



FIRST EDITION

Best practice guidance //

How to respond to vocal vaccine deniers in public



Abstract

This guidance document provides basic broad principles for a spokesperson of any health authority on how to respond to vocal vaccine deniers. The suggestions are based on psychological research on persuasion, on research in public health, communication studies and on WHO risk communication guidelines.

Keywords

COMMUNICATION
DENIAL
IMMUNIZATION
INTERVIEW
PUBLIC HEALTH

Address

requests about publications of the WHO Regional Office for Europe to:

Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (<http://www.euro.who.int/pubrequest>).

Photo credits: Front and back cover: Adobe Stock photos; p.5 WHO; p.7: WHO, p. 9: WHO; p.11 (top): WHO; p. 11 (bottom): Bigstock photos; p.13 WHO/J.Christensen; p.15 WHO/M.Bring ; p. 17: WHO; p. 21: WHO; p. 25: WHO ; p. 27: WHO/Table 4; p.30: M.Mulders; p. 32 (top): WHO ; p. 32 (bottom): Bigstock photos; p.34: WHO; p.35: WHO.

© World Health Organization 2016

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

Contents

Acknowledgements.....	4
Abbreviations.....	4
Chapter 1: Introduction.....	5
1.1. What situation does this document address?.....	7
1.2. The term vaccine denier.....	9
1.3. Who are vocal vaccine deniers?.....	11
Chapter 2: The target audience.....	13
Chapter 3: The speaker.....	15
3.1. Who should be the spokesperson?.....	17
3.1.1. Being a good speaker.....	17
3.1.2. Being a good listener.....	19
3.2. Do's and don'ts of verbal communication.....	21
3.3. Do's and don'ts of nonverbal communication.....	25
Chapter 4: The argument.....	27
4.1. Response to vocal vaccine denier.....	30
Chapter 5: How to behave in a passionate discussion.....	32
Chapter 6: How to protect yourself.....	34
Chapter 7: What now?.....	35
References.....	36
Annex 1: Should you participate?.....	42
Annex 2: HURIER model of listening instruction.....	43

Acknowledgements

This document was commissioned by the WHO Regional Office for Europe (Regional Office), coordinated by Robb Butler and Katrine Habersaat (respectively Programme Manager and Technical Officer of the Vaccine-preventable Diseases and Immunization programme of the Regional Office (VPI)), and produced by Philipp Schmid (M.Sc. University of Erfurt, Germany) and Noni E. MacDonald (Professor, Dalhousie University, Canada).

The authors would like to give special thanks to Dr. Cornelia Betsch (University of Erfurt), Professor Adam Finn (University of Bristol), Catharina de Kat (VPI) and Professor Robert Böhm (RWTH Aachen University) for their very helpful feedback during the development phase. The authors would also like to thank the participants of the 2015 European Regional Meeting of National Immunization Programme Managers (1–3 September 2015, Antwerp, Belgium), the participants of the 2016 technical consultation on addressing vaccination opposition (31 May - 1 June, Belgrade, Serbia) and the members of the European Technical Advisory Group of Experts on Immunization (ETAGE) for their feedback. Furthermore, the authors acknowledge the support from other team members of VPI.

Abbreviations

AEFI		Adverse event following immunization
CERC		Crisis and emergency risk communication
HURIER		Hearing, understanding, remembering, interpreting, evaluating and responding

Introduction



This guidance document provides basic, broad principles for a spokesperson of any health authority on how to behave when confronted by and how to respond to vocal vaccine deniers. Vocal vaccine deniers do not accept recommended vaccines and are not open to a change of mind no matter what the scientific evidence says (see chapter 1.2. for further information). The suggestions on how to respond to vocal vaccine deniers are based on psychological research on persuasion, on research in public health, communication studies and on WHO risk communication guidelines. The guidance is primarily intended for spokespersons of health authorities who want to prepare themselves for a public event with a vocal vaccine denier.

Scientific evidence indicates that no one is born a good *speaker* [1]. Training is needed to achieve this. Not everyone who is asked to speak on behalf of a health authority is a trained spokesperson. Addressing vocal vaccine deniers in the media can be fraught with danger and angst. While the recommended rules of thumb outlined in this document cannot substitute for professional education in rhetoric and interview skills, they provide a practical, easy-to-use approach to improve your ability to respond to issues raised by vocal vaccine deniers. Psychological research has provided very useful insights on how to frame written messages in response to common misperceptions of any kind [2]. The document applies these insights to the specific situation of facing a vocal vaccine denier in a public event and focuses on designing messages to respond to vocal vaccine deniers. Additionally, if the media are visual as well as auditory, the audience will judge your credibility, trustworthiness and competence based also on non-verbal aspects like appearance, expression of emotions, eye contact, response time, etc. [3]. This document offers strategies that address the three main elements of the process of successful communication [4][5] namely *the audience*, *the speaker* and *the argument* in order to maximize the positive impression left by you in a public discussion on vaccine

denial. The strategies presented in the following chapters convey two main rules that serve as guiding principles to rethink the way you debate and achieve the primary goal of a public discussion with a vocal vaccine denier, which is to make the public resilient against anti-vaccine rhetoric:

RULE 1

The general public is your target audience, not the vocal vaccine denier.

RULE 2

Aim to correct the content AND unmask the techniques that the vocal vaccine denier is using.

GOAL

Make the public audience more resilient against anti-vaccine statements and stories; support the vaccine hesitant in their vaccine acceptance decision.

What situation does this document address?



The recommendations and diagnostic processes provided here are broad principles to be used by you effectively to counter the flawed arguments of vocal vaccine deniers in a *public discussion* (Fig. 1: Situation 1). This refers to a situation in which a vocal vaccine denier is expressing arguments of science denialism, and your response can impact how the audience judges you, the topic, your organization and potentially health authorities as a whole. In other words, this is a public, not a private situation. This includes dialogues that are taped or recorded such that the discussion could be made accessible to a broader audience. In contrast, these strategies have little relevance to dialogue between you, a health authority or healthcare professional and a denier that takes place in private (Fig. 1: Situation 2), such as a discussion with religious leaders, concerned parents or any other face to face communication without public audience. There is much psychological research and evidence centred on optimizing interpersonal health communication between a provider and a patient [6] [7], but that is not the focus of this document. Public and private dialogue can be very different in terms of what to respond to, how to behave and whom to address. Face to face private dialogue involves the specific relationship between the conversants, whereas **in a public discussion you must focus primarily on engaging the audience effectively**. The recommendations outlined here relate to the latter situation (Fig. 1: Situation 1) providing basic principles on how to behave and respond to the vocal vaccine denier.

If you are invited for a public discussion you must first decide whether or not to accept the invitation. Before making this decision the decision aid outlined in Annex 1 should be considered.

Situation 1: Public Discussion

Situation 2: Face to face in private

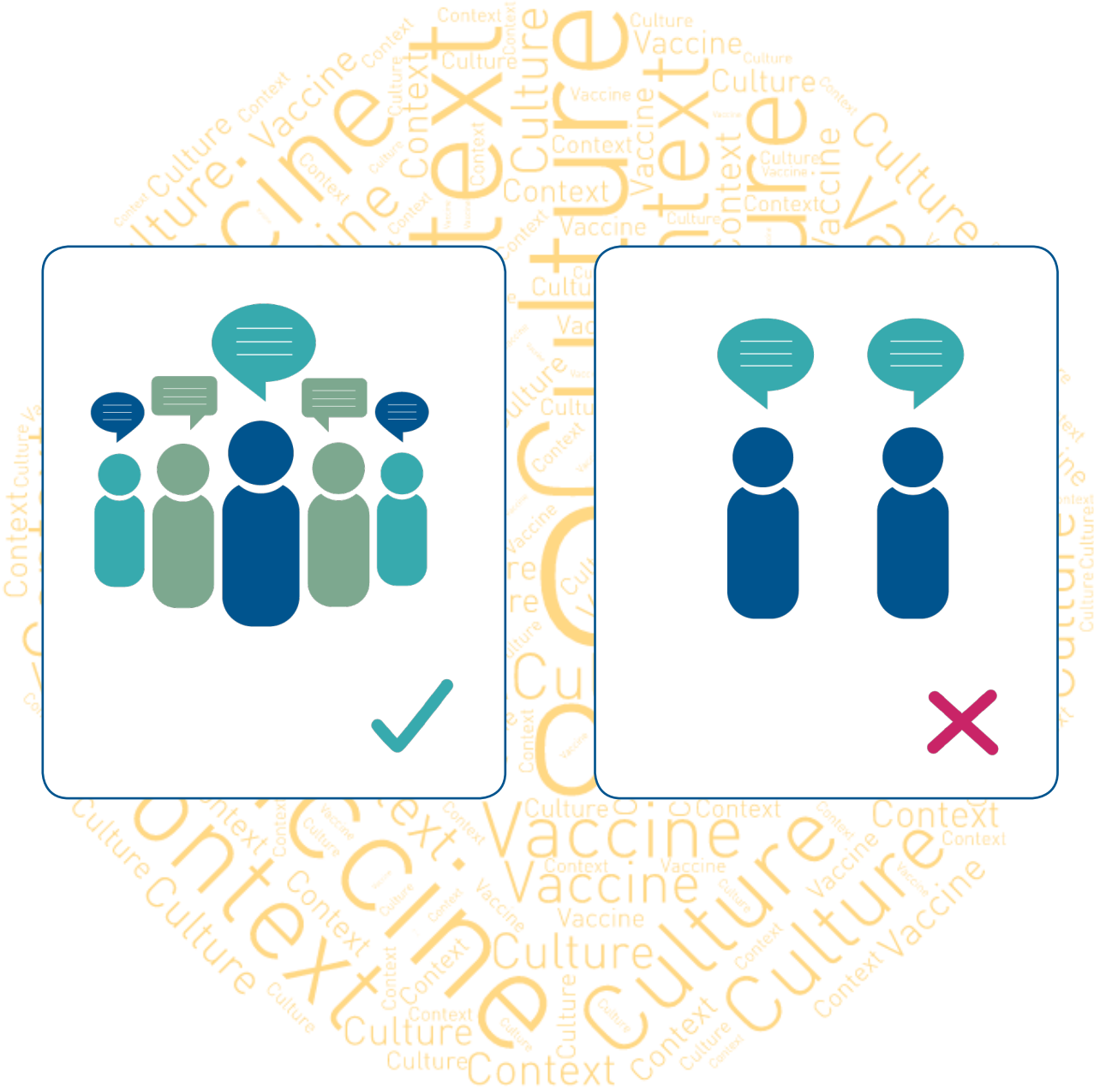
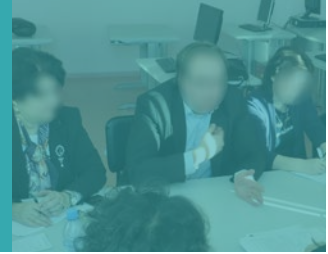


