Research Terms of Reference Risk Communication Community Engagement (RCCE) Assessment Uganda July 2020 Uganda Learning, Evidence, Accountability, and Research Network 1. Executive Summary Country of intervention Uganda Х Type of Emergency Natural disaster/ Conflict Х Pandemic Type of Crisis Sudden onset Slow onset Protracted Х Mandating Body/ DFID Agency **Project Code** 25AMI **Overall Research** 01/07/2020 - 31/10/2020 Timeframe (from research design to final outputs / M&E) Research Timeframe 1. Start collect data: 24 August 2020 5. Internal consortium findings *all tentative presentation/discussion: 15 October 2020 (tentative) Add planned deadlines 2. Data collected: 30 September 2020 6. Outputs sent for validation: 20 October (for first cycle if more 2020 than 1) 3. Data analysed: 10 October 2020 7. Outputs published: 31 October 2020 4. Data sent for validation: 10 October 8. Final presentation: 31 October 2020 2020 Number of Х Single assessment (one cycle) assessments Multi assessment (more than one cycle) Humanitarian Milestone Deadline milestones Х Donor plan/strategy: National Risk TBD Communication Strategy (Ministry Specify what will the of Health) assessment inform and Inter-cluster plan/strategy when e.g. The shelter cluster Х Cluster plan/strategy: Informing TBD will use this data to Risk communication, Social draft its Revised Flash Mobilisation and Community engagement (RCSMCE) pillar and Appeal; Communicating with Communities (CwC) working group; ongoing updating up COVID-19 National Response and Preparedness Plan NGO platform plan/strategy __/_/____ Other (Specify): /__/___

Audience Type &	Audien	nce type	Dissemination				
Dissemination Specify	□ Strate	egic	X General Product Mailing (e.g. U-Learn contact				
who will the assessment	X Progr	rammatic	IIST), HUMANITARIAN PLATFORM for Local and				
inform and how you will	X Opera	ational					
disseminate to inform the audience	□ [Othe	er, Specify]	X Pillar/Working Group Mailings - DFID and U- Learn governance bodies, RCSMCE pillar, CwC working group, Assessment Technical Working Group (ATWG)				
			X Presentation of findings – DFID and U-Learn govergnance bodies RCSMCE pillar, CwC working group, ATWG,				
			X Website Dissemination (Relief Web, REACH Resource Centre, UNHCR Data Portal, U- Learn/MoH Covid-19 Response Information Hub)				
			X Targeted Ministry of Health and donor briefings as necessary				
			X Social media (Twitter and Facebook): U-Learn, Impact Initiatives, ACTED, etc.				
Detailed dissemination	X	Yes	□ No				
plan required							
	Uganda by creating a solid evidence base around risk communication and community engagement approaches, with a focus on COVID-19. This assessment attempts to complement recent and ongoing rapid Knowledge, Attitude, and Practices (KAP) assessments ¹ , which have consistently identified a disconnect between communities' relatively high understanding of Covid-19 and related behaviors, and relatively low uptake of these preventive behaviors. In particular, this assessment aims to explain the 'why' behind this disconnect in order to inform adjustments to national RCCE strategies.						
Specific Objective(s)	•	 Understand to what extent and in what way communities (and more specifically different cohorts within communities; by age, gender, displacement status, marginalized groups²) are able to access timely information about Covid-19 and the related humanitarian response in their area. Understand how communities interpret available information about Covid-19 in order to assess the risks related to Covid-19, and relatedly to determine the relative benefits and detriments of pro-health behavior change. Improve knowledge on effective avenues for risk communication and community engagement during COVID-19 by identifying the most accessible and most trusted communication channels, as well as by identifying strategies for adjusting the risk perception of individuals who are not responsive to available information about Covid-19. Understand to what extent existing AAP mechanisms contribute to successful RCCE activities on community level and what impact they have on building trust in the humanitarian response. Understand to what extent and in what way communities are able to access safe 					

 ¹ Ebola Virus Disease (EVB) KAP (Uganda Red Cross Society, November 2018); EBV KAP (UNICEF, October 2019); EBV KAP (Goal, January 2020); Covid-19 KAP (UNICEF, planning phase).
 ² The specific marginalized/vulnerable groups to be targeted will be defined during the consultation with RCCE stakeholders and confirmed with communities prior to data collection.

		delivery – related to the Covid-19 response and beyond – and whether the Covid-
		19 pandemic has had an impact on this.
	•	humanitarian response in Uganda during the Covid-19 pandemic through
		continuing to track their opinions and preferences, and comparing it to previously
		collected data in 2018 and 2019 by Ground Truth Solutions (GTS) ³ .
Research Questions	1.	Through which communication channels and at what frequency do communities
		a Are there instances of conflicting sources of information around Covid-
		b. If so, how do community members reconcile such conflicting
		Information?
		age, gender, status (refugee/host), marginalized groups)?
		d. Are there specific access barriers different sub-groups within a
		community face in accessing communication channels established for
	2	Covid-19?
	۷.	across different population groups for general and Covid-19 related
		communication?
		a. Are there differences across different sub-groups within a community (by
		age, gender, status (refugee/host), marginalized groups)?
		b. Do these communication channels overlap with those employed by the key Covid 19 responders?
		c What roles do local social networks play in the proliferation and
		circulation of Covid-19 related information and misinformation?
		d. Are there specific access barriers different sub-groups within a
		community face in accessing communication channels?
	3.	How do individuals and communities interpret available information about Covid- 19 in order to assess the risks related to Covid 19, and relatedly to determine the
		relative benefits and detriments of pro-health behavior change?
		a. Are some approaches to packaging the same information (e.g. different
		channels, different messaging, etc.) more effective than others in
		communicating the risks associated with Covid-19 and the benefit of
		behavior change? Which are those and why?
		b. What role does trust, social networks, economic considerations, and
		other external factors play in attenuating or amplify individuals
	4	Which AAP mechanisms are currently in place to support Covid-19 risk
		communications?
		a. How do communities engage with these mechanisms in the context of
		Covid-19?
		b. To what extent do these mechanisms allow for a two-way exchange of
	-	Information and feedback?
	5.	now well have the AAP mechanisms been able to adapt in the Covid-Context for
		related information requests, etc.)?
	1	

³ The quantitative tool will include some questions from past surveys conducted by GTS in Uganda in order to keep tracking the beneficiaries opinion and preferences on the refugee response (<u>https://groundtruthsolutions.org/our-work/humanitarian-reform/</u> and <u>https://groundtruthsolutions.org/our-work/tracking-the-grand-bargain-from-a-field-perspective/</u>).</u>

