Ann Ist Super Sanità 2019 | Vol. 55, No. 2: 195-199
DOI: 10.4415/ANN_19_02_12

Communication and basic health counselling skills to tackle vaccine hesitancy

Valentina Possenti[1], Anna Maria Luzi[2], Anna Colucci[2] and Barbara De Mei[1]

[1]Centro Nazionale per la Prevenzione delle Malattie e la Promozione della Salute, Istituto Superiore di Sanità, Rome, Italy
[2]Dipartimento Malattie Infettive, Istituto Superiore di Sanità, Rome, Italy

Abstract
The Italian law 119/2017 mandates ten childhood vaccinations to allow population aged 0-16 attend educational places and state school. This law enforcement is due to low coverage rates for some vaccine-preventable diseases and to a complex phenomenon known as vaccine hesitancy. Basic health counselling skills represent relevant resources to let healthcare workers effectively address vaccine hesitancy in the population. We indicated recommended communication approaches and basic health counselling skills to be applied by public health professionals according to the specific target population with vaccine deficit that means people not at all or partially reached by vaccinations. Public health professionals are called to know, acquire, use, and adapt basic health counselling skills to effectively address vaccine hesitancy diversely affecting different groups of population.

Key words
- vaccination
- communication
- counselling

INTRODUCTION

The law 119/2017, as conversion of the decree 73/2017, made ten childhood vaccinations (tetanus, poliomyelitis, hepatitis B, diphtheria, pertussis, haemophilus B, measles, mumps, rubella, chicken pox) mandatory in Italy where coverage rates for various vaccine-preventable diseases have been decreasing since 2013 [1-3]. Vaccine hesitancy is defined as the reluctance or refusal to vaccinate despite the availability of vaccines [4], and enlisted among the ten major issues that demand attention from the World Health Organization (WHO) and health partners in 2019 [5]. Namely, it is a complex and context specific behaviour because it varies across time, place and vaccines and is influenced by a number of factors including issues of confidence, complacency, and convenience. Vaccine-hesitant individuals constitute a heterogeneous group of people who hold wide-ranged indecision on some vaccines as well as on vaccination overall: they may accept vaccines but remain concerned, may refuse or delay some vaccines but accept others, or may refuse all vaccines. Basing on this complexity, to date immunization coverage are the proxy data mostly used even if it is known that they are proven to be reliable for small samples and vaccine decrease does not fully coincide with vaccine hesitancy [6]. This relevant issue in public health broadly encompasses communication approaches that public health professionals can adopt to address vaccine hesitancy effectively. An Italian study shows that, even if paediatricians are favourable to vaccines and vaccinations, gaps are retrieved between their overall positive attitudes on one hand and knowledge, beliefs and practices on the other hand, consequently affecting their response capacity to address parents' questions [7]. In general, public health institutions should communicate using strategically established methods and avoiding rushed communication which leads to implementing wrong interventions and losing credibility. In 2010, the WHO suggested that to improve communication effectiveness within the healthcare system some elements are needed, such as development of networks and empowerment of communication competences [8-14]. Moreover, within vaccine communication, public health professionals deal with an even more highly complex process that involves several different stakeholders who are featured by own worldviews, perceptions and needs. In this framework, vaccine communication does not correspond to performing one-way informative interventions or teaching, but initiates mutual dialogue and reciprocal exchange among all people involved, despite their different roles and diverse responsibilities. It entails that communication methods and tools have to be adequately aligned with the specific setting and intended target groups. Both individuals and the com-

Address for correspondence: Valentina Possenti, Centro Nazionale per la Prevenzione delle Malattie e la Promozione della Salute, Istituto Superiore di Sanità, Viale Regina Elena 299, 00161 Rome, Italy. E-mail: valentina.possenti@iss.it.

munity as a whole shall be effectively involved so that homogenous, consistent and strategically coordinated interventions can be implemented [15].

In particular, to effectively address vaccine hesitancy in the general population, basic health counselling skills represent relevant resources to professionals because they are key elements to make healthcare workers create effective relationships with people who can activate their own resources and choose solutions that are consistent with their needs. Basic counselling skills actually stand for in fact the components of a well-structured intervention aimed at helping people to actively face health-related challenges.

Basing on the categorisation by the European Centre for Disease Prevention and Control (ECDC) [16] that identifies four population groups with vaccine deficit, meaning not at all or partially reached by vaccinations (hesitant, unconcerned, active resisters, poorly reached), the authors have associated communication and basic health counselling skills which healthcare professionals need to apply accordingly *(Table 1)*.

