Participant manual

Interpersonal Communication for Immunization

Training for Front Line Workers

UNICEF Europe and Central Asia Region

JOHNS HOPKINS
Center for Communication Programs

Interpersonal Communication For Immunization
Transforming Immunization Dialogue

unicef
for every child

Participant manual

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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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Introduction

Good interpersonal communication can mean the difference between a child being fully immunized or not at all. This Interpersonal Communication for Immunization *Participant manual* seeks to help health workers value, acquire, and consistently use the knowledge, skills, and attitudes needed to communicate effectively with caregivers and communities about childhood immunization.

Interpersonal communication for immunization capacity development is critical. Almost every study of health worker practices in the region finds that interpersonal communication for immunization overall is weak. Yet, at the same time, the vast majority of caregivers of young children cite health workers as their primary source of information about immunization. Health workers and health services must close this gap if nations and the world are to achieve universal immunization.

This *Participant manual* serves as a companion resource to the Interpersonal Communication for Immunization (IPC/I) *Facilitator's Guide* for 3-day IPC/I training for frontline health workers (FLWs) and 5-day Training of Trainers workshops. It serves as both a workbook for trainees and a resource for continued self-study. The *Participant manual* addresses the following topics:

- Principles of communication;
- Respect and equity;
- Gender and power dynamics;
- Empathy;
- Active listening skills;
- Provision of information in a way the caregiver can understand;
- Childhood vaccines and the diseases they prevent;
- How to discuss and address common vaccine fears;
- Group facilitation;
- Identifying and engaging with key community influencers;
- Problem-solving;
- General persuasion skills.

A number of resources are available to support interpersonal communication (IPC) and/or immunization. The intention of this resource is to not only to advise FLWs on what to do, but also on how to do it. A number of strategies, exercises, role-plays, algorithms, scenarios, examples, and tips are included to support the application of knowledge.

This *Participant manual* seeks to help FLWs identify ways to maximize the limited time they often have to spend with caregivers. It walks FLWs through strategies to help overcome barriers to routine immunization, despite the real and perceived limits of control FLWs have over elements of their work.

The manual uses immunization-specific examples throughout, highlighting the language and knowledge specifically relating to routine immunization duties. That said, FLWs can use the IPC skills and values developed while using this resource in any health area in which they work.

Intended use and audience

The primary audience for this manual is frontline health workers (FLWs) who provide immunization services. For the purposes of this package, we have defined FLW as a person who interacts directly with caregivers and communities regarding immunization. The FLW can be a physician, nurse or community mobilizer.

Workshop participants will use the *Participant manual* during training as a tool to facilitate learning and adoption of new attitudes, beliefs, and behaviours. After the training, participants can use the manual alone or with co-workers to review the exercises, and as a reference document for next steps back in their work place.

Module 1.

Introduction and
overview

Module 1. **Introduction and overview**

Module 1 Objectives:

By the end of the module you will:

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.

Session 1.1. Introductions and immunization challenges

Exercise 1: **Introductions and identification of immunization challenges**

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

Training objectives

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.

By the end of this training you 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.

Session 1.3. Pre-test and distribution of Participant manuals

Distribution of training materials

1. HANDOUT 2: Pre-test;
2. Participant manual.

Exercise 2: Pre-test

Session 1.4. FLWs' experiences with immunization

In this training, we will use an active listening and communication approach to identify the caregivers' needs and diagnose their immunization attitudes, so we can give them the proper communication treatment to ensure vaccination.

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. Please keep an open mind and let's see what we can learn together.

Exercise 3: Discuss caregivers' attitudes

Do all of your caregivers have the same attitudes towards immunization, or are there different concerns, different levels of concern or even different categories of caregivers?

- 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.

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?

Session 1.5. Assignments for module summaries

On the last day of this workshop, during Module 8, we will review Modules 2 to 7. Small teams will summarize each of these modules.

In your summary, you will need to answer the following questions:

1. What were the main activities we did during the module?
2. What were the five most important takeaways (knowledge, attitudes or skills) that you took away from this module?

Module takeaway

There are numerous challenges in achieving high immunization coverage. Some of these can be addressed through better interpersonal communication. However, our caregivers are not all alike. 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".

Module 2.

Immunization technical review

Module 2. **Immunization technical review**

Module 2 Objectives:

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

1. Start your 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.

Session 2.1. How vaccines work and health benefits

Elevator phrases

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. It's like a dress rehearsal for the attack of the real disease, your body is already prepared.

It is nice to have a prepared, simple, complete, and clear phrase available to explain concepts or respond to common questions. The more you have prepared your content ahead of time, the more you can focus on your technique for effective communication.

Imagine you have something you want to discuss with your boss, and you happen the meet her when you are both getting in the elevator. This is an opportunity to explain or present your issue. If you have already rehearsed what you want to say in a short period of time, you can take advantage of the few moments together to get your point across.

Over the course of the training you will be developing "Elevator phrases" to address many of the common concerns caregivers have about immunization.

Just like your elevator speech for your boss would need to be tailored to who she is and what she needs to hear, you will need to tailor your Elevator phrases to the caregiver you are meeting with. It is 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 toolbox, so you can use the right tool for the right task.

Exercise 4: Better ways of explaining how vaccines work

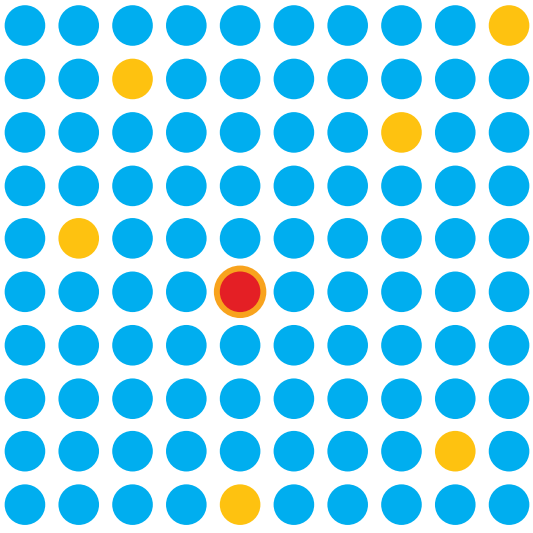
Go to the last two pages of this manual, entitled "Elevator phrases". Write a better way to explain to your patients how vaccination works.

Visuals

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.

This is called community or herd immunity. The threshold of coverage needed varies according to how contagious the disease is. For measles, which is extremely contagious, 95% of the population needs to be vaccinated in order to stop transmission. For polio, which is a little less contagious, 80- 85% of the population being vaccinated will protect those who are unimmunized.

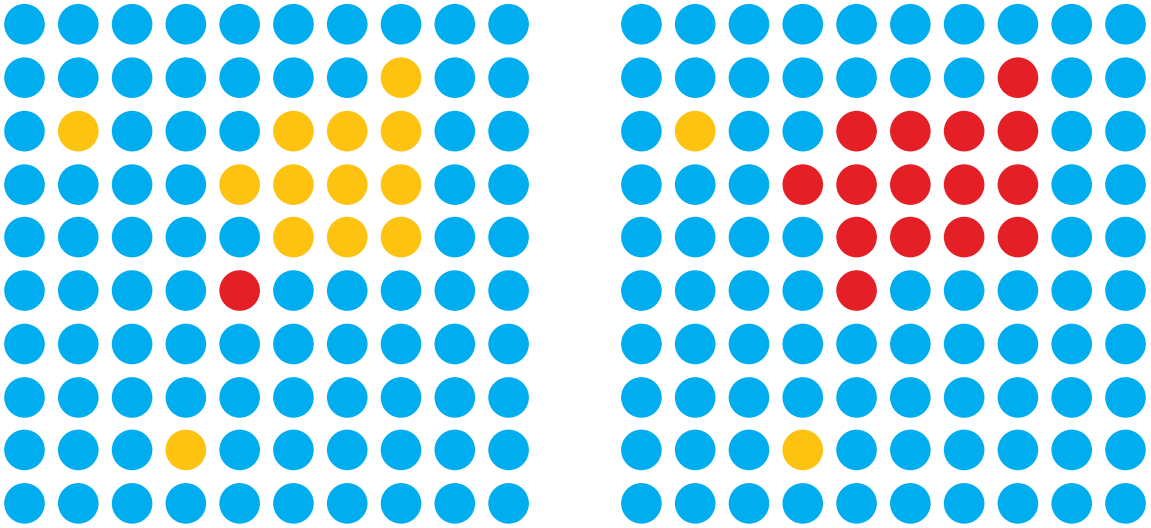
Figure 1. *Community Immunity 1*[1]



1 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?

Community immunity means enough people are vaccinated that they protect the few that are not vaccinated. In the first image, someone has come into the community with a vaccine preventable disease (VPD), indicated by the red dot. There are so many people who are vaccinated (the blue dots) that they can't pass the disease on, and the few unvaccinated people (yellow dots) won't get the disease.

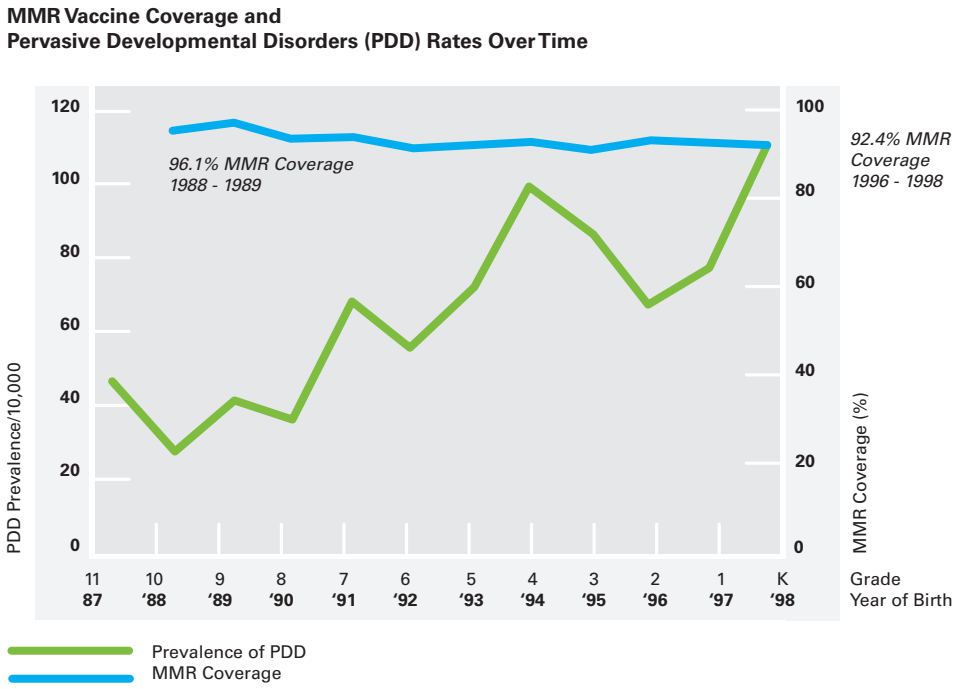
Figure 2. *Community Immunity 2*



In the second set of images, there is a large group of unimmunized people (yellow dots), so when the red dot person with the VPD shows up, they can pass the disease to the nearby yellow dots. They then pass it on to the other yellow dots. Imagine if these yellow dots were young children in a nursery school.

Visual representation is so helpful when you are trying to explain concepts. Here is an example of a visual representation that is used in Canada to refute rumours about MMR's supposed association with autism.

Figure 3. *CommMMR Vaccine Coverage and PDD*[2]



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 more clear, efficient, and emotionally powerful.

Benefits of immunization

The health benefits of immunization are well known and backed up by extensive clinical and epidemiological studies. These direct benefits include:

1. Dramatically reduced diseases and mortality rates for many infectious diseases.
2. Reduced child mortality - an estimated 6 million deaths of children less than 5 years of age are prevented, each year.
3. Reduction in health care cost.

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

4. The indirect health benefit is reduced disease among those who have not been vaccinated. Fewer people with disease-related disabilities.
5. High coverage protects those that can't be vaccinated such as immunosuppressed individuals.

Despite all of these benefits of immunization, our vaccination rates are dropping.

Session takeaway

Use of Elevator phrases and visuals to reinforce and explain concepts such as how vaccines work and community immunity and address concerns can improve the clarity, efficiency, and strength of our communication.

Session 2.2. National coverage trends and vaccine schedule

Exercise 5A: Evolution of immunization in Serbia[3]

Review the following table and answer the following questions:

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?

3 Tailoring Immunization Programmes (TIP) in Serbia, WHO 2016

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.[4]
2013	Irregular supply and shortages of vaccines throughout Serbia up until 2015

4 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.*[5]
2015	Introduction of combined pentavalent vaccine (DTaP-IPV-Hib).
2016	Law on the Protection of Population against Communicable Diseases.
2016	Bivalent OPV (types1 and 3) introduced in the revaccination of children in the 7th and 14th year of age.

Exercise 5B: National immunization schedule for Serbia

Review the national immunization schedule for Serbia below and 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?

Table 2. *National Immunization schedule – Serbia*[6]

Age	Vaccine
Birth	Tuberculosis – BCG Hepatitis B – HepB_Pediatric
4 weeks	Hepatitis B – HepB_Pediatric

5 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.

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

Age	Vaccine
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 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

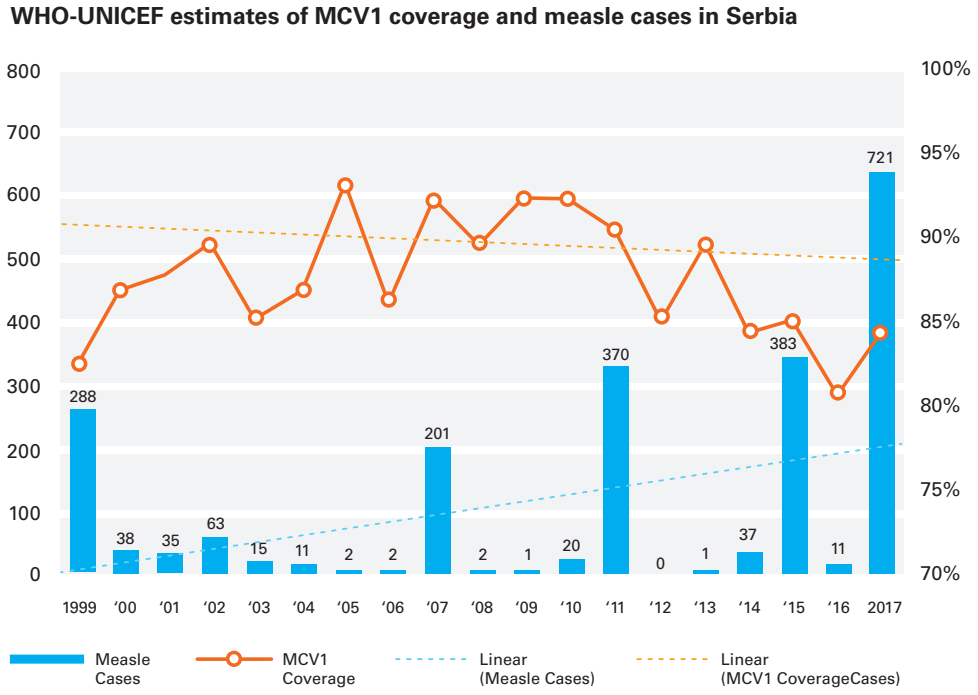
Exercise 5C: Trends in coverage rates and incidence

Figure 4 is a graph from WHO that shows Measles 1 coverage and measles cases up until last year in Serbia. The red line is measles coverage; the blue bar graph is measles cases.

Work with your small group to review the graph and answer the following questions:

1. What was the highest rate of measles 1 coverage in the last 10 years?
2. What was the lowest rate of measles 1 coverage in the last 10 years?
3. What year had the highest number of measles cases, in the last 10 years?

Figure 4. *Measles coverage and cases*[7]



Next, review the below table that shows the difference in coverage between the general Serbian population and Serbian Roma settlements. Answer the following questions:

1. What is the difference in fully immunized rates between the general population and the Roma?
2. When does the drop off in coverage occur?

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

Table 3. *Immunization Coverage*[8]

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
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

8 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
3.6	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
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

Please note that factors that may influence Roma vaccination rates are covered later in the *Participant manual*.

Session takeaway

Coverage rates are falling, and outbreaks of vaccine preventable diseases are increasing. This is a worrisome trend. High immunization coverage not only prevents outbreaks, but protects the vulnerable members of society like those with autoimmune disorders that cannot receive immunizations.

Immunization uptake is not the same across all members of society. Reasons for non-immunization may be different across groups and individuals.

Session 2.3. Vaccine safety processes and protocols in Serbia

Vaccine safety licensing in Serbia

National regulatory agencies in Serbia have, 15 years ago, harmonized vaccine registration procedures with EMA (European Medicines Agency) that oversees quality control of vaccines and medicines in EU countries.

Before a new vaccine is approved and marketed in the EU, a rigorous regulatory procedure that assesses quality, efficacy and safety must be followed.

All vaccines have to obtain a 'marketing authorization' before they can be sold. This is only granted after an evaluation of the data collected during product development and clinical trials. Compliance with good practice in the areas of manufacturing and clinical or laboratory testing is also verified by regulatory agencies prior to approval of a marketing authorization.

The process of vaccines manufacturing is very complex and sensitive and the process itself undergoes a great number of tests. Each newly produced lot of vaccines undergoes strict quality controls, both by the manufacturer, and by independent laboratories before they are used. These strict controls make vaccines much safer in comparison with other medicines.

