Final Project Proposal

IPA Vaccine Hesitancy Project

Background and Rationale:

The evidence demonstrating the benefits of immunization is overwhelming. It is one of the most successful and cost-effective interventions which has improved health outcomes. Vaccines have saved countless lives and improved health and well-being around the globe. However, to prevent the morbidity and mortality associated with vaccine preventable diseases and their complications, and to optimize control of vaccine preventable diseases in communities, high uptake rates must be achieved.

High vaccination coverage is dependent on many factors. The basic requirements are an understanding of the need and value of vaccination in the population, as well as the availability of vaccines and accessibility of immunization services. Vaccination uptake rates in some pockets of developed and developing countries due to multiple reasons remains a challenge for implementing agencies.

Despite the historic success of immunization in reducing the burden of childhood illness and death, episodes of public concern and rumours around vaccines have occurred around the world, spreading quickly and sometimes seriously eroding public confidence in immunization, ultimately leading to vaccine refusals and disease outbreaks.One factor that has become increasingly important to vaccination coverage is vaccine hesitancy that results in the delay or refusal of vaccinations, ranging from a delay in acceptance of one or more offered vaccines to complete refusal of all vaccinations in the immunization programme.

In 2011, the World Health Organisation Strategic Advisory Group of Experts on Immunization (SAGE) noted the growing recognition of the negative impacts of vaccine hesitancy on uptake rates and program efficiency. Based on the concerns about hesitancy and its impact on vaccine uptake rates and the performance of national immunization programs, WHO SAGE established the Working Group on Vaccine Hesitancy in March 2012 to carry out a thorough review and propose recommendations on how to address vaccine hesitancy and its determinants.

According to final report submitted by the SAGE working group in October 2014:

"Vaccine hesitancy refers to delay in acceptance or refusal of vaccines despite availability of vaccination services. Vaccine hesitancy is complex and context specific, varying across time, place and vaccines. It is influenced by factors such as complacency, convenience and confidence"

Recommendations of SAGE working group on Vaccine Hesitancy

While hesitancy to accept immunization has occurred since vaccines were first introduced, in the past decade, hesitancy has been increasing in recognition as a problem that needs attention if we are to achieve and maintain high uptake rates. Here are some important recommendations from the SAGE Working Group:

a) Vaccine hesitancy is a complex and rapidly changing global problem that requires ongoing monitoring.
b) No single intervention strategy exists that addresses all instances of vaccine hesitancy.
c) In low vaccine uptake situations where lack of access to available services is the major factor, vaccine hesitancy may be present, but it should not be the priority of immunization programs to address; improving services and access should be the priority.
d) Create and /or facilitate opportunities for sharing lessons learned about vaccine hesitancy on a regular basis.
e) Within the immunization program and beyond, undertake education and training of health care workers to empower them to address vaccine hesitancy issue in patients and parents.

Work done and subsequent publications from the WHO SAGE Working Group on the growing challenge of vaccine hesitancy provides some important insights into this often misunderstood phenomenon.

The first insight is that the problem lies mainly with the hesitancy of people to vaccinate, and not with vaccine refusers who represent a very small, albeit often outspoken, minority. Secondly, vaccine hesitancy is a complex and fluid challenge with a myriad of possible demographic or socio-psychological root causes, which change with context and over time. There is no quick and easy fix. Thirdly, educating people alone has little or no impact on vaccine hesitancy, Thus, research and development, of equivalent rigour to that done to develop vaccines and vaccination programs, is needed to develop the tools to monitor vaccine hesitancy, to understand the root causes of hesitancy in each context, to tailor solutions accordingly, and to measure impact of interventions. Finally, consistent with a large body of research, the WHO confirms the **important position of healthcare professionals (HCPs) as the cornerstone of public acceptance of vaccination.**

Communication and Vaccine Hesitancy

Poor quality services of any type, including poor communication, can undermine acceptance of vaccination. The communication gap arising from the service provider side can result in myths about vaccination in communities creating a big challenge to programs.

A critical factor shaping parental attitudes towards vaccination is the parents' interactions with health professionals. An effective interaction can address the concerns of vaccine supportive parents and motivate a hesitant parent towards vaccine acceptance. Conversely, poor communication can contribute to rejection of vaccinations or dissatisfaction with care. Such poor communication often results from a belief by the health professional that vaccine refusal arises from ignorance, but can be overcome by persuading or providing more information. Such an approach is counter-productive because it fails to account for the complexity of reasons underpinning vaccine refusal and may even result in a backfire effect.

