

BUILDING TRUST AND RESPONDING TO ADVERSE EVENTS FOLLOWING IMMUNISATION IN SOUTH ASIA: USING STRATEGIC COMMUNICATION



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USING STRATEGIC COMMUNICATION**

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For additional copies and further information, please contact:

Regional Advisor, Programme Communication
UNICEF Regional Office for South Asia (ROSA)
PO Box 5815, Lekhnath Marg
Kathmandu, Nepal
Email: rosa@unicef.org

Cover photo: © UNICEF/ HQ05-0252/Giacomo Pirozzi
MALDIVES: A woman health worker vaccinates a crying toddler being held by her mother, on Kudahuvadhoo Island in Dhaalu Atoll, some 150 kilometres from Male, the capital. An immunisation campaign against measles and polio, aimed at all children under age two, is under way following the tsunami disaster.

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Foreword

Millions of children are vaccinated every year, protecting them from avoidable diseases and tragic deaths. Rarely, adverse events following immunisation (AEFI) occur. While most of them are mild, adverse events are a cause for concern and have to be investigated. If not responded to promptly, serious AEFI can erode public confidence in vaccines and contribute to a drop in immunisation coverage. This could ultimately lead to a resurgence of vaccine preventable diseases.

When an AEFI occurs, appropriate actions have to be taken. These actions include communication. But communication around AEFI is far more than an ad-hoc response and needs to be part of a broader communication plan with trained staff and resources in place to respond correctly and without delay.

Successful communication efforts which support immunisation goals include sustained advocacy for political commitment and resources, social mobilisation to broaden the range of partners and behaviour development communication to shape immunisation-related attitudes and practices of individuals and families. Such communication strategies have to be managed in synchrony with health services and ought to be based on a sound surveillance system.

To develop communication capacity specifically around AEFI, the UNICEF Regional Office for South Asia (ROSA) and the WHO Regional Office for South-East Asia (SEARO) organized a joint regional workshop "Strategic Communication: Building Trust and Responding to Adverse Events Following Immunisation in South Asia", in New Delhi from 9 to 10 August 2004. This working paper synthesises the presentations and debates from the workshop. The workshop, a testimony to the fruitful cooperation between our two organisations, made SEARO and ROSA the first regions to invest in communication capacity building for AEFI.

We express our sincere appreciation to all participants from the Ministries of Health in Asian countries and to our colleagues from WHO and UNICEF headquarters, regional and country offices who contributed to the rich discussions at the meeting.

UNICEF ROSA and WHO SEARO are pleased to share this working paper to inspire greater action in communication for immunisation, especially around AEFI. It is our common hope to see better planned and implemented strategic communication around AEFI to maintain public trust in childhood immunisation and help realise children's rights to life, survival and development.



Cecilia Lotse
Regional Director
UNICEF Regional Office for South Asia



Dr Samlee Plianbangchang
Regional Director
WHO Regional Office for South-East Asia

Introduction

Every year over 150 million children under the age of five are vaccinated in South Asia.¹ Immunisation is essential to save children's lives. It is also an affordable means of protecting whole communities and it reduces poverty. Immunisation has achieved real success in the past 20 years. Smallpox was eradicated in 1979, a massive human endeavour, and today polio is set to become another scourge of the past.

Today vaccines protect nearly three-quarters of the world's children against major childhood illnesses. UNICEF and WHO have been instrumental in assuring increased access of developing countries to high quality affordable vaccines. All EPI vaccines supplied by UNICEF are from WHO recommended sources. Through a process of pre-qualification, WHO advises UN procurement agencies on the quality, efficacy and safety of vaccines available on the market.

Although vaccines produced and regulated in keeping with WHO standards are very safe, no medicine is without risk of a potential adverse reaction. And rarely, adverse events following immunisation (AEFI) occur. While most adverse events following immunisation (AEFI), such as a sore arm or mild fever, are mild, settle without treatment and have no long-term consequences, very rarely serious adverse reaction can occur. Ultimately, any question from the public about the safety of vaccination is a cause for concern. They must be swiftly and effectively investigated and appropriate action has to be taken. Rumours and misinformation about vaccines and immunisation sometimes occur because perceived or true adverse events following immunisation are handled inappropriately. Incorrect information in media coverage on vaccine safety issues can further propagate and sensationalize misinformation. As a result, rumours about vaccines may spread, possibly leading to reduced immunisation coverage and increased childhood illnesses and unnecessary deaths.

Effective communication around vaccine safety, including management of public reactions, requires serious investments of resources and efforts into strategic communication for immunisation. Immunisation managers need to know how to address negative media coverage and to prevent rumours from causing unnecessary drop's in immunisation coverage. In essence, when an AEFI occurs, whether true or perceived, programme managers need to:



Afghanistan: Women, some dressed in burqa, and children, stand in line outside a village health centre awaiting vaccinations during the UNICEF-supported 16-20 June immunisation campaign near the northern city of Balkh.

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- Respond swiftly with accurate information based on evidence;
- Know how to deal with broad vaccine safety issues, often coming from the media, versus individual AEFI cases;
- In case of a rumour, assess the origins of the rumour and be prepared with a number of potential strategies to counter them;
- Foster long-term partnerships with the media to promote responsible public health reporting;
- Build partnerships with professional organizations and credible national spokespersons inside and outside the Ministry of Health;
- Collaborate with the national immunisation committee dealing with vaccine safety issues;
- Work through different channels and spokespeople to promote accurate information and cooperation to ultimately enhance public trust in immunisation;
- Monitor the community's knowledge, attitudes and practices toward immunisation, particularly after an adverse event has occurred;
- Document lessons learned in handling communication responses to AEFI.

Communication around AEFI in South Asia is still a relatively new area with limited experience. To enhance communication capacity in handling adverse events, the UNICEF Regional Office for South Asia (ROSA) and the WHO Southeast Asia Regional Office (SEARO) organized a joint training workshop on Strategic Communication: Building Public Trust and Responding to Adverse Events Following Immunisation in New Delhi, from 9 to 10 August 2004. The workshop brought together government immunisation managers, colleagues from WHO country offices, regional offices and headquarters and UNICEF Immunisation and Programme Communication managers South and East Asian countries. Agenda and the list of workshop participants are in Annex F and G.

This document draws from and synthesises the presentations and discussions from the joint meeting. The case studies presented in this document describe real experiences shared during the workshop.

We hope this report will generate interest to further pursue national training to build communication capacity, particularly at sub-national and district levels among immunisation managers, health workers and vaccinators where effective communication through dialogue and interactions with community members and journalists can make a real difference to foster public trust in immunisation.

Complementary references about adverse events following immunisation, can be found at:

<http://www.unicef.org/immunization/>

http://www.who.int/immunization_safety/

http://www.who.int/vaccine_safety/en/ (Global Advisory Committee on Vaccine Safety)

http://www.who.int/immunization_safety/safety_quality/vaccine_safety_websites/en/
(Vaccine Safety Net)

What is an AEFI?

In order to effectively plan and manage communication strategies around AEFI, we need to understand the causes of AEFI and the system needed for identifying, reporting and managing them. This section provides a short overview of AEFI, its causes and the impact of AEFI on immunisation programmes. Annex A offers an overview of the AEFI investigation process, data to be collected and the role of district and regional managers.



Bangladesh, EPI programme in Kali Nagar, Nawabganj, vaccinating against six communicable diseases. TT3 coverage has increased among pregnant women from 23% in 1991 to 68% in 2003.

© UNICEF/ROSATHOMAS L. KELLY

WHO defines an adverse event following immunisation (AEFI) as:

*"a medical incident that takes place after immunisation, causes concern and is believed to be caused by the immunisation."*²

2.1. Causes of AEFI³

There are four possible causes of an AEFI:

- **Vaccine reaction:** an event caused by some component of the vaccine - the active component of the vaccine itself, the preservative, the stabilizer or other. The majority of vaccine reactions are "common" and expected, mild, settle without treatment and have no long-term consequences. More serious reactions are very rare and are usually of a fairly predictable (albeit extremely low) frequency.
- **Programme error:** an event caused by an error in vaccine preparation, handling or administration.
- **Coincidence:** an event where something happens after the immunisation but is not caused by the vaccine or the programme.
- **Injection reaction:** an event arising from anxiety about the injection.

Vaccines used in national immunisation programmes are extremely safe and effective, although adverse events can occur following immunisation. In addition to the vaccines themselves, the process of immunisation (programme error) can be a potential cause of an adverse event.

Programme errors leading to adverse events⁴

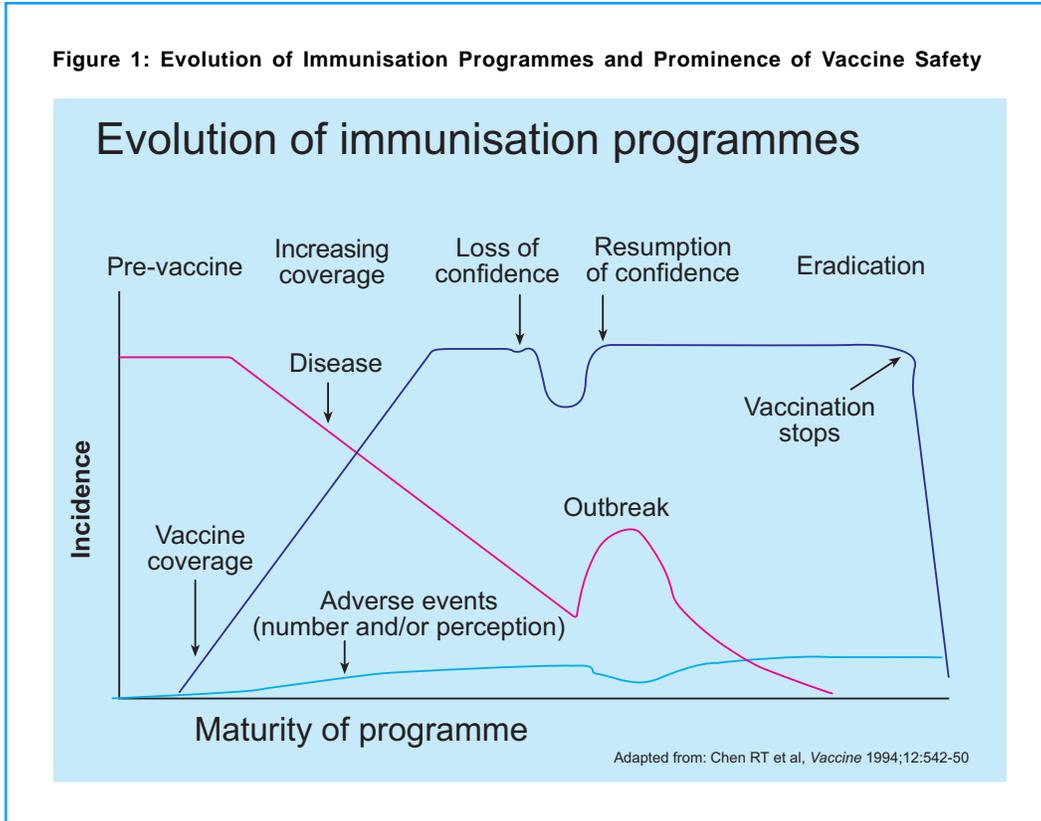
Programme Errors	Possible Adverse Event
Non-sterile injection: <ul style="list-style-type: none">● Reuse of disposable syringe or needle● Improperly sterilized syringe or needle● Contaminated vaccine or diluents● Reuse of reconstituted vaccine at subsequent session	Infection (local suppuration at injection site, abscess, cellulites, systemic infection, sepsis, toxic shock syndrome, transmission of blood borne virus like HIV, hepatitis B or hepatitis C)
Vaccine prepared incorrectly: <ul style="list-style-type: none">● Vaccine reconstituted with incorrect diluents.● Drugs or other substance substituted for vaccine or diluent.	Effect of incorrect diluent or drug.
Immunisation injected in wrong site: <ul style="list-style-type: none">● Subcutaneous instead of intradermal for BCG● Too superficial for toxoid vaccine (DPT, DT, TT)● Buttocks	Local reaction or injection site abscess Sciatic nerve damage (and ineffective vaccine)
Vaccine transported or stored incorrectly	Increased local reaction from frozen vaccine (and ineffective vaccine)
Contraindications ignored	Avoidable severe vaccine reaction e.g., anaphylaxis in case of known history of allergy.

2.2 Impact of AEFI on Immunisation Programmes

The effects of adverse events following immunisation have been documented over past decades in only a few countries, mainly in Europe and in a few African countries. What is known is that the consequences of AEFI (true or perceived) can include loss of public trust in immunisation, changes in public health policies and, in some instances, resurgence of vaccine-preventable diseases. The impact can extend from local to national and international levels, and range from short to long-lasting consequences.

Figure 1 illustrates the evolution of immunisation programmes and emerging prominence of vaccine safety issues that threaten to erode the gains of immunisation programmes.

Figure 1: Evolution of Immunisation Programmes and Prominence of Vaccine Safety



There is a number of documented AEFI examples from Europe and Africa that illustrate how real, perceived or coincidental AEFI and rumours about vaccines and related issues have affected public trust in immunisation services.

