Guidelines for mainstreaming Gender Equality and Social Inclusion and Social and Behavior Change strategies

to effectively reach and ensure access for zero-dose children and their families

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Gavi The Vaccine Alliance

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Abbreviations

DBC	Designing for Behavior Change
FGD	focus group discussion
GAVI	Global Alliance for Vaccines and Immunisation
GESI	gender equality and social inclusion
KII	key informant interviews
PMU	project management unit
SBC	social and behavior change
SNET	Social Norms Exploration Tool
WHO	World Health Organization
ZDC	zero-dose children

Contents

Introduction

These guidelines are designed to support each country secretariat teams' efforts to:

1. Effectively mainstream gender equality and social inclusion (GESI) principles and social and behavior change (SBC) communication
2. Identify and reach zero-dose children (ZDC) and under-immunized children in missed communities in the Sahel, namely Burkina Faso, Mali, Niger, Chad, Cameroon, Central African Republic, and Nigeria
3. Tailor strategies to increase access to, demand, and confidence in immunization

These guidelines build on existing promising GESI and SBC practices from different countries and align with Global Alliance for Vaccines and Immunisation's (GAVI's) Identify, Reach, Monitor, Measure, Advocate (IRMMA) framework. The guidelines also consider best practices presented in *UNICEF 2019 Immunization and Gender: A Practical Guide to Integrate a Gender Lens.*

Although context and capacity differ by country, these guidelines offer a starting point for the design, implementation, and ongoing adjustment of tailored strategies and work plans specific to the needs of each country and people's group context. Your feedback will inform future guideline reviews and revisions. Please direct all feedback to Dr. Enrique Paz, Chief of Party for Raise4Sahel at eepazargandona@worldvision.org.

GESI and SBC concepts

What is GESI?

World Vision uses the following definitions for gender equality and social inclusion.

Gender equality is the state or condition that affords women and girls, men and boys, equal enjoyment of human rights, socially valued goods, opportunities, and resources. It includes expanding freedoms and voice, improving power dynamics and relations, transforming gender roles, and enhancing the overall quality of life so that males and females achieve their full potential.

Social inclusion seeks to address inequality and/or exclusion of vulnerable populations by improving terms of participation in society and enhancing opportunities, access to resources, voice, and respect for human rights. It seeks to promote empowerment and advance peaceful and inclusive societies and institutions.

GESI is a *multifaceted process of transformation* that:

- Promotes equal and inclusive access, decision-making, participation, and well-being of the most vulnerable and marginalized
- Transforms systems, social norms, and relations to enable the most vulnerable to participate in and benefit equally from development interventions
- Builds individual and collective agency, resilience, and action
- Promotes the empowerment and well-being of vulnerable children, adolescent girls and boys, their families, and communities

World Vision's GESI approach and theory of change[1,2] feature five domains of change necessary for gender equality and social inclusion. These include access, participation, decision-making, systems, and well-being.

1 Gender_Equality_and_Social_Inclusion_Approach_2021.pdf (wvusstatic.com)

2 Michie S, Atkins L, West R. The Behaviour Change Wheel: A Guide to Designing Interventions. UK: Silverback Publishing; 2014

Access
The ability to access, use, control, and/or own assets, resources, opportunities, services, benefits, and infrastructures

Participation
The ability to participate in or engage in societal affairs and systems of power that influence and determine development, life activities, and outcomes

Decision-making
The ability to make decisions free of coercion at individual, family, community, and societal levels, including control over assets and the ability to make decisions in leadership

Systems
The availability of equal and inclusive systems that promote equity, account for the different needs of vulnerable populations, and create enabling environments for their engagement

Well-being
The sense of worth, capability, status, confidence, dignity, safety, health, and overall physical, emotional, psychological, and spiritual well-being, including living free from gender-based violence, HIV, and all forms of stigma and discrimination

Why is GESI important for reducing the number of zero-dose children?

Vaccination is impacted significantly by GESI issues. Inequalities for different groups across the five domains create barriers to vaccination, as illustrated by the following examples.

Access: Inequalities in access to vaccination services for people living outside the reach of the health system mean that some population groups will not be vaccinated.

Participation: Lack of health staff from local communities that speak local languages and their unfriendly attitudes may mean that communities are reluctant to get services.

Decision-making: Lack of parental or caregiver engagement when deciding when, where, and how to vaccinate may mean that the process will not meet the needs of the target population.

Systems: Vehicle and petrol funding shortages thwart mobile outreach efforts to serve underfunded communities

Well-being: When women are worried about being attacked when traveling to the vaccination site due to recurrent conflicts, they will not bring their children.

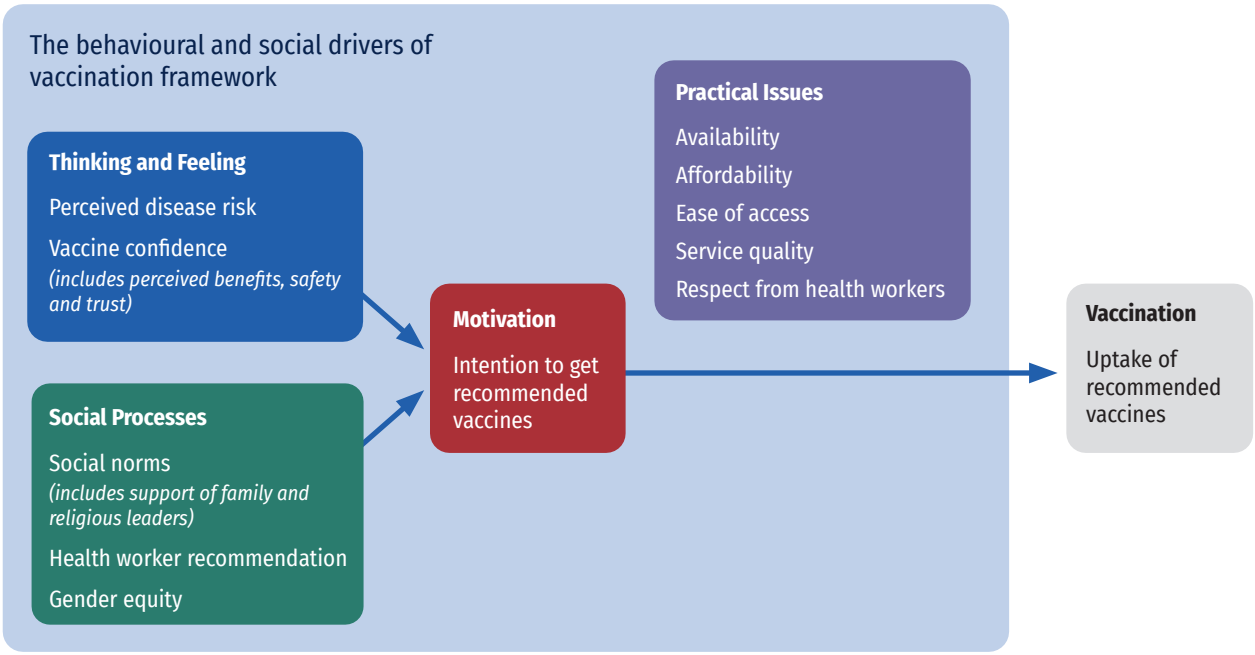
What is SBC?

SBC describes efforts to transform or modify human behavior. Smoking cessation, changing eating habits, and starting to exercise are all examples of individual behavior change. For development practitioners, SBC seeks to understand the behaviors of target audiences that result in learning and change.[3] Desired individual behavior changes might include parents taking their children to get vaccinated according to the WHO schedule or community members staying indoors to curb the spread of a virus.

WHO and UNICEF recently published a framework related to improving vaccine acceptance.[4] This framework defines behavioral and social drivers of vaccination as beliefs and experiences specific to vaccination that are potentially modifiable to increase vaccine uptake. This framework groups these drivers into four domains (see figure below):

- Thinking and feeling about vaccines
- Social processes that drive or inhibit vaccination
- Motivation (or hesitancy) to seek vaccination
- Practical issues involved in seeking and receiving vaccination

Figure 1. TheBeSD Framework



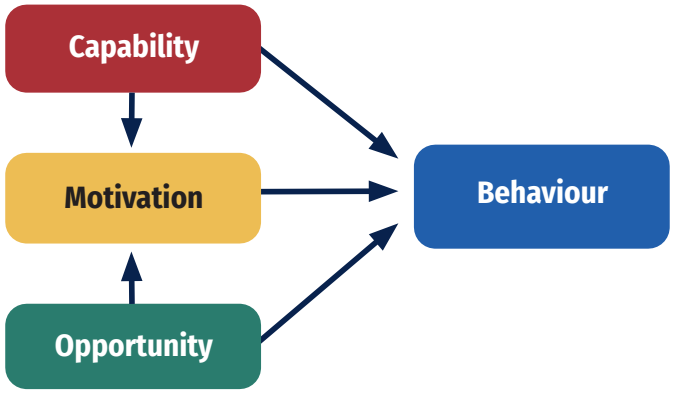
The BeSD working group. Based on Brewer et al. Psychol Sci Public Interest. (2017).

The above framework can be beneficial, particularly when discussing immunization norms and policies at the national level. However, we believe the Capability, Motivation, Opportunity, Behavior model is better suited to the community-based SBC work that INGOs and local NGOs are more likely to experience. If a person has the

3 World Vision (2021). Behavior Change: Practical Implementation Guidance for Programs.

4 Behavioural and social drivers of vaccination: tools and practical guidance for achieving high uptake. Geneva: World Health Organization; 2022.

Figure 2. Capability, Motivation, Opportunity, Behavior model



needed capability, opportunity, and motivation, they are more likely to perform the desired behavior.

Capability: An individual's psychological and physical Capability to perform the desired behavior. Capability can include:

- Physical skill
- Knowledge
- Negotiating skills
- Ability to remember the information necessary to perform the behavior

Motivation: An individual's desire to perform the behavior. Motivation can include:

- Perceived negative or positive consequences
- Perceived social norms
- The belief that they can perform the behavior (perceived self-efficacy)
- The confidence that the desired behavior will lead to the correct outcome (perceived action efficacy)
- The conviction that the desired behavior can further their life goals
- Other drivers that lead the person to either perform or avoid the behavior

Opportunity: The social and physical environment that might encourage or impede the behavior. It's important to note that many marginalized individuals are limited by societal norms and systems, that prevent them from exercising their capability. Opportunity can include:

- The availability of services (such as vaccination services) in a community
- Physical, cultural, or linguistic access to health services. (Including security risks traveling to and from the point of service delivery)
- The cost of a needed service (fees) and/or the opportunity cost (e.g., cost of not working to generate income in order to take a child for vaccination services)
- Women's and men's time burden or availability of time to engage in the desired behavior (e.g. taking a child for vaccination or breastfeeding a child)

- Access to needed commodities or materials in the market (e.g., affordable soap for handwashing)

Capability	An individual's psychological and physical capability to perform the desired behavior *Examples: physical skill, knowledge, negotiating skills, and ability to remember the information necessary to perform the behavior*
Motivation	An individual's desire to perform the behavior *Examples: perceived negative or positive consequences, perceived social norms, the belief that they can perform the behavior (perceived self-efficacy), the belief that the desired behavior will lead to the correct outcome (perceived action efficacy), the belief that the desired behavior can further their life goals and other drivers that lead the person to either perform or avoid the behavior*
Opportunity	The social and physical environment, gender and social norms that might encourage or impede the behavior *Examples: physical, cultural, or linguistic access to a service, reduced fees, access to relevant commodities in the market*

This guide will use the GESI framework and domains described above, with aspects of the Capability, Motivation, Opportunity, Behavior model embedded in the GESI framework.

SBC includes strategic communication that goes beyond delivering information and raising awareness (knowledge). It addresses essential aspects of capability and motivation to influence the change of individual behaviors. Traditional communication tools (e.g., media campaigns, posters) are combined with behavioral science insights to produce tangible differences in people's actions.

Key messages are contingent on formative research that identifies the most critical drivers of the desired behavior (barriers and motivators). Communication tools and strategies incorporate responses to specific behavior statements (e.g., What is the behavior? Who should do the behavior? At what times and under what circumstances should the behavior occur?). SBC acknowledges that broader social factors influence an individual's behavior. The individual's own perceptions and aspirations, as well as those of family and community members, can affect the individual's behavior. Communication efforts, how and when services are delivered, laws and regulations, cultural barriers and enablers, and the social and physical environment also impact behavior.

Why is SBC important for reducing the number of zero-dose children?

