THE CHALLENGE

When COVID-19 hit Africa in March 2020, it was unclear whether the continent’s public health systems would be swiftly overwhelmed by a rapid rise in cases, particularly in densely populated urban areas with poor access to water and sanitation, where social distancing would be impossible to enforce. It was clear that lockdowns would have a devastating economic impact on the continent, with Governments unable to finance the social safety net schemes required to ensure people could afford not to go out to work.

LAUNCHING A MULTI-STAKEHOLDER COALITION FOR CRISIS-RESPONSE
A solution was required to enable people to continue working safely, without jeopardising their health or infecting others.

Safe Hands Kenya was established as a mission-driven alliance of Kenyan companies and community-based organisations to deploy free soap, hand-washing stations and masks to the most vulnerable Kenyans, and to disinfect public spaces in low-income communities, as a first line of defence against COVID-19. We also designed and launched a high profile behaviour change campaign - Tiba Ni Sisi (Kiswahili for “We Are The Cure”) - to motivate people to adopt and use the products and services effectively. By advocating for regular handwashing with soap, we sought to create public health benefits that pay dividends long after COVID-19.
WHAT WE ACHIEVED

Over 550 jobs were directly created by the Safe Hands Kenya programme in the last 5 months within community based organizations and through procurement of locally sourced inputs.

Within the first 5 months, Safe Hands Kenya reached 2 million of the most vulnerable Kenyans with products and services for rapid mass sanitation and the Tiba Ni Sisi campaign reached over 3 million Kenyans with messaging to inform people about the risks of coronavirus and to motivate them to adopt behaviours such as handwashing with soap, mask-wearing and social distancing to reduce their risk of infection. 123 tonnes of locally produced soap and 1750 locally manufactured handwashing stations were distributed, together with 500,000 locally manufactured reusable masks.
We launched in crisis mode - a diverse group of organisations having never worked together in this way before - and learned a great deal from our successes and failures throughout the following months. As the number of cases continue to rise on the continent, we wanted to share our experiences to enable other organisations across the continent and beyond, who might be exploring similar initiatives to respond to COVID or other significant health crises in the future, to accelerate their speed to market by drawing on our learnings.
HOW WAS THE COALITION FORMED?

Safe Hands Kenya was established following conversations between the founders of KOKO Networks and Dalberg Catalyst, who recognised the need to mobilise swiftly and build a broad-based coalition of private sector and community-based organisations to deliver at speed and at scale. All members were required to sign-up to the following principles when joining the alliance:

- **The diversity of our alliance was key to our success.** Private sector partners and the suspension of the profit motive increased our ability to source inputs at a highly competitive cost, and brought specialist expertise, technology, and efficiency. The credibility of community-based organisations with our target audience accelerated the pace of trust-building - critical in a crisis - and enhanced our ability to go door to door, tracking the last mile of the distribution process to ensure products were distributed fairly and used effectively.
At the outset, we identified five key capabilities that we needed to build within the alliance. To establish these five capabilities, we built the following organisational model and process. The rest of the document reflects this structure and provides more colour and context to how we approached each stage.
We drew up a prospect list based on our networks and prioritised potential funders depending on the strength of existing relationships and Safe Hands Kenya’s alignment with their core mission.

In parallel, we created a generic proposal that we could tailor as needed and send out to different funders with whom we did not have existing relationships but whose mission was strongly aligned with ours.

We set up a crowdfunding campaign on GoFundMe to solicit small donations, and used social media to amplify the campaign where possible.

