



Health Workers and COVID-19 Vaccination

SEPTEMBER 2023

Recommendations and
Lessons Learned

Knowledge
SUCCESS

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Executive Summary

The COVID-19 pandemic presented significant challenges for health systems worldwide, as they struggled to allocate limited resources to both routine programs and pandemic-related needs. Health workers emerged as a high-priority group for COVID-19 vaccination, given their regular exposure to the virus while caring for patients (WHO 2023). Vaccinating health workers reduced their risk of serious illness, hospitalization, and death (Rahmani, K et al 2022). It was essential to ensure they were able to carry out their duties of preventing severe illness and death within communities. Health workers also played a crucial role in administering COVID-19 vaccinations to the general population through mass vaccination campaigns. Their collective efforts, combined with setting a global priority for their vaccination, significantly contributed to slowing the spread of COVID-19 and eventually transitioning away from a global pandemic.

The USAID-funded Knowledge SUCCESS (Strengthening Use, Capacity, Collaboration, Exchange, Synthesis, and Sharing) project conducted an assessment to document lessons learned and effective practices in COVID-19 vaccination of health workers, with a specific focus on Africa. This assessment included 20 interviews and six focus group discussions (n=18) with a total of 38 participants representing 26 USAID-funded COVID-19 implementing partners (IPs) from 17 countries: Angola, Burkina Faso, Côte d'Ivoire, Eswatini, Ghana, India, Kenya, Lesotho, Mozambique, Nigeria, Senegal, South Africa, South Sudan, Switzerland, Tanzania, Uganda, and the United States. Interviews and focus group discussions were conducted between March and April 2023 and lasted approximately one hour each.

This assessment identified contributing factors to vaccine hesitancy among health workers (such as knowledge gaps, stigma, cultural influences, misconceptions, and social media misinformation) and focused on lessons learned vaccinating health workers from COVID-19 and their role in vaccinating their clients. These lessons included collaborating for greater impact, closing data gaps, health worker buy-in, health system preparedness, utilizing local influencers, viewing health workers as an audience and not just a channel, learning from previous pandemics, and sensitization of adult vaccination.

Table 1: Summary of key findings

| Theme | Finding | Recommendation |
|---|--|--|
| Vaccine hesitancy among health workers | Health workers experienced COVID-19 vaccine hesitancy due to knowledge gaps about the COVID-19 virus and vaccine, stigma, cultural influences, myths and misconceptions, political and religious influence, perception of vaccine safety and efficacy, social media misinformation, concerns about the “swift” vaccine development period, and lack of access to the vaccine. These factors influenced their ability to confidently recommend the vaccine to their patients. | Provide continual training of health workers throughout the rollout of vaccines or other interventions. Ensure an emphasis on vaccine education and interpersonal communication skills in pre- and in-service training for health workers. These trainings should allow for knowledge exchange and feedback from health workers. |
| Lessons learned | | |
| Collaboration for greater impact | Due to the magnitude of the COVID-19 pandemic, vaccine rollout among health workers was complicated by challenges such as lack of resources, vaccine storage policies, and reduced access to health facilities in hard-to-reach areas. | Governments should work with other actors such as non-governmental organizations, the private sector, and civil society to promote vaccination efforts for health workers. This could include setting up national and local committees that invite health workers to discuss and inform vaccine strategies and implementation. |

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| <p>Closing data gaps</p> | <p>In some cases, it was difficult to track where health workers were, how many there were, and how many doses they had received due to a lack of a comprehensive data repository of health workers and varying definitions of “health workers.”</p> <p>Many countries did not report sex-disaggregated data, which is critical to identifying gender gaps in vaccination and developing targeted messages.</p> | <p>Ensure availability of a national, continually updated database of health workers for improving vaccine coverage data.</p> |
| <p>Health worker buy-in</p> | <p>Most communication to health workers was linear/ one-directional and did not provide them with opportunities for feedback and involvement in decision-making.</p> | <p>Participatory approaches should allow health workers to actively collaborate in the design of vaccine rollout approaches. Social platforms such as WhatsApp were suggested as mechanisms for health workers to provide timely feedback.</p> |
| <p>Health system preparedness</p> | <p>The COVID-19 pandemic revealed health system weaknesses, including too few health workers, inadequate vaccine supplies and storage facilities, and insufficient emergency funds to deal with the pandemic.</p> | <p>Health systems must be strengthened at all levels, including resources (human and financial) to adapt to emergencies and monitor and evaluate the response. This would include securing emergency funds, identifying policy gaps, and strengthening/ developing necessary policies, as well as training health workers to better prepare for emergencies.</p> |

