A qualitative analysis of vaccine decision-makers’ conceptualization and fostering of ‘community engagement’ in India

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Abstract

Background: Globally, and in India, the research literature on vaccination highlights importance of community engagement in achieving national vaccination goals. However, community engagement, and “community” itself, are not well-defined and remains underutilized approach to realize health equity in this context. There is also paucity of literature on community engagement’s effectiveness in achieving vaccination outcomes. To address that gap, this study interviewed influential Indian vaccination decisionmakers to derive a shared understanding of the evolving conceptualization of community engagement, and how it has been fostered during India’s Decade of Vaccines (2010-2020).

Methods: Semi-structured interviews were conducted with 25 purposefully sampled national-level vaccine decisionmakers in India, including policymakers, immunization program heads, and vaccine technical committee leads. Participants were identified by their ‘elite’ status among decisionmakers in the Indian vaccination space. Using Schutz’ Social Phenomenological theory, an a priori framework derived from the Social Ecological Model was used to guide coders’ conceptualizations of communities, community engagement, and related themes. Inter-rater reliability was computed for a subsample of coded interviews, and findings were validated in a one-day member check-in meeting with study participants and teams.

Results: Interpretation of the data elucidated commonly-held understanding of terminology and engagement interventions by elite vaccine decisionmakers. Participants conceptualized ‘communities’ as vaccine-eligible children, their parents, frontline healthcare workers, and vaccination influencers. Engagement with those communities was understood to mean vaccine outreach, capacity-building of healthcare workers, and information dissemination. However, participants indicated that there were neither explicit policy guidelines defining community engagement nor pertinent evaluation metrics, despite awareness that community engagement is complex and under-researched. Examples of different approaches to community engagement ranged from vaccine imposition to empowered community vaccination decision-making. Finally, participants proposed an operational definition of community engagement and discussed concerns related to implementing it.

Conclusions: Although decisionmakers had different perceptions about what constitutes a community, and how community engagement optimally should function, the combined group articulated its importance and reiterated the need for concerted political-will to build trust with communities. At the same time, work remains to be done both in terms of research on community engagement as well as development of appropriate implementation and outcome metrics.

Introduction

The Global Vaccine Action Plan 2011–2020 lists equity as one of its six guiding principles [1]. Resonating this ethos of equity, various national vaccination policies and programs have acknowledged vaccines’ contribution to preventing high-cost treatments averting medical impoverishment, while striving to extend
the benefits of immunization among all [2,3]. Correspondingly, community engagement (CE) for vaccinations is increasingly been recognized and proposed by decisionmakers [4] as a core component of working toward health equity, with a focus on community-based participatory research [5-7]. CE is lauded for its methodological gains in translating research findings [8] and fostering positive perceptions of vaccines and immunization-related interventions [9], while decreasing the likelihood of therapeutic misconception [10]. Also, CE is recognized for its assertion that research and interventions with people and without their inputs is unethical [11]. On the other hand, recurring incidents of vaccine backlash by communities as seen in their skepticism, resistance, and lack of vaccine support are often attributed to ‘inappropriate CE’ [12]. Despite this salutogenic understanding of CE, which has been hypothesized to be a pathway through which population health goals related to health equity can be met [13], several studies have suggested that CE has not been clearly defined or explicated in the context vaccination programs [14,15]. Thus, understanding CE in the vaccination domain is important for an equitable understanding of how CE may be done for different populations such that efficacious vaccines are translated into affordable and globally accessible public health solutions, which are acceptable by all communities [16, 17, 18].

To do so, this study examined CE in the context of India's Universal Immunization Program. While India has made tremendous progress during the “Decade of Vaccines” (2010-2020) by introducing multiple new vaccines along with striving to increase access to new and underused vaccines in the country [19]. However, vaccine decisionmakers are increasingly concerned with only 62% vaccination uptake among vaccine-eligible children (12-23 months), compared to the 90% target set under government's Universal Immunization Program, to be achieved by the end of 2020 [20].

Vaccine studies in the country also indicate the need for embedding CE within India's immunization programs [21, 22, 23]. This growing sensitization about CE among Indian vaccine decisionmakers has been bolstered by the Supreme Court advisory which recommends meaningful dialogue with communities to accelerate vaccination uptake [24]. is also perceived to be an important step in addressing community’s vaccine resistance leading to delays inhibiting vaccines’ timely uptake. For example, the cervical cancer-preventing human papilloma virus vaccine was suspended by the Supreme Court of India in 2010. Later the country’s right-wing groups wrote to the Prime Minister expressing concerns about pharmaco-governance and asserting that foreign companies were pushing the vaccine onto an unsuspecting public. Through July 2020, despite advice by the National Technical Advisory Group on Immunization, the Federation of Obstetric & Gynecological Societies of India, and the Indian Academy of Pediatrics for its inclusion in the Universal Immunization Program, substantial community resistance remains. As a result, the vaccine has been sporadically rolled out in three (Sikkim, Punjab and Delhi) out of 36 states and Union Territories [25, 26].

Documented examples showcase a long history of lack of strategic and tailored CE in India partially leading to community skepticism about vaccines and even lack of trust for vaccinators, aka the vaccine providers. This was often evidenced by covert and overt vaccine resistance. Lahariya 2014 highlights that as early as the mid 1800’s, some Hindus resisted the smallpox vaccine on religious grounds, because the
material used for vaccines was drawn from the lymph of a cow, which is considered a sacred animal by the community [27]. Again, during the National Polio Surveillance Program community resistance ranged from people closing their doors and windows when they heard vaccinators approaching their houses to vaccine backlash such as physical conflict between vaccinators and communities [28]. Recently, in 2017, there was decreased uptake of measles-rubella vaccination in certain Indian states amidst community uproar following social media rumors of political conspiracy and safety concerns about the vaccine [29, 30]. Thus, Indian vaccine decisionmakers suggest that broadening the understanding of CE is critical at this juncture to establish concerted and strategic CE that can facilitate building transparent vaccine communication between communities and decisionmakers (). This may be especially useful in overcoming communities’ myths and fears regarding new vaccines, which are often considerably more expensive than existing ones, and target relatively ‘hidden’ diseases [31, 32]. However, current CE evidence is limited to a few systematic examinations focused on community counselling and vaccination campaigns, often in pockets of high vaccine resistance and low vaccination coverage [33, 34]. These reviews have also focused on public opposition rather than involvement, and with no data being collected to indicate if and how communities are engaged beyond individual decisions to vaccinate themselves and their children [35, 36, 37]. The wider body of academic literature attributes this dearth of CE related studies to the variously premised and sometimes conflicting definitions of and rationales for CE [38] and the absence of CE metrics [39]. Other studies mention that evaluating engagement is challenging, as such activities often occur in the context of ongoing work and adopting more collaborative engagement approaches [40, 41].

