JOINT EDITION IN SUPPORT OF THE EASTERN AND SOUTHERN AFRICA COVID-19 VACCINES READINESS AND DELIVERY TASKFORCE (ESACREDT) DEMAND TWG

Data for action

RCCE FOR COVID-19 VACCINE DEMAND IN EASTERN AND SOUTHERN AFRICA

SPECIAL EDITION ON OLDER PERSONS

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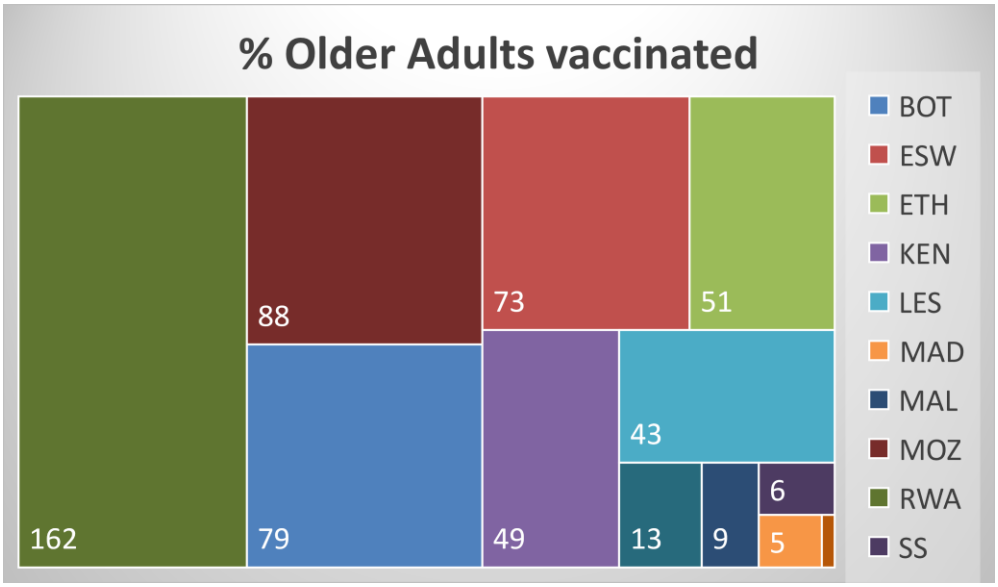
SITUATION ANALYSIS

Despite accounting for the lowest proportion of people over 60 years in the world, Africa could triple the number of older people in three decades, surpassing Latin America and Northern America, and approximating that of Europe.[20]

Data reveals that COVID-19 case fatality increases exponentially after the age of 60 years, however, there has been a diverse range of national interventions prioritizing COVID-19 vaccination which haven't necessarily improved vaccine coverage amongst older persons (OP).



Source: WHO dashboard (14 March 2022) link here

*Denominators do not reflect necessarily total Older Population in some countries

KEY TAKEAWAYS

✓Countries with low rates of primary series coverage should first achieve high primary series coverage rates among the higher priority-use groups such as OP, before offering vaccine doses to lower priority-use groups. (SAGE, 2022)

✓The COVID pandemic has revealed real gaps in data on OP, making it more difficult to include them in the response. African countries with more up-to-date statistics have found it easier to address challenges posed by COVID-19.

✓Despite OP being the age group most willing to take COVID-19 vaccines, a large proportion remain unvaccinated or under-vaccinated.

✓Inadequate communication to OP, difficulties with registration processes, challenges accessing vaccination sites and failures to engage and empower them in the design and delivery of responses are the main bottlenecks hampering uptake.

✓Communication with healthcare workers (HCW) can play an important role in OP's decision to vaccinate. HCW need to be equipped with up-to-date guidance to be able to adequately inform patients about vaccination-related risks and benefits, particularly as OP are more likely to have underlying health conditions and comorbidities therefore more concerns about how vaccines could impact these conditions.

