



Explore & Diagnose

Welcome to *Explore & Diagnose!*

Gathering the necessary evidence to inform intervention design is the critical next step to applying behavioural science.

This phase focuses on uncovering behavioural drivers and barriers through the use of research and data. It involves synthesising existing social and behavioural evidence, identifying gaps where additional research is needed, and building a clear picture of the problem — all in order to guide where and how to intervene.

Why Explore & Diagnose?

Even with a clear problem and outcome in mind, it's easy to make assumptions about what is driving people's behaviours or what might change them.

However, behaviours are rarely shaped by a single factor. They are influenced by a wide range of forces, from beliefs and habits to social norms and structural conditions. The *Explore & Diagnose* phase allows researchers to understand the context, surface hidden barriers, and use this knowledge to design relevant solutions.

How can we Explore & Diagnose the challenge?

In this second phase of the DEPTHS methodology, there are five steps to guide teams through the behavioural research process.

Each step includes specific tools, guidance on why these tools matter, and how to use them. A **case study on increasing childhood vaccination uptake in Lebanon** will exemplify how the tools can be applied in practice.

Before starting *Explore & Diagnose*, make sure to complete all the steps of the Define phase.

Summary of the Explore & Diagnose phase

Before you start: review the major *Define* phase outputs: Problem Definition and Outcome Statement, Stakeholder Map and Target Audience, Behaviour Tree, Prioritization Matrix, System Map (optional), Leverage Point Analysis (optional), Project Canvas



Review existing data and literature to build a foundational understanding of the context. This helps to surface known insights, identify gaps, and determine whether additional research is needed.

Define clear and behaviourally informed research questions aligned with gaps identified during the desk review. Questions should focus on uncovering why behaviours do or do not occur, using behavioural frameworks like COM-B.

Outline the research approach, including who to engage, what methods to use, and how ethical safeguards will be applied. This step ensures that research is practical, targeted, and **ethically grounded**.

Organize and implement fieldwork, including participant recruitment, team training, tool testing, and logistics. Carry out data collection while emphasizing quality, inclusion, and respectful engagement.

Use the COM-B framework to organize insights, develop behavioural profiles, map micro-behaviours, and prioritize key barriers and enablers that will shape the next stage of design.

Initial Desk Research

Primary Research Objectives and Questions

Primary Research Plan
[External] Research Protocol Template

Behavioural Profile
Behavioural Map and Diagnosis

Feasibility-Impact Matrix

Common Pitfalls

Common traps can derail behaviourally informed work, so throughout the *Explore and Diagnose* phase, keep these possible issues in mind:

- **Skipping or rushing the Define phase review.** Jumping straight into research without revisiting outputs like the Problem Statement, System Map, or Project Canvas often leads to duplication, misalignment, or unclear research objectives. For example, a team exploring low immunization uptake might conduct interviews about vaccine beliefs, without noting that the original Prioritization Matrix has already identified caregivers proactively keeping track of their child's vaccination schedule as the central, prioritized target behaviour.
- **Desk research should go beyond a quick literature scan.** This process requires a structured approach, including reviewing diverse sources (e.g., academic, programmatic, behavioural, and policy data), asking targeted questions about the behaviour of interest, and synthesising insights and what is currently known through a behavioural lens. Reviews that don't follow a structured approach may skip critical sources, or fail to acknowledge existing findings, leading to poorly scoped primary research. For example, if a team exploring low immunization uptake failed to analyse caregiver perception surveys, this might result in overlooking existing concerns about provider trust, which could skew design priorities.
- **Writing broad or vague research questions.** If research questions aren't specific to the behaviour of interest, they can result in generic findings that are difficult to act upon. Each question should be linked to a decision. For example, asking "What are barriers to vaccination?" is too broad; "What makes caregivers delay the second dose after the child's first clinic visit?" is clearer and more actionable.
- **Not aligning on whose voices matter.** Failure to identify and prioritize actors such as caregivers, influencers, or service providers can result in missing critical perspectives. For example, a project might focus only on caregivers but miss the influence of grandmothers or community health workers, who shape vaccination decisions. Instead, map and prioritize actors early.
- **Analysing data without unpacking the behavioural drivers behind it.** Too often, findings are catalogued at face value without unpacking the underlying drivers, barriers, or heuristics that shape people's decisions. For example, noting that "caregivers fear side effects" is only useful if we push further, understanding where the fear comes from, and identifying both who or what could shift it. Without this, insights remain surface-level and difficult to act upon.
- **Treating all barriers as equally important.** Without prioritization, teams may spread their efforts too thin. This stage of the *Explore & Diagnose* phase concerns finalizing the research process by prioritizing the behavioural barriers that matter most: those with the greatest influence on the target behaviour and the highest potential to be addressed through the design process. For example, spending equal time on minor myths and major structural barriers — like clinic distance — could dilute resources by splitting efforts across challenges that don't have equal weight. Using a [Feasibility–Impact Matrix](#) can help teams to focus efforts accordingly.
- **Jumping to solutions too early.** The goal of this phase is to gain a deep understanding of behaviours, not to generate or test solutions. Premature ideation can limit curiosity, bias evidence interpretation, and result in interventions that are misaligned with real user needs. For example, suggesting reminder apps before assessing digital access might overlook that most caregivers do not use smartphones — leading to a solution that is irrelevant or inequitable.

CASE STUDY:

Increasing childhood vaccination uptake in Lebanon

Childhood vaccination is one of the most cost-effective public health interventions, yet many children, especially in low- and middle-income countries, remain un- or under-vaccinated.

In Lebanon, home to the world's highest per capita refugee population, vaccine uptake has been undermined by poverty, displacement, and strained health systems. Although national coverage once approached 90%, outbreaks of measles and mumps revealed growing pockets of under-vaccination. In response, the Ministry of Public Health and UNICEF launched the Accelerated Immunization Activities (AIA) programme to expand access through health centers and community outreach — but uptake remained low.

A multidisciplinary team from UNICEF, Nudge Lebanon, and MoPH set out to investigate the issue through a behavioural science lens. Rather than focusing solely on structural barriers, they examined specific behaviours and their drivers, with a focus on caregiver decision-making. During the Define phase, the team articulated a clear outcome: Improving the timely completion of routine childhood vaccinations among un- or under-vaccinated children. They mapped the ecosystem of actors, including caregivers, outreach workers, and PHC staff. They used behavioural mapping and a prioritization matrix to identify “start” and “stop” behaviours across these audiences, ultimately prioritizing caregiver follow-through on appointments as both impactful and feasible to shift.

Optional steps included a system map and leverage point analysis, which revealed how forgetfulness, unclear instructions, and low perceived urgency contributed to missed vaccinations. By Step 5 of the *Define* chapter, the team had documented a clear project scope, surfaced potential risks, and was ready to move into deeper exploration of behavioural drivers. This case study will continue to serve as an illustrative example throughout the

Explore and Diagnose phase, showing how behavioural insights can be applied to guide each step of the process.

The team began by identifying districts with the lowest coverage rates and the most vulnerable populations, focusing on areas with a high concentration of refugee and low-income households. Using behavioural science frameworks — such as the **COM-B**¹ framework to explore capability, opportunity, and motivation — they conducted extensive fieldwork, including interviews with outreach workers, program staff, and healthcare providers, along with direct observation through household visits. They mapped the journey caregivers were expected to take and looked closely at the specific decision points where behaviour broke down, without making assumptions about lack of awareness or access.

This structured approach revealed clear behavioural drop-off points, i.e., moments where intention failed to translate into action. Three key barriers emerged:

- **Cognitive overload:** caregivers feeling overwhelmed by too much information or too many competing tasks
- **Emotional stress:** such as anxiety about clinic visits or fear of judgment
- **Social perceptions:** e.g., concerns about how others in the community might view their actions

These barriers did not reflect an opposition to vaccination but rather the complex realities that caregivers navigated, where attending a clinic often competed with urgent responsibilities like securing food, childcare, or income. By grounding the inquiry in observed behaviour and real-world frictions, the team was able to diagnose where and why caregivers' intentions were breaking down, often in ways that were unconscious or invisible even to the caregivers themselves. These were not always moments of deliberate decisions; rather, they reflected subtle, automatic behavioural responses shaped by stress, habit,

1 Michie, S., van Stralen, M.M. and West, R., 2011. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(1), p.42. <https://doi.org/10.1186/1748-5908-6-42>

and environmental context. Caregivers might not have felt like they were facing barriers, but the behavioural patterns revealed key friction points where intention to follow-through on vaccination quietly unravelled.

***Note:** *While this is a real project that closely followed a very similar process to DEPTHS, there were a few tools from the toolkit that the project team did not apply during implementation. In those cases, we've gone back and retrospectively applied the tools using real project data to illustrate how they might have looked if they had been used at the time.*



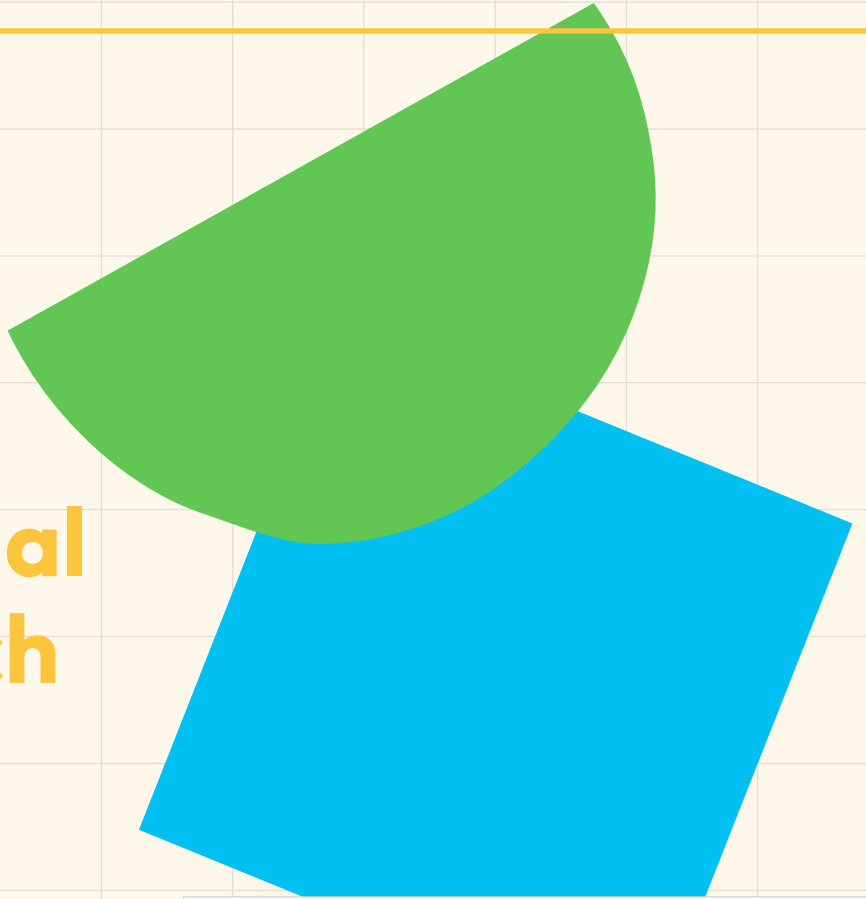
STEP 1:

Conduct initial desk research

In this step:

The purpose of this step is to conduct an initial desk research (sometimes referred to as a “literature review”).

This is a structured process of examining and synthesising existing data and evidence.



Associated Tools:

- [Initial Desk Research](#)

Why it matters:

Before conducting primary research, it is essential to understand the existing landscape of evidence.

A rigorous desk research helps to build a shared understanding of the behavioural challenge, identify well-documented behavioural patterns and influencing

factors, and pinpoint clearly where further information or research is still needed. If these gaps are significant, the desk research can shape a focused plan for primary research, ensuring any new data collection is purposeful and targeted to the areas that matter most.

How to do it:

1. Review the outputs from the *Define* phase and formulate initial questions.

Use the [Initial Desk Research](#) worksheet to prepare the desk research process.

- a. Before initiating the desk research, revisit the key outputs generated during the *Define* phase, including the [Problem Definition and Outcome Statement](#), [Behaviour Tree](#), [Prioritization Matrix](#), [System Map](#), [Leverage Point Analysis](#) (if available) and the [Project Canvas](#). This step helps the team to consolidate what is already known, clarify working assumptions, and sharpen the focus of the desk research.

DEXPLORE & DIAGNOSE

PTHS

DEPTHS TOOLKIT

Initial Desk Research

List and review existing evidence.

A **What do we know or think we know?** *Write down insights and assumptions about the problem, behaviour(s) and audiences of focus. During the Define stage, what have we already observed or heard from stakeholders? What patterns or beliefs are we assuming to be true?*

B **Where should we look?** *Are there baseline data or recent surveys? What reports, insights, or evaluations exist? Who else is working on this? Do they have findings? What's already been tried to shift this behaviour or solve this problem?*

C **What should we look for?** *List and refine initial the desk review questions based on the problem, behaviour(s) and audiences of focus.*

- What do we know about how people are currently behaving in this context?
- How do different population groups experience the issue?
- What do we know about drivers (psychological, social, structural, environmental)?
- What did past efforts reveal—what worked, what didn't, and why?

- b.** Complete the “What do we know or think we know?” section of the **Initial Desk Research** worksheet:
- What insights have already been established through observation or stakeholder input so far?
 - What assumptions emerged during *Define* that need to be validated through further research?

- c.** Complete the “Where should we look?” section. Identify relevant sources for the desk research, such as:
- Programme evaluations and implementation reports
 - Administrative data
 - National demographic and health surveys (e.g., DHS, MICS)
 - Government policy documents and strategic plans
 - Academic literature and peer-reviewed studies
 - Grey literature and unpublished reports
 - Internal data, learning briefs, or field-level observations from partners

Draw on both qualitative and quantitative data — from local and regional sources — to build a comprehensive understanding of the context. Prioritize recent, credible, and context-specific evidence that speaks to both the situation and the behaviour. This includes essential data on service coverage, access, and demographics, as well as sources that help to explain what drives people’s decisions.

Review data from national statistical offices, UN agency databases, Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), national health information systems (HMIS), and sector-specific reports from ministries or NGOs. For insights on behavioural drivers and barriers, review existing KAP surveys, social listening reports, and rapid qualitative assessments conducted in similar contexts.

Combining situational and behavioural evidence provides a stronger foundation for analysis — helping teams to move from understanding what is happening to unpacking why it is happening.

- d.** Finally, use the “What should we look for?” box to tailor and refine initial desk research questions. Prompts to consider when formulating initial desk research questions include:
- What do we know about how people are currently behaving in this context?
 - How do different population groups experience the issue?
 - What do we know about drivers (psychological, socio-cultural, structural, environmental)?
 - What did past efforts reveal? What worked, what didn’t, and why?

2. Conduct the initial desk research

- a. Review and analyse available literature, drawing from both situational and behavioural evidence. When doing so, pay particular attention to the *behavioural* insights. What do the sources say about what people are doing and why? What barriers or enablers are noted? These may be explicitly mentioned, or implied instead through narrative or outcome patterns.
- b. Use different search engines to look for past evidence. In addition to general academic search engines like Google Scholar, consider more specialised platforms to refine desk research like the [3ie Development Evidence Portal](#), [UNICEF's publications](#) or the [Behavioural Evidence Hub](#). AI-powered tools, such as the [World Bank's AVA chatbot](#), and tools for literature reviews like [Elicit](#), can support an efficient discovery of evidence.

Whatever the tool, take care to check primary sources identified through AI tools to ensure accurate context and minimize bias.

- c. It is important to critically assess the literature and evidence collected during a desk research. Different journals and platforms apply varying standards for publication, and even peer-reviewed articles may not always be reliable.

Not all evidence carries the same weight. The following table offers guidance for weighing different kinds of evidence.

Where possible, the desk research should prioritize evidence from systematic reviews, meta-analyses, and other high-quality studies, if these are available.

TABLE 2. TRUSTWORTHINESS ACCORDING TO TYPE OF EVIDENCE

EVIDENCE TYPE	TRUSTWORTHINESS
Systematic reviews and meta-analyses of high-quality studies	Very strong
Multiple RCTs or well-designed quasi-experimental studies	Strong
Single RCTs, strong observational studies, mixed-methods triangulated evidence	Moderate
Case studies, cross-sectional surveys, grey literature with limited rigour	Weak
Anecdotes, expert opinion, advocacy briefs with no data	Very weak

The UK Department for International Development (DFID) provides [guidance on evaluating the strength of evidence](#), as illustrated below in the table below:

TABLE 3. PRINCIPLES OF HIGH QUALITY RESEARCH STUDIES

CRITERIA	DESCRIPTION	HIGH QUALITY EVIDENCE EXAMPLE	LOW QUALITY EVIDENCE EXAMPLE
Conceptual framing	The study explains its main question and links it to what is already known.	A report on SMS reminders for vaccines states its research question clearly, cites past evidence on reminders, and sets out a testable hypothesis.	A paper simply says “we wanted to improve vaccination” without explaining why, or linking to earlier studies.
Transparency	The study is open about how it was done (where, when, with whom, and who paid for it.)	A malaria study explains it was conducted in 3 provinces in 2022, with 600 households randomly chosen, and names UNICEF as funder.	A study reports “data were collected recently in Africa” with no details on location, methods, or funding.
Appropriateness	The way the study was done fits the question being asked.	To measure whether a new drug prevents malaria, researchers run a randomised controlled trial.	To test if a drug prevents malaria, researchers just ask 10 people if they feel healthier after taking it.
Cultural sensitivity	The study considers local customs, beliefs, and context.	A vaccination survey in Nigeria notes that fathers usually decide on children’s vaccines, so it includes both mothers and fathers in interviews.	A survey in Nigeria only asks mothers, ignoring that fathers often influence the decision either directly or indirectly.
Validity	The results really measure what the study claims to measure.	A mosquito net study measures malaria rates with blood tests, adjusts for weather, and rules out other causes.	A mosquito net study only asks people “do you feel healthier?” without checking actual malaria prevalence.
Reliability	The study would give similar results if repeated in the same way.	A survey tool is tested in two towns, gives consistent answers, and shows strong reliability statistics.	A survey tool gives very different results each time it is used, with no testing or explanation.
Cogency	The findings make sense from start to finish, and the study is honest about its limits.	A youth programme evaluation clearly links activities to outcomes, presents data, and admits long-term effects are uncertain.	A youth programme report claims “our activities worked” without showing data and ignores obvious limitations.

d. Make sure to capture findings systematically using a structured tool like a table or matrix. A good desk research will:

- Go beyond listing studies, instead synthesising insights across sources into a coherent picture of the situation and behaviours
- Include both situational and behavioural evidence, revealing how context and drivers interact
- Explicitly identify barriers and enablers
- Use credible, up-to-date, and context-specific sources, which are clearly cited and traceable
- Triangulate findings across multiple types of evidence (quantitative, qualitative, routine data, observational, feedback mechanisms)
- Clearly flag evidence gaps, contradictions, and uncertainties
- Frame insights in a way that is relevant and actionable for stakeholders and decision-makers

e. The format and structure of desk research can vary depending on the project's focus and objectives. Some reviews take a broad approach, summarising the overall context of the problem along with past interventions. Others are more targeted, exploring specific aspects such as common behavioural barriers, interventions that have already been tested, or the characteristics of the affected population. In general, a comprehensive desk research will include the following sections:

TABLE 4. SUGGESTED SECTIONS FOR A DESK RESEARCH

SECTION	DESCRIPTION
Cover Page	Includes title, date, author(s), organisation logos, and confidentiality note if required.
Executive Summary	Provides a concise overview of purpose, key findings, and main recommendations; designed to stand alone.
Introduction	Outlines the purpose, scope, and methodology of the desk research, including conceptual framework or definitions if relevant.
Context and Background	Presents sectoral, demographic, geographic, policy, and programmatic background; synthesises existing literature.
Key Findings	Core of the review, structured into sub-sections. For example: Main behavioural barriers, Key stakeholders related to the problem, Behavioural interventions that have been tested in the past
Gaps, Challenges, and Insights	Identifies limitations in data, evidence gaps, and conflicting findings.
Risk Analysis and Equity Lens	Highlight gaps related to gender, inclusion, human rights; surface risks to implementation.
Strategic Recommendations	Presents actionable and prioritized recommendations, tailored to decision-makers, implementers, and other audiences.
Conclusion	Summarises main takeaways, synthesises findings, and provides overall reflections.
References or Bibliography	Lists all sources cited and consulted during the desk research.
Annexes	Provides supplementary material such as detailed data tables, stakeholder lists, methods notes, or expanded case examples.

Some helpful templates and examples of desk research include UNICEF’s desk research [“Input Into Malaria Communication Strategy to Accelerate Malaria Elimination”](#); the joint UNICEF-NYU Ukraine desk research [“The Power of Youth: Instruments for Effective Youth Participation”](#); and [Save the Children’s Desk Research Template Tool](#).

