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| Acceptance and demand for  COVID-19 vaccines | |
| Interim guidance  31 January 2021 |  |

**This document is intended to serve as practical, how to guidance to support programmes to achieve high acceptance and uptake of COVID-19 vaccines. It accompanies an Excel sheet planning template that should be considered together   
with this document. Please adapt both to your context.**

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# **Introduction**

In January 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a Public Health Emergency of International Concern (PHEIC). The outbreak, the first cases of which were detected in China, has infected millions of people across the world and caused significant loss of life. To protect people from the disease, vaccines against COVID-19 are being developed by several manufacturers in a number of countries. Vaccines, combined with behaviours such as physical distancing, hand hygiene, correct mask wearing, respiratory etiquette, improved ventilation will be the most effective means to protect populations from coronavirus. It is expected that only a limited supply of vaccines will be available in the early days. It will be important for countries to have a good communication plan in place to provide accurate and up-to-date information to families and communities about the COVID-19 vaccines, eligible segments of the population and continuation of recommended behaviours by all community members to prevent infection and transmission. Demand generation interventions will need to encourage eligible populations to be vaccinated and at the same time manage public expectations and convey that vaccine supplies will not be sufficient for everyone in the beginning.

This demand planning guidance document has been developed through a participatory, multi-stakeholder and iterative process by the demand sub-working group of the Country Readiness and Delivery (CRD) workstream of COVAX, the vaccine pillar of ACT-A.[[1]](#footnote-1) The development process was based on a range of scientific evidence, grey literature, existing guidance and plans for new vaccine introductions and mass vaccination campaigns, and a depth of expertise from many organizations with extensive experience in this domain from all regions the world. Experts and implementers from all regional offices and a diverse range of countries were engaged in the process to ensure practical and realistic approaches were taken. A particular focus was placed on social listening and behavioural and social data collection and use, to guide the design and evaluation of targeted strategies to generate and sustain demand.

# **1.** **Social data collection and use**

Before developing communication plans, countries should collect information from multiple sources on people’s perceptions and motivations towards COVID-19 vaccines – using existing studies/reports to the extent possible. In some cases, there may be enough behavioural and social data already available to inform the communication plan – making a quick desk review of these data sufficient. Social media listening has been one of the most useful ways to track public perceptions.[[2]](#footnote-2) Social media can also help in analysing the different perceptions across demographics (age, linguistic, cultural, gender). Data on behavioural and social drivers (BeSD) should also be collected from marginalized as well as mainstream communities, and should sample both men and women, people with disabilities and other marginalized groups, and people of all ages so that their concerns and needs can be addressed through the communication interventions. These data can be collected from various reliable sources, particularly trusted organizations and community representatives that are experienced in liaising with these groups.

Countries will find monitoring social media and mainstream media to understand the rumours, misinformation and public sentiments useful for deciding on messaging and communication interventions. In some countries, there may not be sufficient data readily available. These countries, in particular, should consider conducting rapid assessments using tools such as formal surveys and studies, focus group discussions, media monitoring, informal community feedback, etc., using a mix of qualitative and quantitative data to assess knowledge, attitudes and practices; key influencers in communities; communication channels; the languages in which people prefer to get messages, etc. *Journey to Health* is a human-centred design tool which has been used to understand and analyse barriers to immunization. Countries may consider using it for COVID-19 vaccine introduction.

The available data can then be analysed, triangulated and used to identify audiences, set objectives and decide on messaging, activities, dissemination channels, and timing. Findings from social data should be used to regularly refine and update communication plans and strategies, content development and messages.

# **2.** **Coordination and planning**

In most countries demand generation, social mobilization and communication activities are coordinated through advocacy, communication and social mobilization (ACSM) task forces under the ministry of health or Expanded Programme on Immunization (EPI). When a new vaccine is being introduced in the country, various task forces are set up to work in specific topic areas and ACSM is one such task force. In the context of COVID-19, many countries have set up risk communication and community engagement (RCCE) task forces, which can also be utilized for COVID-19 vaccine introduction. The coordination group should be led by the government and should have representation of key partners who support governments on ACSM/demand generation for immunization. The coordination group should lead the development of communication plans, training and communication materials, crisis communication and monitoring of demand generation activities. The coordination mechanism should be established at both national and subnational level to ensure localization of communication planning and implementation. To make coordination stronger, regular meetings of the ASCM and RCCE task forces should be conducted.

