COVID-19 VACCINATION IN HUMANITARIAN SETTINGS REPORT

2022

HEALTH CLUSTER

World Health Organization

This report is based on findings from the GHC COVID-19 Task Team which has continuously worked on tracking, monitoring and understanding COVID-19 vaccination in humanitarian settings. It includes contributions by countries and Health Cluster partners. This report is a review of recent trends and issues faced at the end of 2022.

Disclaimer *Analysis provided is based on best available information from multiple sources. It is for operational purposes only and is not considered official information reported by WHO or any other partner. Findings are from countries where known and updates change daily. In some cases, countries have not reported or have not been able to provide specified information and as such access for populations affected by humanitarian crisis remains uncertain and a concern.*

Produced by Global Health Cluster, December 2022

Photo credit first page: WHO / Occupied Palestinian Territory / Noor- Tanya Habjouqa
On 24 March 2021 a public sector employee receives his COVID-19 vaccine at a vaccination site by the Health Directorate in Ramallah district.

OVERVIEW

2.6B
PEOPLE LIVE IN COUNTRIES AFFECTED BY HUMANITARIAN CRISES

69
COUNTRIES AFFECTED BY HUMANITARIAN CRISES

324M
PEOPLE NEED LIFE SAVING HUMANITARIAN ASSISTANCE

Nearly 1/3 of the world's population lives in countries affected by humanitarian crises[1], and although COVID-19 vaccination in humanitarian settings has improved through 2022, multiple challenges remain. The Global COVID-19 Vaccination Strategy updated in mid-2022, emphasized the need to build momentum to reduce mortality and morbidity, protect health systems and resume socio-economic activities. Targets include reaching 100% of health care workers, 100% of the elderly population (60+) and other priority at-risk groups completing the primary series and booster doses of COVID-19 vaccination, as well as achieving broader population immunity of 70% coverage. To uphold the **principle of equity** and ensure **populations affected by humanitarian crises are held in equal regard to the broader population**, health care workers, older populations and other priority at-risk groups amongst populations who are affected by humanitarian crises should also be prioritized, as well as achieving 70% vaccination coverage amongst the population affected by crises . However, inequity still exists.[2]