There are several different procedures in Europe to register or license a new vaccine:

- A centralized procedure which is undertaken at EU level by the European Medicines Agency and applies in all Member States.
- A procedure based on 'mutual recognition' between certain Member States that applies only in those countries.
- A national procedure for products that are only licensed for use in that one country.

Once a marketing authorization is obtained, each batch of vaccines must still be assessed for quality before release for use. Both the manufacturer and an official European control laboratory do this. Vaccine manufacturing is a process that lasts for about two years. During this process, 70% of time is spent in quality control and each dose of vaccine is tested around a hundred times. The manufacturer guarantees that the vaccine complies with the prescribed standard, which is much higher than for most medicines. Quality control testing is carried out by independent laboratories in the country of the manufacturer and finally by the importing country.

In addition, after release onto the market, all vaccines are monitored for adverse events following immunization. Suspected adverse events are reported by vaccinators, or by the general public, to the National Regulatory Agencies in all countries. In some countries, they are reported simultaneously to the national public health institutes. The reporting obligations of the various stakeholders are defined in national laws and in the European legislation.

All reported suspected adverse events are collected and regularly evaluated in the large European EudraVigilance database hosted by the European Medicines Agency. Should a safety signal be detected, epidemiological studies are initiated to confirm or refute a safety signal.

Vaccines have to meet additional requirements after licensing, including follow-up measures like stability studies, further confirmatory trials or trials in populations that have not yet been studied. Under EU legislation, licenses also have to be renewed five years after approval.[9]

The Medicines and Medical Devices Agency of Serbia registers vaccines and, in cooperation with the Ministry of Health, issues licences for the use of vaccines. Likewise, it issues certificates on the analysis of every lot of vaccines in use, thus guaranteeing their reliability, safety, and quality.

The vaccines are procured from the manufacturers which have been present for decades in the Serbian market and whose products are of proven quality. The greater part of the vaccines has been produced in the EU countries, and much of the rest is produced locally. Everything the vaccines contain complies with the standards of the World Health Organization and the European Union.

Session takeaway

There are extremely detailed safety protocols observed in developing and manufacturing vaccines. There are also 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. In addition, maintaining cold chain, safe injection practices, and surveillance and management of any reactions are all components of vaccine safety within health worker control.

9 European Centre for Disease Prevention and Control. Let's talk about protection. Stockholm: ECDC; 2016.

Session 2.4. Vaccine hesitancy

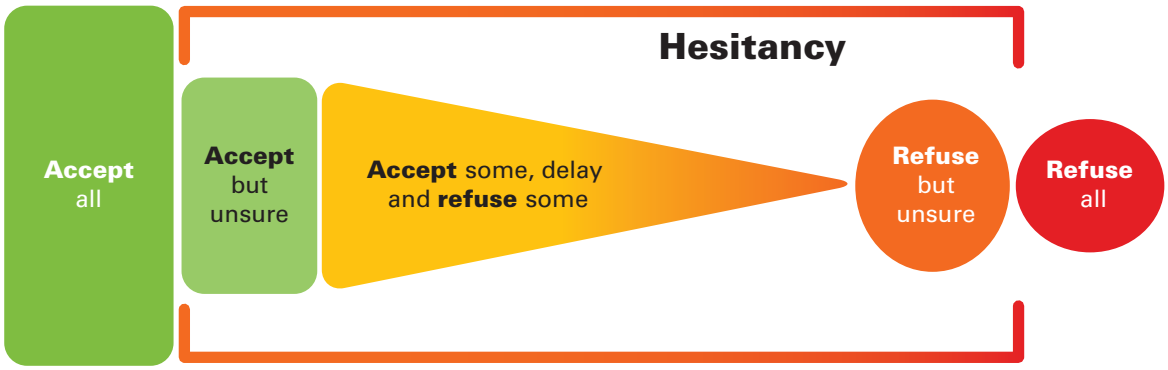
Vaccine hesitancy is a relatively recently described concept that has been defined by the WHO Strategic Advisory Group of Experts (SAGE) as:

> **A delay in acceptance** or **refusal of vaccines**, despite availability of vaccination services.[10]

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.

Figure 5. *Continuum of vaccine hesitancy*[11]



Continuum of Vaccine hesitancy:

- 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.

Most caregivers are extremely motivated to do what's best for their children. They may have various reasons for their actions, and things going on that we don't know about. So, we need to understand their reasons for their choices.

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

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

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.

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?
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 and the absolute refusers, but it's the ones in the middle that can be moved to bring us up to our target of 95% coverage.

No single strategy can address all the different dimensions of hesitancy, but what FLWs say and how they interact with the caregiver can strongly influence vaccine acceptance.

Factors that affect vaccine hesitancy

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.

Figure 6. *The three Cs*[12]

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

The Working Group's Determinants of Vaccine Hesitancy Matrix is a more complex and detailed way of looking at things that cause hesitancy. The matrix arranges determinants in three categories: individual and group, contextual, and vaccine /vaccination-specific influences.

Table 4. *Determinants of vaccine hesitancy matrix*[13]

Individual and group influences	**Contextual**	**Vaccine/vaccination specific issues**
▫ 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	▫ Media and public communication ▫ Anti- or pro-vaccination lobbies ▫ Local politics ▫ Perception of the pharmaceutical industry ▫ Religion, culture ▫ Accessibility of services ▫ Trust in authorities	▫ 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/ attitu desk/ knowledge base of healthcare professionals

One of the major influences on caregivers' vaccine hesitancy is trust in their health care provider.

- Do they feel their doctor or nurse 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?

You have the greatest influence on your caregivers' 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.

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

Session takeaway

Both caregivers and health workers are highly motivated to do what is best for the child. A number of factors influence vaccine hesitancy. 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.

Module 3.

Understanding behaviour
and barriers

Module 3. **Understanding behaviour and barriers**

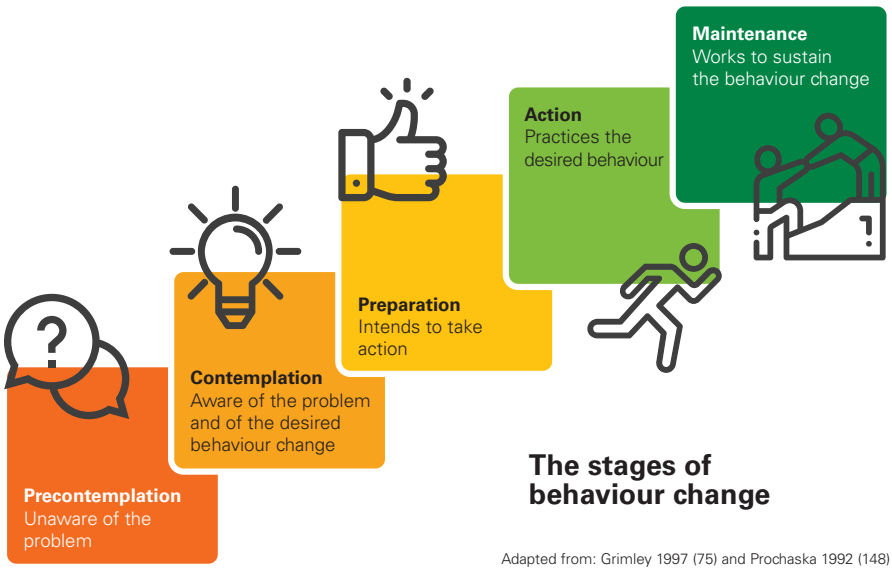
Module 3 Objectives:

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

1. Use theoretical models of behaviour change to think of caregiver needs.
2. Accept that our 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.

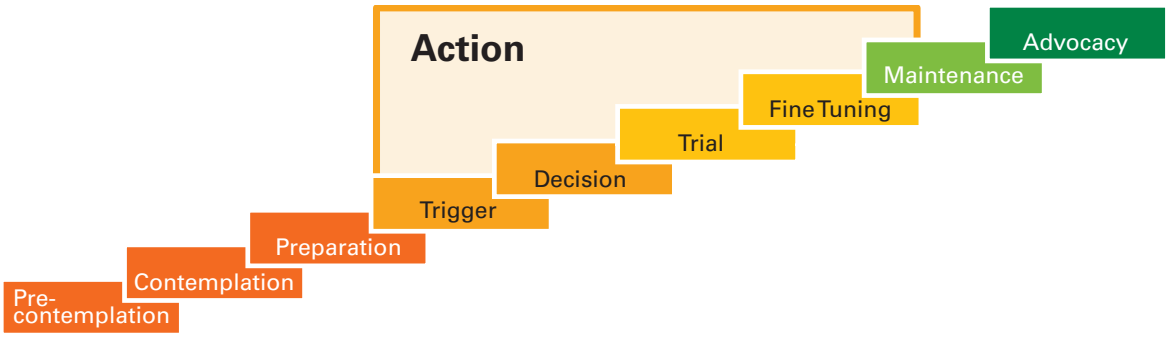
Session 3.1. Understanding models of behaviour change

Figure 7. *Trans-theoretical model of behaviour change*



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

Figure 8. *Expanded steps*



David and Amina have a 2-week-old baby, Ali. Ali got his routine immunizations after delivery at the health center, but David and Amina were so overwhelmed at the birth that they didn't listen very carefully to the health workers' instructions about when to bring Ali back for checkups. 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. We could say David and Amina are somewhere between the pre-contemplation and contemplation step. 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:

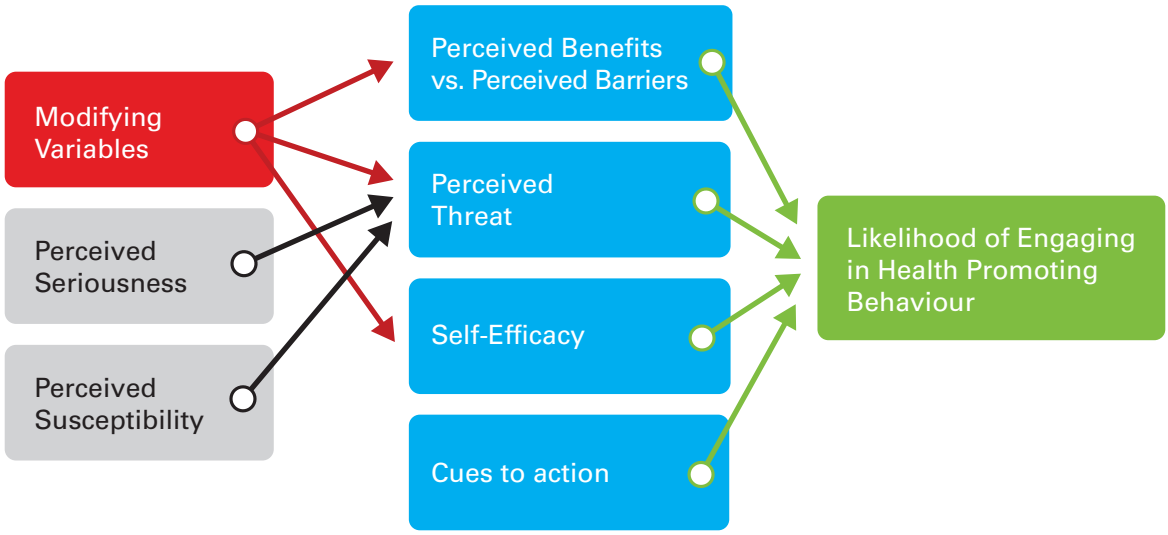
1. Learning more about vaccination,
2. Getting answers to their basic questions, like when and where, costs, etc.
3. Feeling positive about getting their child vaccinated,
4. Getting triggered to make the decision to vaccinate,
5. Deciding (or not) to go get their child vaccinated,
6. Navigating their 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,
7. Consulting with their provider, feeling they are being treated well and that their concerns and fears dealt are addressed,
8. Feeling comfortable and dealing with any side effects, setting up next appointment,
9. Returning for next doses, following up with schedules, etc.

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

Review the following table and answer the following questions:

- 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 journeys. 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 they 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.

Figure 9. *Health belief model*[14]



The **Health belief model** looks at a variety of determinants that can help us or influence how we move up or down the steps.

A person may not accurately judge the seriousness of something, or their actual susceptibility. For example, someone might not consider measles a serious disease, although it really is. 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***. We can think of perceived threat as, overall is this something that is dangerous enough to me that I should be worried or do something differently to deal with.

Immunization Example:

- Overall, is measles something that my child is at risk of, and that is dangerous enough that I need to be worried about it?

This idea of perceived threat relates to complacency, which we saw in the previous module in the 3 Cs.

Another pair of determinants are the **perceived benefits** versus the **perceived barriers**.
Immunization example of perceived barrier:

- *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.*

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

- *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.

Immunization example of perceived benefits:

- *I am seen as a good parent and a socially responsible person if I vaccinate my child.*
- *Or, I don't see the benefits of vaccination as big enough to risk some of the dangers of the vaccines that I have heard about.*

Perceived benefits relate to Confidence, which was the last of the 3 Cs. Perceived benefits and barriers are also related to an extremely important determinant of behaviour called **social norms**.

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.

Another consideration is **self-efficacy**, or the perceived ability to do the behaviour.

Immunization example of self-efficacy:

- *I feel confident that I can handle the stress of vaccinating my child and dealing with the criticism from my mother-in-law when my baby fusses after the shots.*

Finally, **cues to action**, can determine whether someone is likely to perform a behaviour. 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.

Immunization example of cue to action:

- 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.

These behavioural determinants are all things that can help move someone up the steps or make them go down.

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

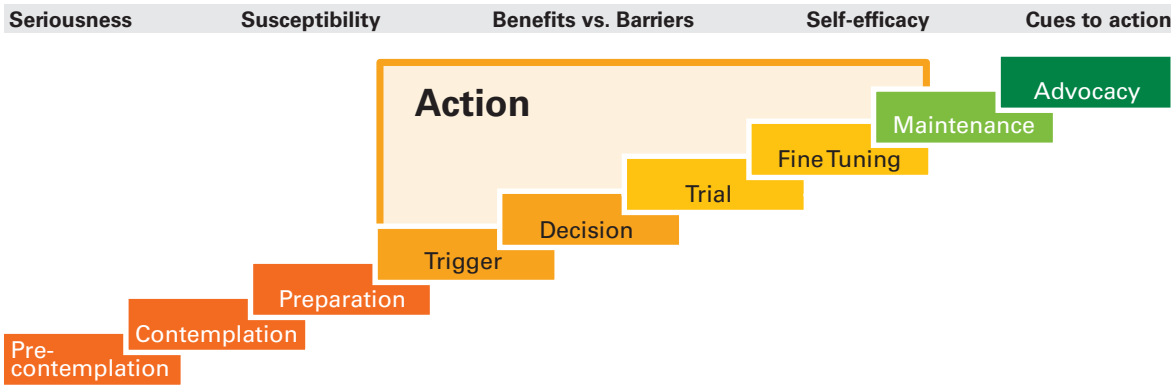


Figure 10 illustrates the steps from the Trans-theoretical model with the determinants from the Health belief model over them. This is a good image to remember when you are trying to identify caregivers' concerns and diagnose what their concerns are, and what "communication treatment" they may need to move up the steps.

As we are working with our caregivers to understand their concerns, we need to see where they are in terms of perceived threat, perceived benefits and perceived barriers, and self-efficacy.

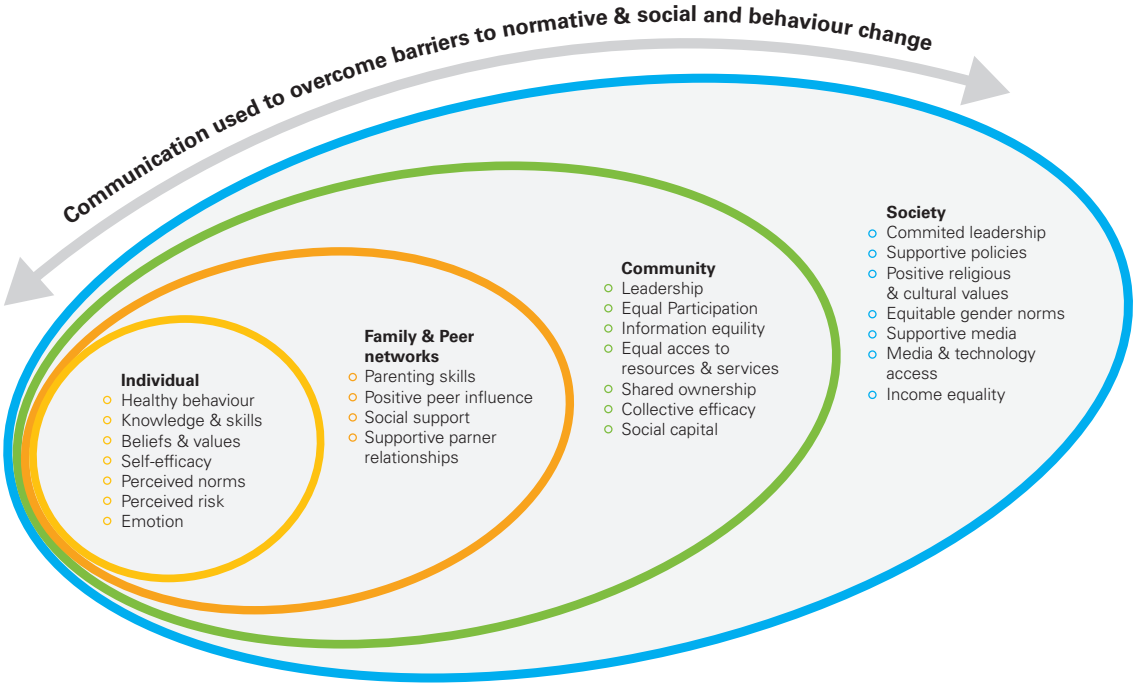
If they don't see vaccine preventable diseases as a threat, we work on that. If they see more barriers than benefits, we work on that. If they seem to lack the belief that they can get their child fully vaccinated, we give them confidence and help them find solutions. If they need a cue to action, we call them to remind them.

