Sample Urban Immunization Social and Behavior Change Strategy

Here is an example of an Urban Immunization Social and Behavior Change (SBC) Strategy developed from a Behavior Profile (an analysis of a behavior based on research into **why** primary actors do or do not adopt a desired behavior). A national immunization program could use such a strategy to significantly increase childhood immunization rates in cities. The strategy proposes a systems approach to behavior change that seeks to ensure all the elements needed to address or leverage critical factors affecting the behavior are in place. This requires collaboration and shared accountability across immunization program units, multiple health system actors, and, potentially, partner organizations. The selected activities directly address or leverage the key barriers and motivators identified through formative research.

A few notes:

- Program managers could decide to measure a sub-set of proposed factor-level indicators based on considerations such as importance and feasibility.
- Supporting actors required to carry out this strategy are listed at the end of the strategy.
- Find a cross-walk from the Behavior Profile to this SBC strategy under **Develop** on the **Design and Manage** tab at https://thinkbigonline.org/resources.
- Learn more about Behavior Profiles at https://thinkbigonline.org/behavior_profile_p.
- The Think | BIG Ideas Library contains many examples of how various programs have addressed or leveraged critical factors to achieve behavior change. Use the search function to explore your particular areas of interest.

Urban Immunization Social and Behavior Change (SBC) Strategy, 2020 - 2025	
Immunization Program Goal	Contribute to reduced child and maternal morbidity and mortality from vaccine-preventable disease by providing high-quality immunization services nationwide
Program Objective to Which SBC Strategy Contributes	Increase childhood immunization rates in urban areas from 69% to at least 90% within 5 years
Desired Behavior	Urban caregivers complete a full course of timely vaccinations for infants and children under 2 years
Behavioral Outcome Indicator	Percentage of children 12-23 months who have received all 8 basic vaccinations (National EPI)
Current Situation and Practices	Sixty-nine percent of urban caregivers adhere to the childhood immunization schedule. Of those who do not adhere to the schedule:

	• Caregivers return late to vaccination appointments. • Caregivers stop bringing child for vaccination. • Caregivers do not bring child born outside the urban area for vaccination.
Steps Primary Actor Must Take to Practice the Behavior	1. Accept first course of vaccinations at birth. 2. If not a facility birth, seek vaccination within 7 days of birth. 3. Mobilize transport, resources, and logistics to attend immunization sessions or appointments. 4. Seek immunizations on schedule from a qualified provider. 5. Complete all immunizations per age requirements.

Key Factors[1] and Factor-Level Indicators	Intervention Areas and Activities		
	Enabling Environment	**Systems, Products, and Services**	**Demand and Use**
STRUCTURAL **Accessibility**: Caregivers do not complete vaccination due to competing priorities such as income generation, housework, child care, illness (B) % of urban women who report lack of time as a reason for late or incomplete vaccination of their youngest child (survey) **Service Provider Competencies**: Caregivers complete vaccination because vaccination staff treat them courteously and fully inform them (M) % of clients who report having two or more elements of respectful care during their last immunization visit at a health facility (survey) **Service Experience**: Caregivers do not complete vaccination because they do not want to wait up to three hours for their child to be seen (B) % of immunization visits in urban areas that take less than 1 hour to complete from time of arrival (facility records)	**Partnerships and Networks**: Engage community structures (community-based organizations, religious institutions, etc.) in support of routine immunization • Recruit and support nongovernmental organizations (NGOs) and community-based organizations (CBOs) to (1) promote routine immunization in their areas through house-to-house visits, community meetings, and special events; (2) call or visit apparent defaulters to discover why they missed the appointment and encourage them to return for vaccination; and (3) refer difficult cases to the vaccination unit or chief medical officer for higher level	**Quality Improvement**: Identify ways to reduce wait times to less than one hour per visit. https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)70137-3.pdf • Track waiting times at all immunization units • Establish new norms in consultation with caregivers, providers, and communities • Design, implement, and assess processes to achieve and maintain or improve upon the new norms **Quality Improvement**: Provide interpersonal communication (IPC) training and supportive supervision to ensure providers support caregivers effectively • Assess IPC training for attention	**Communication**: Design and implement community-based programs that encourage family members, including male partners, to actively support timely vaccination • Develop programs to engage fathers in routine immunization • Work with barbers or other non-health service providers to improve uptake and completion https://www.mcsprogram.org/in-northern-nigeria-barbers-trim-newborn-mortality-one-haircut-at-a-time/ • Prepare statements for religious leaders to read during weekly services **Communication**: Use social (FaceBook, Twitter, WhatsApp) and mass media (radio, TV) to promote timely completion of the immunization schedule

