

DEPLOYING RISK COMMUNICATIONS AND COMMUNITY ENGAGEMENT (RCCE) APPROACHES FOR COVID-19 IMMUNISATION



TABLE OF **CONTENTS**

1. Introduction	3
2. Tajikistan and Kyrgyzstan	9
3. Bolivia	22
4. Democractic Republic of Congo	40
5. Looking Forward	59



1. INTRODUCTION



1.1 BACKGROUND TO RCCE

Risk communication and community engagement (RCCE) is a type of health intervention focused on engaging communities to bring about positive health outcomes. Most fundamentally, RCCE is centred around awareness-raising, information-sharing, and building trust to support behaviour change.

The central approach of RCCE is:

- *Who*: Identifying a target population, including sub-groups, influencers and gatekeepers
- *What*: Informing and educating the target population on what they should do
- *Why*: Motivating and compelling the target population on the need to do it
- *How*: Providing specific guidance, tools, and skills for the target population to change their behaviour

RCCE strategies are flexible and can involve a range of approaches throughout the preparedness, response and recovery phases of a health emergency to build trust, encourage informed decision-making, and positive behaviour change. Typically, RCCE interventions are a component of a broader health emergency preparedness and response approach.

1.1.1 RCCE in the context of COVID-19

The COVID-19 pandemic was an unprecedented health shock in many people's lifetimes. Its disruptive nature, unknown characteristics and a lack of global preparedness presented many complexities for the introduction and uptake of new vaccination, such as:

- The sense of urgency due to the pandemic's speed and scale, including illness and loss of life.
- Initial scarcity of medical information and knowledge about the virus.
- The record speed at which vaccines were developed.
- Multiple vaccines becoming available for use at the same time, with varying messaging around their respective safety and efficacy.
- Limited initial stocks meaning that recipients had to be prioritised, which was not always implemented clearly or consistently across contexts.
- Fluctuation over time and across contexts in the supply and demand for vaccination.
- Disruption by new variants of the advancing evidence and understanding of the virus, including the efficacy of vaccines and number of doses required.
- Fluctuating public messaging which sowed confusion about perceived risk.
- Undermining of public confidence by vaccine safety events and certain governments restricting use of vaccines for their populations.
- Changing restrictions and measures, which contributed to fatigue and eroded trust in governments as authorities on public health information.
- Alarmism and the rapid proliferation of mis and disinformation, particularly through social media channels.
- Disparities in vaccination rates and accompanying measures globally, which undermined perceived risk levels and perceived need for immunisation in less vaccinated parts of the world.

There is a growing body of evidence¹ indicating that RCCE interventions played an important role in the COVID-19 response. Since the declaration of the COVID-19 pandemic in March 2020, the fight against the virus was largely dependent on the adherence of populations to preventive measures and vaccination. Emerging evidence shows that RCCE played an important cross-cutting function that facilitated the successful implementation of key response measures such as testing, contact tracing, social distancing and other preventative measures, self-care and home care, and vaccine uptake.

¹ For example, a compendium of 18 case studies in WHO Europe; a multi-site study by the Robert Koch Institute (RKI) across Germany, Nigeria, Singapore and Guinea; and a UNICEF case study in Pakistan.

1.2 THE CASE STUDIES

1.2.1 Purpose

The researching and writing of the case studies presented in this report forms part of a broader assignment which aims to deliver high-quality global goods associated with Risk Communication and Community Engagement for the Collective Service.

UNICEF and the Collective Service have commissioned these case studies to help build the evidence base on the role of RCCE in COVID-19 immunisation. Collectively, the case studies identify best practices, reflect lessons learnt, and share insights on how RCCE interventions have supported COVID-19 vaccination efforts, with a particular focus on coordination, community systems strengthening and capacity building. This report also seeks to offer actionable recommendations for the Collective Service and other health actors on how to deploy RCCE for future public health emergencies.

1.2.2 Rationale for Cases Selected

The sampling of cases has been undertaken purposively, with the aim of identifying cases representing a diversity of geographical contexts, programming approaches, and under-reported areas. Each of the Collective Service organisations were invited to nominate a case in accordance with these criteria. Key programming approaches and elements illustrated by each the three case studies selected are:

- Bolivia: Youth engagement, use of alternative communications channels and local coordination, led by UNICEF.
- Tajikistan and Kyrgyzstan: Innovative approaches to tracking and monitoring vaccine uptake of people who have participated in Red Cross activities
- Democratic Republic of Congo (DRC): Assessing and actioning insights on socio-behavioural determinants of population adherence to PHSM and acceptance of COVID-19 testing and vaccination.

1.2.3 Approach

The case studies capture in-depth information on different RCCE approaches deployed during the pandemic to promote uptake of COVID-19 vaccination. Data collection for each case study has involved a review of programme documents and relevant secondary data, as well as a series of semi-structured key informant interviews and, some cases, focus group discussions. Populations for the latter have included programme staff, delivery partners and respondent types of particular relevance to each specific case (e.g. local government authorities). Analysis has triangulated data sources to ensure the robustness of the insights presented in this report.

Limitations of the case studies are as follow: engaging with end beneficiaries of interventions was beyond scope in accordance with the time and resources available for conducting the cases. The Bolivia case study team were nevertheless able to interview some beneficiaries with the support of the UNICEF country office.

1.2.4 Structure

This report is structured as follows: Chapter 1 offers an introduction to RCCE approaches, sets out the rationale for the selection of cases examined, and summarises the main findings across the three case studies. Chapters 2-4 take the form of three individual case studies. Each of these case studies explores the context for the intervention under consideration, the objectives and key characteristics of the intervention itself, its contribution to change, influencing factors (both positive and negative) and, finally, key lessons from and any planned next steps for the intervention. Chapter 5 concludes by taking a forward look which draws out lessons, opportunities, and recommendations on RCCE for vaccination.

1.3 KEY FINDINGS

1.3.1 What are the success factors which can make RCCE an effective tool for promoting vaccination uptake?

Taken together, the diverse case studies presented in this report demonstrate that RCCE interventions offer a means of engaging directly with the social, cultural, and behavioural factors that influence vaccine uptake.

Key characteristics of these cases include: identifying underlying concerns or other barriers preventing uptake, including sub-group specific concerns; developing tailored, socio-culturally appropriate messaging and interventions accordingly; building trust by working through change agents; targeting hard-to-reach populations; uncovering undermining factors like misinformation and rumours; supporting sustained behaviour change by being led by and embedded in communities; and strengthening capacities of local health and other relevant actors have a lasting impact on vaccine uptake and overall health outcomes.

The cases also suggest determinants of the success specific to particular aspects of RCCE as follow:

Communications

- **Tailoring messages and channels to the target audience:** For example, WHO's qualitative study across five African countries (including DRC) explored the socio-behavioural determinants of people's adherence to COVID-19 measures and vaccine uptake, and identified key entry points and change agents that could be leveraged, to inform RCCE action planning.
- **Capitalising on existing local events:** In Bolivia, an implementing partner took advantage of a regular local fair in Copacabana attended by Bolivian, but also Peruvian, locals and officials as an opportunity to engage Peruvian authorities on the importance of having up-to-date vaccinations share information about how vaccine campaigns were being organised in Bolivia.
- **Transparency, openness and accountability:** Implementers across the cases referenced that the COVID-19 pandemic was a constantly evolving situation, that required them to be responsive and iterate based on changing circumstances and community needs. Doing so meant being transparent about what is known and unknown, and being unafraid to refer to experts in cases of uncertainty.

Coordination

- **Intersectoral, multi-stakeholder approaches:** In Bolivia, brigades comprised of a team of communicators, health professionals and cultural animators mobilised across over 30 municipalities, engaging with local authorities, health service structures, grassroots organizations and community members and families, to boost uptake of regular vaccination.
- **Being intentional about alignment with government:** In Tajikistan, having the government's endorsement enables the Red Crescent to operate in hard-to-reach areas as an extension of the government, and to access vaccine supplies where necessary. At the same time, building and fostering relationships with local health actors has helped build the reputation of the National Society as a trusted, competent partner, opened up new opportunities and supported sustainability.
- **Working across political divides:** In Bolivia, a key success factor was overcoming the challenges posed by differing political views and alliances, and uniting all stakeholders and institutions behind the common goal of reversing a decline in routine immunisation.

Community systems strengthening

- **Being community-led:** Case study interventions place emphasis on enabling the community to shape activities and empowering them to promote their own health outcomes, which is key to building trust.
- **Two-way dialogue and monitoring to ensure relevance:** Continuous community feedback during implementation is critical to inform iteration – i.e. the refining and/or updating of activities

are messaging based on community insights – including on changing priorities and opportunities (for example, more recently, integrating COVID-19 vaccination into routine immunisation).

- **Working through volunteers from the community:** In Tajikistan and Kyrgyzstan, for example, Red Crescent National Societies work through an expansive volunteer network made up of trusted members of the community, who engage with the community in-person, creating safe and open spaces for conversations that would not be as possible in other settings, and following up with individuals on their specific concerns.
- **Working with and through community leaders and influencers:** In UNICEF's Vaccine Action in Bolivia, working with influential community leaders was a key enabling feature, with leaders advocating for vaccination with community members and organising vaccination drives in their places of worship or own homes. Likewise, in the WHO community action plan in DRC, community leaders and healthcare workers formed the backbone of the implementation, with leveraging existing social structures more effective and efficient than 'top down' approaches which start with central government.

1.3.2 What are some of the specific challenges around deploying RCCE interventions for vaccination?

- **Amplifying misinformation and fuelling distrust:** This is risked if interventions are not informed by careful planning and evidence-based, inclusive solutions and as a result, for example, reinforce existing power dynamics, are culturally insensitive or overpromise and underdeliver.
- **Maintaining accurate, trustworthy messaging that is up-to-date** in light of changing knowledge in rapidly developing scenarios: In Tajikistan and Kyrgyzstan, Red Crescent National Societies framed their campaigns carefully so as to focus on risk prevention and vaccination, rather than commenting on the COVID-19 situation and management itself (e.g., incidence and mortality rates).
- **Conflicting messaging from other sources undermining RCCE efforts:** Early central government decisions to stall the Astra Zeneca roll out caused confusion and suspicion in DRC, undermining trust in vaccination efforts. More locally, traditional healers and religious leaders advocated against vaccines and for alternative medicines. Alternatively, other sources of information may become silent on an epidemic, risking the impression that it is no longer a threat, as in in Tajikistan and Kyrgyzstan where governments deprioritised vaccination once case numbers started to decrease.
- **Reaching diverse, particularly harder to reach, populations:** In Bolivia, challenges encountered by UNICEF's VaccineAction when trying to access geographically remote communities included harsh weather conditions and poor mobile coverage. In regions with populations which migrate regularly for work, some people missed programme activities as a result.
- **Language barriers:** In Tajikistan and Kyrgyzstan, some target sub-groups included migrants and refugees for whom Russian, Kyrgyz or Tajik content was unsuitable. And, in Bolivia, despite messaging in local languages, indigenous populations still lacked some information in Quechua and Aymara.
- **Resource intensity of, and reliance on, working with and through local actors:** In Bolivia, the programme team had to scale down community consultation due to time constraints, communicating directly with leaders only. It was necessarily time consuming to develop joint working and accountability amongst mayors, municipal authorities, health and educational personnel and community leaders. In DRC, implementation of a community action plan informed by the WHO study is reliant on community leaders' motivation to share messages and organise awareness raising events or vaccination sessions, with some more proactive than others.
- **Lack of integration of RCCE efforts with wider public health policy and service delivery:** Although the WHO study improved understanding of socio-behavioural drivers of COVID-19 denial and vaccine resistance, the RCCE community action plan it informed in DRC is unable itself to address all obstacles to PSHM compliance – for instance, lack of money to buy alcohol gel or masks, infrastructure for social distancing, or running water for regular hand washing. It could

also take better account of other public health threats occurring in parallel (e.g. cholera, monkeypox, polio), as well as competition for people's attention in the context of their other concerns (e.g. meeting their basic needs).

- **Timescales for sustained results:** For lasting impact, messages need to be ingrained into everyday decisions and life in the communities which requires repeated reinforcement and takes time. In Bolivia, it will only be possible to embed RCCE approaches into the health sector budget and routine work of health centre staff, once Ministry of Health decisionmakers have recognised their value and there has been a meaningful shift in practice which can be encoded in legislation or policy.

2.

TAJIKISTAN AND KYRGYZSTAN

The role of RCCE in Covid-19 immunisation: a case study on community-led approaches in Central Asia



2.1 BACKGROUND

This case study looks at two projects being delivered by the National Societies of the International Federation of the Red Cross and Red Crescent Societies (IFRC) on COVID-19 immunisation in Central Asia. These projects are: *Building Trust during the COVID-19 Pandemic in Humanitarian Settings*, delivered by the Red Crescent Society of Kyrgyzstan (RCSK); and *Support to IFRC's Preparedness and Response Activities to Combat the COVID-19 Pandemic*, delivered by the Red Crescent Society of Tajikistan (RCST). Each project deploys risk communication and community engagement (RCCE) approaches to support access to reliable and trusted information about COVID-19 and vaccination in priority communities.

2.1.1 Purpose

This case study was commissioned by the Collective Service, a partnership between the IFRC, UNICEF, WHO and GOARN² that seeks to transform how public health and humanitarian actors carry out community-led responses to public health emergencies. This case study examines the key achievements and learnings from the two IFRC projects to shed light on the effectiveness and best practices of RCCE approaches for COVID-19 immunisation. It is intended that this case study, along with a series of others, contributes to the Collective Service's knowledge base around what works for RCCE for immunisation, and to demonstrate proof of concept for the value of RCCE in wider health responses.

2.1.2 Context

Both projects are addressing similar challenges with respect to vaccination barriers and the COVID-19 policy landscape in their respective countries. The objectives and approaches of the projects are thus largely similar, though they have been tailored to meet the needs and realities of the specific contexts.

2.1.3 Pre-project vaccine coverage

Tajikistan launched its COVID-19 vaccination campaign in March 2021, targeting all citizens over the age of 18. According to the Ministry of Health and Social Protection, as of October 2022 (project start), 98.6% of the eligible population had been vaccinated with the first dose and 97.2% with the second dose. Given the high rate of primary series³ coverage of the target population, the government began rolling out the first booster doses in January 2022, and the second booster doses in July 2022.

Coverage of the third dose (first booster) of the eligible population was 94.7% in October 2022, but coverage for the fourth dose was much lower at 27.5%. The RCST thus set out to share information on the importance of booster doses to the general population, as well as to continue to explain the value of initial vaccination to vulnerable and hard-to-reach groups (e.g., migrants, persons with disabilities, persons with tuberculosis).

As in Tajikistan, Kyrgyzstan launched its COVID-19 vaccination campaign in March 2021. However, the vaccination rate was and remains significantly lower than in Tajikistan. As of 1 January 2022 (project start), just under 15% of the population had been vaccinated⁴, making it one of the lowest COVID-19 vaccination rates in Central Asia. With low immunisation coverage in general, the RCSK has focused its project on groups at risk of severe COVID-19, specifically with respect to access to information on vaccination and vaccine hesitancy.

2.1.4 COVID-19 policy environment

In March 2022, Tajikistan lifted all COVID-19-related restrictions and has not reported any new cases since 17 March 2022. While COVID-19 supplies (vaccines, PPE, etc.) are still available, the government has in essence heralded the end of the pandemic. This messaging has influenced citizens' willingness to get vaccinated, and has significantly slowed the rate of COVID-19 vaccine uptake. In Kyrgyzstan, the

² Global Outbreak Alert and Response Network

³ First and second doses

⁴ <https://ourworldindata.org/coronavirus/country/kyrgyzstan>

government lifted most COVID-19 restrictions much earlier, in May 2020⁵. There are currently low levels of trust in government-led immunisation efforts, coupled with widespread misconceptions and myths about the quality and safety and COVID-19 vaccines. This has made it much harder for the government to promote uptake through its regular campaigning.

2.1.5 Barriers to COVID-19 vaccine uptake

Research in both countries indicates that the main barriers to COVID-19 vaccination uptake have been vaccine hesitancy (including of immunisation more broadly); not being able to get vaccinated for medical purposes (e.g., comorbidities), healthcare worker uncertainty, or improper self-diagnosis⁶; perceptions that there is no need to get vaccinated; and being unsure of which information sources to trust. The rapid rollout of COVID-19 vaccination, including of multiple types of vaccines, has provided new opportunities for the spread of misinformation and the undermining of trust in vaccination efforts. These findings indicate the need for improved messaging, awareness-raising, and building trust to promote knowledge, attitude, and ultimately behaviour change in priority populations.

2.1.6 Opportunities for promoting immunisation

Public research in both countries found that the main drivers of COVID-19 vaccine uptake have been trust in medical personnel and trust in the vaccine itself, i.e., its safety and efficacy. Across both countries and across vaccinated and unvaccinated groups, the primary sources of trusted information are medical personnel and TV, followed by the internet. These insights point to key channels and mechanisms to be leveraged by the projects.

With respect to positioning in the health actor landscape, the RCST was well-positioned before the project within the central government structures of the COVID-19 response. The RCST is a member of the National COVID-19 Task Force, the National Platform for Emergency Response, and the COVAX Technical Working Group. The RCST works closely with the Centre of Healthy Lifestyles at the federal Ministry of Health, as well as with local immunisation centres at the district level. This close partnership with the government has given the RCST a mandate to act as its auxiliary arm, particularly for harder-to-reach segments of society. Similarly, the RCSK is part of a central steering committee on RCCE for COVID-19. While it is engaged in partnership with the government through this group, its alliance is not as close as that of the Tajikistan National Society.

2.2 ABOUT THE PROGRAMME

The projects are being delivered by the countries' respective National Red Crescent Societies. The primary aim of both projects is to contribute to COVID-19 vaccination and reduce the incidence of, illness from and mortality of COVID-19 through social mobilisation, including through providing trusted information about COVID-19 vaccination. A secondary aim of the projects is to improve the preparedness and response capacities of the National Societies and key health stakeholders in each country, primarily at the local and community levels.

Both projects focus on leveraging RCCE approaches to reach and serve a set of priority populations in areas with lower levels of uptake. They are anchored in the IFRC's Community Engagement and Accountability⁷ (CEA) approach of actively including the community in the iterative design and delivery of programming. Central to this is the establishment of two-way communications and feedback loops

⁵ <https://www.reuters.com/article/us-health-coronavirus-kyrgyzstan-idUSKBN22V1FK>

⁶ Research shows that there are many cases where community members self-diagnose and think they are not qualified for the COVID-19 vaccine without a medical diagnosis. For example, a woman with a broken arm thought she could not get vaccinated because of her injury. Additionally, some healthcare providers have expressed concerns about administering the vaccine to certain patients, like older people, since they are apprehensive about being held responsible for any adverse reactions.

⁷ <https://www.ifrc.org/our-work/inclusion-protection-and-engagement/community-engagement-and-accountability>

between programme teams and community members, to ensure relevance and build trust to bring about behaviour change.

The projects are fundamentally data-driven and context-specific. Scoping research with the communities was done before the projects were developed to understand each context, including the attitudes, perceptions, knowledge, needs, trusts and fears of specific target sub-populations. Messaging was developed accordingly and disseminated through a multitude of channels, but focused on utilising trusted members of the community (community-based volunteers, medical staff) to counter citizens' misconceptions and adequately reach last-mile individuals.