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| <p>Utilizing local influencers</p> | <p>Local influencers played a key role in reducing vaccine hesitancy among health workers and the wider community. These included local government leaders, professional health associations, and religious leaders.</p> | <p>Identify and recruit community influencers for promoting social behavior change. Remember that the appropriateness and effectiveness of influencers is very context-specific. In some cases, government leaders are not trusted on health issues, whereas in others, they can be valuable champions. Identify the influencers in your community that are trusted on health topics and not seen as having any competing interests.</p> |
| <p>Health workers as an audience and not just a channel</p> | <p>Health workers were considered solely as a channel to pass on health messages to various audiences, rather than a unique audience for vaccine messaging and encouraging behavior change.</p> | <p>Health workers must first be recognized as an audience in need of tailored messaging for their own understanding before they are seen as a channel to pass on public health messages to the community. Develop specific messages for health care workers and engage professional medical associations.</p> |

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| <p>Learning from previous pandemics</p> | <p>In contexts where other health emergencies/outbreaks had occurred, such as polio, measles, rubella, and cholera, previously mobilized resources were used to manage the COVID-19 pandemic. This included training health workers to mobilize households, communities, and caregivers for vaccination, and leveraging local influencers such as teachers.</p> | <p>Document lessons of the COVID-19 pandemic as it relates to health worker needs. Then, apply lessons learned and utilize health strategies developed from previous outbreaks to strengthen future emergency preparedness.</p> |
| <p>Sensitization about adult vaccination</p> | <p>Adult populations, including health workers, are more familiar with and focused on child immunization programs rather than those for adults.</p> | <p>Sensitize the population on the importance of adult vaccines. This could include creating communication campaigns around adult vaccinations and promoting life course immunization. Support health workers with training, job aids, and communication materials to use when conducting patient education or engaging communities on immunization.</p> |

Based on these findings, the following overarching recommendations emerged:

Coordination

- Prepare health systems for emergencies and build on existing health mechanisms, which may include securing emergency funds, building health worker capacity, and strengthening infrastructure.
- Create partnerships between government, non-governmental organizations, and the private sector for better coordination of vaccine efforts.
- Ensure availability of a national database to track health worker statistics, including vaccination data.
- Integrate vaccines for health workers in existing service delivery models.

Rumor management

- Utilize social listening through a national database to track and manage rumors, myths, and misinformation related to vaccination. Engage with health workers to review the main themes and validate rumors they may be hearing from clients.
- Consider noting which rumors health workers believe and collaborating with them to document rumors they have heard. This will help develop tailor-made content for community engagement.
- Train health workers to address misinformation and vaccine concerns.
- Leverage health workers as trusted messengers to respond to rumors from community members when they arise.

Health worker engagement

- Provide continual training of health workers throughout vaccine rollout or other interventions.
- Leverage health workers to be peer supporters and champions of immunization for other healthcare staff, as well more effectively engage with communities.
- Develop quick/clear communication with and among health workers, including providing open feedback channels and treating health workers as an audience.
- Use digital media such as WhatsApp to provide information to health workers and support ongoing training and engagement.

Designing SBC campaigns

- Include health workers in the development of communication tools and strategies, using human-centered design and pre-testing to strengthen health worker engagement in vaccination programs.
- Support building awareness around vaccination across the life course, not only for children.
- Identify and engage local influencers in SBC campaigns.