		a. How has the communities cha b. If at all, how has humanitarian rea	free ang this spo	quenc ed sir s affec nders	y a ice cted ?	and quality of the onset of the the communitie	in Co s' p	teraction with affected wid-19 crisis? perception of and trust in	
	6	b. What perceptions do affected communities have about the response of government and humanitarian actors to Covid-19?							
Geographic Coverage	Instea asses - - -	 istead of a gross national geographic coverage, this assessment will focus on a set of ssessment areas with different characteristics: Refugee settlements (refugee population) – 13 in total Refugee hosting districts (hosting population) – 12 in total General population "high-risk" districts⁴ – 3 in total, potential mix of urban and rural areas General population in "low-risk" district⁵ - – 1 in total, potential mix of urban and rural areas 							
Secondary data	GTS	GTS past AAP assessments in Uganda and region, IFRC, WHO RCCE guidelines and							
sources	toolki share	kits, REACH regional AAP assessments ⁶ , ongoing and completed KAP assessments red through the RCSM-CE pillar, GTS COVID-19 insights from community leaders							
Population(s)7		IDPs in settlements				IDPs in informal sites			
Select all that apply		IDPs in host communities				IDPs [Other, Specify]			
	Х	Refugees in settlements				Refugees in informal sites			
	Х	Refugees in host communities				Refugees [Other, Specify]			
	Х	Host communities			Х	Other commun	itie	es affected by the Covid-	
						19 pandemic in Uganda			
Stratification	Х	Geographical #: Refugee	Х	Grou	лр 1	: Refugee	Х	Group 2: Host	
Select type(s) and enter		districts (host and		com	community community in ref			community in refugee	
number of strata		refugees), high-risk		Рор	ulat	ion size per		districts	
		districts (like border		strat	a is	known?		Population size per	
		districts, Kampala) and a		X Ye	S□	No		strata is known?	
		sample of 'control' areas						X Yes D No	
		Population size per strata							
		is known? X Yes \Box No							
			Х	Grou	ир З	3: Ugandan	Х	Group 4: Ugandan	
				com	mui	nities in high-		communities in low-	
				risk	dist	ricts		risk districts	
				Рор	ulat	ion size per		Population size per	
				strat	strata is known? strata is kn			strata is known?	
Data collections to al/a ¹	v			X Ye	S 🗆	NO Correl atracti		X Yes D No	
	^ •				^	Semi-structure	a (
	Sampling method				Da	ata collection n	net	nod	

⁴ "High-risk" districts are considered those most severely affected by Covid-19 pandemic. The Ugandan Ministry of Health (MoH) prioritized 59 districts in its last Risk Communication Plan, with the support of RCSM-CE pillar 3 districts among these 59 will be selected considering number of Covid-19 cases, transmission rate presence of and points of entries / trafficked commercial routes,

^{5 &}quot;Low-risk" districts are considered those with low risk of being affected by Covid-19 pandemic. One district will be included to compare how population behaviour changes ⁶ For a compilation of reviewed documents please click <u>here.</u>
 ⁷ Exact population TBD after consultation with UNICEF KAP study and DFID

^{*}Likely to use a mixed method approach of qualitative and quantitative data collection but to be determined.

Plan A – if communities a	re accessible and in-person data collection is	s possible
Structured RCCE and	□ Purposive	□ Key informant interview (Target #):
AAP individal-level	Probability / Simple random	□ Group discussion (Target #):
survey		□ Household interview (Target #):
	X Probability / Stratified simple random	X Individual interview (Target #): 1876
	(for refugee population)	□ Direct observations (Target #):
	X Probability / Cluster sampling (for host	□ [Other, Specify] (Target #):
	population and general population)	_ [outo, open/](outoin/
	Probability / Stratified cluster sampling	
	□ [Other, Specify]	
Semi-structured RCCE	X Purposive	Key informant interview (Target #):
and AAP focus group	Probability / Simple random	X Group discussion (Target #): 30
	Probability / Stratified simple random	Household interview (Target #):
	Probability / Cluster sampling	□ Individual interview (Target #):
	Probability / Stratified cluster sampling	Direct observations (Target #):
	□ [Other. Specifv]	□ [Other, Specify] (Target #):
Semi-structured social		
network analysis (SNA)	X Purposive	□ Key informant interview (Target #):
focus group	Probability / Simple random	X Group discussion (Target #): 20
discussions (FGDs) –	Probability / Stratified simple random	Household interview (Target #):
case studies	Probability / Cluster sampling	□ Individual interview (Target #):
	Probability / Stratified cluster sampling	Direct observations (Target #):
	□ [Other, Specify]	□ [Other, Specify] (Target #):
Semi-structured RCCE,	X Purposive	X Key informant interview (Target #): 30
community key	Probability / Simple random	□ Group discussion (Target #):
informant interviews –	Probability / Stratified simple random	Household interview (Target #):
case studies	Probability / Cluster sampling	□ Individual interview (Target #):
	Probability / Stratified cluster sampling	Direct observations (Target #):
	□ [Other, Specify]	□ [Other, Specify] (Target #):
Plan B – if communities rem	hain inaccessible due to Covid-19 health risks and	I remote data collection is required
Structured RCCE and	□ Purposive	□ Key informant interview (Target #):
AAP individal-level	□ Probability / Simple random	□ Group discussion (Target #):
telephone survey	Probability / Stratified simple random	□ Household interview (Taraet #):
	 Probability / Cluster sampling 	X Individual interview (Target #): 900

X Individual interview (Target #): 900

Direct observations (Target #):____

□ [Other, Specify] (Target #):____

X Non-probability / Snowballing using quota sampling

□ Probability / Stratified cluster sampling

Semi-structured RCCE,	X Pu	rposive			X Key informant interview (Target #): 120			
AAP community key	D Pro	obability / Simple random			□ Group discussion (Target #):			
informant interviews	□ Pro	bability / Stratified simple rando	m		Household inter	view	(Target #):	
	□ Pr	obability / Cluster sampling			□ Individual intervie	ew (Target #):	
	Pro	bability / Stratified cluster same	olina		Direct observation	ons i	(Target #):	
	□ [Ot	her, Specify]			□ [Other, Specify]	(Tar	get #):	
Target level of precision	Plan A	Plan A: 90/10 per strata but at differerent geographic levels (see details in the sampling framework						
if probability sampling	below	helow)						
	Plan B' n/a							
Data managamant	Y							
platform(s)	^							
plationii(0)		[Other, Specify]						
Expected ouput		Situation overview #: tbc	Х	Repo	ort #: 1		Profile #:tbc	
type(s) ⁹				•				
	Х	Internal consortium	Х	Pres	entation (Final)		Factsheet #: tbc	
		findings		#: 1				
		presentation/discussion #						
		1		14/ 1				
		Interactive dashboard #:		Web	map #:		Map #:	
Access	Х	Public (available on MOH I website)	nfo	Hub, c	other humanitarian	pla	tforms and IMPACT	
.Visibility Specify which	U-Lea	arn ¹⁰						
logos should be on	Dono	or: DFID						
outputs	Coor	Coordination Framework: U-Learn, RCSM-CE pillar, CwC Taskforce						

2. Rationale

2.1. Rationale

The COVID-19 virus, which originated in Wuhan, China in December 2019, was declared a pandemic by the World Health Organization (WHO) on 11 March 2020. To date, In Uganda, there has been a total recovery of 990 cases as of 28th July, 2020¹¹, there are cumulative cases day by day with currently 1135 cases in-country.

Since 18 March¹², 2020, the government of Uganda has taken several measures to curb the spread of the virus, such as closing borders, enforcing isolation, social distancing policies, affecting in particular gatherings of people, access to places of worship, schools, and public transport. However, public adherence to these restrictions and other preventative behaviors are observed to be relatively low. Recent KAP and other assessments¹³ have identified information gaps, misinformation, and rumors as drivers of this low adherence, but many also note that many individuals who do have access to and do trust correct information about Covid-19 still do not fully adhere to the restrictions or preventive behaviors. Therefore, increased

⁹ Specific products will be determined with IRC and IMPACT, not limited to rumor tracking bulletin style reports, thematic briefs and power point presentations.

¹⁰ Products will be branded as U-Learn with reference to consortium members as appropriate.

¹¹ <u>https://covid19.gou.go.ug/</u>

¹² https://www.health.go.ug/

¹³ Danish Refugee Councils (DRC) "Multi-sector Needs Assessment: COVID-19 Situation in Uganda" (May 2020); GTS "Insights from refugee community leaders – Uganda" (different bulletin from 2020); Population Council and MoH Kenya "Covid-19 KAP (March 2020)

access to information may not fully close the adherence gap. While there have been past KAP studies and assessments related to this topic, particularly around the Ebola response in Uganda, studies have been ad-hoc, smaller-scale, and only focusing on a particular region or geographic area.

