disseminate recommendations from the government. These sources provide *accurate information* that can mitigate concerns and promote preventive actions, even though they may need to be adapted to the local context. Create relevant *communication materials* tailored for and pre-tested with representatives of participants for whom they are intended. *Pre-testing messages and materials* with participant groups, ensures that messages are *context specific* and increases ownership of communities, at-risk people, and other stakeholders. As much as possible, communication materials should contain *actions that people can take* - an instruction to follow, a behaviour to adopt, information they can share with friends and family.

Step 6: Implement

Develop and implement the endorsed RCCE plan with relevant partners to engage with identified participant groups and communities. This should include *capacity building and integration of RCCE counterparts* from international, national, regional, local groups, ensuring participation and accountability mechanisms are defined together. Identify *human, material, and financial resource needs*. Define staff and partners who will do the work (number of people required in the team/organisations), and budget according to the resources. Ensure strong and regular supervision and coordination mechanisms. Close monitoring of fieldwork is essential, and mechanisms should be defined before starting implementation.

Set up and implement a *rumour tracking system* to closely watch misinformation and report to relevant technical partners/sectors. Ensure that rumours and misinformation are responded to promptly with relevant technical information, so that all questions and doubts at every level are answered. Adapt materials, messages, and methodologies accordingly, with the help of the relevant technical group.

Step 7: Monitor

Develop a *monitoring plan* to assess how well the objectives of the RCCE plan are being fulfilled. Identify the *activities* the RCCE team will perform, and the *outcomes* they are designed to achieve, with participant groups (communities, at-risk populations, stakeholders etc.). Establish a *baseline* e.g. the level of awareness or knowledge of a community at a

time before the RCCE plan is implemented. This can be part of the assessment. Measure the *impact* of the RCCE strategy by monitoring changes in the baseline during after RCCE strategy activities are implemented.

If minimal or no changes are seen, identify where the problems are: check whether the activities are fit for purpose, check the content of the narratives, the methodologies, the quality of work conducted by the teams (it is very important to supervise the way team members conduct the activities). Develop *checklists* to monitor activities and process indicators for each activity.

Some of the key considerations in developing an RCCE plan are mentioned below.

Key considerations in developing an RCCE plan[3]

- *Adapt the elements according to the needs and situation of different communities:* Elements of the action plan may differ in different communities depending on their risk levels, community perceptions, needs, local capacities and current situations.
- *Coordinate and plan together with government authorities and partners:* To strengthen preparedness, ensure effectiveness and avoid duplication. it is important from the start to meet, plan and coordinate with partners, existing community networks and government counterparts. *Communities should play a major role* as implementers and leaders in promoting individual and collective behaviour change, to prevent and respond to any humanitarian crisis.
- *Proactively communicate and promote a two-way dialogue with communities, the public and other stakeholders* to understand risk perceptions, behaviours, and existing barriers, specific needs, knowledge gaps and provide the identified communities/groups with accurate information tailored to their situation. People have a right to be informed and understand the health risks that they and their families face. They also have the right to actively participate in the response process. *Dialogue must be established with affected populations* from the beginning. This should happen at *diverse channels and at all levels*, throughout the response.
- *Reduce stigma*: Regular and proactive communication with the public and at-risk populations can help to *reduce stigma, build trust, and increase social support and access to basic needs* for affected people and their families. Stigma can undermine social cohesion and prompt social isolation of groups, which might make the situation worse. Accurate information can help alleviate confusion and avoid misunderstandings. The *language used* in describing the situation, its origins and prevention steps can reduce stigma.
- *Risk communication should include an effective, relevant, and efficient early warning system.* This relies on risks identification, assessment, and analysis (see next point), identifying risk indicators/early signs, defining ways and methods of communication that fit the local culture, language, capacities etc. Early warning is essential for successful outbreak preparedness. For example, a rising numbers of cases of a particular disease should trigger messages of actions individuals and communities should take. This implies *having a system in place for regular and quick reporting of diseases.*
- *Conduct early and ongoing risk analysis and assessments* to identify essential information about *risks (type, characteristics, potential impacts), and* at-risk populations and other stakeholders (their perception, knowledge, preferred and accessible communication channels, existing barriers that prevent people to uptake services and to adopt the promoted behaviours etc.) to develop a plan. In developing a plan, local understandings and perceptions must be considered. *Qualitative methods* such as focus groups and interviews can produce rich, contextual information from a few people. *Quantitative surveys*, such as internet or telephone surveys, can help characterise large numbers of people, but with less context. Both approaches, or a *mix of them*, can help if relevant questions are systematically asked that will shape intervention strategies. As the threat of the humanitarian crisis evolves,

[3] RCCE Action Plan Guidance COVID-19 Preparedness and Response, IFRC, UNICEF, WHO

people's knowledge and beliefs will change, so assessments will need to be ongoing to ensure that interventions remain relevant to people at risk.

- Ensure that all people at risk due to the emergency are *identified, reached and involved*

Key Tips and discussion points[4]

During an outbreak, there is often *confusion and rumours* about the crisis. People will get a lot of different information from media, friends, family, social media, organisations or other sources. Some of these sources may give *conflicting information*.

What happens when people have too much information about a problem that makes it difficult to identify a solution?