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.

The **Socio-ecological model** illustrates the different spheres of influence that govern our behavioural 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.

Figure 11. *Socio-ecological model*[15]



This model emphasizes that for immunization coverage to get back up to safe levels, we have to use communication:

1. At the individual level with our caregivers,
2. With families, for example during visiting nurse home visits,
3. With communities, as for example by Roma health mediators,
4. With society, as for example with public figures making positive or negative statements about vaccines,
5. With policies, as for example making vaccines compulsory, or making vaccination an opt-out approach instead of opt-in.

Reflect on how this model 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 David, Amina, and baby Ali.

15 https://www.k4health.org/toolkits/bridge-ii-project-toolkit

Session takeaway

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.

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 and influence us not to 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 we do it anyway?

- *Write one example:*

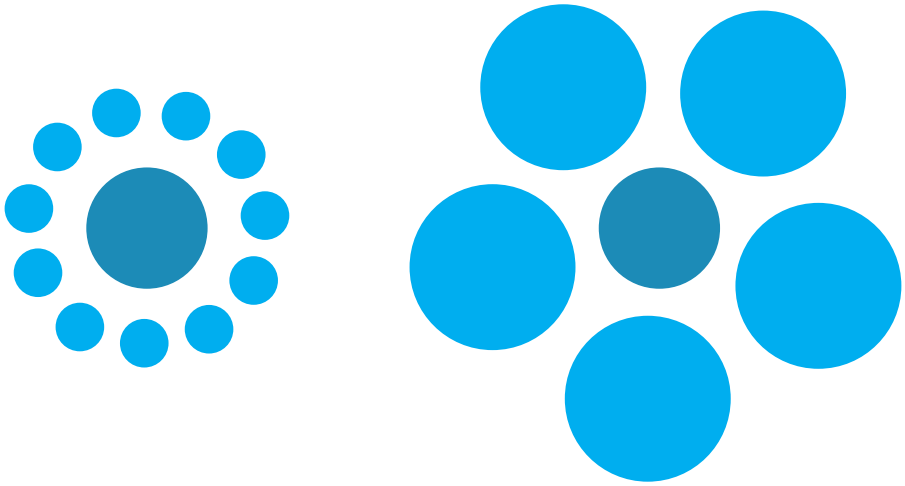
Can you think of one behaviour where everyone knows we should do it, but we don't always do it as we should?

- *Write one example:*

So, even when we have correct information, we don't always act on it. Sometimes our emotions are more powerful than information.

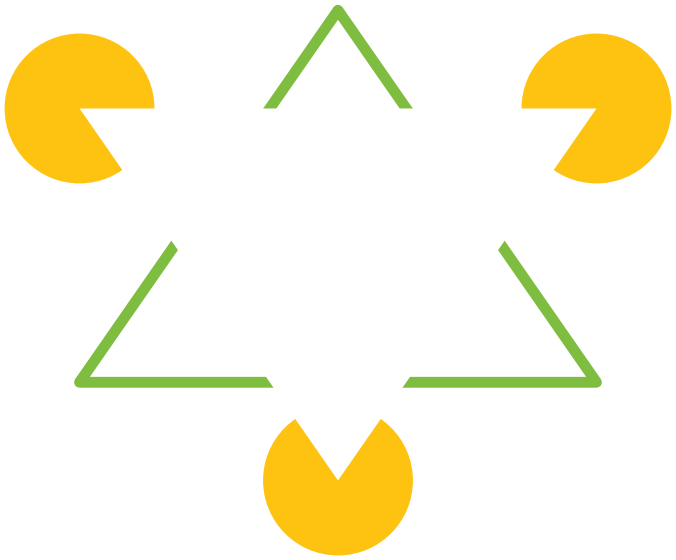
Our brains are powerful information processing systems. The brain is constantly experiencing many different inputs and trying to make sense of them all. Sometimes our brain uses shortcuts, or even makes mistakes, as it tries to help us make sense of all the different stimuli.

Figure 12. *Blue circles*



Which of the center circles looks bigger, the one on the left, or the one on the right?

Figure 13. *Triangles*



How many triangles do you see?

Figure 14. *What do you see?*

We also have lots of mechanisms to process experiential or heard information. We may perceive things as more dangerous than they are, 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."*

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. *"Break a mirror, seven years of bad luck"* or *"If a black cat crosses your path, you will have bad luck"* are common sayings.

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."* Is it possible that your 10-year old car would have had problems even if your friend hadn't borrowed it?

This may help explain why, in the face of all the scientific evidence, that people believe that MMR is linked to autism.

We are terrified by the increase in autism, and we want to believe there is a reason that we can explain, so we see patterns where there is in fact no association.

We don't see or feel the threat of measles, but we do 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 Denmark[16] 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 found[17] 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. To perceive differences between mild and serious adverse effects; rather they perceive both as serious risks 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 that their child may get 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.

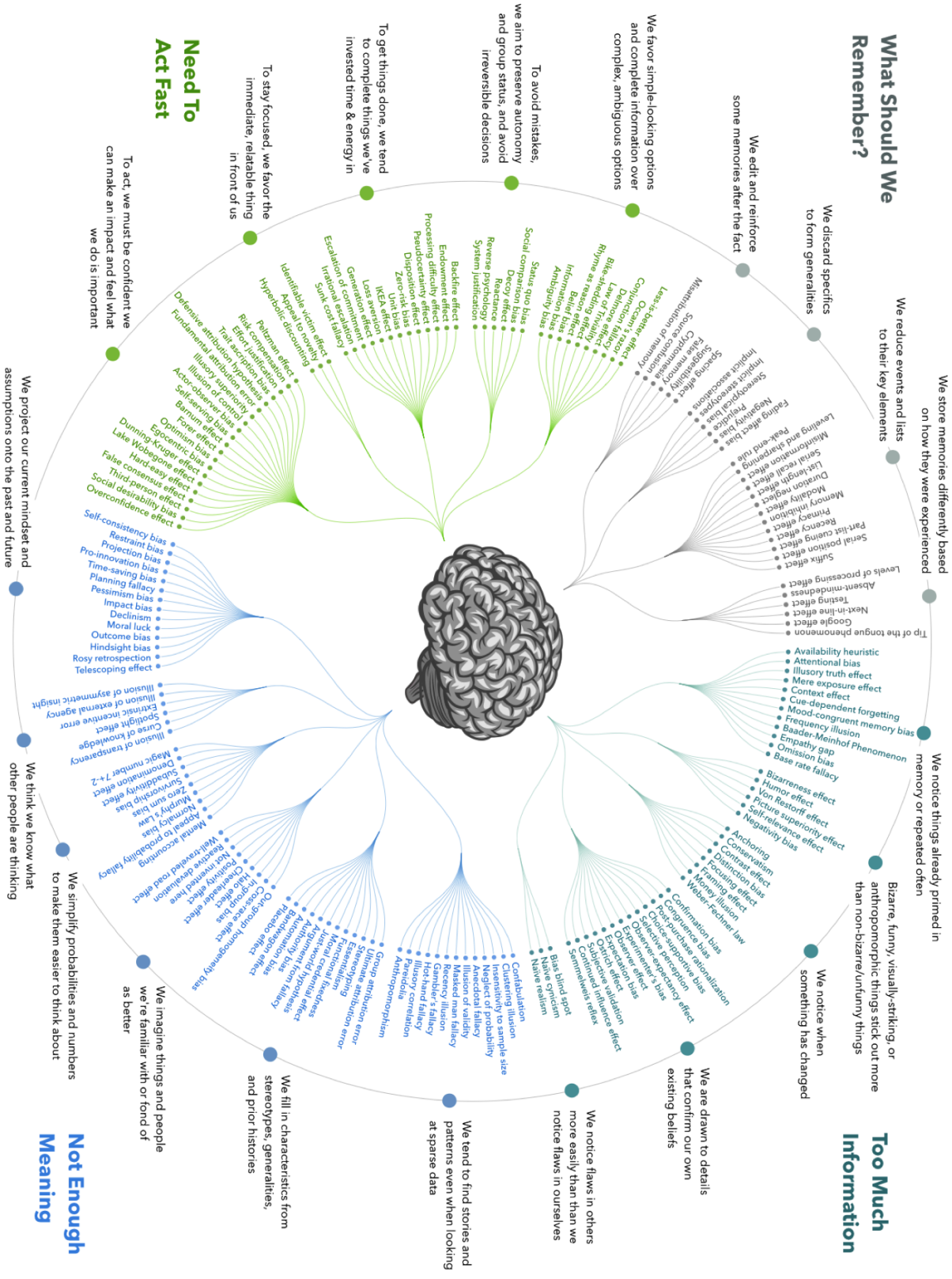
We have introduced a few brain biases but there are a number. **Figure 15** illustrates the Cognitive Bias Codex, which shows a number of such biases.

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.

16 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

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

Figure 15. *Cognitive bias codex*



The way we present information, helps 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. Antivaxxers, 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 and can help us to use biases to our advantage.

Research suggests, for example that frequencies are seen as more real and relatable than percentages. We can use the caregivers' emotional response to frame our conversation and nudge caregivers towards immunization[18].

If we explain the risk of the disease as a frequency (disease X kills 50 people out of 1000 cases) and compare it to the risk of a potential adverse reaction (this impacts X% of the population), 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. The emotion associated with 0.0000001 %, or one hundred thousandth of a percent having a severe reaction is less personal and less risky.

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. Our efforts to be empathetic and make caregivers feel heard and respected can help compensate for the anxiety they may be experiencing.

People look for shortcuts and the simplest solutions, so the way we set up services and systems can make a difference for our caregivers.

Making vaccination an opt-out approach - meaning you have to actively choose NOT to do it - helps to keep coverage high. Making it difficult to choose NOT to vaccinate will discourage people from opting out unless they are extremely resistant.

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.

18 Laskowski, M. Nudging Towards Vacination: 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/

Session takeaway

Humans make decisions based on facts, but also on emotions and perceptions. We are almost inevitably influenced by various cognitive biases. Our commination 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

Exercise 7: Olga and Dr. Musa

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.

Vaccine hesitancy isn't just fear of vaccines, as we saw in the 3 C's - complacency, confidence, and convenience.

There are many reasons caregivers might not be showing up for immunization or completing vaccine schedules. Our first job in ensuring uptake and completion of vaccine services is to understand the caregiver's needs.

Sometimes even the best clinician isn't very good at understanding what their patient needs or wants.

As a medical worker, you first make a diagnosis, before you prescribe treatment. Antibiotics are great. But are antibiotics the solution to all illnesses?

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 solve all their problems and needs as we saw in the case of Olga.

We need to strengthen our skills to understand their concerns and effectively address them, so we can help them complete the steps in *their* vaccination journey. Remember the steps in the vaccine journey are:

1. Learning about vaccines;
2. Getting answers to their basic questions;
3. Deciding (or not) to get their children vaccinated at all;
4. Navigating their way through their healthcare systems;
5. Consulting with their providers;
6. Getting their concerns and fears dealt with;
7. Accepting, delaying or refusing to get their children immunized;
8. Dealing with side effects;
9. Returning for next doses;
10. Following up with schedules, etc.

Session takeaway

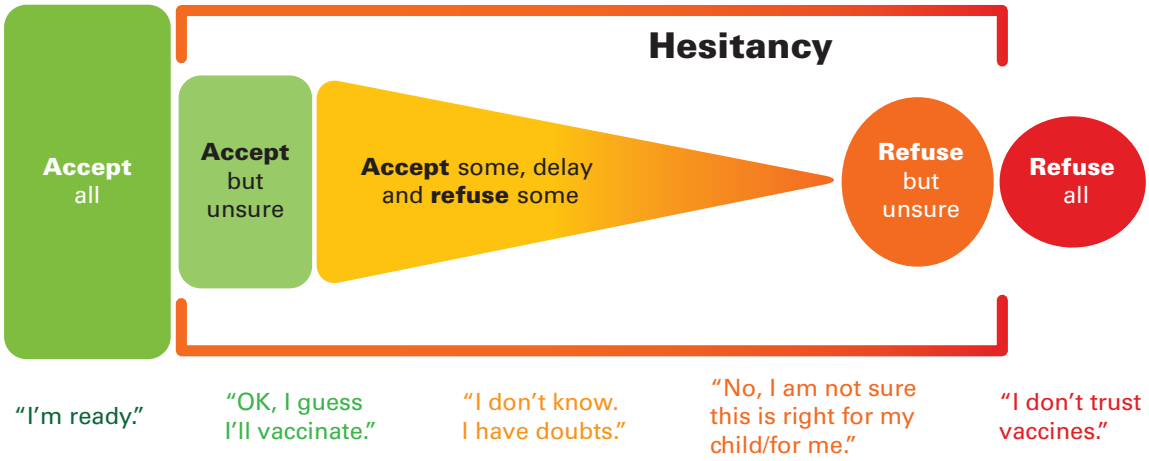
Sometimes even the best clinician isn't very good at understanding what their patient needs or wants. We need to ensure we understand what the true concerns are before we can target our communication to help caregivers overcome the specific barriers they face in choosing to immunize their child.

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

To understand our caregivers' needs, we need to map where on the hesitancy scale our caregiver is.

Figure 16 below provides some examples of what a caregiver in each category might say at each stage. What are some others you can think of?

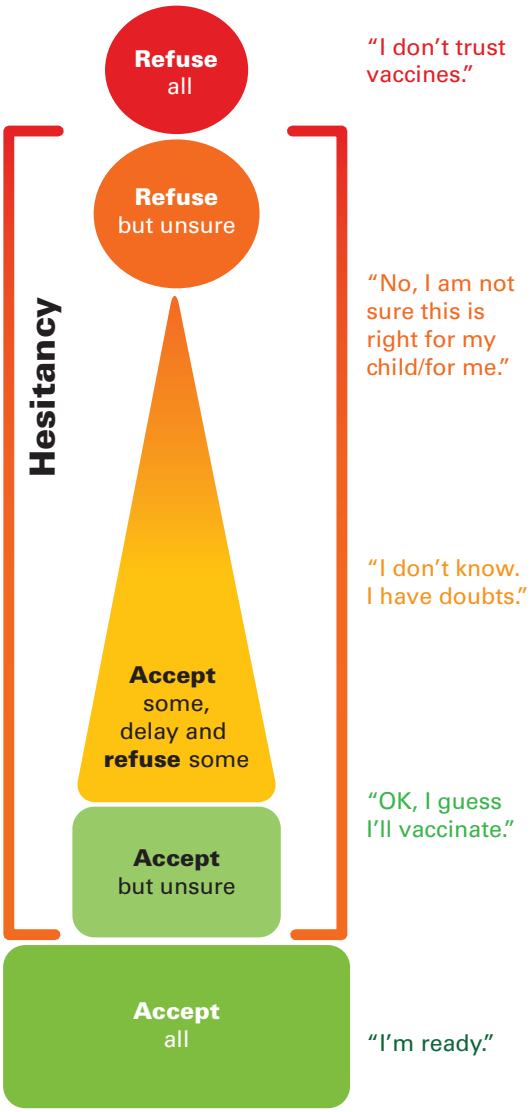
Figure 16. *Vaccine hesitancy continnum*[19]



19 Adapted from: Macdonald, Noni. (2015). Vaccine hesitancy: Definition, scope and determinants. Vaccine. 32. 10.1016/j.vaccine.2015.04.036.

It looks a lot like a stoplight. We'll call this the stoplight from now on for simplicity.

Figure 17. *Traffic light*



When you are driving and 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, you have to slow down and decide what to do. Should you keep going or slow down or stop? In the case of some people, you step on the gas and blast through, but you still have to be aware and make and assessment before you do this.

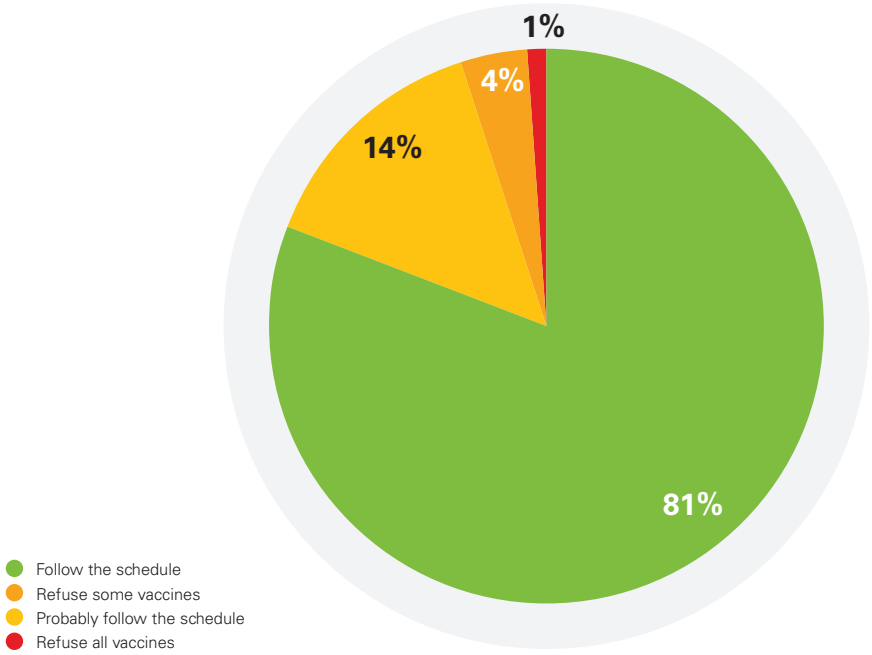
When you are driving and you see a red light, you have to stop.