Figure 1: Two distinct communication situations confronting a vaccine denier, either with or without a public audience either listening to the discussion or listening and watching. These recommendations are applicable to a public discussion. Situations may vary with the context and content of the discussion and the specific vaccine that is addressed by the vocal vaccine denier.

The term vaccine denier



Individuals who refuse on principle to accept a recommended vaccination are commonly referred to as *vaccine refusers*, *vaccine sceptics* or members of an *anti-vaccine movement*. Research on the definition and scope of vaccine hesitancy identified the term *vaccine refuser* as a group on the more extreme side of a hesitancy continuum [10]. Vaccine refusers are those who refuse all vaccinations without doubting the wisdom of this decision [10]. However, this convinced refusal still permits the refuser to consider other opinions or arguments. A vaccine sceptic is defined as a person who “takes a scientific approach to the evaluation of claims” and is “willing to follow the facts wherever they lead” [8].

In contrast, the term *vaccine denier* refers to a member of a subgroup at the extreme end of the hesitancy continuum; one who has a very negative attitude towards vaccination and is *not* open to a change of mind no matter what the scientific evidence says (Fig. 2). A vaccine denier ignores any quantity of evidence provided and criticises the scientific approach as a whole. In fact, vaccine deniers may even counter-react to persuasive arguments [11]. The vaccine denier has characteristics that are similar to religious and political fanatics [12] in that he or she adheres to a belief that is impossible to challenge [13], whereas challenge is the fundamental tenet of scientific progress [14].

The term *movement* as a description for vaccine deniers is also very misleading. A movement implies the image of a powerful, coordinated group, united by a shared collective identity [9]. However, in most European countries vaccine refusers represent a small proportion of individuals with diverse reasons for not accepting vaccines [10]. Of this minority, only a few actively engage in behaviour that seeks to undermine public health activities, and can be considered vaccine deniers. These few deniers certainly do not represent a movement.

For the purpose of this document, the term vaccine denier is used to mean someone who does not accept the process of vaccination while denying scientific evidence and employing rhetorical arguments to give the false appearance of legitimate debate [15]. This document gives recommendations about how to respond to vaccine deniers in a public discussion rather than refusers or sceptics who could potentially be persuaded by scientific evidence and arguments presented in a clear and comprehensible manner.

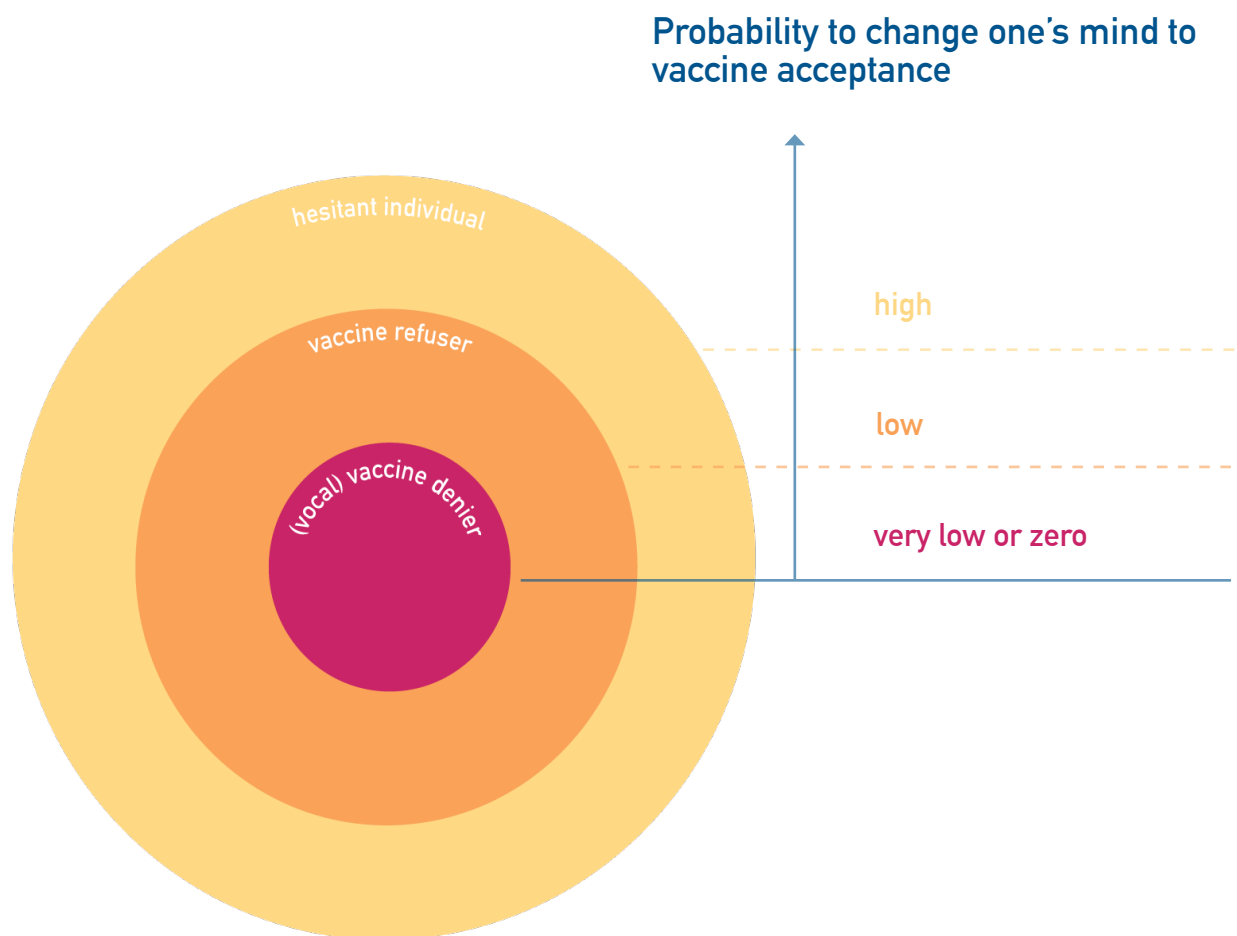
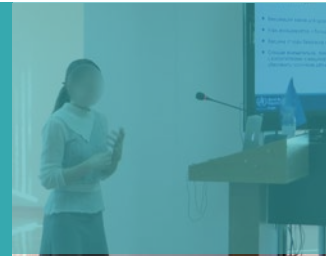


Figure 2: Vaccine hesitancy categorised by the likelihood of a change of mind regarding vaccine acceptance.

Who are vocal vaccine deniers?



When facing a public discussion with a vaccine denier he or she is most likely a vocal vaccine denier. Vocal vaccine deniers do not only ignore any quantity of evidence provided but have an obsessive eagerness to share their denial beliefs. These denial beliefs about vaccinations are as old as the introduction of the first vaccine [16]. While the number of available vaccines has increased and some have improved in effectiveness and reactogenicity, the arguments against vaccination have changed very little [17]. Kata [18] examined the actions that vocal vaccine deniers use to spread their messages (Table 1). These actions result from the belief in arguments that have the ultimate goal of rejecting the scientific approach by neglecting and suppressing the scientific evidence. Research about science denialism provides further insights into the arguments that are used by vocal vaccine deniers to skew the scientific evidence and to justify their actions [15][19]. Designing messages to respond to these arguments is one of the main objectives of this document (see chapter 4 for further information).