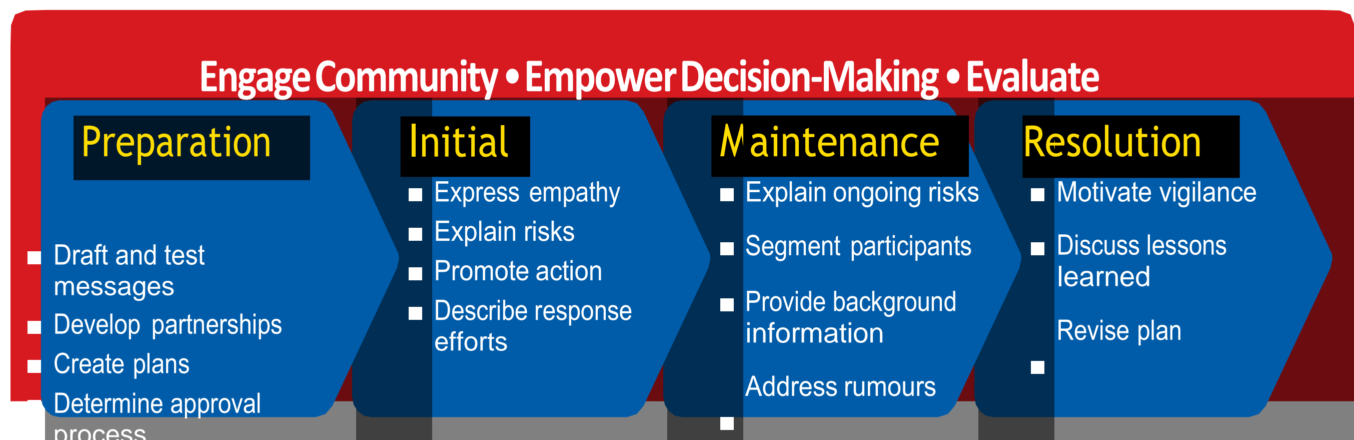
- People might become *fearful and mistrust* health and other recommendations. They might resist and deny the situation.
- This can lead to people *not using medical and other help* and ignore life-saving health advice or escape measures (i.e. quarantine) put in place by authorities and health services to contain the situation.
- Misunderstandings about the disease can lead people to *refuse help from health and other workers*. They may even make threats or use violence.
- Fearful people might start *mistreating people* who have or seem to be sick. This can happen even when they are cured already, due to a lack of knowledge about effectiveness of treatment.
- Field staff, volunteers and community members are best placed to *build trust with communities* and community leaders. Therefore, it is important to *listen to people* and respond to their questions, fears and misinformation with *fact-checked information* that is useful to them.
- *Starting with the positive side* is one way to change a fear filled situation into a more forward looking one, where people identify where they want to be, what *strengths and assets* they have, what *obstacles* hinder the achievement of where they would like to be, what they currently do about it, what support they would need etc. This makes people think collectively and positively. It creates a *"common good"* i.e. reduce health-related risks for everyone and becomes the entry point to strengthen social cohesion and peaceful coexistence.
- *Social mobilisers, community health workers and volunteers* have an important role in providing *timely and actionable information*, so people know how to protect themselves and stay healthy. They can then feel they have the right skills to help mitigate their risks caused by the outbreak.

[4] COVID-19 Novel Corona Virus: Key Tips and Discussion Points for community workers, volunteers and community networks, IFRC, UNICEF, WHO

The role of community engagement in each phase of an emergency[5]

The figure below highlights the role of community engagement in each phase of an emergency:

Figure 7: Community Engagement in Each Phase of an Emergency



Community Engagement during the Preparation Phase

Building *positive relationships with communities*, particularly those who are vulnerable, should be part of the preparation activities. A strong base of *collaboration, trust, and respect* will make the job of those interacting with communities much easier in an outbreak situation and will increase the positive impact of messaging. It is too late to get to know a community when in crisis response mode.

Some ways to engage communities before an outbreak include

- *Meet* face-to-face or by phone
- *Include* communities in response plan development and review
- Determine how members of each community *prefer to receive information* and communicate during an outbreak
- *Test messages* with communities representing different demographics, perspectives, and priorities
- Identify *points of contact* for direct access in an outbreak
- Provide *regular updates* through emails or newsletters during non-outbreak times
- Use *social media* to directly reach community members and to cross-promote activities

The Initial Phase

The initial phase of an outbreak can be characterised by *confusion, uncertainty, and intense media interest*. Information is usually incomplete, and the facts scattered. Information will come to people from various sources and not all of it will be correct. The role of communicators in this phase is to:

- *Acknowledge* the event with empathy
- *Explain* to and inform the public about their risk in simple, clear terms

[5] Crisis and Emergency Risk Communication, Centres for Disease Control, 2018

- Establish organisation and *spokesperson credibility*
- Provide *emergency courses of action,* including how and where to get more information
- *Coordinate messages* with other organisations and agencies
- *Commit to stakeholders* and the public to continue communication and remain accessible

When communicating in the initial phase of an emergency it is important to present information that is *simple, credible, accurate, consistent, and delivered on time*.

Maintenance Phase

The maintenance phase begins when most or all of the direct harm of the outbreak is contained, and the intensity of the crisis begins to subside. The role of communication in this phase includes the following:

- Help the community more accurately *understand its own risks*
- *Provide* background and encompassing *information* to those who need it
- *Generate understanding* and support for response and recovery plans
- *Listen* to stakeholder and participant feedback and correct any misinformation
- *Explain* outbreak recommendations
- *Empower* risk/benefit decision making

Resolution Phase

The Maintenance and Resolution phases often blend into one another as the outbreak continues to wind down. This may take some time as the details of the crisis become clearer. The role of communication in this phase includes the following:

- *Improve appropriate public response* for future similar outbreaks through communication
- Honestly *examine problems and mishaps*, and then reinforce what worked and address what did not work in the recovery and response efforts
- Persuade the public to *support public policy and resource allocation* to the problem

As the crisis resolves, there is a return to some form of normality. Often this is a new normal, which includes an *increased understanding of risks and new ways to avoid them*. While in some cases complete recovery takes years, in the resolution phase most of the recovery systems are in place. This phase is also characterised by a reduction in media and public interest.

Evaluation Phase

When the crisis is over, it is important to evaluate the effectiveness of the communication plan, document lessons learnt and determine specific actions to improve emergency systems or the outbreak plan. Any emergency is a very *important learning opportunity* and failure to learn from it increases the chance of a failed response in the future. When the crisis is over it is important to:

- *Evaluate responses*, including communication effectiveness
- *Document and communicate* lessons learnt - what worked and what did not
- *Determine specific actions* to improve outbreak communication and outbreak response capability
- *Create linkages* to pre-outbreak activities

Targeted Communication

Outbreak communication is more than simply giving information to the "general public." It is important to understand the participant groups and the factors that can influence their comprehension and acceptance of messages. Different audiences have *different priority information needs* based on their relationship to the crisis. While the facts remain the same, the *message delivery and context* may need to be adapted for different participant groups, to address *cultural and accessibility needs*. It should be ensured that messages are *concise, prompt, accurate*, and delivered with *empathy*. Finally, *participant feedback* must be gathered to ensure that participants receive and understand the messages. This will help to reach more people, and deliver messages that are accepted, understood, and acted upon.