SBC efforts are critical to ensure that ZDC receive quality and sustainable vaccine services. These strategies are varied and based on formative research, which identifies key aspects of the capability, motivation, and opportunity of parents or caregivers of ZDC or under-immunized children. SBC interventions go well beyond raising awareness and other traditional knowledge-based approaches. SBC principles will guide various aspects of the design and implementation of programs. They will be applied in our work to engage influencing

groups, such as faith leaders, who are often the leaders and stewards of local attitudes and social norms.

Infrastructure provides the necessary means for people to practice many healthy behaviors (Opportunity). But infrastructure alone is often not enough to ensure behavior change. SBC is essential to our work because it ensures the safe, effective, and sustainable use of the services we provide. It promotes gender equality, government accountability, and other norms that can transform communities. These changes enable vaccine services. To effectively design behavior-change interventions, we must ensure we understand the following about each behavior:

- The behavior we seek to facilitate
- The target groups and influencing groups
- The current behavior being influenced
- The barriers and motivators that influence the practice of the desired behavior
- The interventions that will remove barriers and enhance motivators

Overall context and assumptions

These guidelines assume that addressing barriers impacting the supply and demand for vaccination can reduce the number of ZDC.

Environmental and systemic barriers impact opportunity. Other barriers are rooted in the capability and motivation of caregivers. Although the guidelines include steps to address environmental and systemic barriers, they emphasize social and behavioral components.

Barrier types

Supply-side barriers

Attitudinal barriers: Attitudes of healthcare workers towards zero-dose communities or groups within those communities can include stigmatizing refugees, nomads, migrants, persons with disabilities, those with lower education levels, persons living in poverty, and ethnic and religious minorities. These attitudes may result in healthcare workers failing to provide a quality service to zero-dose communities.

Environmental barriers: Environmental barriers include the distance to vaccination sites, vaccine supply limits, and infrastructure and equipment limitations that compromise health facilities' abilities to vaccinate children.

Systemic barriers: Systemic barriers are multifaceted. Healthcare system barriers include vaccine shortages, lack of trained healthcare workers, and insufficient healthcare infrastructure in remote areas. Community barriers include not providing information in the local language; limited laws, policies, and other forms of government support; and failure to incorporate the input of key groups when determining vaccination intervention logistics (dates, times, locations). Resource barriers include under-resourced supply chains, funding shortages, and lack of final-mile resources.

Demand-side barriers

Attitudinal barriers: Socio-cultural norms and parent/caregiver attitudes regarding vaccination, vaccination campaigns, and general health services can negatively impact efforts to reduce ZDC numbers. Common misperceptions include the notion that the risk of being unvaccinated or the susceptibility to contracting preventable infectious diseases is low.

Environmental barriers: Environmental barriers include long distances and poor security between households and vaccine sites.

Systemic barriers: In most target communities, the cultural norms regarding women impede vaccination efforts. Often, women aren't allowed to travel outside the home without their husbands or a male chaperone, are subject to their mothers-in-law, and are too busy with chores to take their children to vaccination. Influential community members are often unaware of the benefits and effectiveness of vaccines. Boys are commonly prioritized over girls to receive vaccinations. The child's overall health and the costs associated with accessing vaccines can also impact a family's vaccine pursuits.

Who are the zero-dose and under-immunized communities?

These populations are not simply under-served. They are systematically beyond the reach of government or other provider health services and therefore missed by routine immunization outreach. Zero-dose and under-immunized communities often consist of refugees, undocumented migrants, nomadic groups or, ethnic and religious minorities. Within these groups, the economically disadvantaged, single-headed households, persons with disabilities, and young women are particularly marginalized.

Service providers and administrators will receive GESI training

This training is a vital component of the GAVI program because it is critical that those engaged in vaccination at all levels are aware of their unconscious and conscious biases for or against certain groups. Without this, systemic and attitudinal barriers will likely remain, and certain groups will continue to be unreached by vaccination services.

Formative research to inform strategy

The answers to key questions will identify demand and supply side GESI and SBC barriers and motivators and will equip us to develop an effective strategy to reach ZDC and under-immunized populations. Not only is formative research essential to guide initial strategy development, it also needs to be conducted periodically over the project's life to ensure effective implementation as new problems arise. The questions below align with the five World Vision GESI domains. These are illustrative, and you may be able to identify others. Answers may come from a variety of data sources. For example, if your office has already conducted a secondary data or desk review, key informant interviews (KIIs), or focus group discussions (FGDs), use that information to answer your formative research questions. The different methodologies are listed below.

Demand: Assess with caregivers of ZDC

Access: Identifying how to improve caregivers' ability to access services

1. Do marginalized groups have the time necessary to access health services? (FGDs)
2. Do marginalized groups have access to the money and resources needed to access health services? (FGDs)
3. What capability, opportunity, and motivation barriers hinder different groups from accessing vaccination services? (FGDs)
4. Where does your target population get trustworthy vaccination information? What about general health information?? (FGDs)

Participation: Identifying who we need to target to take children to be vaccinated

1. How do men and women support the health of their children? (focus group, desk review)
2. Who takes children to seek health services? Men or women? Grandparents or parents? Brothers or sisters? (FGDs, possibly desk review)
3. What role, if any, do men have? Will they support household chores if the woman takes the child to the health service? (focus group, desk review)

Decision-making: Identifying who we need to target regarding the decision to vaccinate

1. Who decides at the household level whether to access health services (or immunization services)? Does this vary for different groups?[5] (desk review, FGDs)
2. Who makes financial decisions at the household level? How does this impact access to health services? (desk review, FGDs)
3. Who influences your decision-making? (reference group tool)

Systems: Identifying changes in social norms and other informal systems we need to make

1. What vaccination social norms exist related to vaccinations in general; the safety of childhood vaccines (polio, DPT1,2,3, measles); and routine immunizations? How do religious beliefs influence these norms? (desk review, FGDs, barrier analysis)
2. What social norms exist related to seeking health care? (FGDs, barrier analysis, supply-side data)
3. Are there any informal sanctions for those that are unvaccinated? (FGDs, barrier analysis)
4. Are there any informal sanctions for those that are vaccinated? (FGDs, barrier analysis)
5. Are there any kinds of children who don't get vaccinated? (children with disabilities, children born out of wedlock, children born out of rape, etc.) Why? Is it different for boys and girls? Why? (FGDs, barrier analysis)

Well-being: Identifying actions needed to mitigate perceived risks

1. Do people feel they can access vaccination services safely? If not, which population sub-groups feel unsafe? Why do they feel unsafe? (FGDs, desk review)
2. Do all population sub-groups think that the service provider will respect them? If not, which groups feel disrespected? What generates this concern? (FGDs, desk review)

Supply: Assess in target districts with vaccination providers and service users

Access: Identifying actions needed to improve access

1. Which groups do not access vaccination services? (Identified by ethnicity, religion, language, location, internally displaced person, refugee, economic group, or education level) (KII, government disaggregated data)

5 There may be different decision-makers for different kinds of health services. For example, if a child is having trouble breathing, the mother might be expected to make the decision to seek care. However, a different dynamic may exist for preventative care such as antenatal care or childhood vaccination. If immunization services are unavailable in the community, then questions about seeking general health services may serve as a sufficient proxy.

2. Can all community members easily access vaccination sites? Is transportation provided for some groups? Are home visits made for those who cannot travel? (KII triangulated with caregiver focus group results)
3. Can someone using a wheelchair or who cannot climb steps access the vaccination site? What proportion of vaccination sites are accessible? (accessibility audit)
4. Can persons administering vaccinations speak languages spoken by community members, including sign language? (KII with providers, triangulated with caregivers)
5. Is the information at the vaccination site presented in different languages, in written and oral formats, with strong visuals to support those who are illiterate? (review of materials)
6. Is information distributed in such a way that everyone can receive it? Are there special arrangements to disseminate information to groups who do not usually receive general information?[6] (KII, balance with demand information)

Participation: Improving participation of marginalized groups from communities in vaccination

1. Who makes up the paid and unpaid staff (those vaccinating and those who communicate about the vaccination and facilitate the process)? Who delivers vaccines? What is the rate of turnover of paid and unpaid staff (disaggregate by sex, age, disability, and education levels)? Are these groups representative of the local community? Do they speak local languages? Are they sensitive to local cultural issues? (Existing health HR data, KII with senior health administrator to be verified with community and junior vaccination staff)
2. What incentives motivate unpaid staff? Are these sufficient? What additional motivations could incentivize staff? What are the intrinsic motivators for volunteer staff, and how can they be strengthened?[7] (KII with administrator of vaccination services)
3. What barriers prevent other community members from volunteering in support of vaccination efforts? Specifically, what additional barriers exist for women, refugees, migrants, internally displaced persons, persons with disabilities, young people, or older persons? (KII)
4. Can local community members comment on the services provided and hold providers accountable for the quality of vaccination services? (KII and triangulate with caregivers)

Decision-making: Creating a more inclusive decision-making process on vaccination delivery

1. Who makes community-level decisions regarding the location, time, delivery, and administrative requirements for vaccine service provision (disaggregate by sex, age, disability, and education levels)? (KII and triangulate with caregivers)
2. What role, if any, do marginalized groups have when determining vaccination distribution logistics? For example, can they influence the location, date, or time? (KII and triangulate with caregivers)

6 E.g., if faith leaders provide the information, do people who are not part of faith groups have a way to receive information?

7 Effective community volunteer intrinsic motivators that have been shown effective with community volunteers vary by individual. They can include autonomy, a sense of belonging, mastery of new tasks/knowledge, recognition, feeling valued or respected by community members and the health system, manageable workload, etc. For further discussion see Sarriot E, Davis T, Morrow M, et. al. Motivation and performance of community health workers: nothing new under the sun, and yet... Glob Health Sci Pract. 2021;9(4):716-724. https://doi.org/10.9745/GHSP-D-21-00627

3. What, if any, feedback mechanisms are available to service users to impact decisions? How do they work? Is the mechanism accessible in different languages or for illiterate service users? Are there opportunities to provide anonymous feedback? (KII and triangulate with caregivers)

Systems: Identifying systemic changes to make the system more inclusive (mainly from secondary sources, some KII from higher level)

1. What policies and practices help remove barriers to increased female and disadvantaged-group participation in the health workforce, whether in paid or unpaid positions?
2. Is GESI training provided to healthcare workers to ensure they are aware of unconscious bias and issues that may impact their ability to serve all groups?
3. What policies promote greater engagement of marginalized groups in decision-making?
4. Are there any policies that require health centers to be accessible for persons with disabilities or to have translation services available for people who don't speak the language spoken by healthcare providers?
5. Is there sufficient funding to cover the additional costs of reaching harder-to-reach communities? If not, what are the barriers to securing additional funding?
6. Has there been a GESI analysis of the vaccination process and the delivery system to identify necessary changes? If so, what were the findings, and what subsequent actions were taken?
7. Can marginalized groups impact spending on health care services in their communities? If so, provide examples of how they do this. (local government)
8. Can marginalized groups hold the government accountable for the quality of healthcare services in their communities? If so, give examples of how they do this.
9. What are the current strategies/approaches to overcome barriers related to routine vaccination of children?

Well-being: Ensuring the safety and overall well-being of all service providers and users (KIIs)

1. What efforts are in place to ensure everyone can access vaccination sites safely? Are there special provisions for those with disabilities, minority groups, or other vulnerable groups?
2. What processes ensure male and female staff are safe when providing services while still reaching communities in areas where violence or conflict is common? Specifically, do female workers feel safe?

Data disaggregation and analysis to inform strategy and implementation

To identify and target ZDC, it is essential to have reliable data that is disaggregated and analyzed. Factors that may be important in predicting vaccination rates within a community include:

- Sex
- Age
- Disability
- Language spoken
- Education level
- Literacy level
- Faith group
- Ethnic group
- Economic status
- Refugee or migrant status (including internal displacement)
- Distance to the vaccination site
- Prior health-seeking behaviors (e.g., prenatal visit)
- Age at marriage
- Number of children

If this level of disaggregation is possible, local governments can compare the percentage of certain groups accessing vaccination with their overall percentage within the population to identify which groups are not accessing vaccination or are accessing at a disproportionately low rate. It is also important to train vaccination staff to work with caregivers of ZDC and community members to monitor vaccination participation of different groups to verify data on disaggregation. If data disaggregation is impossible, training vaccination staff to collect this data will be even more critical.

Universal design for vaccination:

Creating an inclusive vaccination system accessible to as many people as possible

What is universal design?

Universal design is "the process of designing something to be functional as possible for as many people as possible" and is rooted in architecture.[8] Buildings that adhere to this principle are designed and constructed to meet the needs of any user and, consequently, are better for all users. For example: providing lifts, ramps, and accessible toilets and having wider doorways is essential for wheelchair users, but these design elements are also beneficial for people who have trouble walking up steps or are pushing a stroller.