The core elements of the projects, are:

2.2.1 Information-sharing and awareness-raising activities

Information sessions: Both projects deploy information sessions on COVID-19 risks, vaccination and other health-positive behaviours which are delivered by a network of volunteers. The information sessions take place at the local branches of the National Societies, household visits, and local community health centres. Aside from being forums to disseminate factual, evidence-based medical information, the sessions are designed to be safe spaces for dialogue where the National Societies field questions from the community, log information about rumours, identify frequently asked questions, and gather suggestions and other feedback to improve project activities around delivery and targeting.

During the sessions, volunteers note participants' phone numbers to follow up afterwards and track vaccine uptake, understand any persistent hesitations or barriers to immunisation, and to provide referrals to health experts in instances where specific medical knowledge is required. A valuable aspect of what the RCSK has done is invite medical experts to the sessions to support in the delivery of the health information, since they are trusted authorities for health-related advice.

These experts also support in responding to the audience's questions and concerns in real time. At the sessions, the National Societies also distribute brochures about protective social behaviours (e.g., wearing masks) and other informational material, not restricted to COVID-19.

Public campaigns: In Kyrgyzstan, the National Society is also engaged in visibility campaigns where volunteers go into the community and engage in walk throughs, roundtables, and live broadcasts on social media and the radio. Similarly in Tajikistan, some districts have utilised mass media channels such as the TV and radio to broadcast key messaging around COVID-19, and also address the primary concerns that have been identified through ongoing community engagement activities.

Door-to-door: In Tajikistan, volunteers engage in door-to-door visits with specific hard-to-reach, at-risk groups such as persons with disabilities and individuals with tuberculosis. The RCST has access to a list of individuals from the local health centre and engages these individuals to ensure that they are not being excluded from more traditional campaigns and community gatherings.

Digital tools: In Kyrgyzstan, the National Society has an active social media presence which is used to disseminate information and collect data on perceptions, attitudes and knowledge, including gaps. The RCSK has also set up a WhatsApp group where an expert answers technical questions and concerns from the public.

2.2.2 Capacity building

The projects have been providing various trainings to programme actors and partners. The primary groups trained are the National Societies' network of volunteers. At the start of the project, volunteers received training on aspects such as medical information on COVID-19 prevention and vaccination⁸, key project messaging, how to deliver and engage with communities and sub-groups, how to gather and report on data (including the use of digital tools such as Kobo, for RCSK), and accountability principles.

⁸ For example, scientific information about various vaccines (e.g., J&J, Sinopharm, Sputnik), how volunteers and administrators can protect themselves.

Volunteers are also given regular refresher trainings⁹, though both National Societies acknowledge that there is scope for improved regularity and the updating of the content of trainings. Beyond trainings, manuals, FAQ and other resources have been developed to support volunteer capacity.

The projects have also provided training to healthcare workers on RCCE approaches, community engagement and accountability, and interpersonal skills. National Societies have also delivered capacity building to other members of the community. For example, RCSK has delivered training to religious leaders, and RCST has trained teachers, women's committee representatives, and other members of local communities. Both projects have also trained local health governance actors, such as the Republican Centre for Immunoprophylaxis in Kyrgyzstan, and local immunisation centres in Tajikistan, on technical and RCCE-related information. Both National Societies have also received training on RCCE, facilitated by the IFRC.

2.2.3 Coordination (central, local)

Both National Societies have partnerships with actors at the central level in the response, though the RCST coordinates more closely with its government than the RCSK. In Kyrgyzstan, the RCSK has been active in the RCCE Coordination Group, a multi-stakeholder group comprised of the WHO, UNICEF, USAID, the Republican Centre for Immunoprophylaxis of the Ministry of Health, and others which meets regularly to share findings, develop joint strategies, and devise key messaging around RCCE. In Tajikistan, the National Society is involved in the National COVID-19 Task Force, the National Platform for Emergency Response, and the COVAX Technical Working Group. The RCST is also working closely with the Healthy Lifestyle Promotion Centre on vaccination campaigns and broader health initiatives, cascading engagement to the district level. All information materials, trainings, and fieldwork are coordinated with this branch of the Ministry of Health.

The RCST's close engagement with the Ministry enables it to complement government support at the community level, accessing hard-to-reach groups and bridging last mile vaccine delivery. RCST has also established communication channels to share reporting on a monthly basis, to ensure close coordination with and endorsement by the government. The RCSK is also cooperating with various health system actors at the central and oblast level to coordinate activities and avoid duplication. For example, the RCSK works closely with community authorities (e.g., religious leaders) at the local level to address vaccine hesitancy and strengthen its approach.

More broadly, the National Societies also worked closely with the IFRC to coordinate implementation support, including capacity building and technical expertise, and in donor engagement. Without these coordination efforts, key informants noted that successful programme delivery would not be possible.

2.2.4 Facilitating access to vaccines

The RCST plays a critical role in engaging persons with disabilities and individuals with tuberculosis for vaccination. Volunteers are given a list of these individuals from the local health body and follow up with home visits. If an individual is unable to reach the nearest vaccination point, volunteers facilitate mobile vaccination. Bridging this gap between awareness, willingness, and actual accessibility is a significant aspect of the project.

The National Society in Kyrgyzstan has also acknowledged the importance of improving vaccine access for the most vulnerable, and are seeking to roll out mobile vaccination points in the project's final year. While building awareness and interest in vaccination is important, the project will be limited in its effectiveness if it cannot help ensure access to vaccination for all those who want it.

2.2.5 Evidence- and feedback-gathering

The projects deploy various feedback mechanisms to gather insights from the communities as well as partners to inform new, expanded and/or improved activities. For example, both projects have deployed

⁹ Staff and volunteers touch base monthly to exchange practical and methodological information. National Coordinators also engage staff and volunteers on an ad hoc basis if new information, trends, or needs arise.

initial perception surveys to gain visibility over their target populations, and plan to roll out two more each before the end of the interventions.

The projects also utilise the information sessions and other points of community engagement to receive feedback from priority groups. In Kyrgyzstan, the National Society has been training and equipping volunteers to use Kobo and collect information digitally using tablets. Beyond this, the RCSK is engaging in social media monitoring, and has hired a specialist focused on community engagement and information management to gather, analyse and report these insights.

2.2.6 Monitoring systems

Both projects have been monitoring how their information- and awareness-raising activities influence vaccination uptake. This has been done by cross-referencing the list of participants who have taken part in each session with the list of individuals who have been vaccinated at local immunisation points. Since the beginning of 2023, the Tajikistan National Society has taken this a step further by introducing a voucher system, a paper-based means to understand the project’s impact and prioritise additional advocacy.

At each information session, participants are given a piece of paper with a referral to a designated vaccination centre. Individuals are then asked to hand in the voucher at the centre when they go for immunisation. The project compares the vouchers collected at each centre with the list of those handed out, and follows up with individuals who have not been immunised. The voucher system is an innovative means of explicitly tracking the project’s impact, and also serves as a useful psychological tool to remind people to get vaccinated.

Table 1. Summary of IFRC National Society RCCE Projects

	Kyrgyzstan	Tajikistan
Timeframe	January 2022 – March 2024	October 2022 – December 2023
Geography	Bishkek, Chui Oblast, Osh Oblast, Batken Oblast, Jalal-Abad Oblast	15 districts in Sughd region, 5 districts in GBAO, 10 districts in RRS region
Priority populations	Older people and individuals with chronic illness, including those with tuberculosis Persons with disabilities Migrants and IDPs Women in vulnerable groups People living in conflict-affected areas	Individuals with comorbidities, especially those with tuberculosis Persons with disabilities Migrants General population that hasn’t received the first two shots
Main tools	<ul style="list-style-type: none"> Information sessions through volunteers (75) + follow-ups Public campaigns (physical, social media) Capacity building of local health actors (e.g., trainings) Mobile vaccine clinics (planned) 	<ul style="list-style-type: none"> Information sessions through volunteers (300+) + follow-ups Door-to-door visits, particularly for persons with disabilities / TB Bridging access to vaccines for home administration Capacity building of local health actors (e.g., trainings) Voucher system for monitoring

2.3 KEY CHANGES

The RCCE interventions in Tajikistan and Kyrgyzstan have produced significant changes to the COVID-19 vaccination efforts in the two countries. The RCCE interventions have led to positive outcomes for people prioritised for support and have also had positive secondary effects such as strengthening local health systems and health actors, including the National Societies themselves.

2.3.1 Improving awareness, perceptions and behaviours of end beneficiaries

- **Increased COVID-19 vaccine uptake amongst vulnerable people:** In both countries, the intervention led to increased vaccine uptake amongst vulnerable people (e.g., persons with disabilities, older people, individuals with chronic illness, women in vulnerable groups and migrants). According to key informants, people in these demographics are not only hard-to-reach, but trust amongst them for medical and institutional interventions has been historically low. The projects have made a significant direct impact by accessing these demographics and increasing vaccine uptake through various RCCE mechanisms (e.g., changing knowledge, attitudes and perceptions, building trust, supporting access to vaccines, etc.).
- **Improved behaviours around routine immunisation and healthy lifestyles:** The projects have also contributed to improvements in other health outcomes such as in routine immunisation (e.g., for measles, polio, rubella) and in healthy lifestyle behaviours. Although the primary focus has been on COVID-19 vaccination, both National Societies have leveraged ongoing efforts around information-sharing and capacity building (e.g., of volunteers) to influence other health-related decision-making. In light of declining COVID-19 vaccine relevance, both projects successfully expanded the scope of their activities to work with other target groups (e.g., families, pregnant women) and promote positive messaging around other types of healthy behaviours.
- **Building trust for health interventions:** An increase in vaccination uptake has been one outcome, but the focus for the projects has been on providing safe spaces, creating bilateral feedback mechanisms, and building trust with communities, which has in turn increased uptake. Through regular interactions, community dialogue and consultation, the projects have successfully increased trust amongst target groups for health interventions, as well as for engagement with local health authorities. Not only has this enabled the more effective delivery of immunisation, but has created a positive enabling environment for community buy-in of future health interventions, and the ownership of their own health outcomes.
- **Increased agency and informed decision-making:** As a secondary effect of the RCCE intervention, key informants in Tajikistan and Kyrgyzstan reported an increase in the agency of community members in seeking evidence-based information and support around health. Amongst community members, there is an increased sense of ownership and responsibility towards personal health, which means that they are reaching out to health actors and independently seeking medical attention. Community members have also become more discerning of information being circulated on platforms including social media, and are more critical about the validity of sources that inform their health decision-making. This indicates the success of the intervention in dispelling health myths, rumours and disinformation, and in supporting local communities to consume factual, evidence-based health information.

2.3.2 Improving programme effectiveness

- **Improved the quality and consistency of interventions:** The projects' systematic and inclusive approach to community engagement, feedback and iteration has significantly improved the quality of information and service delivery, which has resulted in an increase in vaccine uptake and community health outcomes. This is supporting the effectiveness and efficiency of programming for the remainder of both projects.
- **Expanded evidence-based of RCCE interventions:** The projects have produced significant new findings and data in terms of vaccine uptake and access to information that is disaggregated by gender, age and disabilities. This data has not only been useful to the design and delivery of the project, but also provides a source of valuable information for future interventions within Central Asian health systems.

The use of data and research in both contexts has been key for iteratively improving on programming. Examples of how the projects have adapted as a result of such insights are provided in Box 1 below.

Box 1. Programme improvements through perception surveys

The projects have utilised findings from the perception surveys to identify and action recommendations around programming. Examples of improved actions as a result of research insights include:

- Tailoring messaging and information campaigns to directly address the concerns and hesitations of priority sub-groups, and utilising influencers and role models from these groups to elicit behaviour change (e.g., young women and their husbands to combat the myth of infertility)
- Addressing misinformation and rumours undermining vaccination efforts by identifying their origins and clearly addressing them through accurate, trusted sources (e.g., medical professionals, religious leaders)
- Promoting reliable and trusted sources of information, and ensuring consistency in messaging across sources to ensure no contradictory information / undermining of trust and confidence
- Ensuring that all information is user-friendly, inclusive, and accessible (e.g., linguistically)
- Establishment of mobile vaccination centres to support less-mobile groups
- Capitalising on the opportunity to discuss and build capacity for routine immunisation

2.3.3 Strengthening local capacity

The projects' support to health systems strengthening has improved the efficacy of the current phase of the projects, as well as supported the longer-term capacity and resilience of local health actors.

- **Improved knowledge and skills of local health actors:** Volunteers, representatives of health governance structures and local administrators are being capacitated and experiencing positive spillovers from the intervention. For example, the Healthy Lifestyles Centre and the Immunoprophylaxis Centres in Tajikistan noted adopting best practices from the RCCE project and the trainings into their own work and programming.
- **Strengthened stakeholder collaboration:** The RCCE intervention has significantly improved coordination and collaboration amongst multiple agencies, healthcare workers and communities through regular meetings, collaborative activities and coordinated service delivery. This increased coordination and advocacy within agencies has not only provided better service delivery for communities but also increased preparedness within agencies for future health emergencies. It has also helped build trust amongst the various health actors in-country. Regular and sustained interactions with stakeholders at the national and sub-national levels have improved relationships amongst stakeholders as well as the ability to collaborate to achieved shared goals.

- **Strengthening of National Societies:** Both National Societies reported that the projects have also led to their own strengthening through the specialist training, resources, information and skills received from IFRC and other partners' support. This has positioned them to deliver current programming more effectively while also opening possibilities for the future programming of these missions. The National Societies also noted that they have benefitted reputationally from the interventions, amongst the community and other health actors due to the achievements realised to date and by association with trusted community-based actors.

2.4 THE PROJECTS' CONTRIBUTION TO CHANGE

Both projects have made meaningful contributions to the changes detailed above, through:

- **Promoting access to timely, accurate information** to hard-to-reach groups that may otherwise not be reached through traditional channels. The projects also continued providing access to information to the wider public on COVID-19 at a time when the broader information environment on COVID-19 is more contracted. Reach has been enabled by a multitude of tools and channels including traditional mass and social media, and face-to-face engagement with communities. Providing this information to the population has not only built knowledge and awareness, but also helped combat persistent misinformation, myths and rumours preventing vaccine uptake and other health-positive behaviours.
- **Knowing the audience and utilising the right sources and gatekeepers:** Providing messaging and interventions tailored to different segments of the target population to change attitudes, perceptions, and ultimately behaviours.
- **Building trust:** Through the above, fostering trust with communities to bring about improved attitudes, relationships, and behaviours, including amongst vulnerable groups that are often forgotten.
- **Embedding feedback mechanisms:** Adopting a community-centric approach with dialogue and social listening has helped gather invaluable insights for design, targeting and delivery, and also helped build trust by giving communities a sense of ownership and empowerment.
- **Taking a multi-stakeholder approach through coordination:** The projects have closely involved representatives from local immunisation centres, health facilities, and administrations to ensure alignment and coordination on key messaging and approaches.
- **Capacitating local health actors:** Strengthening local actors such as volunteers, local health authorities and administrators to be effective players in the current and future interventions.
- **Providing access to vaccines** for populations that have otherwise been excluded.

The National Societies noted that they are to the best of their knowledge the only actors engaging in RCCE activities in their priority communities. While other actors such as the government are also seeking to promote immunisation good practice, the RCCE intervention has had a significant, unique contribution as part of these efforts to elicit behaviour change and other positive outcomes detailed above.

2.4.1 Main success factors

The projects' main success factors to date have been:

- **Using the right conduits,** namely an expansive volunteer network comprised of trusted members of the community, who give a human touch through in-person engagement. Volunteers create safe and open spaces for conversations that would not be as possible in other settings. Volunteers literally go the extra mile to physically access target communities and follow up with individuals on persisting concerns, referring if and as needed. As volunteers are the key link between communities and immunisation, capacitating volunteers has helped multiply the effectiveness of project activities.
- **Being community-led:** allowing the community to shape activities and empowering them to promote their own health outcomes, which is key to trust.

- **Transparency, openness and accountability:** being transparent about what is known and what is unknown, and not being afraid to refer to experts in cases of uncertainty. The projects acknowledge that COVID-19 is a constantly changing context and are willing to be responsive and iterate based on changing circumstances and community needs.
- **Feedback and iteration:** updating programming and messaging through insights from the community, including on changing priorities and opportunities (e.g., routine immunisation).
- **Coordination and being intentional about alignment with government:** Both projects have effectively deployed coordination centrally and locally to strengthen their responses and ensure the mutual success of various interventions. This is particularly key for RCCE, which risks being undermined if messaging is contradictory across sources. In Tajikistan, having the endorsement of the government helps the RCST operate in hard-to-reach areas as an extension of the government, and also access vaccine supplies where necessary to plug such gaps. Building and fostering relationships with local health actors further helps with longer-term sustainability, opens doors for new opportunities, and builds the reputation of the National Society as a trusted, competent partner.

2.5 BARRIERS AND CHALLENGES

The projects have encountered various challenges in their delivery, some of which have been resolved and some of which are outstanding.

2.5.1 Past challenges

- **Physically reaching people:** Harsh weather conditions made it difficult at times for project teams to access various communities. Additionally, low mobile coverage for communications in the mountainous regions poses further challenges for accessing communities.
- **Language barrier of migrant communities:** Some prioritised sub-groups included migrants and refugees for whom Russian, Kyrgyz or Tajik content was not suitable. To address this, the projects have begun producing material in local languages such as Uzbek, Pashto and Farsi to ensure these communities are adequately included.

2.5.2 Ongoing challenges

- **Conflicting messaging at the macro level:** At the central level, the governments are not reporting any new COVID-19 cases and there is an overall decline in the relevance of and attention towards COVID-19. Governments are thus not engaging in the same level of risk communications to the public (e.g., through radio, TV, billboards), which is causing people to become more reluctant about COVID-19 vaccination. This has created an environment for existing hesitancies to persist and become more pronounced. To address this, the National Societies have been collecting insights on community perceptions and sources of hesitancy, myths, and misinformation to better tailor and focus their efforts. Key messages have been piloted with focus groups and will be disseminated to priority groups. Simultaneously, the National Societies are cautious to find the right balance and carefully frame their campaigns such as not to be provocative. The focus is on risk prevention and vaccination, rather than commenting on the COVID-19 situation and management itself (e.g., incidence and mortality rates).

2.6 SUSTAINABILITY

There are some emerging signs of the sustainability of the RCCE projects. By strengthening the local health systems, gathering feedback, and building trust within communities, the projects are building up a more resilient environment for the longer-term sustainability of health initiatives and health outcomes in priority populations.

To promote sustainability, the National Societies are continuing to capacitate their staff, volunteers, and other health actors through refresher trainings. Furthermore, by working closely with local health authorities, the National Societies are demonstrating the impact of the project and hope to garner interest for continued support in such work. Fostering trust in communities, also through the close partnership with local health actors, will further promote sustainability by eliciting local trust in these stakeholders, who can carry out health services after the projects officially end.

However, there are potential threats to sustainability through the reliance on large networks of volunteers. While the RCST and RSK report that volunteers remain highly motivated, this could wane given that volunteers receive no compensation. Ensuring sufficient incentives are provided¹⁰ could be a potential future step for the projects to retain this crucial aspect of the RCCE approach.