Table 1: Actions undertaken to spread messages of vaccine denialism. Adapted from Kata [18].

1.	<p>Skewing the science</p> <p>Vocal vaccine deniers ignore and reject scientific evidence that counters their arguments. They only consider results that seem to confirm their belief. These results either do not represent the scientific consensus, are poorly conducted or misinterpreted by the denier.</p>
2.	<p>Shifting hypothesis</p> <p>Vocal vaccine deniers change the topic that they are addressing when they fear to lose an argument. They are willing to claim any hypotheses that seems to support their core statement i.e. vaccines cause harm.</p>
3.	<p>Censorship</p> <p>Vocal vaccine deniers shut down critics and avoid open discussions. They ban comments or authors from communication platforms (social media, blogs etc.) and censor opposing opinions.</p>
4.	<p>Attacking the opposition</p> <p>Vocal vaccine deniers use personal insults and even legal actions to silence representatives of the scientific consensus.</p>

Individuals who refuse vaccines are a very heterogeneous group [20] [21] and cannot accurately be described in simple terms, such as an anti-vaccine movement. They have very diverse, often very personal reasons for not vaccinating and variable degrees of conviction regarding this mindset. The group of vocal vaccine deniers includes conspiracy-theorists some of whom are very highly educated individuals [16] who are well aware of the available scientific literature [16][22]. These individuals have either integrated the available knowledge about vaccination into their perspective on the issue, no matter how inconsistent [23], or have integrated only selected evidence that seems to confirm their beliefs (confirmation bias) [24]. The diversity of motivations leading to vaccine denial is wide and in most cases cannot be altered by scientific evidence. Thus, you might wonder why you as a spokesperson should address the vocal vaccine denier if he or she is not even willing to consider the evidence concerning vaccines which you will present. This leads us to the question “who is the target audience?”

The target audience

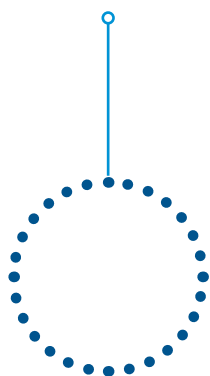


A true discussion always acknowledges different points of view and tests the strengths and weaknesses of different arguments. Effective scientific discourse requires that everyone contributing to the discussion is willing to evaluate all the evidence available, to accept conversational norms [19] and to set the increase of knowledge as the primary common objective of the discussion. Vocal vaccine deniers will not adhere to these basic premises of an evidence-based discussion. Trying to persuade a vocal vaccine denier to change their view in a public discussion will most likely fail. The goal of the public discussion with the denier is *not* to change the mind of the vocal vaccine denier. A public discussion is not really a conversation between the participating parties even if set up so that it appears to be. As a health expert or spokesperson, your audience is the public. The discussion is a good opportunity to inform undecided audience members, called *fence-sitters* [25], convince sceptics [26] and strengthen the knowledge and arguments of all against anti-vaccine rhetoric. This may also strengthen resiliency amongst those who are pro-vaccine who hear the discussion [11]. The key messages are meant to debunk misconceptions about vaccination, equip the general public with knowledge that counters the arguments of a denier and sustain trust in health authorities and the immunization programme.

RULE 1

The general public is your target audience, not the vocal vaccine denier.

Even though the arguments of vocal vaccine deniers have not significantly changed over time, media and communication channels in current use multiply the reach of this misinformation [18]. Anyone can be an “expert” who has contributed to the World Wide Web [18]. Media of all kinds have a strong influence on public opinion [27] and access to the public has increased tremendously over the past few years [28]. Effective media relations allow every health authority to raise awareness about health issues, inform the public and gain publicity using existing channels [29]. It is important to cultivate a positive relationship with your public media counterparts, including organizing meetings on a regular basis. From a public trust standpoint, it is far better to err on the side of too much communication than too little.

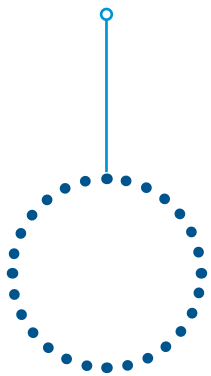


Public media are an opportunity not a threat.

The speaker

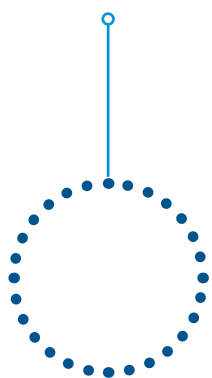


Facing a discussion with a vocal vaccine denier, you (as the spokesperson) should always remember that the most substantial arguments are on your side. Having a vast body of evidence agreed by the majority of scientists to back up your position makes you well-prepared from a scientific perspective. The scientific consensus that you are representing can serve as an initial “gateway” [30] through which to influence your audience’s key beliefs and increase their support for public policy in support of immunization [30]. Emphasizing the existing scientific agreement on vaccine safety and efficiency can strongly influence people’s attitudes towards vaccinations. You should emphasize how overwhelmingly the evidence supports vaccine safety and efficacy – not just one or two studies – and that the vast majority of scientists and clinicians in the field agree with this.



Remember, you are representing the scientific consensus.

Recent scientific research on communication shows that the evidence an argument is based upon is more important than impressions of source credibility [5] in persuading the public. The quality of the evidence you provide not only influences the audience's attitudes towards a health treatment but also increases your credibility [5]. Additionally, presenting messages that contain scientific evidence influences people's attitudes more persistently and makes people more resistant to other arguments than affective associations or simple allegations [31] used by deniers. This implies that in order to be perceived as a credible spokesperson and to influence the audience's attitudes toward vaccinations optimally you need to focus on the evidence.



The key messages need to be well grounded.

It's not just what you say but also how you say it. To maximize your effectiveness as a spokesperson you need to provide the facts; but you need to do this using effective communication skills so the public will be informed and misinformation corrected [32]. Choose the spokesperson carefully (see below) and ensure that he or she understands and is able to use the verbal and nonverbal evidence-based do's and don'ts provided in this document (see 3.2. and 3.3.) effectively.

Who should be the spokesperson?



Awareness of the scientific facts about vaccinations does not necessarily make you a good presenter of the evidence, let alone a good discussant. The way you speak and present evidence and the way you listen to the participating parties of the discussion are key deciding factors for a successful media performance. In conjunction with the verbal and nonverbal do's and don'ts (see 3.2. and 3.3.), these skills are much needed for an optimal response to a vocal vaccine denier in a public discussion. Remember: Even a very good speaker should consider Annex 1 "Should you participate?" before attending a public discussion.

3.1.1.

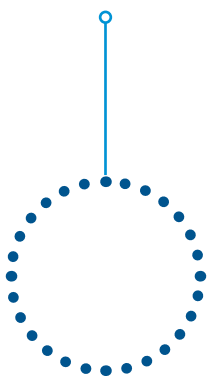
Being a good speaker

When you think of a good spokesperson, these are often described as charismatic, meaning they have a "personal magnetism or charm" [33]; and they are able to inspire audiences [34]. In psychological research, charisma does not describe an inherent uniqueness, but is the result of concrete verbal and nonverbal practices, which lead to more influence, perceived trustworthiness and perceived competence [34]. Antonakis, Fenley and Liechti [34] identified 12 oratory techniques that lead to greater perceived trustworthiness and competence of the speaker (Table 2).

Table 2: Oratory techniques of charismatic leaders. Taken from Antonakis et al. [34].

VERBAL	1.	Metaphors, similes and analogies
	2.	Stories and anecdotes
	3.	Contrasts
	4.	Rhetorical questions
	5.	Three-part lists
	6.	Expressions of moral conviction
	7.	Reflections of the group's sentiments
	8.	Setting of high goals
	9.	Conveying confidence that others can achieve goals
NONVERBAL	10.	Animated voice
	11.	Facial expressions
	12.	Gestures

All these techniques can be acquired through media training and provide a foundation for becoming a charismatic spokesperson. You might be overwhelmed by the amount of techniques that is presented above. To be able to acquire or even master those techniques media training, scenario-based workshops and practical experience are inevitable (see chapter 7 for further information). The key message for now is:

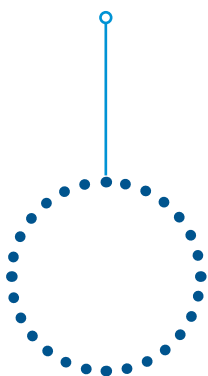


Being a good speaker can be learned.

3.1.2.