As Coronavirus (Covid-19) swept across the world, The World Health Organisation (WHO) with the Ministry of Health (MoH) Uganda kick-started an eight-pillar response plan spearheaded by a national task force for public health emergency coordination and response. A key pillar of the response plan was risk communication, social mobilization and community engagement (RCSM-CE). Through key messaging on transmission, signs and symptoms, prevention and reporting mechanisms, the subcommittee has focused on raising awareness and thereafter promoting preventive behavioral practices. The RCSM-CE sub-committee has further refined and dispatched purpose-built guidelines for community engagement that enable health educators to conduct awareness campaigns at district and village levels, within the framework of government restrictions. Humanitarian and governmental actors have also begun to provide multi-sectoral support during the Covid-19 response; particularly in terms of coordination and accountability towards the affected communities, through awareness and information campaigns on the virus, within the most affected communities with a focus on the high-risk districts¹⁴, but also throughout the territory where responding organizations were already implementing projects.

It is crucial to inform this response and assess whether community engagement is being conducted in an appropriate and inclusive manner, whether it is disseminating the information that people really need, and whether these information and communication messages are being disseminated through the right channels and are both well understood and interpreted in a way that leads to a healthy assessment of risks. In order to rapidly and effectively educate and accurately inform the general public about the pandemic, actors should know what the community beliefs are, the community level of participation, the community accessibility to timely and accurate information as well as what their main and trusted infromation channels are. Beyond that, actors need strategies to combat the tendency of individuals to lower their perceptions of risk over time, which is a trend that is common even when correct information about Covid-19 is readily available.

In addition, this assessment seeks to continue tracking time-series data carried out by Ground Truth Solutions (GTS) on affected people's perceptions of the humanitarian response over the last three years, and understand how COVID-19 has impacted these. In this vein, the role Accountability to Affected Populations (AAP) mechanisms can play in building trust in and strengthening the effectiveness of RCCE efforts, and in supporting the Covid-19 response more generally, will be explored in more detail.

To date, little is also known on how local social networks that underlie community communication channels can have an influence on community behaviour, risk awareness, and risk perception. Networks of community influencers, be they community members, local or religious leaders or local organisations and institutions, may have an important influence on community information ecosystems and could thus be of pivotal importance for effective risk communication and community engagement activities on community level.

In order to address these knowledge gaps, the Uganda Learning Evidence Accountability and Research Network (U-Learn), with support from GTS, started working on rumor tracking and assessments of AAP mechanisms, which are closely linked to this assessment. Effective RCCE (including two-way AAP) is a key operational approach in the response to influence communities' risk perceptions, health behaviors and practices in such a way that they contribute to reducing the risk of an untenable spread of the Covid-19 virus. U-Learn believes that RCCE/AAP assessment(s) results will be key in building trust in communities, which is a prerequisite for any successful current and future response activities in Uganda.

Although some evidence has been generated on this topic, there is a lack of a comprehensive study producing generalizable findings that could feed into a national-level risk communications strategy. There is a need for a more robust study in this area so that government and humanitarian actors can understand 'why' risk communication in communities is not translating into behavior change, and how the strategy can be adapted.

¹⁴ Those districts at the border of Uganda with official/unofficial entry points.

3. Methodology

This study will use a mixed-methods approach to gather secondary and primary data on the above outlined research questions.

In view of the current Covid-19 related uncertainties around field access and the possibility of in-person data collection, separate data collection scenarios are laid out below. If, by the time of data collection start, movement restrictions are lifted and health risks for both data collecting field staff and assessed communities are sufficiently contained, in-person data collection (Scenario A.1) will be conducted. If some restrictions persist but movements are generally possible (Scenario A.2), phone numbers will be collected at random on the ground and subsequent telephone surveys conducted. In case the current operational context remains significantly restricted, an alternative fully remote data collection approach (Scenario B) will be employed. In all three scenarios, a two-pronged approach will be adopted with both quantitative and qualitative methods of data collection to allow for both exploratory and statistical research angles.

If there would be a shift on the movement restrictions once the data collection has started, the collection will be put on hold in order to re-adjust the methodology to the new scenario. As the three scenarios have already been taken in consideration the shift would be relatively smooth, however 3 to 5 days are foreseen to allow the adjustment. According to the completion level of data collection on each assessed areas, collection will be either started again with the new methodology or the sample size will be reduced.

Table 1: COVID-19	and	operational	scenario	planning
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Scenario Planning	Operational Context	Implications for Methodology	Mitigation measure	Data collection sequence
Scenario A.1: Fully operational	No / very low risk related to Covid-19 identified to implement in person data collection No restrictions on movement or data collection modalities IMPACT SOP for data collection during Covid-19 adopted	Primary data collection will take place as expected, quantitative survey will include all indicators	No mitigation will be necessary	 17-24 August: SNA case studies in 4 selected communities 24 August – 21 September: 1876 in-person individual surveys 24 August – 21 September: FGDs ¹⁵and KIIs in assessment locations
Scenario A.2: Partly operational	Low to medium risk related to Covid-19 identified. Some areas might be accessible for in- person data collection some others no.	 Limited possibility for in-person individual interviews Quantitative survey shortened accordingly (25 minutes maximum) 	 Random geographic cluster- sample to collect phone numbers from respondents Subsequent telephone surveys Reduce case study communities to 	 17-24 August: SNA case studies in accessible communities (max. 4) 17-31 August: random collection of respondents phone numbers from past survey studies list

¹⁵ In case the movement restrictions will not allow for in person data collection, FGDs will be replaced with KIIs interviews. Even though communication technologies might allow for implementing remote FGD in certain contexts, this methodology is not suitable for Uganda based on coordination challenges and internet connectivity.

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	Limited movement between settlements and districts House visits possible but limited No gatherings IMPACT SOP for data collection during Covid-19 adopted	•	Geographic limitation for case study communities No or limited FGD		accessible settlements or neighborhoods within Kampala	3.	(refugees areas); collection of phone number list from District Health Taskforce (DHT) 20 August – 21 September: in person and, if risk situation required to, remote phone surveys (individual respondent level) 24 August – 21 September: In-person KIIs surveys where possible and remote telephone surveys elsewhere
Scenario B: Fully restrictive	High risk related to Covid-19 identified. In-person data collection is not possible No movement between locations No house visits No gatherings	•	No face-to-face individual interviews No FGD No SNA case studies Quantitative data collection driven by quota-based snowball sample Quantitative survey shortened to 25 minutes	•	Quantitative data collection through phone-based interviews Qualitative data collection will be conducted as in scenario 2	1.	17 August – 21 September: remote phone surveys (individual respondent level) 24 August – 21 September: remote telephone KII surveys.

3.1 Population of interest

This assessment seeks to answer the above presented research questions across different community environments to test whether information landscapes and prevailing informational needs differ across different population cohorts. A particular focus will be put on the refugee population in Uganda, one of the most vulnerable population groups. With the aim to produce research findings best tailored to informing the ongoing refugee response in Uganda, the geographic unit of assessment for this population group will be the settlement level; all 13 active refuge settlements across Uganda will be assessed.