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, using the example of Serbia. In a 2017 study19 of 824 parents in Serbia who had already had at least one vaccination for their child, about:

- About 81% of parents intended to continue vaccinating their child as per recommendations;
- About 14% said they would probably follow the schedule;
- About 4% would refuse some vaccines; and
- About 1% was not planning to immunize their children.

Figure 18. *Parents intention to follow vaccine schedule*[20]



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. That now gives us a population divided into acceptors, most parents (around 81%) and hesitators (around 19%)[21].

Session 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.

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

21 Source: KAP Serbia, IPSOS, 2017

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:

- 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.
- Around 1% will be vaccine refusers.

Now we will look at the results of the survey about concerns and fears of our vaccine accepters (80%) and hesitators (the 20%) and see how much difference there is in their perceptions.

We will see that there are accepters 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.

Table 5 on the next page shows the level of fears and mistaken beliefs among the general population acceptors and hesitators, and among Roma acceptors and hesitators.

Table 5. *Serbia KAP survey: concerns*[22]

	General Population			Roma		
Beliefs	**Acceptors**	**Hesitators**	**Odds**	**Acceptors**	**Hesitators**	**Odds**
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

22 UNICEF (2017). Knowledge, Attitudes and Practices in Relation to Immunization of Children in Serbia. https://www.unicef.org/serbia/en/reports/knowledge-attitudes-and-practices

	General Population			Roma		
Beliefs	**Acceptors**	**Hesitators**	**Odds**	**Acceptors**	**Hesitators**	**Odds**
Preservatives 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 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

Note: The Knowledge, Attitudes and Practices (KAP) study used Supporters instead of Acceptors in their report. For consistency and clarity, we are using the term "acceptors".

Exercise 8A: Serbia KAP survey: concerns

Take five minutes to review table 5 and answer the following questions:

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 accepters (meaning they vaccinate their children and intend to continue) were there any fears?
4. What were the accepters' top fears?
5. Did those fears prevent the accepters from vaccinating?

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 belief statements such as "MMR causes autism".

The fact that accepters 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.

Exercise 8B: Serbia KAP survey. Roma

Take 10 minutes to review **Table 6** below in your group, and then discuss the following

Table 6. *Serbia KAP survey: Roma population*[23]

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?

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

Other studies from this region give us some additional insight into these issues.

The 2014 Multiple Indicator Cluster Survey (MICS), reports a difference in full immunization coverage between the general population in Serbia, and the population in Serbian Roma settlements. Around 71% are completely vaccinated in the general population versus around 13% fully vaccinated in the Roma population.[24]

According to the 2012 MICS survey in Bosnia and Herzegovina, only 4% of Roma children had all recommended vaccinations compared to 68% non-Roma children.

Given the relatively similar attitudes towards immunization between the general population and the Roma, what do you think the major obstacles to full vaccination among the Roma are?

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 Herzegovina[25] 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.[26]

For example, with caregivers who lack an insurance card, your referral to a social worker or Roma community mediator may be as important as your good communication in getting their child immunized.

The study 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 parents and the opponents of vaccination. Opponents usually consider vaccine-preventable diseases *"mild"* or *"diseases that strengthen immunity"*. Hesitant parents, however, detect risks on both sides, and they seem to find it hard to "rank risks", or to estimate what is more dangerous for a child.

24 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.

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

26 ECDC let's talk about protection

Parents with extremely negative attitude saw no benefits in vaccination. Their main complaint was that vaccination is mandatory by Serbian law and that parents are not left to decide for their children as their main caretakers.

Let's review!

We have looked at the vaccine hesitancy continuum, and seen that:

- The majority of that caregivers, around 80%, are up in the green, willing to go ahead and vaccinate.
- About 14% are yellow: they probably will follow the recommended vaccine schedule.
- Four per cent are orange, they may refuse some vaccines.
- And 1% are red - they will refuse vaccination.

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 and have difficulty assessing the risk of the disease against the risk of the disease. They are concerned about:
  - giving multiple vaccines at once;
  - vaccine quality or side effects;
  - young children being unable to tolerate vaccines.

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 caregivers 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. We will learn more in-depth about the interpersonal communication skills we can use to help with this in Module 4.

Session 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.

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 you 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. Skillfully combine active listening skills to understand caregiver category and identify specific concerns.

Session 4.1. Dialogue creates understanding

Exercise 9: Apples and watermelons

The drawing exercise using Handout 3 and 4 reminded us that effective communication is a two-way dialogue. As a FLW you must not only tell and teach, but also listen and understand.

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.

These subsequent sessions will focus on the following four key active listening skills:

1. Nonverbal communication;
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 caregivers.

Session 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

Nonverbal communication is a powerful tool that sometimes can speak more loudly than our words. We want to ensure we are always using positively.

Exercise 10: Practice nonverbal communication. Mickey Mouse

Table 7. *Aspects of nonverbal communication*[27]

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.

27 UNICEF (2017) Facilitator's Guide: Interpersonal Communication for Immunization. Draft

Aspects	Does not help	Helps
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 floor, standing.
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.

Nonverbal communication includes gestures such as, nodding, smiling, raising eyebrows, and shaking one's head. Nonverbal utterances include, for example: *"Aha"*, *"Mmm"*, *"Hmph"*.

Touch, **if culturally appropriate**, is extremely powerful, along with a smile, and encouraging noises and gestures. If you can shake their hand, smile and nod, you will have gone a long way in 15 seconds to create connection and trust, which is the foundation for everything else.

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

Take five minutes to work with your pater to identify a list of four nonverbal things you could do with every caregiver when you first encounter them, to ensure they feel comfortable and connected.

1. _____
2. _____
3. _____
4. _____

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.

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 and eyes into the position of a smile actually releases endorphins, which make you feel happier!

During our Mickey and Mouse exercise, we saw that poor nonverbal communication really destroyed the health provider-caregiver interaction. We should make sure we use at least four nonverbal tools to make caregivers feel comfortable and connected.

Session takeaway

Positive nonverbal communication gives the caregiver the confidence to communicate openly and honestly about their concerns and feel connection and trust with you. It can often communicate more strongly and more quickly than our words that their concerns are important to us and we have their child's best interest at heart.

Session 4.3. Nonverbal communication. Reading it

Another important active listening skill is reading your caregivers' nonverbal communication to you.

Exercise 12: Nonverbal communication by caregiver

Review **Table 8** with your partner. You have five minutes to discuss and prepare to act out two non-verbal signs of disagreement, concern, and two expressions of agreement or approval per category for the group. They will have to guess what you are expressing.

Table 8. *Nonverbal communication by caregiver*[28]

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

28 UNICEF (2017) Facilitator's Guide: Interpersonal Communication for Immunization. Draft.

If we see signs of concern, that is like a yellow or red light at the stoplight. It tells us we need to slow down and see what's happening, we need to acknowledge the concern.

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.

Session 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

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.

Showing empathy is one of the most important communication skills for FLWs.

Empathy from health care providers increases trust 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.

Table 9. *Empathy versus sympathy comparison chart*[29]

	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 samples of statements from mothers based on statements found in the KAP study conducted by UNICEF:

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

1. *The health worker criticizes me in front of others for not having returned exactly four weeks after the previous dose.*
2. *The health worker ridicules me for my child's torn or unclean clothing.*
3. *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.*
4. *I can't completely understand what the health worker is trying to say to me, but I am afraid to ask questions.*
5. *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.*

Exercise 13: How to show greater empathy in routine immunization

Work with to your partner to discuss what you could do to show more empathy to the caregivers who come to your clinic. Then develop 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. For example:

1. *"I will be kind to caregivers who have difficulty staying on schedule for immunizations."*
2. *"I will tell caregivers that they can bring their children for immunization in the afternoon if that is more convenient for them."*

How I plan to improve routine immunization experience for caregivers:

1. _____

   _____

2. _____

   _____

3. _____

   _____

Table 10. *Simple ways to show empathy*[30]

Say things such as:	• *"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."*
Pay full attention to the speaker	Allowing him or her to speak. Do not interrupt to propose a solution. Letting someone 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.
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 understand that you want the best for your child, and I do too. I care very much about my caregivers."
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.

30 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 angry.
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.

Exercise 14: Showing empathy to baby Elvis' parents

Imagine Mr. and Mrs. Sajdić come to your office bringing baby Elivs, 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, above 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 counseling**, 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 and, the provider shows empathy to their situation.

Session takeaway

Showing empathy is a skill you can strengthen through practice. 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

The types of questions we use with caregivers are also important.

Closed-ended questions

With **closed-ended** questions, you can answer with a single word, such as: yes, no, a number, or something like that. Closed questions might begin with:

- *"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?"*

The caregiver may nod their head yes, 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

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 **why** is not in the list above.

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.

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.

Exercise 15: Closed and open-ended questions

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 vs. open-ended questions*[31]

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 center?	How do you feel about your experience when you come to the health center?
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.

What are the potential advantages of the open-ended version of question?

_____

_____

What are the potential dis-advantages of the open-ended version of question?

_____

_____

31 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
Do you have any concerns?	
Did your baby get her last shots?	
Why don't you want to give your child the MMR vaccine?	
Did Jelena get a fever after the last shots?	
You understood what you are supposed to do if Drago has any serious problems, right?	

Leading questions

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 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, ignored, unknowledgeable, whereas an open question might allow them to express their concerns.

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, correct?"* We need to be strategic in our use of leading questions.

Probing/drawing out questions

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.

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?"

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?"*

Buying yourself time to answer questions

When someone asks you a question, and you need a minute to think about your response, 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."*

When you don't know the answer

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."*

Session 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

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.

Reflective listening is hearing and understanding, and then letting the other person know that s/he is being heard and understood. Reflecting 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.

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 communication, empathy, and special questions.

Exercise 16A: Practice reflecting. Nurse Bakija and Mrs. Hadzic's role play[32]

Review how Nurse Bakija uses reflecting to elicit the mother's concerns and help her feel understood in this role play.

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:	*"Petra seems fussy since she got her shot last week?"*

32 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

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 Mrs. Hadjic's first concern? How did Nurse Bakija reflect back Mrs. Hadzic's first concern?

_____

_____

What was the second concern Mrs. Hadzic raised, after Nurse Bakija reflected back the first concern that Petra was fussy since her shot?

_____

_____

How did the nurse reflect back Mrs. Hadzic's worry that Petra had a fever?

_____

_____

When Mrs. Hadzic said she thought Petra had a fever, Nurse Bakija could have said 'Ok!' and gone straight to just taking the temperature. Instead, he spent that extra time to reflect back the worry, *"I hear your worry"* and then show he was acting on that worry. This reflects that he sees himself and the mother as a team that wants to do what is best for the child.

Taking the time 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.

Here's another example of reflective listening.

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 kind of reactions might the community member have?

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.

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

Take 3 minutes to discuss the following scenario with your partner and determine a reflective listening response. Remember, we are not looking for the scientific response about MMR safety. You want to find a phrase that allows you to reflect that you are hearing Marko's concerns without repeating the false information.

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."*

Write at least one reflective response you could use or that you hear from the group discussion.

_____

_____

Table 13. *Reflective listening*[33]

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.

- 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 communication, empathy, and special questions.

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

- 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 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.

Session takeaway

Reflective listening is a powerful technique to help us to understand our caregivers' feelings and needs. Helping caregivers express their concerns, allows them to feel heard and understood. This helps them open their ears and minds to what we have to say.

Session 4.7. Practice combining active listening techniques

Combining active listening techniques

Now that you have reviewed several active listening techniques (nonverbal communication, empathy, open-ended questions and reflective listening), here is an example of combining them in a natural conversation style.

Exercise 17A: Dr. Vera, Mrs. Ilić and baby Drago[34]

In your group, choose one person to play Dr. Vera, one person to play Mrs. Ilić, (and one person or for example a pen to play baby Drago) to act out the scenario below, reading from the script. The group should read along. At the end of the scenario, you will discuss with your group to answer the following questions.

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.
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)…

34 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

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.
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.

Questions:

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?

Ultimately, Dr. Vera failed to: _____

Exercise 17B: Practice active listening techniques. Secret scenarios

- Reference Handout 5.

When we use active listening, it can help us figure out where caregivers are on the continuum. It helps us to understand what they might need to hear to trigger their decision or determine 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 3 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.

- If caregivers need to talk about vaccines, give them your full attention.
- If caregivers don't know where to start or seem to feel uncomfortable, invite them to express their concerns, and ask any questions.
- Resist the urge to multi-task while a caregiver talks.
- Maintain eye contact with caregivers, restate their concerns to be sure you understand their viewpoint, and pause to thoughtfully prepare your reply.
- Your willingness to listen will likely play a major role in helping caregivers with their decisions to choose vaccination[35].

35 WHO. Talking with parents about vaccines for children. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0006/160755/Talking-with-parents_EN_WHO_WEB.pdf?ua=1

Session takeaway

Even great 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. Practice of active listening is worth the time investment to help us to diagnosis the issue and choose the right response, for effective communication treatment.

Module 5.

Communication during immunization

Module 5. **Communication during immunization**

Module 5 Objectives:

By the end of the module you 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. Negotiate consent forms and refuser forms.
5. Handle refusers successfully.

Session 5.1. Using the opt-out strategy

We have to understand what's going on in our caregivers' heads in order to diagnose where they are on the hesitancy continuum. We have spent a lot of time so far in this training working on understanding our caregivers' needs and beliefs.

Now, we are going to suggest something that kind of goes against some of what we have been saying about understanding your caregivers' needs first.

We know your time is limited, and we know that the majority of caregivers are in favor of immunization. Remember the pie chart that was 80% green from Session 3.4? It showed us that 80% of caregivers intend to complete their child's immunization schedule.

We suggest the opt-out approach during immunization sessions or health consults. This way, you make it clear that immunization is the normal thing that everyone does, because it is the best, safest option.

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."* If this won't work in your context, you would ask if they want to vaccinate their child.

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 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 the shaking hands and the welcoming expression and the smile, is:

ASSUME THEY WILL VACCINATE. Your caregivers are most likely there to get immunization. It's a different context from a home visit or elsewhere. So, move forward assuming they will vaccinate. Most of the time, you will be successful.

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.

Vaccine hesitancy continuum

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.

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. They may even feel a sense of relief that the decision is made for them, with their consent.

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 shots, and the next.

So, we aren't just pushing them through, saying: *"Here, have your vaccines! Bye!"* We have a number of steps to go through, with the green light people and the yellow, orange and red people as well.

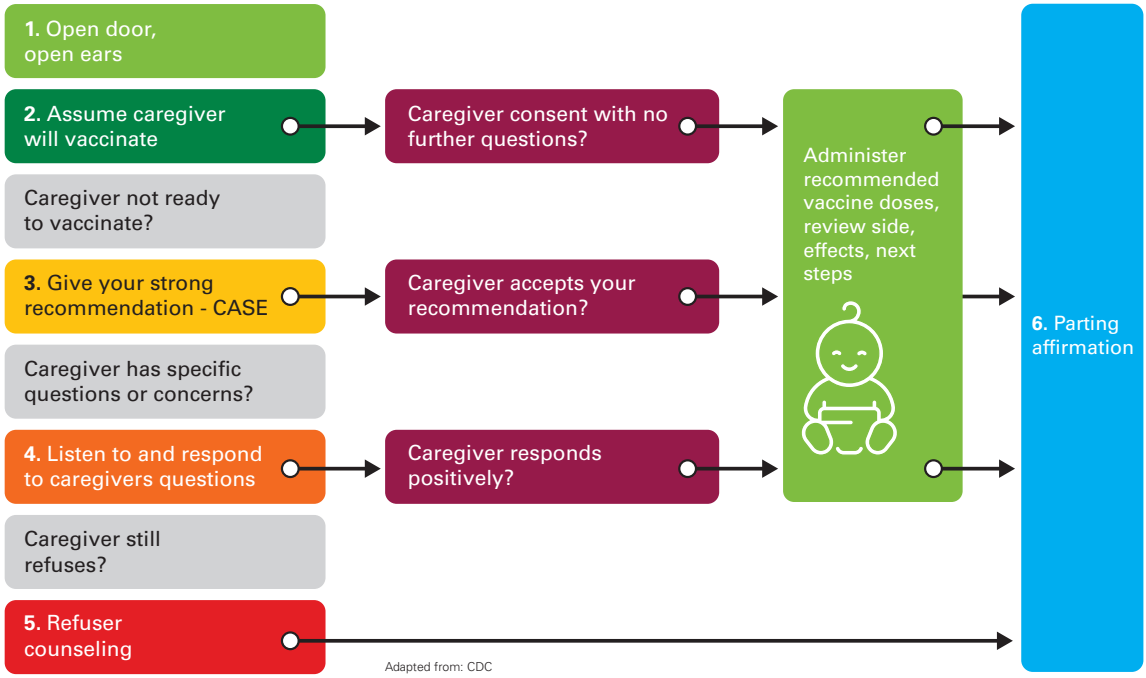
Session takeaway

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

The Algorithm for vaccine communication is a tool to help us apply what we have learned.