How does universal design apply to vaccination services?

Suppose the vaccination system is designed to address the most significant needs and barriers. In that case, it will be functional and beneficial for as many people as possible to the greatest extent possible. Doing so means first considering the needs and barriers for individuals in zero-dose communities, potentially a woman who:

- Is living in remote or nomadic communities
- Has no access to transportation
- Is unable to wait for a long time standing up or in the sun
- Must be accompanied by men
- Is unable to read or write
- Requires written and verbal communication in their native language
- Has limited money
- Has limited time
- Is distrustful of the government
- Is threatened by security risks when accessing any services
- Is unable to leave other children at home when coming to the vaccination site

Below are some key factors to consider and actions to address these challenges. Use this list to assess how well your service is doing and to develop minimum standards for service provision:

Barrier	Possible actions
Language	Provide interpreters at the point of service who can communicate with providers and the local population; provide information in all languages
Cultural	Hire people from minority groups within communities; train providers to be sensitive to cultural needs; engage local groups in finalizing service delivery and information provision design

8 Source: What is Universal Design? | The Universal Design Project

Physical distance	Provide mobile services to supplement existing services in locations that are close, safe, and accessible
Religious beliefs	Engage religious leaders in behavior change communication and service delivery
Financial	Provide financial incentives; cover direct and opportunity costs of accessing a service
Lack of physical mobility	Provide accessible transport; ensure vaccination sites don't have steps or other physical barriers limiting access
Restrictions on individual travel and agency	Make household visits to negotiate permission to access vaccination services
Attitudinal	Provide behavior change communication to address key aspects of capability and motivation barriers that impact accessing vaccination services
Childcare	Provide childcare services at the point of delivery
Security	Provide services in safe locations and at times that are considered safe
Stigma/discrimination	Accompany vulnerable groups; work with service providers to address any stigma or discrimination; promote positive images of excluded groups in information about vaccination; engage vulnerable groups in planning and implementing vaccination service delivery and information provision activities; advocate for actions that enhance equality and inclusion
Time	Stagger vaccination delivery to reduce waiting times or designate specific times and days for different groups
Unpleasant experience	Provide seating and shade as needed; provide food and drinks; ensure there is a latrine nearby
Literacy	Remove any need for caregivers to sign or read any documentation; provide information in oral formats; identify roles to be played in supporting vaccination by illiterate community members

See Appendix 6: Sample quality assurance tool for universal design within service delivery for a sample quality assurance checklist.

Steps in integrating SBC and GESI to reduce the number of ZDC

The table outlines seven steps for integrating SBC and GESI to reduce the number of ZDC. It lists the rationale (Why?), the methodology used (How?), the result (What?), the lead actor (Who?), and other stakeholders (With Whom?)

Step	Why	How	What	Who	With Whom
National and regional level					
1. Identification of groups not accessing vaccination services	To identify priority geographies or groups	Existing ZDC data, collective brainstorming	Target communities and populations identified	Project management units (PMUs), secretariat	Local vaccine providers from target communities
2. Barrier identification	To understand supply-related barriers	Provider KII, user FGDs, participatory learning and action, secondary data	List of identified barriers	PMU, secretariat	Local vaccine providers from target communities
3. Universal design for service delivery	To support the implementation of barrier-free services	Workshop to review protocols and standards based on identified barriers	Revised protocols and standards that remove identified barriers	PMU, secretariat	Local vaccine providers from target communities
Community level					
4. Contextualizing universal design and SBC plan	To adapt universal design and SBC plan to the local context	Engage ZDC caregivers and key community groups	Adapted service delivery and SBC plans	PMU, secretariat, local vaccine providers	ZDC caregivers, key community groups
5. Monitor vaccination participation	To identify ZDC groups	Disaggregated vaccination data	ZDC groups identified	PMU, secretariat, local vaccine providers	Key community groups
6. Identify reasons for persistent non-doers and drop-outs	To remove demand and supply barriers and develop targeted SBC	KIIs, FGDs, barrier analysis, social norms exploration	Prioritized list of identified barriers	PMU, secretariat, local vaccine providers	ZDC caregivers, dropouts
7. Revise and target SBC plan	To vaccinate non-doers and dropouts	Engage ZDC caregivers and key community groups	Revised service delivery and SBC plans	PMU, secretariat, local vaccine providers	ZDC caregivers and key community groups

The objective of the seven steps is to help a country team narrow the focus of their SBC work to groups and individuals for whom removing environmental barriers is insufficient to encourage them to vaccinate their children.

Tools to support GESI and SBC

These guidelines outline several tools that promote sound formative research, design, and social and behavior change. This table summarizes the tool itself, how to use it, and its inherent strengths and weaknesses. The choice of tools will be influenced by a number of factors, including budget, time, and availability of staff.

A secondary data review is the first step in any formative research, and based on the gaps assessed, other formative research tools like focus group discussions can be used. In general, the more that can be learned from secondary data and the more that you can use universal design to reduce barriers to accessing vaccination services, the less you will need to use other tools. Other tools can be used to support Step 6, particulary if you have a community that is still not accessing vaccination services.

The following case examples are provided to guide in the selection of the tools outlined below.

Scenario #1: Vaccination services are well-established in the community and universal design has been used to remove barriers to vaccination services. You can't think of anything else you can do to make the service more accessible or to improve its quality. However, the majority of one section of the population that is still not accessing services.

In this scenario, we are at Step 6 from the table above. You know which groups are not getting children vaccinated but you don't know why. You have tried everything to make sure your service is as good as possible. You can therefore assume that there is a demand issue. A barrier analysis with 45 caregivers from that section of the population who are vaccinating their children and 45 who are not would be a good way to identify the key differences between doers and non-doers, and determinants that impact their behavior. If the barrier analysis identifies awareness-related barriers (e.g., non-doer caregivers have trouble understanding when they should bring their children for vaccination), you could then use focus groups with participants from this section of the population to problem solve or organize a focus group on the journey map to identify constraints at each stage in the vaccination process. If the barrier analysis identifies that gender or social norms are playing a significant role (e.g., non-doer caregivers believe that vaccination will make children sterile and that traditional medicine is better than modern medicine), you could then use the reference group identification and focus groups for social norms exploration to inform Designing for Behavior Change to develop an SBC strategy.

Scenario #2: There have been no vaccination services available in a rural community but some caregivers have travelled to get their children vaccinated in a clinic in the nearest town. You now plan to provide vaccination services in the community because there are concerns that the need to spend money and time travelling is the reason why other caregivers are not getting their children vaccinated.

In this scenario, we are at Step 4 from the table above. Since you are in a new community, you don't know if cargivers will get their children vaccinated at the new vaccination service in their community. However, you do have some information about this community. You could identify if there are certain sections of the population that never travelled to get their children vaccinated before. You could then hold a focus group with them using the journey map to identify quickly which barriers might exist with your planned services. However, this is not a time of barrier analysis or additional focus groups until you know how successful your efforts to vaccinate children within this new service will be. If later on you find yourself at Step 6 and you know which children are not being vaccinated after most children have been, then you can invest in additional work as outlined in scenario 1.

Formative research

Tool	Description	Use	Strengths	Weaknesses
Barrier analysis	Survey 45 caregivers who chose vaccination and 45 who didn't	Understanding the impact of different behavioral determinants	Clarifies the relative importance of different determinants	Needs additional follow-up to understand factors behind determinants
Secondary data review	Review existing studies that help you to understand key questions	Answering key questions	Easy, cost-effective way to identify what is already known; reduces the amount of primary data collection	Data may not be specific to the target geography or the exact behavior; data needs to be verified
Collective Brainstorming	Brainstorm session with key informants to identify ZDC groups and identify relevant barriers	Understanding the assumptions of key informants	Rapid way to understand what is known about barriers for ZDC	It is only a start; findings need to be verified
Reference group identification	Interviews with 15 male and 15 female caregivers about who influences their vaccination choices and actions	Understanding reference groups for our target group	Identifies reference groups requiring mobilization to support vaccination	Focus groups with reference groups are needed afterward
Focus groups for data collection and problem-solving	Focus groups respond to key questions	Understanding key questions	Allows for triangulation and consensus	Participants may change their answers based on the group dynamic
Focus group for social norms exploration	Participatory discussion based on 5 Whys, problem tree, or a vignette	Understanding gender and social norm dynamics driving behavior	Unpacks norms very clearly; allows the development of SBC messaging	Doesn't identify the importance of the norm driving the behavior
Focus group on the journey map	Participants comment on their experience of the vaccination journey	Identification of barriers and enablers	Clear feedback about barriers that exist in the process	Additional follow-up needed to analyze norm-related barriers
Key informant interviews	Key questions asked to individuals	Understanding key questions	Participants are likely to be more open and more precise in response than in a group	Information requires triangulation

Design

Tool	Description	Use	Strengths	Weaknesses
Designing for Behavior Change	A systematic method to design SBC strategies, to remove barriers and capitalize on enablers for behavior change	SBC strategy design	Promotes easy SBC strategy design	Rigid matrix that can leave out vital information

Social and behavior change methods

Tool	Description	Use	Strengths	Weaknesses
Care groups	A group of 10-15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. Each volunteer is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned, and facilitating behavior change at the household level.	Deliver SBC key messages at the household level by a peer educator. Facilitates collection of important household life events that can be used for program design	Provides almost 100% coverage	A community must meet a set of criteria for effective implementation of care groups
Mass media	Different channels to disseminate information for awareness raising (radio messages, flyers, etc.)	Awareness raising	Informs people with actionable, key information such as vaccination days, etc.	Does not necessarily produce behavior change
Channels of Hope	Mobilizes faith leaders and groups to support messaging and action on vaccination	Messages encouraging vaccination, logistical vaccination support	Engages potential, influential community leaders	Faith leaders may not be influential in decisions on vaccination
Citizen Voice and Action	Empowers community members to monitor service provision based on standards	Enhances service delivery by improving service accountability	Allows for immediate feedback to service providers	Less critical if services already meet standards

APPENDIX 1:
Collective brainstorming

This tool is part of a series of tools outlined in World Vision's Gender_Equality_and_Social_Inclusion_DME_Toolkit_2021.pdf (wvusstatic.com).

Collective brainstorming helps you to understand who is excluded in a community, the power dynamics involved in the exclusion, and how to ensure full engagement of marginalized groups in development planning. The focus is on identifying marginalized and vulnerable groups, the causes of their marginalization and vulnerability, and the relevant others who influence the excluded groups' expectations and behaviors (reference groups). Collective brainstorming can also help analyze project-level risks, such as the potential unintended risk of project exclusion, suggested mitigation strategies, and any other information needed to improve the project's inclusivity.

Who participates?

Participants include project team members, knowledgeable local project staff, local community leaders, and representative individuals from vulnerable, marginalized, or excluded groups. Vulnerable, marginalized, and excluded individuals must be represented and participate in this process; otherwise, we will not understand the whole picture. When including persons with disabilities, ensure that you have a range of impairments represented (visual, hearing, mobility, intellectual, and mental).

Directions

Perform the activities below based on the step-by-step guidance provided. The activities will enable you to identify who might be excluded in a proposed project area and help make the dynamics involved in exclusion visible. After that, you can address the vulnerabilities you identified. The outcomes of the activities should then be consolidated into a coherent idea and recorded in the table provided below.

Facilities and materials needed: computer, projector, flip chart, and markers

Human resources needed: one facilitator and one note-taker.

Step-by-step guidance

1. Set up the group of participants.
2. Use the following questions to guide your collective brainstorming:
    a. What social categories exist in your proposed project area (e.g., persons with disabilities, ethnic, religious, occupational, socio-economic status, caste, etc.)?
    b. Of these, which categories of people are the most marginalized, excluded, or vulnerable?
    c. Are there groups of people described in local languages in particularly negative or derogatory ways? If yes, which ones?

d. In what ways are they vulnerable, marginalized, or excluded?
e. Which social norms and/or cultural practices exist in this area that may prevent some people from benefiting from the project?
f. Who are the relevant stakeholders or people who influence the exclusion of marginalized or vulnerable groups?
g. Who are the influential groups or institutions that enforce compliance with exclusionary gender and social norms?
h. How do those influential stakeholders, people, groups, or institutions reinforce the social and gender norms that impede social inclusion?
i. What will be the risk of excluding marginalized and vulnerable groups from the project?
j. What role will these influential stakeholders, people, groups, or institutions play in changing gender and social norms to promote gender equality and social inclusion?
k. How can those excluded, marginalized, and vulnerable people be targeted in the project and benefit from the project interventions?