Being a good listener

In communication studies the importance of listening in any communication process is unquestioned [35][36][37]. To design effective messages you need to listen to the denier. Even though the audience of your message is the general public, it would be a mistake to ignore your discussion partner totally. A discussion is not a platform for a monologue and the public will judge you by the attention, motivation and participation that you as a spokesperson demonstrate in the discussion [38]. The way you listen will be crucial for the public's judgement about your participation. Listening is an active process that includes all your senses and is not limited to hearing [39]. It is a basic communication skill that can be learned and improved [41]. Based on questionnaire research, Brownell [38] identified six interrelated components (Table 3) of listening that can be addressed and trained. The resulting HURIER model [41] (see also Annex 2) provides you with a theoretical visual depiction of components needed to optimize your competency.



Being a good listener can be learned.

Table 3: Interrelated components of listening. Taken from Brownell [41].

1.	Hearing	Concentrating on and attending to the message
2.	Understanding	Comprehending the literal meaning of the message
3.	Remembering	Recalling the messages so that it can be acted upon
4.	Interpreting	Sensitivity to nonverbal and contextual aspects of the message
5.	Evaluating	Logical assessment of the value of the message
6.	Responding	Selecting an appropriate response to what is heard

None of these listening and speaking techniques are easily acquired and even if they are mastered in a training environment, a spokesperson can still be overwhelmed by the stress triggered in a public discussion. The stress in a live-discussion is multiplied by the fact that there will be no opportunity to correct errors once they are made. In the face of well-trained journalists and rhetorically eloquent deniers, more than vaccine knowledge and simple communication training are needed. Coping with stress, managing errors and avoiding rhetorical traps while staying focused and maintaining a confident appearance are skills that can only be acquired through media training and experience.

Don't participate in a public discussion if you are not media trained.

Do's and Don'ts of verbal communication



1. Prepare three key messages

A person's working memory is responsible for storing visual and vocal information and is strongly restricted in capacity [42]. The audience will not be able to recall or even transfer the provided knowledge when confronted with too much information.

Prepare three key messages you really want the public to know and remember.

2. Keep your key messages simple

Do not use scientific jargon or acronyms if you can avoid them. According to research on reasoning, scientific jargon does not increase the speaker's perceived credibility [43] but it jeopardizes that a non-scientific community will understand you [44]. This applies to the use of acronyms, too, such as AEFI for adverse event following immunization. Additionally, research on cognitive psychology shows that unfamiliar words are less likely to be remembered or memorized [45] and should therefore be avoided. If you can, condense your main message into a simple, easily understood "sound bite" – that is, a less than 30 second message that captures your point in a riveting fashion.

Keep your three key messages as simple as possible.

3. Repeat your key message

If you repeat information your audience will be more likely to remember it [46]. It also allows you to focus on the key message in a heated discussion. However, if used excessively, repeating your messages can also be perceived as ignorant. Find a balance between listening and responding to the topic at hand and coming back to key messages.

Repeat your key messages as often as reasonably possible.

4. Don't repeat the anti-vaccine arguments

Repeating an anti-vaccine argument is a “no go”. If you repeat the anti-vaccination information it can inadvertently reinforce the misinformation one seeks to correct [2], because it gets repeated over and over again and will then be easier to remember [47]. Furthermore, if the discussion is filmed, you may see your verbalization of the misinformation lifted out of context and included in an anti-vaccine video.

Stick to your facts and repeat your key messages instead of repeating any anti-vaccine argument.

5. Emphasize high safety instead of low risk (framing)

A medal always has two sides. A burger with 25% fat is 75% fat-free. People would rather buy a burger labelled 75% fat-free than labelled 25% fat, even though the fat content is identical. Research shows that different framing of the same fact can lead to different risk-perceptions and behaviour [48], [49]. Emphasizing the positive rather than the negative aspects of vaccination should increase preference [50] and support [51] for it. This does not mean that you should avoid discussing the risks of vaccines but if you want to get one key message across then this message should highlight the high safety of vaccines instead of the low risk.

Emphasize the high level of safety of vaccines rather than the low probability of AEFIs.

6. Use inclusive terms

Psychological research shows that similarity to an audience is a strong indicator for perceived credibility of a speaker [52]. You as a spokesperson cannot influence the similarity of demographic aspects between the audience and yourself, but you can underline the similarity by using inclusive terms like “we as parents” or “as members of a community”.

Use inclusive terms to underline a shared identity with the audience.

7. Do not question the denier's motivation

What motivates a person to refuse vaccinations might seem interesting, as there are many possible reasons. However, motivational aspects drag the focus away from the facts, and they leave room for highly emotional, personal narratives that have been shown to increase the audience's perceived risk of adverse events [53]. Save such discussions for private personal interactions with refusers and deniers.

Avoid raising questions about the personal motivation of vocal vaccine deniers.

8. Tell the truth

Psychological research shows that even three-year-olds question the credibility of a source when they figure out they have been lied to [54]. Additionally, a vast amount of research highlights the damage to trust and credibility of authorities due to dishonesty [55], regardless of the ethical considerations. Being honest does not mean being negative. Remember to cast your messages in a positive, not negative light, for example: "We have a strong system to detect any potential adverse events and to quickly check whether there are problems with a vaccine. We detected YY, but upon investigation discovered that YY was not due to a vaccine but was due to XX."

Be honest during any discussion.

9. Communicate what has been achieved

Celebrating gains, visualizing results, and focusing on the continued common target, in this case community protection, are recommended strategies to uphold the public's motivation [56]. Furthermore, visible gains intimate what needs to be done to reach the final goal, which also addresses the responsibility of each and every individual.

Communicate what has been achieved so far and what needs to be done.

10. Avoid humour

Humour is a very complex cognitive experience that is very specific to language, culture, and context. It is easily misinterpreted or even perceived as offensive [57]. Even if understood, humour can damage credibility, and undermine the perceived competence of a speaker when used in an inappropriate context [58][59]. It may be seen as “joking” about something that is terribly serious and may even be interpreted as an insult.

Avoid humorous contributions during the discussion.

11. Underline scientific consensus

Research in the area of climate change shows that the belief in a scientific fact increases when consensus is highlighted [60][30]. However, identifying a scientific consensus requires a thorough understanding of the specific area of interest and a layperson will not gain that knowledge all by himself [61]. Therefore, highlighting the scientific consensus in public is a powerful tool to transfer essential scientific knowledge and increase belief in a scientific fact, especially when presented in a simple and short message [62][63].

Underline scientific consensus with regard to vaccine safety and efficacy.

12. Emphasize social benefit of vaccines

Vaccines have individual and social benefits [64]. If enough individuals are vaccinated, then the so-called “community protection” protects individuals who cannot get a vaccine because of their weak immune system or possible allergic reactions to the vaccine. Psychological research shows that emphasizing the social benefit of vaccines increases an individual’s intention to vaccinate [65].

Emphasize the social benefits of vaccines.

Do's and Don'ts of nonverbal communication



1. Keep eye contact

Eye contact has been found to significantly increase the audience's judgement of a speaker's credibility in a live public-speaking situation [66]. If you avoid looking at the person you are talking to, this will, from the audience's point of view, undermine your attractiveness as well as credibility [67]. However, if used excessively, eye contact can also be perceived as unpleasant [68].

Keep eye contact as much as reasonably possible.

2. Stay calm

Crisis and emergency-risk communication (CERC) principles suggest that staying calm in discussions involving risk is important for sustaining trust [69]. Anger, fear and hostility are easily perceived and can undermine the words being spoken. By staying calm, you stay in control of the situation and you are better able to concentrate on the best responses to the vocal vaccine denier's comments. Your comments should be driven by facts, not emotions.

Stay calm during the whole discussion, no matter what is said.

3. Wear suitable clothing

Psychological research has shown that individuals draw inferences about other individuals' characteristics based upon their visual appearance [70]. Therefore, a well-groomed appearance is recommended [71]. Additionally, it is very important to choose clothing, which neither distracts from the messages delivered [72] nor looks too affluent in order to support the key messages and maintain similarity to the audience.

Wear clothing that is appropriate for the specific occasion.

4. Be interviewed in sitting position

Physical size affects the perception of status [73] and authority [74]. As this could be to your disadvantage, it is recommended that the discussion be conducted in a sitting position, so that you are on the same level as your discussion partners. This ensures you will not be forced to look up to anyone (one of the most common nonverbal signifiers of social inferiority [75]) nor, if you are very tall, will you be seen as domineering and intimidating.

Make sure all participants in the discussion are seated at the same level.

The argument



The arguments of vocal vaccine deniers have not changed significantly since vaccines were first discovered [16]. Listening to these arguments and analysing their shared structure prepares you with fundamental knowledge on how to respond. During a discussion, deniers tend to intermingle different arguments and misconceptions (Table 4), which makes it difficult to respond with a clear statement. Therefore the following three steps are recommended for responding to vaccine denial in a public discussion (Fig. 3).

Step 1

Disentangle the core points and address each separately. To identify the core points, you need to be aware of the higher-level topic a vocal vaccine denier is addressing. The main topics related to vaccine denialism are categorized below, based on empirical research from the area of psychology and communication studies [18][76] and WHO's experience (see Fig. 4).

