

Facilitator guide

Interpersonal Communication for Immunization Training for Front Line Workers

UNICEF Europe and Central Asia Region



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Acknowledgements

This training package was developed by the Johns Hopkins Center for Communication Programs, the UNICEF Europe and Central Asia Regional Office, and UNICEF Country Office staff in Bosnia and Herzegovina and Serbia.

We would like to thank Sergiu Tomsa, UNICEF Regional Communication for Development Specialist, Mario Mosquera, UNICEF Regional Communication for Development Adviser and Svetlana Stefanet, UNICEF Regional Immunization Specialist, for their significant contributions to its conceptualization and development.

We also thank Fatima Cengic, Health and Nutrition Specialist, UNICEF Bosnia and Herzegovina and Jelena Zajeganovic-Jakovljevic, Early Childhood Development Specialist, UNICEF Serbia, as well as Dragoslav Popovic, consultant, the representatives of Institutes of Public Health, academia, health workers, Roma community mediators and civil society organizations from both countries for their support and active engagement in pre-testing and finalizing the package.

The materials are based on state-of-the-art resources from UNICEF, the World Health Organization (WHO), European and American Centers for Disease Control, academic journals and the immunization websites of a range of governments and foundations.

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Cover Photo: © UNICEF/UN0302002/Filippov

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Introduction

Health providers have always been an important and trusted source of information for parents and caregivers in the Europe and Central Asia (ECA) region and beyond. The way they interact with families and the quality of their communication and engagement may have a positive or negative influence on caregivers' decision to immunize their children. Open, non-judgmental and empowering communication between health professionals and other community workers who have contact with families can help to build mutual trust and confidence in vaccine, immunization services and the health system in general.

Research in ECA has shown that health workers do not always engage with caregivers in an open and supportive way, often using a patronizing and top-down approach in communication. As a result of time constraints and limited communication capacities, they often fail to understand the immunization-related concerns, fears and expectations of caregivers and fail to identify and address vaccine hesitancy. This can mean lost opportunities to build individual and community confidence in vaccines and to ensure that caregivers promote immunization as a rule, expectation or a community norm.

To help strengthen the communication and community engagement skills of front-line workers¹ (FLWs), the UNICEF Regional Office for Europe and Central Asia (ECARO) has developed this interactive and evidence-based training package to identify and address their own biases and misconceptions and to equip them with the essential knowledge, skills, and attitudes they need for positive and meaningful interpersonal communication. The aims are to:

1. inform and motivate caregivers about the importance of immunization for children,
2. identify and address vaccine hesitancy,
3. increase demand for vaccination,
4. improve immunization coverage.

This resource builds on the global Interpersonal Communication for Immunization package developed by UNICEF Headquarters in partnership with the Johns Hopkins Center for Communication Programs, bringing in the perspectives of ECA countries. The content and materials of the global resource were first reviewed and adapted in close consultation with the UNICEF ECARO, as well as UNICEF Country Offices in Bosnia and Herzegovina and Serbia. The team examined global evidence on behaviour change, immunization, and standards of practice, as well as local studies on knowledge, behaviour, and attitudes. There was also a review of the roles and responsibilities of FLWs; local policy environments and existing communication tools; local resources available to FLWs and how these are used on a day-to-day basis; the challenges faced by FLWs.

1 A front-line worker can be a health provider or a social worker – whether facility- or community-based, professional or volunteer – who is tasked with delivering interpersonal communication and counseling, immunization, or education and outreach to caregivers, clients or community members.

The content, materials, and approach were further refined during a field test with a variety of FLWs and government officials and UNICEF professionals from Bosnia and Herzegovina, Kyrgyzstan, Serbia and Ukraine during a five-day training of trainers (10-14 September 2018) in Belgrade, Serbia.

Not all of the current content, methodologies or tools will be appropriate for every country, training opportunity, or trainee audience. Materials and examples in the package, for example, have been tailored to the specific contexts of Bosnia and Herzegovina and Serbia. Review and adaptation of the package is recommended to maximize its relevance and accessibility for local contexts, immunization priorities and the needs of both health workers and caregivers.²

However, the fundamental concepts, skills and approaches introduced and used across this package apply broadly across the ECA region and can be adapted and applied in other regions worldwide. It is, therefore, a contribution to the expansion of equitable access to immunization and the greater use of evidenced-based content on global health and behaviour change to improve health outcomes.

2 Lee A, Mwaikambo L, Jayarajan N. Making Content Meaningful: A Guide to Adapting Existing Global Health Content for Different Audiences. Baltimore, Maryland: Johns Hopkins Center for Communication Programs; 2016.

Training package adaptation and use

Despite the well-recognized importance of training, the time and resources to plan and deliver quality training is often limited across government and partner organizations working in constrained resource environments and juggling various competing priorities. While adaptation of an existing resource alleviates the need to start from scratch, it can feel like a daunting exercise for a large and/or complex package. Thoughtful adaptation however, can increase the overall usefulness of the training for more successful outcomes and can be managed with a systematic approach. This document provides a review of key principles and steps to guide the adaptation process to tailor the training package to individual needs and priorities.

Guiding principles and framework

Six key steps are outlined below to facilitate the needs assessments and adaptation. These steps should be considered within an overarching framework of three principles or concepts modified and drawn from a model developed by Dizon et al³.

1. ADOPTION

Not all content will require change or significant revision. Modules, sessions, activities, or tools that can be maintained in their entirety, can be adopted without change. This content will generally be comprised of sessions that are grounded in a solid, global evidence base that has applicability regardless of country or culture such as a review of how vaccines work, theories of change and fundamental principles of interpersonal communication or how to address common myths, biases and heuristics. Many of the approaches grounded in adult learning or templates and overall presentation of materials, may also be suitable for adoption.

While most of the content may be suitable for adoption, some of it may not be suitable for inclusion in *your* adaptation based on the needs and parameters of the training you are delivering. This package has been designed in a modular format built on a number of individual sessions and activities to support tailoring of content for audience needs.

3 Dizon et al. BMC Res Notes (2016) 9:442. To adopt, to adapt, or to contextualize? The big question in clinical practice guideline development. DOI 10.1186/s13104-016-2244-7

2. CONTEXTUALIZATION

Some content may be easily adopted by grounding it in details and examples that are culturally relevant. Think, for example, of some of the role play or case study exercises introduced. You may be able to maintain the overall architecture and content of the session by contextualizing the activities and examples so that they better reflect your local environment and resonate with your participants. Contextualization may include but is not limited to:

- Substituting local names for the those used in the package.
- Using local expressions or slang to better reflect common speech.
- Using local images or popularly known character personalities.
- Substituting locally developed communication tools for examples or group work activities for those included in the package.
- Including popular activities or approaches for energizers, re-cap or quiz exercises.
- Translation of materials into the local language.

3. ADAPTATION/REVISION

Some content, materials, or approaches require significant change or revision. This is generally content that references or draws on:

- Local data or research (coverage data, immunization schedules, incidence of outbreaks, behavioural barriers to vaccine uptake or trust in health systems, for example).
- Policies, laws, and power structures (consent or refusal forms, eligibility for school enrolment or travel, or religious edicts, for example).
- Infrastructure and systems issues (stock-outs and supply issues, mechanisms for supportive supervision, roles and responsibilities, and available resources for cadres of health workers, for example).

Some materials may need to be adapted to reflect technological environments or logistical parameters of your training, as well:

- Availability of electricity, equipment, or materials.
- Space for activities or other logistical concerns such as travel or weather.
- Access to media or mobile technology to access tools and materials after the training.
- Needs for printed, audio-visual, or other formats of materials during the training.

In addition to the above framework, it is helpful to keep in mind that adapting training materials is an iterative process. The package is comprised of many articulating parts. As you make changes in one section or one component of the package, they will often reverberate in other sections or components. This requires you to go back and further revise as you strive to balance time for introduction of content; practical application of skills and knowledge; and review and discussion. Allow time in the adaptation process to accommodate the need for more than one round of revision and review to maximize cohesiveness, clarity, and usefulness. A minimum period of 2 months is recommended for the adaptation and planning process.

Steps in the adaptation process

Step 1: Define the audience and conduct a need assessment to prioritize their needs

Broadly defined, a frontline health worker is a social worker or health provider - facility- or community-based, professional or volunteer - who is tasked with delivering interpersonal communication and counselling, immunization, or education and outreach to caregivers, clients or community members. An immunization programme may involve several different types of FLWs, each with unique yet complementary roles in ensuring communities achieve full vaccine coverage. Not only do roles vary but also key characteristics such as education levels, training, competencies, compensation levels and a host of other factors. The most critical step in any training development or adaptation is to clearly understand and prioritize the needs of your specific training audience.

The intended audience for this training package is frontline health workers (FLWs) that serve in a health promotion and preventive care capacity. Their profile is as follows:

- Completed secondary school;
- Trained in maternal and child health areas;
- Provides information and counselling with the aim of encouraging particular behaviours;
- Provides preventive health care services, specifically vaccination.

Conducting a need assessment of your specific audience will help you to better understand and prioritize the training needs of your specific audience. You may not be able to address everything that you have identified as a need in the time or with the resources that you have available for the training, or the time period allocated for the adaptation. Prioritizing or ranking helps ensure that you address the most critical needs for your specific audience. Elements to consider for your needs assessment include but are not limited to the following⁴:

- Clarify who the FLWs are in training group:
 - What are their specific roles and responsibilities (in service provision, counselling, facilitating meetings, group talks, home visits)?
 - What are the preferred learning styles of the FLWs in your training group?
 - What is the local policy environment, and in what ways does this impact FLWs in their day-to-day provision of services?
 - What are the challenges FLWs face?
 - How many of each type will attend?
- Identify the unique biases, barriers, and facilitators for the uptake of immunization in your country:
 - What are the knowledge, attitudes and practices, but also concerns and expectations of both caregivers and FLWs in your country and region regarding immunization?
 - What has helped in the past to address them?
 - How much vaccine hesitancy is there? Is it everywhere, not an issue, or only in one or two small areas?

4 Lee A, Mwaikambo L, Jayarajan N. Making Content Meaningful: A Guide to Adapting Existing Global Health Content for Different Audiences. Baltimore, Maryland: Johns Hopkins Center for Communication Programs; 2016.

- Clarify the communication needs relevant to improving immunization coverage:
 - What are the existing communication tools and resources available and used by FLWs at work and in their personal lives?
 - How are these tools applied on a day-to-day basis?
 - How much do people know about the scientific aspects of immunization?
 - How much do they want to know?
- What training formats are most appropriate for your audiences' capabilities?
 - Consider language needs and previous access to training, especially if you will have a mixed group of participants from different regions or different levels of expertise.
 - What are the most feasible delivery channels for your audience?
 - What is the time availability for training (does the clinic shut down, for example, if they are in an all-day training, or is it best to bring trainees together for 3 days with additional travel time if needed, or offer one module a month over several months during their monthly meetings)?
- What are the personnel, financial, and logistical resources available to commit to training?
 - Consider availability of trainers who are skilled in conducting interactive training or availability of space to break into small groups comfortably for group activities, for example.

Conducting a **review of the local evidence base** may help you to answer many of these questions, or target areas for further exploration. Resources to consider in this review include but are not limited to:

- Literature reviews from the region or country, as well as of local immunization schedules, coverage data, and programme reports.
- Behavioural research that investigates the knowledge, attitudes and practices, of both caregivers and health workers in your country and region, including biases, barriers and facilitators to uptake of promoted behaviours.
- Inventory and/or review other training materials currently used in country that cover related content. These may be helpful in identifying what exactly you need to augment.
- Feedback from any FLWs that have taken this or other similar trainings offered in the country or region before with respect to:
 - Clarity;
 - Usefulness;
 - Organization and layout;
 - Methodologies;
 - Overall content of the training in terms of particular strengths and weaknesses and ability to meet stated objectives.
- Your own observations from delivering or attending related trainings in your country or region.

Once you have reviewed your local evidence base, you may want to gather additional insight by conducting focus group discussions, interviews, or surveys among FLWs and their supervisors to gain further insight into your audience and prioritize the needs of your audience. The results of this exercise should inform your adaptation and improve the relevance and usefulness of the training for your specific audience.

Step 2: Determine the learning objectives

Once you have identified the needs of your audience and parameters of the training you will deliver,

review the learning objectives for each module in the training package against the findings from your need assessment.

- Is there content that you need to delete to prioritize your learning objectives?
- Is there content that you need to develop or adapt from other resources outside of this training package?

Once you have determined this, revise the learning objectives as needed to speak directly to the needs you prioritized from in your need assessment.

Step 3: Repurpose the content

Review the training schedule and materials against your modified learning objectives, and then update the content and training agenda to reflect your learning objectives. Reflect on how the individual module sessions and the activities and discussions that comprise them work together to address each objective you have identified.

- Consider how the new or revised activities integrate within the sessions, and how the sessions integrate or flow within the larger training as a whole. Do the activities and sessions build on each other in a sequential process?
- Building up a foundation, step-by-step and allowing application of each new concept through focused sessions can facilitate the absorption of content.
- Consider the time and materials required to address each objective, in terms of providing a balance of: a) instruction or introduction of content, b) practice or application of skills and knowledge, and c) review and discussion.
- Reflect on the feasibility of the activities. Can you imagine yourself conducting the exercises you are designing? Are the concepts, exercises, and language appropriate for your audience?
- You may need to consult the ranked list of your needs from the results of your need assessment to further prioritize the focus of the training.
- Modify the session content as needed and reflect the changes in the overall training agenda. *This step may require multiple reviews.*

Step 4: Review what tools, such as activity sheets or visual aids are needed for each section

Once you have the main content of the sessions and activities completed, go back to review if there are any supplemental or complementary materials such as activity sheets, video or audio clips, graphics, etc. that also require update or creation for delivery of the sessions. Update these as needed to support your sessions. You may also want to consider if there are additional tools reminders, tips, or resources such as articles that would strengthen the session for your specific audience.

Step 5: Reiterate

As mentioned previously, developing a training is an iterative process. All of the components (agenda, guides, manuals, activity sheets and supporting materials) need to align. Allow time to continue to revise and update across all of the interlocking components. Walking through the training, may allow you to identify areas that need further attention and refinement. Additionally, after you deliver your adaptation, make note of feedback that will allow you to continuously update and improve the training and serve as a resource for others.

Step 6: Test and validate your content

Get input from stakeholders on the content you have adapted or developed and pre-test it among the intended audience, if possible. Evaluate whether the learning objectives were met and revise the content and delivery methods based on pre-test findings. Ensure approval of the adapted package by relevant authorities, organizations, or entities, including but not limited to government officials at national and decentralized levels and supporting NGO partners.

A general checklist of specific content areas that may be helpful to review and cross-reference as you adapt this training package is outlined in **Annex A**.

Trainer's notes

The importance of interpersonal communication for immunization

Immunization coverage remains high overall in the UNICEF Europe and Central Asia (ECA) region, with most countries having maintained coverage above the World Health Organization's (WHO) target of 95 per cent for most vaccines for children under the age of five. However, several countries in the region have registered a decline in immunization in the general population, and very low immunization rates in marginalized groups, including the Roma. In many countries, even when policies, financing, and resources are in place and services are available, a substantial number of children still fail to receive the complete immunization schedule.

A number of studies in the region have investigated the factors leading to decrease in immunization, including a 2017 regional assessment focused on vaccine hesitancy, led by the UNICEF ECA Regional Office.

Caregivers have many reasons for delaying, refusing, or not fully completing childhood vaccination. These may include:

- Individual religious, ethical, and medical considerations.
- The influence of anti-vaccine campaigns.
- Fear of side effects or complications.
- Non-recognition of the benefits of vaccination.
- Inconvenience of services (as perceived by caregivers).
- Mistreatment of caregivers or children by frontline workers (as perceived by caregivers).

Among the key determinants leading to vaccine hesitancy, several were linked to the quality of communication and interaction between caregivers and health professionals. Health professionals are perceived by some caregivers to have insufficient education and knowledge on immunization/vaccines, as well as insufficient interpersonal or direct communication skills (which are lacking in pre-service training in most countries).

Frontline health workers (FLWs) are among the most critical sources of information that influence caregivers' immunization behaviour. The healthcare providers, social workers, community health workers, and community-based volunteers that comprise the frontline of immunization programmes are a crucial bridge between the communities they serve and immunization services.

FLWs who routinely engage in positive and meaningful interpersonal communication (IPC) with caregivers and community members are able to build trusted relationships and increase the likelihood that children will receive the recommended vaccines on-time. Evidence shows that the quality of the interaction between FLWs and caregivers is a key factor in ensuring completion of the vaccination schedule.

UNICEF has taken steps to address this issue through the development of this comprehensive training package for the region. The aim of this training package is to strengthen the knowledge, skills, and attitudes that FLWs need to communicate effectively with caregivers and communities about childhood immunization.

It is important to note that behaviour change is a process. Interpersonal Communication (IPC) training of FLWs can contribute significantly to increased and timely uptake of vaccination. When interpersonal communication is part of a broader social and behaviour change communication (SBCC) strategy that includes advocacy as well as mass media and social media campaigns, the likelihood of large-scale social change is improved.

Implementation of an SBCC strategy for immunization should be accompanied by system-level improvements that address any structural and supply side challenges to ensure quality services are available and accessible. Such challenges may include but are not limited to increasing access to services, clarifying, developing, or enforcing policies, and improving procurement, distribution, and maintenance of vaccine – related commodities.

About this resource: overview of training package

This training package was adapted from a global Interpersonal Communication for Immunization package (developed by UNICEF Headquarters in partnership with the Johns Hopkins Center for Communication Programs), as well as other global and regional scientific and training resources. It was developed between July and August 2018, and field-tested with participants from Serbia, Bosnia and Herzegovina, Kyrgyzstan, and Ukraine in September 2018.

The content and processes of this package are tailored to the local context of Serbia and Bosnia and Herzegovina, but have broader relevance to the region. It is recommended that facilitators review the adaptation guidance provided in **Annex A** to further tailor the training materials to your country context before planning your training. Allow adequate time for any required adaptation as well as translation of materials, if needed.

This training package is designed to help FLWs acquire the knowledge, skills, and attitudes needed to communicate effectively with caregivers and communities about childhood immunization. The package consists of the following resources to deliver a 3-day training for FLWs and a 5-day training of trainers for facilitators:

- Facilitator guide;
- Participant manual;
- Presentation slides;
- Supplemental Resources to carry out the 5 Day Training of Trainers (**Annex F**);
- Sample Training Agenda, Pre- and Post-Test Questionnaire, Training Evaluation and Handouts (**Annex E**);
- Guidance on how to adapt these materials to the local context (**Annex A**).

This *Facilitator guide* is designed to support planning and delivery of group training for FLWs. Supplemental and specially marked materials are also provided to support a 5-day training of trainers (see below).

The companion *Participant's manual* is designed to serve as a workbook for use during group trainings as well as a resource for continued self-study.

The information and exercises they contain are relevant for the contexts of:

- Pre-service training;
- Training workshops;
- Day-to-day supervision;
- Supportive supervision visits;
- On-the-job training (including coaching, mentoring, and peer-to-peer mentoring);
- Self-study.

These tools are designed in a modular fashion to allow adaptation to local context and needs.

Resources for carrying out training of trainers

If you are conducting a 5-day training of trainers (TOT) to prepare trainers to facilitate the 3-day FLWs training, you will find guidance included in specially marked blue boxes at the beginning and end of modules and relevant sessions. Additional materials and detailed facilitation guidance are provided in **Annex A** of the *Facilitator guide*.

If you are leading a 5-day TOT it is recommended you first review the materials in **Annex A** to familiarize yourself with how they integrate into the training sessions. The 5-day TOT encompasses the full content of the 3-day training plus:

- A sample 5-day TOT agenda;
- Supplemental content and exercises including giving and receiving feedback and practice teaching;
- Supplemental slides (annexed in the 3-day presentation slides);
- Supplemental guidance for delivering content.

Training approach

This training package is based on adult learning methods and includes learning based on participant experience, and learning-by-doing activities. It emphasizes participation through small and large group discussions, brainstorming, role play, games, and practice in the classroom. It follows three guiding principles:

1. Building on participant experiences;
2. Step-by- step skill building, including experiencing emotions that increase FLWs understanding and empathy; and
3. Reinforcement of skills through practice.

This *Facilitator guide* is very detailed, with a scripted approach that has been designed to decrease lecturing and increase participation. This ensures participants are given the chance to share their knowledge and experiences, and to engage in applying their new skills and concepts in real-life scenarios.

Each session builds on previously discussed content, such that many subjects are given a brief overview at first, and then later explored in detail. You may modify this approach as needed but are encouraged to first carefully review the materials to see the small building blocks that are embedded in each session.

These training approaches may be slightly different than ones you may have used before, or that are normal in your country. Field-testing has shown, however, that they work very well across different audiences and contexts. Do not be surprised or dismayed if you encounter some initial resistance. Continue to encourage participation and opportunities for peer-to-peer learning. Experience suggests that by the end you and your audience will find the training a success.

Intended audience

This training package is designed for delivery by training institutions for pre-service training, or by government or NGO staff who wish to strengthen the IPC capacity of FLWs.

The intended audience for the 3-day IPC for Immunization training is frontline workers, broadly defined. **A frontline worker (FLW) is a health provider (facility or community-based, professional or volunteer) tasked with delivering interpersonal communication and counselling, immunization services, or education and outreach to caregivers of children under 5 years old, or community members.**

An immunization programme may be comprised of several different types of FLWs, each with unique yet complementary roles in ensuring communities achieve full vaccine coverage. Not only do roles of FLWs vary, but also key characteristics such as education levels, training, competencies, compensation levels, and a host of other factors.

These roles and characteristics are important to consider when planning and delivering training. As a trainer, you must try to ensure that everyone's needs are being met to some extent. You cannot train to just the most experienced or talented, or to the least experienced. You must continually engage both ends of the spectrum.

Training objectives

The objective of the 3-day training package is to help immunization programmes address the following knowledge, attitudes, and practices among FLWs:

1. Understand and apply the key principles on communicating with caregivers.
2. Learn and practice skills to listen and engage in conversations aimed at increasing uptake of vaccines.

3. Improve FLWs' confidence and ability to effectively respond to caregivers' needs and concerns regarding vaccine safety and effectiveness, based on evidence.
4. Increase use of dialogue-based communication to increase immunization rates.

The primary objective of the 5-day TOT is to ensure that trainers master the content of the 3-day training for FLWs, and have the skills needed to deliver a consistent, quality training with it.

How to use the *Facilitator guide*: instructions for trainers

This *Facilitator guide* includes all of the information provided in the Participant manual, (designed as a workbook and learning resource for trainees) and includes additional guidance and content for trainers.

The *Facilitator guide* is organized into individual modules. Each module is comprised of a number of sessions that address specific content through learning activities and discussion. Guidance and instruction is provided for each module and session that addresses:

- Module objectives;
- Time required for module and each individual session within the module;
- Checklist of materials needed for the activities covered within the sessions;
- A script for the facilitators (identified with bullets);
- Instructions for the facilitators (identified by arrows);
- References to corresponding content and exercises in the Participant manual;
- Answers to *Participant manual* exercises;
- Specially marked sections with guidance for those carrying out a 5-day TOT.

The following formatting is used to provide step-by step scripts and instruction for facilitators to deliver content and exercises in each session in an interactive and comprehensive manner.

As mentioned above, the scripted approach was designed to decrease lecturing and increase participation and make it easier for the facilitator to carry out the sessions. It also helps ensure a relatively standardized approach and content, so that almost any trainer could pick up the package and carry out the training with fidelity and success.

Checklist

- ✓ Materials to prepare ahead of time and overall guidance on to the facilitators.

Plenary

- Script of what to say.
 - Details, examples, and answers that may be helpful in guiding the discussion.
 - ▶ *Instructions to the trainer.*

Exercise [Title of exercise]

- Script of what to say, including instructions for partner or small group work (these may also sometime be given first in plenary).
 - Details, examples, and /or associated **HANDOUT** to complete the exercise.
 - Note: Each activity is called an exercise, whether it involves a **HANDOUT**, discussion, role play, or small group or partner work. Exercises are listed in the table of contents for easy reference.
 - ▶ *Instructions to the trainer.*
 - Suggested answers to exercises or prompts.

Wrap Up or Take-Away

- Things that you say to wrap up a session.
 - ▶ *Instructions on what you need to do as the facilitator.*

If you are leading a TOT

- ▶ *Follow the guidance listed here or in Annex F when indicated.*
- ▶ *Facilitators who are leading a regular 3-day training of FLWs can ignore these blue boxes.*

Guidance for the TOT is provided in blue boxes at the beginning and end of each relevant module and session and in **Annex F**.

Using the slides

A presentation slide deck is provided for use during training to project key figures, tables and other information.

Each individual module and session is introduced with a cover slide that provides only the title of the module or session. This slide is intended for display during the introduction of the module or session until you are ready to move to the first content slide.

Guidance is provided to suggest progression to the next slide. Instructions refer to the title of the slide instead of the number of the slide, as it is expected each country may adapt the slides to their needs.

- ▶ *Show slide: Cover slide (Module or Session introduction slide).*
- ▶ *Show slide: Title of slide (Session content slide).*

Preparation for the training

To make the best of this *Facilitator guide* and conduct effective training, trainers should:

1. Read the *Facilitator guide* carefully prior to use and identify what adaptations may be needed for their context, using the guidance in **Annex A**.
2. Adapt the materials as needed (e.g. adding local data, examples, policies, names and settings for role plays, eliminating sessions, etc.) and have them translated.
3. Become familiar with the training agenda, objectives, methodology, materials, and time allocated for sessions and breaks for each module they will deliver.
4. Practice activities before conducting them. Set aside adequate time to plan and seek assistance from co-facilitators or translators.
5. Prepare adequate copies of handouts and other needed training materials in advance.
6. Learn the makeup of the training participants, and prepare to accommodate their education level, professional backgrounds, language, cultural norms and customs, and learning style, level of knowledge, attitudes, and expectations.
7. If you are carrying out a training of trainers, review the specially marked TOT sections, both within the regular sessions and in **Annex F**.
8. Prepare in advance flip charts that you will post and refer to during the training:
 - a. Three C's model;
 - b. Vaccine Hesitancy Continuum;
 - c. Trans-theoretical model (the Steps);
 - d. Trans-theoretical model with expanded action (HBM determinants on VIPPs so you can build the combined model as you speak);
 - e. Socio-ecological model;
 - f. Pie chart with % of Acceptors, Hesitators, Selective Acceptors/Delayers, Refusers;
 - g. Clinical algorithm;
 - h. Categories of caregivers for goal exercise;
 - i. CASE approach;
 - j. Community algorithm.
9. If your country's immunization programme has already developed a "Frequently Asked Questions" guide, consider providing this to participants. If not, consider using or adapting one from WHO, CDC or other sources. See Bibliography for suggested links.
10. To adhere to the suggested times, conduct training with no more than 20 participants as possible.

Module 1.

Introduction
and overview

Module 1. Introduction and overview

Module 1 Objectives:

By the end of the module the participants will be able to:

1. Identify challenges FLWs face with immunization.
2. Define the objectives and ground rules for the 3-day IPC/I training.
3. Begin to identify gaps in knowledge and attitudes on communication for immunization.
4. Begin using the *Participant manual*.

Time: 1 hours and 45 minutes

Checklist

- ✓ Arrange chairs and tables to comfortably accommodate the expected number of participants in a U-shape, if possible, to facilitate discussion.
- ✓ Set up two flip charts with markers and have masking tape within easy reach.
- ✓ Set up slides, projector, and screen.
- ✓ Identify a wall to hang flip charts on that can be seen by participants.
- ✓ Prepare enough copies of printed materials for this Module:
 - **HANDOUT 1: AGENDA**
 - **HANDOUT 2: PRE-TEST**
- ✓ Ensure you have enough paper and pens, VIPP cards and markers, for each participant, already distributed at their seat.
- ✓ Ensure you have one *Participant manual* for each participant to distribute later.
- ✓ Prepare a box where participants can put anonymous questions for the facilitator.

If you are leading a TOT

- ▶ Ensure you have one *Facilitator guide* for each participant.
- ▶ Ensure you have one copy of both the 5-day and 3-day agendas for each participant ready to provide as participants register.
- ▶ Review the 5-day TOT agenda, the blue boxes at the end of each session in Module 1, and Sessions 1.2 A, 1.2 B, 1.5 A and 1.5B in Annex F, for a smooth delivery between the Sessions.

Session 1.1. Introductions and immunization challenges

Time: 45 minutes

Materials:

- ✓ At least one VIPP⁵ card or piece of paper, and marker per person.
- ✓ Flip charts, markers, tape.

Plenary

- ▶ *Show slide: Session 1.1: Participant introductions.*
- ▶ *Carry out formal opening as per your context (10 minutes).*
- Welcome to the course on interpersonal communication for immunization. My name is X and I work at Y, and this is my colleague Q from R. We are the facilitators for this workshop.
- Now please stand up if you work in immunization.
 - ▶ *Give them a minute and encourage if needed. Then motion them to sit down.*
- Great, you're in the right workshop. We look forward to working together.
- Now, our first activity will be introductions. Let me explain how this will work. We will ask you to do two things:
 - First, partner up with one of your neighbours. Introduce yourself to your partner by giving them your name, your job and where you work. Your partner will later have to introduce you to the group.⁶
 - Secondly, after you have both introduced yourselves, both of you will write down one challenge in immunization that you have encountered. It can be any challenge that you want to mention relating to immunization.
 - ▶ *Distribute VIPP Cards or pieces of paper.*
 - ▶ *Hold up a card or paper and marker as you explain that they should write down their challenges (or show a completed one as an example).*
- Please write each immunization challenge on a separate card. If you have more than one challenge, you are welcome to have additional cards!
- We will go around the circle, and you will introduce your partner and read out the cards on immunization challenges. You don't have to say which is yours and which is your partner's card.
- Any questions?⁷

5 Visualization in Participatory Programmes

6 If all the participants and the facilitator(s) already know each other, then instead of introducing each other to the group they will tell the group what their favorite leisure activity is – but they have to do it by miming it. For example, if my partner, Marko, says his favorite activity is jogging, I will say to the group “my partner Marko's favorite activity is” and then I will act as if I'm jogging.

7 You can ask for volunteers to help with grouping. If there are volunteers, they can present first and then help collect and group the cards.

Exercise 1: Introductions

- Ok, let's start. Please introduce yourselves to your partner with your name, your job and where you work, and then write down your immunization challenges on cards. Please help pass out the cards. You have five minutes.
 - ▶ *Hand a stack of cards to the participants on both ends of the U (if participants are seated in a U shape) and have them pass them down until the cards meet in the middle.*
 - ▶ *Show the instructions on the slide or flip chart as a reminder.*
 - ▶ *After five minutes check in to make sure everyone has finished.*

Plenary

- Now let's come back together and go around the circle. Each partner will introduce the other, and you will read out your cards with immunization challenges. As we go around the room, we will take the immunization challenge cards and try to put them up in rough categories.
 - ▶ *Collect the cards as they are read out (you might need to re-read so everyone hears).*
 - ▶ *Tape the cards on the wall or blank flip chart.*
 - ▶ *Group similar challenge cards together e.g. supply, time, communication, dropouts, late comers, people who don't come in, people forget to bring their immunization cards, people are afraid of MMR side effects, etc.).*
 - ▶ *If you get most of the way around the room and you are missing some communication challenges, probe if needed, using questions similar to the following:*
 - Any problem with getting caregivers to come back and complete on time?
 - Any problem with people who won't come in at all?
 - Any problem with people who say they've read something on the Internet, and you don't know what to say?
- Ok, thanks. We have met each other, and we see we have a great group of people with a lot of experience and expertise in immunization, communication, and the local context and challenges.

Takeaway

- We see we have shared challenges with immunization. Many of us have had similar experiences. We will come back to these challenges in a minute. Now let's look at the objectives for this training.

If you are leading a TOT continue with the following points:

- What we just did is the first session of the planned 3-day training for FLWs that this Training of Trainers will prepare you to carry out. Almost every word I just said is included in the Facilitator guide under Module 1, Session 1. You will get the Facilitator guide in a minute.
 - ▶ *Show the Facilitator guide.*
- But, right now, we want to take a few minutes to give some background on why we are here together in this TOT.
 - ▶ *Turn to Annex F and complete Sessions 1.2A TOT and 1.2B TOT, which briefly review the 5-day and 3-day agendas.*
 - ▶ *Then return to the regular Session 1.2 and give a very quick review to model how the session would be lead.*

Session 1.2. Review of training objectives, agenda, and housekeeping

Time: 15 minutes

Materials:

- ✓ Photocopies of **HANDOUT 1: AGENDA**.

Plenary

- ▶ *Show slide: Session 1.2: Review of training objectives, agenda, and housekeeping.*
- This training seeks to help FLWs value, acquire, and consistently use the knowledge, skills and attitudes needed to communicate effectively with caregivers and communities about childhood immunization.
 - ▶ *Show slide: Training objectives.*
- Our objectives are that by the end of this training you all will be able to:
 1. Define and apply key principles of interpersonal communication to communicate about immunization with caregivers of children under 5 years of age.
 2. Learn and practice skills to listen and engage in conversations aimed at increasing uptake of vaccines.
 3. Improve your confidence and ability to effectively respond to caregiver needs and concerns regarding vaccine safety and effectiveness, based on evidence.
 4. Use dialogue-based communication to increase immunization rates.
- Let's review how we plan to meet our objectives over the next three days.
 - ▶ *Show slide: Agenda.*
 - ▶ *Ask participants to take one-minute review their copy of **HANDOUT 1: AGENDA** received during registration. If appropriate for your audience, you may ask participant to read the sessions out loud.*
 - ▶ *Ask for any questions or expectations that were not covered.*
 - ▶ *Write any suggestions on a flip chart - these can be incorporated throughout, time permitting.*
- This training is designed to be interactive. Everyone will be participating, and we expect to all learn from each other.
- Let's review some of the logistics, and our training norms.
 - ▶ *Review logistics (washroom, breaks, lunch etc.).*
 - ▶ *Show slide: Workshop norms.*
 - ▶ *Establish norms for the training e.g. respectful communication, silent phones, timeliness, etc.*
- We have made a small box where you can put anonymous questions. This is a way to ask about something without having to say who it is that wants to know.

Takeaway

- We are here to work together to help increase your knowledge and skills for communicating with caregivers about immunization. We look forward to learning from each other.

If you are leading a 5-day TOT

- ▶ *Continue to Session 1.3 going directly to the Pre-test. Since you passed out Participant Manuals in Session 1.2 B you can skip that portion of Session 1.3.*

Session 1.3. Pre-test and distribution of Participant manuals

Time: 20 minutes

Materials:

- ✓ Photocopies of **HANDOUT 2: PRE-TEST**.
- ✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 1.3: Pre-test and distribution of Participant manuals.*
- We are now going to do a pre-test, which helps in three ways:
 1. It allows you to reflect on your immunization and communication experiences, knowledge, skills, and needs;
 2. It allows us to see where we should focus our time together;
 3. It allows us to track any change in knowledge or attitudes.
- The first thing to note: When you get your pre-test, please give yourself a code name, like Nicola Tesla or Zesna Bugarski or Santa Claus.
- Please pick a name you will remember, because you will use the same name for the post-test. We don't need to know whose test is whose, we just want to be able to see if Santa Claus learned anything new during the training. This helps us see which parts of the training aren't working well and which ones are.
- Second, please fill in everything, even if you aren't sure of the answer. We will go through your responses and see where we need to spend more time during the training.
- Third, you will have fifteen minutes to complete the test. Any questions?
 - ▶ *Clarify as needed.*

Exercise 2: Pre-test

- ▶ *Distribute copies of **HANDOUT 2: PRE-TEST**.*
- ▶ *Remind participants again to choose and use a code name.*
- ▶ *Time participants for 15 minutes.*
- ▶ *Collect tests.*

Plenary

- Thanks, I know it's hard to start a workshop with a test. We hope the pre-test allowed you to think a little bit about your skills and knowledge relating to immunization and communication.
- Now let's look at what else is in store during our next three days.
- We are handing out the *Participant manual*, which we will be using throughout the training. If you look at the first few pages of your Participant manual, you will see that everything we have discussed up to this point is outlined.
- As we move forward, you will be looking at the *Participant manual* to read instructions for group work, exercises, role play scripts, summary tables, etc. so you will need it for each session. It can also serve as a reference for future use.

Takeaway

- You can assess your learning and any change in your own immunization and communication skills for immunization with the post-test.

If you are leading a TOT

- ▶ *Continue to Session 1.4.*

Session 1.4. FLWs' experiences with immunization

Time: 15 minutes

Materials:

- ✓ VIPP cards from Session 1.1.

Plenary

- ▶ *Show slide: Session 1.4: FLWs' experiences with immunization.*
- Now that we are oriented, let's jump in with our first activity. Let's go back to the challenges with immunization that you listed.
 - ▶ *Point to VIPP cards with challenges.*
- You listed challenges with the actual supply of immunization services, challenges getting people to come in at all, and challenges getting people to accept/come in on time/ finish, etc.
 - ▶ *Use whatever categories of challenges they mentioned.*
- During this training, we are going to focus on how we can use dialogue to address some of the challenges especially here.
 - ▶ *Point to cards with communication-related challenges.*
- Who here has already had training in communication? Please raise your hand.
 - ▶ *Wait for hands.*
- Ok great, we have some experienced people in here.
- In this training, we will use an active listening and communication approach to identify the caregiver's needs, to **diagnose** their immunization attitudes, so we can give them the proper **communication treatment** in order to get their children vaccinated.
- Some of these communication skills may help you in immunization as well as other aspects of your job, or even at home. Other aspects of the training may not apply to you or might not resonate for you. But keep an open mind and let's see what we can learn together.
- In the beginning, you discussed with your partner and wrote down various challenges with immunization, including caregivers' attitudes towards immunization.
- Now with your partner, we'd like you to spend no more than three minutes to discuss the question: Do all of your caregivers have the same attitudes towards immunization, or are there different concerns, or different levels of concerns?
- Okay, you can begin. Take three minutes and discuss.

Exercise 3: Discuss caregivers' attitudes

- ▶ *Let them discuss for no more than three minutes and bring the group back together.*
- What did you conclude?
 - ▶ *Go around the different groups and see if at least some of the groups felt that there were different types of caregivers, or even categories.*
- It sounds as if you have encountered different types of immunization attitudes. It also sounds as if you have created groups in different ways. Overall, I am hearing something like:
 - Some people just come in for their immunizations without many problems;
 - Some come in and they are a bit worried, but they accept;
 - Some come in and really are worried and don't always come for or accept all the immunizations;
 - Some caregivers refuse to immunize.
- Is that a reasonable summary of what you have experienced?
 - ▶ *Wait until you get some positive responses, or if some participants have a different way of expressing the categories, let them express that.*
- Now here's an important question for you to think about, and that we will discuss in a minute: Do you think we need to say the same things, to give the same information in the same way, to the caregivers in each category?
 - ▶ *Give them a minute to respond.*

Takeaway

- We have seen that your caregivers have different concerns about immunization, and different needs. Just like with prescribing medicine, we have to diagnose their needs, so we can target our communication "treatment" to what their actual concern is.

If you are leading a TOT

- ▶ *Facilitate a modified version of 1.5 and then move straight to 1.5A and 1.5 B.*
- ▶ *You will model facilitating Session 1.5 without dividing into groups. Your TOT trainees do not have to carry out the full summary assignment that, in the 3-day FLWs training, would be presented in Module 8. By practice teaching, your TOT trainees will have to review the content, which is the purpose of this summary assignment.*
- ▶ *On the last day of the TOT, you will model facilitating Session 8.1, with one summary of a Module, so that trainees will understand what they have to do when leading Sessions 1.5 and 8.1 of the 3-day FLWs training.*

Session 1.5. Assignments for module summaries

Time: 10 minutes

Materials:

- ✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 1.5: Assignments for module summaries.*
- On the last day of this workshop, during Module 8, we will summarize Modules 2 to 7. We need small groups to summarize each of these modules. We will need six teams, each of which will summarize one of the modules between 2 and 7. Let's go around the room and count off one through six.
 - ▶ *Have them count off 1, 2, 3, 4, 5, 6.*
- The first team of "Ones" will summarize Module 2: Immunization technical review. The team of "Twos" will summarize Module 3: Understanding behaviour and barriers, and so on.
- In your summary, you will need to answer the following questions:
 - What were the main activities we did during the module?
 - What were the five most important takeaways (knowledge, attitudes or skills) that you took away from this module?
- These questions are also found in your *Participant manual* in Session 1.5.
- Please take time during the breaks or at the end of the day to meet with your team and discuss your plan for the review. You will be working with your team throughout the training, although there will also be opportunities to work with other participants.
- Do you have any questions about what your assignment is?

Takeaway

- There are numerous challenges in achieving high immunization coverage. Some of these can be addressed through better interpersonal communication. Caregivers have different concerns about immunization, and different needs. Just like with prescribing medicine, we have to diagnose their concerns before we can provide the right response or communication "treatment".

If you are leading a TOT

- ▶ *Continue with the following points:*
- So far, we have:
 - Explained the overall concept and process of the 3-day FLWs training and 5-day TOT;
 - Reviewed the package of materials for the 3-day FLW Training;
 - Gone through Module 1 of the 3-Day FLW training;
 - Learned about the Module Summary process which your FLW trainees will carry out in Session 8.1 as a final review of what they have learned.
- As mentioned earlier, you will have the opportunity to practice teach after we complete each Module. We will begin practice teaching for Module 1 in a few minutes, after we have reviewed facilitation and feedback skills.
 - ▶ *Turn to Annex F: TOT companion resources and complete Session 1.5A TOT: Review of facilitation skills and Giving and receiving feedback, and Session 1.5 B: Feedback skills, and Session 1.5B TOT, Practice teaching for Module 1.*
 - ▶ *When you complete the practice teaching exercise, continue to Module 2.*

Module 2.

Immunization
technical review

Module 2. Immunization technical review

Module 2 Objectives:

By the end of the module the participants will be able to:

1. Start a collection of “elevator phrases,” starting with how vaccines work and their health benefits.
2. Describe country coverage data and discuss factors influencing trends.
3. Describe vaccine safety processes and protocols (procurement and oversight).
4. Define vaccine hesitancy and describe some determinants of vaccine-related behaviour.

Time: 1 Hour and 45 minutes

Checklist

- ✓ Flip chart from Module 1, **Exercise 3** with *Categories of caregiver attitudes*.
- ✓ Flip chart of *Vaccine hesitancy continuum*.

For the TOT

- ▶ Complete Module 2 according to the Facilitator guide.
- ▶ At the end of the module, facilitate the practice teaching exercise the same way you did it for Module 1.
- ▶ Refer to Session 1.5 B in Annex F for a reminder.

Session 2.1. How vaccines work and health benefits

Time: 20 minutes

Materials:

✓ Participant manual.

Plenary

- ▶ *Show slide: Session 2.1: How vaccines work.*
- Now that we are oriented to what we will be doing in this workshop, let's get started with a technical review about immunization. We know that most of you are already up to date on most of this immunization content and want to get to the communication part. But this review will ensure that we are all working from a similar foundation.
- Who would like to give a short explanation in 25 words or less of how vaccination works?
 - ▶ *Take several answers then summarize with the following, or anything better the participants have come up with:*
 - A vaccine is a material containing either weakened or inactivated (killed) microorganisms (like virus or bacteria) or pieces of microorganisms.
 - The vaccine stimulates the immune system to produce the antibodies that further protect the vaccinated person from a certain disease.
- Okay, these explanations are correct, scientifically speaking. But now let's imagine I am a caregiver in your office.
- I process information with my brain, but also with my emotions as a parent. Who can give me a simple explanation of what are vaccines and how do they work in a way that will help me understand AND feel reassured?
 - ▶ *Let them answer. Examples might include:*
 - "It's like an army protecting your child."
 - "It's like you are showing your child's protective system a photo of the disease and saying, watch out for this guy so if you see him, you can jump on him."
 - ▶ *If there are some good ideas, repeat them to make sure the group heard them.*
- Yes, you could say immunization is like a dress rehearsal for the attack of the real disease. Your body is already prepared so you are protected.
- It's nice to have a prepared, simple, complete and clear phrase available to explain things, or to respond to common questions. For effective communication, the more you have prepared your content ahead of time, the more you can focus on your technique.
- How many of you have had the experience of running into someone and when you leave, you say: "Oh too bad, I forgot to mention this important thing...." Or "Wow, I didn't do a very good job of explaining what I meant to say."

- ▶ *Let them answer.*
- Imagine you have something you want to discuss with your boss, and you happen to meet him/her when you are both getting in the elevator. This is your big opportunity to explain or present your issue. If you have already rehearsed what you want to say in a short period of time, an “elevator speech”, you can take advantage of those few moments together to get your point across.
- We are going to work together on creating “elevator phrases” for many of the common concerns that our caregivers have.
- Would the same phrase be useful for all your caregivers?
 - ▶ *Let them answer.*
- You’re right. Just like your elevator speech for your boss would be tailored to who he/she is, what he needs to hear, you will need to tailor your elevator phrase for the caregiver you are meeting with.
- Some caregivers might want a brief analogy like:
 - *“A vaccine makes the body think it’s being attacked, so the body makes weapons that will defend and protect the child in case the real disease comes along.”*
 - *“The vaccine is like a training course for the immune system. The vaccine prepares the body to fight the disease and protect the child, without having to have the dangerous symptoms that the disease can produce.”*
- Other parents might want to hear something like:
 - *“When viruses or bacteria, which are called antigens, enter the body, immune cells known as lymphocytes respond by producing antibodies, but the first time the body encounters the antigen, it can take a while for the lymphocytes to produce antibodies. Vaccines are made of dead or weakened antigens. Vaccines don’t cause an infection, but the immune system still sees them as an enemy and produces antibodies to protect the child. Immune cells called memory cells remain in the body, so for example during a measles outbreak, the memory cells can quickly produce antibodies to destroy the invader and protect the body before it’s too late.”*
- The most important thing for all of these explanations is that they use the word “**protect**”, which is the concept caregivers need to hear and feel.
- It’s good to have several different elevator phrases available for each issue and type of caregiver. You need to have these phrases readily available in your pockets, or in your toolbox, so you can use the right tool for the right task.
 - ▶ *Act out pulling something from one pocket, and then the other pocket as if you are offering them to the participants.*

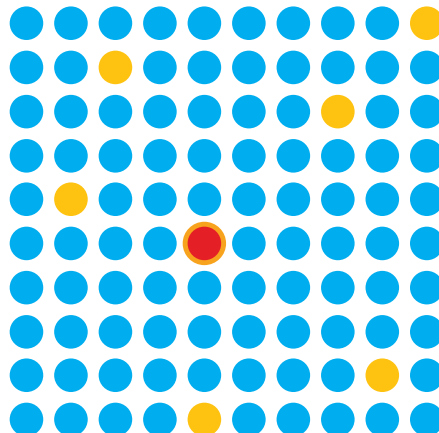
Exercise 4: Better ways of explaining how vaccines work

- Go to the last two pages of your Participant manual, entitled “Elevator phrases”. Write a few elevator phrases for a better way to explain to your patients how vaccination works.
 - ▶ *Give them a minute to write down a couple of good elevator phrases in their Participant manual.*

Plenary

- All right, let's move to another immunization topic. If the vast majority of the population in a community is vaccinated against a disease, the whole community will be protected, including those who have not received the vaccine.
- Who can tell me what this is called?
 - ▶ *Let them answer.*
- Right, this is called community or herd immunity. Who can give an elevator phrase of how you explain the concept of herd immunity to caregivers?
 - ▶ *Let them answer. Remember who explained it, because you will need to refer to them later on.*
- Yes, herd or community immunity means enough people are vaccinated that they protect the few that are not vaccinated.
- The threshold of immunization coverage needed for herd immunity varies according to how contagious the disease is.
- Who can tell me what the coverage threshold for measles is?
 - ▶ *Let them answer.*
- For measles, which is extremely contagious, 95% of the population needs to be vaccinated in order to stop transmission.
- Who can tell me what the threshold for polio is?
 - ▶ *Let them answer.*
- For polio, which is a little less contagious, 80- 85% of the population being vaccinated will protect those who are unimmunized.
- Who would like to explain this figure?
 - ▶ *Show slide: Community immunity 1.*
 - ▶ *Pick a volunteer and let him or her explain. Summarize if necessary.*

Figure 1. Community immunity ¹⁸

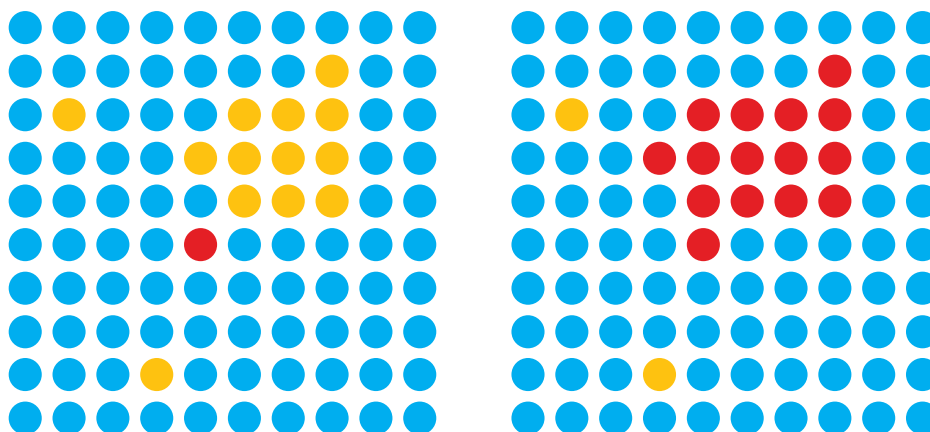


¹⁸ European Centre for Disease Prevention and Control (no date). Immunization: Information for parents and caregivers. What is community immunity and why is it so important?

- In this first image, someone has come into the community with a vaccine-preventable disease or VPD (this person is represented by the red dot.) There are so many people who are vaccinated (the blue dots) that can't pass the disease on, that the few unvaccinated people (yellow dots) won't get the disease. This shows herd or community immunity.

► *Show slide: Community immunity 2.*

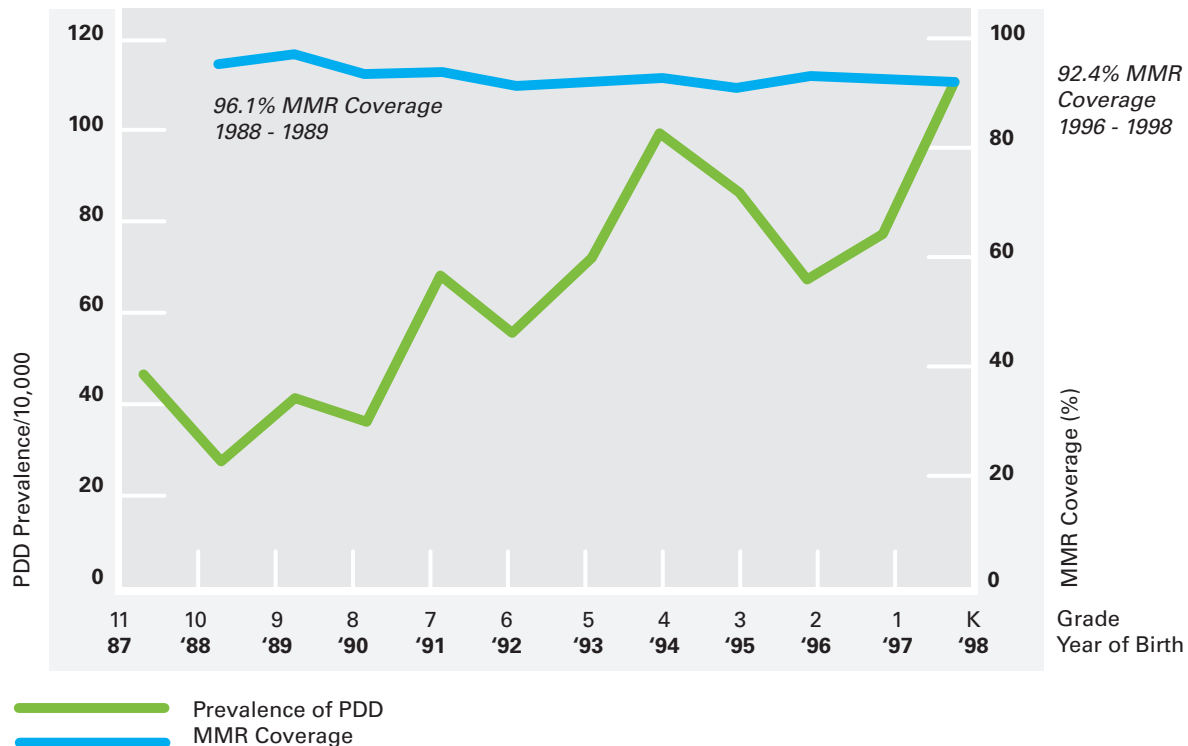
Figure 2. Community immunity 2



- Who would like to explain these two images?
 - *Let them respond.*
- In the second set of images, on the left, there is a large group of unimmunized people (yellow dots). When the red dot person with the VPD shows up, he can pass the disease to the nearby yellow dots, which then pass it on to the other yellow dots.
- On the right, those yellows have gotten the disease and turned red. Imagine if these yellow dots were young children in a nursery school.
 - *Ask the participants who gave the explanation of herd immunity at the beginning:*
 - Would you have liked to have these images available when you were trying to explain herd immunity?
- Visual representation is so helpful when you are trying to explain something. Do you have visual tools that you can use when you are trying to explain immunization issues with caregivers?
 - *Take a few answers.*
- Here is an example of a visual representation that is used in Canada to refute rumours about the supposed association between MMR and autism:
 - *Show slide: MMR coverage and PDD.*

Figure 3. MMR vaccine coverage and PDD⁹

MMR Vaccine Coverage and Pervasive Developmental Disorders (PDD) Rates Over Time



- This image shows that MMR coverage, represented by the top blue horizontal line has been stable, even slightly dropping, over a ten-year period, whereas prevalence of Pervasive Developmental Disorders, a term used for autism spectrum disorders, has been going up during that same period.
- The graph helps to reassure caregivers that there is no association between MMR and autism; perhaps even more than presenting them with a list of scientific studies that have also proven MMR doesn't cause autism.
- When data or concepts are showed visually or graphically, they can really help our interpersonal communication to be clearer, more time-efficient, and more emotionally powerful.
- As we go through our modules, let's identify where we might benefit from more use of visual aids during our communication with caregivers.
- All right, who can give an example of a health benefit of immunization?
 - ▶ Take a few answers.
 - ▶ Show slide: Health benefits of immunization.
- The health benefits of immunization are well known and backed up by extensive clinical and epidemiological studies. These direct benefits include (you have already mentioned some of these):

9 ImmunizeBC (no date). Immunization Communication Tool: For Immunizers. www.immunizebc.ca

Dramatically reduced diseases and mortality rates for many infectious diseases.

- Reduced child mortality - an estimated 6 million deaths of children less than 5 years of age are prevented, each year.
- Reduction in health care costs. Based on the cost of illnesses averted, it is estimated that immunizations will yield a net return of about 16 times greater than the cost. Using a full-income approach, which quantifies the value that people place on living longer and healthier lives, net returns amount to 44 times the cost.
- The indirect health benefit is reduced disease among those who have not been vaccinated.
- Fewer people with disease-related disabilities.
- High coverage protects those that can't be vaccinated such as immunosuppressed individuals.
- Which of these phrases would you want to use during a discussion with a caregiver?
 - ▶ *Let them respond.*
- Are any of these statements untrue?
 - ▶ *Let them respond.*
- These statements are all true, but how many of these are phrased in a way that make them compelling to a caregiver?
 - ▶ *Let them respond.*
- Not too many of them respond very effectively to the most important question for most people in regard to most things: *"What's in it for me?"* We know that some people do think about the wellbeing of society when they are making a decision about immunization, and are motivated by being a responsible citizen, but that's not true for all people.
- So, what would be a good way to talk about the health benefits of vaccination that addresses *"What's in it for me" or "How do the health benefits of vaccination help my child, my family, my community, or my society?"*
 - ▶ *Let them respond.*
- Okay, who has a good elevator phrase to explain *"Why is immunization is important for the health of your child and your family/neighbours?"*
 - ▶ *Let them respond and help them revise it till it's good.*
- Who can summarize our phrase?
 - ▶ *Let them respond.*
- Let's take a moment to write down that phrase along with our other phrases in your *Participant manual*.

Takeaway

- In this session, we have reviewed two things: communication techniques and immunization content.
- The two communication techniques were:
 - The concept of developing, rehearsing and targeting elevator phrases: short, clear, complete phrases that you can have ready, and that are tailored to different audiences' needs.
 - The concept of using visuals for explaining, reinforcing and helping retain information.
- For immunization content, we reviewed how to explain how vaccines work, by comparing them to a dress rehearsal or using another analogy, with emphasis on the word "protect."
- We reviewed how to explain how herd immunity protects those who are unimmunized, and the health benefits of immunization. Now let's look at the vaccination situation in our country.

Session 2.2. National coverage trends and vaccine schedule

Time: 50 minutes

Materials:

✓ *Participant manual.*

- Note: This session actually aims to increase confidence among the FLW trainees, some of who are probably vaccine hesitators. It uses data from Serbia. Please substitute any current data for your country or training context. Ensure your timeline also includes Wakefield's discrediting and the numerous studies that show there is no relation between MMR and autism.

Plenary

- ▶ *Show slide: Session 2.2: National coverage trends and vaccine schedule.*
- We are now going to work in our small groups, using the Participant manual to complete a series of small group exercises.
- Let's review the tasks now, before you divide into your groups and start on the tasks.
- **First**, you will review the overall evolution of immunization in our country and answer some questions that are in your Participant manual.
- **Second**, you will review the national immunization schedule and answer one question.
- **Third**, you will look at coverage data and disease incidence in our country and answer some questions.

