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Community Rapid Assessment on COVID-19:

Behavioural Findings and Insights from Round 1 in Kenya, Madagascar and South Sudan

EVALUATION OFFICE
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PREFACE

The COVID-19 pandemic has ushered in an era of profound change, requiring news ways of doing business while remaining focused on delivering results. For UNICEF evaluation, the pandemic has created both the necessity and the opportunity to use different tools and approaches to understand how the virus is affecting children and their families all over the world.

Effective management, especially for curtailing transmission as well as mitigating secondary impacts of the current pandemic relies heavily on the individual and community behaviors and norms in relation to key protective behaviors such as physical distancing and the use of masks, handwashing, among others. Understanding these behaviors, including how they differ among population groups, how they change over time and in response to which drivers and barriers, needs of affected communities, is crucial in designing an effective response. This in turn requires timely community-sourced data that can be captured in a time-series manner.

The UNICEF Evaluation Office, in collaboration with Communications for Development (C4D) section in Programme Division and the Harvard Humanitarian Initiative developed the Community Rapid Assessment exercise (CRA) as a way to measure the protective practices, health-seeking behaviours, coping strategies and emerging needs of individuals and households in relation to COVID-19. The primary objective was to provide country offices valuable data in order to strengthen the evidence base and inform country-level programming in response to the pandemic. Second to this, the CRA is intended to contribute to UNICEF's overall analytical agenda on COVID in an effort to better position this type work in the overall corporate efforts.

Findings thus far have provided a rich and much-needed picture of the behavioral component of the outbreak at the individual and community levels. In making use of time-series data, it has also provided further opportunities to examine country and region-specific trends over time. And because the CRA is a real-time exercise, analysis, visualization and interpretation of findings are already being used in several country-level fora to guide program changes. The long-term vision is to embed capacity for similar surveys within government data systems at the country level.

This report presents early findings and insights from three countries in Eastern and Southern Africa – namely Kenya, Madagascar and South Sudan. They point to a number of areas where behaviour change strategies and interventions can be adjusted to maximize effectiveness, particularly in relation to specific target populations through socio-demographic data analysis. The findings also demonstrate the value of deploying rapid analytic systems for emergencies like COVID-19 and highlight the importance of gathering data on social and behaviour change to inform decision-making and programme design over the longer term.

The organizational implications are two-fold, from ensuring that evidence generation plans at all levels integrate systematic rapid research to collect and analyse social and behavioural data, as well as facilitate utilizing data through making sure data flow to advocacy and decision-making platforms. We believe that institutionalizing the use of such population surveys in UNICEF evaluation and data for decision making platforms will help strengthen the evidence base for programming at the country level, and ultimately improve results across all sectors of our work. Furthermore, institutionalizing the

generation and use of social and behavioural data for future pandemics as well as other humanitarian crises can help better preparedness, supporting recovery and resilience measures that are people-centred and community-driven.

I would like to thank colleagues in Evaluation Office and the Communications for Development section for their strong collaboration on this exercise at country, regional and headquarters. In particular, UNICEF colleagues in the C4D and evaluation sections of the Eastern and Southern African Regional Office – Natalie Fol, Massimiliano Sani, Urs Nagel, Carole Tronchet Pradhan – provided valuable management and leadership with participating country offices. Country-level colleagues from Kenya, Madagascar and South Sudan in the C4D section also deserve recognition and gratitude for the collaboration and technical management to implement the CRA and take forward actions with national partners – Gopinath Durairajan, Geeta Sharma, Surangani Abeyesekara, and Hoby Razakasoavina. My colleagues in the Evaluation Office – Uyen Kim Huynh and Andres Esteban Ochoa – deserve recognition for conceptualization the study, designing and overseeing the implementation of the survey, and carrying out depth analyses for each of round of data. We would also like to thank Rania Elessawi, from C4D Programme Division, for her ongoing guidance and valuable contributions. As always, Celeste Lebowitz and Geeta Dey provide reliable support throughout. Finally, my sincere thanks to Vincent Petit, Chief of C4D for leading the collaboration with C4D colleagues in this assessment.

My colleagues and I look forward to further supporting country-level C4D and evaluation managers and teams and hope that they will find the insights and implications of this study both useful and timely.

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COMMUNITY RAPID ASSESSMENT ON COVID-19 IN EASTERN AND SOUTHERN AFRICA REGION: FINDINGS AND INSIGHTS FROM ROUND 1 IN KENYA, MADAGASCAR AND SOUTH SUDAN

INTRODUCTION

The coronavirus disease pandemic (COVID-19) has triggered an unprecedented global crisis. As of 25 November 2020, the World Health Organization reported more than 59,204,902 confirmed cases, including 1,397,139 deaths.[1] The related economic crisis is placing tremendous strain on already overburdened social and health services, and is expected to push an additional 85 to 115 million people into extreme poverty in 2020.[2] For children, the impact of the crisis will be felt across multiple dimensions of their lives for years and perhaps decades to come, exacerbating existing exclusions and inequities.

National efforts to combat the spread of the virus rely on key behaviours at the community and individual levels such as frequent handwashing, physical distancing and the use of masks, and health-seeking behaviour, among others. Risk communication and community engagement (RCCE) programmes can reinforce these behaviours, but a 'one-size-fits-all' approach may not achieve the desired results; *lessons learned from the response to the Ebola outbreak in West Africa in 2014-2015 suggest that to be effective, RCCE strategies should be evidence-based*, making use of robust data on the knowledge, attitudes and practices (KAP) of specific communities, as well as how these practices are evolving over time.[3]

The Community Rapid Assessment (CRA) was designed to strengthen this evidence base by gathering rapid time-series social and community-sourced data to examine protective practices, coping strategies and emerging needs in relation to COVID-19.

This report provides a brief overview of the CRA as implemented in three of the eight participating country offices in Eastern and Southern Africa region (ESAR), focusing on 1) key findings and early insights from the first round of data from three selected countries (Kenya, Madagascar and South Sudan) and 2) early lessons and considerations arising from implementing this approach.

The findings provide preliminary recommendations for adjusting current RCCE strategies and interventions. They also demonstrate the value of deploying rapid analytic systems for emergencies like COVID-19 and make the case for continuing to gather data on social and behaviour change to inform decision-making and programme design over the longer term. A fuller analyses of the three countries

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[1] World Health Organization, 'WHO Coronavirus Disease (COVID-19) Dashboard', WHO, Geneva, https://COVID19.who.int/, accessed 13 October 2020.

[2] World Bank, 'COVID-19 to Add as Many as 150 Million Extreme Poor By 2020', press release, World Bank, New York, 7 October 2020.

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

can be found in the [slide deck](), which contains all the data visuals and country-level perspectives and interpretation.

Leaving no one behind

The CRA permits disaggregation of the data along several different dimensions – by gender, age, urban vs. rural, among others. The lack of such disaggregated data has been cited in numerous evaluations as a limiting factor in UNICEF efforts to reach the most vulnerable and ensure no one is left behind, since the voices and needs of these groups may not emerge at the aggregate level. Indeed, the data gathered in the first round of the CRA revealed important differences in relation to variables of age, gender, education and others. For example, in Kenya, men were significantly more likely than women to obtain information on COVID-19 through radio, newspapers and television (60 per cent compared to 50 per cent). In South Sudan, access to distance learning for children varied significantly between states and population groups. In Madagascar, urban populations were significantly less likely than their rural counterparts to have access to safe water and soap in their homes. These differences highlight specific needs as well as possible entry points to improve programming targeting key groups.

WHY THE COMMUNITY RAPID ASSESSMENT?

Developed in partnership with Harvard Humanitarian Initiative, the CRA represents an exciting new approach to harvesting representative data in fast-changing environments. A key innovation of the CRA is its *lightweight yet rigorous approach*, making it *rapid, agile and cost-effective* (averaging $24,000 for the entire exercise per country) while maintaining *robust methodological standards*. Using mainly mobile phone-based surveying methods, the CRA provides not only a ground-level series of data reflecting current behaviours and perceptions related to COVID-19, but a *picture of how these behaviours and perceptions are changing over time in response to rapidly changing circumstances and the evolving disease landscape*.

Crucially, the CRA utilizes a sampling methodology that is probabilistic and representative of the target population, affording a degree of rigour typically only available through large national surveys such as Multiple Indicator Cluster Surveys (MICS) or Demographic and Health Surveys (DHS). In between rounds, data are analysed and presented with country office teams to discuss their strengths, weaknesses, use, and areas to for further improvement to benefit communications for development (C4D) programme strategies.

CONCEPTUAL APPROACH AND METHODOLOGY

The main objective of the Community Rapid Assessment is to provide insights on behavioural drivers related to COVID-19. Since the earliest days of the pandemic, UNICEF country offices (COs) around the world have been conducting KAP studies, which are providing meaningful information to inform programming. However, most of these studies do not take into consideration issues of trust, community dynamics, and other drivers that may influence behaviours. In addition, most of them do not permit analysis over time, and they are not typically designed with representative sampling that allows an accurate picture of behaviour change at the individual level.

The overall conceptual approach of the CRA draws upon the behavioural drivers model (BDM), which offers a framework for analysing the drivers of certain practices or behaviours in a given context. Put another way, the BDM aims to help practitioners move beyond identifying *what people are doing* – the typical focus of a KAP study – to a deeper understanding of **why people do what they do** in a given context in order to inform programme design.

Figure 1: Rapid assessment components within UNICEF behavioural drivers model
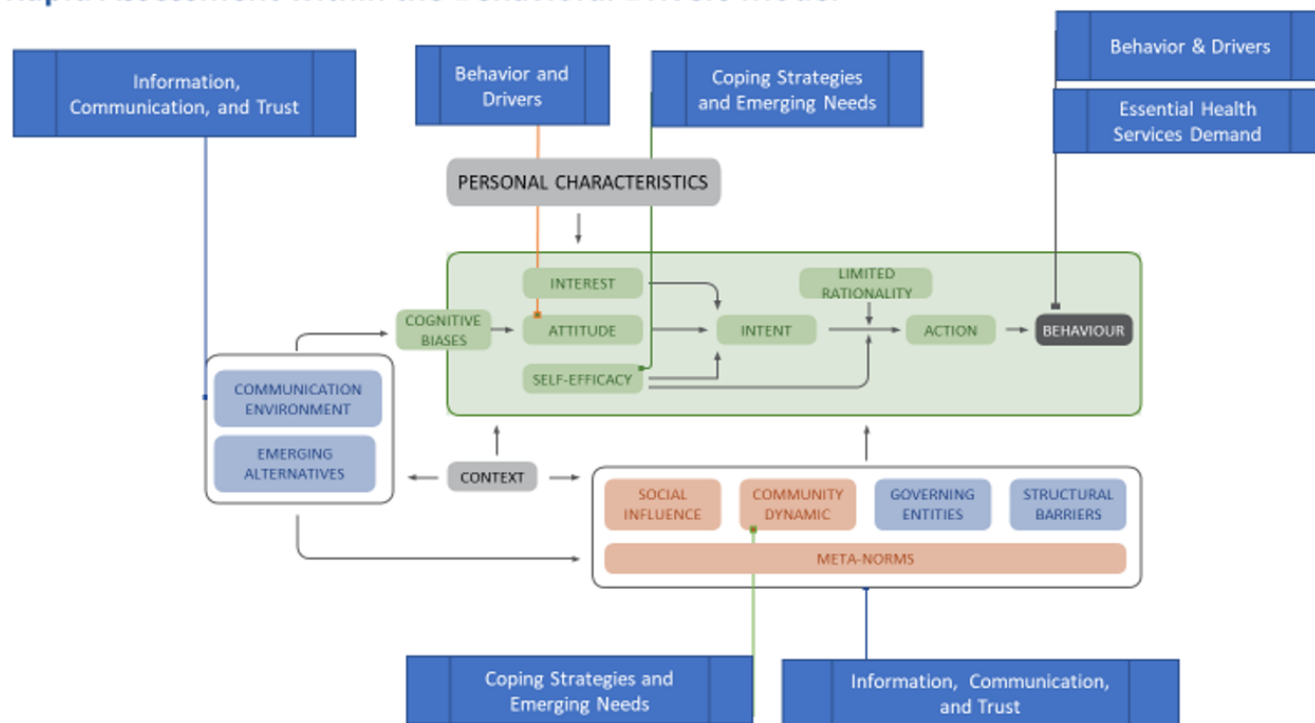
Drawing upon this analytical framework, the CRA explores key issues such as prevalence of protective behaviours and the barriers to adopting them; perceptions about risk; trust in institutions, community

groups and information channels; and coping strategies and emerging needs in relation to COVID-19, among others (see below). Demographic variables include age, gender, rural/urban, and education, in order to test possible relationships between these variables and behaviours.

The CRA utilizes a nationally representative[4] approach using a time-series cross-sectional sample in 12 countries. Data were collected mainly through Viamo, a third-party data research firm, using mobile phones. Random sampling was conducted at a target sample of N=1000/country and weight models were applied ex post facto to ensure representativeness. Participating countries in ESAR currently include Angola, Ethiopia, Kenya, Madagascar, Rwanda, South Africa, South Sudan and Uganda. These countries are in various stages of implementing the exercise, as shown in Figure 2.

Figure 2: CRA phases in participating ESAR countries and COVID-19 incidence rate during data collection

CRA in East and Southern Africa - UNICEF
CRA Stage of Implementation and COVID-19 Incidence Rate

Incidence Rate COVID-19
- 300
- 600
- 900

CRA Implementation Stage
- CRA - Baseline Other
- CRA 1 Round
- CRA Designing
- CRA Launching
- Non-CRA Country

Source COVID-19 Rate
https://coronavirus.jhu.edu/map.html

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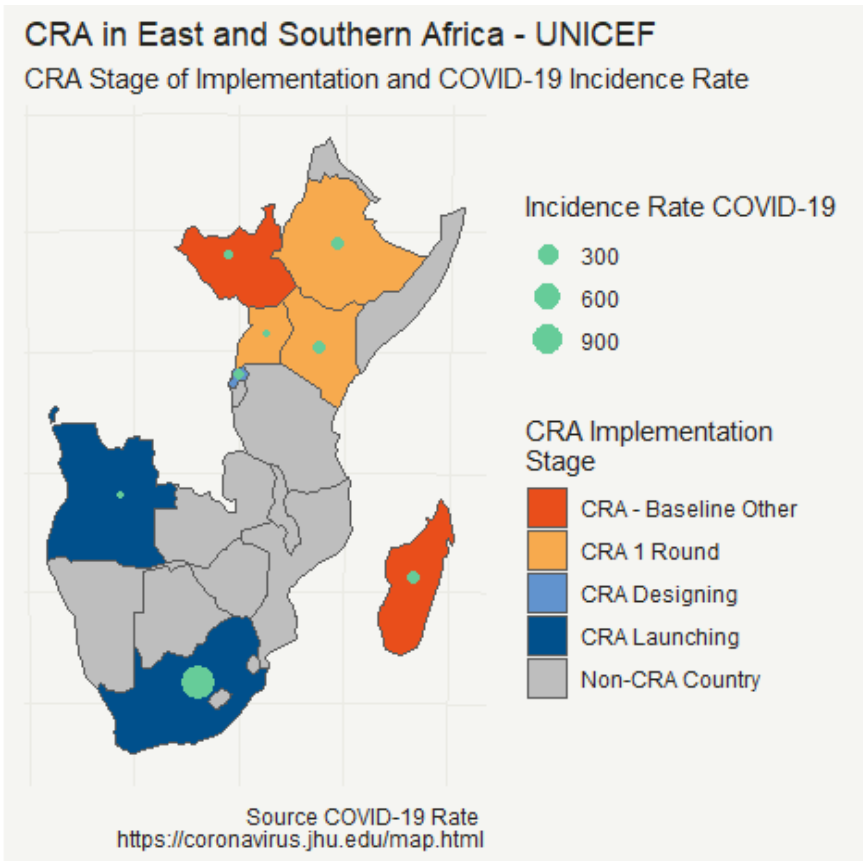
[4] Samples were drawn to be representative at the national level with a probabilistic sample of >1,000 respondents, except for Afghanistan. For Afghanistan, a randomized sample was still used, but it was drawn from a large public database of respondents, using the national hotline for COVID-19 information, instead of from the universe of all cellphone users of a given country. For that country, the design does not reduce its internal validity; it rather limits the interpretation reach.

The general design of the study is at the national level, and results are disaggregated for select demographic and geographic parameters (urban/rural setting, age groups, gender and education level) to provide a more detailed look at trends within these parameters. Subnational units (e.g. provinces and states) are also included as referential variables. Respondents are adult males and females (18 years or older) and the sample sizes vary by country, with an average size of approximately 1,000 respondents. The survey tool is composed of 14-24 questions, mostly drawn from well-established questionnaires. In order to ensure its relevance to a variety of possible country contexts, the CRA allows for minor adaptation at the country level. In Kenya, the survey was delivered through Random Digital Dialling (RDD) using an interactive voice recording (IVR) survey, while in Madagascar and South Sudan the survey was conducted face-to-face.

