COMMVAC deliberative forum report

Ottawa, 28th of June 2011

I. Process

Participants were invited to the meeting about ten days in advance. We selected participants attending the Francophone International Conference on Local and Regional Health Programmes (http://www.plrs-ottawa2011.com/) working in (or on) sub-Saharan Africa.

While we had initially compiled a tentative list of approximately 15 people, 10 of them as well as the International Union for Health Promotion and Education (IUHPE) facilitator) were able to attend the meeting.

Participants mostly included health programme mangers working either at the regional level (such as in provincial health services) or at the national level (at the Ministry of Health) and all coming from sub-Saharan Africa (see list below).

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

The material received (in French) 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).

The meeting was conducted in a very similar way than consultation we had in New York. The meeting took place in the evening (after an intense day at the conference) and was therefore scheduled for an hour and fifteen minutes.

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 as these issues were recognized to be critical for the African context. 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.

The content of the discussion slightly differed from the one we had in New York. This is most probably due to the profile of the participants who were not experts in the field of communication or vaccination but rather health programme managers and coordinators. There was less focus on the taxonomy as such and more discussion around the priority intervention groups and priorities for the SR of effects. While the discussion differed it also converged in many ways, as illustrated in the report, and a lot of the issues and concerns addressed were similar to the ones discussed in New York.

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 systematic reviews 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 those provided by the written cards.

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

a. General comments regarding the taxonomy

- The taxonomy is long and complex
- Not all intervention groups as captured in the taxonomy seem relevant to LMICs context and particularly to sub-Saharan Africa (such as the use of internet for example).
- Greater attention could be paid to issues related to advocacy towards community and religious leaders who have a great influence to play in immunization programs. This links to the creation of social norms (such as traditional leaders, communities, religious leaders) and community mobilization (which is essential in terms of sustainability).
- Non verbal communication could more explicitly be included
- In the African context, it would seem essential to better articulate different types of communications targeted at the population by developing a strategy of communication through development in a integrated fashion (there tends to be an overload of communications).
- It is an issue when immunization is considered through different programs and communication strategies as an individual issue and choice (i.e. the mother chooses to bring or not her child to immunization). It is in reality much more complex and dependent on structural factors, such as the availability of transport, the cultural acceptability of services, the vision of other influential members of the community

on immunization programs (such as grandmothers, husbands for example). This is somehow not sufficiently explicit in the taxonomy.

b. Further clarification/specification/distinction in the taxonomy

- Participants suggested 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, values and attitudes of providers). An essential component of immunization communication programs should address provider's perspective and encourage them to better communicate. Community agents are an essential part of immunization programs. The perception of service providers by the community is also very important. Who are the service providers? Are they members of the community or external people? All these elements have a great influence on immunization programs perception by the community and should be taken into consideration when developing communication strategies.
- 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

  It is essential to link promotion and communication strategies to issues related to the supply of immunization. In that sense they should be considered in a holistic fashion.

c. Suggestion of new categories for the taxonomy

- The creation of social norms (such as traditional leaders, communities, religious leaders)

d. Priority intervention groups relevant to LMICs

The following priority intervention groups/categories were suggested:

- Community mobilization/network/involvement (essential in terms of sustainability) including the role of religious leaders, speaking communities, women's self help group, parents etc)
- Grandmothers, mothers are essential and influential actors when it comes to health, immunization and misconception about these. It is therefore essential to target them and reach them in settings where they are most confident.
- TV mass campaigns
- The use of modern technology seems particularly relevant and offers a great potential in the African context. In that perspective some efforts to approach mobile operators could be considered. It is nevertheless important to acknowledge that such strategies would only reach certain categories of the population and should therefore be considered in conjunction with other strategies.
- To increase access. Communication strategies targeted/addressing remote areas which are often neglected

- To minimize risk
- To recall/remind
- To teach skills (this strategy and approach is not widely used)
- To support (this strategy and approach is not widely used)
- Strategies that would address the wider and structural context in which people live (economic constraints and all resulting issues) although these might not directly link to communications issues.

III) Priorities for Systematic Reviews of effects

A) Suggested priorities for the systematic reviews

-To educate and raise awareness on the use of vaccines and related misconceptions about secondary effects

- The use of modern technologies
- Communication targeted at service providers
- To minimize risks or damage
- Look at issues of isolation and the effects of efforts to invest in mobile clinic strategies (and other similar initiatives) to facilitate access to the programs for isolated population.

B) Discussion related to effect

- As in the New York forum, participants noted that the links between the research review and priorities for intervention groups might require revising the projects objective/expected outcomes accordingly. Is the research going to lead to increase vaccination uptake? The principal research question might need to be reconsidered.
- Why does the project only target children and does not take into consideration women (immunization of women is also an essential strategy to decrease mortality in LMICs)
- In the process of conducting the systematic reviews, it would be essential to refer to empirical and qualitative data and identity strategies that would enable to collect and grasp knowledge that is not documented through more 'formal' and traditional means of evaluation such as trials. There are a substantial number of activity reports and other types of documentation related to experiences and evaluation of communication strategies and immunization programs but these are not necessarily included in these types of research. This issue was also emphasized in NY and briefly discussed in Melbourne and could be picked up during the next partners meeting in Madrid.

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 **involvement of community**– how it was done? At what stage, who? (mothers, grandmothers, religious leaders etc).

- Take into account **perspective of users**, the experience of individuals, family and community with respect to immunization programs, health services, communication strategies etc.
- Further explore the involvement of **different types of stakeholders** (including modern and traditional stakeholders) such as donors, NGOs, CBOs ,faith based organization in terms of support, design, management, implementation of communication strategies.
- The importance of developing **research at the local level** related to local interventions
- To explore **innovation strategies** for funding immunization programs
- It would be interesting to further develop **action research**

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. 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.

Efforts, such as these consultation, seem essential in order to collect and take into consideration the perspectives and issues encountered by stakeholders. Participants encouraged the approach taken and called for similar approaches at different stages of the project. They expressed a lot of interest to be informed on the project developments and engaged in other consultations as appropriate.

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 participate in the online forum and make linkages with other interesting initiatives.

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

- The Health Observatories in Africa
- An Organisation supported by the Fondation Helwet in Ghana: the **Union for African Population Studies**. (The Union for African Population Studies (UAPS) is a pan-African, non-profit, scientific organization whose purpose is to promote the scientific study of population in Africa. For nearly 25 years, UAPS has fostered the networking of researchers, policy makers, and other stakeholders across geographic and language barriers in order to improve research capacity and promote evidence-based policies and programs in population and development in Africa. The UAPS network of nearly 1200 members is able to link multidisciplinary scholars and other professionals for knowledge sharing and to facilitate collaborative research opportunities.http://uaps-uepa.org)
- National monitoring systems

- The Center of information and communication in health (Mali), which is a recent structure that focuses among other things on immunization: http://www.sante.gov.ml/index.php?option=com_content&task=view&id=72&Itemid=74

COMMVAC Deliberative Forum, Ottawa, 28 June 2011, Hôtel Hilton Lac Leamy

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