

## AFRICA CDC WORKING GROUP

### *Strategies to create demand for COVID-19 vaccination in Senegal*

#### Executive Summary

On Friday 18<sup>th</sup> March 2022, Africa Centres for Disease Control and Prevention (Africa CDC) and the Vaccine Confidence Project (VCP) participated in a roundtable convened by the Senegal Ministry of Health and Social Welfare (MSAS), in collaboration with the African Health Observatory (AHOP), and the Institut Pasteur in Dakar (IPD). The objectives of the roundtable were to:

1. share the Africa CDC's new study findings on the acceptability of COVID-19 vaccination in 14 countries, including sub-national research into the acceptability of COVID-19 vaccines amongst healthcare workers, as well as at population level;
2. gain an understanding of the insights from vaccine acceptance research conducted by the local Senegal team, and;
3. discuss how this combined research can help inform the design of strategies to improve COVID-19 vaccination uptake.

The panel discussed the role of policymakers in driving demand and considered relevant strategies to help drive up community confidence in and uptake of vaccination.

Based on the research findings presented it was clear that the key issue is no longer one of vaccine supply but, rather, public demand and acceptance. The fundamental role of listening to communities was stressed in the meeting, with a strong recommendation to collaborate with locally trusted leaders (religious and civil society). It was also strongly recommended to segment different societal groups as each will have distinct access issues, different risk perceptions, and varying drivers of vaccine uptake.

#### Background

In February 2021, Africa CDC and the VCP published a 15-country report measuring COVID-19 Vaccine Perceptions in selected countries across Africa. To further this work, John Nkengasong, Director of the Africa CDC, asked Prof. Heidi Larson to co-convene a Vaccine Confidence Working Group together with the Africa CDC to allow a more coherent approach to vaccine hesitancy research across the Continent.

Johnson & Johnson, the Bill & Melinda Gates Foundation, and Mercy Corps joined this coalition to support the work with both funding and expertise, adding depth to the research and implementation strategies across the African continent.

The objective of the 2022 research is to:

1. provide strong and valuable evidence on the underlying drivers of vaccine hesitancy in the selected countries<sup>1</sup>

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<sup>1</sup> Full country list: DRC, Cameroon, Mali, Liberia, Sierra Leone, Ghana, South Sudan, Nigeria, Cote d'Ivoire, Kenya, South Africa, Uganda, Niger and Philippines (added as a country with vaccine demand challenges for comparison)

- II. work with Africa CDC and other local research partners to develop strategic recommendations for governments and other local immunization stakeholders on ways to deploy these research findings and inform strategies to strengthen acceptance of COVID-19 vaccines and other related interventions.

## Mapping COVID-19 Vaccine Perceptions Across Countries

The Working Group is conducting four waves of quantitative research over 2022, with additional in-depth investigation in select settings. Africa CDC identified the countries they consider to be priorities for support for preparedness to ensure uptake of vaccines, and where they believed that investment could have the greatest impact. The selection of these countries was determined by Africa CDC data comparing current vaccine deployment vs. uptake, as well as their assessment of which countries are best poised to act based on a series of other factors such as political will, vaccine logistics planning, up-to-date supply and demand evidence, previous history with vaccine uptake, and the presence of other stakeholders to support roll-out.

Surveys are being carried out among a nationally representative sample of 1,000 adults in each country. Interviews follow a random route methodology with a sample designed to be proportional to the population distribution across each country.

The initial findings (Wave 1 survey completed February 2022) show that while access to vaccines is improving, demand issues are becoming more important and challenging. Wave 2 goes into the field in early May 2022.

## Main Sessions

### Presentation 1:

*Reflections on the importance of vaccination and presentation of the Platform on Health Systems and Policies of the African Health Observatory (AHOP): its creation, objectives, and vision.*

Dr. Amadou Sall, Director of the [Institut Pasteur de Dakar](#) and Abib Ndiaye, Researcher at the Department of Health and Social Welfare and Focal Point of the [MSAS National Observatory](#)

Tracing the history of vaccination. Despite the progress made in recent decades, vaccination is marred by rumours and sometimes associated with a boycott because of religious prejudice and associated hesitation, as well as fear of side effects.

The National Health Observatory is an integration of health information into a single platform managed by countries. The African Health Observatory (AHOP) Health Systems and Policy Platform is a collaborative partnership to support and promote the transfer of evidence and experience between countries to foster better policies and actions to improve health and well-being. Platform's national centres currently include institutions in Ethiopia, Kenya, Nigeria, Rwanda, and Senegal.

### Presentation 2:

*Results of the Africa CDC study mapping COVID-19 vaccine perceptions across countries.*

Dr Elvis Temfack; Senior Research Officer at [Africa CDC](#)

Findings from ~1,000 interviews in 14 African countries. Wave 1 was completed in Feb 2022 and three further waves are planned over the course of the year. The methodology was chosen to ensure each of the different regions is represented over time to reflect the volatility we are seeing in confidence, uptake, and access.

