

## Assumptions Examples

A thorough accounting of the possible assumptions we’re at risk of making will help to avoid missteps down the road. To help in the process, here is a short-list of general assumptions that have certainly been made before. It’s likely that you’ll recognize many as they span contexts and communities. While this is by no means exhaustive, we hope it’s a helpful starting place when thinking about the assumptions that we and our team members might inadvertently bring to the table.

### Information

Correcting misinformation with accurate information will not necessarily change minds; in fact, corrective messaging carries the risk of unintended consequences.

In a randomized trial, interventions designed to correct misinformation about autism-MMR ties only served to reinforce existing beliefs. None of the interventions studied—ranging from information explaining the lack of evidence of an autism-MMR tie and information about the disease prevented by MMR, to dramatic images and narratives about the disease—increased parental intent to vaccinate. In fact, some did the opposite.<sup>1</sup>

<sup>1</sup> Nyhan et al (2014), Effective Messages in Vaccine Promotion: A Randomized Trial

### Misconceptions

Incorrect knowledge, such as misconceptions about vaccines and diseases, does not always (or often) impair vaccine uptake. Misconceptions may exist, but those misconceptions may not necessarily regulate vaccination decision-making very much.

In Mozambique, mothers shared various misconceptions about vaccines with researchers. However, the researchers also found that “taboos and misconceptions [did not] play an important role in the decision not to vaccinate.” Instead, the “overwhelming barrier” was simply distance to services.<sup>2</sup> Another group of researchers in India, after successfully using micro-incentives to increase coverage, commented that “while [study participants] might appear to believe in all kinds of things, there is not much conviction behind many of those beliefs: otherwise they would not change their minds so easily.”<sup>3</sup>

<sup>2</sup> Sheldon & Alons (2003), A study to describe barriers to childhood vaccination in Mozambique

<sup>3</sup> Banerjee et al (2010), Improving immunisation coverage in rural India: clustered randomised controlled evaluation of immunisation campaigns with and without incentives

### Consideration

Given the importance of immunization, it’s sometimes taken as a given that carers engage in an active decision-making process: thoughtfully weighing costs and benefits, and either deliberately taking or not taking actions. However, very often, the decision is not given such due consideration.

Reflecting on “current theories” surrounding the decision to vaccinate, one group of researchers commented that they “rest upon an assumption of carers who reflect upon the decision to vaccinate or not vaccinate; who calculate the benefits and costs.” However, “[i]t is not clear that carers actually make reflected choices concerning vaccination.”<sup>4</sup> Said another way by a researcher reflecting on his field experience: “It is my impression that in most contexts vaccinations are not thought about very much.”<sup>5</sup>

<sup>4</sup> Holte et al (2012), The decision to vaccinate a child: An economic perspective from southern Malawi

<sup>5</sup> Nichter (1995), Vaccinations in the Third World: A consideration of community demand

## Assumptions Examples (continued)

### Intentions

Strong intentions are not always sufficient (or even necessary) for action-taking. Even the smallest of barriers can work to keep the gap between a positive intention and a corresponding action open.

Among subjects in a Hong Kong study that reported being likely, very likely, or certain to get vaccinated against swine influenza, less than 12% actually did. Strengthening intentions further would have been unlikely to nudge vaccination coverage up. Instead, as the study found, vaccination planning proved a more significant determinant of uptake than intention, such as by “suggesting where, when and how to get vaccination, improving and publicizing accessibility of vaccination centres and opening times.”<sup>6</sup>

6 Liao (2011), Factors Affecting Intention to Receive and Self-Reported Receipt of 2009 Pandemic (H1N1) Vaccine in Hong Kong: A Longitudinal Study

### Access

Making it easier to access vaccinations, while often important, does not necessarily translate into increased coverage. Similarly, increases in access do not always adequately explain high coverage.

In India, a program provided free immunization camps in 60 villages. In each, a social worker educated communities about the program, about the vaccines, and identified eligible children. However, researchers found that “adequate supply of vaccines and education only increased the share of fully immunized children to 17%” (up from 6%).<sup>7,8</sup> In Malawi, researchers found that coverage was actually higher in some areas where carers walked long distances, and vice versa, suggesting that “easy access to vaccinations (short travelling and waiting time) cannot explain why the demand for childhood vaccinations in the study area is so high.”<sup>9</sup>

7 As quoted in Cappelen et al (2010), Demand for Childhood Vaccination: Insights from Behavioral Economics, referencing Banerjee et al (2010), Improving immunisation coverage in rural India: clustered randomised controlled evaluation of immunisation campaigns with and without incentives

8 A concurrent incentive program doubled that coverage figure, by comparison.

9 Holte et al (2012), The decision to vaccinate a child: An economic perspective from southern Malawi

### Resistance

Resistance risks being understood as an irrational rather than a rational reaction. Although people may express resistance in religious or other belief-related terms, entirely rational reasons such as previously experienced or communicated negative events are often at play.

A review of polio eradication programming noted that in Nigeria, “memories of a disastrous Meningitis vaccine test which killed several thousands is still current; in India, the association between a government with a history of sterilisation campaigning, and Auxiliary Nurse-Widwives who are used both to deliver Polio vaccine and to ‘advise’ parents in favor of family planning (under a minimum monthly quota), can be traced to the ‘myth’ of OPV and infertility.”<sup>10</sup>

10 Unicef, Social Mobilisation and Communication for Polio Eradication: Documentation in Nigeria, India and Pakistan (2002-2003)