FINDINGS AND CHALLENGES

THINKING AND FEELING

- Older persons are more willing to take COVID-19 vaccine with higher perception of benefits for their health and with social norm well established.[1]
- In line with studies from other regions, efforts to vaccinate higher risk OP must aim not only to educate and provide vaccine access but also to engender trust in the vaccine development process and vaccination strategies at both national and local levels.[5]
- Low education levels, lack of confidence in the healthcare system's ability to treat patients with COVID-19, and a lower reported number of new daily COVID cases are linked to greater COVID-19 vaccine hesitancy.[5]
- In almost every country across the world, the first population that was vaccinated against COVID-19 were OP, specifically, the most vulnerable and frail, however, no systematic reviews and controlled trials with a substantial proportion of older participants are openly available. Moreover, the lack of adequate scientific data in OP could undermine public trust concerning vaccines in frail OP. [7]
- Some studies reveal that OP in sub-Saharan Africa tend to believe more in Covid-19 related misinformation when they are exposed to it, There is a clear association between susceptibility to misinformation and having low knowledge levels about COVID-19 clinical symptoms, low risk perception of becoming infected, and noncompliance with public health measures.[19]
- In South Africa political factors shape COVID-19 vaccination attitudes, showing that people who trust in governments tend to have more trust in Covid-19 vaccines. [8]
- In Kenya, Mozambique, Malawi, South Africa and South Sudan, HCW over-60 tend to have more trust in vaccines then younger age groups, however, only 46% report higher levels of trust in vaccines, while 74% think that the vaccine is important for their health. [1]
- Inability to get the vaccine brand of choice was the second most reported difficulty for OP willing to be vaccinated (7.4%). This issue was especially seen in Kenya (12%), followed by Ethiopia (10%), Angola (7.5%), Madagascar (6.2%), Mozambique (5.9%) and Tanzania (5.2%). This has decreased over time from 11% in the region as a whole, falling to 5% in Dec. 2021 but increasing to 7.5% in Jan. 2022.[14]
- OP faced several barriers to accessing information, with people over-80 and with disabilities reporting the greatest difficulties. Barriers included: language, literacy and inaccessibility of materials and messages for people with sensory impairments.[12]

SOCIAL PROCESSES

- OP reported thinking that most of the people they know and whom they work with will take the vaccine, indicating that social and work norms are well established among OP.[1]
- The risk of violence, abuse and neglect towards OP has risen during the pandemic, but evidence of impact remains limited. [12]
- Levels of education and competence with digital technology leaves OP behind in terms of access to information about COVID-19, as well as services, resulting in them becoming increasingly isolated and facing challenges in terms of accessing resources and services.[13]

MOTIVATION

- In South Africa, Kenya, Mozambique, Malawi and South Sudan, 81% of HCW over-60 are willing to get the vaccine, however 45.7% reported that access to the vaccine is either not at all easy or (only) a little easy.[1]
- Age was revealed as a significant influencing factor, with support for vaccination increasing with age; people 55 years and older were more likely to take a vaccine. The COVID-19 Democracy Survey, Ask Afrika, and Africa CDC studies all found that age may be an important variable, with OP in all three studies having less concerns and/or being more accepting of COVID-19 vaccination.[2,15]
- OP reported being significantly more willing to take a COVID-19 vaccine, compared to the overall population in ESAR, with vaccine willingness increasing over time and in relation to vaccine availability (January 2022). This was particularly apparent in South Sudan, Uganda and Mozambique, where 100% of OP reported being willing to take vaccine, compared to 72%, 79% and 95% of the overall respondents. OP were also more willing to get the vaccine in Kenya, South Africa, Madagascar, Ethiopia and Tanzania.[14]
- OP reported being less willing to take a vaccine in Zimbabwe (40% compared to 83% of the general populations), Botswana (30% compared to 45%) and Zambia (75% compared to 88%). [14]

PRACTICAL ISSUES

- OP reported difficulties in accessing vaccination due to a variety of reasons, with the most common being that there were no vaccines or appointments available, that appointments were not available at suitable times and that their preferred vaccine was unavailable. [14]
- 70% of adults in Sub-Saharan Africa aged 60 to 64 remain in the labour market; with almost half of those over-65 remaining in the labour market. In some countries such as Burundi, Madagascar, Mozambique, Rwanda and Tanzania, this proportion exceeds 80% among the 60 to 64 year age group and above 60% among those aged over-65.[13]
- Vaccination processes especially those involving digital registration can leave behind OP with lower levels of digital literacy. [13]
- Some studies reveal that mandatory measures must be accompanied by effective education and information strategies specific to the target population, ensuring that the spread of data is supported by scientific evidence.[6]
- A study mapping physical distances from health services in Sub-Saharan Africa reveals that approximately 10% of adults aged 60 years and older across Sub-Saharan Africa have an estimated travel time to the nearest hospital of 6 hours or longer. Thus, physical access to health care will probably play a major role in whether these OP will be able to seek health care services including for COVID-19 vaccination. Some countries with higher population density and poor physical access to hospital care included Ethiopia, Madagascar, Mozambique and South Sudan.[6]
- Limited data availability has resulted in greater reliance on data which is easy to collect, including via social media channels and through computer-assisted technology which disproportionately samples younger and urban populations. [14] As the majority of OP in ESAR live in rural areas, as much as 90% in Rwanda and Malawi, there are multiple barriers to data which includes OP.[17]

Priority-use groups	Vaccine coverage rates of Higher priority-use (I & II) groups
	Low → Moderate → High → Very High
I. Highest priority-use : **Older Adults**, HW, Immunocompromised persons	Primary series + Additional doses* / Booster **
II. High priority-use : Adults with comorbidities, pregnant persons, teachers and other essential workers, disadvantaged sociodemographic subpopulations at higher risk of severe COVID-19	Primary series + Booster
III. Medium priority-use : Remaining adults, children and adolescents with comorbidities	Primary series + Booster
IV. Lowest priority-use Healthy children and adolescents	Primary series + Booster (booster doses in children below the age of 12 years have not been assessed)