Exercise 5A: Evolution of immunization in Serbia and the region

- I will now read out the instructions for the first exercise before you move into your groups.
 - ▶ *Show slide: Exercise 5A.*
- As we know, Serbia has a long history of immunization progress.
- Review Table 1 in your *Participant manual*, and take turns reading the timeline of key events in immunization in Serbia and the world.
- Then your group will answer the questions, in your *Participant manual*, based on the timeline or your experience.
 1. What are some of the events that led to lower immunization rates in Serbia?
 2. What are some things that helped to calm fears about vaccine safety globally?
 3. What other factors have increased uptake of vaccines?
 4. What are some improvements in vaccine safety that have made vaccination even safer in our country?

- Please divide into your groups. You will have 10 minutes to review the timeline and answer the questions.
 - ▶ *Let people move into groups.*
 - ▶ *Time participants for 10 minutes and check in on at five minutes.*
 - ▶ *When everyone has completed bring everyone back for discussion.*

Table 1. Evolution of immunization in Serbia

Year	Event
1839	Vaccination against smallpox becomes mandatory in Serbia.
1927	First systematic immunization in Serbia starts with BCG vaccine; soon afterwards encompassed diphtheria and tetanus vaccines.
1971	Vaccine against measles (monovalent) is introduced.
1980	Last case of diphtheria in Serbia.
1981	Introduction of bivalent measles/mumps vaccine.
1990-1996	Immunization coverage including MMR, below 85% due to numerous difficulties. As a result of the decrease of herd immunity, outbreaks occur of vaccine-preventable diseases (especially measles and pertussis).
1994	Start of continuous use of MMR.
1998	Andrew Wakefield publishes small study of 12 children, based on parental recall, with no controls, stating there is a link between MMR to autism. This creates immediate fear of vaccines. His data was later proven to have been altered, misrepresented and falsified in what has been called "the most damaging medical hoax of the last 100 years" and one of the three all-time classic bogus science stories.

2000	Socio-economic transition after democratic changes.
2004	Investigative journalist in the UK finds that Andrew Wakefield was being paid by lawyers who wanted to sue MMR vaccine manufacturers to get money, several of the parents quoted in his study were part of the lawsuit, and by looking at the original clinical data, proves that Wakefield falsified the data. The other authors on Wakefield's study retract their support for the paper's conclusions.
2006	Negative view surrounding vaccination in Serbia begins to be found on internet forums. British PM Gordon Brown tells public he has given MMR to his son to help counteract public fears.
2006	The Action Plan for the Measles Elimination and the Prevention of Congenital Rubella Syndrome in Serbia was adopted.
2009/10	Major vaccine controversy among Serbian population over vaccine developed for swine flu pandemic lowers coverage for children, especially for MMR vaccine. Aggressive anti-vaccination campaign was established and consolidated during the swine flu epidemics.
2012	The Cochrane Library published a review of dozens of scientific studies involving about 14,700,000 children, which found no credible evidence of an involvement of MMR with either autism or Crohn's disease. ¹⁰
2013	Irregular supply and shortages of vaccines throughout Serbia up until 2015.

10 Demicheli V, Rivetti A, Debalini MG, Di Pietrantonj C (2012). "Vaccines for measles, mumps and rubella in children". The Cochrane Database of Systematic Reviews. 2 (2): CD004407. doi:10.1002/14651858.CD004407.pub3. PMID 22336803.

2014	June 2014 meta-analysis of new studies covering more than 1.25 million children found «vaccinations are not associated with the development of autism or autism spectrum disorder. Furthermore, the components of the vaccines (thimerosal or mercury) or multiple vaccines (MMR) are not associated with the development of autism or autism spectrum disorder.» ¹¹
2015	Introduction of combined pentavalent vaccine (DTaP-IPV-Hib) which includes acellular pertussis, with even fewer side effects, for primary vaccination in the first year and revaccination in the second year of life.
2016	Law on the Protection of Population against Communicable Diseases.
2016	Bivalent OPV (types 1 and 3) introduced in the revaccination of children in the 7th and 14th year of age.

Plenary

- So, what are some of the events that led to lower immunization rates?
 - ▶ *Summarize: war, supply issues, autism rumours, and anti-vax campaigns.*
- What are some things that helped to calm fears about vaccine safety?
 - ▶ *Summarize: Gordon Brown, publishing of large studies that show no relation of MMR to autism, any public statements by leaders?*
- What are some other actions that increased uptake?
 - ▶ *Summarize: obligatory vaccination, seeing the damage caused by epidemics.*
- What are some improvements in vaccine safety that make vaccination even safer or with fewer side effects?
 - ▶ *Bivalent OPV so much lower risk of VDPV, acellular pertussis vaccine.*
- We have reviewed and discussed the evolution of immunization in our country. Now let's go back into our small groups to complete exercises 5B and 5C. Instructions for 5B and 5C are in your *Participant manual*, but we will review them together first.
 - ▶ *Show slide: Exercise 5B and 5C.*

11 Taylor LE, Swerdfeger AL, Eslick GD (June 2014). "Vaccines are not associated with autism: an evidence-based meta-analysis of case-control and cohort studies". *Vaccine*. 32 (29): 3623–9. doi:10.1016/j.vaccine.2014.04.085. PMID 24814559.

Exercise 5B: National immunization schedule for Serbia

- ▶ *Let them regroup.*
- Review the national immunization schedule for Serbia below and take five minutes to discuss the following in your small group: *what would you change in the vaccine calendar, if you had the power to do so, and why?*
 - ▶ *Time the groups for five minutes and then continue with the below points:*
- Let's move straight to **Exercise 5B**.
- Please find **Exercise 5B** in your *Participant manual* and then we will review the instructions together.

Table 2. National immunization schedule – Serbia¹²

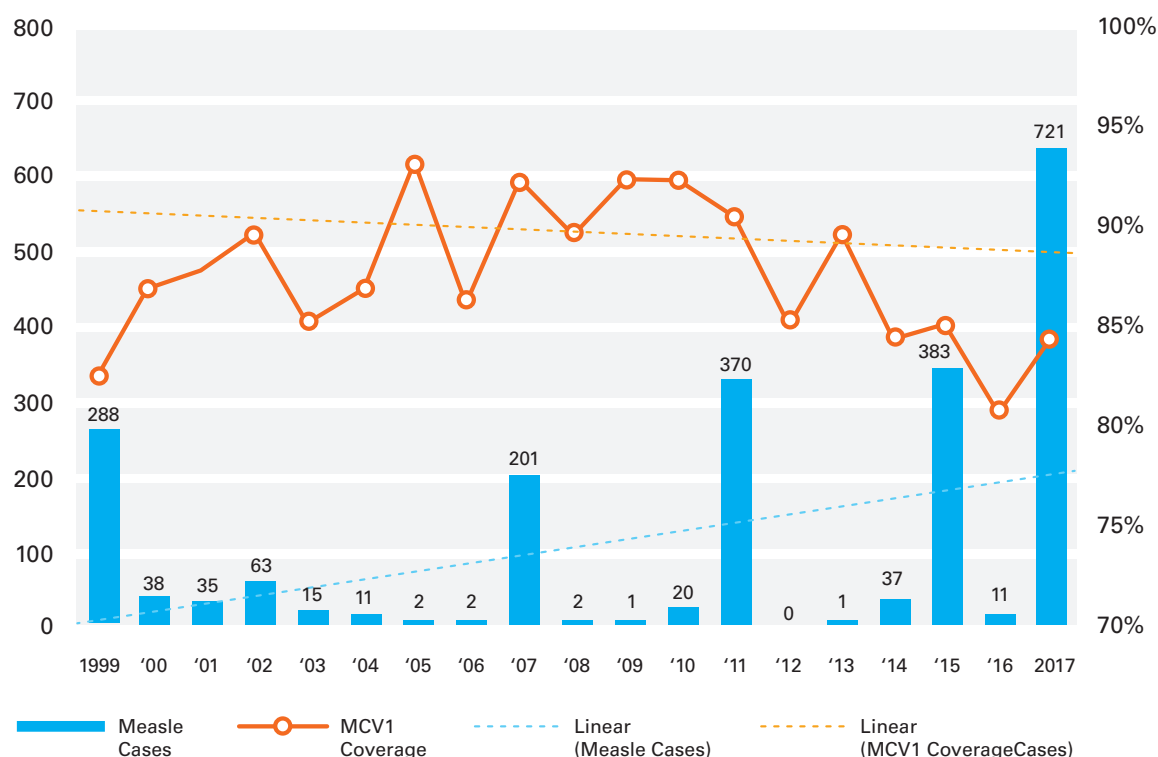
Age	Vaccine
Birth	Tuberculosis – BCG Hepatitis B – HepB_Pediatric
4 weeks	Hepatitis B – HepB_Pediatric
8 weeks	Inactivated poliovirus – IPV Diphtheria, tetanus & acellular pertussis – DtaP Haemophilus influenzae type b (Hib) PCV (Pneumococcal Conjugate Vaccine)
14 weeks	Inactivated poliovirus – IPV Diphtheria, tetanus & acellular pertussis – DtaP Haemophilus influenzae type b (Hib) PCV (Pneumococcal Conjugate Vaccine)
20 weeks	Inactivated poliovirus – IPV Diphtheria, tetanus & acellular pertussis – DtaP Haemophilus influenzae type b (Hib) Hepatitis B – HepB_Pediatric PCV (Pneumococcal Conjugate Vaccine)

12 http://apps.who.int/immunization_monitoring/globalsummary/schedules

Age	Vaccine
12 months	Measles, mumps, rubella – MMR
18 months	Inactivated poliovirus – IPV Diphtheria, tetanus & acellular pertussis – DtaP Haemophilus influenzae type b (Hib) PCV (Pneumococcal Conjugate Vaccine)
2 years	Oral Polio vaccine – OPV
7 years	Measles, mumps, rubella – MMR Tetanus and diphtheria toxoid -Td
14 years	Oral Polio vaccine – OPV Tetanus and diphtheria toxoid – Td

Exercise 5C: Trends

- Please look at **Figure 4** in your *Participant manual* to review the coverage rates for measles and the number of cases of measles in your country in the last few years.
 - ▶ Use the data in **Figure 4** to answer the following questions.
 - What was the highest rate of measles 1 coverage in the last 10 years?
 - What was the lowest rate of measles 1 coverage in the last 10 years?
 - What year had the highest number of measles cases, in the last 10 years?
 - ▶ Next, look at **Table 3** to answer the following questions:
 - What is the difference in fully immunized rates between the general population and the Roma?
 - When does the drop-off in Roma coverage occur?
 - You have five minutes to review this data.

Figure 4. Measles coverage and cases¹³**WHO-UNICEF estimates of MCV1 coverage and measles cases in Serbia****Table 3.** Immunization coverage¹⁴

MICS	Indicator	Description	Serbia	Serbia – Roma settlements
3.1	Immunization coverage against tuberculosis (BCG)	Percentage of 12-23 months old children who have received BCG vaccine before their first birthday (before the age of 1 year)	98.0	94.3

¹³ http://apps.who.int/immunization_monitoring/globalsummary

¹⁴ Statistical Office of the Republic of Serbia and UNICEF. (2014). Serbia Multiple Indicator Cluster Survey and Serbia Roma Settlements Multiple Indicator Cluster Survey, 2014, Final Reports. Belgrade, Serbia: Statistical Office of the Republic of Serbia and UNICEF.

MICS	Indicator	Description	Serbia	Serbia – Roma settlements
3.2	Immunization coverage against polio (OPV)	The number of 12-23 months old children who have received the third dose of OPV vaccine (OPV3) before their first birthday (before the age of 1 year)	86.4	61.0
3.3	Immunization coverage against diphtheria, pertussis and tetanus (DTP)	Percentage of 12-23 months old children who have received the third dose of DTP vaccine (DTP3) before their first birthday (before the age of 1 year)	87.4	64.5
3.4	Immunization coverage against measles, mumps and rubella (MMR1)	Percentage of 24-35 months old children who have received MMR1 vaccine before their second birthday (12-23)	93.4	63.3
3.5	Immunization coverage against hepatitis B (HepB)	Percentage of 12-23 months old children who have received the third dose of hepatitis B vaccine (HepB3) before their first birthday (before the age of 1 year)	91.3	67.8
3.6	Immunization coverage against meningitis (Hib – Haemophilus influenza tip B)	Percentage of 12-23 months old children who have received the third dose of Hib vaccine (Hib3) before their first birthday (before the age of 1 year)	80.4	49.6
3.7	Full immunization coverage	Percentage of 24-35 months old children who have received all recommended vaccines from the national calendar of immunization before their first birthday (second birthday in case of measles)	70.5	12.7

MICS	Indicator	Description	Serbia	Serbia – Roma settlements
3.8	Full immunization coverage at the time of survey	Percentage of 24-35 months old children who have received all recommended vaccines from the national calendar of immunization	80.6	44.1

- Time the groups for 10 minutes and then bring everyone back together for discussion.

Plenary

- First, let's hear about Task B, your review of the national immunization calendar. So what changes if any would you make to the immunization calendar? Why? What are the pros and cons of that?
 - Allow up to 10 minutes of discussion, encouraging the participants to respond to the other participants' ideas.
- Now let's talk about Task C, vaccine coverage and measles cases. Who would like to go first?
 - Let them present moving through each question as below and confirming the correct answers. Check for any questions.
 - What was the highest rate of measles 1 coverage in the last 10 years?
 - **Answer:** 96 or 97% in 2004.
 - What was the lowest rate of measles 1 coverage in the last 10 years?
 - **Answer:** 82 or 83% in 2016.
 - What year had the highest number of measles cases recorded?
 - **Answer:** In 2017, the year after measles coverage was at its lowest.
 - What is the difference in fully immunized rates between the general population and the Roma?
 - **Answer:** 71% versus 13% for on-time complete immunization; 81% versus 44% for complete immunization.
 - When does the drop-off in Roma coverage occur?
 - **Answer:** After the BCG dose.
- Please note that factors that may influence Roma vaccination rates will be covered later, but we can see that the Roma seem to accept vaccination when it's made easily accessible to them, as when the child is born.
- In Task C, we have seen that immunization rates have dropped, and measles cases have gone up, and that Roma coverage rates are similar for BCG and then drop compared to the general population.

- We have good data on the outcomes of the measles cases in Serbia for 2015. The total number of measles cases registered in 2015 was 383.
- The vast majority of confirmed cases, 97.2% were either unvaccinated or persons with unknown vaccination status.
- So, what happened with those 383 cases of measles in 2015 - no big deal, right? It's a normal childhood disease.
- But the highest incidence rate was registered in infants younger than 12 months. These children were too young to have been immunized, but if all the people around them had been immunized, as they should have been, the infants would have been protected by community (herd) immunity.
- That's a lot of sick little babies. There were 138 hospitalizations out of the 383 cases. That's 36% of the cases and the most common registered complications were pneumonia (25% of those hospitalized) followed by diarrhoea, pleural effusion and corneal erosion.
- There were also at least two cases of measles encephalitis. In 2017 there were twice as many cases. You don't want any of that to happen to your patients, or your family or you.
- We are seeing reduction in immunization coverage, especially in MMR, and seeing outbreaks of measles that are having some serious consequences.
- Who has an idea of how many cases of measles there have been in 2018 in Serbia?
 - ▶ *Let them answer [thousands, apparently].*

Takeaway

- These falling coverage and increasing outbreaks are worrisome trends for us as health providers, for our patients, and for our society. We must achieve higher immunization coverage not just to reduce outbreaks of disease, but also to achieve community or herd immunity to protect vulnerable members of society who cannot be protected by being immunized.
- We also know that immunization uptake is not the same in all members of society. These national figures are the average, but there are some groups that have particularly low rates, and some individuals within other groups that normally get vaccinated that aren't getting vaccinated.
- I know that some of these events or issues could be emotionally charged. We will be talking more about vaccine safety protocols, AEFI and contraindications in Module 6.
- If you still have questions about vaccine safety or other worries, please write them on a card and put them in the question box, and we will address them later.

Session 2.3. Vaccine safety processes and protocols in Serbia

Time: 15 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Note: Review and adapt vaccine safety processes, protocols and procurement information to your country.

Plenary

- ▶ *Show slide: Session 2.3: Vaccine safety processes and protocols in Serbia.*
- We want you to have all the information you need to make sure you feel confident in recommending vaccines to your caregivers, and even promoting vaccination in your own social circle.
- In a later session, we will talk about what caregivers are worried about in terms of vaccine procurement, and how we can respond, but for now let's focus on the facts. Who can share their knowledge on mechanisms to ensure vaccine safety in your country?
 - ▶ *Let them answer.*
- There is a fact sheet on vaccine safety processes and protocols (procurement and oversight) in Serbia in your *Participant manual* in Session 2.3.
- Please take five minutes to read the pages on Vaccine Safety Licensing in your *Participant manual*. We will be discussing vaccine origin again in Session 6.5.
- Did this information answer any questions or concerns for you?
 - ▶ *Let them answer.*
- If you have further questions, please write them down and put them in the question box, and we will try to address them before the end of the training.

Takeaway

- There are extremely detailed safety protocols observed in developing and manufacturing vaccines, and there are tight procurement procedures for ensuring that all vaccines procured through WHO vaccine safety licensing meet the same rigorous standards, no matter their country of origin.
- Safety is also related to a number of components that are in our control: maintaining good cold chain, consistent practice of safe injection procedures, and rigorous surveillance and management of any reactions.

Session 2.4. Vaccine hesitancy

Time: 20 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Flip chart from Module 1 - Exercise with categories of caregiver attitudes.
- ✓ Flip chart of Vaccine hesitancy continuum prepared in advance.

Plenary

- ▶ *Show slide: Session 2.4: Vaccine hesitancy.*
- ▶ *Present the flip chart paper you created in Module 1 that lists the categories for different attitudes of care givers.*
- When we were talking earlier about the different categories of caregivers, you identified that some caregivers readily accept vaccines, some refuse them, and some are in the middle, they aren't sure, or they are very worried.
- You were articulating the concept of a continuum of attitudes that has been called **Vaccine hesitancy**.
- Vaccine hesitancy is a relatively recently described concept that has been defined by the WHO Strategic Advisory Group of Experts (SAGE) as:
A delay in acceptance or refusal of vaccines, despite availability of vaccination services.
Show slide: Definition of vaccine hesitancy.¹⁵
- This means that even if services are available, people are choosing to delay or refusing vaccines.
- That word **choosing** is an important one. People vote with their feet. They can come in for vaccination or not. They can refuse to get vaccinated at all or refuse certain vaccines. So, we have to understand what's going on with them, why they feel this way.
 - ▶ *Show slide: Continuum of vaccine hesitancy.*

¹⁵ World Health Organization SAGE working group dealing with vaccine hesitancy (2014) Report of the SAGE working group on vaccine hesitancy October 2014, Page 7.

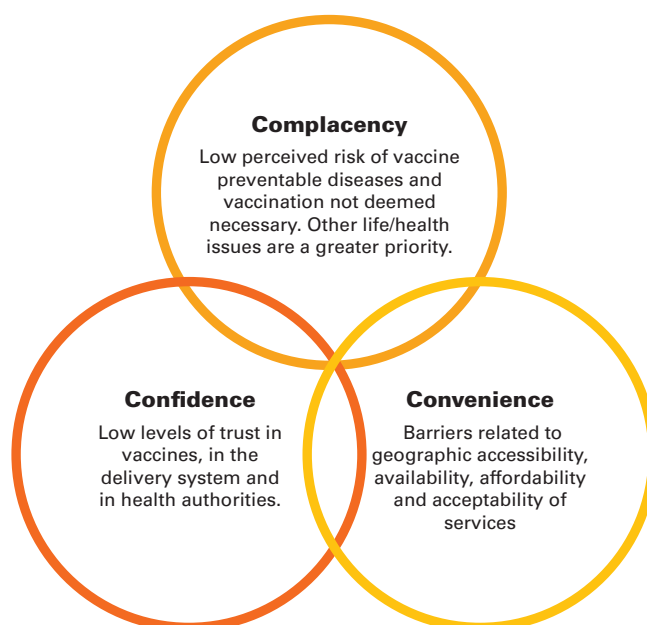
Figure 5. Continuum of vaccine hesitancy¹⁶

- Let's compare our categories to the continuum. How closely do they match?
 - ▶ *Summarize as they correctly noted:*
 - Some caregivers accept all vaccines.
 - Some accept all but are a bit worried by various issues.
 - Some accept some vaccines or delay them or refuse some.
 - Some caregivers refuse vaccines but are unsure whether that's a good idea.
 - Some caregivers refuse all vaccines and are fairly vocal about it.
- We are going to return to this continuum, and the categories of caregivers, throughout the rest of this workshop.
 - ▶ *Post the flip chart of the continuum so you can refer to it over the next sessions.*
- Let me ask a question for you to think about. Do you think any of the caregivers who are on the lower end of this continuum, who refuse vaccines, wake up in the morning and say: "Today I am going to be a terrible caregiver, and do whatever I can to make my kids suffer?"
 - ▶ *Let them answer. If no one answers, call on someone.*
- I don't think so. Most caregivers are extremely motivated to do what's best for their children. They may have a lot of different reasons for their actions, and things going on that we don't know about. We need to understand their reasons for their choices.
- In almost every community, there may be individuals who have lower levels of trust in vaccines, or may doubt, or be indecisive about vaccination.
- These individuals may be considered to be 'hesitant'. They may need a little extra help to come to accept full and timely vaccination.
 - ▶ *Point to the yellow and orange part of the continuum.*
- We are going to focus on these hesitant caregivers for much of the rest of the training:
 1. How do we identify these hesitant individuals who need a little extra help?
 2. How do we listen to and understand their concerns?

¹⁶ Adapted from World Health Organization SAGE working group dealing with vaccine hesitancy (2014) Report of the SAGE working group on vaccine hesitancy October 2014

3. How do we respond to their concerns in a helpful way?
 4. How do we help move them towards vaccination?
- We will also talk about the easy acceptors (the greens) and the absolute refusers (the reds) but it's the ones in the middle that can be moved and have the potential to bring us up to our target of 95% coverage.
 - No single strategy can address all of the different dimensions of hesitancy, but what FLWs say and how they interact with the caregiver can strongly influence vaccine acceptance.
 - Let's look at some of the different factors that affect vaccine hesitancy. You have already mentioned a lot of these during our previous discussions.
 - ▶ *Show slide: The Three Cs model without descriptions.*

Figure 6. The three Cs¹⁷



- In the “3Cs” model, created by a WHO working group of experts who have been studying this issue, they identified three major determinants: Confidence, Complacency, and Convenience.
- What do you think they mean by **Confidence**?
 - ▶ *Let them answer. If no one answers, call on someone, saying, “Any ideas?”*
- Yes, confidence is whether the caregiver – or even the health worker **trusts**:
 1. The effectiveness and safety of vaccines;
 2. The **system** that delivers them, including the **reliability and competence** of the health services and **health professionals** ;and
 3. The **motivations of the policy-makers** who decide on the needed vaccines.

¹⁷ World Health Organization SAGE working group dealing with vaccine hesitancy (2014) Report of the SAGE working group on vaccine hesitancy October 2014.

- Where are people getting a lot of scary information that undermines confidence?
 - ▶ *Let them answer. If no one answers, call on someone, saying, "Any ideas?"*
- Who do you think they trust most: what they hear from friends or on the Internet, or what they hear from their health service provider?
 - ▶ *Let them answer. If no one answers, call on someone, saying, "Any ideas?"*
- We will talk more in later sessions about how people, including all of us smart people here, sometimes end up believing what we believe, and whom patients trust.
- What do you think they mean by **Complacency**?
 - ▶ *Let them answer.*
- Yes, vaccine **complacency** means that people aren't worried about getting the disease or they think the disease isn't very serious, so vaccination isn't seen as that important.
- People may feel they have other priorities or responsibilities that they need to deal with. One of the testimonies to the effectiveness of vaccines is that few people remember what smallpox was like, before immunization wiped it out, or how many people were paralyzed by polio before coverage rates got high enough to eliminate it in the Balkans.
- Who here has seen a case of diphtheria or measles?
 - ▶ *Let them answer. If anyone says yes, ask:*
- How long ago was that? How did your perception of measles as a threat change after seeing a case? Did measles seem more like a real risk, or did you feel that it wasn't that bad a case and not much to worry about?
- As we all say, "seeing is believing," meaning also that not seeing is not believing. If you haven't seen a child with measles-related blindness, or cases of varicella-related encephalitis or Herpes Zoster, you might not be as worried about ensuring that your children are fully vaccinated.
- So, the more successful an immunization programme is, the harder it can be for people to believe that it's a good idea to take a perfectly healthy child and stick a needle in them, and then have to deal with the sore arm and the possible fever plus all the scary things they have heard about vaccines.
- What do you think they mean by **Convenience**?
 - ▶ *Let them answer. If no one answers, call on someone, saying: "Any ideas?"*
- By vaccine convenience we mean, are vaccine services:
 - Easy to get to?
 - Offered at convenient times and locations?
 - Affordable?
 - Provided in a nice place with people who speak your language?
 - Offered in a cultural context where you feel welcome and at home?
 - Does it take all day to get your child vaccinated and the interaction is so stressful that your child is screaming, and you are getting shouted at and you are just miserable?
 - ▶ *Show slide: The three Cs model **with descriptions**.*
- Here are the 3 C's with the descriptions. They are in your *Participant manual*.
 - ▶ *Post the flip chart of the 3Cs where you can refer to it later as needed*
- Now, please turn in your *Participant manual* to **Table 4**, the Determinants of vaccine hesitancy matrix.
 - ▶ *Show slide: Determinants of vaccine hesitancy Matrix.*

Table 4. Determinants of vaccine hesitancy matrix¹⁸

Individual and group influences	Contextual	Vaccine/vaccination specific issues
<ul style="list-style-type: none"> ▫ Personal or community experience with vaccination, including pain ▫ Beliefs and attitudes about health and prevention ▫ Knowledge and awareness, risk/benefit ▫ Immunization as a social norm v. not needed/harmful ▫ Trust in health provider, experience with provider 	<ul style="list-style-type: none"> ▫ Media and public communication ▫ Anti- or pro-vaccination lobbies ▫ Local politics ▫ Perception of the pharmaceutical industry ▫ Religion, culture ▫ Accessibility of services ▫ Trust in authorities 	<ul style="list-style-type: none"> ▫ Risk/benefit (epidemiological/scientific evidence) ▫ Mode of administration ▫ Reliability/Source of the vaccine ▫ Vaccination schedule ▫ New vaccines, formulations or recommendations ▫ Any costs associated with vaccination ▫ The strength of the recommendation/attitude/knowledge base of healthcare professionals

- The Working Group Determinants of Vaccine hesitancy matrix is a more complex and detailed way of looking at things that cause hesitancy. As opposed to the 3Cs, which stood for what?
 - ▶ *Let them answer: Confidence, Complacency, Convenience.*
- The matrix arranges determinants in three categories: individual and group, contextual, and vaccine /vaccination-specific influences.
- Who can read the first column out loud? *If more appropriate for your group read them.*
 - ▶ *If no one volunteers, call on someone to do it.*
- Thanks. Who can read the second column? And the third?
 - ▶ *If no one volunteers, call on someone to do it.*
- Who can read across the bottom row - the last thing mentioned in each column?
 - ▶ *If no one volunteers, call on someone to do it.*
- What do those three things have in common?
 - ▶ *If no one volunteers, say, how about the first and third?*

¹⁸ Adapted from: Conversations to Build Trust In Vaccination, WHO, May 2017

- One of the major influences on vaccine hesitancy is trust in their health care provider, and how robustly their health care provider promotes vaccination.
 - Do they feel their doctor cares about them and wants what is best for their child?
 - Do they feel that the doctor is confident and strong in recommending that they should fully immunize their child?
 - Do they feel they are getting a clear and understandable recommendation from their doctor, but with respect for their opinions too?

Takeaway

- Vaccine hesitancy, failure to vaccinate completely or on time, is influenced by confidence, complacency, and convenience.
- You have the greatest influence on your patients' decision to immunize or not. Studies have shown that, although people get information on immunization from multiple sources, ultimately, they count on their health provider to help them decide. We will talk about this more in the next sessions.

If you are leading a TOT

- ▶ *Facilitate the practice teaching exercise for Module 2, the same way you did for module 1. Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 3.*

Module 3.

Understanding behaviour
and barriers

Module 3. Understanding behaviour and barriers

Module 3 Objectives:

By the end of the module the participants will be able to:

1. Use theoretical models of behaviour change to think about caregivers' needs.
2. Accept that perceptions may not always reflect reality.
3. Begin to recognize the importance of diagnosing your caregivers' needs.
4. Map caregivers on the continuum of vaccine hesitancy.
5. Better understand caregivers' fears and beliefs about vaccines.

Time: 2 hours 15 minutes

Checklist and note to facilitators

- ✓ Flip chart of **Trans-theoretical model of behaviour change** prepared in advance.
- ✓ Flip chart of the Expanded steps model prepared in advance.
- ✓ VIPP cards/paper and tape with the determinants from the **Health belief model** written on them. You will apply these to your flip chart of the expanded steps during the session as you introduce each one.
- ✓ Flip chart of the **Socio-ecological model** prepared in advance.
- ✓ Flip chart of the Pie chart (acceptors and hesitators) to be referenced throughout Module 3 and beyond (substitute with current, local data as needed).
- ✓ Note: Do take the time to follow the script to walk the participants through the steps of behaviour change, because the models of behaviour change are new to many people. Even if you choose to use examples of other behaviours for the case studies, try not to use immunization-related examples. We want the participants to focus on the process of behaviour change and the factors that influence it. If we start with an example of immunization behaviour, they will get distracted into immunization system issues, and lose focus on the behavioural determinants that we want them to think about.

If you are leading a TOT

- ▶ *Complete Module 3 according to the Facilitator guide and then facilitate the practice teaching session for the module.*
- ▶ *Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*

Session 3.1. Understanding behaviour

Time: 60 minutes

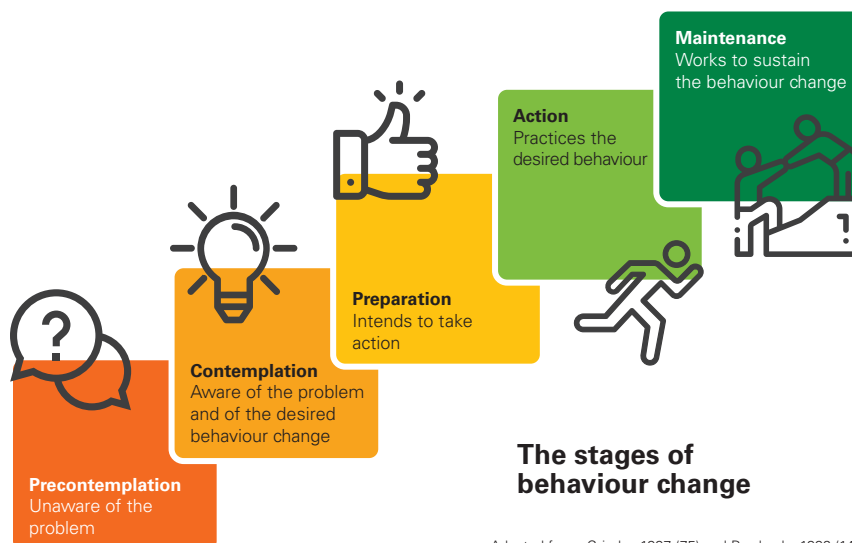
Materials:

- ✓ *Participant manual.*
- ✓ Flip charts with Trans-theoretical model of behaviour change (steps), expanded steps, and Socio-ecological model.

Plenary

- ▶ *Show slide: Session 3.1: Understanding behaviour.*
- In this session, we are going to dig deeper into the interactions between some of the factors that influence caregivers' behaviours. We will review a few models of behaviour change and discuss how we can use these to shape our communication with caregivers.
- Look in your *Participant manual* and find **Figure 7**.
 - ▶ *Show slide: Trans-theoretical model of behaviour change.*
 - ▶ *Also display it on a flip chart which should remain posted throughout the workshop.*
- Let's look at the following diagram. Who can read out loud the first text, at the bottom left step?
 - ▶ *If more appropriate for your group, read these out-loud. Asking others to do it increases interaction and engagement.*
 - ▶ *If no one volunteers, call on someone to do it.*

Figure 7. Trans-theoretical model of behaviour change



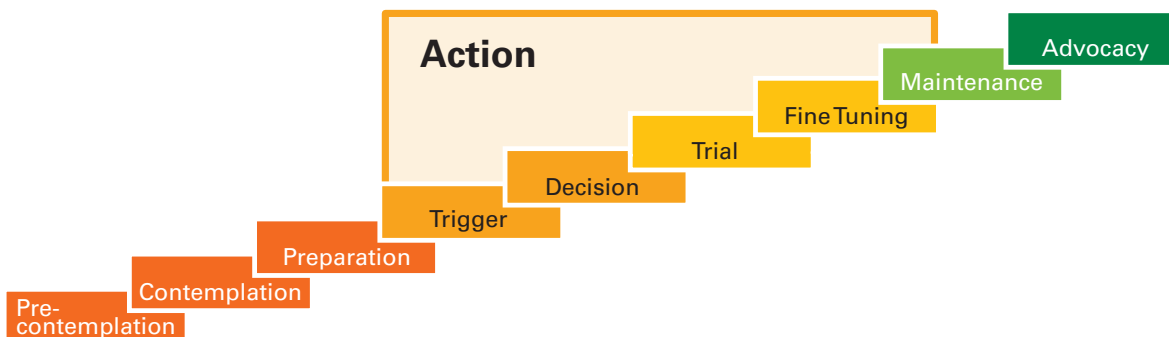
Adapted from: Grimley 1997 (75) and Prochaska 1992 (148)

- Thanks. Who can read the second step? And the third?
 - ▶ *If no one volunteers, call on someone to do it.*
- This looks pretty easy, right? Just go up the stairs.
- We are going to start with a few non-immunization examples to illustrate the behaviour change concepts, so that we aren't thinking immunization, we are thinking behaviours.
- Let's take the example of seat belts. 50 years ago, our stick figure here, Mr. Jankovic, had never heard of seatbelts. So what stage was he in?
 - ▶ *If no one volunteers, call on someone to answer. Then point to the correct stage.*
- Yes, pre-contemplation. He didn't even know about the option. Then he heard about them and thought it would be a good idea. So what stage was he in?
 - ▶ *If no one volunteers, call on someone to answer. Then point to the correct stage.*
- Yes, contemplation. Since he thought it would be a good idea to protect his family, he started looking around to see if he could retrofit seat belts into the car he already had, but it would have cost a fortune. So what stage was he in?
 - ▶ *If no one volunteers, call on someone to answer. Then point to the correct stage.*
- Yes, he was in preparation. He intended to have his family use seat belts, but it wasn't economically feasible. So, he stopped thinking about it for a while. But when his car finally broke down and he needed a new one, Mr. Jankovic bought a car with seat belts. So what stage was he in?
 - ▶ *If no one volunteers, call on someone to answer. Then point to the correct stage.*
- Action. He acted to get the car with the seatbelts. Now do you think the whole family all started wearing seat belts every time they were driving around in the car?
 - ▶ *If no one volunteers, call on someone to answer.*
- No. First they had to get used to this new thing that they perceived as uncomfortable, or they would go for a drive and forget to put them on until they were arriving at their destination.
- Also, they were scared that if they were wearing a seatbelt and the car fell off a bridge into the water, they would be trapped. They focused a lot on this unlikely occurrence, so they didn't want to wear the seat belts.
- Then they agreed they would wear them, but they would take them off as they went over a bridge, but once they took them off to go over the bridge they would forget to put them back on.
- But by reminding each other, and over time, they got used to wearing seatbelts and it became a habit. They felt good about using seatbelts by reading newspaper reports about how many lives had been saved by seatbelts, and they saw their friends and neighbours were wearing seatbelts too. So what stage were they in at this point?
 - ▶ *If no one volunteers, call on someone to answer.*
- Yes, maintenance. As it turned out, studies in the US showed that seatbelts saved many lives. As seatbelt use rose from around 11% in 1981 to about 89% in 2016, car fatalities went down by a huge amount: 45% fewer deaths, and 50% fewer serious injuries.
- Examples of the thing they feared were almost non-existent. In fact:
 1. Less than ½ of 1% of all car crashes involve fire or submersion;
 2. Because wearing the seat belt prevents you from getting knocked unconscious, you have higher ability to escape;

3. Those not wearing a seatbelt were 30 times more likely to be ejected from the car during a crash; and
 4. Three quarters of those ejected, died.
- And remember, the Jankovics had been really worried about being trapped by the seatbelt—something that was in fact a tiny risk, as opposed to the huge risk of dying in a crash when not wearing seatbelts.
 - When they read about these statistics, they knew their perception of risk had been completely inaccurate, and that they were much safer using seat belts.
 - The Jankovics felt safer, and their neighbours were using seat belts, and there were new laws that made it illegal to drive without wearing a seat belt. There were catchy slogans on the radio reminding them to “*click it or ticket.*”
 - And now, with the younger generation having been raised in a context where seat belt wearing is the norm, if you try to drive someplace with a child in the car and you aren’t wearing your seat belt, what do they say?
 - ▶ *If no one volunteers, call on someone to answer.*
 - In a lot of places now, the children themselves tell you to put the seat belt on before you drive. It’s now a complete social norm. Do you remember that some celebrities were severely criticized for driving with their kids not properly buckled into their car seats?
 - So, there were a lot of factors reinforcing the behaviour of consistent seatbelt use:
 - Access to the technology at a reasonable cost
 - Perception of susceptibility/risk
 - Perception of benefits
 - Social norms
 - Legal sanctions
 - Cues to action.
 - We will discuss these factors or behavioural determinants again in a minute.
 - Let’s take an example of another behaviour, use of injectable contraception. We have another stick figure person here on the steps, let’s call her Ana.
 - She’s using the contraceptive pill, but she sometimes forgets to take her pill every day. And she is very worried about getting pregnant right now. Ana has never heard of injectable contraception such as Depo-Provera (Depo) or Noristerat.
 - So where is she in terms of Depo?
 - ▶ *If no one volunteers, call on someone. Point to pre-contemplation.*
 - Pre-contemplation, she’s never heard of it. Now Ana hears about Depo from her friend Violeta and thinks it sounds interesting. So, where is she?
 - ▶ *If no one volunteers, call on someone. Point to contemplation.*
 - Contemplation. Ana goes onto the Internet and starts to learn the facts about Depo and thinks it is a family planning method that would work well for her. She looks around to find out which clinics offer Depo, and how much it costs. So, where is she?
 - ▶ *If no one volunteers, call on someone. Point to preparation.*
 - Preparation. Then Ana goes to the Healthy Family clinic and gets her first injection of Depo. Yay! Where is she?

- ▶ *If no one volunteers, call on someone. Point to action.*
- Action. Now Ana goes to the clinic every three months for her Depo injections. She loves not having to remember to take a pill every night and feels safe knowing she is not at risk of an unplanned pregnancy. What step is she on?
 - ▶ *If no one volunteers, call on someone. Point to maintenance.*
- Maintenance. This looks like a simple, straightforward process. But it's a little more complex. In reality, the Action stage should be divided up into a few more sections, because in fact it's a series of small steps.
- Ana was preparing: she intended to go to get Depo, she had identified several places she could go for Depo, and she was motivated. For two months Ana is thinking about it, *"I really should go."* But she doesn't go. She is stuck here.
 - ▶ *Point to preparation.*
- She had heard about Depo from Violeta, she had found several convenient clinics, she thought Depo was reasonably priced, but that still wasn't enough to overcome her hesitation, or inertia. What do you think it was that got her to stop thinking about it and actually walk out the door and go to the Healthy Family clinic?
 - ▶ *Take a few answers.*
- One day, Ana talks to her friend Mila about how she's interested in trying Depo and Mila says: *"Oh, I use Depo, and I like it a lot. I get it at the Healthy Family Clinic, near your house."*
- Ana says: *"Healthy Family Clinic, that's one of the clinics I was looking at as a possibility, but I just wasn't sure which place to choose or who to go see there."*
- Mila says: *"My doctor there is Doctor Jelena. She is very good, and she really takes listens to me."*
- That afternoon, Ana walks past the Healthy Family clinic and sees a poster outside showing a happy young woman. The poster says: *"Get the life you want! Get Depo!"* Ana walks into the clinic and asks for an appointment with Dr. Jelena.
- So, Ana's discussion with Mila was the **trigger** that got her to finally move from preparation to action. Or maybe that was still part of preparation, and seeing the poster saying *"Get the life you want"* was the trigger that helped her make her decision.
 - ▶ *Post the flip chart of the Expanded steps model and use it to point to each of the action steps as you discuss them with the points below.*

Figure 8. Expanded steps model



- Can you think about something that might have triggered a decision you made?
 - ▶ *Take a few answers and probe, confirm, clarify.*
- Imagine you've been thinking about getting a new cell phone (*point to someone*), you've been looking into the new models, you've researched them, you can't decide.
- There you are in preparation, you want a new phone, and your old phone is just about dead. But you can't make a decision, because although you want the new phone, it's a lot of money, and you have a lot of different factors to consider in making your decision.
- Then your sister says, "*Hey, I just got this new phone, and it's great, so easy to use!*" So, here's your trigger, you want something that's easy to use, and you say, "*Okay great! I've made my decision.*" And you go buy your phone. How do you feel once you've made your decision?
 - ▶ *Take a few answers.*
- Yes, you feel relieved, because you have been hesitating, and now the decision-making is over, and you feel you've made a good decision because you got a recommendation from someone you trust. Your trigger was your sister's recommendation.
- Turns out you've been thinking (*pointing to someone else*) about getting a new cell phone, too, you've been looking into the new models, you've researched them, you can't decide either.
- Your sister recommends the phone, too, and says, "*It's great, it's so easy to use!*" Then you see that another brand is offering a big discount this week, and you say, "*Ok, a discount, that sounds great to me.*" So, here's your trigger, you decide on the other brand.
- Different triggers will work for different people. And triggers are what help you make your decision to act.
- Let's go back to Ana. Ana gets two triggers: her friend's recommendation and then walking by a poster that "spoke" to her. Ana gets triggered to take her action step, she feels confident. She thinks it will be a positive interaction. So, she makes the decision and walks into the clinic to make the appointment.
 - ▶ *Point to decision on the flip chart.*
- She goes from thinking about it to doing it. She's in the action phase. But going to the Healthy Family clinic for Depo for the first time is like an initial **trial**.
 - ▶ *Point to trial on the flip chart.*
- This is actually part of the action step too. Action is really made up of smaller steps, starting with the trigger that helps you make the decision and pushes you up into action, the trial where you have started doing it.
 - ▶ *Point to trigger, decision, trial.*
- Ana has gotten her first shot of Depo, it's just a trial. It's not sure she will continue using it.
- Anna's gone for her first shot of Depo, but afterwards, she is worried because she has a bit of breakthrough bleeding. She goes back to the Healthy Family clinic to see if she can ask Dr. Jelena some questions. Dr. Jelena says: "*I only have five minutes, but I am happy to talk for the time I have.*"
- Dr. Jelena listens to Ana's questions and helps her talk through her concerns, until Ana feels comfortable with her decision to keep using Depo. Dr. Jelena gives her a brochure about side effects from Depo and how to handle them, she reassures her, and encourages her to come back if she has any questions. Let's call this **fine-tuning**.
 - ▶ *Point to fine-tuning on the flip chart.*

- The clinic calls Ana a week before she needs to come in for her next shot, so she doesn't forget. That reminder is an example of a cue to action.
 - ▶ *Write cues to action between fine-tuning and maintenance on the flip chart.*
- Ana stays on schedule and feels comfortable in her decision.
- Now Ana is at the maintenance stage.
 - ▶ *Point to maintenance.*
- Maintenance might also have a step above that is advocacy or recommending it to others. For example, Ana might say to another friend: *"You know, I tried this new kind of contraceptive, Depo, and for me it works out well. No more remembering to take a pill."*
 - ▶ *On the flip chart, point to "advocacy."*
 - ▶ *Show slide: Expanded steps.*
- Let's take a few minutes to discuss what the various influences on Ana were. How did Ana hear about Depo in the first place?
 - ▶ *Let them answer then confirm, pointing at the steps on the expanded steps slide or flip chart as you go along.*
- From her friend Mila. What were the triggers that got Ana to finally walk into the clinic and get Depo?
 - ▶ *Let them answer then confirm.*
- There were a number of triggers that helped her make her decision and do a trial of this behaviour:
 - Mila recommended Depo;
 - Her intended action had approval from a trusted friend;
 - The clinic was nearby;
 - Mila gave the name of a kind and understanding doctor;
 - Ana saw a poster that addressed her motivations: "get the life you want";
 - Ana felt confident she was going to have a good reception with Dr. Jelena;
 - Ana knows where to go and who to ask for, the name of a good provider, so she felt confident getting the appointment and feels confident in her ability to carry out this action;
 - Ana was able to take action and go to the clinic for the first time, having had all these various reassurances and conveniences.
- Which of these factors were health-provider related?
 - ▶ *Let them answer then confirm:*
 - Dr. Jelena was so nice that Mila recommended her.
 - We can also say that health workers put up the poster outside, which made the services more attractive.
- So, getting Ana inside the clinic for a trial of the behaviour was partially due to social influences, and partially due to health provider influences.
- What were the things that got Ana through the fine-tuning stage, that helped ensure she continued coming for her Depo shots, even though she had some worrisome side effects?
 - ▶ *Let them answer then confirm:*
 - Dr. Jelena listens to Ana's questions and helps her talk through her concerns.
 - Dr. Jelena helps Ana feel comfortable with her decision to keep using Depo.
 - Dr. Jelena gives Ana a brochure about side effects from Depo, so Ana has an additional source of credible information.

- Dr. Jelena encourages Ana to come back if she has any more questions.
 - The clinic calls Ana to remind her about her appointment.
- Which of these things were health worker-dependent?
 - ▶ *Let them answer.*
- All of them. A lot of the things that got Ana into the clinic were not health provider related, but the things that kept her coming were. Dr. Jelena is a superstar! She is using listening and discussion to help Ana make a decision and then feel comfortable with it.
- Any questions?
 - ▶ *Clarify as needed.*
- Let's take a few minutes to discuss this model of behaviour change. Let's call it the steps in relation to immunization.
- In a minute, you will work with your partner on a scenario, called David and Amina, moving them "up the stairs".
- Here is the scenario: David and Amina have a 2-week-old baby, Ali.
- Ali got his routine immunizations after delivery at the health centre, but David and Amina were so overwhelmed at the birth they didn't listen very carefully to the health workers' instructions about when to bring Ali back for check-ups.
- They think their next appointment might be at two months. In any case, they have heard vague rumours about possible dangers of childhood immunization, and they aren't sure they will go back for Ali's shots.
- Where do you think David and Amina are, on the steps to behaviour change?
 - ▶ *Let them answer then confirm, pointing to the expanded steps.*
- We could say they are somewhere between pre-contemplation and contemplation. They do not appear to be in a very vaccination-friendly environment, if their family or friends haven't already encouraged them to go for vaccination.
- Let's think about the steps David and Amina would need to take to get baby Ali fully vaccinated. The steps on this vaccination journey might include:
 - ▶ *Walk them up the steps flip chart with this list:*
 - Learning more about vaccination;
 - Getting answers to their basic questions, like when and where, costs, etc.;
 - Feeling positive about getting their child vaccinated;
 - Getting triggered to make the decision to vaccinate;
 - Deciding (or not) to go get their child vaccinated;
 - Navigating their way through their healthcare system for a trial of vaccination - getting an appointment, making logistical arrangements to go to the clinic, remembering to go on time for the appointment;
 - Consulting with their provider, feeling they are being treated well and that their concerns and fears dealt are addressed;
 - Feeling comfortable and dealing with any side effects, setting up next appointment;
 - Returning for next doses, following up with schedules, etc.
- In just a moment you will pair up with neighbour for a short exercise.
- Together you will review **Figure 8: The expanded steps** and discuss what specific things might

have to happen to move David and Amina up these steps on their vaccination journey.

- Before you start, take a moment to remember Ana's story.
- You will have 10 minutes to discuss what specific things might have to happen at each stage to move them along on their journey to vaccination.
- Be ready to report to the other groups what you think might have to happen, at each stage of their vaccination journey, to get Ali fully vaccinated.
- Let's begin!

Exercise 6: David and Amina: moving them up the stairs

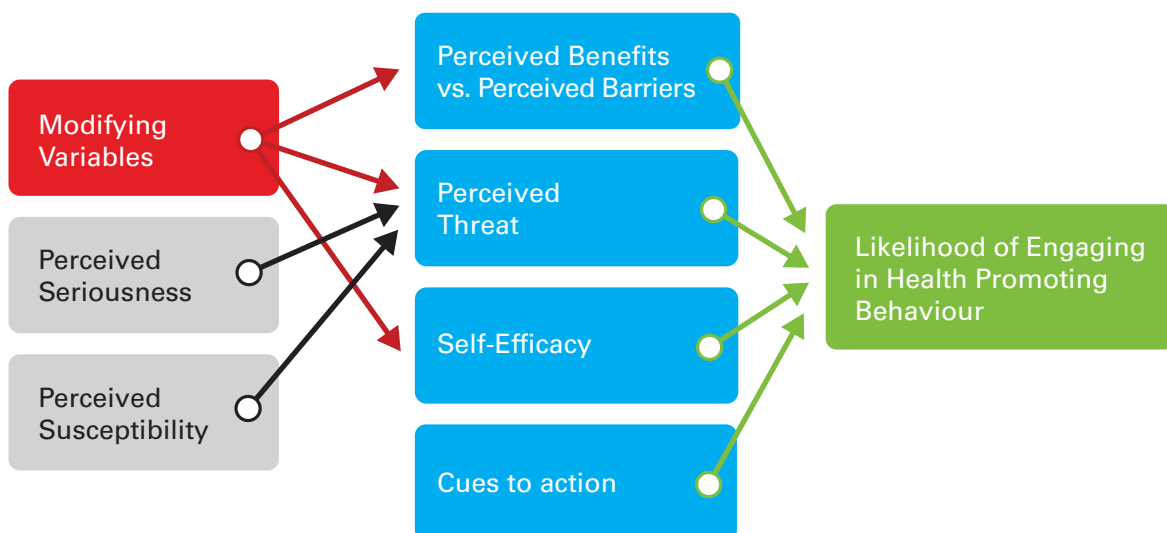
- ▶ Let people partner up.
- ▶ Let them work for 10 minutes in their pairs.
- ▶ Call the group back together after 10 minutes even if they aren't finished.

Plenary

- Who would like to report what their group found?
 - ▶ After the first three groups report, ask the remaining groups if they had anything different to add.
 - ▶ Review *SUGGESTED ANSWERS* below as needed:
 - David and Amina need basic information on when (what age) they are supposed to take Ali for his next vaccination, and why it is important. That would get them to at least Contemplation. They might get that knowledge from a better-informed friend or family member, the radio, a poster, a child health booklet, or a chat with a home visiting nurse.
 - To get David and Amina into Preparation, they might need more basic information like where the immunization clinic is held, on what days, and they might have to arrange transportation.
 - They also might need some confidence building that they will be welcome, and that they would be doing the right thing by taking Ali for his next vaccines. This might have to come from dialogue with someone who can understand their fears and who can help them make the decision - perhaps a trusted family member, a longer, more in-depth discussion with the visiting nurse, or perhaps a friendly phone call from a clinic nurse inviting them to come in and making them feel welcome to come for just a discussion, with no scolding for their lateness. This is all part of Preparation, and without it, the caregivers may not ever come in, or might come in very late.
 - It might take some kind of Trigger to get David and Amina to get from Preparation (thinking about it) to Action - actually going to the clinic.
 - This might need to be a phone call from the clinic nurse with a suggested appointment

- time, or the visiting nurse suggesting a specific date to go to the clinic, or a family member offering to go with them. Something needs to help them make their Decision to walk in the clinic door.
- Once they walk in the clinic, that's their Trial. It will be up to clinic - the reception, the wait time, the health provider's communication skills, to ensure they feel comfortable with their action.
 - They Fine-Tune any problems - like Ali having sore arm or fever afterwards but feel comfortable enough that they will be carrying out the Action of coming back again once, then again, and again until Ali is firmly established on the vaccination schedule.
 - When they continue to come back, they have reached Maintenance.
 - What would it take for them to become advocates, and started recommending immunization to their family and friends? It might take a request from a health provider for them to talk with another family who has questions.
- Good ideas. These are all good ideas. If we:
 - Make them feel really satisfied with our services;
 - Provide praise for being good responsible parents;
 - Give them brochures to share with others;
 - Ask them if they would be willing to talk with other parents about their experiences.
 - They can then become the trigger, or be part of the decision-making or fine-tuning, for someone else.
 - ▶ *Show slide: The Health belief model.*

Figure 9. Health belief model¹⁹



- The Health belief model, **Figure 9** in the *Participant manual*, looks at a variety of determinants

¹⁹ https://en.wikipedia.org/wiki/File:The_Health_Belief_Model.pdf

that can influence how we move up or down the steps.

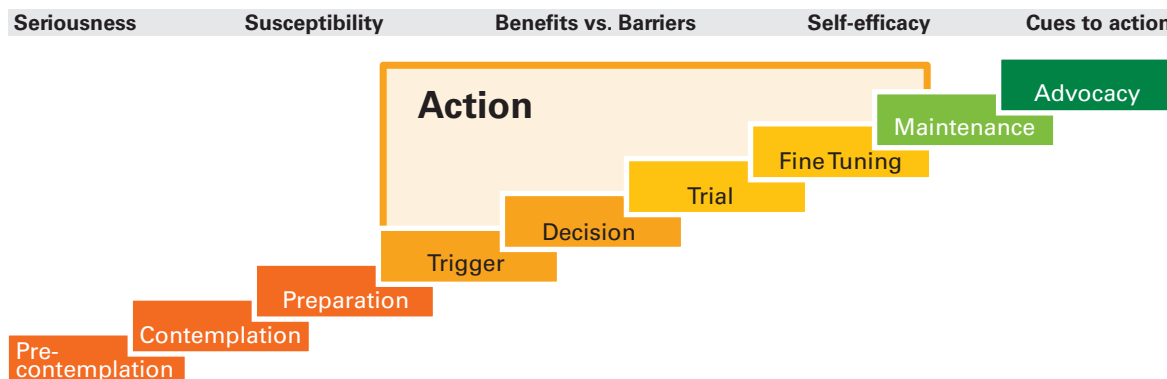
- These determinants include perceived seriousness and perceived susceptibility.
- Who can give an example of what perceived seriousness might mean?
 - ▶ *Let them answer.*
- Yes, perceived seriousness means: *“Do I think that this thing is dangerous?”*
- Who can give an example of what perceived susceptibility might mean?
 - ▶ *Let them answer.*
- Yes, it is *“Do I feel that I am at risk, is this dangerous for me?”*
- Why do we say perceived seriousness and perceived susceptibility?
 - ▶ *Let them answer.*
- The person may not accurately judge the seriousness of something, or their actual susceptibility.
- For example,
 - ▶ *Point to perceived seriousness.*
- Someone might not consider measles a serious disease, although it really is.
 - ▶ *Point to perceived susceptibility.*
- Someone might believe (perceive) that they are not at risk of (susceptible to) HIV because they are faithful to their partner, but they might not realize that their partner is having multiple other relationships.
- Perceived seriousness and perceived susceptibility combine to give the perceived threat.
- Who can give an example of what perceived threat might mean?
 - ▶ *Let them answer.*
- Overall, is this something that I am at risk of, and that is dangerous? So, am I worried about this or not? Is this thing enough of a threat that I need to change my behaviour to deal with it?
- This idea of perceived threat relates to complacency, which we saw in the previous module in the 3 Cs.
- Another pair of determinants is the perceived benefit versus the perceived barrier.
- Who can give an example of what perceived barriers might mean?
 - ▶ *Let them answer.*
- Examples might be:
 - *“I’d like to vaccinate my child, but I have to pay for the physical exam before the vaccination, and I don’t have the money.”*
 - *“I’d like to vaccinate my child, but the health workers are very rude to me.”*
 - *“I’d like to vaccinate my child, but my work schedule conflicts with the clinic hours.”*
- Perceived barriers relate to convenience, which we saw in the 3 Cs.
- Who can give an example of what perceived benefits might mean, in relation to immunization?
 - ▶ *Let them answer.*
- Examples might include:
 - *“I am relieved that my child is protected against these dangerous diseases.”*
 - *“I am seen as a good parent and a socially responsible person if I vaccinate my child.”*
 - *“Perceived benefits relate to confidence, which was the last of the 3 Cs.”*
- If we remember Mr. Jankovic’s family and the seat belts, they were more worried about getting trapped in the car by their seat belts in the extremely rare possibility that their car fell off a bridge,

than they were by the much more likely danger of being killed in a road accident.