2.7 LESSONS

The following learnings about how to effectively deploy RCCE for immunisation were identified through this case study:

- **One-size-does-not-fit-all:** Taking a human-centred design approach is key to deploying activities based on the specific context and characteristics of communities prioritised for support. For example, door-to-door activities and house visits are a useful way to achieve coverage of hard-to-reach groups such as those with disabilities. Similarly, adapting content linguistically to make it accessible to the needs of migrant and minority communities has allowed people from these priority groups to be better included in the interventions. Ultimately, different groups have different accessibility and serving needs, which require tailored, specialist approaches.
- **Engaging key gatekeepers and trusted sources of information:** For the two projects, identifying the right channels and mechanisms for disseminating information was key. This included community volunteers, medical professionals, religious leaders, and other influential community-based members. Using these actors not only facilitates reach, but also makes it easier to gather feedback on the needs and perceptions of target communities.
- **Stay local:** Relatedly, the use of community-based actors helped improve reach, facilitate trust, and allowed stakeholders to address various social and cultural norms leading to vaccine hesitancy.
- **Taking a multi-media approach:** The Kyrgyzstan project in particular highlighted the value of utilising multi-media channels for awareness-raising. This included mass media (e.g., TV, radio) as well as social media (e.g., Twitter, Instagram, Facebook). Leveraging multiple communication platforms has allowed the project to reach varied audiences and reinforce its key messaging across media sources. In both countries, the perception surveys showed that healthcare staff are the most trusted sources of information in their target groups, followed by television. Leveraging these channels and reinforcing messaging across each has been critical for supporting perception and behaviour change.
- **Developing effective feedback systems:** Both projects have benefitted from the development of effective feedback mechanisms that facilitate two-way communication between implementers and communities. This has been critical to refining the interventions by including the voices and

¹⁰ In Kyrgyzstan, RSK volunteers are provided with incentives such as phone credit and vouchers to purchase goods from selected shops, in agreement with RSK. The projects should nonetheless continue to monitor the risk around volunteer motivation given its heavy reliance on volunteers.

needs of the community. Perceptions are not static, so programming needs to be updated and refreshed continuously. It has been important for the projects to use multiple channels to 'measure the temperature' of what people are thinking and feeling, their questions, to track rumours, and have direct engagement / discussions with people in communities prioritised for support.

- **Partnerships are key:** Partnerships, particularly with local government and other public health actors, have been key in facilitating reach and closing the immunisation gap.
- **Monitoring:** The voucher system in Tajikistan has been a valuable tool for monitoring the intervention's effectiveness. Beyond acting as a monitoring mechanism, it has also proven to be an innovative means of psychological nudging, by providing a physical reminder for people to get vaccinated.

The projects have also demonstrated the value of RCCE in supporting immunisation:

- **RCCE as supporting last mile delivery:** National Society volunteers have been able to reach communities in remote areas where the government cannot.
- **RCCE as a tool to build trust,** which was critical for the novelty, speed, and uncertainty surrounding COVID-19 vaccination. RCCE highlights the value of working with community-based actors, given their high degrees of social capital and access.
- **Customisation:** RCCE allows for the customisation of approaches to different sub-groups, which is necessary for overcoming persisting barriers to beliefs and health behaviours.
- **Highly responsive:** RCCE scoping and engagement enables the interventions to be flexible and go to where there is an identified need. For example, the RCST noted that they were able to support the vaccination of 50 Afghan families through mobile outreach.

2.8 NEXT STEPS

Both National Societies will continue iterating and improving on their projects until their close. The RCSK plans on hiring a new staff member who will be dedicated to running a hotline for COVID-19 as well as other health information (e.g., routine immunisation, healthy lifestyles). The RCSK also plans to expand its number of volunteers and to increase its activities providing trusted information about routine immunisation. The project also plans to deploy mobile vaccination units to reach individuals with higher barriers of access to immunisation centres.

In Tajikistan, the RCST will continue targeting its priority groups, and hopes to incorporate volunteers into wider health initiatives. For example, the team hopes to incorporate volunteers more formally into the health system to support community-based surveillance.

2.9 RECOMMENDATIONS

To improve current and future programming, the following recommendations could be considered:

National Societies

- Continue social listening and open more feedback channels with the community to listen to people and ensure project activities are not built on assumptions. This includes listening to the feedback from volunteers and their experiences (e.g., the need for the projects to develop more audio-visual materials, especially for social media platforms).
- Action the insights from the Perception Survey and other feedback mechanisms (e.g., hotline) to better tailor project activities to meet the needs of different groups. More nuanced diversification of the tools and channels deployed (beyond the core information sessions) could help improve reach and uptake.
- Strengthen monitoring mechanisms to track impact.
- Support vaccine access to bridge the gap in instances where reach is insufficient.
- Be agile in capitalising on opportunities to support wider efforts around routine immunisation.
- Promote peer learning and exchange, across National Societies and potentially more broadly; there is a plethora of resources and examples from across the IFRC to benefit from (e.g., volunteer manuals, case studies, feedback approaches, dashboards, etc.)
- Expand and incentivise volunteers, who form the backbone of the intervention.
- Update resources for volunteers (e.g., guidance, manuals) in line with changing circumstances and knowledge about COVID-19.

IFRC

- Continue thought leadership around community-based interventions, disseminating evidence and good practice to influence other donors and actors in the health space globally. This includes sharing good practice and supporting peer learning amongst National Societies across IFRC's global network. Central Asia is the first region globally to operationalise the RCCE Collective Strategy – pull out key learnings, disseminate widely to other partners, donors and stakeholders.

3.

BOLIVIA

Importance of RCCE in Immunisation efforts: Lessons from the VaccineAction Campaign in Bolivia



3.1 BACKGROUND

3.1.1 Context on Bolivia's immunisation system and the impacts of COVID-19

Like many other countries around the world, particularly those that are under-resourced, Bolivia's hospital services collapsed under the strain of COVID-19. Although most people preferred to seek care in the hospital system rather than traditional medicine, health services simply did not have sufficient capacity and resources to deal with the pandemic. The deadly outbreaks of the novel coronavirus also impacted the level of trust people placed in these medical institutions, as they witnessed patients succumb to disease after hospital admission or had loved ones die from COVID-19 while being treated in hospital.

The population was further impacted by the strict public health and safety measures which did not allow family and friends to visit the victims and say their goodbyes. The fallout of the pandemic fell significantly on hospital staff, doctors, and nurses; the health service lost a lot of personnel to the virus. This led to shortages in human resource capacities and challenges in task-shifting arrangements. Budget deficiencies were also a major challenge for health services, especially pronounced by competing demands, pre-existing debt, and new protocols, as the country was caught off-guard in a chaotic response to the pandemic. Under these circumstances, widespread coverage with the vaccine was considered the best defence to fight COVID-19.

Data gathered by ACAPS¹¹ captured the government measures put in place in response to the COVID-19 pandemic. The measures researched for this dataset were social distancing, movement restrictions, public health measures, social and economic measures, lockdowns. The data reveals that none of the public health measures included awareness campaigns, rather focused on physical and social restrictions.

A considerable number of people in Bolivia remain unvaccinated against COVID-19, or have only received partial vaccination, despite consistent global and national efforts to address this issue, particularly in rural areas. Unvaccinated individuals are much more at risk of contracting the infection and acting as carriers, therefore as active health risks in communities.¹²

"I lost my mom, she died from COVID-19," a 17-year-old student in the middle of a street play presenting the theme of the vaccine against this virus. Other young people and adults in the crowd of a street artist-led play performance in El Alto added: "I lost my grandmother", "I lost my dad"; at the conclusion of which the audience agreed in saying that the best thing to do is to get vaccinated because "there is no better gift than to be alive".¹³

In Bolivia, vaccines are strongly recommended and usually routinely given in the early years by the health services that follow and record babies' early care. Parents are incentivized to get their babies vaccinated because without an up-to-date vaccination card, mothers are unable to access benefits for breastfeeding and subsidies offered by the government in support of the mother-child pair. However, after this initial period there is no longer an obligation, leaving it up to parents to take their children to health centres to update vaccines as needed. Not all parents comply with this, which has been a weak link in the coverage of regular vaccines and boosters. In addition to providing vaccines at health centres, there are usually campaigns in schools to carry out the regular vaccinations, with permission from the parents, although that was on hold during the pandemic.

Bolivia's vaccine technology is well developed with an equipped and established cold chain and delivery system. The Expanded Program on Immunization (EPI), through its Vaccination Scheme, protects against 23 diseases with 11 vaccines for kids under 5, with a special focus on 0-1 years.

¹¹ ACAPS was established in 2009 as a non-profit, nongovernmental project with the aim of conducting independent humanitarian analysis to help humanitarian workers, influencers, fundraisers, and donors make better-informed decisions. The project is overseen by the Norwegian Refugee Council, Save the Children and Mercy Corps. ACAPS consulted government, media, United Nations, and other organisations' sources.

¹² Vacunación: Monitoring Report - shared by UNICEF Bolivia

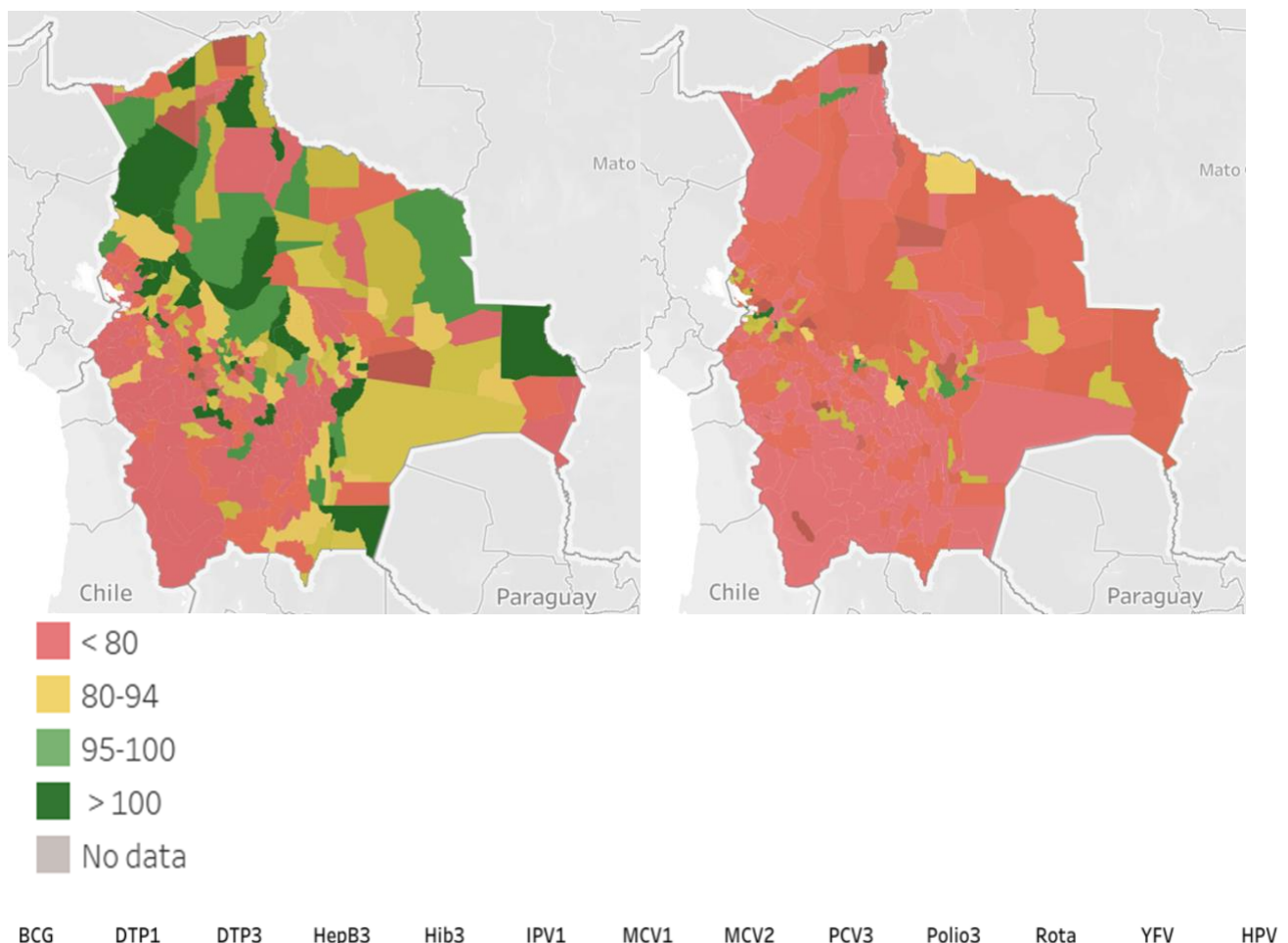
¹³ Edutainment approaches for children and adolescent students supports behaviour change on vaccine promotion against COVID-19 in El Alto, Bolivia - shared by UNICEF Bolivia.

Aside from resourcing challenges, the individual capacity of health service staff is strong. Therefore, the main weakness to improve vaccination coverage lies in communicating health information to the public, which is necessary to emphasise the importance of these life-saving tools and to rebuild the trust deficit in health care services.

“In 2022, the regular vaccination scheme for children had become the main need for risk communications and community engagement (RCCE) strategies, due to the gaps detected in coverage and the outbreaks of rubella and whooping cough detected in Bolivia after many years.”¹⁴

The health sector in Bolivia is structured across three levels - national, sub-national (Departments) and municipalities. At the local level, the health system is organised in networks which can coordinate across one or several municipalities, covering multiple health services and institutions. Under the EPI, Bolivia has traditionally had good vaccine coverage as measured by rates of routine vaccinations prior to the COVID-19 pandemic. However, this trend was reversed during the pandemic, as illustrated in the vaccine coverage maps below.

Figure 2. Comparison of Bolivia regular vaccine coverage (%) between 2016 and 2021



Battling rising mistrust in health services exemplified by active COVID-19 vaccine protests as well as an overburdened system, Bolivia’s health care staff had grown tired and, in some locations, fearful of

¹⁴ The ACT-A HAC Reporting Template (Jan - Dec 2022) shared by UNICEF Bolivia

promoting vaccines. This resulted in a double epidemic - low rates of vaccination among children as well as increasing disinformation in communities, especially fuelled by social media.

A significant number of people felt uneasy and insecure with the lack of sound information on the rapid development of the vaccines and wrongly believed that the vaccines could cause serious harm, even death. Others were confused about access and eligibility, or could not afford to take time off work to deal with the short-term side effects that they or their children might experience.

Additionally, the exclusive focus on COVID-19 took away the importance given to routine childhood vaccinations. Parents either did not take their children to get vaccinated for fear of catching COVID-19 or because they were confused between the regular vaccines and the COVID-19 vaccine.

3.2 ABOUT THE VACCINEACTION CAMPAIGN

Alerted by the worsening situation the EPI, Bolivia requested that the PAHO/ WHO and UNICEF cooperate with the Bolivian government to implement VaccineAction¹⁵, an initiative that sought to promote vaccination against COVID-19 and the regular schedule of vaccines for children and contribute to the increase in vaccination coverage in selected municipalities.

The approach focussed on dialogue and engagement between local authorities, the social structure in health, grassroots organisations, the community and families, to try to restore normal behaviours around regular vaccination schemes and recoup the pre-pandemic coverage.

The VaccineAction strategy incorporated advocacy, public information provisioning, health and social communications, risk communication, and mobilisation to create social and behaviour change to encourage immunisation among the population, especially children. All activities pursued under the programme fell under the following components:

- Advocacy, primarily conducted with local authorities at the municipal level.
- Communications to reaffirm good practices and explain the risks of having a large unvaccinated population.
- Social mobilisation events in the community to encourage interactions with relevant institutions.

“As active funders, UNICEF and partners supported RCCE efforts by the Ministry of Health, local governments, and communities, through vaccination promotion campaigns using alternative means such as contests, street theatre, storytelling, Tiktok and other, to move beyond the usual techniques of television infomercials, printed material, radio and hosting stalls at fairs.”

3.2.1 Objectives of the Campaign

The objectives of VaccineAction can be summarised as follows:

1. To restore public trust in vaccines; activate an intense social, institutional and community mobilisation to promote vaccination. Help families to return to the health institutions and to their normal vaccine practice following the pandemic (during which they stopped attending routine vaccinations). There was also an emphasis on dispelling misinformation and rumours about health and COVID-19.
2. To inform the public about the benefits of vaccines and of the illnesses that can be prevented by vaccines.

¹⁵ Vacunacion: Monitoring Report - shared by UNICEF Bolivia, p1

3. To generate a high intensity campaign with immediate results to increase vaccination coverage. Through advocacy, generate agreements and commitments that establish the basis for continuity and sustainable relationships between health and municipal institutions.
4. Strengthen methods of communication used by the health institutions in targeted municipalities, with a focus on RCCE and health messaging. Support the Health Network coordination and heads of health centres in the execution of action plans that include activities with key groups in each municipality.

3.2.2 Campaign Locations

This programme covered the Amazon, Andean and Valley regions, and operated in six departments- La Paz, Potosí, Bení, Pando, Santa Cruz, Cochabamba. The VaccineAction brigades comprised a team of communicators, health professionals and cultural animators who mobilised to over 30 municipalities. The locations were selected by the Ministry of Health, using criteria such as population; a high risk of reintroduction of illnesses; access and vaccine coverage; distribution across prioritised departments; whether the local authorities could facilitate or contribute to the activities; and that there was consensus and availability for joint work between SEDES, the Health Network, and the host Municipality. Agreement between governing authorities at National and Department levels was also required.

3.2.3 Timelines

UNICEF began planning VaccineAction in early 2022, then issued a call for proposals from potential implementing partner companies in May. Contracts were awarded to three communications companies in October. Activities took place across all target locations between November and December 2022.

3.2.4 Key Partners

- The Ministry of Health and Sports (MSD) of the Plurinational State of Bolivia
- Federation of Municipal Associations (FMA)
- Departmental Health Services (SEDES),
- Municipal Offices
- The Expanded Programme of Immunization (EPI) Bolivia
- UNICEF
- World Health Organisation (WHO)/ Pan American Health Organization (PAHO)
- 3 implementing partners:
 - Agencia TICs Empresarial Bolivia (TICs)
 - TVMos (TV/radio production company)
 - Sukini

UNICEF and PAHO/WHO contributed human resources, technical assistance, and financial resources. UNICEF contracted and coordinated the activities of three implementing partner companies: TICs, Sukini and TVmos. The development of communication materials was led by UNICEF and coordinated with the Federation of Municipal Associations, which brings together all the country's municipal governments, and supervises local mobilisation actions.