Uganda conducted its first Polio National Immunisation Days (NIDs) in 1996. In order to synchronize the campaign with other countries, the dates of the following NIDs were changed to August-September 1997, which coincided with the beginning of the malaria season. In the Southwestern region, a number of children reportedly died following vaccination during NIDs. The tragic deaths of scores of children from malaria were wrongly perceived as resulting from OPV. In the minds of many, the coincidental association was perceived as a causal association. Combined with other factors, including poor social mobilization, little involvement of health workers in the NID planning, and lack of immunisation information among families, routine immunisation coverage plummeted in 1998. In Mbarara district, reported DPT3 coverage plunged from 80 percent in 1997 to 54 percent in 1998. Parents did not receive the information they needed after the coincidental deaths of their children. The lack of information to parents created fertile ground for the anti-vaccine opposition to create rumours and confusion. **This example highlights the importance of providing timely and adequate information to parents about the benefits of immunisation and about AEFI, even for coincidental events.**⁵

In Sweden, DPT coverage dropped sharply in the late seventies after an influential medical leader questioned the need for pertussis vaccination and made his view known to the public. This resulted in many pediatricians losing confidence in pertussis vaccine. DPT

coverage decreased rapidly from 90 percent in 1974 to 12 percent in 1979. The government changed the national policy in 1979, abandoning pertussis vaccine. In subsequent years, a pertussis epidemic with more than ten thousand cases a year and a number of tragic deaths occurred in the country.⁶ **The example from Scandinavia demonstrates the influence of public opinion leaders on immunisation policies, and the importance of addressing public opinion concerns.**

In September of 1998, more than 800 school children in Jordan believed they had suffered from the side-effects of tetanus-diphtheria toxoid (Td) vaccine administered during a nationwide school-based campaign. More than a hundred students were admitted to the hospital. Initially, the government, when informed about the first reported events, advised all schools to immediately stop the vaccination campaign. It did not take long for the media to broadcast the story on TV and radio throughout the country, resulting in mass panic among parents. The AEFI investigation later established that for the vast majority, the symptoms did not result from the vaccine but arose from mass psychogenic illness ("hysteria"). Only ten cases were established to have been true AEFI - which is within the expected range of adverse reactions to Td. This cluster of AEFI occurred against a background of public distrust of government's handling of previous public health issues, and a background of

misinformed media which immediately suggested that a "bad vaccine" was used. After the investigation, the Jordanian Ministry of Health reinstated the Td vaccination campaign, spending time and resources on restoring public confidence in immunisation programmes. **This example underscores the importance of building long-term relationships with the public and the media. It also shows the impact a small cluster of AEFI can have on a national vaccination campaign.**⁷

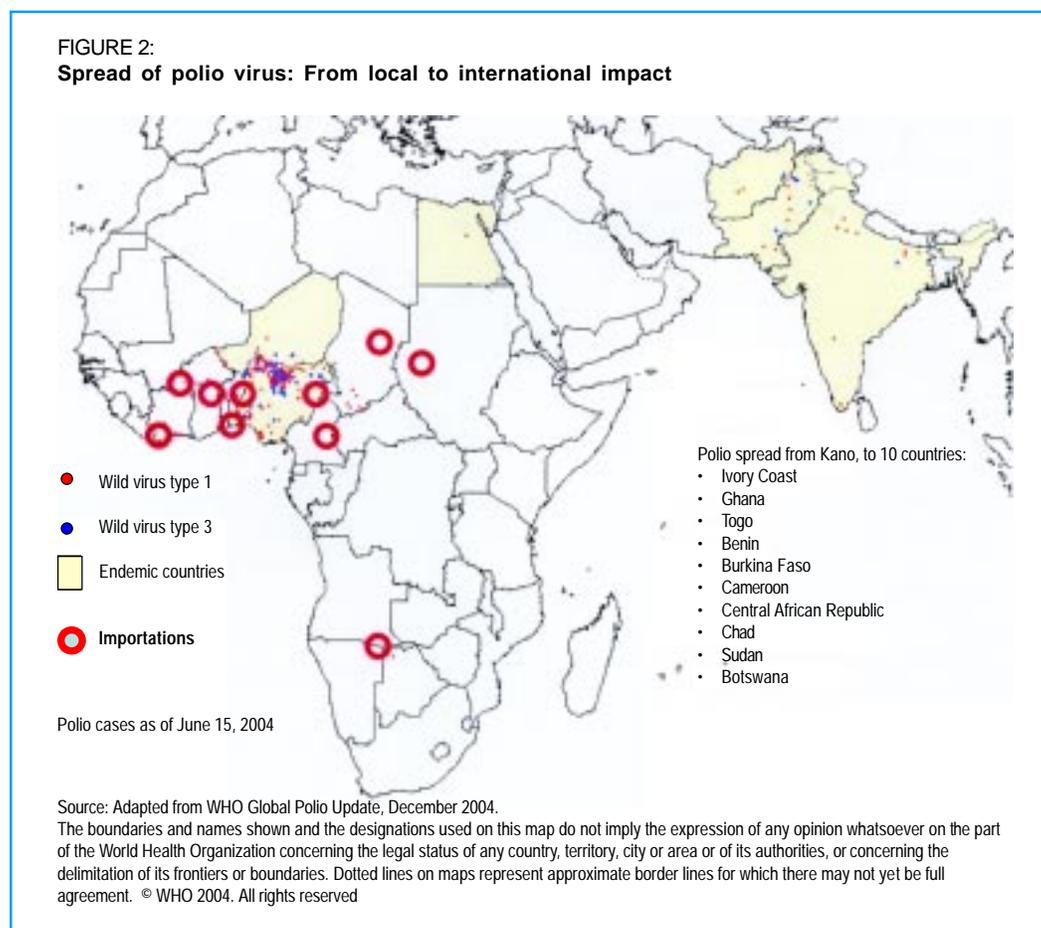
NOTE

that during vaccination campaigns, there is the potential for an apparent rise in the number of adverse events because of the sheer numbers of individuals vaccinated. This can result in a clustering effect of AEFI and immunisation teams need to be prepared in advance.

In Uganda in 1999, an influential FM radio host started to question OPV campaigns, broadcasting numerous anti-OPV messages. Government officials reacted swiftly and put forth a plan of action to counter the rumours and inform communities about immunisation, including the possibility of adverse events. The response included carrying out a survey of people's knowledge, attitude and perception of immunisation, developing messages tailored to people's needs, using multiple channels (including radio) to share information, meeting influential opinion leaders from the media and religious groups to discuss and clarify concerns and questions about OPV. As a result, the broadcasts had very little impact on OPV coverage that year.⁸ **This example demonstrates how governments can effectively counter negative media coverage.**

In Northern Nigeria's Kano state OPV immunisation was halted in August 2003 following rumours circulated by religious clerics that "OPV vaccine could cause sterility in girls." As a result, Kano became the epicentre of a fast-growing outbreak of polio. The outbreak spread into ten African countries that had previously been free of polio (Figure 2). The Nigeria ban on OPV was lifted after 11-months and the campaign was restarted in July 2004. However, the impact was long-lasting. The controversy over safety of the polio vaccine

led to distrust of all immunisation programmes and threatened the acceptance of other public health programmes. The false rumours about the polio vaccine also spread to countries as far as Pakistan and Afghanistan. **This example illustrates how local events can have a national or international impact on immunisation programmes.**



Lessons learned from the evidence

- Health workers and vaccinators need to have a good understanding of the benefits of immunisation and potential adverse events, and should be able to communicate these clearly to families. Opposition or distrust in public services must be addressed.
- Gate keepers to public opinion, such as journalists, community and religious leaders, can be a tremendous resource in assuaging fears and misconceptions about immunisation. Engaging them will go a long way in building trust for immunisation.
- Building and maintaining public trust in immunisation is not a one time effort but a continuous, well planned endeavour.
- During a vaccination campaign, a clustering effect of AEFI may occur and, with it, a heightened public and media interest in vaccine and related issues.
- Any vaccine rumour or misinformation or poorly managed AEFI, whether true or perceived, can have a long-term impact on national as well as international immunisation efforts.
- A proactive approach to communication makes it possible to mitigate potential negative impact of rumours and misinformation on immunisation coverage.

Communication around AEFI

An AEFI, whether real or perceived, can easily become a crisis situation if not managed well. The AEFI may be reported through the local or national media or talked about in the community. Immunisation and communication managers must be ready to respond promptly to prevent a loss of public trust in vaccines, and consequent reduced immunisation coverage and increased disease. Preliminary investigations should be conducted at least within 48 hours for serious AEFI, and events causing public concern.



Afghanistan: On 6 January, a man health worker vaccinates a boy against measles, assisted by another man, at a clinic set up in the Afghana mosque in Kabul, the capital.

An AEFI may or may not be caused by vaccination. In some cases coincidental events occur which appear as if they were the result of vaccination, but are unrelated. Vaccines are mostly administered to the age group of infants and young children who are in the period of their lives when they are vulnerable to many illnesses. Many events that occur just after vaccination may well have occurred whether or not the child had been vaccinated. These events are coincidental, which is often very difficult to explain to parents who see their child vaccinated one day and becoming ill the next. Nonetheless, immunisation managers have to establish the reason for the adverse event and should make a rigorous effort to share the findings with affected family and community members and the media to avoid a loss of community confidence and negative public opinion about immunisation.

REMEMBER

Communication cannot substitute for quality immunisation services and an effective surveillance system for the detection and investigation of AEFI.

Effective communication around AEFI tries to understand and address any covert issues, like a potential distrust in public health services or opposition to vaccines among influential individuals in the community or among media professionals.

Another important consideration is that even though the risk of adverse events from vaccination is minimal, during mass vaccination campaigns when large numbers of doses are provided over a short period of time, a few such reactions may occur within the same geographical area or at the same time, creating a "clustering effect". This could result in increased public concern and negative media coverage. The clustering effect may be due to

a true adverse reaction to the vaccine but appears more visible given the higher number of vaccinations given at the same time. Immunisation teams need to be prepared for this.

An essential element of any good response is the ability to communicate the benefits of vaccination vis a vis the much lower risks of adverse reactions. For more information on expected AEFI rates see Annex B.

3.1 Risk Communication

Vaccines are extremely safe. If vaccines meet WHO requirements, then we know they meet high-quality and very stringent criteria. But they are not totally free from risk. How do we tell the public that there is a finite, but extremely small risk associated with vaccines, and still encourage them to bring their children for vaccination? In preparing a strategic communication plan and messages, specifically around AEFI, we need to understand some of the principles of risk communication.

Risk Communication Essentials

- Note that fear and anger are barriers to effective communication.
- Listen to what the public is saying and try to understand their concerns and the underlying reasons. This includes understanding the local perception of the disease, perception of injections and perception of the vaccine.
- If an AEFI occurs, get information out as quickly as possible. The public needs to know that you share their concerns, that the situation is being investigated and that you will keep them informed.
- Make sure that all partners are giving out the same message. But tailor explicit communication messages to the specific situation. It is useful to differentiate between the general public and the medical community and their respective information needs.
- Risks perceived to be generated by a trusted source are more accepted than risks perceived to be generated by an untrusted source. So have a trusted spokesperson deliver the message.
- Risks perceived to have clear benefits are more accepted than risks perceived to have little or no benefit. It is important to make sure that families and communities understand the benefits of vaccination.
- Risks perceived to be familiar and understandable are more accepted than risks perceived to be exotic. Avoid technical terms and long words or phrases when explaining.
- Media is the gateway to public opinion. Identify and meet the needs of the media.
- Remember that it takes at least three positive points to counter one negative point.
- Keep the media and the public informed.

Adapted from: UNICEF (2004) Building Trust in Immunisation - Partnering with the Media. New York; and: Agency for Toxic Substances and Disease Registry (2001) A Primer on Health Risk Communication Principles and Practices, USA.

Successful risk communication involves processes such as two-way dialogue, active listening and discussion. Individuals differ in their perceptions of risk depending on their life experience and knowledge, and their notion that certain risks may be more acceptable than others. Always emphasize that the risk from the disease, which the vaccine is preventing, is much greater than the risk of any complication that may arise from the vaccine.

3.2 Developing a Communication Plan

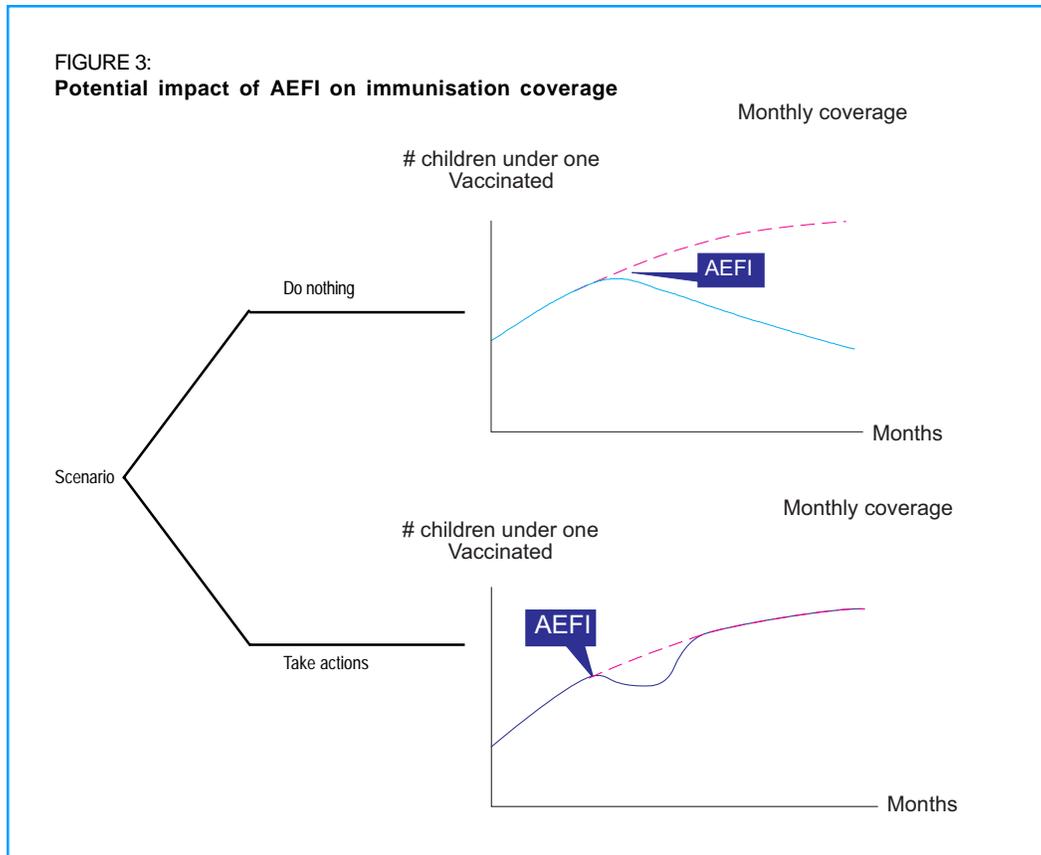
A crisis situation caused by an AEFI can often be avoided by good preparation, training of staff and partners and having a communication plan. A communication plan supporting immunisation programmes or immunisation campaigns is the basic tool for minimizing the possible negative repercussions of an AEFI (and other causes for public concerns around vaccine related issues). In order to have a sustainable impact on behaviours of individuals and among groups on a large scale, communication efforts need to be strategic, participatory, based on evidence from research, results-oriented and well-funded. In addition, strategic communication plans have to be closely coordinated with immunisation services and based on a well-developed surveillance system.

Every immunisation team needs to be prepared with a strategic communication plan. A communication plan allows us to **be proactive as well as reactive** if an AEFI occurs.

Preparing such a plan involves:

- Developing strategic links with journalists and different media (TV, radio, newspaper);
- Research on the level of knowledge, attitudes and practices among community members towards immunisation;
- Training staff, in particular health workers and vaccinators, including on how to communicate vaccine related issues in case an AEFI occurs or when any questions arise around the safety of vaccines;
- Ensure everybody involved knows what the action plan is and what their individual roles are.

Figure 3 visualises the potential impact on immunisation in a situation where there is no strategic communication response to an AEFI versus a situation where there is effective communication related to an AEFI. Both scenarios assume that services are constant.



A strategic communication plan addresses the needs in the short-term (e.g. if an AEFI occurs) and in the long term supports immunisation efforts, both at the national and local level. It is built on multiple communication strategies. One strategy is **advocacy** which aims to shape public opinion and influence decision-makers at various levels to develop and implement good immunisation policies, including allocating sufficient resources.

Another strategy is **behaviour change communication** (also referred to as programme communication) to enhance immunisation knowledge and positively influence attitudes and practices of individuals and groups towards immunisation.⁹ This can be aimed at parents as well as health workers and other critical groups. Behaviour change communication uses a mix of different channels: mass media (e.g. TV, radio), small media (e.g. brochures, flipcharts and street plays) and interpersonal communication channels (e.g. health workers, religious leaders, respected community members).