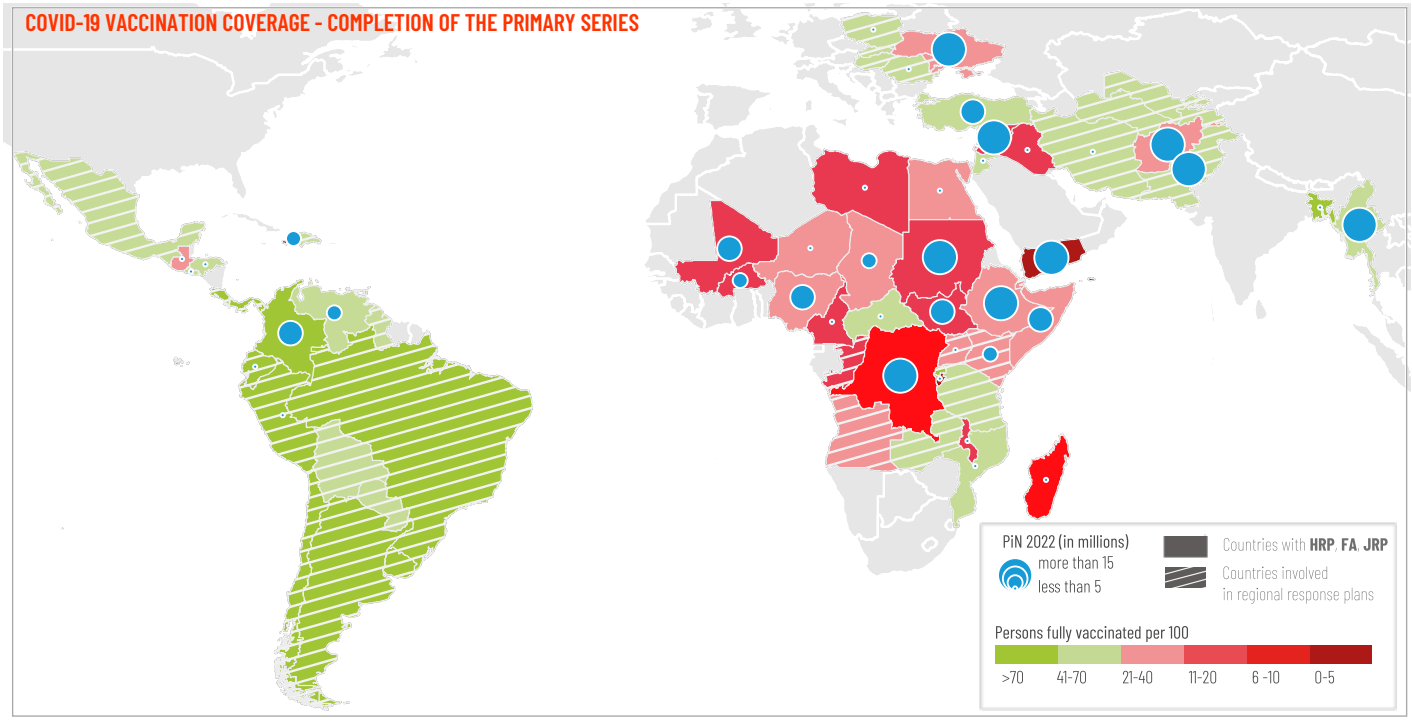


Figure 1. Map showing COVID-19 vaccination coverage (completion of the primary series) and people in need (PiN) of humanitarian assistance in the 69 countries in the Global Humanitarian Overview 2022 as of 13 Dec 2022 (Source, Global Humanitarian Overview 2022, WHO)

[1] *As identified in the Global Humanitarian Overview 2022*

[2] *Data reflected in the map is for illustrative purposes only. Not all data on populations affected by humanitarian crisis are reflected including refugee or migrant data for some countries.*

The boundaries and names shown and the designations used on this map 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 and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Data given is for operational purposes only and is not considered official data by WHO. Data Source: WHO, GHO

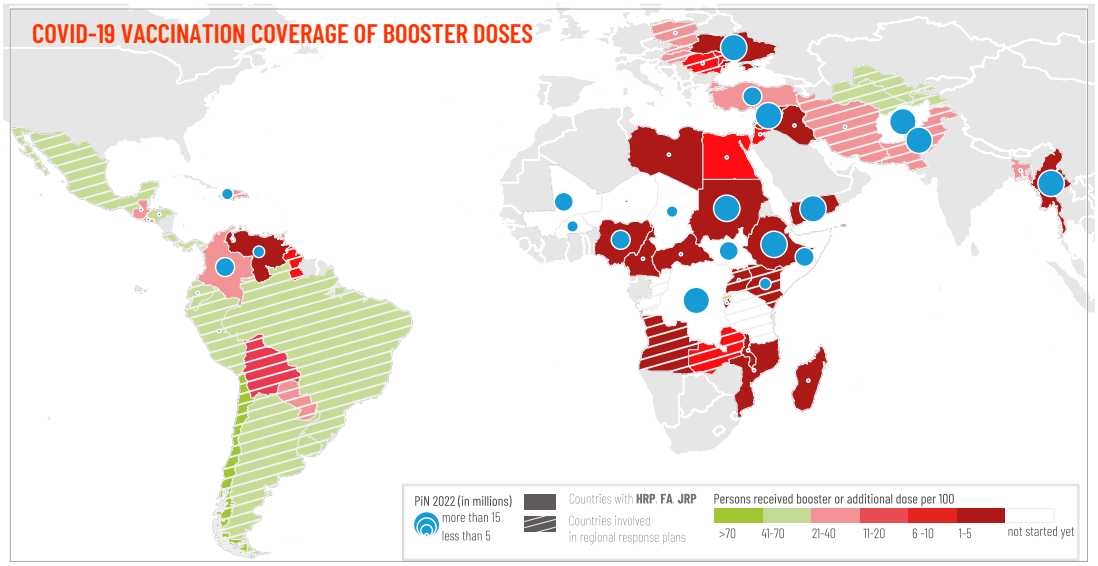


Figure 2. Map showing COVID-19 vaccination coverage (booster doses) and people in need (PiN) of humanitarian assistance in the 69 countries in the Global Humanitarian Overview 2022 as of 13 Dec 2022 (Source, Global Humanitarian Overview 2022, WHO)

NEARLY TWO THIRDS OF COUNTRIES WHO HAVE NOT ACHIEVED 10% VACCINATION COVERAGE FACE HUMANITARIAN CRISES

Globally 8 countries have not achieved 10% coverage of which, 5 have humanitarian crises: Burundi, DRC, Haiti, Madagascar, Yemen.