The findings of this assessment will assist COVID-19 vaccine IPs, host country

governments, and institutions in identifying, documenting, and applying lessons learned to inform future public health emergencies. The information will support ongoing efforts to combat the current pandemic and strengthen future emergency responses and health systems strengthening initiatives.

Introduction

During the COVID-19 pandemic, health systems worldwide faced significant challenges as they had to allocate limited resources to both routine programs and pandemic-related needs. The strain on these health systems was particularly evident as they struggled to balance the demands of regular healthcare services with the urgent requirements imposed by the pandemic.

In response to these unique circumstances, health workers emerged as a high-priority group for COVID-19 vaccination (WHO 2023). There were two main reasons for this prioritization. Firstly, health workers were regularly exposed to the virus due to their frontline roles in providing care and treatment to patients with COVID-19. Vaccinating health workers reduced their risk of serious illness, hospitalization, and death, safeguarding both the healthcare workforce and the patients they served (Rahmani, K et al 2022).

Secondly, health workers played a crucial role in administering vaccinations to the general population. They were at the forefront of vaccination campaigns, supporting the continuity and efficiency of the vaccination process. In addition, their own trust in the vaccine was essential, as it could influence their likelihood of recommending the vaccine to their clients. Health worker support for vaccination was vital for controlling the spread of the virus and protecting people from severe illness, hospitalization, and death.

By providing COVID-19 vaccines to their health workers, governments and health organizations sought to protect these frontline heroes and empower them to carry out their essential duties while minimizing the risk of infection and severe illness. This strategic approach not only helped safeguard the healthcare workforce, but also reinforced its capacity to serve and protect the broader community.

As vaccination efforts progressed, health workers continued to play a pivotal role in the successful implementation of mass vaccination campaigns. Their dedication and expertise were instrumental in educating the public, addressing vaccine hesitancy, and efficiently administering vaccines to millions of people. The collective efforts of health workers, coupled with the prioritization of their vaccination, contributed significantly to the global fight against COVID-19 and the eventual containment of the pandemic.

Specific Objectives

Knowledge SUCCESS led this assessment, with the following objectives:

- Document overarching lessons learned and effective practices in COVID-19 vaccination of health workers, with a focus on Africa.
- Document recommendations to inform the next health emergency response and general health systems strengthening efforts.

Methods

The assessment conducted by the Knowledge SUCCESS project gathered valuable insights. This included 20 in-depth interviews (IDI) and 6 focus group discussions (FGD) (n=18) with a total of 38 participants, including 26 USAID-funded COVID-19 IPs representing 17 countries including Angola, Burkina Faso, Cote d'Ivoire, Eswatini, Ghana, India, Kenya, Lesotho, Mozambique, Nigeria, Senegal, South Africa, South Sudan, Switzerland, Tanzania, Uganda and the United States. USAID provided a list of its COVID-19 vaccine-funded IPs, who then formed the study population. Participants were recruited via email.

These interviews and discussions were conducted virtually using Zoom between the months of March and April 2023, with sessions lasting approximately one hour. The researcher trained two research assistants (one English-speaking and the other French-speaking) to conduct the interviews. At the beginning of each IDI and FGD, the interviewer read the consent form aloud to participants. Verbal consent was sought before recording each session and conducting the interviews. To accommodate participants, the conversations took place in either French (n= 4) or English (n=22). All IDIs and FGDs were recorded and later translated and transcribed for analysis. The French-speaking research assistant translated and transcribed the French interviews, while the English-speaking research assistant transcribed the English interviews.

The interview/FGD guide was developed through a review of secondary data on vaccinating health workers. The transcripts were read, annotated, conceptualized, segmented, analyzed, and reported by a single coder using NVivo, with the goal of identifying common themes and patterns. The inductive analysis situated within the qualitative approach provided a cross-country perspective of the lessons learned and effective practices in COVID-19 vaccination among health workers from USAID-funded partners. Furthermore, the findings were sent to participants for their consensus. Their feedback was incorporated into the report.

Findings

The findings were grouped by theme and are presented below.