Figure 3: The CRA allows for tailored approaches at country level

Country	Survey Size	CRA Type
Kenya	n = 1124	National CRA standard
Madagascar	n = 4282	National and localized baseline with CRA 2nd and 3rd round
South Sudan	n = 1841	Localized baseline with CRA 2nd and 3rd round

The approach envisages two to three rounds of data collection per country, in order to provide time-series data around five main areas of research:
1. *How are behaviours changing over time and why?*
2. *How are communities coping with the disruptions related to COVID-19?*
3. *What are the emerging needs of families and communities?*
4. *Are people's behaviours in relation to COVID-19 affected by their level of trust?*
5. *How can UNICEF adapt its programming to be more relevant?*

Survey questions themselves explore such issues as:
- *What are the main concerns and risks perceived in relation to COVID-19?*
- *Which protective behaviours are being practiced and to what extent, and what are the main barriers to practicing these protective behaviours?*
- *What is the likelihood that parents will send their child(ren) to school if they are re-opened?*
- *To what extent are communities reporting access to essential services during COVID-19?*

- *What are some of the coping mechanisms adopted by families in relation to COVID-19?*
- *What are the most important communications channels for receiving information about COVID-19?*
- *How much does the population report trusting local health care providers?*

CAVEATS AND LIMITATIONS

Table 1: Strengths and weaknesses of the CRA

Strengths	Weaknesses
- Quick adaptation of survey to country needs especially in emergencies. Phones allow for quick and flexible changes in questions. - Reduced costs and time when compared to other alternatives (vs. paper-based). - Standardization facilitates analysis and design. - Sources data directly from individuals rather than head of households. - Richness of cross-tabular analysis with available demographic variables *(Hypothesis testing needed)*. - Temporal element provides richer narrative of evolving situation. - BDM strong adaptability across sectors. - Short surveys in time series allows for quicker results iteration of interventions or strategies.	- Survey length using phones limits extent of investigation. - Variable airtime costs and phone penetration rates may skew representativeness of population. - Limited aggregation and comparability at regional level due to heterogeneity of surveys. - Absence of comparable studies. - Generalized difficulty to integrate different surveys to contrast results. - Observational effect on self-reporting questions on 'practices' (desirability bias) - Demand for adequate analytical capacity across the organization if such high frequency systems are in place.

SELECTED FINDINGS FROM THE FIRST ROUND

Some early results from the first round can provide valuable insights for programming. They will also help to indicate priority areas to consider in the subsequent rounds.

RISK PERCEPTION AMONG DIFFERENT POPULATIONS

Communities are generally highly aware of COVID-19 and concerned about it (Madagascar, South Sudan). A relatively small proportion of respondents did not consider COVID a risk at all.

Figure 4: A significant proportion of respondents in Madagascar and South Sudan considered themselves at high risk
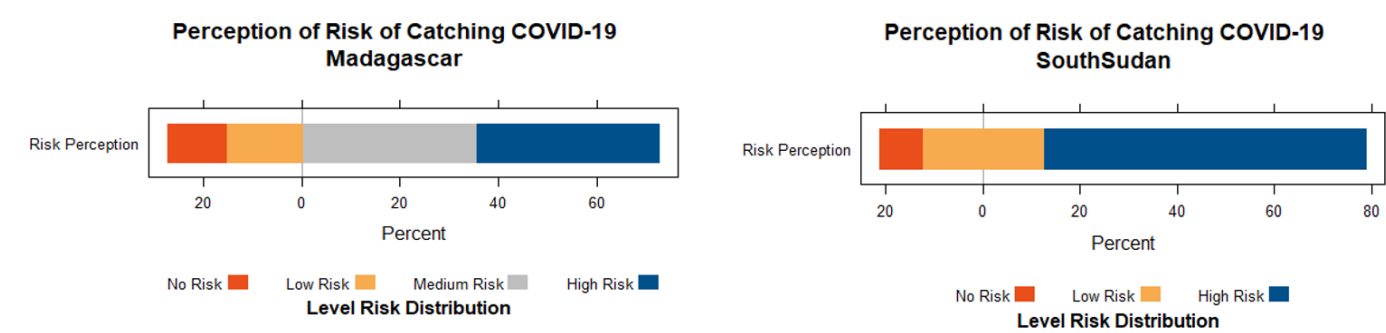
Nevertheless, there is a visible segment that perceives itself to be at low risk of contracting COVID-19, and in some cases, these segments correspond to especially vulnerable populations. For example, in South Sudan, <u>over a third of people over the age of 61 years (39.7 per cent) considered themselves to be at low risk or no risk of contracting the disease, despite the fact that this age group is considered high risk.</u> Similarly, when looking in more detail at risk perception in Madagascar (figure 5), respondents in urban areas were significantly more likely than those in rural areas to consider the virus "very dangerous." The statistical significance of these differences among various population groups will become more apparent as more data points become available in subsequent rounds. However, they already point to differing risk perceptions between setting and age, and this is an important consideration when determining whether the right partners are 'at the table' representing the concerns of these different segments of the population.

Figure 5: Differences in risk perception across different settings in Madagascar
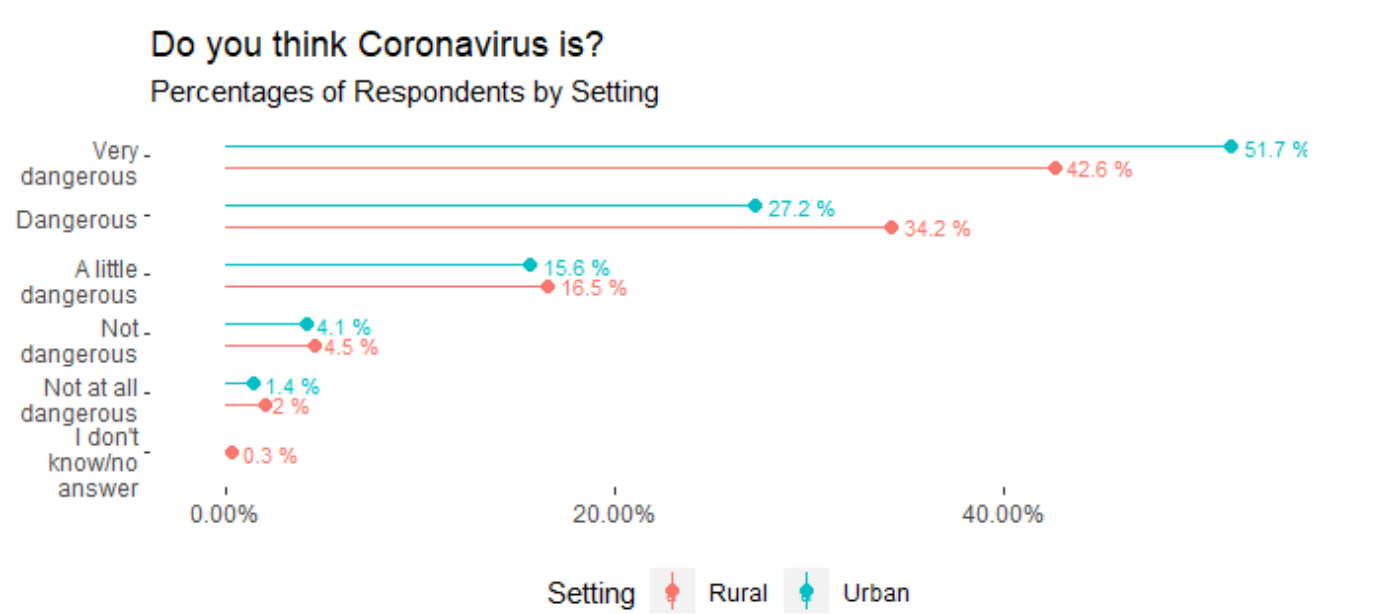
Figure 6: Differences in risk perception across different age groups in South Sudan

Do you believe that you are at high risk, low risk or no risk to contract COVID-19? by Age
Percentages of Yes/No Respondents

18-30 Yrs Old	31-40 Yrs Old	41-50 Yrs Old
High_risk — 67.7 %	High_risk — 67.6 %	High_risk — 63.6 %
Low_risk — 22.8 %	Low_risk — 25.8 %	Low_risk — 26.5 %
No_risk — 9.5 %	No_risk — 6.6 %	No_risk — 9.9 %

51-60 Yrs Old	61 Yrs Old & >
High_risk — 62.8 %	High_risk — 60.4 %
Low_risk — 26.2 %	Low_risk — 30.8 %
No_risk — 11 %	No_risk — 8.9 %
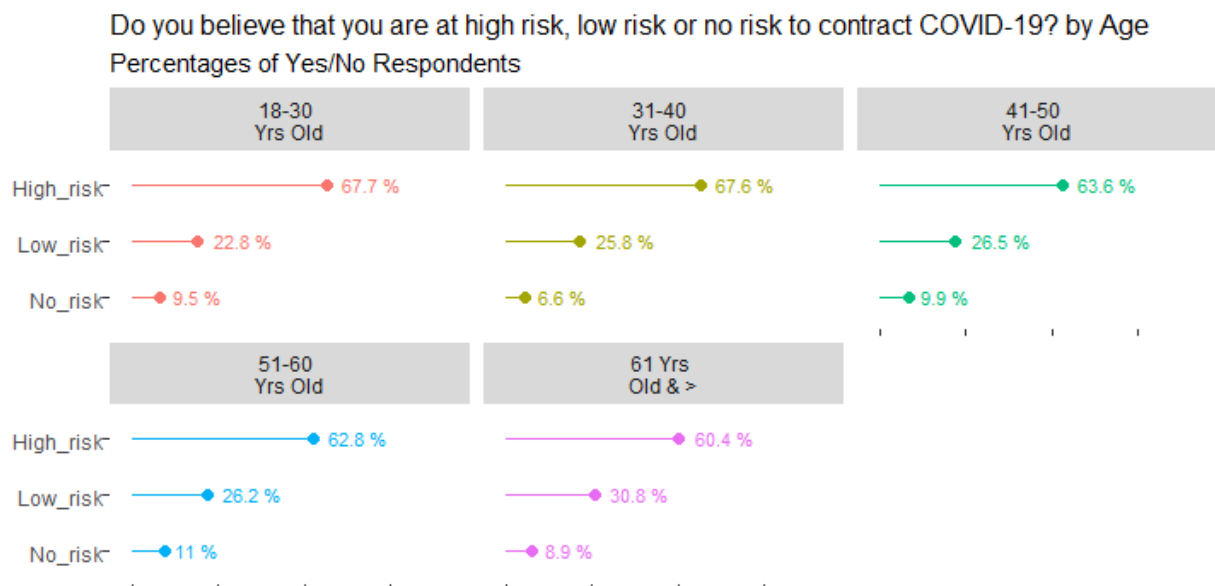
Insight: Looking in more detail at those populations that deem themselves to be less at risk can help identify priority populations for intensified outreach and also help calibrate behavior change strategies specifically tailored to those populations.

PROTECTIVE BEHAVIOURS AND BARRIERS TO ADOPTING THEM

Across all countries, respondents report frequent practicing of protective measures such as handwashing, mask use and social distancing. For example, a vast majority of respondents in Kenya and Madagascar report high levels of compliance in all behaviours examined.

Figure 7: Self-reported frequency of protective behaviours

Protective Practices CRA COVID-19 Kenya - Monthly

Handwashing
Mask Use
Social Distance

Frequency of Practice: Never | Rarely | Sometimes | Most of the time | All of the time

Handwashing Madagascar - Daily

Frequency of Practice: Never or Almost Never | Less than 3 times a day | 3 times a day | More than 3 times a day | All of the time

Mask Use Madagascar - Daily

Frequency of Practice: Doesn't apply | Never | Sometimes | Most of the time | All of the time

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Similarly, in a more standard measure of yes/no for protective behaviours in South Sudan (figure 8) the majority of practices have high levels of self-reported compliance, with the exception of mask ownership (see below).

Figure 8: Protective practices in South Sudan
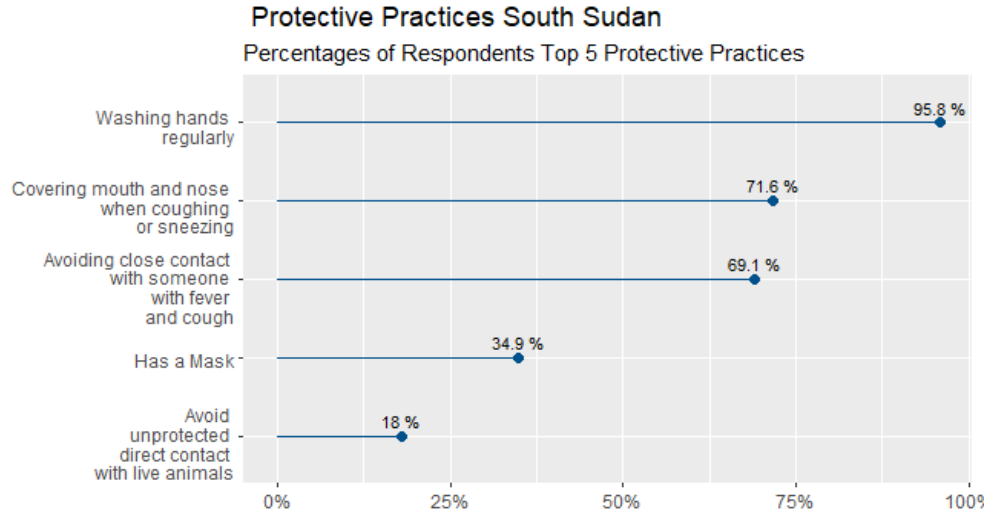
Interestingly, however, the <u>self-reported levels of compliance appear to be higher than what is observed on the ground</u> in some cases. This observational effect can be seen in the data when we compare how respondents report the practice happening around them. For example, in Madagascar, where both types of questions were included, there is a discrepancy between self-reported compliance and how respondents perceive the practice happening in the community around them.

Figure 9: Protective behaviours as reported to the respondent – self – or the community
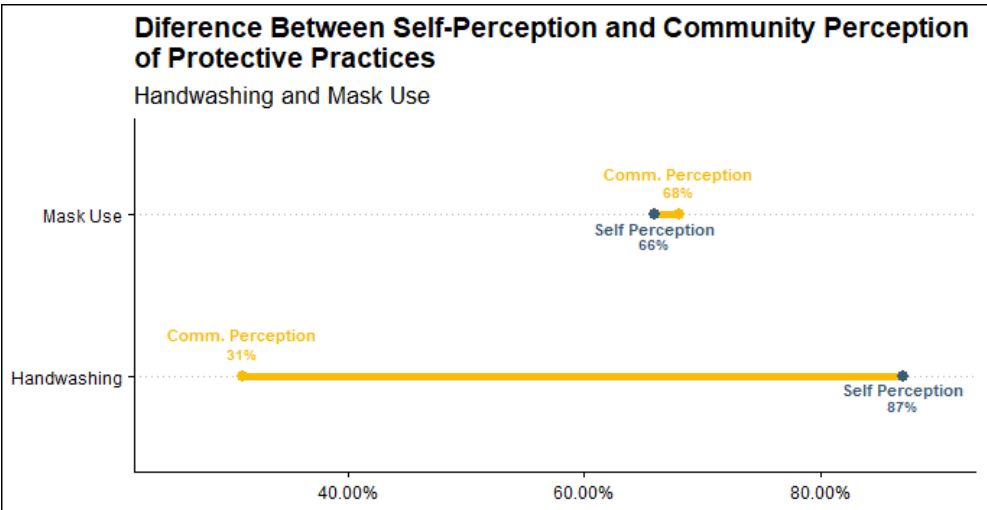
Insight: This may suggest that while individuals perceive the importance of the behavior or recognize a social norm in favor of doing so, there are material or behavioral barriers that prevent them from actually adopting the practice. In other words, even high levels of awareness and intent do not guarantee a change in behavior.

A. Material barriers to protective behaviours

Two specific issues highlighted by the data are the availability of running water and soap at home and mask availability. In Kenya, for example, respondents identified a lack of infrastructure such as washrooms and running water as the second most significant barrier to adopting protective practices (42 per cent of respondents overall), with rural populations slightly more likely to identify this as a barrier. Similarly, in Madagascar, fewer than half of respondents in urban areas reported having access to drinking water in their homes and communities, and access to soap was also limited, as shown in figure 10 below. Notably, these figures suggest significant inequities between urban and rural areas when it comes to access to drinking water and soap, with respondents in urban areas reporting significantly less access.