WITHIN COUNTRIES PEOPLE AFFECTED BY HUMANITARIAN CRISES ARE BEING VACCINATED THE LEAST

Despite considerable improvement in some countries, analysis shows many areas with high numbers of people identified in need of humanitarian assistance and vulnerable groups such as IDPs, refugees, those living hard to reach areas etc., still have lower vaccination coverage compared to the wider population.

RECENT GOOD PRACTICE AND SUCCESS HAS BEEN SEEN

Strong political will, engagement by all stakeholders, leveraging humanitarian partners and tailored strategies e.g., in Somalia and DRC have increased uptake by populations affected by humanitarian crisis. 13 countries have run successful vaccination campaigns since August 2022 increasing coverage nationally.

SEVERE INEQUITY IN BOOSTER COVERAGE RATES FOR PEOPLE AFFECTED BY HUMANITARIAN CRISIS

Booster dose vaccination is ongoing in 21 countries; however, coverage remains low in populations affected by humanitarian crisis when compared to the wider population. Given the existing inequity efforts are focused on completion of the primary series.

National governments are responsible for all populations within their territory including those affected by humanitarian crisis regardless of legal status[3]. However, even when this is reflected in national response and immunization plans, it often remains a challenge to reach people affected by humanitarian crises (e.g., internally displaced persons, returnees, migrants regardless of legal status, refugees, people living in non-government-controlled, insecure or hard-to-reach areas).

The Global Humanitarian Overview (GHO) defines individuals that require humanitarian assistance – either as a result of conflict, natural disaster or other factors. 69 countries are part of the interagency appeals in the 2022 GHO with 324.3 million people in need (PIN) of humanitarian assistance. Of these 69 countries, 30 have specific country appeals - Humanitarian Response Plans (HRP), Flash Appeal (FA), Joint Response Plan (JRP) with a total of 252 million people in need of humanitarian assistance in December 2022, 28 of which have an activated cluster system/Health Cluster.

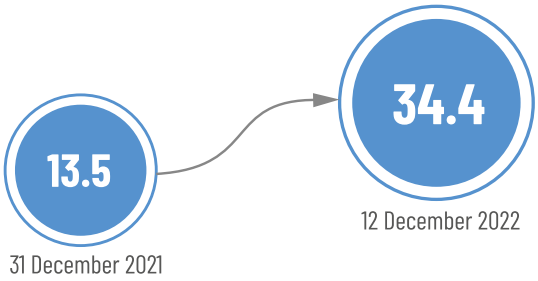
Countries facing humanitarian crises (especially those with a dedicated humanitarian response plan HRP/FA) still face challenges in COVID-19 vaccination coverage. Globally, 8 countries have less than 10% coverage for completed primary series, of which 5 countries have a HRP/ FA/ JRP (Burundi, DRC, Haiti, Madagascar, Yemen)4. 23 countries have less than 20% coverage for completed primary series, of which 15 are in the GHO and 13 have an HRP/FA. As seen in figure 2, countries with higher humanitarian need have low booster coverages rates or have yet to start booster vaccinations.

[3] See GHC Position Paper on COVID-19 vaccination in humanitarian settings published in May 2021 and GHC Advocacy and Information Brief published December 2021, developed through strong discussion and contribution by humanitarian partners, agencies or clusters working to support COVID-19 response in the most vulnerable settings

[4] The remaining three countries are Eritrea where vaccination has not yet started, Senegal and Papua New Guinea. There is also no reporting from the Democratic People's Republic of Korea

Vaccination coverage for the 30 countries with dedicated humanitarian response plans (HRP/FA/JRP)

Across all 30 countries with a dedicated humanitarian response plan in the GHO, vaccination has improved in 2022



Overall, for the 30 countries with a dedicated country humanitarian response plan the situation has improved since 31 December 2021 when 13.5% of people had a completed primary series, whereas 34.4% of people have a completed primary series as of 12 December 2022. Some countries have successfully conducted vaccination campaigns and significantly improved population coverage when comparing the percentage of persons fully vaccinated from January to December 2022. E.g., CAR 7.2% → 40.1%; Somalia 4.8% → 37.4%; Ethiopia 3.4% → 31.9%. (see Figure 3). However, challenges for many other countries persist