Vaccine hesitancy among health workers

When asked about COVID-19 vaccine hesitancy among health workers, many participants noted that health workers experienced vaccine hesitancy due to knowledge gaps about the COVID-19 virus and vaccine, COVID-19 stigma, cultural influences, myths and misconceptions, political and religious influence, perceptions of vaccine safety and efficacy, social media misinformation, and concerns about what some considered a “swift” vaccine development period.

Knowledge gaps

Many participants revealed that health workers needed COVID-19 vaccine training to fill in their knowledge gaps, especially due to rapidly changing policies. One IP from Kenya noted:

“Health workers had a combination of not being familiar with what [vaccine] was coming, not knowing when it was coming, and a lot of concerns about whether or not they were going to have that information they needed in timely manner.”

Another IP from Mozambique revealed the fears created by this knowledge gap among health workers:

“A lot of health workers were saying that they were worried the patients were going to ask questions that they just didn’t have the answer to.”

In some instances, health workers questioned the vaccine’s safety and efficacy, fueled by their existing knowledge gaps. A participant from Lesotho explained:

“I think the initial stage, the uptake [among health workers] was high, because there was a lot of advocacy for health workers to vaccinate, but later with the problems that we’ve experienced, in particular with the antigen expiring and the expiry date being extended every now and then, health workers are losing confidence in the actual antigen, the use of antigen, and we’ve seen less vaccinating.”

This knowledge gap also affected health worker confidence in recommending the vaccine to their patients. An IP based in Switzerland noted:

“What we realized was that for many women, health workers were simply not recommending vaccination and so it was only if a pregnant woman came and said, ‘I would like to be vaccinated.’ Even then health workers were like, ‘Are you sure?’”

COVID-19 stigma

The fear of contracting COVID-19 and the stigma associated with the virus was widespread, affecting health workers as well. One participant from Burkina Faso stated:

“There was also a lot of prejudice about the vaccine and the disease itself.”

Another IP noted that the challenges COVID-19 brought upon communities also affected health workers. A participant from India described a disturbing scene around identifying a COVID-19 patient in their community:

“Nobody was able to go out and everything was restricted at home, and that was a big trauma. In the vicinity, if anybody tested positive for COVID, at least three or four government vehicles would come with sirens and police vehicles. Health workers would also be alerted and come together with other law enforcement agencies, and they will come to your house. They will take the patient for quarantine in isolation. They’ll put a big sticker on your door that [tells everyone] ‘This is the quarantine home because of COVID,’ and that created a lot of stigma.”

Despite the stigma related to COVID-19, some health workers led and supported efforts to reduce stigma within their communities.

Cultural influences

Cultural beliefs played a role in raising COVID-19 vaccine hesitancy and spreading myths and misconceptions about the vaccine. Some IPs noted that some groups linked the vaccine to infertility. For example, an IP in Ghana shared:

“In some cultures, the COVID-19 vaccine was believed to cause infertility. This is based on the cultural beliefs and some health workers were affected by these beliefs. Although health workers are supposed to lead education at the community level, they are also community members and have their cultural beliefs which affect their behaviour. We realized these beliefs were impacting the uptake of the vaccine in other areas and health workers are not exempted.”

Speaking of cultural influence, trust and religious beliefs also played a role. For example, a participant from Burkina Faso noted:

“There were rumours out there that the vaccine was something that was manufactured to reduce the population, and this is something that comes up every time new drugs are introduced into public health.”

Myths and misconceptions also contributed to vaccine hesitancy.

“There were myths that once you vaccinate, you will die or you will develop a medical condition and all that,” noted one IP from South Africa.

Health workers were able to address some of these myths and misconceptions within their communities. For instance, an IP from Nigeria noted:

“There were myths in the community and health workers were able to address those myths. When we were doing vaccines in the community, the people would say, ‘I heard that I’m going to die if I take this thing.’ Health workers were able to convince them to take the vaccine and the next day when they saw those who had been vaccinated alive, others would also join and take the vaccine.”