Figure 10. Availability of water and soap

Water and Sanitation Barriers by Sex and Setting - Madagascar
Percentages of Respondents per Access to Protective Resource
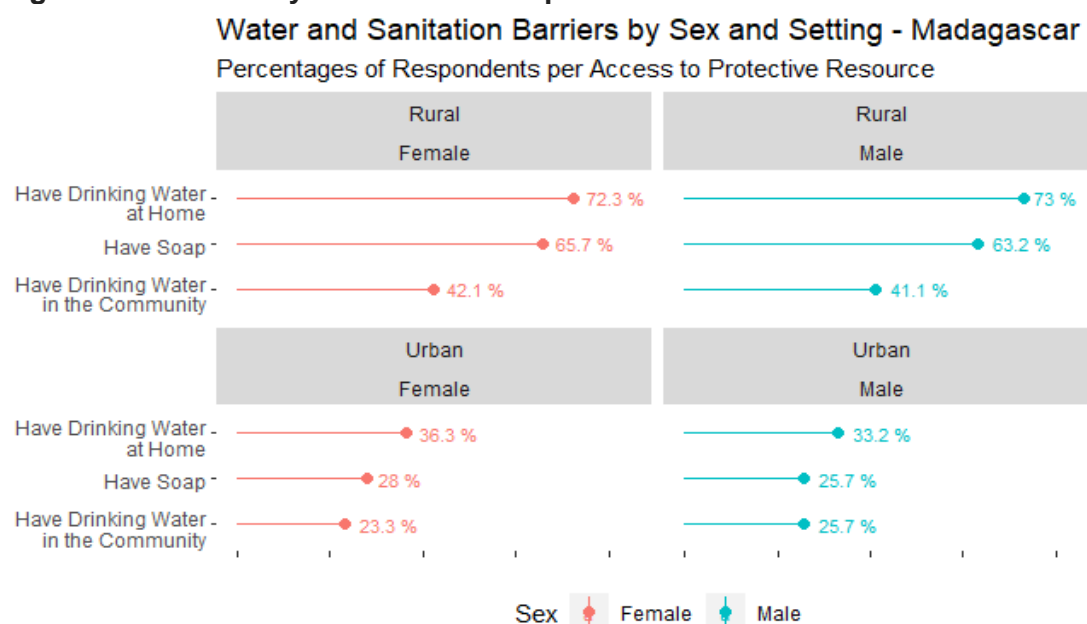
These inequities appear in data related to handwashing practices as well, as shown in figure 11. This will be a point to further review with a more detailed correlation analysis as more data points are gathered.

Figure 11: Handwashing by setting in Madagascar

At this moment how often do you wash your hands?
Percentages of Respondents by Setting
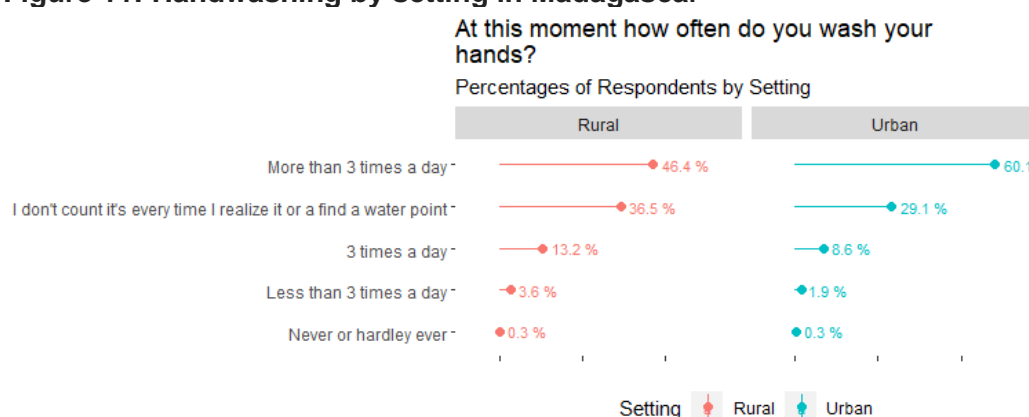
Lack of access to basic personal protection supplies also appears as a significant barrier for some communities. For example, in South Sudan, only 35 per cent of respondents reported owning a mask. However, those who owned masks tended to use them: 29 per cent of people who owned masks actually used them (see figure 12), indicating that there is a supply issue of protective personal equipment.   This could suggest that for some, the barrier is material rather than behavioural, reflecting a lack of masks (whether due to low availability or a perception that they are not affordable) rather than a lack of desire to wear them. Further investigation into the question of why people do not own masks may shed light on this.

Figure 12: People who own masks in South Sudan tend to use them

OWNERSHIP AND USE OF MASK

Has a Mask   Has a Mask and Uses It
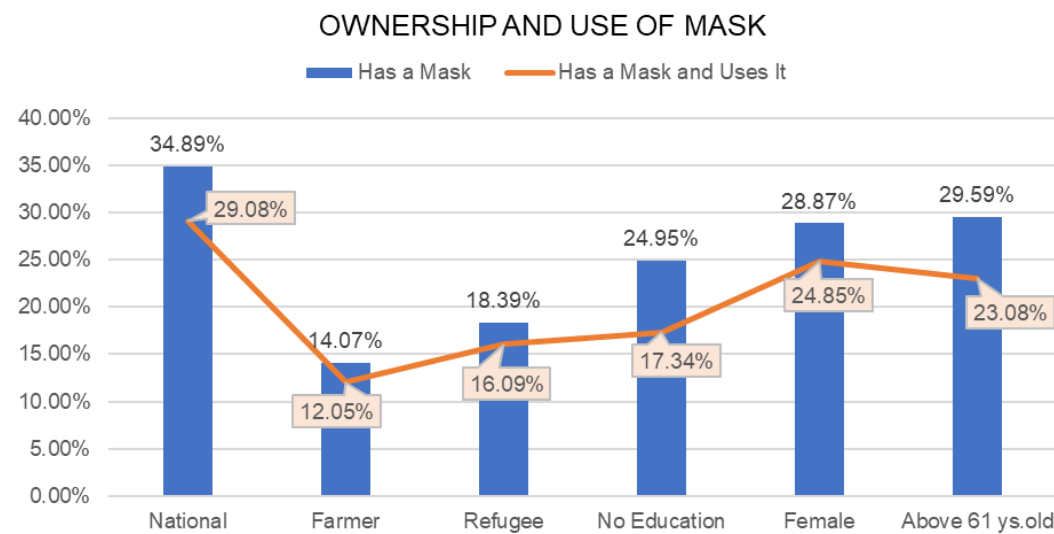
Insight: *Wider coverage of hand washing points in areas with less access to water may be a priority.*

Insight: *Distribution of soap (Madagascar) and masks (South Sudan) for specific underperforming groups like farmers and refugees in South Sudan and urban areas in Madagascar may be priorities.*

B. Behavioural drivers to protective behaviours

As shown in figure 13, the risk of losing relationships or jobs ranks the highest among the barriers for respondents in Kenya.

Figure 13: Perceived barriers to protective behaviours in Kenya

Barriers to Practice Protective Behaviours by Sex and Setting
Percent of Respondents per Annotated Barrier
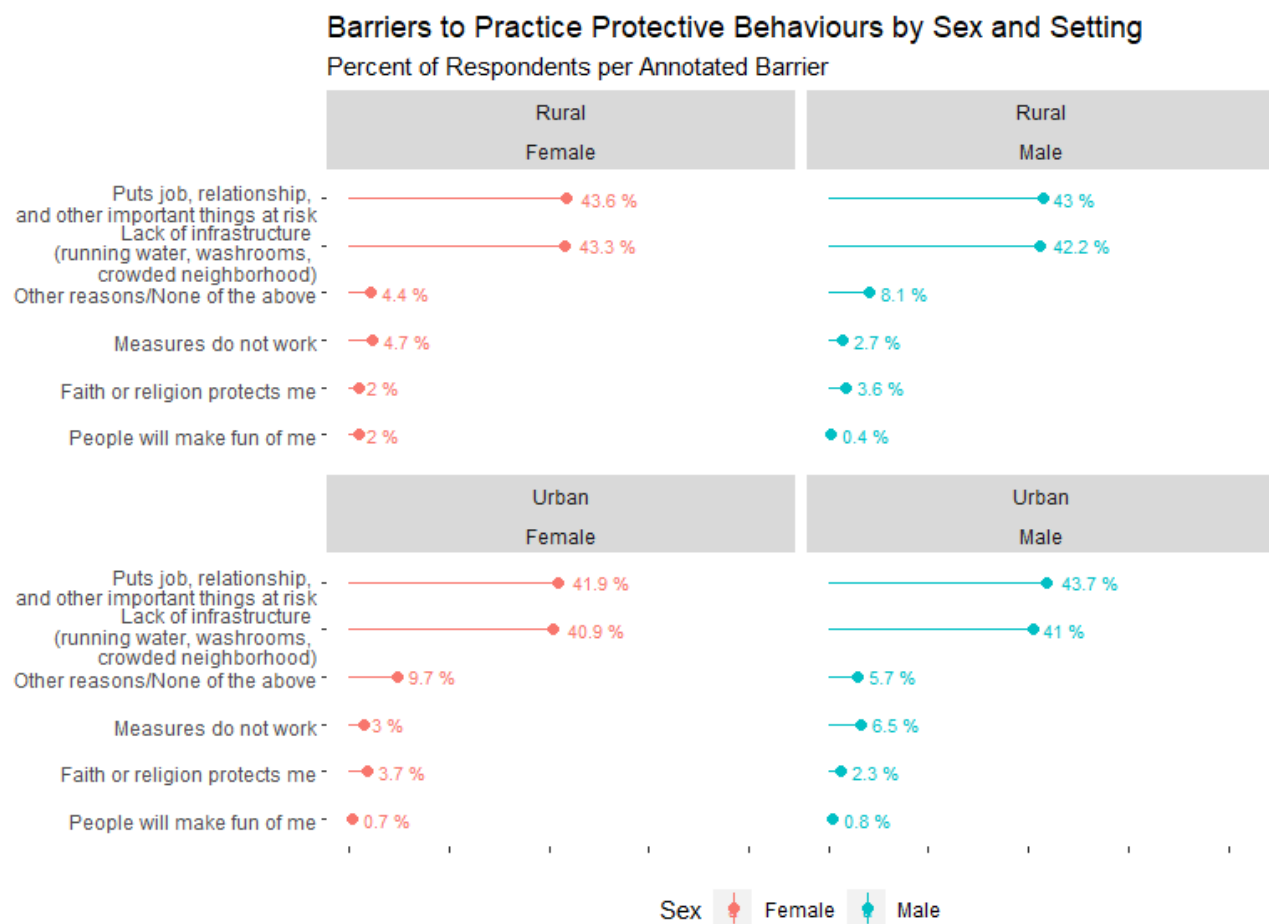
This perception of protective practices having a negative impact on interpersonal relations is also visible in South Sudan. While an overwhelming majority of respondents (97.4 per cent) felt it was important to take actions to prevent the spread of COVID-19 (figure 14), a much smaller proportion of respondents were "very confident" about adopting the recommended measures when people who are important to them disapproved or rejected their decision (figure 15). This illustrates the role that behavioural barriers can play in encouraging or discouraging the adoption of protective behaviours.

Figure 14: Respondents in South Sudan consider it important to take actions to prevent the spread of COVID-19

Do you consider it important to take actions to prevent
the spread of coronavirus in your community?
Percentages of True/False

TRUE	97.4
unknown	1.8 %
FALSE	0.8 %

0.00%   25.00%   50.00%   75.00%   100.00%
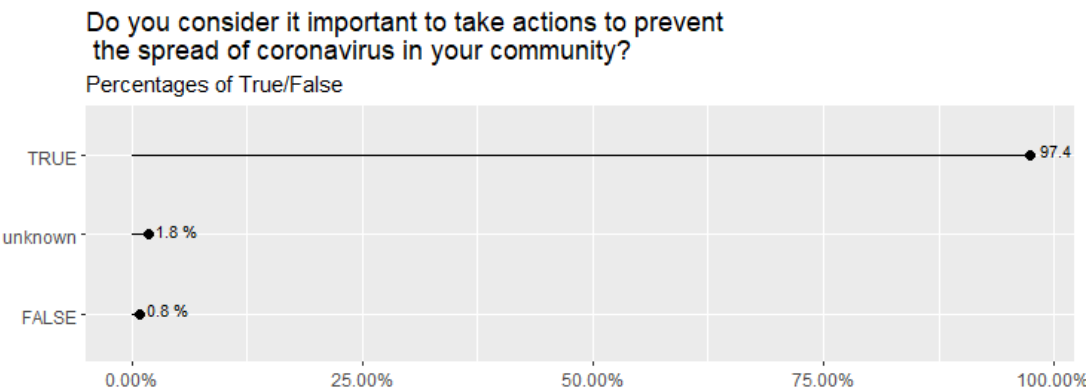
Figure 15: Confidence in adopting recommended preventive measures to prevent the spread of COVID-19

How confident would you be in adopting the recommended preventive measures
even if people who are important to you disapprove/reject your decision
Percentages of Yes/No Respondents

Very confident	64.6
Somewhat confident	22.8 %
Not that confident	7.8 %
Unsure-don't know	2.5 %
Not at all confident	2.3 %

0.00%   20.00%   40.00%   60.00%
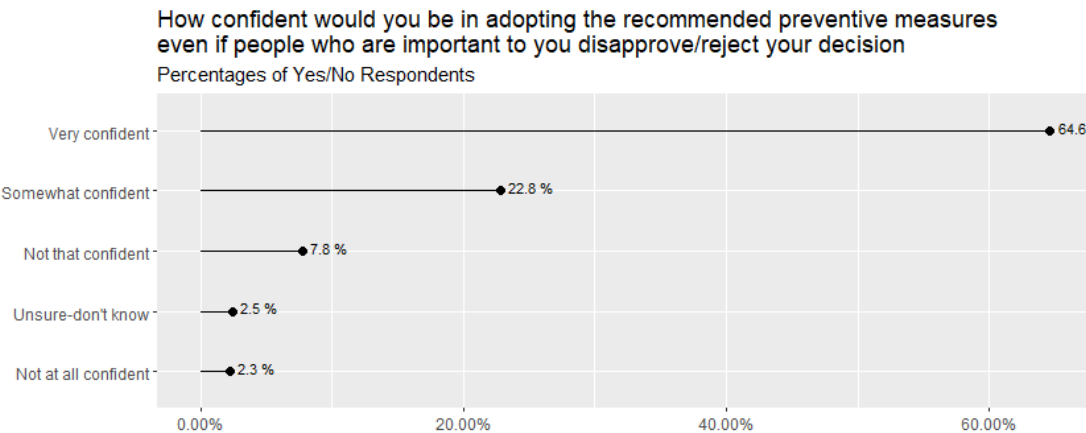
Insight: Further study to identify social barriers may yield valuable insights. Other self-reported data sources suggest that low adherence to measures such as staying at home or reducing trips to the market or store is correlated with increased food security and income loss,5 despite general public support for these measures. A deeper dive into the characteristics of these respondents (e.g. type of labor) and the barriers they perceive to adopting protective practices may suggest pathways for addressing these barriers (for example, outreach with employers, or certain kinds of employers).

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5 Prevent Epidemics, 'Responding to COVID-19 in Africa: Using data to find a balance', part 2, New York, 2020, p.10.

EFFECTIVE CHANNELS FOR RCCE

The data also offer a more detailed view of which communication channels have been most effective in reaching respondents in relation to COVID-19. For example, in South Sudan, respondents were as likely to have heard about COVID-19 through community communication channels as through mass media channels such as radio and television (figure 16). In Madagascar, the majority of the population rely on radio and public health announcements that come from the President or high-level government office. Our data also show that the most trusted sources of information come from the health workers suggesting that a more intensified investment towards distributing and communication accurate information using these community influencers may be worthwhile.

Figure 16: Community channels and mass media channels were most likely to reach respondents in South Sudan with information about COVID-19
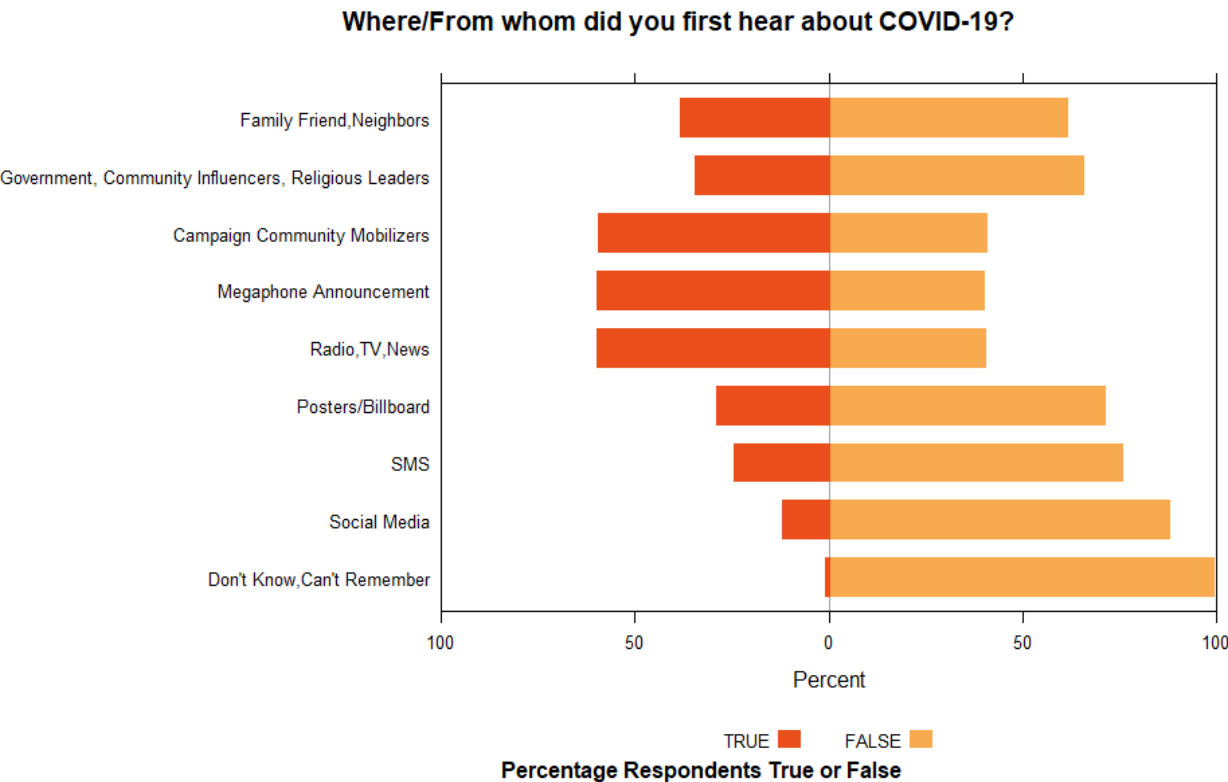
When broken down by age group, the data reveal that certain channels are more likely than others to be effective in reaching certain age groups. For example, among younger populations, the use of SMS appears to be among the more effective communication channels, while for older populations, megaphone announcements appear to outperform other communication channels. These results, matched with observations on the ground, can point to important entry points for reaching specific target populations.