3. Address each question:
   a. Independently, writing down ideas for each question, jot down what comes to your mind first (10 minutes). Silent reflection is powerful!
   b. Working in pairs, share/discuss your answers question by question (10 minutes). What have you written down in common? What else did you think of while sharing?
   c. As a small group, review each question. Discuss and document the most common ideas and what else might be missing (30 minutes). Select one person to act as a facilitator to help ensure everyone shares their thoughts with the group.

4. Brainstorm answers to the following questions in a group. Use flip charts to record your answers.
   a. How can your project change the relationship/status of marginalized people within households and communities? (10 minutes)
   b. Of the options you listed, which are possible/likely to be addressed by your project?

      Have each person rank their preference privately (5 minutes). Collate the answers as a group and discuss ranking results (10-15 minutes). The final result should be at least three good/likely-to-be-addressed actionable projects
   c. What additional information is missing? What else do you need to know to help the project to be more inclusive (to ensure marginalized, vulnerable, and excluded people will be included in and benefit from the project)?
   d. How can the additional or missed information be obtained?

5. Complete the table below as a team. References to the specific questions that should help complete the column are under the column headings (e.g., use responses from question 2a to help complete the first column).

6. Display the matrices on a flip chart and ask the participants to fill out the matrix in plenary. This step will help you understand what information you already have and what additional information you need from the follow-up GESI assessments (it could be from literature in Step 2 or participatory GESI analysis in Step 3 through FGDs and interviews). This step allows you to develop a more realistic understanding of how challenging the issue may be and where you could focus your efforts.

Marginalized social groups	Causes of marginalization and vulnerability	The relevant others who influence the excluded groups' expectations and behaviors (reference groups)	Risk of project exclusion	Suggested mitigation strategies	What else do you need to know to improve the project's inclusivity?
2a, 2b	2c, 2d, 2e	2f, 2g	2b, 2c, 2e, 2i, 2h	2j, 2k, 4a, 4b	4c, 4d

APPENDIX 2:

Focus groups

General guidance on running focus groups

Participant identification

Participants should be from different groups within target communities since groups will have different responses. (e.g., men, women, migrants, persons with disabilities, various faith groups, older and younger parents and caregivers). All the groups identified during the collective brainstorming should have representation. If possible, conduct focus groups with reference groups for the parents and caregivers specified in Appendix 5: Reference group identification. Use those with experience in the community to help you to identify participants.

Logistics

- Ensure that the space for the focus groups is private so that responses cannot be overheard.
- Choose a location that is easily accessible by available transport, has an accessible latrine and water facilities, and is accessible for wheelchair users
- Select a space that is well lit and quiet.
- Identify in advance if anyone needs accommodations such as interpretation into sign language or another language.
- Invite between six and eight people per focus group.
- Provide child care options so that participants don't get distracted.
- Cover transportation expenses.
- Arrange seating in a circle if possible with the facilitator part of the circle. If there are observers, they should be behind the participants.
- Ensure that participants don't have to wait for the focus group to start.
- Provide snacks and refreshment, as needed.
- Allow between 60 and 90 minutes for the session.
- Consider having a facilitator of the same gender as participants in single-sex groups. Men and women are often more comfortable sharing their opinions with someone of the same sex.
- Schedule the discussions at convenient times for caregivers.

The facilitator and note-taker roles

There are two key roles, facilitator and note-taker. A good facilitator creates a comfortable atmosphere, is naturally observant of the reactions of others, and can adapt according to these reactions. Both facilitator and note-taker should show warmth, responsiveness, and a general interest in the respondents while avoiding the extremes of being too formal or too relaxed.

The facilitator and note-taker should be neutral in their behavior and attitudes without exhibiting positive or negative bias toward anything mentioned by the respondents. They should avoid verbal and nonverbal cues. Facial expressions, tone, manners, or body language may indicate an attitude or a judgment without the facilitator or note-taker intending to do so. The note-taker should be as discreet and neutral as possible so that participants do not wonder or worry about what is being written down while they talk.

The facilitator and note-taker need to work as a team. The facilitator should be mindful of the note-taker and allow them time to record their notes before moving to the next question or topic in the FGD Guide. The facilitator should allow the note-taker to ask quick, clarifying questions of the facilitator or the participants, if needed. The note-taker may help the facilitator, if necessary, by pointing out questions that were not well explored or missed entirely.

Welcome and introductions

As participants arrive, welcome them and ask them to sit. Thank the participants and start the FGD with the opening section of the FGD Guide. Make sure you address ethical considerations and obtain consent before moving on to the discussion. You may consider asking a few informal warm-up questions to break the ice.

Guiding the discussion

The exploration section is central to the FGD. Ask questions as they are written in the guide, but allow for flexibility in the sequencing or probing questions. Doing so ensures the natural flow of the discussion. Remember that the FGD Guide is a semi-structured tool to help guide the conversation; it is not a survey instrument that requires asking the questions in the same order and exactly as written on the paper. Let the discussion evolve naturally, without intervening unnecessarily, but without letting things get out of hand.

As participants provide initial responses to each main discussion question, probe and investigate further if particularly relevant issues arise. Use your judgment in deciding when to probe further. For instance, you may decide that the group has sufficiently covered a certain topic and that you do not need to ask probing questions from the FGD Guide. Conversely, you may add a follow-up question that was not in the tool but naturally flows from the direction of the conversation and is likely to produce insights of value to the topic of discussion. Do not get carried away, though, as you need to ensure all the main questions in the FGD Guide get answered within the time allocated for the discussion. If you notice that the discussion is superficial or fails to really start, ask for specific examples to generate more input.

Key principles:

- Be patient.
- Don't stop anyone from talking, but ensure that everyone has a chance to express themselves.
- Avoid taking too active a role in the discussion. The goal is to generate a discussion among participants, not a back-and-forth conversation between the facilitator and the participants.
- If someone dominates the discussion while other participants remain silent, thank the dominant participant for their input and turn slightly to face the other participants, calling on them to express their views.
- Make eye contact while asking probing questions to engage less active participants.
- Intentionally reach out and invite participants who are quiet to share their opinions. Ask questions such as: "What do others think? Who else thinks this way? Who has a different opinion?"
- If the conversation goes off track, do not interrupt. Use the first opportunity to summarize what has been said, then redirect the conversation.
- If anyone wants to leave the discussion, allow them to do so. Remember, participation is voluntary, and participants have the right to withdraw at any time without giving a reason. Be sure to thank those who leave.
- Interruptions are common, especially if you cannot find sufficiently private space. Be prepared to manage these patiently and use this time to review the remaining questions, make additional notes, etc.
- If the interruptions become too frequent, consider rescheduling the FGD.
- Consensus at the group level is not required. It is okay if participants have different opinions on the discussed topics. Get a sense of the general group position or—if there is no agreement—what the various positions are and how the group is roughly split between them.

Closing

Be sure to thank participants for their participation. Explain what will happen with the information shared at the FGD. Respond to any questions participants may have and provide them with contact information should they want to provide additional input or ask questions.

Groups focused on collecting information and problem-solving

Focus groups have the potential to collect information and problem-solve. Within this methodology, we propose that you focus on using focus groups to understand demand-related issues. Therefore, the groups will consist of different types of parents and caregivers. You can also use focus groups on supply issues to solve problems identified through KIIs.

On collecting information: Focus groups are an opportunity to ask a series of questions and get a variety of answers. Watch for body language, which shows that people might disagree with an answer given by someone else, and make sure that you ask the other person to share their differing perspectives.

On problem-solving: This format allows you to question the target population to find out how they would solve the problems or issues they have identified. You can use information and ideas from other focus groups that you have conducted to accelerate the process and validate your findings. For example, you could say to a group of men: "Yesterday, we heard from a focus group of women who said that they don't have time to go to the clinic to get children vaccinated because they are too busy with household chores. They are worried that if they go, they might be beaten by their husbands because the dinner will not be ready on time. Do you agree with this? What do you think could be done to address this issue?"

To prepare for focus groups:

1. Review your overall information needs and problems that you want to solve. The questions outlined in the formative research to inform strategy section are a good starting point.
2. Identify the questions focus group members can answer and the issues they can help to problem solve.

During the group, use the questions and issues as a guideline to ensure that all get answered. Ask additional questions throughout to clarify further points when raised. It is good if one person records responses next to the questions so they can assess if all the questions have been answered or problems discussed. They can then support the facilitator with additional questions based on identified gaps.

Groups focused on exploring social norms in more detail (activity focused)

The groups outlined below are designed to focus more on social norms. The groups can collect data on other issues as well, but they should pay special attention to unpacking social norms.

5 Whys (SNET)

Purpose	Identify and prioritize root causes of a behavior
Use with	Main population groups and reference groups
Time	45-60 minutes per group
Mode	Group discussion, with some work done in pairs
Resources	Flip chart paper (one/behavior), markers, pens/pencils, discussion guide, recording form

How to conduct a group discussion using the 5 Whys Exercise

1. Set up a good place to have the group discussion, ensuring that the location is close to where participants are waiting but far enough away to ensure others do not hear the interview.
2. Gather the group for introductions and an icebreaker to create a cohesive group dynamic.
3. Begin the 5 Whys exercise:
    - Write the first Why question, "Why does X exist?" where X is the behavior of interest.
    - Ask the group to brainstorm why the behavior exists. Select only the responses that indicate a social (or cultural) reason for why the behavior exists. (For example, if the question is, "Why don't mothers take their children to get immunizations?" responses may include "mothers are afraid of visiting the clinic" or "mothers can't afford services." The first is a socio-cultural issue, which is a good choice to explore in the exercise. The former is an economic factor and isn't a good choice to explore further.
    - Divide the group into pairs and provide each pair with one of the social (or normative) responses to the initial "why" question, asking them to continue asking "why." For example, in the next round, participants would ask, "Why are mothers afraid of visiting a clinic?"
    - Partners will take turns: One will ask the initial question and continue to ask why for every answer the other provides until they ask five "why" questions. Each pair should record their answers. In the meantime, the facilitator ensures participants focus on normative factors.
    - The group reconvenes and reports their responses while the facilitator or assistant facilitator notes all answers on a flip chart paper/board.
    - When the compilation is complete, begin to distinguish with the whole group what has emerged as social (or cultural) factors (e.g., immunizations are not safe for certain people) and which are not (e.g., immunizations have harmful health side effects). List them on your paper/flip chart or circle them on the flip chart with the recording responses.
    - On a new flip chart or in open discussion, ask the entire group to rank the top four to eight reasons, allowing pairs of participants to share their responses and have the other participants react.
    - **Before closing, ask the participants questions, such as:**
        - Who or what influences the top reasons?
        - What is their effect on main population groups and the community at large?
        - If people do not do the desired behavior, are there positive or negative consequences? What are they?
4. Thank the group for their participation.

5. Record the top four to eight reasons and key discussion points on the recording form (responsibility of the field team). An example is below:

5 Whys		
Location:	Date:	Interviewer:
Group/subgroup:	Number of Participants:	Note-taker:
Behavior of interest:		
TOP FIVE REASONS FOR THE BEHAVIOR OF INTEREST	KEY DISCUSSION POINTS	
1.		
2.		
3.		
4.		
5.		

Problem tree analysis

Purpose	Identify the root causes, both social and non-social, and how they affect behaviors of interest
Use with	Main population groups and reference groups
Time	30-45 minutes
Mode	Group discussion
Resources	Large sheets of paper (one/behavior), pens/markers, additional papers or index cards and

How to conduct a group discussion using a problem tree analysis

1. Set up a good place to have the group discussion, ensuring that the location is close to where participants are waiting but far enough away to ensure others do not hear the conversation.
2. Gather the group and do introductions and an icebreaker to create a welcoming group dynamic.
3. Begin the problem tree analysis:
   - Draw a large tree with roots on a large piece of paper. (Flip chart paper is best.)
   - Draw a tree for each behavior of interest. Consider subdividing the group to work concurrently on different behaviors. Alternatively, the whole group can work on all the problem trees, analyzing one problem first and then the second. (Three or more behaviors would be too much for one discussion).
   - Write the behavior of interest on the tree trunk.

