

Undertaking

Rapid Assessments in the

COVID-19 context

Learning from UNICEF South Asia



UNICEF Regional Office for South Asia

August 2021

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Publication Date: August 2021

Suggested citation:

UNICEF. Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia. UNICEF Regional Office for South Asia: Kathmandu, Nepal.

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Undertaking Rapid Assessments in the COVID-19 context

Learning from UNICEF South Asia

Acknowledgements

This project was led by the Evaluation Unit of UNICEF Regional Office for South Asia (ROSA), in collaboration with the Research and Evaluation team at UNICEF India. Deepika Ganju (Consultant) conducted the study and co-authored the report and the case study briefs with Tom Pellens (UNICEF ROSA), who also designed the study. Maaïke Bijker (UNICEF India) supported the study design, reviewed the report and provided ongoing feedback. Esther Kaggwa (UNICEF ROSA) provided overall guidance.

The report benefited from the valuable contributions of UNICEF colleagues from country offices across the South Asia region and other key stakeholders. Special thanks to the following for their contributions: Piush Antony and Ram Manohar Mishra (UNICEF India) for the Uttar Pradesh, India case; Deepak Kumar Dey, Yasmin Khan and Mekonnen Woldegorjis (UNICEF Bangladesh) for the Bangladesh case; Ellen Van Kalmthout and Emelia Allan (UNICEF Pakistan), Laura Sheridan and Fatima Ahmed (UNDP), Osman Anwar and Zaigham Hidayatullah (Viamo) and Claudio Alberti (Consultant) for the YPS, Pakistan case; Sunisha Ahuja, Maaïke Bijker, Mita Gupta and Terry Durnnian (UNICEF India) and Dayoung Lee and Pratiksha Barasia (Dalberg Development Advisors) for the school learning, India case; Ivan Ssenkubuge, Stanley Gwavuya and Minaa Rayan (UNICEF Afghanistan), and Anne Jasim-Falher and Sayed Abdul Razaq Sadat (ATR Consulting) for the Afghanistan study; Sevara Hamzaeva, Usha Mishra and Aniruddha Bonnerjee (UNICEF Nepal), Tom Pellens (UNICEF ROSA), Madhu Acharya and Bhimiraj Chapagain (Sharecast Initiative), and Ayesha Bhatnagar (Viamo) for the Nepal study; Kanchan Dyuti Maiti, Neelam Pol, Misaki Akasaka Ueda (UNICEF India), Chayan Roy Chaudhary (Consultant) and Annie Namala (Centre for Social Equity and Inclusion) for the CBM, India case; Louise Moreira Daniels (UNICEF Sri Lanka), Shiloh Sumanthiran and Thashiya Nauki (Verité Research) for the Sri Lanka study; and Jonathan David Shadid and Deepa Risal Pokharel, Zohra Nisar Hunza (UNICEF Pakistan), Tom Pellens (UNICEF ROSA), Mohammad Faisal Khalil (Consultant), Khurram Jilani (Consultant) and Osman Anwar (Viamo) for the RCCE Pakistan case.

We would also like to thank New Concept Information Systems for copy editing and designing the report.

CONTENTS

<i>Acknowledgements</i>	<i>iv</i>
<i>Abbreviations</i>	<i>vi</i>
Chapter 1: Introduction	1
1.1 COVID-19 in South Asia: The context	1
1.2 UNICEF's COVID-19 response	2
1.3 UNICEF-led COVID-19 rapid assessments	2
1.4 Purpose of the report	3
1.5 Structure of the report	3
Chapter 2: Methodology	4
2.1 Overview of the documented rapid assessment cases	4
2.2 Conceptual framework	5
2.3 Case selection, data collection, documentation, analysis and synthesis	5
2.4 Study limitations	6
Chapter 3: Insights from the documented rapid assessments	7
3.1 Data collection and analysis	7
3.2 Sampling	14
3.3 Partnerships	17
3.4 Agility and timeliness	20
3.5 Dissemination of evidence and use of findings	22
Chapter 4: Key lessons from the documented assessments	25
4.1 Planning rapid assessment	25
4.2 Designing rapid assessments	25
4.3 Implementing rapid assessments	28
4.4 Dissemination of evidence and use of findings	28
Annex 1: Overview of data collection approaches and sampling strategies adopted in the nine rapid assessment cases	30
CASE STUDIES	33
1. Assessing the immediate impact of COVID-19 among the most vulnerable in the state of Uttar Pradesh, India	
2. Child and Family Tracker, Nepal	
3. Community-based Monitoring to assess the socio-economic impact of the COVID-19 pandemic on vulnerable populations in India	
4. COVID-19 related Risk Communication and Community Engagement (RCCE) Behavioural Change Study, Pakistan	
5. Impact of the COVID-19 crisis on households in Sri Lanka	
6. Insights and feedback on Corona virus Risk Communication and Community Engagement (RCCE) in Bangladesh	
7. Rapid assessment of learning during school closures across six states of India in the context of COVID-19	
8. Rapid assessment of the socio-economic impact of COVID 19 in Herat Province, Afghanistan	
9. Understanding youth perceptions of COVID-19 in Pakistan	

Abbreviations

CBM	: Community based Monitoring
CSO	: Civil Society Organization
CV	: Community Volunteer
ERB	: Ethical Review Board
FCHV	: Female Community Health Volunteer
GBV	: Gender-based Violence
HQ	: Headquarters, UNICEF
IDI	: In-depth Interview
IVR	: Interactive Voice Response
KII	: Key Informant Interview
LTA	: Long Term Agreement
MIS	: Management Information Systems
MNO	: Mobile Network Operator
M&E	: Monitoring and Evaluation
ODK	: Open Data Kit
RCCE	: Risk Communication and Community Engagement
RDD	: Random Digit Dialling
ROSA	: Regional Office for South Asia, UNICEF
TAG	: Technical Advisory Group
WASH	: Water, Sanitation and Hygiene

Abbreviations for the names of the documented Rapid Assessments

CBM-India	: Community-based Monitoring to assess the socio-economic impact of the COVID-19 pandemic on vulnerable populations in India
CFT-Nepal	: Child and Family Tracker, Nepal
CL-India	: Rapid Assessment of Learning during School Closures across Six States of India in the Context of COVID-19
CV19-Sri Lanka	: Impact of the COVID-19 crisis on households in Sri Lanka
Herat-Afghanistan	: Rapid assessment of the socio-economic impact of COVID-19 in Herat Province, Afghanistan
RCCE-Bangladesh	: Insights and feedback on Corona virus Risk Communication and Community Engagement (RCCE) in Bangladesh
RCCE-Pakistan	: COVID-19 related Risk Communication and Community Engagement (RCCE) Behavioural Change Study, Pakistan
UP-India	: Assessing the immediate impact of COVID-19 among the most vulnerable in the state of Uttar Pradesh, India
YPS-Pakistan	: Understanding Youth Perceptions of COVID-19 in Pakistan

CHAPTER 1

Introduction

1.1 COVID-19 in South Asia: The context

Following the confirmation of the first COVID-19 cases at the end of January 2020, countries in South Asia implemented early stringent mitigation measures from March 2020, including nationwide lockdowns, school closure and travel restrictions.¹ By May 2020 many Governments began allowing businesses to operate and domestic travel to resume, while further promoting the adoption of COVID appropriate behaviour (hand washing, use of masks and physical distancing). With the relaxation of restrictions on mobility in many countries, infection rates began to spike. By May 2020, India had exceeded China in the total number of confirmed COVID-19 cases, and by mid-June 2020 Pakistan and Bangladesh also had more confirmed cases than China.

In the first wave of transmission, the spread of COVID-19 was heterogeneous across countries in South Asia. Cases in Afghanistan began to spike in May 2020, while in Bangladesh and Pakistan cases peaked in June-July 2020, and in India, Nepal and Sri Lanka cases rose rapidly in October 2020.² According to WHO data, by 20 November 2020, the total number of deaths in South Asia (excluding India) was 16,597 and 1,098,005 confirmed COVID-19 cases. India alone accounted for 132,162 deaths and more than 9 million confirmed cases.³ Since April 2021, countries across South Asia

witnessed a new surge in COVID-19 infections. By end July 2021, there were 35.66 million confirmed COVID-19 cases reported and 489,651 deaths in the region, more than a doubling since April.⁴

Besides the direct health impact, the pandemic and extended lockdowns had major social and economic consequences. These resulted in significant disruptions in the delivery and uptake of social services and had adverse consequences for the social and economic well-being of the most vulnerable groups in the region, especially children, women and adolescents.⁵ For example, with health facilities closed and health and nutrition programmes halted during the lockdown, there was an 80% decrease in the number of young children treated for severe acute malnutrition in Nepal and Bangladesh, and a sharp drop in childhood immunizations in Pakistan and India.⁶ Furthermore, it is estimated that 22 million children missed out on early education in the critical pre-school year due to COVID-19,⁷ some 420 million children in South Asia remained out of school due to pandemic control measures, and 4.5 million girls were likely to drop out of school.⁸ Extended lockdowns also curtailed economic activity, impacting the livelihoods of the population and widening equity gaps.⁹ Measures adopted to contain the spread of the virus were estimated to push 132 million people across South Asian countries (India, Bangladesh, Pakistan, Nepal, Sri Lanka) into extreme poverty, and increase food insecurity and poor health.¹⁰

¹ Countries in South Asia comprise Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. Nepal was the first South Asian country to report a confirmed COVID-19 case on 23 January 2020.

² <https://coronavirus.jhu.edu/map.html>; G.R. Babu, S. Khetrapal, D.A. John, et al., Pandemic preparedness and response to COVID-19 in South Asian countries, *International Journal of Infectious Diseases* 104 (2021) 169-74

³ BBC, ourworldindata.org <https://coronavirus.jhu.edu/map.html>

⁴ <https://ourworldindata.org/covid-cases>

⁵ UNFPA, COVID-19: A Gender Lens: Protecting Sexual and Reproductive Health and Rights, and Promoting Gender Equality, New York, 2020; UNFPA, Interim Technical Note: Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage, New York, 2020.

⁶ UNICEF, Direct and indirect effects of the COVID-19 pandemic and response in South Asia, Kathmandu, 2021.

⁷ UNICEF SAR Education COVID-19 response, Update # 12, October 2020

⁸ UNICEF, Direct and indirect effects of the COVID-19 pandemic and response in South Asia, Kathmandu, 2021.

⁹ It is estimated that the Indian economy incurs a loss of USD4.64 billion for locking down the economy for a single day (Acuité Ratings, 2020).

¹⁰ Yadav, A. and B.A. Iqbal, Socioeconomic Scenario of South Asia: An Overview of Impacts of COVID-19, *South Asian Survey*, 2021, Vol. 28, no. 1: 20-37.



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1.2 UNICEF's COVID-19 response

UNICEF's COVID-19 response adapted to the changing needs of the pandemic. Initially, UNICEF supported coordinated efforts for the preparedness, containment and mitigation of the pandemic. When the pandemic transformed from a pure health emergency into a complex crisis with immediate, medium and long term social and economic consequences, UNICEF shifted its response focus to adopt a multi-sectoral approach to protect women's and children's rights through policies and programmes. This required strong coordination with multiple stakeholders involved in the COVID response.

At country level, UNICEF sought to protect children and their families from exposure to the virus, minimize mortality and address the effects of COVID-19 mitigation measures. This included providing accurate life-saving information on COVID-19 through risk communication and community engagement (RCCE); improving infection prevention and control at health, education and community facilities; promoting hygiene; and providing essential Water, Sanitation and Hygiene (WASH) services and supplies. The response also focused on strengthening and preparing health care systems for the new wave of COVID-19 cases. In its response to the socio-economic impacts of COVID-19 mitigation measures, UNICEF supported the continuity of essential health services and vaccinations; provided life-saving nutrition interventions; supported learning continuity through safe school operations or remote learning; strengthened child protection, mental health and gender-based violence (GBV) services to

better protect children and women; and expanded social protection systems and emergency safety nets. UNICEF has also been a key partner in the vaccination efforts against COVID-19, coordinating the procurement and supply of vaccines. The majority of UNICEF's interventions involved the redesign, reallocation and reimagining of regular programmes based on high-quality evaluative evidence, including real-time data.

1.3 UNICEF-led COVID-19 rapid assessments

As the COVID-19 crisis was fast-changing and its impact far-reaching, information was required to quickly and repeatedly assess the situation on the ground, particularly with regard to vulnerable populations, including women and children. In such an unprecedented situation, where there is paucity of reliable information available, it is important to design solutions and advocate for actions that are evidence-based to meet the needs of those who are most affected. In this context, UNICEF Country Offices across the region conducted a variety of rapid assessments or/and similar real-time evidence generating exercises about the COVID-19 pandemic.

Rapid assessments involve evidence generating activities that provide the basis for a quick, reliable and accurate analysis of a situation or intervention. These generally include collecting primary data (quantitative or qualitative, or both), are usually iterative (i.e. involving multiple rounds or phases), and often employ methodologies that are practical and convenient due to time constraints. However, rapid assessments are only one component of a larger evidence-building strategy, where they are complemented by longer-term and more robust research and evaluations.

As lockdowns were in place, and the risk of transmission of the virus needed to be mitigated, traditional face-to-face approaches for data collection could not be adopted. Restrictions on personal movement, the rapidly evolving pandemic situation, the need for quick generation of evidence to inform programmes and policy, constraints of time and limited available resources required rethinking certain traditional methods of evidence generation. This resulted in innovation and learning to adapt evidence generation to the context, needs and data collection constraints imposed by the pandemic. In the South

Asia region, the experimentation with and innovation around different methodologies for various UNICEF-led rapid assessments, partnerships and data use offer a wealth of learning for ongoing and future evidence generation activities. Critical reflection and knowledge sharing are crucial, especially in the context where we are learning as we go.

In this context, key learnings with regard to the design and implementation of rapid assessments in a pandemic situation in the South Asia region were documented to facilitate cross-country learning. Nine cases of rapid assessments, nominated by six country offices, were selected for documentation and cross-case analysis. Short briefs were produced summarizing the key information and lessons learned from each selected case. In addition, key learnings from these rapid assessments were synthesized. This initiative was led by the Evaluation Unit of the UNICEF Regional Office for South Asia (ROSA) in collaboration with the Research and Evaluation team at the UNICEF India Country Office.

1.4 Purpose of the report

This report synthesizes the findings and lessons learned in designing and implementing rapid assessments in the South Asia region in a pandemic context. It provides insights on how to implement a rapid assessment in emergency situations, focusing on the technical and managerial dimensions of the cases rather than the actual findings of the studies.

The COVID-19 pandemic has required a rethinking of data collection methods due to the risk of virus transmission and national lockdowns. Few studies have focused on the impact of the pandemic on evidence generation, and explored the learning around the methods and approaches that can be adopted to generate rapid evidence in an emergency

context, based on their practical application on the ground. This report draws on the documented experiences of multiple rapid assessments conducted in diverse contexts in South Asia during the first wave of the pandemic (March-December 2020) to present insights, learnings, innovations and challenges related to the different methods adopted in implementing these studies. The lessons and recommendations presented in this report will provide guidance for the collection of rapid and robust data in future emergency situations, and would of special interest to Monitoring and Evaluation (M&E) specialists, programme planners and other technical and non-technical audiences to inform future evidence generation activities.

1.5 Structure of the report

[Chapter 1](#) presents the background and context of the report. [Chapter 2](#) provides an overview of the nine documented rapid assessments and the methodology adopted for the selection of cases, data collection, analysis, synthesis and documentation. [Chapter 3](#) presents a synthesis of the key findings and lessons drawn from each of the cases. Findings are presented according to key dimensions of the conceptual framework that guided this documentation and analysis exercise, namely, data collection and analysis methodology, sampling approaches, partnerships and collaboration for implementation, timeliness and agility of the study and the dissemination and use of the findings. The strengths, limitations, trade-offs, innovations and lessons learned in designing and implementing the studies are highlighted in each case. Cross-cutting issues of gender and equity are also discussed. [Chapter 4](#) presents the lessons and recommendations from the synthesis. The nine case study briefs are appended in the second section of this report.



CHAPTER 2

Methodology

2.1 Overview of the documented rapid assessment cases

This report synthesizes findings from the nine selected rapid assessments in six countries of South Asia. Table 2.1 presents an overview of the selected assessments.

Table 2.1: Overview of the Nine Documented Rapid Assessment Cases

Name of rapid assessment	Thematic focus	Geographical scope	Target population
Assessing the immediate impact of COVID-19 among the most vulnerable in the state of Uttar Pradesh, India (UP-India)	Impact of COVID-19; knowledge and practices around COVID-19; experience of livelihood loss; coverage of COVID-19 social protection packages; household well-being	Uttar Pradesh state, India	Beneficiaries of selected Government social protection schemes
Child and Family Tracker, Nepal (CFT-Nepal)	Impact of COVID-19 on children and their families across a range of dimensions of social, economic and mental well-being; access to social services and protection; COVID-19 risk perception, awareness and behaviour	National, Nepal	Households with a child less than 18 years and female community health volunteers (FCHVs)
Community-based Monitoring (CBM) to assess the socio-economic impact of the COVID-19 pandemic on vulnerable populations in India (CBM-India)	Impact of COVID-19 pandemic on socio-economically vulnerable groups, including access to social protection, uptake of COVID-19 protective practices, stigma, and COVID-19 vaccine perceptions	12 districts across 7 states, ¹ India	Community volunteers (CVs) and vulnerable families and their members
COVID-19 related Risk Communication and Community Engagement (RCCE) Behavioural Change Study, Pakistan (RCCE-Pakistan)	RCCE behavioural change, information and trust, coping strategies and evolving needs in the COVID-19 pandemic situation	National, Pakistan	Individuals with mobile phone access aged 20 years and older
Impact of the COVID-19 crisis on households in Sri Lanka (CV19-Sri Lanka)	Impact of the COVID-19 pandemic on households, including food and income security, and access to government relief, health care and education	National, Sri Lanka	Households, mostly female-headed
Insights and feedback on Corona virus Risk Communication and Community Engagement (RCCE) in Bangladesh (RCCE-Bangladesh)	Knowledge, perceptions, information sources and practices regarding Corona virus and response	National, Bangladesh	Citizens aged 10 years+ with online access
Rapid Assessment of Learning during School Closures across Six States of India in the Context of COVID-19 (CL-India)	Needs and experiences with regard to continued school learning; barriers to access and effectiveness of learning solutions; and promising innovations to support remote learning	Six states, ² India	Primary and secondary school-age children, their parents and teachers
Rapid assessment of the socio-economic impact of COVID-19 in Herat Province, Afghanistan (Herat-Afghanistan)	Knowledge, attitudes and practices (KAP) around COVID-19; socio-economic impact of the pandemic on vulnerable groups; services available to women and girls; gendered coping mechanisms and changes in intra-household relationships and decision-making power	19 districts in Herat province, Afghanistan	Households, women, adolescents, children, community health workers and community leaders

¹¹ The study covered the states of Andhra Pradesh, Gujarat, Maharashtra, Rajasthan, Telangana, Tamil Nadu and Uttar Pradesh.

¹² The six states are Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh.

Name of rapid assessment	Thematic focus	Geographical scope	Target population
Understanding Youth Perceptions of COVID-19 in Pakistan (YPS-Pakistan)	Perceptions of the danger and impact of COVID-19 on lives and livelihoods; remote learning and education in the pandemic context; Government's response to the pandemic; and the "new normal" post- COVID-19	National, Pakistan	Young people aged 14-29 years

Key features of the nine documented rapid assessments are:

Geographical scope

The assessments cover six countries in South Asia: Afghanistan, Bangladesh, India, Nepal, Pakistan and Sri Lanka. Five are national level studies, two cover multiple subnational states and two are single subnational state/province studies.

Focus areas

The most common themes are the socio-economic impact of the pandemic; access to social protection and social services; COVID-19 related knowledge, perceptions and behaviours; and coping strategies. Some rapid assessments had a specific focus, such as continued learning and access to education (CL-India) or youth perceptions (YPS-Pakistan). Awareness and perceptions around the COVID-9 vaccination were examined in some cases. Evidence generation about vaccinations increased from early 2021 onwards.

Target population

Some assessments targeted the general population or households; others focused on specific vulnerable groups. Even when households were targeted, an emphasis on women and children was included. The target populations were selected in line with the focus areas of the studies.

Methodology

Mainly remote data collection via telephone surveys, interactive voice response (IVR), and online surveys was used. All the assessments used quantitative methods; some used mixed-methods for additional qualitative data collection. Most assessments directly surveyed household members or sampled individuals; three studies also used community members as 'informants'. A range of sampling approaches were applied and combined, including grid-based, stratified random, purposive and convenience sampling strategies.

Rounds

Four studies were one-off assessments. Five were longitudinal studies covering multiple rounds of data collection (the number of rounds varying between two and six with one- to two-month intervals); of these, three covered a panel.

Partnerships

Assessments were implemented in collaboration with National and State Governments, local implementing partners (e.g., consulting firms, media research and survey organizations, market survey firms, CSOs and think tanks), UN agencies, UNICEF offices (ROSA and Headquarters (HQ)), and UNICEF programme sections internally.

2.2 Conceptual framework

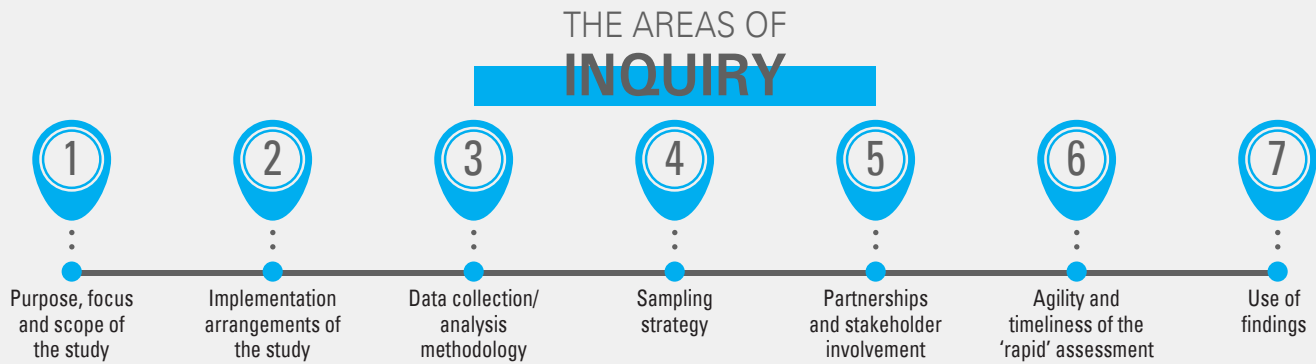
The process of data collection, analysis and documentation of the case studies and synthesis of the findings was guided by a conceptual framework with multiple areas of inquiry (see Figure 2.1). The focus of the exercise was on documenting and analysing the methods and approaches that were used as part of the rapid assessments (the 'HOW') rather than review and synthesize the evidence and findings generated by the rapid assessments (the 'WHAT').

In addition to the dimensions covered in the conceptual framework, the documentation process gathered information on the context within which the rapid assessment took place, which was likely to influence the design and implementation of the assessment, such as for example, the circumstances of the lockdown or the severity of the pandemic at the time of the rapid assessment.

2.3 Case selection, data collection, documentation, analysis and synthesis

The documentation and synthesis process was undertaken between August 2020 and May 2021.

Figure 2.1: The areas of inquiry



A consultant was contracted to support the process of data collection, documentation, analysis, synthesis and report writing, following the steps presented in Figure 2.2.

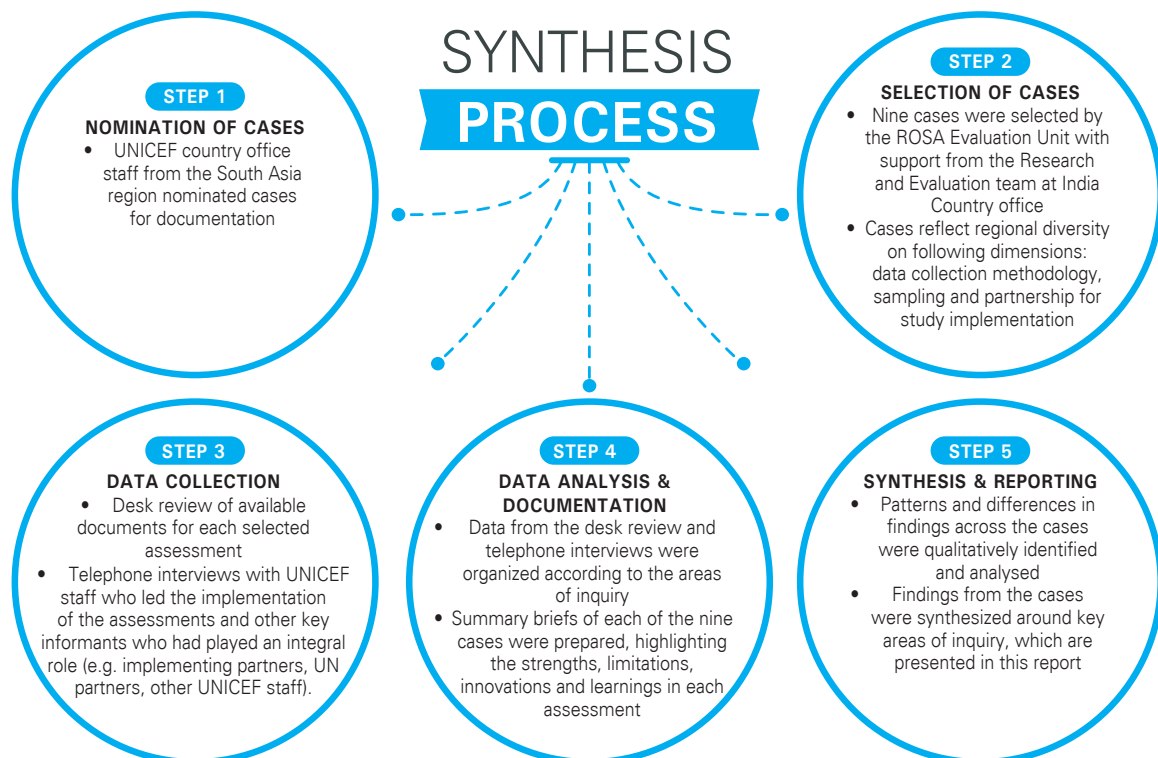
2.4 Study limitations

The scope of this report is to synthesize and present findings and lessons with regard to the design and implementation of rapid assessments in a COVID-19 pandemic situation, based on selected cases in South Asia. As such, it does not present findings from the rapid assessments on the impact of the pandemic in the region. This report does not discuss when a rapid assessment should be adopted for evidence generation; rather,

it provides lessons on 'how' to undertake a rapid assessment after it has been selected as the most appropriate tool for the purpose/objectives of the study.

The study has some methodological limitations. Only nine cases were selected for documentation due to limitations of time and resources. Moreover, it is important to note that this is not a systematic review; the sample was purposively selected to reflect a heterogenous mix of cases, with variance in geographical scope, target population, data collection methods, etc. for the purpose of learning. Hence the findings are not representative of all the rapid assessments conducted at the time across the South Asia region.

Figure 2.2: Case selection, data collection, documentation, analysis and synthesis process



CHAPTER 3

Insights from the documented rapid assessments

This chapter presents a synthesis of the findings and lessons from the nine documented rapid assessments based on the areas of enquiry of the conceptual framework. Section 3.1 presents findings on data collection and analysis; section 3.2 covers sampling approaches; section 3.3 discusses partnerships and collaborations for designing and implementing the studies; section 3.4 focuses on agility and timeliness of the studies; and section 3.5 covers the dissemination and use of findings. Key takeaways and lessons related to gender and equity drawn from the implementation of the cases are also presented. Detailed information on each case is available in the case study briefs appended in the second part of this report.

3.1 Data collection and analysis

This section presents insights and lessons on the data collection modalities (IVRs, online surveys and phone surveys), data collection approaches (mixed methods and longitudinal studies), ethics and quality assurance, and data analysis and reporting based on the selected assessments. Annex 1 presents an overview of the data collection approaches and the sampling strategies adopted in the nine documented assessments.




3.1.1 Data collection modalities

As face-to-face gathering of information through a traditional sample survey mode was not possible in the context of the COVID-19 pandemic due to lockdowns and the risk of spreading the virus, the assessments collected data through remote means using different modalities or a combination of modalities. Four assessments (CBM-India, CFT-Nepal, RCCE-Pakistan, YPS-Pakistan) used IVR calls, three studies (RCCE-Bangladesh, RCCE-Pakistan, YPS-Pakistan) used an online survey and four assessments (CBM-India, CFT-Nepal, CV19-Sri Lanka, Herat-Afghanistan, UP-India) used a phone survey to collect data.

Each remote data collection modality has its strengths and limitations (see Table 3.1) and its selection was driven by both the objectives and scope of the survey as well as the opportunity and context. The Bangladesh and Pakistan assessments (RCCE-Bangladesh, RCCE-Pakistan, YPS-Pakistan) used IVR calls and online data collection modalities because reaching a large sample quickly was a key objective. Moreover, as these assessments had a limited thematic scope, the questionnaires could be kept short. Furthermore, in the case of the RCCE-Bangladesh assessment, the survey took place within the context of the national RCCE partnership, which allowed its network to be mobilized to widely disseminate the online survey link. For both assessments in Pakistan (RCCE-Pakistan and YPS-Pakistan), UNICEF could quickly partner with Viamo, an organization that specializes in IVR data collection and has well-established relationships with Mobile Network Operators (MNOs) in the country, to send out a large number of IVR calls and SMS survey links at low cost. The other assessments used phone surveys to gather data. As these studies were generally broader in scope and/or aimed to probe specific topics more comprehensively, the questionnaires were often longer, which a phone survey accommodated more easily. Also, for several of these assessments an existing database of phone numbers could be accessed through survey partners, which enabled phone surveying.



Table 3.1: Strengths and limitations of different remote data collection modalities

Modality	Strengths	Limitations
<p>Online survey</p> 	<ul style="list-style-type: none"> ■ Very quickly reaches a large sample, to the extent that the survey link can be shared extensively ■ Inexpensive and quickly designed using freely available software (e.g. Google Forms, ODK) ■ Allows respondents to answer at their own convenience ■ Questionnaire can be longer than an IVR, but best remains short to avoid non-completion 	<ul style="list-style-type: none"> ■ Response rate is generally low,¹³ which requires an extensive spread of the online survey link to reach a sufficient sample size ■ Often implemented through convenience sampling, which limits generalizability of findings ■ Limited to respondents with internet/computer access and who are literate ■ Due to short questionnaire format, difficult to probe sensitive issues and get detailed responses
<p>IVR survey</p> 	<ul style="list-style-type: none"> ■ Quickly reaches a large sample, to the extent that multiple calls can be placed at once ■ Once technology is in place the cost is relatively low, although cost varies by country depending on airtime call costs in the country ■ Reaches respondents who are not internet users and are not literate ■ As the survey is self-administered, respondents may be more comfortable answering sensitive questions 	<ul style="list-style-type: none"> ■ Response rate is generally low, which requires a large number of calls to be placed to reach a sufficient sample size ■ Questionnaire needs to remain short in terms of the number of questions and formulation of questions/answer options; this limits in-depth investigation of specific topics ■ Selection of multiple answer options is not possible, which restricts question formulation ■ While open-ended questions are technically feasible to include, the recorded data takes time to process
<p>Phone survey</p> 	<ul style="list-style-type: none"> ■ Response rate is generally higher as compared to IVR and online surveys as a rapport can be built with respondents ■ Allows for somewhat longer questionnaires and selection of multiple answer options (although survey time needs to remain short) ■ Better suited for inclusion of some open-ended questions and therefore for collection of complementary qualitative information ■ Reaches respondents who are not internet users and are not literate ■ More opportunity for data quality control through backchecks, spot checks and interview recording 	<ul style="list-style-type: none"> ■ Generally, more expensive than IVR and online survey because an enumeration team needs to be used (but less expensive than face-to-face interviews) ■ Requires more time as the number of concurrent calls depends on the size of the enumeration team ■ Requires investment in adequate enumerator training and capacity building to avoid enumerator errors/bias ■ Asking and probing sensitive issues over the phone is challenging and may not be appropriate

¹³ This includes partial response without the survey being completed.