Figure 17: Effective communication channels varied by age in South Sudan

Where/from whom did you first hear about COVID?

Percentage of Respondents True and False
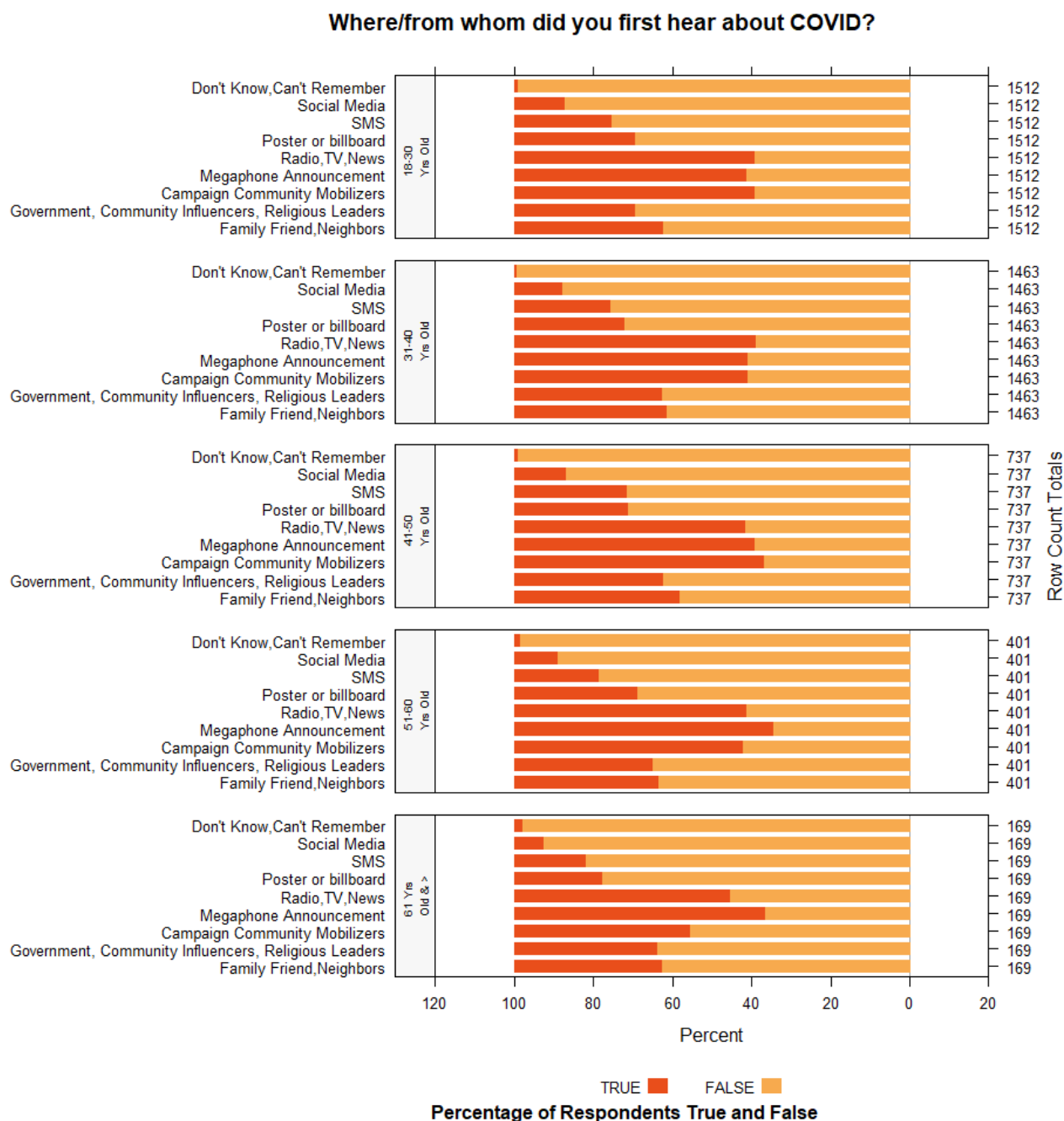
Contrastingly, in Madagascar, the data show that mass media were much more likely to reach respondents than other channels. For example, as shown in figure 18, a large majority of respondents reported having heard about COVID-19 through radio or television. However, interesting differences are evident between local and national channels, with respondents more likely to have been reached through national television (compared to local private television) or local private radio (compared to national radio or private radio from the capital). SMS also emerged as an important channel, with 11.5 per cent of respondents having been reached through this medium.

Figure 18: Communication channels in Madagascar in relation to COVID-19

Through what channels have you heard of Covid
Percentages of Respondents

Channel	Percentage
NA	2 %
National television	18.7 %
Local Private Radio	11.8 %
SMS	11.5 %
Private television from the capital	10.5 %
Private Radio from the capital	6.6 %
Social network	6.4 %
Local Private television	6.3 %
Radio national	3.9 %
Hello allo with megaphone and criers	3.7 %
Community worker	2.4 %
Community members	2.3 %
Health worker	2.2 %
Poster	1.9 %
Internet foreign site	1.6 %
Fokontany	1.4 %
Family	1.4 %
Local newspapers	1 %
Awareness session	0.8 %
Private newspapers	0.7 %
At the church	0.6 %
Internet Malagasy site	0.4 %
Foregin television	0.4 %
Through traditional and community leaders	0.3 %
Local private magazine	0.2 %
Green line 910	0.2 %
Foreign Radio	0.2 %
At school	0.2 %
Training session	0.1 %
Private magazine from the capital	0.1 %
Home visit	0.1 %
Dk	0.1 %

As in the case of South Sudan, a closer look at demographic distributions sheds light on how targeted use of communication channels can improve effectiveness in reaching specific population groups in Madagascar. For example, as shown in figure 19, while television outperforms radio in urban settings, the reverse is true in rural settings, where radio seems to be more effective. In a similar vein, social networks appear to be more important in urban areas, while family, health workers and community members were twice as likely to be effective in rural areas.

Figure 19: Communication channels in Madagascar in relation to COVID-19, urban vs. rural areas

Through what channels have you heard of Covid
Percentages of Respondents by Setting

	Rural	Urban
NA	4 %	1 %
National television	7.4 %	24.3 %
Local Private Radio	21.9 %	6.8 %
SMS	8.3 %	13.1 %
Private television from the capital	3.1 %	14.2 %
Private Radio from the capital	14.4 %	2.8 %
Local Private television	2.8 %	8 %
Social network	2.1 %	8.4 %
Radio national	8.4 %	1.7 %
Hello allo with megaphone and criers	4.6 %	3.2 %
Community worker	3.1 %	2.1 %
Community members	3.3 %	1.8 %
Health worker	3 %	1.8 %
Poster	2 %	1.9 %
Family	2.8 %	0.7 %
Fokontany	2.5 %	0.8 %
Internet foreign site	0.3 %	2.3 %
Local newspapers	0.8 %	1.1 %
Awareness session	1.3 %	0.5 %
Through traditional and community leaders	0.8 %	
At the church	1 %	0.4 %
Private newspapers	0.3 %	0.9 %
Internet Malagasy site		0.6 %
Foregin television	0.3 %	0.5 %
Foreign Radio	0.5 %	0.1 %
Local private magazine	0.2 %	0.2 %
Green line 910	0.2 %	0.2 %
Dk		0.2 %
At school	0.2 %	0.2 %
Private magazine from the capital	0.2 %	0.1 %
Home visit	0.2 %	0.1 %
Training session		0.1 %

Setting ● Rural ● Urban

Insight: *By identifying key groups that have lower risk perception or lack of awareness about COVID-19 and combining this with information about the most effective communication channels for reaching those groups, targeted approaches can be deployed that are likely to be more effective and less costly, as smaller campaigns can be drawn for specific at-risk groups.*
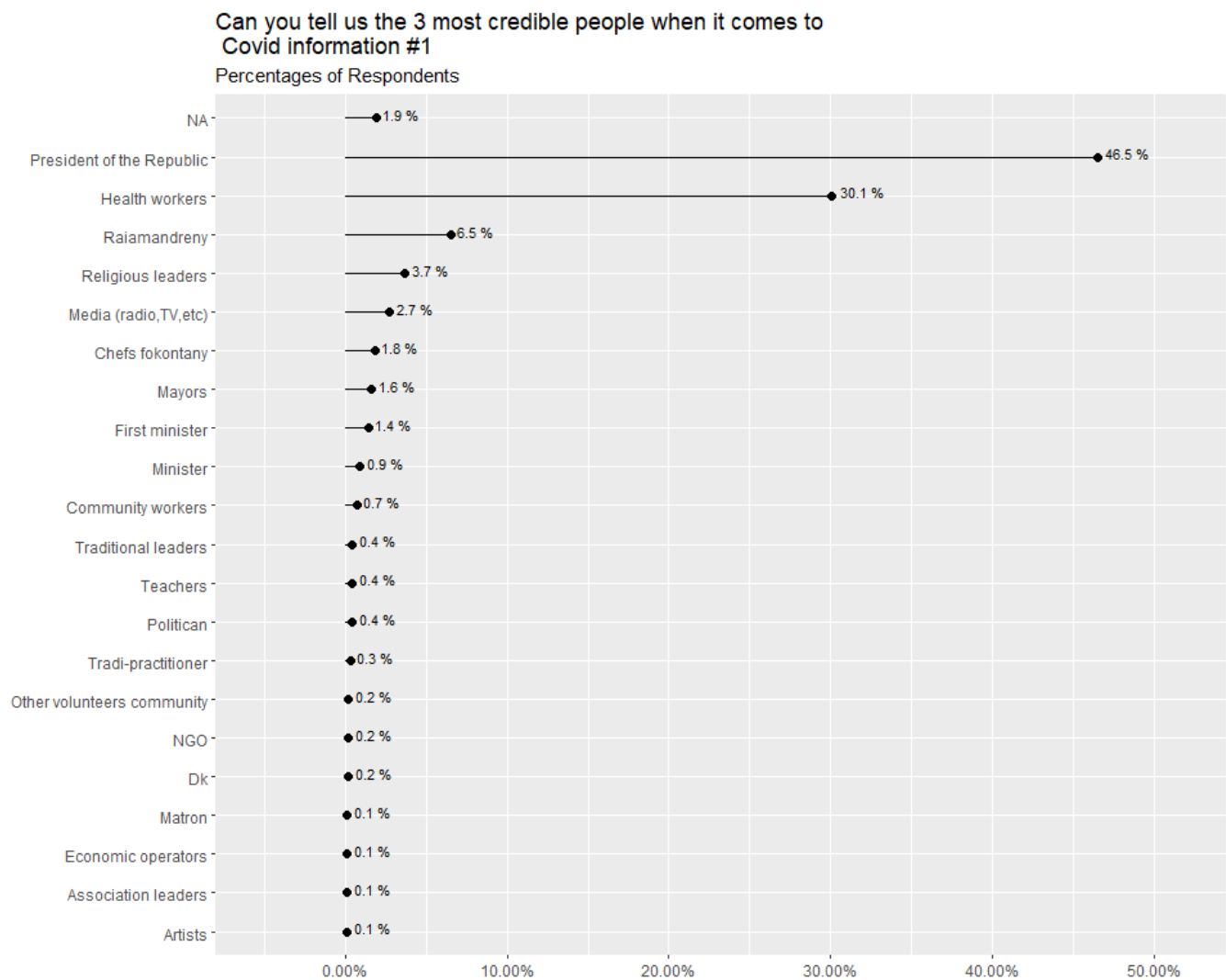
A. The role of trust

As shown in the Behavioral Drivers Model, the value we give to a piece of information is heavily conditioned by its source. The level of trust, familiarity and credibility of a communication channel is a key driver of our receptiveness. Accordingly, the CRA includes elements designed to explore trust in

key individual messengers, community-based response efforts, and health workers in an effort to understand how this shapes behavioural responses.

i. **Key Messengers.** For example, in Madagascar, the baseline survey included a question specifically exploring which individuals were deemed the most credible sources of information in relation to COVID-19. As shown in figure 20, the President of the Republic was identified by respondents as the most credible source of information in relation to COVID-19. Health workers were also a very trusted source, followed by elders, or *Raiamandreny* and religious leaders (the latter two with much smaller margins).

Figure 20: The President of the Republic and health workers were the most trusted source of information about COVID-9 in Madagascar

Can you tell us the 3 most credible people when it comes to Covid information #1
Percentages of Respondents

Source	Percentage
NA	1.9 %
President of the Republic	46.5 %
Health workers	30.1 %
Raiamandreny	6.5 %
Religious leaders	3.7 %
Media (radio,TV,etc)	2.7 %
Chefs fokontany	1.8 %
Mayors	1.6 %
First minister	1.4 %
Minister	0.9 %
Community workers	0.7 %
Traditional leaders	0.4 %
Teachers	0.4 %
Politican	0.4 %
Tradi-practitioner	0.3 %
Other volunteers community	0.2 %
NGO	0.2 %
Dk	0.2 %
Matron	0.1 %
Economic operators	0.1 %
Association leaders	0.1 %
Artists	0.1 %

ii. **Community-based groups.** The data also point to the role that trust can also play in identifying key partners that are likely to be effective in RCCE efforts at the community level. For example, the figures below highlight the most trusted community groups for respondents in Kenya, both in general (figure 21) and specifically in relation to community-based actions for COVID-19 (figure 22). The results are interesting not only as standalones, but in comparison to one another; some groups that score relatively well on overall trust do not see that trust replicated in relation to COVID-19 specifically (see below).
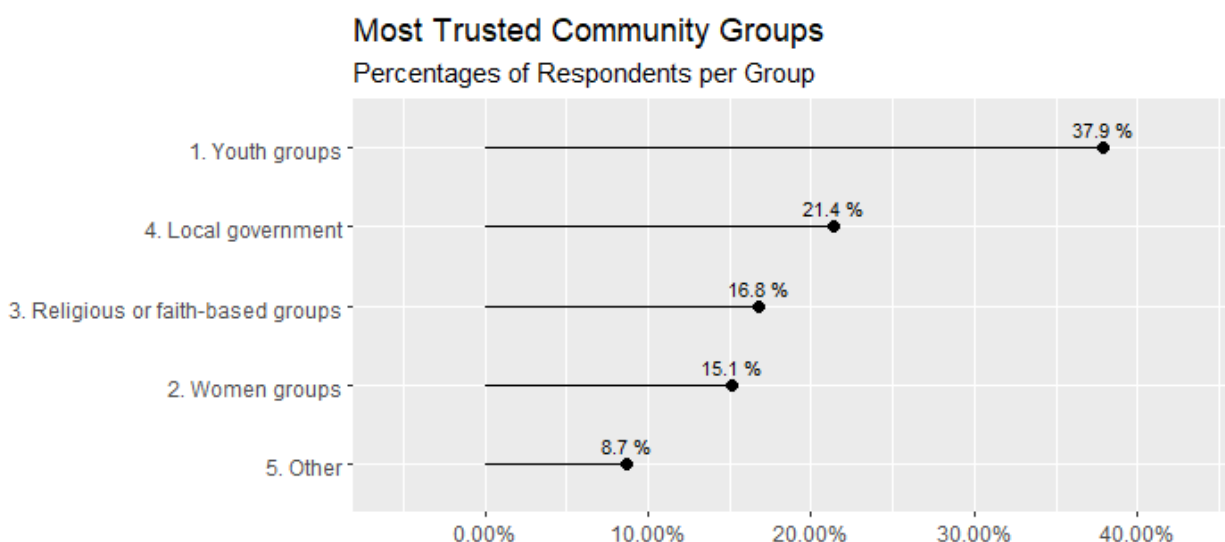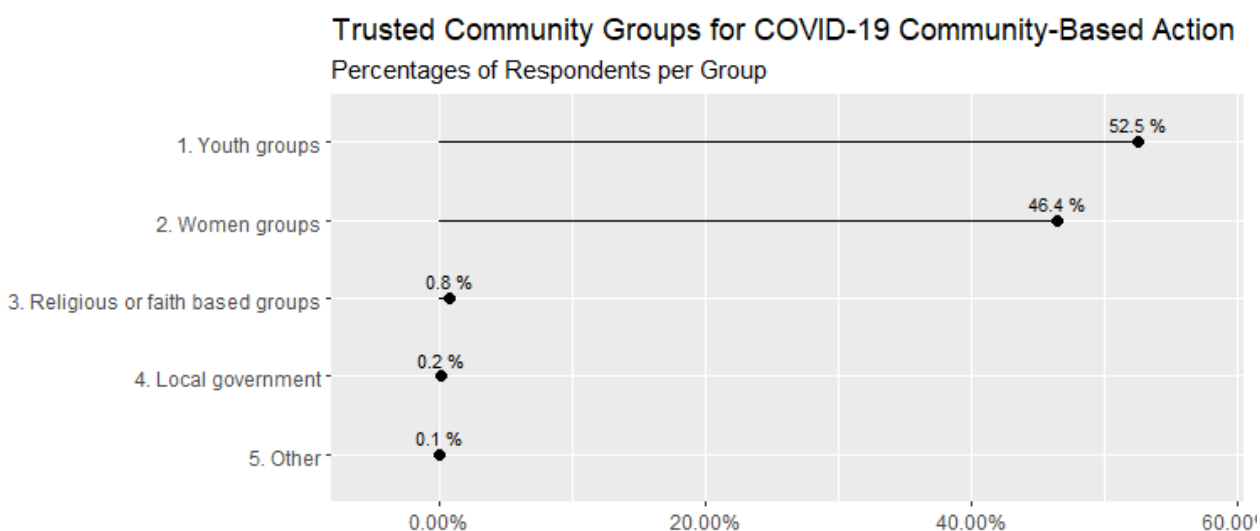
Figure 21: Most trusted community groups in Kenya

