COMMVAC deliberative forum report

New York, 8th of June 2011

I. Process

Participants were invited about two weeks in advance. While we had initially compiled a tentative list of approximately 15 people, 6 of them (as well as the International Union for Health Promotion and Education (IUHPE) facilitator) were able to attend the meeting.

Participants included both members of the IUHPE Board of Trustees and representatives from UNICEF[1] (see list below).

Participants received material on the project 10 days prior to the meeting, and they were presented with the specific questions that would addressed during the dialogue with them including a discussion on the taxonomy, the identification of priorities for systematic reviews as well as priorities for further primary research.

The material received included: a one page briefing on the project, an agenda, as well as the research summary (presenting the taxonomy development and the evidence base mapping).

We began the meeting by providing participants some further background to the project (with power point presentation) and emphasizing how these stakeholders' consultations constitute a critical step for the project in order to guarantee that the reviews are produced in a way that relevant evidence can be useful for different stakeholders and easily picked up for the purposes of implementation by immunization programme planners, managers and policy makers.

The following questions were then addressed with participants:

- Does the taxonomy capture the key intervention groups? Are there important interventions groups missing from the taxonomy?
- What are the overall priority intervention groups relevant to low and middle income countries (LMICs) for systematic reviews of effects? How can this help us to evaluate priorities
- What are the priorities for systematic reviews of effects?
- What are the priority intervention groups for further primary research?

Participants engaged very actively in the discussion, there was clearly a lot of interest and issues to be raised. Given the fact that the questions were all interrelated, the discussion did not follow any specific structure. The dialogue was open so as to allow participants to freely express their views, experiences and recommendations.

[1] See annex I.

At the end of the discussion we provided participants with color cards and asked them, in light of the general discussion, to write down their personal input to the three questions (i.e. priorities intervention groups for LMICs, priorities for SR of effects, priorities for further primary research).

The following report presents the main input and points that arose from the general discussion as well as the input provided by the written cards.

II) Discussion around the taxonomy and with respect to the intervention groups that are relevant to LMICs

a. Categorization and framing of the taxonomy

- The taxonomy includes the main categories but it could be nuanced a bit further and made more specific in some places.
- It might be useful to look at barriers and problems as a way to ensure that the evidence base summaries respond to these. This would also contribute to encourage decision makers to identify what problem they face in particular and to look for what evidence lies in this particular area (taking into account both contextual elements and potential mix of solution/strategies).
- It was acknowledged that systematic reviews traditionally define the intervention and the intervention effect of interest for the review. Systematic reviews rarely ask the question concerning whether an intervention is responding to a problem or the driver of a problem. It was therefore suggested to reframe the labels, aligning the taxonomy along a problem-oriented nature to reflect that the *purpose* issues include a more explicit expression of the assumptions behind them. The names of these categories in the taxonomy could be revised to reflect the nature of the problem to which an intervention that could be found in that category would respond to, how it would target the problem.

b. Further clarification/specification/distinction in the taxonomy

- There is **inconsistency in the taxonomy** as some categories are stated more as objectives (i.e. to increase access, to minimise risks or harms) without a sense of action, while others focus more on action (i.e. to inform or educate would imply to increase knowledge); while "to support" could actually be related to several different objectives.
- Further clarification about the **distinction between *providers* and *consumers*** would be useful. At present the taxonomy does not sufficiently or explicitly grasp providers perspectives in terms of communication, education and behavior change (communication to providers, how providers are trained and prepared to address rumors, side effects, reminders etc) and in terms of incentives (which are relevant both for *recipients* AND *consumers*). Moreover the category "To teach skills" mixes providers and consumers – it might be better to separate them more clearly.
- The distinction between **the supply and demand sides** needs to be made (as the current taxonomy does not explicitly capture the dynamic relationship between the two).
    - For example: What are the dynamics of provider and health worker motivation in terms of vaccination uptake? The experience and provision of care as well as the communication issue influence the demand side.