We identified and reached out to Kenyan diaspora groups in the US and Europe, who could be interested in funding the project.
LESSONS LEARNED

- We realised that it was critical to set up a local bank account, so that different channels for giving for different audiences could be used to maximise the convenience of donation. We focused on GoFundMe, which works well with an international audience but an M-PESA-enabled channel would have been useful to raise funds from Kenyans, both at home and in the Diaspora.
- The crowdfunding space is very crowded - in Kenya there were several public campaigns by different organisations to raise funding for the COVID-19 response, including one endorsed as the official Government of Kenya campaign. People were keen to contribute but certainly in the early days, perhaps were not sure how best to channel their support. In hindsight, it might have been useful for the different campaigns in the country to coordinate more effectively on how each effort was differentiated to avoid replication of effort and allow potential donors to understand the options more clearly so they could make an informed decision on what and how to support.
- It is crucial to update the project website and GoFundMe page with impact metrics on a weekly basis as well as communicate on social media channels. It is also important to have an easily updatable section on the website to recognise funding partners.
- A major celebrity endorsement would likely have been useful in driving more donations. The urgency of the situation meant we didn't have time to spare in establishing contact with high profile people we had no prior relationships with so engaging with individuals and organisations with direct access to celebrities may have made a difference.
- Including details on how to donate in all press mentions of SHK would also have driven more traffic to our GoFundMe page.
- It was important to have every member of the SHK consortium regularly amplifying the GoFundMe campaign, so that fundraising could be a coordinated effort.
- It is critical to move fast in emergency situations like COVID-19 - everyone is looking to disburse early. For many institutions, COVID-19 windows have run out and as of mid-July 2020, giving has returned to business as usual.
- It is important to use the alliance members’ existing networks as cold outreach to large foundations proved relatively unsuccessful.
- In emergency situations like COVID-19, bilateral G2G decisions around donations are typically decentralized to the embassies. It is therefore important to engage with these representatives early on.
We knew that rapid adoption of the products at scale would be driven by their user-friendliness so we adopted a human-centred, inclusive design approach.

It was important to integrate grassroots perspectives into the design process from the outset. Identifying a UX Design lead with deep experience in engaging the target communities was therefore critical in accelerating the design process to ensure it was rooted in their attitudes, preferences, routines and sense of place. Establishing a strong sense of empathy and enabling radical candour with the target audience through focus groups was crucial to go beyond UX theory and ensure practical adoption. This is best done face to face but due to COVID-19 restrictions, we had to also work with Zoom and phone calls, which makes it harder to build trust quickly. We also engaged with community chiefs and elders to gain buy-in from residents and ensure adherence to local governance protocols.

Due to budgetary limitations, we had limited capacity to design and manage mystery shopper programmes. We consequently adopted a broader approach to UX design. Our design lead understood product design from beginning to end, hardware and software, and had the UI skills to monitor and evaluate our products. Someone who runs a makers’ lab has the ideal combination of skills. The involvement of the UX design lead in all stages of the product development, pilot design, manufacturing and distribution process was critical in ensuring user behaviour informed all strategic and tactical decision-making.

Due to the pandemic, on-the-ground UX findings, although limited by social distancing measures, were applied daily in a direct and cost-effective manner, which was essential as the situation evolved so quickly. Reporting of design matters from the field was managed through data sheet analysis, coordination of GIS mapping and M&E of product use.

We created a team to cross-pollinate design and community engagement, freeing up time for engineering and design, technical design of community engagement and media engagement on the ground.

We embraced design learning from the start. When we started out, there were no officially regulated guidelines for mask manufacturing. Once the government developed comprehensive regulations for reusable cloth masks, these became the backbone of our requirement to providers. It is important to keep design and UX fluid in a situation that evolves quickly - for example we needed to suspend a production run as the guidelines changed just after we had approved the order so we needed to go back and re-design and re-order the masks to ensure we were compliant.

Our UX approach also meant we recognised our public spaces strategy needed to be contextualised to each low income area we sought to target. Accordingly, we began cultivating partnerships with community based organisations in the target informal settlements and adopted a participatory approach to situate handwashing stations as we knew the residents would know the most convenient locations to encourage regular handwashing by the maximum number of people.
Based on official statistics and national census information, our target was to reach about 4.9 million people, including 2.5 million people in Nairobi and 2.4 million in the rest of the country. These figures were derived from a vulnerability matrix based on population density, informal employment, access to water, economic status and the number of makeshift houses in each area. The matrix was also based on Kenyan National Bureau of Statistics (KNBS) indices. We later added COVID-19 infection rates and the Kenyan Ministry of Health's designated hotspots to the matrix to ensure it reflected the fast-changing situation on the ground.