3.2.5. Tailoring the initiative to the target communities

In each of the selected municipalities, VaccineAction implementing partners followed several key steps:

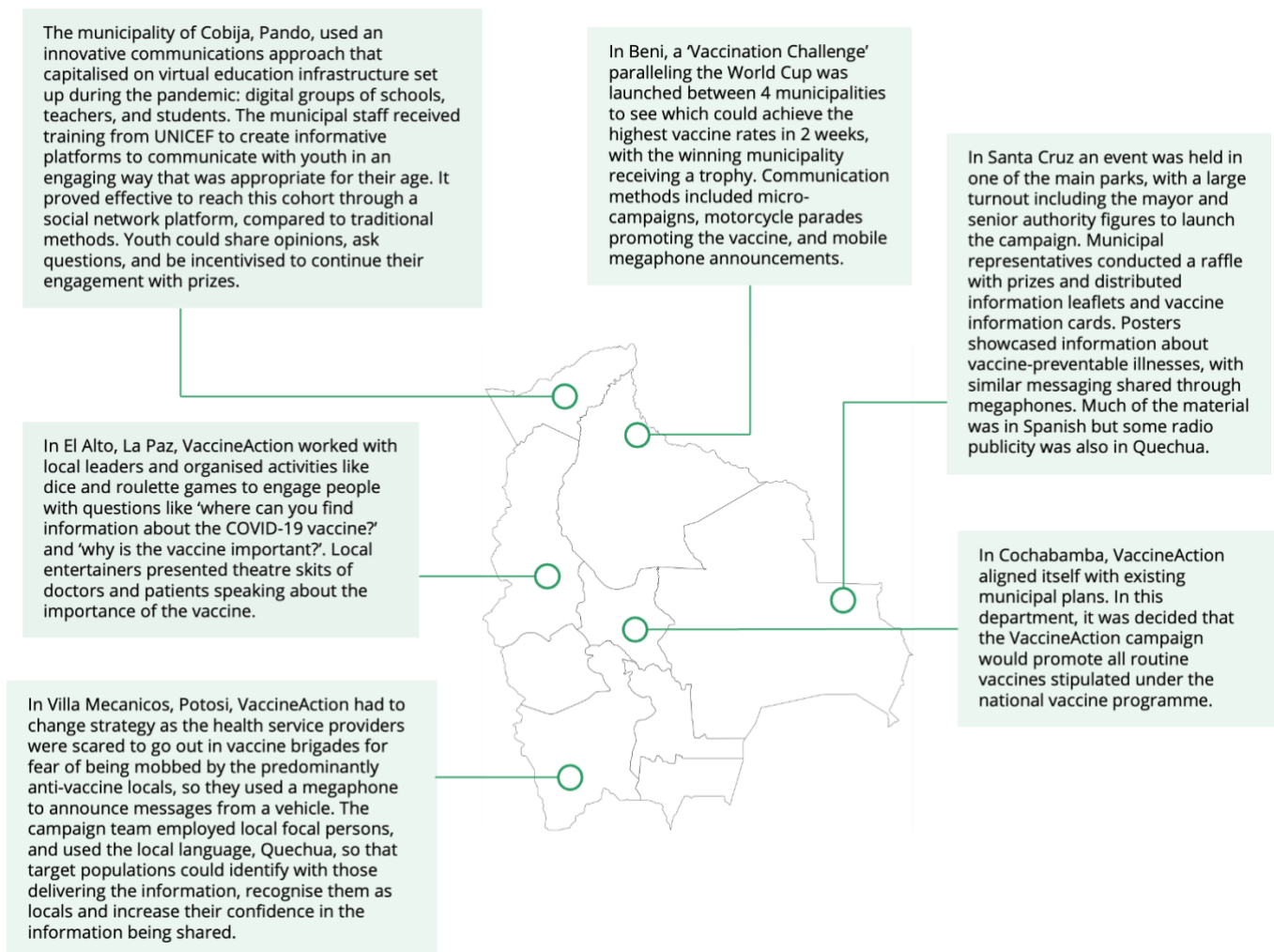
1. Prior coordination (Ministry of Health / EPI, FMA, UN)
2. Generation of expectation / defining the scope of the programme
3. Institutional mobilisation (e.g., municipal government, health, education, police)
4. Social activation to prime the target population (awareness meetings, coordination with social leaders and community organisations, educational institutions, churches)

5. VaccineAction Days as a 'main event' (vaccination brigades and/or fixed and mobile vaccination posts, extended vaccination hours, cultural and sports entertainment and celebrity visits, etc.).
6. Feedback to local authorities and leaders, with recommendations for subsequent stages related to continuity activities and behaviour change. In some cases, this included drafting and printing agreements to establish ongoing commitments between key actors.

To ensure contextual relevance and cultural appropriateness, communication strategies were tailored to the needs of the target municipality which was determined after listening to the needs and requests of health professionals and community leaders, and upon understanding how the municipal authorities were able to be involved. The needs assessment consultation began with rapid participative diagnostics for each location (meetings with the municipality and health service providers, a strength- weakness- opportunity - threat (SWOT) analysis, and participatory workshops) which informed the adaptation of activities to suit these needs. The action plan was also jointly developed with everyone involved. It was a collaborative, multi-stakeholder, bottom-up approach.

As a result, VaccineAction activities varied across the country, recognising the differing needs between cities and rural areas, languages used, and the priorities of targeted municipalities. Below is a snapshot of some of the activities conducted.

Figure 2. Vaccine Action activities by location



Although the individual activities may not be innovative, the use of these methods to build community engagement at the municipal level certainly is. For instance, in Potosí, local beneficiaries said it was novel for the health workers to visit door to door in the communities to administer the vaccine. In other municipalities like Cobija, vaccine drives were combined with an entertaining event, which was made possible with the funds and resources provided by UNICEF. Riding the wave of the World Cup to generate friendly competition between municipalities rallied the local authorities and motivated the health staff as well as the general public in Beni which is not something that municipalities would initiate on their own, but was successful with the know-how from implementing partner Sukini and UNICEF.

Addressing the fatigue and low morale of overburdened and grieving health service staff as a priority was a novel and important approach taken by two implementing partners Agencia TICs Empresarial Bolivia (TICs), and TVMos. Through emotional support sessions guided by a psychologist, the intervention supported and revitalised health personnel in the target municipalities, which allowed them to continue working with greater commitment and renewed motivation.

3.3 KEY CHANGES

The RCCE interventions produced significant increases to both the regular and COVID-19 vaccination coverage in the participating municipalities. The RCCE interventions have led to positive outcomes for their target beneficiaries and have also had a positive influence on the systems of public health communications, such as strengthening relations between health and municipal actors, and building the RCCE capacities of their staff.

3.3.1 Change in Knowledge

“People were better informed about the vaccine and about taking care of their children’s health”.

- Senior health service staff, Beni

TMos, among others, reported a shift among the target population during the mobilisation phase. Locals started to ask questions about immunisation- especially mothers who had lost the habit of taking their babies to get routine vaccines. The local health care providers were prepared and ready to respond to the increase in demand.

“More RCCE is needed, people want more interaction.”

- TVMos

Health staff also learned something about RCCE strategies and the importance of teamwork. In Cochabamba, it was noted that they did not usually work so closely with the community in an integrated way, knocking on doors etc. Vaccine brigades did go out at scheduled times in the past, but the door-to-door approach was a new way of working. Being able to involve and work with a range of skill sets and community figures, all going into communities together was helpful and effective. Communication is often not a priority among health sector staff at all levels, but this initiative made them think more about it and make it a priority through the work that they do.

3.3.2 Change in Attitudes

- A crucial positive change has been the shifts in attitudes of the community members towards vaccination. One beneficiary we spoke to reported that he had never had any vaccines but went to get the COVID-19 vaccine after learning about it through VaccineAction activities in his neighbourhood.
- In Beni, the target communities started being more receptive to the health staff after the VaccineAction intervention. These positive trends also acted as a motivational factor for health care professionals to be more confident and inspired, after having been overwhelmed by the pandemic and experiencing resistance to the vaccines.
- A senior health professional in Beni reported being able to see the effects of advocacy work in action with the municipal authorities during this project.
- The Cobija Municipality reported an important shift in understanding the need to prioritise RCCE:

Some parents in Cojiba were hesitant, confused and sceptical about the vaccine authorisation processes for the different age groups (initially those aged 18 and older then younger groups); the presence of epidemiologists and vaccine specialists were able to help overcome this by explaining it to them.

“In the past, especially in Latin America, ‘bricks and mortar’ projects were favoured by the State and considered more important and easy ways to make citizens happy, for instance building stadiums. But during the pandemic, when people were dying from the lack of accurate information and medical resources, the need for this type of communication and engagement work on immunisation became very clear to the municipality staff in Cobija.”

3.3.3 Change in Behaviours

- Increased agency and informed decision-making: A prominent development from VaccineAction as reported by members of the implementing team was the increase in health information-seeking from community members. They began approaching and meeting with health service staff, vaccine brigades and community leaders to obtain details and information to support their decisions with evidence. In Potosi, two beneficiaries with children reported that they were motivated to get together to discuss how to bring further awareness about immunisation in their communities and even started thinking about other health issues such as child nutrition in schools.
- Increased vaccine uptake and acceptance in target communities for COVID-19 and regular vaccines: In each target municipality it was reported that the vaccine coverage had been increased during the intervention period, indicating that people had either been motivated, convinced or incentivised to get the vaccine and/or bring their children to get vaccinated.
- Improved behaviours around routine immunisation: Amongst community members, there is an increased sense of ownership and responsibility to protect themselves and their families, but also neighbours. Several beneficiaries reported actively seeking out their neighbours to alert them to the vaccine brigade planned visit and encouraged rural family members with unvaccinated children to bring them to the town for vaccination. In El Alto, people did not typically bring their children to routine vaccinations such as yellow fever, tetanus or whooping cough; however, according to one beneficiary they have now started to do so after the VaccineAction campaign.
- Building trust between communities and health staff: The face-to-face engagement was an important strategy and valued by the community members. The target populations became more receptive to the health care workers after the VaccineAction intervention. Previously health staff in

some localities were nervous to go out into the community in vaccine brigades for fear of protests and backlash.

- Unexpected results included an increase in interest and engagement from mayors in the target areas.

3.3.4 Strengthening institutional capacity

- Increasing motivation and incentivising health staff: Implementing partner TICs reported that their “contest” to encourage health personnel was very positive because it motivated the participation and adherence of some authorities, both municipal and health centres, to increase the amount of the prize...“one of the heads of a health centre even put their own money to increase the prize”.¹⁶ Sukini reported that they offered polo shirts to motivate the health staff.
- Strengthened stakeholder collaboration: The RCCE intervention brought local and regional government, health service providers and community leaders together to unite behind a common goal. VaccineAction implementation acts as a model of good practice in institutional cooperation, proving that it is possible to collaborate to achieve better outcomes for citizens.

“The good coordination among groups within different institutions (..and..) inter-institutional alliances were important features of the success.”

- **Senior Municipal staff member, Pando**

- Expanded evidence-base of RCCE interventions: VaccineAction can be regarded as a ‘sandbox’ for trialling RCCE approaches in Bolivia. The implementing partners and local/institutional collaborators carried out a wide range of activities using different strategies and methods to achieve the same goal- increased vaccine coverage and informing citizens about immunisation. VaccineAction has generated valuable information on what works to reach disparate communities, in different locations, and on varying timelines, that can be used by UNICEF, local health services or municipalities when planning future interventions.
- Improved knowledge and skills of local health actors: Health and municipal staff reported having learned a lot from this intervention about RCCE and health communications through the meetings and discussions with all the implementing actors. TVMos is in the process of sending out certificates to the 1700 people that were directly involved in delivering VaccineAction in the localities that TVMos was responsible for to acknowledge their efforts. Senior health and municipal staff mentioned a desire to replicate the RCCE strategies and methods to apply them in their wider work (resources permitting).

“We would like to copy the methods used by VaccineAction in our own work moving forward, and put it into practice with regular vaccine campaigns, for instance at the beginning and end of the year...and organise events for the International Day of the Child, or around Christmas.” - Departmental Health Service (SEDES),

- **Beni**

¹⁶ Interview reported in Vacunacion: Monitoring Report - shared by UNICEF Bolivia, p8

3.4. EVIDENCE OF VACCINEACTION'S CONTRIBUTION

3.4.1 Increase in Vaccine Coverage

- There was a definite 'uptick' in the coverage of vaccines that were promoted, as the number of children vaccinated in the timeframe of Vacunación increased- meaning people had heard, understood and reacted to the information. The results show that the initiative did stimulate demand for the vaccines and motivate parents to bring kids to get vaccinated.
- In each target municipality it was reported that the implementing teams surpassed their established goals. This has also had a direct effect on the subsequent vaccination rates which have not dropped again since the intervention ended in December 2022. An evaluation report is currently being prepared although figures have not yet been reported by the Ministry of Health, except for Beni where they needed to announce the winning municipality of the 'Vaccination Cup'. Implementing partner Sukini were aiming to increase the vaccine coverage by 8% in four departments in Beni, however they exceeded their target by 157%.
- Sukini reported that the winning municipality in Beni saw vaccination numbers increase from 177 in the first week, to 412 in the second week and 933 vaccinated in the final week of the intervention. This evolution shows the positive effect and importance of communication efforts that were carried out through the municipality, and through means of local communication and partnerships between public and private institutions.¹⁷
- Another example is the RCCE campaign carried out precisely to attack the rubella outbreak in the department of Beni, which reached a figure of 170% in the increase in coverage.
- After a post-campaign analysis, health workers in south Cochabamba saw an increased coverage of the regular vaccinations from below 30% coverage to 60%, which was more than they expected for this short initiative.
- In the municipality of Cobija, during the first phase of the vaccine campaign a database was created of vaccinated people, so health and municipal staff could follow the progress and see who came back for the next dose.
- After socialising the topic in schools and among other groups in the neighbourhoods- the Municipality of Cobija saw a reduction in resistance to the COVID-19 vaccine which was a significant effect observed within the period of this initiative.

3.4.2 Improved Community Engagement

- The locals participating in the campaign activities told the TVMos implementing team that previously there was no awareness raising campaign in their community, no one had ever approached them to explain anything about vaccines and immunisation or offer information.

TMos noted that the number of followers of the Facebook pages which were set up for each region rose due to the Vacunacion (VaccineAction) project, and more people have engaged with the content and received information.

3.4.3 Strengthening Health Service Capacity

- Working collaboratively with existing health system across the different municipalities enabled UNICEF to support the Ministry of Health with vaccine promotion activities while simultaneously strengthening their relationship with communities.

¹⁷ Final Communication and Mobilization Report, VacunAcción: Vacunados Ganamos por Goleada, Sukini, p14

- By providing technical support for communications and public health messaging, VaccineAction has built RCCE capabilities among healthcare professionals and local authorities, creating immediate vaccination results as well as long-term capacity strengthening.

3.5 MAIN SUCCESS FACTORS

“This initiative was unique - distinct to what other institutions had been doing. The difference with VaccineAction was that it focused on individual citizens, at the community level, door to door, going into the streets and speaking with people. This was the key to its success. Normally campaigns in the past have been through promotional infomercials on television or radio, not face to face.”

- Health Centre Staff, Cochabamba

Capitalising on existing local events such as regular fairs or markets provided a guaranteed audience for the campaign messages. TVMos took advantage of a regular local fair in Copacabana which unites Peruvian and Bolivian locals and authorities. They were also able to explain to the Peruvian authorities the importance of having up-to-date vaccinations and how the vaccine campaigns were being organised in Bolivia.

Involving community leaders was of utmost importance, so that they were able to approach the communities in a much more coordinated and effective manner, as there are still many social organisations and syndicates operating, such as CNMCIQB-BS (The Bartolina Sisa National Confederation of Campesino, Indigenous, and Native Women of Bolivia). These organisations are very much the ruling power of the communities because whatever is decided in the assemblies of these rural syndicates are always carried out.

In Cobija, good pre-event publicity using various communications channels including national media coverage of the event put a spotlight on the programme. Hosting the main event in a cultural and entertaining place like a park that many people visit, with games and activities for children, food, entertainment for adults and for the whole family to enjoy drew a greater audience. Most significantly, good coordination among groups within different institutions, such as the Departmental (Pando) health secretariat as well as the municipal health directorate and others who were a part of it, achieved inter-institutional alliances which was an important feature of the success.

One main success factor was overcoming the challenge of different political views and alliances. VaccineAction managed to get all stakeholders and institutions to leave their political colours behind, and uniting various actors for the purpose of advancing the health goals and in this case regular vaccines. This is an achievement that was emphasised by several health and municipal staff members interviewed for this study.

A feature which sets the approach used to RCCE in Bolivia apart from others in this series of case studies is the use of different ‘edutainment’ approaches that include street theatre¹⁸, storytelling and social networks made up of young people, women, health professionals and teachers that focus on the most vulnerable citizens. Raul Yujra, director of the Los Andes Educational Unit, affirms that “the playful and friendly way of sharing the benefits of the vaccine through street theatre” has been a strong example on how community engagement centred on youth can not only promote vaccination among students, but also between their parents, close family members and in the whole community.

¹⁸ Traditionally used in many parts of Bolivia, street theatre, locally known as *el teatro callejero* dates back many years and is found in many Latin American countries. It was systematized through Augusto Boal, a Brazilian playwright with his play *El Teatro del Oprimido*, where he promotes a participatory theatre that encourages forms of democratic and cooperative interaction between the participants.

3.5.1 Factors relating to the wider enabling environment

One of the strategies in Beni was to promote vaccination through challenges between municipalities, taking advantage of the attention generated by the football World Cup. The initiative managed to exceed their coverage goal for the month of November, according to official data, increasing coverage by 187% among children under five years old.

3.6 BARRIERS AND CHALLENGES

3.6.1 Challenges

Mid-2022, UNICEF Bolivia received funds which were paired with cut-off times at the end of the year and following a later addition of further funds they expanded the geographic scope. UNICEF's implementation team then had the task of involving 30 municipalities in a period of only 6 months - a much bigger scope than the original one requested by the Ministry of Health. This expansion was perfectly aligned with what the Ministry already had in mind, due to the early success that VaccineAction strategies were having through the first implementing partner Agencia TICs. UNICEF had to contract two more companies- Sukini and TVmos- to cope with the additional municipalities. Due to the later addition of municipalities and long contract-award times of UNICEF Bolivia these implementing partners were challenged with a condensed time frame of only two months.

It takes time to see substantial lasting impacts of such communication activities takes time and messages need to be ingrained into everyday decisions and life in the communities. This requires ongoing reinforcement from health centres to repeat the messaging and ensure the community remains engaged on the topic. Furthermore, in order to embed such RCCE approaches into the health sector budget and routine work of health centre staff, the decision-makers within the Ministry of Health need to understand the value of community level RCCE activities. Only after some time has passed and there has been a sustainable shift in practices, is there a possibility for the messages to be turned into public policy and legislative action.

The Ministry of Health was the ultimate decider of which municipalities were selected, but internal coordination across national, department and municipal/ health network level was challenging on this six-month timeframe. For example, it took over a month to decide which municipalities the programme should focus on and therefore significantly cut into implementation time.

Working with the communities was also very time-consuming and the programme team had to scale down the consultation and discussions that they wished to have with community members, by only directly communicating with the leaders, which turned out to be efficient. The issue here was that the messages they wanted to convey were created in-office and not directly with the population.

There were some necessary steps to follow at a local, regional and national level due to political issues which often interfere in Latin American countries, particularly in Bolivia where the national government and ministries belong to a certain political party; the regional governor to another and the municipality to another.

This is considered a very big barrier in Bolivia since the relationship between these levels of government can be complicated and affect coordination on all social topics. With a clear mandate from the Ministry of Health UNICEF were able to work around it and convince the mayors, the municipal authorities, health and educational personnel and the community leaders to work together. It was essential that no-one rejected the programme, whether it be the church, the government or key gatekeepers that were not interested.