The table below indicates some of the groups that need information during a disease outbreak and their primary concerns:

Table 5: Groups that need information in an emergency and their primary concerns

Participant Groups Affected by Outbreaks	Primary Concerns
Community directly affectedby the outbreak	■ Personal safety ■ Family safety ■ Loss of livelihood ■ Disruption to normal activities (e.g., travel restrictions, businesses closed, voluntary quarantine)
Community immediately outside of the affected area	■ How they can keep the outbreak from affecting them ■ How they can help ■ Risks to self and family ■ Disruption to normal activities
Emergency responders and public health officials	■ Professional responsibilities ■ Availability of resources ■ Personal safety ■ Family ■ If they are directly affected by the outbreak: family safety
Civic leaders	■ Responsibilities ■ Liability and reputation management ■ Resource allocations ■ Opportunities to express concern
Partners (organizations who have an official role in the response)	■ Understanding their role in the response ■ Coordinating with other response organisations ■ Involvement in decision-making process ■ Access to information, reputation management

Community leaders (faith-based organizations, non-governmental organizations, cultural groups, etc.)	■ Safety of communities ■ Representing community needs ■ Listening to community members ■ Taking part in decision-making
Media	■ Getting access to information right away ■ Meeting rapid deadlines ■ Keeping the public informed
Businesses, trade, and industry	■ Employee safety ■ Interruptions in business ■ Loss of revenue ■ Liabilities and reputation
International community (international organizations and other countries may be partners inthe response and provide aid or assistance)	■ Their level of readiness for a similar emergency ■ Any restrictions on trade and travel to protect their citizens ■ Their role in response partnership

Credibility

Message delivery can make or break the credibility of the communicator and the message. This will affect how participants react to the initial message and all communications that follow. Two influencers of credibility are the *speed of release* and the *accuracy of information.*

- ***Speed of Release:*** As soon as lifesaving information is confirmed, it should be released. Even if all of the details are not available, information that is known to save lives should be shared. The speed of a message also indicates *how prepared the government/aid organisations are* to respond. If response actions are not communicated in time, the public assumes the government/organisations are not responding.
- ***Accuracy of Information:*** People depend on the government/other aid organisations for accurate information about the outbreak and what they can do to stay safe or help respond. Therefore, the following actions are suggested:
    - *Getting the facts right.* Before releasing messages, they should be validated with subject matter experts and people familiar with the outbreak.
    - If facts change based on new information, the *information should be quickly updated,* and messaging changes coordinated with other organisations.
    - *Facts and suggested actions* should be repeated often, using simple, easy-to-understand language.
    - What is *known, what is not known, and what is being done* to find out more should be shared without speculation.
    - All communications from all organisations and their partners should *share the same facts*. *Inconsistent messages* increase anxiety and quickly undermine expert advice and credibility.
    - *Fully and clearly explaining messages and their reasoning*, will help to reduce doubts of those affected.
    - *Competence and experience* lend themselves to accuracy. Spokespersons should hold responsible positions and have subject matter expertise, for example, doctors and public health officials.

Trust

One of the most important factors in effective risk communication is how much participants trust communicators and the organisations they represent. Establish trust through ***empathy and openness***.

- ***Empathy:*** Empathy is the state of actively considering and recognising how someone else feels and perceives a situation. *Statements of empathy and commitment* to the response demonstrate that authorities and organisations understand the situation and are working in the best interests of the affected populations. Affected people will be more likely to receive and act on messages if they see responders as being empathetic and acknowledging fear, pain, suffering, and uncertainty.
- ***Openness:*** If information is available which organisations are unable to share, the public should be informed of the reason the information is not available for release at the time (e.g. information is being verified, appropriate authorities are being notified etc.). Openness to questions and two-way conversations should be encouraged to allay doubts and fears.

Accountability to Affected Populations (AAP)

Accountability to Affected Populations (AAP) is an essential part of the response to any outbreak or humanitarian situation. It is critical that affected populations:

- Receive *relevant and timely* information
- *Participate* in decisions that affect their lives
- *Have access* to trusted feedback mechanisms

This will help in ensuring that the needs and interests of affected people and communities are at the *centre of decision-making processes* that guide the response, and in ensuring the most appropriate and relevant outcomes for them, while preserving their *rights and dignity* and increasing their resilience to face situations of vulnerability and crisis. AAP is a central part of any RCCE plan, and it should be reflected in the entire preparedness and emergency response plan.

Key actions required to strengthen the three core pillars of AAP (information provision, participation, and complaints and feedback mechanisms) are indicated below.

The Three Pillars of AAP: Practical Actions

- *Information Provision*

Ensuring that at risk populations receive the *most relevant information they can act on,* and in the most appropriate format, should be prioritised. This should be guided by people's expressed information needs and should include information such as services available, how to mitigate the impact of the crisis on livelihoods and how to address the disruption of personal and family routines. Such information must be *tailored to the context*, and delivered through the most *suitable channels.*

Required actions:

- Have a clear and dynamic view of *vulnerable, affected, and at-risk groups*, who and where they are. *These could include elderly persons, women, young people, children, refugees and migrant population* and other socially vulnerable populations
- Assessing *information needs* as well as *preferred communication language and channels,* of the population and its vulnerable sub-groups is critical. This should be done on an on-going basis given the *challenges of using*

traditional communication approaches in certain situations. Where face-to-face approaches cannot be applied, *digital technology and digital communication,* as well as *localised forms of communication, such as community radio,* have an important role to play in ensuring proximity to the population. However, their applicability must be assessed first.

- *Participation*

Decisions around the emergency response may cause *confusion or resentment* and have adverse effects on the population. It is therefore important that the affected population not only understands the rationale behind those decisions, but are *engaged and participate* in those decisions, especially at the local level. Participation leads to a *level of ownership* amongst the affected population which will help to increase the success and quality of interventions and ensure their *sustainability*.