Several cases used multiple data collection modalities to most effectively and efficiently reach different types of respondents or to gather complementary information. For example, the Pakistan assessments (RCCE-Pakistan, YPS-Pakistan) combined IVR calls with online data collection modalities in order to respectively engage with persons in peri-urban or rural areas who own basic phones and are not internet users, and digitally-enabled persons in urban areas (who own smart phones and have data access). In the CFT-Nepal case, a subsample of the phone survey respondents received a very short (7 questions) IVR call in order to collect complementary information, including questions respondents may have been uncomfortable answering in a telephone survey.¹⁴ The CBM-India case, which used a community-based data collection approach (see below), used an online Google Form to collect data from trained CVs on community perspectives and a phone survey to interview vulnerable families.



Lesson: Data collection modalities need to be selected based on the scope of the survey, profile of the targeted respondents, required response rate, timelines, budget, opportunities (e.g. access to phone numbers, access to technology) and context.

Designing survey tools for remote data collection is challenging in terms of determining the appropriate length of the interview, the number of questions to be included, how to frame questions and the number of answer options that can be responded to easily. The general learning from several of the surveys is that it is difficult to keep questionnaires short because of the range of information needs and interests of the different parties involved in designing the questionnaires. This is particularly important for IVR surveys, which need to remain short to avoid respondents dropping off the call. The Pakistan cases (RCCE-Pakistan, YPS-Pakistan) addressed the limitation of the short questionnaire format by running the IVRs through multiple call waves, which enabled a relatively longer questionnaire to be administered in different calls with the same respondents; however, this approach

comes at the cost of large drops in completion rates across waves and it also requires a longer data collection period. Therefore, in the third data collection round of the RCCE-Pakistan survey, the questionnaire was shortened, which allowed the number of call waves to be reduced from three to two and improve the completion rate.



Lesson: Questions need to be prioritized based on the objectives of the assessment and intended use of the data to ensure short questionnaires. Longer questionnaires can be accommodated but will ultimately come at the cost of lower completion rates. Phone surveys are to be favoured over IVR/online surveys when questionnaires are longer, but they are equally subject to survey fatigue.

As asking and probing sensitive issues over the phone is challenging, questions were asked indirectly in the remote surveys to gather information on sensitive issues.¹⁵ For example, to enquire about domestic violence, married women in the UP-India study were asked a question about changes in their husband's behaviour during the lockdown. In the CBM-India case, selected families were not asked directly about changes in the situation of child marriage or child labour, but rather the CVs' perception about the changing situation in the habitation was surveyed, as such sensitive information is difficult to capture at the family level.

Several approaches were adopted to increase participation and interest in the data collection. In the YPS-Pakistan case, IVR respondents were called via robocall before the survey to inform them that they would receive a call shortly to seek their participation. Other measures used across the cases were adding an introductory text message to highlight confidentiality, anonymity and the voluntary nature of the data collection, using the local language and introducing the survey as a UNICEF research initiative. In the case of CFT-Nepal, respondents were given a top-up for their mobile phones to compensate for their time, which also helped to keep respondents engaged. Furthermore, after the third round, respondents were offered a cash transfer to respond to their needs, which

¹⁴ For example, questions about whether the fear of Corona virus had led to job loss or anxiety about going out.

¹⁵ Questions about sensitive issues such as domestic violence can cause harm to the respondent, particularly when asked directly, as privacy is difficult to ensure during remote data collection and the question may lead to distress on the part of the respondent without an enumerator being able to recognize and respond to it.

also incentivized survey participation in subsequent rounds. The CBM-India case used a personalized approach, by which families and respondents were recruited by CVs to participate in the phone survey, resulting in high response rates.

In most cases, data collection was implemented through external partners with extensive experience in mobilizing, training and supervising survey teams within the different country contexts (see section 3.3, Partnerships). The CBM-India case is an exception as data collection was implemented through specially recruited CVs through a network of civil society organizations (CSOs) with a presence on the ground. While this model allowed data to be collected from respondents with a specific profile targeted by the assessment and from specific, hard-to-reach populations, building the capacity of the CVs and CSOs took time and required constant hand-holding support by UNICEF. Furthermore, the remote data collection was managed by UNICEF in-house through the RapidPro platform,¹⁶ which allowed flexibility to adapt the data collection modality and questionnaires based on learnings on the ground. In the Bangladesh case (RCCE-Bangladesh), data collection was also implemented in-house due to time constraints, which was possible as the survey was kept simple and short using an online survey mode.



Lesson: Different data collection modalities and approaches require different levels and types of capacities to implement the survey. Having sufficient capacity to recruit, train and supervise enumerators is particularly important for phone surveys. The advantage of working with external partners is that their expertise, capacity and networks can be leveraged. A community-based approach using a network of CSOs and CVs with local presence can effectively gather data among vulnerable populations but requires considerable investment in training and follow-up, as well as in-house capacity to design and implement the survey.

3.1.2 Data collection approaches

The assessments adopted different data collection approaches. All the cases gathered quantitative data, and some also gathered complementary qualitative information. While four assessments (CL-India,

Herat-Afghanistan, RCCE-Bangladesh, YPS-Pakistan) were one-off surveys, five studies gathered longitudinal data across different rounds (CBM-India, CFT-Nepal, CV19-Sri Lanka, RCCE-Pakistan, UP-India); of these, three were panel studies (CBM-India, CFT-Nepal, CV19-Sri Lanka).

All the assessments used a strong quantitative data collection approach. This allowed standardized data collection and analysis procedures to be applied in a relatively short time while still reaching a large sample. However, there are limitations regarding the depth and breadth of information that can be collected through remote quantitative surveys, given the constraints of the length of the questionnaires, and including follow-up questions and questions unpacking behaviours in depth. Further, the short format of remote quantitative surveys limits the possibilities to control for bias in responses. As evidenced in some cases (Herat-Afghanistan, RCCE-Pakistan), data on self-reported behaviours asked through single direct questions (e.g. frequency of handwashing) were likely to be affected by social desirability bias. Due to the questionnaire size restrictions, adding indirect questions or questions that further probed behaviours or proxies was not possible.

Given these limitations of remote quantitative surveys, several cases targeted multiple respondents, which allowed for a more comprehensive understanding of the main assessment themes from different perspectives. For example, the CFT-Nepal assessment conducted phone surveys with household heads as well as community health workers; and the CL-India study surveyed parents, students and teachers. Interviewing multiple respondents also enabled data triangulation for validation of the results and allowed the collection of a range of data while keeping individual respondent surveys short. The CBM-India assessment used a highly segmented targeting approach for selecting respondents across various family types within the community in the phone survey, which allowed all the necessary thematic areas of the assessment and people with different vulnerabilities to be covered, while keeping the questionnaire relatively short per respondent. In the Herat-Afghanistan case, triangulation proved to be valuable as there was a difference in COVID-19 practices reported in the survey and those in observations and key informant interviews (KIIs), possibly because of the social

¹⁶ <https://community.rapidpro.io>

desirability bias in responses and the manner in which questions/concepts were translated and understood by respondents.

Some rapid assessments complemented surveys with qualitative data collection. The CL-India and the Herat-Afghanistan rapid assessments organized qualitative interviews with selected national and local stakeholders, while the CFT-Nepal assessment leveraged the backcheck surveys to gather additional qualitative information from a small subsample of respondents. In the RCCE-Pakistan case, while a quantitative survey was the sole method used as part of the longitudinal rapid assessment, its quantitative findings were synthesized on an ongoing basis together with additional, among others, qualitative data sources to produce a periodic RCCE Brief that presented recommendations around the RCCE response.¹⁷ However, respondents of qualitative data collection need to be carefully selected; the experience of the CL-India study indicates that qualitative interviews with some stakeholders, who were too far removed from the ground reality, did not add the expected value in terms of providing sufficient practical insights about the situation on the ground.



Lesson: Mixing data collection methods and targeting different respondents can provide a more complete and in-depth understanding of the thematic areas of interest, help keep data collection tools short and permit data triangulation. Generating data from multiple sources requires the necessary capacity to process, analyse and report the data in a mixed/triangulated way. When including a limited number of qualitative interviews as part of rapid assessments it is important to carefully select informants who are knowledgeable and can provide insights about the situation on the ground.

While several assessments were designed to be one-off exercises as the objective was to generate immediate evidence, longitudinal data collection can be particularly relevant in the context of a rapidly evolving pandemic situation with long-term consequences. Longitudinal data collection has the benefit of analysing the situation over time,

gathering new data as the context and information needs change, and spread information needs over different rounds, which allows questionnaires to be kept short. Among the longitudinal rapid assessment cases, the number of rounds varied between two and six with one- to two-month intervals. Overall, more time was required to implement each round than was planned, particularly at the start. In a future global health crisis situation, a judicious mix of data collection approaches is needed—one-off rapid assessments to address specific and immediate evidence needs and longitudinal data collection to track the long-term impact and outcomes of the response.

Longitudinal surveys need to be flexible to adapt to the changing context and priorities over time.

In these assessments, the survey tool was reviewed and adapted in each round to ensure that the questions were targeted and relevant to the evolving situation, and redundant, not well-formulated or properly translated questions were removed so that people could respond more appropriately. For example, in both the Sri Lanka and Pakistan longitudinal assessments (CV19-Sri Lanka, RCCE-Pakistan), questions were introduced regarding children going back to school after lockdown. Similarly, several survey questions on COVID-19 vaccine hesitancy were incorporated when this topic became more pertinent. However, **adjustments in the survey tools need to be balanced by the value of maintaining certain questions across rounds to create a timeseries dataset that allows for a comparable trend analysis.**

While longitudinal surveys with rounds at short intervals can generate information quickly and regularly, they allow limited time between the rounds to analyse and interpret the data, and adapt the instrument; in such cases an interim review can help recalibrate the study. In the RCCE-Pakistan study, as an interim review indicated little significant change across the monthly rounds, it was decided to take a deliberate pause after the third round to reprioritize questions to suit emerging information needs, revisit the formulation of questions and align the survey data with complementary qualitative data findings.

¹⁷ The UNICEF Pakistan Office synthesized multiple data sources in an RCCE Brief, drawing on, among others, the RCCE rapid assessment survey, behavioural pattern insight from anthropological and social data, social media sentiment analysis, 1166 Helpline data and general media monitoring.



Lesson: In the case of longitudinal assessments, it is important to schedule debriefing sessions after each data collection round to discuss the findings, review data quality, and adjust, if needed, the instruments to the interim learnings and emerging information needs.

Keeping respondents engaged over multiple survey rounds in a longitudinal panel telephone survey can be challenging as panel households become less responsive to the survey due to repeated rounds.

The Sri Lanka study (CV19-Sri Lanka), for example, experienced attrition in each round; in round 3, only around 45% of respondents overlapped with those in rounds 1 and 2. Replacement respondents had to be selected for each round to retain the sample size, and in round 4 a fresh sample had to be selected. In the Nepal assessment (CFT-Nepal), some attrition took place in the sample (from around 7,500 in round 1 to around 6,500 respondents in round 4) because of seasonal agricultural activities, operational issues (e.g. change of phone number), respondent's lack of interest, and change in work/residence status from round 1 (during lockdown) to round 2 (post lockdown). After the third round, respondents were offered a cash transfer to respond to their needs, which incentivized survey participation in subsequent rounds. In the CBM-India



Photo Credit: © UNICEF/Sujan/2021

household panel, attrition was low across rounds (less than 10%) as data collection was organized through CVs who were from the same community as the respondents. A community-based data collection approach has the advantage of ongoing, personal engagement with respondents and the potential of establishing a relationship of trust, which can lower the attrition across rounds.

3.1.3 Ethics and quality assurance

The ethical principle to 'do no harm' was a driving factor for the rapid assessments to mainly use remote data collection modalities. In the rare case that in-person data collection was used, as in the Afghanistan assessment (Herat-Afghanistan) where direct observation had to take place in-person, safety protocols were followed and local persons were trained to conduct the observations to avoid the entry of external field teams into the community, thereby mitigating the risk of spreading the virus. **Standard ethical practices were observed during remote data collection, including taking verbal/online consent prior to data collection, ensuring the confidentiality of the respondents and giving respondents the option to exit the survey at any point.** In cases where respondents were selected from an existing database, only those respondents who had given their permission to be contacted for future research were included in the survey. Sensitive questions, such as questions about harmful practices and domestic violence, were generally avoided, or asked in an indirect, non-personal manner (see above).

Most rapid assessments focused data collection on the adult population. This is mainly because adults were appropriate respondents for the type of information requested but also to avoid data collection among children if not absolutely necessary, taking into account their vulnerability, particularly during the pandemic. Age screening questions at the start of the survey were applied to halt the survey if minors responded. However, a limitation of remote surveys, particularly when self-administered, is that it is not possible to validate the age of the respondent. Furthermore, when children are the respondents—as in the case of the YPS-Pakistan survey—it is not possible to ensure that they do not respond to the survey without parental consent. Therefore, in cases when children are surveyed, an ethics review by an Ethical Review Board (ERB) is required to carefully weigh the harms and benefits and ensure that the rights and welfare

of children are protected. An ERB review, which can take time, needs to be factored into the timeline of the rapid assessment. In the RCCE-Pakistan survey, the rapid survey roll-out schedule did not allow for an ERB review; therefore, only adult respondents were targeted and data collection among adolescents, while considered valuable and initially planned, was dropped. However, an ERB review does not always take time. For example, in the case of the CL-India rapid assessment, UNICEF sought an ERB review through an existing UNICEF Long Term Agreement (LTA) for ethics review, which facilitated a quick review in just eight days.



Lesson: When required, an ERB review needs to be factored into the timeline of the rapid assessment. An ERB review can be done relatively quickly by leveraging existing arrangements for ethics review.

As documented in some cases, there can be a trade-off between investing time in data quality measures and the need to rapidly roll out the assessments. In several rapid assessments, rigorous pre-testing of data collection tools among the survey target population was not done because of time constraints, which affected survey quality and effectiveness. For example, due to the time-sensitivity of the Herat-Afghanistan assessment, the telephone survey questionnaire could not be rigorously pre-tested, which might have indicated that the survey length could be a challenge and highlighted the need for a better translation of questions. Similarly, pre-testing the online and IVR survey tools in the YPS-Pakistan assessment could have improved the study design, thereby increasing response rates, and reducing airtime and data collection costs by limiting initial outreach. The limited time/capacity for pre-testing the questionnaires was offset, to some extent, by using questions from pre-validated and tested tools; however, these tools need to be appropriately adapted to the local context and translated into the local language. Another measure taken in the longitudinal assessments for quality assurance was to review the questionnaires across rounds to modify questions that were not useful/did not work (CBM-India, CFT-Nepal, RCCE-Pakistan). However, this comes with the trade-off of revisiting and improving the formulation of questions and maintaining comparability for trend analysis.



Lesson: Pre-testing the questionnaire among survey respondents should be factored into the study design. While pre-testing needs an investment of time, it improves the tool design in terms of length, sequencing, formulation and translation of questions, leading to improved response rates and a reduction in cost.

Many of the rapid assessments introduced a variety of quality assurance measures, often facilitated by the remote nature of data collection, to ensure quality of data. Quality of data being collected was monitored remotely in real-time through web-based tools/data science packages (e.g., ONA App, ODK, Survey CTO software) and in-built dashboards. Furthermore, the CFT-Nepal and CBM-India assessments applied short backcheck surveys with a sample of respondents to check on survey quality. In the case of the CL-India rapid assessment, quality assurance was further institutionalized by the establishment of an internal Technical Advisory Group (TAG), which provided feedback on the study methodology, questionnaire design, analysis of findings and recommendations, which strengthened the study.

3.1.4 Data analysis and reporting

Across the cases, digital tools were leveraged to enable real-time analysis and reporting. For example, in the UP-India case, data were collected in the web-based Open Data Kit (ODK) and linked to Google Sheets and Infogram software to make findings quickly available. In Nepal, data from the telephone survey were captured in real-time on the ONA App and transferred to Python and R programmes for quick analysis; after each survey round a graphic summary presentation of the key findings was prepared.

Generally, analysis focused on descriptive analysis summarizing data and disaggregating them by the main characteristics of the respondents, which was sufficient to rapidly present findings around the main topics of inquiry for different respondent groups. Data were often analysed by variables such as gender, age, income, employment status and disability to provide a gender and equity perspective. In the case of the RCCE-Pakistan and CFT-Nepal assessments, the UNICEF ROSA pooled the data across the rounds and countries to conduct inferential analysis to examine the drivers of COVID-19 behaviours and perceptions.

The assessments generated a large amount of data; however, not all data were used in analysis and reporting. In the Herat-Afghanistan study, during data analysis, it was found that some of the information collected was not required and was therefore not analysed. In CL-India case, U-report survey data were not analysed and included in the final report because it was complex to analyse them in combination with the main phone survey data due to different sampling methodologies. Particularly for rapid assessments, which require focus on information that is immediately needed, collecting a large amount of data is not an efficient use of resources. Further, respondents provide consent, make time and share personal information for the survey, and it is ethically not correct to collect data that is not used.¹⁸ The rapid roll-out of the assessment can limit the time to strategically prioritize the data to be collected with analysis in mind, particularly when multiple partners are involved in designing the survey.



Lesson: It is necessary to strategically prioritize data that needs to be collected in a rapid assessment in view of the data that can and will be analysed and reported. Only information that is relevant to the study objectives should be gathered. The development of an analysis plan during the design can guide such prioritization.

3.2. Sampling

A variety of sampling strategies were used across the different rapid assessment cases (see Annex 1 for an overview). Several factors determined the sampling strategies adopted: the desired geographical coverage and dispersion, the survey target population, the data collection methods/modalities used, time constraints, and the availability of pre-existing sampling frames. This section presents findings and lessons regarding the sampling strategies from the rapid assessments.

Most of the quantitative surveys used some form of random sampling to mitigate bias in the selection of the sample units. In two cases, non-random sampling strategies were applied. In the case of

the RCCE-Bangladesh, convenience sampling was used—circulating the online survey link through multiple platforms and respondents self-selecting into the survey—because evidence had to be generated quickly at the start of the pandemic and a nationally representative sample frame was not readily available. Despite the likely biases in the sample, the findings were useful to indicate issues and disparities across groups, and rapidly inform initial internal programming and planning in a situation of high uncertainty. In the CBM-India case, purposeful sampling was applied, which allowed respondents, families and districts with specific profiles to be targeted, and particularly reach the most vulnerable. Purposeful sampling was also used for qualitative data collection in other cases; for example, parents and adolescents were purposively selected for qualitative interviews in the CL-India rapid assessment.

To ensure well-distributed geographical coverage, stratified sampling was often applied using stratification by subnational units (e.g. state, province, district) and rural/urban setting. The CFT-Nepal survey achieved the most fine-grained geographical distribution of the sample at ward level by applying grid-based random sampling, wherein wards were randomly selected within each grid on the map of Nepal (applying distance and density optimization algorithms), following which eligible households located in these wards, or in proximate wards, were sampled. In total 7,500 households were selected from 1,837 wards in 640 municipalities. This study demonstrates that unlike a face-to-face survey, where it is difficult and expensive to cover every location across the country, in a telephone survey with appropriate sampling it is possible to achieve fine-grained national coverage in a short time period.

Several rapid assessments also used stratification by respondent characteristics. For example, stratification by gender was applied in the CL-India study, while the UP-India sample was stratified by beneficiaries of different social schemes. Such stratification is an important approach to ensure the representation of specific respondent groups. Stratified sampling requires information about respondents' characteristics of interest (e.g. gender) to be available in the sample frame, which was often

¹⁸ See UNICEF Procedure on Ethical Standards in Research, Evaluation, Data collection and Analysis (UNICEF, 2021)

the case when rapid assessments leveraged existing survey databases as a sample frame. When such information was not available, screening questions at the start of the survey (e.g. asking the gender of the respondent) in combination with soft or hard sample quotas were used as an alternative to guide the targeting of the survey to respondents with a specific profile. However, the use of screening questions comes at the cost of having to make more calls to reach the targeted respondents, which requires additional time and resources. In the case of the YPS-Pakistan survey, this was mitigated by a respondent profiling and segmentation approach. The target population of the rapid assessment were young people. As age information was not available in the phone databases of the MNOs, mobile phone users with a mobile usage profile associated with young people (e.g. subscription to particular education content or job portals) were targeted for the survey. Subsequently, an age screening question determined their eligibility for the survey.



Lesson: The geographical coverage of the sample and its distribution according to target population characteristics can be improved by applying sampling techniques such as stratification and grid-based sampling. The efficiency of applying stratification techniques depends on easy access to relevant information during the sample design.

Efficient and rapid access to sample frames with the desired population coverage and inclusion of phone numbers for remote data collection was a critical factor in the sampling strategy of the rapid assessments and a significant constraint for their representativeness. Some studies were able to draw on previous survey databases (CFT-Nepal, CL-India, CV19-Sri Lanka, Herat-Afghanistan) or mobile phone databases of MNOs (RCCE-Pakistan, YPS-Pakistan). In the context of the pandemic, using an existing database as a ready sampling frame allowed for a quick selection of respondents and the rapid roll-out of data collection. However, the use of readily available databases has its limitations. First, since the available database may have been created for a different purpose, it may introduce bias in the sample

or lack full geographical coverage. For example, as the sample for the adolescent and parent telephone survey in the CL-India case was selected from an existing database, there were concerns that children and families whose children go to private schools may have been overrepresented in the sample. Second, in the CFT-Nepal and Herat-Afghanistan surveys, the existing databases did not have sufficient geographical coverage. The survey partners, through their local networks, had to list additional households in certain provinces and districts respectively to improve the representativeness of the sample frame.¹⁹ Third, if the size of the existing database is limited relative to the intended sample size, the response rate needs to be sufficiently high to achieve the sample size and attrition needs to remain limited in case of a longitudinal panel survey. For example, the CV19-Sri Lanka case used an existing survey database that included around 10,000 households to sample 2,000 households for the longitudinal survey. A partial household panel drawn from the database could be used during the first three survey rounds.²⁰ For the fourth round, however, a new random sample of households had to be selected in the field to replace the sample drawn from the existing database. Finally, as discussed above, respondents from past surveys need to have consented to be re-contacted for follow-up surveys, or approval from ERB needs to be sought. In future surveys, it is advisable to ask for consent from respondents to be re-contacted as standard practice.



Lesson: The use of existing databases of potential respondents with contact details allows for the quick roll-out of data collection. However, such databases may have limitations in terms of representativeness and size, which may require efforts to expand the database. They also influence selection of the sampling strategy and data collection modalities to be used.

In cases where there was no survey database available, the sample frame had to be constructed from lists sourced from UNICEF or partners. In the UP-India case, the State Government provided lists of beneficiaries (including mobile phone numbers) that were extracted from the management

¹⁹ In the case of the Herat-Afghanistan study, local community health workers attached to selected health facilities were recruited to enrol additional respondents in the survey via the random walk approach and collect their contact details.

²⁰ Around 45% of the initial household panel sampled for the first survey round could be maintained for the subsequent two rounds. Due to attrition, additional respondents had to be drawn from the database to meet the required sample size for rounds two and three.

Box 3.1

Random digit dialling (RDD): An alternative sampling strategy when there is no existing sampling frame

None of the rapid assessments used RDD as a sampling strategy. RDD is a sampling technique in which phone numbers are randomly generated based on the prefixes of the MNO. RDD does not require access to pre-existing phone listing. RDD has the advantage that it includes numbers that would be missed if they had been selected from a database or lists that do not fully cover the survey target population, and therefore can avoid coverage bias. However, RDD also has some limitations. First, a large number of randomly generated numbers will be invalid, not working or inactive, which makes it an inefficient

sampling method. Second, response rates among eligible numbers are generally low, even when using a phone survey. Third, the sample frame will not include additional information that can be used for stratification or segmentation, other than location information when prefixes are geographically assigned, which makes it a relatively inefficient sampling technique when specific groups need to be targeted. Therefore, the reduction in bias and improved generalizability of the findings need to be weighed against greater investment in resources and time to achieve the expected sample sizes.

information systems (MIS) of the social schemes of interest. For the CL-India study, the State Governments provided lists of school teachers for sampling, which was extracted from a longer list. However, there was no clarity as to how the subsample was selected or how representative the short lists were.

An inherent limitation of phone- and internet-based data collection is that those who do not own/use a phone or do not have internet access are excluded from the survey. In the South Asian context, it is particularly challenging to reach women in remote surveys as they have less access to mobile and digital connectivity than men, and in some contexts women are more hesitant to answer external calls.²¹ Furthermore, those without access to a phone are often the most vulnerable, which means that the most marginalized are likely to be underrepresented in the samples. Nonetheless, across the cases, several strategies were used to improve the representation of vulnerable groups. The CBM-India case was most explicit in this regard, designing a purposeful sampling strategy that focused on socio-economically marginalized and vulnerable families, and therefore ensuring their representation.²² The UP-India case also had an explicit vulnerability focus as it targeted beneficiaries of social welfare schemes. In some cases, sampling quotas were applied to improve representation of specific groups. For example, the CL-India study

pursued soft quotas to include a total of 700 migrant and vulnerable families across the states. For the Herat-Afghanistan rapid assessment, a sample quota for women respondents was established to ensure their representation. In the Bangladesh case, the online survey link was widely shared with the RCCE network to cover diverse groups, such as women's self-help groups and HIV groups. The use of existing survey databases as sample frames can limit representation of specific vulnerable groups when these were under- or not represented in the initial surveys. For this reason, the survey databases used for the CFT-Nepal and Herat-Afghanistan surveys were expanded with additional respondents from ethnic groups and female respondents respectively. Local networks were used to recruit such respondents into the samples.



Lesson: Remote data collection has an inherent limitation in reaching the most vulnerable who are less likely to have mobile phone/internet access, which needs to be acknowledged in the study. Nonetheless, sampling strategies can improve their representation through, among others, purposeful sampling, use of quotas, and making sample frames more inclusive. However, this comes with trade-offs of reducing the randomness of the sample (and therefore introducing bias) and additional investment in time and resources.

²¹ Rowntree, O. and Shanahan, M. (2020) The Mobile Gender Gap Report 2020. GSMA.

²² The CBM targeted, among others, families including pregnant and lactating women, mothers of children of different vulnerable age-groups, and home returnees.

Compared to face-to-face surveys remote data collection is particularly subject to non-response due to phone connectivity issues and because they are less able to build rapport and keep respondents engaged during the interview. IVR surveys generally have lower response rates as respondents may lack the technical aptitude to respond to the call, may not be accustomed to listening and responding to automated calls, and may find it easier to engage in a telephone conversation. In the case of CBM-India, the survey modality was changed from IVR to a phone survey because of the relatively low response rate experienced during the first data collection round. A low response is especially problematic when a large sample needs to be obtained from the sample frame relative to its size. In the CBM-India case, where respondents were purposefully sampled and enrolling additional, replacement respondents was not straightforward, a high response rate was needed to achieve the targeted sample size. On the other hand, in the Pakistan IVR surveys (RCCE-Pakistan, YPS-Pakistan) response rates of less than 5% did not pose a problem in achieving the intended sample size because a large sample of calls could be initiated—which still remained limited in size compared to the vast size of the MNO databases—at a low cost.²³ Nonetheless, non-response remains an issue as it may introduce bias in the sample as respondents with certain characteristics, for example, women from rural areas, are less likely to respond. Critical to improving the survey response is keeping the questionnaire short. In the case of the RCCE-Pakistan IVR survey, shortening the questionnaire after the second data collection round almost doubled the completion rate of the survey from 0.9% to 1.6%.²⁴



Lesson: While remote surveys, particularly when using IVR calls, are subject to considerable non-response, this is not necessarily problematic for achieving the intended sample size if the sample frames are of sufficient size to engage a large number of respondents and this can be done quickly and at a low cost. Nonetheless, non-response can introduce bias as it may not be random.

²³ For example, during the first round of the RCCE-Pakistan survey 350,000 IVR calls were initiated and 3,151 respondents completed the entire survey (see RCCE-Pakistan case study brief for details).

²⁴ The shortening of the questionnaire allowed the number of times a respondent was called to complete the questionnaire to be reduced from three to two. Because of the length of the questionnaire the same respondent was called several times over the course of several rounds, each time introducing another part of the questionnaire. See the RCCE-Pakistan brief for details.

Incentives can play a key role in increasing the interest of respondents to participate in remote surveys. In the Nepal study, a direct cash transfer, offered after round 3, helped to increase participation in the IVR survey. In the Afghanistan case, to mitigate the risk of non-completion of the survey due to the length of the questionnaire, an incentive in phone credit was provided. However, to avoid the risk of biasing people's responses, the incentive was only mentioned after consent for the survey was provided.

The comparability and representativeness of the data can be improved by the application of population weights and post-stratification calibration. In the CL-India study, sample weights were adjusted to reflect the state-level population distribution to ensure that the survey results were generalizable at the state level and to control for biases in the sampling methodology. Similarly, for the RCCE-Pakistan rapid assessment a weights model was developed to reweight the sample data in line with the sex, urban/rural, age and education distributions of the national population. However, the calibration of sample weights is not a panacea as it cannot reweight respondent groups that could not be covered in the sample. For example, in the RCCE-Pakistan case, ex-post reweighting could not perfectly rebalance the sample because some groups of females (e.g. young urban females) were not represented in the sample.

3.3 Partnerships

In a pandemic context, where the collection of timely and robust data can be challenging, collaborations can facilitate the design and rapid roll-out of an assessment. In this background, all the assessments were implemented through collaborations with one or more partners. While most of the assessments collaborated with local survey, research and consulting organizations (CL-India, CV19-Sri Lanka, Herat-Afghanistan, RCCE-Pakistan, UP-India, YPS-Pakistan), four involved collaborations with National or State Governments (CL-India, Herat-Afghanistan, RCCE-Bangladesh, UP-India), two leveraged partnerships with UN agencies

and RCCE pillar agencies (RCCE-Bangladesh, YPS-Pakistan) and one mobilized a network of CSOs (CBM-India). Several insights and lessons can be drawn from these collaborations.