A third strategy is the use of **social and community mobilization** which creates partnerships that support immunisation efforts and stimulate engagement and commitment for immunisation.¹⁰

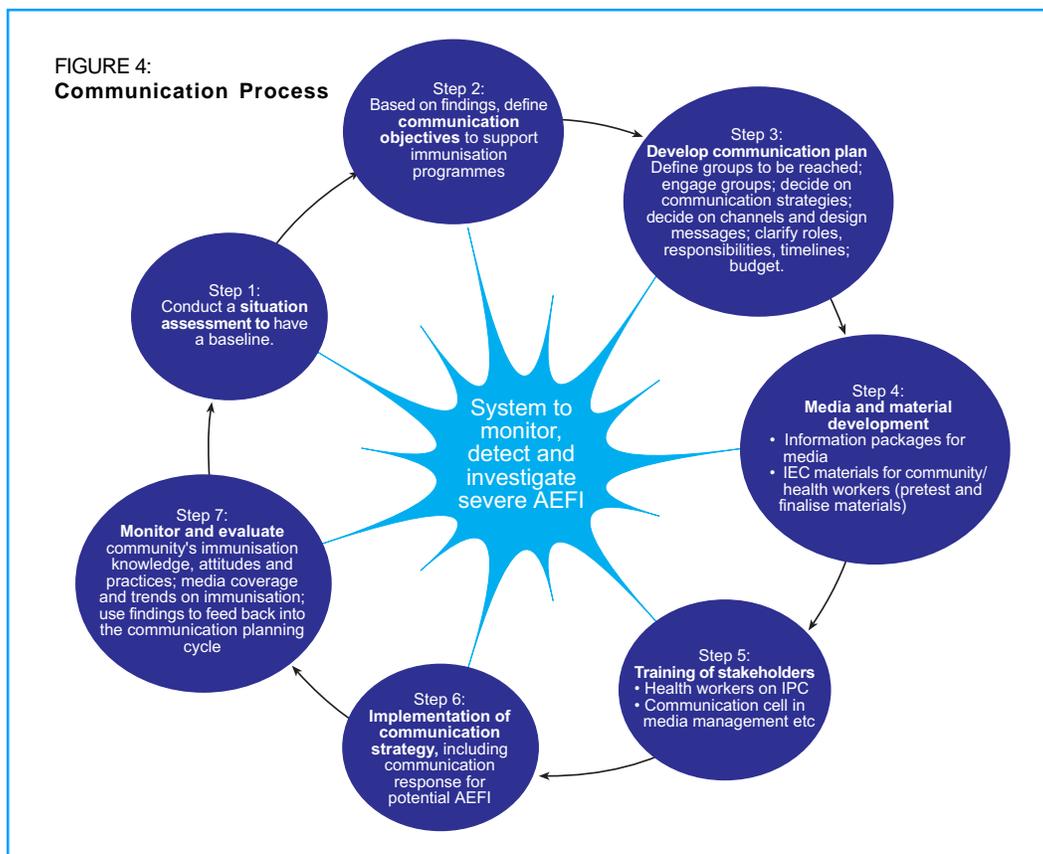
The communication strategy mix varies according to the situation and context. What is important common in all communication strategies is the need for the communicators - the health workers and those who support immunisation programmes - to establish **trust and credibility** among parents and the communities they serve. A person who is perceived as credible and trustworthy is someone who is seen by others as having:

- Empathy
- Competence and expertise
- Honesty and openness
- Commitment
- Accountability

Note that not all issues revolving around public trust are related to AEFI. Some rumours and distrust are attributed to other factors. For instance, experience has shown that some economically, ethnically or socially marginalized groups have less trust in government provided commodities and services. This low level of trust can fuel rumours and opposition to vaccination (e.g. "OPV sterilizes or causes HIV"). Public trust is also influenced by people's individual and collective memories of negative experiences (e.g. forced sterilization campaigns, coercive smallpox vaccination or not receiving needed health services). Possible distrust in vaccines can not be addressed in a one-time response. It is essential that communication efforts are on-going and embedded in a communication plan, based on evidence and using a variety of communication strategies to engage the various targeted audiences.

Ultimately, the communication plan and its strategies, whether this is media advocacy, behaviour change communication with individuals or groups, or community and social mobilization efforts, should all contribute to reducing the number of vaccine preventable diseases among children in South Asia.

Figure 4 provides an overview of the overall communication process and essential steps.

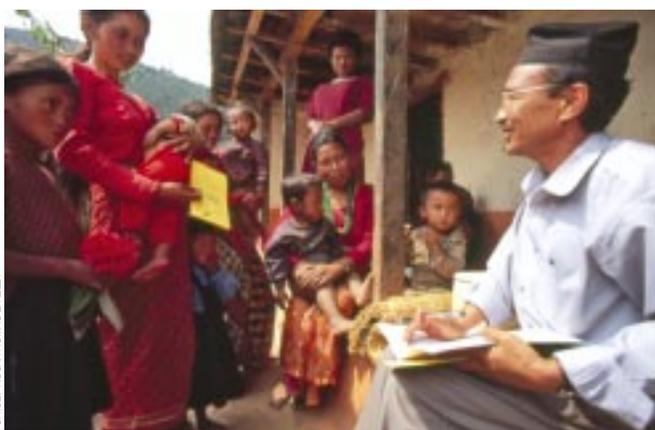


The following sections focus on the essentials in communication around AEFI, namely communication with health workers and vaccinators, secondly communication with affected families and communities, and thirdly communication with the media.

3.3 Communicating with Health Workers

Experience has shown that many health workers do not report an AEFI for fear of blame or sanctions. It is critical to encourage and support health workers to report AEFI, especially in case of programme errors. Moreover, if a true or perceived AEFI occurs, the safety of the local health worker and vaccinator has to be ensured as they might become targets of hostility or be attacked by affected community members. Health workers are an essential source of information in the AEFI investigation. Their roles are also key for future immunisation programmes and other health services.

Doctors, health workers and vaccinators at various levels need to be able to handle queries from the community, especially from parents. Besides information about immunisation, they should be equipped with technical information on possible adverse events and supported by key spokespersons at local and national levels (e.g. immunisation managers, MoH, NRA).



Nepal, in Lapsiphehi VDC, immunization staff check the immunisation and health records of children.

Health workers and vaccinators should be trained in interpersonal communication skills (IPC) with families and communities. This means that health workers are able to share accurate immunisation facts, respond to questions, can clarify possible doubts, and motivating families to adopt healthy behavioural practices, including using immunisation services. IPC involves cultivating good listening skills and the ability to empathise and be supportive.

When health workers are selected for IPC training, class, caste and gender factors should be considered which may impact on their ability to be trusted and respected by families. District immunisation officers could also benefit from training in communication and media management.

IPC training can not be a once off training. It has to be a regular feature of an immunisation programme. Good IPC skills of health workers also rely on support from supervisors and regular monitoring of the quality and accuracy of the information shared.

3.4 Communicating with Families and Communities

The moment an AEFI is reported, immediate steps must be taken to verify the facts and determine what has really happened. Promptly visiting the affected family and community, particularly if a severe AEFI has occurred, is part of a good response.

Meeting with and listening to affected families and community representatives are essential to understanding their concerns and fears, as well as to demonstrate commitment that the event is being addressed. If an AEFI investigation is initiated, communities need to know what actions have been taken. And providing communities with regular information on the status of the investigation will go a long way in allaying potential fears and myths around immunisation in general.

Disseminate a consistent set of easy to understand key messages to concerned families and communities. In case of rumours around vaccine related issues, it may be wise to include the same channels as those used by the ones that spread the rumours. Everyone from the Minister of Health at the national level to the dispensary attendant and primary health centre should know and use the key messages. Annex C provides details on how to respond to rumours.

If a severe AEFI or a cluster of AEFI has occurred, and there is evidence that the vaccination has been the real cause, compensation for the affected child (or children) may emerge as an issue. Communication and immunisation managers need to know if there is an official compensation policy and if setting up support systems for affected children and their parents (e.g. information and expenses hotline, support for travel arrangements, hospital costs) will be possible. This has to be communicated to the affected family and appropriate actions promptly taken.

Lastly, but importantly, monitoring immunisation coverage and tracking attitudes and practices among the affected community (or communities) after the AEFI, whether true or perceived, forms part of a sound communication response to an AEFI. Annex D illustrates sample questions for surveys which look at immunisation-related knowledge, attitudes and practices of individuals.

3.5 Communicating with the Media

Negative media coverage of adverse events following immunisation can have significant impact on public trust in vaccines. Some reactions to vaccines are inevitable, although they should be reduced to a minimum in well-performing programmes. Plans must be in place to react appropriately when an adverse event occurs.

The media are likely to publicize events where there are deaths or adverse events following immunisation, where the national press has unearthed "ominous facts", or where they have obtained information before the health professionals have done so. Health professionals may become the centre of a crisis if they are accused of not having done their job properly or were found not to be truthful.

The media is an important gateway to inform the public and shapes their view and attitudes towards vaccines and immunisation. In the long-term, building partnerships with the media is key to keeping the public regularly informed about immunisation, the benefits and motivate families and communities to make use of immunisation services. Media also plays an important role in advocating for continued and increased investments in immunisation.

What the media are looking for

- Disaster, malpractice and negligence
- Drama with personal aspects
- Controversy or conflict
- Many people affected
- Unexpected outcomes
- Polarity of views
- Location (close to own country or hospital)
- Celebrity link- heroes and heroines

The media like

- A fast response
- Accuracy and simplicity
- Statistics with explanation
- Context (part of a wider picture)
- Comments or explanation from the highest authority possible
- Both-or multiple-sides of the story

The media will ask

- WHO - is affected/is responsible?
- WHAT - has happened? What is being done?
- WHERE - has it happened?
- WHEN - did it happen?
- WHY - did it happen?
- WILL - it happen again?

Source: UNICEF (2004) Building Trust in Immunisation - Partnering with the Media. New York.

Effective communication with the media includes a plan, trained staff, a budget and practised responses to potential "issues" around AEFI. It should be in place before an immunisation campaign starts and as part of the on-going communication support to routine immunisation programmes.

Steps in working with the media

Maintain a database of print and electronic media journalists covering the health beat and establish rapport with them. Ensure that a two-way communication process is maintained so that they can refer to the relevant authority in case of any queries.

Develop information packages of frequently asked questions (FAQs), fact sheets, and other audience-appropriate materials on immunisation, that includes AEFI, and ensure their distribution to all concerned including health professionals, vaccinators, community and media representatives.

Conduct training workshops and field visits for journalists to achieve a better understanding of immunisation advantages as well as the complexities of an immunisation programme. This involves building alliances and forming a media consultation group as well as preparing

monthly or quarterly updates on routine immunisation or new developments relating to immunisation which can be shared easily with the media.

Working through a communication cell: Forming a national communication committee to support immunisation efforts should be part of a long-term communication plan. The communication cell should be the central unit for coordinating the communication response to an AEFI at the national level. Such a committee may be composed of representatives of the Ministry of Health, other relevant government representatives, appropriate professional associations, UNICEF, WHO and other relevant partners. There should be a clear understanding of roles and responsibilities. At the time of an AEFI, the communication cell should:

1. Be functional and active;
2. Be able to work quickly to assess and advise on media and communication needs;
3. Have identified key spokespeople and messages;

4. Have a mechanism to ensure that all parties receive the same message, a ready-to-go press release and be familiar with the communication plan.

Setting up a spokesperson system: Selecting an appropriate spokesperson (or several spokespersons in the different agencies) if an AEFI has occurred is critical. The spokesperson should be a good communicator who is trusted and is able to speak with authority. S/he but may not necessarily be a medical expert, but must have competent knowledge of the immunisation programme. Preparing a list of potential spokespersons and sharing it with all concerned focal points at the district, province and national levels may be useful before an immunisation campaign starts.

Preparing a press statement for the media: Particularly if a severe AEFI is reported a press statement may be essential. The statement should include:

- A complete account of the event, framed in its context (e.g. an isolated event or a cluster of AEFI, or coincidental event);
- An outline of actions taken or planned (such as the AEFI investigation);
- A description of the cause of the event (but only when this is known with reasonable certainty);
- An assurance that corrective action has been taken or will be taken;
- Provide information on the 5W's and H of journalism (when, where, who, what, why and how).
- Provide reference to any relevant publication, video material or web site;
- Provide names and contact details of persons to be reached for additional information or materials.

In addition, monitoring media coverage and reporting trends, especially the local media, and meeting with opponents and supporters from the media, are part of good communication practices. You may have to issue corrections (rejoinders) if incorrect reporting continues.

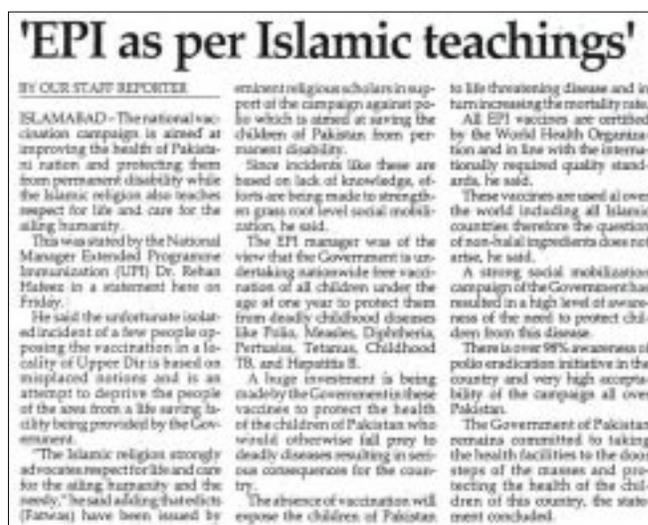
Selecting dissemination channels for the press release: Different media channels exist for communicating with the public. Each of these channels is defined by certain characteristics. Select a channel or mix of channels appropriate to the specific audience that you aim to reach.

Newspapers

- Provide often in-depth coverage.
- Tend to trigger radio and TV coverage.

Radio

- Listenership varies between rural and urban areas.
- In some countries, community radios enjoy high rates of listenership and credibility especially at the grassroots level.



Pakistan: Article in an English newspaper, 2004.

Television

- TV is a primary and instantaneous source of information for millions of people.
- Conveys emotion and image; highly influential.

Think local, national and international: In today's world of increased and free-flowing access to information, media reports traverse continents in split seconds, which may have possible negative consequences for immunisation programmes. The following factors should be considered when working with the news media:

International media	National media	Local media
Seen and read in headquarters of international organizations.	Seen by government and national opinion leaders.	May have broken the story and need to be engaged.
Has resources to produce forensic reporting.	Affects staff in your organization or department.	May be read and believed by more people in the community than national media.
Can help set the national agendas.	Has a wide reach and influences national agendas	Could be stringing for national / international press.

Other channels for reaching smaller groups of audiences are local and folk media. While they reach only a limited number of people compared to TV, print and radio, they can be effective channels if rooted in the community and if they facilitate interpersonal communication.

Organising a press conference when an AEFI has occurred: Press conferences may need to be conducted when there is considerable "buzz" about the AEFI and there is a need to provide accurate facts and de-sensationalise the story. Consider the following important steps when preparing for the press conference:

- Use the communication cell and spokesperson systems to talk to the media.
- If there are several members on the panel, agree beforehand on the key message in response to the AEFI.
- Agree on roles of each panel member beforehand, including the type of questions (media, political etc. each panel member may best handle); decide who will take the lead in the press conference.
- Don't contradict each other in the press conference unless it is critical to clarify something incorrect that has been said.
- Have a media kit ready and share it with journalists. The media kit may consist of: a press release with all the essential information, supplementary background information (e.g. on the benefits of immunisation) and a set of "Frequently Asked Questions" about immunisation.