Required actions:

- *Partnership agreements* should include provisions for establishing processes for and monitoring engagement with and *participation of affected populations* in response decisions and local actions (e.g. through focus groups, town-hall meetings, remote polls, etc.) the organisation of which must be in tandem with the overall response protocols.
- *Alternative mechanisms* for remote engagement, as described below, and *innovative methods* are likely to be more appropriate where traditional, face-to-face participatory approaches are more difficult to implement.
- Specific measures should be included in the response to ensure *participation of the most vulnerable groups, such as people with disabilities, elderly people, women, and children.*

Complaints and Feedback mechanisms

- A cornerstone of being accountable to affected populations is ensuring that *their complaints and feedback are heard and acted upon*, so that responses are effective, relevant and do no harm. Complaints and feedback mechanisms are powerful tools to *track perceptions, rumours, misinformation, and information gaps*, as well as overall satisfaction from the response. Data collected should be aggregated and regularly analysed, to inform decision-making and programme course correction.

Required actions:

- Use *existing mechanisms* rather than setting up specific ones for the emergency response to ensure a timely response.
- Establishing *collective mechanisms with other agencies* is more cost-effective and avoids duplication.
- *Technology-based solutions* are recommended, where face- to face interactions are not possible or need to be limited. This includes use of mobile phones (voice calls, short message services), social media platforms (Internet of Good Things, Facebook, Twitter, Instagram and others) or messaging apps (e.g. WhatsApp trees, Viber, etc.). Interactive radio, video and TV programmes should also be considered, as appropriate.
- If *U-Report* is a well-established platform, it must be used and scaled up for the emergency response.
- Establishing *call-centres*, or using existing ones, should be considered to respond to the outbreak, provided adequate efforts are made to ensure that they work and there is someone to respond at all times, and to create awareness, confidence and trust in the mechanism for emergency response A call centre can fulfil the following functions:

- Provide *timely and relevant information* about the situation
- *Confidentially* receive and appropriately respond to sensitive complaints (Prevention of Sexual Abuse and Exploitation, abuse of authority, fraud/corruption etc.). Specific SOPs and referral pathways should be established
- Monitoring needs, perceptions and evolving trends in the type and quality of the response.

8. MONITORING AND EVALUATION

While we often speak of monitoring and evaluation together, it is important to segregate them, as they have distinct purposes. The purpose of monitoring is to collect information to *review progress of the implementation of the activities in the implementation plan*, and modify the implementation, if necessary, based on the feedback. As a result, it is a *continuous* activity during the implementation of the strategy/plan and *monitors inputs and outputs*. Evaluation, on the other hand, looks for the *outcome* of the implementation of the SBC strategy – whether it achieved the communication objectives specified at the beginning, to what extent, and should also try to understand and identify the reasons for behaviour and social change, or the lack of it, to the extent expected. It is *therefore periodic*, through the programme cycle. It is suggested that this should be undertaken at the end of five years of implementation of this strategy, as behaviour and social change is a process that takes time.

Monitoring

There are two types of monitoring (1) implementation monitoring, which assesses whether activities are being implemented as planned, and to what extent. It should also include the *quality of implementation*, to ensure that activities are being implemented in a manner that is engaging and participative, and that communication materials being developed have a *relatable concept and content and good production values*. Only then can these activities be effective in bringing about behaviour and social change. (2) Behavioural monitoring, on the other hand, looks for *early signs of behaviour change* and is therefore a steppingstone to evaluation. It tries to assess whether, for example, the participant groups who are engaged in the activities are *discussing the issue with others and have taken any steps towards behaviour change, such as looking for information.* This takes place during programme implementation, so that it is possible to *modify the activities*, if necessary, based on the results of behavioural monitoring.

Implementation monitoring

Mass media

Implementation monitoring of mass media, such as TV, radio, social media, IoGT, WhatsApp trees, social media etc. would be done by the responsible organisation/implementing agency, such as Ministry of Health/RBC or UNICEF. To begin with, this would include the progress of the development of the materials, such as TV and radio spots/programmes/dramas, print materials etc., and whether the process is participatory with other stakeholders and representatives of participant groups. This could include, *development of a concept, script development, production etc.* Once draft materials are developed they should be *pre-tested* among a section of the participant group for whom they are intended, to check that the messages are clearly understood, that people like them and can relate to them, and that they do not cause any negative reactions. This can be done through *qualitative research methods*, such as focus group discussions or semi-structured interviews, using a pre-developed discussion guide/questionnaire. The communication materials/products would be finalised based on the feedback received from the pre-test.

A *media plan* would be developed to ensure that reach is maximised, and the budget is optimally used. The implementation of the media plan would then be monitored by the implementing agency, to ensure that it is being implemented as planned. In the case of TV and radio, if *viewership of* TV and listenership of radio programmes is being tracked through a media monitoring agency, this should also be reviewed regularly. If the programmes are interactive, such as phone-in programmes, monitoring should include *number of participants, responses, any feedback received etc.* In the case of IoGT it would include the *number of impressions and engagement*. In the case of WhatsApp trees/groups, indicators would include the *number of posts, responses and actions taken. Social media* could be monitored using *social listening.*

Community engagement

For community engagement activities, Implementation monitoring would be undertaken by community health workers, their supervisors, and frontline workers as well as field staff of other implementing partners. The implementation monitoring plan will depend on the implementation plan, as it will identify the specific activities to be undertaken, by whom, the timeline and the geographic location. The implementation monitoring plan will monitor whether this implementation is taking place as planned, its quality and identify the reasons if it is not if is not being implemented as planned and its quality is not good. A simple monitoring template would be developed, so that is easy for field workers to fill in. A sample format is given below:

Table 5: Sample Community Engagement Monitoring Plan Template

Date of visit: Site visited: Village, district Name Designation, Organisation

Activity	**Description of Activity**	**No. planned**	**No. Implemented**	**Reason for shortfall if any**	**Quality of activities implemented Good/average/not good**	**Communication materials available to support activity**	**Approx. no. of participants in activities Men/women/adolescents/children**				**Suggestions for improvement**
Community meetings							M	W	A	C	
Community theatre shows											
Umuganda											
IPC with caregivers – home visits, group meetings											
Meetings/activities with men's groups											
Meetings with religious leaders											
Etc.											

Behavioural monitoring

Behavioural monitoring would be carried out through *focus group discussions and individual interviews with caregivers and other participant groups* mentioned earlier, such as fathers of children 0-5 years, grandmothers, religious and community leaders. These are informal discussions, which can be conducted by community health workers using a discussion guide developed by the programme. They would cover areas such as *whether the participants are aware of the communication activities taking place, have participated in them, what they think of them and whether it has changed their knowledge, attitudes, and behaviours in any way.* Rather than looking for the final behaviour change we are aiming for, such as ensuring that children are fully vaccinated, behavioural monitoring would look for *the intermediate steps – talking to people in their reference groups or those whose opinion matters to them, looking for more information, or steps taken towards addressing the barriers to behaviour change,* such as fathers becoming more involved in their children's health and welfare.