Apart from the RCCE-Bangladesh and CBM-India assessments, [all the studies leveraged the research and technical expertise and data collection capacity of external partners to collect data remotely for phone, IVR or online surveys.](#) Collaboration with partners that could rapidly mobilize enumerator teams was crucial for the rapid roll-out of phone surveys. As mentioned above, partners' access to existing databases of phone contacts, particularly if the contacts had consented to being called again for follow-up surveys, was another major added value. Furthermore, some partners had on-the-ground networks, which could be leveraged to recruit additional respondents to avoid underrepresentation of certain groups in the sample or to collect a limited amount of in-person data without survey teams moving into the communities. For example, in the Herat-Afghanistan case, as physical movement and access to communities was a major issue in an environment of political insecurity and the lockdown situation, UNICEF partnered with a local research agency, with a presence on the ground across the country, to add female headed households to the sample and conduct direct observation in a limited number of health facilities, using the support of local community health workers.

Partners also provided valuable inputs for conducting the IVR and online surveys based on their experience of using mobile technology for data collection (CFT-Nepal, RCCE-Pakistan, YPS-Pakistan). In the RCCE-Pakistan and YPS-Pakistan cases, the implementing partner's technical inputs on identifying areas with high mobile penetration and internet availability in the country facilitated rapid data collection via IVR and online surveys. In the YPS-Pakistan case, the partner's experience of engaging with young populations in the country for surveys was an added asset; moreover, their strong relationship with MNOs in Pakistan facilitated robust data collection by enabling a segmented targeting of the survey population based on the MNOs' business

intelligence and use of the MNOs' collective bandwidth to rapidly cover a large national sample.

The CBM-India case was unique in that it built a partnership with a network of local CSOs for data collection, using trained CVs as enumerators. Collecting data through a CSO network on the ground allowed information to be gathered from vulnerable communities, which may have been otherwise difficult to reach. The CSOs were able to roll out data collection at the local level as they had a long history and presence on the ground and had the knowledge, expertise and social capital for last mile connectivity.



Lesson: The technical expertise, networks and resources of local partners can be leveraged for remote data collection which, in the context of a pandemic, can help roll out a remote survey, meet the short timelines, promote inclusiveness and contribute to the robustness of the findings.

Collaborations across UNICEF offices and UNICEF sections also supported the roll-out of the rapid assessments. The RCCE-Pakistan study, for example, was designed and implemented by the UNICEF Pakistan Country Office, drawing on questionnaire content, sampling guidance and sample reweighting expertise provided by UNICEF ROSA and HQ, which facilitated the rapid design of the survey and robustness of the data. In the CL-India case, the collaboration was formalized through an internal Technical Advisory Group (TAG)²⁵ that provided regular feedback, which strengthened the study design, survey tools, and analysis of findings and recommendations. The CBM-India case was built through an internal collaboration between UNICEF India's Social Policy Monitoring Evaluation (SPME) and Technology for Development (T4D) sections, bringing together research and technical capabilities. This allowed flexibility in the modalities of data collection and a timely shift from IVR to a phone survey.

In some contexts, ongoing collaborations between UN agencies as part of the COVID-19 response provided a platform to build partnerships to pool resources and optimize data use. In the CV19-Sri

²⁵ The TAG included a representative from the UNICEF's regional education team, a member of the UNICEF India research team and an external sector expert on school education.

Lanka and YPS-Pakistan cases, UNICEF pooled funding with other UN agencies for an efficient implementation of the rapid assessments.²⁶ Besides pooling funding, the partnership can facilitate easy access to required technical capabilities. For example, in the YPS-Pakistan case, the technological and survey partner Viamo could be contracted through an existing LTA held by UNDP. Furthermore, the multiple partners can support a broad dissemination of the findings and optimize their uptake across agencies. Findings from the YPS-Pakistan case informed UN programming in the field of youth engagement and subsequent youth-focused digital surveys in Pakistan. In some cases, as in Afghanistan, where the capacity for data collection and analysis is limited, proactively engaging with other UN agencies and mobilizing their capacity and resources could help to turn around the assessment within the planned timeline.

A positive consequence of these collaborations has been the opportunity to build the capacity of local partners. In the RCCE-Pakistan case, for example, the partner took on board the weight model developed by UNICEF HQ to apply it in subsequent survey rounds, while in the CBM-India case UNICEF built the capacity of the CSOs and anchors, creating a strong cadre of local volunteers who are now trained and sensitive to the need for quality data, and can be used to monitor future interventions.



Lesson: Collaborations between UNICEF offices, within UNICEF sections internally, and across different UN agencies can be leveraged to mobilize funding, access technical capabilities and broaden dissemination of the findings, which can support rapid roll-out of the rapid assessment, robustness of the findings and optimize their use.

While the availability of partners with the expertise, capacity, resources and presence in the country helped to roll out the rapid assessment, **partnerships also required effort and time for coordination.** In some cases, there were delays in initiating the survey as it took time to find a suitable partner and enter into a formal contract with them. However,

²⁶ In the YPS-Pakistan case, an existing collaboration between UNICEF, UNDP and UNFPA, along with other UN agencies, who were part of the joint UN engagement programme for youth, was leveraged. In the CV19-Sri Lanka case, UNICEF and UNDP partnered to implement the study.



Photo Credit: © UNICEF/Dhaka/2021

as documented in several cases, **partners could be quickly brought on board when UNICEF was already collaborating with the partners through existing platforms, had worked with organizations previously, and contractual arrangements could be covered by an existing Terms of Reference/LTAs.**



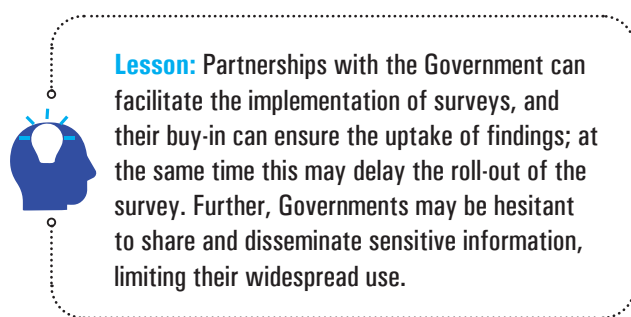
Lesson: It is necessary to map organizations on the ground in advance and establish LTAs with potential partners, so that they can be brought on board immediately in emergency contexts.

Partnerships with National or State Governments also facilitated rapid survey roll-out and uptake of evidence. The UP-India study, for example, was implemented at the request of the State Government as they needed quick evidence to improve the effective implementation of a social protection package as a response to the pandemic. With the State Government's buy-in for the study, UNICEF was immediately provided with a list of registered beneficiaries of the selected social welfare schemes for sampling, and the two assessment rounds were quickly rolled out in just over two weeks during the national lockdown. Based on the evidence and recommendations, the State Government took several immediate measures to address implementation challenges. In the RCCE-Bangladesh case, the Government of Bangladesh (Director General Health Services) was a co-partner in the RCCE pillar for a joint RCCE response plan, which resulted in the quick uptake of the evidence by the Government for planning communication activities.

However, obtaining Government buy-in for a rapid assessment can take time. Therefore, there may be

a trade-off between waiting for the Government to agree to collaborate and quick roll-out of the survey. For example, while UNICEF Sri Lanka had initially planned to partner with the Government of Sri Lanka to conduct the assessment (CV19-Sri Lanka), to rapidly generate evidence on the impact of COVID-19 on families and children UNICEF and UNDP conducted the survey independently as the Government initially did not evince an interest in collaborating. In the CL-India case, it took time and ongoing engagement by UNICEF to address the concerns of the State Governments related to the study design and get their buy-in for the survey. Notably, three of the six states initially selected for this assessment had to be replaced due to these concerns.

Furthermore, rapid assessment findings on the impact of COVID-19 on children and their families and the COVID-19 response were in some cases considered politically sensitive, which can hamper quick Government buy-in and limit dissemination of the findings to other stakeholders and contexts. In the UP-India case, for example, the primary audience of the assessment, beyond UNICEF, was the State Government, which did not want to disseminate the findings publicly; as a result, the findings could not be used more widely as indications or lessons for other states, contexts or actors. Similarly, in the CL-India case, state-specific findings were not publicly shared as they could be politically sensitive, which limited their use in other contexts in India, for example, informing policy and programme formulation around continued learning in other states.



3.4. Agility and timeliness

As the quick generation of evidence in the context of the pandemic was key, all the assessments were designed to be rolled out within a short time frame

to rapidly provide data to inform the COVID-19 response. Insights and lessons drawn from the documented cases regarding the aspects of agility and timeliness in the implementation of the rapid assessments, and challenges, are presented in this section.

Several strategies were adopted for the timely roll-out of surveys. In most cases, the use of digital technology facilitated quick data collection, analysis and reporting. In the UP-India assessment, for example, survey findings were made available to the State Government almost immediately through the use of freely available online-mobile applications (ODK, Google Forms, Infogram) for quick data collection and analysis, real-time monitoring, and to generate the reports. Similarly, the RCCE-Bangladesh rapid assessment was quickly implemented in-house within a month's time using freely accessible tools (Google Forms), although these had limitations in terms of questionnaire design customization and data processing.²⁷

Leveraging the resources and expertise of external partners and internal capability (within UNICEF) also enabled agile survey implementation.

For example in Sri Lanka (CV19-Sri Lanka), the capacity and experience of the research and survey partners in conducting national-level surveys, their network of experienced enumerators across the country and their database of households with contact details based on previous surveys, facilitated the monthly roll-out of multiple rounds of telephone surveys across the country. As mentioned above, leveraging partner capacity could be done particularly quickly when collaborations already existed. For example, in the YPS-Pakistan case, the UN partners were already collaborating through a joint UN programme; the UN partners had worked with Viamo before, and Viamo had well-established relationships with the MNOs in the country to rapidly achieve national survey coverage. However, getting external partners on board can also take time. For one, UNICEF's procurement and contracting processes in some cases delayed the process of co-opting partners for the survey. Existing LTAs can speed up this process, as demonstrated in the Pakistan cases. Furthermore,

²⁷ A more advanced online survey software, KoBo toolbox, was used in subsequent RCCE surveys, which facilitated designing more complex surveys with skips and other logic functions and real-time data validation.

meeting the interests of multiple partners can also stretch the timeline. In particular, the design of the survey instrument with inputs from multiple actors proved to be a lengthy process and required close follow-up. Finally, the CBM-India is a special case given the CBM approach adopted, which leveraged the capacity of CSOs and CVs. Agile implementation to provide evidence quickly had to be built over time as it took a few months to establish the network. However, following ongoing and intensive capacity building over several rounds, the data collection periods shortened, and the findings were presented to key audiences more quickly.



Lesson: Collaborations can support speedy implementation of rapid assessments by leveraging complementary capacities. However, the process of getting partners on board and coordinating inputs from multiple partners can also constrain agile and timely implementation. To ensure that the process is more agile, particularly for contracting external research and data collection capacity, an LTA with technical partners should be in place.

In the majority of cases it was a challenge to meet the planned short timelines of the rapid assessments. Gathering data and ensuring data quality took time, which needs to be factored into the timelines of a rapid assessment. As documented in the CL-India study, which covered a large sample of parents, students and school teachers across six states, the technical partner underestimated the time required to complete survey-related activities in the context of the lockdown and the pandemic. In the longitudinal study in Nepal (CFT-Nepal), the initial monthly periodicity for each survey round was too ambitious given the time required to gather and analyse the data (including coordinating with UNICEF programme staff for input and review, questionnaire iterations, preparation and testing the survey tool, conducting interviews, monitoring, data cleaning, analysis and reporting); as a result, the last three survey rounds were conducted every six weeks. Particularly when a large amount of data is collected, the time for analysis and reporting is often

underestimated given the capacity available, even when digital technology speeds up this process. Also, as it was a challenge to keep questionnaires short, they were often longer than intended, which added to enumeration, analysis and reporting time. For example, in the Herat-Afghanistan case, data collection and analysis took longer than estimated as the survey tool was long, which required time to administer, and to process and analyse the data.



Lesson: Timelines for the completion of activities need to be realistic and commensurate with the scope of data collection and the capacity available to design, implement, analyse and report the data. The use of digital tools can facilitate timeliness, but prioritizing the data to be collected in the short time available remains critical (see data collection section).

There were some trade-offs to making the process timelier. First, in several cases questionnaires were not robustly field pre-tested to meet the short timelines.²⁸ While other quality assurance measures were applied (see data collection section), an investment in more time for pre-testing upfront may have indicated that the survey tool could have had fewer questions, which would have made the data collection process quicker and more efficient overall. Second, the speed of survey implementation varies depending on the data collection modalities used,²⁹ although this needs to take into account the different response rates across modalities, which influences the number of calls to be made to achieve the sample size and therefore the time required to complete the survey. This is illustrated by the CBM-India case, which changed the data collection modality from IVR to a phone survey. It was initially expected that IVR calls would be quicker than making individual calls through a phone survey. However, the response rate was below expectation, requiring CVs to spend considerable time following up with respondents to increase the response rate, which defeated the advantage of sending out IVR calls in a short period of time. Third, meeting short timelines can come at the cost of developing representative sample frames and not

²⁸ This was mostly the case when online or IVR data collection modalities were used, which are often deployed because of their strength to relatively quickly reach large samples.

²⁹ Telephone surveys generally require a longer time frame because the size of the enumerator team limits the number of surveys that can be done in a given time.

reaching a larger sample, and therefore generating more representative findings. For example, the UP-India survey used a limited Government list of beneficiaries as a sample frame to quickly generate the evidence required. The construction of a larger, potentially more representative sample frame could have improved the representativeness of the findings. In the RCCE-Bangladesh case, a comprehensive database of phone numbers could not be leveraged quickly and as time did not permit setting up a remote survey using RDD, an online survey through convenience sampling was used, which limited the generalizability of the findings.



Lesson: To ensure timeliness of the data collection process and the collection of meaningful evidence, it is necessary to constantly monitor and review the roll-out and to take agile decisions to make changes in the data capturing methodology or design of the questionnaire. As far as possible some time should be allocated to pre-testing the survey, which would make the process more efficient in the long run.

3.5. Dissemination of evidence and use of findings

Findings from rapid assessments can be used as an important tool to inform decision making for COVID-19 programme response. Insights and lessons on the dissemination of evidence and use of the study findings by key stakeholders are presented in this section.

3.5.1 Dissemination of evidence

All the assessments made efforts to share the study findings with a range of stakeholders, including National/State Governments, UN agencies, development partners, other UNICEF offices and programme sections and the wider community. Formal and informal meetings were often used to disseminate findings among a range of partners and in some cases events were leveraged for dissemination (the CFT-Nepal survey results, for example, were presented at an e-conference on social protection). Evidence from the assessments has also been widely shared through a variety of materials, including advocacy briefs, fact sheets, policy briefs and reports; for example, evidence from the RCCE-Pakistan assessment has been

synthesized with other data sources to develop periodic COVID-19 RCCE briefs. Findings from the assessments have also been posted on the UNICEF website for wider public dissemination, and data from the CFT-Nepal and RCCE-Pakistan studies have been uploaded on a regional and global dashboard for easy access by UNICEF country offices and the wider public.

Survey findings have also been disseminated within UNICEF sections at the country office as well as regional level. Evidence has also been disseminated at the community level. For example, in the CFT-Nepal case the findings were shared with the community through the implementing partner's newspaper and radio networks as well as during the surveys at the time of telephone interviews with respondents.

As seen in some cases, conducting the rapid assessments in partnership, for example, with the Government or UN agencies (RCCE-Bangladesh, UP-India, YPS-Pakistan) facilitates the easy sharing of findings. For example, in the UP-India case, as a result of the close partnership with the State Government, the assessment reports and their recommendations were disseminated almost immediately to the respective state departments, which resulted in successful advocacy and the implementation of several of UNICEF's recommendations. In the RCCE-Bangladesh case, which had been developed in partnership with the RCCE partners, the dissemination of findings was enabled by the fact that the rapid assessment was conducted within the framework of the RCCE pillar.

However, in some cases public dissemination of evidence was limited due to political sensitivities. In both the CL-India survey and UP-India assessment, the dissemination of the evidence was perceived to be sensitive and was limited to the respective Government partners of states where the study was conducted, and could therefore not be used more widely as indications or lessons for other states, contexts or actors. Furthermore, it limited the visibility that could be given to the social and impacts of COVID-19 on children and their families among a wider audience.

The timing of dissemination is important, particularly in a fast-changing pandemic situation. For example,

in the Herat-Afghanistan case, the preparation of the draft report was delayed, and by the time the report was finalized, the data were not as useful as they could have been if they had been presented earlier.

In cases with high frequency data collection, dissemination may not be able to keep up with the quick generation of evidence. As the RCCE-Pakistan case indicates, although multiple survey rounds were rapidly rolled out, the dissemination of survey findings in real-time, other than through the RCCE briefs and UNICEF internal meetings, remained limited, and dissemination among non-specialist and non-technical audiences was not able to keep up with the monthly survey rounds.

While dissemination of findings was considered important across the cases, sharing of evidence was more opportunistic than planned. While some assessments had a clearly defined audience (e.g. UP-India), for others, designing and implementing a well-structured dissemination plan would have helped enhance the uptake of findings across a range of audiences. A dissemination plan can help identify audiences and users of the information and optimize the uptake of findings, and is especially critical in an emergency context so as to meet the situational needs, work within resource constraints and ensure ethics (i.e. maximizing the benefits of the evidence generation).



Lesson: The formulation of a systematic dissemination plan that aims to reach a range of audiences is necessary for the effective dissemination and use of survey findings.

37.2 Uptake and use of findings

Findings of the rapid assessments were mainly utilized to inform UNICEF/UN partners' programming, communication activities and advocacy (e.g., CBM-India, CV19-Sri Lanka, Herat-Afghanistan, RCCE-Bangladesh, RCCE-Pakistan, YPS-Pakistan) and inform Government planning and guidelines (e.g., CL-India, UP-India).

Overall, the cases provide good examples of the use of findings. For example, the insights and recommendations around COVID-19 in the RCCE-Pakistan briefs (RCCE-Pakistan) were used by the Pakistan's National COVID-19 RCCE Taskforce



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during discussions on the COVID-19 response and for external communication; and in India State Governments used findings from the CL-India survey to develop guidance for remote learning in schools and to inform their planning for school reopening and distance learning. However, it is challenging to demonstrate the specific use of assessment findings. The use of the findings was more concretely identifiable when studies were implemented with a specific identified user. The UP-India assessment for example, was implemented at the request of the State Government to identify the gaps in the coverage of social protection schemes; consequently, based on the evidence and recommendations shared by UNICEF, the State Government took several measures to address the gaps. The uptake of evidence was also more concrete when the survey had a specific area of focus. The YPS-Pakistan study, for example, which specifically focused on understanding youth perceptions related to the COVID-19 pandemic in the country, and was implemented in partnership with multiple UN agencies in Pakistan, informed the design and implementation of several UN programmes for young people in the country during and after the COVID-19 emergency response. Similarly, CL-India survey focused of providing recommendations to better support students' learning during school closure, and the State Governments used the findings to develop guidance for remote learning and their planning processes.

Rapid assessments have resulted in an increase in appetite for evidence generation in several cases (CBM-India, RCCE-Bangladesh, RCCE-Pakistan, YPS-Pakistan). In Bangladesh (RCCE-Bangladesh), the online survey incentivized other RCCE partners to implement their own assessments to generate data on several issues, and in the CBM-India case, the



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Government of India has expressed an interest in expanding the CBM mechanism as a demonstration pilot to be used in future humanitarian crises. Further, lessons learned from the YPS-Pakistan initiative informed subsequent youth-focused digital surveys, co-designed by UN agencies and the Government of Pakistan, to better understand youth perceptions on upcoming policy and programming.³⁰ The RCCE-Pakistan study, which was designed around rapid, time-sensitive and community-sourced data collection, fuelled proposals for further incorporating and institutionalizing social and behavioural evidence into programming and use it as a critical tool for accountability, as well as the experimentation with complementary data collection methods (e.g. observational surveys) to address the challenges of remote surveys.

The buy-in and close involvement of partners (e.g. Governments, UN agencies) in the assessments facilitated the uptake of evidence for policy/programme formulation. However, Governments may be reluctant to disseminate findings due to their sensitive nature, which need to be presented strategically for Government's/stakeholders' buy-in.

³⁰ <https://kamyabjawan.gov.pk/Home/YouthSurveyKJ>

For example, the involvement of the Government of Bangladesh, a co-partner on the RCCE pillar, ensured quick uptake of the evidence for programming to plan communication activities (RCCE-Bangladesh). A lesson from the Sri Lanka assessment (CV19-Sri Lanka) is that while the Government was initially not very receptive to the survey findings because of their sensitive nature, and the timing of the survey, which was just before the elections, presenting the survey findings strategically, highlighting the rigorous study design and methodology to demonstrate the robustness of the evidence, facilitated the buy-in of the Government for the study.



Lesson: Several factors such as the focus of the assessment, its timeliness, and the buy-in and involvement of partners, determine the uptake of evidence for policy/programme formulation. There is a need to identify potential partners/users and engage with the intended users from the start of the study, gather data with attention to use, present evidence at the level of different types of audiences (technical and non-technical) and to share the evidence in a timely way.

CHAPTER 4

Key lessons from the documented assessments

Countries in South Asia have made significant efforts to adopt innovative strategies for evidence generation during the COVID-19 pandemic. Drawing on the cases documented in this synthesis report, this chapter presents lessons and recommendations for planning, designing and implementing rapid assessments in a pandemic situation, and the dissemination and use of the evidence in such contexts.

Planning rapid assessments

When planning a rapid assessment, it is necessary to develop a concrete workplan with realistic timelines for the completion of activities. The time and mechanisms required for quality assurance, as well as the time for coordination with partners need to be factored into the timeline. Timelines need to be formulated in keeping with the scope of the assessments, and the available capacity to design, implement, analyse and report the data. A detailed Gantt chart with planned activities and estimates of the level of effort for the completion of the activities is a useful tool. Being clear about the objectives and scope of the study (thematic, geographical, target population) is therefore important and will help prioritize the data to be collected in the short time available. Identifying potential partners for collaboration as well as the intended users of the evidence, and engaging with them from the start of the study, are critical.

At the time of planning the assessment, ethical issues need to be considered, including potential harms of data collection as well as issues of privacy and consent.^{31, 32} The COVID-19 context presented

unique ethical challenges for data collection as reaching respondents in-person was often not possible, and even when it was physically possible, it may not be necessarily ethical given the risk of causing harm. The principle of 'do no harm' in data collection should guide planning, design and implementation of the rapid assessment. Data collection needs to be necessary and result in clear benefits. Therefore, it is important to have the initial proposal or concept note reviewed by someone with expertise in the ethical dimensions of evidence generation. When required (e.g. surveys covering children and adolescents), a review by an Ethics Review Board should be included in the workplan.³³

Potential evidence-generation partners should be mapped in advance, even before the onset of the emergency, so that they can be quickly mobilized for survey implementation. Collaborations can support speedy implementation of rapid assessments by leveraging complementary capacities. However, as the process of getting partners on board and coordinating inputs from multiple partners can constrain timely implementation, it is important to have a proper understanding of the capacity of potential partners before the start of the project. It is particularly helpful to have LTAs in place with potential partners that can support data collection and analysis, so that contracting their services can happen quickly.³⁴

Designing rapid assessments

When designing a study, the information to be collected should be strategically prioritized, keeping

³¹ United Nations Children's Fund, UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis, UNICEF, New York, 2021.

³² United Nations Children's Fund, Research on Violence against Children during the COVID-19 Pandemic: Guidance to inform ethical data collection and evidence generation, UNICEF, New York, 2020.

³³ UNICEF has a global LTA to obtain ethical review from an established Ethical Review Board.

³⁴ For example, UNICEF has a global LTA with Viamo (see here).

³⁵ An analysis plan can be drafted alongside the development of the data collection tool. It can remain short and take the form of an analysis table. At the basic level it should a) map the questions in the data collection tool onto the research questions/objectives of the rapid assessment, and b) list per question how the data will be analysed (e.g. specifying the indicators that will be calculated and any data disaggregation that will be conducted). Furthermore, the use of the analysed data can be added.

in view the data that can and will be analysed and reported. The development of an analysis plan during the design phase can guide such prioritization.³⁵ To generate relevant data, research and survey questions need to be prioritized based on the objectives of the assessment and the intended use of the data.

Pre-testing the questionnaire among survey respondents should be factored into the study design. While pre-testing of data collection tools among the survey target population requires investment of time, it can improve the overall design in terms of the length, sequencing, formulation and translation of questions, resulting in better response rates, a reduction in cost and enhance the quality of data. This would ensure that the findings are more meaningful and robust/impactful.

Each remote data collection modality has its strengths and limitations (see Table 3.1.). The selection of a remote data collection modality needs to be based on a consideration of multiple factors. These include the scope of the survey (and related length of the data collection tool), profile of the respondents, time and budget available, required response rate, type of data to be collected, technical survey capacity that can be mobilized, opportunity and the local context. For example, IVR calls and online modalities are more appropriate in surveys with limited scope, where the questionnaire can be kept short and the objective is to quickly reach a large sample at a low cost.

Critical to improving the survey response is to keep the questionnaire short. However, designing a short questionnaire may be challenging because of the range of information needs and interests of different parties involved in designing the questionnaire. While longer questionnaires can be accommodated by spreading questions across multiple rounds and different respondents, this can come at the cost of lower completion rates and a longer data collection period. Longer questionnaires can be better administered through phone surveys as compared to IVR/online surveys, but phone surveys are equally subject to survey fatigue.³⁶

Adopting a mix of data collection methods and

targeting different respondents can provide a more complete and in-depth understanding of the thematic areas of interest, help keep data collection tools short and permit data triangulation. However, generating data from multiple sources requires that the necessary capacity is available to process, analyse and report the data in a mixed/triangulated way. When including qualitative interviews as part of rapid assessments, it is important to carefully select informants who are knowledgeable and can provide insights about the situation on the ground.

Remote surveys, particularly when using IVR calls, are subject to considerable non-response; however, if the sample frames are of sufficient size to engage a large number of respondents, and the survey can be done quickly and at a low cost, the intended sample size can be achieved (for example, a vast MNO database can be leveraged for an IVR survey). Nevertheless, non-response remains an issue as it may introduce bias in the sample as respondents with certain characteristics, for example, women from rural areas, are less likely to respond.

While one-off surveys can meet the objective of generating immediate evidence, the collection of longitudinal data is particularly important in the context of a rapidly evolving pandemic situation with long-term consequences. However, in a longitudinal panel telephone survey it can be a challenge to keep respondents engaged as panel households become less responsive to the survey due to repeated rounds. This can be addressed by adopting a community-based approach and organizing data collection through local CVs. This approach has the advantage of developing an ongoing, personal engagement with respondents and at the same time, the potential of establishing a relationship of trust, which can lower attrition across rounds.

Where available, leverage rapid and efficient access to existing sampling frames with the desired population coverage; however, recognize the possible limitations in representativeness. The use of existing databases of potential respondents with contact details (e.g. previous survey databases or Government lists) allows for the quick roll-out of data collection. However, such databases may have limitations in terms of their representativeness and

³⁶ The telephone surveys in the cases were limited to 20-30 minutes, with direct questions and limited answer options.



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size, which may require an effort to expand the database, which in turn may influence selection of the sampling strategy and data collection modalities to be used.

Limitations in the representativeness of the sample frame can be mitigated by applying different sampling techniques. The geographical coverage of the sample and its distribution, according to the characteristics of the target population, can be improved by applying sampling techniques such as stratification³⁷ (e.g. by subnational units such as state, province, district, rural/urban setting and respondent characteristics) and grid-based sampling³⁸. The efficiency of applying stratification techniques depends on easy access to relevant information during the sample design. The comparability and representativeness of the data can also be improved by the application of population weights and post-stratification calibration.³⁹ However, the calibration of sample weights is not a panacea as it cannot reweight respondent groups that could not be covered in the sample.

While remote data collection has an inherent limitation in reaching the most vulnerable, particularly women, who are less likely to have mobile phone/internet access in South Asia, sampling techniques can be used to improve the representation of vulnerable groups. Techniques that can be adopted include stratification, purposeful sampling, the use of sample quotas, recruiting respondents with a vulnerability profile in the sample frame, building a data collection and sampling strategy with a focus on reaching the vulnerable populations (as in a CBM approach), ex-post weighting and using a well-represented sample frame/making sample frames more inclusive. However, the use of such techniques may require additional investment of time and resources. Moreover, the application of non-probability sampling techniques (e.g. purposeful sampling, use of sampling quotas) reduces the randomness of the sample, and can introduce bias, therefore affecting the generalizability of the findings. If necessary, the study limitations in terms of representation of vulnerable groups and the sample profile should be acknowledged.

³⁷ Details of stratified sampling are available in the Sri Lanka case study (CV19-Sri Lanka).

³⁸ Grid-based sampling is discussed in the Nepal study (CFT Nepal).

³⁹ Details of post-stratification calibration of data are available in the RCCE-Pakistan case brief.

Implementing rapid assessments

Depending on data collection modality and approach selected, ensure that appropriate resources and capacities are available to implement the survey.

Different data collection modalities and approaches require different levels and types of capacities to implement the survey. The availability of sufficient capacity to recruit, train and supervise enumerators is important for phone surveys. IVR surveys require technical capacity and technology to adequately record and transmit the survey. A community-based approach of organizing data collection through local networks can effectively gather data among vulnerable populations but requires considerable upfront investment in training and follow-up.

Select partners for implementing the survey strategically, taking into account the timeliness and purpose of the rapid assessment, as there may be trade-offs in collaborating with different partners. While collaborations allow technical expertise, networks and resources of partners to be leveraged to meet the short timelines, promote inclusiveness and contribute to the robustness of the study findings, partnerships also require effort and time for coordination and to meet the interests of multiple partners. Therefore, the time invested to create partnerships needs to be weighed against the objective of generating evidence in a timely manner as well as the purpose of the assessment. For example, bringing Government partners on board may take time, and it may be worth investing time in building the partnership if early buy-in of the Government is critical to achieve the study purpose (e.g. inform Government policy) and the data will remain relevant even if collected at a slower pace. On the other hand, if quick generation of evidence is of essence for its use, it may be better to collaborate with other partners, and build engagement with the Government over time.

Longitudinal surveys should be designed to be flexible so that they can be adapted to the changing context and priorities of a pandemic over time. Adjustments in the survey tools need to be balanced with the value of retaining certain questions across rounds to create a timeseries dataset that allows for a comparable trend analysis. While longitudinal surveys with rounds at short intervals can generate information quickly and regularly, they allow only

limited time between the rounds to analyse and interpret the data, and adapt the instrument; in such cases sufficient capacity needs to be foreseen for quick analysis and reporting and an interim review can help recalibrate the study and make it more meaningful.