Most Trusted Community Groups
Percentages of Respondents per Group

Figure 22: Most trusted community groups for COVID-19 community-based action in Kenya

Trusted Community Groups for COVID-19 Community-Based Action
Percentages of Respondents per Group

Youth groups scored highly on both scales – in general as a demographic cohort and specifically for COVID-19 related action. This high proportion is likely to be adjusted over time when more data points

are included, but overall, it suggests that youth groups enjoy a high level of trust both in general and in relation to COVID-19.

In contrast, while local government and religious/faith-based groups were trusted by 21.4 per cent and 16.8 per cent of respondents respectively, those levels dropped to almost nil in relation to community action around COVID-19. A similar phenomenon is seen in reverse with regard to women's groups: while overall trust in women's groups was relatively low at 15.1 per cent, nearly half of respondents (46.4 per cent) trusted this group in relation to community action on COVID-19. These findings are most likely based on actual experience in which women's and youth groups are likely key partners to support their communities with COVID-19 related programming.

Trust in community groups also varied by age of respondents. While support for youth groups was high across age brackets, trust in women's groups and religious/faith-based groups varied significantly depending on the age of the respondent. Youth groups scored particularly highly among respondents under the age of 18, at 67 per cent. This is particularly significant because whereas religious leaders and government officials are typically key partners in RCCE working groups in ESAR, youth groups and women's groups are not often represented, suggesting a possible misalignment of efforts.

Figure 23: Trust in community groups varied significantly by age in Kenya
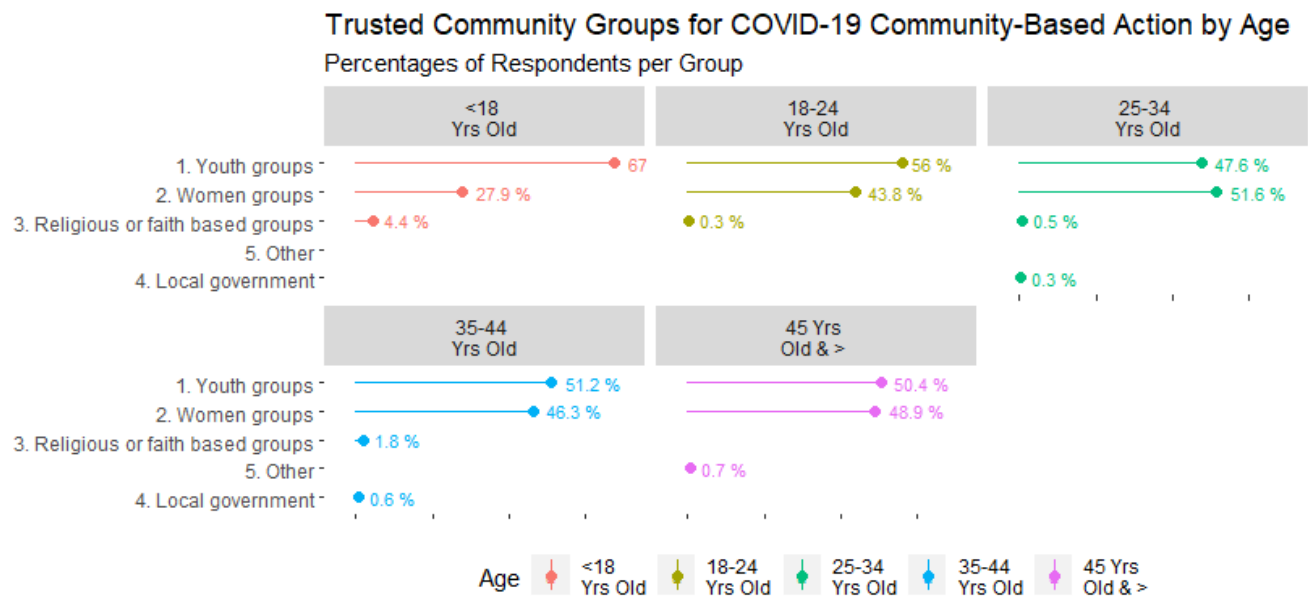
Insight: A focus on traditional C4D partners may bypass actual influencers on the ground, reducing the impact of UNICEF RCCE efforts. These data suggest that it may be worthwhile to pursue a twin-track approach to community engagement in Kenya, with one group of trusted partners relied upon to provide key messaging to the community while another is tapped to engage in COVID-19 programming. It also highlights the importance of engagement with youth groups, as they are the only group to enjoy a stable level of trust by respondents both in general and specifically related to community-based programming.

iii.   **Health workers.** Overall, the three countries report high levels of trust in their local health providers (figure 24), which is good news for the COVID-19 response.

Figure 24: Trust in health care workers was high in all three countries

Do you trust the local health providers to take care fo your family?
National Distribution
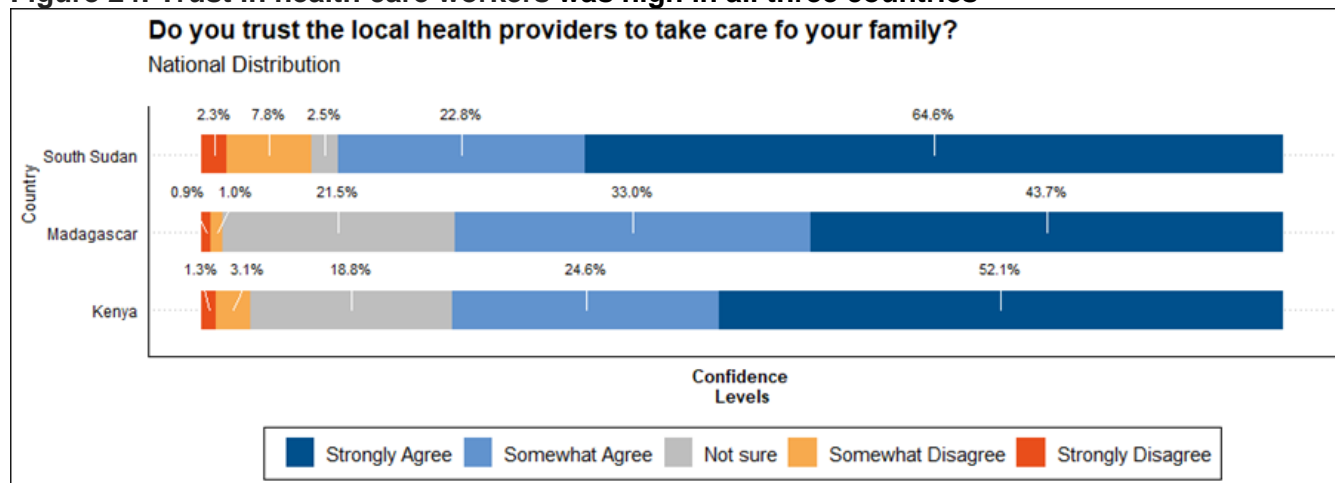
Trust in health care workers did not vary significantly by gender, with both men and women reporting high levels of trust.

Figure 25: Reported levels of trust in health care workers by gender

Do you trust the local health providers to take care fo your family?
Sex Distribution
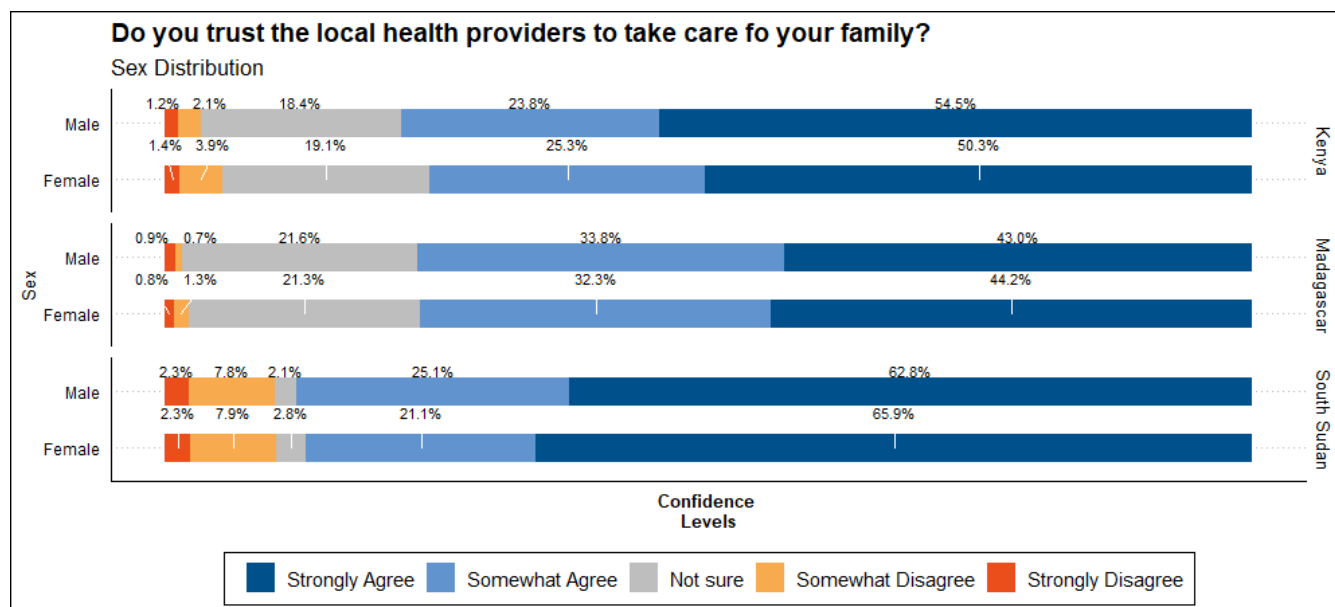
Insight: Further research using more advanced analytical techniques is needed to better understand who these respondents are, why some do not trust health care workers, and what other sources they may find more credible than local health providers.

ESSENTIAL SERVICES UPTAKE

Another key area where CRA data can provide insights is with regard to the uptake of essential services and how these have been affected throughout the pandemic. This is important to help better understand potential relationships between behavioural drivers related to the pandemic and other protective behaviours related to heath care and education, among others.

The CRA data can also provide concrete insights into the compound effects of the virus on the wellbeing of children and their families.

For example, as shown in Figures 26 and 27, most respondents in Kenya and Madagascar continued to visit health centres or seek health services. However, at least one out of every ten respondents were either not seeking or not accessing health services due to COVID-19.

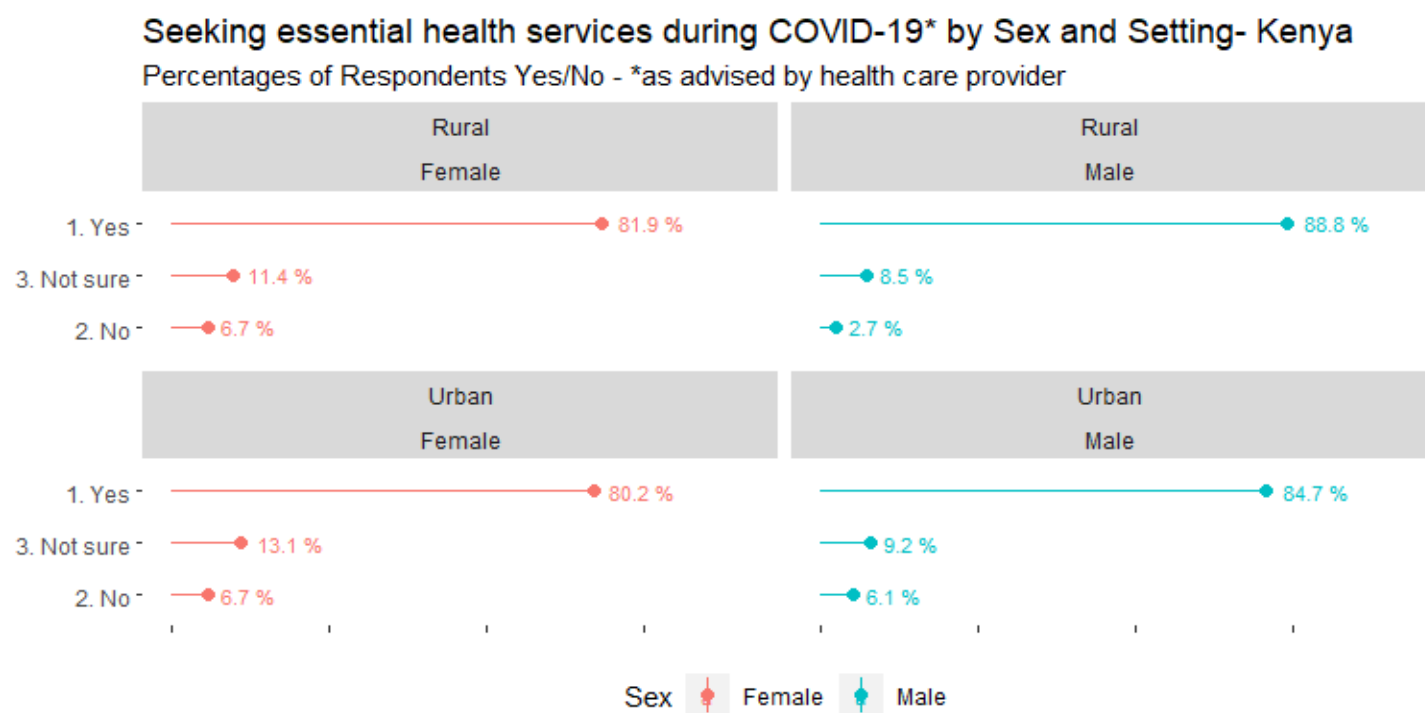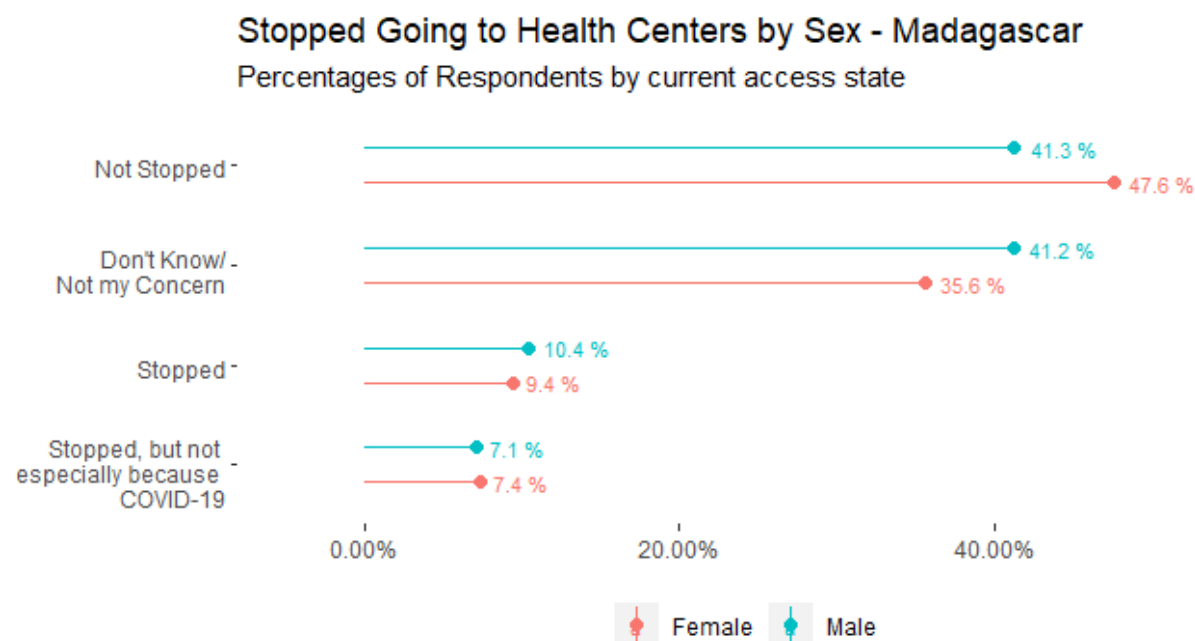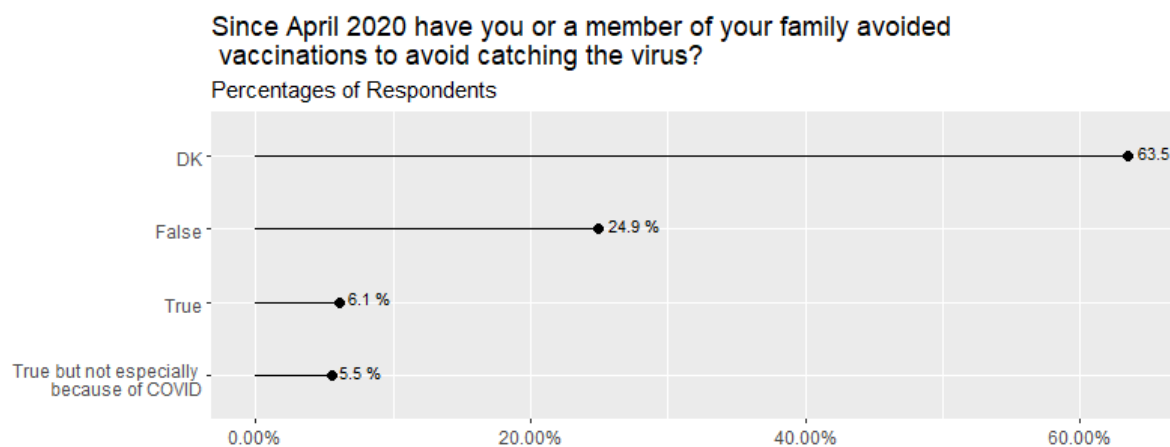**Figure 26: Health-seeking behaviour in Kenya**