- They didn't have an evidence-based perception of threat, and of the barriers and benefits of wearing seat belts.
- In the same way, many caregivers don't see the benefits of vaccination as big enough to overcome the barriers of fear related to rumours they have heard.
- Perceived benefits and barriers are related to an extremely important determinant of behaviour called social norms.
- Who can explain what social norms means?
 - ▶ *Let them answer.*
- Social norms are what people are expected to do. One of the absolute most powerful motivators for people's behaviour is *"What will people think of me?"* And sometime the social norm is to do something that is NOT good for your health.
- For example, there are some caregivers that report that, in their parenting groups, they feel pressure to delay immunization because everyone else in their group is doing it, and they don't want to be criticized. Has anyone heard that story from their patients?
 - ▶ *Let them answer.*
- Another consideration is self-efficacy. Any ideas on what self-efficacy means and how it would relate to immunization?
 - ▶ *Let them answer.*
- Self-efficacy is ones' belief in ones' ability to succeed in specific situations or accomplish a task. Examples might include:
 - *"I feel confident that I can handle the stress of watching my child getting an injection and crying."*
 - *"I feel capable of dealing with the criticism from my mother-in-law when my baby fusses after the shots."*
 - *"I think I will be able to make the necessary appointments and come to the clinic as scheduled, with the proper health insurance card and/or any co-payment that I have to make."*
- Finally, cues to action are reminders that pushing someone to perform a behaviour. We've talked about those already a bit.
- Who can give me an example of a "cue to action" to use seat belts that we often are exposed to?
 - ▶ *Let them answer. Examples might include:*
 - A light or ringing noise that the car makes until you attach your seatbelt.
 - On a plane, there are announcements, signs, and checks by the flight attendants.
- What is an example of a cue to action to get your child immunized?
 - ▶ *Let them answer and confirm with an example:*
 - A phone call from the clinic, a reminder sent by SMS, a poster reminding parents of the importance of vaccination, a regulation by a nursery school that children must be vaccinated before they can attend classes, even a home vaccination record that shows the date when the next vaccination is due.
- Cues to action are important because sometimes people just forget, or they don't really want to do the thing, so a little social pressure or enforcement is needed.
- All these behavioural determinants can help move someone up the steps or allow them to go down.
- **Figure 10** in your *Participant manual* illustrates the steps from the Trans-theoretical model with

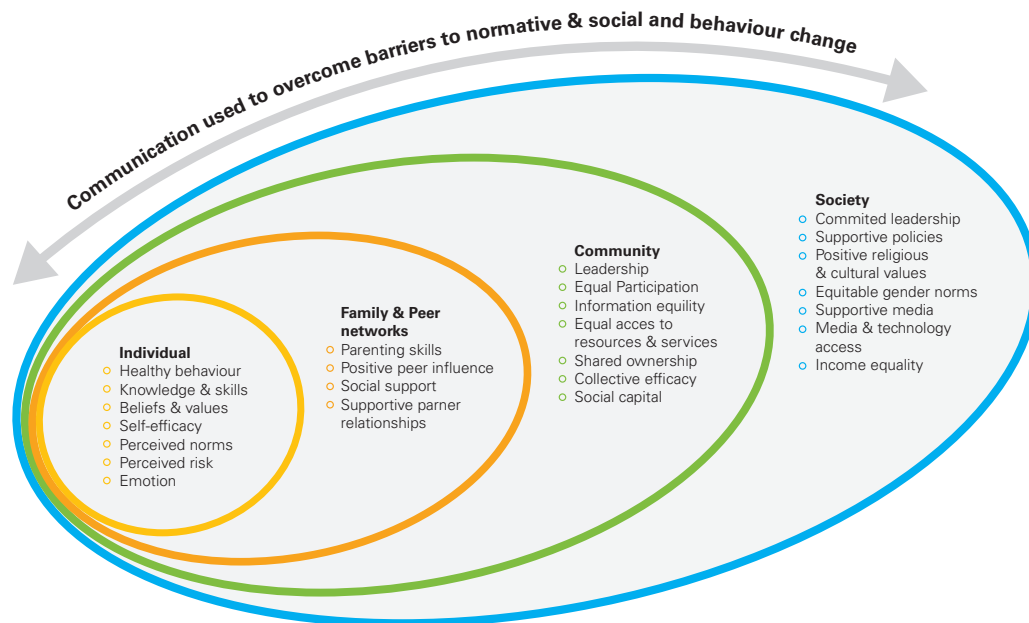
the determinates from the Health belief model over them.

Figure 10. Combined Trans-theoretical model and Health belief model



- This is a good image to remember when you are trying to identify caregivers' concerns. As we are working with our caregivers to understand their concerns, and diagnose what their concerns are, and what "communication treatment" they may need to move up the steps.
- If they don't see vaccine preventable diseases (VPD) as a threat, we work on that. If they see more barriers than benefits, we work on that. If they seem to lack the belief that they can get their child fully vaccinated, we give them confidence and help them find solutions. If they need a cue to action, we call them to remind them, etc.
- Although in the Trans-theoretical or steps model we were looking at one person going up the steps, we know that friends, family, community and policies have a big influence on how we climb them.
 - ▶ *Show slide: Socio-ecological model*

Figure 11. Socio-ecological model²⁰



- This model, **Figure 11** in your *Participant manual*, illustrates the different spheres of influence that govern our behavioral choices and norms. These also influence how we move along the stairs, propelling us forward, keeping us standing still, or even moving us backwards.
- It starts with the individual, which is inside of and influenced by the family, which is part of and influenced by the community, which is part of and influenced by society. Let's call this the eggs.
- This model emphasizes that, for immunization coverage to get back up to safe levels, we have to use communication:

Takeaway

- At the individual level with our caregivers;
 - With families, for example during visiting nurse visits;
 - With communities, as for example by community health mediators;
 - With society, as for example with public figures making positive or negative statements about vaccines;
 - With policies, as for example making vaccines compulsory or making vaccination an opt-out approach instead of opt-in.
- Behaviour change is a process. It has multiple determinants and is influenced at multiple levels. There is no quick fix to changing behaviour, but there are small things we as health workers can do to trigger, remind, reinforce and support caregivers as they go through the process of decision-making and adopting healthier behaviours. Models of behaviour change can help us to diagnose what may be influencing their choices, so we can give more effective and targeted communication treatment.
- We don't have time to discuss this in depth today, but I encourage you to look at it and reflect on how it might relate to our stories of the seat belts and the Depo, as well as how it might align with the vaccine hesitancy model and our story of Ali.
- Any questions?
 - ▶ Clarify as needed.

Session 3.2. Perception biases

Time: 15 minutes

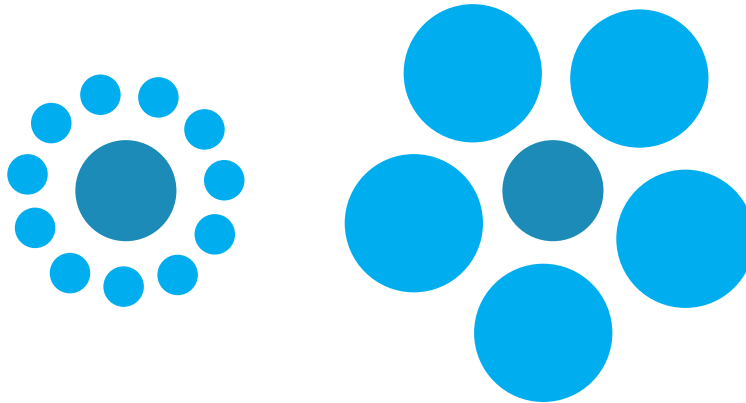
Materials:

- ✓ *Participant manual.*
- ✓ Flip charts of expanded steps and Socio-ecological model.

Plenary

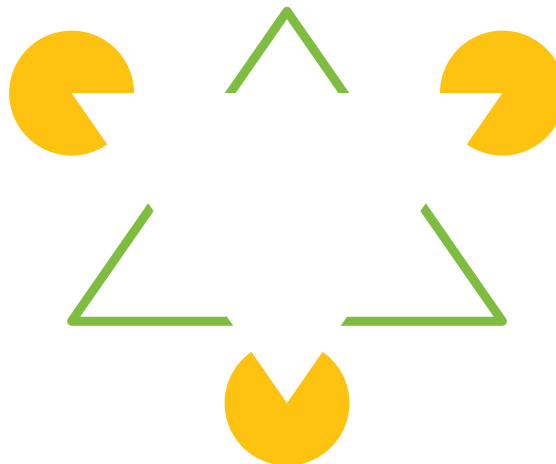
- ▶ *Show slide: Session 3.2: Perception biases.*
- As we have discussed, knowledge alone does not change behaviour. People make choices based on internal and external factors.
- Sometimes we know we should stop doing something, or start doing something, but other factors intervene to make us not do it. Knowing the facts isn't enough. Information alone is not enough.
- Can you think of one behaviour where everyone knows it's dangerous, but they do it anyway?
 - ▶ *Take a few examples.*
 - ▶ *Show slide: Doctor smoking.*
- Can you think of one behaviour where everyone knows they should do it, but they don't always do it as they should?
 - ▶ *Take a few examples.*
 - ▶ *Show slide: Biking.*
- So, even when we have correct information, we don't always act on it. Sometimes our emotions, or other factors, are more powerful than information or logic.
- Our brains are powerful information processing systems. The brain is constantly experiencing many different inputs and trying to make sense of them all. Sometimes our brain uses shortcuts, or even makes mistakes, as it tries to help us make sense of all the different stimuli.
- Let's look at some examples.
 - ▶ *Show slide: Blue circles slide.*
- Which of the centre circles looks bigger, the one on the left, or the one on the right?
 - ▶ *Let the group respond.*

Figure 12. Blue circles



- The circle on the left looks bigger than the circle on the right because it is surrounded by smaller circles. But the two centre circles are the same size.
 - ▶ *Show slide: Blue circles with the red lines added.*
- This illusion happens because our brain uses context to judge size. Since the centre circle on the left is surrounded by tiny circles, the brain thinks it's larger than a circle surrounded by much larger circles.
 - ▶ *Show slide: Triangles.*

Figure 13. Triangles



- How many triangles do you see here?
 - ▶ *Let people respond.*
- Actually, there are no actual triangles anywhere in the illustration.
- Our brain fills in the gaps, because it assumes that there is a triangle there. Our brain extrapolates, based on the small bits of information, to make an image that makes sense, and that is whole and complete.
 - ▶ *Show slide: Green peppers.*

Figure 14. *What do you see?*



- What do you see in this photo?
 - ▶ *Let the group respond.*
- Yes, it's a green pepper cut in half. And we know that there are not actually faces in the green pepper. But our brains tell us that there are.
- When we see things, shapes or information, we want them to make a recognizable pattern. If we see something that looks vaguely familiar, our brain latches onto that piece of vague information and puts it into an already-established "box" where it fits best. Our brains are working hard to make sense of the world.
- In the case of these green peppers, our brain decides that the shape we are seeing looks like a face. In the case of the moon, maybe our brain, or our mother, tells us it looks like a man, or the outline of a rabbit, so then we get used to seeing a face, or a rabbit, and at that point, it becomes very difficult for us to see anything else.
- We've seen that our brain can really play tricks on us. It makes comparisons and comes to incorrect conclusions. Your brain fills in things that aren't there. It misinterprets what it is seeing so that it looks like something familiar.
- These are some examples of how our brain works to process visual information and try to make sense of it.
- We also have lots of mechanisms to process experiential or heard information. We may:
 - Perceive things as more dangerous than they are (remember the Jankovics who were so worried about being trapped by their seat belts);
 - Ignore things that are confusing or that don't conform to our view of the world;
 - Fill in the blanks to make patterns where there really isn't that much data.
- We are all trying to make sense of the world.
- We see this in the fallacy called "*Post hoc, ergo propter hoc*," which translates as "*after, thus because of*."
- Do you know the old sayings: "*Break a mirror, 7 years of bad luck*" or "*If a black cat crosses your path, you will have bad luck*"?
- When something bad happens, you look back and try to find something that would have caused it. You choose an unusual or striking thing that happened before the bad thing. People used to believe that if a baby was born with a red birthmark, it was because the mother ate a strawberry when she was pregnant.

- We try to explain things based on something significant that happened before it. Sometimes we are right: *"I drank a bottle of raki before driving, which is why I had a car accident."*
- But sometimes we are wrong: *"My friend borrowed my car, and now it has engine problems. So, my friend caused my car to have problems."* But, it is very probable that your 10-year old car would have had engine problems, even if your friend hadn't borrowed it. But, because the problems happened after an unusual occurrence (your friend borrowing your car), you blame the problems not on the age of the car, but on your friend.
- This may help explain why, in the face of all the scientific evidence people believe that MMR is linked to autism.
- We are terrified by the increase in autism. We want to believe there is a reason that we can explain. We see patterns where there is none.
- We don't see or feel the threat of measles, but we see and feel frightened by autism. Because MMR is given around the time that autism symptoms emerge, we blame autism on MMR.
- This also helps us feel we can avoid autism by not giving MMR. But, there is a large body of evidence that show that vaccination has nothing to do with whether a child develops autism or not.
- One example is one in Denmark²¹ with over half a million children, which compared children who were vaccinated to children who were not vaccinated. It found that there was no difference in autism rates.
- In Serbia, research has found²² that when caregivers (especially anti-vaccine caregivers) are presented with anecdotal examples of positive and negative experiences with vaccination:
 1. They tend to interpret events as causing one another (vaccination, because it's a memorable and stressful event, is seen as causing something bad that occurred later).
 2. All unwanted effects that happen months after vaccination are attributed to vaccination, even if they are completely unrelated, because they fear vaccination.
 3. They fail to perceive differences between mild and serious adverse effects; rather they perceive both as serious risk of vaccination. This means they give equal weight to the one in ten chance that their child will have discomfort, redness and swelling where the injection was given or will have a fever, as they do to the one in ten million chance the child may get a case of encephalitis. These are not equal!
 4. They also do not compare the risks of adverse effects of measles to the risks of adverse effects of vaccines. Measles is feared less than the perceived risks of vaccines, whereas vaccines are much safer than the diseases they prevent.
- We have been talking about a few brain biases, but there are many of them. **Figure 15** in the *Participant manual* illustrates a range of cognitive biases that you can review later.
 - ▶ Show slide: *Cognitive bias codex.*

21 A POPULATION-BASED STUDY OF MEASLES, MUMPS, AND RUBELLA VACCINATION AND AUTISM Madsen et al, New England Journal of Medicine, Vol. 347, No. 19 · November 7, 2002

22 UNICEF (2017). Knowledge, Attitudes and Practices in Relation to Immunization of Children in Serbia (KAPb). Final Report (Draft. Page 8.)

[illegible]

- These brain biases that we have discussed can make a difference in how we interpret information and make decisions.
- Often, the deciding factor for all of us is not facts; it's emotions or perceptions.
- The way we present information, help caregivers understand that information, and the way in which we convey this information can influence how caregivers weigh the perceived threat and perceived barriers and benefits. Anti-vaxxers, for example, use this to their advantage well. They use little fact and play on people's fear.
- Framing is a way to present data - either positively or negatively - depending on what we want to convey.
- Let's look at an example of framing of frequencies. Which of the following sounds more worrisome?
 - One out of ten children will have a problem like fever, soreness, etc.
 - Nine out of ten children will have no problem.

▶ *Let them respond.*
- If you say: *"one out of ten children will have a problem,"* that can be seen as more frightening than saying: *"nine out of ten children will have no problem."* By using positive framing to discuss risk of a vaccine - nine out of ten will have no problems - you provide reassurance.
- Let's look at frequencies versus percentages. Research suggests frequencies are seen as more real and relatable than percentages.
- If we explain the risk of the vaccine-preventable disease as a negatively framed frequency (diphtheria kills 50 people out of 1000 cases) and compare it the risk of a potential side effect in a positively framed percentage (only about x% of children experience redness and swelling, or fever), this makes the disease seem more frightening, and the vaccine less frightening.
- The emotion of imagining your child being the one in ten million children that have a severe reaction to a vaccine is very powerful. If you frame it as *"there is only a tiny risk of a severe reaction, 0.0000001%, or one hundred thousandth of a percent,"* the emotional response is less personal and risky.
- By telling the truth, but using different ways of presenting data, we can use caregiver's emotional responses to nudge them towards immunization²³.
- Research also suggests that it takes around three positive things to make up for one negative thing because we don't weigh positive and negative things equally. So, our efforts to be empathetic and make caregivers feel heard and respected can help compensate for the anxiety they may be experiencing about choosing to vaccinate.
- People look for shortcuts, and the simplest solutions as they make behavioural decisions, so the way we set up services and systems can make a difference for our caregivers.
- As we will talk about more in depth later, making vaccination an opt-out approach - meaning you have to actively choose NOT to do it - helps keep coverage high.

23 Laskowski, M. Nudging Towards Vaccination: A Behavioural Law and Economics Approach to Childhood Immunization Policy. Texas Law Review volume 94 Issue 3. <https://texaslawreview.org/nudging-towards-vaccination-a-behavioural-law-and-economics-approach-to-childhood-immunization-policy/>

- Making it difficult to choose NOT to vaccinate will discourage people from opting out unless they are extremely resistant. If we set the system up to make getting vaccinated easier, with fewer barriers, it will help to increase the number of people getting their children vaccinated.
- If we set up a system so that every caregiver gets an automatic reminder of their child's next vaccinations, we don't have to remember to do it ourselves, and the parents get the trigger/cue to action that helps increase return visits.
- It is important to keep in mind that these biases influence the decision-making of not just caregivers, but even us, trained health professionals. It is important that we remain mindful of them in our interactions with caregivers.
- We will explore these and other strategies more in-depth as we move through the training.

Takeaway

- Humans make decisions based on facts, emotions and perceptions. We are almost inevitably influenced by various cognitive biases. Our communication needs to use emotions as well as facts, to generate the momentum needed to move people into action and change behaviours.

Session 3.3. Diagnosing your caregivers' needs. Introduction

Time: 10 minutes

Materials:

✓ Participant manual.

Plenary

- ▶ Show slide: Session 3.3: Diagnosing your caregiver's needs. Introduction.
- Vaccine hesitancy isn't just fear of vaccines. Who can remember what the 3Cs are?
 - ▶ Let the group respond. Summarize if needed: convenience, complacency, confidence.
- As in the 3Cs, there are many reasons caregivers might not be showing up for immunization or completing vaccine schedules. Our first job in ensuring vaccination uptake is to understand the caregiver's needs.
- Let's watch a role play as one example of this.

Exercise 7: Olga and Dr. Musa role play

- ▶ Use the below script to act out the role play with another facilitator. You could also have two participants who have had time to practice the role play act it out for the group.

OLGA:	Good morning, are you Dr. Musa?
DR. MUSA:	Yes, please come in, Mrs. Marci. (He smiles, shows her a seat, good eye contact, etc.)
OLGA:	Please call me Olga. (Anxious smile)
DR. MUSA:	Olga, I see that baby Luka already had his first vaccines when he was delivered, and today it's time for his second shot.
OLGA:	Yes. (Handing over vaccine card slowly, looking at doctor sideways.)

DR. MUSA:	Today we are going to give him DTaP. This will be the first of a few shots that will protect him against these dangerous diseases, they are easy to catch and very difficult to treat.
OLGA:	You know, I'm not sure. Maybe not today. (Furrowing her brow.)
DR. MUSA:	But your baby should be vaccinated to protect him against dangerous diseases.
OLGA:	I know that, I just am not ready right now. (Pursing her lips.)
DR. MUSA:	Babies should be vaccinated according to the schedule in order to ensure that they are not exposed to dangerous diseases. If you are worried about vaccine safety, you don't have to worry; it is perfectly safe. Most children are fine. They might have a bit of a sore arm or a fever for a day or two. It's normal, nothing to worry about.
OLGA:	No, no, I need to go now. (Holding her hand up as if to say stop.)
DR. MUSA:	Olga, I know you are worried but it's the right thing to do. I strongly recommend it.
OLGA:	Thank you but no... (Shaking her head 'no'.) Maybe another time. (Olga rushes out.)
DR. MUSA:	Oh dear, another vaccine refuser. I wish these people would listen to me!
OLGA:	(Speaking into imaginary cell phone:) Hi, mom! No, I didn't end up getting the immunizations for Luka. No, I'm not worried about vaccine safety. Dr. Musa explained it all. I was just so afraid of the needles. Do you remember how I almost fainted when I had to get the shot last time? I wanted to ask the Doctor whether we could maybe have the nurse help, so I wouldn't have to watch or something, but he never stopped talking! He never asked me if I had any questions or concerns. I wish he had listened to me.

- As a medical worker, you first make a diagnosis, before you prescribe treatment. Antibiotics are great. But are antibiotics the solution to all illnesses?
 - ▶ *Let them answer.*
- No, antibiotics are only helpful for diseases caused by bacteria that are susceptible to the antibiotic. Similarly, giving the same information to each caregiver, in the same way, won't address their problems, concerns and needs as we saw in the case of Olga.
- We are going to devote the rest of this module to building our skills to understand their concerns and effectively address them, so, like David and Amina, we can help them along their vaccination journey. Remember the steps in journey are:
 - Learning about vaccines;
 - Getting answers to their basic questions;
 - Deciding (or not) to get their children vaccinated at all;
 - Navigating their way through their healthcare systems;
 - Consulting with their providers;
 - Getting their concerns and fears dealt with;
 - Accepting, delaying or refusing to get their children immunized;
 - Dealing with side effects;
 - Returning for next doses;
 - Following up with schedules, etc.

Takeaway

- Sometimes even the best clinician isn't very good at understanding what their patient needs or wants. We need to ensure we understand what the true concerns are before we can target our communication to help caregivers overcome the specific barriers they face in choosing to immunize their child.

Session 3.4. Mapping your caregivers on the Continuum of vaccine hesitancy

Time: 15 minutes

Materials:

- ✓ Flip charts with the Vaccine hesitancy continuum and the Pie Chart.

Plenary

- ▶ Show slide: Session 3.4: Mapping your caregivers on the Continuum of vaccine hesitancy.
- To understand our caregivers' needs, we need to map where on the hesitancy scale our caregiver is.
 - ▶ Show slide: Vaccine hesitancy continuum.
- Where on this continuum would you put the mom, Olga, we just saw?
 - ▶ Let the group respond and confirm: maybe accept but unsure or accept some delay and refuse some.
- How might we identify where our caregivers are?
 - ▶ Let the group respond.
- Here is the same image with some examples of what a caregiver in each category might say.
 - ▶ Show slide: Vaccine hesitancy continuum with phrases.

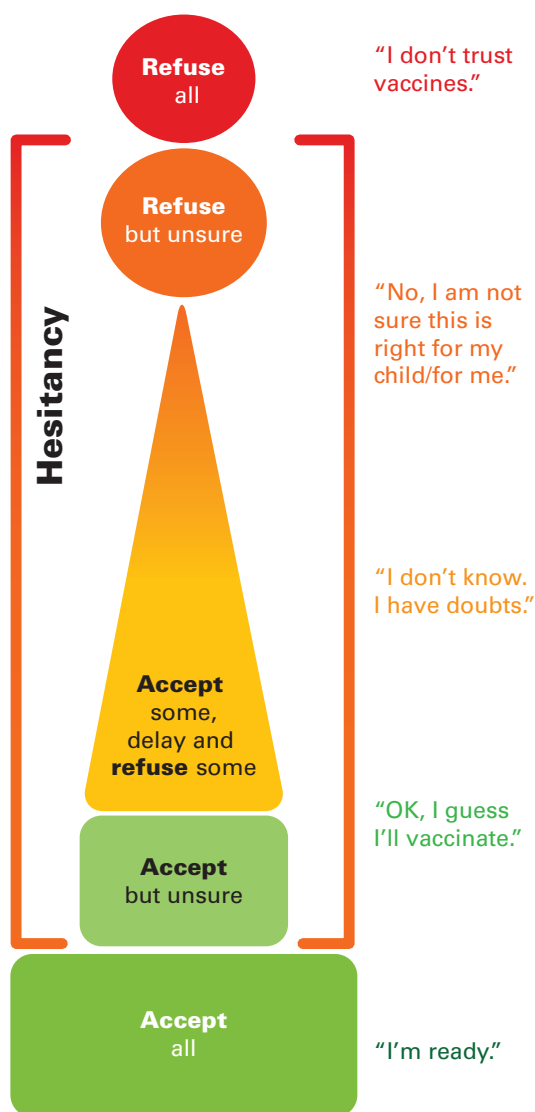
Figure 16. Vaccine hesitancy continuum²⁴



²⁴ Adapted from World Health Organization SAGE working group dealing with vaccine hesitancy (2014) Report of the SAGE working group on vaccine hesitancy October 2014

- Who can read out the categories and the example statements from left to right?
 - ▶ *If more appropriate, read these for participants. Asking others to read increases engagement.*
- What do the colours remind you of?
 - ▶ *If no one volunteers, call on someone. Point to the colours.*
- It looks a lot like a stoplight.
 - ▶ *Show slide: Continuum as stoplight.*

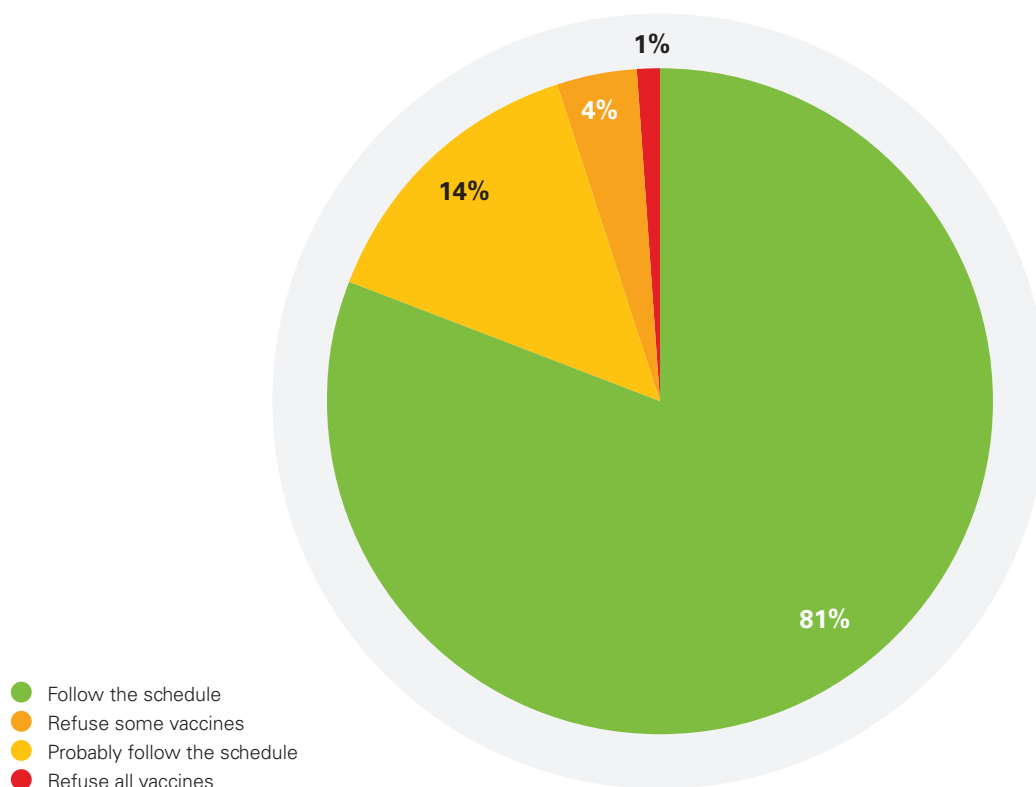
Figure 17. Traffic light



- When you are driving, and you see a green light, what do you do? If no one volunteers, call on someone.
 - ▶ *Point to the colour as you respond.*
- If you see a green light, you can go pretty fast, just check to make sure it's safe to proceed.
- When you are driving, and you see a yellow light, what do you do?
 - ▶ *If no one volunteers, call on someone. Point to the colour as you respond.*
- Yes, in the case of some people, you step on the gas and blast through. But really, if you are driving and you see a yellow light, you need to slow down and decide what to do: should you keep going, or slow down, or stop? When you are driving, and you see a red light, what do you do? If no one volunteers, call on someone. Point to the colour as you respond.
- If you are driving and you see a red light, you have to stop.
- This is similar to how you will have to handle your caregivers that are in the various categories of green, yellow/orange, or red. Let's see how many caregivers fall into those various categories. In a 2017 study of 824 caregivers in Serbia, about 92% of caregivers had already begun vaccinating their children according to the recommended schedule. Of those 92%, who had already had at least one vaccination for their child, about 81% stated that they intended to continue vaccinating their child as per recommendations.

- About 14% said they would probably follow the schedule.
- 4% said they would refuse some vaccines.
- About 1% was not planning to immunize their children.
- Let's call this the pie chart.
 - ▶ Show slide: Parents intention to follow vaccine schedule (Pie chart).
 - ▶ Post flip chart of Pie chart.

Figure 18. Parents' intention to follow vaccine schedule²⁵



- The survey then grouped the 14% who said they would probably follow the schedule, and the 4% who said they would refuse some vaccines, into a group they are calling “hesitators”; and eliminated the refusers from the analysis, since they are extremely unlikely to adopt vaccination, no matter what health workers say or do.
- That now gives us a population divided into acceptors (around 81%) and hesitators (around 19%)
- In the next session, we will take a closer look at the beliefs and fears of these groups, the acceptors and the hesitators.

²⁵ UNICEF (2017). Knowledge, Attitudes and Practices in Relation to Immunization of Children in Serbia (KAPb). Final Report (Draft)

Takeaway

- The vaccine hesitancy continuum helps us to categorize and map caregivers, their vaccine behaviours, and beliefs. Knowing where they fall on the continuum can help us to be strategic and efficient in diagnosing their concerns and targeting our communication.
- Research has shown that about 80% of caregivers plan to continue vaccinations according to schedule, about 19% are hesitant to different degrees, and 1% do not plan on any further vaccination for their children. So, we have about one-fifth of our caregivers that will need extra attention to help them overcome their hesitancy.

Session 3.5. Common fears and beliefs about vaccines

Time: 30 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Flip chart of vaccine hesitancy continuum.

Plenary

- ▶ *Show slide: Session 3.5: Common fears and beliefs about vaccines.*
- We have already discussed your experience with your individual caregivers' fears and beliefs.
- We have seen that probably approximately 80% of your caregivers will be vaccine acceptors, some stronger, some a little more doubtful but still acceptors. Another approximately 20% will be hesitant - somewhat or extremely. And around 1% will be vaccine refusers.
- Now we will look at the results of the survey about concerns and fears of our vaccine acceptors (80%) and hesitators (the 20%) and see how much difference there is in their perceptions.
- We will see that there are acceptors and hesitators in the general population, and in minority populations such as the Roma. It's up to us to understand who our caregiver is and what their concerns are in order to help them move up the stairs on their vaccination journey.
- In a minute, you will divide into your small groups and complete and exercise on this table
 - ▶ *Show slide: Table 5. Serbia KAP survey: concerns.*
- This table shows the level of fears and mistaken beliefs among the general population acceptors and hesitators, and among Roma supporters and hesitators.
- In the first column is the list of mistaken beliefs.
- The second column shows what percentage of the general population agreed with the mistaken belief. It is categorized by those who had said they were planning on continuing to vaccinate their child, called "acceptors," and those who said it was only probable, or not very probable, that they would bring their child for the next set of vaccinations, called 'hesitators'.
- This is expressed as a percentage for each category, e.g. only 9% of acceptors agreed with the mistaken belief that MMR causes autism, whereas 36% of the hesitators agreed with that mistaken belief.
- The column entitled "Odds" shows, in this first example that the hesitators were four times as likely to agree with the mistaken belief.
- In your small groups, you will have five minutes to review **Table 5** in your *Participant manual* and discuss the questions that follow.
- For some of the questions, there is a correct answer. For others, it's up to you to discuss and decide what you think.
- Let's get started!

Exercise 8A: Serbia KAP²⁶ survey: concerns

- ▶ Let participants get into groups.
- ▶ Time the groups for five minutes and bring the group back together to review their answers.

Table 5. Serbia KAP survey: concerns²⁷

	General Population			Roma		
	Acceptors	Hesitators	Odds	Acceptors	Hesitators	Odds
Mistaken Beliefs						
MMR causes autism	9%	36%	4.0	4%	12%	3.0
Better to wait	17%	66%	3.9	25%	36%	1.4
Too many vaccines	17%	55%	3.2	21%	42%	2.0
Preservatives are poisonous	12%	38%	3.2	5%	18%	3.6
VPDs are mild	8%	22%	2.8	12%	5%	0.4
Quality check not good enough	25%	63%	2.5	19%	30%	1.6
Side effects are risky	41%	79%	1.9	36%	60%	1.7
No real danger of an outbreak of VPDs in Serbia	17%	26%	1.5	39%	25%	0.6

26 UNICEF (2017). Knowledge, Attitudes and Practices in Relation to Immunization of Children in Serbia (KAPb). Final Report (Draft)

27 Ibidem

1. What were the top two worries (in terms of %) among general population hesitators?
2. What were the top two worries (in terms of %) among the Roma hesitators?
3. Among those who were acceptors (meaning they vaccinate their children and intend to continue) were there any fears?
4. What were the acceptors' top fears?
5. Did those fears prevent the acceptors from vaccinating?

Plenary

- Who would like to give their answers to the questions for **Table 5**?
 - What were the top two worries (in terms of %) among general population hesitators?
 - **Answer:** side effects, better to wait.
 - What were the top two worries (in terms of %) among the Roma hesitators?
 - **Answer:** side effects, too many vaccines.
 - Among those who were acceptors (meaning they vaccinate their children and intend to continue) were there any fears?
 - **Answer:** yes.
 - What were the acceptors' top fears?
 - **Answer:** side effects, quality check.
 - Did those fears prevent the acceptors from vaccinating?
 - **Answer:** no.
- Any questions on those numbers?
 - ▶ *Let them respond and clarify as needed.*
- In **Table 5**, we see that those who were hesitant were between 1.5 and 4 times more likely than acceptors to agree with the mistaken belief statements such as "MMR causes autism".
- The fact that acceptors have fears about these issues, but they vaccinate anyway, allows us to think that we may not have to completely eliminate hesitators' fears in order to get them to vaccinate.
- We may have to help them articulate and reduce their fears and help them feel more comfortable with the decision to vaccinate by providing the support they need to get from preparation to action.
 - ▶ *Point to the expanded steps flip chart.*
- Let's look now at Roma perceptions of health services.
 - ▶ *Show slide of Roma perceptions of health services.*
- This data comes from a survey of Roma caregivers' experiences with health services.
- In the first column is a list of statements about negative experiences in the health system. The second column shows what percentage agreed with the statement, divided up between those Roma caregivers who were either acceptors or hesitators.
- We are going to move back into our groups. Take 10 minutes to review **Table 6** in your *Participant manual*, and then discuss the questions outlined below it.
- Let's begin.

Exercise 8B: Serbia KAP survey: Roma population

- ▶ Let participants get into groups.
- ▶ Time the groups for 10 minutes and bring the group back together to review their answers.

Table 6. Serbia KAP survey: Roma population²⁸

Perception of services by Roma care givers	Acceptors	Hesitators	Odds
Told by doctors or nurses that I was not a good parent	3%	21%	7.0
I was spoken to in a manner that I did not understand	22%	30%	1.4
I was left to wait longer than the others	31%	58%	1.9
Doctors or nurses refused to treat my child	4%	9%	2.3
Doctors or nurses were rude to me or my child	23%	54%	2.3

1. Which group of Roma had a more negative perception of services - hesitators or acceptors?
2. Do you think the hesitators had a more negative perception of the services they received because they are hesitant about vaccination, or do you think their services were less good because they are vaccine hesitators?
3. Do you think health providers assume that most Roma are hesitators?
4. How could that influence how they treat their Roma patients?

28 UNICEF (2017). Knowledge, Attitudes and Practices in Relation to Immunization of Children in Serbia (KAP).

Plenary

- Who would like to share the answers they have?
 - ▶ *Let them respond to all the questions, then confirm as below.*
- **Question 1:** the hesitators had a more negative perception.
- For **Question 2:** it could be either way, but it seems logical, given what we know about the importance of trust in increasing vaccination rates, that they aren't vaccinating because they feel mistreated and don't trust the health system.
- For **Question 3:** your opinion is what matters.
- For **Question 4,** if health workers assume their Roma caregivers are hesitators, they may approach the encounter already feeling hostile and frustrated, which may make the encounter worse.
- Other studies from this region give us some additional insight into these issues.
- A 2014 Multiple Indicator Cluster Survey (MICS) reports a big difference in full immunization coverage between the general population in Serbia, and the population in Serbian Roma settlements: around 71% completely vaccinated versus around 13% fully vaccinated.²⁹
- In the previous exercises, we saw that Roma caregivers actually were often less likely to agree with the false beliefs about vaccination than the general population, but we see their experiences with the health service seemed to be fairly negative, which could be contributing to the lower coverage rates amongst the Roma.
- Given the relatively similar attitudes towards immunization between the general population and the Roma, what else do you think could be obstacles to full vaccination among the Roma?
 - ▶ *Let people give a few answers.*
- Those are good ideas. It does appear that, for the Roma, **negative interactions with health workers** and **access to services** are big barriers to vaccination, along with issues like lack of knowledge. A qualitative study amongst the Roma population in Bosnia and Herzegovina³⁰ showed that the top obstacles to immunization included:
 1. Fear of child's reaction to the vaccine;
 2. Lack of information about the possible consequences of the diseases against which children are vaccinated;
 3. Generally unsupportive environment;
 4. Lack of health insurance card, beliefs related to informal payments;
 5. Prolonged absence of the guardian.
- Some have focused attention on the segment of under-vaccinated populations that they call '**the poorly reached**' – those with limited or difficult access to services, related to social exclusion, poverty and, in the case of more integrated and affluent populations, factors related to convenience.³¹ Some of these issues can be addressed through communication, but others need a health services or other system improvement.

29 Percentage of 24-35 months old children who have received all recommended vaccines from the national calendar of immunization before their first birthday (second birthday in case of measles) MICS 2014.

30 Focus Group Discussions – Excerpt from the Report (Roma Population) Report, 2010

31 Let's talk about protection. ECDC 2016.

<https://ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/lets-talk-about-protection-vaccination-guide.pdf>

- The 2014 MICS detected **no differences in knowledge** between the groups of caregivers who support and don't support vaccination. While supporters of vaccination worry about vaccine-preventable diseases and less about the safety of vaccines, hesitant caregivers worry about both.
- This is an important difference between the hesitant caregivers and the opponents of vaccination. Opponents usually consider vaccine-preventable diseases "mild" or "diseases that strengthen immunity".
- Hesitant caregivers, however, detect risks on both sides, and they seem to find it hard to "rank risks", or to estimate if the vaccine or the disease is more dangerous for a child. Remember, visuals and how we present information can influence how they perceive these risks.
- Caregivers with extremely negative attitude saw no benefits in vaccination. Their main complaint was that vaccination is mandatory by Serbian law and that caregivers are not left to decide for their children as their main caretakers.
- Let's review where we are.
 - ▶ *Point to the vaccine continuum flip chart and the pie chart.*
- We have looked at the vaccine hesitancy continuum, and seen that:
 - Many caregivers, around 80%, are up in the green and willing to go ahead and vaccinate.
 - About 14% are yellow, they probably will follow the recommended vaccine schedule.
 - 4% are orange, they may refuse some vaccines. 1% are red; they will refuse.
- We can have the biggest impact focusing our attention on hesitant parents. Visuals and how we present information can influence how they perceive these risks.
- We have seen that hesitators overestimate the dangers of vaccines. They are concerned about:
 - Giving multiple vaccines at once.
 - Vaccine quality or side effects.
 - Young children being unable tolerate vaccines.
- We also saw that hesitant caregivers have a hard time comparing or ranking risks-which is more dangerous: the disease or the vaccine.
- We have seen that Roma have many of the same concerns, but there are many other barriers to Roma, such as systematic access issues. Few survey respondents felt that there was low risk of VPD outbreaks, and few felt that VPDs were mild, but immunization was low.
- The questions our caregivers ask and what they say help us to understand where our patients fall on the hesitancy continuum and their specific concerns. Only once our caregivers start expressing themselves can we understand what they need from us.
- We need to help them ask their questions by making them feel comfortable, and by being proactive in ensuring their questions are being asked.
- What are some of the ways we can make our caregivers feel comfortable?
 - ▶ *If no one answers, call on a few people until you get a few good answers.*

Takeaway

- There are a number of common concerns about vaccines across different segments of the population. These concerns may not be the only thing impacting immunization coverage for some segments of the population. Helping caregivers to express their concerns is essential to help caregivers overcome the barriers to full immunization coverage.
- Now let's look in a bit more depth at some interpersonal communication skills you can use to help you with this.

If you are leading a TOT

- ▶ *Facilitate the practice teaching exercise for Module 3, the same way you did for module 1. Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 4.*

Module 4.

Active listening to understand
your caregiver

Module 4. Active listening to understand your caregiver

Module 4 Objectives:

By the end of the module the participants will be able to:

1. Describe the limitations of explanations that are given without getting feedback and confirmation.
2. Master active listening skills including nonverbal communication, empathy, open-ended questions and reflective listening.
3. Skilfully combine active listening skills to understand caregiver category and identify specific concerns.

Time: 3 hours

Checklist

- ✓ Prepare enough copies of printed materials:
 - **HANDOUT 3: PICTURE A.**
 - **HANDOUT 4: PICTURE B.**
 - **HANDOUT 5: SCENARIO SLIPS FOR HIDDEN PROBLEMS.**

If you are leading a TOT

- ▶ *Complete Module 4 according to the Facilitator guide and then facilitate the practice teaching session for the module.*
- ▶ *Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 5.*

Session 4.1. Dialogue creates understanding

Time: 20 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Photocopies of **HANDOUT 3: PICTURE A** (one for each two-person team).
- ✓ Photocopies of **HANDOUT 4: PICTURE B** (one for each two-person team).

Exercise 9: Apples and watermelons

- ▶ *Show slide: Session 4.1: Dialogue creates understanding.*
- We are going to start this session with an exercise.
- Please stand in two lines facing one another. Each person should be opposite another person.
 - ▶ *If there is an odd number of participants, the person without a partner will work with the facilitator.*
- All of you in one line are apples and all the people in the other line are watermelons. You will work in pairs. One apple will work with one watermelon.
- Those who are apples will describe a picture for those who are watermelons.
- The watermelons will draw the picture based on the instructions from the apples. The watermelon cannot see the original page/picture or ask any questions – they must simply draw what they understand based on what the apple says.
- The apple may not repeat any instructions. They may not use any gestures. They may not check to see if the watermelon understands.
- You will need to sit or stand back-to-back with your partner. You should be far enough apart so that you can hear each other well without hearing the other pairs.
- You have five minutes to complete this part of the game.
 - ▶ *Give each Apple a copy of **HANDOUT 3: PICTURE A** and ask them not to show it to anyone.*
 - ▶ *Give each Watermelon a blank sheet of paper and pencil.*
- Let's begin. Apples, please explain to your watermelon how to draw Picture A. Remember, you can only tell the watermelons how to draw the image. You can't use gestures, or show the image, or repeat the instructions. Watermelons, you can't ask any questions, just draw as best you can based on what the apple is telling you.
 - ▶ *After five minutes (or sooner), ask everyone to stop and have the watermelons to show their picture to their apple.*
 - ▶ *After everyone has a good laugh about how unlike the original the watermelons' drawings of A are, tell participants you will give them another chance.*

- We are going to try this again. This time you can ask questions, clarify and confirm, but you still can't use gestures.
 - ▶ Give each Apple a copy **HANDOUT 4: PICTURE B** and ask them not to show it to anyone.
 - ▶ Give all the watermelons another blank sheet of paper.
- Ok, let's begin!
 - ▶ After five minutes (or sooner, if everyone finishes in less than five minutes), stop everyone and ask the watermelons to show their picture. This time the watermelons' pictures should be much closer to the original.
 - ▶ Bring the group back to plenary to discuss.

Plenary

- Those of you who were drawing, how did it feel during the first exercise?
 - ▶ Let them respond.
- What about the second exercise?
 - ▶ Let them respond.
- Why was the second outcome so much better than the first?
 - ▶ Let them respond.
 - ▶ Introduce the concept of active listening with the points below.
- Effective communication is two-way. As a FLW you must not only tell and teach, but also listen and understand.
- Dialogue and feedback are key to understanding. However, in this last exercise, you used dialogue to make sure the person who was drawing understood what your picture looked like. Although we used dialogue, and both parties were talking and asking questions, it was really all about making sure that the one person (the drawer) understood what the other person was saying (or in this case, picturing).
- We have seen that to increase immunization uptake, we need to understand what our caregiver is saying, and they need to understand what we are saying. This involves active listening and confirming responses. Now let's look at some active listening skills.
- We will be focusing on the following four key active listening skills in the rest of this module:
 1. Nonverbal communication: giving and reading.
 2. Showing empathy.
 3. Asking open-ended questions and other types of questions.
 4. Reflecting back what you have been told by the caregiver.
- Using these skills will help you communicate more effectively with caregivers. It will encourage them to trust you and the health system. Once you practice using these tools, it will become more natural and easier. You will become even more expert at helping your patients.

Takeaway

- Active listening is an important skill. It involves encouraging someone to talk, listening to them attentively, and giving them feedback. The more we dialogue with others, rather than talking at them, the more we understand them, and they can be sure they understand us.

Session 4.2. Nonverbal communication. Giving it

Time: 20 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Need two facilitators, one to brief the Mickeys and one to brief the Mouses.

Plenary

- ▶ *Show slide: Session 4.2: Nonverbal communication. Giving it.*
- Who can give me an example of nonverbal communication?
 - ▶ *Let them respond, acknowledge or amend by shaking your head, holding up a hand to say stop, smiling, gesturing, etc.*

Exercise 10: Practice nonverbal communication. Mickey Mouse

- Great, let's get ready for an exercise to practice some nonverbal communication.
- Let's count off into two groups. Let's count out Mickey, Mouse, Mickey, Mouse.
- All of the Mickeys please come to one side of the room to get your assignment and bring your pen with you. We will brief you there.
 - ▶ *One facilitator will go to the side of the room and work with the MICKEYS and explain the Mickey scenario.*
- All of the Mouses, please come to the other side of the room and bring your *Participant manual* with you. We will brief you there.
 - ▶ *The other facilitator will go to the side of the room with the MOUSES and explain the Mouse scenario.*
 - ▶ *Give the MICKEY's their assignment.*
 - You are the caregiver of a young child. Your pen is your baby.
 - Now choose a name for your baby.
 - You will go consult with a doctor, played by one of the Mouses, because you are a bit concerned that your baby has had a mild fever since her vaccination two days ago.
 - You are worried, and you want to know if this might be a serious side effect.
 - Ok, when the Mouses are ready, each Mama or Papa Mickey should find a Doctor Mouse and go find a place to sit together so you can tell the doctor your worries.
 - ▶ *Give the MOUSE's their assignment*

- You are a doctor, but you are burned out and having a very bad day. You are worried because you have had another fight with your mother and you are fed up with patients.
- Please turn to Table 7 in your *Participant manual* entitled “Aspects of nonverbal communication”
- Take one of the *Participant manuals* and show what the page looks like.

Table 7. Aspects of nonverbal communication³²

Aspects	Does not help	Helps
Posture/ Position	Stand with your head higher than the caregiver’s head.	Sit so that your head is level with caregiver’s head.
	Having your arms crossed and being hunched over.	Rest your hands in your lap, sit up straight and face the person you’re talking with.
Eye contact*	Look away at something else, or down at your notes.	Look at the caregiver and pay attention as you speak.
Facial expression	Looking irritated, annoyed, grim.	Positive or at least neutral expression.
Physical barriers	Sit behind a table or write notes while you address community members during a meeting.	Remove the table or the notes; try to be in the same position as the caregiver—sitting on a chair or on the floor, standing.

32 UNICEF (2017) Facilitator’s Guide: Interpersonal Communication for Immunization. Draft

Aspects	Does not help	Helps
Taking time	Acting hurried; greet the person/group quickly; show signs of impatience; look at your watch.	Make the person/community group feel that you have time; sit down and greet the caregiver or group without hurrying, then ask an open-ended question and wait patiently for an answer.
Physical touch	Frustrated, quick, brusque movements.	Using handshake, putting a hand on the shoulder of the caregiver (not just the baby) as you position the child they are holding for vaccination. Make sure caretaker holds the child and comforts it during the vaccination.

- Your Mouse assignment is to find a way to do every single thing on the list of things not to do when you meet your patient, Mickey.
- You should speak as little as possible, just mostly use nonverbal communication to communicate how completely uninterested and fed up you are.
- At the end, we are going to ask the Mickeys to name every nonverbal thing that you did that made them upset, so go for it!
- ▶ *Once everyone is briefed prepare them to pair up and begin.*
- All of the Mouses, go find a Mickey, pair up, and find a place to sit together. You have five minutes to have a very bad interaction with your caregiver and do your consultation of Baby Pen Mickey.
 - ▶ *Give participants five minutes and then bring them back to plenary.*

Plenary

- How did it go? Mama/Papa Mickeys, did you get the answer to your question about whether a mild fever was a serious side effect?
 - ▶ *Let the Mickeys give some answers about what happened and how they felt.*
- That didn't feel good, did it? We asked our Doctor Mouses to use very bad nonverbal communication. Did they succeed? How did they make you feel? How would you like to come back and see that doctor again?
 - ▶ *Let the Mickeys give some answers about what happened and how they felt.*
- Dr. Mouses, how did you feel acting out all that negative nonverbal communication?
 - ▶ *Let the Mouses give some answers about how they felt.*

- Good friendly nonverbal communication benefits both parties. Nonverbal communication can strengthen or contradict what is said in words. Your actions can matter more or speak louder than your words sometimes.
- Now, even though this was just a role play of negative communication,
- Doctor Mouses, please go back to your Mickeys.
 - ▶ *Give them a minute to get back together.*
- Now look your Mickey in the eye and say: "I am sorry for not giving you my full attention."
 - ▶ *Give them a minute to say it.*
- How does that feel, Mouses? How does that feel, Mickeys?
 - ▶ *Give them a minute to respond.*
- Now we are going to do the same thing again. Mouses, look your Mickey in the eye and say: "*I am sorry for not giving you my full attention.*"
 - ▶ *Give them a minute to say it.*
- This time, Mickeys, look your Mouse in the eye and say: "*It's ok, I understand.*"
 - ▶ *Give them a minute to say it.*
- How does that feel, Mouses? How does that feel, Mickeys?
 - ▶ *Give them a minute to respond.*
- Now you will work with your partner (Mickey and Mouse together) on a short task.

Exercise 11: List of four nonverbal actions to make caregivers feel comfortable and connected

- Work with your partner for the next five minutes.
- Make a list of four nonverbal things you could do with every caregiver when you first encounter them, to ensure they feel comfortable and connected. Write it in your *Participant manual*.
 - ▶ *Give them five minutes.*

Plenary

- Could anyone share their list of four nonverbal things they think they could do with each caregiver to create a connection? Anyone else?
 - ▶ *Let a few participants answer.*
- If you are a good interpersonal communicator, you use:
 1. A positive facial expression;
 2. Appropriate eye contact;
 3. Welcoming posture/position;
 4. Friendly natural gestures;
 5. Affirming utterances like: "*mm-hmm*", "*aha*", and "*Hmph*";

6. The power of touch, if appropriate, to show the other person you are listening, and you care;
 7. You also give the person enough time to talk.
- When you use these positive nonverbal communication tools, you give the caregiver the confidence to communicate openly and honestly about their concerns and feel connection and trust with you.
 - And why is that important?
 - ▶ *Let them answer.*
 - Can you give an example?
 - ▶ *Let them answer and confirm as needed with Mickey and Mouse example.*
 - We know that even if you aren't feeling like smiling, if you just put on a smile, the physical action of moving your mouth into the position of a smile actually releases endorphins, which make you feel happier!
 - Let's all stand up and try it.
 - ▶ *Get the participants to stand up.*
 - Start with a big frown on your face.
 - ▶ *You can have them walk around while doing this, if you need more of an energizer. Encourage the participants to make big frowns, praise a few that are doing a good frown.*
 - Now relax your face to a neutral expression - no frown, no smile.
 - ▶ *Note and praise a few that have good neutral expressions.*
 - Now lift the corners of your mouth into a big smile, but don't get your eyes involved, just lift the corners of your mouth.
 - ▶ *Note and praise a few that have good mouth smiles with no eye smiles.*
 - Now let your eyes get involved in the smile. How do you feel?
 - ▶ *Let a few participants answer.*
 - It's amazing how our bodies can influence our brains and our hearts. Sometimes just acting happy can make you feel happy.
 - Take a minute to read through the third column of **Table 7**. Let's skip the first column - "What not to do" - we have already seen that!
 - ▶ *Let them read for one minute.*

Takeaway

- Positive nonverbal communication gives the caregiver the confidence to communicate openly and honestly about their concerns and feel connection and trust with you. Touch, when you can find a way for it to be appropriate, is extremely powerful, along with a smile, and encouraging noises and gestures.
- If you can shake the caregiver's hand, smile warmly and nod, you will have gone a long way in 15 seconds to create connection and trust, which is the foundation for everything else.

Session 4.3. Nonverbal communication. Reading it

Time: 15 minutes

Materials:

✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 4.3: Nonverbal communication. Reading it.*
- Another important active listening skill is reading your caregivers' nonverbal communication to you. How can you tell what your caregiver is feeling or thinking?
 - ▶ *Let them give a few ideas.*

Exercise 12: Nonverbal communication by caregiver

- Pair up with a partner and turn to the empty **Table 8** entitled "Nonverbal communication by caregiver" in your *Participant manual*.
- Identify at least two signs of concern or disagreement and two signs of agreement or approval for each type (gestures, utterances etc.) of nonverbal communication (facial expression, etc.) that a caregiver might show.
- Be prepared to act out at least two nonverbal communications of concern or agreement for the whole group. They will have to guess what you are expressing.
- You have five minutes to discuss and prepare to act out two nonverbal signs of disagreement, concern, and two expressions of agreement or approval per category.
 - ▶ *Bring participants back together after five minutes.*

Table 8. Nonverbal communication by caregiver³³

Type	Positive	Negative
Gestures		
Utterances		
Tone of voice		
Eye contact*		
Facial expression		
Taking time		

Plenary

- Who would like to demonstrate their two signs of concern or agreement using facial expression, while we try to read what you are demonstrating?
 - ▶ *Let them demonstrate. Read them.*
- Would someone else like to demonstrate their two gestures of disagreement or concern while we try to read what you are demonstrating? Make this a tough one!
 - ▶ *Let them demonstrate. Read them.*
- Does anyone have different ways to show agreement using gestures or facial expression?
 - ▶ *Let them demonstrate. Read them.*
- These are what we need to be watching for when we are interacting with caregivers.
- Remember Olga? When Olga was showing signs of concern, if Dr. Musa had just slowed down and said: “*You seem concerned*,” that might have given Olga the opening she needed to say what was worrying her, and what she needed in order to get her child vaccinated.

33 UNICEF (2017) Facilitator’s Guide: Interpersonal Communication for Immunization. Draft.

- Some caregivers may be able to better control their nonverbal communication, but still have concerns, fears and questions. How do we 'read' those?
- This requires proactive engagement and creating spaces and invitations for the caregivers to address questions and express concerns. We will continue to talk more about this over the next couple of days.

Takeaway

- We need to stay attuned to the nonverbal communication of our caregivers, as well as our own. If caregivers are displaying nonverbal signs of concern it is like a yellow or red light at the stoplight. It tells us we need to slow down or stop to see what's happening and acknowledge the concern.

Session 4.4. Empathy

Time: 30 minutes

Materials:

✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 4.4: Empathy.*
- Who can give us a definition of empathy?
 - ▶ *Let a few participants answer, or call on someone saying: Any other ideas?*
- Empathy is having a sense of understanding and compassion for another person. It is sensing what it might be like to be them. It is feeling what another person might be going through.
- For you Mickeys, how did that exercise give you a bit more empathy with patients who might have had negative interactions with health providers?
 - ▶ *Let a few participants answer, or call on someone saying, any other ideas?*
 - ▶ *Answers might include:*
 - I could understand better what it feels like when someone doesn't care about me, doesn't take me seriously, doesn't give me enough attention, doesn't respect me, etc.
- Showing empathy is one of the most important communication skills for FLWs. Empathy increases trust in health workers and is associated with improved clinical outcomes. Empathy can actually help heal!
- When you show caregivers empathy, letting them share their feelings without jumping in to solve the problem, or without judging, accusing, attacking, preaching etc., they will then tend to be more willing to listen to you, and take your advice later on.
- Sympathy, on the other hand, is feeling sorry for another person.
- It's not wrong to show a caregiver sympathy, but empathy can lead to a deeper connection.
- Empathy is more of a peer emotion, feeling for another human like you, instead of feeling sorry for someone who is "less" than you. Feeling both empathy and sympathy makes it easier for you to be kind to the caregiver.
 - ▶ *Show slide: Empathy versus sympathy.*
- Let's look in our *Participant manual* at **Table 9**, the "Empathy versus sympathy comparison chart" and take a minute to read through it.

Table 9. Empathy versus sympathy comparison chart³⁴

	Empathy	Sympathy
Definition	Understanding what others are feeling because you have experienced it yourself or can put yourself in their shoes.	Acknowledging another person's emotional hardships and providing comfort and assurance.
Example	"I know it can be hard to watch your baby get a shot. I have felt that way myself."	"Watching your baby get a shot can be hard, but the pain doesn't last."
Relationship to the issue	Personal understanding.	Understanding the experience of others.
FLW Context	A nurse relating with a patient because he or she has been in a similar situation or experience.	Nurses comforting caregivers or their families.

- It feels good when someone empathizes with you. Likewise, caregivers will likely feel better if they know you empathize with them.
- In contrast, caregivers feel badly when you behave as though their concerns are not real or are not important. When caregivers want to share a difficulty they are having, empathizing with them does not take much time and can greatly improve how they see the services they and their children receive.
- As a bonus for you, it feels good to empathize with a fellow human being!
- Although we as health workers can feel stressed and frustrated in our work, mothers face challenges as well. Here are a sample of statements from mothers based on comments found in the same UNICEF KAP study we have been referencing:
 - *"The health worker criticizes me in front of others for not having returned exactly four weeks after the previous dose."*
 - *"The health worker ridicules me for my child's torn or unclean clothing."*
 - *"The vaccinator treats me very rudely because I am a young mother ... or because of my ethnic group ... or my inability to speak the national language."*

34 Adapted from https://www.diffen.com/difference/Empathy_vs_Sympathy

- *"I can't completely understand what the health worker is trying to say to me, but I am afraid to ask questions."*
- *"Health workers make me feel ignorant for asking them to explain the purpose of the vaccination or why my child needs to return for another dose."*
- How likely do you think it will be for the caregivers who experience these kinds of situation to return for immunization?
 - ▶ *Let them respond.*

Exercise 13: How to Show Greater Empathy in Routine Immunization

- In a moment you will work with your partner to discuss what you could do to show more empathy to the caregivers who come to your clinic.
- In your *Participant manual*, write up to three personal statements about what you will do to improve the routine immunization experience now that you are more aware of caregivers' perspectives. Make your statements as specific as possible. Examples might include:
 - *"I will be kind to caregivers who have difficulty staying on schedule for immunizations."*
 - *"I will tell caregivers that they can bring their children for immunization in the afternoon if that is more convenient for them."*
- You have five minutes to discuss and write.
 - ▶ *Give them five minutes and bring them back together to discuss.*

Plenary

- Did anyone have any good ideas about how they could show greater empathy to their caregivers?
 - ▶ *Let them respond.*
- In a minute, you will go back into your small groups and do another exercise on empathy. But first, look in your *Participant manual* and find **Table 10**: "Simple ways to show empathy." Take five minutes to read through it.