The vulnerability matrix was applied at each administrative level: national, county and sub-location. We assigned a specific weighting to each indicator and then ranked the locations. We determined a cut-off point to arrive at the 4.9 million target.

We then proceeded to determine average soap use, based on a public use case where retail partners would have hand washing stations available for customers to use. We calculated an average of 5kg per retail outlet per week. For hand sanitiser, we started with a private use case model and calculated an average of 3ml per use. We projected demand for hand-washing stations, surface disinfectant and masks using similar models to procure the appropriate quantities of each product.
STRATEGY AND PROJECT SET-UP

○ After securing funding, we also refined our value proposition. We decided to narrow our scope to a few core products and activities to enable strong execution. We considered the expertise of our various alliance partners and determined where we would add the most value.

○ To maximise our impact with the target audience, demonstrate impact and justify our spending to investors, we mapped the landscape of stakeholders involved in the fight against COVID-19. We looked into NGOs and religious groups as well as similar alliances like the National Business Coalition against COVID-19 (NBCC) and established where demand existed as well as where other organisations and coalitions were active to avoid replication of efforts and determine each individual coalition’s strengths.

○ This exercise confirmed our decision to focus on distribution of masks, hand-washing stations and soap, disinfecting public spaces and a supporting behaviour change campaign.
We set up a Steering Committee (comprising founding alliance members and funders, with a rotating Chair) to approve budgets and spending and to review and validate strategy. An Executive Committee comprising the CEO, COO, project management lead and the workstream leads for UX, Distribution, Finance and Communications was established and convened daily to ensure clear accountability for delivery. We also held daily calls with the extended project team to ensure effective coordination and information flow between the wider team. Due to restrictions on physical meetings, we implemented effective and transparent communication through regular Zoom calls, WhatsApp and e-mail.

We defined the contracting entity (Dalberg Catalyst as a US registered non-profit) to receive and disburse funds, and ensured there was a clear scope of work for each alliance partner, supplier contracts and MOUs for grantees to cover product distribution and other deliverables. The key was to provide accountability for delivery whilst incorporating space for change to enable the project to retain agility as the situation on the ground evolved.

Trying to register Safe Hands Kenya in Kenya as a nonprofit would have been a long process (as it is in most countries), and we needed to move fast. Safe Hands Kenya needed a nonprofit legal entity to serve as a fiscal sponsor to accept funds on its behalf. In theory, this could have been any NGO, including one in Kenya, but Dalberg Catalyst was able to move fast due to its affiliation with Dalberg, a founding member of the alliance, and quickly agree to all of the principles laid out as part of the coalition (e.g., zero-profit, etc.).

There are numerous elements to consider when choosing a fiscal sponsor, including ensuring that the organisation can be fully trusted to maintain discretion and control over funds, has great relationships with donors worldwide and good donor reporting capabilities, has access to legal expertise for drawing up contracts etc.
We needed to secure the buy-in of the Kenyan Ministry of Health to ensure we were recognised as an official partner to the Government and therefore initiated conversation from the outset to ensure alignment and complementarity in our approach and to ensure we were compliant with government guidance and policy as it evolved over the period of activity. We also identified strategic interlocutors, including the National COVID-19 Emergency Committee, to ensure we were aware of other organisations’ efforts and were focused on additionality, avoiding replication of efforts. We replicated this process at grassroots level, reaching out to local administration officials and Ministry of Health coordinators in the informal settlements where we sought to implement a public sanitisation strategy.

Within the alliance, maintaining effective communications and information flow amongst a diverse group of partners was critical. We created Google spreadsheets to log each member’s role, deliverables and activities to enable the central communications team to coordinate effectively with the communications teams of each partner organisation.
Our greatest challenge in starting to implement the strategy was to maintain a careful balance between designing and executing pilots in the field to test efficiency and user adoption, building in the learnings to refine our approach, and recognising the urgency of execution at scale in a crisis situation.