The implementation team organised multiple preliminary meetings with the authorities to give them all the information of what was planned. With clear communication and effective people skills, they were able to convince all key actors of the importance of this intervention.

There were also the challenges of working with community leaders and influential cohorts that were less accepting of vaccines e.g., in El Alto the Evangelical Christians did not believe in the vaccine initially, but slowly accepted it after talking with the health professionals in the vaccine brigades that went into the communities. Also, as an incentive to interact with the topic, TVMos gave them T-shirts and balls which helped to engage with the project messaging’.

3.6.2 Barriers

Much like the traditional challenges that are faced with programmatic interventions, time, financial and human resource constraints have been a limiting factor for VaccineAction. The health care staff continue to be overloaded since the start of the pandemic and this programme added additional work for them. Activities had to adapt to their availability and time constraints to work with them effectively. It was also noted that not all authorities understood the project objective quickly and others did not place much priority, once again requiring modifying and addressing these challenges with flexibility.

In some areas there were many competing needs, but VaccineAction could not address them all, so they had to establish a clear scope and then set up longer term agreements in place for continuation in the future (if/when the funds are available). This also required prioritisation in terms of locations that could be covered over the short timeframe. For instance, in Beni, the decision was made to focus on 6 municipalities with high covid rates and high population figures.

This led to other municipalities feeling excluded from the intervention, although they were interested in running the programme, some finally choosing to replicate some elements of the strategy to inform parents about vaccines for children. In El Alto, a sizable region with migrating populations between towns and cities, some people were forced to miss programme activities due to their work schedules. The transiting populations were often the ones unvaccinated and the ones missing the communications, this carried burdens for the rest of the populations. Dedicated resources for activities to address these groups in rural areas would have been beneficial.

Across the country, even in the municipalities that were selected for the programme, there was a request for additional resources that would allow expanded activity (i.e., more money to produce more materials or target a larger population) but budget was the limiting factor. The project teams overcame these limitations with creativity and through staff who have been proactive, skilful, and committed.

“Budget is always a limiting factor at SEDES and for Mayors. Local health services have limited budgets, but they try to do what they can with what is available. UNICEF provided mobilisation costs for gas, radio adverts, graphics which added to the resources and amplified the campaign.”

-Health Centre staff member, Cochabamba

The complexity of communication campaigns was also recognised across the process of implementing the programme. Even though there was some messaging in local languages, it was felt that the indigenous populations in El Alto still lacked some information in Quechua and Aymara.

Most importantly, as demonstrated by the anti-vaccine protesters in Villa Mecanicos Potosi, or by the rumours discrediting vaccines the Municipality of Cobija, Pando which began during the pandemic, medical and government staff in those areas were afraid to promote the COVID-19 vaccine or talk about new outbreaks of resurging diseases like polio and whooping cough due to the strong resistance against vaccine technology. People had grown weary, suspicious, and developed generalised doubt because of

the growing disinformation against vaccination. The programme activities had to find a way forward to reach such groups with the health messages.

The context was different in each location, so adaptability was required from the vaccine brigades. Funds to facilitate logistics were needed for example to access communities with many unvaccinated children on several islands on Lake Titicaca. In some cases the health professionals did not have petrol money so the implementing partner covered the costs of their mobilisation, otherwise they would not be able to get there or would have been demotivated.

3.7 LESSONS

The following lessons learned about how to effectively deploy RCCE for immunisation were identified through this case study:

- “Action research” at the beginning of the initiative gave them useful information which they were able to use in the programme design to achieve great results.
- Partnerships are key: Establishing and facilitating partnerships, particularly between the different levels of government and with public health actors and community leaders, has been key for effective cooperation and for increasing the reach of the intervention.

Sukini worked through local teams which acted as delegates for implementation. Sukini designed a concept for a TV advert of parents playing with their son at 3pm in the afternoon.

The feedback they received from the local team was that nobody plays with their children in Beni at that time of the day in the blistering heat, but instead at the cooler hour of 7pm, so the image should be set in the evening.

Local teams were essential to sense check publicity material to ensure it was locally appropriate and represented the target communities. Together they were able to generate successful products by applying Sukini’s technical skills to the local knowledge.

- Sukini representative

- Engaging key gatekeepers as trusted entry points to the community: Identifying the right channels and mechanisms for approaching a community and disseminating information was key. This meant meeting with influential community leaders, medical professionals, religious leaders, in addition to local government figures. Gaining buy-in and support from these actors was essential, not only to facilitate access and reach, but also to approach the communities in a more coordinated and effective manner.
- One-size-does-not-fit-all: Taking a human-centred design approach is key to deploying activities based on the specific context, characteristics and needs of target groups. For example, door-to-door activities and house visits are a useful way to achieve coverage of hard-to-reach groups such as very rural households. Similarly, adapting content linguistically to make it accessible to the needs of communities has allowed target groups to be better included in the interventions.
- Be relatable: Incorporating professionals from the target areas within the VaccineAction teams, and integrating local languages, and social and cultural norms in the intervention design helped to reach new audiences and gain trust from the communities as they could identify with the ‘face’ of the messaging.
- Taking a multimedia approach: The project used a range of communication methods for awareness-raising and publicising vaccination events, which were selected to suit the

communities and target audiences. This included mass media (e.g., TV, radio), social media (e.g., TikTok, Instagram, Facebook) as well as mobilising among communities with a loudspeaker or attending markets and fairs to distribute information. Leveraging multiple communication platforms allowed VaccineAction to reach varied audiences and reinforce key messaging has been critical for supporting behaviour change. Voice and radio continue to be the medium with the greatest local and municipal impact in semi- and peri-urban areas, but above all for rural areas. Television, audio-visual media and social networks have an impact in peri-urban areas, and mainly urban ones.¹⁹

- **Advocacy, Communication and Mobilisation:** Many people involved in the implementation emphasised the importance of this trio. In addition to mobilising vaccine brigades, vaccination events and fun activities, advocacy among local authorities and community leaders, as well as awareness raising in the community through different means of communication, were both key features to promote sustainable impacts that last beyond activity funding.
- **Education through entertainment:** Games, competitions, or entertaining events such as street theatre have been an innovative and effective way to motivate beneficiaries to engage with vaccine information and encourage or incentivise them to attend the vaccine drives.
- **Taking care of caregivers:** VaccineAction implementing partners understood the state of play of the local health service providers post-pandemic. Since the success of the programme depended largely on these front-line staff, certain activities were designed to motivate, support, and incentivise health staff to enable them to perform their duties well.
- **Importance of human social networks:** findings from this case study echo one of the lessons noted in the Vacunación Monitoring Report; human social networks are a core element of the communication process, allowing the circulation of messages or adapting, promoting, and rechannelling them through digital networks and word of mouth.

VaccineAction has demonstrated the value of RCCE in generating rapid results in immunisation:

- **RCCE as supporting last mile delivery:** With UNICEF funding, the vaccine brigades have been able to mobilise in new ways and reach communities in remote areas where the State health services cannot, and even visit door to door where necessary.
- **RCCE as a tool to build trust,** which was critical for the novelty, speed, and uncertainty surrounding COVID-19 vaccination but also regular vaccines. RCCE highlights the value of working with community health staff, given their high degrees of social capital and access.
- **Customisation:** RCCE allows for the customisation of approaches to different sub-groups, which is necessary for overcoming persisting barriers to health behaviours and targeting specific demographic groups or communities. This differs from national 'top down' campaigns.
- **Highly responsive:** RCCE scoping and engagement enables the interventions to be flexible and directly target the communities most in need, with rapid results.
- **Spotlight on the importance of RCCE over infrastructure projects:** A critical learning for public health and governance decision-makers during the pandemic was the need for this type of communication and engagement work on immunisation. Local governments realised that this level of protection that the State can offer to people is valuable to parents and families in the community (more than some 'brick and mortar' projects).

¹⁹ Vacunacion: Monitoring Report - shared by UNICEF Bolivia, p12

3.8 LOOKING AHEAD

3.8.1 Sustainability

There are some emerging signs of the sustainability of the RCCE intervention, but it is also acknowledged the main objective was to rapidly increase vaccination coverage rather than set up a sustainable mechanism. Although the activities took place over a short period of time, they were quite impactful in terms of level of engagement from the communities, and the knowledge they now possess sets a solid foundation for future vaccination campaigns. More people now have access to information about the regular vaccination schedule and view vaccines as a defence against illness. In addition, by strengthening the local health systems, gathering feedback on what worked, and building trust around health services within communities, the initiative has contributed to building a more resilient environment for the longer-term sustainability of immunisation initiatives in the target populations. The trust established because of these activities will encourage community members to value the protection offered by vaccines and visit the health centres for regular vaccines or other services in future.

Increased resources allocated by the government to health services or municipalities could help these actors retain some of the key elements of the RCCE approach to integrate in future campaigns.

Health staff in Cochabamba are talking with their SEDES (who are responsible for managing campaigns), to stress how important the community engagement work is, and explain that resources are always the limiting factor.

The same staff that were involved in VaccineAction are working through the normal funding framework via the SEDES to apply for funds to launch a similar but wider project across the department, with the brigades of doctors and nurses to go out into the communities each month.

Several respondents informed us that some mayors decided to continue with the campaign after Vacunación in any way they can- for instance they have ongoing written agreements pledging commitment with the implementing partners. Although these municipalities may want to continue (there are good intentions) they may still need support with resources. UNICEF is doing follow-up to see what comes of these agreements and support them as social behaviour change is not possible overnight, rather a mid-to long-term process. Through VaccineAction, UNICEF aimed to stimulate ongoing interaction between health sector actors and municipalities to continue the dialogue.

3.8.2 Next steps

VaccineAction has delivered promise and creativity in managing vaccine promotion and rapidly increasing coverage. It has also highlighted the importance of RCCE efforts as a means to build institutional trust in the health sector and offer suggestions on how this could be sustained. The programme has been an example that the Ministry of Health and Departments would like to emulate, copying the methods/approach used in their own work moving forward, and putting it into practice with routine vaccines campaigns too, such as those at the beginning and end of the year, e.g., the Department of Beni plans to capitalise on important days like the International Day of the Child, or Christmas to organise events.

Adopting a multi-stakeholder approach has illustrated what can be achieved by a joint effort and it is hoped that some relationships established for VaccineAction may continue. It was also noted that social change is a process that takes time and requires ongoing reinforcement. In some cases, further work is needed by the local health centres and municipality to target minority groups that are still resisting vaccines, for instance in Beni, there are some religious groups, parents organisations and anti-vaccine groups, but the SEDES acknowledges the need to continue work to convince them.

3.9. RECOMMENDATIONS

To improve future programming, the following recommendations could be considered:

3.9.1 A longer timeframe

- Would enable UNICEF to organise a more homogenous approach across implementing partners and departments.
- Consider the internal decision-making timelines for coordination and consultation processes within government departments at national, regional, and local levels.
- Behaviour change projects should start with evidence gathering to understand the situation and needs of the target communities.
- A longer period would allow time for the project team to speak with community members at household level, (not just consult local leaders) before implementation. This step would enable them to design a strategy with participation from the public.
- For vaccines that require multiple doses the implementation timeline should allow for the required waiting period between doses.

3.9.2 Community engagement

- Engaging local leaders and influential community figures goes a long way to building trust and gaining access to social groups that may be harder to access. It is important to know and respect the local culture, for example, the norms for approaching indigenous leaders.
- Information gained in the early consultation phase can indicate what types of activities each community would find engaging and which communications methods would be appropriate.
- Local events that are programmed in the community during the project time frame can be exploited as they present an opportunity to reach a large and captive audience.

3.9.3 Methods of communications

- Focus on large-scale communication campaigns as they work well to boost vaccine rates, share information to a wide audience and give a foundation for future smaller campaigns.
- If funding is available, big events have had more impact in terms of vaccination delivery than the smaller health promotion and service delivery systems currently in place which are often limited to the local health centres. For instance, produce and cultural fairs are important in Bolivia because they are key community events that bring together lots of municipalities, neighbourhoods and commercial sectors and they are already programmed into the local calendar.

3.9.4 Logistics and access

- The mode of delivery for regular vaccinations is limited to the health centres where people must go themselves, or occasionally in some educational buildings. Increasing the places for vaccine delivery, including peri-urban locations, may improve access for rural families, people with limited mobility or those who cannot afford to take time off work.
- Facilitating transport (or reimbursing transport costs) for local health workers can help them access rural and faraway communities and motivate them to do so.

3.9.5 Programme management

- Start monitoring early, while activities are still underway to capture progress and useful insights to learn from all stages of the process.

- Covering a large geographical scope and working with multiple implementing partners using different approaches and techniques can be challenging for management and monitoring. Agreeing on communications and reporting mechanisms and frequencies in advance can help to maintain a feasible workload for the management team, considering the human resources available. Delegating greater autonomy and decision-making responsibilities to the implementation teams may also reduce the burden on the management team, when possible.

4.

DEMOCRATIC REPUBLIC OF CONGO

Using Action Research to Strengthen Community Engagement with the COVID-19 Pandemic Response in Sub-Saharan Africa



4.1 BACKGROUND

This case study looks at the approach taken by the World Health Organization's Regional Office of Africa (WHO AFRO) to strengthen risk communication and community engagement (RCCE) strategies to improve COVID-19 vaccination in target communities. This includes a qualitative study using action research to engage key sub-groups in the target communities, and an exploration of the effectiveness of the resulting product- a Community Action Plan.

These Community Action Plans were developed with the target communities on the basis of the research findings. Five countries were included in the study (Congo, DRC, Guinea Bissau, Zambia and Zimbabwe), and several Community Action Plans are under development. For this case study we focus on the Kinshasa Community Action Plan, in the DRC, since this was the first to be launched and implementation is underway.

4.1.1. Context on COVID-19 in Africa and policy decisions for pandemic response

As of 10 March 2023, the confirmed cases of COVID-19 in the WHO African region are reported to be as high as 8,968,069, with 92% of these cases having made a successful disease recovery. In the last two weeks, reports of a 104% increase in cases is being reported, although the deaths remain low²⁰. The COVID-19 pandemic stress-tested and exploited institutional, economic, societal and global solidarity gaps.

In Africa, the spread of the virus was compounded by the simultaneous occurrence of 136 health emergencies, with 38 countries experiencing some level of food shortages due to extreme weather events, political crises or conflicts, which also hindered the pandemic response. Combined, the multiple emergencies and the pandemic exposed the fragility of primary health care in many countries and the chasm between the African continent and the rest of the world in access to advanced medical research, technology and equipment. The gaps witnessed in the delivery of COVID-19 vaccines, personal protective equipment (PPE) and medical oxygen left people on the continent doubly exposed to the disease.²¹

Five countries account for the highest number of cumulative cases: South Africa, Ethiopia, Zambia, Kenya, and Botswana. The five countries that have reported the highest number of cumulative deaths are South Africa, Ethiopia, Algeria, Kenya, and Zimbabwe. The COVID-19 pandemic is generally stable in most countries in the region, however from 26th February to 5th March 2023, there was a 104% increase in the number of confirmed COVID-19 cases observed by the WHO in the Africa Region.²

Since the declaration of the COVID-19 pandemic in March 2020, the fight against the disease remains largely dependent on the adherence of populations to preventive measures, vaccines and testing. Data gathered by ACAPS²² captured the public health and safety measures (PHSM) put in place by governments in response to the COVID-19 pandemic, i.e., social distancing, movement restrictions, public health measures, social and economic measures, and lockdowns. The ACAPS data revealed that across Africa over 35% of PHSM related to strengthening the public health system and isolation/quarantine policies, whereas only 10% were awareness campaigns. Taking the DRC as a specific example, only 1.7% of all government measures were awareness campaigns, yet almost 50% of measures focused on movement restrictions and social distancing. Reports from many sub-Saharan African countries show a laxity in compliance with these preventive measures²³.

The WHO AFRO reported a relaxation of public health measures, refusals, and hesitation in taking vaccines due to the general perception that the COVID-19 pandemic is over.²⁴ However, the appearance

²⁰ WHO AFRO, Weekly Bulletin on outbreaks and other emergencies, Week 11: 6 to 12 March 2023, [OEW11-0612032023.pdf \(who.int\)](#)

²¹ COVID-19 STRATEGIC PREPAREDNESS AND RESPONSE PLAN FOR THE WHO AFRICAN REGION, 1 FEBRUARY 2022–31 MARCH 2023 [Microsoft Word - SPRP 2022 16\(1\) \(who.int\)](#)

²² ACAPS was established in 2009 as a nonprofit, nongovernmental project with the aim of conducting independent humanitarian analysis to help humanitarian workers, influencers, fundraisers, and donors make better-informed decisions. The project is overseen by a consortium of three NGOs: the Norwegian Refugee Council (NRC), Save the Children and Mercy Corps. ACAPS consulted government, media, United Nations, and other organisations sources and the data collection included secondary data review.

²³ WHO presentation of findings Pointe Noire, Congo - shared with the case study team by WHO AFRO.

²⁴ WHO AFRO, COVID-19 Response for Africa monthly bulletin- October 2022, issue 8, [COVID-19 Monthly Response Bulletin.FIN_.pdf \(who.int\)](#)

of new variants highlighted the continued need for information in real-time, targeted and adapted according to the state of scientific knowledge. One of the aims of the WHO AFRO RCCE team has been to develop and align COVID-19 key messages with the current low incidence rates across the region.

4.1.2 COVID-19 Vaccine Coverage

As of 4 December 2022, 30.4% of the African Region's population had received at least one dose of the COVID-19 vaccine, while 24.9% had received the required number of vaccine doses in the primary series. This is much lower than the 63% of the global population who had completed the primary series as of 4 December 2022.²⁵ Only three countries in the WHO Africa region have over 70% of their population having completed the primary series: Mauritius, Liberia and Seychelles, with Rwanda just under 70%. As of Feb 2023, Africa CDC reports that only 6% of the continent has received the booster dose²⁶.

Table 2. 2023 vaccination coverage status in the 5 countries included in the WHO AFRO study

Country	Total Population ²⁷	Persons partially vaccinated with at least 1 dose ²⁸ (% of the population partially vaccinated)	Persons fully vaccinated (% of the population fully vaccinated)	Persons with a booster (% of the population boosted)
Democratic Republic of Congo as of 5/2/2023	95,894,11	10,893,593 (11.4%)	8,576,320 (8.9%)	N/A
Republic of Congo as of 5/2/23	5,835,806	1,476,588 (25.3%)	2,345,356 (40.2%)	N/A
Guinea Bissau as of 5/2/2023	2,060,721	774,740 (37.6%)	426,325 (20.7%)	N/A
Zambia As of 5/02/23	19,473,125	4,043,334 (34.2%)	8,726,339 (29.9%)	1,064,511 (5.5%)
Zimbabwe As of 5/2/23	15,993,524	6,829,405 (42.7%)	415,352,606 (31.7%)	82,815,119 (9.9%)

Box 2: DRC context

The challenges of low vaccination rates in DRC has been a concern since early 2020, with UNICEF warning of a resurgence of diseases such as polio, measles and yellow-fever²⁹. The DRC had a particularly slow vaccination roll-out and uptake for COVID-19, with only 2734 people vaccinated, mostly in Kinshasa, in the first ten days of launching its vaccine campaign, according to BBC News Afrique³⁰.