Since the Covid-19 pandemic affects other parts of the population, the assessment will also cover non-refugee population. In place of a gross nation-wide assessment, the assessment will single out different types of assessment areas across Uganda with specific characteristics that may have an influence on the existing information ecosystem and the access to reliable information on Covid-19 more specifically. Aside from the refugee population, the Ugandan host communities will be included in this assessment. With an ongoing refugee response and a continued presence of humanitarian actors within their community areas, hosts may have a privileged access to reliable information and accountability mechanisms as compared to the rest of the Ugandan population. Thirdly, the general population living in "high-risk" districts¹⁶, which face high Covid-19 infection rates and increased exposure risks through their geographic location at border crossings or important traffic hubs, will be included. Risk communication and community engagement efforts to fight the pandemic may be proliferating in these areas and show different results than in less affected parts of the country. Lastly, a group from a low-risk district will be included to draw a comparison with the aforementioned groups on peculiar aspects related to the risk

¹⁶ High-risk districts will be selected in collaboration with RCSM-CE pillar during the consultation phase using official data realised by MoH and the National Task Force.

perception building process of individuals and communities and how this is influenced by external factors. In addition, due to the volatile and rapid evolving situation of Covid-19 in Uganda, the data collected might be used as a baseline in case the district will become highly exposed to Covid-19 risk. This group will consist of the general population living in a selected district that neither hosts refugees nor faces increased health-hazard risks from the pandemic in relation to other Ugandan districts.

Overview of the population cohorts of interest



Geographical coverage

The assessment will cover all 13 refugee settlements in the country, which host nearly 95% of registered refugees in Uganda, with representative findings at the settlement level (in case in-person data collection is possible). Information on the host population will be collected across all 12 refugee-hosting districts in Uganda, with representative findings at the regional (West Nile and South West Regions) level (in case in-person data collection is possible). Furthermore, findings will be collected among general population living in two high-risk¹⁷ districts (Amuru, Tororo and Kampala) and in one low-risk district (Pakwach) will be covered.

The sampling design will ensure that refugee and host populations can be compared at the national level; however, due to limited geographical coverage for the general population, the comparison between this last group and the refugee/host population will not be possible.

¹⁷ The districts with the highest number of Covid-19 cases were selected according to the information of MoH.



Map 1 Assessment areas

Table 2: Overview of the geographic coverage

Strata	Geographic unit	Number of assessment areas
Refugee population	Settlement	13

Host population	Uganda (nation-wide)	9
Population in high-risk areas	District	3
Population in low- risk areas	District	1

3.2 Primary Data Collection

Table 3: Overview of methods planned for each data collection scenario, by research question

	Data source(s)							
Research Questions	Scenario A.1	Scenario A.2	Scenario B					
Through which communication channels and at what frequency do communities receive information related to Covid-19?	Individual Survey FGDs KIIs	Individual Survey (shorten) FGDs (limited in areas where feasible) KIIs	Phone surveys KIIs					
What are the communication channels most accessible, preferred and trusted across different population groups for general and Covid-19 related communication?	SNA case study Individual Survey FGDs KIIs	Individual Survey FGDs (limited in areas where feasible) KIIs	Phone surveys KIIs					
How do individuals and communities interpret available information about Covid-19 in order to assess the risks related to Covid-19, and relatedly to determine the relative benefits and detriments of pro-health behavior change?	FGDs Klls	FGDs (limited in areas where feasible) KIIs	Klls					
Which AAP mechanisms are currently in place in place to support Covid-19 risk communications?	Individual Survey FGDs KIIs	Individual Survey FGDs (limited in areas where feasible) KIIs	Phone surveys KIIs					
How well have the AAP mechanisms been able to adapt in the Covid-context for non-Covid concerns (i.e. registration process, family unification, other non-Covid related information requests, etc.)?	Individual Survey FGDs KIIs	Individual Survey FGDs (limited in areas where feasible) KIIs	Phone surveys KIIs					

What perceptions do affected			
communities have about the response of government and humanitarian actors to Covid-19?	dividual survey	Individual survey	Phone surveys

Scenario A.1: communities can be accessed for face-to-face interviews

Health risk management

In case that at the moment of data collection the restriction on accessing the communities will be lifted, the data collection process will strictly follow the SOPs¹⁸ elaborated by REACH to reduce the risk for both staff members and local communities. The staff members will be briefed before the data collection on the general guidance and protocol to mitigate the risk of contagion. Staff members and enumerators will be provided with personal protective equipment (masks and hand sanitizer) and instructed to wear in every moment a protective mask and to maintain a safe distance between when conducting inperson interviews. All staff members will be updated on the most recent information released by the Ministry of Health and other official sources in order to be aware of any health risk and to comply with all rules and restrictions which are put in place.

Methodology overview

In case face-to-face community interviews can be conducted, data collection will be implemented in three steps. First, four exploratory case studies will be conducted, which will give room to test a qualitative research approach based on Social Network Analysis (SNA). This approach will focus on qualitative research methods, including community Focus Group Discussions (FGDs), and semi-structured interviews with key informants (KIIs). KIIs will be conducted with community influencers¹⁹ and stakeholders involved in the Covid-19 response. The SNA case studies will be conducted in 4 communities; approximately 5-6 FGDs are foreseen in each community and approximately 10-12 interviews among key influencers and actors involved in the Covid-19 response.

Next, quantitative data will be collected through a large-scale individual-level survey across the targeted assessment areas (13 refugee settlements, 12 host community districts, 3 general population high-risk districts, 1 general population low risk district). The quantitative data collection will be conducted through standardized mobile data collection questionnaires using tablets or smartphones. All the data will be uploaded daily to a Kobo server to allow remote data quality monitoring.

Lastly, another qualitative component, which will build on the four initial case studies, will complement the individual surveys across the assessed areas. This component will consist of both KIIs and FGDs with the objective of getting a deeper and more contextual understanding of communities' perception about RCCE and AAP during Covid-19. Vulnerable groups' specific views will be assessed ensuring their participation in the FGDs and through semi-structured interviews. The sampling will be purposive for both KIIs and FGDs at district and community level respectively. FGDs and KIIs will be implemented in 3 refugee communities, 2 host communities and 3 general population communities living in high-risk and low-risk districts. In each community approximately 5-6 FGDs and 8 KIIs are foreseen (number might change according to data saturation).

Pre-testing

A field test will be conducted to assess the questionnaire in Kiryandongo (the closest refugee settlement to Kampala) prior to the full data collection rollout. The qualitative tools will be tested through mock interviews. Both the quantitative survey tool and the semi-structured qualitative FGD and KII guides will be informed by initial findings from the case studies.

¹⁸ https://www.reachresourcecentre.info/wp-content/uploads/2020/05/DataCollectionSOPCOVID-19.pdf

¹⁹ Key influencers will be identified during the FGDs and from U-Learn partners' previous knowledge of the communities

Risk Communication and Social Network Analysis - Four case studies

While the individual survey will ultimately cover a large geographic area and produce statistically representative results for different population cohorts (refugee, host, general population in high-risk areas, population in control areas), four community-level case studies will serve to paint a more granular picture.

The aim of these case studies is two-fold. Close-up qualitative case studies on community level will first and foremost allow to inform and contextualize general and quantified findings form the quantitative individual survey through a more in-depth qualitative research approach and close community engagement in the data collection process. In addition, these case studies will be used to test a social network analysis approach to answer the research questions around risk communication on community level.

Background

A social network is made up of different actors, such as community members, but also local institutions, organizations or other stakeholders that play a role in influencing community life. The premise of the SNA approach is that these actors are connected by some type of relationship, which can be mapped and analyzed in order to expose a more general structure of the social network and patterns of influence between these actors.

In the context of this assessment, SNA will be used to identify local social networks that underlie community communication channels. The assumption is that these networks may have an important influence on community information ecosystems and could thus be of pivotal importance to tailor risk communication efforts to a specific community environment.

Specifically, the SNA will aim at determining who the key influencers are that shape information flows on community level, how these are connected amongst each other and within their community, and ultimately how they can influence the community members' behavior, attitudes and perceptions around Covid-19 in the short and medium-term (i.e. within the next 6 months).