We spent considerable time and effort testing public vs private use cases for hand sanitiser and soap and despite promising indications on the value of a public-use hand sanitiser solution (e.g. dispensers on the side of matatus for people to use before and after using public transport), the availability of inputs which had to be sourced internationally and imported, constrained our ability to ramp up production of sanitiser at scale so we focused on soap, which could be produced efficiently at scale in Kenya.

We designed a sequenced roll-out, starting with the most vulnerable segments of the population and prioritising the locations where we had connections and/or partners and could move as quickly as possible (i.e. in Dandora).

The slide below illustrates the development of our strategy, informed by pilots and the increasing availability of data on the effectiveness of the different interventions.

Throughout the roll-out phase, we remained flexible in terms of changing roles and priorities. For instance, we initially saw one of our coalition partners as the developer and executor of our strategy in the public disinfection space. It soon became apparent that it was more effective for the partner in question to train partner community-based organisations who are already known and trusted by our target communities.

Our initial approach - broad spraying of disinfectant - was also replaced with the WHO recommended wiping method as soon as this was announced as best practice. The disinfection of surfaces component of our programme expanded to include capacity building for our partner community based organisations as well as community education via the training of trainers.
The maintenance of public handwashing stations and the distribution of face masks and soap took more prominence as the scientific advice and government guidance evolved to place less emphasis on the disinfection of public surfaces.

We adopted a continuous learning mindset. We put in place various measures to reduce leakage and exploitation for commercial gain of the materials we were providing for free. For instance, we changed soap product specifications when we realised that our first selections had high resale value and therefore carried a high risk of being sold on.

Realising that communities were often cynical of the motivations of the government, large non-state actors and the media, we added a peer education approach to our behaviour change communication strategy, driven by our grassroots partnerships, to ensure it was owned and advocated by people respected and trusted within the community.

When declining incomes due to the lockdown started to impact communities’ ability to crowdsource for the purchase of water to refill hand washing stations, we set aside a water resourcing budget line to cover hand washing stations in three settlements for a month. This would buy the communities time to raise the necessary funds to sustain their handwashing stations.

We kept track of the challenges and learnings for each product and at each stage, as outlined below.

<table>
<thead>
<tr>
<th>PHASE</th>
<th>LEARNINGS</th>
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<tbody>
<tr>
<td>PILOT</td>
<td>Develop tools to determine effectiveness/impact of training (e.g. introduce a pre- and post-training assessment). Assess the feasibility of a Training of Trainers model for continuous community education and engagement.</td>
</tr>
<tr>
<td>PILOT</td>
<td>Ensure clear deliverables and deadlines for the public spaces programme are communicated to all stakeholders prior to roll out at scale and that the communications plan is executed successfully.</td>
</tr>
<tr>
<td>PILOT</td>
<td>Ensure local implementation partner buys into and owns the operational and communications plans.</td>
</tr>
<tr>
<td>PILOT</td>
<td>Ensure residents are aware of disinfection activities in advance of operations commencing to ensure they understand the purpose and scope of the activity, the nature of the chemicals being used and the timings of spraying activities. By educating parents, we also ensure children don’t disrupt spraying activities.</td>
</tr>
<tr>
<td>EXPANSION</td>
<td>Need to manage labour requirements with demand for local job creation to stay within budget.</td>
</tr>
<tr>
<td>EXPANSION</td>
<td>Ensure clear roles and responsibilities for sprayers, casual workers and supervisors are established before scaling-up. Consider monthly rotation of cleaners to maximise job creation opportunities for the community.</td>
</tr>
<tr>
<td>EXPANSION</td>
<td>New guidelines from WHO and CDC on public disinfection programmes issued after the pilot phase led to the redesign of the programme and meant we needed to re-engage communities and workers around the changes to ensure they understood the rationale for the change and its implications.</td>
</tr>
<tr>
<td>EXPANSION</td>
<td>Suggest each ward representative identifies a local water supplier who can distribute water daily to designated tanks.</td>
</tr>
<tr>
<td>EXPANSION</td>
<td>Consider re-training supervisors during scale up phase to ensure best practices are being applied across the programme as individual teams build competence and discover efficiencies.</td>
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LEARNINGS – PUBLIC SPACES (SOAP AND HAND WASHING STATIONS)

Need to factor in shifting location dynamics (e.g. lockdown disrupted the flow of products into certain areas). A proactive approach to monitoring emerging hotspots is critical to anticipate potential barriers to distribution and identify alternative locations to re-direct product. Real-time communication with partners is critical to ensuring alignment in planning e.g. re-confirm quantities and location of deliveries 24 hours beforehand.