When applying a behavioural lens to the initial desk research

While not required at this stage, behavioural frameworks like UNICEF’s **Behavioural Drivers Model (BDM)** can be a useful resource. The BDM is not intended as a tool for desk research or analysis, but rather as a conceptual guide that illustrates the multifactorial nature of behaviour. It reminds us that behaviours are rarely driven by a single factor, and that a full understanding requires attention to **psychological, social, and environmental** influences.

Keeping these domains in mind during the desk research process can help researchers notice patterns, surface blind spots, or better organize insights that may later inform diagnosis and design. This reflection is not about fitting data into a model, but about staying open to the layered realities that shape human behaviour. Consider the following prompts while reviewing existing evidence:

- What **psychological** factors — such as knowledge, beliefs, emotion, or self-efficacy — appear to influence this behaviour?
- What **social** influences — such as group norms, relational dynamics, or informal power structures — may be shaping decisions?
- What **environmental** conditions — such as availability of services, structural barriers, or institutional policies — create or constrain opportunities for action?

Learn more about the BDM: <https://www.unicef.org/mena/reports/behavioural-drivers-model>. This model can also be used in conjunction with other frameworks, like COM-B.

3. Determine whether primary research is needed to fill gaps

The final step in this phase is to assess whether existing evidence is strong enough to begin designing solutions or if further insights are needed. Additional research should only be conducted if it will meaningfully strengthen the intervention design process.

- a.** Review the desk research findings, and ask:
 - Do we have enough of an understanding of the behavioural drivers, barriers, and context? For example, if the evidence identifies low clinic attendance but doesn't explain why - such as time constraints, negative provider experiences, or social norms — further inquiry may be needed.
 - Is current evidence lacking any notable groups, or key voices from underserved or marginalized communities? For instance, if the literature focuses on urban caregivers but the intervention will be implemented in rural areas, key contextual differences may be overlooked.
 - Are existing insights outdated, biased, or lacking local relevance? A study from five years ago, or one conducted in a different country or cultural setting, may not reflect the lived realities or current behaviours of the target population.
- Are there any major assumptions or unknowns that still need to be tested? For example, assuming caregivers forget appointments may lead to reminder-based interventions; however, if vaccine hesitancy or mistrust is the core issue, this solution may prove ineffective.
- b.** If key questions remain unanswered, conducting targeted research can help to fill in gaps in understanding. Large-scale studies are not always needed. Additional research could include, for example, engaging with a group that has yet to be consulted, or exploring how a social norm is reinforced, challenged, or maintained within a particular community context. Primary research should be focused and purposeful, avoiding the collection of irrelevant data, the overburdening of communities, or the delaying of the overall DEPTHS process.
- c.** After completing the desk research, return to the Define outputs to update them with any new insights. The Project Canvas, in particular, serves as a living document, anchoring the project's direction and informing all subsequent decisions. Updating the Canvas ensures consistency and alignment across the project.

CASE STUDY:

Increasing childhood vaccination uptake in Lebanon

This initial desk research tool was not developed by the original project team. It is a recreated example based on real project data and context.

Conducting a desk research to understand existing data and evidence about the problem

To begin, the project team reviewed the key outputs generated in the Define phase (The Project Canvas, Problem and Outcome Statement, Behaviour Tree, etc) to determine their existing knowledge of the problem and any research gaps.

The team then gathered existing documentation, including programme reports, previous research and immunization coverage data within Lebanon, along with data from similar contexts (e.g. Jordan, Turkey, and Syria). Documents reviewed included:

- Past UNICEF and WHO immunization programme reports from Lebanon and similar contexts in Middle East and North Africa (MENA)
- Academic research on vaccine hesitancy and dropouts from low- and middle- income countries (LMICs)

- Immunization coverage data from Lebanon
- Qualitative and quantitative research data from past programmes
- Health Systems Data

The researchers reviewed and synthesised key information to improve their contextual understanding of the project's problem statement.

To ensure an efficient desk research process, the project team developed a plan to focus on the key areas and documents to explore and review.

Once the desk research was complete, the researchers organized key findings into a structured spreadsheet. This served as a central repository of relevant data, behavioural insights, and identified gaps. While the spreadsheet can be a final output in some cases, it more often supports a formal synthesis effort — such as a literature review, summary report, or insight synopsis. These products help to distill patterns, surface remaining questions, and inform the focus of subsequent primary research.

D EXPLORE & DIAGNOSE **P** **TH** **S** DEPTHS TOOLKIT

Initial Desk Research CASE STUDY 1: INCREASING CHILDREN IMMUNIZATION RATES IN LEBANON

List and review existing evidence.

A **What do we know or think we know ?**

Previous high immunisation coverage (near 90% RI), however increasing poverty levels and over 1 million refugees entering the country in 2011 has caused coverage to drop. This was seen in 2013 and 2015 with a rise in measles and mumps outbreaks.

UNICEF and MoPH Lebanon AIA programme started in 2017 using community-based outreach to raise awareness on vaccination and refer missing children to nearest participating healthcare centre. However, children are missing their referral appointments.

It appears as if caregivers are forgetting their follow-up appointments or neglecting to attend them. We assume this may be linked to information provided by PHC staff and outreach workers regarding vaccine importance and schedule.

B **Where should we look?**

- UNICEF and other INGO programme reports
- AIA programme data
- 2 past quantitative surveys on the AIA programme effectiveness
- MoPH Lebanon immunisation data
- Past academic research conducted in Lebanon on health behaviours of refugee populations

B **What should we look for?**

- What do we know about how people are currently behaving in this context?
- How do different population groups experience the issue?
- What do we know about drivers (psychological, social, structural, environmental)?
- What did past efforts reveal—what worked, what didn't, and why?

- What is the latest immunisation coverage data in Lebanon? What are the drop-out rates? At what services and points is vaccination offered?
- Which groups have the lowest immunisation coverage rates? What characteristics do these groups have? What are their living conditions and family situations?
- What vaccination services and other health services are available to refugee families and Lebanese families? To what extent do they access other (non-vaccination) health services?
- How do outreach teams in the AIA programme access families? What do they tell families about vaccination?
- What information and training is available to Outreach Workers, PHC nurses and District Supervisors on interpersonal skills and communicating about vaccination, in particular vaccine schedules?
- How effective were past immunisation programmes—were there any programmatic or other challenges? How did families respond to past vaccination efforts by the AIA programme?
- How have community leaders been involved in past vaccination efforts?
- How is data collected in the AIA programme?



STEP 2:

Develop primary research questions

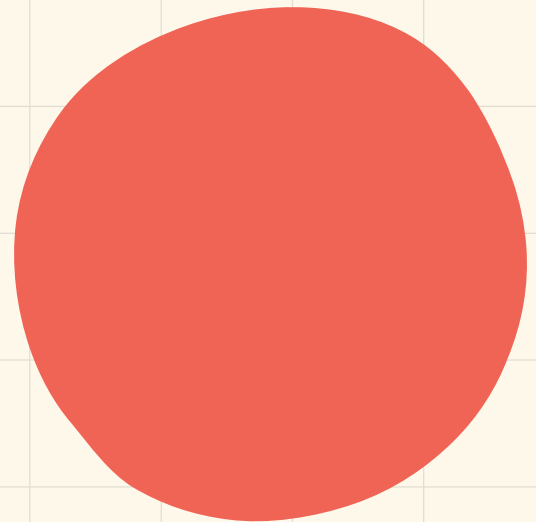
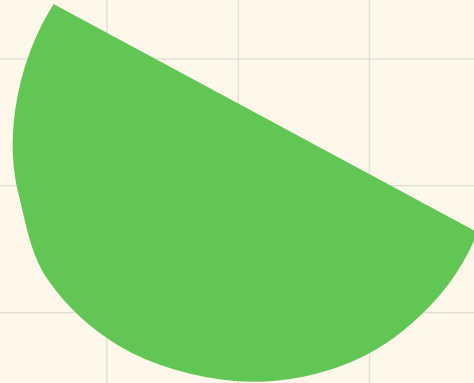
Associated Tools:

[Primary Research Objectives and Questions](#)

In this step:

With the initial desk research complete, the next step is to define the specific behavioural questions that are in need of further exploration through primary research – using the Primary Research Questions worksheet.

This tool ensures that research questions are informed by behavioural science, allowing teams to diagnose the full range of drivers and barriers that shape behaviours.



Why it matters:

Clear and targeted research questions are essential to behaviourally informed inquiry.

Poorly defined or overly general research questions can result in data that is vague, redundant, or difficult to translate into action. In contrast, strong research questions sharpen the focus of inquiry, help to ensure that research instruments are well-aligned with the objectives, and enhance the rigour and relevance of findings.

Refining research questions at this stage achieves the following outcomes:

- **Ensures that research is aligned with the behavioural outcome** articulated during the *Define* phase
- **Focuses the investigation on priority behavioural determinants** at different levels, when questions are grounded in a behavioural model or framework
- **Avoids duplication of existing knowledge**, ensuring that primary data collection is focused on filling genuine gaps in evidence

To help structure this process, use the **COM-B²** model: a practical and widely used approach to diagnose the factors that or inhibit the behaviour of interest. Using a model like COM-B allows teams to systematically map why people do or don't perform behaviours.

The COM-B model is a framework that breaks behaviour down into three essential components: **Capability**, **Opportunity**, and **Motivation**, each with two sub-domains.

- **Capability** refers to the psychological and physical capacity to engage in the activity, including knowledge, skills, and mental faculties.
 - **Physical Capability** refers to physical skill, strength, stamina, or ability needed to perform the behaviour.
 - **Psychological Capability** refers to the mental or cognitive capacity to engage in the necessary thought processes, such as comprehension, reasoning, and memory.
- **Opportunity** encompasses the external conditions that make the behaviour possible, including environmental, socio-cultural, and structural factors.
 - **Social Opportunity** refers to the social cues, cultural norms, and interpersonal influences that shape behaviour.
 - **Physical Opportunity** refers to the environmental factors like resources, time, infrastructure, and access that enable behaviour.
- **Motivation** includes both reflective processes (such as beliefs and intentions) and automatic processes (such as emotional responses and habits) that drive behaviour.
 - **Reflective Motivation** refers to conscious planning and evaluation processes, such as intentions, beliefs, and identity.
 - **Automatic Motivation** refers to the unconscious processes such as emotions, habits, impulses, and reactions.

2 Michie, S., van Stralen, M.M. and West, R., 2011. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(1), p.42. <https://doi.org/10.1186/1748-5908-6-42>

Table 5 below outlines examples of behavioural drivers and barriers for each COM-B sub-domain.

TABLE 5. MAPPING OF BEHAVIOURAL DRIVERS AND BARRIERS IN COM-B FRAMEWORK

SUB DOMAINS	TYPES	DEFINITION
Psychological capability	Knowledge / understanding	How well someone understands the behaviour, service, or related information.
	Memory, attention, decision	How cognitive load, distractions, or competing priorities affect decisions.
	Behavioural regulation	How well someone can monitor and adjust their own behaviour.
Physical capability	Physical skills	The specific physical abilities or skills needed to carry out the behaviour.
	Strength, stamina, mobility	Energy, strength, or physical condition needed to act consistently.
	Health status	Health conditions that may enable or prevent action.
Physical opportunity	Time and scheduling	The ability to act within available time or schedules.
	Availability	Whether services, tools, or products are available when needed.
	Accessibility	Whether people can access services or places (e.g., distance, transport, hours).
	Structural barriers	Physical or systemic barriers that make action difficult or impossible.
Social opportunity	Norms and expectations	What is considered typical, acceptable, or expected in the social group.
	Social support	Support or encouragement provided by others.
	Influence of others	Direct influence from family, peers, leaders, or others in one's network.
	Roles and responsibilities	The roles people are expected to play, and how those shape their behaviour.
Reflective motivation	Beliefs about consequences	What someone believes will happen if they act (or don't).
	Self-efficacy	Whether someone believes they are capable of taking action.
	Intentions and goals	The goals or intentions people set for themselves.
	Identity	How behaviour aligns with a person's sense of self.
Automatic motivation	Emotions	Feelings that motivate or demotivate action.
	Habits	Routine actions performed without much thought.
	Impulses	Sudden urges that may override conscious decisions.
	Cognitive biases	Mental shortcuts or distortions that shape decisions.

Using a framework like COM-B offers several benefits in applied behavioural science projects, such as:

- **Holistic diagnosis:** Considering multiple drivers of behaviour rather than defaulting to a single explanation (e.g. lack of knowledge).
- **Evidence translation:** Serving as a bridge between data and action. By mapping qualitative and quantitative findings to COM-B components, teams can turn insight into targeted design decisions.

- **Strategic focus:** Prioritizing where interventions should focus. For instance, if motivation is high but physical opportunity is low, interventions may need to address structural barriers, not awareness.
- **Supports systems thinking:** Encouraging teams to explore how individual actions are shaped by context, norms, institutions, and infrastructure.
- **Flexible application:** Applicable at any point in the programme cycle: to shape formative research, identify entry points for behaviour change, refine prototypes, or explain why a pilot did or didn't work.

How to do it:

1. Craft research objectives that will guide the primary research process.

Any primary research will build on the initial desk research by addressing specific gaps that have been identified. Rather than listing broad themes or topics, define what must be understood in order to design context-specific, behaviourally informed, practical and promising interventions. Using the COM-B model to structure research objectives ensures a systematic exploration of important factors influencing the target behaviour.

- Review the updated Project Canvas and desk research findings to clarify what is already known, what is assumed but unverified, and what remains unknown, particularly regarding behavioural drivers, lived experiences, and system dynamics.
- Translate knowledge gaps into focused primary research objectives, writing them down in the [Research Objectives and Questions worksheet](#). Avoid generic objectives — instead, focus on the behavioural mechanisms, contextual factors, or system dynamics that truly matter.

- Frame each objective around what still needs to be understood to influence the behaviour. Start with clear, purposeful verbs that signal the focus of the inquiry, such as:
 - *To understand...*
 - *To explore...*
 - *To identify...*
 - *To examine...*

Each research objective should clearly signal which part of COM-B it addresses. Table 6 outlines the difference between strong and weak research objectives, using the example of routine immunization:

TABLE 6: FORMULATING STRONG VS. WEAK COM-B RESEARCH OBJECTIVES

COM-B DOMAIN	WEAK RESEARCH OBJECTIVE	WHY IT IS WEAK	STRONG RESEARCH OBJECTIVE
Capability	To explore parents' perceptions of vaccination	Broad, vague, and doesn't identify an actionable barrier.	To understand how misconceptions about vaccine safety influence parents' decisions to vaccinate their children.
Opportunity	To understand access to services	Lacks clarity on which aspect of access is being studied.	To examine how distance to health services, transportation costs, and clinic hours affect timely childhood immunization in rural areas.
Motivation	To explore caregivers' attitudes towards vaccination	"Attitudes" is too broad and doesn't identify specific motivational mechanisms.	To identify the beliefs, emotions, and social influences that shape caregivers' motivation to complete the full immunization schedule.

Keep these tips in mind when crafting strong research objectives:

- **Targeted primary research does not need to explore everything about the behaviour.** Instead, it should focus on the behavioural drivers and barriers that still need to be understood to inform effective intervention design.
- **Objectives should link to a design or strategy need.** Every objective should support a decision. Ask: Will answering this question help to design a better intervention? If not, refine the questioning.
- **Avoid restating the outcome.** Do not repeat the end goal (e.g., "to improve ANC attendance"). Instead, probe the underlying behavioural dynamics. An improved version would be: "To identify the socio-cultural and structural factors influencing first-trimester ANC attendance among newly pregnant adolescents."

2. Formulate primary research questions

Clear and purposeful research objectives are next translated into structured primary research *questions*. These questions shape data collection and guide the analysis process.

A research objective is a broad, action-oriented statement that outlines what the study seeks to achieve. In contrast, a research question defines exactly what the study will investigate. Research questions also guide what data to collect and who to engage. For example, if a research objective is “to understand how social norms influence adolescent girls’ decisions to attend school during menstruation,” related research questions can include: collect and who to engage. For example, if a research objective is “to understand how social norms influence adolescent girls’ decisions to attend school during menstruation,” related research questions can include:

- What do peers and other girls in their community typically do when menstruating?
- How do peers, parents, and teachers influence girls’ decisions to stay home or attend school?

- What forms of support or stigma do girls experience during menstruation, and how does this affect their behaviour?

A good research question meets the following criteria:

- **focused** on a particular issue (behaviour, belief, barrier or group)
- **answerable** through available research methods
- **yields insights that can inform actions** (decisions, designs and strategies)
- **shaped by an understanding** of what drives people’s behaviour, often exploring the why or how behind specific actions or choices.

Here’s how to formulate primary research questions:

- First, fill in the “Understand the behaviour” section of the [Primary Research Objectives and Questions](#) worksheet. Before exploring behavioural drivers, it’s clarify how the behaviour itself unfolds in practice. This means understanding what the behaviour looks like on the ground, when and

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Primary Research Objectives and Questions

Understand the behaviour
List questions that help better understand the steps and stages of the behaviour.

Research objectives <i>What should we understand, explore, identify, examine?</i>	Research questions <i>Craft exploratory research questions that directly correspond to the identified gaps in knowledge, pull from the database of questions and refine according to the objective</i>
<div style="background-color: black; color: white; padding: 2px 5px; border-radius: 5px; margin-bottom: 5px;">CAPABILITY</div> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<div style="background-color: black; color: white; padding: 2px 5px; border-radius: 5px; margin-bottom: 5px;">OPPORTUNITY</div> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<div style="background-color: black; color: white; padding: 2px 5px; border-radius: 5px; margin-bottom: 5px;">MOTIVATION</div> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>

where it happens, what steps are involved, and where things tend to break down. These descriptive questions ensure the research is grounded in the real-world experiences of those most affected, making later diagnosis of behavioural drivers more accurate and useful. Exploratory questions to understand the behaviour at hand can include, but are not limited to:

- When and where does the behaviour typically occur?
- What steps or decisions are involved?
- What are common drop-off points, or moments of friction?

For example, in the case of childhood immunization:

What are the steps caregivers take to get their child vaccinated – from first hearing about immunization, to deciding to go, to arriving at the clinic? At what age or stage do families typically begin or stop the immunization schedule, and what challenges emerge along the way?

- b.** Using the **COM-B model** helps to structure research questions and frame the inquiry Capability, Opportunity, and Motivation to influence a specific behaviour. Refer to the [Research Questions Database](#) to find prompts to help develop questions for each COM-B domain. Make sure to adapt them to the behaviour and populations of interest.

The following tables pair research objectives with strong vs. weak research questions, using an example of routine immunization:

COM-B DOMAIN

Capability

RESEARCH OBJECTIVE: To understand how perceptions or misconceptions about vaccine safety influence parents' decisions to vaccinate their children.

WEAK RESEARCH QUESTION	WHY IT'S WEAK	STRONG RESEARCH QUESTION
What do caregivers know about vaccines?	Vague — this could refer to any aspect of vaccines (e.g. cost, access, experience)	What safety beliefs and misconceptions lead caregivers of children under two in Kano (Nigeria) to start, delay, or skip scheduled vaccine doses?
Have caregivers received training or health talks on vaccines?	Focuses on format rather than content or beliefs, without addressing how or why misconceptions form.	Which information sources do caregivers in Kano (Nigeria) use when deciding whether to attend their child's next vaccination visit, and how does source credibility affect attendance?
Do caregivers know vaccines are safe?	Assumes yes or no answer, indicating binary and closed thinking.	To what extent do caregivers in Kano (Nigeria) believe routine vaccines are safe, and how does that belief affect starting, delaying, or skipping scheduled doses?

COM-B DOMAIN

Opportunity

RESEARCH OBJECTIVE: To examine how distance to health services, transportation costs, and clinic hours affect timely childhood immunization in rural areas.

WEAK RESEARCH QUESTION	WHY IT'S WEAK	STRONG RESEARCH QUESTION
Is it easy for people to get to the clinic?	Vague and subjective — “easy” varies across respondents.	How far and how long do caregivers in rural Kano (Nigeria) travel to vaccination sites, and how does travel burden affect timely attendance at vaccine appointments?
What is the state of rural health systems?	Too broad and not linked to the specific behaviour.	How do clinic opening hours, staff availability, and service organisation in rural Kano (Nigeria) affect completion of the full immunization schedule for children under two?
Do people want more clinics nearby?	Hypothetical and solution-focused, skipping the behavioural insight.	What location and scheduling constraints lead caregivers in rural Kano (Nigeria) to miss or reschedule vaccination appointments?

COM-B DOMAIN

Motivation

RESEARCH OBJECTIVE: To identify the beliefs, emotions, and social influences that shape caregivers' motivation to complete the full immunization schedule.