Proactively use strategies and incentives to improve participation and interest in the data collection exercise. Several measures, such as providing respondents a top-up for their mobile phone to compensate for their time, adding an introductory text to highlight confidentiality, anonymity and the voluntary nature of data collection, using local language and introducing the survey as a UNICEF research initiative can be adopted to keep respondents engaged in remote surveys. The response rate in IVR surveys can be improved by informing respondents, prior to the survey via an SMS, that they will receive a call shortly to seek their participation.

To ensure timeliness of the data collection process and the collection of meaningful evidence, constantly monitor and review the survey roll-out. Debriefing sessions after each data collection round offer an opportunity to discuss findings and their ongoing relevance, review data quality and take decisions to make changes in methodology and tools.

Dissemination and use of findings

Formulate a systematic dissemination plan that aims to reach a range of audiences to facilitate effective dissemination and use of survey findings.

A dissemination plan can help identify different types of audiences and users of the information (technical and non-technical) and optimize uptake of findings. This is especially critical in an emergency context so as to meet situational needs, work within resource constraints and ensure ethics (i.e. maximizing the benefits of evidence generation). The plan should take into consideration the timing of dissemination, which is important, particularly in a fast-changing pandemic situation. As the use of findings is more concretely demonstrated when studies are implemented with a specific user in mind and the survey has a specific area of focus, identify and engage with the intended users of evidence from the start of the study.

The buy-in of partners (e.g. the Government or UN agencies) facilitates easy sharing and uptake of survey findings; however, strategic decisions around collaborations need to be made at the start of the project to consider any restrictions on dissemination that partners may require. For example, while Government partnerships and buy-in can support the uptake of evidence to inform emergency response, the Government may be reluctant to widely disseminate findings if they are perceived to be politically sensitive. Therefore, a strategic decision needs to be made as to how to maximize the impact of findings: through direct Government engagement and uptake of findings but with limited public dissemination, or by collaborating with alternate partners to ensure wider dissemination.

Report the key methodological features and their limitations as part of the dissemination. It is

important to be transparent about the sampling strategy used and the representativeness of the sample in order to avoid unfounded generalizations, misinterpretation and inappropriate use of findings. Limitations such as potential biases in findings need to be recognized. Ethics requires to disclose any limitations of evidence generation and whose voices are represented and excluded.

Multiple products can be developed and different channels used to aid the dissemination of findings.

Survey findings can be shared with a range of stakeholders during formal and informal events, through a range of materials (e.g. advocacy briefs, fact sheets and policy briefs), and more widely on websites and media (e.g. newspapers and radio) as well as with respondents in the community during the survey.⁴⁰

⁴⁰ The results of some of the surveys are available on the UNICEF website. For example, the CFT-Nepal study findings are available at <https://www.unicef.org/nepal/reports/covid-19-child-and-family-tracker-findings>; findings from Sri Lanka (CV19-Sri Lanka) are available at <https://www.unicef.org/srilanka/reports/covid-19-crisis-household-impact>; and report for YPS-Pakistan survey is available at <https://www.unicef.org/pakistan/reports/understanding-youth-perceptions-covid-19>

ANNEX 1

Overview of data collection approaches and sampling strategies adopted in the nine rapid assessment cases

Rapid assessment case	Data collection approaches	Sampling strategies adopted
Assessing the immediate impact of COVID-19 among the most vulnerable in the state of Uttar Pradesh, India (UP-India)	Single method (quantitative) cross-sectional phone survey (2 rounds), using web-based ODK/Enketo forms	<ul style="list-style-type: none"> 1,364 beneficiaries of social protection schemes (603 in round 1 and 761 in round 2) randomly selected from the Government database, with stratification by beneficiary group and socio-economic zone 517 married women in beneficiary households (235 in round 1 and 282 in round 2) purposively selected
Child and family tracker, Nepal (CFT-Nepal)	Mixed methods longitudinal assessment (6 rounds), using a phone, panel household survey; household phone survey complemented with a) IVR survey, b) short household interviews during backcheck calls, and c) panel phone survey with FCHVs	<ul style="list-style-type: none"> Household survey: 7,500 households with at least one child were randomly selected from an existing database; grid-based random sampling used to select wards, followed by random sampling of eligible households IVR survey: New sample of 1,500 respondents randomly selected in each round from the household survey Short household interviews: Approx. 90 respondents randomly selected from the household survey in each round FCHV survey: Panel of 500 respondents randomly selected from the UNICEF database
Community based monitoring to assess the socio-economic impact of the COVID-19 pandemic on vulnerable populations in India (CBM-India)	Quantitative longitudinal survey (4 rounds); data collection by CVs, supported by CSOs and UNICEF, via two modalities: self-administered panel survey by CVs via Google Forms, and a panel household survey initially conducted via IVR but changed to a phone-based survey during the first survey round	<ul style="list-style-type: none"> Multi-stage, purposeful sampling based on criteria related to COVID-19, vulnerability, rural/urban and thematic areas of interest Ca. 6,000 families selected from 300 habitations (20 families per habitation) in 12 districts across seven states. In each wave, approx. 12,000 interviews conducted
COVID-19 related RCCE behavioural change study, Pakistan (RCCE-Pakistan)	Longitudinal, cross-sectional surveys (6 rounds), using a combination of an online survey via an SMS link for urban respondents and an IVR survey for rural respondents	Stratified, random sampling (stratification by province and rural/urban) with a target sample size of 3,325 respondents drawn from a MNO's database of mobile phone users
Impact of the COVID-19 crisis on households in Sri Lanka (CV19-Sri Lanka)	Longitudinal household survey (4 rounds); in rounds 1-3 data collected via phone survey; in round 4 (post-lockdown) in-person survey conducted	<ul style="list-style-type: none"> Stratified, multi-stage random sampling (by district, Grama Niladari division and households) to achieve a sample size of ca. 2,000 drawn from an existing nationally representative survey database Rounds 1-3 partly panel; in round 4 a new sample was drawn
Insights and feedback on Corona virus Risk Communication and Community Engagement (RCCE) in Bangladesh (RCCE-Bangladesh)	Single method (quantitative), self-administered, short web-based survey using Google Forms, disseminated via social media, email and websites	Sample size of 21,892 achieved through convenience sampling and self-selection (no sample frame)

Rapid assessment case	Data collection approaches	Sampling strategies adopted
Rapid assessment of learning during school closures across six states of India in the context of COVID-19 (CL-India)	Mixed methods (quantitative and qualitative), using desk research, cross-sectional telephone survey with parents, adolescents and teachers, telephone in-depth interviews (IDIs) and U-Report survey	<ul style="list-style-type: none"> • Telephone survey: ca. 5,000 parents, adolescents and teachers sampled through stratified random sampling, selected from existing household survey database and Government-provided teacher lists • IDIs: 45 parents, adolescents and teachers, and 31 sector experts and Government representatives purposively selected to include groups of interest (special needs students and migrants) • U-Report: 617 U-Reporters (self-selected)
Rapid assessment of the socio-economic impact of COVID-19 in Herat Province, Afghanistan (Herat-Afghanistan)	Mixed methods, combining quantitative and qualitative data collection via a cross-sectional telephone survey, telephone KIIs and in-person observation	<ul style="list-style-type: none"> • Telephone survey: 1,279 male and female adult respondents in 19 districts, selected through stratified, multi-stage random/purposeful sampling. The community health facility was used as the primary sampling unit. An existing database was used as the sample frame, complemented with new randomly sampled/listed households in a select number of districts • KIIs and observation: 15 KIIs conducted with purposefully selected community leaders (10) and FCHVs (5)
Understanding youth perceptions of COVID-19 in Pakistan (YPS-Pakistan)	Cross-sectional survey, using a combination of an online survey for urban youth, and IVR survey for rural youth	Sample of 10,437 youth (4,951 through online survey; 5,486 via IVR calls) drawn from a MNO's database of mobile phone users; segmentation and respondent profiling strategy to target young people



CASE STUDIES



Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Assessing the immediate impact of COVID-19 among the most vulnerable in the state of Uttar Pradesh, India



A Case Study

Context

Following the announcement of a complete national lockdown in India on 25 March 2020, the Government of Uttar Pradesh (hereafter State Government) immediately announced and implemented several short-term COVID-specific relief measures for the most vulnerable groups in the state. These included provision of free food ration kits and INR 1,000 cash support to migrant workers, and an immediate direct benefit transfer of INR 1,000 into the bank accounts of daily wage workers and below poverty line (BPL) persons registered with the State Labour Department.¹ The State Government also took steps to implement relief measures announced under ongoing Central Government schemes, including clearing pending wages of beneficiaries of the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) by end March 2020; advance payment of two months pension (April and May 2020) in April 2020 to pensioners² under various welfare schemes; and provision of one month's free supply of food grain to families of MGNREGA

workers, *Antyodaya* beneficiaries, construction workers and small wage earners.

In order to improve the policy response to ensure the intended coverage of the COVID-specific social protection package and address implementation challenges, the State Government requested UNICEF Uttar Pradesh (hereafter UNICEF) to conduct a state-level rapid assessment. The objectives of the study were to assess the immediate impact of COVID-19 among registered beneficiaries of various social schemes in the state, and to provide insights on the knowledge and practices around COVID-19, experience of livelihood loss, coverage of the COVID-19 social protection package, and household wellbeing.

Implementation arrangements

UNICEF, in partnership with the State Government, conducted two rounds of rapid assessments at the beginning of the lockdown in quick succession: the first round took place between 11-14 April 2020

¹ Includes over 3.5 million construction workers, daily wagers and contract workers in urban areas, and carriage pullers, auto-rickshaw, rickshaw and e-rickshaw pullers, and destitutes in rural areas (Government of Uttar Pradesh).

² Includes over 8 million old age, destitute, disabled, leprosy patients and widowed pensioners (Government of Uttar Pradesh).

and the second from 23-27 April 2020. These cross-sectional assessments reached a total of 1,364 respondents aged 18 years and above: 603 in the first round and 761 in the second. Additionally, married women in beneficiary households (235 in round 1 and 282 in round 2) were interviewed to gain their perspective on gender and household relations. The cost of the two assessments was USD 2,500, excluding in-house resources. Use of Open Data Kit (ODK) not only helped in reducing the cost but enabled quick turn out of mobile enabled tools and real-time analysis.

The target population of the rapid assessments included three groups of beneficiaries registered with the State Government: i) MGNREGA beneficiaries, ii) pensioners,³ and iii) registered workers,⁴ who were supported under four COVID-19 social protection schemes: i) provision of free ration, ii) payment of MGNREGA arrears, iii) payment of two months of pension advance, and iv) payment of INR 1,000 as cash assistance to registered workers.

Data collection and analysis

Data were collected remotely through interviews conducted via mobile phones and computers,

which made it easy for interviewers to enter the data with either device available to them during lockdown. Interviews were conducted by enumerators from *Saajhi Duniya*, a reputed civil society organization, experienced in data collection among vulnerable groups. Verbal consent was taken prior to the interview.

Quantitative data were primarily collected; however, the option to enter additional qualitative information in open text boxes during the interview was also available. To ensure efficient entry, enumerators filled the information while interviewing the respondents using a web-based Open Data Kit (ODK) app/Enketo forms as a tool, which was easy to use and accessible from both mobile phones and computers. In order for results to be available immediately to both UNICEF and the State Government, the data collected in ODK were linked to automatically generate findings and reports through Google Sheets, using Infogram, UNICEF's corporate web-based tool for ICO.

The survey tools were designed through a collaborative process between UNICEF's programme teams and the State Government,



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³ Defined in footnote 2 above.

⁴ Defined in footnote 1 above.

and reviewed by UNICEF, *Saajhi Duniya* and Government officials. Web-based tools were used to monitor data quality (e.g. time stamps in ODK), and a WhatsApp group was created by UNICEF for ongoing communication with the enumerators. The codes to generate real-time reports were tested to ensure that the calculated results were correct. Personal IDs (names and mobile numbers) were removed from the data to protect the identity of respondents. Online data were stored on a password protected database and removed from the web after data collection.

Key areas of enquiry in the first round of assessment were receipt of the COVID-specific social protection package, livelihoods and awareness around COVID-19. In the second round additional questions on challenges and barriers to accessing the cash transfers, meeting daily needs and access to education during school closure were included. In both rounds, married women were asked about gender-related issues, including relations within the household, sharing of household work and child-care, and domestic violence. Given the sensitivity of inquiring about domestic violence, particularly through remote surveys, the question was asked in an indirect way inquiring from married women about changes in their husband's behaviour during lockdown.

Phone-based surveys have a limitation of time, which restricts the scope of questions that can be asked. Due to these constraints, the survey tool was designed to cover only a few key issues (12 questions were asked in round 1, and 20 in round 2). As the objective of the assessment was to provide state-level estimates for quick feedback to the programme, data on the socio-demographic profile of respondents were not gathered. Several topics of interest, including more detailed information around gender could not be included. Moreover, while questions on gender-related issues such as domestic violence were included in both assessment rounds, it was difficult to get detailed/complete responses on the phone from women. Such sensitive issues require probing and women in this context may have lacked the privacy to report on personal issues.

Sampling

A sample frame was constructed for both assessment rounds from a list of 10,000 beneficiaries (including mobile phone numbers) across the four schemes provided by each of the concerned Departments of the State Government. Respondents were randomly sampled from the list with stratification by each group of beneficiaries and by each of four socio-economic regions



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(Eastern, Western and Central Uttar Pradesh, and Bundelkhand). The sample size for the two rounds was calculated as 250 completed interviews for each group of beneficiaries (so the total required sample size was 750). This was calculated to estimate the coverage of the four social protection schemes, assuming around 30% to 50% coverage of these schemes based on anecdotal evidence and stakeholders' feedback, and 20% of relative precision in the estimate (95% level of confidence). Oversampling was done to account for the non-responses.

As information on gender representation was not available in the sampling list, gender was not taken into account in the sampling. However, across all sets of beneficiaries, an attempt was made to interview married women in the same household as the respondent. After interviewing the beneficiary, the enumerator asked the respondent if there was a married woman in the same household, and if so, if she would agree to be interviewed.

Overall, the response rate was about 32% for both rounds. Reasons for non-response included incorrect phone numbers listed in the database, mobile phones not working, phone numbers not reachable, respondents not answering the call, or not interested in participating in the survey or did not complete the survey.

This case is unique as it has drawn on contact details of beneficiaries registered in government programmes for the sampling frame. The lists were extracted by the State Government using the MIS of each scheme and beneficiaries were selected from the four socio-economic regions of the state to have a representation of households from each region. As the frames were extracted centrally, there was little likelihood of bias in inclusion of respondents. Getting the State Government partners to provide the listing/sampling frame was not difficult; there was government buy-in as the request for the assessment had come from the government. The lists were provided on the understanding that they would be used exclusively for this assessment. The lists were easy to use, and had the information needed for the selection of respondents and their contact numbers.

As different sampling frames were used in the two rounds of assessments, the data could not be pooled to generate a regional estimate for Uttar Pradesh. However, this level of analysis was not required by programme managers in the states. Moreover, since the two rounds were done in quick succession, there was not much change anticipated in service coverage. The second round mainly helped to unpack and highlight the barriers in access to services (e.g., access to the bank to withdraw cash from the account during lockdown) as well as gather information on access to daily needs and medicines, which had not been covered in the first round.

While the assessment covered beneficiaries of social protection schemes intended for the most vulnerable in the state (those earning a minimum wage, BPL families and those in the poorest income quintile), there were some limitations in the sampling methodology, which may have led to biases. Each of the State Departments shared with UNICEF a short list of contacts per programme from the huge MIS beneficiary list as the sampling frame; however, it is not clear as to how these beneficiaries were selected, other than representation by socio-economic region. Further, respondents who were not in the State Government database of registered beneficiaries, those without a mobile phone and those residing in remote areas without phone connectivity, likely to be among the most marginalized, may have been excluded from the assessment.

Moreover, the sample was not representative of the state's heterogeneity; the sample frame was selected from the state MIS, which did not include any auxiliary variables (e.g. gender, rural-urban, religion, caste) beyond contact details, beneficiary type and socio-economic zone, and was limited in size so the sample could not be stratified. Notably, as the required sample size for pensioners could not be reached as UNICEF could not get sufficient phone numbers of beneficiaries for the sample, round 1 was completed with a smaller sample frame to deliver results quickly; in round 2, additional pensioners were added to the list to achieve the required sample size. As the sample frame differed between the two assessment rounds for the pensioners group, findings on the

coverage of release of pension advance over the two rounds need to be interpreted with caution.

Partnership

A significant feature of the process of implementing this rapid assessment was its collaborative nature and the close partnership between UNICEF and the State Government. UNICEF's ongoing multisectoral engagement with the State Government and its past experience of establishing data gathering and real-time monitoring systems for several State Government flagship programmes, using mobile apps, infographics and data visualization tools, and developing analytics and dashboards, has built UNICEF's credibility in designing and implementing in-house surveys and suggesting policy recommendations based on the evidence. The request for the assessment came from the State Government, and the list of registered beneficiaries for sampling was provided immediately by the various Departments involved in the process, such as the Department of Revenue, Department of Labour and Department of Social Welfare, which ensured quick roll-out of the survey. Notably, a spin-off of using the State Government's sampling

list of beneficiaries for the assessment was their acceptance and ownership of the findings. The survey tools covered topics that were of interest to both the State Government and UNICEF. For example, while the State Government was primarily interested in the coverage of social protection schemes and awareness around COVID-19, UNICEF's focus was to also explore the gender-based impact of the pandemic and the lockdown, including issues of domestic violence and gendered household work.

UNICEF also capitalized on their ongoing relationship and past partnership with *Saajhi Duniya* to roll out data collection at short notice. Notably, *Saajhi Duniya* undertook the survey work on trust, and the formal contract was drawn up later.

A trade-off of this close partnership was that the primary audience of the assessment, beyond UNICEF, was the State Government, which did not want to disseminate the findings publicly; as a result, the findings could not be used more widely, as indications or lessons for other states or contexts or actors.



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Agility/timeliness

Another key feature of the assessment was its very rapid roll-out with the objective of providing the State Government quick evidence and feedback for immediate corrections in the implementation of the social protection package. Notably, each round of assessment was completed in just four days, from data collection and data analysis to report writing, during the peak of the lockdown.

UNICEF was able to quickly leverage available resources and mobilize capacity for data collection at a low cost, to ensure that survey findings would be available to the State Government almost immediately. Online mobile applications were used for quick collection and analysis of the survey data, and to generate the report in a pre-designed, limited-sized template with data visualization. UNICEF could develop the survey tool in-house within a few hours given the open-source nature and easy development of the forms, and their past experience of designing and using ODK for regular programme monitoring.

However, as the formats and templates in the sampling lists provided by the different departments were not standardized, and the contact details of several beneficiaries in the sample were incorrect, it took time to clean/organize the database so that it could be used for sampling and calling respondents.

An important trade-off was that a larger, potentially more representative sample frame was not constructed. Moreover, in the first round, it was not possible to get the required sample size of 250 pensioners and given the pressure to roll out the survey quickly, the survey was conducted with around 80 pensioners who could be accessed from the database. In the second round, however, the required sample size was achieved for all three groups. While both rounds of the questionnaire were reviewed by *Saajhi Duniya* and the government, another trade-off is that the tools could not be pre-tested externally with a sample of the survey target populations as time was a key factor in enabling use of the data.



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Use of findings

Working in close partnership with the State Government resulted in quick uptake of the evidence from the assessments. The assessment reports and their recommendations were presented to a high-powered committee set up to address COVID-19 related issues in the state by the Economic Advisor to the Chief Minister and officials of the respective State Departments. Confidentiality was necessary as findings on the gaps in the coverage of schemes were sensitive, and UNICEF shared the findings and recommendations of the survey with only the relevant Departments, which resulted in successful advocacy and the implementation of several of UNICEF's recommendations.

Based on the evidence the State Government took several immediate measures to address gaps in the coverage of social protection schemes. For example, the Department of Social Welfare prepared a detailed list of pension beneficiaries at the village level to track and support those who had missed the announcement of release of pension advance, to enable them to access their entitlements. The Department of Labour reconciled the bank account numbers and phone numbers of registered workers to ensure that all eligible beneficiaries received an alert from the bank for cash assistance. Based on the evidence that beneficiaries could not access their bank account during lockdown, the Department of Rural Development initiated the disbursement of entitlements/arrears to MNREGA workers in cash through the community level network of *Rozgar Sevaks*.⁵ Following UNICEF's recommendation to deploy more micro ATMs and business

correspondents in low bank density districts, the State Level Bankers' Committee submitted an action plan to the Chief Minister, which was implemented with immediate effect. Furthermore, based on UNICEF's evidence on bank density, the Department of Rural Development has selected one woman-business correspondent (BC Sakhi) per gram panchayat to support people at the village level with their banking needs.⁶

Evidence from the assessments on knowledge and practices around COVID-19 was also used by UNICEF for internal programming. Information gathered in round 2 on online education was shared with the Department of Education, which contributed to the Department initiating block level follow-up through teachers on access to online classes, and the dissemination of the *E-Pathshala* app through women's self-help groups.

The findings of round 1 led to the rollout of the second-round assessment. While round 2 assessment was not planned originally, based on qualitative feedback from round 1 survey indicating that beneficiaries had additional concerns during lockdown, such as barriers to banking access, lack of access to medicines/daily needs and issues related to continuity of education, UNICEF successfully advocated with the State Government to conduct a second round assessment among beneficiaries to include these critical issues.

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

⁵ Government incentive-based village-level coordinators for the Employment Guarantee Scheme.

⁶ As of now, the state of Uttar Pradesh has over 58,000 BC Sakhis. Government services (subsidies, entitlements, pensions etc) and direct benefit transfer (DBT) payouts will be channelled through these Sakhis.

Table: Uttar Pradesh, India, rapid assessment: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none">• Rapid roll-out of two surveys in quick sequence (over two weeks) during the lockdown• Strong partnership with the State Government ensured the uptake of findings and recommendations to address implementation challenges• Agility, rapidness, within a strong partnership with the State Government, led to quick uptake of evidence• Use of innovative web tools allowed quick data collection and analysis, and professionally designed reports	<ul style="list-style-type: none">• The sample was not representative; limited to those with a mobile phone and beneficiaries registered with the Government• Only limited questions could be included in the survey tool as phone-based surveys have a limitation of time• The questionnaires could not be field-tested with a sample of the survey target population due to time constraints
Learnings and innovations	
<ul style="list-style-type: none">• Partnership with the Government can facilitate quick roll-out of a survey and uptake of evidence; however if findings are considered sensitive, they may not be used more widely as indications or lessons for other states or contexts or actors• Freely available web resources and in-house expertise can be leveraged and capacity mobilized at a low cost to ensure real-time data collection and almost immediate evidence generation	

For more information visit:

Key contacts

Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Child and Family Tracker: A case study in Nepal



A Case Study

Context

In March 2020, the Government of Nepal announced a nationwide lockdown to curb the spread of the COVID-19 pandemic. A large proportion of households and children were likely to be adversely affected. Even prior to the pandemic, approximately 28% of Nepal's population was estimated to be facing multidimensional poverty, and children up to 10 years, who represent 21% of the population, were estimated to belong to the poorest age subgroup.¹ With the immediate loss of income as a result of slowing down of economic activity due to the lockdown, families were less likely to afford basics such as food and water, access health care and education, and children were more at risk of child marriage, violence, exploitation and abuse.

In response to the evolving context of COVID-19, UNICEF Nepal set up the Child and Family Tracker (CFT), an evidence generating exercise in the form of a longitudinal survey to rapidly and iteratively capture data for a comprehensive analysis of the

situation. The CFT aims to monitor and assess the social and economic impact of COVID-19 on children and their families, and raise visibility of and awareness on children's issues that emerge and intensify due to the pandemic. The CFT also intends to contribute to evidence-based programming in response to COVID-19.

Implementation arrangements

The CFT was implemented by UNICEF Nepal, in partnership with Sharecast Initiative, Nepal, a media and research organization. UNICEF Nepal designed the data collection tools and analysed the data, while Sharecast implemented the main survey. Viamo, a global social enterprise that specializes in mobile engagement and ICT for development, was contracted to conduct complementary data collection via Interactive Voice Response (IVR) calls. Six rounds of CFT data collection were scheduled every 4-6 weeks starting in May 2020. By end November 2020, four rounds had been completed: a baseline survey (round 1) in May 2020, and

¹ https://ophi.org.uk/wp-content/uploads/VF-Nepal_2018_vs9_21Dec-2_online.pdf

rounds 2, 3 and 4 respectively in July, August and October 2020. Rounds 5 and 6 of the survey were completed by February 2021. The target population were households with at least one child below 18 years. The cost of the study was approximately USD 190,000.

Data collection and analysis

The main, longitudinal survey covered a panel of 6,500 to 7,500 households with children, who were contacted during each data collection round; collecting both quantitative and qualitative data through multiple data collection modalities. Telephone interviews were conducted with a caregiver in the panel household (household head or parent), followed by IVR calls with a randomly selected sub-sample of caregivers.² Back check calls, implemented for quality assurance purposes with a limited random sample of respondents after each round, were leveraged to collect qualitative information. In addition, a telephone survey with female community health volunteers (FCHVs) was conducted in selected districts. Each household survey round took 8-10 days to complete, while IVR calls and FCHV survey round took six days and two days, respectively to complete.

Key areas of enquiry in the household questionnaire were the impact of COVID-19 on employment, livelihood and migration; immediate household needs; receipt of the COVID-specific security package; children's access to education; nutrition and food security; health care seeking; COVID-19 risk perception, awareness and behaviour, and mental wellbeing. Children's health, psychosocial wellbeing, nutrition and child labour were also covered. Furthermore, questions on disability were included to identify households having members with a disability and collect information on access to disability grants.³ A gender lens was included asking about domestic violence and household relations, and in households with pregnant and lactating women information was sought on ANC and delivery services, and breastfeeding. The qualitative back check survey asked respondents to further describe their situation and how COVID-19 affected them socially and economically.

The household survey included approximately 75 questions on average, although it varied across rounds, and took around 20-30 minutes to complete. In a longitudinal phone survey questions need to be pertinent and specific. The same respondents are repeatedly contacted and may tire of answering the same questions in every round. The survey questionnaire was revised in each subsequent round to suit changing priorities of the programme and the situation, as well as rationalise questions to avoid fatigue among respondents. Overall, respondents showed interest in the survey outcomes, which motivated their continued engagement. At the same time, to compensate for their time and for spending talk-time on the survey, household respondents and FCHVs were given a top-up of NPR 100 for their mobile phones, which also helped to keep respondents engaged. Furthermore, after the third round respondents were offered a cash transfer to respond to their needs, which also incentivized survey participation in subsequent rounds.⁴

The IVR module was designed as a short survey (7 questions), which could be completed in



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² IVR calls were sent to 1,500 respondents (from the sampled group of 7,500) after the phone survey.

³ Disability was assessed during the first round based on Washington Group questions.

⁴ All 7,500 households were called in the third round to consult them on the cash transfer. Following high interest, a transfer of NPR 2,000 per child was provided for maximum two children.

just three minutes. The IVR survey gathered complementary information on the availability of water for drinking, cooking and handwashing and the psychological wellbeing of children and adults. It also included questions respondents may have been uncomfortable answering in a telephone survey such as whether the fear of Corona virus had led to job loss or anxiety about going out. The IVR was added to test its value as a modality for community-level data collection (see discussion below).

FCHVs were interviewed to monitor the situation on the ground (e.g. child and maternal mortality) and to follow up on the types of services provided to households in the community during the pandemic. The FCHV survey was kept short, including 22 questions. Keeping FCHVs engaged across the survey rounds was not a challenge as they are familiar with UNICEF and other partners, and had been collaborating with them.

To ensure quality of the data, the survey tools were piloted before each round, enumerators and supervisors rigorously trained, the data monitored through back-checks⁵ and the use of the ONA App⁶ for live monitoring of incoming data flow from each enumerator. Standard ethical practices were observed during the survey. Verbal informed consent was obtained prior to each survey round; and respondents were informed that they could end the interview at any time and their information would remain confidential. Only respondents in Sharecast's database who had agreed to participate in future surveys were contacted for the telephone survey; and, only respondents' phone numbers and household ID (without any name) were shared with Viamo for the IVR survey. Furthermore, enumerators were trained to ask about sensitive issues such as domestic violence and child protection and to respond appropriately with information and links to support services such as counselling centres, child helplines and sources of information on COVID-19 to those in need. Psychosocial counsellors were available on call to provide services to respondents, if needed, during data collection.



Photo Credit: © UNICEF/ Prasad Ngakhusi/ 2021

All the data from the telephone survey were captured in real time on the ONA App on a tablet, from where it was transferred to Python and R programmes for analysis. Information from the IVRs and FCHV survey was used to triangulate the telephonic data. After each survey round, UNICEF analysed the data and prepared graphic summary presentations of the key findings.⁷ To enable analysis by gender and equity, data were disaggregated by sex, income, geographical location, employment, caste, family size, female versus male headed households, and disability status. Qualitative information was planned to be analysed at the end of round 6, and the qualitative and quantitative data will be synthesised in the end line report.

The CFT demonstrates that the entire process of data collection can be digitized combining multiple modalities (and respondents) in a way that considers the strengths and weaknesses of each. The phone survey could cover more questions as rapport is built with the respondent, while the IVR had to be kept short and complementary but allowed self-administration of more sensitive questions. Data science packages (ONA, Python) supported capturing data in real time and efficient quality assurance and analysis. The use of common, unique respondent identification codes

⁵ During each round, 10% of randomly selected household survey respondents were called back to confirm the call, duration and quality of the interview.