Figure 19. *Algorithm for vaccination communication*[36]



Box 1:

- We make caregivers feel welcome, accepted, understood, cared for. We open their ears with our welcome, building trust, and we open our own ears.

Box 2:

- We assume they will vaccinate.
- Instead of saying "How would you feel about getting vaccinated today?" you would say "Today Goran should get his next vaccines."
- We pause and check to see what their reaction is by using our nonverbal reading skills. We are looking for cues in what they say, the questions they ask.

36 Adapted from CDC

- If they are comfortable we proceed to vaccinate (purple box to the right of Box 2). They are one of the green 81% of acceptors.
- If they are hesitant (Gray box below Box 2), we proceed to Box 3.

Box 3:

- Give your strong recommendation using CASE approach, which we will discuss shortly.
- After you give your strong recommendation, if the caregivers seem to accept the recommendation proceed to vaccinate (purple box to right of box 3). That is probably one of your yellow caregivers, one of the "not so easy 14%".
- If the caregivers do NOT seem to accept the recommendation and they seem to have specific questions and concerns (Gray box under box 3), follow the arrow to box 4.

Box 4:

- *Use your toolbox of communication skills to further draw out their concerns and questions, make them feel they are being understood and respected, and help them come to a decision.*
- *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.*

We are going to look at these steps in depth and then will practice moving through the full algorithm in the next sessions.

Session takeaway

The algorithm starts with the assumption that caregivers will choose to vaccine 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.

Session 5.3. Assume they will vaccinate, but check

Most caregivers will probably feel all right with this 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.

Exercise 18: Practice first three steps of algorithm

Pair up with your neighbor 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.

Session 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. 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.

Session 5.4. If they are hesitant, give strong recommendation

Many of your caregivers will be done by now, but some will show you through words or nonverbal cues that they are hesitant.

If the caregivers indicate they are hesitant when you make the vaccination assumption, you will give your strong recommendation. In this strong recommendation, you can use a mixture of components. We will talk about the CASE approach in a following session. First, we are going to identify some Elevator phrases.

Exercise 19: Develop strong recommendation phrases

You have 15 minutes to work in your small group to create at least two phrases for each of the following categories. Write you phrases on the list titled Elevator phrases found on the last two pages of this manual. Review the list in the section below, if you need some ideas.

- Your personal conviction;
- Your personal experience;
- An emotional appeal;
- The concept of protection;
- Social norm that responsible caregivers vaccinate;
- Your concern for the child's welfare.

Examples of phrases for making a Strong Recommendation

Here is a list of a few phrases to use for your strong recommendation. Try these or find some that work better for you:

- *"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."*
- *"As an FLW, I have seen the difference this new vaccine makes. We see many fewer children with ____."*
- *"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."*
- *"These shots are very important to protect him from serious diseases, especially now that there are so many measles outbreaks."*
- *"This office has given thousands of doses of vaccines and we have never seen a serious reaction."*
- *"Almost all caregivers around here vaccinate their children to ensure their child is safe and well cared for."*
- *"I keep up with the most recent scientific literature, and I am confident about vaccine safety."*
- *"I really recommend that you get them today."*
- *"In my experience, my caregivers handle the pain of that shot and any minor side effects easily."*

- *"If I were in your shoes, I would give my child the shot."*
- *"Vaccination is the right thing to do to protect your child."*
- *"I strongly recommend your child get these vaccines today."*

If the caregivers show that they accept your strong recommendation, you can go ahead and administer the vaccines the child needs (purple box to the right of Box 3).

If they accept your strong recommendation, and you vaccinate them, you will also:

- Give your normal counseling on possible side effects;
- Review when to come back and what to do if they have a question or are worried once they return home;
- Give them their departure affirmation. We will also work on this later on.

If after your strong recommendation, the caregivers indicate they still have specific questions or concerns, (gray box under Box 3), you need to spend 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.

Box 4 is where you need to put all of your active listening and psychology skills to work. These are your most challenging diagnosis and treatment cases - your yellow and orange caregivers. You need to:

- Use careful dialogue to elicit and listen to caregivers' questions and concerns, showing you are understanding;
- Respond to their concerns, reassure and motivate them, according to whatever their particular concern is, to the best of your ability.

Exercise 20: Analyzing discussion with Dr. Musa and Olga

Answer the questions below the script through plenary discussion.

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:	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.

1. Did he miss the first step of Box 1, Open door, open ears, welcoming her and creating trust?
2. Did he miss the second step of Box 2, Assume caregivers will vaccinate?
3. Did he forget to do the Strong Recommendation of Box 3? Did he forget to reassure her that Luka would be fine and that she was making the right decision?
4. What did he forget to do?

_____

_____

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

Identify three 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 these questions. Look at your algorithm and the dialogue as you think about this.

1. _____
2. _____
3. _____

Session takeaway

We need to get the right balance between driving along with a green light, nudging caregivers into the vaccination box, or slowing down to give our strong recommendation, or coming to a halt, to see whether we can find the key to unlock the caregiver's yes.

Session 5.5. Dealing with the very hesitant

Exercise 22: Mapping dialogue to the algorithm

Read through the example dialogue below with your partner and complete 2 tasks:

1. Map the conversation onto the algorithm.
2. Identify all the communication techniques Nurse Dora is using.

Nurse Dora and Mrs. Jovanic[37]

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:	You sound quite worried. Let's talk it through together. Tell me more about what you are concerned about, okay?
Mrs. Jovanic:	One of the moms 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. She does seem so young to be having injections against all these diseases at once. Won't it make her ill?
Nurse Dora:	OK, we can talk about this, but do you have other worries as well?
Mrs. Jovanic:	Well, I read also that they can get a sore leg afterwards, so that's another worry.

37 Adapted from 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

Nurse Dora:	(*pausing to allow Mrs Jovanic to interject if she has questions and to observe body language*) 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. You're right that the injection has got five ingredients. It seems a lot, doesn't it?
Mrs. Jovanic:	Yes, that's what I am worried about – is it too much for her?
Nurse Dora:	Children, even newborn 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. 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. So even at her young age, Lamija can handle the five vaccine ingredients, which will protect her while she is so young and vulnerable. And this way, she only has to have one shot, instead of several different ones.
Mrs. Jovanic:	OK, and would she get a sore leg?
Nurse Dora:	Most children don't have any reaction at all, other than crying a bit with the injection, and even then, they generally settle really quickly with a cuddle and some comforting words from mom. It's true that a small number of children, about 10%, can get a redness or a sore area where the needle goes in – but these reactions don't usually distress the child, and only last a couple of days, then go away. 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?
Mrs. Jovanic:	What happens after the shots?
Nurse Dora:	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.

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:	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.
Mrs. Jovanic:	Thanks. I'm still a bit nervous but I think we should get it done.
Nurse Dora:	You've made the right choice to protect Lamija. Why don't you hold her and let her play with her toy while I get the vaccines ready?

What did you notice when you mapped this dialogue to the algorithm?

- *Nurse Dora skipped Box 3 - Strong Recommendation and went straight to Box 4 - Listen to and respond to caregiver's questions. She probably sensed that Mrs. Jovanic was quite fearful, so it was better to go ahead and let her express her fears and respond to them before giving the strong recommendation right at the end.*

There is no one right answer. Every caregiver is different, and every interaction is different.

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.

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.

Which approach to use will depend on your knowledge of the family. Watch and listen. Giving information in chunks, and then checking comprehension or reaction, is a way to ensure you and your caregiver understand each other.

One key point to remember is that when parents express a concern do <u>not</u> say:

- *"I understand **your concern**" or "I can see **why you are worried** about that".*

You want to validate the **emotion** of the concern without validating the **contents** of the concern. Say instead:

- *"I understand that you are concerned"* or *"I can see that you are worried".*

The more you practice these skills of listening and negotiating, the better you will become.

Session takeaway

When you see that a caregiver is very hesitant, put on the brakes, slow way down, and use reflecting and other techniques to create trust. Be prepared to use the mix of science and personal stories that will be most effective in addressing caregivers' questions and concerns.

Session 5.6. In the vaccination box. Decreasing pain

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, since a screaming child and a stressed-out caregiver will both have negative memories and will be less likely to come back.

Some tips for reducing pain and associated stress can be found below and in **Annex D**:

- Reinforce that crying is a normal response for the child and suggest that they stay calm so that the child does not become aware of their stress.
- Explain that the caregiver should try to relax and hold the child in an upright position during vaccination.
- 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 favorite 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 favorite 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. You can watch two examples here:
  https://www.youtube.com/watch?v=MOOxpT9q2mo
  https://www.youtube.com/watch?v=bCljDf5veEs
- There are other things such as use of sugar water, topical analgesics, or oral pain medication that can be used to decrease pain or discomfort during and after the injections.
- *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.

Session 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!

Session 5.7. In the vaccination box. Discussing side effects

Studies in Bosnia and Herzegovina and Serbia, as well as probably your experience, show that side effects are the top concern of both the acceptors and the hesitators.

It's not clear in the studies how much was fear of severe side effects, which are in fact extremely rare, or the unhappiness with minor ones which are common.

As we discussed earlier, 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.

But whether it's an acceptor or a hesitator, it's important to let the caregiver know what to expect and what to do.

It's not an easy subject to discuss, but it's important. Focus groups in Bosnia and Herzegovina[38] revealed that some mothers accepted the side effects because they had been warned and told how to handle them.

> *"My daughter also had these [side effects], perhaps because she would receive three vaccines together. She would get fever, like 40, but they told me to shower the child and to put compresses."*

Others seemed taken by surprise and unhappy:

> *"My husband asked me what they were doing to the children. I came back with her and she had fever and was crying. She received three vaccines and couldn't move her arms. She couldn't move either arm for two days. He felt bad about it. He said I wouldn't do it again. The arm where they give the shot always turns blue. (both Roma, Žeravica)*

Always discuss honestly the known side effects caused by vaccines so that caregivers know what to expect and don't worry. But, don't forget to remind caregivers of the overwhelming benefit of preventing potentially serious diseases with vaccines. It's honest to say that not vaccinating is a risk that will worry you much more than any potential for side effects.

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 second mother quoted above said. This is key.

Exercise 23: Talking about side effects with Mrs. Dudić[39]

Review the below sample script and answer the following questions with your partner.

1. How does this discussion map onto the algorithm? Which box were they in at each point in the discussion?
2. Dr. Marina used a lot of different communication techniques. Please find at least one example of when she used the following techniques:
   a. Pausing to give Mrs. Dudić a chance to ask questions or think;
   b. Reflecting back;
   c. Confirming/reassuring that Mrs. Dudić has done the right thing, made the right choice;
   d. Assigning likelihoods- qualitative estimate of risk (probably, likely, possibly, not very likely, very uncommon, extremely rare);
   e. Positive framing of quantitative estimate of risk (% or frequency);

38 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

39 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

f. Using the concept of protection;
g. Summarizing;
h. Giving control to Mrs. Dudić;
i. Emphasizing the social norm that most people vaccinate;
j. Personal belief/recommendation;
k. Personalization with child's name.

3. How is this similar or different to how you normally discuss side effects with your caregivers?
4. Are there any phrases you could use in your practice?

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?
Mrs. Dudić:	Yes, she is fine now.
Dr. Marina:	Then it is perfectly safe for Minira to have them today. 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*)
Mrs. Dudić:	So, you are sure it's okay for her to get her vaccinations even though she just got over a cold?
Dr. Marina:	Yes, it's fine, and I am very glad you brought her in. 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. 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. Any other questions before we get started on the vaccinations?
Mrs. Dudić:	No, I think it's okay.

Dr. Marina:	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. 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. Most children have no reaction to the shot, but if they do, the commonest thing is a slightly sore arm that will last for a few days and then settles (*pausing*)
Mrs. Dudić:	OK. Anything else?
Dr. Marina:	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. (*pause*)
Mrs. Dudić:	Ok, so it's not just right after the shots I have to worry about, it's later too?
Dr. Marina:	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. 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. It's so important to protect her now, since we have all these measles outbreaks. 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. These symptoms usually go away after 1 to 2 days. 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.

Dr. Marina:	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 because it is the best way to protect from the disease. They find that the slight side effects are a bit of a nuisance, but nothing to worry about. 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?
Mrs. Dudić:	It seems like a lot to think about.
Dr. Marina:	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. That, plus lots of cuddling afterwards, will help the whole process be less painful.
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. Let's get Minira taken care of.

Adapted from Leask

Exercise 24: Reworking the role play

The role play above may not be feasible for your setting. Work with your partner to create your own version of the discussion between Dr. Marina and Mrs. Dudić. Each of you should take turns playing Dr. Marina and Mrs. Dudić.

Both characters can add or cut out things, use different phrases, etc. 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.

Be prepared to present your version to the larger group.

Write down a couple of phrases that you hear from the group presentations that you think would be useful in your practice.

_____

_____

Session 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. Make sure to present the facts so they aren't surprised or frustrated by their child's sore arm and then decide not to come back, and make sure 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."*

Session 5.8. Talking with refusers

As we have discussed, refusers only represent a very small percentage of the population, perhaps 1% - remember the pie 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 hesitators up into the green, it has little effect on refusers.

Exercise 25: Example of dialogue with the vaccine-refusing caregiver[40]

Review the role play script below and write down any phrases that would be helpful in your own work. The caregiver, Mr. Maric, has come in because Radko has a cough. There is a discussion about Radko's upper respiratory tract infection.

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*)
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:	You're right, most children will overcome illnesses without too much of a problem (*acknowledging*). 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. With measles, for example, 9 in every 100 children get pneumonia and some need to go to hospital (*pause*).

40 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

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*)
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:	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.*) Although there has been some research that raises concerns about vaccine safety, each time a concern comes up, new research is done to check whether the results are consistent or not. The vaccines that we use are very safe and serious side effects are very rare. 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*)
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. 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*)
Mr. Maric:	OK, thanks.

Talking with caregivers who refuse vaccines

There is little chance of convincing vaccine refusers to change their views, but we can try to decrease the harm they may do to others.

- Establish trust with these caregivers by listening to their perspective.
- While it is important to respect their opinion, it is necessary to explain the importance of vaccines for the overall health of their child.
- Use the common-ground approach to try to establish some shared trait, even if it's just being fans of the same sports team or having young daughters the same age.
- Explain the risks and responsibilities of not vaccinating their child and offer guidance on what they will need to do differently from other caregivers.
- Correct any anti-vaccine myths and misinformation in a non-confrontational way: don't talk down to them, just refer to facts and invite them to read more materials based on science. But don't spend too much time on arguing back and forth with them.
- Refocus the conversation onto the positive effects of vaccines.
- Address the sometimes existing feeling of victimization or being bullied that anti-vaccine champions sometimes display through displaying empathy. *"You sound frustrated that people don't respect your opinions." "I understand you are trying to do the best you can to protect your family."*

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.

Consent and refusal forms

If you as a clinician you may need 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 just has 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.

Caregivers who refuse vaccines should be reminded at every visit to inform the health center that they are coming into the office, clinic, or emergency department when the child is ill, so 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 caregivers, 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 *"If you choose not to vaccinate your child, understand the risks and responsibilities"* which explains 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.

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, as it could actually make a green parent move down the continuum and refuse vaccines.

Exercise 26: Consent and refuser forms

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).

Take 5 minutes in your group to discuss the questions below for your category. Be prepared to share back with the larger group. Make note of any useful phrases.

Use refusal forms

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?

Use consent forms

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?

No longer using consent forms

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?

Session 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 Four 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, focus on ensuring that their child doesn't endanger others. 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

There seems to be a magical property in door handles. At the end of a patient consult, 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. Of course, probably a lot of our caregivers don't ask the door handle question until we are on the other side of the door.

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 would be a good 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.

- 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.
- 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.

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.

A list of **door handle affirmations** is below. Which categories of caregivers do they belong to?

1. *"Congratulations for doing such a good job of taking care of your child. I look forward to seeing you in a month."*
2. *"I am so proud of the many parents like you who make the effort to keep their children protected and to protect others."*
3. *"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."*
4. *"Thanks Mrs. Dudić, Hasan is a lucky little baby to have parents who love and protect him as you do."*

Session takeaway

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

Module 6.

Communication in depth

Module 6. **Communication in depth**

Module 6 Objectives:

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

1. Establish goals for caregiver interaction.
2. Address caregiver needs using structured approach and tailored content.
3. Discuss 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. Effectively handle consent and refuser forms.

Session 6.1. Establishing goals for acceptors and hesitaters

We have made our caregivers feel that we care, they feel comfortable enough to ask their questions, and based on that we have figured out the caregivers' category and their specific concerns. We have also looked at our own beliefs and needs.

We have spent a LOT of time working on understanding our caregivers' needs and beliefs. 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 that we understand our caregiver's situation, we can figure out our goal for the interaction. Our goals may vary depending on where the caregiver is on the continuum, and thus 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 won't succeed in getting all caregivers to fully vaccinate their children on time, but we can try to increase the number who are fully or at least partially protected.

Exercise 27: Establishing goals for caregivers

*Refers to Handout 6

Remember that some goals might apply to more than one category.