Source: SAGE Roadmap for prioritizing uses of COVID-19 vaccines link here

PROGRAMMATIC RECOMMENDATIONS

THINKING AND FEELING

- Ensure adequate communication and age-friendly materials by including people with disabilities, limited social engagement and/or varying levels of education in communication campaigns, using sign language interpreters, door-to-door visits to households identified as having older residents, simplification of messaging and translation into all languages.
- Consider tailored approaches to OP subgroups by age, sex, functional capacity and location including trust building interventions addressing specific needs and concerns.
- Enhance public confidence in vaccination by providing clear information on the effectiveness and safety of vaccines through changes in vaccination and infection rates.[10]
- Reconsider approaches to interpersonal communication through trusted sources and digital literacy to more effectively target the spread of misinformation among OP. In addition to being less likely to use social platforms than younger generations, OP tend to have fewer people in their social spheres and tend to have more trust in the people they do know.

SOCIAL PROCESSES

- Develop meaningful partnerships with community-based organizations and networks of OP as part of risk communication and community engagement strategies to reach OP in the context of COVID-19.
- Utilize community-centered approaches in which leaders and key influencers amongst OP not only to echo and amplify public health messages but are also involved in design, planning and delivery.
- Promote access to health care and community participation for OP, who face several barriers to participating, including the physical environment, ageist attitudes, social isolation as well as information and communication barriers.
- Consider intergenerational approaches partnering with youth and community platforms to create inclusive environments for OP in order to improve access to COVID-19 vaccines, thereby mitigating the negative affects of social isolation and physical incapacity and improving mental health.

MOTIVATION

- Ensure that HCW can accurately identify OP's knowledge gaps, needs and concerns to support informed decision-making for vaccination. [11]
- Promote meaningful engagement with OP and HCW by amplifying information among HCW and keep them up-to-date with the latest evidence so they are able to share and discuss information about the OP's disease risk and disease severity; vaccine effectiveness and safety; and practical information about how the person can access vaccines.

PRACTICAL ISSUES

- Prioritize vaccine supply to achieve high coverage rates of primary series and booster doses among OP as a higher priority group.
- Consider targeting subgroups amongst OP with tailored demand promotion interventions followed by providing access to vaccination in coordination with service delivery sites.
- Provide clear information on How, Where and When OP can get vaccinated in an inclusive way, noting that OP may be excluded from more general campaigns, particularly those using digital media.
- Consider partnering with private sector to provide or improve transportation options for OP to existing hospitals and health services where COVID-19 vaccines are available. Consider using a 'snowballing' approach to reach OP through their peer networks and community health workers.
- Partner with faith-based and community organizations to support those who need assistance to access vaccination including registering for and attending vaccination appointments.
- Identify where potential pockets of unvaccinated and under-vaccinated OP are, and undertake qualitative research to inform planning, adjust interventions and tailor messages aimed at the specific fears or concerns of these subgroups.
- Disaggregate data collection and data analysis by age and sex, disability and location particularly in COVID-19 research. This may mean revising survey designs to ensure OP are adequately represented in samples and ensuring that age-disaggregated data is analyzed and disseminated after collection.

GOOD PRACTICES FROM COUNTRIES | **TANZANIA Vaccine equity and access for older people here**

RESOURCES

- WHO SAGE Roadmap for prioritizing uses of COVID-19 vaccines
- A report on the impact of COVID-19 on Older People. HelpAge
- WHO, Vaccine Equity
- Strategy to Achieve Global Covid-19 Vaccination by mid-2022 (who.int)
- COVID-19 vaccine manifesto
- Humanitarian inclusion standards for older people and people with disabilities
- The COVID-19 Vaccine Communication Handbook (ENG, PT, FR)
- Considerations for implementing and adjusting public health and social measures in the context of COVID-19 (who.int)
- Interim recommendations for heterologous COVID-19 vaccine schedules (who.int)
- HelpAge International, COVID-19 vaccine equity and access for older people in LMICs
- Assessing the impact of Covid-19 on older people in the African Region

INFORMATION AND DATA SOURCES

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Notes on methodology and collaboration

This report provides key highlights – challenges, key findings and programmatic recommendations based on different sources, following a methodology guided by the Increasing Vaccination Model (Brewer et al., adapted by the BeSD expert working group), and further utilizes UNICEF's Behavioural Drivers Model (BDM). This report is compiled by UNICEF in support to the ESACREDT Demand TWG on a monthly basis, under outputs (1) to enhance knowledge sharing among related partners, and (2) to support the dissemination of regional and national level tools and recommendations on equitable/inclusive immunization demand and uptake.

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