These myths and misinformation from social media or local influencers also affected how health workers performed their duties. A participant from India noted the hesitancy of health workers to vaccinate pregnant women due to fears of being blamed for any negative pregnancy outcomes. Recounting the words of a health worker, the participant noted:

“Okay, so the child may die, or the outcome of the pregnancy may be negative for any reason, and they will blame me.”

Social media was also used to spread misinformation and disinformation that supported vaccine hesitancy. While speaking about reasons for vaccine hesitancy among health workers, one participant from Ghana explained:

“They [health workers] read it on social media. It prevented them from willingly coming up, coming forward to accept and uptake the vaccine. So, the misinformation—yes, prevented them from taking the vaccine.”

However, social media was also a positive channel for spreading accurate information and was used to strengthen COVID-19 vaccine campaigns. It helped quickly correct myths and misinformation, as noted by an IP from Mozambique:

“Besides all the messaging through radios and TV, we also use social media to counter misinformation and disinformation on platforms such as WhatsApp.”

Political and religious influence

Participants recognized the role political and religious leaders played in either supporting vaccine uptake or increasing vaccine hesitancy.

One IP from Uganda, when discussing political and religious influence and the need for rumor-tracking mechanisms, noted:

“Because sometimes the rumours can come from political influence and religious sects..... therefore, it would have been good to create a special fund, and we create indicators for reporting on rumour-tracking rumor management so that the rumours that have been generated do not take root in a particular community.”

Political and religious influencers also utilized their authority to promote COVID-19 vaccination in homes, as an IP from Burkina Faso noted:

“Vaccine at the home level provided a great support in communities and even among health workers. It started from the homes of customary chiefs, village chiefs, traditional chiefs, and finally the homes of the ordinary population.”

“Swift” vaccine development period

Participants also highlighted the perception of COVID-19 vaccine development, noting that the vaccine was perceived to have been developed “fast,” which affected health worker confidence in the vaccine.

One of the participants described:

“Many [health workers] historically knew that vaccines take a certain period of time to develop, but this one [COVID-19 vaccine] seemed to have been fast-tracked, so the element of confidence in the vaccine and coupled with all the rumours, the myths, the misconceptions that were flying about on social media, heightened their [health workers’] own fears.”

Lessons learned from vaccinating health workers and their role in vaccinating their clients

Collaboration

Due to the magnitude of the COVID-19 pandemic, vaccine rollout among health workers was difficult. Challenges including a lack of resources, vaccine storage policies, and access to health facilities in hard-to-reach areas all highlighted the need for greater collaboration among stakeholders.

While discussing the lack of collaboration between the public and private sectors, an IP from South Sudan noted:

“Today in South Sudan, the private sector is not well involved in the COVID-19 response. This is in terms of the laboratory services, as there were few laboratories here. However, a good proportion of the community seek health services from the private sector, so understanding that the resources from the public sector may not be sufficient to address the needs of the community, I think involvement of the private sector is very key and this is something that in my opinion has been left out right from the beginning to date.”

Other participants lauded stakeholder cooperation towards vaccine promotion for health workers:

“We developed a health worker course as a collaborative effort among stakeholders as part of the country and delivery work streams,” noted a participant based in Switzerland.

Closing data gaps

Lack of data proved to be a disadvantage during the COVID-19 vaccine rollout. In some instances, countries were unable to track the number of health workers who had not received the vaccine.

A participant from Nigeria noted the challenge of health worker data gaps in their context:

“So initially, we didn’t have any platform or know how [or] where to get data regarding health workers that were vaccinated. We just had different pockets of data from studies that were conducted. But as a country, we didn’t have

that data that would say ‘[This is] the number of health workers that have been vaccinated.’”

Ensuring health worker buy-in

Health workers are significant players in the health system and especially in the vaccine rollout process. They must be involved at all levels of decision-making to allow for their understanding and support. For example, a participant from Lesotho shared the following:

“Getting their [health worker] buy-in and their understanding of the virus and its treatment and the preparedness plan, I think the important thing is engaging them at length and making sure that they fully understand because they are the ones who are in direct contact with the community.”