⁶ <https://ona.io/home/>

⁷ After the first round a comprehensive baseline report was prepared. A comprehensive end line report is planned

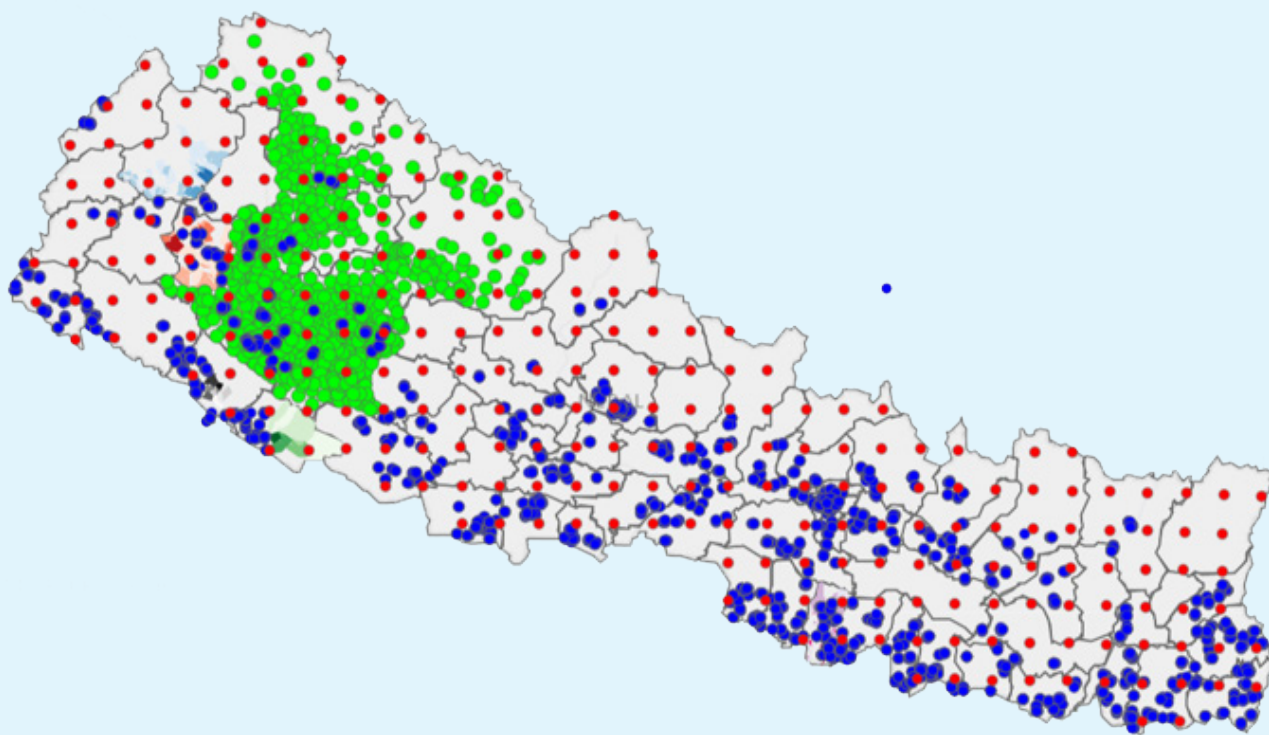
across data collection modalities enables efficient merging of the data. However, the multi-method approach covering a wide range of topics requires allocating sufficient resources in terms of questionnaire design and coordination, data collection and quality control, as well as analytical capacity.

Sampling

Grid-based random sampling was used to ensure geographic coverage across Nepal. Initially 250 wards (out of 6,744) were randomly selected within each grid on the map of Nepal through distance and density optimization algorithms.⁸ Subsequently,

households from a universe of 18,000 respondents with contact details (13,000 respondents drawn from Sharecast Initiative’s existing database⁹, and an additional 5,000 from UNICEF’s database), located in these wards or in proximate wards, were sampled (see Figure 1). Households were randomly selected but only those who were identified in the baseline round as having one child below the age of 18 were retained as eligible for the survey. In total 7,500 households were selected from 1,837 wards in 640 municipalities.¹⁰ Using random sampling, 1,500 households from the sampled 7,500 households were further selected to participate in IVRs.¹¹ A sample of around 500 FCHVs in selected districts

Figure 1: Map of Nepal with sampled wards, overlaid with existing household databases



Red dots=grids; blue dots=locations of wards based on Sharecast Initiative database; green dots=locations of ward secretaries based on UNICEF database

Source: UNICEF Nepal (2020), Guidelines for monitoring and analyzing socio-economic impact of COVID-19

⁸ Wards were selected to be uniformly distributed throughout the grid.

⁹ The database includes households who have been part of Nepal Media Landscape surveys conducted by the Sharecast Initiative over the past years, and additional contacts provided by Sharecast’s district-level media partners, community members and local groups.

¹⁰ Ca. 80% of municipalities/cities in Nepal are included in the sample.

¹¹ Sharecast provided Viamo the list of phone numbers for the IVRs.

was randomly drawn from UNICEF's database containing contact details.¹² Finally, for qualitative interviews, in each round, supervisors randomly selected and contacted up to 90 respondents during back-check calls.

A strength of the grid-based sampling design is that the sample is geographically representative of Nepal. However, as the available household databases had limitations in terms of representation of specific groups, some provinces and ethnic groups (according to the Census of Nepal) were underrepresented after round 1. Sharecast used its networks (community members, media network, and local bodies) to contact these groups remotely and recruit respondents for the survey. This model demonstrates that unlike a face-to-face survey, where it is difficult and expensive to cover every location across the country, in a telephone survey with appropriate sampling it is possible to achieve national coverage in a short time period.

Inclusiveness of the survey was further pursued by collecting data on household members with a disability; and the gender of the household head was asked to understand the gender distribution of the sample data. Almost equal gender representation was achieved (51% men and 49% women) in the sample, and 14% of households included members with difficulty in functioning. A limitation was that people who did not own a phone were not included in the sample, and hence the most vulnerable groups were not represented. Limitations in terms of reaching the more marginalized could be addressed by involving ward officials and other partners on the ground through remote means via the adoption of appropriate technology.

The main household survey was designed as a panel. The respondent was contacted in each round. This allowed for the measurement of the social and economic impact of COVID-19 among the same households over time. Some attrition



took place in the sample (from around 7,500 in round 1 to around 6,500 respondents in round 4) because of seasonal agricultural activities, operational issues (change of phone number, lack of connectivity/difficulty connecting to the number and inconvenient timing of the call), respondents lack of interest, and change in work/residence status from round 1 (during lockdown) to round 2 (post lockdown). The follow-up IVR calls did not follow a panel format but 1,500 respondents from the same sample group were drawn for each round. In the FCHV survey, the same respondents were contacted in each round.

IVRs can generate robust data and some questions, such as job loss, may be better answered in IVRs rather than in a telephone survey. However, IVRs generally have lower response rates as respondents may lack the technical aptitude to respond to the IVR. People may not be accustomed to listening and responding to automated calls, and may find it easier to engage in a telephone conversation. In the CFT, the number of completed calls rose from around 400 in the first two rounds to approximately 700 in rounds 3 and 4.¹³ The direct cash transfer, offered after round 3, helped to increase participation of the IVR, as well as the phone survey.

¹² The FCHV sample was 515 in round 1; 477 in round 2; 507 in round 3 and 506 in round 4.

¹³ The engagement rate (i.e. percentage of unique calls that made contact with the targeted respondent) increased from around 50% in the first two rounds to 95% in subsequent rounds.

Partnerships

UNICEF's collaboration with Sharecast and VIAMO supported the implementation of the CFT. Sharecast had previous experience conducting surveys in the country, including COVID-19 related phone surveys;¹⁴ and its existing database of phone contacts across Nepal, which had been factchecked and cleaned, was an important asset that could be leveraged, as well as its networks across the country to include households to make the database more representative. Furthermore, Sharecast's familiarity with the media landscape in Nepal facilitated the dissemination of the evidence through its network of media channels. Viamo's expertise in implementing IVR surveys also supported the efficient rollout of data collection via IVRs. In sum, the availability of local partners with good capacity and presence in the country helped to roll out the survey. However, as it takes time to find a suitable partner and establish a Long Term Agreement, it is important to map organizations on the ground in advance who could be potential partners, so they can be brought on board immediately in emergency contexts.

Agility/timeliness

This model of a longitudinal survey covering a large sample, with multiple rounds of data collection and analysis, demonstrates that in-depth robust data can be gathered in a short period of time. The quick turnaround of each round of survey required the use of appropriate technology (such as Python that quickly analyses a large amount of data) and a large human resource base. For example, in the household survey, 45 enumerators conducted the interviews and in parallel five supervisors and two research staff monitored the quality of the data.

Nonetheless, it was challenging to complete each survey round every month. The entire process—coordinating with UNICEF programme staff for input and review, preparation and testing the survey tool, conducting interviews and regular monitoring, data cleaning, analysis and writing

up the findings—took time. The time needed to complete all these activities was underestimated and there were unforeseen delays. For example, respondents had to be called multiple times for the survey. Furthermore, since the questionnaire covered multiple socio-economic issues and was designed to be adjusted to evolving information needs, time was needed to be invested in getting inputs from UNICEF programme staff across a range of strategic indicators that were of interest to different programmes. To rapidly implement multiple survey rounds, a full-time data consultant is required to oversee the process. For these reasons, the last three survey rounds were conducted every six weeks instead of every month.

A learning is that given the time and resources needed to analyse each round of data, synthesize and report on the findings at the end of each round, findings can be quickly disseminated by presenting key highlights of the survey data as a dashboard and updating the data in real time. At the same time, the data can be uploaded to a platform with a user-friendly interface, and downloaded for analysis by multiple stakeholders. UNICEF Nepal is developing a dashboard, and the Regional Office integrated CFT data on the regional dashboard to be used by the SAR country offices.

Use of findings

By mid-December the findings of four rounds of the survey had been disseminated to a range of stakeholders including the Government of Nepal, donors/UN agencies (UN Country Team, International Development Partners Group) and NGO partners. UNICEF has been continuously sharing the data with the Government through advocacy and programming, and the National Planning Commission, Ministry of Education and other ministries are using the data. The round 4 results were presented at the e-conference on social protection, which was attended by representatives from line Ministries, development partners, UN agencies and other international organizations.

¹⁴ Sharecast had conducted a rapid KAP survey and a follow-up survey around COVID-19 in Nepal in April-May 2020 during the lockdown via mobile phone. Sharecast also had prior experience of conducting in-person surveys across the country, including the Nepal Media Landscape survey.

The findings are also available on UNICEF’s website.¹⁵ The data have been shared internally with the UNICEF Regional Office and HQ to be used for regional comparison, and anonymized data have been uploaded on a regional dashboard for easy access by UNICEF country offices. The evidence is being used for UNICEF’s internal programming, and findings on the impact on COVID-19 have informed UNICEF’s digital cash transfer programme for surveyed households in Nepal.

Through Sharecast’s communication outreach, enumerators have been sharing survey findings, links to news stories and the UNICEF website with respondents during telephone interviews and back-check calls. Respondents have also been seeking information from enumerators about the survey findings during these calls. Nepal is currently undergoing a process of federalization, and it is

anticipated that empowered communities could use the evidence to inform behaviour change communication messaging for the prevention of COVID-19 in their areas.

Sharecast is also sharing the survey findings with their media networks, including news agencies and radio networks, for wider reach among the general public. Several newspapers such as Nepal Times and Kathmandu Post have published findings from the CFT. Sharecast and UNICEF are collaborating to publish the key strategic results of the study as advocacy briefs.

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

Table: Child and Family Tracker, Nepal: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none"> • Use of grid-based sampling ensured well-distributed national coverage. • Availability of local partners with capacity, networks and databases in Nepal facilitated implementation and reach of households and ethnic groups across the country. • The integrated, multi-method approach enabled coverage of a wide range of socio-economic data; as well as information on ethnicity, income and disability, allowing for an equity lens to be applied. • Used the survey to feed information back to respondents about COVID-19 and helplines. • Technology was leveraged for efficient real-time data collection and monitoring. 	<ul style="list-style-type: none"> • The initial, monthly periodicity was too ambitious for each survey round given time required for questionnaire iterations, data collection and analysis. • People who do not own a phone, who may be the most marginalized, are not included in the survey. • The panel sampling approach across survey rounds resulted in attrition. • The long questionnaires for remote data collection are time consuming and can cause fatigue among respondents.

¹⁵ <https://www.unicef.org/nepal/reports/covid-19-child-and-family-tracker-baseline-findings>

Learnings and innovations

- In order to rapidly leverage local partner capacity and expertise, potential partners are best mapped in advance and long-term agreements established, so that they can be immediately brought on board to work in emergencies.
- The large amount of data generated through multiple survey rounds, survey modalities and a large sample require sufficient investment in trained personnel and appropriate technology.
- Different remote data collection modalities can be effectively integrated through the use of common, unique respondent identification codes and analysis software.
- A phone survey can yield robust data that can be used for a descriptive analysis of the situation as well as advanced, multi-variate analysis to test relationships between different variables.
- Incentives can play a key role in increasing the interest of respondents to participate in surveys.
- Limitations in terms of reaching the more marginalized could be addressed by involving local officials and other partners on the ground through remote means via the adoption of appropriate technology.



This case study brief was produced by the Evaluation Section of UNICEF Regional Office for South Asia (ROSA), with support of the UNICEF Nepal Country Office.

For more information visit:

UNICEF Regional Office South Asia website <https://www.unicef.org/rosa/>

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Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Community-Based Monitoring to assess the socio-economic impact of the COVID-19 pandemic on vulnerable populations in India

A Case Study



Context

With the worsening public health due to COVID-19 pandemic and declining economic situation, towards the end of March 2020, UN agencies in India started planning to assess impact of the pandemic on socio-economic conditions of vulnerable populations. Importantly, the information was needed quickly to sharpen programming and inform Government to combat a rapidly changing situation. Moreover, it was required at several points in time as the spread of the pandemic was gradually increasing and its effects were expected to be protracted.

Towards this, UNICEF India and its state offices instituted several studies. One of the studies was a longitudinal Community-Based Monitoring (CBM) mechanism, implemented in partnership with Civil Society Organizations (CSOs) and its civil society volunteers, to gather evidence directly from families living in the habitations that were

affected by COVID-19.¹ A CBM mechanism, deploying remote data collection modalities, was thought to be the best strategy to gather primary data on the emerging situation as in-person data collection through a traditional sample survey was not possible and given that adequate administrative data was not available.

The CBM particularly aimed at capturing the reality of socio-economically marginalized and vulnerable families, including pregnant and lactating women, mothers of children of different vulnerable age-groups, and home returnees. To this end a panel of respondents from selected families at habitation level along with the community volunteers was set up from whom data was collected at multiple time points. The CBM gathered information from 12 districts² in seven UNICEF programming states (affected by the pandemic, direct or indirectly)³ over a period of 8-9 months, in four waves (rounds).

¹ In India, CBM mechanisms have been used in different sectors; for example, communities regularly monitor the progress of National Health Mission interventions in their areas, resulting in community participation, and which contributes towards strengthening health services at the local level. <https://nrhmcommunityaction.org/about/>

² Half of these districts are predominantly rural where the level of urban population is below 30 % and the rest are urban districts.

³ The seven states are Andhra Pradesh, Gujarat, Maharashtra, Rajasthan, Telangana, Tamil Nadu and Uttar Pradesh.

Implementation arrangements

UNICEF India partnered with a network of 13 CSOs (named as anchor CSO) under a single umbrella CSO (lead CSO), namely—the Centre for Social Equity and Inclusion (CSEI) and Wada Na Todo Abhiyan (WNTA). The CSO partners collected the data through a network of community volunteers (CVs) with UNICEF’s guidance and support. One ‘anchor’ CSO was appointed in each of the 12 districts, managing CVs in each of the selected habitations within the district. Overall, around 300 CVs were engaged in the CBM, with each CV managing and collecting data from one habitation (see Figure 1).

The four waves of data collection were conducted between June and December 2020: the first wave in June-July 2020, and the three subsequent waves in August-September, October-November, and December 2020. The cost of the CBM was approximately USD 170,000 (without staff time investment).

Data collection and analysis

The selection and capacity building of CSOs was of critical importance for the quality of the data collection, and therefore will be discussed in the

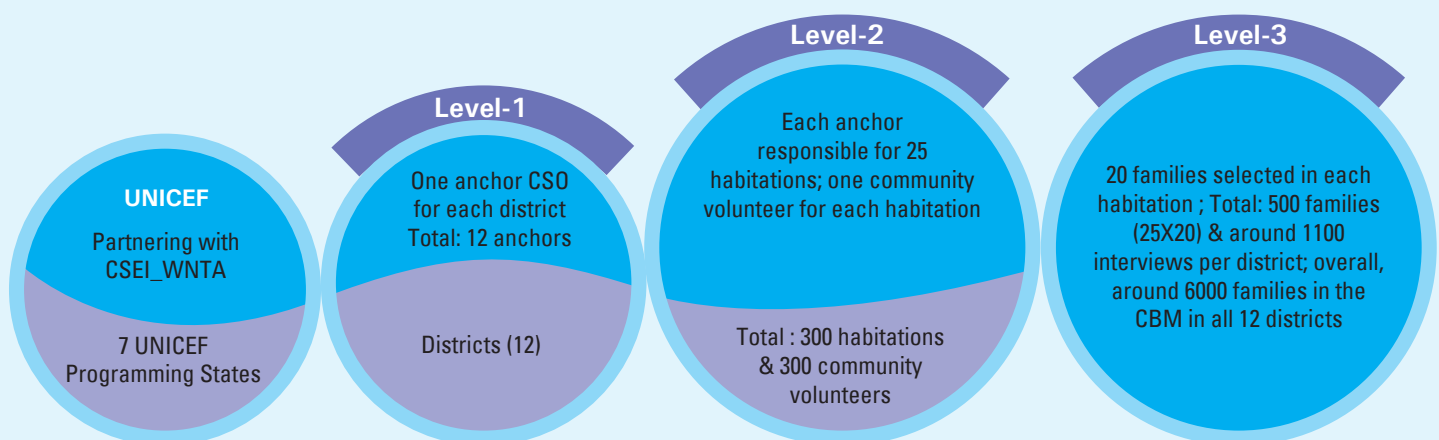
next subsection. In addition, this section reviews the engagement with multiple types of respondents, the deployment of different data collection methods and modalities, the CBM’s focus on equity and gender, and the way data processing, monitoring and analysis was organised.

Selection and capacity building of anchor CSOs and CVs

CSOs at district level were selected based on several factors, like their depth of presence in the district, strength of network in terms of CVs, their apolitical stance, engagement within communities, and, importantly, their readiness to follow agreed ethical and implementation instructions. This ensured that they were able to mobilise the local capacity necessary for periodic data collection on the ground with quality, ethics and political sensitivity in mind.

The lead CSO and anchor CSOs, in collaboration with UNICEF, were responsible for recruiting and training CVs, coordinating/monitoring their work, ensuring their participation or appropriate replacement if needed during the entire assessment period.⁴ For selection of CVs, approximately 40 CVs per district were

Figure 1: CBM implementation mechanism



⁴ Only 4-5 CVs had to be replaced due to personal reasons. 95% of the CVs were residing in the selected habitation or in its neighbourhood, so could maintain easy access to the households. UNICEF had understood this in advance; thus, residing in the selected habitation was one of the priority selection criteria of the CVs.

initially proposed by the anchor CSO. Among these 25 CVs were selected, based on, amidst other criteria, the habitation they lived in and the duration of stay in the habitation, their ownership of a smart phone, some familiarity with technology (to handle Apps on a smart phone), and their education level. Each CV was responsible for gathering data from around 20 families (see sampling discussed below).

The capacity of CVs and the constant hand-holding support to the CSO network were critical for robust data collection. This required UNICEF to invest extensively in cascade training of the CSO network, including the CVs, ahead of all data collection waves.⁵ Furthermore, several WhatsApp groups were created to support the capacity building process as well as monitoring and coordination of the work at the district and state levels.⁶ This process helped build a cadre of 300 CVs with the skills and confidence to monitor their own work in their habitations.

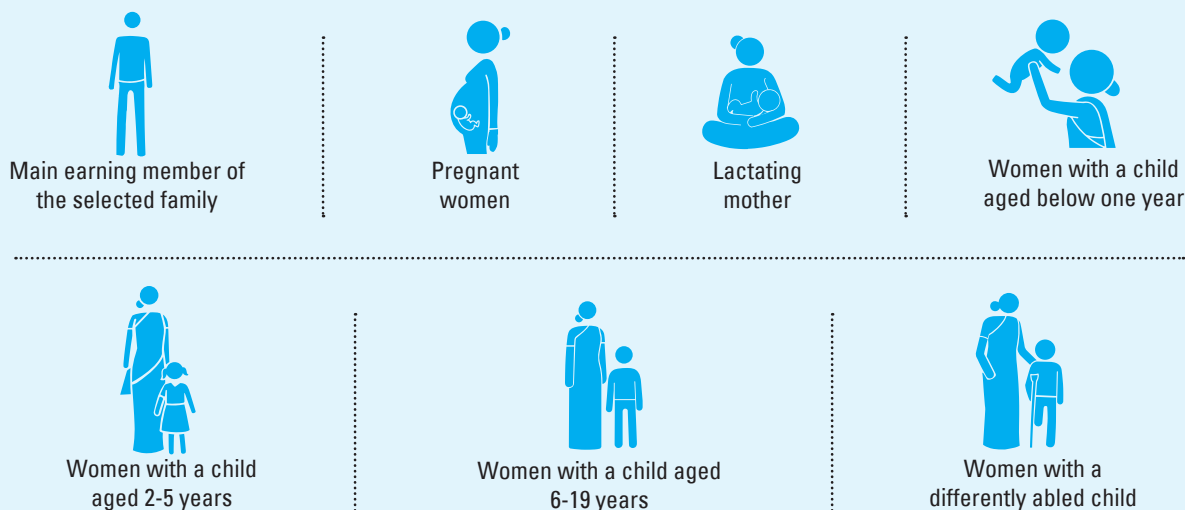
Data collection phases/methods and respondents

CBM data collection had two phases per wave in order to capture a comprehensive set of information at community- and family/individual-level, using two distinct methods. First, information at the community-level—such as availability of services (e.g. WASH facilities, schools, health institutions), awareness about social benefits and role of local government during the pandemic—was gathered from the concerned CV of the habitation through a structured, self-administered questionnaire. Subsequently, in the second phase, all CVs conducted around 50 interviews in their respective habitation among families and their members registered in the panel, targeting seven different respondent types (see Box 1) in order to cover all the necessary thematic areas of assessment and vulnerabilities. For example, respondent type (d) was for capturing immunization of children and fear of pandemic restricting access to immunization centres, while respondents of type (f) were asked questions on continuing education and availability

Box 1

Respondent types at family level

Seven different respondent types were targeted for interviews to be covered in each habitation:



⁵ A central team in Delhi, with representatives from UNICEF and the lead CSO, conducted extensive Training of Trainers for anchor CSOs, followed by anchors, along with a few central team members, training CVs in groups of 25-30 participants in their respective districts. All trainings were conducted virtually

⁶ There was one WhatsApp Group for every district with all CVs and anchors in the group plus the Delhi core team.

of digital infrastructure for studying from home. In total, approximately 12,000 interviews were conducted at the family level in each wave.⁷

Seven types of structured question sets were developed for each type of respondents with inputs from various UNICEF sections. Key areas of enquiry included, livelihood and employment, access to select social protection programmes, food security, WASH and hygiene practices, COVID-related preventive practices, awareness and stigma/fear, and awareness and perceptions about safety of COVID-19 vaccine. While questions were not pretested, data and questions were reviewed after each wave to examine whether questions were well understood. The question sets were modified before each wave to capture the evolving situation of the pandemic, although some questions were retained across all the waves to allow for trend analysis.⁸

Data collection modalities

To mitigate infection risk, data collection was done remotely using different modalities. Data collection among CVs was done via an easy to deploy Google Form, which the CVs completed on their phones. In the case of family-level data

collection, initially in wave 1, an attempt was made to collect data through interactive voice response calls (IVRs) on the Rapidpro platform.⁹ The Rapidpro system was used to push out pre-recorded automated calls to registered respondents (using phone numbers registered by the CVs). Messages were recorded in the 'broad' spoken language of the state. The IVR modality was chosen because community members can respond to IVRs on a basic phone and it does not require respondents to be literate and technically savvy in using a mobile phone. However, there were challenges with collecting data through the IVRs. For one, the IVR response rate was low (around 30%) despite CVs using their network on the ground to try and increase response. Furthermore, the IVR modality suffered from respondents not using a good mobile handset, which resulted in bad audio, and had operational issues such as poor network and unstable connections. There were issues of call drop, as calls were made from Delhi. In some cases, respondents could not understand the questions, as the language used was different from local dialects.

Given the limitations with the IVR mode, the data collection modality was changed quickly during wave 1 to a phone survey. UNICEF's Technology for Development (T4D) team developed a Survey App on the RapidPro platform, which enabled CVs—after thorough training—to call respondents on the respondent's registered mobiles and collect information on the App. The response rate increased substantially (to around 97 %) because of CVs' familiarity with the families. Furthermore, there were fewer network issues with local calls, and CVs could directly schedule the calls with respondents. Challenges of language were significantly reduced as CVs speak the same language as respondents. One limitation of the phone-based survey administered by a CV is that in-depth information about the individual family or any of its members, especially sensitive information such as on violence, sexual abuse and child marriage, is not appropriate to collect. Furthermore, similar to an IVR mode, the



Photo Credit: © UNICEF/KoYande/ 2021

⁷ For example, in wave 2 the following number of respondents were interviewed: 298 CVs, 5,700 main earning members, 850 pregnant women, 974 lactating women, 612 mothers with a child aged up to one year, 1,280 mothers with a child aged 2-5 years, and 2,384 mothers with a child aged 6-19 years.

⁸ For example, questions on home returnees reduced over the waves as a number of home returnees began to return to their place of work, whereas questions on economic conditions, access to social support schemes, access to health and nutrition services, immunization of children etc were maintained across the waves.

⁹ <https://community.rapidpro.io>

amount of information that can be collected needs to remain limited to keep the interview short.

Equity and gender

Equity, gender and ethics were driving considerations in the data collection and its analysis. Respondents were selected to represent the most vulnerable groups, which are often hard to reach through remote data collection. Mothers of differently abled children were specifically sampled—which were challenging to identify and register—in order to examine how the pandemic had affected their children’s access to education.¹⁰ Furthermore, special attention was paid to include female headed households in the sample (around 15-17 % of the total families). Themes that were especially relevant to understand the situation of women and children were included. For example, women respondents were asked about access to maternal and child health care services and schemes, communication on breastfeeding, children’s education and access to social protection. Furthermore, as the CBM included a few sensitive questions, covering issues such as violence against women and children, and there were several questions around welfare of children (to be asked from mothers), mostly female CVs were selected to collect data (more than 75% of the total CVs). Sensitive questions were asked indirectly at community level rather than focusing on the experience of the individual respondent. During analysis, equity and gender was further examined through data disaggregation by gender and the economic/employment status of the household head.

Data processing, monitoring and analysis

The CBM had a component of real time data monitoring. As data entered by the CV were uploaded on the server in real time, a dashboard facilitated the monitoring of data collection status. In addition, the dashboard provided a ‘timestamp’, enabling the central team to assess how much time, on an average, was taken by each volunteer to complete a questionnaire. This helped in giving feedback to the anchor CSO about possible slippages on data quality. Anchors and central team members also

made call-back to respondents (about a 10% of the families) to verify if they had received a call from the volunteer.

Once the individual survey was completed, all the information was transferred to the server at the back end and a spreadsheet was generated, and thus, data were immediately accessible for analysis. Analysis, in view of the in-depth respondent stratification, explored the impact of the pandemic different population groups and also allowed cross-tabulation across a range of issues. These included economic conditions, debt burden, livelihoods, access to health and social services, cash assistance, media preferences and COVID-related topics (e.g. preventive practices, perceptions, vaccination), especially by rural and urban districts.

Sampling

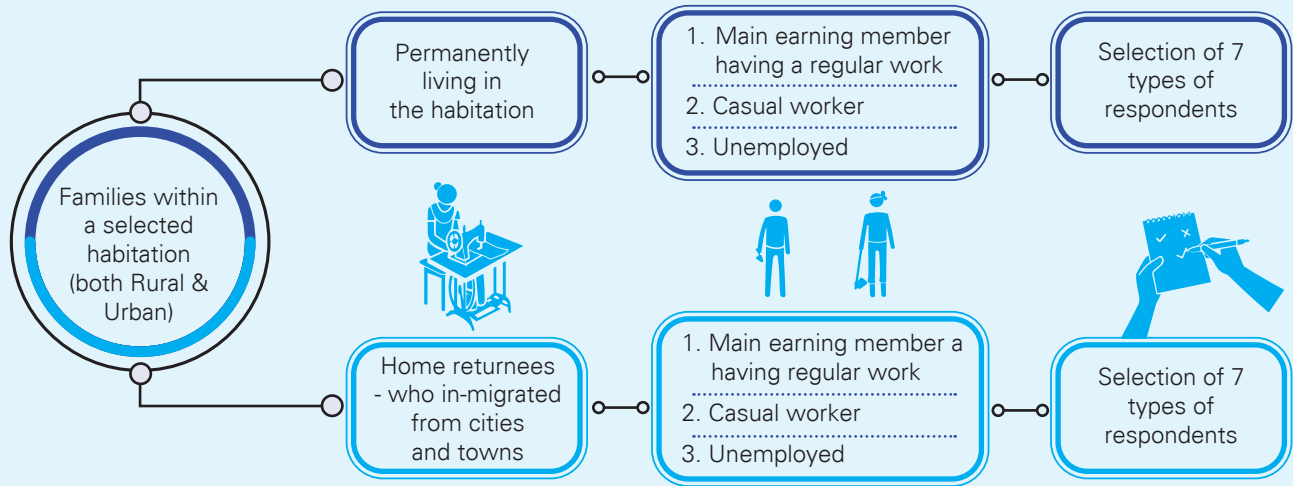
As discussed above, the CBM was designed as longitudinal data collection with a panel of CVs and registered families in specific habitations in selected districts and states. To understand the vulnerabilities in the context of COVID-19, states and districts were purposively selected to include areas with high prevalence of COVID-19 infections and a large proportion of home returnees (those who had returned to the area after the pandemic). Six predominantly rural and six predominantly urban districts were selected. In addition to the percentage of COVID-19 positive cases, the selection of rural districts considered the percentage of agricultural workers to capture home returnees affected by the lockdown due to the pandemic, and urban districts were selected based on the percentage of slum populations where infection level and exodus of families was high.

The selection of habitations (which consisted of villages, gram panchayats or a part of it) was based on a broad study framework of direct or indirect impact on the habitation due to the COVID-19 pandemic. One of the selection criteria was that the habitation should not be in close proximity to each other so geographical spread was guaranteed.¹¹ Each anchor CSO was responsible for the selection of one CV per habitation under their jurisdiction. As

¹⁰ Data collection among differently abled children was dropped after the first wave because, as schools remained closed, there was little value in monitoring their access to schools.

¹¹ An analysis of the selected habitations showed that these were distributed in 144 postal pin code areas.

Figure 2: Family and respondent stratification strategy



discussed above, CVs were selected based on a set of criteria provided by UNICEF in consultation with the lead CSO.

Finally, 20 families were selected per habitation following a stratification strategy to ensure representation of families and respondents with different vulnerabilities (see Figure 2). Given the purposeful sampling, the sample size was determined to enable minimal coverage of different types of respondents across the different family types of interest within a habitation.¹² Applying the selection criteria, CVs registered eligible families and its members (respondents) and gathered critical data from them for enrolment in the study. Overall, in the 12 districts, approximately 6,000 families were targeted. As discussed above, except for wave 1, this target sample size was largely achieved, and CVs were able to ensure respondents' continued participation with limited attrition.

Given that a non-probabilistic design was chosen due to lack of robust (inclusive) up-to-date sample frames, the results should be interpreted with adequate care and do not allow statistical

inference to the population in the districts or states. Nonetheless, it allows for an assessment of the situation and trends over time among specific marginalized groups. Furthermore, while collecting data among specific vulnerable groups was a focus of the CBM, the most vulnerable who do not own a phone may be underrepresented.

Partnerships

The partnerships between UNICEF and the CSO network was critical to set up the CBM. Through this model, both UNICEF and the CSOs built on each other's strengths and capacity. The process of collecting data through a CSO network on the ground allowed the gathering of information from vulnerable communities, which may be otherwise difficult to reach. The CSOs were able to roll out the data collection at local level as they had a long history and presence on the ground and had the knowledge, expertise and social capital for last mile connectivity. This enabled them to recruit CVs and support their training.