The government-led mechanism should have a system for quick clearance and approval of communication content and approaches. Development of standard operating procedures (SOPs) to manage crisis communication can help manage communication in a coordinated approach.

Under the leadership of ACSM/RCCE task force, countries should develop a comprehensive communication plan including crisis communication. The plan should be evidence based (as described in section 1 and include all key areas of demand generation including: identification of target audiences, particularly marginalized communities; objectives; capacity building; key messages; development of communication products in local languages as much as possible; pretesting and finalization; community engagement activities to be implemented; key stakeholders and roles and responsibilities, and monitoring and reporting. Communication planning will need to address and engage various intended audiences, as per the phases of vaccine delivery and to ensure acceptance and uptake. Vaccination for the first cohort will most likely be prioritized for health workers (including community health workers), older adult populations and people with comorbidities. To reach this priority population, appropriate communication channels, based on evidence, will need to be selected and used. This should allow for two-way communications where people can ask questions and get answers, not just receive instructions. Partnership with non-traditional partners, such as long-term care facilities and the private sector working with these populations, will need to be explored.

As not everyone will be eligible for the COVID-19 vaccine in the initial phases, it will be important to continue the RCCE approaches being used for COVID-19 prevention. In this case, reaching out to all populations with key preventive behaviour promotion will be important.

# **3.** **Implementation of mass media plan**

For the introduction of any new vaccine, the population needs to receive accurate, systematic information about the vaccine, such as eligible populations and when and where to get the vaccine. Mass media plans will include focused messages through short and simple public service announcements, news stories, positive testimonials by trusted representatives, features, etc., which will be delivered via radio, TV, and print material, among other means. It is important to build trust among people about the vaccine and to communicate the benefits and safety of vaccines. Dedicated radio and TV programmes can be produced and disseminated, and can feature experts talking about the subject matter, as well as trusted opinion leaders receiving the vaccine. These will be complemented by community engagement/social mobilization activities and interpersonal communication by health workers and others. The channels of communication will be determined by evidence and will be based on considerations such as access, use, availability, credibility of sources, and trust. It will be important to keep credible, accessible, information flowing so that misinformation does not take hold.

# **4.** **Social media monitoring and misinformation management**

Countries should establish a mechanism to regularly track information on both social and main-stream media from the beginning. Countries can then analyse the impact of anti-vaccine sentiments, fake news, misinformation and disinformation. Based on the social media analysis, relevant people will need to assess the situation and provide quick, real-time response as soon as possible to mitigate rumours and disseminate accurate information. This needs to be complemented by robust positive social media output and social mobilization at community level in order to maintain public trust in COVID-19 vaccines and the government. Social media monitoring can also identify influencers, identify positive messaging to amplify and help in informing and updating the communication response.

# **5.** **Crisis communications**

Communication crises can arise due to adverse events following immunization (AEFI), malicious rumours and misinformation, or other vaccine-related events. SOPs should be established (or adapted from previous vaccine introductions) to help ensure effective management of the situation from a communication and trust-building perspective. SOPs should include processes for evaluating a situation, determining any actions, subsequent efforts to monitor the situation and agreeing on any further communications on the issue causing the crisis. Based on news monitoring and social listening, appropriate message content and approaches will need to be rapidly developed and disseminated to counter negative sentiment. It may require working with and mobilizing mass and social media platforms.

Crisis communication should be part of the training at national and subnational levels, and roles and responsibilities of different people will need to be clearly spelled out, e.g. spokespersons, EPI managers, health workers, vaccinators, social mobilizers, community leaders, and others. When crises arise, only designated people should speak to the media and general population. This will help to avoid conflicting messages being given through different sources. The spokespersons will need to be trained in crisis communication. Transparent and accurate information to the media will be critical at all stages of crisis communication. Having some scenario-based planning on communications can be helpful to address possible crises.

As noted, most AEFI are not caused directly by vaccines. However, being transparent about the systems in place to monitor and investigate any AEFI will be helpful if an event occurs. People will appreciate being informed about the investigation and will be more likely to wait to hear the results.