Table 14. *Caregiver position, with goals*[41]

Caregiver position	Goal
Unquestioning acceptor	Keep the caregiver coming in on time till the child is fully immunized, help them become advocates for vaccination, reinforcing vaccination as a social norm and speaking positively of health workers' competence and caring.
Cautious acceptor	Keep the caregiver coming in on time until the child is fully immunized, and the caregiver feels positive, less worried about their decision.
The hesitant	Keep the caregiver coming in on time till the child is fully immunized, caregiver accepts decision to vaccinate, is less hesitant, feels rapport and trust with health worker.
Late or selective vaccinator May need most time but are most likely to change behaviour	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. Trust is established between caregiver and health worker.

41 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

Refuser Unlikely to change behaviour	Caregiver prepared to think about vaccination and consider attending specialist clinic or make a special appointment for further discussion. Feels their concerns are heard, and is not critical of providers. Trust is beginning to be established. 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.

Do work with all caregivers to agree on at least one action, such as:

1. Scheduling another appointment;
2. Encouraging the caregiver to read additional information you provide them;
3. Discussing with a reluctant family member;
4. 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 fulfill the immunization schedule. Just a thirty-second conversation can make a difference in caregivers' motivation as you are taking your leave, e.g.

- *"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?"*

Session takeaway

Success comes in many forms depending on where caregivers are on the continuum. 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, success may simply mean agreeing to leave the door open for future conversations.

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 are the issues and correctly address them.

We have been talking all along about how important it is to:

1. Use techniques of empathy and understanding to create trust and rapport;
2. Use active listening to understand where the caregiver is on the hesitancy continuum;
3. Use active listening understand what exactly their hesitations and needs are;
4. Establish different goals depending on the category of caregiver;
5. Use various **techniques for responding** such as positive framing, social norming, reassuring/ confirming, pausing, summarizing help create emotional support to our caregivers as they are dealing with their concerns about immunization and coming to a decision;
6. Prepare carefully crafted, simple, and clear **Elevator phrases** to address concerns about **specific content**.

The content of your discussion will be determined from your reading of the caregiver's needs. If your caregiver seems worried whether a young baby can handle vaccines, then that's your subject matter. If the caregiver is worried about side effects, that is your subject matter.

Remember, the top worries among hesitators are:

1. Quality of imported vaccines;
2. Not enough quality checks;
3. Side effects of vaccines;
4. Multiple vaccines at once;
5. Vaccines too early, better to wait till child is older;
6. Trigger other diseases;
7. Too many vaccines will hamper child's immunity.

Less frequently believed:

1. Preservatives are poisonous;
2. Vaccines cause autism;
3. It's better to just cure than prevent;
4. It's better to get natural immunity.

The way we structure our responses – both techniques and content - can improve impact the effectiveness of our communication.

Organize your discussion

Prioritize. 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.

> Example: *"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. You can do this by reviewing how you got to this point in the discussion and explaining where you are going.

> Example: *"We have already discussed XYZ, now we will discuss ABC. At the end of ABC, let's review and see what we think. So, now let's talk about A."*

Start with things you agree on and go through those to show you are both on the same page. Then start addressing the challenge or the issues where you may differ.

> Example: *"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? Is there another family member you could enlist to help you find a solution?"*

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.

Use the CASE approach

> CASE is an acronym for Corroborate, About Me, Science, Explain/Advise.

These are the kinds of things you are probably already saying to your caregivers. It simply provides a 4-step structure to help you organize your discussion and helps you move caregivers from preparation to triggering action with your combination response.

Table 15. *CASE approach*[42]

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.

Exercise 28: Read example of CASE approach

Review **Table 16: Example of the CASE approach** for example caregiver statements and provider response for each step. **Note:** 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.

Table 16. *Example of the CASE approach*

Health provider: *"I understand you have some concerns about your child's vaccinations."*	
Caregiver: *"Yes, I want to spread out the vaccinations, so they won't overwhelm my child's immune system."*	

42 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

Health provider: (This is a case for CASE!)	(The health provider responds to this concern using the numbered phrases below)
1: **Corroborate:** *"You are right; children today certainly get more vaccinations than children did years ago."*	***Other example phrases for Corroborate*** *(not for this concern, just for this step):* *"You and I both want your child to be protected against things that might harm her."* *"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."* *"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."*
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."*

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.

Exercise 29: Applying the CASE approach role play

1. Decide who will play Mrs. Ilić, and who will play visiting nurse Emira.
2. If you are playing Mrs. Ilić, read the secret scenario on handout 5. Make nurse Emira work through active listening, to understand what is going on with you, as she uses CASE to address your concerns.
3. If you are Nurse Emira:
   a. Use your skills to put Mrs. Ilić, at ease;
   b. Use active listening skills to help her articulate her concerns;
   c. Address her concern using CASE. If you need ideas, you can review the review example CASE phrases above.

Communicating with confidence

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.

Once you have determined where your caregiver is, establish a goal for the interaction: either vaccination, or further discussion, or the beginnings of a relationship that could lead to trust.

It's helpful to use a structured approach to respond to your caregiver's needs. There are many techniques for responding to your caregiver's needs that have been shown to work, and some that have been shown not to work. Your reading of your caregiver's needs will help you decide what content, and what techniques, to use in responding to their needs.

A list of ideas for what works in discussing caregiver fears and needs, based on a review of scientific studies is provided below. Review the list and identify strategies you can apply in your day-to-day work.

What works

*Based on numerous peer-reviewed scientific journal articles.[43]

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.

43 The review by ECDC

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 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.

Session takeaway

We have reviewed understanding and empathy skills, techniques for responding, and content for responding. CASE helps us organize our response by bringing together the skills we have been learning, and ending 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

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. Caregivers often overestimate the risks of vaccines and underestimate the dangers of the diseases that vaccines protect against.

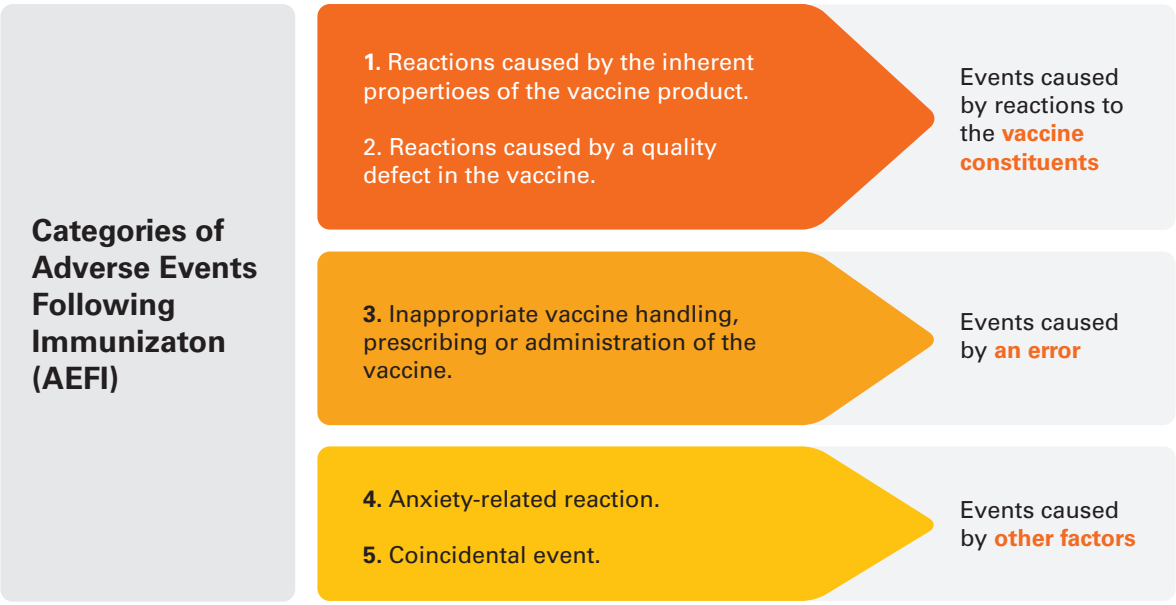
This is not to say that immunizations are perfect. We know that mild side effects are somewhat common, although severe side effects are extremely rare. We know that occasionally, there are adverse events following immunization, or AEFI.

Having a good understanding of AEFI allows us to communicate confidently with caregivers. Let's review an AEFI - an "adverse event following immunization.

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."*

Vaccines used in national immunization programmes are extremely safe and effective, although adverse events can occur following immunization in rare instances.

Figure 20. *Categories of AEFI*[44]



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.

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.

44 World Health Organization. Vaccine safety and false contraindications to vaccination. Training manual. 2017

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.

Exercise 30: Questions about AEFIs

Review **Figure 19** and **Table 17** below to answer the following questions in your small group.

Table 17. *Programme errors leading to possible AEFI*

IMMUNIZATION ERROR	POSSIBLE AEFI
NON-STERILE INJECTION ▫ Reuse of disposable syringe or needle leading to contamination of the vial, especially in multi-dose vials; ▫ Improperly sterilized syringe or needle; ▫ Contaminated vaccine or diluent.	▫ Local injection site reactions (e.g. abscess, swelling, cellulitis, induration) ▫ Sepsis ▫ Toxic shock syndrome ▫ Blood-borne transmission of disease e.g. hepatitis B, HIV ▫ Death
RECONSTITUTION ERROR ▫ Inadequate shaking of vaccine; ▫ Reconstitution with incorrect diluent; ▫ Drug substituted for vaccine or diluent; ▫ Reuse of reconstituted vaccine at subsequent session.	▫ Local abscess ▫ Vaccine ineffective (not strictly an AEFI, but a vaccine failure) ▫ Effect of drug given (e.g. insulin, oxytocin, muscle relaxant) ▫ Toxic shock syndrome ▫ Death
INJECTION AT INCORRECT SITE ▫ BCG given subcutaneously; ▫ DTP too superficial; ▫ Injection into buttocks.	▫ Local reaction or abscess ▫ Local reaction or abscess ▫ Sciatic nerve damage

Vaccine transported/stored incorrectly	▫ Increased local reaction from frozen vaccine ▫ Ineffective vaccine (vaccine failure)
Contraindication ignored	▫ Avoidable severe reaction

1. Which of the five types of AEFI in Figure 19 have you seen?

   _____

   _____

2. How did you handle them, or how would you handle them?

   _____

   _____

3. Which of these programme errors have you have seen in your work?

   _____

   _____

4. Which of these can you do something to prevent?

   _____

   _____

5. How would you talk to a community member about an AEFI that was caused by health worker error?

   _____

   _____

If we can ensure that we as clinicians carry out good vaccine safety practices, there will be fewer AEFIs, which cause even more fear and distrust of vaccines. If we explain quality controls and safety practices to our patients and their caregivers, they will feel more confident about accepting immunization.

Session 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. We need to have good Elevator phrases available to respond to discussions of events like this.

Session 6.4. Talking about contraindications and vaccine origin

"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 diarrhea, 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[45]".

These are NOT contraindications to vaccination. Children with these conditions may be vaccinated safely. Refer to **Annex A** for rare contraindications to vaccination.

Exercise 31: Review of WHO contraindications for routine immunization

Review **Annex A** and discuss answers to the following questions in your small group:

45 WHO. Vaccine Manual Misperceptions About Vaccines. 2017

1. How often do you see these contraindications?

_____

_____

2. What are some ways that we may be missing opportunities to vaccinate children?

_____

_____

Review of the table, reminds us that contraindications are rare. We can take advantage of a visit by a caregiver for non-immunization related concerns to see if the child is up to date on their vaccinations.

Exercise 32: Caregivers' concerns about vaccine origin and procurement

We know that caregivers have concerns about vaccine origin and procurement. Discuss the following questions in your small groups and be prepared to present. After all groups have presented you will write your favorite Elevator phrases on the last two pages of this manual.

1. What do caregivers say or ask about in terms of where the vaccines come from, or what quality controls there are on vaccines? What seem to be their top concerns about country of origin and manufacturing and quality control?

_____

_____

_____

2. What are some ways you have found to respond to these fears?

_____

_____

_____

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."*

Write down your favorite responses for these two concerns in the Elevator phrases pages at the back of this *Participant manual*.

Session takeaway

- Most common conditions, such as mild fever or diarrhea 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.
- You can use the Elevator phrases that the group developed, or some that you devise, to reassure caregivers on their concerns about the country of origin or quality of vaccines.

Session 6.5. Shortcuts for good communication

All around the world, FLWs feel they lack time to practice good IPC skills during immunization sessions. Counseling might take more time than available during a busy routine immunization session.

But showing respect and using other basic IPC skills takes no 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?

It does, however, require more thought, especially at first, until it becomes a habit.

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.

Time yourself while you say this phrase: *"It sounds as if you are worried. Let's take her temperature and talk about what to do."*

It takes 5 seconds. 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.

Similarly, it only takes a few seconds to say: *"Thanks Mrs. Jancovic, you've done a great job keeping Alina protected by keeping her vaccines up to date. See you in a month."*

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:

1. Show the caregiver s/he has your undivided attention (make direct eye contact if culturally appropriate).
2. Smile (if appropriate).
3. Use other nonverbal communication such as nodding the head.
4. Use a pleasant tone of voice.
5. Ensure the caregiver gets to ask their questions.
6. Answer their questions, or if they have many, suggest a time or another person when there will be more time available for discussion.
7. Always, always, end with praise for the caregiver so they walk out with their satisfaction sandwich.

This might even save time, because it might decrease resistance and build trust.

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[46].

46 Adapted from Refresher Training for Frontline Health Workers in Expanded Programme of Immunization (EPI). Module 4: Communicating with Caretakers and Communities for Improved Routine Immunization Coverage. http://www.rho.org/files/rb3/Refresher_Training_Health_Workers_Facilitator_Guide_JSI_USAID_2005.pdf

Exercise 33: Practicing good communication in limited time

How could you improve the FLW's responses below?

1. 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.

   Better response: _____

2. 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."

   Better response: _____

Communication tools

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. They can:

- 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 colors, etc.
- Can be given to caregivers for more detailed information, to read at home, to discuss with family members, etc.

Session 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

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.

The rewards include decreased stress for you, more satisfied caregivers, and improved immunization coverage with fewer drop-outs. This session is dedicated to practicing bringing all the skills together. Let's review for a moment.

We have discussed diagnosis skills to understand where our patients are on the continuum, and what their concerns are:

- Nonverbal communication - giving and reading;
- Empathy;
- Open-ended questions;
- Reflecting;
- Probing;
- Leading questions.

We have discussed treatment techniques to structure our responses when we are dealing with our patients concerns, whatever the content:

- 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.

We have discussed specific content themes and how to incorporate them into your response:

- 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.

We have reviewed different tools, references, and images that can help us communicate, or help us remember:

- Visual aid for community immunity;
- Steady MMR rate and rising autism;
- Algorithm for clinic visit;
- Algorithm for home visit;
- Pain management graphic;
- Contraindication list.

Annex B of this manual provides a comprehensive review of these techniques and more.

Exercise 34: Practice sessions

Use with Handouts 7-11. Choose:

- 1 person to be the FLW;
- 1 person to be the caregiver;
- 1 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.

FLWs, 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 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 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.

- You will have **two minutes** to read through the checklist.

Once you have had your two minutes to prepare, you will have **5 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.

Session takeaway

Structuring your response does require more thought, especially at first. By further practice and reviewing the techniques in Annex B and repeatedly practicing them, you can strengthen your skills even more.

Module 7.

IPC in communities

Module 7. **IPC in communities**

Module 7 Objectives:

By the end of the module you 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.

Session 7.1. Using communication outside the health facility

So, far we have focused on communication in the context of a facility-based immunization session with caregivers.

We looked at the steps model and discussed an individual's journey of behaviour change, with the example of David, Amina, and baby Ali.

We used the algorithm to 1) diagnose the needs of the caregivers and 2) treat those needs with structured conversation.