Table 4: The five characteristics of science denialism (first introduced by Hoofnagle & Hoofnagle [15] and discussed by Diethelm and McKee [19]).

1.	Conspiracies	Arguing that scientific consensus is the result of a complex and secretive conspiracy.
2.	Fake experts	Using fake experts as authorities combined with denigration of established experts.
3.	Selectivity	Referring to isolated papers that challenge scientific consensus.
4.	Impossible expectations	Expecting 100% certain results or health treatments with no possible side-effects.
5.	Misrepresentation and false logic	Jumping to conclusions, using false analogies etc.

Step 2

Identify the technique the denier is using to misinform the public (Fig. 4). With the topic and technique in mind, you can then create a key message shown as Step 3 and use it as a response supported by the verbal and nonverbal methods recommended above.

Figure 3: The three steps in responding to vaccine denialism in public.

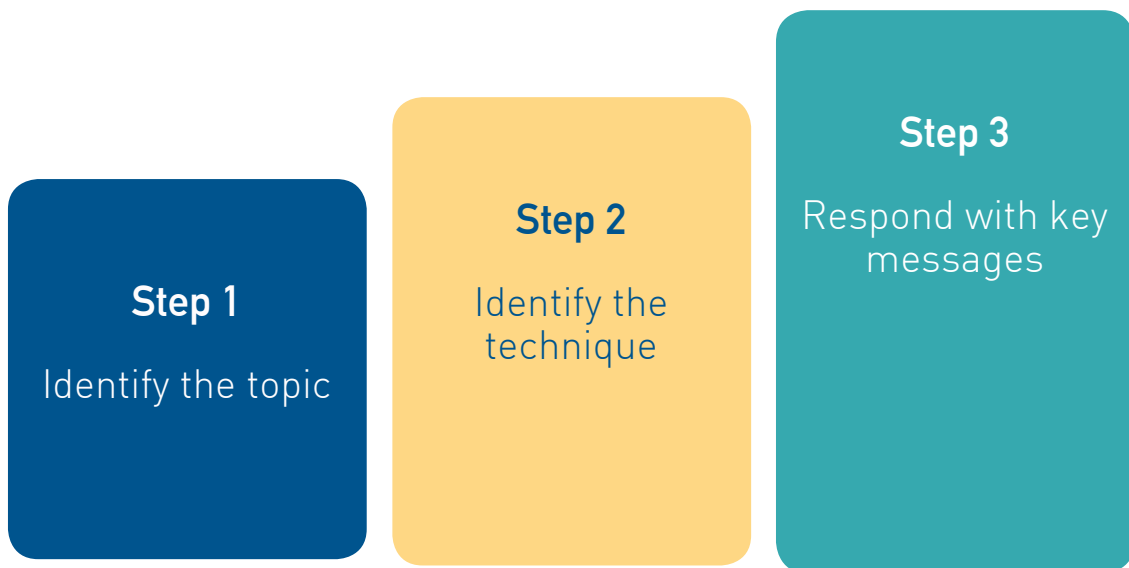
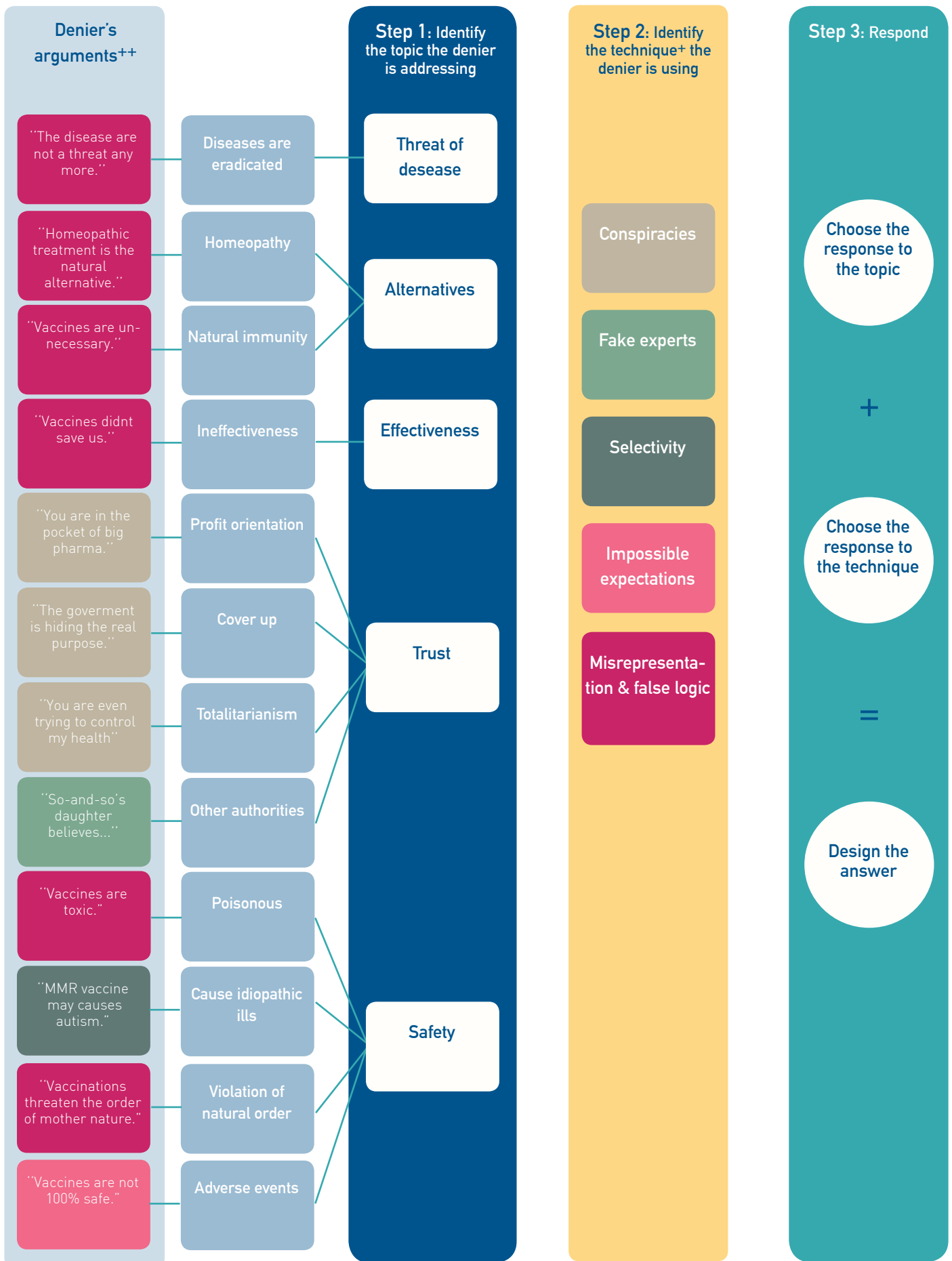


Figure 4: Algorithm of how to respond



⁺ The 5 techniques of science denial are extracted from Diethelm, P., & McKee, M. (2009). Denialism: what is it and how should scientists respond?. *The European Journal of Public Health, 19*(1), 2-4.

⁺⁺ The single example of a common anti vaccine phrase are mostly extracted from Kata, A. (2012). Anti-vaccine activists, Web 2.0, and the postmodern paradigm - An overview of tacticts and tropes used online by the anti-vaccination movement. *Vaccine, 30*(25), 3778-3789.

Response to vocal vaccine denier



Once you have identified the topic under discussion, you then choose one of the following key messages. If you were able to identify the denier's technique, this information can be added to your statement to strengthen your message and discredit the denier. This may not always be possible. In either case, do not feel insecure and stick to your key message in addressing the topic.

RULE 2

Aim to correct the content AND unmask the techniques that the vocal vaccine denier is using.

Key message: **Correct the content**

Threat of disease: "Vaccine-preventable diseases can be very severe, and still cause millions of deaths per year around the world. Even with the best available care in the world, vaccine-preventable diseases can cause permanent disability and even death. Prevention is by far the best intervention."

Alternatives: "There are no equally safe and effective alternatives to vaccinations."

Effectiveness: "The scientific evidence is clear: vaccination is the most effective health intervention for prevention of many serious diseases."

Trust: "We as an institution/agency are aiming to sustain the health of every individual member of the public. We are sorry that you have lost trust in our effort but we hope to regain it."

Safety: "The scientific evidence is clear; vaccination is a safe way to prevent

many serious diseases. Any theoretical risk to the individual and society is far outweighed by the risks to one and all of not doing so.”

Key message: **Unmask the technique**

Fake experts: “Mr X’s argument is based on ideas put forward by people who are job title by profession and who are not considered experts in the field of vaccine safety and effectiveness. Their ideas do not reflect the evidence-based consensus among scientists, nor are they representative of public opinion, as the majority of the citizens of country name are well aware of the huge benefits of vaccinations for the health of every individual.”