The participant elaborated further:

“There’s very little involvement of those at the lowest healthcare level, and those are the key ones who are directly working with the communities. Therefore, getting them to understand and participate in COVID-19 vaccine preparedness plans for the country is important because they are aware of the structures available at [the] community level and what can create more impact at [the] community level.”

Health system preparedness

The COVID-19 pandemic revealed weaknesses in health systems, including insufficient numbers of well-trained health workers and inadequate vaccine supply, storage facilities, and emergency funds to deal with the pandemic.

“Yes, I think for our context, we will need more nurses. Currently the ratio of nurses we have to the population is still quite low, so when an emergency comes and we need these nurses to respond, it becomes a challenge,” explained a participant from South Sudan.

To better prepare health systems for future emergencies, some participants provided possible solutions.

“There must be capacity building, putting in place of tools, job aids, care delivery tools, tools related to data collection, communication tools for social mobilization for vaccination adherence, strengthening of their internal capacity, logistics and their competencies. Ensure they also have the capacity to communicate with beneficiaries and the entire community to give them key and essential messages to adhere to the vaccination program,” a participant from Burkina Faso recommended.

Utilizing local influencers

Local influencers such as professional medical associations, faith leaders, and political leaders play a key role in supporting vaccine uptake. Participants recommended that countries identify these influencers and feature them in campaigns. Some participants explained how they were able to enlist professional health associations to support vaccine campaigns among health workers:

“We engaged doctors’ associations in the country to go and discuss with healthcare providers the importance of [the] COVID-19 vaccine,” noted a participant from Tanzania.

Professional medical associations were also vital in changing their colleagues’ attitudes about vaccine promotion.

“In one of the regions, we had a senior doctor who was against vaccines, and he was telling other healthcare providers and committee members not to take the vaccine. They had a meeting with him, sensitizing him on the importance of vaccines, how the vaccine is safe, and at the end of the day, he was pro-vaccine,” a participant from India shared.

Health workers as an audience and not just a channel

As much as health workers are the public’s primary point of contact on health matters, they must first be recognized as an audience themselves. Communication messages should be developed for their own understanding before they are reduced solely to engines of service delivery. Clear vaccine messaging could build vaccine confidence and encourage healthy vaccine attitudes. For example, a participant from Nigeria noted:

“Each health worker has their own needs. Health workers are always seen as a good channel, but not really as an audience [themselves].”

Learning from previous pandemics

Participants in countries that had experienced recent outbreaks noted the significance of existing health structures in supporting COVID-19 vaccination efforts:

“In some countries, the vaccination structure was existent even before COVID. We had community volunteers called Community Mobilizer Coordinators, and their work was the same: to mobilize households, communities, [and] caregivers for polio vaccination and other routine vaccination,” remarked a participant from India.

Sensitization of adult vaccination

Traditionally, routine immunization programs are associated with children. COVID-19 showed the need for greater sensitization of adult vaccines.

“People really didn’t understand about the vaccination in adulthood, and we had a lot of challenges and even some of them outrightly opposing the vaccination,” a participant from Kenya stated.

An IP based in Switzerland further noted the need to promote adult vaccination programs:

“We have tried having seasonal vaccination program for adults [such as with the flu vaccine], but I think we could have been doing more of it during the vaccine rollout and encouraging countries more specifically to leverage some of their existing platforms.”

Limitations

This study had several limitations. Participants solely represented USAID-funded IPs and did not include other implementers, such as government or non-USAID-funded initiatives. In addition, health workers themselves were not involved in the study. Finally, IPs identified who on their team was best suited to participate in the study. Therefore, these findings should not be generalized to all USAID IPs working towards vaccinating health workers against COVID-19; however, they do shed light on the challenges and opportunities posed by the pandemic regarding vaccinating health workers.