WEAK RESEARCH QUESTION	WHY IT'S WEAK	STRONG RESEARCH QUESTION
Do caregivers think vaccines are important?	Oversimplifies belief systems into a yes or no view and doesn't explore why those beliefs matter.	What do caregivers of children under two in Kano (Nigeria) believe about the importance and benefits of completing the full immunization schedule, and how do these beliefs affect completion?
Are caregivers scared of vaccines?	Leading and narrow-focused line of questioning.	Which emotions do caregivers in Kano (Nigeria) experience at key points in the vaccination journey, and how do these emotions affect return visits?
Who influences vaccination decisions?	Too vague — doesn't explore how or why the influence matters, or what kind of influence it is.	Who influences caregivers in Kano (Nigeria) to vaccinate or delay, and in what ways do spouses, grandparents, peers, and local leaders shape return for scheduled doses?

Write down the selected research questions in the Research Questions section of the Primary Research Objectives and Questions worksheet next to their corresponding objective. Each objective should be paired with a few specific, research questions that make it possible to investigate the issue.

Here are some tips for developing strong research questions:

- **Specify who the question concerns**, including key subgroups if relevant.
- **Specify the behaviour of interest**, as a single, observable action.
- Optionally **specify where the behaviour occurs**, as context can vary across settings.

- **Avoid vague, binary, or double-barreled questions.** For example, replace “Do people trust health workers?” with “What factors influence caregivers' trust in health workers during vaccination visits?”
- **Split broad or compound questions into clear parts.** For example, change “Why do people delay care and not follow up?” to two questions: “What causes delays in seeking care?” and “What prevents follow up after the first visit?”
- **Ensure the questions are decision-relevant.** Before finalizing a question, ask: Will the answer to this help us design more effective solutions? For example: What structural barriers do pregnant adolescents face when accessing antenatal care in informal urban settlements?

CASE STUDY

Increasing childhood vaccination uptake in Lebanon

The Primary Research Objectives and Questions were not developed by the original project team. They are recreated examples based on real project data and context.

Develop clear research objectives

In the previous step of this phase, the research team structured and conducted an initial desk research to assess what was already known about vaccine uptake in the country. Their initial observations highlighted a worrying drop in routine immunization (RI) coverage following the 2011 influx of refugees and rising poverty levels. Despite outreach efforts through the UNICEF-Ministry of Public Health's (MoPH) AIA programme, many caregivers were not following through on referral appointments, suggesting potential behavioural gaps that traditional programmatic approaches hadn't resolved.

Using this early review, the team surfaced a number of working assumptions: that caregivers may be forgetting vaccination appointments, that primary health care (PHC) staff and outreach workers may not be communicating clearly about vaccine schedules, and that daily stressors might be interfering with caregivers' ability to prioritize follow-up visits. These hypotheses were grounded in preliminary AIA programme reports, past quantitative surveys, and government immunization data, but they revealed important gaps that needed further primary research.

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CASE STUDY 1: INCREASING CHILDREN IMMUNIZATION RATES IN LEBANON

Understand the behaviour
How do caregivers in Lebanon access vaccination? How do they learn about vaccination and the vaccine schedule? What steps do families take to access vaccination services?

	Research objectives	Research questions
CAPABILITY	<p>To identify caregivers' knowledge and gaps in caregivers' understanding of the vaccination schedule, including timing, number of doses, and next steps after AIA outreach visits.</p> <p>To explore whether PHC staff and outreach workers have the knowledge and confidence to consistently communicate accurate, understandable vaccination information.</p>	<ul style="list-style-type: none"> What do caregivers, in particular from refugee and host community households, understand about the vaccination schedule (e.g., required doses, timing, and sequence)? To what extent do they understand the immunisation calendar? Do caregivers know where and when to access vaccination services after outreach visits? Are there knowledge gaps or misunderstandings that cause caregivers to delay or skip appointments? How do outreach workers and PHC staff communicate vaccine information to caregivers? Are they confident in delivering clear and correct advice? What skills or support do PHC staff need to accurately track missed doses and plan follow-ups?
OPPORTUNITY	<p>To understand the physical, logistical, and structural barriers (e.g., clinic accessibility, mobility constraints, service hours) that affect caregivers' ability to vaccinate.</p> <p>To examine how social norms, household dynamics, and community beliefs shape caregivers' decisions to vaccinate.</p>	<ul style="list-style-type: none"> What do caregivers think of the AIA programme vaccination experience? Are there any practical issues or challenges e.g. distance to facility, quality of service, time taken, clinic opening hours, that prevent caregivers from attending scheduled appointments? What are the community structures and dynamics of refugee families within Lebanon? What role do social or community norms play in impacting vaccination? What do caregivers believe other families are doing in relation to vaccination? Who are the key influencers, champions or community leaders who communities would listen to for information on vaccination and vaccine schedules? How are decisions related to child immunisation made within these families? Any differences between women and men or age?
MOTIVATION	<p>To explore the beliefs, emotions, and values that influence caregivers' perceived urgency or importance of completing all recommended vaccinations on time.</p> <p>To identify factors contributing to trust or mistrust in vaccination services and how these perceptions impact motivation to act on outreach or PHC guidance.</p>	<ul style="list-style-type: none"> How do caregivers weigh the importance of timely vaccination compared to other daily priorities or stressors? What emotional responses (e.g., worry, pride, guilt, confusion) do caregivers experience in relation to vaccinating their children? Are there beliefs or past experiences that shape caregivers' trust (or mistrust) in health providers or the vaccination process? What motivates outreach workers and PHC staff to deliver a positive vaccination service and/ or go beyond their routine duties (e.g., follow up visits, repeated messaging)?

The team used the COM-B model to guide the development of their research objectives. This model gave them a structured way to think about the various factors influencing caregivers' behaviour. Under Capability, they sought to explore knowledge gaps; for example, whether caregivers understood when and where to return for vaccinations. Under Opportunity, they wanted to understand how clinic hours, transportation, gender norms, and peer influence affected follow-through. And under Motivation, they aimed to examine emotions, trust, and competing priorities that could affect caregivers' decisions to act on referral guidance.

Develop primary research questions

With the COM-B framework in hand, the team translated these focus areas into precise primary research questions. For example, they asked: "How do caregivers weigh the importance of timely vaccination compared to other daily priorities or stressors?" and "What do caregivers know about where and when to access vaccination services after outreach visits?" These questions were designed not only to diagnose behavioural barriers, but also to help the team uncover more nuanced insights around household decision-making and provider-caregiver dynamics.

The resulting research questions served as a foundation for designing tools to capture rich, contextual evidence from Lebanese and Syrian caregivers, health workers, and outreach staff. The questions also helped highlight what wasn't yet fully understood: such as the emotional trade-offs caregivers make when deciding to delay or skip vaccination or the role of informal community reminders.



STEP 3:

Plan the primary research

Associated Tool:

[Primary Research Plan](#)

[\[External\] Research Protocol Template](#)

In this step:

Step 3 translates the research questions into a practical plan. Each question is linked to the information needed, the people best placed to provide it, and the setting where honest, accurate answers are most likely (for example, at a clinic during busy hours to understand waiting times, or at home to explore decision making in the family).

Methods are chosen to fit the question: interviews for how and why, short surveys for how many, or observation when actions are easier to see than describe. The plan also sets out who will be included, how participants will be invited fairly, and the simple tools to keep conversations consistent (such as interview or discussion

guides). It explains how notes, recordings, or forms will be used, and how privacy will be protected.

Where topics are complex or involve sensitive groups, a fuller protocol is prepared and ethics approval is required to ensure safety and responsibility. By the end of the step, the plan clearly links questions to methods, participants, and places; the data collection tools are ready to use; and, when required, an approved protocol and consent materials are in place. A brief pilot and an early team debrief help confirm that the plan is workable and that the information collected will answer the original questions and support programme decisions.

Why it matters:

It's essential to gather the right insights from the right people in ways that are ethical, actionable, and connected to the behaviour we aim to influence. Without a clear plan, there is a risk of collecting data that is too broad, shallow, or disconnected from the behaviour prioritized in the Define phase.

A strong plan also helps to appropriately allocate time and resources. It clarifies roles, identifies where local support is needed, and allows for adaptations to research methods, tools, and materials based on language, literacy, or cultural context. Most importantly, it ensures that teams are not only operationally prepared but also aligned on learning objectives.

How to do it

1. Identify who we need to hear from and how best to engage them

This includes not only the target population, but also members of the broader community and other knowledge sources. Each research question should be matched with the people who are best placed to answer it. Make note of whether any of these groups may be considered vulnerable or have less agency to determine whether they are comfortable participating.

Consider including:

- Primary participants with lived experience of the behaviour (e.g., caregivers in areas with low vaccination rates).
- Influencers who shape decisions (e.g., family members, health workers, peers).
- Context experts who understand systems or structures influencing the behaviour (e.g., local NGOs, government partners).

2. Identify research methods

To uncover why individuals may not engage in a target behaviour, carefully consider the methodological approach.

A range of research methods exist to understand the underlying causes of a given behaviour, and each method has advantages and limitations. Whenever possible, it's worth advocating for a mixed-methods approach, drawing on both qualitative and quantitative techniques for a richer, more holistic understanding:

- Qualitative methods (such as interviews, focus groups, and observations) help to uncover the why behind behaviours, exploring barriers and drivers.
- Quantitative methods (such as surveys) help to measure the what, identifying patterns, frequencies, and relationships across a larger population.

In many settings, resource constraints — whether related to time, budget, personnel, or geographic access — may limit the scope of methods employed. In such instances, it becomes essential to strategically select the approaches that are not only methodologically sound, but also contextually appropriate and logistically feasible. To select the most appropriate methods:

- a. Clarify constraints and operational realities. Consider:
 - What is the current capacity of the team, both in terms of expertise and availability?
 - Will the research be conducted in person, or must it be implemented remotely?
 - Will additional support be required? For example, interpreters, translators, or trusted local facilitators familiar with community dynamics.

- Are there temporal constraints, such as seasonal access, safety concerns, or participant availability, that might affect when and how data can be collected?
- Are there financial constraints that may affect the choice of methods, sample size, or field logistics?

- b. Different methods serve different purposes. Table 8 below summarizes some of the commonly used behavioural research methods, with guidance on when each may be most useful. Rather than assigning one method per question, consider how a combination of methods can help triangulate findings, offset limitations, and deepen understanding.

TABLE 8. QUALITATIVE RESEARCH METHODS

METHOD	USEFUL FOR	STRENGTHS	LIMITATIONS
<p>In-depth semi-structured interviews</p> <p>One-on-one conversations guided by a set of questions to explore experiences and motivations</p>	Exploring individual beliefs, motivations, and sensitive topics in depth.	Flexible format allows participants to share personal experiences in their own words, fostering trust and openness.	Less scalable as interviews take more time, rely heavily on the interviewer’s skill and neutrality, and typically yield insights that are not easily generalizable across populations.
<p>Focus Group Discussions</p> <p>Facilitated discussions with a small group to uncover norms, perceptions, and shared experiences.</p>	Understanding group norms, social dynamics, and shared attitudes.	Efficiently surfaces shared views and social influences, revealing how people respond to others’ opinions and expectations.	Group settings may discourage open discussion of sensitive topics or create risks for participants. Dominant participants can steer the conversation, making it harder to capture diverse perspectives.
<p>Field Observations</p> <p>Watching how behaviours and interactions unfold in natural settings.</p>	Capturing real-world context and observable behaviours.	Provides direct insight into routines, environment, and interpersonal dynamics, including barriers people may not articulate.	If not well introduced, this type of data can feel intrusive — also more open to interpretation, and requires careful coding, note-taking, and often triangulation with other methods to make sense of patterns.

METHOD	USEFUL FOR	STRENGTHS	LIMITATIONS
<p>Mystery User</p> <p>A trained person/researcher simulates a real user experience to assess a process and identify hidden barriers.</p>	<p>Testing service quality or frontline behaviour without observer bias.</p>	<p>Reveals breakdowns or user experience gaps that staff may not notice or report. It is especially useful in service or referral systems.</p>	<p>Requires well-trained assessors and may raise ethical concerns if participation is not disclosed or consented to.</p>
<p>Social network mapping</p> <p><i>To identify influencers, social expectations, and approval/disapproval dynamics around behaviours.</i></p>	<p>Understanding who influences behaviour, how information and norms spread, and where social pressure or support comes from.</p>	<p>Reveals how behaviours are shaped by relationships, not just individual beliefs. Helps to identify people or groups who hold influence over decisions, making it easier to design targeted messages or leverage trusted messengers.</p>	<p>Accurately mapping networks takes time and careful facilitation, especially in communities where relationships are sensitive or hidden. People may hesitate to name influencers honestly, or may overlook informal connections that play a key role in shaping behaviour.</p>

TABLE 8B. QUANTITATIVE RESEARCH METHODS

METHOD	USEFUL FOR	STRENGTHS	LIMITATIONS
<p>Surveys</p> <p><i>Structured questionnaires that gather quantitative data from a larger population.</i></p>	<p>Measuring prevalence, attitudes, or self-reported behaviours across a population.</p>	<p>Allows data to be collected from large numbers of people in a consistent way, making it easier to compare data across locations or groups. Responses can be quickly summarised using simple statistical analysis, especially when using digital tools or pre-coded questions.</p>	<p>Surveys rely on what people say they do, not what they actually do. Responses can be influenced by what participants think is expected or socially acceptable (social desirability bias), and if questions are poorly phrased, confusing, or culturally misaligned, they can lead to misleading or incomplete results.</p>
<p>Service or administrative records</p> <p><i>Routinely collected data from health systems, education records, registration logs, or other service delivery platforms.</i></p>	<p>Understanding actual service uptake, identifying drop-off points, and tracking trends over time.</p>	<p>Uses real-world data to reveal actual behaviour, not only self-reports, often already available, and cost-effective for longitudinal trends.</p>	<p>Data may be incomplete, outdated, or inconsistently recorded — may not include reasons why behaviours occur.</p>

Use the following considerations to help assess which methods are likely to work best for the context, population, and topic of interest:

- **Research goals and the nature of inquiry**
 - Is the goal to understand why something is happening (exploratory), or how often it occurs (descriptive)?
 - Is the aim to uncover deep motivations, beliefs, and decision-making processes — best suited to qualitative methods — or to identify broad patterns and trends across a population, which may require quantitative approaches?
 - Will behaviours be observed in context, or will teams rely primarily on self-reported accounts of beliefs and experiences?
- **Participant characteristics**
 - Are participants likely to feel safe and comfortable speaking openly about the topic? For sensitive issues, such as gender-based violence or reproductive health, individual interviews may be preferable to group settings.
 - Are there language, literacy, or accessibility considerations that could affect participation?
 - Would participants be more at ease in group discussions, or would they engage more freely in one-on-one interactions?
- **Cultural and contextual relevance**
 - Are there locally resonant methods that may yield deeper insights? For instance, participatory storytelling, transect walks, or visual mapping exercises may feel more natural and engaging than structured interviews in some communities.
 - Could certain methods inadvertently reinforce existing power dynamics (e.g., formal interviews conducted by government officials or outsiders)?
- **Sensitivity of the topic**
 - How emotionally or socially sensitive is the topic at hand? Topics involving stigma, trauma, or personal loss often require private, trauma-informed approaches.
 - Does disclosure carry risks for participants, and if so, how can protective environments be created?
- **Need for comparability and standardization**
 - Is there a requirement to generate standardized or comparable data across time, populations, or geographies? In such cases, validated tools such as the BeSD survey on vaccine hesitancy may be appropriate.
 - Alternatively, is open-ended, exploratory data required to identify new insights, surface unanticipated dynamics, or refine behavioural hypotheses?
 - It may be helpful to consult a research specialist to select the right mix of methods and ensure the study design is both feasible and rigorous. UNICEF has different teams that could provide support, such as the BIRD Lab and UNICEF Evaluation.

Bridging the gap between reported and actual behaviour

Data collection often relies on what individuals say — namely, their beliefs, experiences, and self-reported behaviours, but it is critical to recognize the limitations of this. Behavioural science reminds us of two critical truths: what people say is not always what they do, and human memory is fallible and often biased.

Consider a relatable example from everyday life: how much movement we get on a daily basis. A meta-analysis³ comparing self-report surveys of sedentary time with device-measured data (like accelerometers) found that people underestimated sitting time by an average of ~1.7 hours per day, even when asked in simplified formats. The largest gaps appeared when surveys relied on single-item questions such as “How many hours do you sit on a typical day?”, showing how simple self-reports can systematically miss the mark. More detailed formats like time-use diaries or multi-item questionnaires reduced but did not eliminate the bias. These limitations do not imply that participants are intentionally deceptive, but cognitive processes, emotional states, and social dynamics influence recall, interpretation, and communication.

As researchers and practitioners, it is necessary to approach self-reported data with thoughtful rigour, designing research to both respect participants’ perspectives and compensate for these inherent constraints. Common challenges associated with self-reported data include:

- **Social desirability bias.** Participants may offer responses they believe are expected, appropriate, or socially acceptable, particularly in group settings or when discussing sensitive topics.
- **Memory distortion.** Individuals often recall generalized routines or scripted behaviours rather than specific instances. As memory tends to compress repeated experiences into familiar narratives, important variations or context-specific nuances may be lost.
- **Vague or abstract responses.** Without deliberate prompting, participants may default to broad or conceptual answers, reflecting general attitudes rather than concrete behaviour. While such responses

can offer valuable perspective, they may have limited utility when seeking to design interventions grounded in specific behavioural drivers.

By recognizing these patterns, it is possible to effectively tailor research instruments and facilitation techniques, ensuring that the data collected is not only meaningful and respectful but also behaviourally credible and practically useful. This can be achieved by:

- Strengthen inquiry through thoughtful question design that elicits richer and more reliable data:
 - Anchor responses in time: Reference specific timeframes (e.g., “In the past week...” or “Yesterday...”) to aid memory and prompt more accurate recall.
 - Specify context and behaviour: Ground questions in concrete scenarios and observable actions. For example, “What did you do at the clinic?” is more illuminating than “Do you usually attend check-ups?”
 - Prioritize first-hand experiences: Frame questions around what the respondent personally did, rather than what they believe others did.
 - Follow with emotional and motivational probes: Once a behaviour is identified, explore underlying drivers such as feelings, beliefs, or intentions.
 - Avoid leading language: Pose questions in a neutral way rather than planting responses. For example, “What have you heard families say about vaccination” can yield more candid responses than asking “Do most families disapprove of vaccination?”
- Adapting approaches for sensitive or traumatic topics. When exploring highly personal or potentially distressing issues, it is critical to create a supportive environment and apply trauma-informed techniques:
 - Avoid direct disclosure: Participants may feel more comfortable engaging through hypothetical scenarios or third-person narratives.

³ Prince, S.A., Cardilli, L., Reed, J.L. et al. A comparison of self-reported and device measured sedentary behaviour in adults: a systematic review and meta-analysis. *Int J Behav Nutr Phys Act* 17, 31 (2020). <https://doi.org/10.1186/s12966-020-00938-3>

- Use vignettes or visual stimuli: These tools can help depersonalize the conversation, reduce the emotional burden, and spark thoughtful reflection.
- Ensure facilitator preparedness: Those conducting the research should be trained to foster a space that is respectful, empathetic, and free of judgment — particularly when discussing stigmatized or vulnerable experiences.
- Complementing self-reported data with other methods. To further strengthen the behavioural validity of our insights, we can triangulate self-reported data with additional approaches:
 - Direct observation: Observing behaviours within their natural context can reveal patterns or inconsistencies not easily captured through verbal reporting.
 - Participant journaling: Encouraging respondents to record their experiences — via written logs, voice notes, or digital diaries — can yield more immediate and authentic reflections.
 - Repeated engagement: Where feasible, brief follow-ups via SMS, phone calls, or subsequent visits can help capture changes over time and verify earlier responses.

By designing research with these strategies in mind, both the ethical integrity and analytical strength of inquiry is enhanced.

3. Build the research plan

Using the Primary Research Plan worksheet, create an actionable research plan that clearly articulates what is intended to be investigated, how the research team will approach it, and why it matters. It is worth mentioning that for more complex, resource-intensive, and/or ethically sensitive research, it is highly recommended to develop a full research protocol.

The research plan serves as both a planning tool or a foundational document to develop a more in-depth research protocol that can be later used for ethical review.

Below, there are a set of guiding questions to decide whether a research plan is sufficient, or a full research protocol is needed. If the answer is “Yes” to any of these questions, developing a research protocol is highly recommended. If the answer is “Maybe” to any of these questions, a research plan might be sufficient, but it is strongly encouraged to reach out to the organization’s ethics team for further discussion. Finally, if the answer is “No” to all of these questions, a research plan might be sufficient. For additional support, it is recommended to reach out to specific evaluation teams within your organization or external research partners such as academic institutions or research firms. In UNICEF, reaching out to the BIRD Lab can be a good starting point.