Need to improve visibility of last mile distribution beyond delivery of product to retail points – need to verify soap is being used by the intended recipients for the intended purpose and there is no on-selling/leakage.

Ensure alignment between supply and demand on weekly usage of product per outlet to ensure appropriate quantities are being delivered at appropriate intervals – we needed to reduce our weekly usage estimates from 5kg/week/outlet to 2.5-3kg/week/outlet.

Need to receive real time storage capacity feedback from partners to reduce risk of delivering high volumes of product to partners with limited storage space. Useful to identify partners with additional storage capacity in the event of partners reaching storage limits to ensure continuous flow of product to the market.

Need to have candid conversations with partners around absorption capacity to avoid partners stockpiling product with limited ability to manage last mile distribution, particularly due to the slowdown in normal business operations due to COVID-19 when using a co-loading model. Need to follow up regularly with partners to ensure any bottlenecks with distribution are reported immediately and a solution identified.

Handwashing stations (HWS) require a budget line to cover the stipend for an attendant for at least the initial period after installation whilst building community buy-in for the ongoing oversight and maintenance of the HWS.

LEARNING - MASKS

Ensure all shortlisted manufacturers meet national regulations issued by the relevant Bureau of Standards as well as the specific project requirements and can offer flexibility through a range of options. Note that regulations can change mid-way through a production run as new scientific evidence on mask effectiveness emerges and there is a risk of having to re-order to meet new standards.

Ensure any discounted products meet the national regulations and the project quality requirements - this is critical to brand credibility and trust.

Ensure alignment between supply and demand on weekly usage of product per outlet to ensure appropriate quantities are being delivered at appropriate intervals – we needed to reduce our weekly usage estimates from 5kg/week/outlet to 2.5-3kg/week/outlet.

The lack of guidance from WHO, Africa CDC and Kenyan Ministry of Health on how to wash and reuse reusable masks to avoid them becoming a new vector of transmission meant we couldn’t develop clear communications material for the public and there was a risk of unsafe use (e.g. people not washing masks before re-using them or washing them in a way which wouldn’t kill the virus). We decided there was a credibility risk to the Tiba Ni Sisi brand if we developed our own guidelines in the absence of official guidelines and these subsequently turned out to be inappropriate so we waited for the official guidance to emerge but this created confusion for people who wanted clarity on how to wash and re-use masks safely in the meantime.

As the transmission rate grew, the lack of individual packaging for the masks created a risk that our distributors might transmit the virus during handling – consider asking distribution partners to wear disposable gloves and use hand sanitiser when handling masks.

Beneficiaries did not follow the instructions to wash the masks before first use – this needs to be emphasised in public communications.
The scarcity of certain inputs due to global supply chain disruptions caused by COVID-19 meant that we couldn’t reliably plan for production at scale of hand sanitiser and consequently decided to focus on producing soap, masks and hand washing stations, which could all be manufactured locally using predominantly readily available inputs to protect jobs at a time of global disruption and economic fragility.

Users stated a preference for liquid soap above bar soap based on foaminess and to avoid touching the same bar of soap perceived as an infection risk, but it was difficult to source at scale. We thus focused on bar soap and surface disinfectant which were readily available at the local level, as soon as it was proven that transmission would not occur through touching the same bar of soap. We started by distributing 200g soap bars and then switched to 700g bars, which our field testing proved was our users’ preferred format.