It is our perception that typifying an understanding of CE may lead to contextual and ethical application of CE within a complex system of relationships among researchers, policymakers, implementation scientists, and vaccine users. It may also prevent erroneous assumptions about its value and utility, or lack thereof, and inform research and data needs related to CE. This may, in turn, trigger a policy dialogue focused on robust measures to assess what works, how it works, and, over time, if CE efforts have improved vaccination rates. Therefore, this study aimed to examine elite Indian vaccine decisionmakers’ individual perspectives and collective understanding about CE, the circumstances in which CE has been implemented, and how they have fostered CE for effective vaccination.

**Methods**

Schutz’s Social Phenomenology Theory was used as an underlying approach because it is consistent with the belief that ‘conceptualizations’ are socially constructed and appropriated to explore participatory action [42]. This theory also helped direct attention toward considering the dynamic contexts in which CE was conceived and operationalized [43]. Social Phenomenology further helped to treat CE conceptualization and its fostering as intersubjective, integral to institutions and systems, all embedded in history, time, and space [44]. The lead author’s (TD) professional role was that of a translational researcher, supporting evidence-based programs and policy through examination of ecological frameworks using a community-based participatory approach. Her *a priori* assumption was that community engagement can foster social, relational, and ethical progress toward health equity [45].
However, few assumptions were made about how decisionmakers would conceptualize CE and community, as these issues infrequently are described in formal, written documents and must instead be intuited from distally related activities.

In preparing for this study, the lead author (TD) purposefully identified 30 individuals who had authoritative roles related to vaccine discovery, development and delivery, such as national-level vaccine decision-makers who were policymakers, program heads and/or associates in the government, private sector, non-governmental organizations, and country-offices of international donor and UN agencies. Thus, these individuals, by virtue of their knowledge and positions, were the ‘elites’ [46] and were able to provide a unique ‘big-picture perspective’ [47] about CE strategizing and implementation during India’s Decade of Vaccines. Thus, interviews were approached with this status differential in mind [48]. In keeping with the assumptions and beliefs of social phenomenology, a two-step participatory approach for data collection was used: (1) semi-structured elite interviews followed by (2) member check-in meeting [49]. All interactions used a community-engaged approach, including emphases on mutual respect and recognition of the knowledge and expertise of study participants. This included adhering to participants’ preferred meeting dates on December 25 and January 1, even though these were national holidays. Further, the member check-in meeting was democratically conducted rather than using the researcher as a moderator. In addition, the researcher was sensitive that issues related to vaccine resistance were occurring in real time, wherein trust building with the study participants was necessary to obtain ‘good data’ and completion of the project.

The interviews were conducted with 25 individuals who agreed to participate in the study from December 2017 to February 2018. Data also included field-notes written within 24 hours of each interview. The interview topics drew from earlier studies focusing on CE as a strategic tool for vaccine research and rollout [50, 51]. Accordingly, the inquiries explored participants’: (1) conceptualization of community and CE, (2) evolution of CE, (3) fostering support for CE, (4) resources available for CE, (5) partnerships for CE, (6) enablers to CE, and (7) barriers to actualize CE. The interview guide used for this study, including questions and probes, is available as a digital supplement (1) to this article.

Access to participants was obtained using a snowball methodology, beginning from the professional network of the principal investigator (TD). Recruitment emails were sent in December 2017 to each potential participant, followed up with phone calls to identify interest and availability for an in-person interview. Each interview lasted for 50 to 90 minutes, was carried out in English, and in the country-offices of the respective agencies, institutions, and organizations located in or around New Delhi, the capital city of India. Interviews were audio recorded and transcribed verbatim. All personalized information was anonymized.

Once a preliminary analysis of the interview data was completed, TD presented the findings in a one-day member check-in meeting among the study participants and their teams (who held second-line leadership positions) in January 2018. Study participants and their team members who participated in the member check-in meeting were knowledgeable about the issue and were comfortable validating and candidly
critiquing the primary findings. All study participants and their teams were nationally known; thus, in order to maintain confidentiality, identities, names, and organizational affiliations were not used in reporting the findings. Therefore, although participants in the follow-up meeting knew each other no specific responses were linked to any individual or organization. This meeting ensured that interpretations from the interview findings made sense to the vaccine decisionmakers and their teams in India and was a way to verify both data saturation and completeness of the findings, as well as archival document review (part of the overall project, but not of this study). The study was approved by Indiana University’s Institutional Review Board.

Data Analysis

First, all data were transcribed verbatim and entered in N-Vivo12 (QSR International, Melbourne, Australia) for qualitative data management. An a priori coding structure was used to categorize individual participants’ conceptualization of CE, how their interests in CE for vaccination evolved by overcoming barriers and optimizing facilitators, while integrating 'policy push for vaccine uptake' and 'generating vaccination demand pull' approaches for different vaccines under the UIP. Based on the interpretive analysis used in social phenomenology, first-level broad construction of CE was done, followed by the second-level typical constructs, deliberated through critical events or performance of CE ‘duties’ and ‘responsibilities’ throughout the tenure of the decisionmakers [49, 50, 52]. Categories conceptually corresponded with the Social Ecological Model, which has been used to study vaccination uptake and health disparities [53]. Given this loose pre-existing framework a general inductive approach was used [54]. To reach intercoder-reliability (>90%), two coders joined TD, iteratively reviewed, and re-reviewed data for existing and emerging themes and/or patterns, and ultimately crystallized a holistic interpretation through multiple coding conferences. Thereafter the three coders independently coded five interviews to test, reject, accept, or refine the codes [56]. The final coding structure contained 7 multi-dimensional CE themes with 42 nodes. Exemplar interview excerpts illustrate the findings, although the analysis drew from the entire dataset. The coding structure is available in full as a digital supplemental (2) file.

Results

All study participants held national and multi-regional leadership roles in vaccine policymaking, financing, and/or program planning and management across vaccine research, development, and roll-out stages for at least ten years in India. In addition to their roles in India, five participants reported managing programs in multiple countries in Asia, Africa, and Latin America. Table 1 describes the study participants.

This section sequentially shares results organized by the following categories and subcategories:

(1) conceptualization of community, and how stakeholders define community;
(2) conceptualization of CE, with particular attention to analyzing extant efforts;
(2a) capacity building of frontline stakeholders as CE;
(2b) vaccine-related information dissemination as CE;
(2c) targeted community interventions as CE;
(3) different tangible ways in which CE might be fostered; and
(4) evolution and transformation of CE.

**Conceptualization of Community**

Most participants defined communities as ‘beneficiaries of the UIP,’ with a notion of transactional exchange of vaccine related information between the providers and the communities, always with the aim of vaccination uptake. In these cases, communities consisted of the following categories of people: (1) vaccine-eligible children, vaccine-eligible young adults, and their parents and guardians who make vaccination-decisions for the former; (2) frontline healthcare providers who deliver vaccines and sensitize vaccine-eligible populations and their guardians for improved vaccination rates and herd immunity; (3) local-level stakeholders who disseminate information to encourage vaccination uptake; (4) gatekeepers who resist a particular vaccine or vaccination *per se*, and; (5) implementers, a group that includes what is known in India as the 3A's. These are Auxiliary Nurse Midwives, who are the multipurpose workers responsible for administering vaccines among communities of < 5000 people, Accredited Social Health Activists, and Anganwadi Workers, who live with and are responsible for promoting maternal and child health, including interpersonal communication for full immunization coverage, among <1000 people. Few participants took a broader perspective: “It is the whole communities in which those individuals were living.”