Seeking essential health services during COVID-19* by Sex and Setting- Kenya
Percentages of Respondents Yes/No - *as advised by health care provider

Figure 27: Health-seeking behaviour in Madagascar

Stopped Going to Health Centers by Sex - Madagascar
Percentages of Respondents by current access state

Not Stopped — Male: 41.3 %, Female: 47.6 %

Don't Know/ Not my Concern — Male: 41.2 %, Female: 35.6 %

Stopped — Male: 10.4 %, Female: 9.4 %

Stopped, but not especially because COVID-19 — Male: 7.1 %, Female: 7.4 %

● Female ● Male

Levels of health care access seem to vary depending on gender, with 4-7 per cent difference. This information is especially important to take into account when weighing information about specific services where gender plays an important role, such as immunizations and infant check-ups. Clearly, the pandemic has the potential to increase health risks across the board (not only in relation to the virus itself), and is likely to have a higher impact on more at-risk groups such as infants.

Figure 28: A notable number of respondents in Madagascar reported skipping vaccinations for fear of contracting COVID-19

Since April 2020 have you or a member of your family avoided vaccinations to avoid catching the virus?
Percentages of Respondents

DK — 63.5

False — 24.9 %

True — 6.1 %

True but not especially because of COVID — 5.5 %

The CRA survey can also provide insight into key barriers to accessing health services. In Kenya, for example, a majority of respondents reported that the main barrier to seeking health care was cost. Distance to health centres was the second most frequently cited barrier, with perceived poor quality of health care being the third.

Figure 29: Cost is reported as the main barrier to seeking health care in Kenya

Main Barrier To See Healthcare Provider by Sex and Setting - Kenya
Percentages of Respondents per Barrier
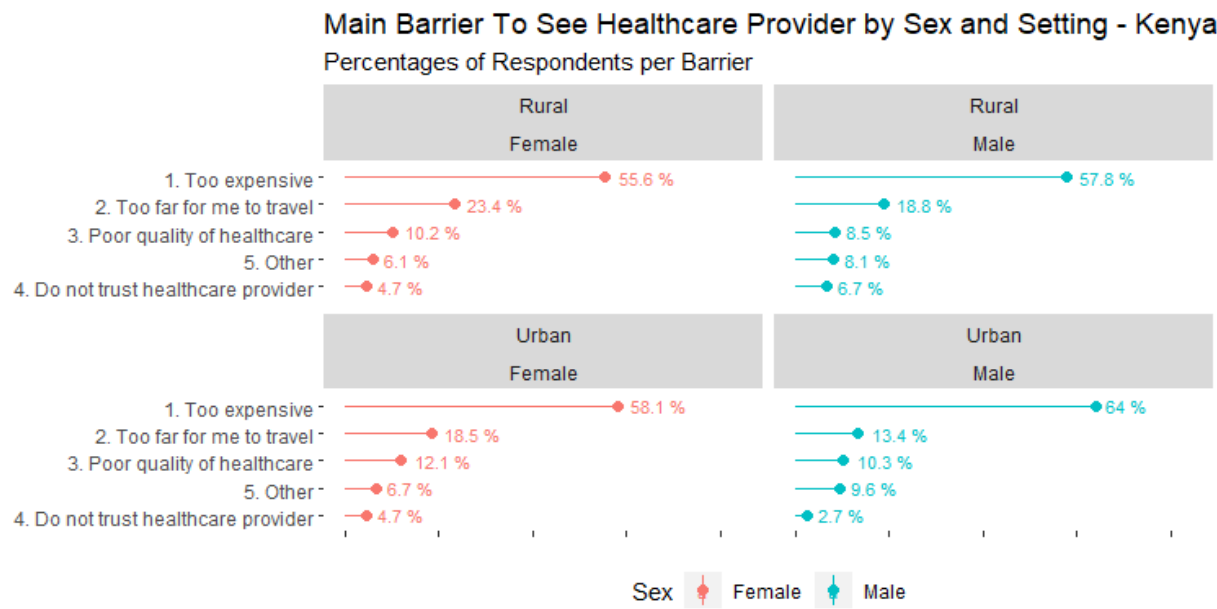
Here again, the role of trust can be seen: distrust of healthcare providers was cited as a barrier.
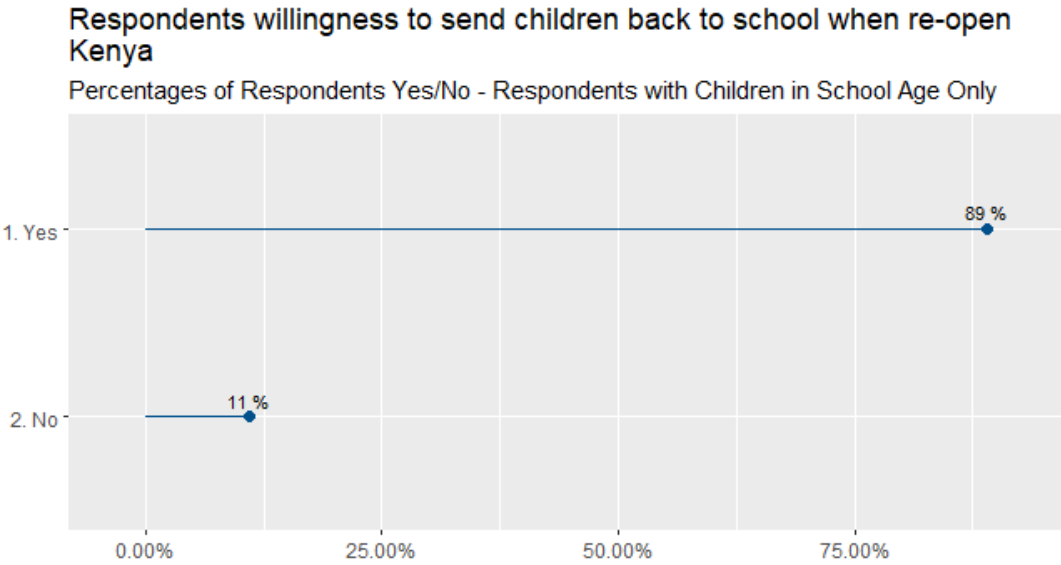
Insight: Adapting current health programming in communities to focus on reported barriers is likely to help mitigate the impact of the pandemic in key areas such as immunization, nutrition and child support services for populations at risk. It is worth considering implementing programs such as limited conditional cash transfer and supporting Community Healthcare Workers during the pandemic to boost their capacity.

EDUCATION: WILLING TO RETURN TO SCHOOL

The pandemic has caused major disruptions in access to education worldwide. While the overall challenge is well known, the CRA allows a more detailed look at how these disruptions are being experienced by respondents. For example, in Kenya, demand for schooling remains high, with a large majority of respondents (89 per cent) reporting their willingness to send their children back to school once they have reopened.

Figure 30: Most respondents in Kenya were ready to send their children back to school

Respondents willingness to send children back to school when re-open
Kenya

Percentages of Respondents Yes/No - Respondents with Children in School Age Only

The importance placed on education is also visible in the figures on distance learning. As shown in figure 32, around 77 per cent of respondents in Kenya had their children either particpating in a children's programme through television, radio or the internet.

Figure 31: Access to education and food security

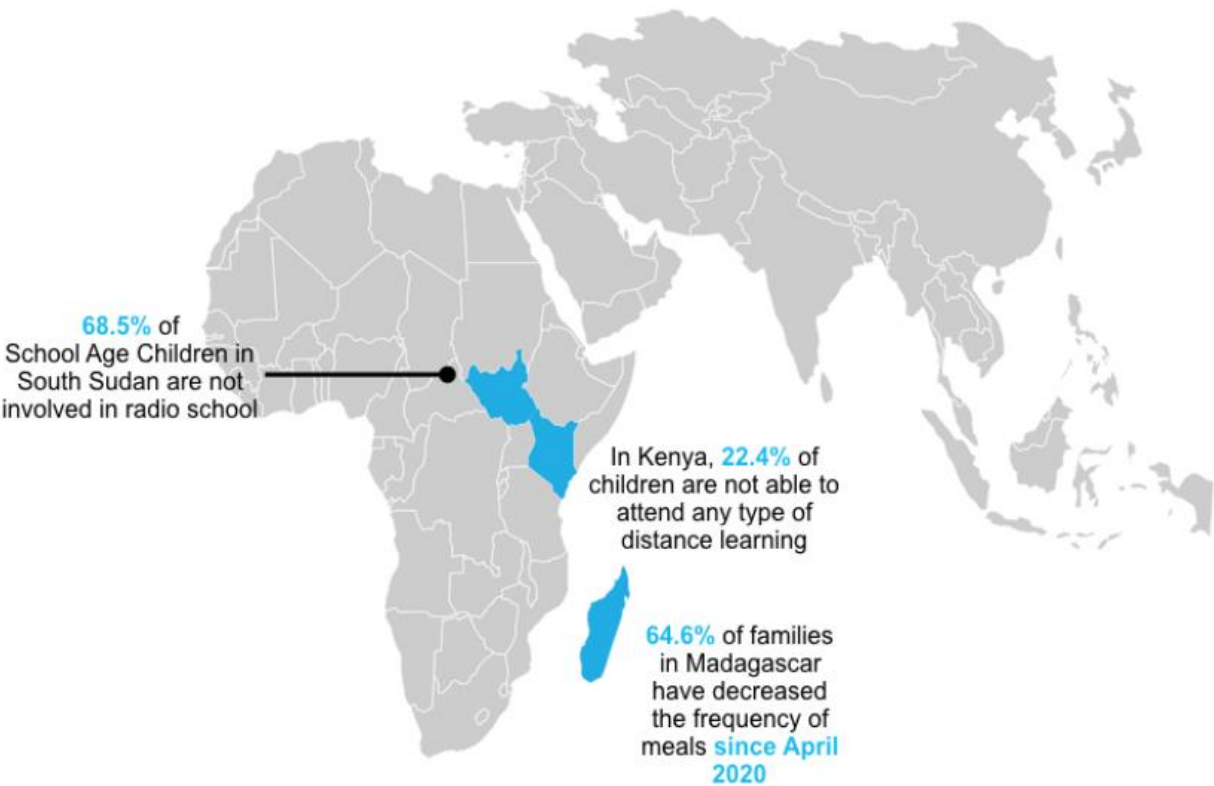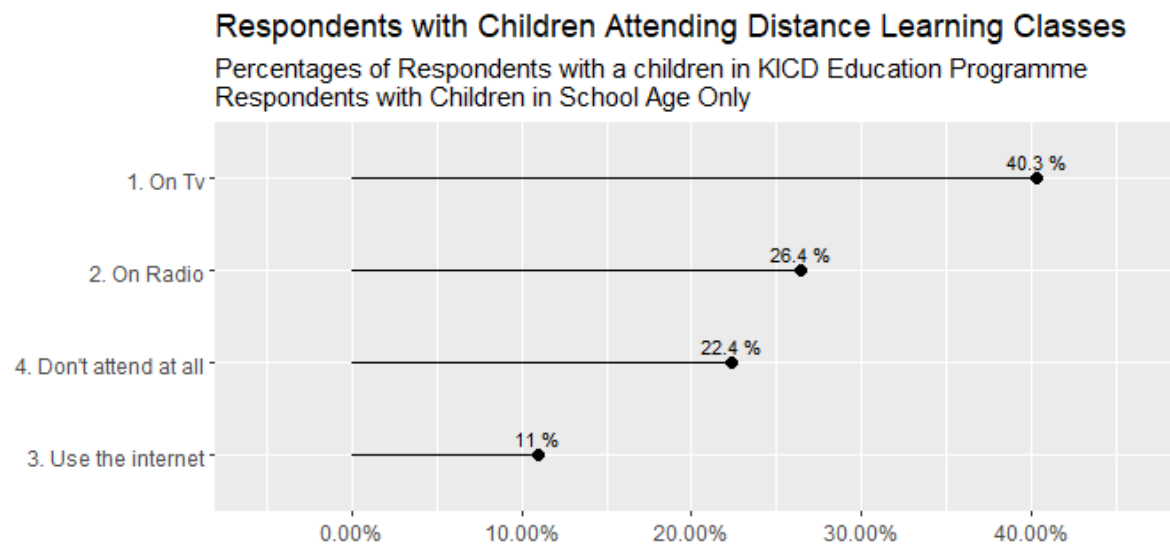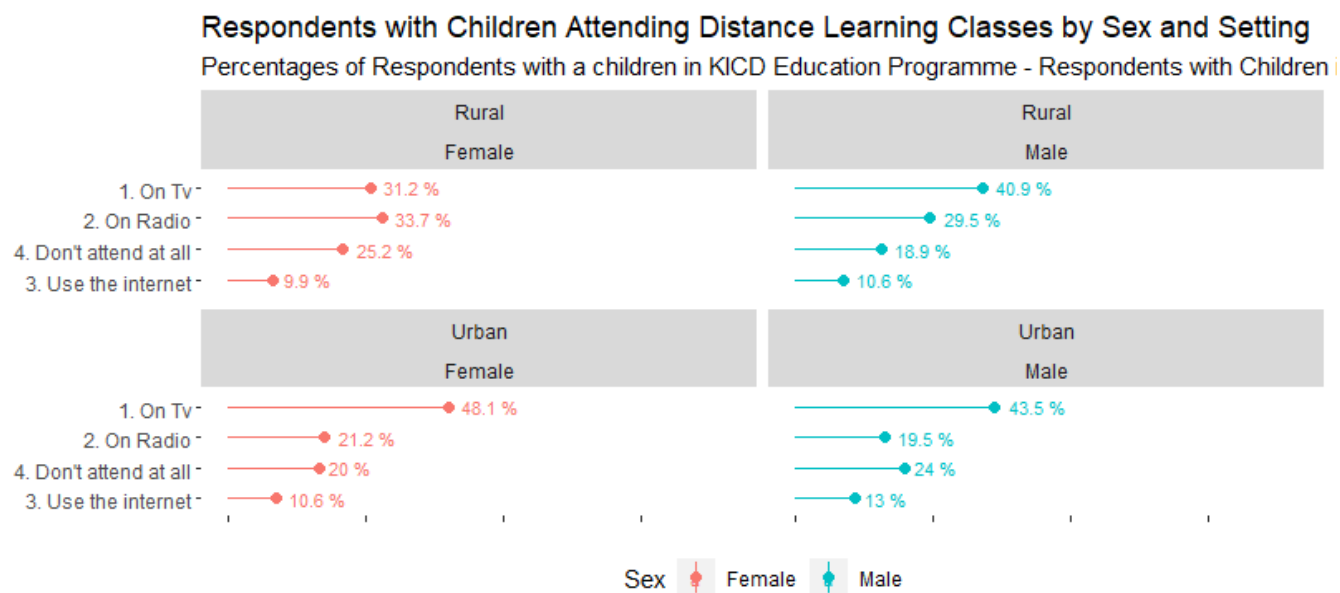
68.5% of School Age Children in South Sudan are not involved in radio school

In Kenya, 22.4% of children are not able to attend any type of distance learning

64.6% of families in Madagascar have decreased the frequency of meals since April 2020

Figure 32: Respondents' children attending distance learning by delivery medium in Kenya

Respondents with Children Attending Distance Learning Classes
Percentages of Respondents with a children in KICD Education Programme
Respondents with Children in School Age Only

| Delivery Medium	Percentage
1. On Tv	40.3 %
2. On Radio	26.4 %
4. Don't attend at all	22.4 %
3. Use the internet	11 %

While 77 per cent is an encouraging figure, it means that approximately one in every three children in Kenya are not accessing their right to education. The CRA provides further insight into the profiles of children accessing and not accessing distance learning, along with the type of distance learning that is more prevalent for each of these profiles. For example, urban children are more likely to be utilizing television for distance learning than their rural counterparts.