- Ask participants to list what they think are the reasons (or root causes) for why people do (or do not do) the behavior of interest. Write each answer on a tree root (the root cause). Encourage the participants to identify all the reasons (root causes). Draw these along the large roots of the tree, indicating that they are root problems.
- Once you've brainstormed with the group on all possible reasons (root causes), select one of the main reasons/root causes.
- **Ask the group:** "Why do you think this happens?" This question will help participants identify the secondary causes. Draw or write the secondary causes as small roots extending from the larger tree root.
- Now, ask the group to consider the top five (more or less, depending on your program objectives) reasons/causes for the behavior of interest. Circle these reasons with a different color marker/pen.
- Continue to ask the group whether and how each of the top five reasons influences different Main Population Groups. Clarify whether one root cause has a more substantial influence on some people than others.
- When discussing specific groups, ask questions about who rewards or punishes people for doing/not doing the behavior of interest you have written on your trunk.
- When completed, discuss what the problem tree shows and how the causes and effects relate to each other

4. Thank the group for their participation.
5. Record the top five underlying reasons/causes and effects and other key discussion points on the recording form (responsibility of the field team). Remember to take a picture of the problem tree, noting the date/group/theme the visual output represents. A template is below.

Problem Tree	
Location:	Date:
Interviewer:	Group/subgroup OR reference group:
Behavior(s) of Interest:	Problem Question/Action:
Top 5 Root Causes of the Problem Behavior 1. 2. 3. 4. 5.	Key discussion points

INSERT DRAWING OF A TREE

Vignettes

Purpose	Explore the social norms that influence the behavior(s) of interest and understand the extent that norms and sanctions are influencing behaviors
Use with	Main population group and reference groups
Time	45-60 minutes
Mode	Group discussion
Resources	Question guides, possibly with images to show participants while reading, recording forms

How to conduct a group discussion with a vignette

1. Set up a good place to have the group discussion, ensuring that the location is close to where participants are waiting but far enough away to ensure others do not hear the interview.
2. Gather the group for introductions and an icebreaker to create a cohesive group dynamic.
3. Begin the vignettes exercise:
    - Read the vignette aloud to your participants.
    - At each pause in the story, stop to ask the open-ended question and prompt a discussion. Encourage all participants to answer before continuing to the next story section. The facilitator must be able to explore deeply and purposefully during the vignette exercise.
    - Ensure that the note-taker captures key points and disagreements as they are shared. Many note-takers use laptops to take notes for vignettes to record the rich discussion.
4. Thank the group for their participation.
5. Review the key discussion points from each question, adding key points not yet included on the recording form below (responsibility of the field team):

Vignette	
Location:	Date:
Interviewer:	Group/subgroup OR reference group:
Behavior(s) of Interest:	Social norm(s) addressed:
Beginning of the story:	

First question break: Question 1: ... Question X:
Continuation of the story:
Second question break: Question 1: ... Question X:

Source: Vignettes in the SNET rely on recent efforts in social norms research, including CARE's Social Norm Analysis Plot, Johns Hopkins University's Global Early Adolescent Study, and Tostan's community assessment tools.

FORMULA FOR CONSTRUCTING VIGNETTES
What is the behavior of interest for the story? *Example: We want parents to take their children for immunization, etc.* 1. What are typical reasons why parents choose to or not to get children immunized? 2. What happens socially in such decisions? Who is typically involved in such decisions?
Questions to explore perceptions about what is common behavior: 1. In your opinion, how many people practice this behavior (most/many/some/few)? 2. What are some of the advantages of practicing this behavior? What are some of the disadvantages? • How many see this as a disadvantage • Are these advantages/disadvantages stronger for some community groups than others?
Questions to explore perceptions about whether others think it is an approved behavior: 1. Do people in your community expect you and people like you to behave this way? 2. How many people have this expectation (most/many/some/few)? 3. Are these expectations stronger for some community groups than others? 4. How many people in your community approve of this behavior (most/many/some/few)? 5. What happens if you do not practice this behavior? • How many people in your community would sanction people if they did not practice this behavior (most/many/some/few)? • Are these sanctions stronger for some community groups than others?

SAMPLE VIGNETTE: WHY DID SHE DIE?

Mariama was 4 years old when whooping cough took her life. This horrible infection took at least 10 children in the community during the short cold season.

Mariama received her first pertussis vaccination. But after seeing news in the media about adverse vaccine effects, Mariama's father, Mulika, decided they would not complete the immunization series. Mariama had already been prone to seizures, and he didn't want to take the risk. After all, most parents in their community did not believe in immunizations. Mariama's mother, Ayana would have loved all her children to be fully immunized.

- **Q1:** In your opinion, how typical is this situation?
- **Q2:** How many families in your community do you think have their children immunized (most/many/some/few)?
- **Q3:** How many people in your community do you think would agree with Mariama's father that immunizations have adverse side effects (most/many/some/few)?
- **Q4:** Who in the family decides whether to get children immunized?

In the morning, Mariama started feeling sick and developed a cough and a mild fever. She stayed home and spent the day playing with her friends outside. The next morning, she began vomiting but appeared to have nothing more than a typical common cold. By that evening, the cough was getting worse, and Mariama began gasping for breath. Her mother grew concerned and asked Mulika if he could give her some money to take Mariama to the clinic.

Mulika grumbled, stating that the child was suffering from a simple cold. He asked Mariama's mother to choose between putting food on the table for the family or taking Mariama to the clinic for a simple cough. Instead, he reached out to his mother, a well-known herbalist in the community, to come and look at the Mariama. His mother quickly confirmed it was a simple cough and gave Mariama some herbs to drink.

- **Q5:** Mariama's father decided it's more important to put food on the table than take Mariama to the clinic. How many people in your community would approve (most/many/some/few)?
- **Q6:** What are the benefits of immunizations? Who do you think benefits most from having children immunized?

By the following evening, Mariama appeared weak, and her skin started to look blue. Mariama's mother called her best friend, whose child recently had similar symptoms. When the friend arrived, she advised Mariama's mother that taking Mariama to the clinic could not help. There was some evil spirit going through in the community, and the only way for Mariama to be healed was through prayer from the priest. The priest came. He prayed for Mariama and stated that whatever the outcome, it would be God's will.

- **Q7:** Who among Mariama's family and friends would most support immunizations?
- **Q8:** Who might approve of Mariama's father's decision?

Mariama was exhausted from coughing and went to her mother's bed to lie down. Just four hours later, her mother found her lifeless in her bed.

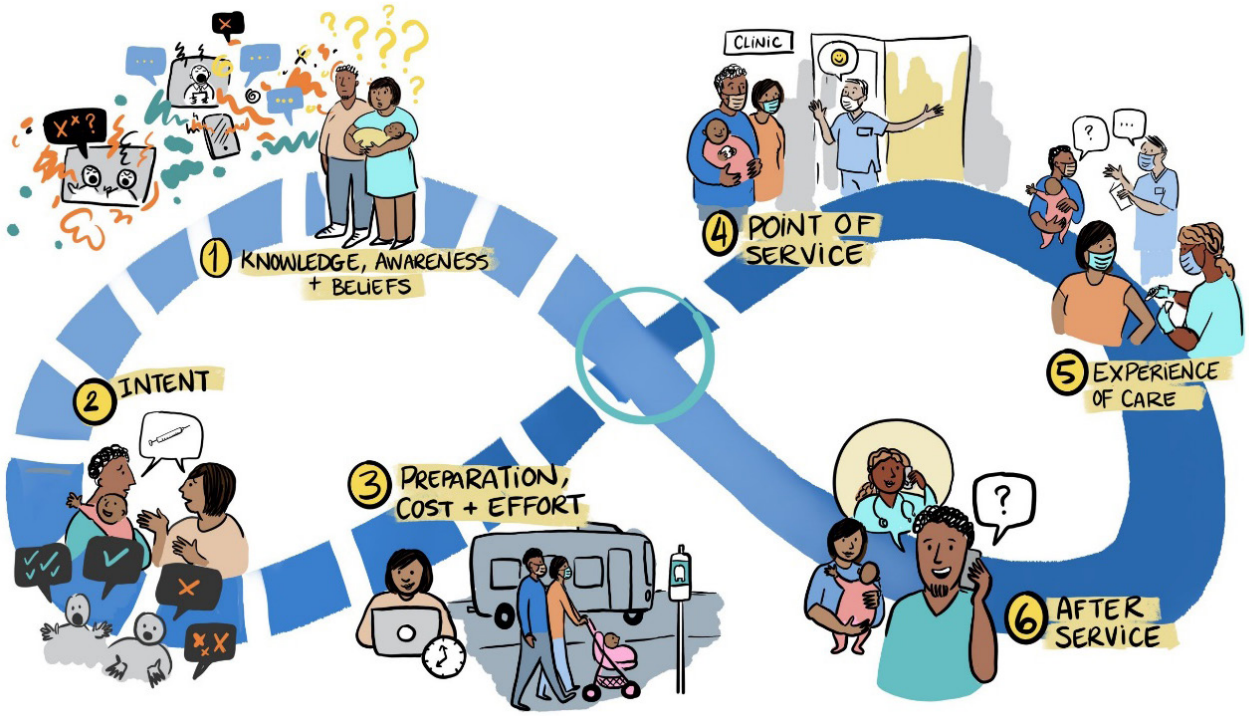
- **Q9:** How might getting immunized have changed Mariama's story?
- **Q10:** What do you think happened after Mariama's death?

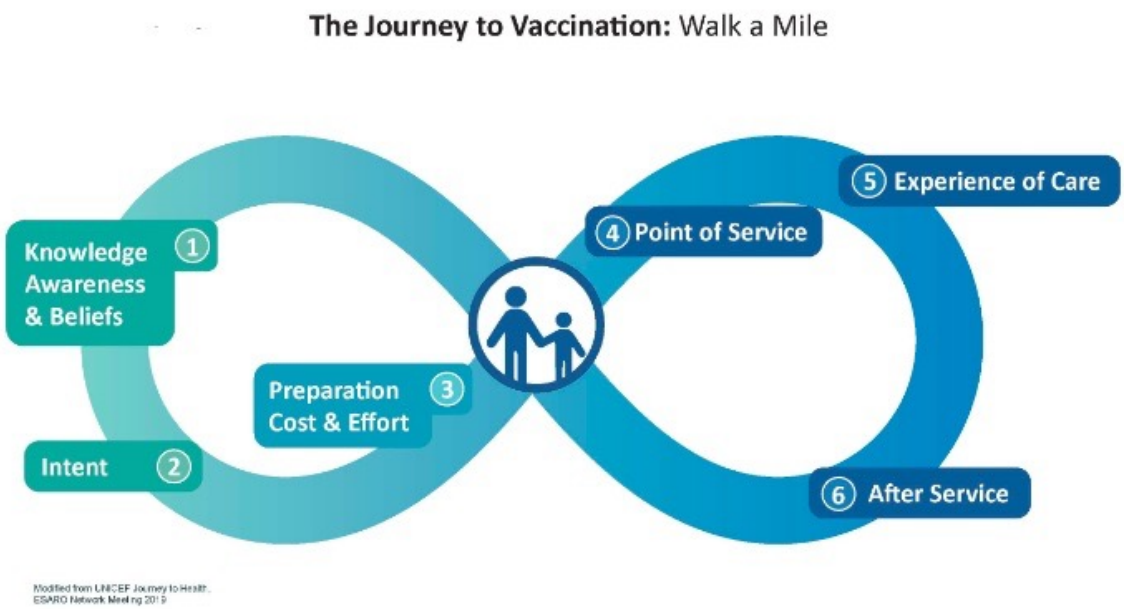
"Journey to Immunization" focus group discussion

Purpose	Identify barriers and enablers to accessing routine immunization services for children
Use with	Healthcare workers at a local healthcare facility, groups of caregivers of children under 2 years old, and reference groups
Time	30-45 minutes
Mode	Group discussion
Resources	Image of "Journey to Immunization," green and red post-it notes, markers, additional papers or index cards and pens, discussion guide, recording form

How to conduct a group discussion using "Journey to Immunization"

1. Set up a good place to have the group discussion, ensuring that the location is close to where participants are waiting but far enough away to ensure others do not hear the conversation.
2. Gather the group and do introductions and an icebreaker to create an inviting group dynamic.
3. Begin the "Journey to Immunization," drawing a map on a piece of paper like one of the examples below. (Flip chart paper is best.)[9]
4. Progress through the procedure, listed below.
5. Thank the group for their participation.
6. Note the facilitators and barriers as well as points of consensus and divergence on the recording form (responsibility of the field team). Take a clear picture of the journey map with the notes, noting the date/ group the visual output represents.





Procedure

Explain to the participants: "This map represents the journey a caregiver may take to immunize her child. We'd like you to consider the six main steps along this journey." They include:

1. Knowledge, awareness, and beliefs
2. Intent
3. Preparation, cost, and effort
4. Point of service
5. Experience of care
6. After service

In this exercise, please try to identify things that make it difficult for caregivers (barriers) and things that make it easy for caregivers (facilitators).