Behavioural monitoring can and ideally should be participatory in nature, if feasible. Participatory monitoring and evaluation has been found to be a key motivator for programme participants. People remain at the heart of the change process, which *fosters ownership and accountability*. People are motivated by *measuring their own progress* and learning about what affects their lives and how to act on it. It is also a *learning opportunity* for community members on change management. Community members, including community health workers and young people, could be *trained* to carry out these group discussions and interviews. Another participatory method called *Most Significant Change* is described below.

Most Significant Change (MSC) involves *collection and selection by community members of stories* of the most significant changes in their lives within defined *domains*, within a particular *time period*. These stories could be collected by community health workers or young people in the community, who could be trained for this. A standard format could be used to record the stories, which could be *written, or audio or video stories, recorded on mobile phones*. The domains could be gaps in knowledge and various issues identified earlier, such as involvement of fathers and support from religious and community leaders. A group of people would then sit together and review the stories in each domain and *select stories* that they feel reflect the most significant changes in people's lives. This process must be done in an *open and transparent* manner. Wherever possible, the *stories should be verified* to ensure their authenticity. These stories would then be passed upward to a higher level for further selection, such as from village to district, where a similar selection process would take place, and then to province and national. This can be simplified.

The final step is sharing the stories and *discussion of the process of change* with stakeholders and contributors so that *learning takes place*, about what is valued. MSC is not just about collecting and reporting stories, but about having processes to learn from these stories to learn about the *similarities and differences* in what different groups and individuals' value. It provides information about *impact and unintended impact* and provides insights into the *values and beliefs* held by different stakeholders. Therefore, it could be used to monitor changes in attitudes towards immunisation among different groups, such as caregivers, fathers and religious leaders and self-efficacy of women to take their children for immunisation. More information on the Most Significant Change Method is available at https://www.intrac.org/wpcms/wp-content/uploads/2017/01/Most-significant-change.pdf It is important in using this method to not only focus on the ultimate behavioural change but also on the *small steps* towards it, as behaviours take time to change and a person goes through many stages before that.

Most Significant Change can also be implemented using *Participatory photography/participatory video* would engage young people in monitoring changes in their own lives and those of their friends, families and peers, and is based on the principles of participatory problem solving of Paolo Friere, similar to *forum theatre*. It involves

training a group of young people as *co-researchers*, rather than objects of research, to take photographs/video on the subject of interest. In this case it could be on the process of changes in taking their children for vaccination, engagement of fathers, or simply documenting implementation of communication activities. This can be done on smart phones and would not need much training, as young people are adept with their phones.

Photographs/video on the subject of interest are then shot followed by a participatory group process of selection of illustrative images/video and appropriate captions. This would include explanations by individuals of *why they shot a particular photograph/video and what it represents to them*. This would be followed by a *group discussion* of the themes in the photographs/videos. An *exhibition* aimed at decision makers would then be organised or a *video screening* in the case of videos. Some users of these methods feel that videos are more versatile and compelling. The photographs/video or written stories could also be used for *documentation, social media, and human-interest stories for advocacy*. Participatory photography/video would also enable *feedback from young people* on whether the communication activities are appropriate or need modification.

Evaluation

As mentioned earlier, evaluation looks at the impact of the communication strategy, and assesses whether the communication objectives have been achieved and to what extent. As the KAP study and the Coverage and Equity Assessment provide baselines for some of the indicators, a *follow up KAP survey at the end of five years of implementation of the SBC strategy, and a follow up Coverage and Equity Assessment* would provide feedback on the effectiveness of the strategy and its implementation. These studies should use *mixed methods*, including both quantitative and qualitative components, so that in addition to providing numbers on defined indicators, they also provide *diagnostics* to understand what worked and what did not, which can be used as the basis of modifying and improving the next phase of SBC.

Indicators

The proposed indicators for evaluation, adapted from the communication objectives identified earlier in this strategy, baselines where available, the targets and means of verification are given in the table below:

Table 6: Indicators for Evaluation of SBC Strategy

Indicator	Baseline	Target	Year	Means of Verification
Knowledge				
% caregivers of children 0-5 years who know the immunisation schedule (disaggregated by gender)	87	95	2026	Follow up KAPB study
% caregivers of children 0-5 years living in urban areas who have comprehensive knowledge about immunisation	79	95	2026	Follow up KAPB study
% caregivers of children 0-5 years living in rural areas who have comprehensive knowledge about immunisation	74	90	2026	Follow up KAPB study
% of caregivers of children 0-5 years who correctly name at least one benefit of immunisation for their children*(disaggregated by gender)	Not available	95	2026	Follow up KAPB study

% of fathers of children 0-5 years who correctly name at least one benefit of immunisation*	Not available	90	2026	Follow up KAPB study
% of grandmothers of children 0-5 years who correctly name at least one benefit of immunisation	Not available	90	2026	Follow up KAPB study
% 0f fathers of children 0-5 years who know where vaccination services are available	Not available	95	2026	Follow up KAPB study
% of caregivers of children 0-5 years who know where they can receive vaccination services*(disaggregated by gender)	Not available	95	2026	Follow up KAPB study
% of caregivers who know where to get reliable information about immunisation*	Not available	95	2026	Follow up KAPB study
Risk perception				
% of caregivers of children 0-5 years who think that their children are at risk of contracting vaccine preventable diseases (disaggregated by gender)	42	75	2026	Follow up KAPB study
Attitudes and beliefs				
% of caregivers of children 0-5 years who have a positive attitude towards immunisation (disaggregated by gender)	83	95	2026	Follow up KAPB study
% of caregivers of children 0-5 years who believe that children should be fully vaccinated (disaggregated by gender)	81.5	95 (in all provinces and districts)	2026	Follow up Coverage Survey
% of mothers-in-law/mothers of female caregivers of children 0-5 years who believe that all children should be fully vaccinated	Not available	90	2026	Follow up Coverage Survey
% of caregivers of children 0-5 years who think vaccines are an effective way to protect their children and themselves from diseases*(disaggregated by gender)	Not available	90	2026	Follow up KAPB study
% of caregivers who agree that vaccination protects not only their children but others in the community* (disaggregated by gender)	Not available	90	2026	Follow up KAPB study
% of caregivers who think that vaccination is a priority for their children's health*	Not available	90	2026	Follow up KAPB study
% of caregivers who think that getting their children vaccinated is an essential practice of a good parent*	Not available	90	2026	Follow up KAPB study
% of caregivers who said they prefer to use traditional medicines for treating side effects of immunisation*		10	2026	Follow up KAPB study