TABLE 9. DECIDING BETWEEN A RESEARCH PROTOCOL OR PLAN

QUESTION	ANSWER	FURTHER GUIDANCE
<p>Will ethics review or institutional approval likely be required?</p> <p><i>(For further guidance on how to decide whether ethics review is needed, consult ‘Sub-step 5: Ethics approval’)</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<p>Research protocols are often required by an ethics board; if ethics review and approval is expected, it is recommended to develop a research protocol.</p>
<p>Will there be data collection from or about vulnerable populations (e.g., children, refugees)?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<p>Collecting data from vulnerable populations requires ethical approval. Some exceptions can be made if (a) the organization routinely collects data from vulnerable populations, (b) the research is part of its regular and existing processes and programmes, and (c) if the project is not going to be part of an academic publication.</p>
<p>Will the research involve collecting personal, sensitive, or health-related information?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<p>Collecting sensitive data and information requires ethical approval.</p> <p>It is important to highlight that all sensitive information will require to be anonymized and have informed consent from participants.</p>
<p>Will the research involve audio, video, or image recordings of participants?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	<p>Audiovisual recordings are personally identifiable data. Collection of personally identifiable data for research generally requires ethical review.</p>

(Table continues on following page)

QUESTION	ANSWER	FURTHER GUIDANCE
Will the research findings be submitted for academic publication or formal dissemination?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	If the primary aim of the academic article is to present research findings, a formal research protocol will likely be required. However, if the research is formative and the article focuses more on describing an intervention or proposed solution, a research protocol may not be necessary — though it is still recommended.

To build a primary research plan or research protocol (if needed), make sure to include:

- a. Research objectives:** Return to the research objectives developed using the COM-B model in Step 2, and reflect on what to explore.
- b. Research questions:** Return to the research questions developed in Step 2 using the COM-B model. These questions translate each objective into focused lines of inquiry. Paired with objectives, these questions form the foundation of the research plan, guiding the selection of methods, the type of data to collect, and the approach to analysis. It is important to note that each objective may have multiple research questions.
- c. Research participants:** Identify the key population groups whose perspectives are essential to answering the established research questions. This includes not only the primary group whose behaviour is in focus, like caregivers, but also those who influence or enable the behaviour, such as family members, health workers, or community leaders. Revisit the Stakeholder and Audience Map worksheet from the Define phase. It is also important to note that the information gathered about the target population will be used as input to develop the Behavioural Profile tool in Step 5 of this phase (Analyse and Synthesise Findings). Be specific about:
 - Who to engage
 - How many participants from each group
 - What variation to capture (e.g., by gender, age, location, or social status)

Documentation of meaningful consent is required when engaging participants in research activities. Meaningful consent entails that participants

are informed of the purpose of the activity, how it will be conducted, how their data will be used, and any potential risks. For more about informed consent see childethics.com.

Apply an intersectional lens to understand how different aspects of identity, such as gender, age, disability, or refugee status, shape people’s experiences. Consider who may be excluded or silenced in typical research modes, and take actionable steps to include them. For example, when studying childhood vaccination, refrain from assuming that mothers are the only decision-makers or clinic-goers: fathers and grandparents may also play a key role.

To uncover these dynamics, ask:

- Who does what?
- Who has what?
- Who decides?

- d. Sampling:** The next step is determining how to identify and engage these individuals. Sampling is the process of selecting a subset of individuals from a broader population to participate in the research. The quality, relevance, and inclusiveness of findings are shaped by the sampling decisions made at this stage. There are a range of sampling strategies, each with distinct advantages and limitations, depending on the research context, objectives, and constraints. It is important to align the sampling strategy with the type of research that will be conducted.

The following table summarizes some of the most commonly used sampling strategies, what they are most suitable for, when to use them, and their strengths and limitations.

TABLE 10. SAMPLING STRATEGIES

SAMPLING STRATEGY	MOST SUITED FOR	STRENGTHS	LIMITATIONS	WHEN TO USE
<p>Simple random sampling is like drawing names from a hat. Every person in the group has an equal chance of being picked. For instance, if there’s a list of all parents in a district, selecting 100 of them at random to ask about their children’s vaccination status uses this method.</p>	<p>Quantitative research. Ideal for surveys or experiments needing statistical inference. Rare in qualitative research.</p>	<p>This method is fair and unbiased because everyone has the same chance of being selected. It helps to create results that represent the whole population.</p>	<p>This strategy requires a complete and accurate list of the population, which can be hard to attain in some areas.</p>	<p>Use when a complete list of the population is available, and the goal is to get a representative view of the whole group.</p>
<p>Systematic sampling selects every n^{th} person from a list, after starting at a random point. For example, export the clinic’s eligible caregiver list ($n=600$) to a spreadsheet. Assign each record a random number and sort by that number. Pick a random start between 1 and 20, then select every 20th record to recruit $n\approx 30$.</p>	<p>Quantitative research. Easier than random sampling, still supports generalization. Can be used in qualitative research but rarely preferred.</p>	<p>This method is simpler than random sampling and still reduces bias, if the list is ordered randomly.</p>	<p>Similar to simple random sampling, this strategy also requires a complete and accurate list of the population.</p>	<p>Use when there is a well-organized list, and a simpler alternative to full random sampling is needed.</p>
<p>Cluster sampling is employed when it’s difficult to reach every individual. The population is divided into groups (e.g., neighbourhoods or health districts) and a few of these groups are randomly chosen. Everyone within the chosen groups is then included. For instance, selecting three districts and interviewing all caregivers located there about vaccines.</p>	<p>Mainly quantitative research. Useful for large, geographically spread populations in surveys. Can work in qualitative research when entire settings (e.g., clinics or schools) are studied.</p>	<p>This method saves time and resources, especially in large or spread-out areas.</p>	<p>This method may give inaccurate results if the selected groups are very different from others that were not chosen.</p>	<p>Use when studying large or spread-out populations, where it’s impractical to reach everyone individually.</p>

(Table continues on following page)

SAMPLING STRATEGY	MOST SUITED FOR	STRENGTHS	LIMITATIONS	WHEN TO USE
<p>Proportionate stratified sampling splits people into smaller groups (strata) like age, gender, or location, and selects participants in the same proportion as they appear in the whole population. For example, if 60% of caregivers live in urban areas and 40% in rural ones, the sample will reflect those proportions.</p>	<p>Both. Great for comparing groups quantitatively; may be used in qualitative research if diversity across strata is a goal.</p>	<p>This strategy ensures that key groups are represented fairly, improving the accuracy of the results.</p>	<p>This strategy requires detailed population information to divide people into the right groups.</p>	<p>Use when it's important to reflect the natural make-up of different groups within the population.</p>
<p>Disproportionate stratified sampling also splits people into strata, but it intentionally selects more people from certain groups (usually smaller or more important ones). For instance, it may focus more on rural caregivers in areas with low vaccination rates, even if they're a small part of the population.</p>	<p>Both. Great for comparing groups quantitatively; may be used in qualitative research if diversity across strata is a goal.</p>	<p>This method allows researchers to focus on important but small groups, helping uncover detailed insights.</p>	<p>This method can create bias in the overall results and could require adjustments to make the sample more balanced.</p>	<p>Use when certain subgroups are small but important to the research and need further representation in the sample.</p>
<p>Convenience sampling picks people who are easiest to reach and willing to participate. For example, interviewing caregivers who visit a vaccination clinic during a study period.</p>	<p>Qualitative research. Often used in early-stage or exploratory studies. Not ideal for inference, but extremely practical.</p>	<p>This method is quick, low-cost, and easy to carry out, making it useful when time or access is limited.</p>	<p>This method may not give a balanced view and results often cannot be applied to the general population.</p>	<p>Use in quick, early-stage, or low-resource research where easy access to participants is needed.</p>
<p>Judgmental purposive sampling selects people who are especially knowledgeable or relevant to the topic, based on the researcher's expertise. For instance, choosing experienced health workers in high-risk areas to discuss vaccine hesitancy.</p>	<p>Qualitative research. Classic in-depth qualitative method—targets key informants with relevant insights.</p>	<p>This method helps to gather rich, relevant insights from people with direct knowledge or experience.</p>	<p>This strategy may reflect the project team's personal bias in choosing participants.</p>	<p>Use when specific, knowledgeable people are best suited to answer the research questions.</p>

(Table continues on following page)

SAMPLING STRATEGY	MOST SUITED FOR	STRENGTHS	LIMITATIONS	WHEN TO USE
Quota purposive sampling ensures a certain number of people from specific categories are included. For example, selecting an equal number of mothers and fathers to study gender differences in vaccine decisions.	Qualitative research. Ensures minimum variation (e.g., gender, age); common in focus groups or small-scale interviews.	This method guarantees that certain types of people are included, even without a full population list.	This method may still introduce bias if individuals that are easiest to find are not representative within the broader group.	Use when it's necessary to ensure a specific mix of participant types, without needing a full list of the population.
Snowball sampling starts with a few participants who then refer others. This method is helpful for finding people who are difficult to reach. For example, beginning with one parent who is hesitant about vaccines, and asking them to refer others they know.	Mainly qualitative research. Best for hidden or hard-to-reach populations. Can also work in mixed methods.	This method helps find and include people who are otherwise difficult to identify or reach.	This method can lead to biased results, as individuals often refer others who are similar to themselves.	Use when studying hard-to-reach populations that are connected through social networks.

The choice of sampling strategy should be guided by the nature of the research questions, available resources, the sensitivity of the subject matter, and the accessibility of different population groups. In many cases, a mixed approach may be most appropriate — for example, using purposive sampling to ensure the inclusion of key subgroups, alongside snowball sampling, to access individuals who may not be reached through conventional recruitment channels.

- e. **Research methods and tools:** This section should describe the chosen data collection approaches and the reasoning behind them. Each method should be selected based on its

relevance, feasibility, and fit with the context and participants. See Table 8 for guidance on selecting an appropriate research method. Clearly document methodological choices to strengthen the credibility of the research.

- f. **Data collection materials:** It's important to prepare the right materials for effective and ethical data collection. These materials should be tailored to the selected method and adapted to the context, accounting for factors like language, literacy, cultural norms, and accessibility. Table 11 on the following page offers a summary of common materials needed for different research methods:

TABLE 11. DATA COLLECTION MATERIALS BY METHOD TYPE

METHOD	MATERIALS NEEDED
In-depth interviews (IDI)	<input type="checkbox"/> Interview guide aligned with research questions <input type="checkbox"/> Audio recorder or transcription tool <input type="checkbox"/> Note-taking template <input type="checkbox"/> Informed consent forms
Focus group discussions (FGD)	<input type="checkbox"/> FGD discussion guide <input type="checkbox"/> Visual prompts or handouts, if needed <input type="checkbox"/> Flipchart/markers, if needed <input type="checkbox"/> Audio recorder or transcription tool <input type="checkbox"/> Note-taking template <input type="checkbox"/> Informed consent forms
Field observations	<input type="checkbox"/> Structured observation checklist or open-ended template <input type="checkbox"/> Contextual map or site layout, if needed <input type="checkbox"/> Discreet note-taking materials <input type="checkbox"/> Observer script (if applicable) <input type="checkbox"/> Consent or ethical protocol (if disclosed)
Mystery user	<input type="checkbox"/> Mystery user script/scenario <input type="checkbox"/> Evaluation checklist <input type="checkbox"/> Debrief form <input type="checkbox"/> Consent and ethical protocol
Surveys (digital or paper)	<input type="checkbox"/> Survey instrument (translated/adapted as needed) <input type="checkbox"/> Data collection platform (e.g., KoboToolbox, ODK) <input type="checkbox"/> Tablets or phones (if digital) <input type="checkbox"/> Printed survey questionnaire (if paper) <input type="checkbox"/> Enumerator script <input type="checkbox"/> Informed consent forms
Social network mapping	<input type="checkbox"/> Mapping tool or template <input type="checkbox"/> Prompt questions to identify influencers and relationships <input type="checkbox"/> Drawing supplies and large paper (or digital whiteboard, if interactive)
Service or administrative records	<input type="checkbox"/> Formal agreement or written permission from the data owner (e.g. Ministry of Health, school administrator) to use the data <input type="checkbox"/> Data dictionary or metadata (if available) to understand how variables are defined and recorded

g. Timeline: Develop a realistic, structured timeline to guide planning, data collection, and preliminary analysis. This should outline the duration and sequencing of activities, while accounting for logistical needs, potential delays, national holidays, and other context-specific constraints. The timeline should include:

- Finalization of research tools
- Time for obtaining all necessary field work approvals
- Ethical review (if required)
- Enumerator training
- Pilot testing
- Data collection periods (by location or target group)
- Time for transcription, translation, and data cleaning
- Preliminary and final analysis
- Check-ins, debriefs, or validation sessions with stakeholders
- Buffer periods and anticipated disruptions

A well-structured timeline serves as a shared reference point and encourages alignment across teams and stakeholders. The example below offers a basic template teams can adapt to fit the scope and complexity of their research:

Activity	Status	W1	W2	W3	W4	W5	W6	...	Lead/Owner
Finalize research tools	Done								Research manager
Obtain field work approvals	In progress								Field coordinator
Enumerator training	Not started								Research manager
....									

h. Roles and responsibilities: Delineate clear roles and responsibilities for each phase of the research process to ensure efficient coordination and accountability. This includes identifying team members responsible for data collection activities, as well as those managing logistics, documentation, analysis, and stakeholder engagement.

For example, a locally based facilitator may be tasked with coordinating field-level implementation and participant engagement, while the central research team oversees tool refinement, quality assurance, and data synthesis. Where external partners or consultants are involved, their contributions should also be clearly defined.

It is also helpful to assign one focal person responsible for quality assurance and troubleshooting across all data collection sites. This role serves as a key link between field teams and the central research team.

i. Ethical Considerations: The project team is responsible for upholding ethics principles for all research involving people, regardless of whether independent ethics review is mandated. In this section, outline how the proposed research will reflect ethics principles for evidence activities. For UNICEF, all activities should be screened through the lens of the “best interests of the child”, and specifically reflect principles of benefit, do no harm, respect, fairness, accountability and integrity. This should include undertaking a preliminary risk assessment and developing a risk mitigation plan to address each identified risk, as well as consideration of standards such as how privacy will be maintained, how to ensure informed consent, and what measures may be required to safeguard participants.

4. Build research tools

With the research plan or protocol in place, the next step is to build the specific tools and materials needed to gather high-quality data. These include instruments such as interview guides, focus group discussion guides, surveys, and observation templates, each designed to capture different types of behavioural insights.

- a. Start by selecting which tool need to be developed based on the selected research methods. See Table 8 for guidance on selecting a research method.

Table 12 summarises commonly used primary research tools, typical use cases, relevance to behavioural research, and relevant resources that offer inspiration or detailed guidance for developing similar tools. This is a non-exhaustive list; these tools are intended as starting points and should be adapted to reflect the specific behaviour, context, and population of interest.

TABLE 12: RESEARCH TOOLS

TOOL	RELEVANT RESOURCES
Survey	<ul style="list-style-type: none"> • WHO/UNICEF (2022), Behavioural and Social Drivers of Vaccination (BeSD) (incl. Childhood Vaccination Survey for Caregivers) • UNICEF (2018), Measuring Social and Behavioural Drivers of Child Protection Issues: Guidance Tool (incl. FGM/C and Child Marriage Standardized Surveys) • J-PAL, Survey Design
In-depth interview guide	<ul style="list-style-type: none"> • Pathfinder International (2001), Conducting In-Depth Interviews: A Guide for Designing and Conducting In-Depth Interviews for Evaluation Input • The Behavioural Insights Team (2022), Explore Field Guide: A practical tool to map and unpack behaviour
Focus group discussion guide	<ul style="list-style-type: none"> • Nyumba et al. (2018), The Use of Focus Group Discussion Methodology: Insights from Two Decades of Application in Conservation • The Behavioural Insights Team (2022), Explore Field Guide: A practical tool to map and unpack behaviour
Observation checklist	<ul style="list-style-type: none"> • The Behavioural Insights Team (2022), Explore Field Guide: A practical tool to map and unpack behaviour
Mystery user guide	<ul style="list-style-type: none"> • Ipsos (2020). Mystery Shopping: Seven Steps to Designing a Better Mystery Shopping Programme
Participatory activities <i>for use in IDIs and FGDs – for example, but not limited to: Cards sort, vignettes, day in the life, choices map, mind and body mapping, gender boxes, social network mapping</i>	<ul style="list-style-type: none"> • UNICEF (2019), Everybody Wants to Belong: A Guide to Tackling and Leveraging Social Norms in Behaviour Change Programming • UNICEF (2020), Participatory Research Toolkit for Social Norms Measurement • UNICEF/First Hand, Rapid inquiry in the HCD4health toolkit

b. Next, design the tools. Pay careful attention to how instruments are structured and how questions are framed, in order to elicit relevant, honest, and useful responses. Keep these suggestions in mind:

- **Structure questions around observable behaviours, decisions, and experiences.** For example, replace “Do you know how to keep your baby healthy?” with “Can you walk me through what you usually do to keep your baby healthy?”.
- **Add questions that explore participants’ lives** beyond the immediate behaviour of interest. Understanding daily routines, priorities, challenges, aspirations, and social relationships can reveal contextual factors that shape behaviour and will inform the development of Behavioural Profiles ‘(see’ Step 5: Analyse and synthesise findings’).
- **Use culturally resonant and accessible language.** Replace technical terms like “complementary feeding” with more colloquial language such as “Which foods did you give your baby, besides breastmilk?”
- **Order prompts in a sequence that is logical and builds trust.** Start with non-sensitive, descriptive questions, such as “Can you describe a typical day with your child?” before progressing to personal or emotionally charged topics — for example, “Have there been times when you worried about your child’s health?”
- **Avoid leading or judgmental phrasing that could bias responses:**
 - In qualitative research, avoid questions framed as “Why didn’t you...” Instead, consider “What are some things that might make it difficult to...?”.
 - In quantitative research, use neutral Likert scale statements, as opposed to asking yes or no questions that imply a “right” answer (e.g., “Do you trust vaccines?”). For example, “I feel confident that vaccines recommended by health workers are

safe,” with responses organized by a scale of strongly agree, agree, neutral, disagree, and strongly disagree.

- **Incorporate probes, visual aids, or examples if needed.** For example, if inquiring about influences on decision-making, use a card sorting activity, or show images of common influencers (e.g., grandparents, religious leaders, health workers) and ask participants to explain who they listen to and why.
- c. Facilitators and/or enumerators play a critical role in shaping how participants engage with the tools. Their ability to build trust, introduce activities clearly, and navigate sensitive topics with empathy can significantly influence the quality and depth of responses. Support these individuals through practical training to ensure consistency and reinforce ethical, respectful data collection.
- d. Where possible, pilot tools informally with a few participants before a full rollout. This helps to surface confusing questions, adjust flow or language, and improve the overall clarity of research tools.

5. Ethics approval

Upholding ethics principles and standards is the responsibility of everyone involved in a research activity. For some activities an independent ethics review is required for assurance that the research design is appropriate and a thorough risk assessment has been completed.

Ethical review processes generally examine how participants are recruited; how data is collected, managed and stored; and how participants are supported after data collection concludes. For instance, ethics review boards will ensure that informed consent forms are written in clear, culturally appropriate language and conveyed in a way that ensures genuine understanding.

Drawing on standards elaborated in the **Belmont Report**⁴ and Declaration of Helsinki, UNICEF's ethical principles guide decision-making across the project lifecycle to protect participants and communities. The key principles are:

- **Benefit:** Evidence generation must have a clear purpose that directly benefits communities while minimizing harm. Activities should be necessary and useful, prioritizing secondary data where appropriate.
- **Do No Harm:** A risk-informed approach must be employed to prevent harm, with a focus on children's best interests. Risk assessments, safeguarding plans, and data protection measures are essential to mitigating potential harm.
- **Respect:** Evidence activities should honor participants' dignity and well-being, ensuring informed consent, minimizing power imbalances, and protecting privacy. Localization and participatory approaches are encouraged, engaging stakeholders meaningfully and respectfully.
- **Inclusion:** All activities should be non-discriminatory, offering inclusive participation. Local expertise and contributions should be acknowledged, with careful consideration of biases and accessibility.
- **Fairness:** The burden and benefits of evidence activities should be balanced, with appropriate compensation for participants and sensitivity to cultural and community dynamics. Equity in outcomes and implementation is essential.
- **Integrity:** Adherence to UNICEF's core values and professional standards is critical. Conflict of interest must be managed, and project partners held accountable for maintaining ethical standards.
- **Accountability:** There must be clear accountability for decisions and actions throughout the project lifecycle. This includes transparent reporting of harms, continuous learning, and ethical publication of findings.