### Presentation 3:

Results of the [socio-anthropological study](#) into the situation of the COVID-19 epidemic among frontline health workers and the community, and the acceptability of diagnostic tests and vaccines for COVID-19.

Professor Cheikh Niang, SAHARA Research Unit of the Institute of Environmental Sciences of the Cheikh Anta Diop University of Dakar

In the context of the COVID-19 pandemic - and to help politicians put in place pandemic response strategies - a study was conducted by the Institut Pasteur and UCAD's SAHARA research group to study the acceptability of rapid diagnostic tests (RDTs) and COVID-19 vaccination among health workers and of the community. The study covered four health districts, including three in the Dakar medical region (Dakar West, Dakar South, Yeumbeul) and one in the medical region of Diourbel (Touba). The study took place between the months of March and May 2021.

### Round Table Discussion

The presentations were followed by discussions and reflections on creating demand for COVID-19 vaccination. The objective of this panel was to identify strategies on the creation of demand for COVID-19 vaccination in Senegal.

The panel was moderated by Dr. Samba Cor, member of the National Committee on Ethics and Health Research, and Head of the Research Division at the DPRS, and there were five panellists:

1. Dr Ousseynou Badiane - Head of Immunisation Division, DPRS
2. Dr Mady Ba - WHO Country Office Disease Control Advise
3. Prof. Cheikh Niang - SAHARA Research Unit of the Institute of Environmental Sciences of the Cheikh Anta Diop University of Dakar
4. Prof. Heidi J Larson - Professor of Anthropology, Risk and Decision Science and Director of the Vaccine Confidence Project; London School of Hygiene & Tropical Medicine
5. Dr Abdourahmane Sow - Head of Epidemic Control at the West African Health Organisation (WAHO)

Panellists and participants were challenged on issues that focused on supply and demand and communication strategies.

### Supply and demand

Willingness to take the vaccine was high at the beginning of COVID-19 but we are now seeing a decline in acceptability in many African countries. A member of the audience mentioned a study (uncited) that shows the more the pandemic evolves, refusal to be vaccinated increases – as people become 'acclimatised' to the risk their motivation to be vaccinated declines.

It is necessary to match supply and demand. To minimise the impact of the pandemic and in anticipation of further waves, there needs to be a coordinated national strategy for strengthening demand. The first step should be building on the fundamental role of listening to communities, and it is strongly recommended to collaborate on this with social leaders (religious and civil society).

## *Communication strategies*

It is strongly recommended that the public's perception of risk is understood by looking at the different societal segments, each of which will have distinct access issues, different risk perceptions and drivers for uptake. Each segment should have a tailored communication strategy, and that strategy must be closely aligned with implementation (explicitly linking driving demand with access).

It emerged that the factors that positively influence acceptability are altruism and advice from health workers. The science must be explained in an accessible way.

Conventional, vertical, slow, and outdated communications are a problem, and more latitude is needed for local partners to adapt strategies to fit the reality of what they are finding on the ground.

Communication, community engagement and implementation teams must be asking the right questions: have there been enough preparations, do we understand what will motivate this target audience to take the vaccine?

There is room for more innovation in the identification of community frameworks of influence – the example discussed was the role barber shops in the United States played in getting a positive vaccination message to hesitant groups (the right messenger in the right place, with accessible vaccines).

The solution will come from listening to the communities themselves – by understanding what motivates them, building a communications framework that speaks to those motivating factors, and making sure the vaccines are where people can access them. Community listening (and a reversal of symbolic power vis-à-vis the community) should be organised to create dynamic dialogue through a "call for help" for collective reflection, then communications and outreach should be co-created.

The implementation of a vaccine passport for access to major events (sporting, religious, cultural) and/or at the borders could generate demand for vaccination.

## **Africa CDC and VCP Strategic Recommendations**

*The following strategic recommendations are based on the learnings from the Dakar Round Table.*

There are a few emerging policy concepts that could be explored to overcome vaccine hesitancy towards the COVID-19 vaccine in Senegal. This is evolving and will continue to evolve as we add insights from the further three waves over 2022, as well as looking to do qualitative research.

Senegal has had a near parity on delivering vaccines into arms that have been delivered to the country. However, two out of three people are still unvaccinated.

Of key concern is the decline in willingness to take a vaccine - 65% to 50% - down 15% from the end of 2020 through to the start of 2022. The data shows that people do not see the issue of COVID-19 as important enough to take the vaccine, coming 4th to malaria, as well as social determinants of health such as access to food and clean water; there are other issues in life that are of more concern. Low uptake is noticeable in rural areas. This could be due to lack of access to the vaccine as

well as linked risk perception; COVID-19 is not the risk in these areas as opposed to urban areas where people live more closely.

#### *Addressing wider concerns on side-effects:*

24% of the unvaccinated agreed with the statement that they won't take it now as they are worried about getting seriously ill or dying. 35% of the respondents in Senegal said they would take the vaccine "if the vaccine was proven to be safe".