Table 10. Simple ways to show empathy³⁵

Pay full attention to the speaker	Allow him or her to speak. Do not interrupt to propose a solution. Giving someone your full attention, and allowing them to be heard, is actually part of the solution.
Allow silence	This gives the caregiver time to reflect, consider her/his next words, and begin to come to terms with what s/he is feeling.
Support and encourage the caregiver	Instead of critiquing him or her or the story being told, or telling them what they should have done different, just say: "that must be hard."
Let them know they are not alone	If it's true, tell him/her it is normal to feel the way they do and that you have felt the same.
Use empathy to show that you share your caregiver's concerns	<i>"I understand that you want the best for your child, and I do too." "I care very much about my patients and their caregivers."</i>
Avoid focusing on a solution	Stay in the moment of letting the person express themselves and letting yourself hear them and feel what they are saying. Don't solve it; hear it.
You can say things such as:	<i>"I feel badly when my baby cries, too."</i> <i>"Being a mother these days is so challenging."</i> <i>"It's hard to make these decisions."</i> <i>"We all want the best for our children."</i> <i>"I hate when that happens to me."</i> <i>"That must have been difficult for you."</i> <i>"I don't know what to say, but I'm glad you told me."</i> <i>(Particularly useful when people tell you about a terrible loss or occurrence.)</i>

35 Adapted from UNICEF (2017) Facilitator's Guide: Interpersonal Communication for Immunization. Draft.

Avoid saying: "I know just what you are going through."	That is almost never true, and it can make people frustrated.
When you are having a hard time feeling empathy...	Try to imagine that the person you are talking to has just suffered a loss or a difficult situation like one you might have recently encountered (or think back to being Mickey in the previous exercise). Think about how you felt then, and how you wanted people to treat you. Just a minute of remembering your own difficulties, and how you felt, might give you a bit more understanding of the person in distress in front of you.
None of us know what someone else is going through	Always try to give people the benefit of the doubt.
Showing empathy is a skill you can strengthen through practice	Let your warmth shine through and your caregivers will feel it.

- Now that we have read through the table, we will get ready to do our group work on empathy.
- I will read the instructions to you first, and then you will get into your groups.

Exercise 14: Showing empathy to baby Elvis' parents

- Imagine Mr. and Mrs. Sajdić come to your office bringing baby Elvis, who is ten months old, but four months behind on his vaccines.
- The caregivers say they wanted to bring Elvis in earlier for his vaccinations, but they were not able to for family reasons. You can tell they are upset, embarrassed, and maybe even a bit defensive. The mother seems not to speak the national language very well and is quite withdrawn.
- In your group, discuss how you might show empathy in a brief way to the Sajdićs who are anxious about coming in late. You can look at **Table 10** - Simple Ways to Show Empathy - if you need some ideas.
- Your task is to show them empathy and create a connection in a limited time. *Don't go any further in terms of counselling; simply put them at ease with empathy and end the scenario.*

- Once you get some ideas, *choose two people in your group to act out Mr. and Mrs. Sajdić*. They show with nonverbal cues that they are upset and feel bad, guilty, defensive, and nervous. Mr. and Mrs. Sajdić only get **thirty seconds** explaining the reason for their visit and showing or saying that they feel bad.
- **Choose one person in your group to play the health worker who responds with empathy to their obvious feelings of distress.** They can use words and nonverbal communication to show empathy and create a connection with the Sajdićs. The health worker can only spend **one minute** using empathy to make them feel more comfortable and create trust.
- Your group has a total of ten minutes to think about how to respond, and to then prepare how you will act out the scene. You are limited to a one-and-a-half-minute role play, in total.
- Your group can give feedback on how you are showing empathy and you can revise your approach, if needed.
- You will then act out the scene for the whole group. Remember, the scene can only go for 90 seconds. The family is anxious about coming late for vaccination; the provider shows empathy to their situation.
- Let's begin. You can find the instructions I just read in your *Participant manual*, under Session 4.4.
 - ▶ *After three minutes, give the groups a two minutes warning.*
 - ▶ *At five minutes, if most of the groups do not seem to have finished, give them two more minutes.*
 - ▶ *Stop the groups at 10 minutes and ask them to present.*
- Which group would like to go first to act out their ideas of how to show empathy to the Sajdić family when they came in with baby Elvis who is overdue for vaccination?
 - ▶ *Choose a group to go first and remind them the scene can only go for 90 seconds.*
 - ▶ *Allow each group to present their example and provide feedback as appropriate.*
 - ▶ *Thank the groups and close the session with the takeaway below.*

Takeaway

- Showing empathy is a skill you can strengthen through practice. Let your warmth shine through and your patients will feel it. It does not take a lot of time to make someone feel welcome, heard, special, and cared about. When we open our eyes and ears, it helps others to do so as well.

Session 4.5. Open-ended and other special questions

Time: 25 minutes

Materials:

✓ Participant manual.

Plenary

- ▶ *Show slide: Session 4.5: Open-ended and other special questions.*
- Now let's discuss special kinds of questions we can use to improve our communications, at work and even at home.
- Who can explain what the difference is between an open-ended question and a closed-ended question?
 - ▶ *Let a few participants answer, or call on someone saying, any other ideas?*
- With **closed-ended** questions, you can answer with a single word - yes, no, a number, or something like that. Closed questions might start with words like:
 - "Are you...?"
 - "Did he...?"
 - "Has he...?"
 - "How many...?"
- Using a lot of closed-ended questions can lead to situations where the health worker says to the caregiver: "Do you understand?"
 - ▶ *Act out the next sentence as you say it: nod your head and smile a little nervously while you say out loud the caregiver's thoughts through a fake smile without moving your lips much.*
- The caregiver may nod their head but inside they are thinking: "I have no idea what she is talking about I don't understand anything. What am I supposed to do if my baby won't stop crying after the shots? I am not coming back here ever again."
- **Open-ended** questions or probing statements usually start with:
 - "How?"
 - "What?"
 - "When?"
 - "Where?"
 - "Tell me more!"
- For example: "How has your child's health been lately?" or "What did you understand from my explanation?" or "Tell me more about what you are concerned about."
- Closed-ended questions give you some basic information. Asking open-ended questions helps you

learn about a concern or problem. Open-ended questions encourage a full, meaningful answer, using the caregiver's own knowledge and/or feelings.

- We often begin questions with the word “*Why?*,” but we have not included it in the list above.
- Who can give me a reason why asking a caregiver a question beginning with the word “*Why*” might actually be a block to communication?
 - ▶ *Let them answer.*
- When you ask someone: “*Why did you do XYZ?*” or “*Why don’t you want XYZ?*,” you may end up putting them on the defensive. It’s important to understand why they did XYZ, but you might try finding a way to ask why that doesn’t make the person feel attacked or criticized.
- Let’s practice with closed and open-ended questions.

Exercise 15: Closed and open-ended questions

- You have 10 minutes to work with your partner to read through the questions in **Table 11** and identify potential advantages and disadvantages of open-ended questions. Then complete **Table 12**, by turning each closed-ended question into an open-ended question.

Table 11. Closed and open-ended questions³⁶

Closed-ended question	Open-ended question
Did you follow what I just told you?	Can you tell me what you understood?
Do you enjoy your experience when you come to the health centre?	How do you feel about your experience when you come to the health centre?
Do you remember what I told you about how to make your baby more comfortable after a shot?	What can you do to make your baby feel more comfortable after his last shots?
When was the baby last sick?	Please tell me about your baby’s health lately.

36 UNICEF (2017) Facilitator’s Guide: Interpersonal Communication for Immunization. Draft.

Table 12. Changing a closed-ended question to an open-ended one

Closed-ended question	Open-ended question [suggested example answers]
Do you have any concerns?	What would you like to know more about?
Did your baby get her last shots?	When were your baby's last shots?
Why don't you want to give your child the MMR vaccine?	What are some of your concerns about the MMR vaccine?
Did Jelena get a fever after the last shots?	How did Jelena do after her last shots?
You understood what you are supposed to do if Drago has any serious problems, right?	Can you tell me what you would do if you noticed any serious problems?

- Bring the groups back together after 10 minutes.

Plenary

- What were a few advantages you found in **Table 12** of asking the question as open instead of closed?
 - Go around the room and confirm that advantages might include:
 - For example, on the last question, you can check to see what the patient understood, when they repeat what they think they were told.
 - This repetition (if correct) also increases their recall of the instructions.
- Are there any disadvantages of asking open questions?
 - Take a few responses and confirm that disadvantages might include:
 - That it takes more skill to ensure you ask open questions, it might take a tiny bit more time, it could open the door to a longer answer from the caregiver.
- What were your ideas for **Table 12**, for converting the closed questions into open-ended questions?
 - Go to the first group and ask them to read the first closed question then their open question.
 - Ask the other groups if they had similar versions.
 - Ask the second group to read the second closed question then their open-ended question.
 - Ask the other groups if they had similar versions.

- ▶ *Continue for all five questions.*
- ▶ *Explain that sample answers are provided in the answer key **Annex E** in the Participant manual.*
- ▶ *Show slide: Changing closed-ended to open-ended answers.*
- Who can explain what a leading question is?
 - ▶ *Let a few participants answer, or call on someone saying, any other ideas?*
- Leading questions are questions that imply what we hope to hear as the answer.
- Leading questions are usually closed-ended, such as: *"You don't have a problem with this, do you?"*
- You had an example on the left side of **Table 12**: *"You understood what you are supposed to do if Drago has any serious problems, right?"*
- Open-ended questions can be less likely than other types of questions to lead the caregiver to respond a certain way, so they are better for creating trust.
- A leading question like: *"You don't have a problem with this, do you?"* could make a patient feel pressured or ignored, whereas an open question might allow them to express their concerns.
- Instead of saying *"You don't have a problem with this, do you?"*, how could you say it in a way that invites the patient to express any concerns?
 - ▶ *Let a few participants answer, or call on someone saying, any other ideas?*
 - *"How do you feel about this? Do you have any questions before we move ahead?"*
- On the other hand, sometimes a leading question might be useful as a confirmation after an open discussion, such as: *"You want to go ahead and get the vaccination, right?"*
- Any questions on open and closed questions?
 - ▶ *Clarify as needed.*
- Sometimes a caregiver will ask a question, and you may not be sure exactly what they are asking about. OR, they may say something, and you aren't sure you understood.
- Who can tell us what techniques we used in the second half of the apple/watermelon game?
 - ▶ *Let them respond.*
- Yes, we used probing, clarification, etc. You can probe with questions such as:
 - *"I'm not sure I am following you- can you help me understand?"*
 - *"Did I understand you correctly, did you mean?"*
 - *"Can you tell me more about what you've heard?"*
- Any other ideas for probing questions?
 - ▶ *Let a few participants answer, or call on someone saying, any other ideas?*
- A few more questions that can help draw out your patient's concerns, and help negotiate decisions and solutions include:
 - *"How do you feel about this?"*
 - *"What part of this do you agree with?"*
 - *"What part of this do you have a problem with?"*
 - *"What would make you feel more comfortable about this?"*
 - *"How can I help you think through this?"*
 - *"What would help you make a decision?"*
 - *"Could you tell me a little more about what you heard?"*
 - *"Is there anything else you need to know before you make a decision?"*

- When someone asks you a question, and you need a minute to think about your response, what are some things you can say to buy yourself some time?
 - ▶ *Take a few responses.*
- Here are a couple of phrases to use while you think:
 - *"I hear what you're saying."*
 - *"That's a good question."*
 - *"Let me think about that for a minute."*
- Finally, if you don't know the answer, what could you say?
 - ▶ *If no one answers, call on someone saying, any ideas?*
- It is important to acknowledge when you don't know the answer, and to above all not to say something that isn't true.
- If you don't know the answer, you can say (again): *"That's a good question, and I'm afraid I don't have a good answer."* **But, make sure you continue with an opportunity to find out and share the information back.**
- For example: *"I don't know, but I will get back to you"* or *"I don't know and I want to find out too; let's look in this reference book/call a professor I know."*

Takeaway

- It is important to ask questions in a way that encourages people to talk freely and to willingly share information. Asking open-ended questions and allowing time for the caregiver to respond also makes the exchange feel more like a **conversation** rather than an interrogation. It's important to be aware of what kind of questions you are using and be sure you are using the ones that will get you where you want to go.

Session 4.6. Reflective listening

Time: 20 minutes

Materials:

✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 4.6: Reflective listening.*
- So far in this module we have looked at:
 1. Nonverbal communication;
 2. Showing empathy;
 3. Asking open-ended questions and other types of questions.
- Who here has heard of reflective listening? Can anyone explain what it is?
 - ▶ *Let them respond and summarize with the below points.*
- Reflective listening is hearing and understanding, and then letting the other person know that they are being heard and understood. Reflecting back entails two key steps:
 1. Seeking to understand a speaker's idea by observing words and nonverbal communication.
 2. Offering the idea back to the speaker, to confirm that the idea has been understood correctly.
- Reflective listening helps people feel understood and encourages them to express themselves further. It can be seen as a combination of the first three techniques: nonverbal, empathy, and special questions.
- Let's listen to how Nurse Bakija uses reflecting to elicit the mother's concerns and help her feel understood in this role play.
 - ▶ *Demonstrate role play with a co-facilitator or with participants who have been briefed and prepared in advance.*

Exercise 16A: Practice reflecting. Nurse Bakija and Mrs. Hadzic³⁷ role play

- ▶ *Demonstrate role play with a co-facilitator or by participants who have been briefed and prepared in advance.*
- What was Mrs. Hadzic's concern?
 - ▶ *Let someone answer, or call on someone saying, any other ideas?*

³⁷ Adapted from Leask et al. Communicating with parents about vaccination: a framework for health professionals (2012). BMC Pediatrics 2012, 12:154 Available at <http://www.biomedcentral.com/1471-2431/12/154>

- Yes, Nurse Bakija heard Mrs. Hadzic say: “Petra isn’t good since she came to the clinic last week for her vaccination. She’s crying all the time now.”
- How did Nurse Bakija reflect back Mrs. Hadzic’s first concern?
 - ▶ *Let someone answer.*

Nurse Bakija:	Good morning Mrs. Hadzic. How are you and baby Petra today?
Mrs. Hadzic:	Good morning, Nurse Bakija. I’m fine. But Petra isn’t good since she came to the clinic last week for her vaccination. She’s crying all the time now.
Nurse Bakija:	(Nodding) Petra seems fussy since she got her shot last week?

- Yes, Nurse Bakija nodded, to show he was listening, and he paraphrased Mrs. Hadzic’s concern by saying “*Petra seems fussy since she got her shot last week?*”
- This allows Nurse Bakija to make sure he has understood correctly, and Mrs. Hadzic knows the nurse is really hearing her. Now let’s listen to what they said next.
 - ▶ *Continue role play.*

Mrs. Hadzic:	(With a worried expression on her face) Yes. I think she might have a fever.
Nurse Bakija:	It sounds as if you are worried. Let’s take her temperature and talk about what to do.

- What was the second concern Mrs. Hadzic raised, after Nurse Bakija reflected back the first concern that Petra was fussy since her shot?
 - ▶ *Let someone answer, or call on someone saying, any other ideas?*
- Mrs. Hadzic added a second concern, that she thought Petra had a fever.
- How did the nurse reflect back Mrs. Hadzic’s worry that Petra had a fever?
 - ▶ *Let someone answer, or call on someone saying, any other ideas?*
- Nurse Bakija validated Mrs. Hadzic’s worry by saying: “*It sounds as if you are worried.*”
- And then, Nurse Bakija showed he was acting on the worry, addressing it, by saying: “*Let’s take her temperature and talk about what to do.*”

- FLWs tend to ask caregivers many factual questions that require short answers. We are always in a rush, so we are trying to save time. Sometimes those short answers can lead to a better understanding of the caregiver's needs, but many times they do not.
- For example, if a mother says: *"My baby was crying too much last night,"* you might want to ask: *"How long was he awake for?"* But a numerical answer (such as, "Three hours") is not so helpful. If instead you reflect back the mother's concern, such as by saying: *"So she was crying a lot?"*, the mother is more likely to feel heard, and say more about her concern, as Mrs. Hadzic did.
- Here's another example of reflective listening.
 - *Read out or have another facilitator read the visiting nurse's response.*

Community Member:	I want to know why some people get to go in and get their vaccines and when I go, I have to sit for hours. Staff at that clinic don't play fair, they just take care of their friends.
Visiting Nurse:	You feel you are not getting equal treatment.

- Notice how the visiting nurse did not question the validity of the caregiver's feelings. The provider just reflected in her own words what she heard, not agreeing or disagreeing, just confirming her understanding.
- What kinds of reactions do you think the caregiver might have?
 - *Let them discuss then ask for a couple of answers.*
- Yes, it might help the angry and frustrated community member calm down because she feels she is being heard, or she might get angrier and say: *"That's what I just said!"* But the chances are she will feel better just hearing the nurse repeat her concern, which means she was heard.
- Using someone's name, as appropriate, can also be very useful in ensuring they feel heard, and feel connected to you, thus creating trust.
- Reflecting back and being non-judgmental are particularly important when the caregiver has serious safety or other concerns about vaccination. Your listening without passing judgment frees the caregiver to honestly express her/his concerns.
- It's a fine balance, though. We don't want to repeat or confirm the patient's concerns; we just need to let them express them. We should not repeat a rumour or false information. We will talk more later about handling rumours.
- Let's keep practicing with another scenario.
- You have three minutes to discuss.

Exercise 16B: Practice reflecting. Marko role play (continued)

- ▶ *Read the following scenario:*

Marko brings in his 13-month old daughter for a bad cough. When asked about the child's vaccination, Marko says: *"My friend says that MMR causes autism, and I shouldn't let them give that vaccine to my daughter."*

Work with your partner for the next few minutes to determine a reflective listening response. We aren't looking for the scientific response about MMR safety. We are looking for a phrase you could say back to show that you hear what Marko is saying, without repeating the false information.

- ▶ *Let them discuss for three minutes.*
- ▶ *Bring them back plenary to discuss.*

Plenary

- Who had an idea of how to reflect back without repeating the false information?
 - ▶ *Let them respond.*
- These are good ideas. We want to reflect back that Marko is concerned, without confirming or agreeing with the thing that made him concerned.
- You might simply say: *"Marko, it sounds as if you are worried by what your friend said."*
- Or you might go a bit further and say *"Marko, it sounds as if you are worried by what your friend said, and you want to make sure you do the right thing for your daughter."*
- You will find a bit more about reflecting in your *Participant manual* in **Table 13**. Please take a minute and review it.
 - ▶ *Give them five minutes to read.*
- Reflective listening might initially seem simple or silly, but it can be a very powerful tool with caregivers and even with your own family. It takes a bit of skill, but it can really help ensure understanding and create trust.

Table 13. More on reflective listening³⁸

Reflective listening is hearing and understanding, and then letting the other person know that s/he is being heard and understood. Reflecting back entails two key steps:

1. Seeking to understand a speaker's idea by observing words and nonverbal communication.
2. Offering the idea back to the speaker, to confirm the idea has been understood correctly.

38 Adapted from UNICEF (2017) Facilitator's Guide: Interpersonal Communication for Immunization. Draft.

- Reflective listening helps people feel understood and encourages them to express themselves further.
- It can be seen as a combination of the first three techniques: nonverbal, empathy, and special questions.

- FLWs tend to ask caregivers many factual questions that require short answers. We are always in a rush, so we are trying to save time.
- Sometimes those short answers can lead to a better understanding of the caregiver's needs, but many times they do not.

- For example, if a mother says: "My baby was crying too much last night," you might want to ask: "How many times did he wake up?"
- But a numerical answer (such as, three times) is not so helpful. If instead you reflect back the mother's concern, such as by saying: "So she was crying a lot?," the mother is more likely to say more about her concern.

Acknowledge the mood or feelings of the caregiver, recognizing her or his emotional state with appropriate words and nonverbal communication. For example, if the caregiver seems stressed, you can say: "You seem a bit stressed. Is there anything I can do for you?"

- To identify the caregiver's mood or feelings, you must quiet your mind and fully focus on the caregiver.
- The caregiver's mood or feelings will be apparent not just in the words used, but also in the tone of voice, in the posture and other nonverbal cues.

Summarize or paraphrase what the caregiver said, using your own words or some of the caregiver's words. Recap the caregiver's message.

- Whatever reaction the caregiver has, continue mirroring what s/he says. This helps the caregiver sort out her/his own experience.
- If the caregiver gets defensive, remain non-judgmental. This can open up the space for true communication.

- Your goal with reflective listening is to get the person to say "yes, that's right!" If you hear that, then you know you are helping your caregiver feel heard, which is a major step towards creating trust and working towards decision and action.
- Using someone's name can also be very useful in ensuring they feel heard, and feel connected to you, thus creating trust.

- You can even mirror the caregiver's physical posture.
- Research has shown that we like people who are like us, and that can even go as far as how you are sitting in your chair or where and how you are holding your hands.
- People on first dates often very closely mirror each other's body language as a way of making a connection.

Reflecting back and being non-judgmental are particularly important when the caregiver has serious safety or other concerns about vaccination. Your listening without passing judgment frees the caregiver to honestly express her/his concerns.

One caution: If you reflect back everything caregivers say, or copy their posture too obviously, it can begin to seem like mocking.

- It is better to mix up reflecting back with other active listening responses such as open-ended questions, probing/drawing out questions, etc.

Try practicing reflecting back with a colleague during a work discussion, or with a family member during a disagreement.

- Both of you will likely benefit, as will the caregivers you seek to help!

Studies have shown that when physicians helped the caregivers to express their negative emotions, the interactions ended up with **increased agreement about treatment**, and facilitated the link between physician and patient.

Takeaway

- These techniques of active listening help us to understand our caregivers' feelings and needs. If we are trying to convince caregivers to vaccinate, we may want to ignore or deny negative emotions in caregivers. But ignoring caregivers' fear or concerns may backfire:
- We need to help our caregivers express their negative emotions and concerns so that the patient feels heard. THEN we can start dealing with the challenges at hand. Until the patient feels heard and understood, anything we say to them may fall on deaf ears.

Session 4.7. Practice combining active listening techniques

Time: 45 minutes

Materials:

- ✓ *Participant manual.*
- ✓ **HANDOUT 5: SCENARIO SLIPS.** These will need to be cut up in advance, so you can quickly pass them out, or have participants draw one out of a bag.

Plenary

- ▶ *Show slide: Session 4.7: Practice combining active listening techniques.*
- Now that you have reviewed several active listening techniques (nonverbal communication, empathy, open-ended questions and reflective listening), let's look at an example of **combining the active listening techniques** to understand patient concerns.

Exercise 17A: Dr. Vera, Mrs. Ilić and baby Drago role play

- In a moment we will divide into our groups.
- The first task in your group is to choose one person to play Dr. Vera, one person to play Mrs. Ilić, (and one person or pen to play baby Drago).
- They should act out the scenario together, reading from the script. The rest of the group should read along.
- After they have finished the script, you will discuss with your group to answer the questions in your *Participant manual*. You will have 15 minutes.
- Let's get started.
 - ▶ *Let them get into groups.*
 - ▶ *Time them for 15 minutes and then bring the groups back together for discussion.*

Dr. Vera:	Good morning, Mrs. Ilić. How are you and baby Drago today? (Smiling, warm gesture). You are right on time for your next set of shots.
Mrs. Ilić:	He is doing well, but I don't think he is happy to be here.
Dr. Vera:	Drago is unhappy about coming to the clinic?

Mrs. Ilić:	Yes. I think he doesn't like being around so many people, and it is so hot.
Dr. Vera:	Mmm (nodding)
Mrs. Ilić:	I even wonder if he knows this is where he gets the shots. He started crying as soon as he saw a white coat.
Dr. Vera:	You think he associates white coats with pain already?
Mrs. Ilić:	Yes! He really started to cry as soon as he saw someone wearing one.
Dr. Vera:	How do you feel when you see a white coat?
Mrs. Ilić:	Well, I don't like to see him in pain.
Dr. Vera:	I respect that. I feel awful when I see my child in pain.
Mrs. Ilić:	Yes, it's terrible.
Dr. Vera:	It is not easy, but you are doing the right thing by getting him vaccinated. How did he do after the last doses?
Mrs. Ilić:	He cried for a long time afterwards, and he was a bit fussy for a few days, but he was okay, I guess. But I just hate seeing him cry so much!
Dr. Vera:	OK, ready to get this next set of shots done?
Mrs. Ilić:	I guess so.
Dr. Vera:	Great. Please hold him steady for me.

1. Identify at least four phrases or actions that demonstrate different active listening techniques that Dr. Vera used, and name the techniques.
2. What was the big issue that Mrs. Ilić was concerned about?
3. Was Dr. Vera successful in helping the mother express her concern about the child's fear of shots and her unhappiness in seeing her child in pain?
4. Did Dr. Vera offer any ways to deal with the child's pain?
5. Sometimes we don't know what to say, or we feel we don't need to address a negative concern. But this could lead to Mrs. Ilić not coming back for another round of vaccinations, so it's important to address her worry. What could Dr. Vera have said to address Mrs. Ilić's concern?
6. Who remembers the last question Dr. Vera asked?
7. What kind of question was this?
8. We have said we want to ask open questions, usually. In what way was it useful to use a closed question here?

Plenary

- Okay, let's go around the room and see what you found for the questions. Who would like to go first?
 - ▶ *Confirm the answers after each group answers with the below.*
- Identify at least four phrases or actions that demonstrate different active listening techniques that Dr. Vera used, and name the techniques.
 - **Answer:** Dr. Vera (Smiling, warm gesture) *"Good morning, Mrs. Ilić. How are you and baby Drago today? You are right on time for your next set of shots."* (**Nonverbal**)
 - Dr. Vera: "Drago is unhappy about coming to the clinic?" (**Reflecting**)
 - Dr. Vera: "Mmm" (nodding) (**Nonverbal**)
 - Dr. Vera: "You think he associates white coats with pain already?" (**Reflecting**)
 - Dr. Vera: "How do you feel when you see a white coat?" (**Open-ended**)
 - Dr. Vera: "I respect that. I feel awful when I see my child in pain" (**Empathy**)
 - Dr. Vera: "It is not easy, but you are doing the right thing by getting him vaccinated. How did he do after the last doses?" (**Open-ended**)
- Who would like to go for **Question 2:** What was the big issue that the mother was concerned about?
 - ▶ *Let the group respond and confirm with suggested answer below as needed.*
 - **Answer:** The child's pain.
- **Question 3:** Was Dr. Vera successful in helping Mrs. Ilić express her concern about the child's fear of shots and her unhappiness in seeing her child in pain?
 - ▶ *Let the group respond and confirm with suggested answer below as needed.*
 - **Answer:** Yes.

- **Question 4:** Did the health worker offer any ways to deal with the child's pain?
 - ▶ *Let the group respond and confirm with suggested answer below as needed.*
 - **Answer:** No, she just acknowledged it and moved on.
- **Question 5:** Sometimes we don't know what to say, or we feel we don't need to address a negative concern. But this could lead to Mrs. Ilić not coming back for another round of vaccinations, so it's important to address her worry. What could Dr. Vera have said to address Mrs. Ilić's concern?
 - ▶ *Let the group respond and confirm with suggested answers below as needed.*
 - **Answer:** "It's normal that Drago cries, but here are some ways to help you and Drago relax. Would you like to sing to him while you hold him, so he feels safe?" (This can relax the mother, too.)
 - "Here's what you can do so Drago doesn't feel uncomfortable, e.g. distract him with a toy, stroke his arm near where I will be giving him the shot, breastfeed, etc."
- There are several things that have been proven to decrease pain during immunization, which we will be discussing in a later session.
- **Question 6:** Who remembers the last question Dr. Vera asked?
 - ▶ *Let the group respond and confirm with suggested answer below as needed.*
 - **Answer:** "Ok, ready to get this next set of shots done?"
- **Question 7:** What kind of question was this?
 - ▶ *Let the group respond and confirm with suggested answer below as needed.*
 - **Answer:** Closed, leading.
- **Question 8:** We have said we want to ask open questions, usually. In what way was it useful to use a closed question here?
 - ▶ *Let the group respond and confirm with suggested answer as needed.*
 - **Answer:** Wraps up, moves the action along.
- So, Dr. Vera did a nice lead-in to vaccination, but she NEEDED TO ADDRESS THE CONCERN of Drago's pain.
- Let's listen to what happened later, when Mrs. Ilić was talking on the phone with her friend Marija:
 - ▶ *Read the below.*

Mrs. Ilić	<p>"Hi Marija. How are things? (Pause-mmmhmm, mmhmm.)</p> <p>No, no, I'm not taking Drago back for his next vaccinations. (Pause)</p> <p>Well, last time we went, I told Dr. Vera that I hated to see Drago in pain. She knew I was upset about making Drago cry and he was already crying when we got there.</p> <p>Then, of course, when he got the shots, he was crying even more. It's too much. I just can't put him through that again... or me!"</p>
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- Dr. Vera did a great job in understanding Mrs. Ilić's concerns, she just didn't address them. Mrs. Ilić went from being yellow to being orange, maybe red.
- Let's do another activity to practice using active listening techniques to understand caregiver needs. We are going to use secret scenarios.

Exercise 17B: Practice active listening techniques. Secret scenarios

- One of you will play the FLW and one of you will play the caregiver. Then you will switch roles.
- Each person will receive a secret scenario that you will use when you are playing the caregiver. Each scenario has a number at the top.
- The first thing you should do when you get your scenario out is check with your partner that you have a different number on your secret scenario slip than they do. If you have the same number, one of you should quickly switch with someone next to you.
- You will have five minutes. Then we will switch roles.
- The FLW will use active listening techniques to identify the caregiver's concern.
- Remember, the FLW is not supposed to address the caregiver's concern. You just have to help them express it, so you know what it is.
- Ok. Let's get started!
 - ▶ Give each person a secret scenario slip you have cut up from **HANDOUT 5: SCENARIO SLIPS FOR HIDDEN PROBLEM** (see below).
 - ▶ Remind the pairs to confirm that they have different numbers on their scenarios and give them a minute to trade with a neighbour if needed so that each partner has a different scenario.
 - ▶ Time the groups for five minutes and ask them to switch roles.
 - ▶ Time them for another 5 minutes then bring them back to plenary for discussion.
- Secret Scenarios from **HANDOUT 5**:
 1. You bring your daughter in for a cough. She is behind on her vaccination schedule because you are worried about the quality of vaccines. You have heard that the government is importing low quality vaccines to save money.
 2. You are reluctant to have your child with a cold vaccinated. You are worried it will make you child sicker.
 3. You are worried about giving multiple vaccines at once. You think that this will increase the side effects, and you don't want your child to be sick "for nothing."
 4. You are a Roma caregiver who thinks your 10-month old child is not old enough to handle all those germs. You want to wait until the child is older to continue with vaccination.
 5. You are a community leader who has come in with your grandchild. You are worried about safety: "I'd like someone to give a guarantee that the vaccine is OK. I watched like a hundred times on TV that vaccines are not OK, that they are harmful, that someone fell terribly ill. It makes one go mad."
 6. You are returning with your child to the clinic the day after his immunization because he is crying a lot and has had a fever for two days after vaccination.

Plenary

- How did this go? How did you each feel doing this?
 - ▶ *Let them respond.*
- Did you as the FLW manage to identify the caregiver's concerns? What were some of the challenges? How long did it take to elicit the caregiver's concern? What were some of your good ideas for understanding?
 - ▶ *Ask a few pairs to share their experiences.*
- When we use active listening, it can help us figure out where caregivers are on the continuum. It helps us understand what they might need to hear to trigger their decision, or what they are fine-tuning (e.g. dealing with pain) before they end up in maintenance or end up dropping back down the stairs and the continuum.
- Giving our caregivers our full attention for three minutes and using good nonverbal skills, open-ended questions, reflecting, etc. can make a huge difference in their trust and compliance.
- Health workers are one of the most important influencers in helping caregivers make the decision to vaccinate fully and on time.
- Your willingness to listen and ask questions in a way that helps you understand without putting caregivers on the defensive, will likely play a major role in helping caregivers with their decisions to choose vaccination.

Takeaway

- We are learning to help patients express their concerns through active listening, like making a diagnosis, in order to choose the right response, or treatment. We have seen that sometimes caregivers have concerns that we don't know about until we ask a bit, and listen a lot, and these concerns could stand in the way of them vaccinating their child.
- We have seen that good health workers don't always listen enough to successfully diagnose the caregiver's needs, like Dr. Musa, or they might listen well, but their style of responding to caregiver concerns may not always be successful, like Dr. Vera.
- We will work on this more in the next few modules.

If you are leading a TOT

- ▶ *Facilitate the practice teaching session for Module 4.*
- ▶ *Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 5.*

Module 5.

Communication during
immunization

Module 5. Communication during immunization

Module 5 Objectives:

By the end of the module the participants will be able to:

1. Use the opt-out algorithm to structure their immunization communications.
2. Formulate effective recommendations.
3. Help hesitant caregivers move towards vaccination.
4. Handle refusers successfully.

Time: 3 hours 30 minutes (210 minutes)

Checklist

- ✓ Test video links.
- ✓ Flip chart of expanded steps, socio-ecological model, stoplight.
- ✓ Flip chart with pie chart.
- ✓ Flip chart with algorithm.
- ✓ Flip chart with Expanded steps model.

If you are leading a TOT

- ▶ *Complete Module 5 according to the Facilitator guide and then facilitate the practice teaching session for the module.*
- ▶ *Refer to Session 1.5B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 6.*

Session 5.1. Using the opt-out strategy

Time: 10 minutes

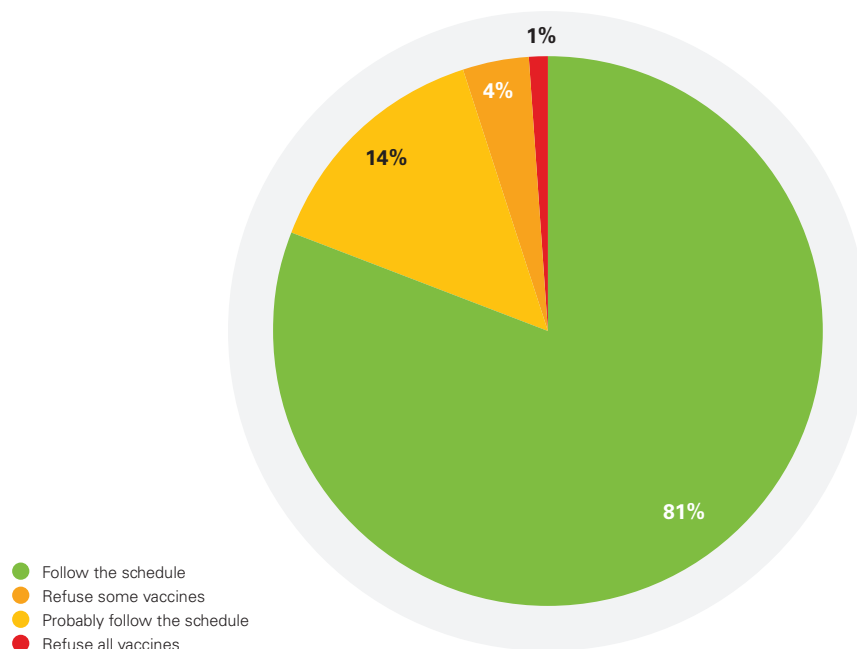
Materials:

- ✓ *Participant manual.*
- ✓ Flip chart of expanded steps, socio-ecological model, stoplight.
- ✓ Flip chart with pie chart.

Plenary

- ▶ *Show slide: Session 5.1: Using the opt-out strategy.*
- Let's summarize where we are. We know that behaviour change is a process, and we have to go beyond providing information or even telling people what to do, in order to increase immunization uptake.
- When we talked about the steps, we focused a lot on what we need to do to help caregivers move up the steps. We need to trigger emotion for decision-making, bring people into trial and help them fine-tune so they go into maintenance.
 - ▶ *Point to flip chart of expanded steps and to the steps as you mention them.*
- If we think about the problem that Doctor Musa had, it was pulling too hard on the trigger and not keeping an eye out for the reactions relating to self-efficacy: *"I can't watch the shots!"*
- Dr. Vera, on the other hand, had Mrs. Illic in trial, but missed the fine-tuning by not dealing with the pain.
- We know that behaviour is influenced at multiple levels: individual, family and peers, community.
 - ▶ *Point to flip chart of socio-ecological model.*
- We talked about how often the most powerful influencer is what others will think of them. We know that people often make decisions based on emotion rather than reason, and that all of use struggle with perception biases that can stand in the way of making good decisions.
- We know that our caregivers have various attitudes, beliefs, and readiness to accept vaccination, as we discussed at the beginning, saw on the continuum, and reviewed in the surveys.
 - ▶ *Point to continuum and pie chart.*
- In order to help our caregivers move towards on-time and complete immunization, we have to work a bit harder to understand their needs and to build trust, especially if our caregiver comes from a different profile to ours.
- We have spent a lot of time so far in this training working on understanding our caregivers' needs and beliefs. This is partially because we as health workers are often very good at talking, but not always as good at listening. And we have twice as many ears as we have mouths, right?

- But seriously, with the effort invested in listening and understanding our caregivers, we develop trust and connection, which is as we have seen, one of the missing elements in overcoming hesitancy.
- Now we are going to suggest something that kind of goes against some of what we have been saying about understanding your patients' needs first.
- We know your time is limited, and we know that the majority of caregivers are in favour of immunization. Remember the pie chart that was 80% green?
 - ▶ *Show Slide: Pie chart – Parents' intentions in relation to vaccination.*



- It showed us that around 80% of caregivers said they intend to complete their child's immunization schedule. So, we are suggesting the opt-out approach, which you already may be using, so that the default choice is vaccination.
- This way, you make it clear that this is the normal thing that everyone does. Instead of saying: "What do you want to do about shots?" or "What are your opinions on immunization?" you state: "Now it's time for Goran's shots." Or "Today, we will give Goran his vaccines."
- Of course, if this won't work in your context, you would ask if they want to vaccinate their child, and you couldn't use this presumptive approach.
- When your caregiver comes in, you will make them welcome, feel at ease, to help caregivers feel trust and connection right away, using all the skills you have been practicing. This will help them be open to your recommendations. And you will have your ears and eyes open to watch for any nonverbal or verbal signs of concern that might indicate you need to slow down.
- The next thing you will do, after the above step of creating trust with shaking hands and the welcoming expression and the smile, is:

- **ASSUMETHEYWILL VACCINATE.** They are mostly likely there to get immunization. It's a different context from a home visit. So, move forward assuming they will vaccinate.
- Most of the time, this will work. If the caregivers seem okay with it and don't ask too many more questions, you go ahead and give the appropriate vaccines. It's like you have a green traffic light.
 - ▶ *Show slide: Stoplight.*
- Remember this?
- If you hear: *"Ok, I'm ready,"* or *"Ok, I guess I'll vaccinate,"* you can look both ways but proceed.
- We don't want the caregivers to get too confused and start wavering. Studies have shown that **many caregivers actually prefer a guiding style**, so that the caregivers don't have to feel that they made the decision themselves.
- Why might caregivers prefer that doctors tell them what to do about vaccinating?
 - ▶ *Let them respond or call on someone.*
- One simple reason is that it's hard to make complex decisions. If they follow the doctor's recommendation, they don't have to sort through all those confusing pieces of information that they have seen and heard, and try to make it into a recognizable pattern, like we did with the triangles, or decide which risk is bigger, and try to make sense of it all, and make a decision.
- They may even feel a sense of relief that the decision is made for them, although with their consent. Remember the cell phone example?
- Once we have helped them agree to vaccination, we still have to make sure they are happy with the decision, and we have prepared them to be satisfied caregivers who return for the next round, and the next.
- So, we aren't just pushing them through, saying: *"Here, have your shots, bye!"* They are in trial and fine-tuning, so we have to get them solidly into maintenance.
- We have a number of steps to go through, with the green light people and the yellow, orange and red people as well.

Takeaway

- People want to do what the social norm is, in most cases. Most people vaccinate, and it's time-efficient and persuasive to work with the assumption that the caregivers will vaccinate their child.
- Using a guiding style, while checking for any reactions that indicate hesitancy, has been shown to be effective, and satisfying for the caregivers as well.

Session 5.2. Algorithm for vaccination communication

Time: 15 minutes

Materials:

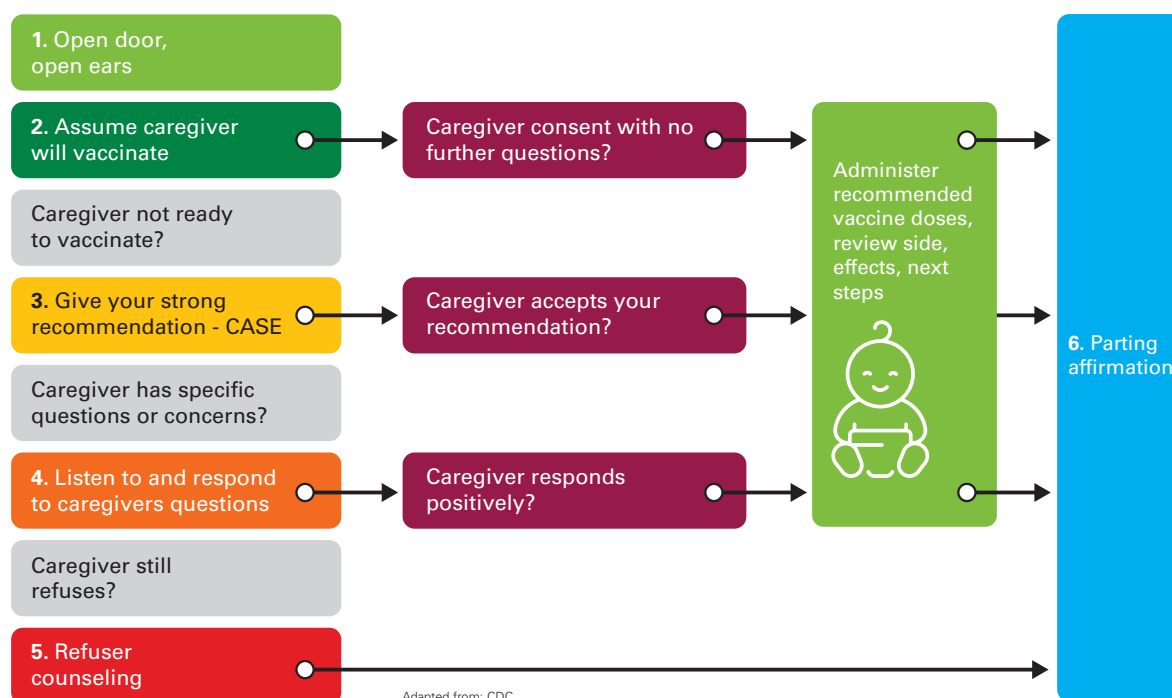
✓ *Participant manual.*

Plenary

► *Show slide: Algorithm for vaccine communication.*

- Let's take a look at **Figure 19** and see how we can use this algorithm to guide us through our opt-out strategy.

Figure 19. Algorithm for vaccination communication



- Who can remind me how we have been beginning our practice encounters with caregivers? Please come and show us on the diagram.
 - *Ask someone to come and point to and read the first box.*
- Yes, when the door opens, ears need to be opened.
 - *Point to box 1.*

- Whose “ears and eyes” need to be open here?
 - ▶ *Let them respond and confirm: health provider’s and caregiver’s ears and eyes.*
- What do we say and do for this step?
 - ▶ *Let them respond.*
- Yes, we make caregivers feel welcome, accepted, understood, cared for. We open their ears with our welcome, building trust, and we open our own ears.
- What do we do next? Please come and show us on the diagram.
 - ▶ *Ask for a volunteer.*
- Yes, we assume they will vaccinate.
 - ▶ *Point to box 2.*
- What do we say?
 - ▶ *Let them respond.*
- *“Today is time for Goran’s vaccines.”*
- What do we do next?
 - ▶ *Let them respond.*
- We check to see what their reaction is. Do they seem comfortable?
 - ▶ *Point to purple box to the right of box 2.*
- Or do they seem hesitant?
 - ▶ *Point to grey box below box 2.*
- And how are we checking to see if they seem hesitant?
 - ▶ *Let them respond.*
- We are using our nonverbal reading skills, and we are looking for cues in what they say, and the questions they ask.
- What do we do if they seem to be comfortable and don’t show any hesitation?
 - ▶ *Point to purple box to the right of box 2.*
 - ▶ *Let them respond.*
- Yes, you vaccinate the child.
 - ▶ *Point with your finger, follow the arrow pointing to the vaccination box and then circle around the words in the green box, reading them out.*
- That is probably one of your green caregivers, one of the “easy 80%”.
 - ▶ *Point to the flip chart of the pie chart.*
- What do we do if, when we say: *“Today is time for Goran’s vaccines,”* the caregivers seem to be hesitating, worried, not ready to vaccinate?
 - ▶ *Point to grey box below box 2.*
- Should we continue to assume they will accept vaccination?
 - ▶ *Let them respond.*
- No, you follow the arrow down to box 3.
 - ▶ *Point to box 3.*
- Now you give your strong recommendation. We are going to work in Module 6 on ways to structure your strong recommendation including an approach called CASE. We are still working in a presumptive mode. We are just trying to see if a small push will get them into the vaccination box.

- After you give your strong recommendation, if the caregivers seem comfortable and don't seem to have any more worries or questions, what do you do?
 - ▶ *Point to the purple box to the right of box 3.*
 - ▶ *Let them respond.*
- The caregiver has accepted your strong recommendation, and you vaccinate the child.
 - ▶ *Point with your finger, follow the arrow pointing to the vaccination box and then circle around the words.*
- That is probably one of your yellow caregivers, one of the "not so easy 14%."
 - ▶ *Point to flip chart with pie chart.*
- After you give your strong recommendation, if the caregivers do NOT seem to be comfortable, and they seem to have additional specific questions and concerns, what do you do?
 - ▶ *Point to the grey box under box 3.*
 - ▶ *Let them respond.*
- Yes, you go to box 4. You use your toolbox of communication skills, your active listening techniques, your elevator phrases, to further draw out their concerns and questions; make them feel they are being understood and respected; and help them come to a decision.
- The caregiver's real concern may not come out at first. It might be buried deeper. Remember Olga? We need to make sure we are allowing enough time, pauses, and empathy for their concerns to come out.
- And once the concerns are expressed, we need to address them in a satisfactory way- remember Dr. Vera and Mrs. Ilic?
- This is a tricky step, but you may be able to move some of these approximately 5-10% of caregivers up into the acceptor box.
- Any questions?
 - ▶ *Clarify as needed.*

Takeaway

- We can use this algorithm to guide us through immunization communication.
- The algorithm starts with the assumption that caregivers will choose to vaccinate but helps us decide what to do if they show hesitation. We are checking to see if we have a green light, or a yellow light, or a red light, with our caregivers. Let's practice some of these steps in the next session.

Session 5.3. Assume they will vaccinate, but check

Time: 15 minutes

Materials:

- ✓ *Participant manual.*
- ✓ *Flip chart with algorithm.*

Plenary

- ▶ *Show slide: Session 5.3: Assume they will vaccinate, but check.*
- ▶ *Show slide: Clinic algorithm.*
- We have said that most caregivers will probably feel all right with this guiding approach of “Doctor knows best.” But not all caregivers feel that way. That’s why we are always checking with them to see how they are reacting, if we can just keep going or if we need to put on the brakes and figure things out.
- If the caregivers indicate through their nonverbal or verbal communication that they are hesitant, as we have learned about in the last few sessions, then you know you have to slow down, like at a yellow light, and see what is going on.
- With your partner, you will practice the first three steps in a minute.
- What are the first three steps?
 - ▶ *Point to the algorithm.*
 - ▶ *Let them respond then confirm clearly.*
- Step 1: Box 1 - Open doors, open ears.
- Welcome them by shaking hands; giving a welcoming expression, smile, or whatever else you can do to immediately create trust and rapport. Praise the caregiver in a reasonable fashion, opening their ears to listen to you, and opening yours.
 - ▶ *Point to Box 1.*
- Step 2: Box 2 - Assume caregiver will vaccinate.
- “It’s time for your child’s vaccines.”
 - ▶ *Point to Box 2.*
- Step 3: Check their reaction to the assumption of vaccine acceptance. See if you go to the purple box or to the grey box.
 - ▶ *Point to the two boxes: purple and grey, next to Box 2.*

Exercise 18: Practice first three steps of algorithm

- Pair up with your neighbour and take turns being the caregiver and the health worker, as you move through the first 3 steps.
 1. Welcome;
 2. Assume vaccination;
 3. Check the assumption.
- The caregiver can choose how to react, verbally or nonverbally. The health worker has to correctly understand the reaction and tell the caregiver what he thinks the reaction was, positive or hesitant.
- Remember, we are only doing the first three steps. You won't go any further than reading the reaction. Simply understand it and identify which box you move to next. Don't respond to it.
- Try it at least three different ways, with different reactions.
- Ok let's begin!
 - ▶ Give them five minutes then bring them back to plenary for discussion.

Plenary

- How was it?
 - ▶ Let them respond.
- Any creative or successful ways to put caregivers at ease, and tell them it's time for their child's vaccines?
 - ▶ Let them respond.
- Any unusual or hard to read reactions from the caregivers?
 - ▶ Let them respond.
- If you had a challenging experience with this, please share it with the group.
 - ▶ Let them respond.
- Any other reactions and ideas?
 - ▶ Let them respond.
- So, to review: when we say it's time for vaccination, if the caregivers seem ok...
 - ▶ Point to the purple box.
- What will we do with them?
 - ▶ Let them respond.
- We will vaccinate them, do our normal counselling about side effects, when to come back, and as we or they touch the door handle, we will appreciate their efforts.
 - ▶ Point to vaccine box and affirmation box.
- They are done!!

Takeaway

- With most of our caregivers, we will be able to move them through the first tier. We just have to check to make sure they are not hesitant.
 - ▶ *Point to purple and grey boxes next to and under Box 2.*
- As we said before, if the caregivers indicate through their nonverbal or verbal communication that they are hesitant, then you know you have to slow down, like at a yellow light, and see what is going on.
 - ▶ *Point to grey box under Box 2 and then to Box 3 - Strong recommendation.*
- We will look at this in our next session.

Session 5.4. If they are hesitant, give strong recommendation

Time: 45 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Flip chart with algorithm.

Plenary

- ▶ *Show slide: Session 5.4: If they are hesitant, give strong recommendation.*
- ▶ *Show slide: Clinic algorithm.*
- Many of your caregivers will be over in the vaccination box by now, but some will show you through words or nonverbal cues that they are still hesitant. We saw with Dr. Musa, when he ignored Olga's cues of hesitancy and tried to bulldoze through, it didn't work.
 - ▶ *Point to grey box under Box 2.*
- If the caregivers indicate they are hesitant, then what will you do?
 - ▶ *Let them respond then confirm clearly:*
- Give your strong recommendation. We will work more on CASE in Session 6.3.
 - ▶ *Point to Box 3 on the algorithm.*
- In this strong recommendation, you can use a mixture of components.
- Let's take a few moments to practice this.

Exercise 19: Develop strong recommendation phrases

- We are going to work in your small groups. I will review the instructions with you.
- You will have 15 minutes to work with your group to create a list of elevator phrases you might use for your strong recommendation.
- You will write your phrases on the list titled "elevator phrases" found on the last two pages of your *Participant manual*.
- You should create two phrases for each of the 7 categories you find listed in your *Participant manual* under Session 5.4. There is a list of 'example phrases' you can review there as well if you need a few ideas.
 1. Your personal conviction that vaccination is safe and important.
 2. Your personal experience with vaccinating thousands of children.
 3. An emotional appeal to them as parents, or you as a parent.
 4. The concept of vaccines as protection.

- 5. Social norm that responsible caregivers vaccinate their children.
- 6. Your personal concern for the child's welfare.
- 7. History, referring to the history of vaccination, caregiver's childhood.
- Let's get started!
 - ▶ *Allow the groups to work for 15 minutes then bring them back together.*

Plenary

- How was that?
- Who would like to read out their phrases for 1?
 - ▶ *Continue with each question, asking for groups to read out their suggestions until they start repeating, at which point you can ask- did you have anything different?*
- Thanks, those are good phrases.
- Please take the time to write down two or three elevator phrases that you just heard that you think would be good to have available.
- So now, you have given an extra little push with your strong recommendation. If the caregivers show that they accept your strong recommendation, what do you do?
 - ▶ *Point to the purple box to the right of Box 3, then follow the arrow to the vaccination box.*
- If they accept your strong recommendation, and you vaccinate them, what else will you do?
 - ▶ *Show a pushing motion like you are pushing the caregivers into the vaccination box.*
 - ▶ *Let them answer then point to vaccination box.*
- You will do your normal counselling on side effects and review next steps: when to come back, and what to do if they have a question or are worried. And, then what will you do?
 - ▶ *Let them answer.*
 - ▶ *Point to departure affirmations box.*
- You will give them their departure affirmation. We will also work on this later on.
- If, after you give your strong recommendation, the caregivers indicate verbally or nonverbally that they have additional questions or concerns, what do you need to do?
 - ▶ *Let them respond then confirm clearly, pointing to the grey box under Box 3, and then to Box 4.*
- If they still show concern, you need to spend a little more time with them. You are in Box 4 now. We still have a good chance of helping these caregivers decide to protect their children.
- Who would like to make a guess about approximately what percent of caregivers will need to have this extra time spent in discussion?
 - ▶ *Let them respond or call on someone.*
- We don't really have an exact figure, but yes, less than 10-20% might be a good guess, because probably around 80-90% will have already agreed to vaccinate before you get to Box 4.
- Box 4 is where you need to put all of your active listening and motivational skills to work. These are your most challenging diagnosis and treatment cases, your yellow and orange caregivers. There won't be too many of these, but when you meet one, you need to:

1. Use active listening, especially reflective listening, to elicit caregivers' questions and concerns, showing you are understanding;
 2. Respond to their concerns, reassure and motivate them, according to whatever their particular concern is, to the best of your ability.
- Who remembers Dr. Musa and Olga? Let's analyse their discussion.

Exercise 20: Analysing the discussion with Dr. Musa and Olga

- ▶ Act out the role play with a co-facilitator or brief two participants to prepare the role play in advance.

OLGA:	Good morning, are you Dr. Musa?
DR. MUSA:	Yes, please come in, Mrs. Marci. (He smiles, shows her a seat, good eye contact, etc.)
OLGA:	Please call me Olga. (Anxious smile)
DR. MUSA:	(TURNING TO PARTICIPANTS) So, how am I doing? (pause for response)
DR. MUSA:	(STILL TALKING TO PARTICIPANTS) I do think I did a great job on step one, Welcome and Trust. I was warm, smiling, nodding, etc. She's feeling comfortable. Her ears are open to hear about vaccines. (He bows.)

- Let's continue!

DR. MUSA:	Olga, I see that baby Luka already had his first vaccines when he was delivered, and today it's time for his second shot.
OLGA:	Yes. (Handing over vaccine card slowly, looking at doctor sideways.)
DR. MUSA:	Today we are going to give him DTaP. This will be the first of a few shots that will protect him against these dangerous diseases, they are easy to catch and very difficult to treat.

DR. MUSA:	(TURNING TO THE PARTICIPANTS) So, where am I on the algorithm? How am I doing? (Pause for response) [Box 2]
DR. MUSA:	(TO PARTICIPANTS) Yes, I did a great job on step two. I gave the vaccine assumption, and she seems pretty much ok, maybe a little hesitant, but I figured I would just keep going. I explained what vaccines I was giving, and why they were important. BUT THEN SHE SAYS....
OLGA:	I know that, I just am not ready right now. (Pursing her lips.)
DR. MUSA:	(TO PARTICIPANTS) Olga hesitated. SO WHAT DID I DO? I gave her lots of good information, and I gave a good strong recommendation. That usually works!
DR. MUSA:	Babies should be vaccinated according to the schedule in order to ensure that they are not exposed to dangerous diseases. If you are worried about vaccine safety, you don't have to worry, it is perfectly safe. Most children are fine- they might have a bit of a sore arm or a fever for a day or two. It's normal, nothing to worry about.
OLGA:	No, no, I need to go now. (Holding her hand up as if to say stop)
DR. MUSA:	Olga, I know you are worried but it's the right thing to do. I strongly recommend it.
OLGA:	Thank you but no! (Shaking her head no.) Maybe another time. (Olga rushes out.)
DR. MUSA:	(TO PARTICIPANTS) I gave her my strong recommendation and lots of information. This is so frustrating. I wish these people would listen to me!

- So, what happened here? Did Dr. Musa say anything that was factually untrue?
 - ▶ *Let them respond.*
- Did he miss the first step of welcome and creating trust?
 - ▶ *Point to Box 1, let them respond and confirm: No!*

- Did he miss the second step of Assuming vaccination?
 - ▶ *Point to Box 2, let them answer then confirm: No!*
- Did he notice that she was hesitating, and give his **strong recommendation**?
 - ▶ *Point to Box 3, let them respond and then confirm: Yes!*
- Did he forget to reassure her that Luka would be fine and that she was making the right decision?
 - ▶ *Let them answer then confirm: No!*
- He gave a strong recommendation. He put his heart into it. What did he forget to do?
 - ▶ *If they say: he didn't give her a chance to ask questions or discuss her concerns, say: EXACTLY!*
- He was good at the welcome; the assumption of vaccination; and he gave information. He even heard her initial hesitation after Box 2 and went for the strong recommendation in Box 3. Where he made the mistake was Where did he make the mistake?
 - ▶ *Let them answer.*
- Really, it was Box 3 ½. He sensed that she wasn't going to accept, she was going down instead of accepting and going into the purple box, so instead of listening, he talked at her!
- He went back up to Box 3, and just didn't stop recommending enough to see what the problem really was. He never went to Box 4.
- What techniques could he have used that might have made all the difference and helped Luka get his vaccination, with possibly less discussion needed?
 - ▶ *Let them answer.*
- Yes, if he had used probing, active listening, drawing out, reflecting, etc. Or, just stopped pushing long enough for Olga to speak.
- Now let's take a few minutes to work with a partner.