% of caregivers of children 0-5 years who believe that traditional healers have a positive attitude towards immunisation (think it's a good idea)	49	85	2026	Follow up KAPB study
% of caregivers of children 0-5 years who believe they should take their children with disabilities for immunisation (disaggregated by gender)	Not available	90	2026	Follow up KAPB study
% of fathers of children 0-5 years who believe they should take their children with disabilities for immunisation	Not available	90	2026	Follow up KAPB study
% of caregivers who trust the safety and efficacy of vaccines*.	Not available	90	2026	Follow up KAPB study
% of caregivers who think that the benefits of immunisation outweigh their fear of side effects*(disaggregated by gender)	Not available	90	2026	Follow up KAPB study
% of caregivers who hesitate or refuse one or more vaccines for any reason*	Not available	5	2026	Follow up Coverage and Equity Study
Gender				
% of caregivers of children 0-5 years who believe that spouses/co-parents have a positive attitude towards immunisation (think it's a good idea)	93	100	2026	Follow up KAPB study
% of fathers of children 0-5 years taking their children for immunisation/supporting their wives to take them.	Not available	90	2026	Follow up KAPB study
% of caregivers who report that they have the ability to take the decision to vaccinate their children (disaggregated by gender, urban/rural) * (self-efficacy)	Not available	95	2026	Follow up KAPB study
% of caregivers who think that immunisation is the mother's responsibility*	Not available	15	2026	Follow up KAPB study
Social norms				
% of caregivers who think that most of their close family and friends want their children to be vaccinated*	Not available	90	2026	Follow up KAPB study
% of caregivers who think that getting your children vaccinated Is the normal expected behaviour of families like theirs*	Not available	90	2026	Follow up KAPB study

% of caregivers who are willing to share their positive experience with the community*	Not available	90	2026	Follow up KAPB study
Religious and community leaders				
% of caregivers of children 0-5 years who believe that religious leaders have a positive attitude towards immunisation (think it's a good idea)	90	100	2026	Follow up KAPB study
% of prominent leaders (including religious leaders and/or umbrella organisations) who publicly engage in favour of vaccination*	Not available	90	2026	Follow up KAPB study
% of religious and/or community leaders from districts with low vaccine coverage who say they are willing to advocate publicly for vaccination in their community*	Not available	90	2026	Follow up KAPB study
# of religious leaders taking actions to support and encourage caregivers of children 0-5 years to take their children for immunisation, including those with disabilities	Not available		2026	Follow up KAPB study
% of leaders in the community who think they should encourage families to take all their children for immunisation*	Not available	90	2026	Follow up KAPB study
% of community leaders taking actions to support and encourage caregivers of children 0-5 years to take their children for immunisation, including those with disabilities	Not available	85		Follow up KAPB study
Health workers				
% of community health workers trained in interpersonal communication and counselling skills	Not available	95	2023	Training records
% of health workers at health centres trained in interpersonal communication and counselling skills	Not available	95	2023	Training records
% of health workers having the minimum required interpersonal communication skills for immunisation services*	Not available	90	2026	Observation study
% of community health workers who feel confident they can effectively promote immunisation within their communities*	Not available	90	2026	Follow up KAPB study

% of health workers who think they have the necessary means to mobilize communities to promote vaccination within communities*	Not available	90	2026	Follow up KAPB study
% of health workers who say they get the necessary means (funds, transportation etc.), to access the vaccination site*	Not available	95	2026	Follow up KAPB study
% of health workers who think that communicating with caregivers about immunisation is highly important*	Not available	95	2026	Follow up KAPB study
% of vaccinators counselling caregivers about benefits of vaccination*	Not available	95	2026	Follow up KAPB study
% of caregivers who say they feel satisfied with the information provided by health workers about AEFI*	Not available	90	2026	Follow up KAPB survey
% of health workers who think that vaccinating children with disabilities is a priority	Not available	90	2026	Follow up KAPB study
% of health workers who declare using available means (home visits, SMS, phone calls etc.) to remind caregivers where and when to go next for vaccination*	Not available	90	2026	Follow up KAPB study
% of health workers who declare being motivated by their work*	Not available	90	2026	Follow up KAPB survey
% of health workers who say they get enough social recognition and respect from their community*	Not available	90	2026	Follow up KAPB study
Quality of service				
% of caregivers who think the service is convenient*	Not available	95	2026	Follow up Coverage and Equity Study/KAPB study
% of caregivers who think it is affordable to take their children for vaccination*	Not available	90	2026	Follow up Coverage and Equity Study/KAPB study
% caregivers satisfied with the quality of the service experience*	Not available	95	2026	Follow up Coverage and Equity Study/KAPB study
% of caregivers from a vulnerable group that felt welcomed at the health facility/vaccination point*	Not available	90	2026	Follow up Coverage and Equity Study

% of caregivers who said they were unable to vaccinate their children due to structural barriers (lack of vaccination, vaccination site too far away, times inconvenient, waiting time too long etc.) *	Not available	10	2026	Follow up Coverage and Equity Study/KAPB study
% of health facilities where health staff organize education sessions on nutrition, communicable diseases, including those that can be prevented by immunisation*	Not available		2026	Follow up Coverage and Equity Study
Microplanning and community engagement				
% of facilities that involve communities in microplanning*	Not available	90	2026	Follow up Coverage and Equity Study
% of caregivers from a vulnerable group that declare being involved in the development of micro plans*	Not available	90	2026	Follow up Coverage and Equity Study
# of districts that systematically use community-based mechanisms to organize open community-based discussions about immunisation*			2026	Follow up Coverage and Equity Study
% of health facilities that are equipped with effective social accountability mechanisms*	Not available	90	2026	Follow up Coverage and Equity Study
% of health facilities that have a functioning health committee (or similar) that includes community members and meets at least quarterly			2026	Follow up Coverage and Equity Study
% of caregivers who say they cannot take their children to the vaccination site during service hours because of competing priorities*	Not available	15	2026	Follow up Coverage and Equity Study/KAPB study
% of caregivers who report having support from family or neighbours to manage competing priorities while they take their children for vaccination*	Not available	90	2026	Follow up Coverage and Equity Study/KAPB study
Advocacy				
Actions taken by government authorities to increase # of health centres in hard to reach areas (Meetings, policy papers, instructions issued)			2023	Ministry of Health records
Actions taken by government authorities to increase # of outreach immunisation sessions (Meetings, policy papers, instructions issued)			2023	Ministry of Health records