Conclusion

This study sought to document overarching lessons learned and effective practices in COVID-19 vaccination of health workers, mostly focusing on Africa. After 26 interviews/focus group discussions with USAID-funded COVID-19 vaccine IPs, the assessment identified factors contributing to vaccine hesitancy among health workers (such as knowledge gaps, stigma, cultural influences, misconceptions, and social media misinformation) and lessons learned vaccinating health workers from COVID-19 and their role in vaccinating their clients. These lessons included the following: collaborating for greater impact, closing data gaps, health worker buy-in, health system preparedness, utilizing local influencers, viewing health workers as an audience and not just a channel, learning from previous pandemics, and sensitization of adult vaccination. This information will support COVID-19 vaccine IPs, host country governments, and institutions as they identify, document, and apply lessons learned to inform the current COVID-19 pandemic response and refine future

emergency responses and health systems strengthening efforts to ensure resilient health systems.

Recommendations

Based on our findings, we recommend that COVID-19 vaccine IPs, host country governments, and institutions take the following suggestions into account when designing and implementing future public health emergency programs:

Coordination

- Prepare health systems for emergencies and strengthen existing mechanisms, which could include ensuring emergency funds, building health worker capacity, and reinforcing infrastructures.
- Create partnerships between government, non-governmental organizations, and the private sector for better vaccine coordination.
- Establish or scale up a national health worker database to track relevant statistics, including vaccination data.
- Integrate vaccines for health workers in existing service delivery models.

Rumor management

- Establish a national social listening database to track and manage vaccine rumors, myths, and misinformation. Engage with health workers to review the primary themes and validate rumors they may be hearing from clients.
- Consider noting which rumors health workers believe and collaborating with them to document rumors they have heard. This will help create specific content for community engagement.
- Train health workers to address misinformation and vaccine concerns.
- Leverage health workers as trusted messengers to respond to rumors from community members when they arise.

Health worker engagement

- Provide ongoing training throughout vaccine rollout or other interventions.
- Position health workers as peer supporters and immunization champions for other healthcare staff, as well as raising their esteem in their communities.
- Develop quick/clear communication with and among health workers, including providing open feedback channels and treating them as a unique audience.
- Use digital platforms such as WhatsApp to communicate with health workers to support ongoing training and engagement.

Designing SBC campaigns

- Include health workers in the development of communication tools and strategies, using human-centered design and pre-testing to strengthen their engagement in vaccination programs.
- Support awareness building around life-course vaccination, countering

- narratives that immunization is only for children.
- Identify and engage local influencers in SBC campaigns.

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Annex: Interview and/or Focus Group Discussion Guide

Background

- Tell me about your work with health workers (HWs) in relation to COVID-19

vaccination.

- Describe the vaccine uptake among HWs in country X? (successes and challenges).

Vaccine hesitancy among health workers

- Were there HWs in your program who were reluctant to receive the COVID-19 vaccine? (What reasons did they give?)
- Did your project work to address these challenges? If so, how?
- Were there differences in uptake among HWs based on other factors (age, sex, health facility level, etc.)?
- What do you think could have been done differently to respond to vaccine hesitancy among HWs?
- Do you think vaccine hesitancy among HWs affected their obligation/role in vaccinating clients? Why or why not?

Role of HWs in vaccinating others

- Did your project focus on HW training and support to vaccinate others? If so, what measures did your project put in place to support health workers' efforts to vaccinate clients?
- What strategies can be applied to enhance HW capacity to counter myths and misinformation related to vaccines?
- Do you think there are any particular roles HWs can play in addressing concerns about safety and effectiveness of the COVID-19 vaccine?

Preparing for the future

- What are your top two or three lessons learned from the COVID-19 pandemic regarding implementing vaccine programs among HWs that could be applied in other emergency situations (unrelated to COVID-19)?
- If someone new was to manage a similar project in the next emergency, what would you recommend they need to know and do to achieve better results?
- Ten years from now, if we find ourselves in a similar situation facing another pandemic or emergency, what actions would you take within the first three months to ensure HWs feel confident taking a vaccine and are supported to provide vaccination services to their clients during an emergency?
- What are your top two recommendations for vaccinating HWs in response to a pandemic or future emergency?

Closing

- Is there anything else you'd like to share with me today?
- Is there anyone else you recommend I speak to about this topic?