UNICEF built capacity of the CSOs and anchors, ensured quality of the data gathered, and brought methodological rigor to the study, to ensure robust

¹² It was estimated that 50 respondents had to be interviewed for such minimal coverage.

findings. Through this process CSOs, anchors and CVs had a sense of value that people were listening to them and community issues were being tracked and highlighted. This led to their active participation and motivation to learn new innovative technology to be used for the CBM. Furthermore, for CSOs, it created a strong cadre of local volunteers who now are trained and sensitive to quality of data and aware of the power of evidence gathering, which can be used to monitor many future interventions.

The CBM was also built on close internal collaboration among UNICEF Sections. Collaboration between UNICEF India's Social Policy Monitoring Evaluation (SPME) Section and Technology for Development (T4D) staff allowed flexibility in the data collection modality and a timely shift from IVR to a phone survey. Programmatic Sections such as Health, Communication for Development (C4D), Nutrition and Child Protection under leadership of the SPME Section all contributed to the design of the data collection tools.

Agility/timeliness

Agile implementation of the CBM to provide evidence quickly was built over time. Planning, conceptualizing and designing the study, including networking with CSOs across the country, began in April 2020 and took a few months. Initially during wave 1, there were concerns about the delay in data collection due to use of the IVR mode and the time needed for training CVs. However, following ongoing and intensive capacity building over several waves, the data collection periods shortened, and the findings of different waves have been presented to key audiences quickly. On average, each data collection wave took eight weeks to complete (2 weeks pre-fieldwork, 3 weeks for data collection among CVs and families, and 3 weeks for data cleaning, validation and analysis), with the last round implemented in four weeks.

The internal capacity of UNICEF's T4D team to quickly shift from IVR to a phone survey allowed to agilely adapt to the initial low response rates. Switching the data collection modality from IVRs to

a phone survey also means a trade-off between time and increasing the response rate because sending out IVR calls is quicker than making individual calls in a phone survey. However, since a sufficiently high response was required to cover registered panel of households, CVs had to spend a lot of time following up with respondents to answer the IVR to increase the response rate which defeated the advantage of sending out IVR calls in a short period of time.

Use of findings

The CBM findings had both internal as well as external audiences. Findings were initially shared at internal UNICEF meetings with programme sections and state offices, which allowed for evidence-informed programme adaptation. For example, the C4D section used the findings to refine their communication strategy. Findings were also shared with UNICEF globally to inform situation reporting on the pandemic. Internal uptake of findings at UNICEF India varied across units because some units were engaged in their own evidence-generating exercises. Also, due to limited geographical coverage at state level, findings remained underused by UNICEF state offices despite their relevance to learn about the evolving situation of vulnerable groups across states.

Findings have also been shared with the Government of India, including with NITI Aayog and Members of Parliament. A fact sheet with key findings was prepared and formally shared with concerned Ministries. In addition, findings were presented at more informal events, such as brownbag lunches with Government staff. Dissemination has been mostly targeted to specific external audiences rather than mass dissemination via the media in order to be able to well explain the findings and avoid out-of-context use, which may be politically sensitive. Government has expressed interest in expanding the CBM mechanism, indicating that the usefulness of the exercise does not just lie in the specific evidence generated through the four data collection waves but also as a demonstration pilot of the mechanism itself that can be used in future humanitarian crises.

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

Table: Community-based Monitoring, India: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none">• CBM has a strong equity and gender focus, giving voice to different vulnerable groups, in particular women.• Managing the survey inhouse through the RapidPro platform allowed flexibility to adapt the data collection modality and questionnaires.• Use of CVs to implement the survey resulted in high response rates and low attrition across the waves.• CBM is built on a strong partnership with CSOs, which also built their capacity to implement CBM in the future.	<ul style="list-style-type: none">• Capacity building of CSOs and CVs takes time and close follow-up.• The phone survey is not well suited to gather qualitative data via open-ended questions or detailed information on sensitive issues.• The most vulnerable who do not own a phone are likely underrepresented.• The use of purposeful sampling does not allow for statistical inference to the larger population.
Learnings and innovations	
<ul style="list-style-type: none">• Remote data collection through CVs using well-structured questionnaires works to frequently monitor and assess the situation of vulnerable groups in times of emergency and can be set up in a few months and with ample coverage; however, it requires partnership with CSOs with an established local presence as well as considerable effort to build capacity and a constant training process.• The IVR modality is not well suited for a survey that requires high response rates due to constraints in enrolling additional respondents in the sample.• The combination of surveying both CVs as well as multiple types of respondents enabled a wide range of information to be collected, although it was a challenge to keep the number of questions limited.	

For more information visit:

Key contacts

Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

COVID-19 Related RCCE Behavioural Change Study in Pakistan



Photo Credit: © UNICEF/Bukhari/ 2021

A Case Study

Context

Risk communication and community engagement (RCCE) is a critical element of disease response. In the context of the evolving COVID-19 pandemic, there was a need to rapidly gather community-level data on COVID-19 related behaviours and its drivers over time. UNICEF Pakistan experimented early in the pandemic with quantitative and qualitative remote data collection around people's knowledge, attitudes and practices related to COVID-19;¹ the information was synthesized in periodic RCCE Briefs and disseminated among Government and development partners. Nonetheless, consistently collected longitudinal data across the country about changing behaviours and perceptions, their drivers, needs and challenges were missing.

Against this background, UNICEF Pakistan implemented a longitudinal survey with national coverage that collected data directly from people at the community level. Similar surveys have been

implemented across the region and globally with support of the UNICEF Regional Office for South Asia (ROSA) and UNICEF Headquarter (HQ). The study focused on RCCE behavioural change, information and trust, coping strategies and evolving needs in the COVID-19 pandemic situation. It aimed to gather evidence over multiple rounds to enable UNICEF Pakistan and other stakeholders to develop an effective and dynamic RCCE response to the COVID-19 pandemic. An additional objective was to learn about approaches for rapid, time-sensitive and community-sourced data collection during emergencies.

Implementation arrangements

UNICEF Pakistan, with technical assistance from and in collaboration with UNICEF ROSA and HQ, implemented the study. Viamo, a global social enterprise that specializes in mobile technologies for data collection and ICT for development and has a strong presence in Pakistan, was responsible for

¹ Among others, UNICEF conducted short chatbot surveys via WhatsApp through its community-based polio staff, and in-depth qualitative interviews with health staff and other community members.

conducting the survey and descriptive data analysis. The target population were individuals with mobile phone access, aged 20 and above. The study, which was planned to cover six rounds of data collection, was designed and contracted in June-July 2020 at a cost of USD 41,225. Four rounds of data collection were conducted in 2020: round 1 in August, round 2 in September, round 3 in October and round 4 in December 2020. The remaining two rounds were conducted between January and March 2021.

Data collection and analysis

The study was designed to gather quantitative data across the four provinces and three administrative areas² of Pakistan through monthly cross-sectional surveys. As in-person data collection was not possible in the COVID-19 context, the survey was conducted remotely using mobile technologies. To adapt the data collection modalities to the diverse digital environments in Pakistan and optimize cost, two methods were used: an online survey for digitally-enabled persons in urban areas (who own smart phones and have data access), and an audio version of the same survey via interactive voice responses (IVRs) for persons in peri-urban or rural areas who own basic phones and are not internet users.³ In all, 4,137, 3,577 and 3,488 respondents respectively, completed the first three rounds; on average 73% via IVR and 27% via the online survey.

UNICEF HQ provided a survey questionnaire template with questions that addressed elements of a behavioural model, which were applied to COVID-19 related behaviours.⁴ UNICEF Pakistan adapted the questionnaire to the Pakistan context in collaboration with ROSA, although a standard set of questions was maintained to enable comparison with similar surveys implemented in other countries. The questionnaire covered three modules: 1) behaviour and practices, including risk

perception and preventive measures; 2) coping strategies and emerging needs, including financial, social and psychosocial coping mechanisms; and 3) information, communications and trust. After implementation in the first two rounds, the questionnaire was selectively adapted over the next two rounds to respond to new information priorities of the evolving COVID-19 situation.⁵

The IVR pilot indicated that the initial questionnaire, which covered the same 30 questions as the online survey, was too long and could not be administered in a single wave as it is difficult to keep IVR respondents engaged. The IVR survey was, therefore, fielded in three waves to reduce the risk of drop out. Respondent engagement in the IVR survey was further enhanced by using local languages for the audio recording and introducing the survey as UNICEF research.⁶ On average, urban respondents took 10 minutes and 40 seconds to complete the online survey, compared to IVR rural respondents who took 11-14 minutes. Despite these measures to enhance respondent engagement, the questionnaire was substantially shortened in the third round to further optimize completion rates.⁷

Ethical considerations regarding the risk of in-person data collection during the pandemic were a key factor in opting for remote data collection. Furthermore, an introduction text was inserted to highlight confidentiality, anonymity and the voluntary nature of the data collection, balancing the need for informed consent and keeping the introduction concise. Ethics was also the main consideration to target adult respondents, since data collection among adolescents, while considered valuable and initially planned, would have required ethical review by an external ethical review board, which the rapid survey roll-out schedule did not allow.

² The provinces are Baluchistan, Punjab, Sindh and Khyber Pakhtunkhwa, and the administrative areas are Islamabad Capital Territory, Azad Jammu and Kashmir and Gilgit-Baltistan.

³ The online survey was distributed through SMSs that included a link to the questionnaire, which could be completed on a smart phone or computer.

⁴ UNICEF's Behavioural Drivers Model was used as the conceptual framework. This model is used to understand and guide social behaviour change promoted by UNICEF.

⁵ Questions were added in round 2 about respondents' trust in schools implementing protective measures and their intention to send children back to school.

⁶ Introducing the survey as UNICEF research improved respondent engagement rates by almost 14% following survey piloting before the first round.

⁷ The survey had 31 questions in the first round, 33 questions in round 2 and 20 in round 3. In addition, a limited number of socio-demographic questions were included.



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Viamo analysed the data using descriptive statistics. Data were disaggregated by sex, province and age group, as well as by response mode (online survey vs IVR, urban vs rural). Because the sample data were selected cross-sectionally across rounds and were not distributed in line with the national population (see below), special attention was paid during analysis to making the data comparable across rounds and more representative of the national population. Sample data were reweighted during analysis on key characteristics (gender, age group, rural/urban, education) in accordance with their population distribution. This was made possible because a probabilistic sampling strategy had been applied.

Using mobile technologies for data collection allows the flexibility to make quick changes in the questionnaire, and to implement the survey at lower costs, with less time and human resources

as compared to other alternatives (e.g. paper-based or phone survey). This is particularly valuable in emergency contexts. However, there are certain limitations. An IVR or online survey, due to its short format, can include only a limited number of questions and qualitative information through open-ended questions cannot be easily gathered.^{8,9} This also meant that self-reported COVID-19 preventive behaviours (e.g. handwashing) could not be further probed to address socially desirable responses. Moreover, it is difficult to probe sensitive issues. Discussions are ongoing on ways to address social desirability bias in self-reported responses in remote surveys, such as IVRs, including for example, rigorously pre-testing the questionnaire in a sub-sample, having follow-up questions in multiple-wave IVRs and using indirect questioning techniques.¹⁰ Furthermore, observational surveys of behaviours are planned to triangulate the findings in combination with ongoing qualitative research.

⁸ These technologies allow including open-ended questions. However, data processing and analysis takes time. Moreover, in the case of IVR, voice recorded responses can break the flow and speed of the survey.

⁹ Furthermore, as the IVR modality does not allow multiple answer options to be selected, some questions had to be divided into separate questions, lengthening the survey. Also, IVR constrains question formulation as questions need to trigger single answer responses.

¹⁰ For example, in an IVR survey in Afghanistan, respondents were asked in an indirect way about behaviours they observed in the community, which mitigated social desirability bias in responses.

While the short intervals between survey rounds enabled quick and regular generation of information, it allowed limited time to analyse and interpret data, and adapt the instrument. Furthermore, little significant change could be observed across the monthly rounds. As a result, it was decided to take a deliberate pause in the survey after round 3 (in November 2020) to reprioritize questions to suit emerging information needs, revisit the formulation of questions and align the survey data with complementary qualitative data findings.

Sampling

To achieve a sample with national coverage, the survey used the database of a major mobile network operator (MNO), with a user-base of several hundred thousand citizens, as the sampling frame. As a mobile phone owner can own multiple SIM cards, to mitigate the risk of multi-SIM bias¹¹ one MNO was selected to run the survey and the user-base of the MNO was locked in the target locations. This base was the sample universe which was used for each round of the survey.

A stratified random sampling strategy was adopted, wherein the strata were formed based on the geographical location of the provincial/administrative area and urban/rural area. Equal sample size targets were set per province/area to enable analysis at this subnational level, with a margin of error of 1% and confidence interval of 95%.¹² This totalled an overall target sample size of 3,325. Urban stratification, which determined the use of the online data collection modality, was based on the selection of main cities across provinces, including the capital territory.

Given the provincial/area sample targets were achieved to varying degrees across rounds (often overshooting the sample target), the national sample composition by province varied across rounds. As the sample was biased towards the rural population during the first two rounds, the number of days on

which the online survey remained live was increased to improve the urban response rate. To strengthen comparability across rounds, the datasets across the three rounds were initially trimmed to a uniform sample size of 3,125, harmonizing the data composition across rounds on key variables. The comparability and representativeness of the data were further improved by the application of population weights. Furthermore, from the fourth round onwards, rural/urban location was asked in the questionnaire to triangulate residence data, which was previously drawn from SIM registration information included in the MNO database.

While the study achieved wide coverage across provinces/administrative areas in Pakistan, it was challenging to reach women in similar numbers as men. Unlike geographical location, the demographic information of users is not available in the MNO database, making it more difficult to segment and target the sample by gender. Further, ownership of mobile phones is higher among males, and men are more likely to answer the phone and complete the survey.¹³ Although a male/female target sample was estimated during the survey design phase based on population distribution, a quota was not imposed to reach an approximately equal sample of women and men, which would be more expensive and time consuming as it requires more calls to be made. The proportion of women in the sample varied between 20-30% across rounds, with a higher proportion during the third round when extra efforts were made to reach more women. However, the gender imbalance in the sample was addressed by reweighting the sample data during analysis.¹⁴

The survey completion rates increased over time as a result of improved targeting and the shortening of the questionnaire. In the case of the IVR survey, while completion rates across rounds were very low due to the use of multiple waves, they almost doubled from 0.9% to 1.6% between the first and third rounds after the number of call waves

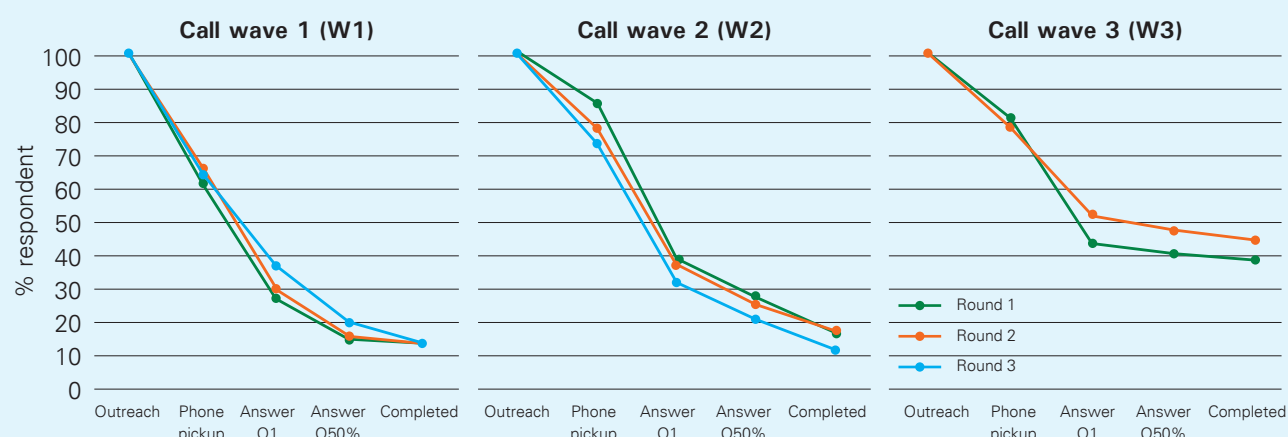
¹¹ This means that there could be dual coverage of the same sample units in the sample frame.

¹² Sample sizes were set at 665 units per province/area, except for Islamabad, Gilgit-Baltistan and Azad Jammu and Kashmir, for which the joint target sample size was set at 665 units.

¹³ Rowntree, O. and Shanahan, M. (2020) The Mobile Gender Gap Report 2020. GSMA.

¹⁴ Ex post reweighting could not perfectly rebalance the sample because some groups of females (e.g. young urban females) were not represented in the sample.

Figure 1: Engagement/drop off rates across different waves for the three IVR survey rounds



Source: Viamo, Pakistan

was reduced to two due to the shortening of the questionnaire.¹⁵ Figure 1 provides an overview of the percentage of IVR respondents who continued to be engaged during the different stages of the survey, across waves and for different rounds. Completion rates for the online survey ranged from 0.09% in the second round to 0.18% in the third round.¹⁶ The low completion rates did not pose a problem in achieving the targeted sample size in the given time period because Viamo's well-established relationship with MNOs in Pakistan allows sending out a large number of calls/SMSs at relatively low cost. However, certain groups and locations are more difficult to reach and engage, which require more calls for a given number of completed surveys.

Partnership

The study was designed and implemented through a close collaboration between different UNICEF units, both across offices (Pakistan Country Office, ROSA and HQ) as well as sections (Communication for Development section and Evaluation section). As the primary intended user of the study, UNICEF Pakistan decided on the questionnaire content, sampling strategy and implementation modalities. It could build on the methodological design work,

including questionnaire template prepared by UNICEF HQ, and draw on technical assistance from ROSA to refine, among others, the questionnaire, the sampling and the ethics. UNICEF Pakistan could further leverage the analytical capacity of the other offices. For example, the weight model for data analysis was developed by UNICEF HQ.

Furthermore, UNICEF Pakistan worked in close partnership with Viamo to rapidly roll out the survey, based on a mutual interest to learn and adapt. As UNICEF and Viamo had worked together in Pakistan before, a collaboration based on trust and open communication could be quickly established. Viamo used its experience to provide technical inputs on the use of different technology tools in rural and urban areas for different target groups, and to identify areas where mobile penetration was greater. It also leveraged its relationship with MNOs in Pakistan to implement the survey efficiently.

The partnership facilitated the rapid design and implementation of the survey rounds, which was important in the emergency context. It put in place complementary sectoral, technical and analytical capacity and human resources to ensure quality

¹⁵ In absolute numbers, during the first round 350,000 IVR calls were initiated and 3,151 respondents completed the entire survey (in three waves). During the third round 150,000 calls were initiated and 2,383 respondents completed the entire survey (in two waves).

¹⁶ In absolute numbers, during the second round one million SMSs were sent to achieve 888 completed online surveys. During the third round, only 600,000 SMSs were sent to achieve 1,105 completed surveys.

of the survey. Nonetheless, the speed at which the rounds were implemented and the ongoing COVID-19 emergency context put pressure on the ability to coordinate, rapidly adapt the survey across rounds and analyse the data. However, it also offered opportunities for capacity building. For example, Viamo took on board the weight model developed by UNICEF HQ to quickly apply it in subsequent survey rounds. In addition, the survey data were used by the different units to deepen analysis and disseminate the findings. For example, ROSA is using the data for regional analysis drawing on similar data from other countries. While multiple use of data is an important benefit of the partnership, it also required trade-offs for questionnaire design in terms of adapting it fully to the local context and learnings, versus maintaining standard questions to enable inter-country comparability.

Agility/timeliness

The study was designed and contracted, and the survey prepared for roll-out, over a period of six weeks, which is short in light of external partner contracting, sampling design and the data collection modalities used. Review of the translated IVR audio recordings took longer than planned, delaying the roll out of the IVR survey. Three survey rounds were completed quickly, and the findings disseminated every month.¹⁷ The rapid roll-out of the study was possible because Viamo could be promptly brought on board through an existing Long-Term Agreement (LTA). Furthermore, the internal UNICEF collaboration meant that questionnaire preparation could start from an existing template, and design capacity was mobilized at multiple levels.

However, due to the rapid roll-out and the quick survey frequency, there were some trade-offs. For one, the tight timelines and budget constraints allowed little time to pre-test the survey questionnaire (for both design and translation into

local languages), analyse and interpret the data, and adapt the survey instruments. As a result, questionnaire pre-testing remained limited to an internal review by UNICEF and Viamo staff, and to verification that the technology was functioning properly.¹⁸ Moreover, to avoid delays in the survey roll-out, the initially planned inclusion of adolescents aged 15 and older as respondents was dropped as this would have required external ethical review. A learning is that sufficient technical and analytical capacity needs to be in place if quick rounds of data collection are planned.

Use of findings

The survey findings from multiple rounds were shared with the Government, UN agencies and donor agencies in Pakistan. UNICEF Pakistan synthesized the findings from the three survey rounds with other data sources, both quantitative and qualitative, to develop periodic COVID-19 RCCE Briefs.¹⁹ These briefs, with insights and recommendations, were used by Pakistan's National COVID-19 RCCE Taskforce, led by the Ministry of Health Services, for internal COVID-19 response discussions and external communication. For example, the survey findings were used to persuade the Government about the complacency around COVID-19 preventive behaviours that had set in across the country.

The survey data were also shared internally with other UNICEF divisions. Furthermore, at the regional and global level, ROSA and HQ have used the survey data from Pakistan, together with data from other countries, to examine behavioural drivers in line with UNICEF's Behavioural Drivers Model. The data are planned to be uploaded on regional and global dashboards for further easy access and dissemination.

Nonetheless, despite some of the above dissemination efforts, these efforts were not driven by a well-established dissemination plan,

¹⁷ During round 2 and round 3, data collection took only one week or less. Findings were reported one week after the end of the survey.

¹⁸ The need for pre-testing was moderated by the fact that the initial questionnaire template included questions sourced from well-established surveys.

¹⁹ RCCE Briefs drew on other data sources, such as, behavioural pattern insight from anthropological and social data, social media sentiment analysis, and data from the 1166 Helpline.



Photo Credit: @UNICEF/ Ramzan Chaudhry/ 2020

aimed at reaching a range of audiences to inform the RCCE response to the COVID-19 pandemic. Dissemination was also not able to keep up with the monthly rounds, which affected its use. Therefore, the sharing of findings with non-specialist or non-technical audiences had remained limited, although further dissemination efforts are planned based on more advanced data analysis.

The study achieved its objectives to learn about rapid, time-sensitive and community-sourced data collection. The experience is fuelling proposals for

further incorporation and institutionalisation of social and behavioural evidence into programming and use it as a critical accountability tool; as well as the experimentation with complementary data collection methods (e.g. observational surveys) to address the challenges of remote surveys.

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this longitudinal rapid assessment are summarized in the table below.

Table: RCCE, Pakistan, rapid assessment: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none"> • Use of mixed remote data collection modalities allowed adaptation to diverse digital environments and optimization of cost. • The sample had national coverage and reweighting strengthened its representativeness. • Monthly survey rounds were rapidly rolled out. • Technical support to meet quick deadlines was mobilized through partnership. 	<ul style="list-style-type: none"> • Short questionnaire format limited the variables that could be investigated. • Non-phone users were not included and specific groups (e.g. females) were underrepresented in the sample. • Social desirability bias likely affected self-reported behaviour data. • Rapid roll-out constrained survey pre-testing, data analysis and dissemination. • A dissemination plan is missing, which limits use.
Learnings and innovations	
<ul style="list-style-type: none"> • Separating an IVR survey into several call waves allows for longer questionnaires, but affects survey completion rates; hence, it requires larger outreach numbers. • Low completion rates do not prohibit achieving survey sample targets and timing as long as concurrent outreach to a large number of potential respondents is possible at low cost. • Longitudinal surveys need to be flexible to review and adapt to the changing context and priorities over time; an interim review could help recalibrate the study. • High frequency and rapid rollout of data collection in an emergency situation requires planning for sufficient technical and analytical capacity; partnership can provide support for this, although it also requires foreseeing coordination time. • An integrated approach that includes observational and qualitative studies could help triangulate the findings. 	



This case study brief was produced by the Evaluation Section of UNICEF Regional Office for South Asia (ROSA), with support of the UNICEF Pakistan Country Office.

For more information visit:

UNICEF Regional Office South Asia website <https://www.unicef.org/rosa/>

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Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Impact of the COVID-19 crisis on households in Sri Lanka



A Case Study

Context

Sri Lanka imposed a national lockdown from 20 March 2020 to May 2020, to contain the spread of the COVID-19 pandemic. The Government of Sri Lanka (GoSL) continued to impose various travel and other restrictions over the year dependent on the COVID-19 risk in given areas. As in other countries, Government-imposed restrictions and the pandemic had wide-ranging socio-economic consequences on households in Sri Lanka.

To generate real-time evidence and inform rapid policy formulation and responses by the GoSL and partners, UNICEF and UNDP initiated a survey to assess the impact of the pandemic on families over time. The survey sought to assess impacts on households on several socio-economic fronts, including the impact on food and income security, and access to Government relief, health services, and education.

Implementation arrangements

The survey was implemented by UNICEF and UNDP, Sri Lanka, with the support of Verité Research, an independent think tank in Sri Lanka,

and Vanguard Survey, a market research company in Sri Lanka. UNICEF and UNDP led the conceptual framework, Verité Research designed the study methodology, conducted the technical analyses and generated survey reports, and Vanguard was responsible for sampling and data collection.

The survey was designed to have multiple rounds from May to December 2020. By the end of 2020, four survey rounds had been completed. Rounds one and two were conducted in May-June 2020 (during lockdown), round three in July 2020 when the lockdown had begun to ease, and round four was conducted from the end of October (post country-wide lockdown) for a month. The target population were households across the country. The four survey rounds were implemented at an approximate cost of USD 37,000.

Data collection and analysis

The survey was designed to collect data from a nationally representative sample of approximately 2,000 households. The idea was to do consecutive rounds with the same households, as much as possible. Due to sample attrition across rounds

ca. 50% of the sample needed to be replaced to maintain the targeted sample size (see below). In view of the need to launch the survey during the national lockdown and the COVID-19 pandemic, data in rounds one to three were collected through telephone surveys. For round four, which happened post-lockdown, the survey switched to in-person data collection with a fresh sample of households in order to increase respondents' responsiveness (see below).

The survey questionnaires were developed by UNICEF, with inputs from UNICEF's programme sections, the UNICEF Regional Office/HQ and UNDP. The questionnaires were pre-tested prior to each round and revised for each round based on the changing information needs of UNICEF programme sections and to suit the priorities of the prevailing situation. Rounds one and two gathered quantitative data. Key areas of enquiry in these two rounds were the impact the COVID-19 pandemic had on household income, food consumption, children's education, and access to health services, Government-provided social assistance and the

COVID-19 relief package. Gender- and equity-related issues were explored with regard to the impact of the pandemic on pregnant/lactating women and children below age five, as well as daily wage workers. In round two questions on access to drinking water and soap, and parental concern for children's well-being were included. In round three, a few open-ended questions were introduced to probe findings from round two, such as reasons as to why households had not received the Government social assistance transfer.¹ In round four, the questionnaire was modified to include additional issues such as whether children had rejoined school after they had reopened, and reasons thereof, and disciplining of children (violence against children) as this issue had been highlighted at the time of pre-testing of the questionnaire.

The survey was administered to the female of the household, unless only the male head of the household was available, because the female head was seen to be best placed to answer family-related questions such as children's education, food consumption, supplementary nutrition for pregnant/



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¹ The response rate to the open-ended questions was limited as only 79 respondents provided an answer to the open-ended question about perceived reasons for not receiving social assistance.

lactating women and children, and access to health care. As a result, women were well-represented in the survey; in each round, approximately 70% of the respondents were women.

Verbal consent was taken from respondents prior to the survey, and responses were voluntary. As round four was conducted in-person, enumerators followed COVID-related health and safety protocols. To further reduce risk, the in-person survey avoided any high risk COVID-19 areas. Ongoing monitoring ensured quality of the data.

To enable analysis by gender and equity, data were disaggregated by gender (households with pregnant and lactating women and/or children under five, and malnourished children) and employment status (daily/monthly/weekly wage workers).

Due to the limitations of telephone surveys, the survey had to be limited to 20 minutes and questions needed to be direct with limited answer options. As a result, it was difficult to collect qualitative data. It was also difficult to develop a rapport with respondents and assess whether participants were paying attention to the questions. Responses from round three, for example, suggest that respondents were not concentrating, were misunderstanding questions, or were selecting answers randomly from the list of options. Respondents seemed to become less responsive in survey rounds post-lockdown as they were reluctant to spend time responding to a phone survey. There was also an element of fatigue in the sample across the multiple survey rounds, which could have affected the quality of data. Due to these concerns, round four was conducted in person to elicit more in-depth information and cover additional topics of interest.

Sampling

The survey sample was designed using stratified multi-stage random sampling to achieve precision,

national representation and unbiased selection. A sample size of 2,000 households was first determined to have statistical results within +/- 2 margin of error at a 95% confidence level. To ensure national geographical representation, the sample was stratified by district, distributing the sample across districts in proportion to the national population residing in the district.² The household samples for telephone survey rounds were subsequently drawn from an existing, nationally representative household database that Vanguard Survey had developed through previous surveys.³ For round four, a new random sample of households was selected on the ground in accordance with the sampling strategy used to develop the database.

While the stratification and random selection approach adopted in this assessment ensured national representation and avoided selection bias, the sample covered only those who owned a phone, so those from the most vulnerable groups may have been underrepresented in the phone surveys.⁴ Another limitation was that it was hard to retain the same cohort/panel across the rounds. Each round had some attrition; while the sample of ca. 2,000 was retained across the first three rounds,⁵ in round three, only around 45% [N=960] of respondents overlapped with those in rounds one and two. Round three was therefore a partial panel, and additional respondents had to be drawn from the database to meet the required sample size.

Partnership

UNICEF and UNDP partnered to implement the survey. Such collaborations among UN agencies were encouraged by the UN Resident Coordinator Office in Sri Lanka when relevant for the COVID-19 response. This enabled to pool funding for the survey from both agencies. Furthermore, the survey was implemented in collaboration with Verité Research and Vanguard Survey. UNICEF had worked with at least one of these organizations previously, and they were quickly brought on board. Verité Research's

² Based on the 2012 Census of the Department of Census and Statistics, Government of Sri Lanka.

³ The database included over 10,000 households who had been previously selected through stratified, multi-stage random sampling. Besides the district stratification, Grama Niladari (GN) divisions had been randomly sampled within the districts to achieve further dispersion. Households had been randomly selected within the GN division by enumerators following an in-person random walk process. Households had been requested phone numbers and permission to call them for future surveys.