Selectivity: “Ms Y is cherry picking the scientific evidence, taking fragments from here and there which appear to back up her position and ignoring the bulk of solid evidence that disproves it. As long as she does not consider the scientific evidence as a whole, we will not have a fruitful discussion.”

Misrepresentation and false logic: “Mr Z is misrepresenting the facts and reaching false conclusions. I will repeat what is supported by an overwhelming body of scientific evidence...”

Impossible expectations: “In science, this argument is called an impossible expectation. No medical product or intervention, from aspirin to heart surgery, can ever be guaranteed 100% safe. Even though we will never be able to ensure 100% safety, we know that the risks of vaccine-preventable diseases by far outweigh those of the vaccines administered to prevent them.”

Conspiracies: “Ms P is saying that there is a complex and secretive conspiracy behind the promotion of vaccines. This idea totally ignores the mass of scientific evidence produced by independent scientists all over the world on the benefits of vaccines in protecting public health and well-being. It also overestimates the power and tries to discredit the motives of health authorities everywhere. In the end it boils down to a simple fact: in places where vaccines are widely used, people lead healthier lives. This has been shown time and time and time again.”

How to behave in a passionate discussion

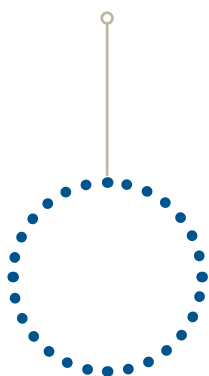


A public discussion is about convincing other people that what you are saying is right and to mitigate the negative impact that the denier/adversary has on the audience. Arguments should be appealing and compelling, they should be relevant, consistently explained, and justified. Your argument or position becomes less appealing to any audience when you fail to remain calm, rational, and reasonable. Emotional behaviour is no substitute for rational arguments. You may find that your adversary is failing to understand your position, but if you become too agitated, he or she will take this as a sign of weakness and conclude that you are beaten. Rather than helping to convince your audience, raising your voice or making insulting remarks will only serve to make your adversary more confident.

In passionate discussions you need to remain patient. Withhold judgment and speak with level tones. Passion is good, as long as both you and your adversary are discussing in a reasonable manner. Remain steady and calm and the audience will find you approachable and trustworthy. If you are a passionate person and speaker learn to control your temper and relax. Breathe deeply. Don't let stress and pressure drive your attitude and interactions. Never get personal: directing attacks to your adversary's lifestyle, integrity or honesty should be avoided.



When responding to vocal vaccine deniers and vaccination opponents, it is easy to forget that the objective is not to try and convince the vocal vaccine denier/objector to change their mind or concede defeat (very rarely will such a person admit to being wrong). Instead, the goal of the discussion is to mitigate the negative impact that the denier/adversary has on the audience. To do this you will need to remain calm, rational and reasonable while identifying the arguments of your adversary and drawing on the messages and techniques outlined in this chapter.



Remember to remain patient.

How to protect yourself?



In extremely rare circumstances your personal safety and security may be compromised by your pro-vaccination viewpoint. Security threats, and the response and considerations required to deal with them, are highly specific to context, culture, and time. Nevertheless, you should consider the following general guidelines when discussing or presenting your opinion (see Fig. 5 below).

Figure 5: Steps of how to protect yourself

Be aware that ...

- Your evidence and opinion may put your personal safety in jeopardy.
- The listeners may have a high level of anxiety, concern and outrage on the topics you are discussing.



Therefore ...

- Never deliver your arguments alone. At a minimum be accompanied by the press officer from your office, or another member of your team.
- Have an exit strategy. Know how you would leave the premises if you felt insecure or under threat.
- Never provide private information i.e. your home or work address or contact details.
- Do not ignore threatening emails or letters. Any such correspondence should be reported to local authorities.



Remember ...

- You have the right to say 'No'. Your personal safety comes first. Consider the context and time of the discussion, and weigh up whether it is safe for you to take part.
- Your mind stores thousands of pieces of information which it uses to warn you that something is wrong. *Trust your instincts* when you feel uncomfortable, get away from whatever situation you are in. You will only know if you were wrong if you ignore your instincts - is it worth the risk?

What now?



You have already made an important step in preparing yourself for a public discussion with a vocal vaccine denier by reading this document. However, scenario-based media training is essential to be able to put the outlined theory and recommendations into practice. Only by training your responses and facing honest feedback provided by colleagues and experts in the field of debating will you be able to improve your impact in a public discussion. Therefore, the Regional Office provides workshops on the issue of how to respond to vocal vaccine deniers for spokespersons of health authorities in Member States. For additional information on the general issue of how to respond to vocal vaccine deniers and on the workshops, please visit the Regional Office website.

www.euro.who.int/vaccinehesitancy

References

- [1] Ericsson, K. A., Prietula, M. J., & Cokely, E. T. (2007). The making of an expert. *Harvard business review*, 85(7/8), 114.
- [2] Cook, J., & Lewandowsky, S. (2011). *The debunking handbook*. Sevlord Art.
- [3] Burgoon, J. K., Birk, T., & Pfau, M. (1990). Nonverbal behaviors, persuasion, and credibility. *Human Communication Research*, 17(1), 140-169.
- [4] Cope, E. M. (1867). *An introduction to Aristotle's rhetoric*. Wm. Brown Reprint Library.
- [5] Hample, D., & Hample, J. M. (2014). Persuasion about Health Risks: Evidence, Credibility, Scientific Flourishes, and Risk Perceptions. *Argumentation and Advocacy*, 51(1), 17.
- [6] Duggan, A. (2006). Understanding interpersonal communication processes across health contexts: Advances in the last decade and challenges for the next decade. *Journal of health communication*, 11(1), 93-108.
- [7] Arnold, E. C., & Boggs, K. U. (2015). *Interpersonal relationships: Professional communication skills for nurses*. Elsevier Health Sciences.
- [8] Shermer, M. (2010). Living in denial: When a sceptic isn't a sceptic. *New Scientist*, 2760, 36-37.
- [9] Diani, M. (1992). The concept of social movement. *The sociological review*, 40(1), 1-25.
- [10] MacDonald, N. E. (2015). Vaccine hesitancy: Definition, scope and determinants. *Vaccine*. doi:10.1016/j.vaccine.2015.04.036
- [11] Nyhan, B., Reifler, J., Richey, S., & Freed, G. L. (2014). Effective messages in vaccine promotion: a randomized trial. *Pediatrics*, 133(4), e835-e842.
- [12] Webster's Encyclopedic Unabridged Dictionary of the English Language. (1996) New York: Gramercy Books, p. 697.
- [13] Postman, Neil (1976). *Crazy talk, stupid talk: How we defeat ourselves by the way we talk and what to do about it*. New York: Delacorte Press.
- [14] Popper, K. R. (1959). *Logic of scientific discovery*. Hutchinson, London.
- [15] Hoofnagle M, Hoofnagle C. What is denialism. Available at: <http://scienceblogs.com/denialism/about/> (Accessed on 12 May 2015).

- [16] Wolfe, R. M., & Sharp, L. K. (2002). Anti-vaccinationists past and present. *BMJ: British Medical Journal*, 325(7361), 430.
- [17] Wolfe, R. M., & Sharp, L. K. (2000). Acts of faith: religion, medicine, and the anti-vaccination movement. *Park Ridge Center Bulletin*, 9-10.
- [18] Kata, A. (2012). Anti-vaccine activists, Web 2.0, and the postmodern paradigm—An overview of tactics and tropes used online by the anti-vaccination movement. *Vaccine*, 30(25), 3778-3789.
- [19] Diethelm, P., & McKee, M. (2009). Denialism: what is it and how should scientists respond?. *The European Journal of Public Health*, 19(1), 2-4.
- [20] Poland, G. A., & Jacobson, R. M. (2001). Understanding those who do not understand: a brief review of the anti-vaccine movement. *Vaccine*, 19(17), 2440-2445.
- [21] Betsch, C., Böhm, R., & Chapman, G. B. (2015). Using behavioral insights to increase vaccination policy effectiveness. *Policy Insights from the Behavioral and Brain Sciences*, 2, 61-73.
- [22] Rogers, A., & Pilgrim, D. (1995). Paper One: Immunisation and its discontents: An examination of dissent from the UK mass childhood immunisation programme. *Health Care Analysis*, 3(2), 99-107.
- [23] Festinger, L., Riecken, H. W., & Schachter, S. (1956). *When prophecy fails*. Minneapolis: University of Minnesota Press.
- [24] Wason, P. C. (1968). Reasoning about a rule. *The Quarterly journal of experimental psychology*, 20(3), 273-281.
- [25] Leask, J. (2011). Target the fence-sitters. *Nature*, 473(7348), 443-445.
- [26] WHO (2013). *The Guide to tailoring Immunization Programmes TIP*. Available at: http://www.euro.who.int/__data/assets/pdf_file/0003/187347/The-Guide-to-Tailoring-Immunization-Programmes-TIP.pdf
- [27] Anastasio, P. A., Rose, K. C., & Chapman, J. (1999). Can the media create public opinion? A social-identity approach. *Current Directions in Psychological Science*, 8(5), 152-155.
- [28] Castells, M. (2001). *The Internet galaxy: Reflections on the Internet, business, and society*. Oxford University Press, Inc.
- [29] Motion, J., & Kay Weaver, C. (2005). The epistemic struggle for credibility: Rethinking media relations. *Journal of communication management*, 9(3), 246-255.