- **Step 1 looks at the knowledge, awareness, and beliefs about childhood immunization on the part of caregivers and people who influence them.**
- **Step 2 relates to the point at which the caregiver decides to immunize (or NOT to immunize) their child**.
- **Step 3 examines the preparations a caregiver must make to immunize their child once they have decided to do so**. Preparations can include making arrangements to pay for the immunizations and the effort needed to immunize.
- **Step 4 examines a caregiver's experience at the point of getting the child immunized**. This can include transportation or travel, times and days that services are offered, waiting time, whether the place is comfortable, etc.
- **Step 5 looks at the caregiver's experience when receiving immunization care.** This might include how the caregiver was treated, how the healthcare worker explained the vaccine, etc.

- **Step 6 looks at the caregiver's experience after receiving the service**. These might include home visits after vaccination, reactions to the vaccines, etc.

If the group is small (six to eight people) and everyone seems to participate actively, discuss the following questions as you might in a regular focus group discussion. If the group is large or if it appears that some group members prefer to reflect a bit more before speaking, you can divide people into pairs to discuss each question and then have each pair share their responses.

Say to the group, "I'd like for you to think about the caregivers of children in the communities you serve." (If you are talking with community members, then ask, "I'd like you to think about caregivers of children in your community.")

1. In your opinion, what do caregivers and people around them **hear, believe, or know about childhood immunization** that would encourage a caregiver to immunize their child?

2. In your opinion, what do caregivers and people around them hear, believe, or know about childhood immunization that would discourage a caregiver from immunizing their child?

3. In your opinion, what would help a caregiver decide to get their child vaccinated (**Intent**)?

4. In your opinion, what would make it hard for a caregiver to decide to get their child vaccinated (**Intent)**?

5. After a caregiver decides to get their child vaccinated (**Preparation**):
   a. What might make it easy for them to prepare to get the child vaccinated?
   b. What might make it difficult for them to prepare to get the child vaccinated?

6. Once a caregiver arrives at the health center or outreach post (**Point of Service)**:
   a. What might make it easy or attractive for them to stay and complete the child's vaccination?
   b. What might make it difficult for them to stay and complete the child's vaccination?

7. When the immunizations are administered to the child (**Experience of Care**)
   a. What might make the experience easy for or attractive to the caregiver?
   b. What might make the experience difficult for or unpleasant to the caregiver?

8. After the child receives their immunizations (**After Service**)
   a. What might make it easier for the caregiver and/or make it more attractive to return for the next immunization?
   b. What might make it more difficult for the caregiver and/or less attractive to return for the next immunization?

After hearing the responses for each step, ask clarifying questions to ensure you understand what the participants are communicating. Note the responses next to the appropriate point on the journey. Use green post-its for facilitators and red post-its for barriers (or use a red and green marker).

If there is time, ask participants what they think of each suggestion and note points of convergence and divergence of opinion.

Sample recording form

Location:	Date:	Interviewer:	Note-taker:
Group/subgroup:		Number of participants:	
Step	**Barriers**	**Enablers**	**Observations**
1. Knowledge, awareness, and beliefs			
2. Intent			
3. Preparation, cost, and effort			
4. Point of service			
5. Experience of care			
6. After service			
Other observations			

Source: The Vaccine Demand Hub, Journey to Vaccination Map

APPENDIX 3:
Key informant interviews

Key informant interviews provide an excellent way to quickly gather the information needed to answer the key questions you have identified from the Formative research to inform strategy section. Key informant interviews will be used primarily to understand vaccination supply-related questions and will target vaccination service providers, health policymakers, and administrators.

Identifying interviewees: Interviewees should be responsible for vaccination services in the target geographic area or have national-level oversight of vaccination-related policy, service planning, and budgeting.

Question identification: Because each person has a different experience and understanding, identify the key questions you will ask that person. The questions should not be the same for everyone. Develop a question list for each type of respondent. Use the interviews to clarify information identified during focus groups or other key informant interviews. For example, "In focus groups with caregivers, we understand that they never received information about vaccination in their local language. What do you do currently to provide information in local languages?"

Probing: Continue to ask clarifying questions. For example, "Do you provide information in local languages everywhere? If not, why not?"

Recording: Record information below the prepared question list. Interviewers can add additional questions and notes as needed.

APPENDIX 4:
Barrier analysis

A barrier analysis survey improves understanding of the factors influencing particular behaviors. Implementers use barrier analysis findings to create more effective social and SBC interventions. barrier analysis is often a part of a Designing for Behavior Change process in which the findings from the barrier analysis immediately impact SBC interventions or plans.

In the barrier analysis survey, respondents answer whether they do or do not engage in the specific behavior of interest (for example, vaccinating their child). Respondents who report doing the behavior are categorized as "Doers," and those who report not doing the behavior are categorized as "Non-doers." Each respondent then answers a series of questions about the personal, social, and environmental factors that might affect that behavior. Finally, data analysis compares the personal, social, and environmental factors among the "doers" with those of the "non-doers." If the responses between the two groups are similar, then that factor is not considered an influencing factor in the behavior itself. If the responses of "doers" and "non-doers" are different, the assumption is that the factor may somehow influence the behavior.

Barrier analysis can be used at the start of a behavior change program to determine key messages and activities for intervention. It can also be used in an ongoing program focusing on behaviors that have not changed much (despite repeated efforts) to understand what keeps people from making a particular change. Barrier analysis surveys are sometimes helpful in getting a general idea of key behavioral determinants across a large area, such as across an entire health district. However, ***barrier analysis is MOST useful when applied at the hyper-local level in a specific community or among a particular population, as the determinants that influence behavior are often not the same between ethnic, language, or religious groups or communities.*** Projects often find it best to conduct barrier analysis surveys after they have completed some basic formative research that allows them to identify primary differences among groups within a project area.

Initial training of trainers for barrier analysis typically takes eight full days. Those who complete this initial training of trainers can usually design a barrier analysis, train a team of four to six enumerators, complete the survey of 45 doers and 45 non-doers, and analyze the results in about five days or fewer. While hiring a consulting firm to conduct the barrier analysis and analyze the results is possible, projects typically prefer to use their implementing staff to collect and analyze the data. Most staff learn valuable information and gain informative perspectives about their communities when they collect and analyze the barrier analysis data.

In a complete barrier analysis, questions related to 12 "determinants of behavior" are included alongside questions related to the specific behaviors of interest. These determinants are derivatives of theories of behavior (principally from the Health Belief Model and the Theory of Reasoned Action). They include people's perceptions of:

1. **Self-Efficacy:** The belief that one has the knowledge and skills to do the behavior.
2. **Social Norms:** The perception that people important to the actor think they should or should not do the behavior.

3. **Positive Consequences:** The positive things the person thinks will happen as a result of doing the behavior.
4. **Negative Consequences:** The negative things the person thinks will happen as a result of doing the behavior.
5. **Access:** The availability of needed products or services required for doing the behavior. Access includes barriers related to the cost, distance, and cultural acceptability of products and services.
6. **Policy:** The presence of laws and regulations that may affect whether people are able to do a behavior.
7. **Culture:** The extent to which local history, customs, lifestyles, values, and practices may affect behaviors.
8. **Cues to Action/Reminders:** The presence of reminders that help someone remember to do the behavior.
9. **Susceptibility:** A person's perception of the likelihood that a behavior's negative consequences will occur.
10. **Severity:** The perceived degree of severity of the negative consequences that could occur.
11. **Action Efficacy:** The extent to which a person believes a behavior will lead to the associated positive consequences or avoid the associated negative consequences.
12. **Divine Will:** The extent to which a person believes actions and their consequences are the result of God's will and, therefore, out of their control.

Because the survey question design integrates each of these 12 determinants, it is possible to discover which determinants have the greatest influence on a particular behavior during the data analysis. Historically, the first four are the most significant determinants of behavior (perceived self-efficacy, social norms, positive consequences, and negative consequences). We recommend that they always be included, while other determinants may be more or less useful depending on the context.

You may also choose to add some questions related to social norms that you have identified in discussions with caregivers of target groups. Adding these norm-related statements can help to identify differences in beliefs of certain norms between doers and non-doers.

For example in Ghana, it was identified that there are beliefs that illness can be caused by "juju" or personal sin. For this reason, this question was included:

> *Do you think that your child could get polio, diphtheria, yellow fever, measles, tuberculosis, or pertussis as a punishment for your behavior?*

It was also understood that men didn't normally bring the child for vaccination but were often instrumental in indirectly (by deciding how much money to provide to the female caregiver to take the child for vaccination) or directly deciding if the child would be vaccinated, so this question was added:

> *Do you agree that it should be the father's decision whether or not to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?*

It was also understood that there may be some difference in actual (cost of transport) and perceived cost (loss in earning or productive farming time) between bringing children for vaccination, so we added a question:

> *How costly is it to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?*

Some key factors to consider:

Defining the behavior clearly is critical: In Ghana, since there were a large number of people who had brought their children for at least one of the vaccinations, the behavior for doers was identified as those caregivers of children who had completed all their vacccinations according to the vaccination schedule. In other locations, this would need to be adjusted so that you have sufficient doers to be able to collect 45 responses in your target geography.

Translation and testing: Translation should be conducted by a staff member with enumerators who are from the target region and know the language used there. Terms like advantages and disadvantages may not translate well to local languages without careful discussion on how to translate and explain. If in doubt, refer to the determinant that is being collected. It is imperative that the questionnaire is tested first with both doers and non-doers before commencing the full exercise to ensure the questions and terminologies are clear. It is good if an experienced enumerator or staff member conducts the initial questionnaire to demonstrate and to prompt discussion on areas that are not clear.

Data collection: Data can be collected using devices on software such as KoboCollect. This will make it easier to collate the data once collected and to ensure that all questions are answered. Additionally, you can assess the time taken to collect the data and the location where the data was collected. This allows you to exclude any data that may not have been collected correctly.

Using staff to collect data: It is critical that project staff are engaged in collecting the data to make sure that any external enumerators are asking the questions correctly and know how to assess if a child is fully vaccinated.

Getting support of medical staff: In certain areas it may be hard to find doers. If this occurs, you can ask for help from the vaccination providers to identify people who have completed the full vaccination schedule with their child. However, it is important the the staff are not listening into the conversation so that the participants feel they are unable to answer honestly.

Getting precise answers: The coding process for open-ended answers can be hard. This is made easier if enumerators write down what the person said. If what they said is not clear, it should be clarified. The enumerators can then come together after the responses have been collected to classify the responses into no more than eight types of response.

Don't probe too much on open-ended questions: If you keep probing too much, the respondent may simply tell you something just because they feel you want an answer. This answer will not be an accurate representation of their thoughts. It is better to record a "don't know" or "didn't answer."

Analysis of barrier analysis results

Barrier analysis results are put into an Excel table which has pre-populated formulae. Here is an example taken from data collected in Ghana. Only partial data was collected for 25 doers and four non-doers. The total number of doers was entered in the first row of the table and the total number of non-doers was entered in the subsequent row, highlighted in green. The p value was set at 0.05, meaning that there was focus where the probability of statistical significance of data was above 95%. As a result, p-values less than 0.05 appeared in blue in the column labeled "p-value" along with results statements in the columns to the right.

Barrier Analysis Tabulation Sheet

Parents bring their children the get vaccinated per the vaccination schedule

Total Doers	25	<--Be sure to complete these two cells! (Total Doers + Non-doers should be 90 or greater)
Total NonDoers	4	
p-value to show results: p<	0.05	*(This can now be adjusted)*
Estimated Prevalence of Behavior	10%	*(If unknown, leave as 10%)*

Determinants	Doers: +Exp. (A)	Non-doers: +Exp. (B)	Doers: -Exp. (C)	Non-doers: -Exp. (D)	Doers %	Non-doers %	Diff.	Odds Ratio	Confidence Interval		Estim. Relative Risk	p-value	*Results Statements (based on ERR or reciprocal [1/ERR])*	
									Lower Limit	Upper Limit				
1. Perc. Self - Efficacy : What makes it easier?														
Mother knows schedule	4		21	4	16%	0%	16%				11.714			
Free service	8		17	4	32%	0%	32%				14.235			
Education at health care facility	7		18	4	28%	0%	28%				13.500			
Benefit of vaccination	3	3	22	1	12%	75%	-63%	0.05	0.00	0.59	0.062	*0.004*		Non-doers are 16.1 more likely to give this response than Doers.
Nurses treat us well	1		24	4	4%	0%	4%				10.375			
Other services available	3		22	4	12%	0%	12%				11.227			
Nearby health center	3	1	22	3	12%	25%	-13%	0.41	0.03	5.32	0.439	0.484		
Family or spouse support	1		24	4	4%	0%	4%				10.375			
2. Perc. Self - Efficacy: What makes it Difficult?														
Mother or child sick	4	1	21	3	16%	25%	-9%	0.57	0.05	6.98	0.600	0.658		
No diffficulty	12	1	13	3	48%	25%	23%	2.77	0.25	30.38	2.458	0.390		
No proper clothing	1		24	4	4%	0%	4%				10.375			
Long waiting time	1		24	4	4%	0%	4%				10.375			
Conflicting schedule	7	1	18	3	28%	25%	3%	1.17	0.10	13.20	1.148	0.901		
Access - distance and costs	3		22	4	12%	0%	12%				11.227			
Pressure to buy weaning food	1		24	4	4%	0%	4%				10.375			
vaccine not available		1	25	3	0%	25%	-25%	0.00			0.000			
3. Perc. Positive Consequences: What are the advantages?														
Vitamins through vaccine	1		24	4	4%	0%	4%				10.375			
Nutrition advice	2		23	4	8%	0%	8%				10.783			
Health of child	22	4	3	0	88%	100%	-12%	0.00			0.089	0.464		
4. Perc. Negative Consequences: What are the disadvantages?														