This lack of demand led the Government of the DRC to give away over one million of the 1.7 million Astra Zeneca doses received under the COVAX initiative which was co-led by the [Coalition for Epidemic Preparedness Innovations](#) (CEPI), [Gavi](#) and the World Health Organization (WHO), alongside key delivery partner [UNICEF](#). The vaccine was distributed to several neighbouring countries including Angola, Ghana and Senegal in order for them to be used before they expire.

²⁵ WHO AFRO, Covid-19 Vaccination in the Africa Region - monthly bulletin, issue 10, 10 December 2022 [CV-20221210-eng.pdf \(who.int\)](#)

²⁶ [Africa CDC - Vaccination](#)

²⁷ All population figures taken from Africa CDC [COVID-19 Vaccination – Africa CDC](#)

²⁸ All vaccine figures taken from Africa CDC [COVID-19 Vaccination – Africa CDC](#)

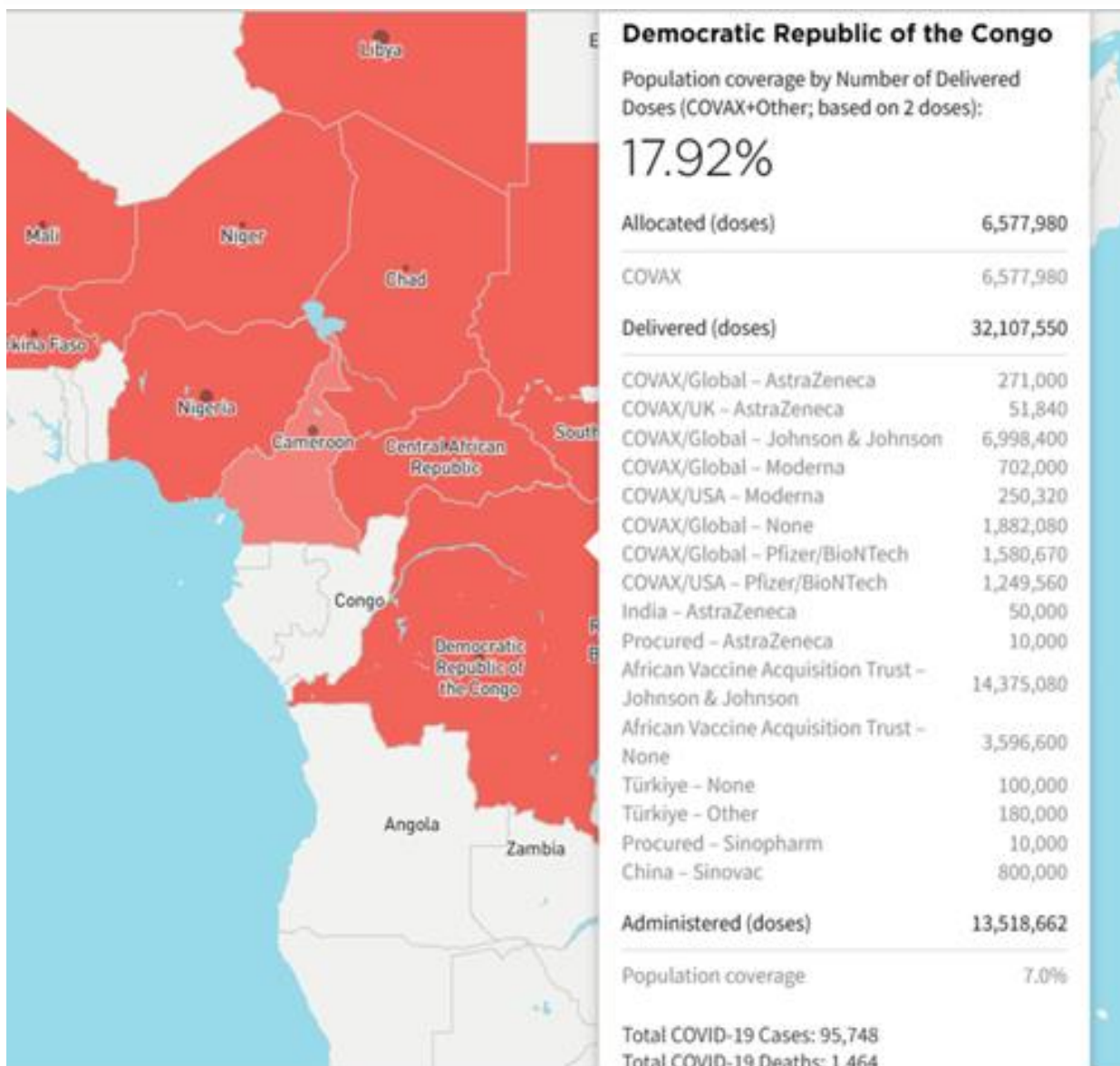
²⁹ May 2020, [Declining vaccination rates in the Democratic Republic of the Congo could lead to resurgence in deadly diseases, UNICEF](#)

³⁰ May 2021, [Covid-19: pourquoi la vaccination contre le coronavirus en RDC est-elle si lente ? - BBC News Afrique](#)

The vaccine launch was delayed in DRC by a month, due to precautionary measures while awaiting the conclusions of studies on the Astra Zeneca vaccine which, according to some countries, caused blood clotting disorders in people on whom it was administered. The BBC reported that since the first COVID case was announced in the DRC, the public were somewhat mistrustful, either due to believing conspiracy theories about COVID and/or the vaccine, or because they did not believe that COVID existed. This finding was also supported by a vaccine willingness survey, which highlighted the need for a large-scale public sensitisation campaign³¹.

In addition, logistical problems were also to blame for the slow redistribution. The country faced difficulties in management of the cold chain as well as the insufficient number of vaccinators to quickly reach priority areas. The image below from OCHA's Humanitarian Data platform (HDX) shows the status of the vaccine roll-out in DRC as of 14th March 2023, with a total population coverage of only 7% according to the number of administered doses.

Figure 3. COVID-19 vaccination in DRC (December 2022)



³¹ [COVID-19 Vaccine Acceptance in the Democratic Republic of Congo: A Cross-Sectional Survey](#)

4.2 ABOUT THE QUALITATIVE RESEARCH STUDY AND COMMUNITY ACTION PLANS

The WHO AFRO in Brazzaville, Congo, developed the Community-Based Surveillance and Response project to strengthen the efforts of selected Member States in the African region to detect and respond to health emergencies such as the COVID-19 pandemic in high-risk areas. This project covered 12 countries and included action research, screening and testing, provision of community-based infection prevention and control kits, assessment of communities in high-risk areas, and implementing RCCE activities.

4.2.1 Objectives of the research study

The WHO AFRO launched a qualitative study and used an action research approach³² to better understand social-behavioural determinants of population compliance with recommended public health and social measures, vaccine uptake and testing in the context of the COVID-19 pandemic. The qualitative research investigated the epidemiological situation, access to information and disinformation regarding COVID-19, prevailing perceptions and beliefs, as well as enabling and inhibiting factors of vaccine and testing acceptance. The overall objective was to inform new strategies for RCCE that seek to improve compliance with public health and social measures and vaccine uptake. The study aimed to identify key entry points and change agents within the communities that could be leveraged to initiate improved RCCE strategies, thereby utilising and strengthening existing community systems.

4.2.2 Description of the research study

At the time of the Ebola outbreak in 2015, the WHO AFRO understood the need for rapid studies and for increased listening activities among the population to inform their work in a timely manner. There was no time for large academic studies, so they needed to adapt the methodology to gather and analyse qualitative data rapidly. The WHO AFRO RCCE and COVID-19 response team kept this in mind when the need for qualitative data became apparent during the COVID-19 pandemic.

This rapid qualitative study was based on social group ethnography and took place between April and October 2022. In June 2022, primary data was collected in Congo, DRC, Guinea Bissau, Zambia and Zimbabwe where COVID-19 incidence rates were high. Feedback sessions were held in September and the study report was completed in October 2022.

To complete this multi-country study in less than six months, one of the strategies was to engage people from the local communities as researchers and train them in qualitative data collection methods. Having a larger, locally based research team allowed for a short data collection timeline of just five to ten days in each country.

Firstly, the country research teams identified ten social groups within the communities to target for data collection: community health agents, health professionals, traditional healers, religious leaders (catholic, Muslims, traditionalists, 'Église Noire'), teachers, transporters, women leaders, youth leaders and women and men from the general population. Research was conducted via informal interviews, focus groups, semi-structured interviews with key informants and participatory observations with key informants. At each study site, focus groups were held with each of the ten social groups as well as individual interviews with key informants to get in-depth perspectives.

After transcription, the data analysis was done using Atlas Ti, at which point themes were identified. To speed up the analysis process and validate the findings, the research teams held a feedback session at each study site to present and discuss the findings with the Public Health Emergency Operation Centres, technical coordination, mayors, and heads of districts, and presented the study protocol to the Congo

³² The aim of action research is to bring about a transformation of understanding in the participants that underpins changes in their social circumstances. It is a democratic problem solving approach achieved through a cyclical process that moves between initial problem identification and reflection to planning, taking action, [Action Research - methods@manchester - The University of Manchester](#)

Ministry of Health. The Community Action Plans were brainstormed with the community participants during these feedback sessions.

In the case of the DRC Community Action Plan, the activities agreed by the community were:

1. An identification phase to map:
 - the most influential places of worship and religious leaders, i.e. those whose churches or houses of prayer have more than 1000 followers and who are frequented by the faithful. The aim is to identify 500 religious leaders and 100 places of worship;
 - the most influential traditional healers who have many patients. The traditional healers who participated in the study and traditional healers' associations will be contacted, with the aim of identifying 150 traditional healers who have places of consultation;
 - 200 active women's and 200 youth groups with at least 100 members, and their leaders;
 - 1000 teachers from 100 schools (primary, middle and high schools). Identifying 10 teachers and directors in each school;
2. Establish a partnership alliance with ACSA (Association of Health Communicators in Africa, DRC Chapter), a socio-professional association bringing together communicators (mostly journalists) who, through their profession, disseminate messages and information on public health emergencies. The DRC is among the countries that have contributed to the development of the association.
3. Set up a jury to decide on the awards of champions of vaccinations and rapid tests. The social group leaders that organises the most (quantifiable) activities, i.e., vaccinate and/or test people, will receive a certificate or prize in recognition of being the best community mobilizer. The health zone will do the same and win the prize for best RCCE performance. The jury is made up of the RCCE Ministry of Health team at the provincial level (Communication Task Force at the level of the provincial health directorate, the RCCE WHO team and the Chief Medical Officers of the health zones concerned by the initiative)
4. Briefing groups of selected religious leaders, traditional healers, teachers and women and youth leaders on COVID-19 prevention and control: community-based action research, how to use rapid antigen tests, information on vaccines, and PHSM.
5. Talks in the community coupled with demonstrations of vaccination and testing, facilitated by religious leaders, traditional healers and teachers. In the churches and traditional healers' place of work, the talks will be accompanied by an opportunity to be vaccinated and/or tested.
6. Workshops to update and translate messages into the country's languages with:
 - RCCE actors to review the messages and the choice of local languages in which the messages will be disseminated
 - Meeting with the media to take stock of the situation and how to meet the challenges of disseminating messages in local languages
7. Supervise and document activities: select 9 supervisors of field activities to train. Document activities: reports, good practices, photos and community testimonials. The supervisors are the 'Community Animators' of the health zones implementing the RCCE action plan, RCCE actors at the provincial level and WHO RCCE focal point and the WHO Active Research focal points in each health zone.

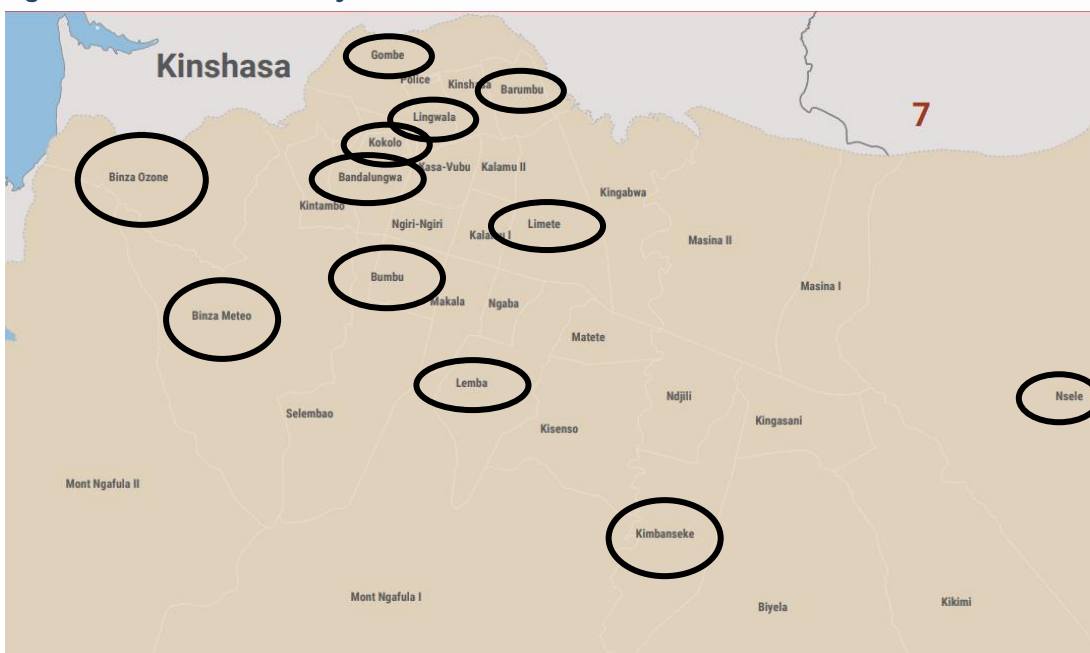
The Kinshasa Community Action Plan was initially designed for activities to take place over two months, however, due to some delays and competing programmes, the activities are still underway. Furthermore, the initial budget has not been fully utilised so the DRC WHO office will continue to support the community level RCCE work while there is budget and still evident demand from the communities involved.

4.2.3 Geographic Coverage

The study targeted a range of capital cities, large cities and a few rural towns: Congo (Brazzaville, Pointe-Noire), DRC (Kinshasa, Lumumbashi), Guinea Bissau (Bissau, Bafata), Zambia, and Zimbabwe (eight provinces, specifically the districts of Binga, Insiza, Gokwe South, Rushinga, Makonde, Seke, Chiredzi, Epiworth, Mbare, Zengeza). The selection criteria for inclusion in the study was a high COVID-19 incidence and high resistance (non-compliance) among the population to PHSM. The location was not taken into account in the selection, and since rural populations generally had lower incidence rates across Africa, there was a slight bias towards large towns and cities.

To date, Community Action Plans have been developed for Kinshasa in the DRC, and Brazzaville in Congo, with a third under development for Pointe Noire in Guinea Bissau. The Kinshasa Community Action Plan covers 11 Health Zones (two of which receive informal support in green) as shown on the map.³³ The health sector in DRC is divided into 'health zones' which oversee healthcare across several communes.

Figure 4. Kinshasa Community Action Plan Health Zones



4.2.4 Key Partners

- Bureau Régional WHO AFRO
- Bureau Pays WHO RDC
- Secrétariat Technique de riposte contre COVID-Ministère de la Santé Publique, Hygiène et Prévention (DRC)
- Bureau Pays WHO Congo
- Ministère de la Santé et de la Population du Congo
- Guinea Bissau World Health Organisation Country Office
- Guinea-Bissau Ministry of Public Health
- Zimbabwe Ministry of Health and Childcare
- and others in Zambia

³³ 2020 [RD Congo: Carte des zones de santé- juillet 2020 | HumanitarianResponse](#)

4.2.5 Expected Outcomes

Expected outcomes of the rapid qualitative study were evidence and insights about compliance with PHSM and vaccine uptake in the targeted sites. This data would form the basis of recommendations and inform new strategies for RCCE, articulated in a revised Community Action Plan for each location. The main objective of the Action Plans is to inform WHO AFRO's community-based surveillance and response project by strengthening the ownership and commitment of influential leaders in promoting COVID-19 vaccination, screening and rapid tests and encouraging compliance with public and social health measures among their communities. These Action Plans focused on interpersonal communication among influential and prominent figures, health service providers and the community.

In DRC, the Ministry of Health had been working on vaccine promotion since the initial government roll-out, however it was slow and proved difficult to improve vaccine acceptance and uptake.

4.3 KEY CHANGES AND CONTRIBUTION OF COMMUNITY ACTION PLANS

4.3.1 Changes in Knowledge

The first major change is that the WHO country teams have been able to revise their RCCE strategies based on the evidence and recommendations from the qualitative research and tailor their approaches in the study locations. The findings and the community level feedback sessions enabled the WHO RCCE and COVID-19 response teams to collectively prioritise actions and beneficiaries. Furthermore, the findings from the qualitative study add to the body of evidence generated to inform RCCE interventions.

For the healthcare workers who participated in the WHO training day, they reported learning technical information such as details on how the antigen test works and why they are preferred, how to do action research, and how to best protect themselves with personal protective equipment. The colleagues of the participants benefited from this training indirectly because they shared what they learned with peers in the Health Zone- realising the importance of everyone having access to this knowledge.

At the community level, large groups of people have been exposed to the messages promoted by their religious leader or other authority figure and attended the COVID-19 information sessions organised by these influential figures in conjunction with the Health Zone staff. It was reported that some people who are at a higher risk due to pre-existing conditions have understood that they can better protect themselves by having the vaccine.

"It has only been two months since the community leader briefing sessions began under the Kinshasa Community Action Plan, but we have seen an impact compared to how things were before. People thought COVID was a rich person's disease! But now they see it affects everyone." - Community Healthcare Worker

4.3.2 Changes in attitudes

All respondents interviewed for this case study mentioned a shift in attitudes among most of the community members where they work.

One Community Healthcare worker said the experience of this RCCE intervention taught her that "all problems have obstacles, but to address them you must confront those who are causing the obstacles, to understand why they resist, why they have doubts. This was our experience with those who were previously ignorant about COVID-19 and denied it, but once we approached them and explained prevention and control, and how to manage the illness for those who have it we saw their attitudes changing. It was the first time these people had it explained to them."

4.3.3 Changes in behaviour

The Action Plan for Kinshasa was completed first, and although it has only been implemented since September, there have been some noticeable results. Even the churches like l'Église des Noirs, Kimbanguist Church and traditional healers that were resistant at the beginning and didn't want to talk about the COVID-19 vaccine, are now cooperating with the community intervention and accept the vaccine; they even have hand washing facilities in the churches and encouraged testing. This change was seen since the implementation of the action plan, during which there was a process of providing information, giving briefings and holding community dialogues with the target communities.

This intervention has strengthened relationships between the WHO DRC RCCE team and the Health Zones, and forged new relationships with key influencing actors in the communities. The Community Action Plan has also led to the development of two-way communication channels that remain active for troubleshooting and information sharing between all three parties.

"I have seen that my work is now more in cooperation with local leaders than it was before. There is trust, and harmony in the relationship." - Community Healthcare Worker

In most interviews conducted for this case study, it is the shift in behaviour of leaders and members of the Église des Noirs ('Black Church') during this intervention timeline that stands out as a sign that this approach is having effect. These leaders and their followers have typically been among the most resistant to COVID-19 vaccination, and even denying its existence. Following the WHO briefing under the Kinshasa Community Action Plan, several leaders of the Église des Noirs have organised multiple vaccine sessions at their place of worship for their followers and some followers have already had two doses.