As reported in *Table 1*, it emerges that the use of basic health counselling skills mainly applies to three out of four population categories which are hesitant, unconcerned and poorly reached. Above all in the two cases of hesitant and unconcerned people, who are characterised by a strong misinformation, public health professionals should implement the basic techniques for active listening, such as reformulation or investigative skill, as well as be prepared engaging in information discussions. In the case of poorly reached individuals (people not accessing vaccinations because of social exclusion or work/time pressure), vaccine promotion is required to be developed mostly at community level, concerning the wider institutional and professional network that involves integrated collaboration overall. On the contrary, regarding the two subcategories of active resisters, i.e., "convinced and content" and "committed and missionary", extensive discussions and debate are supposed to be avoided because they shall reveal to be seldom productive, non-productive or even counter-productive. However, the other's point of view does not have to be underestimated and healthcare professionals should show openness and a non-judging attitude to allow antivaccination activists further contacts or a re-examination position in future.

COMMUNICATION AND BASIC HEALTH COUNSELLING SKILLS

Basic health counselling skills consist of:

- knowledge of the counselling scope that does not correspond with giving advice and quick solutions or general information, but relates to facilitation process in order to activate personal resources in the individual who shall be able to deal with difficulties or perplexities responsibly and manage the own worries in an aware and informed manner;
- self-awareness both of qualities that can favour or hinder the relationship and of personal communication style;
- knowledge of and capacity to use the relational skills (empathy, self-awareness, active listening) which are fundamental to the relation creation and maintenance;
- knowledge of the counselling process to structure an intervention in phases that in turn envisage some fundamental steps (initial greeting, relationship building by active listening, main problem assessment, feasible goal setting, alternative solution proposal, summarising, evaluation, termination or referral, closure and final greeting);
- strengthening the capacity of team working and networking.

The relational skills (empathy, self-awareness, active listening) are integral parts of counselling and can be learned and perfected with specific training [17, 18].

Empathy is the ability to know how to enter into another person's scheme of reference, the capacity to see the world through the other person's eyes and, grasping information from his/her rational and emotional point of view (thoughts, experiences, emotions, and mean-

Table 1
Communication and basic health counselling skills to be applied by public health professionals per target population with vaccine deficit

Target population with vaccine deficit		Communication and basic health counselling skills to be applied by public health professionals
Hesitant	Uninformed Misinformed Well-read and open-minded	Need to be prepared for discussion Reformulating objection Recognising emotional status Issue(s)/concern(s) expressed not to be minimised Delivering scientifically-grounded and personalised information
Unconcerned	Uninformed Informed but self-serving	Need to be prepared for discussion Informing appropriately (few information) Stimulating questions according to investigative skill Summing-up Verifying levels of effective understanding
Active resisters	Convinced and content Committed and missionary	Favouring exchange of views to allow a position re-examination Extensive discussions and debate to be avoided (seldom productive, non-productive or counter-productive) Other's point of view not to be underestimated
Poorly reached	Socially excluded Working and time pressured	Networking and integrated collaboration among health professionals and institutions which promote vaccination, even to facilitate services' access

ings), to understand the person's requests and needs. By showing empathy, healthcare workers live "as if" they were the others but staying separate from the others, otherwise they would no longer be able to help people and meet people needs. Being empathic does not mean confusing the two viewpoints: empathy is in fact supported by distinction and not confusion. In the professional relationship between experts and lay public, empathy contributes to maintain separation between the two different roles [19-23].

Self-awareness relates to being familiar with the own "inner world" that is the cultural reference scheme, value system, perceptions, emotions, and personal conceptual maps. Other factors to be aware of are: the context, the self-observation and self-monitoring capacity, the management of nonverbal and paraverbal language that is the emotional expression underlying the verbal content [17].