Most of the participants acknowledged their distance from the community, mentioning “if *I* went to the community nobody will accept me,” while comparing the sense of community with local organizations because they “help raise community demand for routine immunization.” These organizations included grassroots non-profit organizations (NPOs), community-based organizations (CBOs) like women's self-help groups, local-level representatives of occupational groups like brick-kiln workers and barbers, and the local-chapters of technical and youth organizations such as the Indian Association of Pediatricians, Indian Medical Association; Rotary Club, Lion's Club, National Cadet Corps, National Service Scheme, and Nehru Yuva Kendras. Several NGO heads identified themselves as communities for their people-centric approach though, in most of these expressions, fractious relationships and issues of incompatibility between decisionmakers [mostly government or donors] and NPOs were evident.

“….they [Government or donors] want to clip our wings. This is very sad because we [NPOs] bring up issues [local issues of the communities], which you [Government or donors because of being at the national-level] might never know.”

Some participants identified vaccine-gatekeepers, people who were suspicious that vaccination is a political agenda against minority groups, as communities. Interventions targeting their positive vaccination decisions increasingly came across as an area of CE.
“... in Mallapuram the mother generally said ‘no’ to vaccination because their husband lived in the Middle East [who were proxy decision-makers for their child’s vaccination]. We [decisionmakers] then realized that we have to find a way to tap the men [fathers] who are influencing immunization acceptance back home.”

Finally, although the media was not definitively identified as ‘community’ in this section, it was unclear whether the media was part of the community or a driver of community’s vaccination decision outcomes. Most participants had the perception that media spread misinformation and promulgated negative sentiments among vaccine priority populations about vaccines, and thus expressed the need “to stop negative media so that they [media] do not “blindly publish”, or “over-sensationalize when it is not an Adverse Event Following Immunization.”

Conceptualization of CE

The participants perceived CE both as a strategy and tool in implementation terms, and variously defined CE as segments of processes comprising of: (1) vaccine policy and program formulation; (2) capacity-building of frontline stakeholders; (3) vaccine information dissemination among communities to promote vaccination uptake, and; (4) targeted community-level interventions to curtail the recurring incidents of vaccine-related community backlash. There was evidence of relational goals of CE, like “longer-term trust building” [between the vaccine decision-makers and the communities], driven to “...understand what is going on in people’s minds [regarding vaccinations]."

Intuitively, all the participants proposed ongoing and early CE for better vaccination outcomes:

“The moment you leave the village... [Communities] will say, ‘Are you mad that you listened to them [vaccine decisionmakers] and got your child vaccinated?”

“We could reach almost 98% of our targets [communities for HPV vaccinations]. We always go to the communities earlier and have media campaigns, and interpersonal communications to sensitize people on what [vaccine] we would give to their children.”

However, several participants critiqued that CE interventions came in waves, mostly during vaccine introductions, before and during vaccine trials, and in case of a disease outbreaks. They also noted that there were no tools or metrics to measure its impact. They speculated that these deficits may be because:

“The Immunization Technical Unit was not built with a CE model [CE frame] for immunization. Like, you [Government] compensate Accredited Social Health Activists for fully immunizing children and trainings attended, but not for doing CE.”

Participants described a top-down and decentralized vaccine governance structure where vaccine policy formulation and vaccine introduction were made at the Ministry, considering disease burden, vaccine
cost, cold-chain and supply chain issues. These were completely funded by the Ministry of Health and Family Welfare (MoHFW) and the international donors.

“...[CE is like] a chandelier, the [MoHFW] is the hook. The different lights are the different partners, they are held at right distances in the right manner. In immunization, the roles and partnerships [of national level decisionmakers] are clearly defined.”

The development of the vaccine policy and vaccine operational guidelines in English and Hindi (the official language of India which is understood, spoken, and read by more people than English) by the technical bodies of MoHFW, such as the Immunization Technical Support Unit, and the Mission Steering Group, was conceptualized as CE too. Participants mentioned that the “state translated and modified [these documents] if they think that something is to be added or deleted,” though there were no examples of any such revisions incorporated based on communities’ recommendations.

Except the Vaccine Policy (2011), which recommended enhancing communities’ vaccination acceptance and confidence, and vaccine-specific Operational Guidelines, which recommended community-facing strategies, participants did not identify any sub-population-based CE-specific policy. Almost half of the participants cited the Communication Strategy for Polio Eradication, published by the UNICEF and USAID CORE Group, detailing intensive outreach for polio vaccination, as nearest to any CE guideline. Three participants, considering India’s diversity where “every mile the language changes, the culture changes” suggested having a “village-level communication strategy.” Participants noted strategic programs like Mission Indradhanush and Intensified Mission Indradhanush to achieve 90% immunization “to the last child” as CE.

The heads of organizations and technical bodies often criticized chasms in this one-way, top-down approach as “working in silos” and “not real CE,” and feared that it would ultimately “hinder an integrated approach.” A few participants identified potential CE occurring in spaces like Village Nutrition and Sanitation Days, which are organized monthly at rural childcare centers. There, communities can ask question about the vaccines and vaccination strategy. However, these participants were doubtful that communities possessed any emancipated voice beyond seeking or resisting vaccines.

**Capacity Building of Frontline Stakeholders**

Some participants mentioned cascade training of trainers for the 3As and local Master Trainers to motivate communities for full immunization as CE. Notably, the CE roles of the 3As and other local stakeholders were different. The Auxiliary Nurse Midwives and Anganwadi Workers were salaried staff for vaccine administration among communities and the Accredited Social Health Activists received honoraria for counselling and escorting the communities for vaccinations. However, the local NPOs and CBOs were instrumental in carrying out community-based activities to motivate community’s vaccination decisions, and, in the case of vaccine trial conducting organizations, were conduits between researchers and vaccine clinical trial participants.
Participants conceptualized the 3-day Boosting Routine Immunization Demand Generation course for the 3As, and vaccination sensitization trainings for the local-level vaccine-champions (community advisory boards, local religious leaders, barbers, and CBO members), as CE. In these instances, it appeared that some interpersonal tactics were imparted to frontline stakeholders, which were later delegated to them. However, a few participants questioned the ‘quality CE outcomes’ from these trainings:

“So, you [Government] piggy back everything on that the Community Healthcare Worker, who talks to communities about everything immunization, family planning, maternal health, school health, adolescent health, non-communicable diseases, and cancer...[but] you are not actually engaging or doing CE.”

