Canadian Guidance on Addressing Vaccine Hesitancy to Help Foster Vaccine Demand and Acceptance

Section 4. Recognize and Diagnose Underlying Factors in Refusal or Delay in Vaccine Acceptance: The Guide to Tailoring Immunization Programmes TIP

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Building Resilient Pro-Vaccine Communities

Building the capacity to improve vaccine acceptance and uptake

The Canadian Vaccination Evidence Resource and Exchange Centre (CANVax) is an online database of curated resources to support immunization program planning and promotional activities to improve vaccine acceptance and uptake in Canada. As an online resource centre, CANVax aims to increase access to evidence-based products, resources, and tools to inform public health professionals in immunization program planning and promotion.

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PREFACE

This document was adapted from the **Western Pacific Regional Guidance on Addressing Vaccine Hesitancy to Help Foster Vaccine Demand** document, drafted in 2017 in response to the recommendation at the meeting of the Technical Advisory Group (TAG) on Immunization and Vaccine-Preventable Diseases in the Western Pacific Region (WPR), in July 2016.

Purpose and Specific Objectives of the Guidance as per WPR

The main purpose of the regional guideline on vaccine hesitancy is to help Member States to:

1. Identify the extent of vaccine hesitancy in the country.
2. Identify vaccine-hesitant population subgroups.
3. Diagnose the demand- and supply-side immunization barriers and enablers.
4. Design evidence-informed strategies to address hesitancy appropriate for the subgroup setting, context and vaccine.
5. Receive and provide support for regional coordination to successfully address vaccine hesitancy in the country.

The initial WPR draft, including the two Aide Memoires, was written by Noni E MacDonald, Dalhousie University, Halifax Canada, with input from Eve Dubé, Institut national de santé publique du Québec, Québec, Canada, Lisa Menning and Melanie Marti, Immunization, Vaccines and Biologicals, World Health Organization (WHO), Geneva, Switzerland and Sarah Long, Dalhousie University.

Canadian Guidance

The WPR document was then re-crafted by Noni E MacDonald and Eve Dubé to address the Canadian context, and sections were updated.

Each section has been written to integrate with the other sections but also to be able to stand alone. The main emphasis is on the diagnosis of hesitancy and focuses on interventions that can increase vaccine uptake at the program and individual levels.

For the full report of the Canadian Guidance on Addressing Vaccine Hesitancy to Help Foster Vaccine Demand and Acceptance, please visit https://canvax.ca/canadian-guidance-addressing-vaccine-hesitancy-help-foster-vaccine-demand-and-acceptance-full.

Hesitancy is not uniform across a population. Analysis of vaccine uptake data from a province or territory may be able to detect subgroups with lower-than-expected coverage rates, given available vaccination services.[1] Targeting these fence-sitters is an important component in addressing hesitancy to improve vaccine acceptance rates. Hesitant subgroups may be linked by a variety of factors, including geography, culture, socioeconomic and/or other factors, especially behavioural factors and determinants categorized by complacency, confidence and/or constraints.

Guide to Tailoring Immunization Programmes (TIP)

The Guide to Tailoring Immunization Programmes (TIP), an evidence- and theory-based behavioural insight framework issued in 2013 by the WHO Regional Office of Europe, provides tools to recognize, diagnose and address vaccine hesitancy and delays in vaccine acceptance.[2-3] TIP was developed in response to concerns about low vaccine uptake and hesitancy raised by countries in the EUR region. TIP is not a communication tool, but rather a diagnostic guide to define and diagnose behaviour-related hesitancy determinants and propose appropriate interventions. The TIP Guide includes proven methodologies and tools to:

1. Identify and prioritize populations susceptible **to vaccine-preventable diseases**.
2. Diagnose the demand- and supply-side barriers **to vaccination and motivators for increasing vaccine acceptance** and then,
3. Design an evidence-informed response to support vaccination.

Rather than selecting several intervention strategies and then rolling them out across a country, TIP focuses on segmentation of the population to determine the subgroup(s) at risk, followed by a diagnosis of the relevant barriers and enablers of vaccine uptake in the subgroup(s), and then selecting interventions tailored to the findings, context and available resources for each subgroup. TIP has been used in a number of countries in Europe to determine and address low vaccine coverage problems. For example, in Sweden (Addressing inequities in immunization: TIP implementation in Sweden), the TIP process was used to find the barriers and motivating factors for the MMR vaccination in communities with low coverage.[4]

TIP Example in Sweden – low MMR coverage

Three groups were identified:

1. The anthroposophic community located south of Stockholm
2. The Somali community in northern Stockholm
3. Undocumented migrants in Gothenburg and Stockholm

An interdisciplinary project group was formed that had broad knowledge on vaccines, epidemiology, health communication, research methods and local service provision. After a situation analysis was conducted and the research statement was defined, three qualitative sub-studies were conducted based on in-depth interviews with parents and children, health clinic staff, health professionals and other informants. The results were then formatted according to the TIP model. A two-day workshop followed, where the results of the formative research results were discussed and strategic priorities identified. Four initiatives were designed to address barriers and to support vaccine motivators.

This example shows the complexity of the TIP process, and the time and breadth of skills needed. One key element is the engagement with the affected community to assess barriers and motivational factors. The TIP process has also been applied to assess how health care workers' uptake of seasonal influenza vaccine can be improved, leading to a specific document on this topic for immunization program managers.

In 2016, an external review of TIP implementation in Bulgaria, Lithuania, Sweden, and the United Kingdom was carried out.[5] Four strengths of TIP were commonly noted, including the value of the social science approach, the strength of interdisciplinary work, the growth in the immunization program's ability to listen and learn, and to understand community as well as individual perspectives. There is a strong demand in Europe for this type of research to help

program managers address subgroups with low vaccine uptake rates. The review did note that more work is needed to design and implement interventions based upon the TIP findings, focusing on principles of enhanced local ownership, integration of diagnosis and intervention design, follow-up meetings, advocacy, and incentives for decision makers to implement the needed changes. The complexity of the program, the resources, and expertise needed to execute this well were noted.

Simplified TIP

While TIP has been successful in the European Region and was adjusted to fit South Africa, it has become evident that a more simplified version, one that is less arduous and time consuming, less reliant on external consultants and specific expertise, is needed. This is being developed at WHO headquarters. Key elements of success from TIP that will be focused on are engaging with the underimmunized communities to listen and learn about the barriers, and gain a better understanding of the motivators for accepting immunization. Extrapolating from the patient setting (see Section 5.9 – Use effective discussion techniques to introduce immunization and to address concerns[RX1]) – it is asking the question "W*hat would it take to move you to a yes?"* at the community/subgroup level, and then listening carefully to the answers and probing further to ensure fulsome understanding of the barriers and motivators, that makes the difference. In many instances it is not one factor, but a combination of circumstances, beliefs, misunderstandings, misinformation, and lack of trust that have led to low uptake. Carefully listening is the key to adjusting the program to address the barriers and supporting motivation to accept immunization.

KEY POINTS

- Since hesitancy is not uniform across a population, immunization programs must detect subgroups where there is a problem.
- The WHO EURO Guide to Tailoring Immunization Programmes (2013) is a helpful tool.[2] Available from: http://www.euro.who.int/en/health-topics/communicable-diseases/poliomyelitis/publications/2013/guide-to-tailoring-immunization-programme.
- Critical elements of TIP are to probe gently, and listen carefully to learn about concerns, barriers and motivators.

References

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