Active listening helps both professionals and people focusing on the other's point of view, it can be triggered through bidirectional communicative channels that facilitate useful information exchange flows and participatory processes. It is fully based on empathy and on accepting the other's point of view, as well as on creating a positive relationship and a non-judging approach [19]. To listen actively, the adoption of a reference methodology articulated in empathic reflecting is necessary. It encompasses the use of four specific communicative techniques: reformulation, clarification, investigative skill, first-person messages [24]. In particular:

- reformulation corresponds with repeating what the other has just said, using the same words or rephrasing in a more concise way by other terms, without adding any other concepts or different content (*"Then you are telling me that…", "This means that you think…", "In other words…"*);
- clarification uses the outlining emotions associated with the content communicated, referring to verbal, paraverbal and non-verbal communication (*"From the look on your face it seems to me that you are worried"; "From the tone of your voice, I can feel you are uncertain about what I am saying"*);
- the investigative skill is the ability to ask, selecting the most appropriate question type according to the specific situation: "open questions" to be preferred at the beginning of the conversation because they allow wider answer options, extend and deepen the relationship, encourage opinion and thought expression; closed-ended questions are clearly defined, they induce a unique answer, and often stress only one reply option, limit the communication and make it more focussed, demand only objective facts and sometimes may seem restrictive and obstructing (*"When…?", "Where?", "Who?"*). Questions starting with *"Why"* can be perceived as accusatory, and should be preferably avoided;
- the use of first-person messages helps to distinguish between professional's and another person's opinions contributing to avoid conflicts. This technique serves also to create a non-judgmental and an autonomous decision-making process (*"I think that…", "In my opinion…"*) [17, 18].

THE USE OF COMMUNICATION AND BASIC HEALTH COUNSELLING SKILLS TO ADDRESS VACCINE HESITANCY

As indicated, public health professionals need to know, acquire and implement basic vaccine counselling skills when dealing above all with seven out of nine challenging population groups, even if such these competences can be also helpful somehow with people totally refusing vaccinations. Knowledge and correct use of basic health counselling skills allow in fact healthcare workers achieve an effective vaccine communication because relying on a structured and personalised intervention. Vaccine communication need to acknowledge individual risk perception that does not depend only on the effective hazard but to a greater extent also on the outrage linked to it, basically related to emotional factors prevailing on the hazard itself [25-27]. Within vaccine communication, by "actively listening" to people fears and being aware of the wide-ranged determinants for the perceived risk, public health authorities have better opportunities to understand and to deal with the origin of perception [28-30]. Especially as far as particular groups are concerned, in the case of childhood vaccinations the main parents' fears and worries refer to adverse reaction effects or vaccine safety [31, 2]. If people perceive empathy and consideration to their doubts and opinions, they will be in turn more willing to listen and trust. On the contrary, when people perceive sense of distance, the trust level would be reduced and emotional components of perception prevail on the rational part, not activating listening triggers even if adequate scientific communication was developed. Vaccine communication bases on the participatory communication model featured by an interactive exchange assessment overall, where the understanding of social and personal issues is decisive to make scientific information a useful knowledge to citizens [32, 33].

People should not perceive to be passively advised as "just getting reassurance by experts": in the current communication approach the public sphere is put at the centre of the whole process [25, 27].

If vaccine communication can be considered an interactive process of information and opinion sharing among individuals, groups and institutions, healthcare workers provide people with constructive, up-to-date and meaningful messages and direct-access information services, using a varied range of tools in order to allow them make the best possible decisions about their own health. This make that an important step within the counselling intervention relates to verifying levels of effective understanding in people after having provided scientifically-grounded and personalised information. Looking at the big picture as a whole, in fact, in a multistakeholder scenario the position of public health professionals toward individuals or communities is fundamental as per their key advocacy role in being at the helm of the processes, from planning to development, monitoring and evaluation. Such a framework necessarily demands for strategic communication planning, favoured by the integrated participation and collaboration of institutions, services and systems involved at different levels (national, regional and local) [34-38].

The professional practice of healthcare workers is framed in a specific organisational system and, more broadly, in a complex context where they refer to other stakeholders, institutions and media. Thus, health professionals need to be aware of web-based and new media for two reasons: on the one hand, knowing the kind of information that flows through the net could be useful to forestall some possible criticism; on the other hand, groups on social networks may constitute extremely valuable tools to keep individuals up to date with advices and to promptly hinder false or ambiguous knowledge they could have found on the web. Health information-seeking behaviour on the web shows, in fact, how often people turn first to the Internet both using information to formulate their thoughts and making their own judgements on preferred treatments [39]. Web 2.0, forums and social networks, which enable two-way and multi-way communication flows, have spread out anti-vaccination voices to broader reach than ever before while, years ago, they would have been restricted to certain countries [40]. Health professionals are getting used to situations where the "health blogger" or the "concerned mother" are as important as – or even more influent than – a general practitioner or paediatrician, strongly influencing individual decision-making process [41-45]. Aware and skilled communication processes can facilitate relationships because even in presence of a world wide web 2.0, they do represent significant tools for collaboration building and achieving shared solutions. The public health goal is actually to stimulate professionals to reflect upon the need to recognize, develop and adapt basic health counselling skills in order to provide adequate information and emotional support to people who show hesitant attitudes towards vaccinations and can be allowed to activate informed and responsible decisions.