- Some interventions are interventions concerned with organising of supply side, and not related to communication (i.e. most of the ones under to increase access) – these may not be necessary for this review.
- If the supply side organisation interventions were going to be included, then
- It would be useful to provide a better separation of demand side and supply side – in fact, some of the current categories might fit better under 'to support' (e.g. transportation assistance, childcare services).
- health workers motivation should get attention.

c. Suggestion of new categories for the taxonomy

Participants suggested adding the following categories which are particularly relevant in the context of LMICs

- *To change social norms* (attitudes, values – social and cultural norms)
  - Within institutions such as the Ministry of Health
  - Within communities
- *To change attitudes*
- *To build trust*
  - Reassurance
  - Improve quality
- '*To minimise risks or harms'* which could be linked to 'to build trust'

d. **Priority intervention groups relevant to LMICs**

The following priority intervention groups/categories were suggested:

- To support
- Existing enabling environment to support vaccination
- To involve the community – which will help to develop /build trust—(which might then become another taxonomy)
- To involve the community in research (and area we need more evidence on).
- To teach skills (and change attitudes)
- To minimize risk of harms transitions/"to build trust"
- Health/service provider skills, attitudes and availability
- To improve quality
- To encourage continuity
- To increase access to adds
- Common Media campaign and use in community structures
- Web based approaches are not common but there is for example evidence emerging on the use of SMS (as reminders for vaccination)
- Power relationship between husband and wife

III) Priorities for Systematic Reviews of effects

A) Suggested priorities for the systematic reviews

- The use of new technologies such as cell phones for example[2]

[2] Note that a text messaging programme in Kenya and Uganda is being documented by UNICEF and others

- "Mix" of communication channels –what's the optimal mix, cost effectiveness of using different and mixed approaches, interventions and synergies[3]
- The role of community health workers as interface
- Immunization days as a rallying point for re energizing commitment around vaccination (approach widely developed in LMICs- to what extent is it really effective?)
- Usefulness of mass campaigns –an approach that is extensively used but what is its real impact?
- School based interventions – school as a platform/setting for communication interventions for vaccination.
- Role of supporting interventions, networks, mechanisms, dynamics (taking into account the role of religious/local traditional communication networks)
- The role of policy support to immunization
- The importance of political will and support at all levels
- Investigation on the reasons for dropout rates + response as a critical issue for LMICs
- Service and resources availability
- The SR could take specific vaccines focus/have subcategories with:
    - Measles (evidence from MDG country reports and UN reports)
    - Polio (based on information provided by UNICEF)
    - DPT (high coverage)

B) Comments and issues to be taken into consideration

- The critical need and importance of documenting community based interventions (communication for social change) related to immunization – this relates to the discussion held in Melbourne on other ways of pulling evidence that should be considered in the realm of the project or as a next and complementary step to the project. Note that the IUHPE has developed a tool for documenting health promotion case studies in the Eastern Mediterranean region that could support this process.
- Try to specify the contextual elements that contribute to the effectiveness of interventions (cultural, institutional systems, political and economic environment) as well as the supporting conditions (such as legislation for example).
- Examine the gender dimensions of all studies.
- Where should a communication interventions start? Should it be through antenatal or postnatal care. The importance of prenatal care in that respect is not sufficiently acknowledged.
- It might be interesting to have a look at the indicators coming from the monitoring and evaluation of measles in the context of MDGs as countries engaged in the MDGs are reporting annually on these (this would constitute potential source of readily available data).

[3] UNICEF is currently developing a paper that describes the different channels of communication and mixed approaches.

C) Discussion related to effect

What is the effect that we are looking at in the context of this research and what does uptake refer to in this regard? Are we referring to increased coverage, improved reminder rates?

The links between the research review priorities and priorities for intervention groups might require revising the projects objective/expected outcomes accordingly. Is the research going to lead to increase vaccination uptake?

IV) Priorities for further primary research

Participants expressed that the following would be areas of interest for further primary research as some of these issues are critical and not appropriately documented and evaluated.