Figure 33: Distance learning disaggregated by gender and setting

Respondents with Children Attending Distance Learning Classes by Sex and Setting
Percentages of Respondents with a children in KICD Education Programme - Respondents with Children

Rural Female
1. On Tv	31.2 %
2. On Radio	33.7 %
4. Don't attend at all	25.2 %
3. Use the internet	9.9 %

Rural Male
1. On Tv	40.9 %
2. On Radio	29.5 %
4. Don't attend at all	18.9 %
3. Use the internet	10.6 %

Urban Female
1. On Tv	48.1 %
2. On Radio	21.2 %
4. Don't attend at all	20 %
3. Use the internet	10.6 %

Urban Male
1. On Tv	43.5 %
2. On Radio	19.5 %
4. Don't attend at all	24 %
3. Use the internet	13 %

Sex ● Female ● Male

Similarly, we see mixed results in terms of who is not attending at all, with rural females and urban males being less likely to attend. Additional data and observations from the ground can help provide more context of to help further understand these dynamics in Kenya. In South Sudan, meanwhile, available data paint a more complicated picture. As shown in figure 34, in most cases children are not attending distance learning classes.

Figure 34: The majority of children are not attending radio distance learning classes in South Sudan

Respondents's Children on Radio Distance Learning Classes
South Sudan Respondents by Resident Type
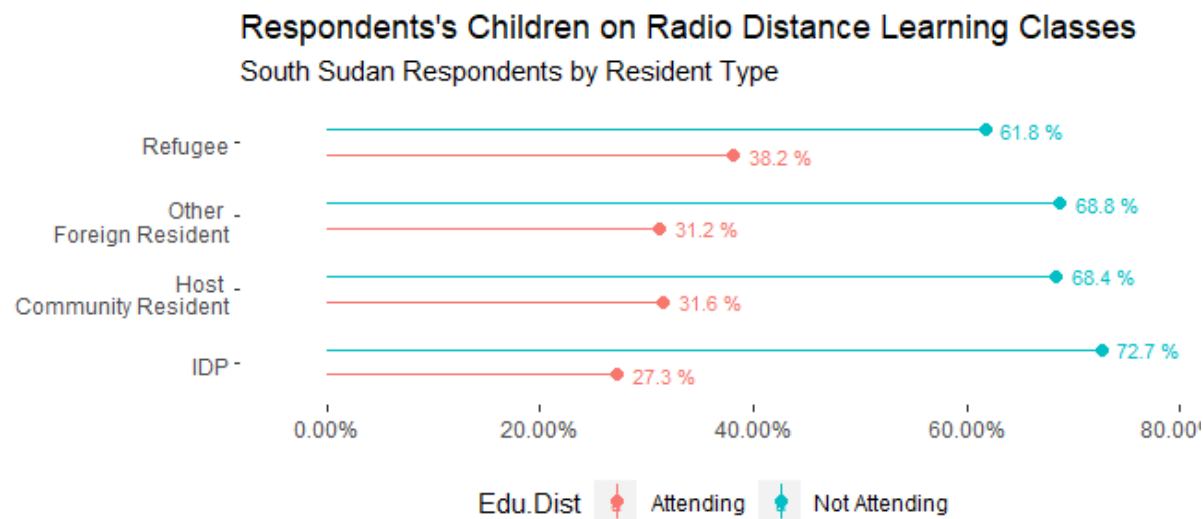
Interestingly, it appears that refugee children are more likely to be participating in distance learning (via radio) than other respondents.

Insight: Follow-up surveying to exploring the reasons why particular groups of respondents' children are or are not participating in distance learning may yield insights into how to increase uptake. In addition, further information on the quality of the education should be gathered.

STIGMA

The CRA has also provided important insights on the way that social influences – namely stigma or opprobrium – may affect expected behaviours.
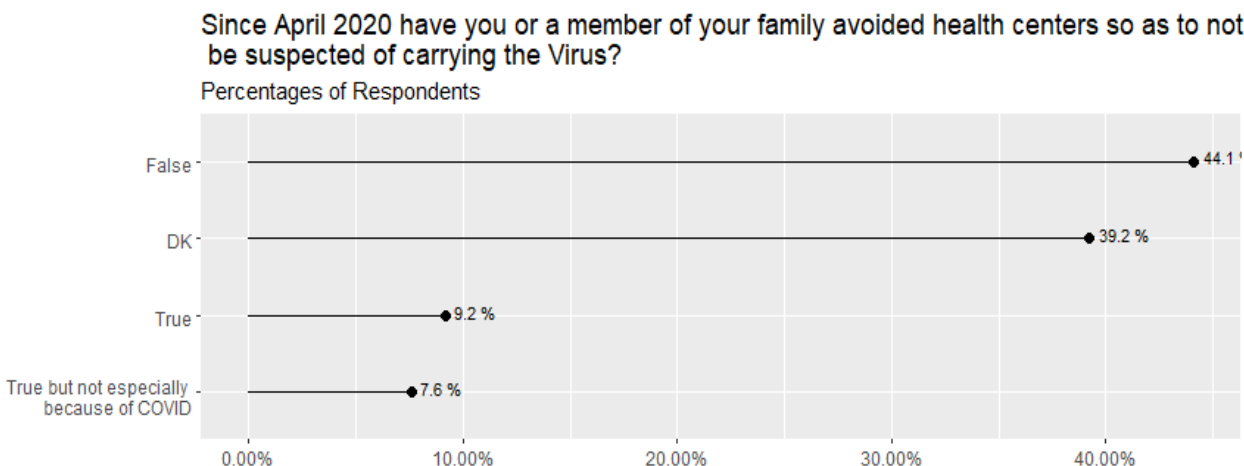
For example, in Kenya, as figure 29 shows respondents' main concerns with regard to the potential social impact of contracting COVID-19, disaggregated by gender and setting. Losing a job or housing was the concern most frequently cited, followed by the fear becoming socially isolated. This is particularly salient for rural females in comparison to their urban counterparts. Other issues commonly cited included anxiety and depression and fear of discrimination as a result of contracting COVID-19.

Figure 35: Perceived social consequences of contracting COVID-19 in Kenya

COVID-19 Most Concerned Social Consequences by Sex and Setting
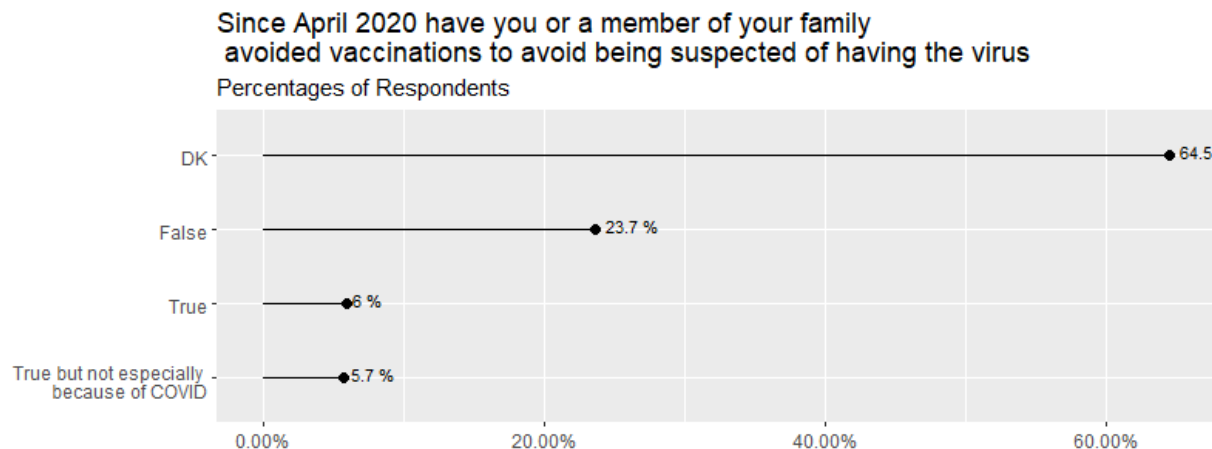Percentages of Respondents per Concern
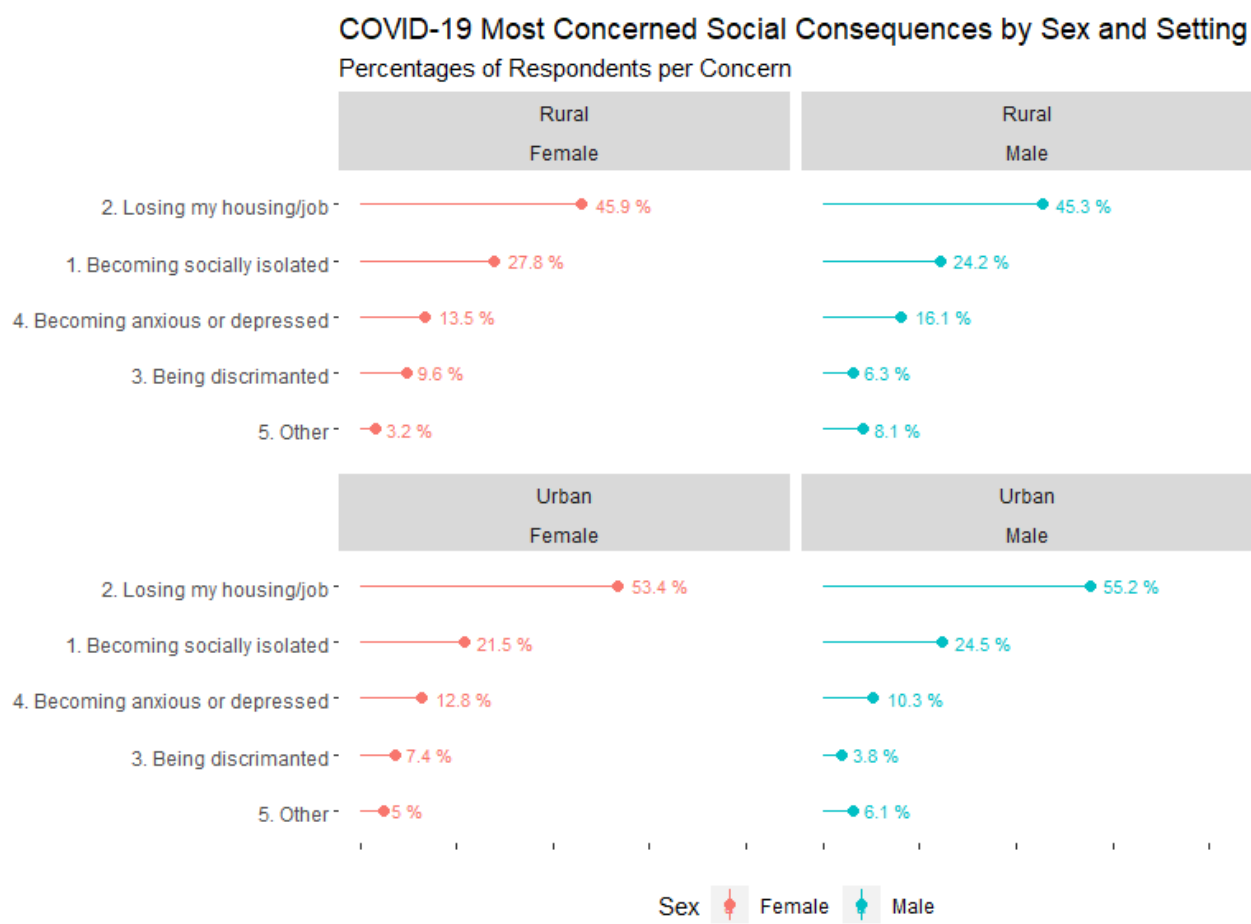
In Madagascar, at least 9 per cent of respondents avoided visiting health centers for fear that others might suspect them of having the virus, as shown in figure 30.

Figure 36: Respondents in Madagascar avoiding health centres due to fear of stigma

Since April 2020 have you or a member of your family avoided health centers so as to not be suspected of carrying the Virus?
Percentages of Respondents

False	● 44.1
DK	● 39.2 %
True	● 9.2 %
True but not especially because of COVID	● 7.6 %

0.00%   10.00%   20.00%   30.00%   40.00%

More worrisome is the fact that about 6 per cent of respondents reported having avoided vaccinations for the same reason. If such numbers were to be extrapolated to the entire population, it could mean that thousands of households are avoiding vaccinations for fear of being stigmatized, putting at risk the wellbeing of multitudes of children.

Figure 37: Respondents in Madagascar avoiding vaccinations due to fear of stigma

Since April 2020 have you or a member of your family avoided vaccinations to avoid being suspected of having the virus
Percentages of Respondents

DK	● 64.5
False	● 23.7 %
True	● 6 %
True but not especially because of COVID	● 5.7 %

0.00%   20.00%   40.00%   60.00%

The data in Madagascar also show that these fears are at least partly warranted, as around 10 per cent of respondents also indicated that if someone they knew were to contract COVID-19, they would refuse contact or refuse to allow that person to frequent events, as shown in Figure 33.