Exercise 21: Using probing, active listening, drawing out, reflecting etc.

- With your partner you will think of 3 phrases or questions Dr. Musa could have used to figure out what Olga was having a hard time with, and when he should have used it.
- You will have five minutes. Let's begin.
 - ▶ *Let them work on it for five minutes and then call them back to plenary.*

Plenary

- Who can give one phrase or question they think Dr. Musa could have said, and when they think he should have said it?
 - ▶ *Let them respond.*

- Any others?
 - ▶ *Let them respond.*
 - ▶ *Repeat what they said, if they seem good. If they don't, ask the participants how they might make the phrase/question even better.*
 - ▶ *Give a few other techniques/phrases if needed.*
- As soon as she said she was unsure or even before, when she was giving nonverbal cues Dr. Musa could have said: *"It's great that you came in to get Luka vaccinated, but you seem unsure. What would make you feel more comfortable?"*
- And then, PAUSE! This would give her time to think and then speak.
- Later on, when she says she's unsure:
 - *"I see you're not ready. What would you like to ask me?" OR,*
 - *"You seem a bit anxious, how can I help you?" OR,*
 - *"What is bothering you about giving Luka his vaccines today?" OR,*
 - *"What's on your mind?" OR,*
 - *"What would it take to make you feel more comfortable?"*
- These were some good ideas.

Takeaway

- We need to get the right balance between driving along with a green light, nudging caregivers into the vaccination box, or slowing down slightly to give our strong recommendation, or slowing way down, like for a yellow light, and even stopping, to see whether we can find the key to unlock the caregiver's yes.

Session 5.5. Dealing with the very hesitant

Time: 20 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Flip chart with algorithm.

Plenary

- ▶ *Show slide: Session 5.5: Dealing with the very hesitant.*
- As we said in our last session, when we see that the caregiver is very hesitant, we need to spend extra time and go carefully.
- Let's practice with this some more by reviewing a conversation between nurse Dora and Mrs. Jovanic.

Exercise 22: Mapping dialogue to the algorithm

- In just a moment you will pair up with your neighbour and read the script in your *Participant manual* together.
- Once you have read through the scenario, you will have two tasks:
 1. Map the conversation onto the algorithm.
 2. Identify all the communication techniques nurse Dora is using.
- Now, please split up so you each are working with a partner and carry out the two tasks.
 - ▶ *Give them 10 minutes with a one-minute warning and bring them back together to discuss.*

Nurse Dora:	Good morning Mrs. Jovanic. Nice to see you today (Smiling and gesturing to the chair) It is so hot today, isn't it! So today is the day for Lamija's first infant vaccinations.
Mrs. Jovanic:	Well, I'm not sure, I'm pretty nervous. She seems so young to get all these shots. Is it really safe?

Nurse Dora:	<p>You sound quite worried. (Reflecting, empathic response) Let's talk it through together.</p> <p>Tell me more about what you are concerned about, okay? (Further building rapport- we are on the same team- and eliciting concerns with open ended question)</p>
Mrs. Jovanic:	<p>One of the mums in my mothers' group said that one of the injections has got five ingredients and that's too many for their immune systems to cope with.</p> <p>She does seem so young to be having injections against all these diseases at once. Won't it make her ill?</p>
Nurse Dora:	<p>OK, we can talk about this (structuring discussion, guiding) but do you have other worries as well? (Eliciting further concerns)</p>
Mrs. Jovanic:	<p>Well I read also that they can get a sore leg afterwards, so that's another worry.</p>
Nurse Dora:	<p>(Pausing to allow Mrs. Jovanic to interject if she has questions and to observe body language)</p> <p>Right, let's talk about Lamija's ability to handle the five ingredients, and then we can talk about the chances of getting a sore leg (signposting and structuring of explanation).</p> <p>You're right that the injection has got five ingredients. It seems a lot, doesn't it? (Empathic response, reflecting her stated concern, and pausing to see how mother is doing.)</p>
Mrs. Jovanic:	<p>Yes, that's what I am worried about. Is it too much for her?</p>
Nurse Dora:	<p>Children, even new-born babies, have to deal with enormous amounts of bacteria and other foreign material every day. In fact, children are exposed to more antigens from a common cold than from vaccines.</p> <p>What is great is that babies' immune systems can handle this, and the vaccines these days are so refined that babies can easily cope with several vaccines in one go. (Chunks of information provided followed by pauses for mother to raise further questions and for Dora to observe mother's body language).</p> <p>So even at her young age, Lamija can handle the five vaccine ingredients, which will protect her while she is so young and vulnerable. (Reinforcing protection concept.) And this way, she only has to have one shot, instead of several different ones.</p>

Mrs. Jovanic:	OK, and would she get a sore leg?
Nurse Dora:	<p>Most children don't have any reaction at all, other than crying a bit with the injection, (Positive framing of risk) and even then, they generally settle really quickly with a cuddle and some comforting words from mum (Empowering).</p> <p>It's true that a small number of children, about 10%, can get a redness or a sore area where the needle goes in (acknowledging) – but these reactions don't usually distress the child, and only last a couple of days, then go away.</p> <p>So, what I ask mothers to do is to watch their child after the injection, and if they are concerned, bring them back to the clinic so we can check them over. How does that sound? (Moving towards a decision but avoiding being overly persuasive,)</p>
Mrs. Jovanic:	What happens after the shots?
Nurse Dora:	<p>Lamija may be a bit unsettled for a day or so after her injection but she shouldn't be ill with it. This leaflet tells you about what to look out for once you go home, and what to do if you are concerned. (Trying to trigger decision by providing external reinforcement and offering support so mother feels self-efficacy about handling side effects at home)</p>
Mrs. Jovanic:	Oh, this leaflet is helpful. Sometimes it's hard for me to keep all this information straight. This will be nice to look at once I get home.
Nurse Dora:	<p>Is there anything else you would like to discuss? I know you want to make sure Lamija is protected from harm, and I do too. (Pause).</p> <p>Thousands of mothers with babies the same age as Lamija have come into our clinic for injections of these five-ingredient vaccines, and I have never seen a problem.</p> <p>These new technologies mean that Lamija doesn't have to get as many shots, and she still gets the protection she needs.</p> <p>If I were you, I would go ahead and get her shots done today.</p>
Mrs. Jovanic:	Thanks – I'm still a bit nervous but I think we should get it done.
Nurse Dora:	<p>You've made the right choice to protect Lamija. (Confirming, reassuring) Why don't you hold her and let her play with her toy while I get the vaccines ready?</p>

Plenary

- How did it go?
- How did the conversation follow the algorithm?
 - ▶ *Let them respond.*
- Yes, in this scenario, nurse Dora did Box 1: Open door, open ears, and then she did Box 2: Assume vaccination.
 - ▶ *Point to Boxes 1 and 2.*
- Then what did she do? Box 3: Strong Recommendation, or Box 4: Listen to and respond to caregiver's questions?
 - ▶ *Point to Boxes 3 and 4.*
 - ▶ *Let them respond.*
- Nurse Dora went straight to Box 4. She did not try to nudge Mrs. Jovanic with a strong recommendation. Why do you think she skipped Box 3?
 - ▶ *Let them respond.*
- Yes, Nurse Dora could see almost immediately that Mrs. Jovanic was extremely concerned, and she knew she had to slow way down so that Mrs. Jovanic did not shut down and become resistant.
- She went to Box 4, spent quite a bit of time using active listening and responding techniques, and when she saw that Mrs. Jovanic responded positively, she moved to the vaccine box.
- What technique did Nurse Dora use immediately after Mrs. Jovanic said she was quite nervous and worried about safety?
 - ▶ *Let them respond.*
- Nurse Dora used "reflecting" to put on the brakes and slow the process down. This way, the mother felt heard and understood, so she could bring out her concerns.
- What other techniques did you see her using?
 - ▶ *Let them respond [see notes in dialogue].*
- One key point is that when parents express a concern, do not say:
 - *"I understand your concern!" or "I can see why you are worried about that!"*
- You do not want to validate the contents of the concern. Say instead:
 - *"I understand that you are concerned!" or "I can see that you are worried!"*
- This way you validate the **emotion** of the concern without validating the **contents** of the concern.
- Remember, people need help making a decision. The phrase *"If it were my child, I would go ahead and vaccinate"* may be all they need to nudge them into the action.
- Thanks to everyone for their ideas. There is no one right answer, every caregiver is different, and every interaction is different. The more you practice these skills of listening and negotiating, the better you will become.
- Too much science will frustrate some caregivers. Too little science will frustrate others. For some caregivers, too much anecdotal information will not hit the mark. For others, a story from your experience about an unprotected child who became ill or knowing that children in your family have received all of their vaccines, will be exactly on target.
- Giving information in chunks, and then checking comprehension or reaction, is a way to ensure you and your caregiver understand each other.

- Sometimes caregivers come in very aggressive and defensive. If you are non-judgmental and show empathy, kindness and understanding, the caregivers may be taken off guard and put their fists down.
- We will be doing some more practice sessions for working with the very hesitant caregiver and the refuser in a later session.

Takeaway

- When you see that a caregiver is very hesitant, put on the brakes, slow down, and start using reflecting and other techniques to create trust. The approach to use will depend on your knowledge of the family. Watch and listen. Be prepared to use the mix of science and personal stories that will be most effective in addressing caregivers' questions and concerns.
- See if they just want to be heard, and then reassurance that they are doing the right thing by vaccinating. Be like the waiter in a restaurant. When you make your order, they always say: *"Great choice!"*

Session 5.6. In the vaccination box. Decreasing pain

Time: 20 minutes

Materials:

- ✓ Participant manual.
- ✓ Slides.
- ✓ Video links.

Plenary

- ▶ *Show slide: Session 5.6: In the vaccination box. Decreasing pain.*
- Once you get your caregiver over into the vaccination box, what are a few of the things you still have to do before you have successfully vaccinated the child?
 - ▶ *Let them answer.*
- **Decrease the Stress and Pain of the Vaccination Process:** One way to decrease caregiver hesitation is to show caregivers ways they can make the vaccination visit less stressful for the child.
- A screaming child and a stressed-out caregiver will both have negative memories and will be less likely to come back. It is estimated that about 10% of patients avoid or miss medical procedures because of needle fears.³⁹
- Here is where Dr. Vera made her mistake with Mrs. Ilic and Baby Drago. She got them into the vaccination box, but she didn't deal with Mrs. Ilic's concern about the pain, which she **knew** about. So, she got this round of shots done, but Baby Drago may not come back for the rest of his shots.
- Who can give an example of a technique they use to decrease pain and stress during immunization?
 - ▶ *Let them answer, as long as they are still adding new ideas.*
- These are great ideas. You can begin by reinforcing to the caregiver that crying is a normal response for the child and suggesting that the caregiver can decrease their child's stress by acting calm and confident, even if they don't feel that way.
- The caregiver should try to relax and hold the child, preferably in an upright position, during vaccination. Now let's watch a video of how this is done in some contexts.
 - ▶ *Show the video: <https://www.youtube.com/watch?v=MOOxpT9q2mo>*
 - ▶ *If there is time show the video: <https://www.youtube.com/watch?v=bCljDf5veEs>*
- What do you think? There are a lot of techniques you can use to make this a less stressful experience for all of you. Let's briefly review. You can follow along in your Participant manual in Annex D.
 - ▶ *Show slide: Reducing pain during vaccination.*
 - ▶ *Point to each as you review.*

39 Reducing the pain of childhood vaccination: an evidence-based clinical practice guideline. A. Taddio et al Canadian Medical Association Journal, December 14, 2010 CMAJ 2010. DOI:10.1503/cmaj.101720

Reducing Vaccine Injection Pain in Children

A Guide for Health Care Providers

Preparation:

- Review this evidence-based guide
- Provide parent/caregiver with information and tools
- Discuss pain management strategies

Procedure:

Combine strategies to improve pain relief



Practice and Documentation

1. Assess pain
2. Document pain score
3. Assess parent and child satisfaction
4. Reflect and plan approach for next vaccine

Document:

- Age of child
- Vaccines given
- Pain-relieving strategies used
- Pain score
- Parent/child satisfaction

Source: <https://www.aboutkidshealth.ca/>

- Use **structured conversation** to explain to the caregiver what you will do and what you need from her before you begin preparing the child for vaccination. This will give her a greater sense of control.
- Begin with oral vaccines or less painful ones and finish with the most painful one.
- For infants, you can suggest that caregivers use a favourite blanket or toy to distract the baby from the pain of the shots, and that they touch and soothe the baby, talk softly, and smile and make eye contact during the shots.
- After shots for infants, mothers may wish to cuddle or breastfeed.
- For toddlers, there are many more options to distract from the pain of the shot, including telling a favourite story, singing, or taking deep breaths and blowing out the pain.
- After the shots, toddlers can be praised for getting through the shots and reassured that everything is okay.
- There are other things such as breastfeeding during injection or use of sugar water for non-breastfed infants, topical analgesics, or oral pain medication that can be used, as well as rapid injection for intramuscular vaccines, without aspiration.⁴⁰
- **Do not** tell children **“this won’t hurt”**, as this type of statement, when used alone, has been shown to be ineffective in reducing pain at the time of injection and, as it is deceptive, can decrease trust.⁴¹

Takeaway

- Reducing and managing pain during vaccination can be very important in increasing adherence with the vaccination schedule.
- There are several methods, and your caregivers will appreciate your effort to make the visit less stressful. You might enjoy having less crying, too!

40 Reducing the pain of childhood vaccination: an evidence-based clinical practice guideline. A. Taddio et al Canadian Medical Association Journal, December 14, 2010 CMAJ 2010. DOI:10.1503/cmaj.101720

41 Ibid

Session 5.7. In the vaccination box. Discussing side effects

Time: 40 minutes

Materials:

✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 5.7: In the vaccination box. Discussing side effects.*
- Who remembers the top concern of both the acceptors and the hesitators in the KAP study we discussed in Module 3?
 - ▶ *Let them answer and confirm: side effects.*
- It was not clear in the study how much was fear of severe side effects, which are in fact extremely rare, or the unhappiness with minor ones, which are more common.
- As we discussed earlier, other research found that vaccine refusers did not distinguish much between mild side effects like a sore arm or fever, and the extremely rare one in ten million adverse effects like MMR-related encephalitis. They lumped all side effects in together.
- Some refusers say they wouldn't do anything that wasn't 100% safe for their child. But we know that nothing is 100% safe, not even driving or coming on the bus to the clinic.
- We have to help caregivers realize that the slight risk of side effects from vaccines is much less than the major risk of the diseases.
- Whether it's an easy green acceptor or a hesitator, it's important to let the caregiver know what to expect and what to do in terms of side effects.
- Remember the discussion between Nurse Dora and Mrs. Jovanic? What was Mrs. Jovanic worried about?
 - ▶ *Let them answer.*
- She was worried about giving the injection with five ingredients, and she was worried about side effects.
- What did Nurse Dora do to help Mrs. Jovanic overcome her worry about side effects?
 - ▶ *Let them answer.*
- She explained that there was only around a 10% possibility of a sore arm, but that if she was concerned, she could come back to be checked. She also gave her a leaflet on what to do when you go home after vaccination, which helped Mrs. Jovanic feel she was more able to cope with the possible side effects.
- How do you all talk with your patients about side effects? Do you have a printed instruction sheet or explain what to expect and what signs indicate the need to come back, or...?
 - ▶ *Let them give some answers.*

- Discussing side effects with caregivers is not an easy subject to discuss, but it's important. Focus groups in Bosnia and Herzegovina⁴² revealed that some mothers accepted the side effects because they had been warned and told how to handle them.
 - "My daughter developed temperature too, maybe because she received three vaccines at once. It was 40 degrees. But they said the same, to give the child a shower and put cold packing."
- Others seemed taken by surprise and unhappy because they were not adequately prepared for what to expect or what to do:
 - "My husband told me: "What are you doing with the kids?" I bring her home and she has a temperature and is crying. She receives three vaccines at once and she can't move her arms. Neither arm for two days. It's difficult for him to watch it. And he says: "We won't have you vaccinated anymore, my child. Her arm always turns blue at the site of injection."
- Who can give me an elevator phrase that they use to explain side effects while they are vaccinating a child?
 - ▶ *Let them respond.*
- Any other ideas?
 - ▶ *Let them respond.*
- If there was a phrase you just heard that you think would work well for you, please write it down in your *Participant manual*.

Exercise 23: Talking about side effects with Mrs. Dudić

- In a minute, you will work with your partner to analyse a role play.
- You will review a dialogue between Dr. Minira and a hesitator, Mrs. Dudić, with one of you playing Dr. Minira and one of you playing Mrs. Dudić.
- At the end of the role play, you will answer the questions that you will find with the role play script in your *Participant manual* in Session 5.7.
- All right, you have 15 minutes to review the role play and answer the questions. Let's get started.
 - ▶ *Give them 15 minutes to work and then call them back to discuss.*
- How does this discussion map onto the algorithm? Which box were they in at each point in the discussion?
- Dr. Marina used a lot of different communication techniques. Please find at least one example of when she used the following techniques:
 - Pausing to give Mrs. Dudić a chance to ask questions or think;
 - Reflecting back;
 - Confirming/reassuring that Mrs. Dudić has done the right thing, made the right choice;
 - Assigning likelihoods- qualitative estimate of risk (probably, likely, possibly, not very likely, very uncommon, extremely rare);

42 Public Health Institute of Republic of Srpska, (2011) Knowledge, attitude and practice survey on routine immunisation, new vaccines and public confidence in the health care system. and interventions in Bosnia and Herzegovina

- Positive framing of quantitative estimate of risk (% or frequency);
 - Using the concept of protection;
 - Summarizing;
 - Giving control to Mrs. Dudić;
 - Emphasizing the social norm that most people vaccinate;
 - Personal belief/recommendation;
 - Personalization with child's name.
- How is this similar or different to how you normally discuss side effects with your caregivers?

Talking about side effects with Mrs. Dudić ⁴³

Dr. Marina:	Good morning, Mrs. Dudić. Nice to see you and Minira again. Please have a seat. I understand Minira is ready for her next set of vaccinations today.
Mrs. Dudić:	Yes, that's right. But one thing, Minira had a slight cold last week, she seems to be over it now, but I just wondered if it was safe.
Dr. Marina:	So, she was sick recently, but she's back to her normal self now? (Reflecting)
Mrs. Dudić:	Yes, she is fine now.
Dr. Marina:	Then it is perfectly safe for Minira to have them today. (Confirming) It would have been fine for her to get the vaccinations even with her cold, but this way she is starting out cheerful and happy. (Pausing to allow mother to interject if she has questions, observing body language)
Mrs. Dudić:	So, you are sure it's okay for her to get her vaccinations even though she just got over a cold?

43 Adapted from Leask et al. Communicating with parents about vaccination: a framework for health professionals (2012). BMC Pediatrics 2012, 12:154 Available at <http://www.biomedcentral.com/1471-2431/12/154>

Dr. Marina:	<p>Yes, it's fine, and I am very glad you brought her in. (Confirming)</p> <p>I have done a lot of research into vaccination after illness and I strongly believe you are doing the right thing to vaccinate Minira now. (Confirming, personal belief/recommendation)</p> <p>We will be vaccinating her against measles, mumps and rubella, and Hib – all serious diseases. It's so important for her to be protected as soon as possible. (Protection) Any other questions before we get started on the vaccinations?</p>
Mrs. Dudić:	No, I think it's okay.
Dr. Marina:	<p>There will be two injections. I will give her one in one arm and one in the other arm. If you hold Minira sitting on your lap and let her play with her toy before and during the shots, she will cry less. (Helping mother understand what's going to happen so she feels in control, and planning to minimize pain)</p> <p>The injections may upset her for a few moments, but most children settle straight away after some comforting, and nine out of ten don't have any other side effects at all (Positive framing of risk using frequency).</p> <p>Most children have no reaction to the shot (positive framing using qualitative risk estimate) but if they do, the commonest thing is a slightly sore arm that will last for a few days and then settles. (reassuring)</p> <p>(Pause to allow questions or clarification).</p>
Mrs. Dudić:	OK. Anything else?
Dr. Marina:	<p>Minira may have some mild symptoms, such as a slight rash and a fever, and she may feel a bit unwell 7 to 11 days after the vaccine. (Qualitative assessment of risk)</p> <p>(Pause)</p>
Mrs. Dudić:	Ok, so it's not just right after the shots I have to worry about, it's later too?

Dr. Marina:	<p>Yes, that's right, she may be a little under the weather in a week, but it should pass easily. Fever is a normal reaction and shows the body is fighting the weakened germs that were given in the vaccine. (Reassuring)</p> <p>The body fights these weakened germs, and she might have a little fever, a little sore arm. But then Minira's body is well prepared to fight even the real, strong dangerous germs that might come along. (Protection)</p> <p>It is so important to protect her now, since we have all these measles outbreaks. (Protection)</p> <p>There is a slight chance that about 3 weeks after the vaccine, she may get a mild form of mumps, with swelling under her jaw. But this is very uncommon and happens in only about 1% of children (positively framed qualitative and quantitative risk estimates). These symptoms usually go away after 1 to 2 days.</p> <p>So probably a little rash and fever in a week or so, and then a very slight chance of swelling under her jaw, that would happen in about 3 weeks. (Summarizing and assigning likelihoods)</p> <p>All in all, the side effects of the vaccine are usually mild, and they are a lot milder than the risks of having measles, mumps or rubella diseases. Almost all caregivers choose to vaccinate (social norm) because it is the best way to protect from the disease. (Protection)</p> <p>They find that the slight side effects are a bit of a nuisance, but nothing to worry about.</p> <p>If you have any questions or worries, you are welcome to bring her back to the clinic and we can check her over. How does that sound? (Structured information using chunks and checks and unbiased expectation of consent)</p>
Mrs. Dudić:	It seems like a lot to think about.
Dr. Marina:	<p>Yes, it's a lot of information, but we want you to have all the facts. I can review this again with you after we do the shots. Would you like to hold Minira on your lap while I get the shots ready? You can help me hold her arm, so she doesn't move, and distract her with her doll during the shots. (Giving more control to Mrs. Dudić, minimizing pain)</p> <p>That, plus lots of cuddling afterwards, will help the whole process be less painful. (Explaining what to expect, moving the process along as a normal thing.)</p>

Mrs. Dudić:	Fine, yeah, that's OK. I will try to play with her and keep her happy while you got the shots ready.
Dr. Marina:	You are making the right decision. (Confirmation) Let's get Minira taken care of. (Protection)

Plenary

- How did it go?
 - ▶ *Let them respond.*
- Let's review the questions.
- First: how does this discussion map on the algorithm? Which box were they in at each point in the discussion?
 - ▶ *Let them respond then summarize.*
 - **Answer:** Yes, Dr. Marina started in Box One, with her welcome, and went to Box Two, with her assumption that Minira was getting her vaccines.
 - She heard Mrs. Dudić's concern about Minira being sick (the grey box under Box Two), so she went down to Box Three and gave her strong recommendation: *"I strongly believe you are doing the right thing to vaccinate her now."*
 - She checked to see which direction Mrs. Dudić was going by asking a presumptive, leading question: *"Any other questions before we get started on the vaccinations?"*
 - When she got the confirmation that Mrs. Dudić was accepting the strong recommendation and moving to the right, Dr. Marina then started working in the Vaccination Box.
- Did she finish the actions in the Vaccination Box?
 - ▶ *Let them respond.*
- No, she got started with reviewing side effects, and pain management, but she hadn't finished giving the doses or reviewing next steps.
- Did she do the final Box 6, Parting affirmation?
 - ▶ *Let them respond.*
- No, she hadn't gotten that far. We will review that in a later session.
- Dr. Marina used a lot of different communication techniques. Who can give us at least one example of when she used the following techniques:
 - Pausing to give Mrs. Dudić a chance to ask questions or think.
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
 - Reflecting back.
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
 - Confirming/reassuring that Mrs. Dudić has done the right thing, made the right choice.

- ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- Assigning likelihoods - qualitative estimate of risk (probably, likely, possibly, not very likely, very uncommon, extremely rare).
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- Positive framing of quantitative estimate of risk (% or frequency).
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- Using the concept of protection.
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- Summarizing.
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- Giving control to Mrs. Dudić.
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- Emphasizing the social norm that most people vaccinate.
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- Personal belief/recommendation.
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- Personalization with child's name.
 - ▶ *Let someone give an example and confirm by using the bolded answers in the script above.*
- How is this similar or different to how you normally discuss side effects with your caregivers?
 - ▶ *Let them respond.*
- Great, thank you. In just a moment you are going to work with your partner to adapt this role play to be more realistic to your work setting by making our own versions.
- Let me explain.

Exercise 24: Reworking the role play

- When you pair up, you will each take turns playing Dr. Marina and Mrs. Dudić.
- Both characters can add or cut out things, use different phrases, but if you are playing Dr. Marina, be sure you use at least one of each of the techniques that Dr. Marina used, as listed above.
- You don't have to use as many examples of each one but try to use each technique at least once.
- You have five minutes to replay the role play, using your own style and any phrases you would like to add or change. Be prepared to demonstrate your role play to the whole group
- Any questions?
 - ▶ *Clarify as needed.*
- Let's begin!
 - ▶ *Time them for five minutes and bring them back together.*

Plenary

- ▶ *Bring the group back together.*
- How did that go?
 - ▶ *Let them respond.*
- What were the main things you changed in the role play?
 - ▶ *Let them respond.*
- Who would like to come up and replay their version of Dr. Minira and Mrs. Dudić.
 - ▶ *Get at least one group to come do their version.*
- Thanks. Are there any other groups that would like to demonstrate their version?
 - ▶ *Let them come present.*
- Thank you. Are there any phrases that you just heard, or read in the original dialogue, that you found useful and that you could use?
 - ▶ *Let them respond.*
- One useful phrase to use might be:
 - “I can’t give you a 100% guarantee that your child won’t have any side effects at all from the shot. Nothing in life is 100% safe. But I can 100% guarantee that I am giving you the best advice. Vaccination is the best protection, and it is what I choose for my own family.”
- Please take a minute to write down in your *Participant manual* a couple of phrases that you just heard that you think would be useful in your practice.
 - ▶ *Give them two minutes.*
- Thanks. In our next session, we will talk about caregivers who are not willing to vaccinate their children.

Takeaway

- Always discuss honestly the known side effects caused by vaccines so that caregivers know what to expect and to do, and they don’t worry. You can frame it in terms of “*what to expect after the shots*” or “*normal reactions might include...*”
- But, don’t forget to remind caregivers of the overwhelming benefit of preventing potentially serious diseases with vaccines. You can say: “*I am much more worried about leaving your child unprotected than I am about the potential for minor side effects like crying, slight fever or swelling, etc.*”
- Use your judgment about what a caregiver needs - more detail, less detail, but do present the facts so they aren’t surprised or frustrated by their child’s sore arm and then decide not to come back, as the mother quoted above said. This is key.

Session 5.8. Talking with refusers

Time: 30 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Flip chart with algorithm.
- ✓ Flip chart with pie chart.

Plenary

- ▶ *Show slide: Session 5.8: Talking with refusers.*
- ▶ *Show slide: Algorithm.*
- We have just reviewed the algorithm from Box 1 through Box 4, and then over to the vaccination box. What boxes have we not done yet?
 - ▶ *Let them answer.*
- Yes, we have not yet done Box 5: Refuser counselling, or Box 6: Parting affirmation. How many of you here have dealt with caregivers who come to the clinic but who refuse to vaccinate their children, or who won't bring their children to the clinic at all?
 - ▶ *Let them answer.*
- As we have discussed, refusers only represent a very small percentage of the population, possibly around 1% according to our pie chart?
 - ▶ *Point to flip chart.*
- It is very unlikely that a refuser will change their mind based on our interactions with them. We must try to keep the door open, but we shouldn't spend too much time trying to convince them to vaccinate.
- A number of studies have shown that although communication can be very effective in bringing yellow and orange hesitators up into the green, and keeping acceptors in the green, it has little or no effect on changing refusers' minds.
- You still want to be sure you have given an effort, to make sure you can't help this person move into vaccination.
- We are going to practice with this now. I will explain what we are going to do and then you will pair up to complete the task with a partner.

Exercise 25: Example of dialogue with the vaccine-refusing caregiver

- We are going to do a role play exercise between Dr. Luminitsa and Mr. Maric. The caregiver, Mr. Maric, has come in because Radko has a cough. There is a discussion about Radko's upper respiratory tract infection.
- First, decide which character you will play. Then read the dialogue out loud together, and answer three questions.
- You will find the script and the questions in your *Participant manual* in Session 5.8.
 1. Would you classify Mr. Maric as a refuser?
 2. What were some of the phrases that Dr. Luminitsa used that you thought were useful?
 3. If Mr. Maric came back to your clinic two weeks later, what would you say to him?
- You have 10 minutes to do the dialogue and answer the questions. Let's get started!
 - *Let them work for 10 minutes and bring them back together for discussion.*

Dr. Luminitsa:	Do you mind if we take a moment to talk about Radko's vaccinations?
Mr. Maric:	Ah, yes, we did some research into it and decided not to vaccinate him.
Dr. Luminitsa:	OK, can I just talk it through, so I understand your decision? (Asking permission to discuss and use of a guiding style)
Mr. Maric:	Yeah, OK.
Dr. Luminitsa:	To start with can I just ask you how important you think it is to get Radko protected from the diseases vaccines are designed to prevent? (Assessing importance- perceived threat, perceived benefits and barriers)
Mr. Maric:	Well, mostly the diseases aren't that much of a problem in healthy children and we keep Radko very healthy with a good diet, organic food, and plenty of fresh air.

Dr. Luminitsa:	<p>You're right. Most children will overcome illnesses without too much of a problem (acknowledging).</p> <p>Unfortunately, there are still children that get pretty sick with these diseases, and sadly a significant number of children end up in hospital with complications from the disease.</p> <p>With measles, for example, 9 in every 100 children get pneumonia and some need to go to hospital (<i>pause</i>).</p>
Mr. Maric:	I didn't know that.
Dr. Luminitsa:	Yes, it can still be a serious problem. Could I ask now how you feel about vaccines? (Assessing confidence - has perception of threat increased?)
Mr. Maric:	I'm not all confident in them being safe.
Dr. Luminitsa:	What have you heard? (Exploring)
Mr. Maric:	Well on one internet site it said that children can get brain damage and all kinds of problems after vaccination. And the drug companies try to cover it up.
Dr. Luminitsa:	That sounds frightening (empathic response). Which vaccines are you most concerned about? (Eliciting specific concerns)
Mr. Maric:	The MMR one because it can cause autism.
Dr. Luminitsa:	<p>I understand you are concerned about vaccinations (building rapport by accepting rather than rebutting concerns) but I'd just like to give you my view if that's OK? (Mr. Maric nods.)</p> <p>New research is always being done, all over the world, to check on safety and side effects, and the results consistently show that the vaccines that we use are very safe, and serious side effects are extremely rare.</p> <p>Would you like to look at the MMR vaccine decision aid, which can help you weigh up the risks of the vaccine and the diseases? (Respecting autonomy, offering information)</p>

Mr. Maric:	Well, I guess I could have a look but I'm still pretty cautious about Radko getting these shots.
Dr. Luminitsa:	Well, take a look at the decision aid and then if you like, come back to the clinic for another talk. (Looking to trigger) We have a clinic each Tuesday and I'll be here most weeks. Would you like to come back in two weeks? (Leaving door open to further discussion, providing a cue to action)
Mr. Maric:	OK thanks.

Plenary

- How was that exercise?
 - ▶ *Let them respond.*
- What did you all find for the first question: Would you classify Mr. Maric as a refuser?
 - ▶ *Let them respond.*
- He may not be. He seemed as if he were open to discussion, he wasn't hostile, and he seemed to respond to some of the discussion. He may just be a very deep orange that with some support, might move into willingness to at least partially vaccinate.
- What were some of the phrases that Dr. Luminitsa used that you thought were useful?
 - ▶ *Let them respond.*
- If Mr. Maric came back to your clinic two weeks later, what would you say to him?
 - ▶ *Let them respond.*
- There are no easy answers. Here are some phrases that have been suggested to use as a last attempt to move caregivers into the vaccination box:
 - *"I want to provide you the best care I can for your child, and I strongly believe that vaccination is a best practice. I would never recommend something that I think would hurt them. Here is my phone number. If you want to think about it and call me back tomorrow, I would be happy to make time to get the vaccinations done whenever you can come in."*
 - *I'm worried. I hear what you are saying, and I understand that you are concerned. But, I am worried about your child's health if you make this decision not to vaccinate. Your child will not be protected, and every child needs, and has the right, to be protected."*
 - *"What is it that you know that I don't know? I am a trained and experienced health care worker, up to date on all the latest science, with years of experience. And I truly believe, based on everything I know, that vaccination is the right choice."*

- *“By making the decision not to vaccinate your child, you are limiting their future possibilities for education and travel. They may not appreciate the choice you made. And you yourself, you were vaccinated, right? I have seen a few teenagers who suddenly have the opportunity to travel abroad with their high school sports team, but they can’t go because they don’t have the proper vaccination, and they don’t have time to do the series of shots. And when that happens, that is not a happy teenager.”*
- Commit to continuing the dialogue about vaccines and reiterate to them you are available to take care of their child whenever they need health care.
- Caregivers who refuse vaccines should be reminded at every visit that if the child is ill, they need to inform the health centre or wherever else they are going to (office, clinic, or emergency department, for example), so that appropriate measures can be taken to protect others.
- When scheduling a visit for an ill child who has not received vaccines, take all possible precautions to prevent contact with other patients, especially those too young to be fully vaccinated and those who have weakened immune systems.
- If a caregiver refuses to vaccinate, you can share a fact sheet similar to the one found in **Annex D**.
- The fact sheet should explain the risks involved with this decision, including risks to other members of their community, and the additional responsibilities for caregivers, such as notification of health care personnel about their child’s vaccination status during illness.
- You also can tell the caregiver that you would like to continue the dialogue about vaccines during the next visit, and then make sure to do so.
- While we are on the topic of refusals, let’s take a few moments to talk about refusal and consent forms.
- The way in which these forms are explained and when they are introduced can have a big impact on caregiver’s decisions, especially if they are hesitant.
- We want to approach these conversations thoughtfully, so we can use them to our advantage. If possible, reference the actual policies or regulations on the forms, so you are clear about on the specific instances they are required and why.
- If you as a clinician are obligated to have refusing caregivers sign a vaccine refusal form, be sure to explain to the caregiver the purpose of this form: e.g. that this is required to go into the record to explain why you the health worker didn’t do your job to vaccinate this child. The form in no way means that you will not provide health care to their child.
- If your clinic is still obliging caregivers to sign consent forms that state that the caregiver accepts the risk of vaccination, you need to be clear about the reason for the consent form, and what it means. The manner in which we introduce and talk about these forms is critical.
- Let’s take a few minutes to learn from each other’s experiences on these forms.

Exercise 26: Consent and refusal forms

- ▶ *Skip this exercise if it is not relevant or modify it to reflect the updated policy guidance for your country.*
- We are going to divide into 3 groups:
 1. Those that use refusal forms;
 2. Those that currently use consent forms;
 3. Those that previously used consent forms, but no longer do (or ever have).
- You may fall into more than one category. Choose the group that is most critical to you. We can have multiple groups of one category if we need.
- In your groups, you will take 10 minutes to discuss and answer 2 questions for your category. You will find the questions in your *Participant manual* in Session 5.8.
- Be prepared to share back with the larger group. Make note of any useful phrases you hear during the report out of the groups.
 - ▶ *Let people get into groups. It may make sense to have small groups all dedicated to Refusal forms or consent forms. Tailor to the group's needs.*
 - ▶ *Time them for 10 minutes and then ask them to report out.*
 - ▶ *Bring the group back to plenary.*
- Questions for refusal forms group:
 1. What can you say during the process of having caregivers sign the refusal forms to help diminish the impression that you are refusing liability or refusing to take care of the child if it has a problem?
 2. How can you use the refusal form process to educate the caregivers about their responsibilities to protect others e.g. if the child is sick, they should notify the clinic that they are bringing in an unvaccinated child that is ill?
- Questions for using consent forms group:
- If your clinics still use the forms, you have the following two tasks.
 1. Take 5 minutes and discuss briefly:
 - a. The purpose of the consent forms.
 - b. When do you introduce the concept and what do you say to the caregivers?
 - c. What do parents think about these forms and why do they think that?
 - d. How do you respond to caregiver's beliefs?
 2. Based on the experiences of those in the group, can you identify a better way to explain the forms to the caregivers to reduce the rumours about them?
- Questions for no longer using consent forms group:
- If your health facilities have stopped using consent forms, you have the following two tasks:
 1. Discuss what you say to caregivers about why you used to have them and now you don't.
 2. Based on the experiences of those in the group, can you identify a better way to explain to caregivers why you stopped using the forms to reduce the rumours about them?

Plenary

- Let's hear from the first group. What did you decide?
 - ▶ *Allow each group a few minutes to report out.*
- Thank you for these ideas. Please take a moment and make note of any phrases or examples that could be helpful for your work in your *Participant manual*.

Takeaway

- Although you might have a slight chance of succeeding in negotiating with refusers until they decide to vaccinate, it is highly unlikely. It is worth spending time in Box 4 to make sure you aren't in fact dealing with an Orange, a very hesitant caregiver, as Mr. Maric may be.
- Once you have used all your techniques, and the caregiver is still adamant and even vocal about refusing vaccines, then you can focus on ensuring that their child doesn't endanger others. You also can tell the refusing caregiver that you would like to continue the dialogue about vaccines during the next visit, and then make sure to do so.
- We must use the process of filling in consent and refusal forms to strengthen the connection with our caregivers. When and how we introduce the forms can impact caregiver decisions. Preparing elevator phrases in advance can improve these interactions.

Session 5.9. Final affirmation. The “door handle” phrase

Time: 10 minutes

Materials:

- ✓ Participant manual.
- ✓ Flip chart with algorithm.
- ✓ Flip chart with Expanded steps model.

Plenary

- ▶ *Show slide: Session 5.9: Final affirmation. The “door handle” phrase.*
- What do you think a door handle question is?
 - ▶ *If no one answers, call on someone saying, any ideas?*
- I call them door handle questions because there seems to be a magical property in door handles. At the end of a patient consultation, as soon as the patient or the health provider touches the door handle, another question comes out.
- Often if a patient has wanted to ask something but they are feeling shy, they will wait until the very last minute because then they realize it's their last chance. Have any of you here experienced this?
 - ▶ *If no one answers, call on someone saying, have you experienced this?*
- Of course, probably a lot of our patients don't ask the door handle question until we are on the other side of the door. How do you deal with this?
 - ▶ *If no one answers, call on someone saying, any ideas?*
- Here are a few questions you might ask before your or their hand hits the door handle:
 - *“Is there anything else you wanted to ask me?”*
 - *“Is there anything else I can do for you?”*
 - *“Is there anything else you need to know before you make a decision?”*
- The caregiver may or may not have any last questions or requests, but they will feel extremely grateful that you asked.
- If the caregiver doesn't have any last questions, this is the time for you to ask a final question: *“So let's review: what are your/our next steps? (e.g. What will you do to make sure your baby's fever stays down, when will you come back?)”*
- Asking the caregiver to repeat back what they have understood, or what they think they are supposed to do when they get home, is a powerful way to see how successfully you have communicated with them.
- If they can't correctly re-state what you have asked them to do, you need to try explaining it again, or in another way.
- You want to give a satisfaction sandwich to your caregivers. Think of the door as the bread, and everything that goes on the consultation room as the meat.

- When your caregiver comes through the door, that's when we open their ears and ours with the warmth and empathy. When they are going out the door, you want them to be feeling confident, appreciated and affirmed about having made the right choice.
- A satisfied caregiver is a repeat caregiver- and we want them to keep coming in till their child is fully protected.
- Once a caregiver has done one set of vaccines, they have done their *Trial*. Keeping the caregiver satisfied and supported is part of the *Fine-tuning* we talked about previously.
 - ▶ *Point to these steps on the flip chart of the expanded steps (Trans-theoretical model).*
- Remember the concept of "*Cues to action*"? This is very important in getting caregivers to come back, and we want to come back, to get them in *Maintenance*, and possibly move them into *Advocacy*.
 - ▶ *Point to these steps on the expanded Trans-theoretical model.*
- Asking caregivers to repeat back instructions, including what to expect and when they should return, is a way to check that they know what to do, and it also anchors it better in their memory.
- Does your clinic provide written appointment slips for follow-up visits? Do you have another way of reminding caregivers when to return for the next set of vaccinations?
 - ▶ *Let them answer, probe for more ways.*
- Reminders and follow-ups have been shown to be quite powerful in increasing uptake and decreasing late vaccination.
- If you helped a caregiver overcome a lot of doubt and fear in order to vaccinate, contact them a few days later with a quick phone call, email, or other follow-up. This could have a big effect on the likelihood that they will return.
- If you have the ability to phone hesitators a week before their next visit to remind them, this can have a measurable impact on uptake.

Takeaway

- Our final interaction with caregivers should focus on reviewing next steps, and leaving them feeling good about the interaction, and their choice to vaccinate.

If you are leading a TOT

- ▶ *Facilitate the practice teaching session for the module.*
- ▶ *Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 6.*

Module 6.

Communication
in depth

Module 6. Communication in depth

Module 6 Objectives:

By the end of the module the participants will be able to:

1. Establish goals for caregiver interaction.
2. Address caregiver needs using structured approach and tailored content.
3. Discuss Adverse Events Following Immunization (AEFIs) with confidence, distinguishing between vaccine constituent-related events, error-related events, and anxiety-related or coincidental events.
4. Discuss vaccine origin and contraindications with confidence, successfully distinguishing between medically-indicated contraindications and mistaken beliefs about contraindications.
5. Use empathy and communication support materials for greater time-efficiency.
6. Demonstrate skills in applying listening techniques, responding techniques, and response content.

Time: 3 hours and 10 minutes

Checklist

- ✓ Flip chart with expanded action steps.
- ✓ Prepare enough copies of printed materials:
 - **HANDOUT 6: GOALS FOR CAREGIVERS**
 - **HANDOUT 7: CHARACTER INFORMATION CASE ROLE PLAY**
 - **HANDOUT 8: CAREGIVER SCENARIO 1 TO THE CAREGIVERS**
 - **HANDOUT 9: OBSERVATION CHECKLIST TO THE OBSERVERS**
 - **HANDOUT 10: CAREGIVER SCENARIO 2 TO CAREGIVERS**
 - **HANDOUT 11: CAREGIVER SCENARIO 3 TO CAREGIVERS**
- ✓ Questions from question box that you have taken time to review and consider how to discuss with the group.

If you are leading a TOT

- ▶ *Complete Module 6 according to the Facilitator guide and then facilitate the practice teaching session for the module.*
- ▶ *Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 7.*

Session 6.1. Establishing goals for acceptors and hesitators

Time: 20 minutes

Materials:

- ✓ *Participant manual.*
- ✓ VIPP cards or cut-up of **HANDOUT 6: GOALS FOR CAREGIVERS**, cut into strips in advance.
- ✓ Flip chart with categories of caregivers listed in a column on the left prepared in advance.

Plenary

- ▶ *Show slide: Session 6.1: Establishing goals for acceptors and hesitators.*
- We have spent a LOT of time working on understanding our caregivers' needs and beliefs. We have also looked at our own beliefs and needs.
- With the effort invested in listening and understanding our caregivers, we develop trust and connection, which is as we have seen, one of the missing elements in overcoming hesitancy.
- In the last module, we reviewed the algorithm together. The algorithm helps us understand where our caregivers are, and what their needs are, and how to proceed.
- As we are going through the algorithm, and we understand our caregiver's situation, we need to figure out our goal for the interaction. Our goals may vary depending on where the caregiver is on the continuum, and as a result, what boxes we end up in on the algorithm.
- We may have the overall goal of getting all caregivers to fully vaccinate their children on time, but for those who are lower on the continuum, and thus down in the lower boxes of the algorithm, we may only be able to increase the number who are at least partially protected or are still open to discussing it. We thus may have different goals for certain categories of caregivers.
 - ▶ *Point to the flip chart of the continuum. Flip chart with a table of caregiver categories listed (see below).*
- Let's assign some goals to the different categories of parents on the continuum.

Exercise 27: Establishing goals for caregivers

- I have some goal statements. I am going to walk around and hand them out randomly.
 - ▶ *Distribute the cut-up slips of paper from **HANDOUT 6: GOALS FOR CAREGIVERS** until you have passed them all out. Give them to people who have been less engaged.*
- Ok. Let's begin. You will read out loud the goal statement on your paper, and which category you think it belongs to. We will discuss as a group, and then you will come and paste it in the correct category on the flip chart.

- Remember, some goals may belong to more than one category.
- Who would like to start?
 - ▶ *If no one volunteers call on someone.*
 - ▶ *Continue round-robin, guiding the group using the table below until you have gone through all of the goal statements.*
- Great, thank you! Take a moment and complete in your *Participant manual* to chart the goals for each caregiver position.
 - ▶ *Show slide: Caregiver position, with goals.*
 - ▶ *Give everyone two minutes and then move to the rest of the discussion.*

Table 14. Caregiver position, with goals⁴⁴

Caregiver position	Goal
Unquestioning acceptor	<p>Keep the caregiver coming in on time till the child is fully immunized.</p> <p>Help them become advocates for vaccination, reinforcing vaccination as a social norm and speaking positively of health workers' competence and caring.</p>
Cautious acceptor	<p>Keep the caregiver coming in on time till the child is fully immunized.</p> <p>Caregiver feels positive, feels less worried about their decision, and feels they made the right choice.</p>
The hesitant	<p>Keep the caregiver coming in on time till the child is fully immunized.</p> <p>Caregiver accepts decision to vaccinate, is less hesitant, and feels rapport and trust with health worker.</p>
<p>Late or selective vaccinator</p> <p>May need the most time, but are likely to change behaviour</p>	<p>Caregiver willing to move a step further towards full and timely immunization, or willing to come in again to discuss it after reading/discussing further at home.</p> <p>Trust is established between caregiver and health worker.</p>

⁴⁴ Adapted from Leask et al. Communicating with parents about vaccination: a framework for health professionals (2012). BMC Pediatrics 2012, 12:154 Available at <http://www.biomedcentral.com/1471-2431/12/154>

Caregiver position	Goal
Refuser Unlikely to change behaviour	<p>Caregiver prepared to think about vaccination and consider attending specialist clinic or make a special appointment for further discussion.</p> <p>Feels their concerns are heard and is not critical of providers.</p> <p>Trust is beginning to be established.</p> <p>Caregiver is aware of the risks of not immunizing the child and the risks an unimmunized child can pose others e.g. at clinic and knows what to do if the child gets sick.</p>

Plenary

- Although different caregivers may have different goals, it is important to work with all caregivers to agree on at least one action, such as:
 - Scheduling another appointment for further discussion;
 - Encouraging the caregiver to read additional information you provide them;
 - Discussing with a reluctant family member;
 - For the satisfied users, see if you can get them to the very top of the stairs, to advocate with others for vaccination.
- Remember, just because someone accepted on the first try (green light) doesn't mean they don't need praise, confirmation, and a sense of commitment to enable them to fulfil the immunization schedule.
- As we said in the session on parting affirmation, just a thirty-second conversation as you are taking your leave can make a difference in caregivers' motivation to complete the vaccination calendar. For example:
 - *"I want to congratulate you for doing such a good job of taking care of your child. I look forward to seeing you in a month."*
 - *"I am so proud of the many caregivers like you who make the effort to keep their children protected and to protect others. Is there anything else I can do for you?"*
 - *"I know you have a lot of questions still. I am always available to talk as you are making your decision. We both want what's best for your baby, so come back anytime to discuss."*

Takeaway

- Success comes in many forms. It may mean that caregivers accept all vaccines when you recommend them, or that they schedule some vaccines for another day. For very vaccine-hesitant caregivers or refusers, success may simply mean agreeing to leave the door open for future conversations.

Session 6.2. CASE approach

Time: 30 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Photocopies of **HANDOUT 7: CHARACTER INFORMATION CASE ROLE PLAY.**

Plenary

- ▶ *Show slide: Session 6.2: CASE approach.*
- Every caregiver has the right and expectation to receive positive and friendly communication and engagement from the service providers.
- This can help them feel relaxed and open to communicate their fears and concerns, which gives the chance to the health provider understand what the issues are and correctly address them.
- We have been talking about how important it is:
 - To use **techniques of empathy** to create trust and connection;
 - To use active **techniques for listening** to understand where the caregiver is on the hesitancy continuum and what their hesitations and needs are;
 - To aim for **different goals** depending on the category of caregiver;
 - To use various **techniques for responding** such as positive framing, social norming, reassuring/confirming, pausing, summarizing;
 - To use carefully crafted, simple, clear **content for responses**, or elevator phrases, to address concerns about specific content.
- We have learned **techniques** for creating trust, for listening, and for responding, and specific **content** for responding.
- Many of the **response techniques**, like positive framing, reassuring/confirming, and social norming, etc. help create emotional support to our caregivers as they are dealing with their concerns about immunization and coming to a decision.
- Your **response content** comes from your reading of the caregiver's needs. If your caregiver seems worried whether a young baby can handle several vaccines at once, that's your subject matter. If the caregiver is worried about side effects, that's your subject.
- Who can remember the top concerns of caregivers?
 - ▶ *Take a few responses then confirm.*
- The top worries among hesitators are: the quality and safety of vaccines, side effects, and multiple vaccines at once.
- The way we structure our responses to address concerns – both techniques and content – can improve impact the effectiveness of our communication.
- First, organize your discussion by **prioritizing** the information to be covered.

- You can let your caregivers identify what they want more information on. Usually, you have a limited amount of time, and caregivers will only be able to absorb a limited amount of information, so let them choose what their priorities are, and in what order.
 - You can say something like: *“It sounds as if you have a few concerns. I am hearing XYZ. Which of these would you like to discuss first?”*
- Use structured communication, what we call **signposting**, so they can follow along as you give information.
- Review how you got to this point in the discussion and explain where you are going. Say something like *“We have already discussed XYZ, now we will discuss ABC. At the end of ABC, we can review, and see what we think. So, now let’s start with A.”*
- Start with simple issues before going to complex ones and **start with things you agree on**. Start by identifying ways that you are both on the same page. Then you can start addressing the challenges or the issues where you may differ.
- You can say something like: *“We both agree we want baby Elvis to stay healthy and grow strong. We both agree it’s hard to find time to come for immunizations. I hear you saying that your husband doesn’t prioritize you taking time away from work to take Elvis to the clinic. Is that correct? So what kind of solution do you think you could find to this? Is there another family member you could enlist to help you find a solution?”*
- Second, use simple language! Use plain language and simple explanations without too much medical terminology or medical jargon.
- Don’t assume that everyone understands “basic” things about immunization, vaccines and disease. You may need to review some basics, using simple language, before getting into more complex concepts.
- Try using analogies to make things easier to understand. Many good elevator phrases use analogies to make vaccination concepts, or concepts of risk, more understandable.
- Third, try using the CASE approach.
 - ▶ *Show slide: CASE Approach.*

Table 15. CASE approach

1	Corroborate	Acknowledge the caregiver’s concern and find some point on which you can agree. This sets the right tone and keeps the exchange from becoming a defensive debate.
2	About Me	Describe what you have done to build your knowledge base and expertise.

3	Science	Describe what the science says.
4	Explain/Advise	Give advice to caregiver, based on the science.

- These are the kinds of things you are probably already saying to your caregivers. CASE simply provides a 4-step structure to help you organize your discussion to help you move caregivers from preparation to triggering action with your combination response.
- Who can read out the first line of the slide: **‘C’ for Corroborate?**
 - ▶ *Let someone read it out, or if more appropriate for your audience review each step.*
- This is where you are opening their ears, getting them to feel comfortable. Hopefully because they came in, and with what you have already discussed and done with them, they are on the “Preparation” step.
 - ▶ *Point to expanded steps flip chart.*
- With “C,” we are creating a connection with the caregiver.
 - ▶ *Motion a back and forth connection with your hands between you and an imaginary caregiver.*
- Who can read out line 2 on the slide: **‘A’ for About Me?**
 - ▶ *Let someone read it out or if more appropriate for your group you can read these out.*
- This allows you to be seen as a credible person, whose recommendation (coming later) might be enough to trigger action.
 - ▶ *Motion to your shoulders, as if you are showing yourself off proudly.*
- Who can read out line 3 on the slide: **‘S’ for Science?**
 - ▶ *Let someone read it out.*
- This brings in additional reinforcements. It’s not just me, or the government, it’s science speaking.
 - ▶ *Motion with one hand pointing up at the source of external wisdom - science.*
 - ▶ *For the following sentence, use all three hand motions - back and forth connection, shoulder touch, pointing to science - at the appropriate time.*
- We agreed with “C” that we and the caregiver are connected. We are on the same page, we agree on something, our wish to do what’s best for the child, for example.
- We showed with “A” that we are a credible, trusted speaker with extensive experience and expertise. By bringing in “S” for Science, we are adding another, external validation of what we are saying.
- Who can read out line 4 on the slide: **‘E’ for Encourage/Advise?**
 - ▶ *Let someone read it out.*
- This is where you bring it together and you make your push, trying to trigger the decision to act. Your advice needs to come from the heart, with a personal conviction and a call to action.
 - ▶ *Use both hands to give a “thumbs-up” while pushing your hands forward- like you are pushing the person to action.*
- Who has an idea of why we are calling this approach CASE? Why do we use the initials to spell out CASE?
 - ▶ *Let them respond.*

- Just as I am sure you did during your medical training, we use acronyms to remind ourselves of the steps of a task. You remember the steps by saying, “C-A-S-E, I’ve done C and A; what did S stand for again? Oh, that’s right, I need to quote science.”
- Why have I been doing this little dance with the hand gestures?
 - ▶ *Show with your hands: back and forth connection, shoulder touch, point to science, thumbs-up push.*
 - ▶ *Let them respond.*
- An acronym can remind you of the names of the steps; a visual representation can help you remember the **emotions** you are trying to trigger with the steps.
- And we remember that often, it’s not rational thought that changes behaviour or leads to decisions and action, it is emotions.
- Who remembers Nurse Dora, Mrs. Jovanic and Lamija?
- When Nurse Dora was helping Mrs. Jovanic overcome her concerns about the pentavalent vaccine, and side effects, she used many techniques to build trust and help Mrs. Jovanic feel heard.
- She also used many techniques and elevator phrases to respond. At the end of their discussion about whether or not Mrs. Jovanic was ready to vaccinate baby Lamija, Nurse Dora said the following:
 - ▶ *Show slide: Nurse Dora’s case, don’t read it out.*
- Nurse Dora: Is there anything else you would like to discuss? I know you want to make sure Lamija is protected from harm, and I do too. **(Pause)**. Thousands of mothers with babies the same age as Lamija have come into our clinic for injections of these five-ingredient vaccines, and I have never seen a problem. These new technologies mean that Lamija doesn’t have to get as many shots, and she still gets the protection she needs. If I were you, I would go ahead and get her shots done today.
- Who can remind us of the four steps of CASE?
 - ▶ *Let them respond: Corroborate, About me, Science, Encourage/Advise.*
- Who can read out the slide, the last thing that Nurse Dora said, and identify what the C, the A, the S, and the E?
 - ▶ *Let them respond.*

Exercise 28: Read example of CASE approach

- Now let’s practice with a partner.
- When you pair up, you will first take a few minutes to look at **Table 16:** Example of the CASE approach in your *Participant manual* and choose a role to play.
- One of you will read out what the caregiver says, and one will read what the health worker says in the left column. You don’t have to read out the other examples on the right column, but please read through them.
- You have five minutes to read the example.
 - ▶ *Give them five minutes and bring them back together.*

Table 16. Example of the CASE approach

<p>Before the following discussion begins, the health provider has already welcomed the caregiver, put them at ease, and with active listening skills, she has helped them articulate their concern.</p>	
<p>Health Provider: “I understand you have some concerns about your child’s vaccinations.”</p>	
<p>Caregiver: “Yes, I want to spread out the vaccinations, so they won’t overwhelm my child’s immune system.”</p>	
<p>Health Provider: (This is a case for CASE!)</p> <p>(The health provider responds to this concern using the numbered phrases below)</p>	
<p>1: Corroborate: “You are right; children today certainly get more vaccinations than children did years ago.”</p>	<p><u>Other example phrases for Corroborate (not for this concern, just for this step):</u></p> <p>“You and I both want your child to be protected against things that might harm her.”</p> <p>“It’s true, some children may have mild side effects from vaccines like sore arm or fever. But these are normal side effects that produce a bit of discomfort then pass quickly. And they are nothing compared to the pain and suffering a child would go through, if they got the disease.”</p> <p>“We both want the best for your child.” “I know it’s hard to watch your child crying while getting a shot or having a sore arm.”</p>

2: About Me: *"Our practice follows the national schedule because it is carefully designed to protect children at the time they are most vulnerable to disease. I served on a committee that reviewed the schedule and I feel very confident that it's the best approach."*

Other example phrases for About Me:

"I just attended a conference that emphasized the risks of late vaccination during the current measles outbreak."

"As a result of my own questions, I have read the latest studies to ensure I have all the facts."

"I went to a refresher training on immunization last month which gave me a lot of up to date information that gives me even more confidence in our vaccines."

"I just read a new study that said XYZ."

"I have vaccinated tens of thousands of patients, so I have some experience with this."

3: Science: *"Although children get more vaccinations today, they actually receive smaller amounts of material than back when they got fewer vaccinations, because technology has enabled us to make vaccines that have only the part of the cell that creates the immune response."*

Other example phrases for Science:

"Studies involving hundreds of thousands of children demonstrate the vaccine's safety with only a tiny risk of major side effects- about the same risk as the risk of being hit by lightning."