- [30] Van der Linden, S., Leiserowitz, A. A., Feinberg, G. D., & Maibach, E. W. (2015). The scientific consensus on climate change as a gateway belief: Experimental evidence. *PLoS one*, 10(2), e0118489.
- [31] Petty, R. E., & Cacioppo, J. T. (1986). The elaboration likelihood model of persuasion (pp. 1-24). Springer New York.
- [32] Covello, V. T., Sandman, P. M., & Slovic, P. (1988). Risk communication, risk statistics, and risk comparisons: A manual for plant managers (pp. 1-57). Washington, DC: Chemical Manufacturers Association.
- [33] Bowie, N. (2000). A Kantian theory of leadership. *Leadership & Organization Development Journal*, 21(4), 185-193.
- [34] Antonakis, J., Fenley, M., & Liechti, S. (2012). Learning charisma. Transform yourself into the person others want to follow. *Harvard business review*, 90(6), 127-30.
- [35] Di Salvo, V. S. (1980). A summary of current research identifying communication skills in various organizational contexts. *Communication Education*, July. 29: 283-290.
- [36] Sypher, B. D., Bostrom, R. N., & Seibert, J. H. (1989). Listening, communication abilities, and success at work. *Journal of Business Communication*, 26(4), 293-303.
- [37] Brownell, J. (2010). *The Skills of Listening-Centered Communication*. *Listening and Human Communication in the 21st Century*. Ed. Andrew D. Wolvin. West Sussex, UK: Blackwell Publishing, 2010. 141-57.
- [38] Brownell, J. (1994). Teaching listening: Some thoughts on behavioral approaches. *Business Communication Quarterly*, 57(4), 19-24.
- [39] Warren, J. T., & Fassett, D. L. (2014). *Communication: A Critical/Cultural Introduction*. Thousand Oaks: SAGE. SAGE Publications.
- [40] Wolvin, A. D., & Coakley, C. G. (2000). Listening education in the 21st century. *International Journal of Listening*, 14(1), 143-152.
- [41] Brownell, J. (2006). *Listening: Attitudes, Principles and Skills*. 3rd ed. Boston: Allyn and Bacon Publishers.
- [42] Baddeley, A. (1992). Working memory. *Science*, 255(5044), 556-559.
- [43] Jackson, L. D. (1992). Information complexity and medical communication: The effects of technical language and amount of information in a medical message. *Health communication*, 4(3), 197-210.
- [44] Joiner, T. A., Leveson, L., & Langfield-Smith, K. (2002). Technical language, advice understandability, and perceptions of expertise and trustworthiness: The case of the financial planner. *Australian Journal of Management*, 27(1), 25-43.

- [45] Hulme, C., Maughan, S., & Brown, G. D. (1991). Memory for familiar and unfamiliar words: Evidence for a long-term memory contribution to short-term memory span. *Journal of Memory and Language*, 30(6), 685-701.
- [46] Ebbinghaus, H. (1964). *Memory: A contribution to experimental psychology* (H. A. Ruger & C. E. Bussenius, Trans.). New York: Dover. (Original work published 1885).
- [47] Zajonc, R. B. (1968). Attitudinal effects of mere exposure. *Journal of personality and social psychology*, 9(2p2), 1.
- [48] Tversky, A., & Kahneman, D. (1981). The framing of decisions and the psychology of choice. *Science*, 211(4481), 453-458.
- [49] Levin, I. P., Schneider, S. L., & Gaeth, G. J. (1998). All frames are not created equal: A typology and critical analysis of framing effects. *Organizational behavior and human decision processes*, 76(2), 149-188.
- [50] Marteau, T. M. (1989). Framing of information: Its influence upon decisions of doctors and patients. *British Journal of Social Psychology*, 28(1), 89-94.
- [51] Linville, P. W., Fischer, G. W., & Fischhoff, B. (1993). AIDS risk perceptions and decision biases. In J. D. Pryor & G. D. Reeder (Eds.), *The social psychology of HIV infection* (pp. 5-38). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- [52] Kreuter, M. W., & McClure, S. M. (2004). The role of culture in health communication. *Annu. Rev. Public Health*, 25, 439-455.
- [53] Betsch, C., Ulshöfer, C., Renkewitz, F., & Betsch, T. (2011). The influence of narrative v. statistical information on perceiving vaccination risks. *Medical Decision Making*, 31(5), 742-753.
- [54] Jaswal, V. K., & Malone, L. S. (2007). Turning believers into skeptics: 3-year-olds' sensitivity to cues to speaker credibility. *Journal of Cognition and Development*, 8(3), 263-283.
- [55] Renn, O., & Levine, D. (1991). Credibility and trust in risk communication. In R. E. Kasperson & P. J. M. Stallen (Eds.), *Communicating risks to the public* (pp. 175-218). Dordrecht, The Netherlands: Kluwer.
- [56] Weick, K. E. (1984). Small wins: redefining the scale of social problems. *American Psychologist*, 39(1), 40.
- [57] Bell, N. D. (2007). How native and non-native English speakers adapt to humor in intercultural interaction. *Humor-International Journal of Humor Research*, 20(1), 27-48.

- [58] Munn, W. C., & Gruner, C. R. (1981). "Sick" jokes, speaker sex, and informative speech. *Southern Journal of Communication*, 46(4), 411-418.
- [59] Hackman, M. Z. (1988). Reactions to the use of self-disparaging humor by informative public speakers. *Southern Speech Communication Journal*, 53(2), 175-183.
- [60] Lewandowsky, S., Gignac, G. E., & Vaughan, S. (2013). The pivotal role of perceived scientific consensus in acceptance of science. *Nature Climate Change*, 3(4), 399-404.
- [61] Shwed, U., & Bearman, P. S. (2010). The temporal structure of scientific consensus formation. *American sociological review*, 75(6), 817-840.
- [62] Van der Linden, S. L., Leiserowitz, A. A., Feinberg, G. D., & Maibach, E. W. (2014). How to communicate the scientific consensus on climate change: plain facts, pie charts or metaphors?. *Climatic Change*, 126(1-2), 255-262.
- [63] Myers, T. A., Maibach, E., Peters, E., & Leiserowitz, A. (2015). Simple Messages Help Set the Record Straight about Scientific Agreement on Human-Caused Climate Change: The Results of Two Experiments. *PLoS one*, 10(3), e0120985.
- [64] Andre, F. E., Booy, R., Bock, H. L., Clemens, J., Datta, S. K., John, T. J., ... & Schmitt, H. J. (2008). Vaccination greatly reduces disease, disability, death and inequity worldwide. *Bulletin of the World Health Organization*, 86(2), 140-146.
- [65] Betsch, C., Böhm, R., & Korn, L. (2013). Inviting free-riders or appealing to prosocial behavior? Game-theoretical reflections on communicating herd immunity in vaccine advocacy. *Health Psychology*, 32(9), 978.
- [66] Beebe, S. A. (1974). Eye contact: A nonverbal determinant of speaker credibility. *Communication Education*, 23(1), 21-25.
- [67] Burgoon, J. K., Coker, D. A., & Coker, R. A. (1986). Communicative effects of gaze behavior. *Human Communication Research*, 12(4), 495-524.
- [68] Hall, J. A., Coats, E. J., & LeBeau, L. S. (2005). Nonverbal behavior and the vertical dimension of social relations: a meta-analysis. *Psychological bulletin*, 131(6), 898.
- [69] Reynolds, B. J. (2011). When the facts are just not enough: Credibly communicating about risk is riskier when emotions run high and time is short. *Toxicology and applied pharmacology*, 254(2), 206-214.
- [70] Hall, C. C., Goren, A., Chaiken, S., & Todorov, A. (2009). Shallow cues with deep effects: Trait judgments from faces and voting decisions. In E. Borgida, J. L. Sullivan, & C. M. Federico (Eds.), *The political psychology of democratic citizenship* (pp. 73-99). New York: Oxford University Press.
- [71] Bovée, C. L. (2003). *Contemporary public speaking* 2nd ed., San Diego, CA: Collegiate Press.

[72] McGuire, W. J. (1966). Attitudes and opinions. *Annual review of psychology*, 17(1), 475-514.

[73] Montepare, J. M. (1995). The impact of variations in height on young children's impressions of men and women. *Journal of Nonverbal Behavior*, 19(1), 31-47.