We tested a range of hand washing stations - both existing models and bespoke models built to our specifications to maximise adoption and reflect Human-Centred Design principles of accessibility for women and children and differently-abled people. Whilst the preference was to procure our own design hand washing stations, local manufacturers were simply not able to produce them fast enough at scale so we decided to procure existing models that were of sufficient quality and could be adapted (i.e. by adding bag hooks and multiple taps) to optimise user experience. We distributed two sizes of stations: one with a 100L tank and one with a 500L tank.

Mask manufacturing was complicated by the change in regulation by the Kenya Bureau of Standards, which issued new technical requirements for mask manufacturers in the middle of the first production run, forcing us to re-design the masks and re-order. We chose black elastic rather than white to prevent staining from repeated use and needed to tighten the elasticity to ensure adequate fit.
We were fortunate that one of our manufacturing partners took on product delivery whilst we selected and engaged a prime mover. We onboarded a dedicated, flexible prime mover with the capacity to move goods in bulk to the end user. We needed them to be able to manage long haul and short haul distribution, as well as to cover multiple locations in a day. We used a different logistics partner to transport our teams to the field. We were fortunate that our coalition partners were willing to transport whatever was required in a fast-changing situation - their flexibility and agility was critical.
DISTRIBUTION PLAN

We leveraged our private sector coalition partners’ Internet of Things (IoT)-enabled order and replenishment systems, existing distribution centres and informal retail networks in the target communities to enhance our efficiency and speed to market.

Some companies use GIS mapping (i.e. logging specific geo-pins) and mobile technology (e.g. customised apps) in their regular course of business. This is proprietary for each company and enables guidance for delivery drivers, visibility over stock movements and digitised handovers of stock. The GIS mapping typically provides far greater visibility than Google Maps can in many urban neighbourhoods and rural areas, enabling companies to map their areas of operation and/or customer locations in precise detail.

Safe Hands Kenya adopted these digital systems for the distribution of essential products, layering the distribution maps of participating SHK private sector partners over the top of demographic/population maps. The technology platforms enabled us to monitor the demand/supply situation in real time and act quickly to resolve bottlenecks and coverage gaps.

For example, Dalberg Research and other SHK members provided numerous detailed maps that showed variables including locations of confirmed cases of COVID-19, locations of suitably-equipped medical facilities, population density across Greater Nairobi, distribution of populations aged 50+ or 65+, income distribution, percentage of shared toilets per county or urban locality and access to clean water. This information was critical in locating concentrations of particularly vulnerable or at-risk people and identifying where we could have the most impact.

We minimised distribution costs by using direct shipments and “piggy-backing” on the existing distribution processes of coalition members. For example we adopted a co-loading principle whereby retail outlets co-load our product with their products to reduce the cost of distribution. We simplified co-loading instructions by distributing a one-pager setting out tactical instructions to primary contacts and directly instructed individuals in charge of the various stages of the distribution process to avoid miscommunications through the different layers of the distribution process.

We complemented this private sector led distribution approach with community partnerships that relied less on technology-driven distribution and monitoring methods but had the advantage of being able to target distribution directly to the most vulnerable population groups through established and trusted channels. The majority of our distribution activities were conducted under these community partnerships as the project evolved.

Through these partnerships, we recruited respected community members, the majority of whom were single mothers, to distribute the items to their most needy neighbours and paid them through a daily stipend. We cycled the distributors out of the program every two weeks to uplift as many households as we could and avoid bias.
BEHAVIOUR CHANGE

- It was not sufficient to deliver handwashing stations, soap and masks to people to ensure adoption. People need to know why and how to use them and must want to use them for adoption to be truly effective. We launched a behaviour change campaign to complement the product distribution to motivate all Kenyans to play an active role in protecting themselves and their loved ones by washing their hands regularly with soap, wearing a mask and social distancing.

- The campaign rallied people with a strong call to action #TibaNiSisi (Swahili for "we are the cure"), emphasising individual agency in the face of the pandemic. It was designed to cut through the fear and helplessness that many people felt - especially those marginalised economically or through poor health - and demonstrate what they could do, simply and for free, to protect their health, prevent the spread of the virus and help save lives.