SNA - Data collection approach

Four communities will be selected in which a light-touch SNA will be conducted. Building on IRC's operational SNA methodology²⁰ and informed with previous IMPACT studies²¹, the approach applied in these case studies will mainly focus on participative community mappings integrated in focus group discussions (FGD), as well as key informant interviews (KII) with identified community influencers and Covid-19 responders. Data collection for the case studies will roll out in three steps (see Table 4).

Given the importance of mutual trust and contextual knowledge to this SNA methodology, the four case study communities will be selected based on U-Learn consortium member's pre-existing contextual knowledge and proximity to communities through previous engagements. Communities with which close ties already exist and which are well known to the consortium members will be preferred as case studies to test the SNA approach. The final determination of the four case study communities will also be influenced by the need for diverse inputs (e.g. covering multiple geographies, multiple nationalities, new versus older settlements). This specific criterion will be only used for the selection of the communities for the SNA case studies that for the characteristics of the approach; the communities for the quantitative and qualitative assessment activities related to RCCE will be randomly selected (or in specific cases other criteria might be used, in agreement with RCCE partners during the consultation phase).

SNA - Focus Group Discussions

In-person FGDs will be conducted with 5-8 purposely selected community members. In 1-1.5 hour sessions, a community mapping along with semi-structured group discussions will be held. In each community, several FGDs, separated by

²⁰ IRC SNA toolkit: <u>https://www.rescue.org/sites/default/files/document/1263/socialnetworkanalysise-handbook.pdf;</u>

²¹ https://www.impact-repository.org/document/agora/ad364375/impact_area-based_assessment_toolkit_201812.pdf

gender²², will be held until data saturation is reached. FGD participants will be identified through preexisting key informant networks in the selected communities and subsequent snowballing. An effort will be made, to allow for FGDs with different vulnerable or marginalized groups (women, elderly²³, persons with disabilities, and others); vulnerable groups²⁴ will be confirmed ahead of data collection with community leaders / local authorities.

SNA - Key informant interviews

In a second step, key informant interviews will be held with community influencers, who were identified through the community FGDs. The number will depend on the number of identified community influencers. Interviews will be semistructured and focus on the KI's interactions within their community (in terms of frequency and quality) with a special emphasis on risk communication around Covid-19. The aim of these KI interviews is to gain a better understanding on how identified community influencers are shaping the information flow around Covid-19 in their communities (including where they get their information from and what preferences they have for receiving it).

A second group of KI will be comprised of local authority representatives and Covid-19 responders within the assessed communities, who engage in RCCE activities. KIs will be identified through knowledgeable IRC and GTS field staff, who know responders in the selected communities and also through community FGD participants. Further RCCE responders can be identified with the help of the RCSM-CE pillar and the relevant District Task Forces. Semi-structured interviews will be carried out with these KIs focusing on their experience in carrying out RCCE activities in the case study community. An emphasis will be put on perceived impact, key challenges and lessons learnt. This information will complement the community perspectives captured in FGDs and participative mapping exercises.

Geographic Unit	Step 1: community FGDs	Step 2: KI interviews with community influencers	Step 3: KI interviews with Covid-19 responders
Community A	5-8 participants per FGD. #FGD until data saturation	Interviews with identified community influencers. #KII dependent on identified influencers (max. 10)	5-8 representatives from local authorities, field staff and other RCCE responders
Community B	5-8 participants per FGD. #FGD until data saturation	Interviews with identified community influencers. #KII dependent on identified influencers (max. 10)	5-8 representatives from local authorities, field staff and other RCCE responders
Community C	5-8 participants per FGD. #FGD until data saturation	Interviews with identified community influencers. #KII dependent on identified influencers (max. 10)	5-8 representatives from local authorities, field staff and other RCCE responders
Community D	5-8 participants per FGD. #FGD until data saturation	Interviews with identified community influencers. #KII dependent on identified influencers (max. 10)	5-8 representatives from local authorities, field staff and other RCCE responders

 Table 4: Social Network Analysis case study data collection overview

²² Ahead of data collection, the communities will be consulted to confirm which group division need to be envisaged in the FGDs.

²³ Elderly people are considered above 60 years old.

²⁴ Vulnerable groups will be confirmed during the consultation with the RCCE stakeholders, possible groups include (elderly, people with disabilities, market vendors, truck and moto-taxi drivers)

The SNA case studies will identify the key influencers and their network of influence within the observed communities. The final output will be a qualitative description of the relationships between key influencers and their communities, among the key influencers and between key influencers and their information sources. The output will include: list of key influencers²⁵, influencers mapping and their communication strength capacity and level of trust. Possible formats could include a standalone narrative brief, or narrative sections within the broader Risk Communication and Community Engagement narrative report. It will inform which role these actors can play in supporting the RCCE strategies of government and humanitarian actors for effectively communicate and influence the community members.

Quantitative component: Individual survey

A quantitative survey will be conducted at individual level, in the targeted geographic areas. A total of 1876 interviews will be carried out across the targeted areas.

Sampling

Sampling will rely on a random sample design in order to allow for statistical representativeness across the four population groups of interest. The 1876 interviews will be broken down into four separate samples representing each of the above discussed population groups of interest:

- A sample of refugee respondents allowing for results with 90% confidence level, 10% margin of error for the refugee population at settlement level.
- A sample of host population respondents allowing for results with 90% confidence level, 10% margin of error at national level.
- A sample of the general population in high-risk areas without presence of refugees allowing for results with 90% confidence level, 10% margin of error at district level
- A sample of the general population in control areas (low-risk districts) without presence of refugees allowing for results with 90% confidence level, 10% margin of error at district level.

Due to the extended area of the district units, a **cluster sampling** strategy will be adopted (rather than a simple random sample) for operational efficiency in all locations (for host and general population) except within refugee settlements where a stratified random sampling will be instead adopted. This sampling approach will allow to reduce travel time between interviews as randomly selected interview locations will be grouped (at random) rather than loosely scattered. However, this sampling method is prone to sampling biases towards the less densely populated the assessment areas and the larger the predefined cluster size. To mitigate this so called "design effect" a design effect coefficient will be applied increasing the number of interviewed individuals in the selected clusters in order to achieve the same level of precision as in a simple random sample.

Table 5: Sample overview

Strata	Geographic unit	Name of Geographic unit	Number of assessment areas	Statistical representativeness	Population	N of individual interviews per geographic unit
		Adjumani ²⁶			214,477	
Refugee population	Settlement	Bidibidi	13	90% confidence level,	232,722	12 y 70 - 1026
		Imvepi		10% margin of error	66,11	13 X 79 - 1020
		Kiryandongo			67,712	

²⁵ The list of key influencers will not include personal identifiers, only profile types.

²⁸ Adjumani is a location comprised itself of 17 small refugee settlements. The target sample size for Adjumani will be split proportionally across all 17 sub-settlements.

		Kyaka li			123,378	
		Kyangwali			123,039	
		Lobule			5,511	
		Nakivale			132,7	
		Oruchinga			7,911	
		Palabek			53,806	
		Palorinya			122,811	
		Rhino			120,164	
		Rwamwanja			72,666	
		Adjumani			508,000	
		Arua			503,800	
		Isingiro			480,800	
		Kamwage			218,300	
Host population	Uganda (nation-wide)	Kikuube		90% confidence level, 10% margin of error	290,700	23427
	· · · ·	Kiryandongo			410,700	
		Koboko			318,300	
		Kyegegwa			190,500	
		Yumbe			798,200	
General		Amuru		90% confidence level	107 000	85
nonulation		Tororo		10% margin of error	537.400	126
in high rick	District	101010	3		1 002 000	05
areas		Kampala			1,333,300	60
General population	D : <i>i</i> : <i>i</i>			90% confidence level.	110 500	
in "low-risk areas"	District	Pakwech	1	10% margin of error	142,500	85

In each assessment area, i.e. in each refugee settlement, as well as in refugee hosting districts, high-risk districts and control districts, randomized Global Positioning System (GPS) points will be generated across the entire geographic unit. The number of generated GPS points in each assessment area is dependent on the population size within each. For refugee settlements zonal population data from UNHCR/OPM where available will be taken as a reference, while for non-refugee areas UBOS census data will be referred to.