Results for each question were put into column B for doers and C for non-doers. Open-ended questions, questions 1-6 and question 18, needed to be coded before tabulation. The enumerators compared responses to come up with a list of the main responses. All the other calculations were made automatically and results statements were automatically generated. Even with a small sample size, results statements indicate where there are the largest differences between doers and non-doers. However, with the correct sample size of 45 doers and 45 non-doers, the results would be much clearer and reliable. The differences are around:

- The perceived seriousness of preventable illness (Q10 – perceived severity)
- How easy it is to bring your child for vaccination (Q7 - perceived access)
- Perceived negative consequences of vaccination (Q3 – perceived negative consequences)
- The existence of laws/regulations that make it less likely to get children vaccinated (Q12 – Policy)
- Desire for your child of good health (Q18)

These differences can be used to develop a DBC strategy. If there are some confusing results from the barrier analysis, this is worth investigating within focus groups. For example, non-doers were more likely to want good health for their child than doers. Instinctively, this seems wrong as you would think that if they wanted good health for their child, then they would get them vaccinated. You could examine other responses to understand this, for example, that the non-doers don't see the same seriousness of illness that is prevented by vaccines, to perhaps understand that the non-doers want their children to be healthy but aren't worried about vaccination because they don't think the consequences will be severe if their children gets one of the preventable diseases. You could test this within a focus group to verify if this is correct or if another factor is at play, such as they don't trust vaccination as modern medicine compared to traditional medicine.

Tabulation table example

Barrier Analysis Questionnaire from Ghana

Group: Doer ❑ Non-Doer ❑

Barrier analysis questionnaire on immunization of children aged 12-23 months according to the Ghanaian immunization schedule

Behavior statement

Mothers of children aged 12-23 months bring their children to the health centers to receive their vaccinations according to the immunization schedule

Demographics

Name of enumerator: _____ Questionnaire No.: _____

Date: ___ / ___ / ___

District: _____

Informed Consent Form: Barrier Analysis Survey

Hi. My name is _____ , and I work with _____

Objective: We are conducting a survey to analyze barriers to access to immunization in selected districts of Fanteakwa South District.

Procedure: If you agree to participate, we will ask you questions about vaccination. 50 minutes.

Benefits: Your participation can benefit you, your health center, and the community by providing information to help improve children's immunization levels.

Voluntary Participation and Withdrawal: It is your choice to participate in this survey or not. Participation is not mandatory. You can decide to participate at the beginning and then change your mind. You can skip questions or stop taking the survey at any time. You will not be penalized if you decide not to participate in the survey.

Confidentiality: The matters we discuss will remain confidential to the extent permitted by law. We will not publish your name, although we will write reports containing information from your district.

Contact persons: If you have any questions or concerns about the survey or your participation, you can contact Gabriel Adeniji 0543830886 or 054987411

Consent Statement

I have read the above information, or it has been read to me. I have had the opportunity to ask questions about this matter. All questions have been answered to my satisfaction. I voluntarily consent to participate in this survey. I understand that the information collected will be treated as confidential and will only be used for the purposes stated on this form. I will receive a copy of this informed consent form.

_____	_____	___ / ___ / ___
Name of the participant	Signature	Date (dd/mm/yyyy)

Person giving consent

I certify that the nature and purpose, potential benefits, and potential risks associated with participation in this evaluation have been explained to the prospective participant. I have answered all questions that were asked and witnessed the above signatures on the date indicated above.

_____	_____	___ / ___ / ___
Name of the participant	Signature	Date (dd/mm/yyyy)

Section A - Screening Questions

1. How old is your youngest child? _____ ← write age here
   - ❑ A. 12-23 months or less
   - ❑ B. 0-11 months or 24 months or more → *End the interview and look for another respondent*
   - ❑ C. I don't know / I can't say → *End the interview and look for another respondent*

2. Have you vaccinated your child?
   - ❑ A. Yes
   - ❑ B. NO
   - ❑ C. I don't know / I can't say

3. Do you have a health card for your young child?
   - ❑ A. Yes
   - ❑ B. No → *End the interview and look for another respondent*
   - ❑ C. I don't know / I can't say → *End the interview and look for another respondent*

IF THE ANSWER TO QUESTION 3.A IS YES → EXAMINE THE HEALTH CARD TO VERIFY THAT ALL REQUIRED VACCINATIONS FOR YOUR AGE ARE DONE AND MARK AS A DOER.

THE CHILD HAS RECEIVED ALL REQUIRED IMMUNIZATIONS FOR THEIR AGE → **MARK DOER AND MOVE TO SECTION B**

THE CHILD HAS MISSED ONE OR MORE REQUIRED IMMUNIZATIONS AT THEIR AGE → **MARK NON-DOER AND MOVE TO SECTION B**

Doer/Non-Doer Classification Chart

Doer (All of the following)	Non-Doer (any of the following)	Do not interview (any of the following)
Question 1 = A	Question 1 = A	Question 1 = B or C
Question 3 = A	Question 3 = A	Question 3 = B or C
EXAMINE THE CARD		
Child is completely vaccinated per the schedule	Child is not completely vaccinated per the schedule	

Group: Doer ❑ Non-Doer ❑

Explanation of behavior

In the following questions, I will discuss immunizations for your child under 12-23 months. By this, I mean all the immunizations your child should receive from birth to 23 months of age periodically.

Section B: Research Questions

(Perceived self-efficacy) skill, knowledge

1. What makes it easy to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

   [Write all responses here. Probe with, "What else?"]

(Perceived self-efficacy)

2. What makes it difficult for you to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

   [Write all answers here. Probe with, "What else?"]

(Perceived positive consequences)

3. What are the benefits of bringing your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

   [Write all responses here. Probe with "What else?"]

(Perceived negative consequences)

4. What are the disadvantages of bringing your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

(Perceived social norms)

5. Who are all the people who approve of bringing your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

   [Write all answers here. Probe with, "Who else?" or "Any particular person?"]

6. Who are all the people who disapprove of bringing your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

   [Write all answers here. Probe with, "Who else?" or "Any particular person?"]

(Perceived Access)

7. How difficult is it for you to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?
   - ❑ A. Very difficult
   - ❑ B. A little difficult
   - ❑ C. Not difficult at all
   - ❑ D. I don't know/can't tell

(Cue to Action/Recall)

8. In your opinion, how difficult is it to remember to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?
   - ❑ A. Very difficult
   - ❑ B. A little difficult
   - ❑ C. Not difficult at all

(Perceived Susceptibility/Perceived Risk)

9. How likely is it that children in your community will get polio, diphtheria, yellow fever, measles, tuberculosis, or whooping cough in the next three months? Very likely, somewhat likely, not at all likely?
   - ❑ A. Very likely
   - ❑ B. Somewhat likely
   - ❑ C. Not at all likely

(Perceived severity)

10. How serious is it if your child gets polio, diphtheria, yellow fever, measles, tuberculosis, or whooping cough? Very serious, somewhat serious, or not at all serious?
    - ❑ A. Very serious
    - ❑ B. Somewhat serious
    - ❑ C. Not at all serious

(Perceived action efficacy)

11. How likely is it that your child will get polio, diphtheria, yellow fever, measles, tuberculosis, or whooping cough if you bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule? Very likely, somewhat likely, not at all likely?
    - ❑ A. Very likely
    - ❑ B. Somewhat likely
    - ❑ C. Not at all likely

(Policy)

12. Are there any laws or community rules that make you more likely to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

    ❑ A. Yes **Which ones?**

    [Write all answers here. Probe with, "What else?" or "Any particular law?"]

    ❑ B. Don't know

    ❑ C. No

(Culture)

13. Are there any rules or cultural taboos that make you more likely not to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

    ❑ A. Yes **Which ones?**

    [Write all answers here. Probe with, "What else?" or "Any particular rules?"]

    ❑ B. Don't know

    ❑ C. No

(Perception of the divine will)

14. Do you think that your religion supports you to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

    ❑ A. Yes

    ❑ B. No

    ❑ C. I don't know/can't tell

(Perception of the divine will)

15. Do you think that your child could get polio, diphtheria, yellow fever, measles, tuberculosis, or pertussis as a punishment for your behavior?

    ❑ A. Yes

    ❑ B. No

    ❑ C. I don't know/can't tell

(Perceived Social norms.)

16. Do you agree that it should be the father's decision whether or not to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?

    ❑ A. Agree

    ❑ B. Disagree

    ❑ C. I don't know

(Perceived Access)

17. How costly is it to bring your child aged 12-23 months to a health facility for immunization according to the immunization schedule?
    - ❑ A. Very costly
    - ❑ B. Somewhat costly
    - ❑ C. Not at all costly

(Common desire)

18. What do you want most for your children?

THANK THE RESPONDENT FOR THEIR TIME!

You may also use a shortened form if your enumerators are experienced or if someone else is recording the answers while they are being asked by the enumerator.

Group: Doer ❑ Non-Doer ❑

Tabulation Form for Barrier Analysis Questionnaire on immunization of children aged 12-23 months according to the Ghanaian immunization schedule

Behavior statement

Mothers of children aged 12-23 months bring their children to the health centers to receive their vaccinations according to the immunization schedule

Demographics

Name of enumerator: _____ Questionnaire No.: _____

Date: ___ / ___ / ___

District: _____

_____	_____	___ / ___ / ___
Name of the participant	Signature	Date (dd/mm/yyyy)

Person giving consent

I certify that the nature and purpose, potential benefits, and potential risks associated with participation in this evaluation have been explained to the prospective participant. I have answered all questions that were asked and witnessed the above signatures on the date indicated above.

_____	_____	___ / ___ / ___
Name of investigator	Signature	Date (dd/mm/yyyy)

Section A - Screening Questions

	A	B	C
1. Child age	12-23 months	0-11 or 24+ → **END**	Don't know → **END**
2. Child vaccinated	Yes	No	Don't know
3. Health card	Yes	No → **END**	Don't know → **END**
Fully immunized	Yes ↓	No ↓	
Group	DOER	NON-DOER	

Section B: Research Questions

1. **Easy**				
2. **Difficult**				
3. **Benefits**				
4. **Disadvantages**				
5. **Approvers**				
6. **Disapprovers**				
7. **Difficult access**	Very	A little	Not	Don't know
8. **Remember**	Very	A little	Not	
9. **Community likely**	Very	Somewhat	Not	
10. **Serious**	Very	Somewhat	Not	
11. **Child likely**	Very	Somewhat	Not	
12. **Laws**	Yes	Don't know	No	
12A Example	↓			
13. **Rules**	Yes	Don't know	No	
13A Example	↓			
14. **Religion**	Yes	No	Don't know	
15. **Punishment**	Yes	No	Don't know	
16. **Father decision**	Agree	Disagree	Don't know	
17. **Costly**	Very	Somewhat	Not at all	
18. **Desire**				

Resources on barrier analysis

You can download copies of the following resources:

- Designing for Behavior Change: For Agriculture, Natural Resource Management, Health, and Nutrition in English and French
- A Practical Guide to Conducting a Barrier Analysis in English, French, and Arabic
- Barrier analysis questionnaires that others have used, many translated from English to various languages
- Behavior Bank: results and reports from their barrier analysis studies

APPENDIX 5:

Reference group identification

This process interviews 30 parents and caregivers of children at the right age for vaccination (15 men and 15 women). Participants identify their reference groups (people influential in helping them decide about getting their children vaccinated). Conduct interviews at a specific location or wherever the parents or caregivers are using the proposed script, below. **Note that the purpose is to identify participants for a focus group with reference groups in order to understand the social norms that are influencing the views of the reference groups, who in turn influence the views and behaviors of caregivers. Therefore, the relationship is recorded, not the name.**

We are trying to identify what influences individual community members' thoughts about vaccinating their children. The information will not be shared outside the interview team, and all information provided will be anonymous. Please can you confirm your consent to participate in the interview?