[1] B = Barrier and M = Motivator

Key Factors[1] and Factor-Level Indicators	Intervention Areas and Activities		
	Enabling Environment	**Systems, Products, and Services**	**Demand and Use**
SOCIAL **Family and Community Support**: Caregivers complete vaccination because community structures such as health committees and community health workers inform and encourage them (M) % of urban caregivers who report that a community actor positively influenced their decision to immunize (survey) **Family and Community Support**: Caregivers do not complete vaccination because one or more family members object (e.g., husband, mother-in-law) (B) % of urban mothers who report that a close family member objects to childhood immunization (survey) **Norms**: Caregivers complete vaccination because virtually every family in their community does (M) % of urban mothers of children 0-24 months who say most mothers vaccinate their children (survey) **INTERNAL** **Attitudes and Beliefs**: Caregivers do not complete vaccination because they fear side effects such as fever, discomfort, crying, swelling (B) % of urban mothers of children 0-24 months who report fear of side effects as a reason for incomplete vaccination (survey) **Knowledge**: Caregivers do not complete vaccination because they do not know about or remember the 2nd measles dose (B)	problem-solving • Recruit and support religious institutions/leaders to promote immunization through sermons and marital/pre-marital counseling **Partnerships and Networks**: Collaborate with relevant ministries to ensure immunization of families seldom using health services • Through Ministry of Health (MOH), establish memoranda of understanding with Ministries such as Interior, Women, and Children and Youth to institute mechanisms for assessing young children's immunization status, providing immunization information, referring migrant and "street" children for immunization services, and including childhood immunization in conditional cash transfer programs	to effectively communicating key messages (e.g., vaccines given and diseases prevented, managing side effects, when to return, immunization card), respect for client, tailored counseling, and problem-solving to reduce defaulting • Provide updated IPC training to vaccinators, community health workers, and others who come into contact with caregivers • Include critical IPC indicators in supervision and monitoring protocols **Quality Improvement**: Give each immunization unit access to a telephone or mobile phone credit for calling caregivers who have missed an appointment • At facility level, assess the current system for identifying and contacting defaulters • Ensure immunization register contains caregiver contact number whenever possible • If a facility telephone is not available, explore feasibility of providing phone credits to staff http://www.panafrican-med-journal.com/content/article/28/24/pdf/24.pdf • Establish a schedule for telephoning defaulters and	• Promote the normalcy and positive impacts of routine immunization, and the positive experience caregivers have at health facilities • Monitor social media to be aware of and respond to any emerging anti-vaccination activities • Develop a social media campaign aimed at young parents • Use national radio and TV to reinforce the benefits of completing the immunization schedule, promote the successes and impact of the national immunization program, and highlight the quality of services • Hold TV, radio, and social media discussions featuring health care providers, religious and community leaders, and parents **Communication**: Provide support materials for use with low- and non-literate caregivers • Update current immunization flip chart to include new vaccines • Develop or adapt audio and visual materials for migrant and immigrant populations who do not speak the local languages • Develop a waiting room immunization video • Consider a celebration card to

Key Factors[1] and Factor-Level Indicators	Intervention Areas and Activities		
	Enabling Environment	Systems, Products, and Services	Demand and Use
% of urban mothers of children 0-24 months who know that their child should have a 2nd measles vaccine at age 15 months (survey)		ensuring call-backs at times convenient for caregivers	encourage complete vaccination https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-016-0497-9
Supporting Actors	MOH and EPI Decision-makers, Decision-makers at Ministries of Interior/Children/Women; Health Center Managers; Vaccinators, Community Health Workers; Religious Leaders, NGO Managers and Staff, CBO Leaders and Members, Community Relays; Grandmothers, Fathers, Other Household Members		

Sources

ACCELERATE Urban Immunization Behavior Profile
Campaign Focuses on Promoting Value of Immunizations, https://www.aafp.org/news/family-medicine-americas-health/20160812hip-immunizations.html
How Social Media, Tech Influences Vaccination Campaigns in Kenya, https://redcrosschat.org/2016/08/04/social-media-tech-influences-vaccination-campaigns-kenya/
Communication strategies to promote the uptake of childhood vaccination in Nigeria: a systematic map, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4754015/
African Vaccination Week 2018 Toolkit, https://afro.who.int/sites/default/files/2018-04/REV_Engl_16_04_18_2018%20MEDIA%20TOOLKIT.pdf
Social Media Initiative in Ukraine: Analysis of Online Conversations on Polio, Vaccination, and Routine Immunization, http://www.comminit.com/polio/content/social-media-initiative-ukraine-analysis-online-conversations-polio-vaccination-and-rout
WHO vaccine-preventable diseases: monitoring system. 2019 global summary, http://apps.who.int/immunization_monitoring/globalsummary/countries?countrycriteria%5Bcountry%5D%5B%5D=DJI
ACCELERATE Ideas Library, https://acceleratorbehaviors.org/ideas_library