Actions taken by government authorities to increase # of health centres in urban areas with flexible timings (Meetings, policy papers, instructions issued)	2023	Ministry of Health records, spot checks by supervisory staff
% of EPI budgets dedicated to demand generation activities*	2022	RBC records
# of positive stories in media about immunisation	2026	Media audit
% of employees in the private sector whose children are fully immunized	2026	Private sector company health records

9. ACTION PLAN

The steps involved in implementing mass media activities, social mobilisation/social change communication activities, capacity building, advocacy and developing public-private partnerships are detailed below:

Mass media

- Design a *communication concept, plan, actions and tools to promote immunisation*, including for children with disabilities. While there should be one overarching concept and brand, it will probably need to be adapted for different participant groups in different settings.
- Develop TV, radio spots and content for TV/radio programmes, *Internet of Good Things, WhatsApp Trees and other social media.*
- Develop *job aids and print materials* such as a flip chart, brochure, flyer, posters, banners etc.
- Document and disseminate through various platforms *positive stories of parents, particularly fathers who have fully immunised their children*. This will include stories on TV, radio, social media and community theatre.
- Integrate messaging into the *Itetero and Urunana radio/TV dramas* if relevant and feasible.
- Integrate relevant messaging into the *discussions of the community based Itetero and Urunana listening clubs/groups,* if immunisation content is included.
- Include relevant messaging into the *ongoing UNICEF led campaign on ECD*, including nutrition and WASH.

Social mobilisation/Social change communication

- Design and implement *partnerships with relevant government bodies, NGOs and civil society organisations* to facilitate *community engagement* around immunisation.
- Design and implement *partnerships with relevant government bodies and faith-based organisations* (like Rwanda Interfaith Council for Health) to leverage support from *religious leaders and other community influencers* in promoting immunisation.
- Design and implement *partnerships with relevant government bodies and the disability organisations* (such as NCPD), in supporting the rights of children with disabilities to immunisation at different levels
- Design and implement *partnerships with relevant media houses* (such as Media High Council), influencers and media celebrities, to increase the *quantity and quality of media reporting of positive stories* on immunisation
- Develop partnerships and scripts for *community theatre.*
- Support government and civil society organisations in *facilitating community-based forums on social norms and gender barriers and practices related to immunisation*, through existing community-based platforms (Umuganda, parent's evenings etc.).

Capacity Building

- Capacity building of *community health workers and health care providers at health centres on interpersonal communication and counselling*, service orientation and positive attitude towards caregivers, including encouraging them to bring children with disabilities for immunisation.
- Capacity building of *religious leaders, community leaders and other community groups* on immunisation, encouraging parents, particularly fathers, to take their children for immunisation and *changing gender norms* about father's involvement in child health and rearing.
- Capacity building of *media and influencers* on spreading positive stories on immunisation and stopping spread of myths and rumours

Advocacy

- Meetings and workshops to advocate with *government authorities and policy makers at national and district level to increase access to immunisation services* for all children, including those with disabilities and ensure *adequate budget for SBC strategy implementation.*
- Develop, use and provide appropriate communication materials – presentation, brochure, leaflet
- Advocate with *media* to carry positive stories on immunisation, stories of role models/'positive deviants'.

Public-private partnerships

- Conduct workshop to *identify opportunities for PPP*
- Advocate/enter into partnerships with *mobile phone service providers* for reduced rates for SMS/content.
- Enter into partnerships with *media houses* to produce *entertainment education content*, negotiate *reduced rates* for broadcasting content/TV, radio spots/jingles.
- Develop appropriate *communication materials* to be used on such occasions – presentations, brochure etc.
- Establish PPP with *appropriate agreements on roles and responsibilities* and working arrangements
- *Hold regular PPP meetings* to advance the PPP agenda, including increasing support for immunisation of staff, supporting outreach and resource mobilisation.

The two-year Action Plan to implement the SBC strategy is summarised below:

Table 7: Action Plan

Activity	Description	Timeline (to be updated closer to start date)	Responsibility
Strategy dissemination	Meetings and workshops at different levels	Dec 2021	Ministry of Health/RBC/RHCC
Mass media			
Development of communication materials	Development and pre-testing of video, audio, print communication materials	Sep-Dec 2021	RBC, RHCC, UNICEF
Develop partnerships with TV, radio, social media influencers to produce and broadcast content on their channels	Meetings with TV, radio channels and social media influencers	Dec 2021	RBC, RHCC, UNICEF

and carry content free/at reduced rates			
Develop partnerships with internet service providers for reduced rates for SMS/data for content	Meetings with internet service providers with effective presentations and materials to negotiate agreements.	Dec 2021	Ministry of Health/RBC/RHCC
Training workshop for development of TV, radio, social media content with producers and stakeholders	Orient content producers of TV, radio, I0GT, social media on communication issues to be included in content. Co-create programmes/content.	Dec 2021	Ministry of Health/RBC/RHCC, partners
Development of content for mass media and social media	Development of content for TV, radio programmes, IoGT and social media	Jan-Mar 2022	Ministry of Health/RBC/RHCC, UNICEF, other partners
Development of media plan for mass media and social media	Development of media plan for TV/radio spots, social media placement and media buying	Dec 2021	RHCC, UNICEF
Implementation of mass media activities	Implementation as per media plan	Jan 2022-Dec 2023	Ministry of Health/RBC/RHCC
Set up/integrate into existing viewing/listening groups/clubs	Group viewing/listening of TV/radio programmes on immunisation, followed by facilitated discussion	Mar 2022	RHCC/Implementing partners
Community theatre			
Development of scripts for community theatre and training of actors	Workshop with producers of community theatre plays and actors for script development	Jan 2022	Ministry of Health/RBC/RHCC, partners, civil society organisations
Development of implementation plan for community theatre shows in villages	Identify villages for community theatre shows, timelines and logistics	Apr 2022	Implementing partners
Implementation of community theatre plan	Monitor implementation of community theatre shows in villages as per plan and community engagement/need for modification	May 2022 onwards	Implementing partners
Capacity building			
Training needs assessment of community health care workers and health workers at health centres	Assessment to identify gaps in knowledge and skills of health care workers so that they can be improved	Jan/Feb 2022	