Critical Role of Pediatricians and Medical Professionals –

Two fundamental considerations have emerged from research done by Angus Thomspson et al and others. First, hesitancy must be viewed in context. Even where vaccination refusal is suspected, hesitancy is often not the primary cause of incomplete immunization. The root causes of sub-optimal vaccination coverage may be due to challenges known as the 5a Taxonomy: Access; Affordability; Awareness; Acceptance (hesitancy); or Activation. Second, the foundation of vaccination acceptance is achieved through public trust; trust in vaccines and vaccine producers in the healthcare profession and the government.

Healthcare professionals (HCPs) are a trusted source of vaccine information. Popular decisions to vaccinate are based on trust, not only in the HCP but also in the vaccine producers and the government.HCPs often underestimate the importance of their recommendations, yet they are a trusted source of vaccine information and a major driver of vaccine uptake. Many hesitant parents cited reassurance and vaccine information from their HCP as the reason for changing their minds and accepting vaccines. However, HCPs may underestimate their influence, have low perceived/actual self-efficacy to influence a decision, have decreased time to discuss vaccination, use prescriptive, factual language to address enquiries, which may have limited effectiveness in changing behavior [Know-Do Gap].

Pediatricians can play a key role in strengthening trust in immunization systems and ensuring services are appropriate, understood and accepted by communities making them more likely to be used sustainably.

Pediatricians are most effectively positioned in the community to communicate the value of vaccines and help identify, and sometimes correct the myths and miscommunication ingrained in the community about vaccine uptake.

Medical professionals including family physicians besides Pediatricians who take primary level care of children also play a crucial role in vaccine acceptance. Our experience in polio eradication has confirmed that when it comes to health related issues, people listen to their family doctor even if they are not qualified in modern systems of medicine. It was also observed that pediatricians are trend-makers in their district/city and if they convey the right messages, other practitioners follow and reinforce those messages in a way that resonates with their local population.

Pediatricians, through state, local, national and international chapters work closely with government and other partner organizations. They are often, although not always, viewed more neutrally than government or the official program, which at times can be the source of mistrust. The underlying problem is that most pediatricians and medical professionals are not trained in communication approaches to pass on standard messages to build vaccine confidence and identify strategies to address vaccine hesitancy, as it was not part of their medical school curriculum or their training.

IPA Vaccine Hesitancy Project:

The International Pediatric Association (IPA) is a 107 years old umbrella organization of one million pediatricians of the world taking care of more than one billion children. IPA represents pediatricians from over 140 countries and 150 member societies enabling them to work together to improve the physical, mental and social health and wellbeing of all children, from birth through adolescence.

IPA has conducted Immunization Champion workshops in Johannesburg (2010), Melbourne (2013) and Vancouver (2016 with AAP) to train a pool of Immunization Champions. IPA regional societies, including the Asia Pacific Pediatric Association (APPA) and Union of National African Pediatric Societies and Associations (UNAPSA) among others, have also trained their pediatric leaders in immunization advocacy.

IPA through its Technical Advisory Group on Immunization (TAGI) has also worked proactively as an important partner of the Measles and Rubella (MR) Initiative since 2010.

IPA is a well-placed advocate to voice key messages for vaccine promotion. We propose to play a crucial role in addressing vaccine hesitancy by bringing together a coalition of organizations who are key stakeholders to deal with this pressing issue. . The issue continues to spread like wild fire across the world and threatens to nullify the significant gains of immunization so far. Given the ability to reach out to local communities through regional and national pediatric societies, IPA's membership is poised to recognize localized issues and bring them to the attention of national leadership.

Although reports of public concerns and questions around the safety and relevance of vaccines have been on the rise, aside from monitoring of adverse events following immunization (AEFI), there is neither systematic monitoring of broader public vaccine concerns nor a tool to assess risk levels of rumours and concerns to potential programme disruptions, vaccine refusals and potential disease outbreaks.

Studies undertaken by several individuals and organizations have recognized the important role of medical professionals but until now no one has tried to involve them systematically. It is time for the IPA to take initiative and mobilize its huge network to unite and take action on the important issue of vaccine hesitancy.

Goal and Objectives of the IPA Vaccine Hesitancy Project

Goal

The ultimate goal of this project is to reduce vaccine hesitancy in communities, disseminate the "value of vaccination" (VoV), increase demand for immunization, and to help reach the targets of the Global Vaccine Action Plan (GVAP), and the Sustainable Development Goals (SDGs).