"The immunological challenge from a vaccine is nothing compared to what kids get every day. An ear infection is a bigger immunological challenge for your child's system, or even playing on the playground."

4: Encourage/Advise: *"We want all the children in our practice to be immunized so that they are well protected and have the greatest chance for a long, healthy life. If it were my child, I would follow the schedule, to protect her as much as I could."*

Other example phrases for Explain/Advise:

"It's worth the slight discomfort to know he is getting the protection he needs for a long, healthy life. I know you will be able to comfort your baby afterwards, and you will feel good about having given him the protection he needs. If it were my baby, I would go ahead and vaccinate."

Plenary

- Did anyone have questions after reading that example of using the CASE approach to respond to a caregiver who wanted to spread the immunizations out over time?
 - ▶ *Let them answer.*
- CASE works by letting the caregiver feel you are agreeing with them on at least something, you know what you are talking about, science is on your side, and you strongly recommend an action. The steps in a CASE response provide momentum towards a decision.
- Now, that you are familiar, you are going to practice putting into action as if you were a home visiting nurse talking with a caregiver.

Exercise 29: Applying the CASE approach role play

- ▶ *Distribute copies of **HANDOUT 7: CHARACTER INFORMATION CASE ROLE PLAY**.*
- You will pair up with your neighbour in a moment.
- Decide which of you will play the visiting nurse, Nurse Emira, and which of you will play the caregiver, Mrs. Ilić.
- I will pass around the scenario to Mrs. Ilić. She will silently read her character information, which gives background about her concerns.
- Nurse Emira, you have five minutes to use your active listening skills to understand Mrs. Ilić's concern, and to formulate a response following the CASE steps. All that you know is that you need to do a three-month check-up for Baby Drago Ilić.
- Ok, let get started. Please pair up and raise your hand if you are Ilić.
 - ▶ *Give **HANDOUT 7: CHARACTER INFORMATION CASE ROLE PLAY** to each person playing Mrs. Ilić.*
 - Scenario: Mrs. Ilić, you know you are getting a home visit from the visiting nurse for a routine check-up for Baby Drago. You know that Drago's next shots are overdue. Don't say the following immediately, make the nurse work for it: You are not planning on getting the next set of shots for him. You hate to see Drago in pain, and you don't think it's worth it. You were very upset with how much Drago cried during the last session with Dr. Vera, and you are not willing to go through it again.
 - ▶ *Time them for 5 minutes and then bring them back together for discussion.*

Plenary

- Okay, we're back. Did anyone playing Nurse Emira have a hard time understanding the mother's concern?
 - ▶ *Let them respond.*
- Did anyone have a hard time formulating a CASE response?
 - ▶ *Let them answer.*
- Okay, let's start with this pair. How did you make a CASE response to Mrs. Ilić's concerns?
 - ▶ *Let a few people give their CASE responses.*
- Any comments or questions?
 - ▶ *Clarify as needed.*
- Congratulations, those were some good ideas on how to formulate a CASE response.
- You need to feel confident in your knowledge and belief that immunization is the right choice. Review research and have discussions with reliable sources of information to feel you have done your due diligence.
- A list of ideas for what works and what doesn't in discussing caregiver fears and needs, based on a review of scientific studies, is provided in your *Participant manual* under session 6.2 and in **Annex C**.
 - ▶ *Hold up the Participant manual and show them the list.*
- We do not have time to go through these now, but it is worth reviewing to see what ideas you can use in your work.

Takeaway

- CASE helps us organize our response by bringing together the skills we have been learning.
- There are: understanding and empathy skills, there are techniques for responding, and there is content for responding.
- CASE puts these together with an emotional progression, ends with a strong personalized recommendation, such as *"If I were you,"* which may help tip the caregiver into action.

Session 6.3. Adverse Events Following Immunization

Time: 40 minutes (longer if participants have submitted questions)

Materials:

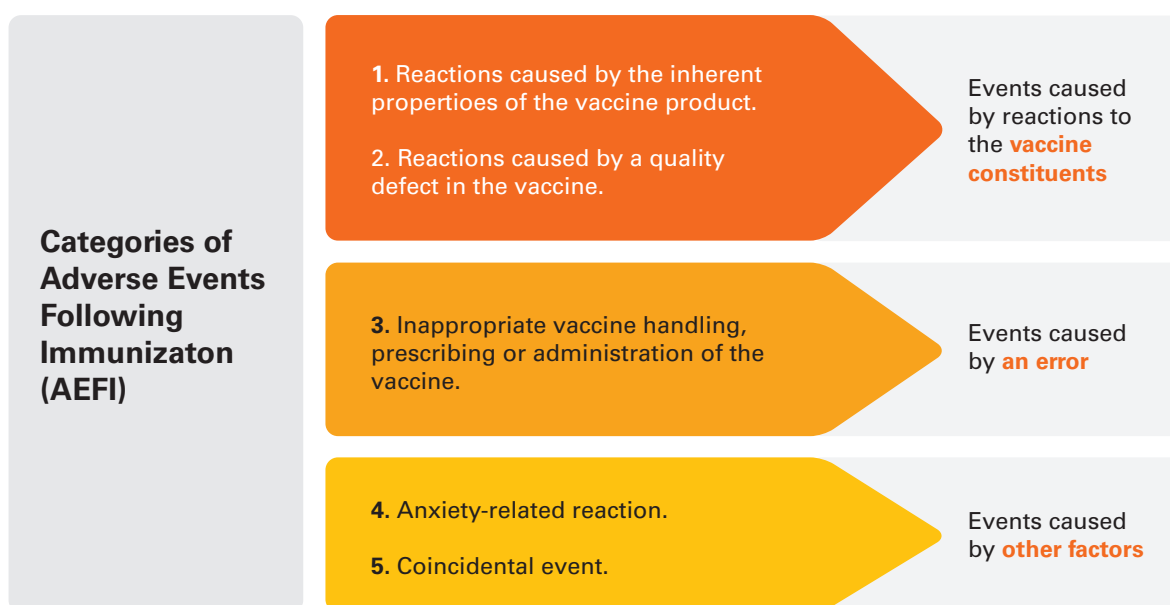
- ✓ *Participant manual.*
- ✓ Questions from question box that you have taken time to review and consider how to discuss with the group. If no questions were submitted, skip the first activity.

Plenary

- ▶ *ONLY DO THIS NEXT SECTION IF PEOPLE SUBMITTED ANONYMOUS QUESTIONS. If there are no questions skip to the fifth bullet, beginning with “In Module 2...”*
- ▶ *Show slide: Session 6.3: Adverse Events Following Immunization.*
- We are going to take a few minutes to read out and answer some of the questions about vaccines that people have submitted so far during the workshop.
- There were some good questions and we are glad you brought them up. It's better that you have a chance to express your concerns and worries about these issues.
- Health workers are people too. We have worries or questions, and sometimes it can be hard for us to ask these questions and get reliable answers.
- If you have worries simmering in the back of your mind that haven't been elicited and addressed, this might influence your confidence in immunization and your ability to successfully protect your patients.
- We have had a chance to go through your questions and prepare some answers.
 - ▶ *Read out questions.*
 - ▶ *Allow 10 minutes depending on how many questions, how complex, and how much discussion there is.*
- **In Module 2** we reviewed the immunization schedule and vaccine safety standards. We saw that because immunization has dropped, we are having epidemics that are costing lives and health.
- We have also talked about how caregivers' top worries are side effects and vaccine safety.
- We said that caregivers often overestimate the risks of vaccines and underestimate the dangers of the diseases that vaccines protect against.
- This is not to say that immunizations are perfect. We know that mild side effects are somewhat common, although severe side effects are extremely rare. We know that occasionally, there are adverse events following immunization, or AEFI.
- Having a good understanding of AEFI allows us to communicate confidently with caregivers.
- Who can give us a definition of an AEFI?
 - ▶ *Let them respond.*

- The WHO defines an adverse event following immunization (AEFI) as:
 - “A medical incident that takes place after immunization, causes concern and is believed to be caused by the immunization.”⁴⁵
- It's particularly important to look at those words “*is believed to be caused*” by the immunization, because sometimes the adverse event is not related to the vaccine at all, or it's related to health worker error rather than the innate properties of the vaccine itself.
 - ▶ *Show slide: Categories of AEFI.*

Figure 20. Categories of AEFI⁴⁶



- Let's review **Figure 20: Categories of AEFI** on this slide. How many different AEFI types does the slide show on the left, and how many categories of events are there?
 - ▶ *Let them respond.*
- Yes, there are five types of AEFI listed, that are grouped into three categories of events: 1) those caused by reactions to the vaccine constituents, 2) those caused by programme error, and 3) those caused by other factors.
- When we talk about AEFIs, we often mean the first two categories.
- Category one is reactions caused by the inherent properties of the vaccine product itself or reactions caused by a quality defect in the vaccine. These are extremely rare events.
- Category two is problems caused by inappropriate vaccine handling, prescribing or administration of the vaccine - lapse in cold chain, non-sterile injections or injection site errors, etc. These may be more common.

⁴⁵ World Health Organization Regional Office for Europe (no date) Vaccine Safety Messages

⁴⁶ Ibid.

- These are valid concerns that we as health providers need to have good responses to.
- The third category is one that we as health providers need to be able to respond to as well.
- Even if someone has an anxiety reaction or a coincidental problem that happened right around the time of an injection, and we are pretty sure it had nothing to do with the vaccination, we need to have good responses ready for these cases.
- Let's prepare to do and exercise where we develop some responses to these events.

Exercise 30: Questions about AEFIs

- Please look in your *Participant manual* under Session 5.3 and find the questions for Exercise 30.
- You will have 20 minutes to discuss the questions and devise good answers in your small groups. Which AEFIs have you have seen in your work, and how did you handle them?
 1. What would you say to a caregiver who asks about a reported case of AEFI (a child got an abscess) that may be due to health worker error?
 2. What would you say to a caregiver who said she knows someone whose child was paralyzed from a vaccination?
 3. What would you say to a caregiver who says he heard about someone who had a really bad allergic reaction to a vaccine?
 4. What other major AEFI-type questions do you get frequently, and how do you respond?
- Let's begin!
 - ▶ *Let them move into their small groups.*
 - ▶ *Time them for 20 minutes then bring the group back together.*

Plenary

- What were some of the good responses your groups found for the questions in the last exercise?
- Who can give us an elevator phrase for the following?
 - What would you say to a caregiver who asks about a reported case of AEFI (a child got an abscess) that may be due to health worker error?
 - ▶ *Let them respond and move to another group for the next question.*
 - What would you say to a caregiver who said she knows someone whose child was paralyzed from a vaccination?
 - ▶ *Let them respond and move to another group for the next question.*
- What would you say to a caregiver who says he heard about someone who had a really bad allergic reaction to a vaccine?
 - ▶ *Let them respond and move to another group for the next question.*
- What other major AEFI-type questions did you get frequently, and how do you respond?
 - ▶ *Let them respond.*
- Were there any other good elevator phrases that came out?

- ▶ *Let them respond.*
- Who can give us some ideas for an elevator phrase if there is an AEFI that was fairly clearly not related to the vaccination, but was just a coincidence?
 - ▶ *Let them respond.*
- If we can ensure that we as clinicians carry out good vaccine safety practices, there will be fewer AEFIs, which cause fear and distrust of vaccines.
- In your *Participant manual*, you will find **Table 17**, which outlines the types of AEFIs that we can avoid through good programme and clinical management.
- If we explain quality controls and safety practices to our patients and their caregivers, they will feel more confident about accepting immunization.

Takeaway

- Vaccines used in national immunization programmes are extremely safe and effective, although adverse events can occur following immunization. Vaccine constituent-related events are extremely rare.
- More often, errors in administering immunization (programme or worker error) cause an adverse event, along with things that have nothing to do with the vaccination. Things that are classified as AEFIs are sometimes caused by anxiety, or an event that happened coincidentally near the time of a vaccination.
- We need to have good elevator phrases available to respond to discussions of events like this. We will talk more about handling rumours in Session 7.

Session 6.4. Talking about contraindications and vaccine origin

Time: 30 minutes

Materials:

✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 6.4: Talking about contraindications and vaccine origin.*
- In our last session, we talked about Adverse Events Following Immunization. In this session, we will talk in more depth about a couple of other issues that are sources of concern among caregivers.
- First, let's talk about contraindications.

Exercise 31: Review of WHO contraindications for routine immunization

- **Annex A** of your *Participant manual* lists the WHO contraindications for routine immunization⁴⁷. Please take five minutes to review the table with your partner.
 - ▶ *Give five minutes for participants to review **Annex A** and then bring them back for discussion.*

Plenary

- How often do you encounter the contraindications listed here?
 - ▶ *Let them respond.*
- The medically indicated contraindications are fairly rare. What are some ways that we may be missing opportunities to vaccinate children?
 - ▶ *Let them respond.*
- Most common conditions, such as mild fever or diarrhoea are not contraindications to immunization, and vaccinations can still proceed.
- We should take advantage of a visit by a caregiver who is coming in for non-immunization related concerns to see if the child is up to date on their vaccinations.

⁴⁷ World Health Organization Regional Office for Europe 2017 Vaccine Safety and False Contradictions to Vaccination, Training Manual

- We've talked some more about vaccine safety; answered some of your questions; discussed the various ways we can prevent AEFIs; and reviewed contraindications so you can be sure you are not missing any opportunities to protect as many children as you can.
- Are there any more questions about AEFIs, contraindications and missed opportunities?
 - ▶ *Let them respond and answer any questions.*
- We know that caregivers have concerns about vaccine safety and procurement.
- Now we will work in our small groups to discuss our experiences with this, how we have handled it, then together let's find a better, more consistent way to talk about this.

Exercise 32: Caregiver concerns about vaccine origin and procurement

- in your small groups you will discuss **vaccine origin**, **safety** and **quality** and answer 3 questions.
- We aren't talking about side effects here, just about concerns about country of origin and manufacturing and quality control.
- Here are the questions you will be discussing in your group:
 1. What do caregivers say or ask about in terms of where the vaccines come from?
 2. What are caregivers' top concerns about vaccine quality, other than country of origin?
 3. What are some ways you have found to respond to these fears?
- You have 15 minutes to discuss these questions and prepare your best elevator phrases to share with the whole group.
- You can find the questions in Session 6.4 in your *Participant manual*.
- Let's begin.
 - ▶ *Let them break into groups.*
 - ▶ *Give them 15 minutes, with a two minutes warning, and then bring them back to plenary.*

Plenary

- Who would like to share what their group found in terms of top concerns about vaccine origin, and your best elevator phrases to reassure them?
 - ▶ *Let several of the groups give their answers, until they seem to be saying the same things, at which point you can just ask the other groups: "Did you all have anything different?"*
- Who would like to share what their group found in terms of top concerns about vaccine quality, and your best elevator phrases to reassure them?
 - ▶ *Let several of the groups give their answers, until they seem to be saying the same things, at which point you can just ask the other groups: "Did you all have anything different?"*
- Were there any other top concerns that your group discussed, and for which you found good ideas for responses?
 - ▶ *Let them respond.*

- Some people have made the comparison that we buy cars that are manufactured in other countries, and we trust that their various in-country manufacturing regulations, and our country's import regulations and motor vehicle administration together, will ensure that all the various imported vehicles have met the same safety standards.
- To promote the image of vaccine quality and safety, one suggested phrase is: *"Your child is perfectly fit for vaccination. I have quality vaccine in my fridge that has been kept in great condition. I will use brand new syringe and needles, so everything is set for a safe vaccine experience."*
- Now please write down your favourite responses for these two concerns in the Elevator Phrases pages at the back of your *Participant manual*.
 - ▶ *Give them one minute to write these down.*
- Is there anything else we could review or discuss that would help you feel more confident about vaccine safety, or more comfortable talking with your patients about it?
 - ▶ *Give five minutes for discussion here.*

Takeaway

- Most common conditions, such as mild fever or diarrhoea are not contraindications to immunization, and vaccinations can still proceed.
- We should take advantage of a visit by a caregiver who is coming in for non-immunization related concerns to see if the child is up to date on their vaccinations.
- Caregivers' concerns often revolve around country of origin of vaccines, or their quality. You can use the elevator phrases that the group developed, or some that you devise, to reassure caregivers.

Session 6.5. Shortcuts for good communication

Time: 10 minutes

Materials:

✓ Participant manual.

Plenary

- ▶ *Show slide: Session 6.5: Shortcuts for good communication.*
- All around the world, FLWs feel they lack time to practice good IPC skills during immunization sessions. Counselling might take more time than you feel you have available during a busy routine immunization session.
- But we know that showing empathy and giving praise doesn't take much more time than your typical interaction with a caregiver. Remember how quickly you were able to help those very uncomfortable parents of baby Elvis to feel more at ease in just 90 seconds?
- This might even save time, because it might decrease resistance and build trust.
- When Mrs. Hadzic said she thought Petra had a fever, Nurse Bakija could have said, ok, and gone straight to just taking the temperature, but he spent that extra time to reflect back the worry: *"I hear your worry"* and then showed he was acting on that worry. This reflects that he sees himself and the mother as a team that wants to do the best for the child.
- Now everyone, please stand up. We are all going to repeat the words: *"Okay, I'm going to take her temperature now"* out loud while timing how many seconds it takes to say it:
 - ▶ *Have them stand up and get ready to time themselves.*
- Now let's say *"Okay, I'm going to take her temperature now"* and time how long that takes.
 - ▶ *Let them repeat the phrase out loud while timing it.*
- How many seconds did that take? Maybe three seconds? Now we will time how long it takes to say the following phrase: *"It sounds as if you are worried. Let's take her temperature and talk about what to do."* Ok, let's repeat the phrase and time how long it takes to say.
- *"It sounds as if you are worried. Let's take her temperature and talk about what to do."*
 - ▶ *Let them repeat the phrase out loud while timing it.*
- How many seconds did this take?
 - ▶ *Let them give a few answers - around five seconds.*
- So, this took about five seconds. After the mom said she thought the child had a fever, you could have just gone straight to taking the child's temperature but taking the extra few seconds to say this type of phrase is time well worth the effort, to create that essential trust. You could even say this as you are starting to get the thermometer, so it's no extra time.

- Now, who can time me?
 - ▶ *Let someone volunteer.*
- Please time how long it takes me to say this statement: *"Thanks Mrs. Jancovic, see you in a month!"*
 - ▶ *Let them time you.*
- Now time how long it takes me to say this statement: *"Thanks Mrs. Jancovic, you've done a great job keeping Alina protected by keeping her vaccines up to date. See you in a month!"*
 - ▶ *Let them time you.*
- How much more time did it take to say the second sentence, as opposed to the first sentence?
 - ▶ *Let them answer.*
- It can be tempting to just send the acceptors off with a quick "thanks" but do spend the extra 10 seconds to make them feel good about their decision to come for vaccination, and to motivate them to come back on time, and feeling positive.
- Consider this simple dialogue:
 - *FLW: Good morning, Mother.*
 - *Caregiver: Good morning, Nurse.*
 - *FLW: What can I do for you today?*
 - *Caregiver: I have come for my child's immunization.*
- Such a dialogue can be handled well, or it can be handled poorly.
 - Done poorly, the FLW speaks in a harsh tone and does not look at the caregiver.
 - Done well, the FLW smiles warmly as s/he says: *"Good morning"* and maintains eye contact as s/he asks why the caregiver has come.
- At a minimum, you can and should:
 - Show the caregiver s/he has your undivided attention (make direct eye contact if culturally appropriate).
 - Smile (if appropriate).
 - Use other nonverbal communication such as nodding the head.
 - Use a pleasant tone of voice.
 - Ensure the caregiver gets to ask their questions.
 - Answer their questions, or if they have many, suggest a time or another person when there will be more time available for discussion.
 - Always, always, end with praise for the caregiver so they walk out with their satisfaction sandwich.
- Let's try a few examples together.

Exercise 33: Practicing good communication in limited time

- ▶ *Show slide: Session 6.5: Shortcuts for good IPC when time is limited.*
- I am going to read you an exchange. Please tell me how to improve the health workers response.
 - *Caregiver: "Good morning, Miss/Sir. I'm here for Zora's vaccines."*
 - *FLW: "Put your baby in your lap so I can reach her thigh."*

- What is a better response?
 - ▶ *Take a few examples.*
- Let's try another:
 - Caregiver: *"Are there any side effects from the vaccines you are giving him today?"*
 - FLW: *"Don't worry, Mother. The side effects are very mild. Now hold the baby while I give the injection."*
- What is a better response?
 - ▶ *Take a few examples.*
- In the improved interactions, the caregiver should feel valued, respected, heard, understood, and appreciated. This may make them more likely to return, which will increase immunization coverage. In addition, caregivers might tell others how kind and effective you are.⁴⁸

Plenary

- Another shortcut that we have mentioned is **using communication tools** like visual aids or brochures. The algorithm and CASE are also example of **job aids** that helps us remember and structure the steps of communication.
 - These communication tools are not just helpful to help you do a better job of explaining and helping caregivers better understand and remember information, they can save you time.
- What are some of the materials that you use in your discussions with caregivers and community members?
 - ▶ *Let them answer.*
- What are some other ways that support materials can make communication more effective and efficient?
 - ▶ *Let them answer.*
- Communication tools, or job aids, or behaviour change communication support materials:
 - Serve as a talking points reminder to FLWs so you don't forget steps or content.
 - Help FLWs explain complex information in a simple quick way: like elevator phrases already packaged up.
 - Reinforce key points and messages. Using a job aid or something printed or visual gives you more credibility, since people tend to respond both intellectually and emotionally to external sources of information: *"If it is in print, it must be true, it's not just the health worker who thinks this way."*
 - Create positive emotion with pictures of happy babies, bright colours, etc.
 - Can be given to caregivers for more detailed information, to read at home, to discuss with family members, etc.

⁴⁸ Adapted from Refresher Training for Frontline Health Workers in Expanded Program of Immunization (EPI). Module 4: Communicating with Caretakers and Communities for Improved Routine Immunization Coverage

Takeaway

- Using empathy and communication support materials may save you some time by helping to build trust and provide information in an efficient and emotionally appealing manner.

Session 6.6. Bringing it all together

Time: 60 minutes

Materials:

- ✓ *Participant manual.*
- ✓ Photocopies of:
 - **HANDOUT 8: CAREGIVER SCENARIO 1 TO THE CAREGIVERS**
 - **HANDOUT 9: OBSERVATION CHECKLIST TO THE OBSERVERS**
 - **HANDOUT 10: CAREGIVER SCENARIO 2 TO THE CAREGIVERS**
 - **HANDOUT 11: CAREGIVER SCENARIO 3 TO THE CAREGIVERS**
- ✓ Flip chart with algorithm.

Plenary

- ▶ *Show slide: Session 6.6: Bringing it all together.*
- We have talked about the importance of structuring our communication, using various techniques and content.
- Structuring does require more thought – especially at first, until it becomes a habit. After a while, it should become your standard operating procedure, that is, normal.
- You have learned to walk through the algorithm to help you communicate effectively and efficiently.
- We have practiced techniques like using empathy, open-ended questions and reflecting back to ensure understanding. We have worked on elevator phrases to ensure we have good content nicely packaged.
- The rewards include decreased stress for you, more satisfied caregivers, and improved immunization coverage with fewer dropouts.
- Who can name some diagnosis skills we have discussed, meaning how do we understand where our patients are on the continuum, and what their concerns are?
 - ▶ *Let them respond, confirm as needed:*
 - Nonverbal communication: giving and reading;
 - Empathy;
 - Open-ended questions;
 - Reflecting;
 - Probing;
 - Leading questions.
- Who can name some treatment techniques we have discussed, meaning how to structure our responses when we are dealing with our patients concerns, whatever the content is?
 - ▶ *Let them respond and confirm as needed:*

- Identifying a goal;
- Structured response;
- Signposting;
- Pausing;
- Tailoring;
- Establish common ground- start with what you agree on;
- Presenting scary things in percentages versus positive things in frequencies;
- Positive framing;
- Referring to misinformation in key messages can actually reinforce misperceptions, so don't put the myth in your summary, put the positive facts in the summary;
- Strong personal recommendation;
- Assist in decision-making by eliminating unimportant factors or unsuitable options;
- Identify logistical problems (e.g. lack of health insurance card) and refer for solutions;
- End with plan/next steps;
- Send caregiver away feeling cared for.
- Who can name some content areas we have discussed? This means what are the themes to focus on, what are the ingredients you should include in your response?
 - ▶ *Let them respond and confirm as needed:*
 - Concept of protection;
 - Self-efficacy;
 - Self-perception as a good parent;
 - Perception of severity and susceptibility;
 - Quote science;
 - Relative risk of disease and vaccine;
 - Mild side effects that show the vaccine is working, versus extremely rare side effects that are more severe;
 - Procurement and quality control of vaccines;
 - Some of the scare stories you may have heard were due to health care provider mistakes, nothing to do with the vaccines themselves;
 - Their motivation to do the right thing for their child;
 - Their motivation to do what others do;
 - Your personal conviction;
 - Your personal experience;
 - Your concern and care for their child;
 - People now increasing MMR vaccination rates since they see the danger of measles;
 - Helping to decrease pain during and after vaccination;
 - Cues to action;
 - Decreasing harm by refuser.
- Who can name some tools we have looked at? This means any images, references, etc. that can help us communicate, or help us remember?
 - ▶ *Let them respond and confirm as needed:*

- Visual aid for community immunity;
 - Steady MMR rate and rising autism;
 - Algorithm for clinic visit;
 - Algorithm for home visit;
 - Pain management graphic;
 - Contraindication list.
- Thank you and great job. There is a list in **Annex B** of your *Participant manual* that reviews many of these techniques and content phrases.
- We are now going to practice pulling it all together now in a few immunization consultations.

Exercise 34: Practice sessions

- I am going to review the assignment first, then we will break into groups of three.
- Once you are in your small groups, you will choose one person to be the FLW, one person to be the caregiver, and one person to be the observer.
- We will do three different role plays, so each of you will have a chance to be the FLW, the caregiver and the observer.
- **Caregivers**, you will be given a backstory scenario, which will inform you of what your concerns and your potential reactions to what the FLW says should be.
 - Just like a real caregiver, if your concerns aren't identified through active listening, and aren't addressed with good responses, you may not be willing to vaccinate. We are going to make the FLW work hard.
 - You will have **two minutes** to review your back-story.
- **FLWs**, you will need to use all the tools and skills you have learned so far, as we just reviewed them. You will work your way through the algorithm according to what your caregiver says and does.
 - If you get your caregiver into the vaccination box, you will role play giving the vaccinations while decreasing pain during and after, talk about handling side effects at home, next steps and then give the parting affirmation.
 - You can take a few minutes to prepare by looking at algorithm and the observation checklist to remind you of techniques you can use, and you can refer to **Annex B** in your *Participant manual* ("Review of IPC for Vaccination") for techniques and content, if needed. You can use these as you do the role play, too.
 - You will have **two minutes** to review possible techniques and content you might want to use in **Annex B**.
 - If you find yourself stuck, and you can't get the caregiver to move forward, you can ask the observer if they want to try using a questioning or responding technique that might unlock the caregiver's door.
 - After you do the role play, you, FLWs, will get to look at the scenario that the caregiver was using and see what they were waiting for before they would move to the next step.

- The goal is not for you, FLWs, to use all of the skills on the checklist. The checklist allows you to get ideas before you do the role play, and to see which ones you used, to see if you used a skill that you might not have used in the past.
- **Observers**, you will use the checklist, ticking the box for the skills you see demonstrated. Listen and see how you think you would be handling the caregiver. You will give feedback afterwards.
 - Observers, you will **have two minutes** to read through the checklist and be glad you don't have to be the first one to play the FLW.
- **Everyone**: once you have had your two minutes to prepare, you will have **five minutes** to carry out your role play.
- Once the role play is done, the group will have **five minutes** to discuss how it went.
- The FLW should review the checklist that the observer has used, to see what techniques he or she used, and to see what techniques or content might have been helpful.
- The caregiver can express how he or she felt, what prevented her/him from responding positively, etc.
- When we come back, be prepared to present your role play to the whole group. Then, we will rotate roles.
- You will find the instructions I just reviewed in your *Participant manual* in **Session 6.6**.
- Any questions?
 - ▶ *Clarify as needed.*
- Let's begin!
 - ▶ *Let them break into groups of 3.*
 - ▶ *Distribute copies of **HANDOUT 8: CAREGIVER SCENARIO 1 TO THE CAREGIVERS.***
 - ▶ *Distribute copies of **HANDOUT 9: OBSERVATION CHECKLIST TO THE OBSERVERS.***
 - ▶ *Time 10 minutes and give a one-minute warning at 9 minutes.*
 - ▶ *Begin report out with the below questions.*
- Who would like to demonstrate their role play first?
 - ▶ *Let them demonstrate setting a timer for five minutes.*
 - ▶ *Check in with the observer.*
 - ▶ *Call on another group if time allows.*
- Thanks to the teams. For the other groups, did your scenario go a similar way?
 - ▶ *Let them answer.*
- What were some things that all the "FLWs" did well in their scenario?
 - ▶ *Let them answer and check in with the observers.*
- What were some things that could be improved in how the FLWs handled concerns?
 - ▶ *Let them answer and check in with the observers.*
- What were some things that could be improved in how the FLWs discussed side effects or did their final affirmation and next steps?
 - ▶ *Let them answer and check in with the observers.*
- Well done, thanks. Any further questions on this scenario?
 - ▶ *Clarify as needed.*
- Let's do another scenario, switching roles. It should be a little easier to do this time.
- The caregiver should try to time and see how long the scenario takes this time.

- Again, you have five minutes to go through the consultation, and five minutes to discuss in your group.
 - ▶ *Distribute copies of **HANDOUT 11: OBSERVATION CHECKLIST TO OBSERVERS.***
 - ▶ *Distribute copies of **HANDOUT 10: CAREGIVER SCENARIO 2 TO CAREGIVERS.***
 - ▶ *Time 10 minutes and give a one-minute warning at nine minutes.*
 - ▶ *Begin report out with the below questions.*
- Who can demonstrate first?
 - ▶ *Let them demonstrate (ensure a different group from last time).*
- Thanks to the team. For the other pairs, did your scenario go a similar way?
 - ▶ *Let them answer.*
- What were some things that all the “FLWs” did well in their scenario?
 - ▶ *Let them answer and check in with the observers.*
- What were some things that could be improved in how the FLWs handled concerns?
 - ▶ *Let them answer and check in with the observers.*
- What were some things that could be improved in how the FLWs discussed side effects or did their final affirmation and next steps?
 - ▶ *Let them answer and check in with the observers.*
- Well done, thanks. Any further questions on this scenario?
 - ▶ *Clarify as needed.*
- Let’s do another scenario, switching to the final role.
- The caregiver should try to time and see how long the scenario takes this time.
- Again, you have five minutes to go through the consultation, and five minutes to discuss in your group.
- Go back to your group.
 - ▶ *Distribute copies of **HANDOUT 9: OBSERVATION CHECKLIST TO OBSERVERS.***
 - ▶ *Distribute copies of **HANDOUT 11: CAREGIVER SCENARIO 3 TO CAREGIVERS.***
 - ▶ *Time 10 minutes and give a one-minute warning at nine minutes.*
 - ▶ *Begin report out with the below questions.*
- Who can demonstrate first?
 - ▶ *Let them demonstrate.*
- Thanks to the pair. For the other pairs, did your scenario go a similar way?
 - ▶ *Let them answer.*
 - ▶ *If time allows you can have another group present.*
- What were some things that all the “FLWs” did well in their scenario?
 - ▶ *Let them answer and check in with the observers.*
- What were some things that could be improved in how the FLWs handled concerns?
 - ▶ *Let them answer and check in with the observers.*
- Well done, thanks. Any further questions on this scenario?
 - ▶ *Clarify as needed.*
- Thanks to all of you for working hard on these scenarios. Are there any more questions or comments on communicating during immunization consultation?
 - ▶ *Give them a minute to think and respond to questions for a few minutes.*

Takeaway

- Communication with caregivers is always challenging, but through your work in this training, you are developing new skills and resources.
- Structuring your response does require more thought, especially at first. By further practice and reviewing the materials in **Annex B**, and the activities in your *Participant manual*, you can strengthen your skills even more.

If you are leading a TOT

- ▶ *Facilitate the practice teaching session for Module 6.*
- ▶ *Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 7.*

Module 7.

IPC in communities

Module 7. IPC in communities

Module 1 Objectives:

By the end of the module the participants will be able to:

1. Strengthen IPC skills for use outside of health facilities with:
 - a. Caregiver families in their homes;
 - b. Poorly reached groups such as Roma;
 - c. Community leaders;
 - d. Community groups.
2. Increase skills for handling rumours.

Time: 1 hour and 35 minutes

Checklist

- ✓ Flip charts of: steps with determinants, socio-ecological model, and clinical algorithm.
- ✓ Flip chart for *Community algorithms* created in advance.
- ✓ **HANDOUT 12: ROMA COMMUNITY HEALTH MEDIATORS** for each person.

If you are leading a TOT

- ▶ *Complete Module 7. At the end, facilitate the practice teaching session for the module.*
- ▶ *Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Continue to Module 8.*

Session 7.1. Using communication outside the health facility

Time: 10 minutes

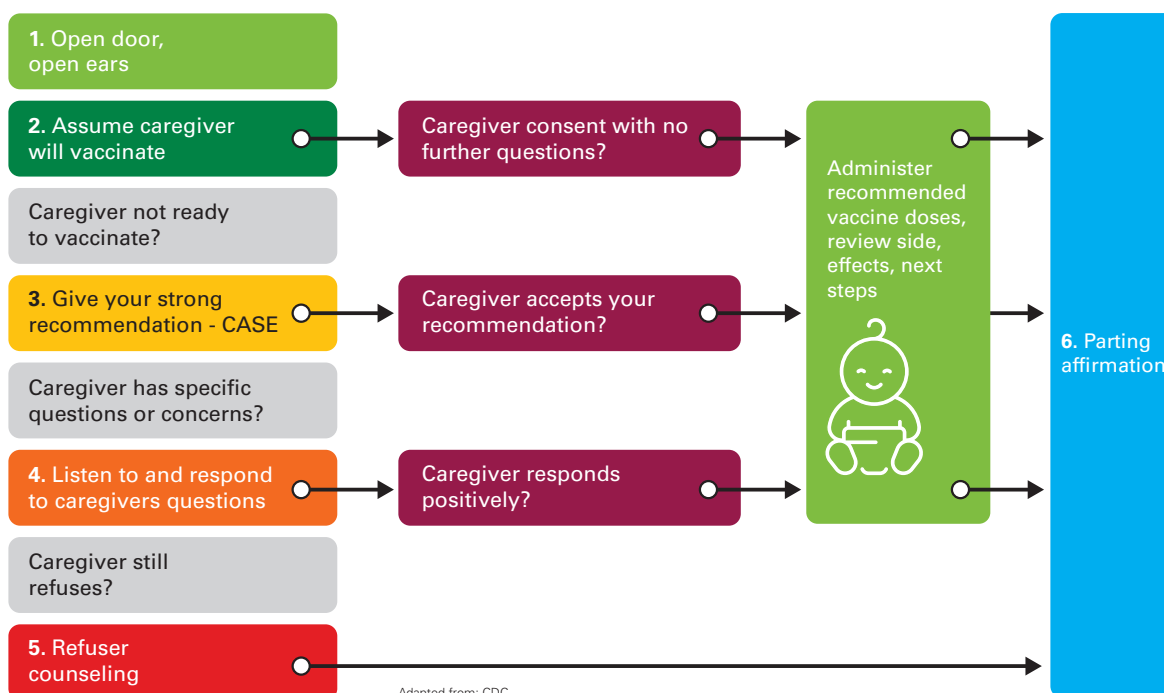
Materials:

- ✓ *Participant manual.*
- ✓ Flip chart with Step model with determinants.
- ✓ Flip chart with “eggs” model (Socio-ecological model).
- ✓ Flip chart with Community algorithms.
- ✓ Flip charts, markers, tape.

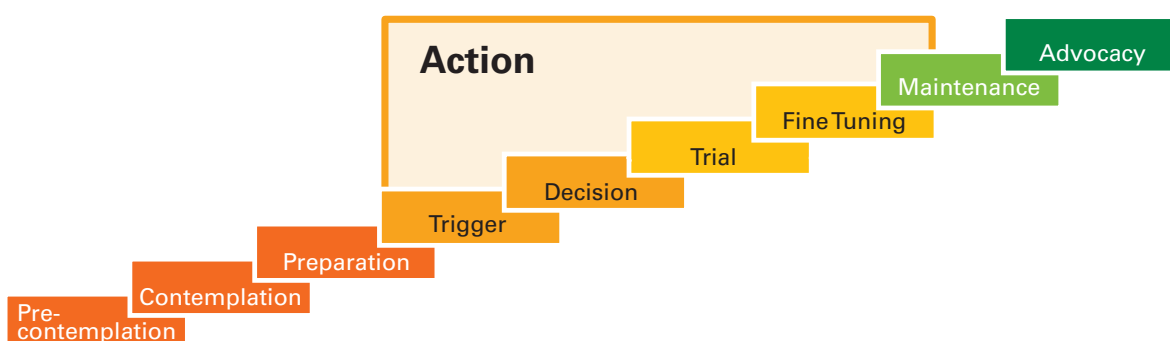
Plenary

- ▶ *Show slide: Session 7.1: Using communication outside the health facility.*
- In our last module, we focused on IPC in the context of an immunization session with caregivers. What model did we use to walk our way through the clinic visit?
 - ▶ *Let them respond.*
 - ▶ *Show slide: Clinic algorithm.*

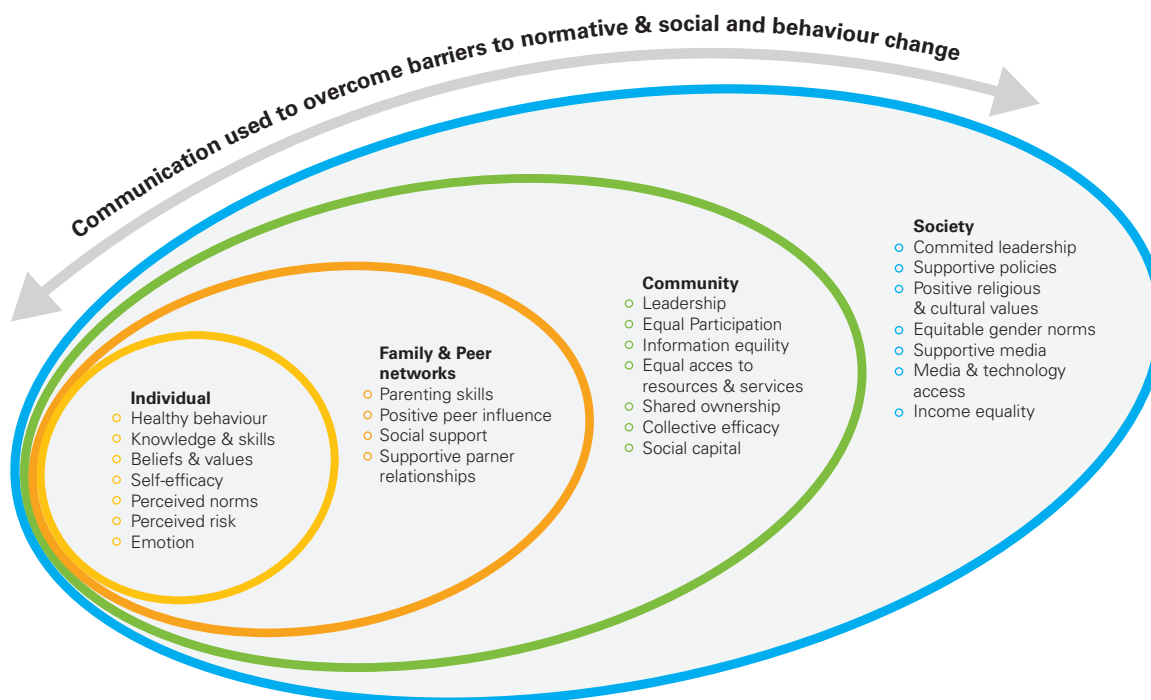
Figure 21. Clinic-based algorithm



- What are the three basic steps in following the algorithm?
 - ▶ *Diagnose needs, treat needs, end with positive next steps.*
- Let's look again at these expanded steps of behaviour change.
 - ▶ *Point to flip charts with expanded steps with determinants.*



- With David and Amina and their baby Ali back in Module 3, we looked at where they were on the steps and diagnosed their needs: what “treatment” or assistance they needed to get to each of the next steps, and what determinants might be in play.
- The steps focus on the individual’s journey of behaviour change. Let’s step back from thinking about one on one communication, and individual behaviours, and think about the big picture for a minute.
- Individuals are influenced by their families, community and society as pictured in the Socio-ecological model.
 - ▶ *Point to flip chart with the Socio-ecological model.*



- Given this model, what advantages are there to speaking with people outside of the health facility?
 - ▶ *Let them respond and list on flip chart.*
 - ▶ *Prompt if necessary with:*
 - More time is available;
 - Reach caregivers who would not necessarily come to health facility;
 - Less stressful interaction because no vaccines are given;
 - FLW can create rapport with extended family of caregivers;
 - Opportunity to reinforce messages given in clinic;
 - Reach influencers who may not have young children;
 - Reach larger groups.
- In previous modules, we learned a number of approaches and skills to help increase immunization uptake during clinic consultations. In this module, we will use what we have learned in the community.
- What are some of the situations or contexts we are in, in the community?
 - ▶ *Let them respond and list on flip chart.*
 - ▶ *Prompt if necessary with:*
 - Home visits;
 - Group talks;
 - Meetings with leaders;
 - Visits with under-reached populations.
- Let's start with home visits in the next session.

Takeaway

- Home visits and other opportunities to engage family and community networks are opportunities to influence individual behaviours and social norms in support of immunization. Strong interpersonal communication skills are critical to apply in these non-facility-based settings.

Session 7.2. Home visits

Time: 20 minutes

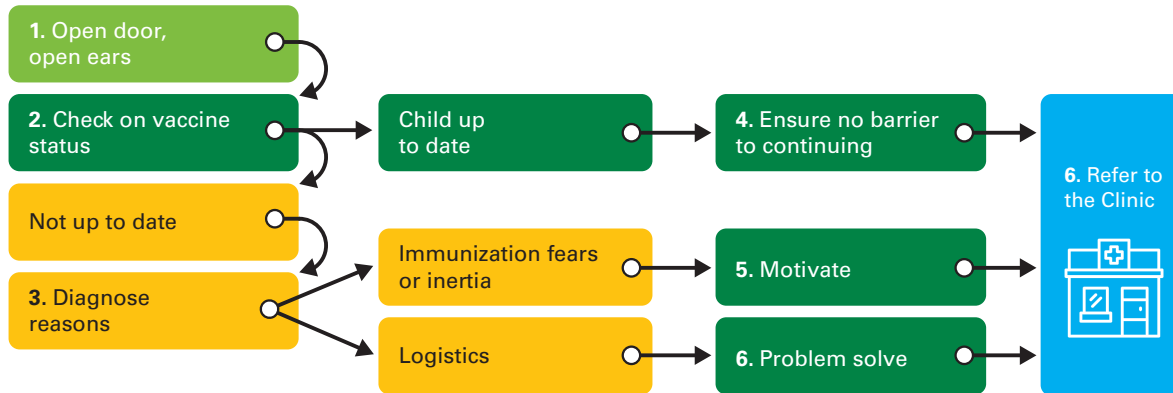
Materials:

✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 7.2: Home visits.*
- Now let's look at the role of visiting nurses. What is their role when visiting families? How can they increase immunization coverage?
 - ▶ *Let them respond and list on flip chart:*
 - They can ensure that the children are up to date on their vaccines.
 - They can follow up with children who are overdue.
 - They have more time for diagnosing caregivers' opinions about immunization and discussion about their concerns.
 - They can talk with family influencers.
- What is different in a home visit from what happens in a health facility? We talked about this some in the last session.
 - ▶ *Let them respond and list on flip chart:*
 - They have more time to answer questions.
 - They know the family in their home environment and can bring other members of the family or social network into decision-making.
 - They may see people who would never come in to the health facility.
 - They are probably not providing immunizations at the time of the visit.
- As said above, we apply the same principles of interpersonal communication in the community.
- First diagnose the issue, then treat the needs as possible. Here is an algorithm for communication during a home visit. It is **Figure 22** in your manual.
 - ▶ *Show slide: Communication algorithm for home visits.*

Figure 22. Communication algorithm for home visits



- We move through it in a very similar way to the clinic algorithm. We will practice using it now in a role play.

Exercise 35: Role play - visiting nurse and family feelings

- You will work with your partner for this exercise.
- When you pair up, you will find **Table 18** in your *Participant manual*. It provides an incomplete sample role play script of Merjem, a Visiting Nurse that arrived at the home of Adnan and Dina Imamovic.
- Dina has invited her into the house and they are sitting together in the main room.
- Together with your partner, decide which one of you will be the mother, and who will be the visiting nurse.
- Read out the dialogue together, and as you read each line, map out where the conversation is on the home visit algorithm.
- When you get to the questions written in bold in the dialogue boxes (“Not up to date”, “immunization fears or inertia”, and “logistics”), discuss what Merjem could say, ask or do to help the mother.
- You will complete the story by writing in how you think the dialogue could continue in a way that helps solve Dina’s barriers to vaccination.
- You will have 10 minutes. Any questions?
 - ▶ Clarify as needed.
- Let’s begin!
 - ▶ Give them time to pair up.
 - ▶ Time them for 10 minutes and then bring the group back together.

Table 17. Role play: visiting nurse and family

Merjem:	Good morning. I am Nurse Merjem, part of the Visiting nurse programme. I have come to do Baby Omar's 4-month check-up. How are you and Omar doing?
Dina:	You are welcome. Omar and I are doing fine. What is it you want to discuss with me?
Merjem:	Sorry if I didn't explain well. I am new in the area. I am working with the Visiting nurse programme, as you probably know, our role is to visit new mothers and make sure that you and your new baby are doing well. I understand that Omar was born four months ago?
Dina:	Yes, he was born 16 weeks and 2 days ago. He is doing very well see how fat he is?
Merjem:	That's wonderful that he is growing well. Would you mind showing me Omar's health card? I would like to review it with you.
Dina:	Yes, I have it here. (Omar has gotten his vaccines for birth, 4, and 8 weeks.)
Merjem:	What could Merjem say here?
Dina:	Well, honestly, I know I should go back, but... My husband asked me what they were doing to the children at that clinic, because I came back from the clinic with Omar and he was crying. He received three vaccines and couldn't move his arms. My husband was pretty unhappy. He said I shouldn't go back with Omar again. The arm where they give the shot always turns blue.
Merjem:	What are some things Merjem could ask or say here?

Dina:	What do you think Dina might reply?
Merjem:	
Dina:	

Plenary

- Who would like to report back on this role play? What did you think Merjem said in the first blank box?
 - ▶ *Let them respond.*
- What did you think Merjem could have responded in the second blank box?
 - ▶ *Let them respond.*
- What did you imagine Dina might have said, to the response you provided in the second blank box?
 - ▶ *Let them respond.*
- Did any of you suggest to Dina that they include her husband in the discussion?
 - ▶ *Let them respond.*
- Does anyone have any other questions about communicating about immunization with parents during home visits?
 - ▶ *Clarify as needed.*
- There is an additional sample role play exercise in your *Participant manual*.

Takeaway

- Following the community algorithm can help you to structure your communication for immunization during home visits for greater effectiveness. Take advantage of the presence of family members, especially husbands and mothers-in-law, to discuss the importance of immunization, and problem-solve as needed to ensure attendance at the health clinic.

Session 7.3. Engaging with groups with special concerns

Time: 15 minutes

Materials:

- ✓ *Participant manual.*
- ✓ **HANDOUT 12: ROMA COMMUNITY HEALTH MEDIATORS.**

Plenary

- ▶ *Show slide: Session 7.3: Engaging with groups with special concerns.*
- Who remembers what the evidence said about reasons for low immunization rates amongst the Roma?
 - ▶ *Wait for a response and **prompt** if necessary with: mixture of vaccination beliefs, cultural, logistics and access issues).*
- For the Roma, they have communications needs for immunization, but they also may need some help with problem solving for access issues.
- Who can give some examples of other groups in their patient population that may have special concerns that will require targeted communications approaches?
 - ▶ *Let them answer and summarize with the following, adding examples they have given.*
- Some groups have concerns that are specific to them. Cultural and access issues for the Roma, language barriers with minority populations, and religious concerns for certain groups may all require specially tailored approaches.
- Let us take a few minutes to learn how one Health mediator worked with one Roma family.

Exercise 36: Roma community health mediator

- I am going to handout an article. You will have 5 minutes to read it and then we will discuss it together.
 - ▶ *Give everyone **HANDOUT 12: ROMA COMMUNITY HEALTH MEDIATORS.***
 - ▶ *Check in at four minutes and give them an extra minute or two if needed to finish.*
 - ▶ *Call the group back together to discuss.*

Plenary

- What are some key take-aways from this article?
 - ▶ *Write responses on flip chart.*
 - ▶ *Prompt if necessary:*
 - Mobilizers play critical role;
 - Immunization coverage increased;
 - Mobilizers more credible and effective since they are part of the community;
 - Measles was avoided in this community;
 - Good record keeping;
 - Mobilizers holistic, not only working on immunization;
 - Not many mobilizers, based in health centres.
- What can other FLWs learn from this in terms of working with special groups?
 - ▶ *Write responses on flip chart.*
- As we have discussed, that while time is limited when interacting with caregivers, expressing interest in their non-health concerns goes a long way in building trust. You don't have to necessarily solve their problems; you just have to show empathy and show that you care about their lives.
- Keep in mind that certain groups have different methods and styles of communicating that may seem unusual or even offensive to you, but in their culture, these styles of communicating may be perfectly appropriate and even positive.

Takeaway

- Learn as much as you can about special groups' concerns, motivations and influences, so you can employ appropriate techniques and channels of communication, and tailor the content to address their triggers for decision-making.
- When you are dealing with a caregiver who comes from a very different background, use empathy to put yourself in their shoes.

Session 7.4. Advocacy with community leaders

Time: 15 minutes

Materials:

✓ *Participant manual.*

Plenary

- ▶ *Show slide: Session 7.4: Advocacy with community leaders.*
- What are types of community leaders that can influence increased immunization coverage?
 - ▶ *Take a few responses and confirm or prompt with the below.*
- These can include:
 - Elected officials;
 - Informal community leaders;
 - Community workers;
 - Community-based traditional health providers;
 - Religious leaders and groups affiliated with religious institutions;
 - Leaders of women's groups;
 - Other organized health groups (health committees);
 - Teachers, caregiver - teacher groups, school health programmes;
 - Local staff or groups associated with other areas of social and economic development, such as agricultural extension workers or leaders of groups focused on women's or children's rights, and leaders and staff of NGOs.
- You need to meet with the community leaders who seem to be the strongest, most motivated, and best able to help with immunization activities. Share with them immunization programme information.
- Who are the leaders that have influence over immunization beliefs, attitudes, behaviours, and resources in your community?
 - ▶ *Let them respond and write down responses on flip chart.*
- What specific role can each of these kinds of leader play in reducing barriers to immunization?
 - ▶ *Let them respond and write down responses on flip chart.*
- Remember it is important to diagnose the leaders attitude to immunization and determine if they are a friend or a foe, and what benefits (or risks) they may perceive in helping you. This may help you structure your conversation with them.
- So now we have identified:
 - ▶ *Show slide: Session 7.4: Steps to consider when engaging community leaders.*

- Which community leaders might have a role to play in increasing immunization uptake;
- What role each leader might have- thus the “ASK.” The ASK is what you want to get from them. It could be:
 - Funding;
 - A sermon supporting immunization;
 - Hosting a meeting with health workers and caregivers at the school;
 - A visit to an influential person who is unsupportive of immunization, or...
- Remember that it is important to diagnose the leaders’ attitudes to immunization and determine if they are a friend or a foe, and what benefits (or risks) they may perceive in helping you. Identifying their motivations (what is in it for them) can help you structure your conversation.
- Now we know whom we need to talk to and about what. So how should we go about this discussion?
- Let’s answer this in a partner exercise.

Exercise 37: Role play with community leader

- With your partner you will complete the role play **Exercise 37** in your manual.
- One of you will be a community leader. Choose one from the list on the flip chart that we just discussed.
- The second person will be the FLW. You might inspire yourself from previous modules and diagnose your target first:
 - Are they a vaccine supporter, hesitator or a complete refuser?
 - Diagnose what it would take to get them to openly support vaccination, and then use your CASE approach, or another one, to engage them and get their support.
 - Help them think about what’s in it for them as a leader to support vaccination.
- Once you have finished dialoguing with your partner complete the self-assessment in **Table 19** in the *Participant manual*. Would your partner rate you the same?
- You will have 10 minutes for the role play and assessment. Any questions?
 - ▶ *Clarify as needed.*
- Let’s begin!
 - ▶ *Time them for five minutes and then bring the group back together.*
- Scenario:
 - **Community Leader:** You have never spoken about immunization and know very little about it (pre-contemplation stage). You are a public figure and are known to have a 1-year-old son who you have not yet immunized with MMR. You have heard vague rumours about MMR and autism.
 - **FLW:** You are a FLW who knows the community leader socially. You have been asked by your supervisor to see if the community leader would publicly support immunization by having his son immunized with MMR and publicly endorse MMR in a leaflet about immunization soon to be published by the health authorities in his community.

Table 18. *Self-assessment*

Technique	Yes	No
Positive nonverbal communication		
Displayed empathy		
Mostly used open-ended questions		
Used reflective listening (at least once)		
Established community leader's knowledge, attitudes, fears etc. about immunization		
Established community leader's practice (if one year old immunized yet for MMR)		
Explored beliefs and responded to concerns about immunization		
Handled question about rumours (if applicable)		
Made a clear request for support from community leader (the ASK)		
Had a clear door handle closing		

Plenary

- Who would like to report on how they did? What if anything is different than talking to a caregiver?
 - ▶ *Let two or three report and discuss.*

Takeaway

- Community leaders can be extremely influential in good or bad ways. It's important to engage them, even those who may be hostile, with a clear "ask."
- Just as with caregivers at various levels of the continuum, our goals will be different depending on who the community leader is.

Session 7.5. Community groups

Time: 10 minutes

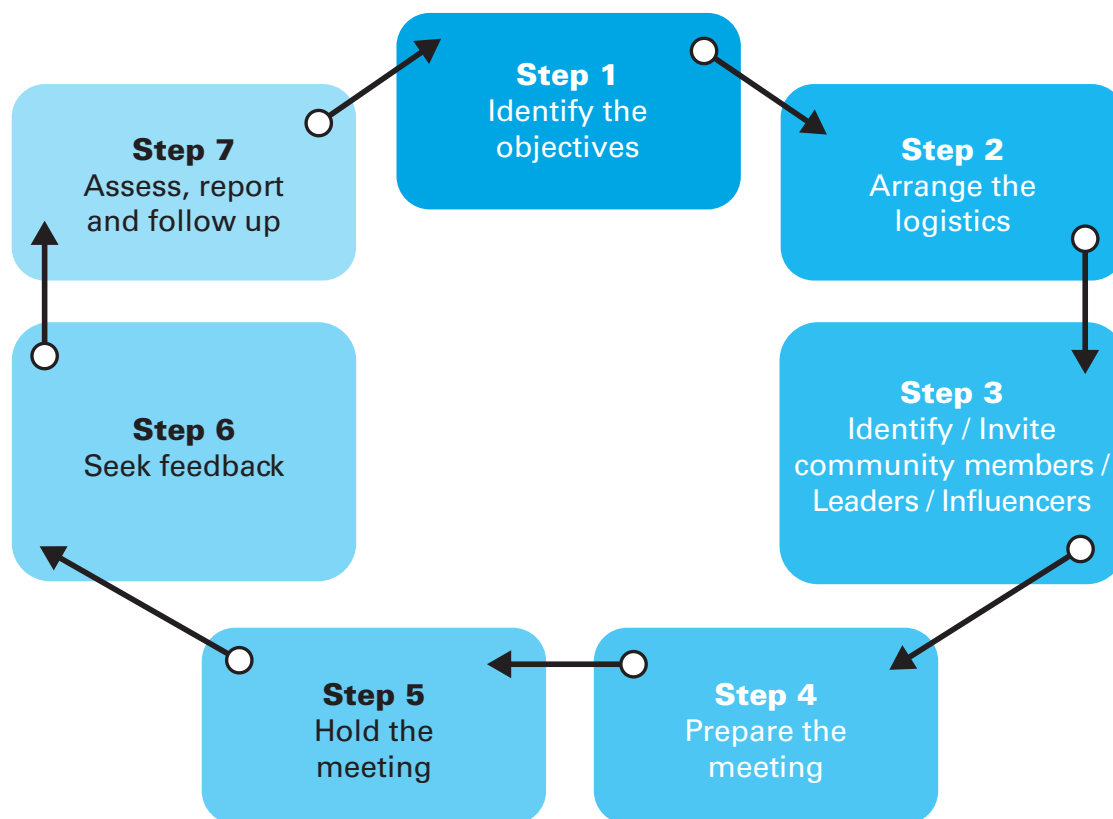
Materials:

✓ *Participant manual*

Plenary

- ▶ *Show slide: Session 7.5: Community groups.*
- What are some situations that might motivate you to arrange a community conversation about your immunization programme?
 - ▶ *Let them respond and prompt if necessary:*
 - If you have large numbers of families who do not bring their children for immunization;
 - If you have a high dropout rate;
 - If any children have had serious adverse reactions after immunization;
 - If you believe there are negative rumours circulating in the community about immunization.
- The appropriate people to invite will depend on the context and situation:
 - If you have large numbers of families who do not bring their children for immunization, you could invite representatives of those families and also any of their neighbours who do bring their children for immunization.
 - If you have a high dropout rate from the immunization programme in parts of your community, you could invite caregivers from families whose children started their vaccinations but did not complete them.
 - If children have had serious adverse reactions after immunization, you might invite the caregivers of those particular children, together with other caregivers whose children were not adversely affected.
 - If you believe there are negative rumours circulating in the community about immunization, you might invite those who you believe are being influenced by the rumours, together with community leaders and other influential people in your local community who support immunization.
- Let's consider the following scenario:
 - A health worker glances at the calendar and realizes they have scheduled a community outreach meeting for the following day. The next day, they arrive at the venue and find no one there.
- What are the possible reasons no one showed up to attend the immunization meeting?
 - ▶ *Let them respond and prompt if necessary:*
 - Did not plan or prepare ahead of time;
 - Did not identify or invite community members or leaders/influencers;

- Did not promote the meeting.
- How could this have been avoided?
 - ▶ *Let them respond and prompt if necessary:*
 - Decide on purpose of meeting;
 - Identify participants and influencers;
 - Invite once time and venue are arranged;
 - Learn from previous meetings.
- Community conversations will be successful when everyone is given the opportunity to be heard. Many will not participate fully in a meeting unless they feel at ease and believe their opinions will be heard. Therefore, in organizing a successful community conversation, you should consider the following points:
 - Decide on the purpose of the conversation and advertise it widely;
 - Decide who should attend or be invited;
 - Prepare an agenda for the meeting;
 - Decide on the date and time;
 - Make sure that everyone you want to attend is informed about when and where the meeting will take place;
 - Choose a meeting place where there is little interference, so that everyone will be able to hear one another's views;
 - Facilitate the conversation in an open and non-judgmental way, so everyone feels included and respected.
- Turn to **Figure 23** in your manual.
 - ▶ *Show slide: Planning community meetings.*

Figure 23. Planning community meetings⁴⁹

- These steps illustrate one way of avoiding the scenario we discussed at the start of this session.