- The importance of **cultural beliefs and practices/social norms** that prevail in a community –both in terms of barriers and opportunities- need to be further explored. Communication interventions that focus on knowledge and information are not sufficient. There needs to be more attention paid to attitudes and values.
- The **involvement of community**– how it was done? At what stage, who (such as a women with disability for example).
- Further explore the **role of different stakeholders** such as donors, NGOs, CBOs ,faith based organization in terms of support, design, management, implementation of communication strategies.
- The **equity issue** in the eradication of specific disease (such as polio for example) where one can see a social gradient as it is the case in other health outcomes.
- **Positive deviance**: Explore if there are cases where immunization rate stayed high during difficult times (such as rumors, internal political conflict etc). This could constitute an interesting base for further research to find out what communication activities were done to sustain/enable routine immunization).
- What is the optimist **mix of communication strategies** and interventions
- Interface between **supply and demand** side (communications, interaction)
- Explore the source, factor, context for motivated **human resources/providers** of immunization programmes
- How **public trust** is built

V. Evaluation on how the dialogue was conducted

The material sent in advance was very useful in terms of preparation, and it was clearly presented.

The power point presentation provided a good foundation and start to the meeting. It enabled clarification of the project's background, how and where the materials were developed so far, and how the consultation forum would fit in the overall project.

Participants appreciated the open nature of the dialogue, as it enabled them to address key issues, and draw upon the full range of people's experience and expertise.

They also appreciated the opportunity to be informed about this project, and the possibility of linking it to other initiatives or grey literature and as a critical input for the field of immunization programs. The project was perceived as providing some new and innovative approach to these issues and they were impressed by the quality of the work undertaken so far.

Participants also appreciated the transparency on the barriers/limitations and challenges that the project encounters. It was useful to acknowledge these in the discussion and in thinking of future opportunities.

VI. Follow up with participants

There was a strong interest from participants to be kept informed about the project progress, to be consulted again at critical times both for input on specific outputs (such as the evidence summaries for example), to provide contacts of individuals that could participate in the online forum, to participate themselves in the online discussion if useful and to make linkages with other interesting initiatives.

Participants also mentioned some initiatives and documents that could be useful to the project including:

- The UNICEF “communication framework for new vaccinations”
- The report on the text messaging projects (Uganda and Kenya) that should soon be available
- Annual reporting from African countries and others on progress on MDG 4 with regard to measles specifically
- UNICEF country good practice from child and maternal health programmes
- John Hopkins University and other partners are currently developing a research initiative on immunization where some important links could be made
- Review from OB – we need to double check what this was referring to.

COMMVAC Deliberative Forum, New York 8th of June 2011, Hotel Lucerne

List of Participants

Amuyunzu-Nyamongo, Mary
Executive Director, African Institute for Health and Development (AIHD), Kenya
Member of the IUHPE Board of Trustees
Email: manyamongo@yahoo.com

Bensaude De Castro Freire, Sara
Scientific projects and publications Coordinator, IUHPE HQ, France
Email: sbensaude@iuhpe.org

Claycom, Paula
Senior Advisor, Communication for Development, UNICEF HQ, USA
Email: pclaycomb@unicef.org

Jones, Catherine
Programme Director, IUHPE HQ, France
Email: cjones@iuhpe.org

Kagwa, Paul
Assistant Commissioner, Health Promotion and Education, Ministry of Health, Uganda
Member of the IUHPE Board of Trustees
Email: paulkagwa@yahoo.co.uk

Lin, Vivian
Professor of Public Health, School of Public Health, La Trobe University, Australia
IUHPE Global Vice- President for Scientific Affairs
Member of the IUHPE Board of Trustees
Email: v.lin@latrobe.edu.au

McKay, Susan
Communication for Vaccination specialist, UNICEF HQ, USA
Email: smackay@unicef.org

Manoncourt, Erma
Management Development Specialist / Associate- Development Works International
IUHPE Global Vice President for Communications
IUHPE Chair of the Global Working Group on Social Determinants of Health
Member of the IUHPE Board of Trustees
Email: emanoncourt@yahoo.com

Sakaedani- Petrovic, Akiko
Communication for Develpment specialist, UNICEF HQ, USA
Email: asakaedani@unicef.org