Interviews: Giving interviews is for many a daunting task, particularly around sensitive "issues" and with television where appearance and composure matter. Becoming a good "interviewee" requires practice. Simple language (avoid technical jargon), clothing, body language and tone of voice all matter.

Sound bytes: When you have only a few seconds in front of a microphone or in a meeting you need to use memorable phrases -- sound bites that will stay with your audience long after you have left. The best sound bites get to the heart of the problem without lengthy explanations. Broadcast producers like them and listeners and viewers remember them. The sound bite should capture and communicate the one key message you want to leave with the audience, if they remember nothing else. Try to repeat the sound bite at least once during an interview with the media. For example:

- Immunisation is the most cost-effective health intervention.
- Immunisation is the right of every child.

WHEN TALKING TO THE MEDIA:

"Tell them what you want to tell them, tell them again, and tell them what you told them."

Techniques for difficult interview situations:

- **Block:** Respond to negative questions with a positive answer (Question: "How many children have died from vaccination?" Answer: "Immunisation saves lives. Since our immunisation programme began, XX children have been vaccinated. Without vaccination, children's risk of the getting a potentially life threatening disease is far greater than the risk of the vaccine.")
- **Bridge:** Having answered a difficult question, add something linked but positive.
- **Correct what is wrong:** Immediately correct information from the interviewer that is wrong. Be assertive, not aggressive and state the facts simply, factually and in a friendly way.
- **Don't repeat any negative question/statement in your answers:** For example: "Some children have become ill from vaccines. Why do we have immunisation programmes?" should be countered with a positive "Vaccines save children's lives."
- **Stay cool:** No matter how bad it gets don't get angry or defensive. Stay friendly, polite and warm.
- **Be assertive:** Means stating what you want to say in a clear way without getting aggressive; take time to think about the response and don't be rushed or forced.
- *"No comment"* is **not an option**, nor is there really an *"off the record"*!

Monitoring and Evaluation Basics

In any communication intervention, it is essential to develop a system to monitor the process and evaluate the results. A communication plan supporting immunisation efforts must include a monitoring and evaluation component.

Even if a crisis situation is short-lived, for instance if there was no apparent effect of an AEFI on local immunisation coverage, we should be able to assess our communication plan and if needed modify the strategies in light of the experience.

WHY do we monitor and evaluate communication interventions for immunisation?

The main reasons include:

- To gather and analyse data to see if we are on track and help us in our planning and implementation of communication strategies and activities;
- To measure (and document) what we have accomplished;
- To see if we are being effective and how effective we are;
- To find out how we can do better;
- To find out whether or to what extend the project benefits outweigh the costs;
- To convince others of the value of our work.



Afghanistan: On 6 January at the start of the nationwide measles immunization campaign, children, including an older girl carrying a toddler, look through a broken window into a clinic set up at the Afghana mosque in Kabul, the capital.

WHAT do we monitor in communication interventions?

The main areas are:

- What do families and communities know about immunisation? What is their perception of vaccines, diseases, injections?
- What are common barriers to immunisation?
- Are we reaching the groups of people we would like to reach, the target audiences, with our communication plan (e.g. decision makers, health workers, parents, religious leaders, journalists etc)?
- Were our messages broadcasted or printed, where, how often? What other messages are being aired/ printed?
- Are our messages correctly understood?
- Are there changes in the knowledge, attitudes and practises related to immunisation among the groups of people we seek to reach?
- Is the immunisation coverage improving or not and to what extend? Why?
- Did any AEFI occur previously? What was the community's response? Are there any general issues around lack of public confidence in immunisation? Which ones? Why?

HOW do we monitor public opinion, particularly if a serious AEFI or an AEFI causing public concern has occurred?

- Visit and discuss with affected families, traditional and religious leaders etc.
- Dialogue with district health officers and health workers in charge of immunisation.
- Review media coverage: look into the style and accuracy of reporting; are the rights of the child respected?; are certain media and journalists more supportive or unsupportive than others? In this review include local, national and regional media.
- Survey or conduct focus group discussions among representative samples of the intended groups, and collect qualitative and quantitative data, to see if we are on track with our communication interventions.
- Review immunisation coverage data.

Key points in monitoring:

- Include communication indicators in the immunisation monitoring plan.
- Ensure that data collection and analysis includes qualitative indicators which provide information about attitudinal and behaviour-related information. For instance, reasons why individuals choose not to vaccinate their children; perceptions of vaccines/health workers etc.
- Share immunisation data with health educators and engage them in data analysis, micro-planning and workplan development.

What are indicators?

Indicators give us an indication of the magnitude and direction of change over a period of time. They must be chosen carefully at the beginning of a communication intervention.

Here are important characteristics of indicators for measuring change:

Clear:	Precise and unambiguous
Relevant:	Appropriate for the change
Specific:	Linked to the strategic goals
Economic:	Affordable and available
Adequate:	Sufficient to assess change
Monitorable:	Can be validated
Culturally sensitive:	Easily understood

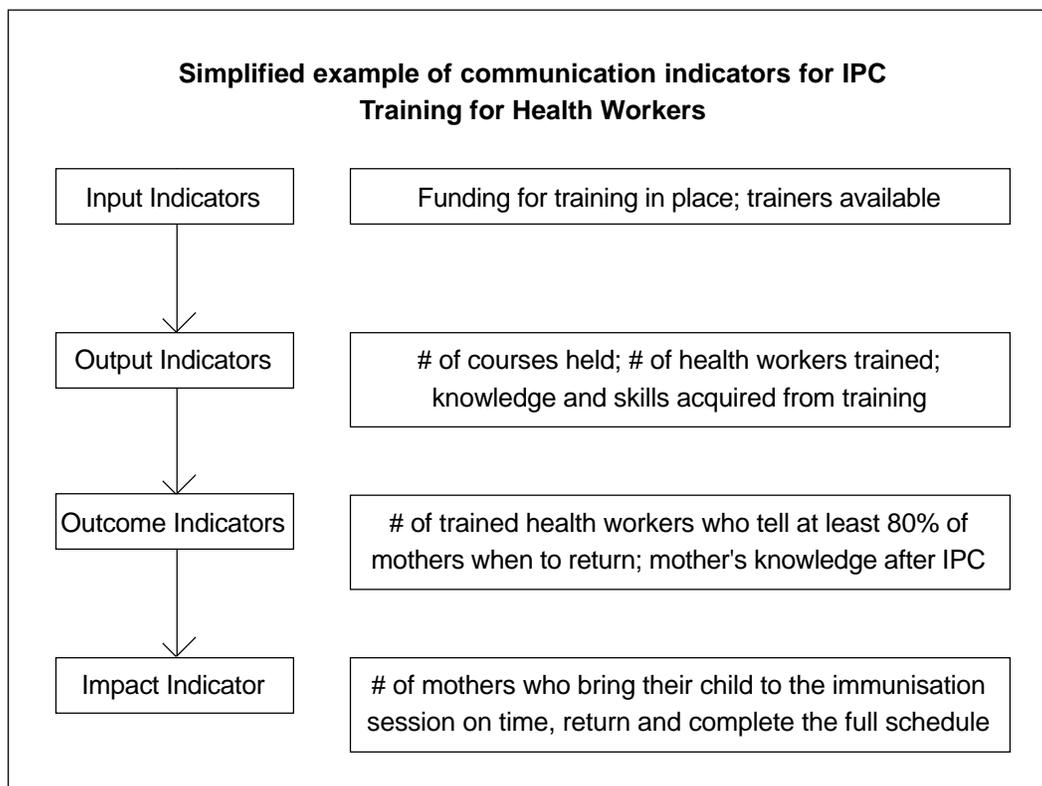
AND

Need not only be quantifiable:	Quality may be relevant
Need not only be a number:	Pictures, stories, etc. could be used

Different types of indicators:

- **Input Indicators:** Measure the quantity, quality and timeliness of resources provided for a project or programme for example funding, human resources, equipment; communication materials, or organisational capacity.
- **Output Indicators:** Measure the quantity; quality and timeliness of products or services created or provided through use of the inputs. They measure immediate results, for example number of people exposed to a message or participating in community action.
- **Outcome Indicators:** Measure short-term effects of a project or programme. They are often changes in attitudes or behaviours following an intervention, for example the number of care givers who say that they took their child for vaccination after watching a TV spot on polio.

- **Impact Indicators:** Measure long-term effects on the people and their surroundings. For example increase in the percentage of routinely immunised children in a region or a country following years of programmatic intervention. Annex E provides a more detailed overview of different communication indicators.



What is evaluation?

Evaluation answers the "so what?" question of our communication efforts. Evaluation provides information on whether the changes are generating results in terms of appropriate behaviour and social change through the communication interventions in an efficient, effective and sustainable manner. It helps to:

- Identify which communication interventions are more or less successful in terms of behaviour and social change outcomes related to immunisation. Evaluation also guides decisions on resource investment or on scaling up or down of these interventions;
- Rethink the causality of the problem, if the intervention seems to have little effect on behaviour change, and to make the communication interventions more strategic;
- Identify new issues that have emerged that need to be addressed using communication interventions.

Monitoring and evaluation are complementary. Both must be on-going processes. Using only one is not sufficient.

Experiences from South Asian Countries

The following experiences from South Asian countries in responding to AEFI are excerpts from presentations made at the UNICEF ROSA and WHO SEARO joint workshop on "Building Public Trust and Responding to Adverse Events following Immunisation", New Delhi, 9-10 August 2004. Although these may not be complete accounts of the events, they illustrate particular points and lessons learned for communication around AEFI.

5.1 AEFI in Bangladesh

Background

In 2003, six children were reported ill in Jamalpur (Dhaka division) apparently after receiving measles vaccine. Three of them died. Affected communities reacted with grief and anger. Many lost confidence and didn't want their children to be vaccinated any more. The news travelled fast to neighbouring communities, and the media reported these events incorrectly. The number of children attending EPI sessions dropped. The AEFI investigation pointed to a probable contamination of the vaccine at the time of reconstitution.

Response included:

- Local district and sub-district health officers visited the village immediately and met with the affected families and neighbours. They also met with local government representatives, religious leaders, teachers in the village to talk about the tragic incidents and to clarify questions.
- A joint Government/WHO/UNICEF team of senior programme managers visited the village the day after the incident and held a community meeting. They also visited the affected parents and children to investigate what had happened.
- Samples were collected (autopsy report and viscera). Tests were conducted at central laboratory and sample sent to a laboratory in Geneva.
- The government, with support from WHO and UNICEF, conducted assessments of vaccine management practices and implemented an action plan to address the identified gaps.
- As part of the global strategy for vaccine quality, WHO advised the government on vaccine regulatory issues including the implementation of post marketing surveillance system (AEFI monitoring) for vaccines.

Communication efforts included:

- Monitoring closely media reports and trends;
- Establishing a system to handle media queries;
- Translating press clippings into local languages and sharing with field staff;
- Preparing Qs and As for journalists;

- Personalised briefings with key reporters;
- Responding to negative media coverage through quick rejoinders.

Lessons learned

1. A preliminary investigation conducted within the first 48 hours is critical to start an early response to the AEFI, and prevent the development of mistrust in the national immunisation programme.
2. The investigation showed that vaccinators and health workers had limited knowledge about possible adverse reactions and were not trained to respond to parents' questions and concerns. It underlines the importance of training in communication skills for AEFI, especially interpersonal communication skills, to more effectively dialogue with parents and community members.
3. When AEFI are serious, communication becomes even more critical and difficult. Immunisation programmes need to prepare a comprehensive communication plan and train staff to be ready for the worst.
4. The communication efforts should engage the media to avoid incorrect reporting. But it also should engage communities as news between villages travel fast.

5.2 AEFI in Pakistan

Background

In October 2003, an outreach team visited a small village in Sialkot district to provide immunisation services. Eight of 13 children vaccinated that day developed adverse reactions after two hours, including high-grade fever, vomiting and diarrhoea. All eight children were admitted to the hospital. Six children recovered and two died. The investigation identified a programme error as the cause of the AEFI. For two weeks, the same syringe was used to reconstitute the vaccine, and the vaccinator, running out of diluent, used plain water.



Pakistan: Two men health workers, one of whom is carrying an insulated box containing polio vaccines, walk on a dirt roadway separating makeshift buildings in the Qadir Abad community for Afghan refugees in Quetta, capital of the south-western province of Balochistan. The health workers are participating in the NID, targeting 30 million children in Pakistan.

Response included:

- An investigation team visited the affected village, the parents and the paediatric ward of the district hospital.
- Blood samples of the hospitalised children were sent for culture and sensitivity test. The autopsy of one of the deceased children was done. The viscera were sent to chemical examiner for evidence of poisoning.
- The communication support included:
 - Engaging the media at different levels (national, district and local);
 - Holding exclusive media briefings;
 - Offering regular technical briefs for journalists;

- Monitoring media reporting (news items, articles or statements), reviewed by an interdepartmental forum which determines the cause of action to be taken in case of incorrect media coverage: e.g. rebuttal, informal clarification with the reporter or editor, organizing a press conference; sending out a general response by electronic media.
- Sharing relevant information with parents;
- Regular mandatory orientation for all team members, including on safety and efficacy of vaccines.

Lessons learned

1. A proactive approach with the media facilitated a balanced coverage when the adverse events occurred. This included giving technical briefings for the media, issuing press releases, and senior government officials serving as spokespersons on a regular basis.
2. Regular training of field staff (vaccinators / MOs) on AEFI and close supervision are critical to prevent programme errors and maintain public confidence.
3. While district teams were trained in advance to establish AEFI surveillance, strengthening their capacity in communication planning and media management would be a useful investment.
4. Learning from the polio eradication experiences in communication, routine immunisation programmes do require greater communication support to engage media and communities regularly.

5.3 Adverse events during a vitamin A campaign, Assam, India

Background

The state government in Assam launched a state-wide "Pulse Vitamin A" Campaign in November 2001. During the week after the campaign, children developed adverse reactions and a few children died. Instantly, the media picked up the news. Many journalists reported the events incorrectly and numbers of affected children were inflated. Some reported erroneously that the vitamin A given to children was outdated. Other reports confused the vitamin A campaign with the Pulse Polio campaign, which had an impact on the polio programme as well. It was reported that health workers were not properly trained. The reports caused wide-spread panic in the state. Scores of parents started rushing children who had no signs of any adverse events to hospitals. Moreover, the local reports were quickly picked up by the international media. In the end, two laboratories in India and Australia confirmed that the vitamin A used in the campaign met all recommended standards, and post-mortems confirmed that vitamin A was not the cause of death.

Response included:

- The state government ordered an inquiry headed by a senior government official.
- There was a joint WHO and UNICEF investigation team lead by the Deputy Director of the National Institute of Nutrition.
- Samples were sent to the national testing laboratory as well as to Australia. Several post-mortems were conducted.
- The national government established a high level committee to review the situation and made recommendations for future vitamin A programmes.