Takeaway

- Community meetings provide an alternative channel of not only reaching groups of caregivers, but also for reaching persons that influence their decisions about immunization. These meetings need to be well planned and publicized ahead of time.

49 Adapted from UNICEF (2017) Facilitator's Guide: Interpersonal Communication for Immunization. Draft

Session 7.6. Proactive rumour management

Time: 25 minutes

Materials:

✓ Participant manual.

Plenary

- ▶ *Show slide: Session 7.6: Proactive rumour management.*
- Stories about negative consequences of immunization often circulate in communities.
- If negative stories are not dealt with appropriately, they can cause serious problems for the effective delivery of immunization services.
- There are true reports of negative consequences, such as an injection-related abscess. What kind of AEFI is this?
 - ▶ *Let them answer: **Type 3**, events caused by an error.*
- And, false reports of negative consequences, such as a child developing autism after receiving MMR, which would be classified as what kind of AEFI?
 - ▶ *Let them answer: **Type 5**, coincidental event.*
- We have already talked some about how to handle actual negative events caused by immunization in a previous session.
- Now, let's take a few minutes and brainstorm a list of false rumours, myths, and misconceptions about immunizations.
 - ▶ *Record these on flip chart so that everyone in the training can see them.*
 - ▶ *Number the rumours.*
- Great, thank you. We are going to use these for a small group exercise.

Exercise 38: Role play - rumour management

- Let's pair up in two lines. The line on my left will be FLWs, and the line on my right will be caregivers.
 - ▶ *Give them a minute to get into the two lines.*
- Caregivers, your role is to believe the rumour/myth/misconceptions we just discussed. Take 20 seconds and choose one but keep it to yourself.
 - ▶ *Give them a moment.*
- FLWs, you will have 60 seconds to practice responding to and effectively addressing the caregiver's beliefs. Pretend this is a real visit with a caregiver and use the skills you've learned throughout the day.
- You will have one minute. At the end of one minute the FLW will move down the line to a new caregiver and a different rumour. Health workers let your caregiver know if they need to choose a different rumour.

- You will play the FLW with three different caregivers and deal with their false beliefs. Then you will switch to being a caregiver for three rounds. Any questions?
 - ▶ *Clarify as needed.*
- Ready, set, go!
 - ▶ *Time them for one minute.*
- Everyone, please, stop! FLWs, please move to a new caregiver on your left and practice again.
 - ▶ *Time them for one minute.*
 - ▶ *Repeat for one more round so each FLW has practiced with three different caregivers.*
- Everyone, stop. Now we are going to switch roles. The FLWs are now going to be caregivers. Choose a rumour that you did not work with in your role as an FLW.
 - ▶ *Give them a moment to choose.*
- Please begin.
 - ▶ *Time them for one minute and have them rotate.*
 - ▶ *Repeat two more times and then bring everyone back to their seats.*

Plenary

- So, what have we learned from this exercise?
 - ▶ *Record responses on flip chart and discuss.*
- Let's list some of the elevator phrases that you used:
 - ▶ *Record responses on flip chart.*
- Remember to write down the elevator phrases you feel are the most useful at the end of your manual.
- Any negative and false rumours about immunization that you hear are circulating should be communicated to your supervisor as soon as possible.
 - ▶ *Show slide: Session 7.6: Rumour management – key steps.*
- The following suggested actions cannot be carried out by you alone. Immediate reporting is important, and advice should be sought before you take action.
 - First, try to find out what the rumour is, who was the original source of the rumour and who is spreading the rumour now.
 - Try to establish whether there is any reason for the rumour spreading — there might be a political or religious reason, or it might simply have arisen from lack of information or incorrect information about the immunization programme.
 - Remember, we need to distinguish between negative stories that may be true, such as an AEFI (a child who gets an abscess) and negative stories that are not true- which we will call false rumours.
 - True stories about AEFI need to be met with careful handling in ways as we discussed previously, whereas false rumours need a different approach. Here we will focus on dealing with false rumours.
 - Once you have gathered information, arrange a meeting with opinion leaders such as local government officials, traditional and religious leaders, community leaders and other health workers.
 - In the meeting, begin by providing information about the immunization programme and the diseases it can prevent.

- Try to ensure that those present are free to ask questions and express concerns. Discuss and reach agreement on collective ways to correct the negative rumour and the wrong information about the immunization service.
- Key steps we can take are:
 - Identify the correct information about vaccines and how to deal with the rumour.
 - Disseminate correct information about immunization to the public. This can be done through individual discussions, and through communication materials like leaflets, regional or national campaigns, radio programming, etc.
 - It is important to remember that, unless you have specialized training on dealing with media, you should avoid doing interviews or other media appearances.
- Strategies that can be used to reach the hard-to-convince include the following:
 - Identify the groups that are involved in perpetuating the rumours/misinformation.
 - Engage key informants to find out the nature and reasons for rumours/misinformation.
 - Visit influential people/leaders for one-on-one discussions.
 - Hold discussions with leaders and community member to address the rumours/misconceptions.
 - Seek endorsement statements from credible authorities (government, church leaders, medical professionals, etc.).
 - Invite respected/trusted authorities to participate and discuss the issues with community members.
- Resources on rumour management are listed at the end of Session 7.6 in your *Participant manual*.

Takeaway

- Be proactive in dealing with all rumours. First, try to find out what actually happened. You don't want to deny an actual AEFI, but you want to frame the response to it. Enlist the support and advise of others, avoid media unless you have specialized training, and use prepared elevator phrases.
- Remind groups to prepare for their Module review presentations in the morning.

If you are leading a TOT

- ▶ *Facilitate the practice teaching session for the Module 7.*
- ▶ *Refer to Session 1.5 B in Annex F for a reminder if needed. Modify the time as needed to stay on schedule.*
- ▶ *Remind your volunteer group to prepare a module 2 review as described in Session 1.5 on the first day. They will demonstrate the exercise for Session 8.1 to model how the Session would be run in a 3-day training.*
- ▶ *Continue to Module 8.*

Module 8.

Review, next steps
and closing

Module 8. Review, next steps and closing

Module 8 Objectives:

By the end of the module the participants will be able to:

1. Gain confidence in presenting on communication concepts and skills.
2. Recall the workshops' key takeaways.
3. Plan how to apply new skills in their workplace.
4. Provide feedback on workshop content and process.

Time: 2 Hours

Checklist

- ✓ Prepare enough copies of printed materials:
 - **HANDOUT 13: POST-TEST**
 - **HANDOUT 14: WORKSHOP EVALUATION**
 - **HANDOUT 15: PREPARED CERTIFICATES OF COMPLETION**

If you are leading a TOT

- ▶ *Review all of the TOT boxes in each Session so you can integrate the content smoothly into your review and closing.*
- ▶ *You will demonstrate the Module 2 review for Session 8.1 to model how the session would be run in a 3-day training. You may instead wish to ask a group of volunteers to prepare the summary in advance and have them demonstrate.*
- ▶ *Since participants have already familiarized themselves with the content through practice, teaching, you can move straight to 8.2.*

Session 8.1. Review of content

Time: 50 minutes

Materials:

✓ Participant manual

If you are leading a TOT

- ▶ *Demonstrate (or ask for a volunteer to prepare and demonstrate in the summary review for Module 2).*
- ▶ *Ask for questions or comments for the group, and then conclude the exercise by letting them know that when they are leading a 3-day training they would continue with the full exercise through the Module 7 summary.*
- ▶ *Continue to 8.2.*

Plenary

- ▶ *Show slide: Session 8.1: Review of content.*
- We are going to get started reviewing what we have learned in the last three days.
- Remember your review should cover:
 1. What were the objectives of the module?
 2. What were the main activities we did during the module?
 3. What were the most important skills and knowledge that you took away from this module?
- Please act out at least one skill or piece of knowledge that you gained from this module.
- The first team will give their summary of **Module 2**. You have five minutes to present. We will give you a one-minute warning.
 - ▶ *Give them a one-minute warning.*
- Questions or comments for this team?
 - ▶ *No more than three minutes for each Q&A.*
 - ▶ *Summarize.*
- Thanks. Now, the team for **Module 3**, please come up and present. You have five minutes to present. We will give you a one-minute warning.
 - ▶ *Give them a one-minute warning.*
- Questions or comments for this team?
 - ▶ *No more than three minutes for each Q&A.*
 - ▶ *Summarize.*

- Thanks. Now, the team for **Module 4** please come up and present. You have five minutes to present. We will give you a one-minute warning.
 - ▶ *Give them a one-minute warning.*
- Questions or comments for this team?
 - ▶ *No more than three minutes for each Q&A.*
 - ▶ *Summarize.*
- Thanks. Now, the team for **Module 5**, please come up and present. You have five minutes to present. We will give you a one-minute warning.
 - ▶ *Give them a one-minute warning.*
- Questions or comments for this team?
 - ▶ *No more than three minutes for each Q&A.*
 - ▶ *Summarize.*
- Thanks. Now, the team for **Module 6**, please come up and present. You have five minutes to present. We will give you a one-minute warning.
 - ▶ *Give them a one-minute warning.*
- Questions or comments for this team?
 - ▶ *No more than three minutes for each Q&A.*
 - ▶ *Summarize.*
- Thanks. Now, the team for **Module 7**, please come up and present. You have five minutes to present. We will give you a one-minute warning.
 - ▶ *Give them a one-minute warning.*
- Questions or comments for this team?
 - ▶ *No more than three minutes for each Q&A.*
 - ▶ *Summarize.*
- Those were good summaries. Any other questions or comments?
 - ▶ *Give a minute to see if there are questions or comments.*
- We have learned a lot going through these modules together. Thank you, everyone!

Session 8.2. Exercise on reflecting and planning

Time: 20 minutes

Materials:

✓ Participant manual.

If you are leading a TOT

- ▶ *You should be ahead of schedule since you only spent 10 minutes on 8.1. You will use the extra time here for planning.*
 - ▶ *Facilitate Session 8.2 as indicated, except omit the actual 15 minutes allocated for the exercises.*
 - ▶ *Simply review it with the group so they are familiar with how to lead it when they deliver the training.*
 - ▶ *Continue with the below points.*
- ▶ *Now, we are going to dedicate a little time to planning the training you will deliver.*
- ▶ *Please form groups with those from your region or institution that you may work with to co-facilitate the 3-day FLW training.*
- ▶ *The groups should be no larger than 5-6 people.*
- ▶ *You will have 30 minutes to discuss the following questions:*
 - *When do we plan to schedule the training?*
 - *What additional adaptation do we still need to do and how much time do we need to allow for it?*
 - *Who will finalize any adaptations or translations needed for the Facilitator guide, Participant Manual, slides, handouts, etc.?*
 - *Who will handle the workshop preparations and logistics (Invitations, approvals, venue, travel, food, equipment, etc.?)*
 - *Who will produce the printed materials?*
 - *Who will organize any official opening or closing, and any certificates of participation?*
- ▶ *Let's begin!*
 - ▶ *Let them get into groups and then bring them back after 30 minutes to wrap up.*
- ▶ *What did you take away from this exercise?*
 - ▶ *Take a few responses.*
- ▶ *Remind them that allowing adequate time to plan and prepare will help ensure a successful training for facilitators, participants, and caregivers.*
 - ▶ *Move to Session 8.3.*

Plenary

- ▶ *Show slide: Session 8.2: Exercise on reflecting and planning.*
- We are going to start this Session with an exercise to help us think about how we can apply what we have learned in the training.

Exercise 39: Reflecting and planning

- In just a moment we will break in groups of 2. You will work with a partner that works in the same context and possibly the same facility as you do:
 - FLWs that work inside a clinic should pair up and FLWs that work in the community should pair up.
 - When you have found your partner, you will discuss and answer the questions in Session 8.2 of your *Participant manual*
 - You will have 10 minutes. Let's begin!
 - ▶ *Let them get into groups.*
 - ▶ *Give a two minutes warning after 8 minutes and then bring the group back together to discuss.*
1. Think back over the last month to identify a communication challenge you encountered in your immunization work. Describe the situation and the challenge.
 2. Based on what you have learned in this workshop; is there anything you would now do differently?
 3. Go through this manual and identify five of the most useful IPC skills, phrases or approaches you learned. List them here.
 4. How can you integrate each of these into your regular routine?
 5. What will be your next steps in using what you have learned in your work?

Plenary

- Could a few pairs explain how you plan to implement your new communication skills, once you go back to your regular place of work? Who would like to go first?
 - ▶ *Let a few pairs give their plans, and then ask if anyone else would like to share their plan.*
- Thank you. This is one of the most important things you will do at this workshop: planning how to put into action what you have learned.
- We hope you will be able to use some of the skills immediately. Remember to look back at your *Participant manual* to refresh your memory in a couple of weeks.

Session 8.3. Post-test

Time: 20 minutes

Materials:

- ✓ Photocopies of **HANDOUT 13: POST-TEST**.
- ✓ Pens.

Plenary

- ▶ *Show slide: Session 8.3: Post-test.*
- Please complete the post-test we are handing out. It is similar to the one that you took at the start of the workshop.
- By comparing the two results we can see how the workshop went and make adjustments to the workshop content.
- You also will be able to self-assess any change in your attitudes, beliefs, or knowledge.

Exercise 40: Post test

- ▶ *Distribute copies of **HANDOUT 13: POST-TEST**.*
- Remember the code name you used at the start of the workshop and please use that again. You will have 15 minutes to complete the post-test.
 - ▶ *Give a two minutes warning.*
 - ▶ *Collect tests.*

Session 8.4. Workshop evaluation

Time: 5 minutes

Materials:

- ✓ Photocopies of **HANDOUT 14: WORKSHOP EVALUATION**.
- ✓ Pens.

Plenary

- ▶ *Show slide: 8.4 Workshop evaluation.*
- Before we close, we would like you to please complete a workshop evaluation.
- This will allow us to see what worked well for you, what didn't work well and how we can improve the workshop.
- Please do not put your name on the form. This should not take longer than five minutes.

Exercise 41: Workshop Evaluation

- ▶ *Distribute copies of **HANDOUT 14: WORKSHOP EVALUATION**.*
- ▶ *Give a one-minute warning after four minutes*
- ▶ *Collect evaluation forms.*

Session 8.5. Closing

Time: 20 minutes

Materials:

- ✓ Prepared **HANDOUT 15: CERTIFICATES**.
- ✓ Note: You may want to allow more time for the closing depending on the official remarks or form presentation of certificates.

If you are leading a TOT

- ▶ *Use the following wrap-up statement for your TOT:*
- Thank you again for your participation, hard work, and valuable contributions in this workshop. We have all learned from each other, and it has been a pleasure to work with this team.
- We wish you success as you go back to carry out your training of Front Line Workers.
- Do you have any final questions about the training package?
 - ▶ *Clarify as needed.*
- We will now have closing remarks and distribute certificates of completion.
 - ▶ *Handover to anyone giving official closing remarks.*
 - ▶ *Distribute certificates.*
 - ▶ *Close training.*

Plenary

- Thank you again for your participation, hard work, and valuable contributions in this workshop. We have all learned from each other, and it has been a pleasure to work with this team.
- We wish you success as you go back to your clinics and communities.
- Remember, the *Participant manual*, with the model dialogues, algorithms, lists of tips, and the elevator phrases you wrote down, will continue to be a resource after this workshop. We encourage you to use it as a refresher and resource.
- Do you have any final questions about the *Participant manual*?
 - ▶ *Clarify as needed.*
- We will now have closing remarks and distribute certificates of completion (if applicable).
 - ▶ *Handover to anyone giving official closing remarks.*
 - ▶ *Distribute **HANDOUT 15: CERTIFICATES**.*
 - ▶ *Close training.*

Annexes

Annex A: Adaptation guidance

Checklist: General session content to review for adaptation

Overview

- ☐ Title Page of all materials.
- ☐ Introduction of *Facilitator guide* and *Participant manual*.
- ☐ Tailor training objectives to needs identified in needs assessment.
- ☐ Agenda, pre-and post-test, exercise handouts, and evaluation to ensure alignment and consistency with changes to content.
- ☐ Substitute any visual aids used in the country, or helpful examples from the region.
- ☐ Substitute relevant country timelines, local coverage, incidence of disease, and national immunization schedules for relevant group work activities.
- ☐ Update Vaccine Safety Processes and Protocols to reflect current policies for country or region.
- ☐ Substitute relevant country data on fears, beliefs, biases, and side effects.
- ☐ Substitute relevant country data on caregiver experience, barriers and facilitators, especially from specific ethnic or religious populations.
- ☐ Review and contextualize example case studies and other examples as needed.
- ☐ Review and contextualize role play scripts, names, and scenarios as needed.
- ☐ Expand or reduce the content for time. Adjust recommended session timing based on training length and pre-test findings.
- ☐ Include locally relevant images.
- ☐ Add culture-appropriate icebreakers.

Module 1. Introduction

Session 1.3. Pre-test:

- ☐ Code names examples for Pre-test.

Module 2. Immunization technical review

Objectives

- ☐ Update country names for objective 4.

Session 2.1. How vaccines work and health benefits

- ☐ Substitute any visual aids used in the country, or helpful examples from the region.

Session 2.2. National coverage data and trends, disease risks, and vaccine schedules

- ☐ Multiple group work activities use country level data from Serbia and Bosnia and Herzegovina as examples for the region.
- ☐ Substitute relevant country timeline for *Evolution of immunization* activity.
- ☐ Substitute local coverage and incidence data for group work activity on trends in coverage rates and incidence.
- ☐ Substitute relevant national immunization schedule (or WHO recommendations) for group work activity to review immunization schedules.

Session 2.3. Vaccine safety processes and protocols

- ☐ Update to reflect current policies and protocols for country safety processes and protocols.

Module 3. Understanding behaviour and barriers

Session 3.1. Understanding behaviour

- ☐ Review example and choice of family planning for contextualization as needed.
- ☐ Review example of David, Amina, and Baby Ali for contextualization as needed.
- ☐ Note characters from both examples are referred to throughout the modules.

Session 3.2. Perception biases

- References research from Serbia. Review and substitute an example from country, if available.

Session 3.3. Diagnosing your caregivers' needs introduction

- ☐ Review role play script of Olga and Dr. Musa for contextualization as needed. Note characters and scenario are referred to across modules.

Session 3.4. Mapping your caregivers on the continuum of vaccine hesitancy

- References research conducted in Serbia. Review and replace with example from country, if available.

Session 3.5. Common fears and beliefs about vaccines

- Small group work activity references research from Serbia, Bosnia and Herzegovina, on the general population and among the Roma. Review and substitute current, country level data if available.
- Note research on fears and beliefs is referenced across modules.

Module 4. Active listening to understand your caregiver

Session 4.4. Empathy

- Quotes from research conducted in Serbia and Bosnia and Herzegovina, and among the Roma are included. Review and update with current examples from the country if available.
- Review example scenario of Mr. and Mrs. Sajdic for any needed contextualization.

Session 4.6. Reflective listening

- ☐ Review role play script of Nurse Bakija and Mrs. Hadziic for contextualization as needed.
- ☐ Review of scenario of Marko for contextualization as needed.

Session 4.7. Practice combining active listening techniques

- ☐ Review role play script of Dr. Vera, Mrs. Llic, and Baby Drago for any needed contextualization. Note characters and scenario are referred to across modules.
- ☐ Review of scenarios used in Handout 5 for hidden problems exercise.

Module 5. Addressing our and our caregivers' needs

Session 5.4. If they are hesitant, give a strong recommendation

- ☐ Re-uses role play script of Olga and Dr. Musa. Review for contextualization as needed and align with any previous changes. Note characters and scenario are referred to across modules.

Session 5.5. Dealing with the very hesitant

- Review role play of Nurse Dora and Mrs. Javonic for any contextualization needed.

Session 5.8. Talking with refusers

- Review role play example of Dr. Luminita and Mr. Maric for any needed contextualization.
- Review discussion and exercise on refusal and consent forms. Update or remove to reflect current country policies on consent and refusal. Provide policy statements if available.
- Review Happy Family Clinic exercise for any needed contextualization.

Module 6. Communication during immunization

Session 6.2. CASE approach

- Review role play script between Nurse Emira and Mrs. Ilić for any needed contextualization.
- References previously used research from Serbia and Bosnia and Herzegovina and quotes from Roma community on side effects. Review and update with current country level data if available.
- Review role play script of Mrs. Dudic and Minira for any needed contextualization

Session 6.6. Bringing it all together

- Review scenarios across handouts for any needed contextualization or increased relevance.

Module 7. IPC in communities

Module may have limited relevance for FLWs based exclusively in facilities.

Session 7.1. Using communication outside the health facility

- References scenario of David, Amina, and Baby Ali. Review and align with any updates made previously.

Session 7.2. Home visits

- Review role play script with Merjem and Dina for any needed contextualization.

Session 7.3. Special needs of the Roma

- References previously introduced research among the Roma and uses a case study of Roma community mediators. Review and update as needed for country level example.

Session 7.4. Advocacy with community leaders

- Review role play scenario for any needed contextualization.

Module 8. Review and next steps

Session 8.3. Post-test and evaluation

- Code names for pre-test.

Annex B: Misperceptions about contraindications

Clinicians and other health-care providers might misperceive certain conditions or circumstances as valid contraindications or indications of precaution for vaccination when they actually do not preclude vaccination. These misperceptions result in missed opportunities to administer recommended vaccines. Among the most common conditions mistakenly considered to be contraindications are diarrhoea, minor upper respiratory tract illnesses (including otitis media) with or without fever, mild to moderate local reactions to a previous dose of vaccine, current antimicrobial therapy and being in the convalescent phase of an acute illness.

Vaccine	Conditions commonly misperceived as contraindications (i.e. vaccine may be administered under these conditions)
For all vaccines: OPV, MMR, Hib, hepatitis B, varicella, HPV	Mild acute illness with or without fever DTwP, DT, Tdwp, Mild-to-moderate local reaction (i.e. swelling, redness, soreness); low-grade or moderate fever after previous dose No previous physical examination of a person appearing to be well rotavirus, PCV, Current antimicrobial therapy Convalescent phase of illness Preterm birth (except hepatitis B vaccine in certain circumstances) Recent exposure to an infectious disease History of penicillin allergy, other non-vaccine allergies, relatives with allergies or receiving allergen extract immunotherapy
DTwP	Fever of < 40.5 °C, fussiness or mild drowsiness after a previous dose of DTP or DTwP Family history of seizures Family history of sudden infant death syndrome Family history of an adverse event after DTP or DTaP Stable neurological condition (e.g. cerebral palsy, well-controlled seizures or developmental delay)

Vaccine	Conditions commonly misperceived as contraindications (i.e. vaccine may be administered under these conditions)
Tdwp	<p>Fever of $\geq 40.5^{\circ}\text{C}$ for < 48 h after vaccination with a previous dose of DTP or DTwP</p> <p>Collapse or shock-like state (i.e. hypotonic hyporesponsive episode) within 48 h of receiving a previous dose of DTP or DTwP</p> <p>Seizure < 3 days after receiving a previous dose of DTP or DTwP</p> <p>Persistent, inconsolable crying lasting > 3 h within 48 h of receiving a previous dose of DTP or DTwP</p> <p>History of extensive limb swelling after DTP, DTwP or Td that is not an arthus-type reaction</p> <p>Stable neurological disorder</p> <p>History of brachial neuritis</p> <p>Latex allergy that is not anaphylactic</p> <p>Breastfeeding</p> <p>Immunosuppression</p>
OPV	<p>Previous receipt of one or more doses of oral poliovirus vaccine</p>
MMRc,d	<p>Positive tuberculin skin test</p> <p>Simultaneous tuberculin skin testing</p> <p>Breastfeeding</p> <p>Pregnancy of recipient's mother or other close or household contact</p> <p>Female recipient of child-bearing age</p> <p>Immunodeficient family member or household contact</p> <p>Asymptomatic or mildly symptomatic HIV infection</p> <p>Allergy to eggs</p>
Hepatitis B	<p>Pregnancy</p> <p>Autoimmune disease (e.g. systemic lupus erythematosus or rheumatoid arthritis)</p>

Vaccine	Conditions commonly misperceived as contraindications (i.e. vaccine may be administered under these conditions)
Varicella	Pregnancy of recipient's mother or other close or household contact Immunodeficient family member or household contact Asymptomatic or mildly symptomatic HIV infection Humoral immunodeficiency (e.g. agammaglobulinaemia)
HPV	Immunosuppression Previous equivocal or abnormal Papanicolaou test Known HPV infection Breastfeeding History of genital warts
Rotavirus	Prematurity Immunosuppressed household contacts Pregnant household contacts

DT, diphtheria and tetanus toxoids; DTP, diphtheria toxoid, tetanus toxoid and pertussis; DTwP, diphtheria and tetanus toxoids and whole-cell pertussis; HBsAg, hepatitis B surface antigen; Hib, Haemophilus influenzae type b; HPV, human papillomavirus; OPV, oral poliovirus; MMR, measles, mumps and rubella; PCV, pneumococcal conjugate vaccine; Td, tetanus and diphtheria toxoids; Tdwp, tetanus toxoid, reduced diphtheria toxoid and whole-cell pertussis

- a) Antibacterial agents have no effect on the response to live, attenuated vaccines, except for live oral typhoid vaccine, and have no effect on inactivated, recombinant subunit or polysaccharide vaccines or toxoids. Typhoid vaccine should not be administered to people receiving antimicrobial agents until 24 h after the last dose. If feasible, to avoid a possible reduction in vaccine effectiveness, antibacterial drugs should not be started or resumed until 1 week after the last dose of oral typhoid vaccine.
- b) Hepatitis B vaccination should be deferred for infants weighing < 2000 g if the mother is documented as HBsAg-negative at the time of the infant's birth. Vaccination can be done at a chronological age of 1 month or at hospital discharge. For infants born to HBsAg-positive women, hepatitis B immune globulin and hepatitis B vaccine should be administered within 12 h of birth, regardless of weight.

- c) MMR and varicella vaccines can be administered on the same day. If not, the two vaccinations should be separated by at least 28 days.
- d) HIV-infected children should receive immune globulin after exposure to measles. They may receive varicella and measles vaccines if their CD4+ T-lymphocyte count is $> 15\%$.
- e) Measles vaccination might suppress tuberculin reactivity temporarily. Measles-containing vaccine can be administered on the same day as tuberculin skin testing. If testing cannot be performed on the same day, it should be postponed for at least 4 weeks after vaccination. If a skin test is urgent, it should be understood that reactivity might be reduced by the vaccine.
- f) If a vaccinee experiences a presumed vaccine-related rash 7–25 days after vaccination, he or she should avoid direct contact with immunocompromised people for the duration of the rash.

Annex C: Review of interpersonal communication for immunization

Key steps

Each engagement with a caregiver, regardless of their position, is an opportunity to reinforce demand for immunization, identify and address fears, concerns, myths, misconceptions, improve the understanding of vaccine used, disease prevented, potential side effects and how to address them.

Listening

Use active listening techniques to identify continuum category and specific topic of concern:

Welcome: I'm glad to see you.

Nonverbal: giving and reading.

Empathy:

- *"I feel badly when my baby cries, too."*
- *"Being a mother these days is so challenging."*
- *"It's hard to make these decisions."*
- *"We all want the best for our children."*
- *"I hate when that happens to me."*
- *"That must have been very difficult for you."*
- *"You're not alone, a lot of people have this problem."*
- Nonverbal communication - sending and reading.

Open ended questions:

- *"What's on your mind?"*
- *"How do you feel about that?"*

Probing questions:

- *"Can you tell me more about that?"*
- *"Did I understand you correctly, did you mean?"*
- *"I'm not sure I got that. Please help me understand"*

Closed, leading questions:

- *"You're here for your child's vaccinations, right?"*

Reflective statements for unspecified concern:

- *"You seem concerned, let's talk it through together."*
- *"I see you're not ready. What would you like to ask me?"*

- *"It's great that you came in to get your son vaccinated, but you seem unsure. What would make you feel more comfortable?"*
- *"You seem a bit anxious- how can I help you?"*
- *"I'm hearing that you are a bit worried today."*

Reflective statements for specific concerns:

- *"So, you are concerned about whether your child is too young to handle vaccines?"*
- *"So, you are worried that your child will have a fever after the vaccination?"*
- *"I'm hearing that you are concerned about vaccine side effects."*

Responding

Use responding techniques to address concerns, reassure and motivate:

- Identify probable goal for client communication depending on continuum category- advocate for vaccination, complete the vaccination schedule, accept today's vaccines, consider accepting, have a future discussion.

Structure the response:

- Structured response CASE Corroborate, About Me, Science, Explain/Advise.
- Structured interaction give overview of what you will do (discuss, sign consent form, vaccinate, review next steps, etc.).
- Tailor response to client profile, concerns, use child's name.

Establish common ground:

- Start with what you agree on, establishing common ground:
 - *"I understand that you want the best for your child, and I do too. I care very much about my patients."*
 - *"You are right, children today certainly get more vaccinations than children did years ago."*
 - *"You and I both want your child to be protected against things that might harm her."*
 - *"I can see why you might want more information."*
 - *"It's true, some children may have mild side effects from vaccines like sore arm or fever."*
- Address their concerns, don't ignore them, but don't repeat the misconceptions. *"It sounds as if you are worried. Let's look at what we know and talk about what to do."*
- Focus on the concept of protection.

Structure decision-making:

- Help decision-making by eliminating unimportant factors and unsuitable options, and then comparing the most important options:
 - *"How do you feel about this?"*
 - *"What part of this do you agree with?"*
 - *"What part of this do you have a problem with?"*
 - *"What would make you feel more comfortable about this?"*
 - *"How can I help you think through this?"*
 - *"What would help you make a decision?"*
 - *"Could you tell me a little more about what you heard?"*

- *"It sounds as if you are concerned about X, but you also want to make sure your child is protected. Do you think you can go ahead and do what most parents do and vaccinate?"*
 - *"Is there anything else you need to know before you make a decision?"*
 - *"OK, can we just talk it through, so I understand your decision?"*
- Two distinctions to make:
 - Differentiate between common mild side effects and extremely rare severe side effects.
 - Compare risks/inconvenience of these side effects versus risks/dangers of VPD.
- Say: *"Most people choose X."*
- Use rational and emotional appeals: science, stories and your heart.
- If the client misunderstands something, say: *"Sorry, maybe I didn't explain that very well."* And try explaining in a different way.
- Try to figure out what could be their trigger: *"What would it take for you to feel comfortable vaccinating your child today? /coming to the clinic for vaccination?"*

Techniques to use when giving information:

- Pausing (give them time to ask, think, give you time to read them)
- Chunking (splitting information into digestible chunks)
- Checking (checking for reaction, understanding)
- Rhetorical questions (We all want the best for our children, right?)
- Positive framing. Saying: *"90% have no side effects"* (versus saying *"10% have problems"*) or *"Almost all parents choose to protect their children by vaccinating on schedule"* versus *"Some parents choose not to vaccinate on time or at all."*
- Give control to caregiver: *"How does that sound?" "Are you okay with that?" "How would you feel about that?"*

Highlight your personal conviction:

- *"I strongly believe in the benefits and safety of vaccination."*
- *"I believe in vaccines so strongly that I vaccinated my own children and grandchildren on schedule."*
- *"I have vaccinated all of my children and feel very comfortable about it."*
- *"I keep up with the most recent scientific literature, and I am confident about vaccine safety."*
- *"I served on a committee that reviewed the vaccine schedule and I feel very confident that it's the best approach."*
- *"I just attended a conference that emphasized the risks of late vaccination during the current measles outbreak."*
- *"As a result of my own questions, I have read the latest studies to ensure I have all the facts."*

Share your personal experience:

- *"I have vaccinated 1000s of babies and I have never seen anything more severe than crying, a sore arm, or a fever."*
- *"As an FLW, I have seen the difference this new vaccine makes; we see many fewer children with [name of disease]."*
- *"This office has given thousands of doses of vaccines and we have never seen a serious reaction."*
- *"In my experience, my patients handle the pain of that shot and any minor side effects easily."*

The social norm that responsible parents vaccinate:

- *"Almost all parents around here vaccinate their children to ensure their child is safe and well cared for."*
- *"It's the right thing to do to protect your children and to protect others."*

Express your concern and care for their child:

- *"I am worried about leaving your child unprotected against the dangers of these diseases."*
- *"I care very much about your child's welfare, as you do, and I would never recommend anything that I thought wasn't in her best interest."*
- *"I want what's best for her, too."*
- *"I would be worried if you chose not to protect your child."*
- *"These days, these shots are even important to protect him, especially now that there are so many outbreaks of serious diseases."*
- *"Our practice follows the national schedule because it is carefully designed to protect children as soon as possible, at the time they are most vulnerable to disease."*

Safety and quality of vaccines:

- As discussed during Session 5.2, reassure about origin and quality of vaccines, and your safe handling/injection techniques
- Quote science:
 - *"Although children get more vaccinations today, they actually receive smaller amounts of material than back when they got fewer vaccinations, because technology has enabled us to make vaccines that have only the part of the cell that induces immune response. "*
 - *"The immunological challenge from a vaccine is nothing compared to what kids get every day. An ear infection is a bigger immunological challenge for your child's system, or even playing on the playground. "*
 - *"It's been estimated that your child's immune system is so strong, it could handle 10,000 immunizations at once."*
 - *"Studies involving hundreds of thousands of children demonstrate the vaccine's safety with only a tiny risk of major side effects- about the same risk as the risk of being hit by lightning."*
 - *"Your risk of having a severe reaction, like anaphylaxis, is about the same as being struck by lightning, about 0.0001th of a percent (one in a million, but better to frame as a percentage)."*
 - *"Getting immunized against varicella also reduces your child's chance of contracting a very dangerous flesh-eating disease. A child's risk of developing certain infections such as flesh-eating disease is 40–60 times greater when they have been infected with the varicella virus."*

Give your strong recommendation:

- *"If I were in your shoes, I would go ahead and protect my child by giving her the shots."*
- *"Vaccination is the right thing to do to protect your child."*
- *"I strongly recommend your child get these vaccines today."*
- *"It's hard to watch your child crying while getting a shot or having a sore arm. But it's worth it to know he is getting the protection he needs for a long, healthy life."*
- *"We want all the children in our practice to be immunized so that they are well protected and have the greatest chance for a long, healthy life. If it were my child, I would follow the schedule to protect her as much as I could."*

Buying time:

- *"I hear what you're saying..."*
- *"That's a good question!"*
- *"That's a question many people ask about."*
- *"Let me think about that for a minute."*
- *"That's a good question, and I'm afraid I don't have a good answer. Let me check in my WHO reference guide/ask a colleague/ask my supervisor, or I can give you a website to look at."*

Decrease vaccine pain or handle refuser

- Help caregivers use distraction and soothing to decrease pain and stress of immunization.
- If parent refuses vaccine, clarify delayer/refuser's responsibilities.

Check client understanding

Check that client understands and can repeat back to you the next steps:

- *"Can you tell me what you understood about which presents more risk - vaccines or the diseases they prevent?"*
- *"So, tell me again, what will you do to make your baby feel more comfortable after these shots?"*
- *"I just want to make sure I was clear enough; can you repeat when will you come back for your next shots?"*
- *"Can you repeat back to me what you need to do if your child gets sick, since he hasn't had his shots?"*

Send client away feeling cared for

Finish with affirmation of client, even if they have not chosen to vaccinate today.

- *"I want to congratulate you for doing such a good job of taking care of your child. I look forward to seeing you in a month."*
- *"I am so proud of the many parents like you who make the effort to keep their children protected and to protect others. Is there anything else I can do for you?"*
- *"As your child's doctor, I am worried about her being unprotected from these diseases, but I respect you for listening to what I have to say and why I am concerned. Thanks for coming in and please don't hesitate to come back if you would like to discuss some more."*

Tools to support discussion

- Visuals, e.g. community immunity.
- Brochures.
- Graphs.
- Reference tables.

What works

(Based on numerous peer-reviewed scientific journal articles⁵⁰)

1. **Tailoring:** use the child's name, tailor the content to caregivers' concerns, and establish a common bond. *Example:* child the same age or a favourite colour.
2. **Frame the discussion:** Make the discussion about "being protected" rather than about vaccine safety.
3. **Make those who accept vaccination more visible:** build on and reinforce vaccination as a social norm. Use words like "almost all caregivers" or "Scientists agree" on the importance of immunization.
4. **Show that being unprotected is socially unacceptable** and is an irresponsible thing to do.
5. **Guide** caregivers to reliable sources of information.
6. **Actively counter misinformation** without being confrontational or dismissive.
7. **Use simple visual aids:** Brochures that are easy to understand, visually appealing, and that facilitate discussion increase mothers' confidence in vaccination, and have been shown in one study to reduce belief that multiple vaccines overload the immune system.
8. **Assist with decision-making:** This is extremely important, since sometimes "analysis paralysis" leads people to make no decision at all. People end up with decision fatigue, and they need help making a decision or want someone else to decide for them. One easy technique is to use "social proof," saying "*Most people prefer to XYZ*" or "*Most people choose ABC.*" People think that if other people are choosing that option, then they probably should too.
9. **Structure decision-making** to eliminate unattractive or unimportant factors to help people narrow down their choices to those that seem most suited. If you help caregivers identify what things are really important to them, and eliminate the small issues, that will simplify their decision.
10. **Use rational and emotional appeals** together.
11. **Provide accurate information** about the effectiveness of vaccination, as well as about the risks: "*Vaccinations are almost 100% safe, but they, like everything else is not 100% safe. We are exposed to risks every day – we give our children baby aspirin and antibiotics, we*

50 The review by ECDC

take them in the car, we take them for walks in the park where they could be hit by lightning or crushed by a falling tree branch... But we balance the risks and decide which is better for our child, knowing we can't eliminate every possibility of risk. We need to apply the same approach to vaccination."

12. **Use numerical and graphic data** to compare the potential risks of the MMR vaccine with the potential risks of measles, mumps and rubella. This has been shown to be effective.
13. **Use one rhetorical question:** *"Do you want to protect your daughter against pneumonia?"* or *"If there was a vaccine to protect your daughter against pneumonia, would you have her get it?"* Note: A study using these types of questions found that using both kinds of rhetorical questions together or using one rhetorical question and one graphic representation of the risks, seemed to act as overkill. Caregivers were less likely to intend to vaccinate when they were presented with the double approach. They may have been resisting what they perceived as too much pressure.
14. **Positioning:** As part of our brain biases, we tend to prefer choices that are in the middle. If you offer three options, a basic, a medium, and a top version, most people will choose the one in the middle. Manufacturers will take a basic cell phone and then add two additional levels of features to it to make a medium phone and a luxury version. Not because they expect many people to buy the luxury version, but because its presence makes the phone in the middle seem like the right choice. Even someone who only wanted a basic phone will often end up "upgrading" to the middle version. If you can present your desired outcome as something in the middle of two other choices, there is a higher probability that someone will accept it.
15. **A reduced coverage message helped improve intention to vaccinate:** *"Last year, 93% of children in one country got their MMR shot on time. Only 56 people got measles last year. This could change if too many caregivers chose not to have their child get the MMR shot. If only 73% of people had their MMR shot, many more people would get measles. For example, in a town of 50,000 people, about 1,900 would get measles. About 380 of those people would be sick enough to have to go to hospital."*
16. **Present scary things in percentages and present positive things in frequencies.** Research has shown that people are less afraid of a risk when you say: *"Only one tenth of one percent of people will have a problem"* versus *"Only one out of every thousand people will have a problem."* Somehow people can imagine themselves as that one out of a thousand people, but they have a harder time imagining themselves as representing that one tenth of one percent of people.
17. **Decrease pain and stress during vaccination** by relaxing, rehearsing, blowing out the pain, distraction, rubbing the skin near (not on) the injection site, breastfeeding, positioning, sugar water, topical analgesia, etc. Remember the video clips?
18. **Make the "vaccination journey" easier:** increased accessibility, better welcome and patient flow, scheduling, and timing has been shown to increase uptake.

What doesn't work

1. Vaccine-hesitant caregivers often perceive information provided by health providers as incomplete or biased. Too much pressure or contradiction of caregivers' beliefs can turn them off completely.
2. Mentioning risks without doing a full risk-benefit comparison, as in the table of VPD and vaccine risks, has been shown to decrease intention to vaccinate in hesitant caregivers.
3. One study found that messages using dramatic narratives and visuals were not successful they increased misperceptions about MMR and did not increase intention to vaccinate in caregivers with the least favourable vaccine attitudes.
4. Expending much effort to convince anti-vaccinators that their opinions are wrong.

Key messages on MMR diseases⁵¹

Measles:

- The number of children catching measles is rising.
- Measles is one of the most contagious infectious diseases.
- To be protected, children need to be vaccinated twice with the MMR vaccination, which also protects them against mumps and rubella.
- If unprotected, the child is almost certain to catch measles if in contact with an infected person.
- The child will be at risk of severe complications if infected with measles after reaching adulthood.
- Measles are likely to cause long-time illness and severe complications in adults.
- The complications of measles include chest infections, fits, swelling of the brain, and brain damage, possibly leading to death.
- It is never too late to get vaccinated against measles.

Mumps:

- To be protected, children need to be vaccinated twice with the MMR vaccination, which also protects them against measles and rubella.
- If unprotected, the child can catch mumps if in contact with an infected person.

Rubella:

- Rubella is a highly contagious disease which puts unborn children at high risk.
- If a pregnant woman is infected within the first 20 weeks of pregnancy, the child is at high risk of being born with a range of serious life-long disabilities. Spontaneous abortion occurs in up to 20% of cases.
- Anyone who is not immune to rubella can pass on the virus. Get vaccinated now – don't wait until you or someone close to you is pregnant.

⁵¹ European Centre for Disease Prevention and Control. Conducting health communication activities on MMR vaccination. Stockholm ECDC; 2010

Complications from Measles, Mumps and Rubella:

- Measles may lead to complications in as many as 20% of all cases, and it is worse in adults. Measles may cause chest infections, fits, encephalitis (swelling of the brain) and brain damage, sometimes causing death. About one in 1,000 measles cases develop encephalitis, and 25% of those affected will never be able to go back to regular school or hold a normal job. Between one in 1,000 and one in 3,000 measles cases result in death.
- Mumps can cause viral meningitis, permanent deafness and encephalitis. Rarer complications include inflammation of the pancreas, ovaries and testicles. In pregnant women, there is a severe risk of miscarriage when infected during the first trimester.
- Rubella can cause congenital rubella syndrome (CRS) which can occur when a woman becomes infected during the first trimester of pregnancy. CRS may cause fatal death, premature delivery and serious birth defects. Rubella can also cause encephalitis in one in 6,000 cases. Other complications include low platelet levels, haemorrhage and pain, and/or swelling of the joints.

MMR and autism:

- Autism is such a strong and emotive issue and something we all care about. However, the link made by one doctor to autism has been firmly discredited, and I can show you study after study that demonstrates that there is no link between the MMR vaccine and autism. Unfortunately, once a seed of doubt has been planted it tends to grow and is fuelled by sensational media and internet coverage that isn't concerned with the facts. The real issue here is the very real risks from not being protected. I wish the voices of those who have been victims of not getting vaccinated could be heard more loudly and clearly.

Annex D: If you choose not to vaccinate

If you choose not to vaccinate your child, understand the risks and responsibilities⁵²

If you choose to delay some vaccines or refuse some vaccines entirely, there can be risks. Please follow these steps to protect your child, your family, and others.

With the decision to delay or refuse vaccines, you are taking on an important responsibility that could put your child's health and even life into risk

Any time that your child is ill and you:

- **make an emergency call;**
- **ride in an ambulance;**
- **visit a hospital emergency room; or**
- **visit your child's doctor or any clinic**

you must tell the medical staff that your child has not received all the vaccines recommended for his or her age. Keep a vaccination record easily accessible so that you can report exactly which vaccines your child has received, even when you are under stress.

Telling healthcare professionals your child's vaccination status is essential for two reasons

- When your GHIA is being evaluated, the doctor will need to consider the possibility that your child has a vaccine-preventable disease, such as measles, mumps, pertussis or diphtheria. These diseases still occur, and the doctor will need to consider that your child may have one.
- If your child has a vaccine-preventable disease, the healthcare workers who help your child can take precautions, such as isolating your child, so that the disease does not spread to others.

⁵² World Health Organization, Regional office for Europe

Some people are at higher risk of infection

One group at high risk for contracting disease is infants who are too young to be vaccinated. For example, the measles vaccine is not usually recommended for babies younger than 9-12 months. Very young babies who get measles are likely to be seriously ill, often requiring hospitalization.

Other people at high risk of contracting diseases are those with weaker immune systems, due to other existing diseases or medications they are taking (such as some people with cancer, autoimmune diseases or transplant recipients).

Before an outbreak of a vaccine-preventable disease occurs in your community

- Ensure that your child is adequately immunized for his or her age according to the routine immunization schedule.
- Talk to your child's doctor or nurse to be sure your child's medical and immunization records are up to date regarding vaccination status. Ask for a copy of the updated record.
- Keep your child's school, childcare facility and other caregivers updated on your child's vaccination status.
- Be aware that unimmunized children can catch diseases from people who don't have any symptoms. You cannot tell who is contagious.

Communities depend on high immunization coverage to keep vaccine-preventable diseases from spreading. The more parents who choose not to vaccinate their children, the greater the risk of spreading diseases.

You put not only your child but also your community at risk when you decide not to vaccinate.

When there is vaccine-preventable disease in your community

- It may not be too late to get protection by getting vaccinated. Ask your child's doctor.
- If there are cases (or in some circumstances, a single case) of a vaccine-preventable disease in your community, you may be asked to take your child out of school, childcare or organized activities (for example, playgroups or sports).
- Your school's childcare facility or other institution will tell you when it is safe for an unvaccinated child to return. Be prepared to keep your child home for several days or up to several weeks.

- Learn about the disease and how it is spread. It may not be possible to avoid exposure.
- Each disease is different, and the time between when your child might have been exposed to a disease and when he or she may get sick will vary. Talk with your child's doctor to get their guidelines for determining when your child is no longer at risk of coming down with the disease.

BEWARE

- Any vaccine preventable disease can appear at any time in the European Region because all of these diseases still circulate either here or elsewhere in the world.
- Sometimes vaccine-preventable diseases cause clusters of cases and outbreaks, i.e. an increased number of cases in a given time and area.
- For some diseases, one case is enough to cause concern in a community. An example is measles, which is one of the most contagious diseases known. This disease spreads quickly among people who are not immune.
- In most cases, there is no way to know beforehand how severe diseases will be in your child.

Learn more by asking your health care provider for the sheet titled **"Vaccine-preventable diseases: signs, symptoms & complications"**

If you know your child is exposed to a vaccine-preventable disease for which he or she has not been vaccinated

- Learn the early signs and symptoms of the disease.
- Seek immediate medical help if your child or any family members develop early signs or symptoms of the disease.

IMPORTANT

Notify your doctor, local medical facility, ambulance or emergency room personnel that your child has not been fully vaccinated before medical staff have contact with your child or your family members. They need to know that your child may have a vaccine-preventable disease so that they can treat your child correctly as quickly as possible. Medical staff also can take simple precautions to prevent diseases from spreading to others if they know ahead of time that their patient may have a contagious disease.

- Follow recommendations to isolate your child from others, including family members, and especially infants and people with weakened immune systems.
- Be aware that for some vaccine-preventable diseases, there are medicines to treat infected people and medicines to keep people they come in contact with from getting the disease.
- Ask your healthcare provider about other ways to protect your family members and anyone else who may come into contact with your child.
- Your family may be contacted by the state or local health department that tracks infectious disease outbreaks in the community.

If you travel with your child

- Review the WHO travellers' information website (www.who.int/topics/travel) before travelling to learn about possible disease risks and vaccines that will protect your family. Diseases that vaccines prevent remain common throughout the world.
- If you are aware that you or your child have a vaccine-preventable disease, do not spread disease to others. Do not travel in such condition, as you or other family members could still be infectious. If an unimmunized person develops a vaccine-preventable disease while travelling, to prevent transmission to others, he or she should not travel by a plane, train or bus until a doctor determines the person is no longer contagious. In certain instances, public health authorities may prevent you from travelling, due to the risk of disease spreading.

Check your own status

- Make sure to check your own immunization status, as you are putting your child at risk of disease when you are not fully vaccinated.

For more information on vaccines, visit:

<http://www.euro.who.int/en/health-topics/disease-prevention/vaccines-and-immunization/publications/communication-and-advocacy/immunization-resource-centre>

Annex E: Handouts

Handout 1. 3-Day training sample agenda

*Note: Registration begins at 8:30

	Day 1	Day 2	Day 3
9:00-10:30	(9:00-9:15) Opening Remarks (9:15-10:30) Module 1: Introduction and Overview	Module 4: Active Listening to Understand Your Caregiver	Module 6: Communication in Depth, continued
10:30-10:45	15 Minute Break	15 Minute Break	15 Minute Break
10:45-12:30	(10:45-11:15) Module 1: Introduction and Overview, continued (11:15- 12:30) Module 2: Immunization Technical Review	(10:45- 11:15) Module 4: Active Listening to Understand Your Caregiver, continued (11:15- 12:30) Module 5: Communication During Immunization	(10:45- 11:30) Module 6: Communication in Depth, continued (11:30-12:30) Module 7: IPC in communities
12:30-13:30	1 Hour Lunch	1 Hour Lunch	1 Hour Lunch
13:30-15:00	(13:30-14:30) Module 2: Immunization Technical Review, continued (14:40 -15:00) Module 3: Understanding Behaviour & Barriers	Module 5: Communication During Immunization, continued	(13:30-14:05) Module 7: IPC in communities, continued (14:05 -15:00) Module 8: Review, Next Steps, and Closing
15:00-15:15	15 Minute Break	15 Minute Break	15 Minute Break
15:15-17:00	Module 3: Understanding Behaviour & Barriers, continued	(15:15- 16:00) Module 5: Communication During Immunization, continued Module 6: Communication In-depth (16:00- 17:00)	Module 8: Review, Next Steps & Closing, continued

Handout 2. Pre-test questionnaire

Please give yourself a Code Name: _____

Circle your responses to the following questions

1. Your role in vaccinating your patients is to encourage them to complete vaccination even if they are hesitant.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

2. I know how to handle caregivers who refuse to accept all or some vaccinations.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

3. In general, I am comfortable giving explanations to my patients about the value of vaccines.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

4. In general, I am comfortable giving explanations to my patients about the safety of vaccines.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

5. In general, I am comfortable giving explanations to my patients about contraindications.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

6. In general, I am comfortable giving explanations to my patients about AEFI's.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

7. Measles is a very serious disease.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

8. The vaccine against measles does not cause autism

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

9. The vaccine against hepatitis B is effective in preventing this disease.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

10. I feel comfortable discussing how to handle mild vaccine side effects.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

11. I feel comfortable discussing rare but severe vaccine side effects.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

12. Waiting until a child starts to speak before giving MMR, puts that child and other unimmunized children at risk.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

13. Childhood immunization is one of the most effective health interventions ever.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

14. Childhood immunization is less expensive than treating childhood diseases.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

15. Perceived mistreatment by service providers is an important reason some caregivers do not get their children fully vaccinated.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

16. The quality of the interaction between health workers and caregivers is a key factor in ensuring completion of the vaccination schedule.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

17. If caregivers trust FLWs, they are more likely to get their children immunized.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

18. You should not spend much time with a vaccine refuser.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

19. I feel well-prepared to handle difficult conversations about vaccination with my patients.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

20. I have a solid set of skills for understanding my patients' needs and creating trust with them.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

21. Please list four active listening skills.

1.

2.

3.

4.

22. Please list five phrases to use with a caregiver who has hesitation about vaccination.

1.

2.

3.

4.

23. Please list the five categories of vaccine attitudes.

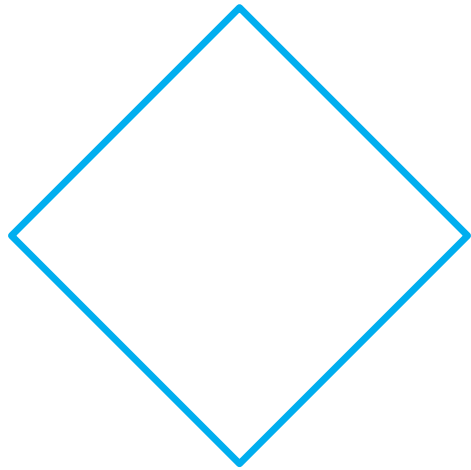
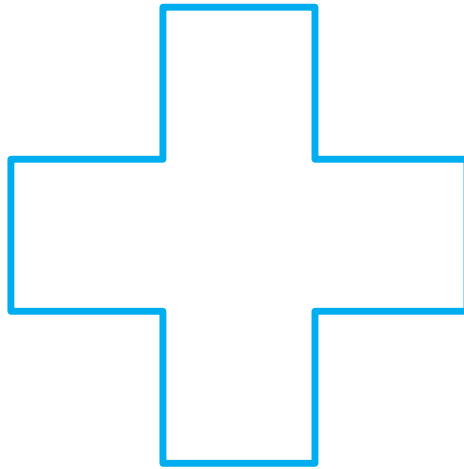
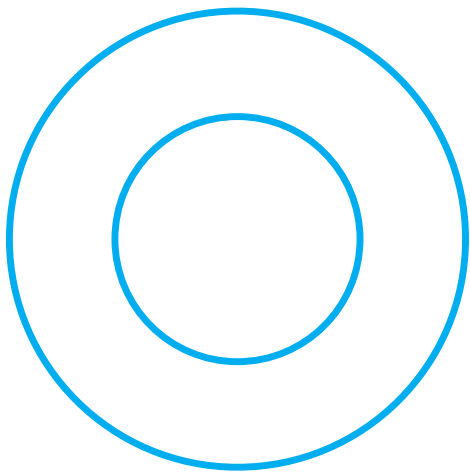
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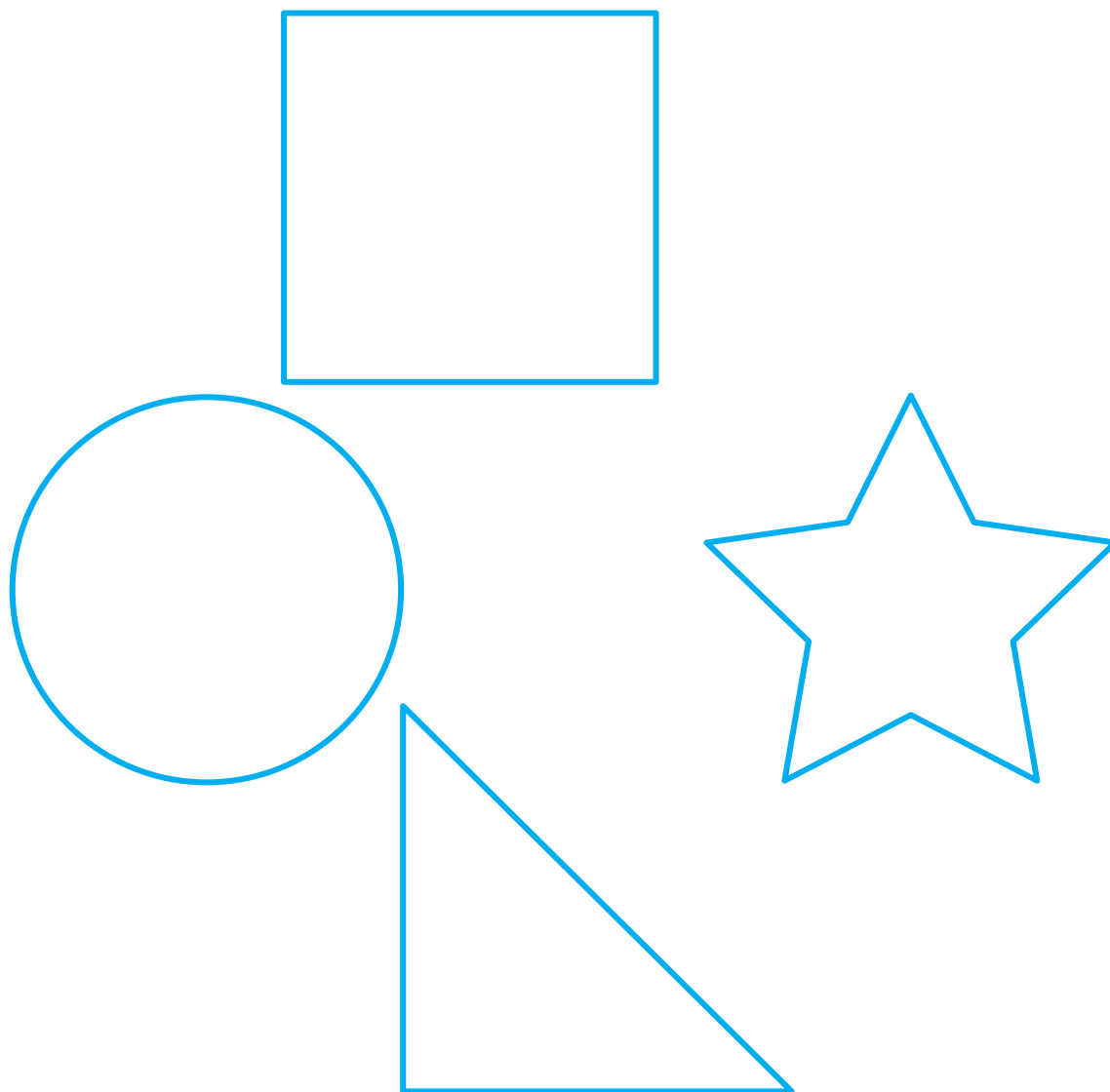
2.