These principles emphasize a proactive, thoughtful approach to ethical compliance, ensuring that the rights and dignity of children and communities are protected throughout evidence activities.”

4 U.S. National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Washington, DC: U.S. Government Printing Office, 1979), <https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html> (accessed June 19, 2025).

Behavioural research often requires engaging directly with individuals to understand their lived experiences, perceptions, and behaviours. Even when such engagement is not inherently sensitive, it may touch on deeply personal issues or involve vulnerable groups. For example, primary research on childhood vaccination may involve asking caregivers about trust in health services, past trauma, or difficult family dynamics—eliciting sensitive information even if unintentionally. In studies that involve sensitive topics, it may also be necessary to provide participants with a debrief or referral to relevant support services.

To determine whether formal ethics review (e.g., via an Institutional Review Board or national ethics committee) is required, teams should reflect on the following questions:

- Is the data being collected from or about people?
- Is the data identifiable (e.g., names, photographs, voices, or other traceable attributes)?
- Are any participants considered vulnerable (e.g., minors, displaced persons, survivors of violence, individuals with disabilities)?
- Does the research address sensitive topics (e.g., reproductive health, mental health, violence, illegal activity)?
- Could participation result in harm, distress, stigma, or legal or social risk?
- Will findings be shared externally (e.g., in donor reports, public presentations, or academic journals)?

If the answer to one or more of these questions is yes — or if there is uncertainty — teams should consult a local ethics advisor or board. Even when formal approval is not mandated, a clearly defined internal ethics protocol should still be established to ensure informed consent, confidentiality, and participant protection.

See Table 13 on the following page for additional resources on ethical research.

TABLE 13. ETHICS RESOURCES

NAME	WHEN TO USE IT	SOURCE
UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis	To better understand procedures that establish minimum standards for UNICEF evaluations and ensure ethical oversight and accountability.	UNICEF
Ethical Considerations When Applying Behavioural Science in Projects Focused on Children	To better understand how the ethical behavioural science principles apply to projects that impact children. There is also a decision-support checklist for practitioners. The tool guides practitioners through key ethical decision points during an applied behavioural science project, and supports practitioners to identify when other perspectives may be needed.	UNICEF
Revised Common Rule Consent Forms	Guidance and templates for oral consent, remote consent (for studies conducted over the phone, for example), minors, etc. There is also a “basic elements of consent forms” checklist that is useful to review when creating consent forms for the primary research stage.	Johns Hopkins University
Basic course on Ethical Principles and Standards for Evidence Activities Involving People	This course presents ethics principles and standards for evidence activities, including practical examples.	UNICEF
IRB Research Plan for New Data Collection	Use it as a reference template when drafting a research protocol for any ethics or IRB submission, making sure to adapt it to your institution’s forms and rules.	Johns Hopkins University
Research Plan Instructional Guide	Aids in explaining what an ethics review board will look for when reviewing a research plan.	Johns Hopkins University

CASE STUDY:

Increasing childhood vaccination uptake in Lebanon

The Research Plan and Research Protocol were not developed by the original project team. They are recreated examples based on real project data and context.

Plan the research and develop a Research Protocol, including ethics IRB approval

Now that the project team was equipped with a strong understanding of the desired behavioural outcome — along with the key research objectives and questions — the project team formalized their research plan. Considering it was a sensitive topic that involved engaging with vulnerable populations (e.g., Syrian refugees), the project team decided to also develop a more comprehensive research protocol, based on the research plan.

For each of their research questions, the team determined the individuals required for conducting

research, along with the appropriate research tools best suited for gathering information.

To support decision-making around participant sampling and research methods, the project team considered key constraints like time, budget, and potential behavioural biases that could have impacted the quality of their findings. They decided on a mixed-methods approach of qualitative and quantitative research, in addition to the recruitment of participants with a direct experience of vaccination services, and other key stakeholders.



DEPTHS TOOLKIT

Primary Research Plan CASE STUDY 1: INCREASING CHILDREN IMMUNIZATION RATES IN LEBANON

Pull the objectives and questions from previous activity and build on it to get to the primary research plan.

What to explore?

1. **Capability:** To identify caregivers' knowledge of gaps about the vaccine schedule and health worker communication.
2. **Opportunity:** To understand structural, logistical and social barriers to timely vaccination.
3. **Motivation:** To explore beliefs, emotions and trust factors influencing caregivers' intent to vaccinate on time.

What to ask?

1. What factors prevent caregivers from completing their children's vaccination schedules on time, even after a referral?
2. How do frontline health workers and outreach staff communication about follow-up appointments, and what barriers affect this communication?

Who?

1. **Primary participants:** 20-24 caregivers of under-/unvaccinated children
2. **Secondary participants:** Outreach workers (8-10), PHC staff (6-8), PHC managers and district health authorities (4-6), community leaders (4-6), MoPH stakeholders (4)

Sampling method: Purposive sampling to ensure representation; snowball sampling to reach undocumented or mobile refugee households. Variation captured: Gender, nationality, location, transportation access, outreach exposure

How?

1. In-depth interviews with caregivers, PHC staff and outreach workers to explore beliefs and motions.
2. Focus group discussions with community leaders and caregivers to uncover norms and collective experiences.
3. Structured observations of clinic visits and outreach interactions to observe real-world dynamics

When?

- Tools development and piloting: September 2017
- Fieldwork: September - December 2017
- Preliminary analysis: January 2018
- Stakeholder debrief and revision: February 2018
- Planning for prototyping: February - May 2018

Materials

Recording and note-taking equipment, including audio recorders. Accessibility and language aids, such as translated materials, visual cards for low-literacy participants

Roles and responsibilities

Project Lead (oversight, protocol review, partner coordination); Field Coordinator (recruit and manage facilitators); Research Assistant (transcribe, clean and code data); Arabic Translator (translate tools and transcripts)

Ethical considerations

IRB approval required
Protection of vulnerable populations: Special care for refugee households
Equity and inclusion: Prioritize hard-to-reach groups.

Overall, the Research Plan and Protocol proved to be critical throughout the project, helping the team to:

- Agree and align on their research plan
- Ensure there was clear documentation of their processes and actions, including any changes in course, objectives, or approaches
- Conduct their research with vulnerable populations and children in Lebanon, acting as a supporting document for ethics approval from the IR board

Research Plan

See sample research plan on the following pages.

Note: *While an actual Research Protocol would be longer and more comprehensive in its detail, for this case study we have developed some sample content of what could have been included in the Research Protocol. Please remember this is illustrative.*

RESEARCH PROTOCOL

Date: September, 2017

Study Contacts:

Principal Investigator: All Osseiran, Lead Behavioural Scientist, Nudge Lebanon

UNICEF Country Focal Point: Joanne Yammine, SBC Officer, UNICEF Lebanon

BIRD Lab Focal Point (for Study): Benjamin Hickler, Behavioural Scientist, UNICEF, BIRD Lab

1.0 Study Title:

Using behavioural insights to increase the demand for childhood vaccination in low resource settings

2.0 Background:

Lebanon has generally maintained high immunization coverage rates, nearing 90% for most routine vaccines (Diphtheria, Tetanus, Pertussis (DTaP), Hepatitis B, Oral Poliovirus Vaccine (OPV), and Haemophilus influenzae type B (HiB)). However, a rise in poverty levels, coupled with an influx of more than a million refugee in 2011 — many of whom were missing routine vaccines posed significant challenges to the national immunization program, which provides vaccination to more than half the children residing in Lebanon.

Evidence of weakening immunization coverage rates was first detected following a measles outbreak in 2013, and a drastic rise in the cases of mumps in 2015. This was validated by a district-based cluster survey conducted in 2016. The survey revealed pockets of low immunization coverage rates in several districts, among both refugee and host community households.

As a strengthening strategy to the national immunization program, the Ministry of Public Health (MoPH) Lebanon, in collaboration with United Nations Children's Fund (UNICEF), launched an accelerated immunization activities (AIA) programme in November 2017 to provide free quality immunization services for every child through the primary healthcare system. In addition to the support offered to primary healthcare centers (PHCs), the programme employed a community-based outreach approach to (a) identify un- or under-vaccinated children, (b) educate and raise awareness of caregivers on the importance of childhood vaccination, (c) collect children's vaccination records, (d) refer children missing vaccines to the nearest participating healthcare center, and (e) follow-up with caregivers to ensure that full immunization is achieved. Raising awareness, strengthening public healthcare system, and providing access to free quality services are necessary prerequisites to facilitate and enable the uptake of childhood vaccination. However, these measures are seldom enough to ensure sufficient demand from beneficiaries.

The target sample consisted of households with children aged 0-16 years who were falling behind their routine vaccination schedule according to Lebanon's national immunization calendar. The sample included households that were previously referred to a health care centre but failed

to maintain their children's vaccination up to date (follow-up visits), as well as newly identified households with un- or under-vaccinated children (outreach visits). Households with children who were up to date with their vaccination were excluded from the trial.

3.0 Study Objective(s) and Expected Outcomes:

Despite caregivers' best intentions, evidence from years of research in psychology and the behavioural sciences on vaccine uptake point to the presence of decision biases and social influences (henceforth behavioural barriers) that impact the motivation to vaccinate. The expected outcome of this research is to identify these behavioural barriers and address them using the appropriate behaviour change techniques is critical for the success of any campaign or activity seeking to boost national immunization rates.

Following the COM-B model, the study objectives are:

Capability

- To identify caregivers' knowledge and gaps in caregivers' understanding of the vaccination schedule, including timing, number of doses, and next steps after AIA outreach visits.
- To explore whether PHC staff and outreach workers have the knowledge and confidence to consistently communicate accurate, understandable vaccination information.

Opportunity

- To understand the physical, logistical, and structural barriers (e.g., clinic accessibility, mobility constraints, service hours) that affect caregivers' ability to vaccinate.
- To examine how social norms, household dynamics, and community beliefs shape caregivers' decisions to vaccinate.

Motivation

- To explore the beliefs, emotions, and values that influence caregivers' perceived urgency or importance of completing all recommended vaccinations on time.
- To identify factors contributing to trust or mistrust in vaccination services, and how these perceptions impact motivation to act on outreach or PHC guidance.

3.1 Research Questions:

Primary Research Questions:

1. What factors prevent caregivers from completing their children's vaccination schedules on time, even after a referral?
2. How do frontline health workers and outreach staff communicate about follow-up appointments, and what barriers affect this communication?

4.0 Study Design/Methodology.

Given the complexity of vaccination behaviour, a mix of qualitative and observational method include:

Method	Purpose
In-depth interviews	To explore individual beliefs, emotional drivers, and decision-making processes related to vaccination. These will capture caregivers' personal experiences, PHC staff's communication practices, and outreach workers' perspectives.
Focus group discussions	To examine collective perceptions, social norms, group dynamics, and shared community experiences. FGDs with caregivers, leaders, and influencers will provide insights into the wider social and cultural context influencing vaccine uptake.
Structured field observations	To capture real-time interactions at PHCs and during household visits, documenting behaviours, communication styles, and systemic bottlenecks in service delivery. Observations will also provide contextual data on household dynamics and community settings.

Rationale of these methods

- Interviews will capture nuanced caregiver motivations and emotional contexts, especially for refugees who may distrust formal systems.
- FGDs will enable us to gather insights at scale and support group-based activities (e.g. community network mapping with participants). However, this method will not be used for more sensitive topics (e.g. gender norms within the refugee communities), or potential issues like discrimination at health clinics.
- Observations at vaccine clinics will document the vaccination process, including system bottlenecks or behavioural patterns not captured in verbal responses. Observations within the community will document information on the interpersonal relationships between outreach workers and caregivers, as well as community and household dynamics and living conditions.
- Where feasible, participant journaling and visual aids (vignettes or calendars) may supplement verbal recall.

Integration of Methods

The use of multiple qualitative and observational methods will enable triangulation, strengthening the reliability and validity of findings. For example, themes emerging in interviews will be compared with group dynamics observed in FGDs and behaviours documented through field observations. This layered approach ensures that both individual and systemic perspectives are represented.

4.1 Sampling Criteria and Recruitment:

Sampling Technique

A purposive sampling strategy will be applied to ensure that participants reflect the characteristics most relevant to the study objectives, particularly households with un- or under-vaccinated children. For harder-to-reach populations, especially undocumented or highly mobile refugee caregivers, snowball sampling will complement recruitment by drawing on trusted community actors and outreach teams. This mixed approach will maximise diversity while ensuring access to populations at heightened risk of incomplete vaccination.

Inclusion Criteria

- Caregivers (mothers, fathers, grandparents, or other guardians) of children aged 0-6 years who are un- or under-vaccinated according to Lebanon's national immunization calendar.
- Households that were previously referred to a PHC but failed to complete vaccination schedules, as well as newly identified households with missed doses.
- Outreach workers, PHC staff, PHC managers, community leaders/influencers, and Ministry of Public Health (MoPH) representatives directly involved in vaccination demand and delivery.

Exclusion Criteria

- Households where children are fully up to date with vaccinations.
- Caregivers who are unwilling or unable to provide informed consent
- Individuals under the age of 18, unless participating as caregivers of younger siblings and with guardian consent.

Sample Sizes and Rationale

The sample sizes are designed to balance depth and breadth: large enough to capture variation across refugee and host populations, while remaining feasible within the project timeframe.

Primary participants (caregivers):

20-24 caregivers across seven districts. This sample is sufficient to reach thematic saturation in qualitative interviews, while allowing variation by gender, nationality, geography, and household

mobility.

Secondary participants:

- 8-10 outreach workers (to explore household engagement practices).
- 6-8 PHC nurses and staff (to capture communication strategies at service delivery points).
- 4-6 PHC managers/district-level health authorities (to understand system-level challenges).
- 4-6 community leaders or influencers (to capture community and normative influences).
- 4 MoPH stakeholders (to reflect policy-level perspectives).

Variation to Capture

Recruitment will aim to ensure diversity across:

- Gender (mothers and fathers as decision-makers).
- Nationality (Syrian refugees, Lebanese host communities, and other minority groups where present).
- Geography (urban vs. peri-urban districts).
- Mobility (households with and without access to transport).
- Exposure (households previously visited by outreach workers vs. those not reached). This variation will allow the study to map behavioural barriers and enablers across different household types and community contexts.

Recruitment Procedures

Participants will be identified in collaboration with PHCs, outreach workers, and community-based organisations. Outreach staff will provide referrals to eligible households, and snowball techniques will be used where initial access is limited. Recruitment will emphasise voluntary participation, with clear communication that refusal will not affect access to services.

4.2 Consent/Assent

Informed consent: All participants will be provided with an overview of the study, including purpose, confidentiality, and their right to withdraw. Participants will be asked to sign a consent form or provide recorded verbal consent.

4.3 Methods of Data Collection:

This study will employ a combination of qualitative and observational methods, each carefully matched to the research questions and designed using behavioural insights best practices. The

primary methods include semi-structured interviews, focus group discussions (FGDs), and structured observations in both community and healthcare facility settings.

Data Collection Methods and Tools

- **Semi-structured interviews:** One-on-one interviews with caregivers, PHC staff, and outreach workers will be conducted using COM-B aligned guides. These guides will probe knowledge, opportunity, and motivational factors, while allowing flexibility to capture nuanced beliefs, emotions, and decision-making processes.
- **Visual prompts and vignettes:** To support recall and depersonalise sensitive issues (e.g., mistrust, shame, fear), visual materials and hypothetical vignettes will be incorporated into interview and FGD tools. These approaches reduce social desirability bias and make participation more engaging, especially for low-literacy participants.
- **Focus group discussions (FGDs):** FGDs will be conducted with community leaders, caregivers, and influencers to capture shared experiences, social norms, and group dynamics. Facilitation guides will ensure consistency across groups, with built-in exercises (e.g., community mapping) to encourage interactive dialogue.
- **Structured observations:** Field researchers will use observation checklists to systematically document PHC interactions (e.g., communication at registration and vaccination points) and outreach household visits (e.g., referral processes, family responses, social dynamics). Photos and short video recordings may be taken to capture contextual details, with participants' consent, and all images will be anonymised before analysis.

Data Collectors

Research activities will be implemented by trained facilitators sub-contracted by Nudge Lebanon and UNICEF Lebanon. These facilitators will include both male and female researchers to enable culturally sensitive engagement with diverse participants. All field researchers will sign confidentiality agreements and adhere to safeguarding protocols.

Training and Capacity Building

To ensure correct and consistent application of the methodology, all data collectors will undergo a structured training process. Three in-person workshops will be held at least one week prior to fieldwork. Training will combine:

- Theoretical components (study objectives, behavioural science framing, safeguarding, and informed consent procedures).
- Practical exercises (role-play of interviews and FGDs, mock observations, use of visual prompts and checklists).
- Safeguarding orientation (how to handle disclosures of distress, sensitive issues, or safeguarding concerns in line with UNICEF's protocols).

Supervision and Quality Assurance

- **Daily debriefings:** At the end of each research day, virtual debrief sessions will be held with field researchers and the project team to review emerging findings, identify challenges, and reinforce adherence to protocols.
- **Spot checks:** Senior researchers from Nudge Lebanon will accompany a subset of interviews, FGDs, and observations to ensure fidelity to the guides and ethical standards.
- **Documentation:** Research guides and annotation sheets will be provided to all facilitators to capture observations consistently and to supplement audio recordings.

4.4 Data Entry and Analysis:

A thematic analysis will be conducted using the COM-B framework. Coding will be structured around capability (e.g., awareness of schedule, recall accuracy), opportunity (e.g., access, system navigation, social expectations), and motivation (e.g., fear, shame, priorities, trust in the health system). An additional tagging of behavioural profiles will identify participants with similar behaviours, demographics, beliefs, and needs. Triangulation will be used to validate self-reported behaviour with observations and facilitator notes. Comparative analyses will be conducted across refugee versus host populations and across different PHCs/districts. NVivo or Dedoose will be used for qualitative coding, and social network data will be mapped using matrix visualisations.

Data Handling Procedures

- **Transcription:** Interviews and focus groups will be transcribed in Arabic and/or French and then translated to English by trained research assistants contracted for this study. Transcribers will sign confidentiality agreements.
- **Coding:** Coding of transcripts and field notes will be conducted by members of the research team trained in qualitative methods, using NVivo or Dedoose. Double-coding will be applied to a sample of transcripts to ensure reliability.
- **De-identification:** All transcripts will be de-identified by removing names and other direct identifiers during the transcription process. Participants will be assigned unique study IDs. The key linking IDs to participant information will be stored separately on a secure server accessible only to the project team members.
- **Storage/Transfer:** Electronic data will be stored on UNICEF's secure, password-protected servers. Files transferred between team members will use encrypted channels (SharePoint). Physical field notes, if used, will be scanned, uploaded, and then stored in a locked cabinet at the local partner office.
- **Access:** Access to data will be restricted to authorised members of the study team. Each team member will use individual login credentials and the unique password to access the documents. Access rights will be granted and monitored by the principal investigator.

- **Archiving:** At the end of the study, de-identified datasets and final codebooks will be archived on UNICEF’s secure servers for the 5 years. Any personal identifiers will be permanently deleted after analysis is complete.

5.0 Data Protection and Study Participant Confidentiality

- **Data privacy:** No personally identifiable information will be recorded. The faces of people in photos and videos will be blurred.
- **Sensitive topics:** Interviews may explore emotional topics like shame, confusion, or mistrust. Trauma-informed approaches and vignettes will be used where appropriate. As many participants are considered vulnerable populations as refugees, additional care will be taken, including ethics training for researchers and providing participants with links to further follow-up psychosocial support, if needed.
- **IRB Review:** The protocol will be submitted to an institutional review board (IRB) for ethical clearance.
- **Equity:** Care will be taken to include hard to reach and underrepresented voices, particularly female-headed households or households where caregivers are not literate or digitally connected.
- **Compliance with local requirements:** All study procedures will comply with applicable data protection laws and regulations in Lebanon. Access to participant data will be limited to authorised study personnel only, and all reasonable safeguards will be taken to ensure confidentiality, in accordance with local ethical and legal requirements.

5.1 Risk Assessment and Management:

Participation in this study is considered to pose minimal risk. However, given the study’s focus on vulnerable populations such as refugees and low-income households, careful risk management measures will be put in place.

Potential Risks and Harms

- **Emotional distress:** Discussions on vaccination decisions may surface feelings of guilt, shame, fear, or mistrust of the health system.
- **Social risks:** Caregivers may fear stigma for admitting lapses in vaccination or expressing mistrust of healthcare providers.
- **Privacy concerns:** As refugees may be undocumented or marginalised, participants may worry about misuse of information or unintended disclosure.
- **Power dynamics:** Caregivers may feel pressure to participate if approached by outreach workers or community leaders.