- The creative approach used colour, visuals and language to stand out as a strong, compelling call to action without using scare tactics and motivated user-generated content so people could share stories of how they are adopting the mantra "We are the cure".

- www.tibanisisi.co.ke was the central digital home for the behaviour change campaign and www.safehandskenya.com was the corporate website, linked to the GoFundMe page for donations.

- The behaviour change campaign was carefully sequenced to first raise awareness and build understanding of the coronavirus - explaining the symptoms (and the fact that infected people can be asymptomatic), how it is transmitted and how it affects the body - before calling people to action to increase the sense of ownership around stopping the spread of the virus. We started by developing top line key messaging, e.g. “To stop the spread, we need to get ahead of it! Prevention is key” and then worked on practical calls to action like “Have a Covid-19 safety routine: clean hands, clean surfaces, safe distances”.

- Over and above the behavioral change issues, the campaign also had to cut through fear and address myths that surrounded the management of COVID-19. We carefully monitored social media and our field teams provided a regular flow of insights into misinformation starting to proliferate so we could develop accurate, fact-based information to set the record straight.

- Initially launched across various Nation Media Group platforms to maximise visibility, the #TibaNiSisi campaign then focused on Facebook as the most popular social media channel in Kenya amongst our target audience and we maintained a careful balance of multimedia content, which is usually the most engaging format for users, with static graphics to respect the reduction in disposable income our target audience could allocate to data bundles. We engaged Facebook’s public policy team to boost the reach of our campaign and they donated advertising credits.
We launched partnerships with radio stations particularly popular with our target audiences in the different locations, for example a reggae-themed promotion on Ghetto Radio, Kenya's largest Sheng station (a mix of Swahili and English), which encouraged listeners to call in with their stories of how they were “being the cure” to compete to win the opportunity to record a reggae track with one of the country's top reggae producers.

We drew heavily on our coalition partners' knowledge of how young people were reacting and responding to the pandemic as well as leveraging the UX team's findings to develop relevant and engaging content. For example, after a few weeks, the public health risk of contracting COVID-19 had been overtaken by the immediate and brutal economic impact of the loss in revenue from people whose ability to earn a living had been reduced or destroyed as a result of the lockdown. Acknowledging the real challenges people were facing and meeting them in that emotional and psychological space was critical to continuing to be able to communicate public health messaging in a way that would resonate with people.

When COVID-19 infection rates spiked during Ramadan, as a result of people gathering together in close proximity, we launched a campaign on two radio stations popular with the Muslim community in Nairobi and Mombasa. The campaign adapted messaging that had been used for Easter in a print campaign and explored how people could celebrate Ramadan whilst protecting their health and that of their loved ones.

Community partnerships have been key to getting the messages across using WhatsApp and local activations from skateboarding to music. TibaNiSisi has also uncovered a range of new influencers, respected in their communities, who have modelled positive behaviour changes. These include trash collectors, graffiti artists and former prisoners who have turned their lives around.

More than 3 million Kenyans engaged with the hashtag #TibaNiSisi on digital, including online quizzes to test people's knowledge. #TibaNiSisi was also promoted using 30- and 90-second TV and radio spots, presenter mentions and more bespoke campaigns such as the Ghetto Radio example mentioned earlier. The campaign also consists of songs recorded by popular artists, educational animations and instructional videos to use on social, around proper hand-washing, mask usage and DIY hand-washing stations. The brand was featured on T-shirts, masks, posters, leaflets and hand-washing stations.

We noted, in some communities, a resistance to top-down behaviour change communication driven by a distrust of figures of perceived authority including the mass media, non-profit organisations and the government. We therefore engaged community-based door to door distributors and hand washing station attendants to engage directly with individuals, personalising the messaging and busting stubborn myths. This approach was geared at empowering people with the messaging and content to act as informal peer educators within their own social circles and amplify campaign messaging throughout the communities' long standing social networks. Approximately 50,000 households were reached directly across Dandora, Kawangware, Kibera and Greater Eastleigh under this grassroots approach.