Each geographic unit, such as a refugee settlement or a district of interest, will be broken down into zones. From the total number of surveys required in each geographic unit (see Table 5), a proportion will be completed in each zone based on

²⁷ The sample for the Host Community population will be collected from 27 randomly selected clusters of 9 host districts.

the population size. To assess population density within a zone of the geographic unit, REACH will use recent satellite imagery to define areas with no population, low and high density. REACH will overlay settlement/district and zone boundaries over the satellite imagery, first delineating areas that are clearly uninhabited (marshland, rivers/open water, etc.). In remaining zone areas, a rough estimation of density will be manually conducted, with areas being categorized as high density in areas with visible clustering of shelters (i.e. villages) and low density in areas with dispersed shelters with lots of open space separating them. Where available, point data on villages and other population areas will be used to assist in the classification of high density areas. Based on this classification, the generation of points within the zone will be generated with twice the probability of generation within areas classified as high density than those with low density (and zero probability in areas classified as uninhabited).

Enumerators will be assigned a series of GPS points, which they will locate using the mobile application Maps.me. From the GPS point, the enumerator will locate the nearest household to the point. If there are several households that are equidistant from the assigned GPS point or none visible from the point, the enumerator will use the pen method, spinning a pen to randomly select the respondent for interview or choose a direction to walk.²⁸ If a respondent and all of their house hold members are unavailable or unwilling to participate in the survey, the enumerator will use the pen method from the first household (needing replacement) to locate another household. A randomized selection algorithm that is part of the deployed quantitative survey will allow the enumerator to select a random respondent from the adult members present within the household visited. This is a crucial step of the sample randomization design, as surveys are designed on the individual-level as opposed to the household-level.

To ensure enumerator adherence to assigned GPS points, daily spatial verification will be conducted. Observations (individual interviews) that are duplicates of the same assigned GPS point or that are collected too far (more than 150 meters) from the random point will be removed.

Qualitative component: community FGD

A qualitative component will compliment the quantitative individual survey. This qualitative component will be focussed on the community level to capture community members' perspectives and experiences related to RCCE and AAP. Additional effort will be made to ensure that the experiences and perceptions of the vulnerable community groups will be included in the FGDs, as their voice may go unheard in the large-scale quantitative survey. If the participation of representantives from these vulnerable groups in the FGDs will not be feasible, then KIIs will be organized instead to ensure the inclusion of their special needs. In each of the different assessment areas, communities will be selected at random for FGD roll out. When feasible, at least one community with a Covid-19 case(s) will be included in each assessed area²⁹. As the refugee population and the population living in high-risk areas are *a priority* considered more vulnerable to the risks that the ongoing pandemic poses, more emphasis will be put on those communities in capturing contextualized qualitative data. This will be reflected in the number of communities targeted for each of the population groups of interest (see Table 6).

Although a semi-structured interview guide for these FGDs will be developed, follow-up topics may be included in later-stage FGDs as preliminary quantitative results will be produced.

Table 6: FGD overview

Geographic unit and population of interest	Location	FGD target group	Number of FGD
	Community 1	Female FGD (3) Male FGD (3)	18

²⁸ During the data collection training, enumerators undergo extensive training on how to use Maps.me, locate assigned GPS points, and identify the nearest household. Enumerators are also trained on the pen method.

²⁹ A risk assessment will be done to ensure that, despite the presence of active Covid-19 case, the access to the communities is still safe for both the data collection team and the communities. FGDs will be organized in open space (outdoor), limiting the group to 6 persons and ensuring sufficient space among participants.

Settlement (refugee population)	Community 2	Female FGD (3) Male FGD (3)	
	Community 3	Female FGD (3)	
Host District (host	Community 1	Female FGD (3)	12
population	Community 2	Female FGD (3)	
High-risk district (general population in high-risk	Community 1	Female FGD (3) Male FGD (3)	12
districts)	Community 2	Female FGD (3) Male FGD (3)	
Low - risk (general population in low-risk districts)	Community 1	Female FGD (3) Male FGD (3)	6
	48		

The target of 48 for FGDs has been identified in order to adequately capture specific sup-groups based on gender, age, as well as those populations identified as particularly vulnerable in order to capture their specific need. The number of FGDs may be revised up- or downward during the data collection in the event that data saturation is achieved or due to unforeseen accessibility constraints.

Qualitative component: Key Informant Interviews

The qualitative components will be enriched with KIIs from both the communities and the actors involved in the Covid-19 response.

Actors from the communities will include community based organization members, local leaders and representatives of the vulnerable groups. Also the KIIs will incorporate the view of the actors directly involved in the Covid-19 response (local authorities, Village Health Teams, District Task Force, NGOs members) and the providers of local services (health and education mostly). The different types of actors interviewed will help in understanding the perspective of their category on the different blocks of information sought.

KI stakeholder group	Information sought	Distribution (total)	Distribution (by gender)
Non governmental and	Experience with BCCE	Refuges sottlements: 10	20 mala Kla, 20 famala Kla
Non-governmentar and	Experience with RCCE	Relugee settlements. To	20 IIIdie KIS, 20 IeiIidie KIS
community-based	activities	Host population districts: 10	
organization members	Adoption of preventing	Districts at high-risk: 10	
	measures	District at low-risk: 10	
Representatives of	Experience with RCCE	Refugee settlements: 3	6 male KIIs, 6 female KIIs
vulnerable groups	activities	Host population districts: 3	
	Risk perception	Districts at high-risk: 3	
	Adoption of preventive	District at low-risk: 3	
	measures		
Local service providers	Actions related to RCCE	Refugee settlements/ host	15 male Kls, 15 female Kls
(with a focus on health)	implemented	population districts: 10	
	Difficulties encountered	Districts at high-risk: 10	
	Communication channels used	District at low-risk: 10	
	Follow-up with communities		

Village Health Teams ³⁰	Actions related to RCCE	Refugee settlements/ host	15 male Kls, 15 female Kls
	implemented	population districts: 10	
	Difficulties encountered	Districts at high-risk: 10	
	Communication channels used	District at low-risk: 10	
	Follow-up with communities		
Local authorities /	Actions related to RCCE	Refugee settlements: 10	20 male Kls, 20 female Kls
Community and local	implemented	Host population districts: 10	
thought leaders	Difficulties encountered	Districts at high-risk: 10	
	Communication channels used	District at low-risk: 10	
	Follow-up with communities		
	152		

Scenario A.2: limited access to communities

In case the access to communities will be limited, the methodology of scenario A.1 will be adapted. The access to each district/community will be evaluated case per case and in-person data collection will be implemented only in communities where the risk is lower. In the communities that cannot be accessed with in-person data collection, the methodologies foreseen for Scenario B will be implemented.

SNA cases studies

The SNA case studies will be implemented only in the communities where the risk is limited and manageable. The number of case studies might be reduced according to the accessibility of communities. Given that SNA analysis will be implemented in communities already known by U-Learn partners, the number of cases studies implemented will depend on the number of communities with U-Learn partners' presence that can be accessed.

Quantitative component: individual survey

The methodology foreseen for this scenario is very similar to the one for scenario A.1, however, the length of the questionnaire shall not be longer than 25 minutes to reduce the contact between enumerators and interviewed.

As a mitigation measure, lists of phone numbers from past survey respondents, from U-Learn contacts lists and DHT will be compiled. This mitigation measure will allow to promptly switch to Scenario B in case in-person data collection will not be possible.