Specifically, the first activity that made them change their minds was the briefing of religious leaders from the Limete health zone to which they were invited on February 14, 2023. Two church representatives had taken the vaccine and had pledged to raise awareness within their church. The second activity that involved them was the briefing of youth and women leaders on February 27, 2023. Four youth leaders from the black church and two women leaders from this church attended the meeting and took the vaccine. A total of 120 church devotees have received vaccination in two separate community dialogue sessions in March 2023, with the second such activity being initiated by the Church itself.

Box 3: Key accomplishments of this RCCE initiative in Kinshasa

Key accomplishments as of March 17, 2023:

- 450/500 religious leaders briefed
- 250/300 traditional healers briefed
- 130/200 female leaders briefed
- 130/200 young leaders briefed

Total tally as of March 26, 2023:

- 81 churches have organised dialogues
- 8,000 people reached by local communication (interpersonal communication)
- 3,580 vaccinated
- 2555 tested

Also, the briefed leaders facilitate many response activities (listing of contacts, decontamination of households, dissemination of key messages in their churches and workplaces or public places) which are not measured but contribute to improved practices. Overall, there is a sign of community engagement and shifting perceptions as well as behaviours which has led to an increase in COVID-19 vaccinations. Similar sentiments have been noted by Health Zone workers, such as the example below.

“Since COVID started, all Health Zone staff have been working on similar issues to those covered in the Action Plan.

But since the WHO involvement, we have stepped up our activities and are able to enrich their work with the training from the WHO. My day to day work was a bit lighter before but now this WHO project has opened up my thinking, and the action research approach gave me access to groups within the population that I have never worked with before, like sex workers or abandoned, homeless street children; I now work 7 days a week because I see how much there is to do.

Sometimes the leaders have limited time during work hours so they call me at any time because they need info or advice. Almost every day someone is calling to ask for advice or to request that I come do a COVID-19 test, or proposing to organise a vaccine session in their community. My phone does not get a break! This recent increase in activity from the community members is proof of the project’s impact.”

- Community Healthcare Worker

4.3.4 Role of Community Action Plans for COVID-19

The WHO DRC team are able to track and quantify the results of activities that have been implemented under the Kinshasa Action Plan, for instance the number of community leaders that they have briefed as part of the community action plan, the number places of worship or schools promoting public and social health measures, vaccination campaigns and rapid tests (and therefore how many people vaccinated, and tests distributed). These give concrete evidence on the direct sphere of influence of this intervention.

However, there is a broader impact that is harder to quantify. Beyond the direct activities that the WHO country office is involved in, it has not been possible to measure the impact that the community leaders and influencers have had on good practices with PHSM because of their engagement with the initiative.

There is an element of curiosity and desire to replicate elsewhere the positive changes that have started to take place in the target communities. For instance, a health worker from another Health Zone asked staff from a health post under the Kinshasa Community Action Plan, how it was possible that they were able to organise a vaccination session that vaccinated 100 people. The colleague explained how this WHO initiative had briefed selected leaders in the community to bring them on board with the RCCE objectives, amplify specific health messaging among the community, and ultimately organise vaccination sessions.

One community health worker reported “since collaborating with the community leaders, I have seen that they have been promoting protection from COVID-19”. He had heard comments from people in the community confirming this, and there is also a survey that the healthcare workers do from time to time among the community to see who has been vaccinated in their household, their attitude towards vaccines, and to see if they had any reaction following the vaccination. This survey helps them to ‘take the pulse’ on COVID-19 vaccine acceptance and uptake in the community.

In addition to COVID-19 tests provided by the government, the WHO DRC office provides materials such as COVID-19 tests, gloves, alcohol gel, masks to the Health Zone for the community healthcare staff to use during awareness raising talks or vaccination sessions with the community. This allowed them to do their jobs confidently and feel protected when doing household or community visits. One healthcare worker explained that in the WHO training she learned the best way to protect herself with personal protective equipment beyond just the mask and alcohol gel, and that she had since been confident to visit households to follow up with people who reported COVID-19 symptoms. Places of worship did not previously receive any alcohol gel or masks from the government, but noted having received such materials from the WHO and put them into use.

The implementation of Community Action Plans requires buy-in and commitment from a chain of key actors at different levels who are all responsible for implementing the plan: 1) the selected community leaders, 2) the Health Zones have focal points for communication 3) provincial health service provider 4) WHO DRC country RCCE lead who oversees the Community Action Plan from the top, along with other colleagues who are involved with specific roles integrated in the work.

Box 4: Example of an influential community leader acting as a catalyst for change

In January 2022, Sauveur Kueto, Parish Secretary and Director of local NGO 'IDV', participated in a one-day training organised by the Binza Météo Health Zone for religious leaders, under the Kinshasa Community Action Plan. He learned from health professionals and RCCE experts about the origins of COVID and how it spreads, symptoms, the risks of contamination, how to protect yourself, how to control it among the community, and how to take an active role in the Community RCCE Action Plan. He listened to the findings of the qualitative study, along with national COVID-19 statistics that were presented. The training was followed by a voluntary vaccination session.

Once briefed, these leaders were asked to pass on the messages to their parishioners. Sauveur returned to his parish and explained what he'd learned to the Priest, who gave Sauveur the time during mass to speak to the 4000-strong congregation about the risks of COVID-19, and prevention and control measures.



He invited them to get vaccinated at a session that was organised at the church in February and another in March. Healthcare staff from the Binza Météo Health Zone came to the church on two occasions, vaccinating 80+ people and together they have organised 10 informative talks on COVID-19 vaccines and health and safety measures. In addition to sharing information to raise awareness of COVID-19, the Church set up a hand washing and alcohol gel station. The parishioners were very receptive and took the messages on board.

Since Sauveur has been a proactive RCCE representative in his community and is also the coordinator of an NGO for vulnerable people, the Health Zone staff asked him to select two women members to receive the same training, so that they in turn can become RCCE representatives and raise awareness of COVID PHSM in their neighbourhoods. The two women have been out in their communities five times in the few weeks since their training, using a megaphone to spread key messages.

4.4 MAIN SUCCESS FACTORS

The speed at which the qualitative study was conducted across five countries was a key success factor. It permitted the WHO regional and country teams to gain valuable information with which they were able to revise and tailor their RCCE approaches.

Involving community leaders was of utmost importance. They were able to approach the different social groups within communities more effectively since they already had a position of influence and are trusted local figures. The existence of such willing influential figures and leaders in the communities who are motivated to act as representatives is a key enabling feature of this RCCE approach. The fact that they have places of worship, and places of consultation or gathering where they can host and organise awareness raising talks or vaccine sessions with healthcare staff for their followers means that people can receive information or go to have the vaccine in a familiar place with a community leader they trust.

Leveraging existing community social structures has proven to be effective and efficient. It has meant that the initiative did not need to hire a huge project team to implement the Community Action Plans, since the community leaders and healthcare workers form the backbone of the implementation.

Tackling the barriers to vaccine uptake at a community level, as opposed to a 'top down' approach taken by the government in the past has had notable results.

4.4.1. Factors relating to the wider enabling environment

A healthcare worker from the Binza Ozone Health Zone recalled that there were other COVID-19 initiatives that had operated in the same communities in 2021, organised by Caritas, and GAVI through the Red Cross. These were awareness raising activities to promote the vaccine, explain how to identify symptoms and to encourage people to take tests if they had symptoms. The Caritas intervention offered testing, awareness raising activities targeted around 100 people during one of the COVID-19 peaks.

One community healthcare worker noted that in addition to the awareness raised in the community by this intervention, the change in mentality in some cases was also due to the fact that people have had experiences with COVID-19, or seen family members die from it, so they may have been more accepting of the information shared with them through this intervention.

4.5 BARRIERS AND CHALLENGES

4.5.1 Challenges

4.5.1.1. Challenges of conducting the qualitative research during a pandemic

Conducting a rapid qualitative study during the tail end of a pandemic posed several challenges. Human resources was a major challenge- since the data collection phase was so short. It needed to have two researchers in each focus group who must have been trained in advance. These researchers need to speak local languages. Nurses were needed to conduct the semi structured interviews.

For this type of anthropological listening research, the WHO AFRO team decided to work with Atlas Ti, not with KOBO collect. In some countries where there is political unrest, the respondents were hesitant or scared to be recorded. The process of conducting the interview or group discussion, transcribing from the recording (when recording was possible) and translating data was very time consuming.

Kinshasa is large and comprises 35 Health Zones, however this study and action plan was limited to target 9 of them.

4.5.1.2 Challenges in implementing the Community Action Plan

Once the community leaders and influential figures have been identified and fully briefed in a one-day training, the Community Action Plan relies completely on their motivation to spread the key messages in their communities and proactively coordinate with the Health Zone staff to organise awareness raising events or vaccination sessions. Healthcare workers noted that some community leaders have been more proactive than others so far, and therefore certain communities may not benefit from the intervention.

The community health workers do still see some resistance among certain sub-groups in the population. For instance, one interview respondent described the challenges of working with vulnerable populations, having planned a COVID-19 awareness raising and vaccination activity with some homeless youth. The night before, she confirmed the time and place with the youth group leader who had called her to organise the activity. When she arrived, the youth raised lots of questions and put up resistance, repeating the conspiracy theories that they had heard. She talked to them to explain but they refused, saying they wanted to go to drink alcohol instead, so she and the vaccination team left. The youths' leader asked her to come back one week later, after he had spoken to them to try again. This group was included in the qualitative research because the youth leader was invited and was on board. He did a COVID-19 test and took the vaccine, to show the group that he was fine.

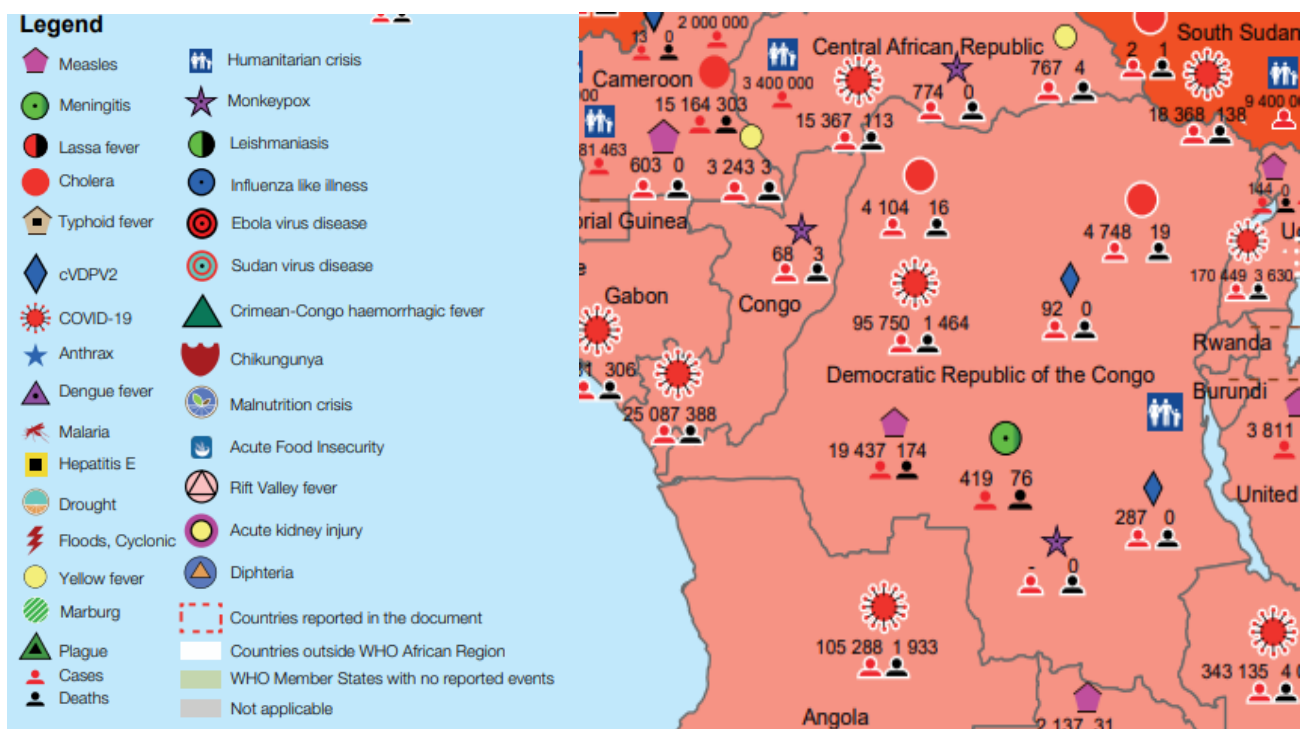
4.5.1.3. Challenges in measurement and quantifying impact

One of the biggest issues has been to document the number of people who have been sensitised by these religious leaders and who have taken the vaccine in other (fixed) vaccination sites, apart from those that the WHO teams set up. In addition, other results are harder to measure such as the number of people who have been sensitized by these religious leaders or other leaders, or received information through one of the RCCE community engagement activities.

4.5.2 Barriers

In many communities, COVID-19 is not the only concern, and people are struggling with poverty, health issues or other basic needs. The map below shows the range of other outbreaks monitored by the WHO AFRO, as reported in the Outbreaks and Emergencies Bulletin, Week 11: 6 to 12 March 2023. In addition to COVID-19 these include cholera, monkeypox, polio, measles and a suspected meningitis outbreak.

Figure 5. Other outbreaks being monitored by WHO



Box 5: Barriers to acceptance of COVID-19 public health and safety measures and vaccines identified by the WHO AFRO qualitative study

- Rumours that the vaccine affects masculinity; fears of women becoming infertile after having the vaccine.
- Strong tradition of traditional healers, and many believed they could cure COVID-19 with plants- even some health workers generally prefer to be treated by traditional healers.
- Difficulties to comply with PSHM i.e., buying masks or antibacterial gel when people can barely afford food. In some areas there is no running clean water so hand washing is also difficult.
- People did not trust tests that were analysed in a lab, but preferred rapid tests to see results immediately.
- Beliefs in witchcraft as being behind the disease and therefore did not accept the logic of how it spreads according to medical information.
- Several churches/denominations did not participate/collaborate with the response to COVID-19
- Deep suspicion between traditional healers and health workers
- People did not believe health workers, or suspected them of colluding with the authorities.
- Problems to motivate the health staff
- Need to readapt preventative measures that are considered costly and difficult to respect.
- Health staff don't trust each other- think that some are benefiting financially from the vaccines.
- Lack of trust in political and some health authorities

The qualitative research conducted by WHO AFRO was focused on understanding COVID-19 denial and vaccine resistance, as well as reasons for non-compliance of PSHM. Although a lot has been achieved by sharing accurate information and raising awareness, this intervention could not remove all the obstacles to PSHM compliance, for instance lack of money to buy alcohol gel or masks, infrastructure for social distancing, or running water for regular hand washing.

A healthcare worker mentioned that the social networks had a major role to play in diffusing misinformation and rumours about the coronavirus. People heard conspiracy theories from Europe and were influenced by them, sharing them with friends and family through social media or in conversation. There were also home-grown rumours, perpetuated by some traditional healers and religious leaders, and particularly from the Église des Noirs who are against any vaccines and who advocated for locally grown plants to treat COVID-19. These types of strong beliefs and advice shared by leaders in the community reinforced the mistrust and fear among the population.

4.6. LESSONS

Box 6: Top level findings of the qualitative study conducted across five countries

- RCCE without evidence is not useful
- People's fears and beliefs are important for effective RCCE
- The drivers and determinants of adherence to PHSM against COVID-19 and acceptance of COVID-19 vaccines and tests are dynamic and vary depending on the context and population group. Hence the importance of conducting rapid studies to inform the strategies of community response projects.
- Need for context-specific information on COVID-19, public health measures, vaccines and vaccination among the populations
- People need facts but also clear and scientific answers on the dynamics of the epidemic in neighbourhoods.
- Physical social distancing is hard to abide by in dense areas.
- Important and effective to work with local religious leaders.

4.6.1 Lessons from action research and implementing the Community Action Plan in DRC

- **The value of good qualitative data:** Qualitative data can add value in outbreak/ health emergency contexts to help service providers and international agencies explain the quantitative data and understand the characteristics of social behaviour within target communities. The findings from these five countries provide a rich and evidence-based set of guidelines to inform future RCCE initiatives. The findings can be extrapolated and applied in other African countries and used to inform the design of other health interventions, not just for COVID-19. The findings of the study are being used to influence the messaging design for several Community Action Plans and interventions.
- **Engaging key gatekeepers as catalysts for change:** The main differences with the WHO strategy used in this COVID-19 RCCE intervention- compared to campaigns led by other international organisations or the government of DRC- are that the WHO used an action research approach, and identified the community leader 'gate-keepers' and engaged them as a priority to become active catalysts for change. The other interventions did not do this, rather they approached the community as one homogenous group and did not benefit from leveraging these trusted focal persons.
- **Leveraging for efficiency and value for money:** Building a knowledge base among key community leaders and entrusting them with responsibility for their community creates a domino effect, achieving a wide reach on a lower budget. "This action plan was not very expensive to develop or implement and yet is having more impact than giving money to other organisations to implement vaccine campaigns." - WHO AFRO
- **Gaining buy-in from the Ministry of Health:** This was an early and important step (they approved the study protocol), particularly since the intervention relies on Health Zone staff to implement the Community Action Plan and adds to their daily workload. One comment from a health professional was that there are not good channels or modalities for information flow from the community level up to higher levels of the health sector, however capturing information from community listening could benefit the Ministry of Health. Furthermore one respondent commented that even the mass week-long campaigns organised by the government in the past were not very successful so there is a possibility for the government to observe the effects of this community-based approach.

- **Importance of human social networks:** Identifying the major social groups and community leaders allows this approach to make the most of these natural community networks to spread information and persuade their peers of the importance of the vaccine. The early success of this RCCE approach proves the importance of social networks as a core element of the communication and trust-building process. The categories of social group leaders that were identified in the early stages of implementing the Community Action Plans continue to serve as 'communities of practice'. There is a two-way line of communication, through WhatsApp groups chats, that remains useful to the WHO country office, the community leaders and health workers (see Next Steps section below).
- **One-size does not fit all:** This study highlights the need to understand the beliefs and practices of the target population at the community level before designing a community response initiative, so that the content and means of delivery are appropriate and relevant to the community members.
- **Sharing the responsibility:** The evidence gathered in the qualitative study illustrates the importance of a multi-layered approach where health staff work in collaboration with a range of community actors and associations, in order to engage the full range of socio-demographic groups within the population. This shared responsibility keeps the different parties motivated, and they can also hold each other accountable.
- **Demand generation:** this RCCE approach of sharing information and raising awareness has stimulated a demand from the target communities for the vaccine, tests and up-to-date information. Two health zones, Kinshasa and Selembao, have been served indirectly by the RCCE efforts and have benefited from this project even though they were not formal targets of the project. This represents a demand and also points to efficiencies and achieving good value for money.

A major difference between government measures or campaigns and this intervention is that the government efforts were very much 'copy/paste' but in the WHO intervention, after the qualitative study they could target the groups in society that were still rejecting the vaccine and tailor the Community Action Plans. With this approach the WHO and health workers could understand why there was resistance among different social groups.