**Vaccine-Related Information Dissemination**

Most respondents mentioned “bilateral information transfer [interpersonal and behavior change communication] sent down to communities” as CE. In the same vein, most participants denoted the Communications Officer as the CE human resource. In fact, one participant said, “The role of communication, I mean CE, sorry using the wrong word again.”

“We use all sorts of communication channels to make people understand what we are going to give their children and why.”

Some participants highlighted the need to be creative and explore web-based media considering its easier usage, cost-effectiveness, and penetration to interior locations:

“Nobody is interested to read your mobile texts. So, use GIF messaging.”

There were few examples acknowledging bottom-up information, going from the community to the government which facilitated realizing the vaccine program goals:

“In a construction site we [participant’s organization] did the mapping. But when we reached the community after a fortnight, they [community] have already migrated. The local person would tell us the whereabouts of the mobile community and we could then reach them through the Accredited Social Health Activist network.”

Some participants highlighted campaign-related booklets like the area-based ‘Underserved Strategy,’ developed after a polio outbreak in Uttar Pradesh in 2002 among the Muslim populations, the ‘Social Mobilization Network’ formed in 2001 to sensitize families to polio immunization, ‘My Village my Home’, a pictographic vaccination tracking method in the shape of a hut, where each column of the hut contains vaccination details of each new-born in the village, and media trainings of “State Immunization Officers on how to handle the media and stop negative media,” as CE.

Vaccine-champion-engagement and celebrity-engagement to motivate communities’ vaccination decisions came across as another form of CE, though there were mixed reactions regarding this strategy.
“The Deputy Collector used to vaccinate his child in the [community], and then the parents [with vaccine-eligible children] believed.

“Our communication campaigns are pathetic. What is the point in having [a film star in his 70s] there? We have no way of measuring CE. Does he convey safety of the product? To sell a toothpaste or a phone we spend hundreds of millions of dollars. How much is going into selling something far more important as vaccines?”

**Targeted Community Interventions**

Some participants perceived CE as a [right of the communities], “communities want the leadership to come to them. ...just sit with them [communities], work with them and that is CE. The leader needs to go to the community at least once or twice. It really increases the communities’ motivation and trust.”

Others suggested more emancipatory understanding of CE:

“[Vaccine] demand generation is another thing [than CE]. It means that you [government/vaccine providers] are giving we [vaccine-eligible community] are accepting. Policy influencing is that where the [empowered] community thinks that certain things needs to be changed [and advocates for that].”

Intervention programs reflected a range, between vaccine imposition and respectful engagement with community stakeholders, where participants’ responses reflected balanced trade-offs between CE’s time and resource investments and feasibility, emphasizing that it is a “marathon, and not a sprint,” “an expensive process” and “took 20 years to learn about community and how to do CE.”

“In XXXX district community was very resistant and started beating the vaccination team. Then we had to contact a local muscleman, briefed him that this [carrying on with the vaccination drive] is important, and then told him to make an announcement that vaccination is not a bad thing.”

“We engaged with the staff of Aligarh Muslim University, Jamia Milia Islamia and Jamia Hamdard [institutions of higher education that were created to manifest indigenous ethos and spirit of diversity in India], who went to the field. That helped to address the issue of vaccine hesitancy among religious leaders [especially the Muslim religious leaders].”

Later, in the member check-in meeting, participants reiterated that effective CE conceptualization and conduct will require devising CE performance and outcome indicators and advocating their incorporation in immunization surveillance instruments in India. Herein, all the participants emphasized the need to document CE effectiveness and its relational gains:

“... as a country, I will not be ashamed ...., very poor in documentation. You will hardly see any papers from the learnings of polio eradication. This is so because the people who are doing CE do not have the time to document.”

**Fostering of CE**
Though a strict categorization of responses by organizations would not be accurate, a spectrum with seven different expressions and patterns of CE fostering roles by participants was deciphered, ranging loosely from empowered (‘1’) to disempowered (‘7’). These examples helped identify tangible ways in which CE goals could be realized. Exemplar quotes in Table 2 explain the quasi-sequential empowerment ranking of different engagement strategies to foster CE.

All participants acknowledged “decision-makers’ good intention for CE but they were not matched with recipes of successful CE models.” Again, most of the CE interventions reported were during the National Polio Surveillance Program (a campaign of the World Health Organization and MoHFW initiated in 1995 to ensure polio eradication through house-to-house poliovirus vaccine delivery), with minimal evidence of institutionalization, replication or scale-up of these during introduction of other vaccines. Examples of such interventions were:

“...approaching the brick-kiln owners, getting the list of all the children, and sending it to the Government officials [vaccine decisionmakers] requisitioning vaccination...”

**Evolution and Transformation of CE**

All participants indicated that CE was still a “very poorly understood space,”“complex,” and there were “several gaps to understand this puzzle.” Three participants from NPOs critiqued that it is “offhand,”“ad-hoc practices to douse the fire,”“firefight,” or “control big chaos and help put things back to normal” and recommended “real community engagement” and a “scientific approach to CE.” Recollecting CE’s evolution, participants noted that the earlier paternalistic prevention impositions has built a negative community memory, and jeopardized communities’ trust on vaccine authorities:

“...the vaccine fear was connected to the family planning program, when women were forcibly sterilized.”

There was some evidence of pragmatic pressures by external provider/donor organizations (e.g., “GAVI funding went partly for community mobilization”) that reinforced renewed systems-thinking and inclusive bottom-up models, like:

“We were not really very serious and formed a small community group. [Initially, the community group] came, had some snacks and went off. CE really didn’t go beyond that. But by then the NIH and USAID wanted Community Advisory Boards or CABs ...and then we learnt how necessary it was.”

Consequently, several participants indicated recent and direct interactions between vaccine decisionmakers and communities while referring to “The Prime Minister’s Office invites suggestion from the public” and “Health Minister issues letters to each Accredited Social Health Activist and Auxiliary Nurse Midwife encouraging them to vaccinate every child.”

In the day-long member check-in meeting, participants jointly came up with a robust definition of CE, which can be summarized as:
“CE is an upstream policy imperative rather than downstream interventions to build trustworthy relationships between vaccine decisionmakers and communities. It involves demystifying vaccine science and transparent communication for empowered community agency. This would enable communities to critically analyze vaccine related myths and misinformation and enable knowledge co-production in building community sensitive vaccine policies and programs. CE is incumbent to sustained political-will and resources to ensure evidence-informed, tailored, vaccine policies and programs, providing equitable, quality, and tangible vaccination and capacity building benefits to community members.”

Recognizing the relational gains of CE, meeting participants recognized the need to carry out interventions in ways such that trustworthy relationships between communities and decisionmakers is established. There were comments reflecting realizations like “If we [decisionmakers] close the doors once again to the community, we might lose their trust, and not get the communities back, ever again.” They also recommended creating more opportunities for relationship-building and group discussions between community healthcare workers and vaccine decisionmakers.