Qualitative component: FGDs and Klls

The FGDs will be implemented only in the communities where the risk is considered low (no high spread of Covid-19 cases, a limited number of cases found); the FGDs will be carried out following a strict safety procedure, allowing distance among participants and ensure that the facemasks are worn during the discussion. In case the risk will be considered too high for the implementation of FGDs, semi-structured individual interviews will be conducted instead via phone calls.

KIIs will be realized in person where possible and remotely elsewhere.

This scenario is thus an in-between scenario combining scenario A.1 and scenario B.

³⁰ Village health teams are defined as "non statutory community (village) structure formed by community volunteers that manage all matters related to health and crosscutting issues" (VHT Strategy and Operational Guidelines)

Scenario A.3: limited access to communities

Scenario A.3 is an alternative option in case the communities are formally accessible but the fast changing of the Covid-19 situation would make it unclear if the access will be preserved for the full duration of the data collection. In this scenario, the **qualitative component** will be implemented in person only in the communities where the risk is considered low (as detailed in the scenario A.2) while the **quantitative component** will be implemented remotely via phone calls (as detailed in the scenario B)

This scenario will ensure that the qualitative component of the assessment is maintained, limiting the risk to staff and participants by deploying only a limited number of staff in the field for the qualitative data collection only.

SNA cases studies

As per scenario A.2

Quantitative component: individual survey

As per scenario B.

Qualitative component: FGDs and Klls

As per scenario A2

This scenario is thus a hybrid between scenario A.2 and scenario B. Scenario B: communities cannot be accessed, remote interviews

In case communities will remain inaccessible for U-Learn data collectors, in-person data collection will be replaced with remote phone surveys. The SNA approach, which would be tested in community case studies, heavily relies on in-person engagement with community members in focus group discussions and interactive community mapping exercises. For this reason, the case studies will not be part of a remote data collection scenario.

Individual phone surveys

On the quantitative approach, the sample design will have to be adapted, if communities remain inaccessible. Remote phone surveys will not allow for sufficient probability sampling across the above outlined population groups and within the areas of interest. Instead, a **non-probability purposive sampling** approach will be employed. This method will be refined **by quota-based and probability proportionate sampling** to offset the randomization constraints. The geographic sampling units (i.e. assessed settlements, districts and groups of districts) with higher population will make for a higher number of interviews to be conducted. Non-probability purposive quota sampling, with minimum quotas for male, female and marginalized/vulnerable groups³¹ such elderly and PWDs respondents (might be confirmed ahead of data collection with communities), aims to ensure that a robust cross-section of the assessed population is represented in the sample. Nevertheless, results will be **indicative** rather than statistically representative for the population sub-groups (refugee population, host population, population in high-risk areas, and population in control districts) The survey will remain on individual level.

In the refugee districts (refugee and host population), by means of convenience, the initial pool of respondents will be identified through contact list of past survey respondents that were randomly selected. If needed, the pool will be integrated with contact list shared by Village Health Teams (VHT) and with U-LEARN's local network (including beneficiary lists, and key informant contacts from previous assessments). In areas outside the refugee districts, i.e. in high-risk and control districts without refugee population, U-Learn will rely on initial contacts shared through the Uganda Ministry of Health and District Task Forces. This will ensure a first wave of interviews at the end of each respondents themselves will be asked to "drive"

³¹ The <u>Washington Group Short Set</u> will be the standard used for ensuring quota.

the sampling by recommending new participants³² in their assessment location. If either male or female respondents remain underrepresented in the sample, purposive sampling methods will be used to ensure that minimum quotas are met in the final sample (e.g. respondents can be asked to recommend other participants of a specific gender). Specific attention will be put on the selection of a first pool of respondents, which should consist of a varied group of respondents (including both men and women, young and elderly and in the case of refugee settlements, ethnic minorities) in each assessment location to avoid inherent biases and "echo chambers" in the sample construction.

Table 7: Individual telephone survey - sample overview

				Sample size
Individual Survey	Assessment location	Population type	Population	(# refers to successful calls)
	Refugee settlements			
	Adjumani		214,477	79
	Bidibidi		232,722	79
	Imvepi		66,11	79
	Kiryandongo		67,712	79
	Kyaka II	1	123,378	79
	Kyangwali		123,039	79
	Lobule	Refugee population	5,511	79
	Nakivale		132,7	79
	Oruchinga		7,911	79
	Palabek		53,806	79
	Palorinya		122,811	79
	Rhino Camp		120,164	79
	Rwamwanja		72,666	79
	Total			1027
	Refugee-hosting districts			
	Adjumani		508000	20
	Arua		503800	20
	lsingiro		480800	20
	Kamwenge		218300	15
	Kikuube		290700	15
	Kiryandongo	Host population	410700	20
	Koboko		318300	15
	Kyegegwa		190500	15
	Lamwo		206400	15
	Madi Okollo		154000	15
	Obongi		268100	15
	Yumbe		798200	30
	Total			215
	General population in high-ris	sk districts		
	Tororo	General population in high-risk district		60

³² Each respondent will be asked to provide the contact of four potential participants but only one will be contacted. The pool will serve as a back-up in case the first contact is not successful.

	Amuru	General population in high-risk district	60
	Kampala	General population in high-risk district	60
	Total		180
	General population in low risk	district	
	Pakwech	General population in control district	60
TOTAL			756

Enumerators will be trained REACH staff operating out of a dedicated call center. Survey data will be collected using the KOBO platform. The number of the phone calls might increase to ensure coverage of marginalized/vulnerable groups.

Qualitative KI surveys

In the absence of FGDs, in Scenario B, qualitative data will be collected through semi-structured key informant interviews (KII). Community voices will be more difficult to capture through KIIs. Nevertheless, different stakeholder groups can be targeted as a proxy to tap into community-level experiences with regards to RCCE and AAP.

A first pool of KIs will be KIs will be identified through knowledgeable IRC and GTS field staff, as well as through RCSM-CE pillar partners, who know relevant stakeholders in communities of interest. In parallel, individual survey responders will be asked to identify KIs within their community. Subsequently, the first wave of KIs will be asked recommend further KIs and a snowballing method can be employed to reach the target number and distribution of KIs.

KIs should be selected based on their knowledge on Covid-19 related informational needs within their communities, the existing information channels, as well as on existing accountability mechanisms that allow community members to voice their concerns and questions. Typical community member profiles can include but not be limited to:

- School managers
- Teachers
- Community workers
- Doctors/Health workers
- Local religions leaders
- Local charity workers
- Local council representatives

The different types of actors interviewed will help in understanding the perspective of their category on the different blocks of information sought.