The intervention has demonstrated the value of RCCE in effecting social behaviour change to support immunisation:

- **Customisation:** RCCE allows for the customisation of approaches to different sub-groups, which is necessary for overcoming persisting barriers to beliefs and health behaviours.
- **RCCE as supporting last mile delivery:** By working through local leaders this initiative has been able to reach certain demographics that were unaffected by previous campaigns.
- **RCCE as a tool to build trust:** RCCE was critical to tackle the resistance in certain social groups and highlight the value of working with community-based actors, given their high degrees of social capital and access.

4.7. LOOKING AHEAD

4.7.1 Sustainability

Thinking about sustainability of the intervention, the WHO made sure they worked with the existing health services at community level (Health Zones) so that their RCCE capacities would be strengthened through this initiative and put them in a better position to deal with COVID-19 and future health emergencies. The staff from the Health Zones are the first point of contact for the community, so the

intervention built on their existing roles. By using healthcare staff to collaborate with the local leaders the WHO aims to set in place practices and behaviours that will continue beyond the end of this intervention. The intervention also engaged the Provincial Health Division which covers all Health Zones of Kinshasa. In this way, all levels under the Ministry of Health are included. This qualitative study engaged the Ministry of Health, but the implementation work targets the lowest level of health service.

4.7.2 Next Steps

4.7.2.1 Reorganising/revising action plans based on the findings

Two action plans have been developed in the Republic of Congo and DRC, and another is being developed for Guinea Bissau. Once in place, the community members, local health service providers and WHO can continue to implement the activities that were defined in the plan.

4.7.2.2 Communities of Practice- WhatsApp

In several countries the WHO is using WhatsApp networks that they have established as localised communities of practice. These group chats serve as a place for key members of the community to ask questions, share rumours, and receive up to date information. There are group chats for Imams, pastors, traditional healers - this creates more opportunities for the WHO and Health Zone staff to engage with religious and community leaders, and traditional healers and vice versa. Following the success of the WhatsApp groups in Cameroon, the WHO has set up WhatsApp groups DRC to support the implementation of the Community Action Plan.

Since the WHO and Health Zone staff are in the group chat they can share up to date information, correct misinformation or dispel rumours. One Health Staff worker mentioned that she prompts the leaders via the WhatsApp chat if they have not been too active in organising awareness raising events or vaccine sessions for some time. Any WHO DRC team could activate these networks to interact and collaborate with these social groups. In this way the response time should be faster in the event of future health emergencies.

4.8 RECOMMENDATIONS

There were several clear recommendations that emerged from the qualitative research from the five countries, which are listed below. We have attached more details on each point in Annex 1.

Box 8: Recommendations from the qualitative research conducted in 2022, in five sub-Saharan countries

- Rethink an integrated approach to managing COVID-19 and other public health emergencies in a balanced partnership with communities.
- Working with and through trusted community organisations and influential local actors
- Improve education and awareness, using all means of communication available.
- Restore trust between communities and state representatives.
- Reinforce positive health seeking behaviour.
- Upgrade infrastructure and resourcing for COVID-19 Vaccination, quarantine, and isolation centres.
- It is important to understand the context and culture of the target communities in depth, through a socio-anthropological study.
- Consistency in Policy for COVID-19 PHSM including vaccination and strict law enforcement.
- There is a need to implement risk communication and community engagement mechanisms that will go beyond COVID-19.

Recommendations that arose from the experiences of those implementing the Kinshasa Community Action Plan are as follows:

4.8.1 Community engagement

- Engaging local leaders and influential community figures goes a long way to building trust and gaining access to social groups that may be harder to influence ‘from the outside’.
- Information gained in the research phase can indicate what types of challenges the implementing teams will face and allow them to prepare relevant messaging to address these.

4.8.2 Methods of communications

- Simple communication methods can be effective, for instance word of mouth, giving a talk to a congregation gathered after Sunday mass, or using a megaphone around the neighbourhoods. WhatsApp is proving to be an effective way to ensure the community leaders have accurate information to share within their community, and that they have contact with experts if they wish to ask for advice.
- Visual aids such as banners or T-shirts for the vaccination team were suggested as ways to reinforce the message and ensure that these implementation teams are recognised.
- Audio messaging in the form of a fixed loudspeaker playing a pre-recorded message was suggested to accompany the vaccination sessions, in order to alert the community to the event that is underway and encourage more to attend.

4.8.3 Logistics and access

- By bringing the information and vaccinations to familiar places in the community, people can attend an informative talk or vaccination session organised by someone they trust in a place that they regularly visit (therefore avoiding accessibility issues).
- Facilitating transport (or reimbursing transport costs) for local health workers can help them access rural and faraway communities and motivate them to do so. Two community healthcare workers suggested that the WHO could provide water for the vaccination teams and community healthcare workers when they spend long days holding events in the community.
- The financial incentive offered to community leaders for their efforts is appreciated.

4.8.4 Continuity and vaccine coverage

- Progress is evident from these first two months of implementation, however, social behaviour change takes time to become widespread and ingrained in societal norms.
- The vaccine uptake needs to continue until the coverage is at an acceptable level according to the Ministry of Health, so ending this intervention too soon would likely end this ambition.
- Continue the awareness raising events coupled with vaccinations.
- Consider implementing the Community Action Plan in the rest of the Kinshasa province, and as a priority in other locations with low vaccine rates.
- Think about other priority targets such as the homeless, the "kuluna" (street children), refugee associations, people living with physical disabilities, athletes and cultural operators or influencers. These populations are extra vulnerable groups and in some of these cases it is harder to locate/keep track of them.

4.8.5 Programme management

- Strengthen monitoring mechanisms to track the interventions contribution to change.
- Promote peer learning and exchange among healthcare workers, so that those who have not benefited from the training can learn from their colleagues.
- Continue social listening through the community healthcare workers and WhatsApp groups to identify any groups for whom this approach is not working, or if any of the selected leaders are not active in their roles.
- Continue supporting the Community Action Plan activities as long as there is budget and ongoing demand from the target populations.
- Roll out this approach to other Health Zones that were not initially included.
- One health professional we spoke to recommended there is a need to monitor information on the ground, such as what rumours or beliefs are circulating, and pass it up to the Ministry of Health; this may help the health staff to prevent disinformation and prevent rumours starting.

4.8.6 Strengthening health sector institutions

- Create more space for engagement with the higher levels of the health service providers to ensure the RCCE approach is not working in isolation at the community level, and valuable learning is taking place at all levels.

5. LOOKING FORWARD



5.1 LESSONS FOR RCCE APPROACHES FOR VACCINATION

Overall, effective RCCE approaches for vaccination require a comprehensive approach that involves multiple components and actors. Best practices for developing and deploying RRCE approaches in vaccination, by stage in the programming cycle, include the following.

5.1.1 Context analysis and intervention design

- **Gather good quality, timely data** through community consultations or rapid research to improve the design, including targeting and tailoring, of interventions.
- **Understand community dynamics**, language, culture and behaviours as a starting point to ensure most appropriate means of communication are used.
- **Customise activities to specific (micro)locations** – in some cases, this means designing new activities and in others, supporting existing ones.
- **Restore trust** between communities and state representatives where needed, particularly hospitals and local elected officials.
- **Address barriers to access** faced by hard-to-reach communities directly in intervention design (through, for example, outreach, mobile clinics, door to door services, covering transport costs etc.)
- **Develop community feedback mechanisms, and other sources of monitoring information, early on** to gauge how messages are being received and test assumptions as context and perceptions shift, and improve design and delivery, and strengthen community engagement (particularly where project timelines are short).
- **Encourage healthy competition** amongst different administrative units of local government and reward good practice.

5.1.2 Delivery

- **Understand the audience**, including their concerns, beliefs, values, knowledge, perceptions of risk, and attitudes towards vaccination. The general public does not exist as a unit, but rather as a combination of sub-groups. Segmenting the population into sub-groups assists in identifying stakeholder groups (e.g., those most at risk, those indirectly impacted, the influencers, gatekeepers and decision-makers). Undertaking audience research ex-ante is key to a successful RCCE campaign.
- **Tailor messaging** to the local context, including the literacy level, linguistic and sociocultural aspects of the target population.
- **Use clear and concise messaging** that addresses the audience's concerns and highlights the benefits of vaccination. Foregoing jargon and technical terms will aid in gaining the target audience's understanding and can build trust.
- **Provide accurate and transparent information** about the vaccine, its safety, efficacy, and potential side effects. Being honest with the audience is a key means of building trust. Providing accurate, timely, and up-to-date information, while being transparent about any uncertainties, can help build confidence and combat vaccine hesitancy.
- **Provide clear, actionable steps** that the audience can take to reduce their risk, protect themselves, and get vaccinated.
- **Proactively address vaccine hesitancy** by acknowledging and understanding concerns, dispelling myths and misconceptions, and providing evidence-based information. Actively dispelling myths and rumours about the vaccine can prevent the replication of misinformation and fear at the community level.
- **Identify key stakeholders** who can act as trusted messengers to influence vaccination behaviour. Such actors could include community leaders, healthcare workers, religious leaders, and local organisations. These gatekeepers and influencers are key vehicles for building credibility and trustworthiness of vaccine messaging, and enhance reach within the community.

- **Work with and through established figures of trust** within communities, as well as staff and volunteers who are community members themselves.
- **Use a variety of communication channels and mediums**, including traditional media, social media, community outreach to reach different segments of the population, physical visual elements etc.
- **Develop shared accountability** for the design and implementation of the intervention amongst community leaders, local organisations, and government agencies. Establishing close feedback loops with the community is critical for rolling out an effective campaign. Dialogue should be established from the beginning, through diverse channels, and are all levels throughout the response.
- **Factor in resources needed to facilitate community healthcare workers** to fulfil their roles in RCCE interventions, particularly when accessing harder-to-reach areas (e.g. travel costs, food/water or small per diems).
- **Enable access to vaccination** through easy and convenient access points, including mobile vaccination clinics, community-based vaccination sites, vaccine transportation services, and household visits. Democratising access, especially in more dispersed communities, will aid uptake.
- **Continuously monitor and evaluate** the effectiveness of the approach, including whether you are reaching the intended audience, how the target audience is understanding the messaging, whether the intended behaviour change is taking place, and adjusting as needed based on feedback from the target population.
- **Coordinate** and plan with authorities and partners, using existing mechanisms where they exist or creating new ones, to promote complementarity, identifying gaps and avoiding duplication.
- **Retain flexibility** during implementation to enable rapid adaptation to contextual changes and learning.
- **Use public gathering spaces, and existing events**, that are free, accessible and well-known in the community to ensure greater turnout and address hesitation.

5.1.3 Close out and sustainability

- **Leverage existing community structures** (leaders, groups) to build capacity and support longevity of interventions and their results.
- **Work with existing health care service** providers to strengthen their RCCE capacity, and in some cases also increase knowledge.
- **Avoid one-off activities** which can lay a good foundation or build momentum but are not sustainable, and typically use more budget than is available without external support.
- **Collaborate creatively with anti-vaccination groups** to tackle misinformation head on and influence harder-to-reach groups.
- **Ensure necessary service delivery infrastructure is in place** to ensure that advocacy is supported by readily available services.
- **Develop strong networks of trust and coordination between local stakeholders** to enable sustainable improvements in capacity and delivery, and build preparedness for future pandemics.

5.2 GAPS AND OPPORTUNITIES

The following have been identified as elements of programming that merit further examination:

- **Furthering government ownership and capacity:** Although governments have been involved in some capacity, how could RCCE for immunisation be better embedded so that capacities, resources, and systems are there when next needed, perhaps unexpectedly?
- **Self-sustainability at the community level:** To what extent will the community mechanisms that have been established (e.g., Community Action Plans) be self-sustaining – ‘owned’ and adapted by communities on a needs-basis for their own health outcomes?

- **Potential for scale:** Given the very local and context-specific nature of most interventions, what is the potential for them to be scaled if more resources were allotted and timeframes elongated?
- **Tackling social media and disinformation:** The COVID-19 pandemic saw the rise of the rapid and exponential spread of mis- and disinformation through social media. How can future RCCE programming measures effectively address this challenge?
- **Cost and logistics burden:** With governments, donors and other partners covering the financial and procurement aspects of COVID-19 vaccination (vaccine supplies, cold chain infrastructure, PPE, etc.), how will local actors continue to fund vaccine initiatives once donor funding has ended (or if governmental priorities and budgets change)? How can local authorities and communities enhance preparedness, rather than relying on response?
- **COVAX alignment:** How do these initiatives align with COVAX, particularly areas led by UNICEF and WHO?

5.3 RECOMMENDATIONS

For the Collective Service

Short-term (quick wins)

- **Share experiences and disseminate evidence:** Facilitate the sharing of evidence and lessons around what does and does not work across countries, organisations and mediums. Create spaces for honest reflection and learning, and disseminate widely through various forums and channels (e.g., social and mass media, amongst technical bodies, etc.). Codifying learnings as practical tools and guidelines will also be useful for promoting uptake and operationalisation.
- **Promote RCCE as a cross-cutting approach for ongoing and future health work:** Advocate for the integration of RCCE principles and tools into existing and future programming. These case studies demonstrate how RCCE can be effectively used to promote behaviour change and strengthen the relevance, effectiveness, and sustainability of public health responses.

Medium- to longer-term

- **Stress the importance of monitoring:** Effective monitoring mechanisms should form an integral part of all health programming. RCCE has shown the value of integrating knowledge, attitudes and perceptions (KAP) monitoring into performance management, as important qualitative indicators of progress. Relatedly, the Collective Service could support partners to better capture the wider indirect impacts of their work, which are often hard to measure but critical for learning and evidencing effectiveness.
- **Support continuity:** Determine how to best support interested stakeholders (e.g., local authorities, governments, CSOs) to continue the momentum and/or direction of travel of programming once official donor support has ended. This can help support change to be more transformative and sustainable.
- **Build learning and collaboration structures:** Establish cross-organisational and cross-country learning channels (e.g., communities of practice) that continue to be active and build on momentum from COVID-19. These peer learning mechanisms will remain useful for ensuring that the experiences and knowledge from COVID-19 are institutionalised to inform preparedness for and response to ongoing and future epidemics.
- **Follow up on longer-term sustainability:** Revisiting case study programmes and reviewing RCCE interventions can help shed light on which approaches have had a lasting impact.
- **Capitalise on existing structures:** Collective Service partners should engage closely with in-country teams to determine how the community-level and health system networks that were developed for these programmes can be used for other projects and future campaigns.
- **Ensure utility:** Monitor the uptake of the Collective Service's evidence base and tools, and seek feedback from users.

- **Advocate for information harmonisation:** Support, to the extent possible, an enabling information and policy environment as inconsistent messaging (e.g., on vaccine safety and efficacy) sows public confusion and distrust. Advocate for consistent framing and messaging of public health information to reinforce the legitimacy of information and public support. The Collective Service is well-placed to add value by linking policy and programming more closely.

For Implementers

Short-term / Quick wins

- **Be self-reflective:** on, for example, the pros and cons of approaches, being cognisant of communities that may be left behind due to priority targeting.
- **Be community-led:** Continue working with and through communities and embedded community actors.

Medium- / Longer-term

- **Monitor early:** Build monitoring mechanisms early on into programming, e.g., setting baselines, and track progress consistently to determine which approaches are working well and less well.
- **Integrate RCCE into wider programming:** Integrate RCCE approaches into other health initiatives to support more holistic health improvements.

For Donors

- **Invest in RCCE proof of concept:** Support RCCE approaches and/or principles – e.g., tailored local solutions, building trust for social norms change, two-way dialogue – in future programme design. Investing in such programmes and advocating for RCCE as a cross-cutting approach in the donor arena can support more holistic and effective health responses in the future.
- **Support longer programme timeframes:** Although the programmes reviewed helped quickly increase vaccine coverage, future programming would benefit from longer funding periods to allow for ‘deeper’ interventions for even greater and more sustainable impact. Investing more and for longer in building capacity, systems, and trust can support more resonant outcomes.

References

Collective Service: Risk Communication and Community Engagement (RCCE) Coordination in Public Health Emergencies, Including COVID-19. Interim Guidance. October 2022. (https://www.rcce-collective.net/wp-content/uploads/2022/11/RCCE_Coordination_Guide_October-2022-3.pdf)

IFRC, UNICEF, WHO: RCCE Action Plan Guidance: COVID-19 Preparedness and Response.

Pan-African Health Organisation. COVID-19 Risk Communication and Community Engagement (RCCE) Planning Template.

UNICEF: COVID-19 Global Risk Communication and Community Engagement Strategy. December 2020 – May 2021. (<https://www.unicef.org/media/90706/file/COVID-19-Global-Risk-Communication-and-Community-Engagement-Strategy.pdf>)

UNICEF Bolivia, (2022) Vacunación presentation (PPT): PILOT BEHAVIOR CHANGE STRATEGY IN THREE MUNICIPALITIES- The best Gift is to be Alive

UNICEF Bolivia, (2022) VACUNACIÓN Summary: AN INITIATIVE OF COMMUNICATION AND SOCIAL MOBILIZATION IN SUPPORT OF THE INTEGRAL VACCINATION OF THE FAMILY

UNICEF Bolivia, (2022) ACT-A ANNUAL REPORTING TEMPLATE JANUARY – DECEMBER 2022

UNICEF Bolivia, (2022) Edutainment approaches for children and adolescent students supports behavior change on vaccine promotion against COVID-19 in El Alto, Bolivia

UNICEF Bolivia (2022) Vacunación monitoring report

WHO Europe, UNICEF: Risk communication and community engagement for COVID-19 vaccination, Implementation Tool.

WHO Europe: Risk Communication and Community Engagement: a compendium of case studies in times of COVID-19.

WHO AFRO RCCE / WHO Country/Comission Laboratoire et Recherche (2022), Les déterminants socio-comportementaux de l'adhésion de la population aux mesures de santé publique, aux mesures sociales, et l'acceptation des tests et des vaccins contre la COVID-19: Une étude qualitative rapide dans la province de Brazzaville

WHO Regional Office AFRO/DRC Country Office/Secrétariat Technique de riposte contre COVID-Ministère de la Santé Publique, Hygiène et Prévention (2022), Renforcement de la surveillance et de la réponse à base communautaire. Plan d'action de renforcement de l'engagement communautaire dans la réponse à la pandémie de la COVID-19 dans la Ville Province de Kinshasa

WHO Regional Office AFRO/Country Office/Ministry of Health, (2022) Presentation RESULTATS ETUDE QUALITATIVE BRAZZAVILLE

WHO Regional Office AFRO/DRC Country Office/Secrétariat Technique de riposte contre COVID-Ministère de la Santé Publique, Hygiène et Prévention (2022), Presentation RESULTATS ETUDE QUALITATIVE KINSHASA

WHO Regional Office AFRO/Congo Country Office / Congo Ministry of Health and Population, (2022) Presentation RESULTATS PRELIMINAIRES ETUDE QUALITATIVE POINTE-NOIRE

WHO Regional Office AFRO/WCO /Ministry of Health, (2022), Presentation RESTITUCAO : ESTUDO QUALITATIVO BISSAU & BAFATA



DEPLOYING RISK COMMUNICATIONS AND COMMUNITY ENGAGEMENT (RCCE) APPROACHES FOR COVID-19 IMMUNISATION