Training of community health workers and health workers at health centres on IPC skills/counselling and use of communication materials	Development/adaptation of appropriate training modules; cascade training; provide appropriate communication materials, including job aids, posters, brochures, and leaflets	Mar 2021-Jun/Jul 2022	Ministry of Health/RBC/RHCC implementing partners
Plan and implement social recognition of community health workers and health workers at health centres at community events	Identify events and details of how community health worker and health workers at health centres will be recognised	Jan 2022	Implementing partners, civil society organisations, local leaders and authorities
Community engagement			
Develop partnerships for undertaking community engagement activities	Identify appropriate implementing partners, including civil society organisations and enter into partnership agreements for implementing community engagement activities	Dec 2021/Jan 2022	Ministry of Health/RBC/RHCC, civil society organisations, implementing partners
Develop partnerships with government bodies and disability organisations, such as NCPD	Plan activities to ensure children with disabilities are immunised and not hidden	Jan/Feb 2022	Ministry of Health/RBC/RHCC
Development of community engagement plans at village, district, province level	Develop community engagement plan in a participatory way with communities, including mother care groups, mother's union/groups, men's groups/clubs, youth groups/clubs, religious and local leaders, identifying those responsible for implementation, roles and responsibilities, identifying resources and how monitoring will be undertaken	Jan-Mar 2022	Implementing partners, Community Health Workers, other field workers
Develop plan for inclusion of immunisation in local events and festivals, songs, dances	Setting of booths with communication materials and community health worker at community events, development of songs and proverbs on	Jan-Mar 2022	Implementing partners/civil society organisations, community health workers

	immunisation. Use of banners, posters and leaflets		
Develop plan for including immunisation in *Umuganda* and other relevant community-based platforms with coordinators and local authorities	Identify villages, decide timeline with local leaders, provide appropriate communication materials and resource persons	Jan-Mar 2022	Local authorities, coordinators of community-based platforms, Community Health Workers, other field workers
Develop monitoring plan for community engagement activities	Develop monitoring plans identifying activities, location, timeline for implementation and frequency of monitoring	Mar 2022	Implementing partners, community health workers, other field workers, supervisors, coordinators
Implementation of community engagement plan	Implement and monitor as per plan	Apr 2022-Dec 2023	Implementing partners, community health workers, civil society organisations, NGOs
Religious leaders			
Develop partnerships with faith-based organisations	Develop partnerships with faith-based organisation, such as the Rwanda Interfaith Council for Health, to get their members to promote immunisation, including for children with disabilities and end myths, rumours and misinformation, increase father's involvement.	Jan 2022	Ministry of Health/RBC/RHCC
Workshops for religious and community leaders	Workshops at national, provincial and district levels to increase knowledge about immunisation among religious and community leaders, provide with job aids and appropriate communication materials, including those quoting from religious texts.	Mar 2022	Ministry of Health/RBC, RHCC, other partners
Implementation and monitoring	Implement and monitor whether religious and community leaders are speaking about	Apr 2022-Dec 2023	Implementing partners, community health workers

	immunisation to community members		
Advocacy			
Advocacy meetings with government officials and other partners at different levels	Advocate for increasing access to immunisation services in urban and hard to reach areas and ensuring adequate budget for SBC for immunisation, ensuring services for children with disabilities, using appropriate communication materials.	Jan 2022-Dec 2023	Ministry of Health/RBC/RHCC
Develop partnerships with media organisations, celebrities, and social media influencers	Develop partnerships with media organisations, such as the Media High Council, to increase the quantity and quality of positive stories, development of content and negotiate rates for airtime. Develop partnerships with celebrities and social media influencers to advocate for and include content on benefits of immunisation.	Jan 2022	Ministry of Health/RBC/RHCC
Workshop with media partners	Increase knowledge of media personnel on immunisation, share relevant and interesting positive stories that they can carry.	Feb 2022	Ministry of Health/RBC, RHCC//other partners
Regular follow up meetings with media partners to sustain interest	Share news positive stories and progress of immunisation programme	Mar 2022-Dec 2023	Ministry of Health/RBC/RHCC/other partners
Field trips for media	Field trips for media representatives once in 6 months or when there is something new to share, to see actual situation on the ground and shoot it	Mar 2022-Dec 2023	Ministry of Health/RBC/RHCC
Implementation and monitoring	Monitor number of positive stories on immunisation carried by media	Mar 2022-Dec 2023	RBC, RHCC
Public-private partnerships			

Conduct workshop to identify opportunities for private-public partnerships	Advocate for children of all employees and partners to be fully immunised. Map areas of work and interests of private organisations and identify areas of mutual interest, opportunities for resource mobilisation.	Jan/Feb 2022	Ministry of Health/RBC/RHCC
Develop private-public partnerships and plan	Identify suitable partners and enter into partnership agreements. agree on activities to be implemented, resources required and timeline.	Mar 2022	Ministry of Health/RBC/RHCC
Implementation and monitoring	Implement and monitor activities to ensure children of employees and partners are fully immunised and activities are being carried out as planned.	Apr 2022-Dec 2023	Ministry of Health/RBC
Monitoring			
Develop detailed monitoring plan	Develop detailed monitoring plan including activities, timeline, geographic areas, frequency of monitoring and assign roles and responsibilities	Dec 2021/Jan 2022	Ministry of Health/RBC/RHCC implementing partners
Implement monitoring plan	Jan 2022-Dec 2023		Ministry of Health/RBC, RHCC implementing partners
Evaluation	Evaluate outcome of SBC strategy and effectiveness in achieving communication objectives	Jan 2027	Ministry of Health/RBC/RHCC

Acknowledgments and references