Lessons learned

1. The pervasive negative and incorrect media reporting led to a drastic drop in the vitamin A coverage in the whole state. It required substantial efforts and resources to redress the situation. In order to prevent similar situations, a long-term communication plan and pro-active strategy should be in place. A media workshop to train journalists was held in the state capital.
2. The case also illustrates that negative media reports about one campaign can easily affect another campaign. In this case the Pulse Polio campaign was affected because of the association with the 'Pulse Vitamin A Campaign'.

5.4 Adverse events during the distribution of iron-folic acid tablets, West Bengal, India

Background

In July 2004, as part of the government programme to reduce anaemia, iron-folic acid tablets were distributed to adolescent girls in schools. In one school, three girls developed nausea and vomiting shortly after taking the tablets. Several other girls started panicking and complained of the same symptoms. All the girls were sent to the hospital. After a few hours, symptomless, they were allowed to return to their homes.

Response included:

- An investigation team was swiftly established to examine the possible cause of the symptoms.
- Expiry dates of the tablets were checked and sent to the laboratory.
- The District Magistrate Medical Officer and the Central Ministry of Health met with parents of the affected girls and shared with them information about the investigation process.
- Various government departments were involved in the response to the AEFI. Factual information about possible adverse reactions and required treatments was shared with physicians, medical colleges, private practitioners and government health officials.
- When the story was reported in the electronic media, the District Magistrate and UNICEF organized a media briefing the day after the event. The briefing included sharing with journalists the rationale for the campaign, and the advantages of iron-folic acid in reducing anaemia. Journalists were also encouraged to report responsibly and correctly, and not to sensationalize the incidents.

Lessons learned

1. This example demonstrates that an effective response can mitigate potential negative media reporting. After the press briefing no incorrect reports were published in the electronic media.
2. The response ensured that all concerned state government departments were involved, which facilitated the information flow, transparency and accountability.

5.5. AEFI in Afghanistan

Background

In 2002, in Nahrin district, 4,600 children were vaccinated during a Measles Mortality Reduction Campaign (MMRC). Five weeks following the vaccination, immunisation monitors from a NID campaign reported in four villages approximately 150 children with abscesses which were thought to be related to the earlier measles vaccination.

Community members started blaming the vaccinators and health workers. And routine immunisation coverage dropped from 100 to 8 children a month. The investigation traced the AEFI to a programme error, i.e. to poor aseptic precautions, untrained vaccinators and use of unsuitable diluent.



Afghanistan: Young boy vaccinated during the 2nd round of MMRC campaign in Nahrin District of Baghlan Province in May 2003 (8 months after the abscess incident).

PHOTO COURTESY OF DIANE ARAKI

Responses included:

- A joint Ministry of Health, UNICEF and WHO investigation team went to the district after the report of AEFI a few weeks later.
- The team met with community elders, children and their parents to discuss what had happened.
- Dressing changes and necessary antibiotics were provided to affected children. Free of charge additional treatment by a local physician was organized.
- The findings from the investigations were shared with community leaders, affected parents and health workers.
- Over a period of six months the investigation team returned regularly and the affected children were observed for long-term effects.
- Close monitoring and supervision of vaccine supplies was undertaken during follow-up campaigns and routine immunisation.

Lessons learned

1. Initially health workers were not trained on the risk of adverse events and possible treatment options. Such training was organised at the regional, provincial and district level in May 2003 to strengthen the quality of immunisation services.
2. Afghanistan did not have AEFI surveillance guidelines when the incidents occurred. This was subsequently addressed. In 2003, the Ministry of Health, UNICEF and WHO drafted surveillance guidelines for the country.
3. While early reporting of AEFI is essential, the Nahrin experience shows that even AEFI which are reported late have to be taken seriously and investigated.
4. Spending time, talking and listening to community leaders and parents - and keeping them informed - was a key ingredient in regaining the community's trust.

PHOTO COURTESY OF DIANE ARAKI



Afghanistan: Female vaccinators in Takhar Province, during the MMRC campaign in May of 2003.

5. When children were questioned, parents were asked first for permission.
6. They avoided laying blame or making assumptions before the investigation was completed.
7. Even if there were no newspapers or telephones, word travelled fast!
8. Women on the investigating team were an asset, which made it possible to communicate with mothers and female community members.
9. Long-term follow-up of AEFI is sometimes necessary to increase the community trust in the programme.

Conclusion

Experiences from South Asia and elsewhere have shown that AEFI, whether true or perceived, impact on immunisation programmes. They can severely erode public confidence and can contribute to a resurgence of preventable diseases. AEFI and public concerns about vaccination have to be taken seriously, investigated, and appropriate actions taken. These actions include effective communication.

Communication around AEFI is far more than a short-term reaction when an AEFI has occurred. It has to be a pro-active strategy, embedded in a long-term communication plan. Such a plan needs to be strategic, participatory, based on evidence from research and results-oriented. Having a well developed communication plan is a sound investment into immunisation efforts, saving money and time in the long-run.

It is worth remembering that communication plans are developed based on the epidemiological situation, scientifically supported evidence, and a good analysis of the socio-economic and cultural environment of the different target audiences. Equally important is that the communication plan is closely linked to the service delivery component of the immunisation programme. Every immunisation programme should have a long-term communication plan. Dealing with AEFI is an important aspect of such a plan.

Communication plans need to take into consideration the different causes of an AEFI. A vaccine-related reaction is clearly of immense concern to everyone involved in immunisation. While communicating science to the public generally is challenging for many, if a true vaccine reaction has occurred, facts need to be explained in understandable terms to the public.¹¹ Communicating coincidence is not simple either. In cases where a coincidental AEFI has been established, it is helpful to provide details if the same vaccine has been administered to other children who have not shown any reaction. Perhaps the most challenging adverse event to explain to the public, because it can be prevented relatively easily, is a programme error. Good training and supportive supervision of health workers and vaccinators in vaccine preparation, handling and administration is essential for ensuring a well managed programme and minimising any risks for programme errors.

Successful communication also relies on an effective surveillance system to detect, investigate and manage AEFI. WHO and UNICEF encourage countries to establish such



Pakistan: A man health worker administers a dose of vitamin A to an infant held by another man, in the Qadir Abad community for Afghan refugees in Quetta, capital of the south-western province of Balochistan. The community is participating in the NID, targeting 30 million children in Pakistan.

systems, which involves a national regulatory authority and networking with the scientific community to verify hypotheses and monitor quality, safety and efficacy of vaccines. In many countries in the region, however, surveillance systems do not always perform adequately. This makes it difficult to monitor and update data on quality, safety and efficacy of EPI vaccines at country as well as global levels. Countries in South Asia would do well if further investments were made into bolstering AEFI surveillance systems, including strengthening district-based surveillance.

An aspect only briefly touched upon in this paper, but a critical factor to be prepared for, is that an AEFI can trigger latent mistrust of public health services and commodities in general. Lack of information, religious or otherwise motivated opposition or negative past experiences with public health services can be the root of frustration among marginalized communities. If an AEFI occurs and is not handled well, such frustration can easily trigger widespread rejection of vaccines.

Communication around AEFI has to be monitored and regularly assessed. Monitoring media reporting is one essential component. However, no national or local media coverage does not necessarily mean, that an AEFI is not on people's minds. Tracking parents' and community members' immunisation-related knowledge, attitudes and practices is particularly essential after an AEFI has occurred. It allows us to monitor if our communication interventions are going well or not. It also permits us to assess if an AEFI had any long-term impact on immunisation-related behaviours.

In today's globalised world, reports of an AEFI or general vaccine safety issues can traverse continents in split-seconds. Governments and donors in South Asia are well advised to further invest into communication for immunisation, including strengthening AEFI communication capacities. It is not sufficient anymore to merely say that "vaccines are good". But we need to explain better to the public why the benefits of vaccines and immunisation unequivocally outweigh the rare risks of an adverse event.

While there is no hard and fast rule for communication around adverse events, this paper emphasises that there are several essential elements which immunisation teams should take. These include:

- Develop and harness media skills (including interview skills) among immunisation managers at national, provincial/state and local levels to communicate effectively vaccination related issues.
- Build partnerships with the media to advance responsible public health reporting on the whole. It pays off to have a communication team and a designated spokesperson in place, which regularly share facts about vaccines and immunisation with journalists, organize press briefings, issue news releases, and monitor media trends.
- Develop interpersonal communication skills (IPC) of health workers and vaccinators for them to discuss immunisation benefits and adverse events with parents and community leaders. Such IPC training has to go hand in hand with supportive supervision and a caring attitude to ensure that parents receive correct immunisation information and feel comfortable to ask questions or discuss any concerns they may have.
- Talk with families and communities to identify immunisation related knowledge, attitudes and practices. Particularly after a serious AEFI has occurred, it essential to immediately visit and communicate with affected caregivers. Communities have to be kept informed about the AEFI investigation to maintain the credibility of the programme and allay possible concerns.

Way Forward

The following action points are recommended to further advance communication for immunisation, especially AEFI related communication, so that public trust in vaccines is maintained and ultimately more children are protected from vaccine-preventable diseases.

- Develop a comprehensive communication plan for immunisation, which includes a specific AEFI component, a detailed implementation strategy and steps to monitor and evaluate communication efforts.
- Develop specific communication guides and tools based on evidence and past lessons learned from communication revolving around vaccination and related issues.
- Train immunisation managers at national, provincial/state and district levels to strengthen their capacity in communication planning, management and assessment.
- Document AEFI responses and communication aspects, and develop sound case studies, which offer lessons learned and good practices that can be shared widely.
- Share regularly experiences among immunisation managers and health communicators at regional level to harness communication for immunisation efforts.
- Foster strong partnerships at regional, national and sub-national levels.



Nepal: Grandfather taking pride in his grandchildren, Sindhupalchowk.

ANNEX A: AEFI Investigation



WORLD HEALTH ORGANIZATION

AEFI INVESTIGATION

AIDE MEMOIRE

An **adverse event following immunization (AEFI)** is a medical incident that takes place after an immunization, causes concern and is believed to be caused by the immunization. Programmes providing immunization services should include **a system for AEFI detection and reporting, investigation and management, data analysis, corrective action, relevant communication and evaluation of the system.**

The ultimate **goal** of an investigation is to determine whether the vaccine or immunization process is responsible for the reported event(s) or to find another cause and correct it if possible, and reassure the public.

There are **4** possible causes of AEFI:

Vaccine reaction: event caused by some component of the vaccine – the active component of the vaccine itself, the preservative, the stabilizer or other. The majority of vaccine reactions are “common” and expected, mild, settle without treatment and have no long-term consequences. More serious reactions are very rare – usually of a fairly predictable (albeit extremely low) frequency;

Programme error: event caused by error in vaccine preparation, handling or administration;

Coincidence: event where something happens after the immunization but is not caused by the vaccine or the programme; and

Injection reaction: event arising from anxiety about the injection (needle).

The **purposes of investigating AEFI** cases are:

- 1) to confirm a reported diagnosis of AEFI and clarify the details and outcome;
- 2) to determine whether unimmunized persons are experiencing the same medical event(s);
- 3) to investigate the link between the vaccine given and the AEFI;
- 4) to determine the contribution of operational aspects of the programme to the reported AEFI;
- 5) to determine whether a reported event was isolated or part of a cluster;
- 6) to determine the cause of the AEFI so as to provide the best intervention/ medical care and take any further action deemed necessary.

In most cases, a preliminary **investigation** of an AEFI can be made by the health worker who detected the case, e.g. a health centre staff member or a nurse or physician in a hospital.

Serious AEFI cases or AEFI clusters should be investigated immediately with involvement from central levels including epidemiological and/or clinical expertise. A cluster of AEFIs can be defined as two or more cases of the same adverse event related in time, place or vaccine administered.

Inadequate planning or response may lead to a crisis with loss of confidence in the vaccination service. It is essential that programme managers:

- 1) **anticipate** the crisis and be prepared to deal with it when it occurs;
- 2) **verify** the facts of any event before making any public statement;
- 3) **are familiar with a plan** for reacting to any crisis should it happen. If no plan exists programme managers should develop one;
- 4) **be well informed** so that appropriate national and regional managers can be rapidly briefed to take charge and deal with political and media enquiries.

✓ Checklist

1. Be prepared

- Read the resource documents on reporting, management and investigation of AEFIs.
- Develop standards: case definitions for reportable AEFIs, use of reporting forms and investigation procedures.
- Designate and train staff to conduct an AEFI investigation using the investigation form.
- Train staff on how to collect specimens.
- Establish procedure, criteria and designated person for notifying WHO and UNICEF (if UN- supplied vaccine) or other relevant party depending on procurement mechanism
- Establish a National Technical Advisory Committee with representation from major medical organizations
- Identify a spokesperson for public communications.

2. Receiving a report

- Ensure immediate reporting of most serious events and rapid attention to reports received
- Verify the information in the report and classify and assess the AEFI using established case definitions. Decide whether it needs further investigating.
- If investigation is warranted, travel to the location of the AEFI, or delegate responsibility to another trained person

3. Investigate and collect data

- Ask about the patient
- Ask about the vaccine and other drugs potentially received
- Ask about other vaccinees
- Ask about immunization services
- Observe the service in action
- Ask about cases in unvaccinated persons
- Establish a more specific case definition if needed
- Formulate a hypothesis as to what caused the AEFI

Collect specimens if appropriate:

- from the patient
- the vaccine (and diluent if applicable)
- the syringes and needles

4. Dispatch specimens to appropriate testing facility (laboratory, regulatory authority, etc.)

5. Analyze the data

- Review epidemiological, clinical, and laboratory findings
- Summarize and report findings

6. Take action

- Communicate with health staff
- Communicate findings and action to the parents and public
- Correct problem (based on the cause) by improving training, supervision, and/or distribution of vaccines/injection equipment
- Replace vaccines if indicated

Key data to be collected

1) Data on each patient

- demographic data about patient, including a unique case number, age, sex, place of residence, family history;
- history of patient's present illness - symptoms and when each appeared and its duration, treatment, outcome, diagnosis;
- history of patient's past illnesses e.g., reactions to previous vaccine doses, drug allergies;
- pre-existing disorders, current medications;
- immunization history - vaccine, number of doses received, date, and place of last immunization or immunizations, mode and site of administration;
- laboratory results about blood, stool, or other samples, if appropriate and available
- full autopsy report with toxicological screening and histo-pathological analysis
- look for common environmental exposures between patients.

2) Data about the vaccine(s) (and diluent if applicable) administered to the patient

- Lot number(s)
- Expiry date(s)
- Manufacturer(s)
- Vaccine storage
- Identify where the vaccine(s) was distributed
- Whether other children were immunized with same lot or same vial at same session and elsewhere
- Results of procedures to control vaccine quality
- Laboratory test results about vaccine, if appropriate.

3) Programme-related data.

- Common practices in storing and handling vaccines, and vaccine administration in the health centre in which the suspected immunization (or immunizations) were given. This may help identify products mistakenly used instead of vaccine or diluent

4) Background data

- Establish if cases have been reported from elsewhere and actively look for additional cases among other vaccinees and at large in the community

Role of the district/regional manager

1) Training

- Staff should be trained in diagnosing, treating and reporting of AEFIs, and differentiating between mild, non-significant reactions and more serious events.