Objectives

1. To reduce refusals by increasing the effectiveness of the conversation between HCPs and patients on healthy preventative behaviors utilizing behavior-centered approaches, building trust and creating a positive decision to vaccinate.
2. To empower national pediatrics societies and pediatricians to use broader VoV messaging to communicate the need for immunization more effectively.
3. To promote the VoV to the general public, media, politicians and decision makers.
4. Document, analyze and share impact of pediatric advocacy, effects of enhanced communication techniques and influence of counter measures

To complete these objectives a project team will be established by IPA with a technical project advisor to execute the activities outlined below:

Activities:

To accomplish these objectives and to achieve our overall goal, we will do the following to mobilize stakeholders and engage key experts on developing resources and tools.

1. Create a Steering Committee of experts (SCoE),
2. Conduct situational analysis & workshops in selected countries
3. Information and communication vide IPA members about VoV
4. Disseminate key VoV messages through mass media platforms, for maximum outreach.

1. Create a Steering Committee of Experts

IPA will identify and invite a pool of global professionals from various fields related to vaccines and immunizations including social scientists, media experts and experts dealing in behavior centered communication to form a Steering Committee of Experts (SCoE) to provide technical guidance.

2. Conduct Situational Analysis & Workshops

As a baseline assessment, the project team will conduct a scoping review of the literature and review data available from UNICEF, WHO, GAVI and other partners to identify countries with significant number of unimmunized children and vaccine hesitancy issues. We will do a quantitative analysis of coverage and refusals (which vaccines, which populations) in those countries.

Based on the analysis, we will select up to 10 countries to survey individual pediatricians with questionnaires with support from the national societies, to understand the views on vaccine hesitancy and the comfort levels with parents, media and policy makers on vaccination issues.

In the identified 10 high priority countries (preferably1-2 each in 7 IPA Geographical areas), targeted interventions will be done in a phased manner over the next 2 years based on a landscape analysis. The project team will conduct a 2 day Training of Trainers workshop (ToT) to train 55 Master trainers (7 regional coordinators and 4 from each targeted countries). Master Trainers will be selected through nomination by the IPA regional and national societies as per criteria decided by the IPA Executive Committee (EC). The SCoE will suggest international trainers to conduct the ToT workshop.

Following these training workshops, we will coordinate in-country workshops for pediatricians identified by national societies based on their skills and commitment. There will be 40 participants in the national workshop and 5 trainers (4 national and 1 regional).One invited representative of the Steering Committee or IPA EC will attend as an observer.

The project team will develop a training package which will include behavior centered communication, advocacy and media training.

In the workshop IVAC VoICE tool, motivational interviewing technique, TIP approach (developed and tested by the WHO European regional office, modified for target audience) and advocacy and communication tools will be utilized to train Immunization champion pediatricians to proactively communicate positive immunization messages tailored to different stakeholders and understand how and when to respond to criticisms or misinformation. This will empower pediatricians to talk to parents using

behavior centered communication tools, dealing with media in case of vaccine misinformation issues and doing advocacy with stakeholders.

VoICE is an online tool to assist advocates in identifying messages that express the broader value of immunization. Saad Omer and team from Emory University have developed modules for health care professionals. Sanofi Pasteur has developed a training package for HCPs on behavior-centered communication. All of these modules will be reviewed and adapted for training of pediatricians

We propose that national pediatric societies in these countries form a consortium of in-country partners to work with federal and state governments offering expertise of these trained Immunization Champion Pediatricians (ICPs), and to design a cascade of training sessions to reach to district level pediatricians for maximum impact.

3. Information and Communication Vide Members:

To proactively promote the "Value of Vaccination" (VoV), IPA will develop an effective, communication package including, key messages, printed documents, presentations, and short media clips, with a clear strategy to reach as many pediatricians as possible.

The project team will be sharing developed material and resources with IPA member societies. The member societies, along with their country partners/agencies, will be utilizing these materials and resources for VoV messaging. The project team will take regular feedback from member societies for their country specific needs, and based on their feedback, will modify the tools and materials for each case. The IPA will provide support and participate if possible in the societies' meetings with the aim to describe and proactively communicate the core messages from the VoV package.Additionally, wherever possible, an IPA designated representative will attend the workshops, seminar, and conferences to advocate the VoV message. The project team will encourage the national member societies of the IPA to include VoV messaging and raise the issue of vaccine hesitancy in their conference and seminar agendas as a priority topic to be covered.