⁴ The risk of underrepresentation of vulnerable groups due to phone ownership attenuated by a high penetration of mobile connections in Sri Lanka. In January 2021 the number of mobile connections in Sri Lanka was equivalent to 141.7% of the total population. <https://datareportal.com/reports/digital-2021-sri-lanka>

⁵ The sample size was 2,067 in round 1, 2,005 in round 2 and 2,116 in round 3.

experience in designing and conducting robust telephone and in-person surveys, and Vanguard Survey's large national database of households (with phone numbers) that could be contacted for research, were leveraged for the survey.

UNICEF had initially planned to partner with the GoSL to conduct the survey. However, as the Government experienced difficulties to conduct a survey during the lockdown and due to remote working conditions, UNICEF and UNDP conducted the survey independently to rapidly assess how families and children across the country were affected by the crisis. A trade-off exists between waiting for an agreement to collaborate with Government and rapidly rolling out the survey to respond to evidence needs in emergency contexts.

Agility/timeliness

The survey was rapidly rolled out. A Terms of Reference was finalised at the end of April 2020,

while the first round of data collection took place in early May. The subsequent two rounds followed on a monthly basis.⁶ Each of these first three remote data collection rounds took between six to nine days only to complete. This could be achieved because both Verité Research and Vanguard Survey are local organizations and have the capacity and experience to conduct national-level surveys in Sri Lanka, drawing on a strong network of experienced enumerators. Furthermore, Vanguard Survey's existing nationally representative household survey database, including phone numbers, could be immediately used to identify a sample for the phone survey. Furthermore, UNICEF had worked with Verité Research before, which facilitated their engagement. The fourth round was implemented later and took longer to complete,⁷ since a new sample had to be drawn and data collection was implemented through in-person interviewing. As discussed above, the timely roll-out of the survey came with a trade-off in terms of not



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⁶ Round 1 took place between 1 May and 6 May 2020; round 2 between 30 May and 7 June 2020; and, round 3 between 13 July and 21 July 2020.

⁷ Round 4 took place between 25 October and 4 December 2020.

having Government fully onboard at the start of the exercise.

Use of findings

Findings from the survey are the only comprehensive documented survey of the socioeconomic impact of COVID-19 on households in Sri Lanka to date. The evidence informed UNICEF's response and advocacy. For example, findings from rounds two and three on the cash transfer programme in Sri Lanka informed UNICEF's advocacy for a stronger social protection response. Furthermore, results were shared with UN agencies and the International Monetary Fund, World Bank, Asian Development Bank and Department of Foreign Affairs and Trade, Australian Government, to inform their internal programming.

The findings of the first and second rounds were shared with various Government departments, but

the initial uptake was limited due to Government's sensitivity about findings during a complex national context (as they revealed the adverse impact of the pandemic on household income, food consumption and access to health care, and particularly on households with pregnant/lactating mothers and children under five years). A learning was that survey findings, particularly if they are sensitive, need to be presented to Government strategically and in a comprehensive manner even if that means taking longer to be able to present results highlighting the rigorous study design and methodology, to demonstrate the robustness of the evidence.

The GoSL became more receptive to the evidence after round three. UNICEF presented the findings of the first three rounds to the Presidential Task Force on Economic Revival and Poverty Eradication in August, which agreed on the importance of subsequent rounds and provided inputs into the questionnaire of round four.



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Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

Table: COVID-19 Sri Lanka: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none">• Generated an unparalleled longitudinal data set on the socioeconomic impact of the pandemic in Sri Lanka.• The survey rounds, particularly the first three rounds, were rapidly rolled out.• A robust sampling strategy was designed that ensured precision, national representation, and an unbiased sample.	<ul style="list-style-type: none">• The survey was subject to sample attrition between the survey rounds and a new sample had to be drawn eventually.• The sample of the first three rounds was limited to phone owners.• The Government initially showed low interest and uptake of survey findings.• Phone interviews limited the nature and number of questions that could be asked, and may have affected the quality of data collected.
Learnings and innovations	
<ul style="list-style-type: none">• Rapid roll-out of a remote survey with national representativeness was made possible by having access to an existing, nationally representative household database with phone numbers.• It is important to contextualize and methodologically frame the survey findings with the Government, particularly at politically sensitive times such as elections.	

For more information visit:

Key contacts

Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Insights and feedback on Coronavirus Risk Communication and Community Engagement in Bangladesh



A Case Study

Context

To contain the spread of the COVID-19 pandemic, the Bangladesh Government announced a nation-wide lockdown on 25 March 2020. Risk communication and community engagement (RCCE) regarding the pandemic was an essential part of the early response, led by the Director General of Health Services (DGHS), Government of Bangladesh, through an RCCE pillar including representatives from multiple sectors. UNICEF was one of the partners supporting the Government of Bangladesh to design, advise, implement and monitor a collective plan of action for COVID-19 response and recovery.

This rapid assessment was conducted during the initial phase of the lockdown and the pandemic to gain quick citizen feedback on COVID-19 risk communication activities across the country. The assessment aimed to gather data on citizen's knowledge and perceptions about the virus and protective behaviours, and media preferences; and to collect disaggregated data to identify disparities across groups (e.g. gender, age). Hence, the rapid assessment was designed with a specific thematic focus and wide geographical scope to rapidly and

early on shape the national communication plan and inform policies aimed at ensuring social inclusion in this effort.

Implementation arrangements

UNICEF Bangladesh implemented the rapid assessment, in collaboration with around 35 RCCE partner organizations and the DGHS. UNICEF staff led the design, implementation and analysis of the short online survey, which formed the core of the rapid assessment. It was designed, implemented and reported in a short period of approximately one month, with the survey being online between 25 March and 10 April 2020.

Data collection and analysis

The rapid assessment entailed an online web survey at the national level among respondents aged 10 years or older. UNICEF and RCCE partner organizations circulated a single web link for completion of the survey through multiple available platforms, including social media (Facebook, Messenger, WhatsApp), websites and email, and the link could be opened in any device with an internet connection.

The questionnaire design was kept simple, using freely accessible Google Forms. The survey was short covering only 23 mainly closed-ended questions¹ and taking 15 minutes to complete. Participation was voluntary and self-administered. Prior to starting the survey online consent was asked as well as an age question to screen out respondents below a specific age.

Data were monitored in real-time using an inbuilt dashboard, and statistical software was used for analysis, which allowed efficient recoding, data quality checks and more advanced exploratory statistical analysis. Findings were disaggregated by gender, age group, residence (rural-urban), education level and household occupation status (unemployed, monthly salary, etc.). The results of the survey were regularly downloaded and analysed, and the preliminary data shared in the weekly meeting of the RCCE group. Final findings were reported through graphs and tables in a short PowerPoint presentation for quick dissemination at the end of the survey.

While the use of simple and freely accessible Google Forms enabled rapid roll-out, it comes with limitations in terms of questionnaire design customization and data processing.² A more advanced online survey software, KoBo Toolbox,³ was used in subsequent RCCE surveys. Switching to KoBo Toolbox helped to ensure that enumeration errors were minimized as data validation could take place in real time as data were collected. KoBo also facilitates designing complex surveys with skips and other logic functions.

This online survey was the first evidence generation initiative of the RCCE pillar in Bangladesh in the context of the COVID-19 pandemic, and served the objective of quickly generating feedback from citizens. Following this survey, other RCCE partners started implementing their own assessments and sharing their findings with the group.

Sampling

The online survey was designed to reach a large number of respondents rapidly at a low cost.

Respondents were recruited through non-probability, convenience sampling and included those who had a mobile phone/computer and internet access. Respondents self-selected into the survey. While a sample of 900 was estimated, a total of 21,892 completed responses were received by the end date of the survey. The scheduled survey end date determined the ultimate sample size.

The RCCE pillar members made efforts to cover diverse groups, including women, across the country by widely sharing the survey link with their network partners, such as women's self-help groups and HIV groups. This is important from an equity perspective, although it could not prevent, given the online data collection modality, that the most vulnerable, those without a mobile phone and internet access, were not being represented.

The convenience sampling and self-selection meant that the sample distribution did not reflect the general population. The majority of respondents were male (83%), in the age group 18-35 years (68%), from urban areas/municipalities (63%) and drawing a monthly salary (50%). Furthermore, while the survey covered all eight Divisions in Bangladesh, more than 50% of responses came from two Divisions, with Dhaka having largest coverage. Therefore, generalizing the survey findings to the population is not possible. Nonetheless, in a



¹ An open-ended question on the district of the respondent was included, but it proved to be time-intensive to code and spell-check them.

² The dataset came in text format and required time to prepare for analysis.

³ <https://www.kobotoolbox.org>

situation of high uncertainty due to the pandemic, and given the non-availability of a nationally representative sampling frame with mobile numbers at the time, the findings of the assessment were useful to indicate issues and disparities across groups, and rapidly inform the initial internal programming and planning of the RCCE pillar.

Partnerships

While UNICEF led the design and implementation of the survey, the rapid assessment was a collective effort in line with the Government of Bangladesh's insistence for a joint RCCE response plan on COVID-19. The partnership between the Government of Bangladesh and the RCCE stakeholders in Bangladesh was mobilized through the RCCE pillar to implement the rapid assessment. The RCCE pillar includes representatives from the Government, private sector, research institutions, communication agencies, UN agencies, and bilateral and civil society organizations.

The DGHS was involved at every stage of the rapid assessment: DGHS officials attended weekly meetings of the RCCE pillar during which the rapid assessment was discussed and provided inputs on the survey, e.g. reviewing the questionnaire. The RCCE partners reviewed and pre-tested the draft questionnaire and assessed the initial study findings prior to wider dissemination. They were also critical in disseminating the online survey link among their partner networks to expand the reach of the survey.

Agility/timeliness

Rapid evidence generation at the start of the national lockdown with the objective of obtaining quick feedback from citizens was the priority for the rapid assessment. As a comprehensive database of phone numbers could not be leveraged as a sample frame nor did time allow setting up a remote survey using random digit dialling, it was decided that an online survey using available platforms, such as Facebook, to contact a large cohort would be the most rapid and cost-effective option. This has come with the trade-off that the sample is self-selected, the findings not generalizable and groups without internet access are not covered.

The rapid assessment in terms of design, data collection, analysis and reporting was done in



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a short time span. Online data collection took around two weeks, which was preceded by 10 days of survey design, followed by three days of data cleaning and reporting. Furthermore, use of a data dashboard and ongoing analysis allowed preliminary findings to be shared during weekly RCCE meetings.

Use of findings

The dissemination of the findings was facilitated by the fact that the rapid assessment was conducted within the framework of the RCCE pillar and its weekly meetings; and had been developed in partnership with the RCCE partners. This ensured quick uptake of the findings to shape communication activities and trigger further short surveys. Since the RCCE pillar is co-partnered by DGHS, Government was actively engaged in this process and helped shape further evidence generation. For example, DGHS requested UNICEF/ RCCE partners to conduct a follow-up survey on mask use and develop communication campaigns informed by the survey findings. Subsequent rapid surveys also indicated that service providers and affected people were being stigmatized, which resulted in a communication campaign addressing stigma around health providers.

This online RCCE survey had several spin-offs with regard to evidence generation. Notably, the survey had a demonstration effect, incentivizing other RCCE partners to implement their own assessments to generate data on several issues, which were shared at RCCE meetings. Following the rapid assessment, UNICEF established a new collaboration for evidence generation with the World Bank.

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

Table: RCCE, Bangladesh, rapid assessment: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none">• Short and simple questionnaire design and web-based data collection modality allowed reaching substantial sample size in short time span and with limited resources.• Overall agile implementation enabled to feed citizens feedback into planning and programming in timely manner.• Leveraging of RCCE pillar partnership and Government involvement aligned with Government's joint RCCE response plan, and facilitated dissemination of the online survey and its findings.	<ul style="list-style-type: none">• Convenience sampling and self-selection meant that the sample distribution does not reflect the population and findings are not generalizable.• Online survey excluded most vulnerable population without internet access.• Use of simple online tools limits questionnaire design customization, data processing and quality control.
Learnings and innovations	
<ul style="list-style-type: none">• Simple online survey tools can be leveraged to rapidly generate evidence covering a large number of respondents at low cost to the extent that the online survey can be quickly distributed through multiple channels.• Use of more advanced survey design tools, e.g. KoBo Toolbox, can improve the quality of the survey design and data generated.• In a situation of high uncertainty and non-availability of nationally representative sampling frame, non-generalizable findings can be considered sufficiently credible to guide initial planning and programming; and trigger further evidence generation.	

For more information visit:

Key contacts

Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Rapid Assessment of Learning during School Closures across Six States of India in the Context of COVID-19



Photo Credit: © UNICEF/ Panjwani/ 2020

A Case Study

Background

The COVID-19 pandemic has caused unprecedented disruptions to students' learning globally. In India, following announcement of the national lockdown in March 2020, schools across the country were closed to contain the spread of the virus.¹ By April 2020, it was estimated that over 247 million students were out of school in India.² The short- and long-term impact of prolonged school closure, including learning losses and unequal access to distance learning, could be large.

In response to the COVID-19 crisis and to promote learning during school closure, various State Governments in India initiated a variety of remote learning solutions. Given the urgency of the situation, rapid roll-out was prioritized over carefully examining what works.³ This rapid assessment aimed to present the needs and experiences of parents, students and teachers with regard to continued learning, and identify barriers to access and effectiveness

of solutions as well as promising innovations to support remote learning. The purpose was to provide recommendations for UNICEF teams, State Governments and the Government of India to better support students' learning in this context.

Implementation arrangements

The rapid assessment was conducted by the UNICEF India. Dalberg Development Advisors, a strategy and policy advisory firm, implemented the study, including qualitative data collection and data analysis. Kantar, a market research, survey and business consultancy firm, implemented the phone survey. The assessment covered six states of India, namely, Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Uttar Pradesh. States were selected to represent geographically diverse areas, with different levels of COVID-19 impact and educational capacity; and prioritized based on UNICEF's ongoing relationship with the State education departments and their buy-in in the study.

¹ Schools remained closed at the time the rapid assessment took place (August-September 2020).

² UNICEF (2020). "Urgent action needed to safeguard futures of 600 million South Asian children threatened by COVID-19".

³ Dalberg and UNICEF India (2020), Rapid Assessment of Learning During School Closure in the Context of COVID-19.

The study was conceptualized in April 2020, and further designed and contracted in June 2020. Data collection took place during August-September 2020 (over a period of six weeks) and reporting in October 2020. The target population were primary and secondary school-age children, their parents and teachers. The approximate cost of the assessment was USD 125,500.

Data collection and analysis

This rapid assessment used a mixed method approach drawing on five data sources, which were applied through remote means. Quantitative data were collected through, first, telephone surveys with 5,029 parents of children (mostly aged 5-13 years), adolescents (14-18 years) and government school teachers using Computer Assisted Telephonic Interviews (CATI); and, second, through an online survey that reached 617 eligible youth U-Reporters (aged 14-18 years).^{4,5} Qualitative information was gathered via in-depth telephone interviews with a sub-set of 45 parents, adolescents and teachers as well as 31 sector experts and ecosystem players (from civil society, educational foundations, government representatives). Finally, a desk review of existing reports and datasets informed the study design (e.g. prioritization of questions and indicators) and enabled triangulation of findings.

The main research theme was how best to support student learning during school closures/partial re-opening currently and in the long term. While the quantitative survey focused on the perceptions of parents, teachers and students towards the experience of continued learning during COVID-19, the qualitative study gathered information on key stakeholders needs and wants; the landscape of interventions; and the perceptions of government/CSO providers of their reach, relevance and effectiveness. It should be noted that the survey assessed perceptions and did not measure the effectiveness of learning through standardized tests.

As the telephone survey had to be administered in a short time frame, it did not allow for an in-depth exploration of issues. The survey tools contained approximately 60 questions with a duration of 20-25 minutes. Designing the questionnaire was challenging in terms of determining the appropriate length of the interview, number of questions to be included, framing questions for different respondents (teachers, parents and children), and the number of answer options that could be responded to easily in a telephone/online survey. Moreover, asking teachers, who are a part of the government system, questions about the challenges they were facing was sensitive. Notably, the survey was administered in the local dialect rather than in the state language for better engagement.

The parent and adolescent phone surveys inquired about children's mental wellbeing, although the issue could not be probed in detail over the phone and therefore attributed to COVID-19. The issue of mental health was not probed in the qualitative interviews either, which was a missed opportunity. More sensitive topics, such as domestic violence, were not included in the questionnaire as respondents may not have been comfortable answering these questions in a remote survey, privacy could not be ensured, and rapport building was not possible.

Because the rapid assessment included data collection among vulnerable groups, in particular children, ethics was an important consideration. UNICEF sought approval from an Internal Review Board (IRB) for the study through an existing Long Term Agreement (LTA) with the Board, which facilitated a quick review in just eight days. Field teams were trained in UNICEF's guidelines on ethical research during COVID-19. Protocols to refer children in distress were followed and those who needed support were given details of the child helpline number. An internal Technical Advisory

⁴ U-Report is a social messaging tool and data collection system developed by UNICEF, which sends SMS/online polls and alerts to its participants, collecting real-time responses, and subsequently publishes gathered data. In March 2021, there were 544,717 U-Reporters in India, of whom 66% were aged 15-24 years. <https://india.ureport.in>

⁵ A total of approximately 4,000 responses were received in the U-Report survey, of which ca. 15% were selected for analysis based on the following criteria: respondents were aged 14-18; belonged to one of the six survey states; were studying in school; and, had used some form of learning tools or materials.

Group (TAG) was also established to provide quality assurance on the methodology and findings.⁶

Furthermore, a gender lens was applied throughout the study: the list of key informants who were interviewed was gender balanced wherever possible; the survey/interview guide was gender-neutral and could be administered and responded to by both genders; and the data were disaggregated by gender. However, the quantitative data did not indicate significant differences by gender or vulnerable groups on several key indicators, and the qualitative interviews with parents and adolescents further confirmed the quantitative findings. A limitation of the study is that it could not specifically capture the challenges faced by girls perhaps because adolescent girls may not have had access to a mobile phone, or parents may have supervised them while they spoke to the enumerators. Moreover, caregivers may have given socially acceptable responses. A learning is that the qualitative study could have collected the voices of girls through group calls/focus group discussions

and a time-use study with adolescent boys and girls could have been included to gain better insights. The involvement of a gender expert on the design of the survey tool and interview guide could have strengthened the gender focus in the data collection.

Overall, the telephone surveys elicited a good response (see below) as respondents were not working during the lockdown and were willing to share their views. Fielding the survey with adolescents was not a challenge; they were able to respond to the questions and discuss their experiences in the pandemic situation. Parents were keen to participate as issues around children's education in the context of the pandemic were very relevant at the time. As the survey was based on self-reported information, there was a possibility of social desirability bias in responses. Also, some parents were concerned that the information would be shared with the school but were willing to participate when they were informed that the information would be kept confidential.



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⁶ In line with UNICEF's procedure for quality assurance in research and UNICEF's Standard Operating Procedures, an advisory committee was established given the study has a value for over USD 100,000.

The use of different data sources, both quantitative as well as qualitative, allowed for mixed data analysis and quick validation of emerging insights and recommendations. However, some opportunities were missed to take full advantage of a mixed methods approach and implement each method robustly. First, the qualitative study could have been conducted after the quantitative survey so findings from the quantitative survey could have been probed in-depth in the qualitative study. Second, several contextual issues could have been further probed during in-depth interviews with a larger sample of key informants, which would have provided deeper insights on the survey findings and a broader, more holistic perspective. Furthermore, a limitation of the assessment is that the interviewed government stakeholders provided macro-level information but were too far removed from the community to provide insights on the situation on the ground. The assessment should have drawn on a variety of government/school stakeholders at the state, district, block and community levels (e.g., school education department secretaries, SCERT officials, district and block education functionaries, community members), who would have provided a more complete picture, and these findings could have been triangulated with information from parents, teachers and adolescents.

There were also some limitations with regards to the mixing of the quantitative data collection methods. A challenge was combining the online U-Report survey and the phone survey in terms of identifying the domains to be covered in each survey (the U-Report survey can only cover a couple of questions as compared to a telephone survey) and analysing the data in combination as the two surveys used a different sampling methodology and covered a different demographic profile (U-Reporters are a digitally knowledgeable group with access to the internet). Given that the final U-Report survey sample was also small, the data were ultimately not referenced in the final report. Another limitation is that the teachers surveyed were not necessarily from the same geographical areas as parents and

adolescents who were interviewed in the phone survey; hence, the data from the two surveys could not be correlated.

Sampling

For the parents and adolescents phone survey, Kantar's existing national database, covering nearly 750,000 households/contact numbers of people from diverse backgrounds across India, was used to construct a sample frame that was four times the target number of respondents in each state. Only those respondents in Kantar's database who had indicated their willingness to participate in later surveys were considered for this assessment. Teachers were randomly selected from a list of government school teachers provided by the State education departments. Getting the teachers data from the State Governments took time as they did not want to provide access to the entire state teacher database. Most State Governments provided a shortlist of teachers from which a sample could be drawn, although in the case of Kerala and Madhya Pradesh teacher lists could ultimately not be obtained. This may have been possible if there would have been more time to gain further government buy-in.

The sample of the phone survey was designed to be evenly spread across the six study states and to provide a 95% level of confidence and 5% margin of error. Around 500 parents of children (5-18 years) and ca. 300 adolescents (14-18 years) were sampled in each of the six states. Stratified systematic random sampling was used to select respondents, using gender and rural/urban stratification to approximate an equal split for these categories. Respondents were selected across multiple districts (and towns and villages within each) in every study state to avoid clustering errors. Soft quotas were pursued to include a total of 700 migrant and vulnerable families across the states.⁷ People with disability were not explicitly targeted in the survey but were included in in-depth interviews. Parents of children with a disability were purposively selected from Kantar's existing database (i.e., four families; one each in Bihar,

⁷ Vulnerable households were sampled through a focus on Scheduled Tribe/Scheduled Caste households and Below Poverty Line households available in the Kantar database. For migrant households, eligibility questions at the start of the survey were used to screen for them.



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Kerala, Madhya Pradesh and Gujarat) based on a preliminary review. The teachers' survey was conducted in only four states (see above), with a sample size of around 200 teachers in each of the four states.

To recruit U-Reporters, UNICEF state offices shared the U-Report survey with their networks, and the survey was kept active for a certain period of time on the internet. Outreach for the survey was also done in colleges through volunteers from the National Service Scheme (NSS)/National Cadet Corps (NCC). Initially, the U-Report survey was planned for only the six study states; however, as respondents from other states were keen to participate, the survey was opened to all states. While approximately 4,000 survey responses were received, only ca. 15% were considered for analysis because the respondents were aged 14-18 years, lived in one of the six states, were studying in school and had used some form of learning tools and materials. The sample size of U-Reporters in the study states, which ranged from 32 in Gujarat to 334 in Uttar Pradesh, was not large enough to allow an analysis across the key indicators.

For the qualitative interviews, parents and adolescents were purposively selected from telephone survey respondents as well as by team coordinators from their community. Coordinators, who had moved to their home district during the lockdown, were asked to identify and recruit respondents from their area for in-depth interviews. In each study state, targets were set with different categories of respondents (e.g. families without smartphones, families in rural/urban areas, families in government/private schools). Local recruitment had a higher response than recruitment through the telephone.

The sampling strategy had a number of challenges and limitations; some of which were mitigated. First, whilst the use of an existing database for the adolescent and parent telephone survey provided a ready sampling frame, allowing for a quick selection of respondents and roll-out of data collection, there may be some bias in the sample frame as the database may have been created for a different purpose. For example, this led to an overrepresentation of families whose children go to private schools. To improve the generalizability

of the findings, population weights were applied on the sample from the parent and adolescent survey, resulting in equal representation from urban and rural areas, gender parity and greater focus on government schools.⁸ It also allowed rebalancing the state distribution in line with their population sizes.⁹ Second, the shortlists of school teachers provided by the State Governments as sample frames may not have been representative of the teacher population. Each State Government prepared the shortlist differently and it was not always clear how the list was developed.¹⁰

Furthermore, the teacher survey only covered government school teachers, and therefore does not represent all teachers. Weights were also applied on the teacher level data but just to recalibrate the sample for state level populations. Third, households without phones were not included in the phone survey, thereby possibly excluding the most vulnerable populations, especially women and girls, who have less access to phones. Nonetheless, the quota for vulnerable and migrant households ensured that the perspectives of some vulnerable groups were included. Finally, it was a challenge to reach the intended sample for the telephone survey in a time-efficient manner: a number of inter-locking quotas had been set for the survey, targeting migrants and Scheduled Tribe parents took time as they had to be called multiple times to complete the interviews, and in some cases the contact numbers and names of teachers did not match in the database.

Partnerships

While this was a UNICEF-led rapid assessment, it drew on the research expertise and data collection capacity of Dalberg and Kantar. Dalberg did not just function as data collection implementing agency but provided technical oversight and managed all aspects of the assessment, including designing and supervising the survey and analysing the data.

The TAG provided a platform to involve and leverage additional expertise. Members of the TAG included a representative from UNICEF's regional education team, a member of UNICEF India research team and an external sector expert on school education. Their expertise and feedback strengthened the study design, survey tools, and analysis of findings and recommendations. Specifically, the education expert who had worked with Government, provided the perspective that would be of interest to the government and the expert of UNICEF Regional Office brought in a regional perspective.

Some states were hesitant to partner on the survey due to concerns related to the study design (e.g. small sample size at the state level) and because the findings could be politically sensitive. Three of the six states initially selected were replaced due to State Government concerns regarding the survey. It took time and on-going engagement by UNICEF to get the State Governments' buy-in for the assessment.

Agility/timeliness

This model demonstrates that a short timeline does not inhibit robust study design and QA/ethics processes to be followed. Overall the assessment was conducted in a relatively short time period (four months from signing the UNICEF-Dalberg agreement to the presentation of the final report), balancing a short timeline with methodological rigor. The qualitative interviews with key sector experts proved to be particularly valuable to understand in a rapid way what was happening on the ground.

Nonetheless, the timeline was ambitious given that there were a number of activities to be completed. It was challenging to meet the tight timelines and to generate evidence quickly before schools opened. The time required to complete some activities was underestimated, such as data collection in the context of the pandemic, and incorporating feedback

⁸ Enrolment data from the District Information System for Education (DISE) were used to make the analysis representative of the six states, controlling for gender, social category, region (urban versus rural), grade (primary versus secondary), type of school (government versus private school), social category and state population.

⁹ As an equal sample size was drawn from each state, not controlling for different state demographics would have skewed the results towards smaller states.

¹⁰ For example, the Gujarat list was based on regional representation, Bihar shared a generic list of 700 teachers and Uttar Pradesh did a random selection of 1,000 teachers from their database.

from the TAG at different stages of the study.¹¹ Furthermore, it took time administratively to initiate the rapid assessment and get State Governments' buy-in for the survey.¹² During this preparation phase, three states were replaced in the study, and it took time to get the governments of the replacement states on board.



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Furthermore, trade-offs had to be made between timeliness and coverage and scale of the data collection. While the study moved fast and the findings were presented according to schedule, more states and teachers could have been covered in the assessment if more time had been available. Another trade-off is that there was not enough time to popularize the U-Report survey and reach a larger sample of U-Reporters. Therefore, a learning from this assessment is that timelines need to be sufficiently realistic; phone surveys take time as people may not have the time or may not be available to respond to the survey, may have other pressing concerns (e.g., getting back their jobs/livelihoods), and fatigue can set in when responding to a phone survey, especially among vulnerable populations.

Use of findings

Some State Governments agreed to participate in the survey and gave their permission for the assessment only if state-specific findings were not publicly shared. Consequently, state specific data are not being disseminated and therefore limits their use. State policy briefs were disseminated among State Government counterparts, and national report without state specific findings was shared with the Secretary, Ministry of Education, Government of India. The overall findings were furthermore presented to organizations that were consulted during data collection.

The State Governments used the findings in the development of guidance for remote learning and their planning processes. For example, the Uttar Pradesh State Government incorporated the recommendations of the rapid assessment in their guidelines for moving back to remote learning when COVID-19 infections surged again in the first half of 2021, in particular for teachers to regularly engage parents and for small-group, face-to-face classes to be organized with children outdoors. Other State Governments used the findings to inform their planning documents and strategy proposals for schools reopening or addressing the digital divide among students.

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

¹¹ The contract with Dalberg was extended by two weeks for analysis and reports to be submitted, and because data collection took longer than planned.

¹² The discussion with Dalberg started in April 2020 and the ToR was issued in the first week of June 2020.

Table: Continued learning, India, rapid assessment: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none">• Strong collaboration with an experienced technical partner enabled robust study design and implementation.• The study was implemented rapidly across six states covering perspectives of multiple stakeholders through mixed methods.• The phone survey achieved a good response.• The study paid particular attention to the inclusion of vulnerable groups in data collection (although the most vulnerable may not have been reached because of the remote data collection modalities).	<ul style="list-style-type: none">• The sample frames for the phone surveys did not represent fully the population distribution, which required ex-post recalibration of the sample.• Obtaining government buy-in required time and confined the publication of the findings.• Due to time constraints, the U-Report survey achieved only limited sample size, and therefore its data remained underused.• Remote data collection did not allow for in-depth exploration of issues and coverage of sensitive issues.• While a gender lens was applied, gender issues could have been explored more, guided by stronger involvement of a gender expert.
Learnings and innovations	
<ul style="list-style-type: none">• A short timeline does not inhibit robust study design and QA/ethics processes to be followed.• Review and feedback by the TAG enriched the study.• Phone surveys do not allow for an in-depth exploration of issues and need to be supplemented with a well-designed qualitative study.• The use of sample quotas can enforce representation of certain harder to reach groups in the survey but requires increased survey effort and time.	

For more information visit:

UNICEF Regional Office South Asia website <https://www.unicef.org/rosa/>

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Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Rapid assessment of the socio-economic impact of COVID-19 in Herat Province, Afghanistan



Photo Credit: © UNICEF/ Omid Fazel/ 2020

A Case Study

Context

Afghanistan's first case of COVID-19 was registered in Herat Province in February 2020. With increasing number of returnees from Iran, Herat became a COVID-19 hotspot and restrictions on movement were introduced to mitigate the risk of transmission. In Afghanistan, as elsewhere, the most vulnerable groups to bear the brunt of the crisis were considered to be women, adolescents and children, facing reduced access to contraceptive supplies and therefore risk of unwanted pregnancies,¹ increase in maternal and child deaths² and gender-based violence.^{3,4} Home to the highest number of the country's poor people,⁵ Herat Province was particularly vulnerable to the socio-economic impact of the pandemic.

To address the large data gap and inform the COVID-19 response of the Government of Afghanistan and multiple UN agencies, UNICEF conducted this rapid assessment. Given the vulnerable position of women and children, the rapid assessment had a particular emphasis on understanding the situation of these vulnerable groups, including people with disability. More specifically, the objective was to generate evidence on: knowledge, attitudes and practices (KAP) around COVID-19; the socio-economic impact of the pandemic on the welfare situation of vulnerable groups; the services available to women and girls; and, finally, gendered coping mechanisms and changes in intra-household relationships and decision-making power.