Discussion

This study was able to identify elite decisionmakers’ core conceptualizations of community, CE, and both extant and aspirational approaches to CE related to vaccination programs in India. In reviewing these findings with study participants, a core definition of CE emerged, focused on upstream relationships (bidirectional), fostering trust, transparent communication, capacity building, and political-will to ensure such approaches. Participants indicated that much of the extant work being conceptualized as CE is primarily downstream delivery and even imposition of services for vaccination uptake. While such things can be beneficial (e.g., vaccination), it likely matters to whom they done, in what way, and with what level of community voice (e.g., changing “to whom” to “with whom”). Given that directive imposition has resulted in community backlash to vaccination campaigns both in India and other parts of the world, including violence and hiding children from vaccinators, achieving national policy goals and fostering equitable distribution of public health outcomes may be difficult without a revised approach to CE. Concomitant to this must be an increased focus on CE metrics to promote greater understanding of processes and goals.

Notably, being an Indian but performing the research at an American university, and reflexivity issues gave TD the identity of an 'informed outsider,' which allowed for considerable interpretive latitude and probing opportunities during interviews and member check-in meetings. It also allowed her to gain increased access to elites [56]. Studies on ‘elite interviewing’ mention that such access can be rare, because such people are hard to reach, surrounded by gatekeepers, and have power and ability to protect themselves from intrusion and criticism [57, 58]. This study also benefited from the fact that none of the CE strategies/interventions were ranked as ‘best practice’ over another by institutional mandate or leadership, unlike the traditional ranking of engagement models in Holland Matrix (1997) [59], or
Arnestein’s Ladder [60]. This helped reduce social desirability issues among the participants, who would not be seen as ignoring a best-practice approach when answering honestly about CE.

We found, in some cases, that only a section of the public was perceived as ‘community’ and ensuring full immunization to communities under UIP was considered the most important CE goal. Full immunization is a step toward equitable health outcomes. However, as noted in other literature [61, 62], a reductionist approach to conceptualizing communities may inhibit formation of trusted collaborations with the communities, ultimately compromising the creation of communities’ agency [63]. Some authors have described this as ‘conservative corporatism’ which, contrary to the ‘whole community approach’ [64], can lead to fragmented health governance, introduce barriers to building comprehensive people-centered vaccine policy reform [65], and risk defining communities as internally homogenous entities, which is unlikely to be the case given the diversities prevalent in India [66]. This may also undermine tailored CE strategies for particular sub-populations leading to the latter’s trust on vaccinators and empowered vaccination decision making, especially among whom vaccine hesitancies are high, and/or vaccination uptake is low [67, 68].

While findings supported current iterations of CE in making substantive contributions to vaccine demand generation and disease eradication, communities were often seen as offering ‘passive demand.’ Ideally, communities would actively seek vaccines and there would be community demand reflecting social support for vaccination as a norm [69]. Head’s research goes so far as to suggest that utilitarian CE may foster health inequities [70]. Gopichandran’s work looks into the relational gains of CE and posits development of trust between vaccine decisionmakers and communities as a result of shared CE goals integrated into vaccination targets [71]. Accordingly, doing empowered CE may require a paradigm-shift to perceive communities as integral parts of the policy and delivery systems, incorporate CE metrics into vaccine surveillance, and create new roles with a focused responsibility to coordinate CE.

It appears that the national-level CE response was an equilibrating reaction to appease community outrage rather than an integral approach set in place a priori. Adhikari et. al. has defined such CE as ‘short-hand’ [72], often resulting in wasted resources, with the potential to create mistrust rather than enhance benefits, create legitimacy, or share responsibility [72, 73]. Other authors have envisaged that such CE in the longer run can give rise to communities as agents of the government, and CE becoming an ‘involvement industry’ ‘procured from external organizations’ [74, 75]. To alleviate this, Folayan et. al. (2019) have recommended memoranda signed between the government and local partner organizations at the study design stages [76].

That said, Webber seems to doubt whether national government-based public health initiatives might ever be able to stray too far from a top-down approach, postulated as the ‘two-community thesis’ [77]. Other authors suggest that deviation from this paradigm will require transformative leadership which is difficult to achieve in the public service sector with the prevailing traditional organizational thinking, policies, and management techniques [78].
While frontline local stakeholders played a role in Indian vaccination efforts as two-way conduits between decision-makers and the community, more studies are recommended to examine complex issues derived thereof, such as internal chasms and accountability mechanisms between the 3As, and motivational erosion when CE work is not compensated financially. Prior research would not suggest, though, that social media could replace this in-person work. Ramsbottom’s et al.’s study found that, although social-media messaging is a cost-effective mechanism for vaccine information dissemination, it might not be the best approach for India, and could leave out social media illiterate populations, those with erratic and sporadic internet connectivity, and areas where vaccine communication needs to be translated to local dialects [80].

Limitations

Ensuring open discussion with vaccine decisionmakers and their team members on a potentially controversial topic like CE for vaccination was not always easy; it took time to convince the potential participants to participate. Some of the elites were difficult to access because of the ongoing community uproars around Measles- Rubella and HPV vaccines which were playing out in real time in the country during the study’s time period [81, 82]. Despite these structural impediments, theoretical saturation was ensured by virtue of interviewing nearly the entire group of elite vaccine decisionmakers in the country. This was achieved by utilizing TD’s professional networking and familiarity with some of the study participants, use of a sensitive mix of knowledge and intercultural humility, flexibility to re-schedule appointments after office hours or on national holidays, and use appropriately persuasive multiple communication channels like Facebook Messenger, or WhatsApp [83], in addition to emails and phone calls. Nonetheless, the study findings were limited by the inherent limitations of a qualitative study design. However, generalizability within India might be more strongly inferred than would be typical given the high percentage of decisionmakers who provided data. In addition, all the study participants were interviewed in or around New Delhi. While the individuals who were interviewed each had a national or international scope to their decision making, this centrality may have influenced the findings in some way. Finally, some of the findings related to intended actions in the future rather than things that had already been completed; this hampered the ability to ascribe definite actions in some cases. However, existing literature demonstrates that intentions are moderately good predictors of future behavior [84, 85].

Conclusion

The results from this study can be used both to understand past CE challenges and successes and to prospectively plan community-led, tailored CE initiatives for better vaccination outcomes. Of note, there appears to be conceptual tension between multiple vaccination-related goals, such that each can be perceived as CE for health equity; namely, top-down vaccination programs may be successful in achieving some short-term immunization, but there may be backlash, and longer-term increases in immunization rates may suffer as a result. At this stage, it will be critical to devise CE process and
outcome indicators for vaccination programs in India, and to advocate for their incorporation in vaccination surveillance datasets. As of now, the suggestions herein are theoretical – and evaluation metrics would allow for demonstrations of how CE impacts a variety of important outcomes, and, ultimately, foster replicability of successful efforts within India and internationally.