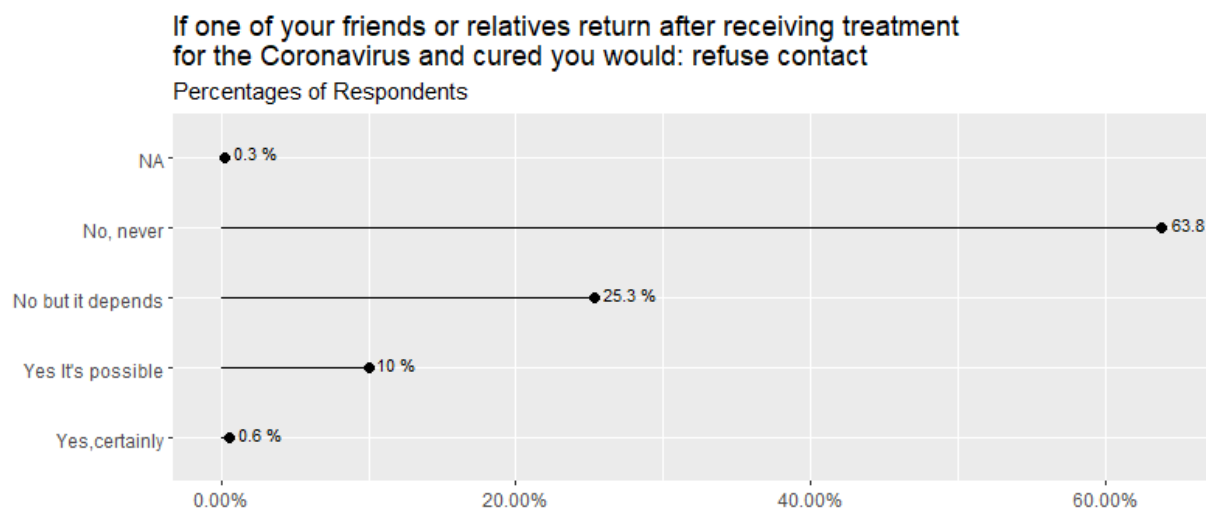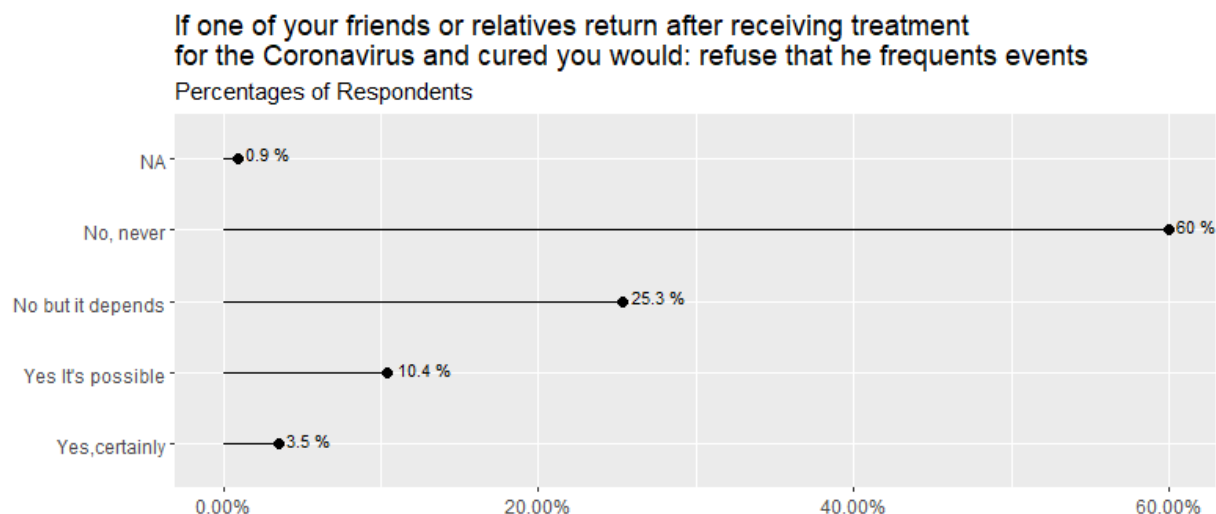**Figure 38: Refusing contact with people who were sick with COVID-19, Madagascar**

If one of your friends or relatives return after receiving treatment
for the Coronavirus and cured you would: refuse contact
Percentages of Respondents

Figure 39: Social exclusion of people who were sick with COVID-19, Madagascar

If one of your friends or relatives return after receiving treatment
for the Coronavirus and cured you would: refuse that he frequents events
Percentages of Respondents

Insight: *Overall, the results show the importance of integrating issues of rejection and stigma into RCCE efforts, as this appears to be affecting behaviours such as access to health services and might complicate reintegration of COVID-19 survivors into their communities.*
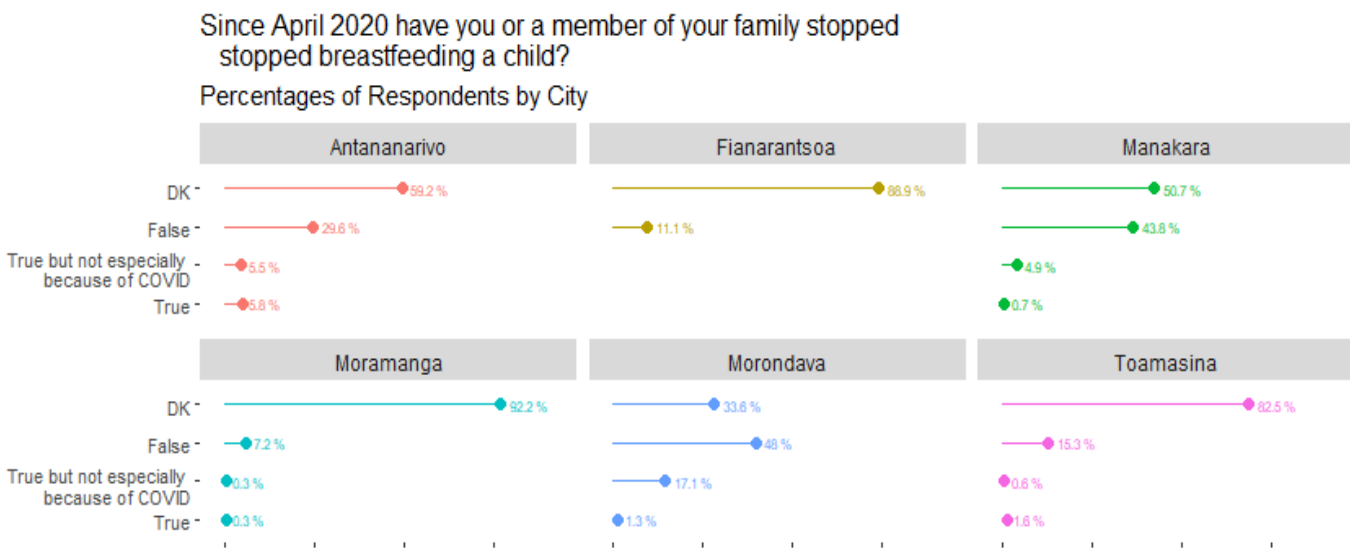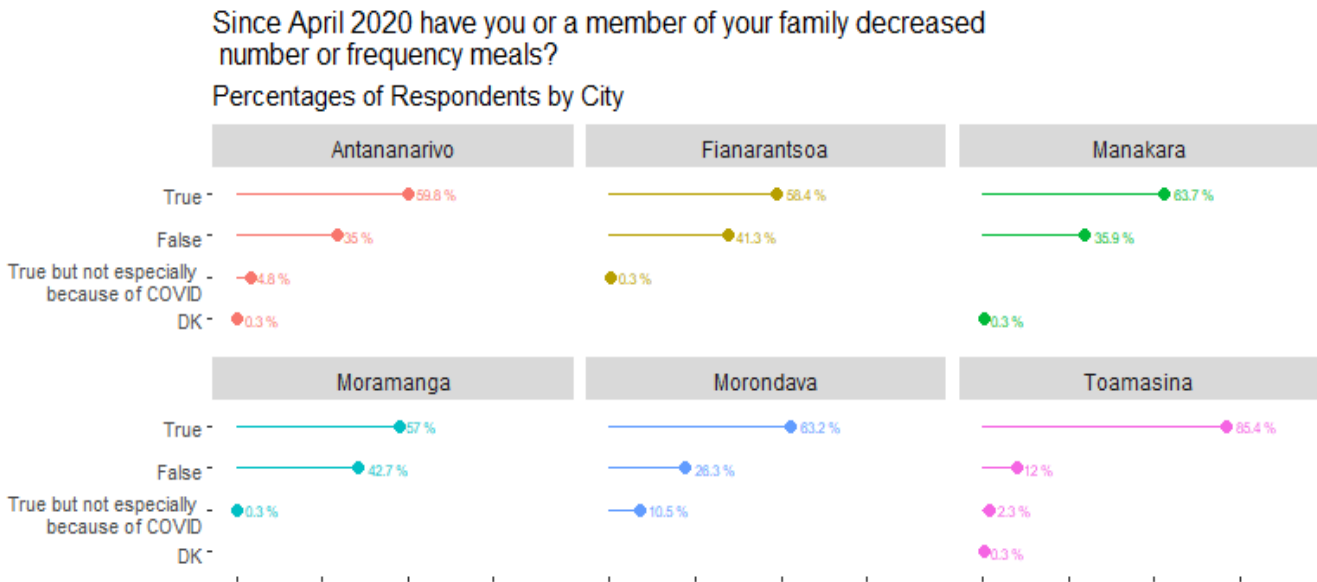
EMERGING NEEDS

Data from the CRA are also shedding light on emerging needs in relation to the pandemic. As shown in figure 40, 71.1 per cent of respondents in Madagascar reported having to reduce their consumption of products, and 64.6 per cent – about three out of every five respondents – reported having to reduce the number of meals they consume in a day.

Figure 40: Most respondents in Madagascar have reduced consumption of products and meals as a result of COVID-19

Emerging Needs from COVID-19 Impact - Madagascar
Respondents reporting as affected with impact from COVID-19
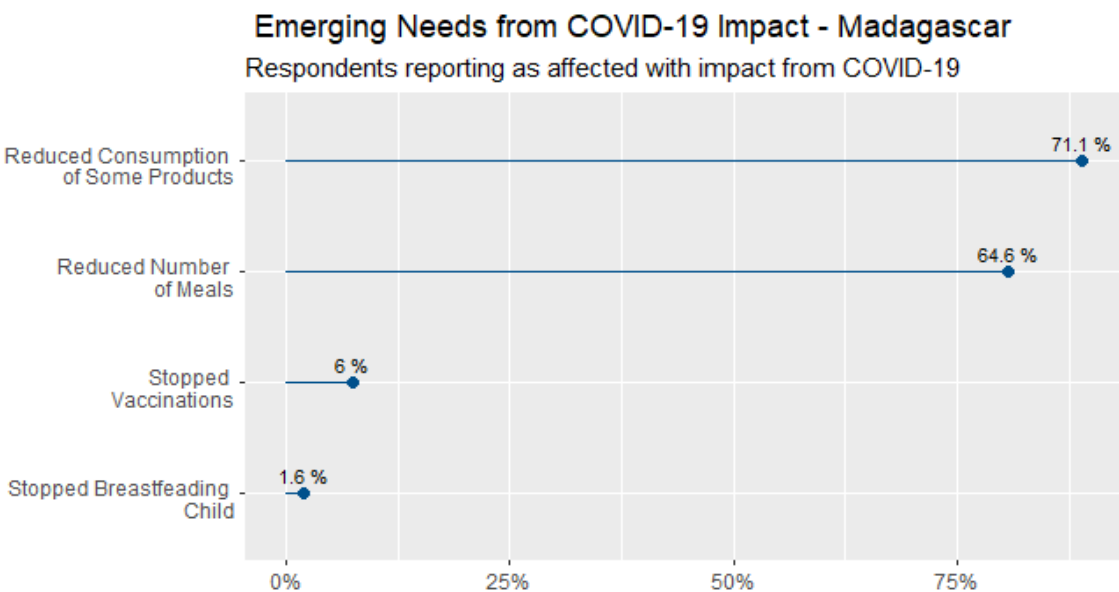
As noted above, around 6 per cent reported having stopped vaccinations, while 1.6 per cent reported that they had stopped breastfeeding. While this latter figure may appear marginal, the impact is potentially very damaging for the growth and nutrition of the children experiencing those conditions. Further disaggregating these results can help identify geographical areas where these conditions are particularly prevalent, as shown in Figures 41 and 42.

Figure 42: Decreased meals disaggregated by city

Since April 2020 have you or a member of your family decreased number or frequency meals?
Percentages of Respondents by City

Since April 2020 have you or a member of your family stopped stopped breastfeeding a child?
Percentages of Respondents by City

Insight: CRA data can provide early signals of emerging needs related to the pandemic and point to areas where increased support services for families and their children are required. Thus far, where this set of questions has been deployed, data show an apparent impact on areas such as nutrition, which warrants further review on the ground as well as complementing these early diagnostic data with other administrative data available at country level.

EARLY LESSONS AND OBSERVATIONS FROM IMPLEMENTING THE CRA

The CRA has demonstrated that *UNICEF country offices can develop a robust evidence base for programming even in the midst of a crisis, when access to target populations is compromised.* Rapidly-evolving crisis situations have traditionally presented challenges to data-gathering, requiring COs to prioritize timeliness of evidence over quality. Utilizing mainly mobile phone technology, the CRA reduces the need for such compromise by combining the timeliness of a rapid assessment with a methodological rigour typically reserved for much heavier exercises such as MICS.

Some information gleaned from CRA can be fed into programmes in real time, although there are important limits to what this first baseline snapshot can provide. Crucially, however, the experience has provided 'proof-of-concept', demonstrating that it is possible to utilize a rapid, lightweight, cost-effective tool to harvest representative data that can be disaggregated among target populations.

PROGRAMMATIC LESSONS

1. **Understanding drivers of behaviour – why people do what they do in a given context – is crucial to UNICEF programming, and in particular for designing effective RCCE strategies.**

   Current monitoring and evaluation systems track limited information on coverage of RCCE interventions without unpacking the factors that influence individual and collective behaviours. As some of the early findings of CRA suggest, this may result in a misalignment of efforts. Recognizing that behaviour and social change are complex phenomena, further insight into public opinion, levels of trust and engagement mechanisms will enable better programme strategies that are community-responsive and people-centred.

2. **Different demographic groups may have very different behaviours, motivations and needs.**

   Understanding these differences can help fine-tune the RCCE approach, calibrating it to specific target groups. Previous assumptions about priority target groups or the most influential partners may be challenged, requiring a realignment of targeting efforts. To this end, demographic characteristics are crucial to understanding the needs, behaviours, and most effective channels for engaging different populations (by gender, education, age, geographic location, income/occupation).

3. **Identifying trusted community influencers is key.**

   These may vary by age, geographical area, and even by issue, with some groups and channels of communication being more trusted on some subjects than others. Identifying the key influencers for each target group can help improve uptake of public health measures in relation to COVID-19. More broadly, these insights will be valuable for RCCE efforts in general, and in the longer term for strengthening community and citizen engagement.

4. **Baseline and time series data harvested through CRA will provide valuable insights in multiple programme areas and will enhance preparedness for future crises.**

   Multiple data points will also provide a means of monitoring progress of interventions over time. This is particularly important in rapidly changing disease landscapes, when outbreaks and infection rates increase rapidly.

METHODOLOGICAL AND GENERAL DESIGN LESSONS

1. **Disaggregation is crucial.** The findings in all three countries reveal important differences in behaviours, needs and entry points for different target populations. The use of these data, especially when hypotheses are tested against specific demographic variables (e.g. age, gender, geographical location), allow programme managers to determine the types of investments that are needed depending on the target group. These levels of disaggregation can prove especially critical when specific behaviours or needs are observed by a specific group (such as a given age category, for example, which has proven to be significant in the context of COVID-19).

2. **Complementing CRA information with qualitative data can provide a more complete picture of the situation.** While short surveys cannot address all questions or probe deeply into issues, they can offer signposts for further investigation. In addition, they can help fill gaps: current global datasets have mostly been collected through digital platforms, which can limit representation of specific population groups. Further qualitative investigation, especially through field observations, can help fill these gaps. In the long term, investing in systematic qualitative data collection relevant to RCCE will enable quicker decision-making and programmatic action.

3. **Standardization + adaptability = uptake.** Short surveys like the CRA that keep a core set of standardized questions allow comparison between countries while giving COs the flexibility to include country-specific questions based on their priorities and what they 'need to know'. This approach enhanced stakeholder buy-in from the outset, increasing the likelihood that the data will be used – not only by UNICEF, but by partners as well. In Kenya, for example, the CRA tool was included into the national survey on COVID-19. Utilizing simple, effective tools like CRA can enhance UNICEF efforts to strengthen national capacity for evidence-gathering.

4. **Timing is key.** Baseline data from the CRA and similar surveys will be most impactful if followed by a *series of data points* collected at *critical time periods.* Collecting time-series data provides crucial information on trends, allowing programme managers to see how behaviours are changing over time in response to changing circumstances and programme interventions. Being strategic about *when* these data are collected – at key moments such as reopening of schools, for example, or the introduction of new public health measures – can inform programme managers, national partners and stakeholders in real time of the impacts of the pandemic and their related policies.

IMPLICATIONS AND NEXT STEPS

1. The overall takeaway from implementing the CRA is that **it is possible, and indeed crucial, to rapidly gather representative population data on individual and community behaviours during a public health crisis to enable a timely and calibrated programmatic response.**

2. Utilizing mainly mobile telephone technology, the CRA is able to rapidly gather representative data from individuals and communities even during lockdown or other circumstances that restrict conventional data-collection approaches. This has important implications for UNICEF data-gathering efforts in humanitarian situations in general, where timeliness is key and access to target populations may be compromised. The CRA has also demonstrated the importance of gathering social and behavioural data in such contexts, offering early insights into how current efforts can be further refined to enhance the ongoing response as well as preparedness for future crises. **Further developing this capacity across the organization will strengthen not only the UNICEF response but also that of partners, and increase buy-in among national partners to prioritize this approach.**

3. The CRA is light and cost-effective when compared to paper-based, nationally representative face-to-face surveys, while remaining methodologically robust. The academic partnership with Harvard Humanitarian Initiative ensures the validity of the data, and analytical support from headquarters in partnership with regional office teams is available to COs on an on-demand basis. The experience implementing CRA thus far has however demonstrated the need to prioritize data literacy, including data needs, collection methods, analysis capacity, and knowledge of how to use these data. **Further capacity-building at the regional and country levels is required to capitalize on this experience and sustain momentum going forward. In addition, UNICEF should further develop partnerships with credible institutions that can support a 'data for action' agenda.**

4. **As the remaining ESAR countries continue to provide data from these short survey modules, the Evaluation Office will continue to provide full visualizations of these data**, analysed by demographic cohort, as well as, building regression models to determine specific drivers of behaviours. The Evaluation Office will provide hypothesis testing of key questions derived from discussions of its use and usefulness with country offices. Another evaluative report that will include additional analyses and all 8 participating ESAR countries will be authored and released. Upon completion of the CRA, we will propose ideas for institutionalizing systems reform to allow for high quality, community-sourced and standardized data with the objective that it will serve multiple purposes.

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