7.0 Findings Dissemination

Findings from this study will be disseminated in a way that ensures transparency, respect for participants, and alignment with UNICEF and Ministry of Public Health (MoPH) standards.

Dissemination to Stakeholders

- Preliminary results will be presented to the MoPH, UNICEF Lebanon, and Nudge Lebanon in a joint debrief session to validate findings and refine interpretation.
- A final report will be shared with national stakeholders, including PHC managers and outreach supervisors, to inform programming decisions and potential prototype development.
- A policy brief will be prepared for decision-makers highlighting key behavioural barriers and recommendations.

Dissemination to Participants and Communities

- A simplified summary of findings will be developed in Arabic, using clear and accessible language. This will be shared through community meetings facilitated by outreach workers and community leaders.
- Where appropriate, visual posters or leaflets with key insights and recommendations (e.g., service accessibility improvements, communication messages) will be made available at participating PHCs.
- No individual or household data will be shared; only de-identified, aggregate findings will be communicated back.

Publication Rights

- The investigators retain the right to publish study results in academic or practitioner journals, subject to UNICEF and MoPH review and approval prior to submission.
- Any publication will ensure that individual participants cannot be identified, and only de-identified data will be used.
- Authorship and acknowledgement will follow internationally accepted standards, recognising the contributions of UNICEF, MoPH Lebanon, Nudge Lebanon, and the research team.

Risk Management Plan

- **Informed consent:** Participants will be provided clear, simple-language information about the voluntary nature of the study, confidentiality measures, and their right to withdraw at any time without consequence.
- **Safeguarding training:** All facilitators and research staff will undergo training on safeguarding, trauma-informed interviewing, and UNICEF’s child protection protocols prior to data collection. Referral pathways: If a participant shows signs of distress, or discloses sensitive safeguarding issues (e.g., neglect, abuse, exploitation), field staff will follow UNICEF Lebanon safeguarding protocols and provide referral information to local psychosocial support or protection services.
- **Minimising distress:** Sensitive questions will be asked using vignettes or indirect framing to depersonalise experiences where appropriate. Researchers will be trained to stop or pause an interview if a participant shows discomfort. • **Privacy and confidentiality:** All data will be de-identified, and no personally identifiable information will be disclosed. Photos or videos taken for observation purposes will have faces blurred.
- **Equity safeguards:** Special attention will be given to ensuring that marginalised groups (e.g., female-headed households, illiterate caregivers) are included and treated respectfully. No group will be disadvantaged by participation.

Oversight and Monitoring

The Principal Investigator will be responsible for monitoring risks and safeguarding adherence throughout the study. Daily debriefings with field teams will include a review of any safeguarding issues or participant concerns. Any incidents will be documented, reported to UNICEF’s safeguarding focal point, and addressed promptly.

6.0 Timetable

Outline key timeline for this study (add/delete rows as needed)

ACTIVITY (e.g., pilot test tools)	WHEN (month/year)
Tool development and piloting	Sept.–Oct 2017
Training of field researchers and safeguard orientation	October 2017
Exploratory primary data collection (fieldwork in PHCs and communities)	Nov.–Dec. 2017
Transcription, translation, and preliminary analysis	Dec. 2017 – Jan. 2018
Stakeholder debrief and joint validation workshop (MoPH, UNICEF, Nudge Lebanon)	January 2018
Revision of findings	February 2018
Drafting and submission of final study report to UNICEF.MoPH	March 2018

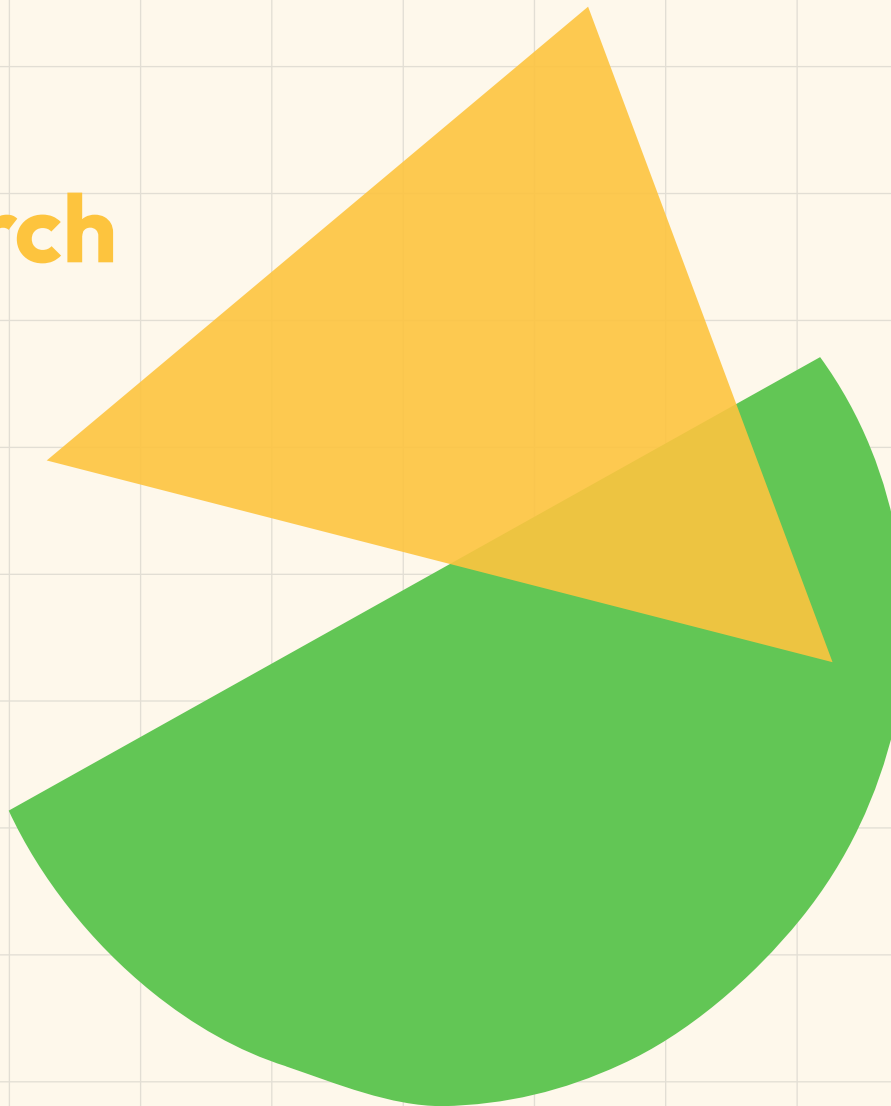


STEP 4:

Conduct the primary research

In this step:

This step entails preparing for and carrying out primary data collection in the field, including finalising logistics, training the team, recruiting participants, and implementing the research plan with rigour and flexibility.



Why it matters:

Strong fieldwork is essential for producing behavioural insights that are rich, reliable, and relevant. Without proper preparation and oversight, critical voices may be missed, data quality may suffer, and ethical risks may increase. This step ensures that the research is thoughtfully planned and sensitively conducted, to ensure inclusion, accuracy, and ethical integrity.

How to do it:

1. Prepare for field work

Before heading into the field, it's important to ensure that the research is well-planned and set up for success. Confirm the following steps and procedures are in place:

- a. Field team have clear roles and responsibilities:** Each team member should have a specific role, such as recruiter, enumerator, facilitator, translator, or note taker. When possible, matching interviewers to participants based on gender, language, or cultural background can increase comfort and trust. This is especially important when working with marginalized groups or sensitive topics. For example, mothers may prefer to be interviewed by fellow mothers.
- b. The field team is trained on tools and ethical guidelines:** All team members should be trained on the research tools, including how to use the guides, ask follow-up questions, and record responses accurately. Make sure enumerators or facilitators are trained to probe beyond the broad, high-level action the project is trying to influence (e.g., getting vaccinated), in order to uncover the smaller, often overlooked steps and decisions that shape whether a behaviour happens. For example, researchers should consider whether and how caretakers plan ahead, discuss with family, and remember appointments— smaller decisions or actions that bridge the gap between intention and follow-through. Brief the field team to listen for unexpected behavioural insights (e.g., unanticipated motivators, unusual influencers, or surprising points of friction) and record them, even if they fall outside the discussion guide. Ethical training should cover informed consent, confidentiality, respectful engagement, and handling sensitive topics and disclosures.
- c. Research participants are recruited according to the sampling strategy** (see Table 10. Sampling strategies for more detail): This may include building simple screening tools, such as a brief checklist or set of questions to confirm key criteria like age, caregiver status, geographic location, or vaccination history, to ensure participants meet the required characteristics. For example, if the study focuses on caregivers of children under five who missed routine vaccinations, the screener might ask: “Do you have a child under the age of five?” and “Has your child missed any routine immunization appointments in the past year?” Careful recruitment is especially important when aiming to include underserved or underrepresented groups.
- d. Data collection is scheduled appropriately:** Fieldwork should be scheduled with sensitivity to local routines, customs, and seasonal events. Special care should be taken to avoid clashing with work, caregiving duties, or religious observances, especially for women or other groups with limited free time.
- e. Appropriate locations are selected:** The interview or discussion setting should feel safe and comfortable for participants. Choosing the right location helps to create an environment where participants can speak openly and without fear of judgment or interruption. For example, interviews with adolescent girls may be better conducted

in schools or health centres, rather than at home where family members are present.

- f. Necessary approvals are granted:** Fieldwork should only proceed once the required permissions and approvals are in place. This may include IRB or ethics committee approval, as well as formal or informal authorization from local authorities and community leaders.
- g. Research tools are tested:** Research tools should be tested before fieldwork begins to ensure they are clear, culturally appropriate, and aligned with the research objectives.

- h. Other logistical arrangements are in place:** Teams should also confirm that materials, devices, transport, and any translation support are in place.
- i. Security and safety protocols are developed:** Before fieldwork begins, researchers should ensure all team members are aware of relevant safety procedures, especially when working in hard to reach or conflict-affected areas. This includes protocols for communication, transportation, emergency contacts, and actions to take if conditions change unexpectedly. Briefings should also cover cultural norms, local sensitivities, and any restrictions that could affect team mobility or participant comfort.

2. Collect data

Once fieldwork begins, it's important to monitor the quality of work and respect for participants. While the field team leads day-to-day interactions, the project team should provide support by promoting good practices and addressing challenges as they arise. Key best practices to reinforce with the team include:

- a. Informed consent is given by participants:** Participants must understand the purpose of the research, how their information will be used, and what their rights are. Consent can be verbal or written, depending on context. If recording audio, taking photographs, or capturing video, additional consent must be obtained specifically for those activities.
- b. Space is created for trust and openness:** The best insights often come when participants feel safe and unjudged. Team should be encouraged to take time at the start of each interaction to build rapport, explain the purpose of the work clearly, and listen with curiosity, rather than rushing through questions.
- c. Power dynamics are respected:** Field teams should be trained to recognize who holds power in group settings and adapt facilitation accordingly. In qualitative interviews, attention should be paid to gender, age, and social dynamics that may influence who speaks and how freely.

- d. Performative or expected responses are considered:** Particularly in group settings or when interviewing community members used to programme visits, participants may give answers they think are expected. Teams should be encouraged to probe gently but specifically to unpack underlying motivations or contradictions.
- e. Documenting what's not said:** Note takers and facilitators should be encouraged to go beyond quotes. Capturing tone, hesitation, body language, or contradictions can add critical context when synthesising social and behavioural data. Non-verbal cues are especially important when working across language or cultural differences.
- f. Daily debriefs are built in:** Teams should come together at the end of each day to discuss what's working, what feels off, and what unexpected themes are emerging. Debriefs are a key moment to adjust tools, refine probes, and align on what to explore further the next day.



STEP 5:

Analyse and synthesise findings

In this step:

The goal of this step is to shift from raw findings to a clear, coherent understanding of what enables, drives, or inhibits the behaviour in question.

Three different behavioural frameworks frame the analysis of the data to identify insights:

- **Behavioural Profiles** illuminate who the key actors are, what shapes their choices, and what challenges they navigate.
- **Behavioural Mapping** and **Diagnoses** trace the micro-behaviours along the pathway to behaviour, and identify barriers and enablers behind these micro-behaviours.

These tools provide the foundations for designing interventions, and will guide the solutions created in the next phase.

Associated Tools:

- [Behavioural Profile \(optional\)](#)
- [Behavioural Map and Diagnosis](#)
- [Feasibility–Impact Matrix](#)

Why it matters:

Insight doesn't come from data alone. Rather, how we make sense of this data brings findings into a coherent behavioural narrative and clarifies not only what is occurring, but why.

Critically, this step anchors the work at hand in the lived experiences of real people.

Behavioural profiles bring actors into focus. **Behavioural maps** trace the small, often unnoticed actions that make or break outcomes. And **behavioural diagnoses** expose where behaviour breaks down and what stands in the way.

Done well, this step will accomplish the following:

- **Identify strategic entry points for change.** For example, data could reveal how vaccination drop-off rates increase after the first shot, with no follow-up system currently in place within the health system.
- **Distill complexity into clear, actionable patterns.** For example, both quantitative and qualitative data could reveal how caregivers tend to miss vaccination appointments on days where there is extreme weather.
- **Ensure designs respond to real-world constraints—not assumptions.** For example, after noting how some refugee mothers rely on male relatives who are only available on weekends for transport to the clinic, consider how weekday appointments may not be feasible for some households.
- **Build the behavioural foundation for solutions to be prototyped next.** For instance, after consulting findings from both caregivers and health care workers who noted a lack of communication from the health system, a potential solution could be designing a follow-up message that reminds caregivers of the date of the next scheduled vaccine.

This ensures a focused, evidence-based understanding of where change is needed, and what is required to make it possible, when designing interventions.

How to do it:

1. Clean the data

After primary research, data is rarely ready for immediate use. For example, transcripts may be incomplete, notes may need clarification, and inconsistencies may need to be resolved before meaningful patterns can emerge. Before any analysis can begin, raw data needs to be cleaned, coded, and sense-checked. Two helpful guides for navigating this stage include:

- The SAGE handbook of Qualitative Data Analysis
- The World Bank's DIME Handbook (focused on rigorous, large-scale data collection)

When transcribing interviews or focus group discussions, AI tools can speed up the process significantly, though human review should be used to ensure accuracy

and nuance, especially for non-standard dialects or sensitive topics. Well-reviewed transcription software includes Auris, Trint, TurboScribe, and Descript.

2. Conduct quantitative analysis

Quantitative data, such as survey responses, service records, or administrative datasets, should be analysed in a structured way to identify patterns and trends at scale. This type of analysis can help answer key questions such as:

- How common is the target behaviour among the population of interest?
- How do behaviours vary across different groups (e.g. by gender, location, caregiver type)?
- Are specific attitudes or access barriers associated with greater or lesser likelihood of completing the behaviour?
- What proportion of individuals drop off at key points in the service journey?

Quantitative analysis might include frequency counts, cross-tabulations, correlations, or regression analysis, depending on the dataset and available skills. Where relevant, survey questions should be mapped to COM-B domains to interpret findings through a behavioural lens.

For existing datasets (e.g. vaccination records or attendance logs), descriptive statistics are often enough to highlight trends and flag where behavioural bottlenecks occur.

See the Learn more section for guidance on basic statistical methods, data cleaning, and survey-based research.

3. Organize and tag qualitative data

Qualitative data (e.g., interviews, focus groups, observations) should be organized and tagged in a way that supports structured analysis. Tagging means linking observations or quotes from participants to the behavioural drivers that might be influencing their actions, using a framework like COM-B.

- a. Start by sorting transcripts, notes, or excerpts based on who the data is regarding (e.g., caregivers, providers, influencers) and what behaviour it relates to (e.g., completing vaccination, seeking ANC).
- b. Create a simple coding matrix to help structure the analysis, for example by mapping behavioural drivers or barriers against COM-B domains. Table 14 provides an excerpt of coding matrix using a routine immunization example:

TABLE 14. CODING MATRIX

COM-B SUB-DOMAIN	DRIVER OR BARRIER	TAG
Physical capability	Barrier	Limited physical mobility
Psychological capability	Barrier	Competing priorities
	Barrier	Limited knowledge of vaccine schedules
	Driver	Knowledge of vaccine benefits
Physical opportunity	Barrier	Distance to the clinic
	Barrier	Unfavourable clinic hours
	Driver	Bundled services
Social opportunity	Barrier	Unfavourable descriptive norms
	Driver	Influence of mother-in-law
Reflective motivation	Barrier	Fear of side effects
	Driver	Belief in vaccine efficacy
Automatic motivation	Barrier	Present bias
	Barrier	Emotional overload
	Driver	Helpful habit or routine

Sort through the data (transcripts, notes, quotes) and tag excerpts using specific tags, not only the broad domain. A high level of detail helps to surface patterns, contradictions, and priority barriers that are directly useful for design. For example:

- Quote: “I didn’t go back because I thought one shot was enough.”
→ Tag: Limited knowledge of vaccine schedules
- Quote: “My neighbour told me her baby got sick after the vaccine.” → Tag: Fear of side effects
- Quote: “I ask my mother-in-law for advice regarding my child’ health.” → Tag: Influence of mother-in-law

Use a spreadsheet, shared document, or qualitative coding software such as [Dedoose](#), [NVivo](#), or [Atlas.ti](#) to organise and tag data. If working manually, colour-coding or margin labels can support quick tagging. If using a cloud-based version of these tools, ensure that any data sharing complies with UNICEF data protection policies and informed consent agreements.

4. Create behavioural profiles (optional)

This step is particularly useful if the research — both desk research and primary data — generates rich detail about the people behind the explored behaviours. This means obtaining insight not only into what people do, but why, in what context, and with what challenges.

A behavioural profile is a tool used to synthesise insights about the capability, opportunity, and motivation-based drivers behind a specific behaviour or set of behaviours within a target population. While other similar tools such as user personas or demographic segmentation focus on demographic traits or broader needs, a behavioural profile is specifically designed to uncover the “why” behind behaviours, drawing on frameworks like COM-B.

Developing a behavioural profile is especially helpful when an intervention requires a deep understanding of behavioural drivers in order to be effective. It can also be useful if there are people who can be differentiated by a set of specific behavioural barriers, habits, emotions, and

socioecological context. For example, two caregivers might look similar demographically (they are both 30-year-old mothers living in rural areas with two young children) but their behavioural profiles differ: one delays vaccination because she believes her child is not at risk and fears side effects (low motivation), while the other fully intends to vaccinate but misses appointments due to long travel distances and lack of childcare (low opportunity).

While a user persona might group these women together based on age, location, and caregiving role, behavioural profiles would separate them based on the different drivers influencing their behaviours.

For each behavioural profile, aim for at least 15 participants that share a common set of traits and behavioural features. It is important to highlight that 15 participants as a total sample size of the research might be insufficient if there is high heterogeneity — i.e., high variability in participants’ profiles and responses.

TABLE 15. TYPE OF INFORMATION REQUIRED TO DEVELOP BEHAVIOURAL PROFILES AND POTENTIAL SOURCES OF INFORMATION

TYPE OF INFORMATION	POTENTIAL SOURCES
<p>Basic Demographic Information: Data such as age, gender, education, household type, income level, geographic location, role in their community (e.g., caregiver, healthcare worker, religious leader, etc.).</p> <p>These data provide necessary context and help to distinguish how different populations experience behavioural drivers differently.</p>	<p>Stakeholder and audience map (Step 1 — Define phase): Review of existing administrative data that was used to build the stakeholder and audience map.</p> <p>Initial desk research (Step 1 — Explore & Diagnose phase): Administrative data such as data sets from the Ministry of Health, existing data sets from UNICEF, etc.</p> <p>Primary research (Step 4 — Explore & Diagnose phase): Data collected through surveys.</p>
<p>In-depth behavioural information that can be structured around a behavioural model (e.g., COM-B mode): Coded, grouped, or analysed using a framework like COM-B, this includes data on people’s capability (knowledge, skills), opportunity (social and physical context), and motivation (beliefs, emotions, intentions) related to the target behaviour.</p>	<p>Plan primary research (Step 3 — Explore & Diagnose phase): A pre-defined behavioural model to analyse the data collected during the primary research. For example, the COM-B model.</p> <p>Primary research (Step 4 — Explore & Diagnose phase): Qualitative information typically gathered through in-depth interviews, focus group discussions, and/or observations, which help to identify barriers and enablers related to the target behaviour.</p>

Unlike fictional personas, these profiles are rooted in evidence. They help to move beyond abstract categories like “caregiver” or “youth” by giving form to real people navigating real decisions. Most importantly, they help to shape intervention strategies by illuminating actor-specific needs and the contexts in which decisions are made. Here are steps to take to create behavioural profiles:

- a. Review data from the fieldwork. While scanning the information, identify groups of actors who share similar behaviours, beliefs, influences, or experiences. These groups may be defined by role (e.g., frontline nurse, adolescent girl), life stage (e.g., first-time mother), or social position (e.g., respected elder, decision-maker in the home). If there are meaningful differences within a group, such as confidence levels, decision-making power, or social standing, this may require creating more than one profile.
- b. Synthesise key findings about the background information, typical behaviours, motivations, knowledge, and norms relating to each profile. Use the Behavioural Profile worksheet to structure

these findings. When planning the development of behavioural profiles, consider adding additional research questions to the research plan to learn more about the key actors being researched. For each profile, synthesise the following in the worksheet:

- **About me:** Key demographic information about who the person is and their living conditions.
- **Behaviours:** Information on the typical day-to-day behaviours and habits of the person, as well as any contextual information on when, where, and how they would conduct the target behaviour.
- **Beliefs, Knowledge and Attitudes:** What the person believes, knows and thinks about the target behaviour.
- **Community and Social Norms:** Overview of the community and social structures of this person, the religious, cultural, and gender norms influencing them, and who influences them.