References

1. Plan WG. Plan 2011–2020. Geneva: World Health Organization. 2013. http://www.who.int/immunization/global_vaccine_action_plan/GVAP_doc_2011_2020/en/
2. Boyce T, Gudorf A, de Kat C, Muscat M, Butler R, Habersaat KB. Towards equity in immunisation. Eurosurveillance. 2019 Jan 10;24(2):1800204.
3. Chang AY, Riumallo-Herl C, Perales NA, Clark S, Clark A, Constenla D, Garske T, Jackson ML, Jean K, Jit M, Jones EO. The equity impact vaccines may have on averting deaths and medical impoverishment in developing countries. Health Affairs. 2018 Feb 1;37(2):316-24.
4. Boxelaar, L, Paine, M, Beilin, R. Community Engagement: for Whom? Proceedings of International Conference on Engaging Communities. Brisbane: Queensland Department of Main Roads, 2005.
5. Boston PQ, Mitchell MM, Collum K, Gravlee CC. Community engagement and health equity. Practicing Anthropology. 2015;37(4):28-32.
6. Wallerstein N, Duran B. Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. American journal of public health. 2010 Apr;100(S1):S40-6.
7. Wallerstein NB, Yen IH, Syme SL. Integration of social epidemiology and community-engaged interventions to improve health equity. American Journal of Public Health. 2011 May;101(5):822-30.
8. Reynolds L, Sariola S. The ethics and politics of community engagement in global health research.
9. Pramanik S, Ghosh A, Nanda RB, De Rouw M, Forth P, Albert S. Impact evaluation of a community engagement intervention in improving childhood immunization coverage: a cluster randomized controlled trial in Assam, India. BMC public health. 2018 Dec;18(1):1-3.
10. Fregonese F. Community involvement in biomedical research conducted in the global health context; what can be done to make it really matter?. BMC medical ethics. 2018 Jun 1;19(1):44.
11. Gibson A, Britten N, Lynch J. Theoretical directions for an emancipatory concept of patient and public involvement. Health.: 2012 Sep;16(5):531-47.
12. Larson HJ, De Figueiredo A, Xiaihong Z, Schulz WS, Verger P, Johnston IG, Cook AR, Jones NS. The state of vaccine confidence 2016: global insights through a 67-country survey. EBioMedicine. 2016 Oct 1;12:295-301.
13. Fawcett S, Schultz J, Watson-Thompson J, Fox M, Bremby R. Peer reviewed: Building multisectoral partnerships for population health and health equity. Preventing chronic disease. 2010 Nov;7(6).
14. Kagee A, De Wet A, Kafaar Z, Lesch A, Swartz L, Newman PA. Caveats and pitfalls associated with researching community engagement in the context of HIV vaccine trials. Journal of health
psychology. 2020 Jan;25(1):82-91.
15. Tindana P, de Vries J, Campbell M, Littler K, Seeley J, Marshall P, Troyer J, Ogundipe M, Alibu VP, Yakubu A, Parker M. Community engagement strategies for genomic studies in Africa: a review of the literature. BMC medical ethics. 2015 Dec 1;16(1):24.
16. Pratt B, de Vries J. Community engagement in global health research that advances health equity. Bioethics. 2018 Sep;32(7):454-63.
17. Goldstein S, MacDonald NE, Guirguis S. SAGE Working Group on Vaccine Hesitancy. Health communication and vaccine hesitancy. Vaccine. 2015 Aug 14;33(34):4212-4.
18. Obregón R, Chitnis K, Morry C, Feek W, Bates J, Galway M, Ogden E. Achieving polio eradication: a review of health communication evidence and lessons learned in India and Pakistan. Bulletin of the World Health Organization. 2009;87:624-30.
19. Paul S, Sahoo J. Four new vaccines for routine immunization in India: What about hemophilus influenza B and pneumococcal vaccine? Journal of family medicine and primary care. 2015 Jan;4(1):9.
20. IIPS I. National Family Health Survey (NFHS-4), 2015–16. International Institute for Population Sciences (IIPS), Mumbai, India. 2017.
21. Ibid 19.
22. Gurnani V, Haldar P, Aggarwal MK, Das MK, Chauhan A, Murray J, Arora NK, Jhalani M, Sudan P. Improving vaccination coverage in India: lessons from Intensified Mission Indradhanush, a cross-sectoral systems strengthening strategy. bmj. 2018 Dec 7;363.
23. Laxminarayan R, Ganguly NK. India's vaccine deficit: why more than half of Indian children are not fully immunized, and what can—and should—be done. Health Affairs. 2011 Jun 1;30(6):1096-103.
24. Ibid 22
25. Zimet GD, Meyerson BE, Dutta T, Forster A, Corcoran B, Hanley S. Political and Public Responses to Human Papillomavirus Vaccination. InHuman Papillomavirus 2020 Jan 1 (pp. 363-377). Academic Press.
26. Sankaranarayanan R, Basu P, Kaur P, Bhaskar R, Singh GB, Denzongpa P, Grover RK, Sebastian P, Saikia T, Oswal K, Kanodia R. Current status of human papillomavirus vaccination in India's cervical cancer prevention efforts. The Lancet Oncology. 2019 Nov 1;20(11):e637-44.
27. Lahariya C. A brief history of vaccines & vaccination in India. The Indian journal of medical research. 2014 Apr;139(4):491.
28. Solomon R. Involvement of civil society in India's polio eradication program: lessons learned. The American journal of tropical medicine and hygiene. 2019 Oct 3;101(4_Suppl):15-20.
29. Das MK, Singh D. Vaccine news in India: trend and content analysis of online mass media. International Journal of Community Medicine and Public Health. 2018 Sep;5(9):3951.
30. Rao M & Govindarajan V, Scroll in, Feb 24, 2017 WhatsApp rumours about vaccinations hamper India's drive to halt measles and rubella. Accessed on March 1,
31. Ibid 22
32. Ibid 25
33. Dimala CA, Kika BT, Kadia BM, Blencowe H. Current challenges and proposed solutions to the
effective implementation of the RTS, S/AS01 Malaria Vaccine Program in sub-Saharan Africa: A
systematic review. PloS one. 2018 Dec 31;13(12):e0209744.
34. Sarrami-Foroushani P, Travaglia J, Debono D, Braithwaite J. Implementing strategies in consumer
and community engagement in health care: results of a large-scale, scoping meta-review. BMC health
services research. 2014 Dec 1;14(1):402.
35. Adhikari B, James N, Newby G, Von Seidlein L, White NJ, Day NP, Dondorp AM, Pell C, Cheah PY.
Community engagement and population coverage in mass anti-malarial administrations: a
systematic literature review. Malaria journal. 2016 Dec 1;15(1):523.
36. Farmer J, Taylor J, Stewart E, Kenny A. Citizen participation in health services co-production: a
roadmap for navigating participation types and outcomes. Australian Journal of Primary Health.
2018 Jan 16;23(6):509-15.
37. Ministry of Health and Family Welfare, Government of India Drugs and Cosmetics (First Amendment)
Rules. New Delhi: Government of India Press; 2013.
38. Enria L, Lees S, Smout E, Mooney T, Tengbeh AF, Leigh B, Greenwood B, Watson-Jones D, Larson H.
Power, fairness and trust: understanding and engaging with vaccine trial participants and
communities in the setting up the EBOVAC-Salone vaccine trial in Sierra Leone. BMC Public Health.
2016 Dec 1;16(1):1140.
39. MacQueen KM, Bhan A, Frohlich J, Holzer J, Sugarman J, Ethics Working Group of the HIV Prevention
Trials Network. Evaluating community engagement in global health research: the need for metrics.
BMC Medical Ethics. 2015 Dec 1;16(1):44.
40. Martin GP, Carter P, Dent M. Major health service transformation and the public voice: conflict,
challenge or complicity?. Journal of health services research & policy. 2018 Jan;23(1):28-35.
41. Forsythe LP, Carman KL, Szydlowski V, Fayish L, Davidson L, Hickam DH, Hall C, Bhat G, Neu D,
Stewart L, Jalowsky M. Patient engagement in research: early findings from the Patient-Centered
Outcomes Research Institute. Health Affairs. 2019 Mar 1;38(3):359-67.
42. Schutz A. The problem of personality in the social world. InCollected papers VI. Literary reality and
relationships 2013 (pp. 199-240). Springer, Dordrecht.
43. Uddin J, Sarma H, Bari TI, Koehlmoos TP. Introduction of new vaccines: decision-making process in
Bangladesh. Journal of health, population, and nutrition. 2013 Jun;31(2):211.
44. Weston C, Gandell T, Beauchamp J, McAlpine L, Wiseman C, Beauchamp C. Analyzing interview data:
The development and evolution of a coding system. Qualitative sociology. 2001 Sep 1;24(3):381-
400.
45. McElfish PA, Post J, Rowland B. A social ecological and community-engaged perspective for addressing health disparities among Marshallese in Arkansas. International Journal of Nursing & Clinical Practices. 2016 Jul 30;2016.