4. Disseminate key VoV messages through mass media platforms, for maximum outreach:

IPA will use mass media technologies to reach broader audiences in conveying the core messages of the VoV, countering any vaccine misinformation. This will be doneby preparing educational materials, video clips , posters, statements, etc developed with clear plain-language messaging for all audiences.

Monitoring and Evaluation

With the limited scope of this project, it is not possible to conduct an depth assessment of the impact on vaccine hesitancy and increase in coverage. The project team will be collecting following data for assessing the impact of the interventions.

Process Indicators:

1. **Survey data:** The finalised tool and the collected data collated in excel sheets for analysis and dissemination, compiled as a lessons learned document and summarized to identify additional opportunities.
2. **Training data –** The training data collected by utilising a suitable tool designed to assess the knowledge of the participant pre- and post-training. The program will collect the data for analysis and report purposes to validate training effectiveness.

Deliverables of the Project (Expected Outcomes):

- Establish a pool of Master Trainer pediatricians in each selected country who will conduct a series of workshops for pediatricians in their country focused on behavioral family communication, through use of effective communication techniques for public , media and advocacy competence.
- Develop in-depth understanding of key country specific vaccine hesitancy issues through joint efforts of the Project Advisory Board and the Master Trainers.
- Build country specific communication plans which foster an enabling environment with positive vaccine stories. The communication plans will target families with small children, general public and governments.
- Document, analyze and share through publications qualitative insights and lessons learned regarding vaccine hesitancy issues, impact of pediatric advocacy, effects of enhanced communication techniques and influence of counter measures. Data from the post project survey of pediatricians and documented communication events will be available.

Vaccine Hesitancy Proposal Budget

Activity	Unit	Cost (rate*hrs/month)	Duration (months)	Total (USD)	Comments/Notes
Personnel					
Technical Advisor	0	16,000	24	$ -	Direct cost or In-Kind contribution from IPA Executive
Project Manager	1	900	24	$ 21,600.00	New hire or IPA supported
Project Team Members	2	2,400	24	$ 115,200.00	New hires - 2 team members for curriculum development, materials development, media communication, etc
			Personnel	**$ 136,800.00**	
Literature Review					
Literature procurement ***(articles if necessary)***	**1**	1,000	6		
			Literature Review	**$ 6,000.00**	
Workshops					
Master Trainers Workshop (venue, AV, catering, 2 days)	10	5,000	2	$ 50,000.00	Cost for 2 days of training for 65-70 people (5 trainers + 4 representatives per country)
In Country Workshop ***(venue, AV, catering, 2 days)***	10	5,000	6	$ 50,000.00	Each workshop will have 47-50 people
Travel ***(10 countries - travel for 3 persons - 4 nights)***	10	10,000	1	$ 100,000.00	Travel needs to be budgeted for 1 SC, 1 Regional, 4 Incountry experts & 40 in country participants, 1 project manager basically 2 international, 1 regional, 44 within country travel

Accommodation ***(10 countries - travel for 3 persons - 4 nights)***	10	20,000	1	$ 200,000.00	Travel needs to be budgeted for 1 SC, 1 Regional, 4 In country experts & 40 in country participants, 1 project manager basically 2 international, 1 regional, 44 within country travel
			Workshops	**$ 400,000.00**	
Value of Vaccine Materials					
Materials Development ***(workshop curriculum, guide books, reference materials, printing, etc)*** ***(10 sets - 1 per country)***	10	2,000	6	$ 20,000.00	
Digital asset development ***(video clips, audio statements, etc)*** ***(10 sets - 1 per country)***	10	1,000	6	$ 10,000.00	
Social Media Campaign	10	500	6	$ 5,000.00	
			Materials	**$ 35,000.00**	
Evaluation and Dissemination					
Evaluation and Dissemination workshop	10	5,000	3	$ 50,000.00	
			Eval and Dissemin	**$ 50,000.00**	
			Total USD	**$ 627,800.00**	***Avg cost per country $62,780 USD***

Timeline

S.N	List of Activities	Year -One 2018				Year –Two 2019			
		Q-1	Q-2	Q-3	Q-4	Q-1	Q-2	Q-3	Q-4
1	Proposal and workplan submission								
2	Establish Steering Committee								
3									
4									
5									
6	Conduct a landscape analysis through IPA member societies								
7	Develop an effective, professional communication strategy &material								
8	Dissemination of communication material								
11	Identify high priorities 10 countries for targeted intervention								
12	Host workshops in10identified priority countries								
13	Review Meeting of Program team and IPA EC ,SC								

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