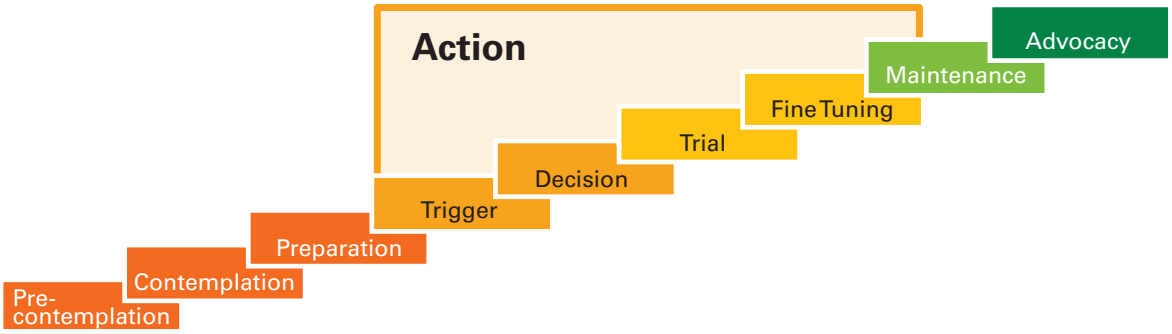
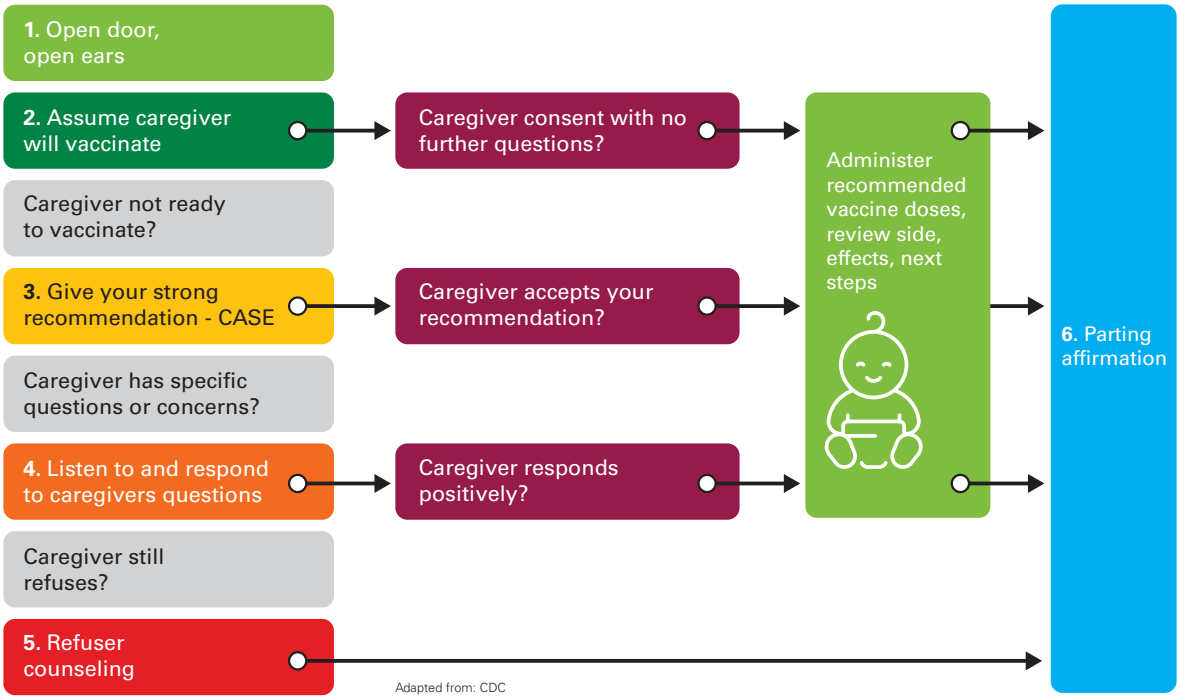
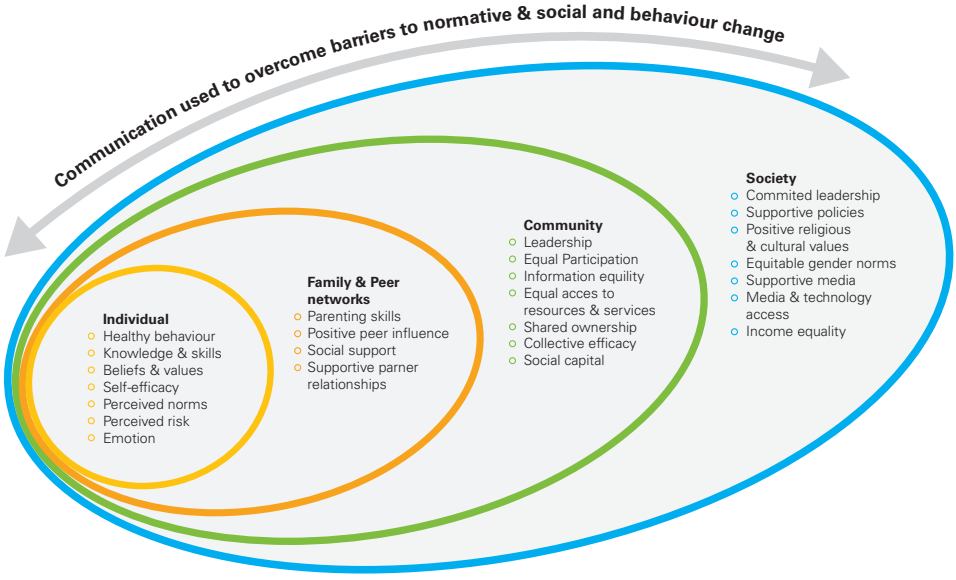


Figure 21. *Clinic-based algorithm*



We reviewed the socio ecological model and discussed how individuals are influenced by their families, their communities, and by society.

The opportunity to interact with caregivers outside of the facility, through home visits or community meetings can provide insight into the barriers caregivers face and the social norms that are influencing their behaviour.



Advantages to speaking with people outside of the health facility may include:

- More time, reaching caregivers who would not necessarily come to health facility;
- Less stressful interaction if no vaccines given;
- Greater chance that FLW has time to create greater rapport with family;
- Opportunity to reinforce messages;
- Can reach influencers who may not have young children;
- Can reach large groups.

Some of the situations and contexts health workers have the opportunity to engage outside of the facility setting to improve uptake of immunization services include:

- Home visits;
- Group talks;
- Meetings with leaders;
- Visits with under-reached populations.

While these contexts are slightly different than facility-based immunization visit, the same principles and techniques of interpersonal communication apply. This module will look at how to effective use the skills we have been practicing in these different contexts to promote immunization.

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

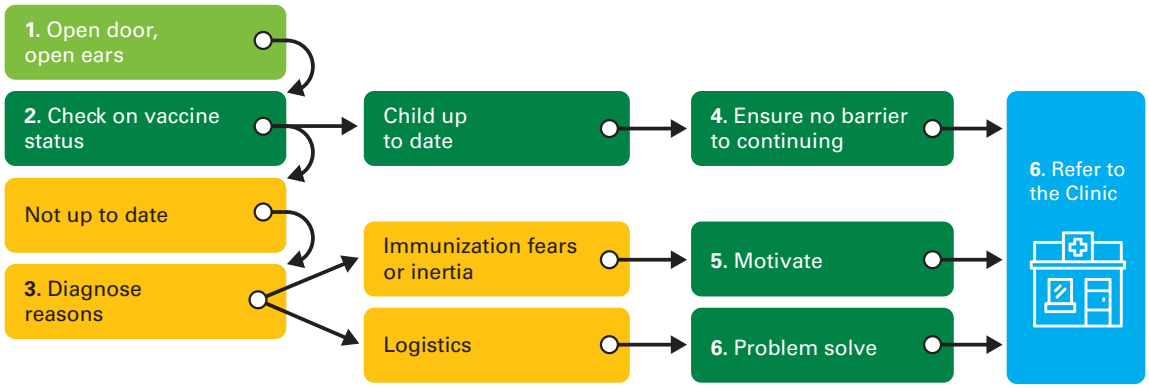
Even if home visiting nurses do not directly provide immunization, they have a significant role to play in increasing immunization coverage. They can:

- Ensure that the children are up to date on their vaccines;
- Follow up with children who are overdue for their next round of vaccines;
- Spend more time to diagnose caregivers' opinions about immunization, discuss their concerns, and answer questions;
- Talk with the family in their home environment, and can bring other members of the family or social network into decision-making;
- They may also see people who would never come in to the health facility, thereby extending services to those that need it most.

Although communication during home visits is a little different from communication during clinic visits, the principles are the same.

First diagnose the issue, then treat the needs as possible. Here is an algorithm for communication during a home visit. We move through it in a very similar way to the clinic algorithm.

Figure 22. *Communication algorithm for home visits*



Exercise 35: Role play - visiting nurse and family feelings

Table 18 below provides a 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. Write in how you think the dialogue could continue in a way that helps solve Dina's barriers to vaccination.

Table 18. *Role play - family feelings about vaccination*

Merjem is a Visiting Nurse. She has arrived at the home of Adnan and Dina Imamovic. Dina invites her into the house. They sit together in the main room.

Merjem:	Good morning. I am Nurse Merjem, part of the visiting nurse programme. I have come to do Baby Omar's 4-month checkup. 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 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:	
Merjem:	
Dina:	

Here is another scenario for you to work with on your own. Create a brief role play for the below characters. See how many of the following you can incorporate in the nurse's response:

- Positive nonverbal communication;
- Empathy;
- Open-ended questions;
- Reflecting/paraphrasing the caregivers concerns;
- Diagnosing the mother's needs;
- Providing reassurance and motivation.

To the mother: You have a 13-month old child who is up to date on her vaccines except for MMR, which is a month overdue. You are hesitating because you want to wait until your baby starts talking. You are worried about autism, but you are embarrassed to say so.

To the nurse: You know the mother very well from previous visits. Before this visit you noticed that the MMR is overdue. You are taking this opportunity during a routine regular visit to encourage the mother to get the child immunized with MMR.

Session 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. Working with groups with special concerns

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. We saw this earlier when we looked at data that highlighted reasons for lower immunization coverage rates among the Roma included relationship and logistics issues.

Exercise 36: Roma community health mediators

Refer to Handout 12: Roma community mediators.

Read the article. Write any take home points below and identify what other FLWs can learn from this experience.

_____

_____

_____

Keep in mind that certain groups have different methods and styles of communicating. These may seem unusual or even offensive to you, but in their culture, these styles of communicating may be perfectly appropriate and even positive.

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.

Session takeaway

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

In addition to family, community leaders can also influence immunization coverage. Who are some of the community leaders that have influence over immunization beliefs, attitudes, behaviours, and resources?

You need to meet with these 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?

_____

_____

_____

What specific role can each of these kinds of leader play in reducing barriers to immunization?

This may be helpful to consider in terms of what is it that you want (your ask) of them. This could be a sermon, speaking at a school, a meeting, with an individual family or influential person that is unsupportive of immunization, or funding.

_____

_____

_____

Who would have the most credibility to advocate with the leaders you have identified?

_____

_____

_____

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.

Exercise 37: Role play with a community leader

Find a partner pairs and try role playing the following scenario, with one of you playing the Community Leader, and the other the FLW. The FLW will rate themselves using the self-assessment checklist in **Table 19**, then share with Community Leader to get their feedback.

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.

Diagnose your target. 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, to engage them and get their support. Help them think about what's in it for them as a leader to support vaccination.

Table 19. *Self-assessment*

Technique	Yes	No
Positive nonverbal communication		
Displayed empathy		
Mostly used open-ended questions		
Used reflective listening (at least once)		
Established community leaders' knowledge, attitudes, fears etc. about immunization		
Established community leaders 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 leaders (the ASK)		
Had a clear door handle closing		

Session takeaway

Community leaders can be extremely influential in good or bad ways. It's important to engage with 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

There are many situations where you might decide to arrange a community conversation about your immunization programme, for example:

- 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 neighbors 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 finds no one there.

What are the possible reasons no one shows up to attend the immunization meeting?

_____

_____

How could this have been avoided?

_____

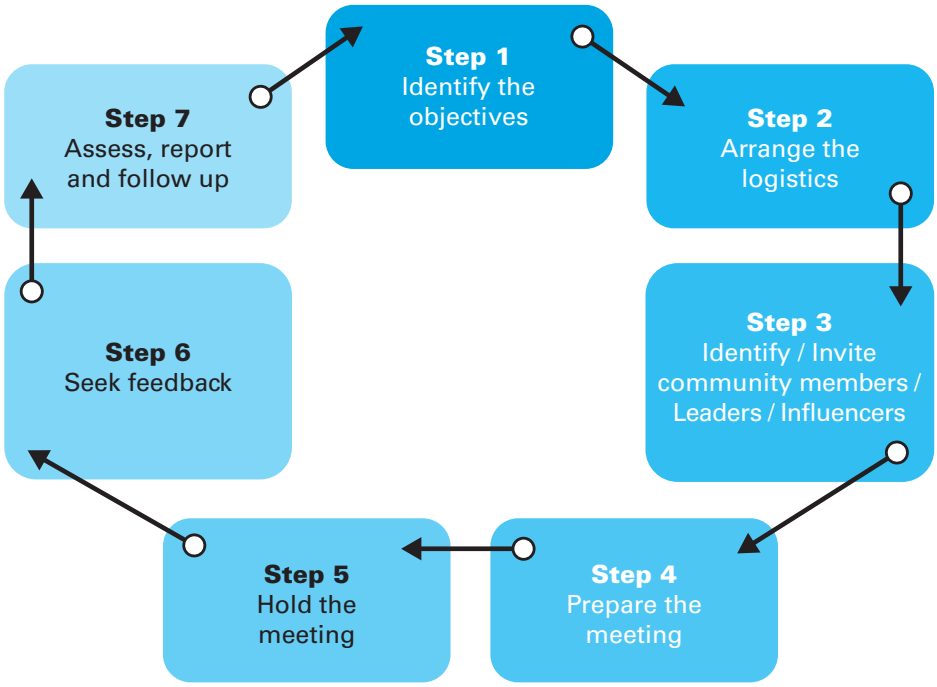
_____

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;
- Try to ensure you have some kind of support materials and visuals.

Although organizing a meeting can seem like a simple thing, preparing and hosting a successful event can take quite a bit of planning and coordination. Allowing adequate time for preparation of logistics and following up is critical. Equally important is following up on the action items or questions that result from the meeting. **Figure 23** illustrates one way of organizing for successful community meetings

Figure 23. *Planning community meetings*[47]



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 in order to be effective.

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

Session 7.6. Proactive rumour management

Stories about negative consequences of immunization often circulate in communities. There are true reports of negative consequences, such as an injection-related abscess, and false reports of negative consequences, such as a child developing autism after receiving MMR.

If such negative stories are not dealt with appropriately, they can cause serious problems for the effective delivery of immunization services.

What are some of the false rumours, myths, and misconceptions about immunizations that you have heard?

_____

_____

_____

Any negative and false rumours about immunization that you hear are circulating should be communicated to your supervisor as soon as possible.

Exercise 38: Role play - rumour management

Pair up with your partner and decide who will play the caregiver and who will play the FLW.

Caregivers will choose one rumour from the list we just brainstormed together.

FLWs will have **1 minute** 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. At the end of one minute you will move to new caregiver with a new rumour, and then repeat for a third time with a third caregiver.

After 3 rounds you will switch roles. After you have played both roles for three rounds, turn to the last two pages of this manual and write down at least 1 elevator phrase you used or heard during this exercise that you think are the most useful.

Steps to address negative rumours

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 **identify**:

- What the rumour is?
- Who was the original source of the rumour?
- Who is spreading the rumour now?
- 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 one way, whereas false rumours need a different approach. Here we will focus on dealing with false rumours.

Once you have gathered this 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 include:

- 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 community meetings, communication materials, regional or national campaigns, radio programming, etc.

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.

It is important to remember that, unless you have specialized training on dealing with media, you should avoid doing interviews or other media appearances. Additional resources on rumour management are listed below.

Write 1 key take home point from the review of Modules 2- 7.

Session 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.

Module 8.

Review and next steps

Module 8. **Review and next steps**

Module 8 Objectives:

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

1. Gain confidence in presenting communication concepts and skills.
2. Remind themselves of the workshop key takeaways.
3. Clear up any outstanding issues.
4. Plan how to use new skills.

Session 8.1. Review of content

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

6. _____

_____

Session 8.2. Reflecting and planning

Exercise 39: Reflecting and planning

Work with a partner that works in the same setting as you (facility or community for example) to discuss and answer the following questions.

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?

_____

_____

_____

Session 8.3. Post-test and evaluation

Post-test questionnaire and evaluation form provided by facilitators.

Session 8.4. Workshop evaluation

Evaluation form provided by facilitators.

Session 8.5. Closing

Remember, the Participant manual will continue to be a resource and a reminder after this workshop. We encourage you to go through it a couple of weeks from now to refresh your knowledge and remind yourself of these techniques and skills.

Elevator phrases

Elevator phrases continued

Annexes

Annex A: **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)b 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	Fever of ≥ 40.5 °C for < 48 h after vaccination with a previous dose of DTP or DTwP Collapse or shock-like state (i.e. hypotonic hyporesponsive episode) within 48 h of receiving a previous dose of DTP or DTwP Seizure < 3 days after receiving a previous dose of DTP or DTwP Persistent, inconsolable crying lasting > 3 h within 48 h of receiving a previous dose of DTP or DTwP History of extensive limb swelling after DTP, DTwP or Td that is not an arthus-type reaction Stable neurological disorder History of brachial neuritis Latex allergy that is not anaphylactic Breastfeeding Immunosuppression
OPV	Previous receipt of one or more doses of oral poliovirus vaccine
MMRc,d	Positive tuberculin skin test Simultaneous tuberculin skin testing Breastfeeding Pregnancy of recipient's mother or other close or household contact Female recipient of child-bearing age Immunodeficient family member or household contact Asymptomatic or mildly symptomatic HIV infection Allergy to eggs
Hepatitis B	Pregnancy Autoimmune disease (e.g. systemic lupus erythematosis or rheumatoid arthritis)

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 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 B: **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.
Non-verbal: 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."*
- *Non-verbal 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 one 10,0000th 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 articles.[48])

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 favorite color.
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 <u>almost</u> 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 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.

48 The review by ECDC

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 favorable vaccine attitudes.
4. Expending much effort to convince anti-vaccinators that their opinions are wrong.

Key messages on MMR diseases[49]

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.

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 fetal death, premature delivery and serious birth defects. Rubella can also cause encephalitis in one in 6,000 cases. Other complications include low platelet levels, hemorrhage and pain, and/or swelling of the joints.

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

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 fueled 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 C: **If you choose not to vaccinate**

If you choose not to vaccinate your child, understand the risks and responsibilities[50]

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-preventabte 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.