46. Aberbach JD, Rockman BA. Conducting and coding elite interviews. PS: Political Science and Politics. 2002 Dec 1;35(4):673-6.

47. Harvey WS. Strategies for conducting elite interviews. Qualitative research. 2011 Aug;11(4):431-41.

48. Lancaster K. Confidentiality, anonymity and power relations in elite interviewing: conducting qualitative policy research in a politicised domain. International Journal of Social Research Methodology. 2017 Jan 2;20(1):93-103.

49. Ibid 46.

50. Kumar S, Quinn SC, Kim KH, Musa D, Hilyard KM, Freimuth VS. The social ecological model as a framework for determinants of 2009 H1N1 influenza vaccine uptake in the United States. Health Education & Behavior. 2012 Apr;39(2):229-43.

51. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qualitative health research. 2005 Nov;15(9):1277-88.

52. Elo S, Kyngäs H. The qualitative content analysis process. Journal of advanced nursing. 2008 Apr;62(1):107-15.

53. Ibid 45

54. Ibid 51

55. Ibid 46

56. Ibid 47

57. Ibid 48.

58. Hochschild JL. Conducting intensive interviews and elite interviews. In Workshop on interdisciplinary standards for systematic qualitative research 2009. National Science Foundation.

59. Holland B. Factors and strategies that influence faculty involvement in public service. Building the Field of Higher Education Engagement: Foundational Ideas and Future Directions. 2019 Jan 25.

60. Arnstein SR. A ladder of citizen participation. The city reader. 2015 Jul 16;279.

61. MacQueen KM, Bhan A, Frohlich J, Holzer J, Sugarman J, Ethics Working Group of the HIV Prevention Trials Network. Evaluating community engagement in global health research: the need for metrics. BMC Medical Ethics. 2015 Dec 1;16(1):44.

62. O'Mara-Eves A, Brunton G, McDaid G, Oliver S, Kavanagh J, Jamal F, Matosevic T, Harden A, Thomas J. Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. Public Health Research. 2013;1(4).

63. Kuhlmann E, Burau V. Strengthening stakeholder involvement in health workforce governance: why we need to talk about power. Journal of health services research & policy. 2018 Jan;23(1):66-8.

64. Ramsbottom A, O'Brien E, Ciotti L, Takacs J. Enablers and barriers to community engagement in public health emergency preparedness: a literature review. Journal of community health. 2018 Apr
65. Martin GP, Carter P, Dent M. Major health service transformation and the public voice: conflict, challenge or complicity?. Journal of health services research & policy. 2018 Jan;23(1):28-35.

66. Folayan MO, Oyedeji KS, Fatusi OA. Community members’ engagement with and involvement in genomic research: Lessons to learn from the field. Developing World Bioethics. 2015 Apr;15(1):1-7.

67. Howard-Grabman L, Miltenburg AS, Marston C, Portela A. Factors affecting effective community participation in maternal and newborn health programme planning, implementation and quality of care interventions. BMC pregnancy and childbirth. 2017 Dec 1;17(1):268.

68. Gopichandran V. Public trust in vaccination: an analytical framework. Indian journal of medical ethics. 2017 Apr 1;2(2):98-104.

69. Gibson A, Britten N, Lynch J. Theoretical directions for an emancipatory concept of patient and public involvement. Health: 2012 Sep;16(5):531-47.

70. Head BW. Community engagement: participation on whose terms?. Australian Journal of Political Science. 2007 Sep 1;42(3):441-54.

71. Ibid 68.

72. Ibid 35

73. Ibid 68.

74. Ibid 70

75. Webber DJ. Explaining policymakers’ use of policy information: The relative importance of the two-community theory versus decision-maker orientation. Knowledge. 1986 Mar;7(3):249-90.

76. Ibid 66

77. Ibid 75.

78. Newman PA, Rubincam C. Advancing community stakeholder engagement in biomedical HIV prevention trials: principles, practices and evidence. Expert review of vaccines. 2014 Dec 1;13(12):1553-62.

79. Dutta T, Meyerson B, Agley J. African cervical cancer prevention and control plans: A scoping review. Journal of cancer policy. 2018 Jun 1;16:73-81.

80. Keoprasith B, Kizuki M, Watanabe M, Takano T. The impact of community-based, workshop activities in multiple local dialects on the vaccination coverage, sanitary living and the health status of multiethnic populations in Lao PDR. Health promotion international. 2013 Sep 1;28(3):453-65.

81. Firstpost, Nair N, Dec 2017 Won't take Modi-RSS vaccine': Myths, quacks derail Malappuram vaccination drive putting lakhs of children at risk. Accessed on March 20, 2018. https://www.firstpost.com/india/wont-take-modi-rss-vaccine-myths-quacks-derail-malappuram-vaccination-drive-putting-lakhs-of-children-at-risk-4236543.html

82. Cheatham A, February 26, 2018, Duke Global Reproductive Health, Despite Government Policy, Cervical Cancer Progress Stalls in India. Accessed on March 20, 2018.
http://dukecenterforglobalreproductivehealth.org/2018/02/26/despite-government-policy-cervical-cancer-progress-stalls-in-india/.