2) Supervision

- Non-serious AEFIs (e.g. abscesses) reported by peripheral health workers should be reviewed with training during site visits.

3) Investigation and collection of data

- Following a report of a serious AEFI, the manager should be responsible for investigation, collection and reporting of data. This may be under the overall supervision of a national team.

4) Communication

- The manager or designated person should set up the means for continuous communication between health workers and the community, directly and through the media. The public should be informed frequently about what is being done during an investigation and reassured where necessary.

5) Correction of the problem

If an AEFI was caused by programme error the actions to be taken will probably include one or more of the following:

• Logistics

Improving logistics will be the appropriate response if programme errors can be traced to the lack of appropriate supplies or equipment, or to a failure in the cold chain.

• Training

Solving operational problems through training will deal with lack of skills and knowledge and with poor attitude.

• Supervision

Regular supervision and intensified when needed e.g., problems detected in reporting or programmatic errors identified.

Did the vaccine or its delivery cause the reactions?

It will be necessary to determine if there is a causal association between the vaccine and the adverse event. In each case the following should be considered:

Consistency of findings – are all reported AEFIs the same?

Temporal sequence – confirm that the symptoms of AEFI occurred only after, not before, the vaccine was given and if the vaccine-event interval is compatible with a vaccine reaction

Biological plausibility – does the medical event seem plausibly due to an effect of the vaccine or other concomitant or preceding conditions?

Previously known reaction – check if this type of reaction is known to be related to the vaccine and with which frequency

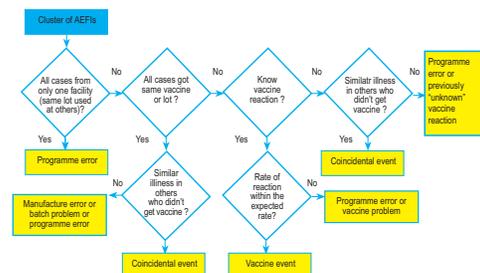
Specificity and strength of association – establish if the same events are being reported in unvaccinated persons and if so, how often and if the cluster is limited to one health center or not

Concomitant or preceding conditions

AEFI evaluation requires a 2 by 2 table of exposures and outcomes and data should be collected in order to more fully complete the table and calculate a risk of event from receipt of the vaccine i.e. $(a/a+c)/(b/b+d)$. Cell a represents case reports only i.e. $(a/a+c)/(b/b+d)$. Cell a represents case reports only

	Possible Adverse Event	No vial at Adverse Event
Vaccinated	a	c
Unvaccinated	b	d

Suggested steps for the identification of the most likely cause of a cluster of AEFIs



Words of advice

- The investigation should start within 24 hours of notification
- There is seldom need to test the vaccine unless clearly indicated by the epidemiologic investigation, but cold chain should be maintained
- A national committee can be very helpful in reviewing the outcome of the investigation and communication of findings
- Access medical files
- Rule out alternative aetiologies than the vaccination. The fact that an adverse event of the same nature has been previously related to a particular vaccine does not always mean that the case under investigation is also related to the vaccine
- Have direct discussions with the patients or parents if possible

Additional information on the definitions, monitoring, management and investigation of AEFIs can be found on the World-Wide Web at www.who.int/immunization_safety/en

Vaccine Assessment and Monitoring
Department of Immunization, Vaccines, and Biologicals
Department of Immunization, Vaccines, and Biologicals
20 avenue Appia, 1211 Geneva 27, Switzerland
Tel: +41 22 791 4468 Fax: +41 22 791 4210
Email: immunizationsafety@who.int

ANNEX B: Expected Rates of AEFI¹²

Following tables show the rates of occurrence of common, mild and rare, serious adverse events following most common childhood vaccines used in the EPI.

Vaccine	Local reaction (pain, swelling, redness)	Fever >38°C	Irritability, malaise and systemic symptoms
BCG	90-95%	-	-
Hib	5-15%	2-10%	-
Hepatitis B	adults ~15% children ~ 5%	1-6%	-
Measles / MMR /MR	~10%	5-15%%	5% (rash)
Oral poliomyelitis (OPV)	-	<1%	<1% ^a
Tetanus / DT / Td	~10% ^b	~10%	~25%
Pertussis (DTP - whole cell)	up to 50%	up to 50%	up to 55%

a Symptoms include diarrhoea, headache, and/or muscle pains

b Rate of local reactions likely to increase with booster doses, up to 50 to 85%

Vaccine	Reaction	Onset interval	Number of doses per reaction	Reactions per million doses
BCG	Suppurative lymphadenitis	2-6 months	1 in 1-10 000	100- 1000
	BCG osteitis	1-12 months	1 in 3 000 to 1 in 100 million	0.01 - 300
	Disseminated BCG infection	1-12 months	~1 in 1 million	0.19-1.56
Hib	None known			
Hepatitis B	Anaphylaxis	0-1 hour	1 in 6-900 000	1-2
Measles/MMR/MR^a	Febrile seizures	6-12 days	1 in 3000	330
	Thrombocytopaenia (low platelets)	15-35 days	1 in 30 000	30
	Anaphylactoid (severe allergic) reaction	0-2 hours	~1 in 100 000	~10
	Anaphylaxis	0-1 hour	~1 in 1 000 000	~1
	Encephalopathy	6-12 days	<1 in 1 000 000	<1
Oral poliomyelitis	Vaccine associated paralytic poliomyelitis	4-30 days	1 in 2.4-3 million	~0.4 ^c
Tetanus	Brachial neuritis	2-28 days	0.5-1 in 100 000	5-10
	Anaphylaxis	0-1 hour	1 in 100 000 to 1 in 2 500 000	0.4-10
Tetanus -diphtheria	None extra to tetanus reactions			
Pertussis (DPT- whole cell)	Persistent (> 3 hours) inconsolable screaming	0-24 hours	1 in 15 to 1 in 1000	(0.1-6%) 1 000-60 000
	Seizures	0-2 days	1 in 1750 to 1 in 12 500	80-570 ^b
	Hypotonic, hyporesponsive episode (HHE)	0-24 hours	1 in 1000-33 000	30 - 990
	Anaphylaxis	0-1 hour	1 in 50 000	20
	Encephalopathy (note: risk may be zero)	0-2 days	0-1 in 1 million	0-1

a Reactions (except anaphylaxis) do not occur if already immune (~90% of those receiving a second dose); children over six years unlikely to have febrile seizures.

b Seizures mostly febrile and risk depends on age, with much lower risk in infants under the age of 4 months.

c VAPP Risk higher for first dose (1 in 750,000 compared to 1 in 5.1 million for subsequent doses), and for adults and immunocompromised.

As disease incidence declines due to effective immunisation programmes, the occurrence of AEFI will receive more attention. AEFI may occur coincidentally after immunisation, some events may be caused by faults in the storage, handling and administration of the vaccine (programmatic error), and some may be associated with the properties of vaccines themselves. AEFI due to programmatic errors in the storage, handling, or administration of vaccine are more common than AEFI due to the properties of vaccines. Monitoring of AEFI is important for the success of the immunisation programme, since such events can influence community acceptance of immunisation. Careful surveillance and investigation of AEFI are necessary to identify causes of these events that require correction. The most common errors linked with immunisation are listed below.

Errors which can lead to AEFI

- Too much vaccine given in one dose.
- Improper immunisation site or route.
- Syringes and needles improperly sterilized.
- Vaccine reconstituted with incorrect diluent.
- Wrong amount of diluent used.
- Drug inadvertently substituted for vaccine or diluent (can result from inattention when reading labels on vials resulting in mistaking content).
- Vaccine prepared incorrectly for use e.g. an absorbed vaccine not being shaken properly before use.
- Vaccine or diluent contaminated.
- Vaccine stored incorrectly.
- Contraindications ignored e.g. a child who experienced a serious reaction after a previous dose of a vaccine is immunized with the same vaccine.
- Reconstituted vaccine used beyond six hours after reconstitution or not thrown out at the end of an immunisation session and used at a subsequent one.

Reasons for misleading information about rates

Millions of doses of a vaccine may be administered during a mass vaccination campaign or supplementary immunisation activity (SIA). Even if adverse events occur at the same rate as for the rest of the year, it could be anticipated that this will result in a more concentrated occurrence of AEFI than usual. For instance, if the normal rate of sore arms following administration of measles vaccine is twelve sore arms per 100,000 doses of measles vaccine and if a country gives on average 100,000 doses of measles vaccine in one year, then we would expect those twelve sore arms to be reported over the year, approximately one per month. If a campaign is carried out when one million doses of measles vaccine are given in a week, we would expect 120 cases of sore arms to be reported in the week if the rate stays the same as usual.

To the outside observer this might appear as an alarming outbreak of sore arms associated with the campaign. In fact, the rate is unchanged. This concept is important for programme managers to get across to staff, politicians, media and parents.

If we apply this idea to serious events such as paralysis following administration of oral polio vaccine (OPV) during or soon after National Immunisation Days (NIDs), there is the potential for the situation to create grave concern in the community. The rate of vaccine-related paralysis following administration of OPV is of the order of one case per two to three million doses administered. During NIDs in China and India in 1996, around 160 million doses of OPV were administered in one week. It would not have been unusual to have had reported up to 50-80 cases of paralysis following the NIDs. In actual fact, very few cases were reported (some may have occurred but have not been reported). Programme managers were aware of the expected rate and were able to monitor reports of AEFI accordingly. It is important to balance the occurrence of the few cases of vaccine-associated adverse events with the much larger number of cases of naturally-occurring polio which would have occurred if the NID had not taken place.

For detailed information about background rates of adverse events following immunisation, see:

"Supplementary Information on Vaccine Safety, Part II: Background Rates of Adverse Events Following Immunization, (WHO/V&B/00.36)

<http://www.who.int/vaccines-documents/DocsPDF00/www562.pdf>

ANNEX C: Dealing with Rumours¹³

Background

- Who starts rumours? People who may have contradicting vested interests: they could be the health workers themselves, traditional healers, medical practitioners, the press, politicians/political groups, anti-vaccine lobbyists, religious/cultural objectors.
- Examples of rumours: "OPV is a contraceptive to control a population to limit a certain ethnic group"; "OPV is contaminated by the AIDS virus or mad-cow disease"; "children are dying after receiving OPV".
- What fuels rumours: inadequate/inaccurate knowledge, mistrust of the government, past untoward or negative experiences with/poor treatment by health workers, ulterior motives (greed), desire for publicity, coincidental events.

Responding to rumours

- Analyze the situation: Move quickly to respond to rumours, but first clarify the extent of the rumour or misinformation (type of messages, circulating, source, persons or organizations spreading the rumour); determine the motivation behind the rumour (lack of information, questioning of authority, religious opposition...).
- Turn the rumour around: Go to the source. Ask the source what the solution is, acknowledge shortcomings if necessary and offer the source the chance to be part of the solution.
- Advocate: Target key opinion leaders for meetings (politicians, traditional/religious leaders, community leaders, health workers); launch a corrective campaign at the highest level, e.g. the Minister of Health, Governors, district administrators, etc.; meet with local leaders at sites where the individuals/groups are comfortable and can feel at ease to ask questions and have peers present.
- Strengthen alliances: Involve all immunisation partners through social mobilization committees, ICCs, etc.; alert and collaborate with relevant ministries and NGOs; encourage onward briefings (cascade effect).
- Conduct training: Train volunteers and health workers to handle rumours; disseminate tailored information on common misconceptions and guidelines on response; promote positive key messages.
- Mobilize communities: Empower local people to address and take responsibility for the issue; "demystify" polio eradication, taking the initiative to the community via films, street plays, schools, community seminars, discussion groups, etc.
- Recruit assistance from the health community: Establish linkages and good interpersonal relationships with and seek collaboration from doctors in the public and private sectors, nurses and vaccinators, NIDs volunteers, other members of partner organisations, e.g. Rotarians.
- Conduct a mass media campaign: Involve all appropriate media, e.g. TV, radio, newspapers, street theatre (national and local stations/editions); seek out media that have been misinforming the public; call on previously established relationships with the media; delegate one spokesperson to handle the media questions; display confidence, e.g. photograph and publicise the First Lady or another prominent personality with good charismatic appeal while giving OPV to her/his own baby or to a baby in the presence of its mother; interview pop idols/sports persons explaining the truth; print resources where appropriate, e.g. questions and answers on common misconceptions, positive messages.

Proactive activities to prevent and limit rumours

- Use local NGOs, religious organisations or community groups that have the respect of these groups/individuals as mobilisers and educators.
- Involve communities through leaders in planning/implementing health activities.
- Approach communities promptly; ensure frequent contact.
- Present health issues as national issues.
- Discuss NIDs with public and private practitioners in advance, obtain support.
- Make communication and social mobilisation a continuous activity: Design strategies that establish continuity between NIDs and routine immunisation.

Lessons learned and important reminders:

- Rumours often start during NIDs, so make sure that you are ready to provide immediate responses. Take the time to deal with rumours. Doing so will benefit immunisation campaigns as well as routine immunisation. Disseminate consistent messages.
- Resources for rapid response to rumours are rarely budgeted. Be sure to plan for this eventuality and anticipate resources that would be required in terms of partner networks, human, material, financial and time resources.
- Programmes with limited resources may not want to provide resources for something that may or may not be a problem. This is why contributions from established partners are instrumental. Therefore, build and nurture on-going relationships with communities (religious, social, media).
- Programme implementers tend to give insufficient attention and importance to communication vis a vis "technical priorities." Communicators must insist to be part already in the planning phase of an immunisation campaign or programme and must be proactive in integrating communication elements in the campaign/programme. Tailor immediate and ongoing strategies and respond accordingly in cooperation with all stakeholders.
- The process of decentralization may complicate a rapid response. It is important to understand the local structures and bureaucracy and establishing good working and social relationships with the local authorities to ensure smooth collaboration toward rapid response.

ANNEX D: Sample KAP Survey Questions

Some sample questions are provided below that can be used for surveys on knowledge, attitudes and practices (KAP) in relation to immunisation.

Knowledge

- Do you know how many visits you need to make to fully immunize your child?
- Do you know whether your child needs to complete the full course of immunisation?
- What are the scheduled dates of vaccination for your child before s/he reaches one year?
- Do you know if s/he will not be fully protected from the diseases if one or two doses are missed?
- Do you know the benefits of TT vaccination for women?
- Do you know how many TT shots you will need to gain full protection from maternal neonatal tetanus?

Attitudes

- Do you take your child for immunisation when s/he is sick?
- Do people in your community need to know more about full immunisation?
- Measuring attitudes through statements measured on a 5-point Likert scale (from strongly agree through strongly disagree). An example of such a statement is: "If a woman friend is pregnant, I would strongly advise her to have the full course of vaccinations for her child."

Practice

- How many times have you had your child vaccinated?
- At what points in time (schedule) have you had your child vaccinated?
- Have you completed the full immunisation schedule for your child that involves 5 visits to the health post?