# **6.** **Advocacy and stakeholder engagement**

When a new vaccine is being introduced in the country, the public will have questions and concerns regarding the vaccine and its effectiveness, safety, previous use, cost, etc. Advocacy meetings and events with key stakeholders in the country are crucial for demand generation. Key stakeholders include parliamentarians, the interagency coordinating committee (ICC), the national immunization technical advisory group (NITAG), relevant line ministries and departments, other medical units (such as infectious diseases and those that work with adult and older adult populations), medical and nursing associations, other public health associations, civil society organizations, donors, media, and others. Advocacy at national level will be very important for proper budget allocation for COVID-19 vaccine introduction, including adequate funds for demand generation activities. Advocacy meetings also should be organized with relevant stakeholders at subnational levels. At community level, advocacy with community influencers, community leaders, religious leaders, and others will need to be done to create an enabling environment and to garner support for COVID-19 vaccines. An advocacy kit, including frequently asked questions (FAQ), factsheets and relevant materials, will need to be developed and disseminated to build the commitment of in-country partners and stakeholders for COVID-19 vaccine introduction.

Due to the complexity of the introduction of COVID-19 vaccines there is a special need to closely engage national and subnational media personnel before, during and after introduction. Advocacy to media personnel on the rationale of COVID-19 vaccine introduction, the vaccines’ safety and effectiveness, and their roles and responsibilities in reporting correct and accurate information is crucial for successful introduction of COVID-19 vaccine.

# **7.** **Community engagement and social mobilization**

****Community engagement activities are an integral part of every development programme. For new vaccine introduction, communities should be engaged in the development of microplans and design of the vaccine delivery approach, defining communication activities, implementing and monitoring vaccination activities. Communities should be engaged in localizing the messages – using local terminology when communicating, and to check that people have understood the message being disseminated. Community engagement should include all social mobilization activities, and efforts should be made to engage community leaders, religious leaders, local community-based organizations, youth groups, mothers’ and fathers’ groups, etc. Social mobilizers and community health workers will be the vehicles to provide timely accurate information to communities, distribute print materials, engage with communities in relation to COVID-19 vaccine introduction, and inform health facilities of community concerns or needs related to the vaccine. Community leaders and community health workers can play important roles in tracking eligible unvaccinated people in communities and encouraging them to go for vaccination. Programme managers need to focus on underserved communities and work with them to map the older adult population, people with comorbidities, and people at elevated risk of infection and transmission. Specific efforts will be needed to reach refugees, migrant populations and other vulnerable groups. Additionally, the needs of older adults and those with pre-existing conditions will need to be paid attention to. Introducing the COVID-19 vaccine also creates an opportunity to identify zero dose children in communities and to promote routine immunization.

# **8.** **Capacity building**

Capacity building of health workers, social mobilizers, community leaders and civil society organizations will be very important, so that they are proficient in the vaccine preparations and communication needs and approaches – as well as the roles they can play. Interpersonal communication training modules for health workers will need to be integrated into the training being organized at national, subnational and community levels and localized to address local contexts. These modules should cover interpersonal communication in general and COVID-19 vaccine-specific communication and should include practice. Capacity building of spokespersons, ACSM/RCCE task force members and media will also need to be factored in during the planning phase. Partnering with media and providing them with structured media orientation to orient them about the vaccine, allow them to ask questions (preferably of experts, including government officials) and to encourage responsible reporting based on facts will help in mitigating misinformation.

# **9. Monitoring, learning and evaluation**

****Monitoring and supervision of communication activities will be important to show the effectiveness of communication interventions during the vaccine rollout and to make course corrections as needed. Therefore, demand planning should include plans and activities for the monitoring and evaluation of relevant activities linked with the national deployment and vaccination plan (NDVP) and performance indicators. This will also include developing a monitoring checklist and rapid surveys to assess the effectiveness of communication activities. Lessons learned should be quickly adapted for course adjustments, disseminated, and considered in any future vaccine introduction efforts.

WHO and UNICEF continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO and UNICEF will issue a further update. Otherwise, this interim guidance document will expire 2 years after the date of publication.

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1. The members of the demand sub-working group [are published](https://www.gavi.org/sites/default/files/covid/covax/COVAX_the-Vaccines-Pillar-of-the-Access-to-COVID-19-Tools-ACT-Accelerator.pdf) (last accessed 29 January 2021). Conflicts of interest are managed in full respect to the COVAX decision-making principles outlined in the same publication. [↑](#footnote-ref-1)
2. *Vaccine misinformation management field guide*. New York: United Nations Children’s Fund, 2020 (<https://vaccinemisinformation.guide/>). [↑](#footnote-ref-2)