83. Ibid. 47

84. Frew PM, Archibald M, Martinez N, del Rio C, Mulligan MJ. Promoting HIV vaccine research in African American communities: does the theory of reasoned action explain potential outcomes of involvement? Challenge (Atlanta, Ga.). 2007;13(2):61.

85. Albarracin D, Wyer Jr RS. The cognitive impact of past behavior: influences on beliefs, attitudes, and future behavioral decisions. Journal of personality and social psychology. 2000 Jul;79(1):5

Tables

Table 1: Profile of vaccine decision-makers in India who participated in this study, 2018
| Academic background (Basic science and research = Basic Science; Public Health/Community Medicine, Humanities/Management = Humanities/Public Health) | Category of organization of employment (Govt. of India = GOI, Technical body of the GOI = Technical body, UN organization, Donor organization = Donor, National level NPOs with policy influencing and vaccine roll out role = NPOs (Policy influencing), International /National Level NPOs with vaccine research and roll out role = NPOs (Research, roll-out, advocacy) | Governance levels | Organizational role for community engagement (Establish regulations = Regulatory, Carry out surveillance/research = Surveillance/research, Provide funding = Financial support, Develop policy guidelines/technical support = Technical support, Develop communication strategies and materials = Communication strategies, Implement nationally sanctioned policies and programs = Policy and program implementation) | Leadership's level of decision making (Asia-Pacific region, National level, State level) |
|---|---|---|---|---|
| Basic Science | GOI | Ministry | Regulatory | National level |
| Basic Science | GOI | Ministry | Regulatory | National level |
| Basic Science | GOI | State nodal organization | Policy and program implementation | State level |
| Humanities& Public Health | GOI | State nodal organization | Policy and program implementation | National level |
| Basic Science | GOI | State nodal organization | Policy and program implementation | National level (Retired) |
| Category                  | Type                                      | Recipient                                      | Region          |
|---------------------------|-------------------------------------------|------------------------------------------------|-----------------|
| Basic Science             | Technical body, GOI                       | Technical consortium                           | National level  |
| Basic Science             | Technical body, GOI                       | Ministry                                       | National level  |
| Basic Science             | GOI                                       | Ministry                                       | National level  |
| Basic Science             | GOI                                       | Ministry                                       | National level  |

| Category                  | Type                                      | Recipient                                      | Region          |
|---------------------------|-------------------------------------------|------------------------------------------------|-----------------|
| Basic Science             | UN organization                           | Country office in India                        | Asia-Pacific region |
| Basic Science             | UN organization                           | Country office in India                        | Asia-Pacific region |
| Basic Science             | UN organization                           | Country office in India                        | Asia-Pacific region |

| Category                  | Type                                      | Recipient                                      | Region          |
|---------------------------|-------------------------------------------|------------------------------------------------|-----------------|
| Basic Science             | Donor                                     | Country office in India                        | National level  |
| Basic Science             | Donor                                     | Country office in India                        | National level  |
| Basic Science             | Donor                                     | Country office in India                        | National level  |

| Category                  | Type                                      | Recipient                                      | Region          |
|---------------------------|-------------------------------------------|------------------------------------------------|-----------------|
| Basic Science             | NPOs (Policy influencing)                 | Principal recipient projects                   | National level  |
| Basic Science             | NPOs (Policy influencing)                 | Principal recipient projects                   | National level  |
| Basic Science             | NPOs (Policy influencing)                 | Principal recipient projects                   | State level     |
| Humanities/ Public Health | NPOs (Policy influencing)                 | Principal recipient projects                   | National level  |

| Category                  | Type                                      | Recipient                                      | Region          |
|---------------------------|-------------------------------------------|------------------------------------------------|-----------------|
| Humanities/ Public Health | NPOs (Research, roll-out, advocacy)       | NPOs with India office only                    | Asia-Pacific region |
| Basic Science             | NPOs (Research, roll-out, advocacy)       | NPOs with India office only                    | Asia-Pacific region |
| Basic Science             | NPOs (Research, roll-out, advocacy)       | Country                                        | Asia-Pacific    |
| Category                  | Type of NPOs (Research, roll-out, advocacy) | Location in India | Activities                      | Level          |
|---------------------------|--------------------------------------------|-------------------|----------------------------------|----------------|
| Basic Science             | NPOs (Research, roll-out, advocacy)        | Country office in India | Surveillance/research & Technical support | National level |
| Humanities/Public Health   | NPOs (Research, roll-out, advocacy)        | Country office in India | Policy and program implementation | National level |
| Science                   | NPOs (Research, roll-out, advocacy)        | Country office in India | Policy and program implementation | National level |

Table 2: Broad categorization of ownership and fostering of CE by vaccine decision-makers in India, 2018
| Categorization of ownership and fostering of CE by vaccine decision-makers | Exemplars |
|---|---|
| 1. CE as a community empowering role | “Some journalist misinterpreted and had adverse reports. Honestly, we didn’t get that much support from authorities in my headquarters but my CAB met within few days and went ahead and said that we are willing to give out rejoinder to this news report because we know you have been very very meticulous about protecting the individuals, have been transparent and sensitive to community.” |
| 2. CE as vaccine delivery with the help of frontline workers | “I always appreciate my workers. The hard work that our ANMs and field staff are putting in is tremendous. So if we have coverage of 90%, it is not my contribution, it is all because of my field workers who are doing a great job” |
| 3. CE as a part of the organizational structure | “There was the country and the regional programs where there was advocacy efforts to engage the community. There was a representative in the senior management team from the CRP. Representatives of the Board of Directors, who in one capacity or the other were the advocates of the community.” |
| 4. CE as a proactive social and altruistic responsibility | “I remember there were two places in Tripura where the vaccines was transported through helicopter. First time Government of India gave that fund. Although the beneficiary children were only 15 I argued that if 100% children are to be immunized you have to somehow send the vaccines to this remote place. Else, it will take 7-8 days to reach there.” |
| 5. CE to comply to GOI and/or global mandates | “Since we did not have any great experience in vaccine trial and community engagement it (CE) was introduced to us through our sponsors and collaborators like National Institute of Health” |
| 6. CE as a duty delegated to the States and lower offices | “No no, we do not do that part. Government of India does not run the programs at the peripheral levels.” |
| 7. CE as vaccine imposition/delivery | “When children were dying and JE vaccine was introduced, people were fighting to get the vaccine. There was a firing in three places. People got a notion that if the vaccine stocks were finished we will go and their child will not get vaccinated, and so the rush and the panic ‘me first’ ‘me first.’” |

### Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Supplement2CodesCE.docx
- Supplement1InterviewScheduleCE.docx