3.

4.

24. Please describe the best way to communicate with a vaccine denier.

Handout 3. Picture A

Handout 4. Picture B

Handout 5. Scenario slips

Instructions

- Cut up so that each scenario is on an individual slip of paper. Do not print front to back.
- Ensure you have two copies of each scenario, so that after the first person in the pair plays the caregiver with a hidden problem, the second person can choose another scenario to act out the caregiver with the hidden problem.

1. A caregiver brings her child in for a cough. She is behind on her vaccination schedule because she is worried about the quality of vaccines. She has heard that the government is importing low quality vaccines to save money.

2. A caregiver is reluctant to have her child with a cold vaccinated, she's worried it will make the child sicker.

3. A caregiver is worried about giving multiple vaccines at once- he thinks that this will increase the side effects, and he doesn't want the child to be sick "for nothing."

4. Mrs. Ilić has a home visit from the visiting nurse for a routine check-up for Baby Drago, but she is not planning on getting the next set of shots for him. She hates to see Drago in pain and was very upset with how much Drago cried during the last session with Dr. Vera, and she is not willing to go through that again.

5. A Roma caregiver thinks the child is not old enough to handle all those germs. She wants to wait until the child is older to continue with vaccination.

6. A community leader is worried about safety: "I'd like someone to give a guarantee that the vaccine is OK. I watched like a hundred times on TV that vaccines are not OK, that they are harmful, that someone fell terribly ill. It makes one go mad."

7. A caregiver returns with the child to the clinic the day after his immunization because he is crying a lot and has had a fever for two days after vaccination.

Handout 6. Goals for caretakers

Instructions

- Do not print on both sides.
- Cut out statements to make individual slips.
- Not everyone needs a copy. Randomly distribute slips to various participants in the plenary - maybe those who need to be encouraged to participate more.

Have caregiver speak positively of health workers' competence and caring.

Keep the caregiver coming in on time till the child is fully immunized.

Caregiver is aware of the risks of not immunizing the child and the risks an unimmunized child can pose others e.g. at clinic and knows what to do if the child gets sick.

Trust is beginning to be established.

Caregiver feels their concerns are heard and is not critical of providers.

Feels rapport and trust with health worker, despite disagreement.

Trust is now established between caregiver and health worker.

Caregiver willing to move a step further towards full and timely immunization, or willing to come in again to discuss it after reading/ discussing further at home.

Help caregiver become an advocate, reinforcing vaccination as a social norm.

Caregiver now prepared to think about vaccination and consider attending specialist clinic or make a special appointment for further discussion.

Caregiver now accepts decision to vaccinate, is less hesitant.

Keep the caregiver coming in on time till the child is fully immunized.

Caregiver now feels positive, less worried about their decision to vaccinate.

Handout 7. Character information

CASE role play

Instructions: Give the scenario to each person playing the role of Mrs. Ilić

- Mrs. Ilić, you know you are getting a home visit from the visiting nurse for a routine check-up for baby Drago. You know that Drago's next shots are overdue.
- Don't say the following immediately, make the nurse work for it: You are not planning on getting the next set of shots for him.
- You hate to see Drago in pain, and you don't think it's worth it.
- You were very upset with how much Drago cried during the last session with Dr. Vera, and you are not willing to go through that again.

Handout 8. Caregiver scenario 1

Instructions: Give Scenario to the 1st caregiver character in each group.

You are a first-time mother. You are fairly sure your baby was vaccinated at birth, at the health centre. You are coming in because your baby has a cough and runny nose. You haven't planned on vaccinating your child because you have heard rumours that vaccinations are dangerous.

- If the FLW suggests getting your child vaccinated, you respond that you are worried about the dangers of vaccines.
- If they probe more, you will say you heard that vaccines can cause dangerous side effects. If they probe even more, you will say you have heard that vaccines can cause autism and paralysis.
- If the FLW doesn't probe much, you can say you don't think you are ready to vaccinate. Don't allow vaccination until they encourage you to express your concerns, as described above.
- If the FLW has probed enough to understand your concerns and gives you some good reassurance about how rare dangerous side effects are, and they give you a reasonable explanation about the false information about the link between autism and vaccines, then you can say you still aren't ready and you need to think about it.
- If the FLW asks you an open-ended question that encourages you to express your concern, then you can say that you think you will vaccinate your child later, but you don't think it is safe to vaccinate your child now because she has a cold.
- If the FLW reassures you that it is safe to vaccinate even if the child has a cold, then you say you don't want to make your child suffer so much pain during the shots.
- If they explain how you can decrease the pain during the shots, you agree to vaccinate.

Handout 9. Observation checklist

Instructions: Give one handout to each person for use when they play the role of observer.

Observers: Please check all that are used by the FLW.

A: Listening skills:	
Welcome	<input type="checkbox"/>
Nonverbal communication: giving and reading	<input type="checkbox"/>
Empathy	<input type="checkbox"/>
Open ended questions	<input type="checkbox"/>
Probing to understand further	<input type="checkbox"/>
Leading questions	<input type="checkbox"/>
Reflecting questions or statements	<input type="checkbox"/>
B: Responding skills:	
Structured response - road map/signposting, CASE	<input type="checkbox"/>
Tailoring - using child's name, caregiver concerns	<input type="checkbox"/>
Starting with what you agree on - common ground	<input type="checkbox"/>
Pausing, chunking, checking	<input type="checkbox"/>
Assist in decision-making: <i>"Most parents choose X," or "It sounds as if XYZ is really important to you. Option B sounds like it would suit your needs best."</i>	<input type="checkbox"/>
Identifying what it would take - a trigger or cue to action - for hesitator	<input type="checkbox"/>
Personal conviction	<input type="checkbox"/>
Personal experience	<input type="checkbox"/>
Use science and stories, facts and your heart	<input type="checkbox"/>
FLW's concern and care for the child	<input type="checkbox"/>
Strong recommendation: <i>"If it were my child, I would vaccinate!"</i>	<input type="checkbox"/>

C: Content:	
Encouraging/praising caregiver for coming in or for caring	<input type="checkbox"/>
Focus on concept of protection	<input type="checkbox"/>
What to say about the consent form	<input type="checkbox"/>
Safety and quality of vaccines	<input type="checkbox"/>
Immunological challenge of vaccines is very small compared to normal environment or an ear infection.	<input type="checkbox"/>
Most children don't have any problem other than a quick cry during the injection.	<input type="checkbox"/>
Some children may experience mild side effects such as slightly sore or swollen arm, or a fever. Severe side effects are extremely rare.	<input type="checkbox"/>
We welcome you to come back if you have any questions or worries.	<input type="checkbox"/>
We want you to feel confident, as we do, that vaccination is the best way of protecting your child.	<input type="checkbox"/>
Extremely rare side effects of vaccines are much less of a risk than the diseases they protect against.	<input type="checkbox"/>
Decrease pain and stress during vaccination	<input type="checkbox"/>
How to reduce side effects at home like painful arm or fevers	<input type="checkbox"/>
Checking caregiver understanding of next steps	<input type="checkbox"/>
For refusers, ensuring they know their responsibilities to protect others	<input type="checkbox"/>
D: Tools	
Use of visual aids	<input type="checkbox"/>
Use of FAQs	<input type="checkbox"/>
Use of tables in manual	<input type="checkbox"/>

Handout 10. Caregiver scenario 2

Instructions: Give the Scenario to the caregiver character in each group after teams have rotated roles.

You are a mother of three. You vaccinated your first two children. You are coming for a six- month check-up for your third child.

- If the FLW suggests getting your child vaccinated, you respond that you don't want to get any more vaccinations.
- If the FLW probes, you will say you don't think that vaccines are that important.
- If the FLW encourages you to say more about this, you can say you feel that VPDs are easy enough to treat or cure, why risk the side effects of vaccinations that everyone talks about.
- If the FLW responds well to this by explaining that the risk of serious effects from VPDs are much higher than the risks of any severe side effects from vaccination, you can say thank you for explaining the relative risks of disease and vaccines. But you aren't ready to vaccinate yet.
- If the FLW uses good listening skills like reflecting and probing to help you express your concerns, you can tell her that even though vaccination seems like a good idea, you don't want to give your child any more vaccinations because you are afraid of giving him too many vaccines at once.
- If the FLW has probed enough to understand your concerns and gives you some good reassurance about giving several vaccines at once, then you can say- I just don't know what to do.
- If the FLW does a good job helping you think through your concerns, and helps bring you towards a decision to vaccinate, you can say you still aren't ready and you need to think about it.
- If the FLW asks you an open-ended question that encourages you to express your concern, and says something like *"what would it take for you to feel comfortable vaccinating your child,"* then you can say that you just don't want to make your child suffer so much pain after vaccination- the last vaccines made your child very fussy afterwards for several days.
- If they respond well to that, then you agree to vaccinate.

Handout 11. Caregiver scenario 3

Instructions: Give Scenario 3 to the caregiver character in each group.

You are a father of two. You refused to vaccinate your first child. You are coming for a 12-month check-up for your second child, who has not received any vaccines except BCG at birth. You are vocally opposed to vaccines and feel that they are dangerous. No matter what the FLW says, you are not going to accept vaccination.

The only real goal for this visit would be to maintain a positive relationship between the caregiver and the FLW, and to make sure the caregiver understands their responsibilities in terms of not bringing their sick, unvaccinated child into the clinic without notifying the clinic, so they can avoid infecting other patients.

- The emphasis here is seeing if the health worker can find ways to keep you from getting defensive, and tries to keep the communication positive, not confrontational.
- If the FLW suggests getting your child vaccinated as part of the check-up, you respond in a hostile manner that you don't want your child to receive any vaccinations, and you don't want to listen to any lecture about vaccines.
- If the FLW doesn't immediately realize you are a hesitator, and they don't put on the brakes and back off, then you can escalate your refusal, refuse to discuss any more, even shout at the FLW. If the FLW does realize they have to back off, slow down and open up, you can then continue the discussion. If they keep pushing you and making you feel criticized, you can stand up and walk away.
- If the FLW asks you about your reasons for refusing vaccines in a non-confrontational, maybe reflecting manner, such as *"It sounds as if you don't want your child to be vaccinated. Do you mind telling me more about your thoughts on this?"*- then you say you feel like it should be your choice, and you become calmer.
- If the FLW asks *"Why don't you want any vaccines?"*- using the word WHY, or if they are somewhat confrontational with you, if they don't immediately become very calm, open and understanding- you will get angry and defensive and say you don't want vaccines because they are being imposed on the population by an overly-authoritarian government which has ties to the corrupt pharmaceutical industry. Stand up like you are going to walk out of the office.
- If the FLW does a good job in being non-confrontational and not putting you on the defensive, using extremely humble, open and non-judgmental approaches, you can have a calm discussion, be open to coming back to talk again, thank the FLW for their time, etc.

You will not accept vaccines, but you say will be open to discussion in the future, and you will agree to notify the clinic if your child is sick so that when you bring your child in, the clinic can make sure there's no chance you might infect others.

Handout 12. Roma community health mediators



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Roma health mediators - empowering communities

The Krasnici family is only one of 160 in the settlement whose children have, thanks to mediator Aleksandra, received the protection they need from infectious diseases, including measles.

Jelena Terzic

26 January 2018

Belgrade, Serbia - Five years ago, Roma health mediator Aleksandra Paunovic entered the home of six-member Roma family Krasnici.

The parents, Nadja and Naser, expected help from her, and it soon became clear to the children that they would grow to love her, as they say, as aunt. Djevahire, who is now thirteen years old, recalls that day: "It was my birthday," she says smiling, "She was kind, she is still kind to us, she always helps us".

The health mediator sees that she could not even afford to buy a birthday cake for the girl that day, though she wanted to. At the time, Djeva and her brother, two sisters and parents needed more than just a cake.

"We did not have anything, just bare walls", recalls the mother Nadja Krasnici. Back then they moved from an informal settlement into a public housing apartment. They were displaced from Kosovo * and lived for more than ten years without basic necessities.

The family did not have a registered place of residence, documents or a steady income, and they relied on Aleksandra's help.

"We did not have anything, just bare walls."

mother Nadja Krasnici

"First we went through the registration procedure to obtain ID cards, healthcare insurance cards and registration at the local Primary Healthcare Center for their new address, as well as social assistance," explains the health mediator. Immunization of the four children followed. Until then, the children did not receive a single vaccine.

"If my child is not vaccinated, it's as if I do not have them, many diseases can attack them," Nadjija is now aware.

Health mediators know if every child is vaccinated, and they are up-to-date with the immunization schedule. They have an insight into the situation on the ground from the database that they regularly update on the computers in their offices in the primary healthcare center. Roma health mediators believe that the epidemic of measles was avoided in Roma settlements that they visit precisely because of the program they are part of.

"In every family we know the situation of every child, their age, and whether their vaccinations are updated or not. With these data we go to the pediatric nurse, see what is needed and then we call to warn the parents, and go with them to get their vaccinations," Aleksandra explains.

The Krasnici family is only one of 160 in the settlement whose children have, thanks to mediator Aleksandra, received the protection they need from infectious diseases, including measles. This was especially important during the epidemic of the epidemic in Belgrade, which started in early November 2017 and saw 408 registered cases.

Vaccination campaigns were organized in Roma settlements, involving epidemiologists, doctors and nurses, in cooperation with the Ministry of Health and the Institute for Public Health "Milan Jovanovic - Batut".

"There were dozens of children [vaccinated] during one of the vaccination campaigns. Many of them received their first vaccines as teenagers, but since we have been working with them, the response is great," says Aleksandra.

The database contains information, not just about vaccination, but about everything that Roma health mediators do for families whose homes they visit, whether they live in public housing or in non-residential settlements.

"If my child is not vaccinated, it's as if I do not have them, many diseases can attack them."

mother Nadja Krasnici

Roma health mediator Aleksandra Paunovic helped the Krasni family in the first years of the life of eight-year-old Gzim, who was born with a neurological health condition.

When these types of difficulties are recognized in a timely manner, their mitigation or elimination is more likely. That is why it is important for health mediators to help parents become involved in early intervention. Aleksandra says she is familiar with the complete history of child's disease.

"She scheduled every exam and followed up on it, sometimes even several times a week. We could have hardly done it without her," admits Naser Krasnici's father, while he practices with Gzim and his sister Fatmira, who attend the second and third grade of primary school. The children each give correct answers to their proud father.

"She also secured child allowance payments and disability support for Gzim," adds Naser.

"She scheduled each exam and followed up on it, sometimes even several times a week. We could have hardly done it without her."

father Naser Krasnici

The health mediators are Roma women and mothers. That's why it's easier for the families they help to take their advice.



"When we enter a family, first we meet the parents, the children and the older members of the family, write down all the information about them, and put it in the database. Then we start resolving specific problems.

There are many cases where we have to explain everything from the beginning: we also bring personal hygiene products and advise family how to use them, and we especially tell women how to protect themselves. They can always call us. Once we got a call at 1 am from a woman who went into labor. We rushed over, took a taxi and took her to a maternity ward. "Tatjana Stankovic, another Roma health mediator, describes just one part of her work.

"We visit new mothers and attend the baby's first weighing. We tell them about the importance of breastfeeding, and if a mother has lost her milk, we try to provide a breastmilk substitute, which is not cheap at all.

We also often encounter domestic violence. We have to be very careful then. We usually report it anonymously, through the Primary Healthcare Center, because we also have to take care of our own safety. But we never remain silent, "adds Tatiana.

The Ministry of Health launched the Roma health mediators project in 2009 as a response to the needs of Roma communities. UNICEF, in partnership with Telenor, supports this to strengthen the capacities of Roma health mediators and empower Roma communities to access their rights.

*Kosovo in accordance with United Nations Security Council Resolution 1244.



Handout 13. Post-test

Please give yourself a Code Name: _____

Circle your responses to the following questions:

1. Your role in vaccinating your patients is to encourage them to complete vaccination even if they are hesitant.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

2. I know how to handle caregivers who refuse to accept all or some vaccinations.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

3. In general, I am comfortable giving explanations to my patients about the value of vaccines.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

4. In general, I am comfortable giving explanations to my patients about the safety of vaccines.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

5. In general, I am comfortable giving explanations to my patients about contraindications.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

6. In general, I am comfortable giving explanations to my patients about AEFI's.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

7. Measles is a very serious disease.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

8. The vaccine against measles does not cause autism

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

9. The vaccine against hepatitis B is effective in preventing this disease.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

10. I feel comfortable discussing how to handle mild vaccine side effects.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

11. I feel comfortable discussing rare but severe vaccine side effects.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

12. Waiting until a child starts to speak before giving MMR, puts that child and other unimmunized children at risk.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

13. Childhood immunization is one of the most effective health interventions ever.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

14. Childhood immunization is less expensive than treating childhood diseases.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

15. Perceived mistreatment by service providers is an important reason some caregivers do not get their children fully vaccinated.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

16. The quality of the interaction between health workers and caregivers is a key factor in ensuring completion of the vaccination schedule.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

17. If caregivers trust FLWs, they are more likely to get their children immunized.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

18. You should not spend much time with a vaccine refuser.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

19. I feel well-prepared to handle difficult conversations about vaccination with my patients.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

20. I have a solid set of skills for understanding my patients' needs and creating trust with them.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

21. Please list four active listening skills.

1.

2.

3.

4.

22. Please list five phrases to use with a caregiver who has hesitation about vaccination.

1.

2.

3.

4.

23. Please list the five categories of vaccine attitudes.

1.

2.

3.

4.

24. Please describe the best way to communicate with a vaccine denier.

Handout 14. Workshop evaluation

Please complete the following sentences with the best word or phrase to describe your reactions to the workshop.

1. I felt like I most wanted to participate when

2. The key concept from the workshop that I took away was

3. The facilitators were

4. The atmosphere can be described as

5. The sequence/flow of activities was

6. If I were leading the workshop, I would have done _____
_____ **differently.**

7. My favourite module was Module _____ Why?

8. My least favourite module was Module _____ Why?

Please rate the following aspects of the workshop by circling your response.

9. I felt supported in trying to use the tools or techniques learned in this module.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

10. This workshop did not provide me with any new skills.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

11. This workshop will not change how I communicate with caregivers on immunization.

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

12. I would rate this workshop as:

Strongly Disagree					Strongly Agree				
1	2	3	4	5	6	7	8	9	10

Handout 15. Scoring guide for pre- and post-tests

The respondents indicate their level of agreement with 20 statements using a ten-point scales. “1” on the scale is “Strongly Disagree” and “10” is “Strongly Agree”.

To score this section of the test, sum the numbers selected for each of the 20 questions. A perfect score is 200 (20 total questions with a “10” selected for each).

There are four additional open-ended questions. A perfect score for this section is 150 points.

A perfect score for the entire test adds up to 350 points. To convert to a percentage 350 points would be 100%. There is no explicit threshold for “passing” the test.

Here are the correct answers for the open-ended questions.

1. Please list four active listening skills.

Ten points for answers containing these key words. Maximum of 40 points.

- Empathy
- Open-ended questions
- Reflective
- Probing
- Nonverbal communication

2. Please list five phrases to use with a caregiver who has hesitation about vaccination.

Ten points for these types of phrases. Maximum of 50 points.

- Any phrases using a strong recommendation
- Any phrase using safety and quality of vaccines
- Any phrase expressing the FLW’s concern and care for the child
- Any phrases using social norms
- Any phrase using the personal experience of the FLW
- Any phrase highlighting the FLWs personal experience

3. Please list the five categories of vaccine attitudes.

Ten points for each category. Maximum of 50 points.

- Accept all vaccinations
- Accept but unsure
- Accept some, delay and refuse some
- Refuse but unsure
- Refuse all

4. Please describe the best way to communicate with a vaccine denier.

Ten points for any response that have at least one of the following key points. Maximum 10 points.

- Do not spend too much time
- Show respect
- Ensure the caregiver understands the importance of telling FLWs that the child has not been vaccinated if the child is brought in for treatment

Handout 15. Materials checklist

This sheet provides guidance on the types and numbers of materials required to deliver the training to assist planning and preparation.

	Material	# Of Copies Needed <i>(For 30 Participants- adjust as needed)</i>	Comments
*Found in Annex E of the Facilitator guide			
1	Handout 1: 3-day AGENDA	1 per person (30)	Provide at Registration
2	Handout 2: Pre-test	1 per person (30)	Session 1.3
3	Handout 3: Picture A	1 per every 2 people (15)	Session 4.1
4	Handout 4: Picture B	1 per pair (15)	Session 4.1
5	Handout 5: Scenario slips	2 slips per pair (10 copies)	Session 4.7 – Cut in advance
6	Handout 6: Goals for caregivers	2 copies	Session 6.1 – Cut in advance
7	Handout 7: Character information CASE role play	1 per pair (15)	Session 6.2
8	Handout 8: Caregiver scenario 1	1 per 3-person team (10)	Session 6.6
9	Handout 9: Observation checklist	1 per person (30)	Session 6.6
10	Handout 10: Caregiver scenario 2	1 per 3-person team (10 copies)	Session 6.6
11	Handout 10: Caregiver scenario 3	1 per 3-person team (10 copies)	Session 6.6
12	Handout 12: Roma community health mediators article	1 per person (30)	Session 7.3
13	Handout 13: Post-test	1 per person (30)	Session 8.3

14	Handout 14: Evaluation	1 per person (30)	Session 8.4
*Found in Annex E of the Facilitator guide			
15	Scoring sheet for pre/post-test	Facilitators Only (1)	Not for distribution
16	Materials list (this document)	Facilitators Only (1)	Not for distribution
*Found in Annex F of the Facilitator guide			
17	5-Day TOT agenda	1 per person (30)	Provide at Registration
18	TOT session guidance	Facilitators only	Not for distribution
19	Self-assessment checklist	1 per person (30)	Session 1.3 - Closing
Primary resources			
20	Facilitator guide	3-Day: Facilitators Only (2) 5-Day: 1 per person (30)	3-Day: Module 1-8 5-Day provide in Session 1.5B * Print and bind with a divider for each module. Include Annexes in bound document with divider.
21	Facilitator guide annexes (A-F)		Include in printed document with dividers when printing and assembling
22	Participant manual	1 per person (30)	3-Day Provide in Session 1.3 5-Day provide in Session 1.2A *Print and bind with a divider for each module. Include Annexes in bound document with divider.
23	Participant manual annexes (A-F)		Include in printed document with dividers when printing and assembling
24	Presentation slides (*5-Day supplemental slides annexed in 3-day presentation)	Presentation	Not for distribution. *Requires integration into 3-day deck

Equipment and Supplies			
25	Projector	1	More if presenting in two languages
26	Screen	1	More if presenting in two languages
27	Flip charts packs	8 (1 per small group & facilitator)	
28	Flip chart stands	4 - 5	May not be able to tape on venue wall
29	Boxes of multi-coloured markers	3 - 4	
30	VIPP cards (or sticky notes) of different sizes and colours	5 packs	Session 1.1, Session 3.1 (adding determinants to expanded steps); Session 6.1 (Goals); generally useful
31	Tape	2 rolls	
32	Scissors	2 pairs	
33	Blank paper	1 pack	
34	Pens	1 per person	
35	Name Tags	1 per person	
36	Registration Sheet	1 per day	
37	Question box	1	
38	Printer, if available	1	
39	Handheld microphones for participants with batteries	2	
40	Clip on microphones for facilitators	2	
41	Headsets if translating	1 per person	

*Flip charts to prepare in advance			
42	3Cs model		Session 2.4
43	Vaccine hesitancy continuum		Session 2.4
44	Trans-theoretical model (the Steps)		Session 3.1
45	Expanded steps		Session 3.1 Add HBM determinants with VIPPS across the top in Session
46	Socio-ecological model		Session 3.1
47	Pie Chart with % of Acceptors, Hesitators, Selective Acceptors/ Delayers, Refusers		Session 3.4
48	Clinical algorithm		Session 5.2
49	Table with caregiver position categories for goal		Session 6.1
50	CASE approach		Session 6.2
51	Community algorithm		Session 7.2

Overview of supplemental TOT materials

The materials in this section are designed to serve as supplemental companion resources to the 3-day training package on Interpersonal Communication for Immunization for Frontline Workers in Serbia and Bosnia and Herzegovina. Their purpose is to assist Master Trainers facilitate a 5-day Training of Trainers (TOT) to prepare trainers to conduct the 3-day training for frontline workers (FLWs).

The primary objective of the 5-day TOT is to ensure that trainers master the content of the 3-day training package, and have the skills needed to deliver a consistent, quality training with it.

This resource is designed for use in conjunction with the *Facilitator guide*, *Participant manual*, Hand-outs, and other components of the 3-day training package. The companion resource consists of the following components:

1. Sample 5-day TOT Agenda;
2. 5-day TOT Companion guidance;
3. Self-Assessment Form for practice facilitation exercises;
4. 5-day TOT Companion slide presentation.

Instructions on when and where to introduce TOT content are provided in blue boxes at the beginning and end of relevant modules and individual sessions within the 3-day Facilitator guide. New content and activities specific to the facilitation of the 5-day TOT are provided in the following sections of this annex.

When using this resource, trainers will need to have the 3 *Facilitator guide*, the *Participant manual*, and all associated materials in front of them. Facilitators will use the 3-day *Facilitator guide* to lead the majority of the individual sessions for the 5-day TOT. This companion resource details supplemental content only with a focus on:

- Introduction and objectives of the TOT;
- Facilitation skills and giving receiving feedback;
- Practice facilitation exercises;
- Adaption and planning.

Material presented under each day uses the same organization and format used in the Facilitator guide. To make the best of this *5-day TOT Companion guide* and conduct an effective TOT, it is recommended that trainers:

- Read the Companion agenda, Supplemental session guidance in the Annex and in the specially marked blue boxes, and slides carefully prior to use, and identify any changes may be needed for their context.
 - Trainers may, for example, want to integrate the companion slide deck and 3-day slide deck for smooth delivery.
 - Trainers may also want to prioritize or extend the practice facilitation exercises for some sessions based on specific audience needs. There is buffer time built into the agenda to accommodate this or longer discussion sections as needed.

- Know the training agenda, objectives, methodology, materials, and time allocated for sessions and breaks for each module you will deliver, as well as make note of when to switch between the *Facilitator guide* and *this Annex*. This will help ensure transitions between the *Facilitator guide* and *Companion guide* are smooth, and efficient.
- Practice activities before conducting them. Set aside adequate time to plan and seek assistance from co-facilitators or translators and prepare all handouts and materials in advance. During a TOT, trainees will be wearing multiple hats, that of trainee and trainer. The more organized and prepared you are grinding them between these roles as they learn the content, the better learning experience they will have.
- Learn the makeup of the training practice participants. Prepare to accommodate their education level; professional backgrounds; language, cultural norms and learning style; and level of knowledge, attitudes, and expectations.
- Conduct training with fewer than 20 participants, as possible, in order to adhere to the suggested times and allow for a participatory and interactive training.

Annex F: Training of trainers resources

Companion guide

Module 1. Introduction

Session 1.2A TOT Objectives of 5-day training of trainers

Time: 10 Minutes

Materials:

- ✓ Slides.
- ✓ Facilitator guide.
- ✓ Participant manual.

Plenary

- This training of trainers workshop has been designed to prepare you, as trainers, to carry out the 3-day FLW training. This training of trainers or TOT will last for 5 days.
- Our primary purpose during the 5-day TOT is to ensure that you as trainers have the skills to train FLWs on the 3-day interpersonal communication for immunization training package, and that you master the content of the 3-day training package in order to deliver a consistent, quality training.
- The objectives for our 5 days together are that by the end of the training you will be able to:
 - Demonstrate familiarity and understanding of training content in the 3-day package, which aims to increase FLW skills in interpersonal communication for immunization.
 - Demonstrate ability to use a standardized format & materials to deliver high-quality, participatory training to FLWs.
 - Strengthen group facilitation skills grounded in adult learning principles and participatory approaches.
- So, the objectives of the TOT are to ensure you know all of the content in the 3-day training, and you have the skills to carry it out successfully. Does anyone have any questions?
 - ▶ *Clarify as needed.*
- Does anyone have any expectations for this TOT that they would like to add?

- ▶ *Write them on a flip chart and clarify that they will be incorporated as possible, if not already covered.*
- Now that we have looked at what we aim to achieve, let's briefly discuss how we are going to achieve it in our time together.
 - ▶ *Briefly hold up a copy of each agenda as you speak.*
- You have a copy of 2-different agendas at your seat: 1) a 5-day TOT agenda, for the TOT we are doing now, and 2) a model of a 3-day agenda, for the training you will be carrying out after this TOT.
- Since our schedule is tight, we are not going to go through the 5-day agenda together, but you will be able to follow along now and read through it later.
- The 5-day TOT includes the full 3-day package as well as additional time for practice facilitation, review of facilitation skills, and discussion about adapting the content for specific needs.
- It follows three guiding principles: 1) building on participants' experiences, 2) step by step skill building, and 3) reinforcement of skills by practice.
- For this TOT, we will act as facilitators as we review the 3-day training with you, and then give you opportunities to practice facilitating the 3-day training yourself, further strengthening your facilitation skills.
- You will have opportunities to practice teach in small groups at the end of each module and receive feedback from your peers.
- Let's quickly review some basic housekeeping and establish some norms for our time together.
 - ▶ *Allow 5 minutes for announcements about administrative and logistic tasks, and basic norms such as silencing phones, no smoking, etc.*
 - ▶ *Continue to Session 1.2B TOT below.*

Session 1.2B TOT Review of FLW training package

Time: 15 Minutes

Materials:

- ✓ Slides.
- ✓ Facilitator guide.
- ✓ 1 Participant manual for each person.

Plenary

- Now that we have a sense of what we will be doing in the TOT, let's take a quick look at the 3-day training package that you will be carrying out with FLWs.
- The intended audience for the 3-day training is FLWs broadly defined. For the purposes of this training, a frontline worker or FLW is a health provider, facility or community-based, professional or volunteer, tasked with delivering interpersonal communication and counselling, immunization

services, or education and outreach to caregivers of children under 5 years old, or community members.

- Who here knows who they will be training, once you finish this TOT?
 - ▶ *Let them answer. If no one answers, probe with: community workers? Clinic workers? What kind?*
- How do you think you will be training- in mixed groups, or by category of personnel?
 - ▶ *Let them answer. If no one answers, probe.*
- Who can name one advantage of training in mixed groups?
 - ▶ *Let them answer. If no one answers, probe: (e.g. learn about other FLW's roles, experiences, how clinical and community services are organized, other perspectives and tricks and tips.)*
- Who can name one advantage of training only one category of FLW together? Anyone else?
 - ▶ *Let them answer and confirm that all participants share the same job description and many of the same challenges.)*
- As you have stated, your immunization programme may be comprised of several different types of FLWs, each with unique, yet complementary roles in ensuring that communities achieve full immunization coverage.
- Not only do their job descriptions and tasks vary, but so do key characteristics such as education levels, training, competencies, compensation, etc. These roles and characteristics are important to consider when planning and delivering training so that the training serves the needs of the participants.
- As you plan your trainings, you may have to decide whether to train mixed categories together, or perhaps the decision has been made for you.
- In either case, as a trainer, you must try to ensure that everyone's needs are being met to some extent. Even within a single category of FLW, there will be variation in terms of communication abilities, motivation levels, attitudes and experience. You cannot train to just the most experienced, or to the least capable. You must continually engage each end of the spectrum.
- The training package for the 3-day FLW training on Interpersonal Communication for Immunization consists of the following resources:
 - ▶ *Hold up the Facilitator guide, Participant manual, Sample 3-day Agenda as you speak.*
 - Facilitator guide;
 - Participant manual;
 - Presentation slides;
 - Supplemental resources to carry out the 5-day Training of Trainers (Annex F);
 - Sample Training agenda, Pre- and Post-test questionnaire, Training evaluation and Handouts (Annex E);
 - Guidance on how to adapt these materials to the local context (Annex A).
- Although in the future, you will be carrying out the training as the facilitators, in this workshop we will first go through the training process with us playing the role of facilitators, and you playing the role of the FLWs who are being trained, following the *Participant manual*.
- Then you will have the opportunity to review the content in both the *Facilitator guide* and *Participant manual* and practice facilitating the sessions with them.
- So, you will need to wear two hats or play two roles, during this workshop. First, you need to

imagine yourself as a FLW who is going through the 3-day training, and see how understandable it is, how useful it is in your context and for the category of personnel you will be training. Think of how you could help make the training and the *Participant manual* as useful as possible for the FLWs you will train.

- Secondly, you will practice facilitating the training using the *Facilitator guide* that we are using.
- Try to see how you can improve the explanations and instructions that are included in the *Facilitator guide* to help the training flow.
- Almost everything we will say is included in the *Facilitator guide* as a script, so that even someone who hasn't participated in this TOT should be able to pick up the *Facilitator guide* and run the training as we are doing it now. But, as we said, you may find ways to improve the clarity, make it more participatory, or to adapt it to your trainees' needs.
 - ▶ *Show the Participant manual again.*
- The companion *Participant manual* is designed to serve a workbook that FLWs will consult as they go through the group training, as well as for continued self-study.
- In the *Participant manual*, you will find exercises, role plays, summary tables, tips and suggestions, etc., so you will need it for each session of the training. The answer keys for the exercises are found at the back of the manual. It can also serve as a reference for participants' future use.
- As we explained just now, we will first facilitate the sessions while you are using just the *Participant manual*, so you see how the *Participant manual* serves you as the FLW trainee.
- Then at the end of the module, you will look at your copy of the *Facilitator guide* to see how to deliver the session. When you are working as the facilitator, you will use your *Facilitator guide* to guide you through the sessions.
- When exercises require handouts, these will also be indicated along with instructions on how to use them.
- The presentation slides also provide a helpful resource for many images and key points, but you should be able to completely facilitate the training with the *Facilitator guide*, *Participant manual*, copies of the Handouts and, pre-prepared and blank flip charts, and blank paper.
- This is a lot of information and a lot of moving pieces, but it will all come together once we get moving into the sessions.
- Now let's take a look at the *Participant manual* for the 3-day FLW training.
 - ▶ *Distribute Participant manuals.*
- Let's look at our *Participant manual*. Remember, we did our introductions just as you would for Session 1.1 of the 3-day FLW training, by introducing our partner and identifying immunization challenges.
- Who can tell me the title of Session 1.2 of the 3-day FLW training?
 - ▶ *Let someone respond. If they take a minute, tell them.*
- It's not on the agenda; it's in your *Participant manual*.
 - ▶ *Let someone respond.*
- Yes, Session 1.1 was Introductions. Session 1.2 was Review of training objectives, agenda and housekeeping. So, have we done that?
 - ▶ *Let someone respond.*

- We have reviewed the training objectives for the TOT. That was Session 1.2A TOT, which is part of the TOT resources, but we haven't reviewed the regular Session 1.2 in the regular 3-day FLW training.
- So now let's look at the regular Session 1.2 of the Participant manual which reviews the training objectives for the 3-day FLW training.
 - ▶ *Return to Session 1.2 in the Facilitator guide and continue as per instructions, using the Facilitator guide for Sessions 1.3 and 1.4.*

Session 1.5A TOT Review of facilitation skills and giving and receiving feedback

Time: 20 Minutes

Materials:

- ✓ Slides
- ✓ 1 Facilitator guide for each person

Plenary

- As we discussed earlier, during this TOT we will have practice facilitation sessions after each Module. We will do this in small groups in order to allow each person as many opportunities to practice delivering the content as possible.
- Before we jump into our Module 1 practice facilitation session, however, we want to take a few minutes to review key facilitation skills.
- Think for 30 seconds about a training (or trainer) that you liked or learned a lot from. Choose a few words that describe why the training experience was positive for you.
- Now think about a training (or trainer) you have had that was less positive and identify a few words that describe why the training was not positive.
- Who can share their words for what made your training experience positive, words that could finish the sentence: A trainer should....
 - ▶ *Let many participants respond until you stop getting new words.*
- Who can share their words for what made your training experience negative, words that could finish the sentence: A trainer should not....
 - ▶ *Let many participants respond until you stop getting new words.*
- We are going to learn a lot about interpersonal communication skills in general over the next few days, but you have just listed a number of important points to keep in mind when running a workshop, training or group discussion. Good communication skills include:
 - ▶ *Show slide: Good communication skills.*
- Speaking clearly;

- Looking at various participants in turn, not just those in front;
- Encouraging participation by calling on shy participants or those who aren't paying attention;
- Using a moderate amount of gestures and movement to keep participants' attention;
- Knowledge of the content:
 - If you are familiar with the training content, you can put all of your effort to making sure your audience is participating and understanding.
 - In addition to the content, the more familiar you are with the flow of the exercises and the guide, the more attention you have for your audience. Take time to familiarize yourself with the material before facilitating.
- Knowledge of your audience:
 - The success of your training depends on your ability to share what you know in a way that your audience understands it.
 - It is important to adapt language and break down concepts to improve understanding. It is likewise important to know if certain content is too much of a review and you can move more quickly to keep participants engaged.
- Ability to engage your audience and make learning fun:
 - If you can get participants to participate with questions, discussions, activities, images and jokes they are more likely to remember what they are learning.
 - If you have found that certain content is too much of a review, you can ask the participants to explain topics that you had planned on explaining.
- Ability to relate training to everyday life:
 - If you use stories, examples, and common explanations to connect the concepts you are teaching to the participants' everyday life and work, participants are more likely to see training as useful, and remember what you are teaching.
 - Many examples are provided in the sessions in the Facilitator guide, but you may want to supplement with others that work better for your trainees.
- Ability to keep control of the group and maintain a supportive environment:
 - Ensure no one dominates the discussion, and that everyone is encouraged to participate and treated with respect.
- Enthusiasm for what you are doing:
 - If you are not excited to share what you are teaching, you cannot expect anyone else to be interested in learning it from you.
- It is also helpful to keep in mind that even if we have been in trainings and are very knowledgeable about something, we may not facilitate well without practice. Facilitation is a skill, and like any skill is strengthened by practice.
- We are going to begin our practice facilitation with the sessions in Module 1. You will work in small groups.
- Each of you will take turns facilitating a session within your small group. You will use the Facilitator guide and any associated handouts and facilitate according to the instructions in the Facilitator guide, and the rest of the small group, your team, will act as your trainees.
- After you facilitate your session, you will have a moment to self-assess. This means you will reflect on what you think went well, and what you think you need to work on. Then, your team

members will give you additional constructive feedback on how you can improve your facilitation skills, based on their observations.

- Who has an idea of why we suggest that the person who facilitates should do their own self-assessment to their team first, before the team gives their feedback?
 - ▶ *Let them respond and then confirm.*
- Yes, it's usually less painful if you can say how you feel you did first, before others give their opinions.
- Giving and receiving feedback can be tricky. Let's take a few moments to discuss feedback. Can someone explain what we mean by feedback?
 - ▶ *Take a few responses and then summarize with the below.*
- Feedback is information that we give to others or a group about what they do or say, and how they affect others with their words and actions.
- The purpose of feedback is to help the person identify what they are doing well and how they can improve. We use feedback every day in lots of situations - at work, at home, in a restaurant, etc.
- In the practice training sessions, we might want to think about two kinds of feedback- one on the training package itself, and one on how the person facilitated the session.
- If we have comments about a session, or an exercise, and ways we think it could be improved, that's feedback about the training package. For example, in the field test of this training, the participants gave feedback that the instructions for the partner introduction exercise were not clear, so those instructions were clarified in the Facilitator guide. That's feedback on the training package and should be provided to the trainers.
- On the other hand, if the session or exercise is okay, but the participant who is practice-facilitating it skipped some sections, or didn't speak loudly enough, or forgot to give the explanation of the group work or kept their back to us the whole time they were reading out a slide, we would give feedback on facilitation to that participant.
- As we just said, one of the best ways to do feedback is to let the person self-assess first, because it gives the person the chance to process how they did before others provide feedback.
- When the team gives feedback, it should be done in a specific, positive and constructive manner. This is supposed to be a learning experience. Everyone has room to improve their skills, so we need to make sure the feedback is helpful.
- Who can give me an example of a piece of specific and positive feedback you might give to someone after they have facilitated?
 - ▶ *Allow 1 or 2 responses (examples: we could all hear you very clearly; you showed good energy when you were presenting).*
- Who can give me an example of constructive, negative feedback?
 - ▶ *Allow 1 or 2 responses (example: If you would project your voice a little more, we could hear you better).*
- In order for feedback to be useful, it should have certain qualities. When giving feedback to another person, it is important to give it in a way that is **specific**.
- I'm going to give four feedback phrases. Think about which of these you would find more useful.
 - ▶ *Read out the numbered phrases in bold and let them discuss.*
 - ▶ *At the end, summarize if necessary by reviewing the notes in italics next to the numbered phrases.*

1. *"You weren't very good."* (Not useful - what wasn't good about it?)
 2. *"You looked nervous."* (Bad example, but getting better - now we know what the problem was)
 3. *"You seemed a bit nervous. Do you think you could look directly at the audience a bit more, and give a few smiles when you are speaking?"* (Good - we've identified the problem, and there's a couple of ideas of the solution.)
 4. *"You seemed a bit nervous- did you feel that way? What do you think you could do to project more confidence and give a more relaxed, enjoyable feel to the session?"* (Here, we check our impression of the problem, and we turn it over to the person to find a solution.)
- **You want to be specific, positive and constructive.** If you noticed a person used only yes or no questions, you don't want to say: *"Hey, you should stop using yes or no questions."*
 - You need to open their ears with positive feedback, and then add the constructive feedback. How could you tell them in a specific, positive and constructive way that they should use open-ended questions?
 - ▶ *Allow one or two responses.*
 - You could use phrases like: "I think you did a good job projecting your voice. However, I noticed that many of your questions were yes/no questions. How about adding some open-ended questions?" or "What about if you tried..."
 - Try to give strengths first. This helps the person relax enough to hear the "negative" feedback. Then provide an area for improvement, asking them to find solutions, if possible. Then finish with a positive remark, which leaves them comfortable enough to process and absorb the feedback. For example:
 - *"You explained the diagram really well. But did you notice that when you were explaining the diagram, you had your arms crossed? It would help us understand better if you had pointed to the parts of the diagram as you were describing them. Your explanation was good and pointing to the diagram would make it better and more lively."*
 - Another example would be: "That was a really productive session, but the session ran too long because the discussions went on too long and got off-topic. It was good that you eventually were able to get the participants back to the task at hand and bring the session to a close. What do you think might be helpful to help you with time keeping? All in all, you did a great job keeping the group engaged."
 - Finally, feedback should only address things that can be changed in relation to the situation at hand. Feedback should never be given as a judgment or evaluation of personal character or characteristics.
 - Receiving feedback can be difficult; your feelings might be hurt. Try not to take it personally and focus on seeing how you can grow in your skills.
 - If you are receiving feedback that is disappointing, or difficult to understand, you might try using clarification and reflective listening. Try re-stating what the other person said in terms of feedback. For example: *"Thanks for giving me feedback to help me improve my training skills. Help me understand, you are finding that I am not speaking loudly enough?"*
 - Because feedback can help us to improve, it is always nice to thank the person providing feedback, even if it kind of hurt!
 - Any questions or comments?
 - ▶ *Clarify as needed.*

- One of the best ways to improve your facilitation skills is to have someone take a video of you as you facilitate. Has anyone here ever had that done? How was it?
 - ▶ *Let them respond.*
- Yes, it is always a learning experience to see and hear yourself facilitating. If you would like someone to video you using a phone, you can do so, and then watch the video after the session. This is a really powerful way to assess your own performance and see how you are doing. In the next session, Session 1.5B TOT, we will start our practice facilitating. You can try it then, or later if you like.

Takeaway

- Know your content but create an atmosphere that gets your participants to contribute their experiences and knowledge as much as possible. The more you can get them engaged and make the training relevant to their daily life and needs, the more likely they will be to implement their new skills.
- Facilitation skills can be improved through practice, and through feedback. Self-assessment is the first kind of feedback to do, then others can give specific constructive suggestions for how to improve.
- Giving a sandwich of positive feedback (*"It went well overall"*), constructive negative feedback (*"Try moving out from behind the lectern to show more energy"*) then positive (*"You really followed the session guide well"*), will help the person hear and internalize the feedback.
 - ▶ *Continue to Session 1.5B.*

Session 1.5B TOT practice teaching module 1

Time: 60 Minutes

Materials:

- ✓ Slides
- ✓ Enough copies of the Facilitator guide for each person.
- ✓ Participant manual.
- ✓ Flip chart, markers, and tape.

Plenary

- Now we are going to start practice facilitating, using the Facilitator guide. Module 1 is fairly easy and has short sessions, so this should be a good way to start practice facilitation.
- We will use the same technique to practice teaching each of the remaining modules.
- I am going to explain the instructions and then we will break into groups of three.

TOT practice teaching exercise

- You will work in small groups. Your first task is to choose:
 - 1 person to be the facilitator, using the *Facilitator guide*;
 - 2 or 3 people to be the FLW trainees and follow along in the *Facilitator guide*.

⇒ *(Option: you could suggest that 1 of the “FLWs” could video the facilitator on their cell phone so they could review it after the session.)*
- Each person will have the opportunity to play the role of the facilitator. If you are new to training, let someone else in your group go first and take a later turn being the facilitator.
- I am going to give each of you a Facilitator guide
 - ▶ *Distribute Facilitator guide to each trainee.*
- The introduction section provides background the design and development of this training and instructions on how to use the guide.
- Each Module has objectives and an overall time allocation. There is a checklist of things to do before the module starts. There are a lot of things to prepare before facilitating Module 1, and then there are only a few additional things to prepare for the remaining Modules, such as handouts or pre-prepared flipcharts.
- Each Session also has an approximate time allocation and materials checklist.
- The blue headers help you keep on track if you are leading plenary discussions, leading group or partner exercises, when to pass out handouts, or other materials.
- The guide is scripted with step-by-step instructions in order to:

- Decrease lecturing;
 - Increase participation;
 - Make it easier for the facilitator to carry out the sessions;
 - Ensure a relatively standardized approach and content, so that almost any trainer could pick up the package and carry out the training with fidelity and success.
- The black dots or bullets are what you should say. The arrows give instructions to you on what to do.
- At the end of most sessions there will be a takeaway box that says what you should clearly state as a wrap up for the session.
- At the beginning and end of relevant sessions there is a blue box, which contains notes for the facilitators of the TOT. We are using them along with the guidance and materials in Annex F for this TOT. You can ignore them when you are practice teaching during this TOT and when you are leading a 3-day training.
- Any questions so far?
 - ▶ *Clarify as needed.*
- Let's look briefly at Module 1. The first facilitator will begin with Session 1.1, the second will continue with Session 1.2, and the third with Session 1.3, rotating through the regular 3-day FLW training sessions in Module 1 until our time is up. If you have more than 5 members in your group, you will go back up to Session 1.1 and repeat the sessions until each group member has had a chance to facilitate a session.
- The FLWs will participate as the audience and make note of any feedback they have for the trainer.
- After practice facilitation, there will be a few minutes for feedback. First, the facilitator will take a minute or two to self-assess, based on this self-assessment checklist. We will do this practice facilitation exercise after each module and you can compare your progress with the self-assessment list.
 - ▶ *Distribute Handout: Self-assessment checklist.*
- After the facilitator has had a chance to self-assess, the "FLWs" will have a few minutes to provide any additional feedback on the facilitation. When you are providing feedback to the facilitator, start with something they did well. Use the checklist as a starting point to identify at least two strengths and one area that could be improved.
- These sessions have different lengths according to the number of activities. The point is to practice delivering the scripted content and small group instructions, especially the back and forth questioning, letting the FLWs respond, encouraging them to respond if they don't answer, etc.
- The "FLWs" do not need to actually do the small group activities in the session, but you should go through the process of explaining the instructions, dividing into groups, etc. Your group can move at your own pace, but to allow everyone the opportunity to practice with the content, please take no more than 15 minutes for each person's combined facilitation and feedback.
- Any questions?
 - ▶ *Clarify as needed.*
 - ▶ *Time the groups for 1 hour, checking in every 15 minutes to suggest the rotate if they have not.*
 - ▶ *Walk around to observe and provide support and feedback.*
 - ▶ *After an hour, bring the group back together for a brief feedback discussion as outlined below, and then close the session.*

Plenary

- How did the practice facilitation exercise go?
 - ▶ *Take a few responses.*
- What was easy or what was difficult or surprising about facilitating these sessions?
 - ▶ *Allow the group to discuss.*
- How was it to use the *Facilitator guide* as a guide for facilitating the sessions?
 - ▶ *Allow the group to discuss.*
- What are some examples of facilitation feedback that your group discussed?
 - ▶ *Allow the group to discuss.*
- How do you think it will be different facilitating for the actual training?
 - ▶ *Allow the group to discuss.*
- Was this exercise helpful? How could we make it more helpful?
 - ▶ *Allow the group to discuss.*

Please note: supplemental slides for the TOT are included at the end of the 3-day Training presentation. Please review and integrate as needed.

Takeaway

- Facilitation is a skill that grows stronger with practice. It is not always easy to stand up in front of others, especially if they are not engaged or resistant to what you are saying. Hopefully, this exercise has helped illustrate that practice and feedback can help strengthen facilitation skills and the delivery of a successful training. We will continue practice facilitation after each module this week.
- Before delivering the training yourselves, it may be helpful to have a full practice session with your co-facilitators, and review who is doing what.
- Thank you for your participation and valuable contributions. We will now continue with the next Module.
 - ▶ *Continue to Module 2.*
 - ▶ *You will use this same practice facilitation exercise at the end of each module, through Module 7.*

5-Day TOT Agenda

*Note: Registration begins at 8:30

	Day 1	Day 2	Day 3	Day 4	Day 5
9:00-10:30	Opening Remarks (9:00-9:30) Introduction to TOT, and Module 1: Introduction (9:30-10:30)	Module 3: Understanding Behaviour and Barriers	Module 5: Communication During Immunization	Conclude, Module 6	Module 8: Review and Next Steps
10:30-10:45	Break	Break	Break	Break	Break
10:45-13:00	(10:45-12:00) Conclude Module: 1 Module 1: Practice Facilitation (12:00- 13:00)	(10:45- 11:30) Conclude Module 3 (11:30- 12:30) Module 3: Practice Facilitation (12:30-13:00) Module 4: Active Listening to Understand Your Caregiver	Conclude Module 5	(10:45- 11:45) Module 6: Practice Facilitation (11:45- 13:00) Module 7: IPC in communities	Conclude Module 8 and Closing
13:00-14:00	Lunch	Lunch	Lunch	Lunch	Lunch
14:00-15:30	Module 2: Immunization Technical Review	Module 4, continued	(14:00-15:00) Module 5: Practice Teaching (15:00 -15:30) Module 6: Communication in Depth	(14:00-14:30) Conclude Module 7 (14:30 -15:30) Practice Facilitation	Buffer if additional time needed/used during practice or discussion sessions
15:30-15:45	Break	Break	Break	Break	Break
15:45-17:00	(15:45-16:00) Conclude Module 2 (16:00-17:00) Facilitation	(15:45- 17:00) Conclude Module 4 (15:45- 17:00) Module 4: Practice Facilitation)	Module 6, continued	Module 7 Practice Facilitation	Module 8: Post-test, Evaluation, and Closing

Self-assessment checklist for facilitation sessions. TOT									
Techniques	How did I do?							Comments	
	Module								
	1	2	3	4	5	6	7		
Covering all the material:									
Did I successfully follow the script in the guide, or make it better?									
Did I forget anything, or skip any sections that I should have done?									
Nonverbal:									
Did I look at each participant at least once, and avoid just looking at the slides/manual/flipchart?									
Did I smile a few times?									
Did I use gestures to draw them out or make them feel included?									
Interactive:									
Did I encourage the "FLWs" to participate?									
Besides saying "Does anyone have an example or idea?"; did I also say: "Does someone else have another idea or perspective about that?"									
Energy/movement:									
Did I project my voice to reach everyone									
Did I show energy/enthusiasm with my body?									

Pacing:								
Did I speak with some momentum, but pause to let people think and respond?								
Did I keep the session moving along well?								
Positive reinforcement:								
Did I give praise for participation e.g. <i>"Thanks, that's one example"</i> or <i>"good answer"</i> or <i>"great idea"</i>								
Reflecting and summarizing:								
Did I reflect or summarize participant's statements? (e.g. <i>"If I understood you correctly, you have a question about XYZ,"</i> or <i>"Here are a few of the ideas that I am hearing from the group."</i>)								
Other issues:								
Anything else?								

Annex G: Selected bibliography

1. Australian Government Department of Health and Aging (2013) Immunisation Myths and Realities: Responding to arguments against vaccination. A Guide for Providers 5th Edition, 2013
2. Cairns G, MacDonald L, Angus K, Walker L, Cairns-Haylor T, Bowdler T. Systematic literature review of the evidence for effective national immunisation schedule promotional communications. Stockholm: ECDC; 2012.
3. CDC (2018) Preparing for Vaccine Questions Parents May Ask (4/17/18) available at <https://www.cdc.gov/vaccines/hcp/conversations/downloads/prepare-infants-508.pdf>
4. CDC (2018) Talking with Parents about Vaccines for Infants (4/17/18) available at <https://www.cdc.gov/vaccines/hcp/conversations/downloads/talk-infants-508.pdf>
5. Demicheli V, Rivetti A, Debalini MG, Di Pietrantonj C (2012). "Vaccines for measles, mumps and rubella in children". The Cochrane Database of Systematic Reviews. 2 (2):CD004407. doi:10.1002/14651858.CD004407.pub3. PMID 22336803.[FN 3]
6. European Centre for Disease Prevention and Control (no date). Immunization: Information for parents and caregivers. What is community immunity and why is it so important. [Figures 1 and 2]
7. Immunization Action Coalition (no date). MMR Vaccine Does Not Cause Autism. Examine the Evidence! <http://www.immunize.org/catg.d/p4026.pdf>
8. ImmunizeBC (no date). Immunization Communication Tool: For Immunizers. www.immunizebc.ca [Figure 3]
9. Jacobson, Robert M. Approaching the Vaccine- Hesitant Parent using C-A-S-E, Mayo Clinic. Available at http://www.mnaap.org/pdf/Making_the_CASE_for_Vaccines_MNAAP.pdf
10. Leask et al. Communicating with parents about vaccination: a framework for health professionals (2012). BMC Pediatrics 2012, 12:154 Available at <http://www.biomedcentral.com/1471-2431/12/154>
11. MacDonald, N. E. (2015). Vaccine hesitancy: Definition, scope and determinants. Vaccine. doi:10.1016/j.vaccine.2015.04.036
12. O'Keefe, D.J. & Nan, X. (2012) The Relative Persuasiveness of Gain- and Loss-Framed Messages for Promoting Vaccination: A Meta-Analytic Review. *Health Communication*, 27: 776–783, 2012
13. Statistical Office of the Republic of Serbia and UNICEF. (2014). *Serbia Multiple Indicator Cluster Survey and Serbia Roma Settlements Multiple Indicator Cluster Survey, 2014, Final Reports*. Belgrade, Serbia: Statistical Office of the Republic of Serbia and UNICEF. [Table 3]
14. Taddio A. et al. Reducing the pain of childhood vaccination: an evidence-based clinical practice guideline (summary). CMAJ. 2010 Dec 14;182(18):1989-95
15. Taylor LE, Swerdfeger AL, Eslick GD (June 2014). "Vaccines are not associated with autism: an evidence-based meta-analysis of case-control and cohort studies". Vaccine. 32 (29): 3623–9. doi:10.1016/j.vaccine.2014.04.085. PMID 24814559. [FN 4]
16. UNICEF (2017) Facilitator's Guide: Interpersonal Communication for Immunization. Draft
17. UNICEF (2017). Knowledge, Attitudes and Practices in Relation to Immunisation of Children in Serbia (KAPb). Final Report (Draft)
18. World Health Organization (2012)

19. World Health Organization (2013). The Guide to Tailoring Immunization Programmes TIP. Available at: http://www.euro.who.int/__data/assets/pdf_file/0003/187347/The-Guide-to-Tailoring-Immunization-Programmes-TIP.pdf
20. World Health Organization (2017) How to respond to vocal vaccine deniers in public. Best practice guidance- WHO Regional Office for Europe 2017
21. World Health Organization SAGE working group dealing with vaccine hesitancy (2014) Strategies for Addressing Vaccine Hesitancy – A Systematic Review of Strategies October 2014.
22. World Health Organization SAGE working group dealing with vaccine hesitancy (2014) Report of the SAGE working group on vaccine hesitancy October 2014. [Figure 6]
23. Yaqub O et al. (2014) Attitudes to vaccination: A critical review. *Social Science & Medicine*. 2014; 112
24. LINKS TO FAQs from WHO, CDC, Oxford University, etc.
 - a. <https://www.cdc.gov/vaccines/parents/parent-questions.html>
 - b. <http://www.who.int/features/qa/84/en/>
 - c. <http://www.immunize.org/handouts/vaccine-questions.asp>
 - d. <http://www.immunize.org/handouts/easy-to-read-q-and-a.asp>
 - e. <http://vk.ovg.ox.ac.uk/faqs-about-vaccines>
 - f. <https://www.caringforkids.cps.ca/handouts/vaccines-myths-and-facts>



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