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DEPTHS TOOLKIT

Behavioural Profile

Complete one worksheet for EACH key role in the community

Actor: _____

About me

Who am I?
Gender, age, family, education level

Where do I live?
Living Conditions (rural, urban slum, conflict zone, nomadic etc)

Responsibilities
In my family and community, I am responsible for:

Behaviours

Habits and Behaviours:
What does my day to day look like?

Target Behaviour Context:
When, where and how is the target behaviour happening or not happening? Are there any environmental factors affecting the behaviour e.g. resources, time, cost?

Beliefs, Knowledge and Attitudes

My beliefs and attitudes to this behaviour are...

The things I know or don't know about this behaviour are...

The things I think will prevent me doing this behaviour are...

Community and Social Norms

My community and social structure include.

The community, religious and/ or gender norms that I believe are...

The people I'm most influenced by are...

Motivation and Priorities

I'm motivated by...

I want/ need to...

My main priorities are...

- **Motivation and Priorities:** The key motivations, priorities, wants, and needs driving this person’s decision-making and behaviours.

When building behavioural profiles, keep the following note in mind that **a strong behavioural profile should evoke empathy**. It should feel like a real person — someone whose daily realities, values,

and constraints are understood. When done well, these profiles become more than summaries; they serve as living reference points throughout the process. Return to them during behavioural mapping, diagnosis, and design to stay grounded in the lives and contexts of the people the work is meant to serve.

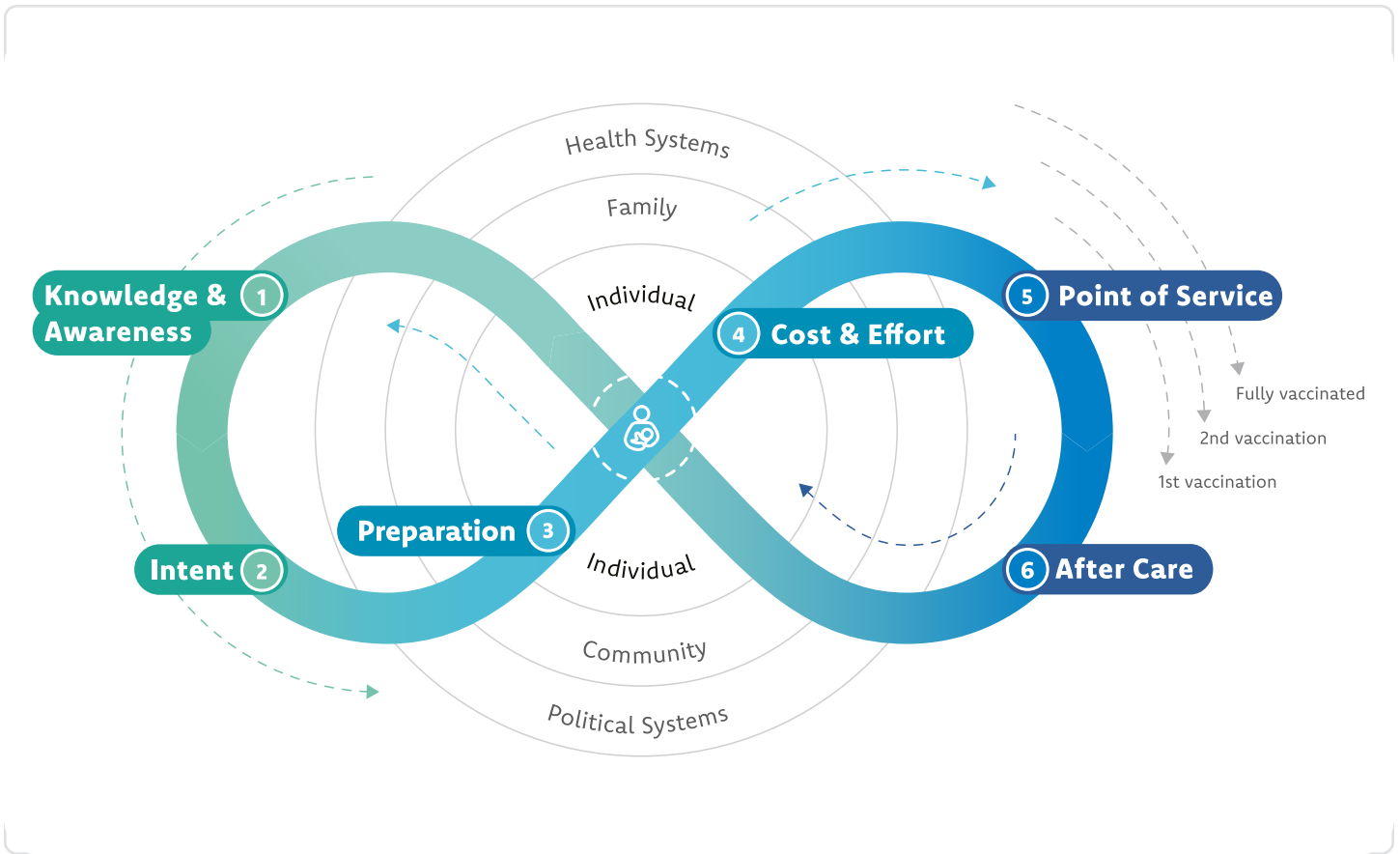
5. Build a behavioural map and diagnosis

The [Behavioural Map and Diagnosis](#) worksheet helps to break down complex behaviours into smaller, observable steps: micro-behaviours. Rather than looking at a behaviour in isolation (e.g. “getting a child vaccinated”), this worksheet maps out the full behavioural journey: what happens before, during, and after the key action. For each moment in the journey, the tool helps to compare the ideal behaviour (what will ideally occur) with the real behaviour (what actually occurs). The tool then helps to identify the barriers and enablers that hinder or support the desired behaviour, along the different steps of this journey. By visualising the journey in this way, teams can spot the specific points where

people get stuck, delayed, or drop off, and begin to design solutions targeted at those points.

Similar tools, such as user journeys and service journeys, are used in human-centred design and service design. These tools can vary in complexity: from quick, informal sketches to detailed, multi-actor maps. Some have even evolved into broader frameworks used across sectors to diagnose behavioural challenges.

One example is the Journey to Health and Immunization developed by UNICEF, which outlines the sequence of



decisions and actions a caregiver must navigate to access and complete routine immunization or other health services. Common Thread also offers a simple template and guide on how to develop behavioural maps, as well as the Center for Advanced Hindsight from Duke University.

To develop a behavioural map and diagnosis:

- a. Identify the key profile (e.g. caregiver, health worker, adolescent) whose behaviour is the focus, and write it down. If behavioural profiles have already been developed for this actor, use it to map and tailor the journey specifically to that profile.
- b. Define the target behaviour, or the specific action of interest (e.g. completing the full immunization schedule, registering a birth, practicing exclusive breastfeeding in the first 6 months, enrolling and

regularly attending early childhood education, consistently using a latrine rather than open defecation).

- c. Next, map the journey moments. These will be the smaller, observable steps that lead to or surround the target behaviour. These steps should capture what happens before, during, and after the target behaviour.

Table 16 on the following page provides illustrative examples of journey moments, across a range of behaviours linked to child rights outcomes. While not exhaustive, the list is intended to guide teams in thinking through the kinds of micro-behaviours that may be relevant to their context. It can be adapted based on the specific actor, behaviour, and setting.

TABLE 16. EXAMPLE JOURNEY MOMENTS ACROSS BEHAVIOURAL AREAS

COMPLETING THE FULL IMMUNIZATION SCHEDULE	REGISTERING A BIRTH IN THE FIRST 6 MONTHS	PRACTICING EXCLUSIVE BREASTFEEDING IN THE FIRST 6 MONTHS	ENROLLING AND REGULARLY ATTENDING EARLY CHILDHOOD EDUCATION	CONSISTENTLY USING A LATRINE RATHER THAN OPEN DEFECACTION
1. Hearing about vaccines and the schedule	1. Learning about the need to register a birth	1. Learning about the benefits and skills of breastfeeding during pregnancy	1. Learning about the availability and value of ECE	1. Hearing about safe sanitation practices
2. Receiving a reminder for the first visit	2. Understanding the timeline and process	2. Initiating breastfeeding within the first hour after birth	2. Deciding to enrol the child	2. Accessing or constructing a functional latrine
3. Attending the first appointment on time	3. Gathering necessary documents or forms	3. Breastfeeding on demand, day and night	3. Completing registration or paperwork	3. Making the latrine convenient, clean, and private
4. Receiving and understanding return date	4. Planning when and how to go	4. Avoiding giving water, formula, or other foods	4. Preparing the child for the first day	4. Using the latrine for all defecation needs
5. Planning and preparing for the follow-up visit	5. Travelling to the registration site	5. Seeking advice when facing difficulties (e.g. pain, low milk)	5. Bringing the child consistently each morning	5. Encouraging consistent use by all household members
6. Returning for the next scheduled dose	6. Submitting the documents and completing the process	6. Sustaining exclusive breastfeeding through the 6th month	6. Continuing attendance throughout the school year	6. Maintaining the latrine regularly to ensure usability
7. Completing the full immunization schedule	7. Receiving and keeping the birth certificate			

The UNICEF Journey to Health and Immunization framework. UNICEF, Demand for health services field guide: a human-centred approach. New York: UNICEF, 2018.

- d. For each journey moment, describe what the profile would ideally do if everything went as intended: this is the ideal journey. Use clear, concrete, and observable language that focuses on actions, rather than hopes or general intentions. The ideal journey should reflect what the actor does, not what they know, feel, or believe (e.g. “Caregiver brings child to clinic” rather than “Caregiver is aware of the importance of vaccines”). This should also reflect a sequence that flows logically with each moment building toward the target behaviour, assuming that key supports, services, and information are in place.
- e. Describe what happens in reality. This is the real journey: the observed or reported actions that people take. For example, “Mother breastfeeds but occasionally gives water based on family advice”; “Caregiver brings the child on some days, but skips when busy or when older siblings are home”. Focus on what the actor does, not on interpreting why they do it – that comes in the next step. The real journey should reflect actual behaviour based on field research, observation, and practitioner insight.

When describing the real journey, it’s important to identify *drop-off points*: moments where the actor stops progressing toward the target behaviour. These are steps in the journey where actions are delayed, skipped entirely, or never completed. Drop-off points often signal high-friction moments where behavioural support is most needed. A drop-off does not necessarily mean someone has “failed”; it may be temporary (e.g. repeated delays) or more final (e.g. never returning for a service). Examples of drop-off points include:

- A caregiver brings a child for the first vaccine dose, but doesn’t return for the next.
- A parent begins registration, but stops halfway due to missing paperwork.
- A mother breastfeeds exclusively for 2 months, then introduces water or food early.
- A child is enrolled in school, but stops attending regularly after a few weeks.

To highlight these moments:

- Mark them clearly in the real journey row (e.g. using a specific symbol or different colour).
 - In the diagnosis step, pay special attention to these points. They are often where the most significant barriers are concentrated.
 - Drop-off points are not always the final step. They can occur anywhere along the journey and still disrupt progress.
- f. Next, examine each journey moment to understand why the real journey diverges from the ideal, and why the behaviour is not occurring as intended. Identify the behavioural barriers that are generating the gap between the ideal journey and the real journey, including the specific capability, behaviour, or motivation-related factors that are blocking progress at each step of the journey. This step should be based on the data already collected during the desk research and primary research, rather than speculations and assumptions. The goal is to translate qualitative and quantitative insights into clear, actionable behavioural barriers, using the COM-B model as a lens. For each barrier, use data from the research to ask:
- What is preventing the actor from doing this?
 - What part of COM-B does this relate to? (Capability, Opportunity or Motivation)
 - What exactly does it look like in this context?

Refer back to **Table 5. Mapping of Behavioural Drivers and Drivers in COM-B Framework** to support the diagnosis process. This table breaks down each part of the COM-B model into more specific behavioural drivers, with definitions to guide analysis.

The table is intentionally generic and should be adapted based on the specific behaviour, actor, and context. Make sure to avoid generic statements such as “low awareness” or “lack of access.” Instead, describe the specific type of barrier present, and how it manifests in the real world. For example:

- Instead of noting “caregiver lacks motivation,” write: “Caregiver believes one vaccine dose is enough, and does not see value in returning.” (Reflective motivation: beliefs about consequences.)
- Instead of noting “clinic access is an issue,” write: “Clinic only opens during market hours, when caregivers are working.” (Physical opportunity: time and scheduling.)

g. Map out enablers by considering what factors are already helping the actor move toward the desired behaviour — these could already be present in the context, could be reinforced. Also consider what factors could help further move the actor towards the desired behaviour if they were strengthened. These are enablers, making the behaviour easier, more likely, or more appealing to perform. Enablers can include existing strengths, support systems, or moments of success observed during research. Like barriers, they should be described clearly, and be grounded in real data rather than assumed ideals. Return to the data and look for:

- Quotes that express positive intention or commitment
- Enabling dynamics (e.g., peer support, reminders, community mobilization)
- Aspects of the environment or routine that smooth the path to action

Enablers are not just the absence of barriers: they are active drivers of positive behaviour. Identifying them can reveal opportunities for nudges, reinforcement, or scaling what works.

h. Make sure to build a Behavioural Map and Diagnosis worksheet for each key actor involved in the behaviour. For example, if both caregivers and health workers influence a vaccination journey, build one map for the caregiver, and a separate

one for the health worker. Each actor has a distinct role, decision-making process, and set of behavioural barriers, and combining them into a single map can obscure important differences.

If the research suggests significant variation within the same type of actor (for example, rural vs. urban caregivers, mothers vs. grandmothers, or younger vs. older adolescents) consider developing separate behavioural maps and diagnoses for each subgroup. This allows for a more nuanced understanding of the journey and helps to surface differences in barriers, drop-off points, or motivations that might otherwise be missed. That said, avoid over-segmenting, unless the data strongly supports meaningful differences. Focus on distinctions that are behaviourally relevant and actionable.

Here are some tips to develop a strong behavioural map and diagnosis :

- **Make it visual if needed.** Visual collaboration tools (e.g. [Miro](#), [Mural](#), [Figma](#)) can be used to make the mapping process more interactive and easier to navigate, especially when journeys become more complex. Colour coding barriers and enablers by COM-B domains can help to highlight patterns and clusters across the behavioural journey.
- **Consider reporting and dissemination needs.** The worksheet serves as a tool for structuring analysis, but it doesn’t need to be the final output. Depending on how findings will be shared, the map can be expanded into a narrated report, visual presentation, or synthesis deck.
- **Use the draft journey as a basis for feedback and validation.** This can also be shared with subject matter experts, practitioners, or community members for feedback and validation, especially if critical gaps or assumptions are identified during analysis.

6. Prioritize key behavioural barriers and enablers

After diagnosing a broad set of behavioural barriers and enablers, it's time to narrow the focus. This sub-step helps to identify which barriers and enablers matter most, and which ones teams are best positioned to address. It ensures the design process is both grounded in insight and oriented toward impact.

Prioritization is not about discarding complexity. It's about choosing a place to begin, where our actions can remove the most friction, unlock new possibilities, and deliver measurable change.

While prioritizing different barriers, it's important to revisit the *Define* phase and understand how each barrier affects the overall problem and its broader context.

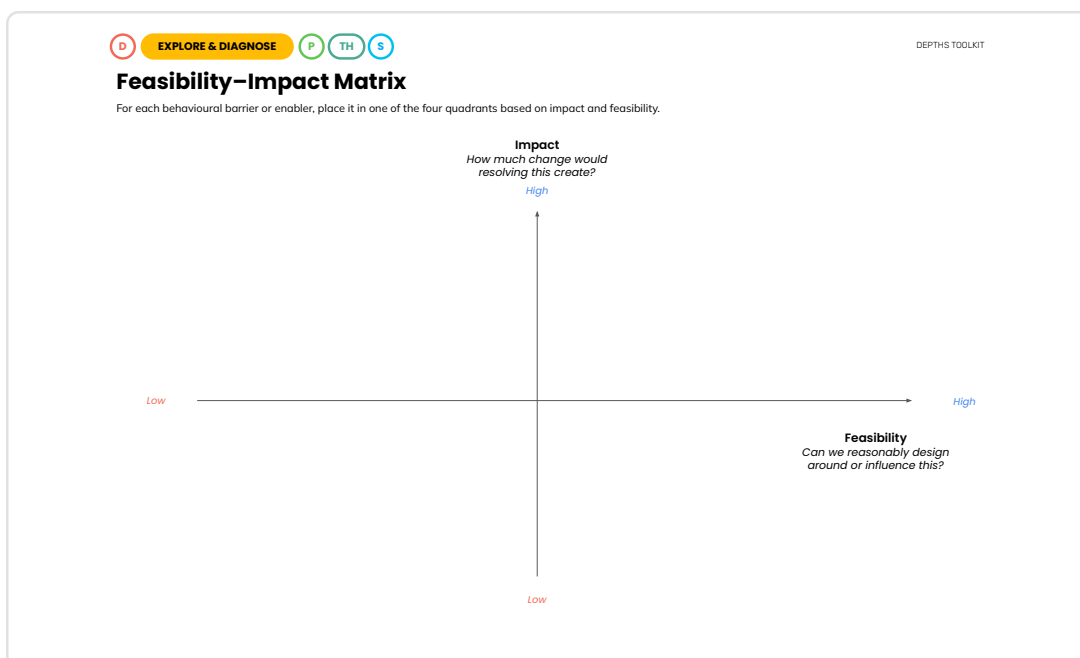
During this phase, teams move from a long list of behavioural barriers and enablers to a shortlist of 4–6 priority focus areas that will guide the *Prototype and Design* phase.

Each priority should:

- Address a clear behavioural drop-off point
- Be grounded in formative evidence
- Be actionable — something design can influence
- Offer significant potential to shift behaviour

To create a shortlist of focus areas:

- Revisit the behavioural maps and diagnoses to scan the full set of behavioural drop-off points, along with the corresponding barriers and enablers identified during diagnosis. For each drop-off point, consider:
 - Which moments are most critical to enabling the full behaviour?
 - Are certain barriers or enablers recurring across multiple actors or stages, suggesting systemic importance?
- Revisit the *Define* phase's key outputs — in particular, the Stakeholder and Audience Map, the Behaviour Tree, and the optional System Map with its leverage point analysis. Reflect on the following questions:
 - Does this barrier recur across different actors identified in the Stakeholder and Audience Map?
 - How does this barrier affect key behaviours of different actors mapped in the Behaviour Tree?



- Where does this barrier position itself in the System Map? Does it align with an identified leverage point?
 - How does this barrier compare to others in terms of equity impact? Does it exclude a specific type of audience in the Stakeholder and Audience Map?
- c.** Use the Feasibility–Impact Matrix to assess feasibility and impact. For each barrier or enabler, assess the following:
- **Impact:** If addressed, would this meaningfully increase the likelihood of the target behaviour occurring?
 - **Feasibility:** Is it realistic to address this within the team’s mandate, resources, timeline, or political/organizational constraints?
- d.** Map each barrier/enabler onto the matrix. This process encourages teams to design only for what is both possible and meaningful
- High Impact / High Feasibility
→ Prioritize for design
 - High Impact / Low Feasibility → Flag for longer-term change or advocacy
 - Low Impact / High Feasibility → Deprioritize, unless part of a larger enabling condition
 - Low Impact / Low Feasibility
→ Remove from scope
- e.** Select 4–6 focus areas to prioritize from the top quadrants of the Feasibility–Impact Matrix. Ensure that the focus areas:
- Cover key actors and moments in the behavioural journey
 - Include a mix of dynamics related to capability, opportunity, and motivation
 - Reflect a coherent design opportunity — not just isolated insights

When prioritizing behaviours, look for patterns across data, as opposed to isolated anecdotes. Consider equity, and which barriers disproportionately affect marginalized groups. Teams should reflect on the question, “If this was solved, what else might become possible?”