50 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 schools 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 D: **Reducing pain**

Reducing Vaccine Injection Pain in Children
A Guide for Health Care Providers

Preparation
Consider using the evidence-based strategies described below in order to minimize pain during vaccine injections in infants/children/teens in your practice. Discuss this information with the parents/caregivers and children/teens prior to vaccine injections.

Prepare Parents and Children

- Encourage parents/caregivers and children (when applicable) to prepare for the procedure ahead of time and to use evidence-based strategies to minimize pain and distress in children during vaccine injections.
- Provide parents/caregivers with the HELPinKIDS Information Sheet: A Guide for Parents, Caregivers and Children on How To Reduce Vaccine Injection Pain in Children.

Rapid Injection Without Aspiration

- Perform all intramuscular injections quickly without prior aspiration. Aspiration is not necessary because the sites used for vaccination are devoid of large blood vessels.

Breastfeeding OR Sweetening Agent

- Encourage mothers to breastfeed infants during vaccine injections. Ensure that an adequate latch is established prior to injection.
- Alternatively, infants can be given sugar water.
- Sugar water can be made by mixing 1 packet of sugar with 2 teaspoons of water. Feed some to the infant with a syringe or pacifier right before the injection (within 1-2 minutes).
- Sugar water is indicated for the management of painful procedures only, not for general comfort or as a food supplement.

Topical Anaesthetics

- Can be used for children of all ages.
- Available for purchase from a pharmacy without a prescription.
- Must be applied up to 1 hour before injection, either at home or upon arrival to the appointment. Check product instructions.
- Consider providing topical anaesthetics in your practice for a minimal fee or no cost to parents/caregivers.
- Two doses may be needed (one for each arm or leg) if 2 or more injections are being given. Specify injection site(s) to parent/caregiver.

Upright Position and Holding

- Infants, children, and teens should not be positioned supine.
- Infants and children should be held by a parent or caregiver in a position that is most comfortable for them and their parent or caregiver (bear hug, on parent/caregiver's lap). Children may lie down after the injection.
- If held by a parent/caregiver, have parent sit on a chair or stand against the examination table to minimize the risk for accidental falls. Keep limbs exposed. Have parent/caregiver secure the child, but advise against undue force as it increases distress.

Multiple Injections

- When multiple vaccines are being administered, always inject the most painful vaccine last.
- There is insufficient evidence for or against simultaneous injections.

Tactile Stimulation Near Injection Site

- Offer to rub/stroke the skin near the injection site with moderate intensity prior to and during injection in children aged 4 years and older.

Distraction (Led by Provider, Parent/Caregiver or Child)

- Distraction involves taking the child's attention away from the procedure. It is effective for children of all ages.

1. Involve parents/caregivers and children in helping to select the best distraction strategy for the child and involve them in helping with distractions.
2. Choose an age-appropriate strategy:
   Infants: toys, bubbles, singing, directing the infant's attention to something in the environment that would be of interest to them.
   Toddlers: toys, bubbles, pop-up books, songs, party blowers, kaleidoscopes, singing, directing attention to something in the environment, non-procedural talk (favourite book, etc.)
   School-aged children: toys, stories, videos, books, joking, music, counting, non-procedural talk (favourite movie, etc.)
   Adolescents: games, videos, books, joking, music (iPods, MP3 players), non-procedural talk (favourite video game, etc.)
3. Stay focused on the child and interact with the child throughout the procedure.
4. Provide verbal and physical reminders for the child to continue to pay attention to the distraction strategy.
5. Re-direct the child's attention back to the distraction strategy if their attention wanders to the procedure.
6. Use a variety of distractions, and multi-sensorial distractions, as necessary.
7. Maintain a positive attitude.
8. Praise the child for engaging in distraction behaviours.

Deep Breathing

- Prompt children 3 years and older to take slow deep breaths.
- Deep breaths can be facilitated by using bubbles or pinwheels, which also act as distracting techniques.

Simple Suggestion

- DO NOT tell children that "it won't hurt" because evidence shows that this is ineffective. It also promotes distrust. Instead, tell children how potential discomfort will be minimized.

Combine strategies described above to improve pain relief.

Practice and Documentation
Health care providers are encouraged to develop a consistent approach to immunization pain management in their practice. This includes: integrating pain management education, preparing parents/caregivers and children in advance whenever possible, ensuring consistent understanding among team members of the effective strategies, implementation and documentation of strategies used, and children's pain. Providers are encouraged to modify the pain management plan for individual children, as needed, in order to minimize pain and distress.

In collaboration with www.aboutkidshealth.ca

A Guide for Parents, Caregivers and Children on
How to Reduce Vaccine Injection Pain in Children

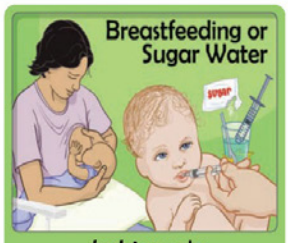
- Read this information sheet to learn about ways to reduce pain and distress in children during vaccine injections.
- Discuss and plan with your child (when appropriate) and health care provider what you will do to reduce pain and distress in your child.

During the Procedure

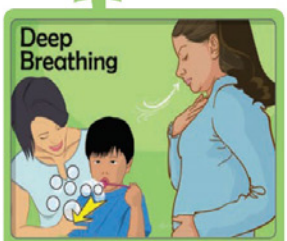
Combine strategies to improve pain relief

4 years of age and older

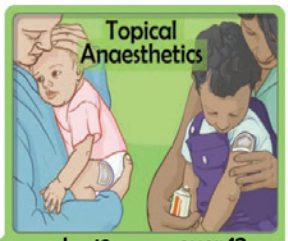
all ages



babies only



3 years of age and older



under 12 months | over 12 months

all ages

PAIN

HELP Eliminate Pain inKidS

After the Procedure

1. Ask your child (or judge yourself) how much pain or hurt he/she had.
2. How satisfied are you and your child with the pain strategies used?
3. Review with your health care provider.
4. Plan for the next vaccination.

Add to your vaccine diary:

- What you did for pain
- How much pain your child had
- Your satisfaction
- Notes for next time

see over

Appendix to Taddio A, Appleton M, Bortolussi R, et al. Reducing the pain of childhood vaccination: an evidence-based clinical practice guideline (summary). *CMAJ* 2010. DOI 10.1503/cmaj.092048.

A Guide for Parents, Caregivers and Children on
How to Reduce Vaccine Injection Pain in Children

Preparation
Read this information sheet to learn about how to reduce pain and distress in your child during vaccine injections. Use the information to plan for your child's vaccine injections. Discuss the information with your health care provider and child (when appropriate).

During the Procedure

Prepare Your Child Ahead of Time
- Tell your child what they need to know and answer their questions:
  - What will happen?
    - *You will get a medicine called a vaccine in the arm with a needle.*
  - Why is the vaccine being given?
    - *To keep you healthy.*
  - How will it feel?
    - *There may be a pinch and some pushing or pressure that will last a few seconds.*
  - How can we minimize any potential discomfort?
    - *Some children think it is uncomfortable and some think it is OK. We don't know how it will feel for you. We are going to do different things so that it is not uncomfortable for you.* (Then discuss what you will do.) *You can help by* (suggest strategies such as playing with a favourite toy).
- In general, tell young children (under 4 years old) just before the procedure and older children at least 1 day before – it helps them to plan how they will cope.
- Involve and listen to your child – they often have helpful suggestions for how to manage their pain (for example, let them choose a toy to bring).

Stay Calm
- Your actions and words can influence your child's reaction. Infants and children often look to their parents to understand how to act and feel. If you are calm, and use your normal voice, your child will feel that everything is OK.
- Avoid the following words and phrases because they increase distress and focus attention on the procedure:
  - **High anxiety words:** "hurt", "pain" or "shot"
  - **Reassuring words:** "It'll be over soon" or "you'll be OK"
  - **Apologizing words:** "I'm sorry you have to go through this" or "I know it hurts"

Upright Position and Holding


- You should not lay your baby, child or teen down.
- Have your child sit up-right. Infants and young children should be held (for example, bear hug, on your lap). Hugging feels comfortable and helps children to stay still. Children can lie down after the injection.
- Sit on a chair or stand against the examination table to minimize the risk for accidental falls. Keep limbs exposed. Secure your child if necessary but do not use undue force – this increases child distress.

Rub Skin Near Injection Site
- In children aged 4 years and older, offer to rub/stroke their arm near the injection site before and during vaccine injections.

Distraction
- Distraction involves taking your child's attention away from the procedure. It is effective for children of all ages.
- Distraction can be provided by either the parent, health care provider, or by the child (if the child is old enough).
  1. Choose something that will work for the age of your child:
     Babies: toys, bubbles, singing, directing the baby's attention to something in the room.
     Toddlers: toys, bubbles, pop-up books, songs, party blowers, singing, directing the child's attention to something in the room.
     School-aged children: toys, stories, videos, books, joking, music, counting, talk about something else (favourite movie, etc.)
     Teens: games, videos, books, joking, music (iPods, MP3 players), talk about something else (favourite video game, etc.)
  2. Stay focused on your child and interact with your child.
  3. Help your child pay attention to the distraction being used.
  4. Try different distractions if needed.
  5. Maintain a positive attitude. Praise your child for engaging in distraction behaviours.

Deep Breathing
- Prompt your child 3 years or older to take slow deep breaths. Deep breaths can be made easier by using bubbles or pinwheels, which also act as distractions.

Breastfeeding OR Sweetening Agent


- Start breastfeeding your baby a few minutes before the vaccine injection and continue to breastfeed during, and for a few minutes after, the injection.
- Alternatively, feed your baby sugar water right before the vaccine injection.
- Sugar water is made by mixing 1 packet of sugar with 2 teaspoons of water. Feed some to the baby with a syringe or pacifier 1-2 minutes before the needle.
- Sugar water should only be used for the management of painful procedures, not for general comfort or as food.

Medicine: Topical Anaesthetics
- These are pain-relievers that are applied on the skin where the vaccine is being injected. They are effective and safe for all ages.
- Available for purchase without a prescription in a pharmacy.
- Must be applied ahead of time (up to 1 hour): at home or upon arrival to the appointment. Check the product instructions.
- Be sure to apply to the correct location: either upper arm (over 12 months) or upper outer thigh (under 12 months).
- Two doses may be needed (one for each arm or leg) if 2 or more injections are being given.
- Can cause temporary changes in skin colour (redness or whitening). If there is a rash, it could be an allergic reaction – check with your health care provider.

After the Procedure
Ask your child (or judge yourself) how much pain or hurt he/she had. Discuss this with your health care provider and make a plan for how you will manage pain the next time your child has vaccine injections.

Combine strategies described above to improve pain relief.

In collaboration with www.aboutkidshealth.ca

Appendix to Taddio A, Appleton M, Bortolussi R, et al. Reducing the pain of childhood vaccination: an evidence-based clinical practice guideline (summary). *CMAJ* 2010. DOI 10.1503/cmaj.092048.

Annex E: **Solutions to exercises**

This Annex serves as an answer key or reference of suggested answers for relevant exercises provided in the *Participant manual* and reviewed over the course of the training. Exercises are organized by Module

Session 2.2. National coverage trends and vaccine schedule

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

1. What are some of the events that led to lower immunization rates in Serbia?
   - War, supply issues, autism rumours, Wakefield and anti-vax campaigns.
2. What are some things that helped to calm fears about vaccine safety globally?
   - Gordon Brown; publishing of large studies that show no relation of MMR to autism.
3. What other factors have increased uptake of vaccines?
   - Obligatory vaccination, seeing the damage caused by epidemics.
4. What are some improvements in vaccine safety that have made vaccination even safer in our country?
   - Bivalent OPV so much lower risk of VDPV, acellular pertussis vaccine.

Exercise 5C: Trends

1. What was the highest rate of measles 1 coverage in the last 10 years?
   - 96 or 97% in 2004.
2. What was the lowest rate of measles 1 coverage in the last 10 years?
   - 82 or 83% in 2016.
3. What year had the highest number of measles cases recorded?
   - In 2017, the year after measles coverage was at its lowest.
4. What is the difference in fully immunized rates between the general population and the Roma?
   - 71% versus 13% for on-time complete immunization; 81% versus 44% for complete immunization.
5. When does the drop-off in Roma coverage occur?
   - After the BCG dose.

Session 3.1. Understanding behaviour

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

- 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.

Session 3.5. Common fears and beliefs about vaccines

Exercise 8A: Serbia KAP survey: concerns

1. What were the top two worries (in terms of %) among general population hesitators?
   - Side effects, better to wait.
2. What were the top two worries (in terms of %) among the Roma hesitators?
   - Side effects, too many vaccines.
3. Among those who were acceptors (meaning they vaccinate their children and intend to continue) were there any fears?
   - Yes.
4. What were the acceptors' top fears?
   - Side effects, quality check.
5. Did those fears prevent the acceptors from vaccinating?
   - No.

Exercise 8B: Serbia KAP Survey. Roma population

1. Which group of Roma had a more negative perception of services - hesitators or acceptors?
   - The hesitators had a more negative perception.
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?
   - 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.
3. Do you think health providers assume that most Roma are hesitators?
   - Your opinion is what matters.
4. How could that influence how they treat their Roma patients?
   - 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.

Session 4.5. Open-ended and other special questions

Exercise 15: Closed and open-ended questions

Possible solutions to Table 12: Changing a closed-ended question to an open-ended one

Closed-ended question	**Open-ended question [suggested examples]**
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?

Session 4.5. Open-ended and other special questions

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

1. Identify at least four phrases or actions that demonstrate different active listening techniques that Dr. Vera used, and name the techniques.
   - 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)**
2. What was the big issue that Mrs. Ilić was concerned about?
   - The child's pain.
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?
   - Yes.
4. Did Dr. Vera offer any ways to deal with the child's pain?
   - No, she just acknowledged it and moved on.
5. What could Dr. Vera have said to address Mrs. Ilić's concern?
   - *"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."*
6. Who remembers the last question Dr. Vera asked?
   - *"Ok, ready to get this next set of shots done?"*
7. What kind of question was this?
   - Closed, leading.
8. We have said we want to ask open questions, usually. In what way was it useful to use a closed question here?
   - Wraps up, moves the action along.

Session 5.5. Dealing with the very hesitant

Exercise 22: Mapping dialogue to the algorithm

Suggested answers in italics and in brackets

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:	You sound quite worried. ***(reflecting, empathic response)*** Let's talk it through together. 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)***
Mrs. Jovanic:	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. She does seem so young to be having injections against all these diseases at once. Won't it make her ill?
Nurse Dora:	OK, we can talk about this ***(structuring discussion, guiding)*** but do you have other worries as well? ***(Eliciting further concerns)***
Mrs. Jovanic:	Well I read also that they can get a sore leg afterwards, so that's another worry.

Nurse Dora:	***(Pausing to allow Mrs. Jovanic to interject if she has questions and to observe body language)*** 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)***. 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.)***
Mrs. Jovanic:	Yes, that's what I am worried about – is it too much for her?
Nurse Dora:	Children, even newborn 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. 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)*** 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.
Mrs. Jovanic:	OK, and would she get a sore leg?
Nurse Dora:	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)***. 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. 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)***
Mrs. Jovanic:	What happens after the shots?

Nurse Dora:	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)***
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:	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.
Mrs. Jovanic:	Thanks – I'm still a bit nervous but I think we should get it done.
Nurse Dora:	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?

Session 5.7. In the vaccination box. Discussing side effects

Exercise 23: Talking about side effects with Mrs. Dudić

Talking about side effects with Mrs. Dudić[51]

Suggested answers in italics and in brackets.

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?

51 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:	Yes, it's fine, and I am very glad you brought her in. ***(Confirming)*** 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)*** 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?
Mrs. Dudić:	No, I think it's okay.
Dr. Marina:	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.)*** 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).*** 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)*** ***(Pause to allow questions or clarification).***
Mrs. Dudić:	OK. Anything else?
Dr. Marina:	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)*** ***(Pause)***
Mrs. Dudić:	Ok, so it's not just right after the shots I have to worry about, it's later too?

Dr. Marina:	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)*** 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)*** It is so important to protect her now, since we have all these measles outbreaks. You are making the right decision. ***(Confirmation)*** Let's get Minira taken care of. ***(Protection)***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. 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)*** 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)*** They find that the slight side effects are a bit of a nuisance, but nothing to worry about. 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)***
Mrs. Dudić:	It seems like a lot to think about.
Dr. Marina:	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)*** 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.)***

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)***

Session 6.1. Establishing goals for acceptors and hesitators

Exercise 28: Establishing goals for acceptors and hesitators

Table 14. *Caregiver position, with goals*[52]

Caregiver position	Goal
Unquestioning acceptor	Keep the caregiver coming in on time till the child is fully immunized. Help them become advocates for vaccination, reinforcing vaccination as a social norm and speaking positively of health workers' competence and caring
Cautious acceptor	Keep the caregiver coming in on time till the child is fully immunized. Caregiver feels positive, feels less worried about their decision, feels they made the right choice.

52 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
The hesitant	Keep the caregiver coming in on time till the child is fully immunized. Caregiver accepts decision to vaccinate, is less hesitant, feels rapport and trust with health worker.
Late or selective vaccinator May need the most time, but are likely to change behaviour	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. Trust is established between caregiver and health worker.
Refuser Unlikely to change behaviour	Caregiver prepared to think about vaccination and consider attending specialist clinic or make a special appointment for further discussion Feels their concerns are heard, and is not critical of providers Trust is beginning to be established. 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.

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