Conflict of interest statement

There are no potential conflicts of interest or any financial or personal relationships with other people or organizations that could inappropriately bias conduct and findings of this study.

Received on 16 October 2019.
Accepted on 16 May 2019.

REFERENCES

1. Italia. Legge 31 luglio 2017, n. 119. Conversione in legge, con modificazioni, del decreto-legge 7 giugno 2017, n. 73, recante disposizioni urgenti in materia di prevenzione vaccinale. Gazzetta Ufficiale della Repubblica Italiana – Serie Generale n. 182, 05 agosto 2017. Available from: www.gazzettaufficiale.it/eli/id/2017/08/5/17G00132/sg.
2. Giambi C, Fabiani M, D'Ancona F, et al. Parental vaccine hesitancy in Italy – Results from a national survey. Vaccine. 2018;36(6):779-87. doi:10.1016/j.vaccine.2017.12.074
3. Istituto Superiore di Sanità. EpiCentro. Il portale dell'epidemiologia per la sanità pubblica. Morbillo, ultimi aggiornamenti. Available from: www.epicentro.iss.it/problemi/morbillo/aggiornamenti.asp.
4. World Health Organization. Report of the SAGE working group on vaccine hesitancy. Geneva: WHO; 2014. Available from: www.who.int/immunization/sage/meetings/2014/october/SAGE_working_group_revised_report_vaccine_hesitancy.pdf?ua=1.
5. World Health Organization. Ten threats to global health in 2019. Geneva: WHO; 2019. Available from: www.who.int/emergencies/ten-threats-to-global-health-in-2019.
6. Petrelli F, Contratti CM, Tanzi E, Grappasonni I. Vaccine hesitancy, a public health problem. Ann Ig. 2018;30:86-103. doi:10.7416/ai.2018.2200
7. Filia A, Bella A, D'Ancona F, Fabiani M, Giambi C, Rizzo C, Ferrara L, Pascucci MG, Rota MC. Childhood vaccinations: knowledge, attitudes and practices of paediatricians and factors associated with their confidence in addressing parental concerns, Italy, 2016. Euro Surveill. 2019;24(6):pii=1800275. doi: https://doi.org/10.2807/1560-7917.ES.2019.24.6.1800275
8. Sweet M. Pandemic lessons learned from Australia. BMJ. 2009;339:424-6.
9. Deirdre HD. The 2009 influenza pandemic. An independent review of the UK response to the 2009 influenza pandemic. 2010. Available from:
10. http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/416533/the2009influenza-pandemic-review.pdf.
11. Tay J, Ng YF, Cutter JL, James L. Influenza A (H1N1/2009) pandemic in Singapore public health control measures implemented and lessons learnt. AAMS. 2010;39(4):313-24.
12. World Health Organization, Regional Office for Europe, University of Nottingham. Recommendations for good practice in pandemic preparedness. Copenhagen, Denmark: WHO Regional Office for Europe; 2010. Available from: www.euro.who.int/__data/assets/pdf_file/0017/128060/e94534.pdf.
13. World Health Organization. Report of the review committee on the functioning of the international health regulations (2005) in relation to Pandemic (H1N1) 2009. Geneva: WHO; 2011. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf.
14. Greco D, Stern EK, Marks G. Review of ECDC's response to the influenza pandemic 2009-2010. Stockholm: ECDC; 2011. Available from: http://ecdc.europa.eu/en/aboutus/Key%20Documents/241111COR_Pandemic_response.pdf.
15. World Health Organization. Public health measures during the influenza A(H1N1) 2009 pandemic. Meeting report. WHO Technical Consultation 26-28 October 2010, Gammarth, Tunisia. WHO; 2010. Available from: http://whqlibdoc.who.int/hq/2011/WHO_HSE_GIP_ITP_2011.3_eng.pdf.
16. ASSET. Action plan on science in society related issues in epidemics and total pandemics. Action plan handbook. Available from: www.asset-scienceinsociety.eu/outputs/deliverables/action-plan-handbook.
17. European Centre for Disease Prevention and Control. Let's talk about protection. Stockholm: ECDC; 2016. doi: 10.2900/573817
18. Luzi AM, De Mei B, Colucci A, Gallo P. Criteria for standardizing counselling for HIV testing. Ann Ist Super Sanità. 2010;46(1):42-50. doi: 10.4415/ANN_10_01_06
19. TELLME. Transparent communication in epidemics:

learning lessons from experience, delivering effective messages, providing evidence. Practical guide for health risk communication. New communication strategies for institutional actors. Available from: www.tellmeproject.eu/node/390.
20. Rogers CR. La terapia centrata sul cliente. Firenze: Martinelli; 1989.
21. Watzlavick P, Beavin JH, Jackson DD. Pragmatica della comunicazione umana. Boringhieri; 1976.
22. Gadotti G (Ed). La comunicazione sociale. Soggetti, strumenti e linguaggi. Milano: Arcipelago; 2001.
23. Gadotti G, Bernocchi R. La pubblicità sociale. Maneggiare con cura. Roma: Carocci; 2010.
24. Polesana MA. La pubblicità intelligente. L'uso dell'ironia in pubblicità. Milano: Franco Angeli; 2005.
25. De Mei B, Luzi AM. Le competenze di counselling per una gestione consapevole delle reazioni personali e dei comportamenti dell'operatore nella relazione professionale. Dossier. Milano: Zadig; 2011.
26. TELLME. Transparent communication in epidemics: Learning Lessons from experience, delivering effective messages, providing evidence. A new model for risk communication in health. Available from: www.tellmeproject.eu/node/314.
27. Sandman PM. Risk = Hazard + Outrage: Coping with controversy about utility risks. Engineering News-Record; 1999. p. A19-A23.
28. Covello VT. Social and behavioral research on risk: uses in risk management decisionmaking. In: Covello VT, Mumpower JL, Stallen PJ, Uppuluri VRR (Eds). Environmental impact assessment, technology assessment, and risk analysis. Berlin, Heidelberg, New York, Tokyo: Springer-Verlag; 1985.
29. European Commission. Assessment report on EU-wide pandemic vaccine strategies. 2010. Available from: http://ec.europa.eu/health/communicable_diseases/docs/assessment_vaccine_en.pdf.
30. Centers for Disease Control and Prevention. Provider resources for vaccine conversations with parents. Available from: www.cdc.gov/vaccines/hcp/conversations/about-vacc-conversations.html.
31. Sjoberg L. Risk Perception by the public and by experts: a dilemma in risk management. Human Ecology Review. 1999;6(2):1-9.
32. Lambert TW, Soskolne LC, Bergum V, Howell J, Dossetor JB. Ethical perspectives for public and environmental health: fostering autonomy and the right to know. Environmental Health Perspectives. 2003;111(2):133-7.
33. Leiss W, Krewski D. Risk communication: theory and practice. In: Leiss W (Ed). Prospects and problems in risk communication. Waterloo, Ontario: University of Waterloo Press; 1989. p. 89-112.
34. Slovic P. The perception of risk. London and Sterling: Earthscan Publ. Ltd; 2000.
35. Biasio LR. Vaccine hesitancy and health literacy. Hum Vaccin Immunother. 2017;13(3):701-2. doi: 10.1080/21645515.2016.1243633
36. Beck U. La società del rischio. Roma: Carrocci Editore; 2000.
37. Biocca M. La comunicazione sul rischio per la salute. Nel Teatro di Sagredo: verso una seconda modernità. Torino: Centro Scientifico Editore; 2002. (Comunicazione in Sanità Vol. 6).
38. Leiss W. Three phases in the evolution of risk communication practice. Annals of the American Academy of Political and Social Science. 1996;545:85-94.
39. National Research Council. Improving risk communication. Washington, DC: National Academy Press; 1989.
40. Kata A. Anti-vaccine activists, Web 2.0 and the postmodern paradigm. An overview of tactics and tropes used online by the anti-vaccination movement. Vaccine. 2012;30:3778-89.
41. European Centre for Disease Prevention and Control. Communication on immunisation – building trust". Technical document. Stockholm: ECDC; 2012.
42. CDC Facebook page. Available from: https://www.facebook.com/CDC/.
43. Markoff J. Entrepreneurs see a Web guided by common sense. New York Times; 2006.
44. De Mei B, Luzi AM. Il valore aggiunto delle competenze di counselling per una comunicazione efficace in ambito professionale. Dossier. Milano: Zadig; 2011.
45. Catalan-Matamoros D, Peñafiel-Saiz C. How is communication of vaccines in traditional media: a systematic review. Perspectives in Public Health. 2018;138(4). doi: 10.1177/1757913918780142