ANNEX E: Different Communication Indicators¹⁴

	Input	Output	Outcome	Impact
1. How many booklets were produced?		X		
2. What was the programmatic impact on child survival?				X
3. What percentage of trainees used the new skills in their workplaces?			X	
4. Does the district committee enforce the law against unlicensed people giving immunisation injections?		X	X	
5. How many viewers discussed the TV spot with their friends?			X	
6. How many new volunteers were recruited to help with social mobilisation?		X		
7. How well did the volunteers do their jobs?			X	
8. What is the budget for this communication intervention?	X			
9. Did the project go over budget?	X			
10. What is the overall cost/benefit of those communication activities?				X
11. How many radio spots were aired?		X		
12. How many communities did the outreach team meet with to schedule outreach sessions?		X		
13. How many health workers told mothers when to return for the next immunisation?			X	
14. Is there a communication person on the district management committee?	X			
15. Has there been a reduction in polio cases?				X

ANNEX F: Workshop Agenda

Strategic Communication Workshop: "Public Trust and Responding to Adverse Events Following Immunisation", New Delhi, India, 9 to 10 August 2004

Workshop Objective:

To develop enhanced capacity in applying strategic communication approaches to foster public confidence in immunisation, particularly in the case of adverse events following immunisation. This will be addressed through sharing latest evidence, identifying communication gaps, operational bottlenecks, sharpening communication skills, including press interviews, and agreeing on key elements for an AEFI communication strategy.

Expected Outcomes:

- 1) Strategic communication emphasized and placed in on-going immunisation planning process
- 2) Communication procedure developed within AEFI rapid response system
- 3) Five core skills strengthened in effective media handling in case of AEFI

Agenda

Monday, 9 August 2004

- 08:00 - 08:30 Registration
- 08:30 - 09:00 **Inauguration**
Opening Statement: Dr. Sadig Rasheed, Regional Director, UNICEF ROSA
Opening Statement: Dr. Samlee Plianbangchang, Regional Director, WHO SEARO
Concluding note of thanks: Dr. Esther Guluma, Deputy Regional Director, UNICEF ROSA
- 09:00 - 09:30 Refreshments
- Chairperson:** Dr. Esther Guluma, Deputy Regional Director, UNICEF ROSA
- 09:30 - 09:45 **Overview of Workshop and Introduction of Participants**
Wing-Sie Cheng, Regional Programme Communication Advisor, UNICEF ROSA
- 09:45 - 10:15 **Overview of AEFI Surveillance and Response Guidelines**
Objective: To provide an overview and arrive at a common understanding on the current AEFI guidelines and programmatic responses in South Asia. (15 min presentation followed by discussion)
Presenter: Adwoa Bentsi-Enchill, Medical Officer, FCH/IVB/VAM, WHO, Geneva
- 10:15 - 10:45 **Impact of AEFI on Immunisation: A Review**
Objective: To provide a technical update on how AEFI have impacted on immunisation coverage and vaccine preventable diseases. (15 min presentation followed by discussion)
Presenter: Dr. Anne Golaz, Regional Immunisation Advisor, UNICEF ROSA

- 10:45 - 12:00 **Learning from Experiences**
Objective: Based on country presentations on experiences with AEFI cases, the session will facilitate sharing of experiences among participants and identify key areas in communication which must be addressed to avoid erosion of public confidence in immunisation.
Facilitators: Wing-Sie Cheng, Regional Programme Communication Advisor and Ulrike Gilbert, Programme Communication Officer, UNICEF ROSA
- 12:00 - 13:00 **Role of Strategic Communication in Addressing AEFI**
Objective: To enhance participants' understanding on the concept and role of strategic communication, particularly behaviour change communication, advocacy, social mobilization and mass media, to address AEFI effectively. (Two 15 min presentations followed by plenary discussion)
Presenters: Wing-Sie Cheng, and Martin Dawes, Regional Communication Advisor, UNICEF ROSA
- 13:00 - 14:00 Lunch
- Chairperson:** Dr Brent Burkholder, Regional Advisor Immunisation and Vaccine Development, WHO SEARO
- 14:00 - 14:45 **Managing Media and Building Trust after Adverse Events - International Lessons**
Objectives: To share lessons learned in addressing resistance and rumours faced in different parts of the world and provide suggestions on how to pre-empt/contain these. Further, to provide insights into the implications of AEFI on global confidence in vaccines. (15 min presentation followed by discussion).
Presenter: Dr. Heidi Larson, Senior Communication Advisor, UNICEF New York
- 14:45 - 15:30 **Development of Effective Media Communication in the Case of an AEFI**
Objective: To strengthen media and communication skills. Session will include film presentation on core techniques, "do's and don'ts", development of plan, interviews and press conference.
Facilitator: Martin Dawes, Regional Communication Advisor, UNICEF ROSA
- 15:30 - 16:00 Refreshments
- 16:00 - 17:30 **Development of Effective Media Communication in the Case of an AEFI**
Facilitator: Martin Dawes, Regional Communication Advisor, UNICEF ROSA

Tuesday, 10 August 2004

08:30 - 09:00 Recap of the previous day

Chairperson: Dr. Brent Burkholder, Regional Advisor Immunisation and Vaccine Development,
WHO SEARO

- 09:00 - 10:00 **Interview Playback and Peer Feedback**
Facilitator: Martin Dawes, Regional Communication Advisor, UNICEF ROSA
- 10:00 - 10:30 Refreshments
- 10:30 - 13:00 **How to Communicate in an Immunisation Crisis**
Objective: To build interpersonal communication skills in case of AEFI as well as to identify main elements of a strategic communication plan.
In working groups, participants will examine different scenarios and develop a strategic communication plan. Based on the group work, participants will develop role plays to tackle AEFI and maintain public trust. The role-plays are followed by peer feedback and discussion in the larger group, in order to identify key steps and elements of a comprehensive strategic communication plan.
Facilitator: Wing-Sie Cheng, Anne Golaz, Heidi Larson, Ulrike Gilbert, Diane Lynn Araki
- 13:00 - 14:00 Lunch
- Chairperson:** Dr. Esther Guluma, Deputy Regional Director, UNICEF ROSA
- 14:00 - 15:00 **Proactive Communication to Build Public Trust**
Objective: To identify strategies to enhance public trust in immunisation as part of on-going communication for immunisation plans and to explore the role of data for strategic communication in immunisation programming.
Facilitator: Wing-Sie Cheng and Ulrike Gilbert, UNICEF ROSA
- 15:00 - 15:30 Presentations and discussion
- 15:30 - 16:30 Refreshments
- 16:30 - 17:30 **AEFI Communication Protocol Development**
Objective: To come to an agreement on communication steps to follow within the first 24 - 48 hours after AEFI occurs, and what should be done on a longer term to mitigate potential erosion of public confidence. The discussion will thus revolve around:
Part I: Communication in the first 24 - 48 hours after an AEFI, a reactive response that has to be managed well in order to preserve public trust;
Part II: Long-term positioning of communication for routine immunisation, in particular, due to regular occurrence of AEFI. It involves deliberating on proactive steps by applying strategic communication - a combination of advocacy, social mobilization and behaviour change communication - to build and maintain public trust, as well as increase acceptance of routine immunisation as a behavioural norm.
This session will carefully review key steps and elements of a communication response for Part I, as identified in previous sessions and agree on a minimum standard. Participations will also agree on the follow up process, that is, Part II, formulating a communication strategy at country level, how to "pre-empt" and contain potential negative public opinion related to AEFI, as well as promote positive perception of routine immunisation.

- 17:30 - 18:00 Presentations and consensus on minimum elements for AEFI communication protocol
Facilitators: Wing-Sie Cheng, UNICEF ROSA; Martin Dawes, UNICEF ROSA; Heidi Larson, UNICEF HQ
- 18:00 - 18:15 **Evaluation**
- 18:15 - 18:30 **Workshop Closure and Way Forward**
Dr. Esther Guluma, Deputy Regional Director, UNICEF ROSA
Dr. Brent Burkholder, Regional Advisor Immunisation and Vaccine Development, WHO SEARO

ANNEX G: List of Participants

AFGHANISTAN

- 1 Dr. Ashraf Aini**
National EPI Manager Ministry of Health, Afghanistan
E-mail: nationalepi2004@yahoo.com

BANGLADESH

- 2 Dr. Jucy Merina Adhikari**
Assistant Project Officer, EPI
UNICEF Bangladesh Country Office, BSL Office
Complex, 1, Minto Road, GPO Box 58
Dhaka-1000 Bangladesh
Tel:- 880-2-9336701-10 Ext:-458
Fax:- 880-2-9335641-42
E-mail: jmadhikari@unicef.org
- 3. Dr. Serguei Diorditsa**
Medical Officer - EPI
World Health Organization
Dhaka, Bangladesh
- 4 Dr. Md. Lutfor Rahman**
Programme Manager (EPI)
Directorate-General of Health Services
EPI Bhaban, Mohakhali
Dhaka, Bangladesh
Tel:- 880-2-8614653
Fax:- 880-2-8613247
- 5. Mr. Naseem-Ur Rehman**
Chief Communication & Information
UNICEF Bangladesh Country Office
BSL Office Complex, 1, Minto Road
GPO Box 58, Dhaka-1000 Bangladesh
Tel:- 880-2-9335807
Fax:- 880-2-9335641-42, Mobile :- 880-171-595045
E-mail: nrehman@unicef.org

DPR KOREA

- 6 Dr. Yong Sik Han**
National EPI Program Manager
Ministry of Public Health
Pyongyang, DPR Korea
Tel:- 850-2-3817913
Fax:- 850-2-3817916
- 7. Mr. Son Il Kim**
Interpreter, Ministry of Public Health
Pyongyang, DPR Korea
Tel:- 850-2-3817913
Fax:- 850-2-3817916

INDIA

- 8. Ms. Geeta Athreya**
Programme Communication Officer
UNICEF India Country Office, 73 Lodi Estate,
New Delhi - 110003, India
Tel:- 91-11-24690401
Fax:- 91-11-24627521
E-mail: gathreya@unicef.org
- 9. Ms. Ramani Atkuri**
Project Officer, Health & Nutrition
UNICEF Bhopal Office
E7/650, Area Colony
Bhopal - 462016, India
Tel :- 91-755-2466568 / 5272106
Fax :- 91-755-2463623
E-mail : ratkuri@unicef.org
- 10. Dr. A.R. Belambe**
SEPIO, Family Welfare Bureau
Kutumb Kalyan Bhavan
Pune-411001, India
Tel:- 91-20-26139476, Mobile:- 91-9850056518
Fax:- 91-20-26127159
- 11. Dr. A.R. Chandrasekaran**
Project Officer, Health
UNICEF Bhubaneswar Field Office
44, Surya Nagar, Bhubaneswar-751003
Orissa, India
Tel:- 91-674-2403977
Fax:- 91-674-2403976
E-mail: rchandrasekaran@unicef.org
- 12. Mr. Tapas Kumar Datta**
Programme Communication Officer UNICEF
Bhopal Field Office for Madhya Pradesh &
Chhattisgarh E7/650
Area Colony, Bhopal, India
Tel:- 91-755-2465031
Fax:- 91-755-
E-mail: tadatta@unicef.org
- 13. Ms. Girija Devi**
Programme Communication Officer
UNICEF Office for Rajasthan
B-9 Bhawani Singh Lane, C-Scheme
Opp. Nehru Sahakar Bhawan
Jaipur - 302001, Rajasthan, India
Tel: 91-141-2222694 / 2222636
Fax: 91-141-2223865
E-mail: gdevi@unicef.org
- 14. Dr. Pradeep Halder**
Assistant Commissioner (UIP)
Ministry of Health and Family Welfare
Government of India, 106-D Wing, Nirman Bhawan,
New Delhi, India
Tel:- 91-11-23019728 / 23016126
Mobile:- 91-9811297433
Fax:- 91-11-23019728
E-mail: pradeephalder@yahoo.co.in
- 15. Dr. D.C. Jain**
Deputy Commissioner (T)/CH
Ministry of Health and Family Welfare
Government of India, Nirman Bhawan
New Delhi, India
Tel:- 91-11-23370804
- 16. Dr. Suresh Joshi**
Project Officer, Health
UNICEF Gandhinagar, Plot No. 70, Sector - 19
Gandhinagar, Gujarat, India
Tel:- 91-79-23225366
Fax:- 91-79-23225364
E-mail: sjoshi@unicef.org
- 17. Dr. Vijaykumar Moses**
Project Officer, Health & Nutrition
UNICEF State Office for Bihar & Jharkhand
8 Patliputra Colony, Patna, Bihar, India
Tel:- 91-612-2261621 / 2261728 Ext:- 207
Fax:- 91-612-2261620
E-mail: vmoses@unicef.org

- 18. Ms. Kiran Negi**
Communication Officer
UNICEF Office for West Bengal and Assam
219/2, A.J.C.Bose Road
Kolkata - 700017, India
Tel:- 91-33-22872477 / 22872467 / 31016521
Fax:- 91-33-22872510
E-mail: knegi@unicef.org
- 19. Dr. Vibhavendra Singh Raghuyamshi**
Asst. Project Officer, Routine Immunization
UNICEF State Office for Bihar & Jharkhand
Patliputra Colony, Patna, Bihar, India
Tel:- 91-612-2261621 / 2261728
Fax:- 91-612-2261620
E-mail: vraghuvamshi@unicef.org
- 20. Dr. Karan Sagar**
SSA, National Polio Surveillance Project
Jawahar Lal Nehru Stadium
New Delhi, India
Tel:- 91-11-24367730
- 21. Dr. K. Subramani**
Joint Director & State EPI Officer, No. 359
Anna Salai, Office of the Director of Public Health &
Preventive Med., DMS Campus
Chennai, India
Tel:- 91-44-24336674 / 9443025303
Fax:- 91-44-24336674
- 22. Ms. Savita Varde-Naqvi**
Communication Officer (Sr. Officer Media / External
Relations)
UNICEF India Country Office
73 Lodi Estate, New Delhi - 110003, India
Tel:- 91-11-2469 0401Ext:- 212
Fax:- 91-11-24691410
E-mail: snaqvi@unicef.org

MALDIVES

- 23. Mr. Mohammed Saeed**
Programme Officer
UNICEF Maldives Country Office
UN Building Raiiydhebbai Higun
Male, Maldives
Tel:- 960-322017
Fax:- 960-326469
E-mail: msaeed@unicef.org

MYANMAR

- 24. Dr. Anshu Banerjee**
Medical Officer
Yangon, Myanmar

NEPAL

- 25. Mr. Prabhat Bangdel**
Immunization Programme Officer
UNICEF Nepal Country Office
P.O. Box 1187 UN House, Pulchowk
Patan, Nepal
Tel:- 977-1-5523200 Ext:- 1109
Fax:- 977-1-5527280 / 5535395
E-mail: pbangdel@unicef.org
- 26. Dr. Rajendra Bohara**
National Professional Officer
World Health Organization, P.O. Box 109
UN House, Pulchowk, Patan, Nepal