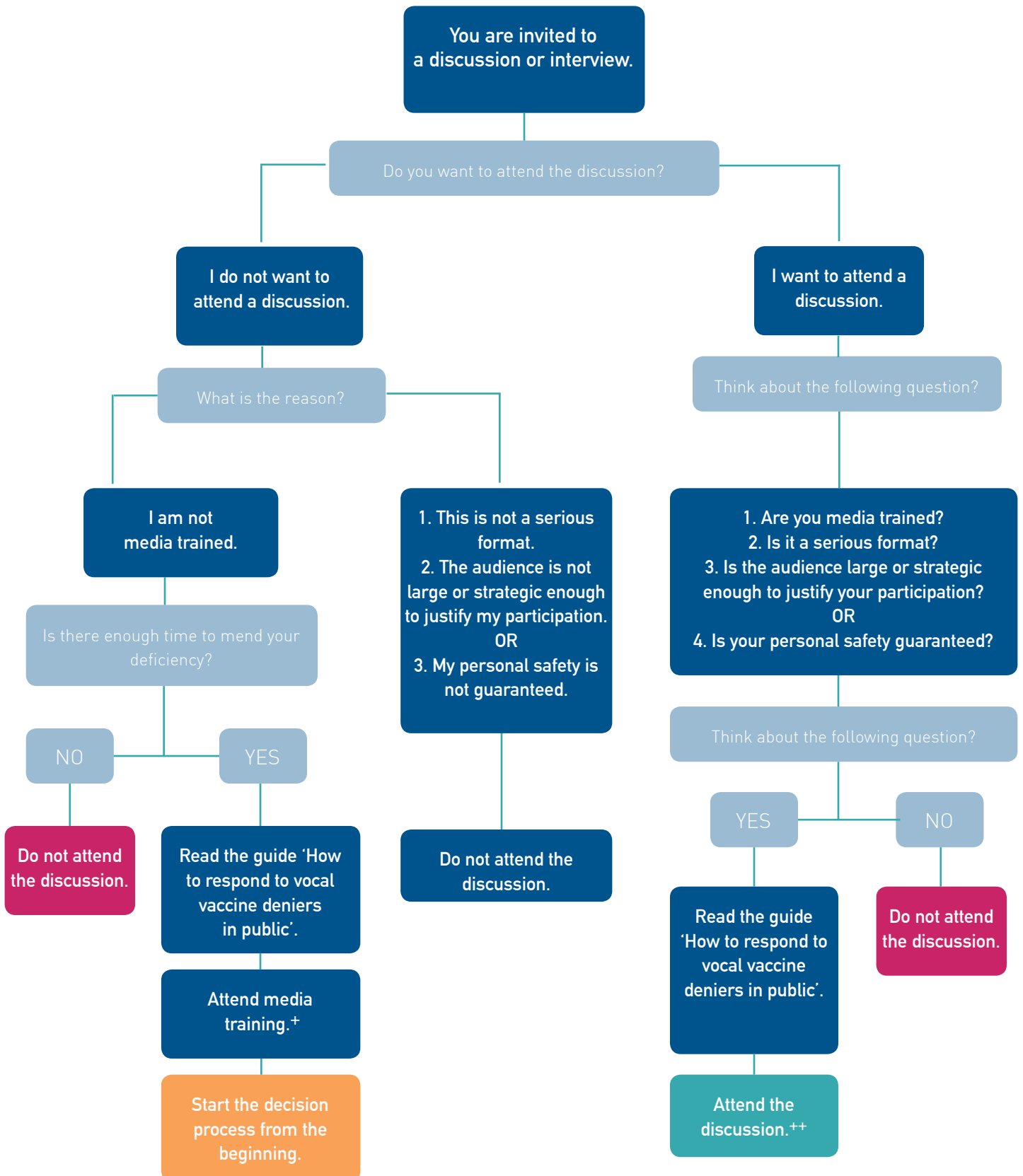
[74] Stulp, G., Buunk, A. P., Verhulst, S., and Pollet, T. V. (2012). High and mighty: Height increases authority in professional refereeing. *Evolutionary Psychology*, 10, 588-601.

[75] Schwartz, B., Tesser, A., & Powell, E. (1982). Dominance cues in nonverbal behavior. *Social Psychology Quarterly*, 45, 114-120.

[76] Leask, J. A., & Chapman, S. (1998). 'An attempt to swindle nature': press anti-immunisation reportage 1993-1997. *Australian and New Zealand journal of public health*, 22(1), 17-26.

Annex 1: Should you participate?

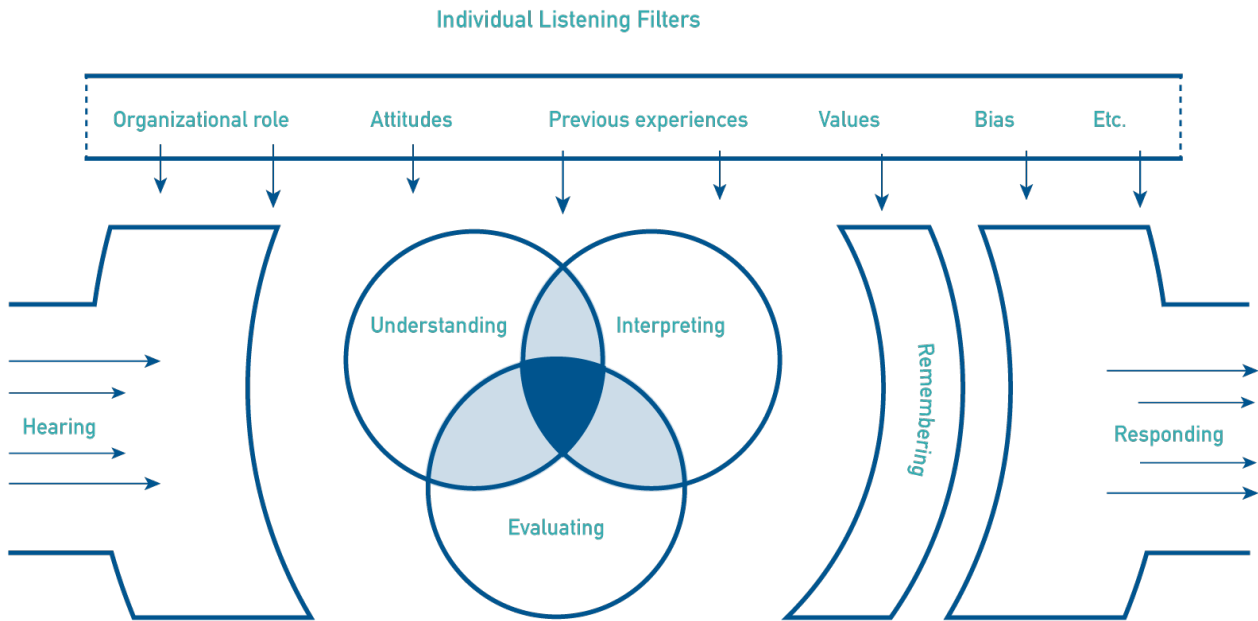
Things to consider **before** discussing or presenting your evidence



+ Consider attending the training 'How to respond to vaccine deniers?' See chapter 7 for further information.

++ Remember: The document does not make up for professional media training. If you want to learn more about the issue then please see chapter 7 for further information.

Annex 2: HURIER model of listening instruction⁺



+ Reproduced with the permission of Judith Lee Brownell.

The HURIER Model visualizes six interrelated skills of listening; hearing, understanding, remembering, interpreting, evaluating and responding. By identifying and addressing these skills listening can be learned in sub steps:

- **Hearing:** listening is determined by the physiological process of hearing sounds. This also involves the management of your attention and focus.
- **Understanding, interpreting, evaluating:** after receiving what was being said you automatically try to understand, interpret and evaluate the message. Especially these three sub steps are influenced by interpersonal relations and the context, e.g. your organizational role, attitudes, personal experiences, values and cognitive bias. By reflecting on these individual listening filters you improve your listening skill and reduce misunderstandings.
- **Remembering:** the next step is your memory. Being able to remember the most important parts of a message and inhibit unnecessary information will enable you to respond in an appropriate way.
- **Responding:** your response, as the final listening step, reveals your ability to listen to your discussion partner.

The general public, i.e. your key audience, will judge your performance based on your ability to pay attention to, understand, interpret, evaluate and remember what the vocal vaccine denier said.



The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Austria	Iceland	Romania
Azerbaijan	Ireland	Russian Federation
Belarus	Israel	San Marino
Belgium	Italy	Serbia
Bosnia and Herzegovina	Kazakhstan	Slovakia
Bulgaria	Kyrgyzstan	Slovenia
Croatia	Latvia	Spain
Cyprus	Lithuania	Sweden
Czech Republic	Luxembourg	Switzerland
Denmark	Malta	Tajikistan
Estonia	Monaco	The former Yugoslav
Finland	Montenegro	Republic of Macedonia
France	Netherlands	Turkey
Georgia	Norway	Turkmenistan
Germany	Poland	Ukraine
Greece	Portugal	United Kingdom
Hungary	Republic of Moldova	Uzbekistan