1. *Who do you trust to talk to when deciding whether you should vaccinate your child? What relationship or role does this person have in your life? (Record the relationship, not the name.)*
2. *Is there anyone else you have talked to about whether you should vaccinate your child? Who? What relationship or role does this person have in your life?*
3. *Other than the people you have just mentioned, is there anyone else who has offered advice about whether you should vaccinate your child? Who? What relationship or role does this person have in your life?*
4. *Other than the people you have just mentioned, is there anyone else who has given you information on options about getting your child vaccinated? Who? What relationship or role does this person have in your life?*

Thank you for your time and your ideas. Do you have any questions for us?

Use Form 1 to record the data and Form 2 to analyze the results.

Analyzing the data

In the Ghana example, reference groups identified included spouses, neighbors, faith leaders, and parents/mothers-in-law. Since focus groups already included spouses, it was decided to include older men and women in the focus group for the reference group along with faith leaders.

Form 1: Recording form for rapid analysis

Rapid analysis of reference groups				
Location:		**Sub-group: men/women:**		**Date :**
Interviewer: **Note-taker:**				
Participant name	1. Who do you trust to talk to when deciding whether you should vaccinate your child? What relationship or role does this person have in your life? (record the relationship, not the name; e.g., husband, mother-in -law, sister, friend, etc.)	2. Is there anyone else you have talked to about whether you should vaccinate your child? Who? What relationship or role does this person have in your life?	3. Other than the people you have just mentioned, is there anyone else who has offered advice about whether you should vaccinate your child? Who? What relationship or role does this person have in your life?	4. Other than the people you have just mentioned, is there anyone else who has given you information on options about getting your child vaccinated? Who? What relationship or role does this person have in your life?

Form 2: Rapid analysis template

Rapid analysis of reference groups							
Location:	**Date:**			**Group/sub-group:**			
Behavior of Interest: Vaccinating your child							
Question: Who influences you in deciding whether you should vaccinate your child?							
Responses:	**Person type, e.g., neighbor**	**e.g., teacher**					**Person type x**
Individual 1							

APPENDIX 6:
Sample quality assurance tool for universal design within service delivery

Below are possible standards for actions to make the vaccination system accessible for everyone at different stages in the vaccination process. These standards should be reviewed and adjusted based on local contextual issues, including an analysis of what has worked.

Stage in system	Action	Yes	In progress	No	Comments
Planning	Were community groups, including representatives of marginalized groups, engaged in the planning process for information and service provision?				
	Did community groups identify the best locations for providing services?				
	Did community groups identify the best time for providing services?				
	Did community groups identify the best way to inform people about vaccination services?				
	Did the planning process address issues outlined in the rest of this table?				
	Were roles for community members providing information and services identified?				

Information about vaccination	Is oral information about vaccination available in all languages the local population speaks?				
	Is written information about vaccination available in languages read by the local community?				
	Is there another way for people who can't read to access written information?				
	Are images representative of local culture and dress?				
	Do images show both men and women supporting the vaccination process?				
	Have both men and women been provided with information about vaccination?				
	Have reference groups (individuals who influence vaccination decisions) been identified and engaged in information provision?				
Coming to the vaccination service location	Is vaccination provided in locations close to all community members?				
	If not, has transportation been provided for people living further away?				
	Can people that have to pay to travel to the location receive money to cover costs easily?				
	Can vaccinations be provided at people's homes if they cannot leave home?				
	Is the location safe for all community members?				
	Is the location convenient for all community members?				
	Are vaccinations provided at a convenient time for those that bring the children?				

Arriving at the vaccination service location	Does the location have a latrine nearby?				
	Are there separate latrines for men and women?				
	Is there shade where people can wait?				
	Are there places people can sit down while they are waiting?				
	Is the location accessible for a person using a wheelchair or who cannot walk up steps?				
	Is there food or water available?				
	Is childcare available or a safe space where siblings of vaccinated children can remain?				
	Is there someone welcoming people and answering questions in a language they can understand?				
	Is the waiting time kept to a minimum?				
Receiving the service	Is there someone who can translate for vaccination service providers who cannot communicate in all languages the local population speaks?				
	Are there both male and female staff who can provide vaccinations?				
	Are local community members involved in providing vaccinations?				
	Are vaccinations provided in a private space where others do not see them?				
Evaluating the service	Can community members provide feedback on the service to a community member or in an anonymous way?				
	Is this feedback used to improve the service?				

APPENDIX 7:

Self-assessment tool on GESI and SBC capacity

Formative research

Tool	Description	Prior Experience	Support Needs
Barrier analysis	Survey with 45 caregivers who vaccinated and 45 who did not vaccinate		
Secondary data review	Review of existing studies that help you to understand key questions		
Collective brainstorming	Session with key informants to identify ZDC groups and identify relevant barriers		
Reference group identification	Interviews with 15 male and 15 female caregivers about who influences their vaccine thoughts, decisions, and behaviors		
Focus groups for data collection and problem-solving	Focus groups respond to key questions		
Focus group for social norms exploration	5 Whys, problem tree, or vignette		
Focus group on the journey map	Participants comment on their experience of the vaccination journey		
Key informant interviews	Key questions asked to individuals		

Design

Tool	Description	Prior Experience	Support Needs
Designing for Behavior Change	A systematic method to design SBC strategies, to remove barriers and capitalize on enablers for behavior change		

Social and behavior change methods

Tool	Description	Prior Experience	Support Needs
Care groups	A group of 10 to 15 volunteer, community-based health educators who regularly meet with project staff for training and supervision. Each volunteer is responsible for regularly visiting 10 to 15 neighbors, sharing what they have learned, and facilitating behavior change at the household level.		
Mass Media	Various channels used to disseminate information for awareness raising (radio messages, flyers, etc.)		
Channels of Hope	Strategy to mobilize faith leaders and groups to support messaging and action on vaccination		
Citizen Voice and Action	Program that empowers community members to monitor service provision based on standards		

APPENDIX 8:

Designing for Behavior Change Framework

Reducing the number of ZDC and under-immunized children requires SBC interventions that are both evidence-based and context-appropriate. The DBC Approach is a practical, easy-to-use method for creating such interventions. Using the DBC Approach starts with filling in a framework to understand better how to integrate the approach into programming. The DBC Framework is a user-friendly tool that helps project designers and implementers design or modify an evidence-based behavior change strategy or intervention to make it more effective in promoting a new behavior. It utilizes simple formative research to identify which determinants of behavior change are blocking or enabling the practice of the behavior and plans a strategy that addresses those barriers and motivators.

The DBC Framework is helpful at any point in the life of a project. However, it is best to use the approach when designing the program to get the most out of the process. **Many partners save time and money by conducting barrier analysis (or other formative research) and creating a DBC Framework during program design or at the onset of implementation.** Doing so reduces costs compared to conducting them later and making changes once a program is underway.

The DBC Approach is applicable to fragile and conflict-affected situations. In such contexts, the DBC Framework can be especially useful in understanding the population's surroundings, mindset, or priorities and, therefore, how the behavior change strategy needs to be tailored to address them.

Using the DBC Approach can help reduce the number of ZDC and under-immunized children in the following ways:

- **The DBC Approach is evidence-based,** making it easier to harmonize your work with that of the Ministry of Health and other partners.
- **Instead of guessing what beneficiaries think, users learn to conduct simple, quick, and cost-effective formative research** (such as the barrier analysis) to create their framework, revealing the perspectives of the people who would be performing the new behavior. The study findings are then used to design new or modify existing activities that minimize (or eliminate) those barriers and pave the way for behavior change. Projects advancing behavior change activities informed by formative research are likely to be more effective.
- **Using the DBC Approach can help more clearly define (and measure the progress of) behaviors associated with the project's objectives.** Moving a child from zero-dose to immunized or under-immunized to fully immunized may require several specific behaviors (e.g., bringing a child to an outreach post, keeping a health card, returning for vaccination at the proper time, or reporting a new birth). Clearly defining the behaviors the project seeks to change is as important as targeting the barriers to their adoption. Unfortunately, surprisingly few projects take the time for this critical step. Without clear definitions, some projects can miss the finer details that help change behavior and measure it.

- **The DBC Approach is useful across all sectors and programs.** Nutrition program staff and immunization program can each use the same tool to design interventions to promote the behaviors associated with their objectives. Using the same tool can help users from different programs or sectors to integrate their activities so that the same activities promote behaviors across programs in an integrated manner.
- **Your staff will grow in understanding and empathy for project participants.** Using project staff to conduct the research not only reduces the cost; it also helps them gain insight into their beneficiaries' thoughts about the behavior and begin empathizing with them. Furthermore, when project staff conduct barrier analysis and other formative research and help with the coding, tabulation, and analysis, they discover the results themselves, thus avoiding the need to explain where the results came from and why they hold meaning. Because they helped gather and analyze the data, there is immediate ownership and buy-in, even if the results contradict their original perspective.

Define the behavior statement: The behavior statement consists of: "who will do the behavior" + "action verb in present tense" + "details" (frequency, quantity, duration, etc.). For example, "Mothers of children under 1 living in Border District A" + "bring their children to the immunization outreach post" + "according to the immunization schedule."

Identify the priority and influencing groups: Use barrier analysis to identify the **determinants of behavior change.** Doing so helps define why some priority group members do the desired behavior while others do not.

Use barrier analysis results to identify Bridges to Activities: Plan ways to minimize identified barriers and reinforce motivating factors.

Apply research to identify activities: The goal of these activities is to increase the number of priority group members doing the target behaviors.

Research is critical to understanding why the priority group is or is not changing. Program staff often feel confident they already know why community members are not adopting the promoted changes. However, they are frequently surprised by the results of the barrier analysis study.

Below is an example of a blank DBC Framework and a completed DBC framework.

The Designing for Behavior Change (DBC) Framework

Behavior	Priority Group/ Influencing Groups Description	Determinants	Bridges to Activities	Activities
To promote this behavior	Among this priority group	We will focus on these determinants of behavior change (identified through formative research)	By minimizing these barriers and reinforcing these motivators	By Implementing these behavior change activities.
Outcome Indicator:		Process Indicators:		

Example of a Designing for Behavior Change framework: Osino

Behavior	Priority Group or Influencing Groups	Determinants	Bridges to Activities	Activities
Behavior Statement: Caregivers of children 12-23 months old in Osino, Ghana bring their children to get vaccinated according to the immunization schedule.	**Priority Group:** Caregivers are mostly women who are married and live along the highway between Accra and Kumasi. Most work in petty commerce and also are in charge of domestic work. Population is mostly Christian or Muslim with a large number who practice traditional religion. Mothers tend to be the decision-makers about child vaccination, while men support vaccination by providing money for transport to the vaccination site. Most children are vaccinated according to the schedule. While vaccination services are free, there can be a cost for transport and the opportunity cost of missed income from time away from work. Health workers routinely follow up by phone or by home visits to defaulters. **Influencing groups.** Health care workers, husbands, other family members	**Perceived Negative Consequences:** Doers are about seven times more likely than non-doers to say that there are no disadvantages to vaccination. **Perceived Access**: Doers are about nine times more likely than non-doers to say that it is not at all difficult to bring their child in for vaccination **Perceived Severity**: Non-doers are MANY times more likely than doers to say that it would be not at all serious if their child contracted a vaccine-preventable illness.	Reinforce the perception among mothers that there are no serious disadvantages to vaccination. Reinforce the perception that it is not difficult to bring a child in for vaccination. Strengthen the perception that vaccine preventable diseases can be very serious.	Information campaign Work with caregivers' parents to remind their children how many children used to die of preventable illness and to help them to bring children for vaccination
Outcome indicator: % of children not vaccinated according to schedule		**Process indicators**		

Resources on the designing for behavior change approach

You can download copies of the following resources:

- Designing for Behavior Change: For Agriculture, Natural Resource Management, Health, and Nutrition in English and French
- Decision Guide for Program Managers: What You Need to Know About the Designing for Behavior Change Approach
- Advanced Workshop on Designing for Behavior Change: Focus on Activities
- Designing for Behavior Change: A Practical Field Guide