By the end of this step, the focus has shifted from scattered field insights to a structured, behaviourally informed foundation for action. Rich behavioural profiles have been developed, and the sequence of micro-behaviours that lead to or obstruct change have been traced. Furthermore, the barriers and enablers that shape those behaviours have been diagnosed, and the most strategic areas for intervention have been prioritized. Teams now possess more than a set of findings — this is instead a grounded, human-centred understanding of how change happens, and where it gets stuck. These insights can now propel teams into the next phase: Prototype and Design, where it’s time to begin translating evidence into solutions.

CASE STUDY:

Increasing childhood vaccination uptake in Lebanon

The Behavioural Profile and Behavioural Map and Diagnosis were not developed by the original project team. They are recreated examples based on real project data and context.

Synthesise and analyse findings

After completing the desk and primary research, the project team synthesised the data across interviews from the caregivers, health workers, outreach workers, and MoPH staff. They synthesised key data relating to the COM-B behavioural domains, along with information regarding the wider context, behaviours, beliefs, and motivations of the different participants. Based on this data, they were able to analyse and extract key insights to identify a number of personas — participants with similar contexts, behaviours, wants, and needs.

Develop a behavioural profile

The team tagged the data according to the identified personas, with one being a Syrian mother living in an informal settlement. The project team then collected all of the data they had from five research participants considered to be part of this ‘persona type’. They used this data to develop a Behavioural Profile, which summarized key information relating to the persona’s characteristics, overall behaviours, beliefs, motivations and norms.

This tool allowed the team to consider the wider context impacting a Syrian mother’s decision-making and behaviours — beyond solely vaccination. They continued to use this Behavioural Profile throughout the project to remind themselves of who they were designing for, and what other factors may influence their decisions.

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EXPLORE & DIAGNOSE
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DEPTHS TOOLKIT

Behavioural Profile

CASE STUDY 1: INCREASING CHILDREN IMMUNIZATION RATES IN LEBANON

Actor: Mother

About me

Who am I?
Gender, age, family size, education level
Female Syrian mother in my 30s.
Primary education only- basic reading and writing.

Where do I live?
Living Conditions (rural, urban slum, conflict zone, nomadic etc)
Informal tented settlement in Bekaa Valley- moved here in 2015 when we arrived in Lebanon. It's a rural area with limited healthcare infrastructure. It's very overcrowded with water and sanitation issues.

Responsibilities
In my family and community, I am responsible for:
I take pride in caring for my family. I do all childcare and household duties. Sometimes I support my husband with working on a farm.

Behaviours

Habits and Behaviours:
What does my day to day look like?
I wake early as the sun rises to prepare meals and get my children ready. I fetch water, clean, and help in the farm fields when needed. I don't travel far from the home, but I do visit the Primary Health Center only when someone is seriously ill or when I receive a strong reminder or visit from the outreach worker.

Target Behaviour Context:
When, where and how is the target behaviour happening or not happening? Are there any environmental factors affecting the behaviour e.g. resources, time, cost?
I have five children and the outreach workers told me three of them still need vaccinations. I missed follow-up vaccination appointments because I wasn't sure when to go or which vaccine was next. They did give me a vaccination card once, but I lost it. The health center is far, transport is expensive, and I don't always feel comfortable going alone. Outreach workers came a few weeks ago, but I didn't fully understand what I needed to do next.

Beliefs, Knowledge and Attitudes

My beliefs and attitudes to this behaviour are...
I believe vaccines help protect my children, but there are other things that are more important like feeding them and trying to educate them

The things I know or don't know about this behaviour are...
I'm not always sure which vaccines my child still needs, or when the next dose is due. I don't know if it's okay to go late once you miss the time. It's hard as I don't always understand the outreach workers.

The things I think will prevent me doing this behaviour are...
The time and cost of transport. Especially going alone- is it safe?

Not knowing when I need to go or how many times

I forget, then am embarrassed to go late

Community and Social Norms

My community and social structure looks like...
There are many Syrian refugees in the camp, so we have formed friends and leaders. My husband meets with the leaders once a week to understand what is happening in the community

The community, religious and/ or gender norms that I believe are...
I don't think it's always appropriate for women to travel alone, especially long distances or at night. I also prefer not to be alone with a man who isn't known to me. I can make decisions about the house and my children, but I ensure I get my husbands permission for some decisions

The people I'm most influenced by are...
My sister-in-law. We travelled from Syria all together. They are our only family now. I also speak to our neighbours who have children similar age to mine.

The only person I regularly speak to outside my community is the outreach worker.

Motivation and Priorities

I'm motivated by...
Being a good mother. Nearly everything I do is to help protect my children and try to give them what they need. It's important the community sees me as a good wife and mother

I want/ need to...
Have everything I need to look after my children to keep them safe and healthy.

One day I want to leave this camp and set up a long-term home.

My main priorities are...
Keeping my children safe and happy

Looking after the home and caring for my husband while he supports us

Develop a Behavioural Map and Diagnosis

This Behavioural Map and Diagnosis was not developed by the original project team. It is a recreated example based on real project data and context. Some details may not be completely accurate, but the purpose is to illustrate what a completed Behavioural Map could look like in practice.

Building on the Behavioural Profile, the project team developed a Behavioural Map and Diagnosis to trace the Syrian mother's journey toward getting her children vaccinated. Drawing from insights collected during the field research, they began by identifying key "moments" in a caregiver's immunization journey (from hearing about vaccines to completing the full series). These seven moments helped to structure the Behavioural Map and made visible the step-by-step process that caregivers navigate.

For each moment, the team then defined two factors: the ideal behaviour that would lead to full and timely vaccination, and the real behaviour caregivers were exhibiting, based on field observations and in-depth interviews. For example, at the end of their first vaccination visit, the ideal was for caregivers to ask about the date of the next vaccination and receive a note with a written date. However, the real behaviour exhibited was more uncertain. Caregivers often heard

the date of the second dose vaccine verbally but had no way to record it, leading to forgetfulness later.

Next, the team diagnosed the barriers causing this gap, using the COM-B model. In the case above, the issue was one of psychological capability (difficulty retaining information) and physical opportunity (lack of take-home reminders). At the moment of remembering the date, caregivers often forgot or felt overwhelmed, which the team coded as automatic motivation, shaped by cognitive overload and emotional stress.

However, not all behaviours diverged. For example, in the second journey moment (i.e., attending the first vaccine visit) caregivers were largely consistent with the ideal. This revealed that the real bottlenecks began after the first visit, reinforcing the importance of focusing interventions on follow-up behaviours rather than initial awareness.

Finally, the team identified existing enablers at each step. These included verbal encouragement from health workers, positive early experiences with vaccines, and informal reminders from peers. This process helped the team to identify which micro-behaviours mattered most, why they were breaking down, and where low-cost nudges could support change. The Behavioural Map became a

foundational diagnostic tool to guide ideation and prototype development.

While this example focuses on Syrian caregivers, the broader research also revealed distinct barriers among Lebanese families. These included a lack of trust in the quality of vaccines and services offered, and a belief that they were entitled to better care than what was provided through programmes aimed at non-Lebanese populations.

DEPTHS TOOLKIT

EXPLORE & DIAGNOSE		P	T	S	Actor: <u>Caregiver</u>		
Journey moment What phase of the journey is this?	1. Hearing about vaccines	2. Attending first visit	3. Receiving return date	4. Planning return visit	5. Remembering the date	6. Returning on time	7. Continuing full schedule
Ideal journey What does the ideal journey look like?	Caregiver listens to trusted health or community source and asks for details about vaccination schedule.	Caregiver brings child to the health center and receives the first vaccine dose on time.	Caregiver asks about and receives a written appointment date and verbally confirms understanding.	Caregiver discusses and arranges time and transport with household, planning return in advance.	Caregiver uses appointment card or phone note to remember return date and mentally prepares in advance.	Caregiver takes child to clinic on or near scheduled date for second dose.	Caregiver continues following the full vaccine schedule until all required doses are completed.
Real journey What does the real journey look like?	Caregiver hears about vaccines in passing from informal sources but does not actively seek clarification.	Caregiver brings child to the health center and receives the first vaccine dose on time.	Caregiver hears the return date verbally, but does not write it down or remember it later.	Caregiver delays planning due to uncertainty, competing priorities, or lack of support.	Caregiver forgets return date or gets distracted by daily stress and emotional load.	Caregiver postpones return, often missing the scheduled follow-up.	Caregiver drops off after one or two doses and doesn't complete the full schedule.
Barriers What barriers are making that the real journey is different from the ideal one? Use the COM-B model to diagnose the type of barrier that is present.	Social Opportunity: Limited peer discussion or norms around follow-up. Reflective Motivation: Low perceived urgency to act.	(no barrier - same behaviour)	Psychological Capability: Low literacy and information retention. Physical Opportunity: No existing reminder or take-home material.	Physical Opportunity: Clinic far, transport costly, safety concerns. Social Opportunity: Husband's indirect control of household travel (contextual).	Automatic Motivation: Cognitive overload and emotional stress. Psychological Capability: No external prompt or memory aid.	Reflective Motivation: Perceived low benefit vs. high cost. Physical Opportunity: Wait times, unclear procedures, and long queues.	Social Opportunity: Limited norms around completing series. Automatic Motivation: Negative stories from peers about clinic experience. Physical Opportunity: Lost or damaged card.
Enablers Existing motivators, influences, removable friction, etc that would enable the key actor to complete the desired behaviour.	Existing peer networks and local NGOs; interest in child's well-being.	Early positive social norm for first vaccine; trust in frontline workers.	Health worker guidance; some caregivers may jot down reminders informally.	Family routines, coordination with others going to clinic, proximity of services.	Informal reminders from neighbors; strong intention if reminded.	Sense of responsibility; past positive interactions with health center.	Verbal encouragement from health workers; habit formation if reminders continue.

Apply a Feasibility–Impact Matrix

This Feasibility–Impact Matrix was not developed by the original project team. It is a recreated example based on real project data and context. Some details may not be completely accurate, but the purpose is to illustrate what a completed Feasibility–Impact Matrix could look like in practice.

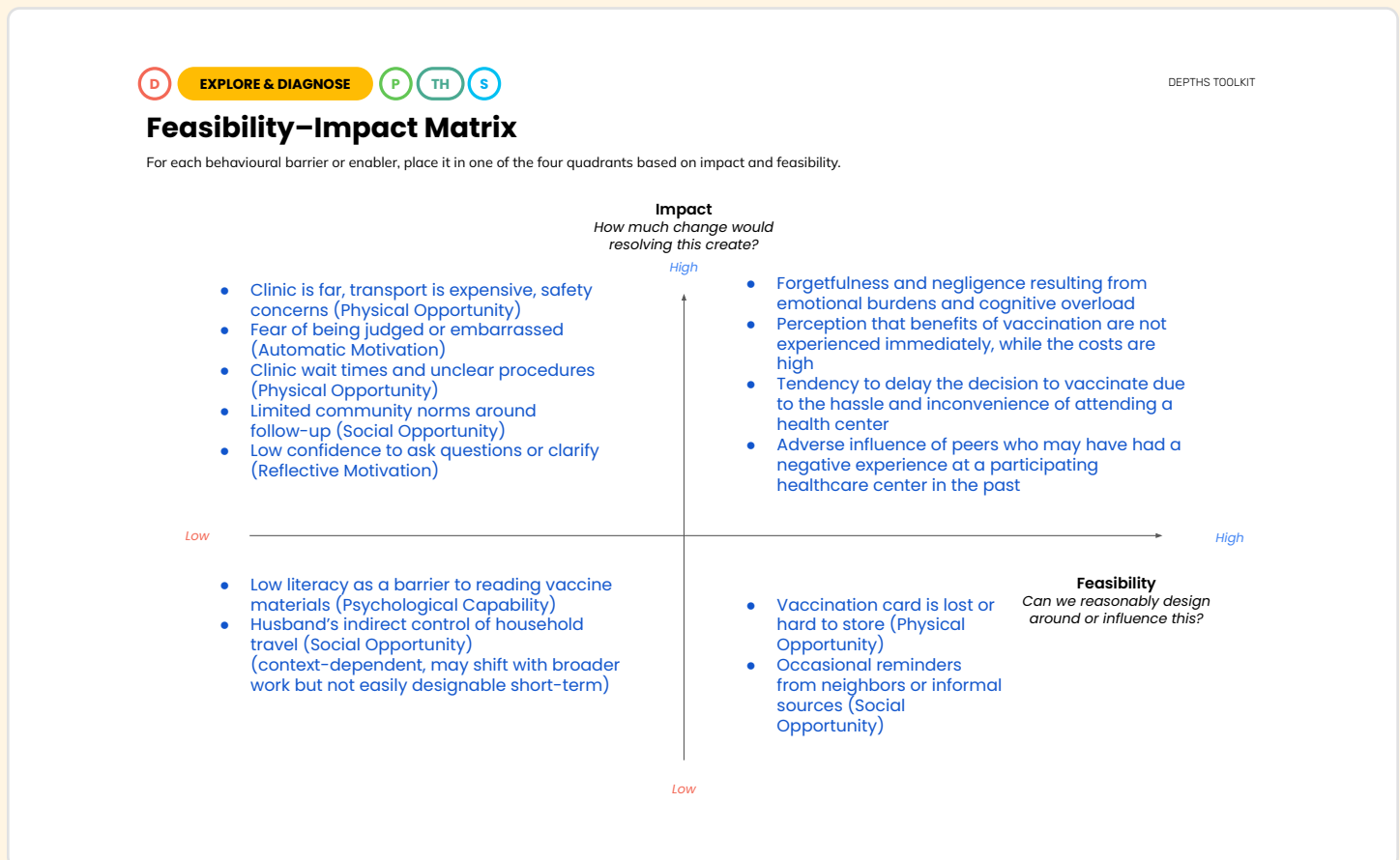
After completing the Behavioural Map and Diagnosis, the project team used the Feasibility–Impact Matrix to prioritize which barriers and enablers should be addressed in the design phase. Each factor was assessed based on its potential impact on the caregiver’s ability to complete the vaccination journey, and the feasibility of influencing it through behavioural design. The barriers were also considered against the System Map and the Behaviour Tree that were developed in the previous Define phase. This helped the team to understand the role each barrier played in the broader context of the problem.

This process aided the team in their transition from identifying behavioural drivers to selecting practical points of intervention. While certain challenges — such as the long distance to the clinic — were recognized as

important, they were considered less feasible to address directly within the scope of the project. In contrast, the team prioritized barriers that were both highly influential and actionable. These included the following:

- forgetfulness and inaction linked to emotional strain and cognitive overload
- the perception that vaccination benefits are delayed while the effort and side effects are immediate
- a tendency to postpone vaccination due to the inconvenience of attending health services
- the discouraging influence of peers who had previously experienced poor treatment at healthcare centers

By organizing these insights within the matrix, the team identified a focused set of behavioural challenges to guide the design of interventions. This ensured that their efforts were both strategic and responsive to the daily experiences of caregivers.



Final checklist for *Explore & Diagnose*

- Initial Desk Research
- Primary Research Objectives and Questions
- Primary Research Plan and Protocol
- Behavioural Map and Diagnosis
- Feasibility-Impact Matrix

Optional:

- Behavioural Profile

Learn more

This field guide is designed with practical tools, frameworks, and methodologies for teams to apply behavioural science to a range of real-world challenges. As behavioural science draws from multiple disciplines, including human-centred design, experimental economics, and systems thinking, we've curated a selection of approaches that reflect this diversity. Behavioural science is a vast and constantly growing field, and it would be impossible to capture every tool or perspective in a single guide — that's why we've included this section for those who are curious to go deeper. The following section offers additional resources to explore specific topics introduced in the guide, offering an option to continue a self-paced learning journey.

“I want to understand the foundations of qualitative research and when to use it.”

If you're new to qualitative research or want a clear, structured introduction, [Allison Hurst's Introduction to Qualitative Research Methods](#) is a fantastic place to start. This free textbook walks through everything from research questions to analysis, with many real-world examples to help bring concepts to life.

To deepen your understanding of when qualitative methods are appropriate and how to defend their rigor, turn to [Hammarberg et al.'s article \(2016\) in Human Reproduction](#). The article lays out what makes qualitative research credible, and offers practical advice for explaining methodological choices to funders, reviewers, or skeptics who may be unfamiliar with the approach.

“I want to learn how to identify high quality evidence.”

One widely used resource and framework used to assess the quality of evidence is the [GRADE approach](#), commonly found in meta-analyses and systematic reviews. Essentially, GRADE provides a transparent and structured method to rate our confidence in the available evidence. It categorizes evidence quality into different levels based on factors that can downgrade or upgrade our confidence, such as risk of bias, consistency, directness, and precision. This helps reviewers to evaluate not only what the evidence says, but how much trust they can place in those findings.

“I want to learn how to decide on sample size for qualitative studies.”

Forget one-size-fits-all rules. Instead, explore the concept of “information power” introduced by [Malterud et al. \(2016\)](#). This idea helps researchers to focus on the value of information each participant brings to a study, rather than arbitrary notions of saturation — providing a more strategic and meaningful way to plan your sample.

“I want to adopt a decolonial approach to my qualitative research.”

The [Center for Critical Qualitative Health Research \(CCQHR\) at the University of Toronto](#) offers a wealth of advanced materials. Their website includes curated reading lists on Indigenous and decolonial methods, health anthologies in Spanish and Portuguese, and recorded lectures from leading thinkers. All are freely available online and on their YouTube channel.

A seminal resource in this field is *Decolonizing Methodologies: Research and Indigenous Peoples* (2nd ed., 2012) by Linda Tuhiwai Smith, which critically examines how research practices intersect with colonial histories and offers practical approaches for decolonising research. The textbook is available for purchase, or can be accessed for free [here](#).

“I want access to journals and ongoing learning opportunities.”

To stay up to date with emerging ideas and methodologies, consider exploring two open-access journals: the [International Journal of Qualitative Methods \(IJQM\)](#) publishes high-quality articles that push methodological boundaries, while [Forum: Qualitative Social Research \(FQS\)](#) has been sharing innovative work in English, German, and Spanish for over two decades.

“I want guidance on how to design and analyse qualitative research.”

If you're ready to take a deeper dive into designing your own qualitative research, these textbooks are essential:

- FHI 360 – [Qualitative Research Field Guide](#), which includes practical steps for introducing Qualitative Research Methods.
- [Creswell & Poth's Qualitative Inquiry and Research Design](#) guides you through five major approaches including narrative and grounded theory, with detailed examples.
- [Green & Thorogood's Qualitative Methods for Health Research](#) is especially relevant for those working in public health or clinical settings.
- [Maxwell's Qualitative Research Design](#) emphasizes the importance of coherence and interactivity in research design, with tools to help build strong proposals.

“I want to learn more about how to use different quantitative approaches for my research.”

Exploratory quantitative research often begins with surveys, descriptive statistics, and cross-tabulations to examine relationships between behaviours, beliefs, and context. Start by learning how to frame good research questions, choose appropriate indicators, and structure survey instruments that generate useful, analyzable data.

The [DIME Analytics Data Handbook](#) is an excellent step-by-step guide to managing data workflows (from planning to collection, coding, and storage) tailored for teams working in real-world development settings. For a more structured academic foundation, the [Springer textbook on Quantitative Methods for the Social Sciences](#) provides accessible explanations of descriptive statistics,

variable types, and data visualization techniques. For those working in health contexts, [Mixed Methods in Health Sciences Research: A Practical Primer](#) by Curry and Nunez-Smith offers guidance on how to thoughtfully combine quantitative and qualitative approaches for real-world research questions.

“I want to learn more about different behavioural frameworks to guide my research and analyse data.”

For those aiming to learn more about different behavioural frameworks that could be used for both guiding the primary research, as well as analyzing qualitative data, here are some additional resources to learn more about frameworks that have been mentioned in this chapter:

- [The World Health Organization's Behavioural and Social Drivers of Vaccination \(BeSD\) Framework](#) provides a structured tool for diagnosing and addressing the drivers of vaccine uptake. It categorizes influences into four domains: what people think and feel, social processes, motivation, and practical issues — making it particularly suited for immunization-related research and planning.
- The Socioecological Model which was first developed by Urie Bronfenbrenner is a widely used framework that focuses on different networks surrounding a person. [UNICEF has a tailored version for children.](#)
- [The Behavioural Drivers Model \(BDM\)](#) offers a flexible, context-sensitive framework that allows teams to explore the cognitive, social, emotional, and environmental factors that shape human behaviour. It is particularly useful in formative research and in identifying opportunities for targeted interventions.
- For those seeking a simpler model grounded in behavioural psychology, [Fogg's B-MAP \(Behaviour–Motivation–Ability–Prompt\) model](#) provides an accessible lens through which to understand and influence behaviour.

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