Communications need to be honest and factual about side-effects. These COVID-19 vaccine side effects should be explained using similar side effects associated with other well accepted vaccines, especially short-term ones that might make people feel unwell (and perhaps take time off work) but carefully counter this with the risk of long-term COVID-19 illness. One of the most common side effects is pain and numbness of the muscle at the injection site which could be explained as being less painful as compared to pain from intramuscular penicillin.

Clarity and honesty in communication is needed - and should be rolled out across the areas of lower uptake. However, any intervention needs to be aligned with linking demand to supply, and immediate action - promoting the vaccine while ensuring access to vaccines is easily and readily available.

#### *Clarity between access to vaccination vs vaccine hesitancy:*

There are questions the data raises regarding policy activity that might be impacting attitudes to the vaccine as well as uptake. For example, in urban Diourbel, the data shows that there is high uptake and strong sentiment to take the vaccine amongst the unvaccinated. This contrasts to peri-urban Thies with low uptake and higher "no" response to being vaccinated. In Thies we note a low uptake - 85% unvaccinated - and this must be due to practical constraints of access as much as it is a hesitancy issue, despite 45% of the unvaccinated saying no to a vaccine.

This needs to be investigated - why is the sentiment higher in Diourbel? To what extent does access to healthcare help boost positive attitudes towards the vaccine? Why is the uptake so low in Thies - is this due to hesitancy, or has access to vaccines been an issue?

#### *Addressing stay-at-home parents:*

Stay-at-home parents are less likely to say the vaccine is "safe, important and effective" than the general population. They are also the highest group (33%) to say that they would take the vaccine if it was proven safe. Therefore, there is a policy opportunity to inform "stay-at-home parents" on the safety of the vaccine.

However, there is also scope to make any approach to them part of a joint vaccination programme that targets "family vaccination" - amongst the unvaccinated 53% would get their children vaccinated to protect them, as opposed to 36% vaccinating to protect themselves.

Our data shows that such engagement must be through the channels to which they have access. Amongst stay-at-homes, the response showed that the highest reaching media mediums are TV (90%), radio (79%), and community led (77%). Stay-at-home parents also have lower social media use than working and the unemployed - this medium is therefore not suitable.

Looking at the Africa CDC data alongside that of Prof Niang's research, the intervention must take place when stay-at-home parents are able to access it. This needs to take account of their wider duties – so the intervention would need to be able to reach stay-at-home parents, and women in particular – once they “have finished their housework” and can get out of the house, which usually happens later in the day when vaccination centres are closed. This is usually after hours from the HCP point of view, and therefore need to be available beyond any 9 to 5 working hours and this availability could be created by using alternative vaccination centres like on-call pharmacies that remain open overnight. Any communication needs to come with the “right message at the right time for access to the vaccine, linking demand to supply, and immediate action”.

#### *Role models and messengers:*

Professor Niang's qualitative research raised the issue of leadership attitudes driving social acceptance for the younger generation. This might be a useful route to explore given the high proportion of younger people not seeing COVID-19 as something of concern to them (55% of 18-24 see COVID-19 as exaggerated - the highest age group). In addition, 80% expressed the most trust in what they hear from family and friends.

How do we address the issue of youth hesitancy as they “do not see it as an issue for them”? There could be empowerment of some young people willing to take the vaccine who would serve as champions for their peers through sensitization and action through proof of taking the vaccine. Is there a way to encourage elders to impress on younger family members to vaccinate for the “greater good” and a sense of family duty?

#### *Learnings from Ebola:*

The fears invoked by the Ebola vaccine are echoed in COVID:

- The relative newness of the disease
- Unfamiliar two-dose regimen
- Possible deployment during an emergency
- Post-traumatic stress suffered by those in outbreak areas
- Unfamiliar targeting (i.e., high-risk individuals of different ages rather than children)

As part of the preparedness for the roll-out of the Ebola vaccine, Johnson & Johnson, the VCP and other partners developed the Ebola Vaccine Communication, Community Engagement and Compliance Management (3C) Gap Analysis Tool<sup>2</sup> in November 2019.

The Ebola Vaccine 3C Gap Analysis tool is a framework that establishes a country's readiness for Ebola vaccine deployment in non-emergency and emergency scenarios in terms of communication, community engagement and vaccine compliance management (3C). It does this by establishing the gap between 3C items the country has in place and what 3C items should be in place for optimal vaccine deployment, acceptance, and compliance.

This tool establishes four levels of readiness:

- LEVEL 3: Where 3C items are fully available and functional/operational
- LEVEL 2: Where 3C items are partially available or partially functional/operational

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<sup>2</sup> <https://www.worldvision.ie/media/3madylni/ebodac-3c-gap-analysis-tool.pdf>

- LEVEL 1: Where 3C items are not available or not functional/ non-operational but in the process of being developed
- LEVEL 0: Where 3C items are not available or not functional/non-operational and there are no plans of developing them

The level of readiness may be redefined by national authorities based on existing regional and national context.

The Tool is designed to prepare for vaccine deployment in a variety of different scenarios; regardless of the exact vaccine profile, across Sub-Saharan African countries, and is a pre-existing tool that has been proven in the field and could be considered for adaptation for the COVID-19 vaccine roll-out.