- 27. Dr. Govinda Prasad Ojha**
Director, Child Health Division
Ministry of Health, Dept. of Health Services
Teku, Kathmandu, Nepal
Tel:- 977-1-4261463, Mobile:- 977-9851069528
Fax:- 977-1-4262263
E-mail: gpojha@healthnet.org.np
- 28. Ms. Deepa Risal Pokharel**
Assistant Programme Comm. Officer
UNICEF Nepal Country Office
P.O. Box 1187 UN House, Pulchowk Patan, Nepal
Tel:- 977-1-5523200
Fax:- 977-1-5527280 / 5535395
E-mail: deepapokharel@yahoo.co.uk
- 29. Mr. Sharad Ranjit**
Assistant Programme Communication Officer
UNICEF Nepal Country Office, P.O. Box 1187
UN House, Pulchowk, Patan, Nepal
Tel:- 977-1-5523200, Mobile:- 977-9851054146
Fax:- 977-1-5527280 / 5535395
E-mail: sranjit@unicef.org

PAKISTAN

- 30. Dr. Altaf Bosan**
GAVI Hep.B Immunization Advisor
World Health Organization,
Chak Shahzad, Islamabad, Pakistan
Tel:- 92-51- 9255360
Fax:-92-51-9255086
E-mail: fshafique@unicef.org
- 31. Dr. Ihsanul Haq**
Secretary Health, Government of NWFP
Health Department, Khyber Road
Peshawar, Pakistan
Tel :- 92-91-9210342
Fax :- 92-91-9210419
- 32. Mr. Suleman Malik**
Programme Communication Officer
UNICEF Pakistan Country Office
61a Jinnah Ave., 7th Floor, Saudi Pak Tower,
P.O. Box 1063, Islamabad, Pakistan
Tel:- 92-51-2800133-42
Fax:- 92-51-2800132
E-mail: smalik@unicef.org
- 33. Dr. Fouzia Shafique**
Assistant Project Officer, EPI
UNICEF Pakistan Country Office, Shah Faisal
Avenue., 7th Floor, Saudi Pak Tower
P.O. Box 1063, Islamabad, Pakistan
Tel:- 92-51-2800118 / 2800133
Fax:- 92-51-2800132
E-mail: fshafique@unicef.org
- 34. Ms. Julia Spry-Leverton**
Chief, Advocacy and Communication
UNICEF Pakistan Country Office
Shah Faisal Avenue., 7th Floor, Saudi Pak Tower
P.O. Box 1063, Islamabad, Pakistan
Tel:- 92-51-2800133-42, Mobile:- 92-3005002595
Fax:- 92-51-2800132
E-mail: jspryleverton@unicef.org

SRI LANKA

- 35. Ms. Surangani Abeyesekera**
Assistant Communication Officer
UNICEF Sri Lanka Country Office
No. 5 Geethanjali Place
Colombo-3, Sri Lanka
Tel:- 94-11-2555270
Fax:- 94-11-2551333
E-mail: sabeyesekera@unicef.org
- 36. Dr. Sapumal Dhanapala**
Assistant Project Officer, Maternal & Child Health
UNICEF Sri Lanka Country Office
No. 5 Geethanjali Place
Colombo-3, Sri Lanka
Tel:- 94-11-2555270 Ext:- 216
Fax:- 94-11-2551333
E-mail: sdhanapala@unicef.org
- 37. Mr. Geoffrey Keele**
Communication Officer
UNICEF Sri Lanka Country Office, No. 5
Geethanjali Place, Colombo-3, Sri Lanka
Tel:- 94-11-2555270 Ext:- 250
Fax:- 94-11-2551333
E-mail: gkeele@unicef.org

WHO South-East Asia Regional Office

- 38. Dr. Brenton Burkholder**
Regional Advisor, IVD
WHO South-East Asia Regional Office, I.P.
Estate Mahatma Gandhi Marg,
New Delhi-110002, India
Tel:- 91-11-23370804
Fax:- 91-11-23370106
E-mail: burkholderb@whosea.org
- 39. Mr. Stephane Guichard**
Technical Officer, VSQ
WHO South-East Asia Regional Office, I.P.
Estate Mahatma Gandhi Marg
New Delhi-110002, India
Tel:- 91-11-23370804
Fax:- 91-11-23370106
- 40. Ms. Harsaran Bir Kaur Pandey**
Information Officer
WHO South-East Asia Regional Office, I.P.
Estate Mahatma Gandhi Marg, New Delhi-110002
India
Tel:- 91-11-23370804
Fax:- 91-11-23370106
- 41. Dr. Arun Thapa**
Regional Adviser, IVD
WHO South-East Asia Regional Office, I.P.
Estate Mahatma Gandhi Marg
New Delhi-110002, India
Tel:- 91-11-23370804
Fax:- 91-11-23370106
E-mail: thapaa@whosea.org
- 42. Ms. Anita Saxena**
WHO South-East Asia Regional Office, I.P.
Estate Mahatma Gandhi Marg,
New Delhi-110002, India
Fax:- 91-11-23370106

WHO Switzerland HQ

- 43. Dr. Adwoa Desma Bentsi-Enchill**
Medical Officer, FCH/IVB/VAM
World Health Organization, 20 Avenue Appia 1211
Geneva - 27, Switzerland
Tel:- 41-22-7911154
Fax:- 41-22-7914210
E-mail: bentsienchilla@who.int

UNICEF Regional Office for South Asia

- 44. Ms. Wing-Sie Cheng**
Regional Adviser, Programme
Communication (*has since been transferred to
UNICEF EAPRO*)
UNICEF Regional Office for South Asia
P.O. Box 5815, Leknath Marg, Lainchaur
Kathmandu, Nepal
Tel:- 977-1-4417082 Ext:- 244
Fax:- 977-1-4418466
E-mail: wscheng@unicef.org
- 45. Mr. Martin Dawes**
Regional Adviser, Communication
UNICEF Regional Office for South Asia
P.O. Box 5815, Leknath Marg, Lainchaur
Kathmandu, Nepal
Tel:- 977-1-4417082 Ext:- 221
Fax:- 977-1-4418466
E-mail: mdawes@unicef.org
- 46. Ms. Ulrike Gilbert**
Programme Communication Officer
UNICEF Regional Office for South Asia
P.O. Box 5815, Leknath Marg, Lainchaur
Kathmandu, Nepal
Tel:- 977-1-4417082 Ext:- 266
Fax:- 977-1-4418466
E-mail: ugilbert@unicef.org
- 47. Dr. Anne Golaz**
Regional Adviser, Immunization
UNICEF Regional Office for South Asia
P.O. Box 5815, Leknath Marg, Lainchaur
Kathmandu, Nepal
Tel:- 977-1-4417082 Ext:- 241
Fax:- 977-1-4418466
E-mail: agolaz@unicef.org
- 48. Dr. Esther Guluma**
Deputy Regional Director
UNICEF Regional Office for South Asia
P.O. Box 5815, Leknath Marg, Lainchaur
Kathmandu, Nepal
Tel:- 977-1-4411757 (D.L.)
Fax:- 977-1-4418466
E-mail: eguluma@unicef.org
- 49. Dr. Sadig Rasheed**
Regional Director
UNICEF Regional Office for South Asia
P.O. Box 5815, Leknath Marg, Lainchaur
Kathmandu, Nepal
Tel:- 977-1-4419469 (D.L.)
Fax:- 977-1-4418466
E-mail: srasheed@unicef.org

50. Ms. Roko Ramesh
Programme Assistant
UNICEF Regional Office for South Asia
P.O. Box 5815, Leknath Marg, Lainchaur
Kathmandu, Nepal
Tel:- 977-1-4417082 X 238
Fax:- 977-1-4418466
E-mail: rramesh@unicef.org

UNICEF NYHQ

51. Dr. Francois Gasse
Senior Project Officer
UNICEF NYHQ, Division of Health
UNICEF, 3 UN Plaza, NY, NY 10017, U.S.A
Tel:- 1-6462473137
Fax:- 1-212 326 7768
E-mail: fgasse@unicef.org

52. Dr. Heidi Larson
Senior Communications Adviser
UNICEF NYHQ
Division of Communication
UNICEF, 3 UN Plaza, NY, NY 10017, U.S.A
Tel:- 1-212 326 7762
Fax:- 1-212 326 7768, Mobile:- 1- 646 207 5179
E-mail: hl Larson@unicef.org

USAID Washington

53. Ms. Ellyn W. Ogden
USAID, Polio Eradication Coordinator
GH/HIDN/MCH, 1300 Pennsylvania Ave
NW, Washington DC 20523, USA
Tel:- 1-202-712-5891
Fax:- 1-202-216-3702

RESOURCE PERSON

56. Ms. Diane Araki
Interior Health, Infection Control Surveillance
Project, 740 Carmi Ave.
Penticton BC V2A 8T8, Canada
Tel:- 250-770-3436, Mobile:- 250-488-0420
Fax:- 250-770-3410
E-mail: diane.araki@interiorhealth.ca

Endnotes

- 1 These countries are: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.
- 2 WHO (2005) Aide Memoire - AEFI Investigation. Geneva. Accessed on 3 March 2005 at http://www.who.int/immunisation_safety/aeft/en/
- 3 *ibid*
- 4 WHO Western Pacific Office Regional Office (1999) Immunisation Safety Surveillance - Guidelines for Managers of Immunisation Programmes on Reporting and Investigating Adverse Events Following Immunisation, WPRO/EPI/99.01.
- 5 UNICEF ESARO (2003) Combating Antivaccination Rumours: Lesson Learned in East Africa. Unpublished report. Kenya.
- 6 Gangarosa, E.J., Galazka, A.M. et al (1998) Impact of Anti-vaccine Movements on Pertussis Control: the Untold Story, *The Lancet*, Vol 351, January 31.
- 7 Kharabsheh S. et al (2001) Mass Psychogenic Illness following Tetanus-diphtheria Toxoid Vaccination in Jordan. *Bulletin of the World Health Organization*, 79 (8).
- 8 UNICEF ESARO (2003): Combating Anti-vaccination Rumours: Lesson Learned in East Africa. Unpublished report.
- 9 A useful reference for KAP surveys is: Bhattarai, M.D. et al. (no date) Rapid Assessment of Perceptions, Knowledge and Practices related to Immunisation Injection Safety in Nepal. Children's Vaccine Program/PATH.
- 10 For more detailed information on various communication strategies, please refer to: UNICEF ROSA (2004) Strategic Communication for Behaviour and Social Change in South Asia. Kathmandu, Nepal.
- 11 Offit, P and Coffin, S (2003) Communicating Science to the Public: MMR Vaccine and Autism. *Vaccine* (22) 1-5.
- 12 WHO Western Pacific Office Regional Office (1999) Immunisation Safety Surveillance - Guidelines for Managers of Immunisation Programmes on Reporting and Investigating Adverse Events following Immunisation, WPRO/EPI/99.01
- 13 Adapted from: WHO, UNICEF, USAID (BASICS II and CHANGE projects) (2002) Communication for Polio Eradication and Routine Immunisation: Checklists and Easy Reference Guide. WHO/POLIO/02.06
- 14 Scott Wittet (2003) Communication Indicators for M&E. Children's Vaccine Program at PATH, on: CD ROM Communication for Immunization Workshops, produced by UNICEF as a partner in GAVI.

Glossary of Terms

Adverse event(s) following immunisation (AEFI): an adverse event following immunisation (AEFI) is a medical incident that takes place after immunisation, causes concern and is believed to be caused by the immunisation.

Adverse reaction: an undesirable outcome caused by a vaccine (or drug) where there is evidence suggesting a causal relationship. The difference between adverse events and adverse reactions is that adverse events may coincide with (i.e. occur at the same time), but not necessarily caused by, vaccine administration.

Advocacy: a continuous and adaptive process of gathering, organising and formulating information into argument, to be communicated to decision-makers through various communication channels, with a view to influencing policy decisions and leadership, resource allocations, acceptance and commitment for a development programme.

Behaviour change communication (or programme communication): a research-based consultative process of addressing knowledge, attitudes and practices of families and communities; through identifying, analysing and segmenting participants' needs (wants and desires); by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods.

Cluster: two or more cases of the same or similar event related in time, geography (e.g. at a health unit or immunisation outreach post), vaccinator and/or vaccine administered.

Interpersonal communication (IPC): refers to face-to-face communication. IPC can either be one-on-one or in a small group (e.g. a health worker who dialogues with a group of village women or men). The objectives of IPC are to share information, respond to questions and doubts, motivate the individuals to adopt healthy behavioural practices or use certain health services (such as immunisation). IPC involves listening skills, the ability to empathise and be supportive.

Serious adverse events following immunisation (AEFI)

A serious adverse event is any untoward medical occurrence that:

- results in death,
- requires inpatient hospitalization or prolongation of existing hospitalization,
- results in persistent or significant disability/incapacity, or
- is life-threatening.

Note: WHO recommends that certain types of AEFI should be considered serious (i.e., significant) enough to warrant urgent investigation and proper management although these categories of adverse events are not based on the standard definition above. These include:

- AEFI that may have been caused by a programme error (e.g., clusters of AEFI, bacterial abscesses, severe local reactions, high fever or sepsis, BCG lymphadenitis, toxic shock syndrome),
- serious events (including deaths) of unexplained cause occurring within 30 days after a vaccination, and
- AEFI causing significant parental or community concern.

Social mobilization: a process of bringing together all feasible and practical inter-sectoral social partners and allies to determine felt-needs and raise awareness of, and demand for, a particular development objective. It involves enlisting the participation of such actors, including institutions, groups, networks and communities, in identifying, raising and managing human and material resources, thereby increasing and strengthening self-reliance and sustainability of achievements.

Strategic communication: an evidence-based, results-oriented process, undertaken in consultation with the participant group(s). It is intrinsically linked to other programme elements, cognisant of the local context and favouring a multiplicity of communication approaches, to stimulate positive and measurable behaviour and social change.

Surveillance: the continuing, systematic collection of health data that are analysed and disseminated to enable public health decision-making and action to protect the health of populations.

Acronyms

AEFI	Adverse Event Following Immunisation
BCC	Behaviour Change Communication
BCG	Bacille Calmette-Guérin vaccine (against Tuberculosis)
DPT	Diphtheria Pertussis Tetanus vaccine
EPI	Expanded Programme on Immunisation
FAQ	Frequently Asked Questions
HW	Health Worker
IEC	Information, Education, Communication
IFA	Iron Folic Acid
IPC	Interpersonal Communication
KAP	Knowledge, Attitude, Practice
MoH	Ministry of Health
NGO	Non Government Organisation
NID	National Immunisation Day
NRA	National Regulatory Authority
OPV	Oral Poliovirus Vaccine
PSA	Public Service Announcement(s)
PEI	Polio Eradication Initiative
Td	Tetanus diphtheria vaccine
TT	Tetanus toxoid vaccine
UNICEF	United Nations Children's Fund
UNICEF ROSA	UNICEF Regional Office for South Asia
WHO	World Health Organization
WHO SEARO	WHO Southeast Asia Regional Office

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All participants to the workshop, for providing the substance to this working paper.

Dr. Adwoa D. Bentsi-Enchill (WHO Headquarters), Stephane Guichard (WHO SEARO), Dr. Anne Golaz and Teresa Stuart (UNICEF ROSA), Heidi Larson and Dr. Francois Gasse (UNICEF NY), for reviewing the document to ensure technical soundness and consistency.

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United Nations Children's Fund
Regional Office for South Asia
P. O. Box 5815
Lekhnath Marg
Kathmandu, Nepal

Telephone: 977-1-4417082
Facsimile 977-1-4418466 / 4419479
www.unicef.org