Table 8: Distribution of KIs amongst stakeholder groups and gender

KI stakeholder group	Information sought	Distribution (total)	Distribution (by gender)
Non-governmental and	Experience with RCCE	Refugee settlements: 10	20 male Kls, 20 female Kls
community-based	activities	Host population districts: 10	
organization members	Adoption of preventing	Districts at high-risk: 10	
	measures	District at low-risk: 10	
Representatives of	Experience with RCCE	Refugee settlements: 6	9 male KIIs, 9 female KIIs
vulnerable groups	activities	Host population districts: 6	
	Risk perception	Districts at high-risk: 6	

	Adoption of preventive	District at low-risk: 0	
	measures		
Local service providers	Actions related to RCCE	Refugee settlements/ host	15 male KIs, 15 female KIs
(with a focus on health)	(with a focus on health) implemented		
	Difficulties encountered	Districts at high-risk: 10	
	Communication channels used	District at low-risk: 10	
	Follow-up with communities		
Village Health Teams	Actions related to RCCE	Refugee settlements/ host	15 male KIs, 15 female KIs
	implemented	population districts: 10	
	Difficulties encountered	Districts at high-risk: 10	
	Communication channels used	District at low-risk: 10	
	Follow-up with communities		
Local authorities /	Actions related to RCCE	Refugee settlements: 10	20 male KIs, 20 female KIs
Community and local	implemented	Host population districts: 10	
thought leaders	Difficulties encountered	Districts at high-risk: 10	
	Communication channels used	District at low-risk: 10	
	Follow-up with communities		
Total number of KIs			152

4 Roles and responsibilities

This assessment is conducted through the framework of U-Learn's activities. The Uganda U-Learn consortium is implemented by the Response Innovation Lab (hosted by Save the Children International), IMPACT Initiatives, the International Rescue Committee (IRC) and their implementation partner Ground Truth Solutions (GTS). While IMPACT will lead the research side of this assessment, there will be substantial support from other consortium partners at various stages of the assessment cycle. Technical support during the research design and subsequent analysis phase will be provided by GTS and IRC. In particular, Ground Truth Solutions (GTS) will provide technical expertise in the design of indicators and in the analysis of the qualitative data relevant to the AAP part of the assessments. With their operational engagement in RCCE and their active participation in relevant coordination bodies, the IRC will provide both technical input to this study and support the adequate involvement of external coordination mechanisms in order to ensure relevance of findings to the Covid-19 response and ultimate results uptake of responders. The RIL will support the dissemination of the assessment results through the Learning Hub (LH). This process will be guided by a jointly elaborated dissemination plan (see below).

Task Description	Responsible	Accountable	Consulted	Informed
Research design	IMPACT Assessment Officer	IMPACT Research Manager	IMPACT Research Design / Data (RDD) Unit, ULEARN, DFID, RCSMCE Task Force actors	IMPACT Country Coordinator, DFID
Supervising data collection	IMPACT Assessment Officer/IMPACT Field Manager	IMPACT Research Manager	IMPACT RDD Unit, ULEARN	Database Officer/Data Specialist

Table 3: Description of roles and responsibilities

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Data processing (checking, cleaning)	Database Officer	Data Specialist	Field Manager + field team , IMPACT RDD Unit,	IMPACT Research Manager/Assessment Officer
Data analysis	Database Officer, Ground Truth Solutions	Data Specialist	IMPACT RDD Unit, U-Learn	IMPACT Research Manager/Assessment Officer
Output production	IMPACT Assessment Officer, Ground Truth Solutions	IMPACT Research Manager	IMPACT Reporting Unit, ULEARN,	IMPACT Country Coordinator
Dissemination	IMPACT Assessment Officer, Research Manager, RIL Learning Hub	IMPACT Country Coordinator	ULEARN, IMPACT Communications Unit	DFID, RCSMCE Task Force actors, CwC, ATWG, etc.
Monitoring & Evaluation	IMPACT Research Manager	IMPACT Country Coordinator	HQ Research Department	U-Learn
Lessons learned	IMPACT Research Manager	IMPACTCountry Coordinator		HQ Research Department

Responsible: the person(s) who executes the task

Accountable: the person who validates the completion of the task and is accountable of the final output or milestone

Consulted: the person(s) who must be consulted when the task is implemented

Informed: the person(s) who need to be informed when the task is completed

5. Data Management Plan

Detailed Data Management Plan is available upon request.

6. Monitoring & Evaluation Plan

• Please complete the M&E Plan column in the table and use the corresponding Tools in the Monitoring & Evaluation matrix to implement the plan during the research cycle.

IMPACT Objective	External M&E Indicator	Internal M&E Indicator	Focal point	ΤοοΙ	Will indicator be tracked?
Humanitarian stakeholders are accessing IMPACT products	Number of humanitarian organisations accessing IMPACT services/products Number of individuals accessing IMPACT services/products	# of downloads of x product from Resource Center	Country request to HQ		X Yes
		# of downloads of x product from Relief Web	Country request to HQ	-	X Yes
		# of downloads of x product from Country level platforms (Response Info Hub webpage)	Country team	1	X Yes
		# of page clicks on x product from REACH global newsletter	Country request to HQ	User_log	X No
		# of page clicks on x product from country newsletter, sendingBlue, bit.ly	Country team		X No
		# of page clicks on x product from Learning Hub webpage	Country request to HQ		X Yes
IMPACT activities contribute to better program implementation and coordination of the humanitarian	Number of humanitarian organisations utilizing IMPACT services/products	# references in HPC documents	Country team	Reference_I og	National COVID response and preparedness plan, MoH Uganda COVID-19 Guidelines, WHO Country Strategy, UNICEF Country Strategy, COVID-19 CwC ToR
Тезропзе		references in single agency documents			
Humanitarian stakeholders are using IMPACT products	Humanitarian actors use IMPACT evidence/products as a basis for decision making,	Perceived relevance of IMPACT country-programs	Country team	Usage_Feed back and Usage_Surv ey template	Usage survey to be conducted at the end of the research cycle. Possibly November 2020

	aid planning and delivery Number of humanitarian documents (HNO, HRP, cluster/agency strategic plans, etc.) directly informed by IMPACT products				targeting RCSMCE partners and corresponding actors
Humanitarian stakeholders are engaged in IMPACT programs throughout the research cycle	Number and/or percentage of humanitarian organizations directly contributing to IMPACT programs (providing resources, participating to presentations, etc.)	# of organisations providing resources (i.e.staff, vehicles, meeting space, budget, etc.) for activity implementation	Country team	Engagement _log	X No
		# of organisations/clusters inputting in research design and joint analysis	Country team	Engagement _log	X Yes
		# of organisations/clusters attending briefings on findings;	Country team	Engagement _log	X Yes

7. Data Analysis Plan

Find <u>here</u> the link to the Data Analysis Plan.

8. Dissemination plan

This assessment aims to fill the information and knowledge gap around Risk Communication and Community Engagement and aims to be an operational tool for the humanitarian actors to inform their communication strategy. For this reason, the different actors will be consulted during the design phase to understand which documents would facilitate the uptake of the results into their operations.

Additional to the consultation, a detailed dissemination plan is detailed below to inform the humanitarian actors during the implementation of the study and once the final results are available.

Possible this tentative plan will be updated during the consultation phase in order to fit the humanitarian actors' information needs.

- Internal Planning dates **External Milestones** January February March April May June Secondary data review of risk communications and AAP literature (22nd June) July Joint research design with IRC and GTS; development of TOR for deep-dive assessment (6th July) Joint development of data collection tools (10th Aug) Consultations with DFID, the RCCE pillar, and other coordination bodies as necessary (first week of Aug) August Pilot Survey Tool (15th Aug) Start Data Collection (24th Aug) September Data collected (30th September) consortium findings presentation/discussion October Internal (15th October) Develop and finalize findings products (30th October) Findings dissemination in RCCE pillar and other relevant November coordination groups (6th November) December
- A. Key events and planning dates of the broader humanitarian community, which should be taken into consideration when developing the dissemination plan:

Dissemination plan

The following actions wil be implemented to faciltate the dissemination and uptake of findings.

- 1. Engagement: engaging key actors during the research design phase to ensure knoledge and information gaps are properly address and that the assessment findings will be used by the humanitarian actors.
 - 1.1 Circulate ToR thorugh different coordination mechanisms to collect feedback and inputs.
 - 1.2 Organize structured consultation round (RCCE, CwC, ATWG, among others).
- 2. Dissemination of findings

- 2.1 Define which outputs will facilitate the consultation and the results' uptake.
- 2.2 Organize on-line webinar to launch report.
- 2.3 Engage key actors in generating discussion around the assessment's findings organizing round-table (in person / on-line).

Communications: the findings will be communicated through mailing list and post on social media