To further build trust for #TibaNiSisi we engaged artists to create COVID-19 sensitization wall murals in their own neighbourhoods. The murals serve as visual behavior change nudges and are designed to tell stories and use humour and emotion to convey practical information in a way which also brings the neighbourhood to life and stimulates conversation. A total of 12 murals were created across the city, some of which have already featured in national and international media.
Given that we were operating in a crisis, we had to consider the balance between achieving comprehensive M&E and speed of execution. We rigorously tracked the distribution of products into the market and where we identified distribution partners were experiencing challenges, worked with them to resolve issues or reallocated supply to partners who were more efficient in distribution.

Given the challenges in physical movement due to lockdown restrictions, typical distribution M&E practices such as mystery shoppers were difficult to deploy so we were reliant on manual data entry.

For community distributions, validation was conducted by placing confirmation phone calls to samples of the tracking sheets. We were however often delayed in catching discrepancies because we were short-staffed.

Assessing the effectiveness of behaviour change was more difficult to quantify as we had no time to conduct extensive baseline assessments of people's level of knowledge, attitudes towards and behaviour around COVID-19 and then return after the campaign was activated to assess the changes. We relied on tracking the number of people reached through different channels (e.g. social media, radio and print advertising, community engagement etc), which was less than optimal.
The Safe Hands Kenya model was designed to address a specific set of immediate public health needs in a crisis situation. However, we sought to design our interventions in ways which would continue to pay public health dividends long beyond the immediate threat of COVID-19.

For example, improved hand washing practices advocated as part of the first line of defence by reducing the risk of infection by COVID-19 also has broader proven public health benefits, including fewer deaths and serious illness from diarrhea-based diseases, which are a major killer of children under 5 in many countries in Africa and Asia.

We prioritised the role of local leaders and influencers in contextualising and implementing solutions for their community, specifically in terms of taking long term responsibility for the management and resourcing of handwashing stations. Having built a no-cost peer education model at the community level, we anticipate that the impact of each educator will continue to reverberate across their individual social networks and wider community.
The Tiba Ni Sisi campaign, whilst specific to COVID-19, sent a clear empowerment message to people that they can and must take responsibility for public health. The behaviour changes advocated through the campaign can be applied beyond COVID-19 to reduce the risk of infection in the event of future pandemics.

Finally, we sought to amplify the impact of Safe Hands Kenya beyond the country’s borders. Additional chapters of Safe Hands were established in Tanzania and Ethiopia, with the support of Dalberg.

In Tanzania, Safe Hands is planning on reaching 100,000 households in its first phase, starting in Dar Es Salaam. Similarly to the Safe Hands Kenya model, Safe Hands Tanzania relies on the expertise of its alliance members, which includes UNICEF, Coca-Cola, local brewing companies and other private sector actors. Its partnership with the CEO Roundtable of Tanzania, which hosts the project management team, facilitated private sector involvement.

As with Safe Hands Kenya, one of the main challenges is raising funds outside of the private sector while remaining adaptable. In a demanding environment, charities and other non-private sector funders request set objectives and plans, which Safe Hands Tanzania has not been able to provide as it had to retain the agility to adapt to the community and the government’s evolving needs. Its ability to raise funds outside of the private sector is now improving as its goals become clearer.

As the COVID-19 pandemic evolves and to ensure its sustainability, Safe Hands Ethiopia has adopted a broader WASH approach. The Safe Hands Kenya model was adapted to enable the government to play a more significant role in distribution. The Ethiopian government manages an effective distribution network enabling Safe Hands Ethiopia to reach the most vulnerable Ethiopians directly. Alliance members remain in charge of production. Moreover, as private sector actors are obliged to retain employees during the COVID-19 crisis, their incentive to get involved in COVID-related activities is high. A decrease in business activity has meant that some employees have had more time available to dedicate to efforts to stem the spread of the pandemic. Safe Hands Ethiopia has also kept some businesses alive by building their production capacity, enabling them to scale up both within and beyond Ethiopia once the crisis subsides.