¹ United Nations Population Fund. New UNFPA projections predict calamitous impact on women's health as COVID-19 pandemic continues. 28 Apr 2020. <https://www.unfpa.org/press/new-unfpa-projections-predict-calamitous-impact-womens-health-covid-19-pandemic-continues>

² UNICEF. As COVID-19 devastates already fragile health systems, over 6,000 additional children under five could die a day, without urgent action. <https://www.unicef.org/press-releases/covid-19-devastates-already-fragile-health-systems-over-6000-additional-children>

³ <https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/?explore=country&country=Afghanistan#search>

⁴ Thornton Jacqui. Covid-19: Millions of women and children at risk as visits to essential services plummet BMJ 2020; 369 :m2171 <https://www.bmj.com/content/369/bmj.m2171>

⁵ https://www.mppn.org/wp-content/uploads/2019/03/AFG_2019_vs9_online.pdf

Implementation arrangements

The rapid assessment was conducted by UNICEF, Afghanistan, with the support of Assess, Transform, Reach Consulting (ATR), a national research firm with experience in data collection across the country. UNICEF designed the assessment and ATR implemented the survey. The study was conceptualized in March 2020, and further designed and contracted from April to June 2020. Data collection was conducted from 10 July to 6 August 2020, followed by analysis in September and reporting in November 2020. The target population was households with men, women, adolescents and children, community health workers (CHWs) and community leaders. The approximate cost of the assessment was USD 80,000.

Data collection and analysis

This cross-sectional assessment used a mixed methods approach, drawing on three data sources: a KAP survey administered to 1,278 male and female respondents aged 18 years and above (616 female and 662 male); key informant interviews (KIIs) with five female CHWs⁶ and ten community leaders who are members of the health *shura*⁷; and 56 observations of areas around selected community health facilities.

To mitigate risk of COVID-19 infection, and in the context of the volatile security situation and intensifying conflict in Afghanistan, data collection was conducted remotely to a large extent, demonstrating that despite challenges remote data collection is possible even in complex contexts like Herat. The KAP survey and KIIs were conducted via phone.⁸ An existing database of phone numbers was leveraged (see below), and CHWs, who knew the communities and had access to them, were recruited and trained to collect additional phone numbers from community members and community key informants. Whilst direct observation—by definition—had to take place in-person, the same

local CHWs were trained to conduct the direct observations avoiding the entry of external field teams in the community, and therefore mitigating the risk of spreading the virus.

The telephone survey, which was translated into the local language, included around 70 questions and lasted approximately an hour. It covered the main themes of the study.⁹ The KIIs covered most of the same themes but also expanded on specific topics. In particular, female CHWs were asked about the impact of the pandemic on the provision, availability and use of health services and challenges faced. The direct observations provided information on actual behaviour, as compared to reported practices, and included, among others, observations of COVID-19 preventive practices (e.g. safe distancing). The mixed methods approach enabled a more comprehensive understanding of the main assessment themes and allowed for data triangulation. For example, interviews with community leaders allowed an exploration of the needs and engagement regarding COVID-19 from a community perspective. Triangulation proved to be valuable as there was a difference in COVID-19 practices reported in the survey and those in observations and KIIs; possibly because of the social desirability bias in responses, and the way questions/concepts were translated and understood by respondents (e.g. on risk perception and domestic violence).

The rapid assessment had a strong emphasis on gender and equity. Many questions specifically focused on the impact of the pandemic and challenges for women, adolescents and children.¹⁰ In addition to emphasizing analysis by gender, the survey examined challenges and coping by members of the households living with disability. Furthermore, women featured strongly as respondents. To achieve an equal representation of women and men as part of the survey, extra

⁶ In Afghanistan, community-based health care is provided through health posts/community health facilities served by CHWs, which are linked to supporting health facilities. <https://chwcentral.org/the-community-based-healthcare-system-of-afghanistan/>

⁷ Each community with a health post has a health committee—the Shura-e-sehie. Shura members are selected by the community. Health shuras provide leadership and support to all health-related activities in their community. <https://chwcentral.org/the-community-based-healthcare-system-of-afghanistan/>

⁸ Data for the telephone survey were collected using SurveyCTO software. The SurveyCTO programme ensured smooth transfer of data with no risk of data loss or corruption and allowed access to the raw data in real-time.

⁹ Knowledge, risk perception, hygiene practices and sources of information related to COVID-19; the impact of the pandemic on income, livelihoods and food security; and, support received from the Government and coping strategies.

¹⁰ For example, the survey asked about major COVID-19 related challenges for women, men and children separately.

phone numbers of women were collected via CHWs. Initially interviews were planned only with female caregivers in the household, but later it was decided to interview an equal proportion of men and women respondents because in the cultural context of Afghanistan women have limited access to mobile phones, may lack the time and privacy to respond to remote surveys and men are often decision-makers in the household. Data on domestic violence were collected, although the study recognized its limitations as it is not always easy to share such information over the phone with someone who is not known and may put women in danger. Therefore, it recommended specific studies on gender-based violence and suggested, in order to better understand women's contexts and sensitive issues, follow-up interviews at a convenient time proposed by women. Prominent female community members could also be included as key informants. Finally, because of the strong focus on the situation of women and children, female enumerators were used as well as female CHWs.

Because of the sensitive nature of some of the topics included in the rapid assessment, external ethical review was obtained. The UNICEF global Long-Term Agreement (LTA) for ethical reviews was used rather than a local Internal Review Board because of the long process the latter requires. Only respondents in the existing database who had consented to participate in future surveys were contacted for the telephone survey. Data collection was undertaken with the highest consideration of confidentiality. CHWs were trained to collect the data following guidelines for physical distancing and data collection in the context of COVID-19.

Data quality assurance was incorporated in the rapid assessment in several ways. Among others, the supervisor regularly verified the survey data being collected, 10-15% of the survey interviews were monitored through call-backs, and the data were monitored in real-time through the use of Survey CTO software. However, because of the time-sensitivity of the rapid assessment, the telephone survey questionnaire could not be rigorously pre-tested. This might have indicated that the

survey length could be a challenge and allowed for improved translation of questions.

Sampling

The sample size target for the quantitative survey was 1,200 respondents from 19 districts in Herat Province, covering six urban, three peri-urban and ten rural districts. A few smaller districts with less than 50,000 population were excluded from the sampling plan.¹¹ The sample size was divided in equal urban, peri-urban and rural strata (400 respondents each) to allow for disaggregated analysis at the strata level with a margin of error of less than ± 5 and 95% confidence level. Subsequently, the strata sample size was allocated to the districts more or less in proportion to their population size.



The community health facility served as the primary sampling unit (PSU), while communities within their catchment area constituted a secondary sampling unit (SSU). Out of the 118 health facilities identified in Herat Province for this rapid assessment, 29 facilities were sampled. Subsequently, two to four communities per health facility and 20 households per community were selected. The health facility was used as a PSU because the available sample frame was organized with the health facility as the sampling unit (see below). Health facilities and communities were selected through a combination of purposive and convenient sampling, while

¹¹ Three districts were excluded. This was for two main reasons: first, the household phone numbers in selected districts were not collected in an accessible database and, second, for security and logistical constraints (ATR, 2020, Rapid Welfare Monitoring Assessment of COVID-19 Impact).

households, with at least one female respondent per household, were randomly selected from each of the chosen communities.

The sampling frame for the telephone survey was constructed from an existing database of household phone numbers in Herat Province collected during a previous UNICEF-led evaluation¹² in September and October 2019. As this database did not cover all the districts and urban areas in Herat, CHWs attached to selected health facilities were recruited to enrol 620 additional respondents in the survey (via the random walk approach) and collect their contact details to update the sampling frame.

CHWs, who knew the community well, further purposively selected key informants in their area and collected their phone numbers. Ten health facilities were selected through simple random sampling and from these, one community leader, who was a member of the health *shura*, was interviewed. As all the community leaders were male, five female CHWs were also interviewed.

The actual sample size achieved for the phone survey was 1,279 because of oversampling to ensure sufficient female representation. A challenge was to reach women respondents in rural areas (women comprise 47.4% of rural respondents in Afghanistan; however, only 45% of the rural sample were female respondents).¹³ As fewer women have access to a mobile phone, they remain hidden and it is difficult to speak to a female member of the household if the phone is answered by a male. To reach women respondents and talk to them directly, the database was reviewed to locate female-headed households. At the same time, a sample quota for women respondents in the survey was established and female CHWs were tasked with locating additional eligible respondents in their catchment area. Given that contacting female respondents has been a challenge in national surveys as well, in future to enrol women respondents, in addition to a contact number for the household, women's phone numbers also need to be collected.

Despite limited network connectivity with phone numbers out of reach or switched off, and no telecommunication company working in one area due to the presence of the Taliban, the targeted sample size per health facility in the catchment area was mostly achieved. Two communities had to be replaced with two others in the same district due to network issues. Due to the length of the questionnaire, non-completion of the survey was a risk. To mitigate this, an incentive of 50 AFN in phone credit was provided. To avoid the risk of biasing people's responses, the incentive was only mentioned after consent for the survey was provided. Therefore, the payment was not a direct incentive to participate but functioned as an incentive to complete the survey.

Overall, only nine selected respondents refused to be interviewed and 25 interviews were rejected due to quality issues such as incomplete surveys. The monetary incentive may have contributed to the high response rate (although not the initial interest to participate); as well as the fact that some of the respondents were drawn from an existing project database, people were interested in taking part in the study given that COVID-19 was considered a critical issue, and more than one phone number was collected from respondents.

Partnerships

UNICEF collaborated with ATR to implement the assessment. It led and conceptualized the study, developed the survey tools, provided the sample frame of a previous evaluation and supported the roll-out of the survey. ATR further operationalized the design (e.g. sampling) and was responsible for data collection, data analysis and report preparation.

As physical movement and access to communities was a major issue in the context of the political insecurity in Afghanistan and the lockdown situation, ATR, who had a presence on the ground in most areas of the country, and the experience and resources to conduct surveys in the country, mobilized its networks to implement the

¹² Over 10,000 phone numbers were collected for UNICEF's Community Based Nutrition Package, IHSAN project, which were used as a sample frame for the evaluation of the project.

¹³ ART, 2020, Rapid Welfare Monitoring Assessment of COVID-19 Impact.

assessment. However, given the limited capacity for data collection and analysis, these processes took time (see below). A lesson learned is that UNICEF could have proactively engaged with other UN agencies and mobilize additional resources and capacity, which could have improved the timeliness of the assessment.

The assessment was implemented in coordination with the Ministry of Public Health (MoPH), Government of Afghanistan. The Government's vast network of CHWs was leveraged for the assessment, and the Community Based Health Coordination Department, MoPH, through the Herat Department of Public Health and Agency for Assistance and Development of Afghanistan (AADA), an NGO in Herat, facilitated coordination with CHWs in selected areas.

Agility/timeliness

While this was conceptualized as a 'rapid' assessment, the process took around eight months from conceptualization to reporting. While UNICEF had a comprehensive database of households with phone numbers for Herat Province that could be quickly mobilized, data collection and analysis took longer than anticipated. As the survey tool was long, it required time to administer, and to process and analyse the data. There is a need to be strategic in prioritizing the information that can be collected in a rapid assessment in a short period of time. During analysis it became clear that some of the information gathered in the survey was not required and was not analysed. In a subsequent national survey in Afghanistan conducted by UNICEF and Viamo, a global social enterprise that specializes in mobile technologies for data collection and ICT for development, a shorter tool with focused questions was designed.

While UNICEF began working with ATR to design the study before formal contracting to speed up its roll-out, the procurement and contracting process via UNICEF's supply systems took approximately a month. To make the process more agile, an LTA should be in place, particularly to recruit providers for data collection. For example, the existing LTA for



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ethical reviews allowed ethical review to be obtained in 13 days, which is still long when rapid roll-out of data collection is needed but relatively short compared to when no existing arrangements are in place. In a subsequent survey, UNICEF Afghanistan leveraged UNICEF's global arrangement with a remote survey provider to implement a national survey. Moreover, the data collection process itself should be agile so that it can be quickly activated. UNICEF is working with the Afghanistan National Statistics Information Agency (NSIA) to establish Multiple Indicator Cluster Survey Plus (MICS+),¹⁴ which will ride on the Demographic and Health Survey (DHS) framework and set up a more robust process for rapid data collection, including building capacity and setting up computer systems and basic equipment, and operationalizing it.

Use of findings

Data is perishable, particularly in the fast-changing pandemic situation. The preparation of the draft report was delayed, and by the time the report was finalized, the data were not as useful as they could have been if they had been presented earlier. Nonetheless, UNICEF pre-empted the finalization of the draft report and presented findings from initial analysis at the UNCT Working Group on Gender. Furthermore, UNICEF programmes used the data internally. However, opportunities have been missed to influence the response package to COVID-19 in Afghanistan.

¹⁴ http://mics.unicef.org/methodological_work/7/MICS-PLUS

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

Table: Herat, Afghanistan, rapid assessment: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none">• Mixed methods approach enabled comprehensive understanding of the situation and allowed for data triangulation to validate accuracy of the findings.• Gender focus in the questionnaire and gender-sensitive data collection permitted analysis by gender and coverage of women's perspective.	<ul style="list-style-type: none">• The survey length, contracting process, prioritization of information to be collected and complex political context required time, which meant that findings could not be disseminated in a timely manner.• Due to time constraints the questionnaire could not be rigorously pre-tested, which could have optimized the tool in terms of length and translation of the questions.
Learnings and innovations	
<ul style="list-style-type: none">• Triangulation of results from multiple data sources (survey, KIIs, observations) can be valuable in addressing the social desirability bias in responses.• Rapid assessments require prioritization of information that need to be collected in a short period of time.• Need to pre-position data collection systems for a rapid response e.g., having an LTA in place for enumerators/data collectors, and working with NSIA on the MICS+ approach.	

For more information visit:

Key contacts

Undertaking rapid assessments in the COVID-19 context: Learning from UNICEF South Asia

Understanding Youth Perceptions of COVID-19 in Pakistan



A Case Study

Context

Over two-thirds (64%) of Pakistan's population is under the age of 30.¹ The impact of the COVID-19 pandemic on adolescents and youth in Pakistan was considered to be substantial; many were unable to continue attending school due to closure of educational institutions or were laid off from work as a result of the economic crisis. However, during the first months of the pandemic outbreak little evidence had been generated on the needs and challenges of adolescents and youth in Pakistan in the pandemic situation; and the Government of Pakistan had not considered adolescents and youth as a unique group in its response.

In this context, UNICEF, UNDP and UNFPA, who had been working together on the joint UN youth engagement programme in Pakistan, partnered to conduct a national-level study to understand youth perceptions related to the COVID-19 pandemic and ensure that young people's voice would inform the country-level response. The study covered four

areas: perceived dangers and impacts of COVID-19 on young people's lives and livelihoods; remote learning and education given COVID-19 restrictions; perceptions about the Government's response to the pandemic; and, how youth imagined the "new normal" post COVID-19.

Implementation arrangements

The youth perceptions study (YPS) was jointly conducted by UNICEF, UNDP and UNFPA, in collaboration with Viamo, a global social enterprise that specializes in mobile engagement and ICT for development, which implemented the survey and conducted the analysis. Accountability Lab Pakistan, an organization promoting accountable institutions and good governance, also contributed to survey design. The study was designed and implemented in April-June 2020 with data collection taking place over just eight days in May 2020. Initial, non-disaggregated findings were shared in May, followed by gender- and age-segmented findings and final reporting in June 2020. The cost of the survey was USD 20,873.

¹ <http://hdr.undp.org/en/content/unleashing-potential-young-pakistan>

Data collection and analysis

Data collection took the form of a national-level cross-sectional survey that gathered quantitative data from young people aged 14-29 years across Pakistan.² Since the COVID-19 crisis made travel and in-person interviewing extremely difficult and ethically inappropriate, the survey was conducted through remote means using two data collection modalities: an online survey for digitally enabled youth (who owned smart phones and are internet users) in urban areas, and an audio version of the same survey via interactive voice responses (IVRs) for youth in peri-urban or rural areas who owned basic phones and were not internet users. The online survey was in English, distributed through SMSs and supplemented through social media advertising including a link to the survey on an online platform.³ The IVR survey was localized into different regional languages and broken up in different call waves with the same respondent to ensure maximum engagement. A total of 10,437 respondents completed the survey in a short period of eight days: 4,951 through the online survey and 5,486 via IVR.⁴

The survey questionnaire was developed by UNICEF, UNDP and UNFPA, with support from Viamo and Accountability Lab Pakistan. Questions covered the four areas of enquiry (see above). While the questions itself were gender neutral, gender-related issues were explored through gender disaggregation and inclusion of answer options that were particularly relevant to analyse from a gender perspective; for example, the impact of the COVID-19 pandemic on school dropout, child work, early marriage for girls, violence and cyberbullying. The survey encompassed 27 and 31 questions for the IVR and online components respectively.⁵ While this is relatively limited compared to face-to-face surveys, it is long particularly for an IVR survey. It was challenging to keep the questionnaire short because of the interest of the different partners to cover several topics. The IVR pilot indicated that the questionnaire could not be administered in a

single call as it was difficult to keep IVR respondents engaged in such a long survey. Therefore, to reduce the risk of drop-out, the IVR survey was fielded in four call waves divided thematically.⁶

Informed consent was taken from respondents prior to the survey and no personal identification information was collected. For online survey respondents a consent paragraph was included covering intended use of the findings, guaranteed anonymity, voluntary participation and that participation could be terminated at any time, while for the IVR call a shorter prompt was recorded indicating that their personal details and responses would be kept confidential and used only for the benefit of the area. Since in Pakistan persons below 18 years cannot own a mobile phone by law, in such cases, parents needed to provide consent for their children to participate. However, a limitation of the remote survey modalities is that it was not possible to ensure that children would not answer the surveys themselves without consent.

Analysis was kept straightforward, using descriptive statistics, to allow for rapid dissemination. Data were disaggregated by gender, province, education, employment status and age group, as well as by response mode (online survey vs IVR, urban vs rural). This allowed to provide disaggregated conclusions; for example, by digitally enabled and not digitally enabled youth, or by gender. The conclusions covered the four focus areas of the study. The final report also draws some evaluative conclusions about the success of the COVID-19 Social Behavioural Change Communication (SBCC) messaging based on the perceived danger levels among youth. However, this should be considered with caution given that survey did not explore the linkage between exposure to SBCC messages and risk perception. The data of the open-ended questions were not analysed in the end. Therefore, a learning is to consider in advance the value of adding open-ended questions in online surveys in light of the planned analysis.

² The age group 14-29 was targeted to include youth as defined by the UN (persons between the ages of 15 and 24 years); Those aged 14 years were included to cover issues of child protection.

³ The online survey was hosted on Typeform (<https://www.typeform.com/>)

⁴ IVR calls were spread over 8 days with a target to reach 6,000 respondents. In the online survey, bulk SMSs were sent out on a single day and the survey was open for the same period as the IVR to reach a target of 4,000 respondents.

⁵ Two open-ended questions and two demographic questions that were included in the online survey were not asked in the IVR.

⁶ The number of questions in each IVR wave ranged from 3 to 9. The four IVR waves were fielded over 7 days: after wave 1 was sent, wave 2 was fielded on day 3, wave 3 on day 5 and wave 4 on day 7.

The YPS demonstrates that combination of online and IVR surveys can quickly gather a vast amount of quantitative data. However, limitations are that it is not possible to collect detailed information as questionnaires need to remain short and answer options limited, particularly in the case of IVR, which does not allow multiple answer options to be selected. Furthermore, these modalities are not appropriate to gather sensitive information, although indirect questions can be included to explore sensitive topics.⁷ Administering the IVR survey through multiple call waves offered a solution to ensuring respondent engagement despite the questionnaire length. However, it comes at a cost of large drops in completion rates across waves and requires the waves to be spread across multiple days (see below). However, in Pakistan, this could be mitigated by Viamo through its established relationship with multiple mobile network operators (MNOs), which have the capacity to send out an unlimited number of calls/SMSs concurrently. Finally, because the survey needed to be rapidly rolled out, the survey instrument could not be pre-tested with the targeted respondents. Pre-testing could have improved the tool design (sequencing and framing of questions, identifying questions that lead to drop out, limiting and simplifying the answer options) and reduced airtime losses associated with incomplete responses and drop out.

Sampling

To achieve wide national coverage the target was to engage 10,000 young Pakistanis between 14-29 years, either through the online or IVR survey. The target sample size was determined by the resources available and considered to be sufficiently large to add to the generalizability of the findings to youths in Pakistan. The national phone database of two leading MNOs was used as the sampling frame. However, since these phone databases do not just represent the young population, Viamo implemented a segmentation and respondent profiling strategy, in collaboration with each MNO's business intelligence unit, in order to effectively target young mobile phone users.

Business intelligence data on phone ownership (e.g. smart phone or basic phone) and usage patterns



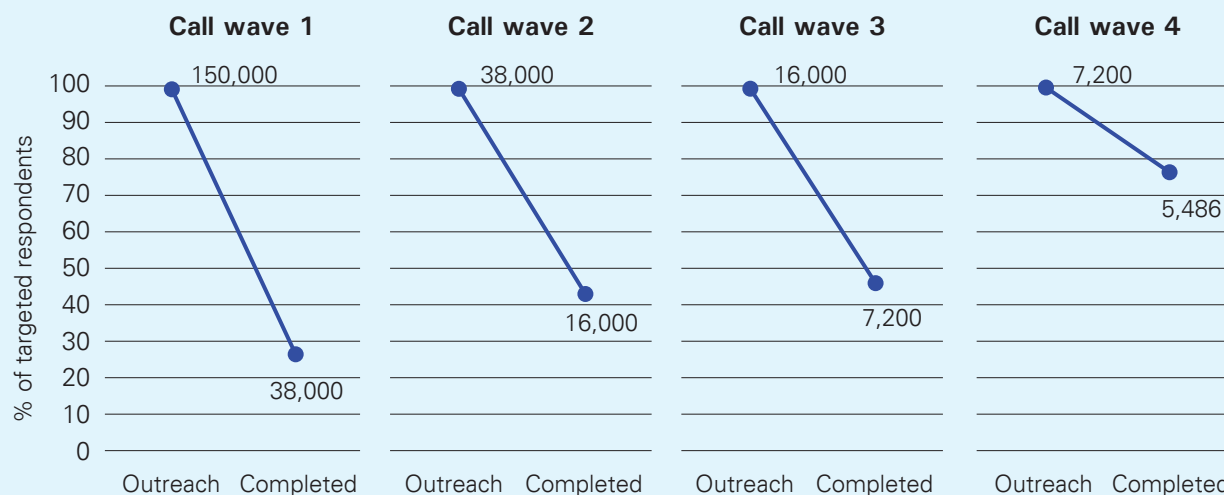
Photo Credit: © UNICEF/ Sharmin/ 2020

(e.g. subscription to particular education content or job portals, high data versus low data usage) was used to reach out to specific groups who had a high likelihood of being part of the target group. SMSs and IVRs were sent to mobile phone subscribers who fit the segmentation criteria, and participants who met the age criteria for the survey (14-29 years) were subsequently invited to complete the survey. This multi-level segmentation strategy increased the productivity of the survey outreach and the engagement rate. Additionally, youth who were engaged in the UN joint youth engagement programme in Pakistan were purposively included in the sample. The aim of including adolescents and youth who are part of the programme's forums, networks and groups was to strengthen engagement with youth and make young people who are already engaged in the programme feel valued being asked their opinion.

Around 2 million SMSs were sent to urban smart phone users, which together with the social media advertising resulted in 4,951 completed online surveys. In the case of the IVR survey, approximately 150,000 calls were placed to achieve 5,486 completed surveys across the 4 call waves (3.6% overall response rate). As Figure 1 shows, response rates per wave increased, starting with a response rate of 25% of wave 1 and 76% response rate in wave 4. While the overall response rate is low, it is relatively high compared to a similar IVR survey that UNICEF Pakistan implemented with

⁷ For example, the survey included a question 'Which statement do you think will apply the most to the protection of young people once coronavirus situation is under control?' with answer options related to increased instances of online violence such as cyberbullying and some girls getting married early among other answer options.

Figure 1: Response rates and number of IVR calls across waves



Source: Viamo, Pakistan

Viamo (see RCCE Behavioural Change Survey, also a case study in this volume),⁸ mainly because the other survey applied provincial sample quota, which requires more calls to be made to achieve the sample quota. Furthermore, in order to increase participation and interest in the survey, IVR respondents were called via robocall before the survey to inform them that they would receive a call shortly to seek their participation. In the case of the online survey, SMSs were sent in name of the partnering UN agencies to help build credibility and trust.

With respondents coming from 140 out of 152 districts in Pakistan the survey had wide geographical coverage. A lesson learned is that the geographical representativeness could have been improved through further provincial segmentation or stratification. Beyond the rural-urban stratification and sample size target quota of 4,000 ‘digitally abled’ urban respondents and 6,000 ‘not digitally abled’ rural respondents, no further stratification or sample quota by other characteristics was imposed. This means that the data is not representative of the national youth population, thereby limiting the generalizability of the findings. For example, women were underrepresented in the survey, making up only 29% of the sample. This may be due to women’s historical lack of access to mobile and

digital connectivity; most SIMs are registered with men and mobile phones are often a shared asset especially in rural areas. Setting sample quotas for different sub-groups could have made the sample more aligned with the population distribution. However, this would have come at the cost of a lower response rate (i.e. more calls to be made per completed survey) and additional time to increase the participation of specific respondent categories.

Partnerships

Ongoing partnerships were leveraged to design and implement the study and generate quick results. UNICEF, UNDP and UNFPA, along with other UN agencies, are part of the joint UN engagement programme for youth and have established joint working groups focusing on multiple initiatives across Pakistan, which facilitated the process. The interests of the UN agencies were brought together for this study, and all the agencies pooled their resources and used the data for their programmes.

UN partners capitalized on their internal resources and pooled funding to design and implement the study. Viamo’s support could be rapidly mobilized and took the form of a collaboration rather than a deliverable-based client-contractor relationship. This was possible because Viamo had worked

⁸ The first round of the RCCE Behavioural Change survey had an overall response rate of 0.9% across three call waves. This improved to 1.6% in the third round of the survey when the number of call waves was reduced to two.

previously with UN agencies in Pakistan. The study was covered by an existing Terms of Reference by UNICEF Pakistan with Viamo and UNDP had an existing Long Term Agreement with Viamo. UNICEF and UNDP provided technical support to Viamo at all stages of the study, which took time but helped to ensure quality of the results. Viamo provided valuable inputs based on their experience in using mobile technology for data collection, engaging with young populations in Pakistan for surveys and their knowledge of areas of high mobile penetration and internet availability in the country.

An important advantage was Viamo's strong relationship with MNOs in Pakistan. This enabled the segmented targeting of the survey based on the MNOs' business intelligence, the use of the MNOs' collective bandwidth to rapidly survey a large national sample and ensured access to reduced call rates.

Agility/timeliness

Overall the study was implemented in a relatively short period of eight weeks from design to reporting, with reporting/dissemination of preliminary findings taking place a week after the end of data collection. Agile coordination among partners was possible because the partnership between UNICEF, UNDP and UNFPA was already quite strong and there was an element of trust in the team. Furthermore, having Viamo, a trusted partner, in an ongoing contract who could be easily mobilized, facilitated the process to move quickly and contributed to the quality of work. As the entire survey was managed digitally, data collection was quick and cost-effective. The established relationship between Viamo and the MNOs in Pakistan also allowed quick roll out of the IVRs and SMSs. Importantly, the capacity of MNOs in Pakistan to broadcast a large volume of calls and SMSs concurrently, enabled to achieve the targeted sample size within a limited number of days despite a low response rate.

However, there were some trade-offs. The survey instruments were designed based on past experience/good practices and were not pilot tested in the field, so they could be launched immediately. The survey tool could have had

fewer questions, which would have made the data collection process quicker and more efficient (avoiding the use of multiple call waves spread over different days). Conducting the study in collaboration with multiple UN agencies, with different programme interests, required some time to jointly design the survey tool and finalize the report, although given the existing collaboration this was managed in a few weeks. Data could have been disseminated more quickly across multiple partners through the use of data dashboard accessible to all partners.

Use of findings

The survey report was widely disseminated,⁹ and the findings used by several UN agencies in Pakistan working on youth-related issues to inform the design and implementation of effective programmes to meet the needs of young people during and after the COVID-19 emergency response. For example, the findings informed a COVID-19 adolescent and youth campaign through social media and radio. Furthermore, UN partners organized online training and mentoring on COVID-19 among young leaders addressing some of the topics covered in the study such as mental health. Advocacy briefs and articles were published, and a webinar for youth and youth practitioners was organised to disseminate the study findings.

Findings from the YPS have further informed future UN programming in the field of youth engagement by enhancing focus on emerging issues such as mental health, online learning and misinformation online. Additionally, lessons learned from this initiative have informed subsequent youth-focused digital surveys which have been codesigned by UN Agencies and the Government of Pakistan to better understand youth perceptions on upcoming policy and programming¹⁰ and also to establish a baseline for some key indicators for the Pakistan Youth Development Index. The results have also been utilized to inform UNICEF's programming on education continuity campaigns and innovation challenges.

Summary learnings

The strengths, challenges, learnings and innovations related to the implementation of this rapid assessment are summarized in the table below.

⁹ The report is available on the UNICEF website: <https://www.unicef.org/pakistan/reports/understanding-youth-perceptions-covid-19>

¹⁰ <https://kamyabjawan.gov.pk/Home/YouthSurveyKJ>

Table: YPS, Pakistan, rapid assessment: Summary Learnings

Strengths	Challenges
<ul style="list-style-type: none"> • Large sample size, combining online and IVR data collection modalities, enabled wide geographical coverage among urban ‘digitally abled’ and rural ‘not digitally abled’ youth. • Use of digital technology through MNOs allowed for remote data collection in a short period (8 days) and at a low cost. • Existing collaboration between UN agencies (UNICEF, UNDP and UNFPA) facilitated the process by bringing together common interests and resources. • UNICEF’s existing contractual relationship with Viamo could be leveraged to quickly roll out the survey. • Viamo’s expertise in mobile phone-based surveys and partnership with the MNOs in Pakistan supported rapid data collection. 	<ul style="list-style-type: none"> • Online and IVR surveys need to remain short, which constraints depth and breadth of data collection; they are not well suited to gather qualitative data via open-ended questions, or detailed information on sensitive issues. • The sample does not have the same distribution as the youth population in Pakistan—for example, underrepresentation of women—which limits the generalizability of the findings. • Youth without mobile phone access not represented. • Piloting the survey instruments could have improved the design, thereby increasing response rates and reducing collection costs.
Learnings and innovations	
<ul style="list-style-type: none"> • Relatively long questionnaires can be fielded through IVRs by using multiple call waves, but it comes at the disadvantage of a high non-response rate and extra days of data collection; a disadvantage which can be mitigated when a large number of calls can be fielded concurrently (at low cost). • Different data collection modalities can be combined to reach groups with different degrees of digital ability and literacy. • The use of business intelligence data for respondent segmentation and profiling enables targeting of the respondents and increases survey productivity (i.e. response rates). 	

For more information visit:

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