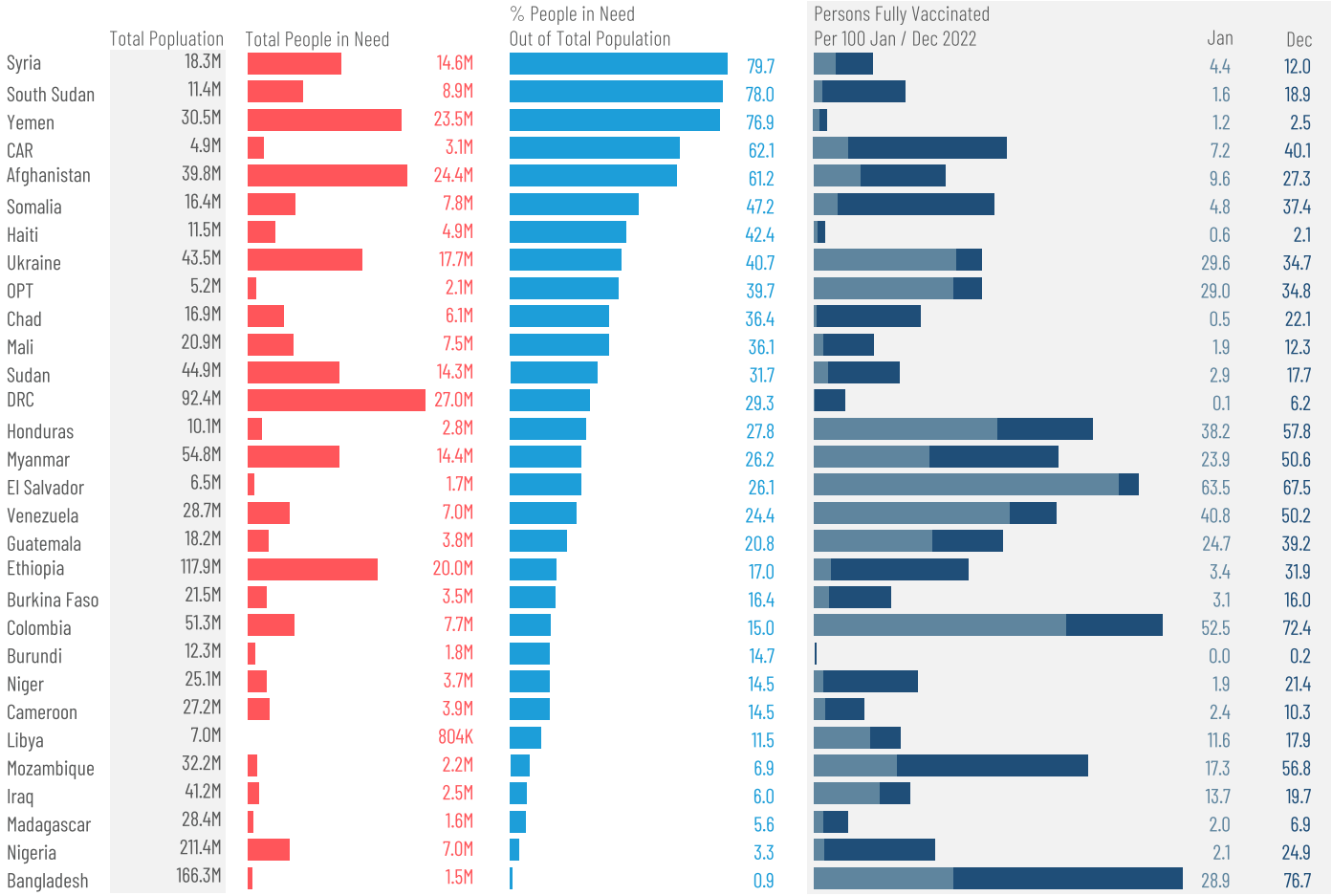


Figure 3. Table to show countries with dedicated humanitarian response plan (HRP, FA, or JRP), total population, population in need of humanitarian assistance (PIN), percentage of PIN and progress of national vaccination coverage (% who have completed the primary series) since January 2022 as of 12 December 2022 (Source, WHO, GHO, UN Population Division)

INEQUITY BETWEEN COUNTRIES STILL EXIST

Countries with the highest humanitarian needs are vaccinated the least

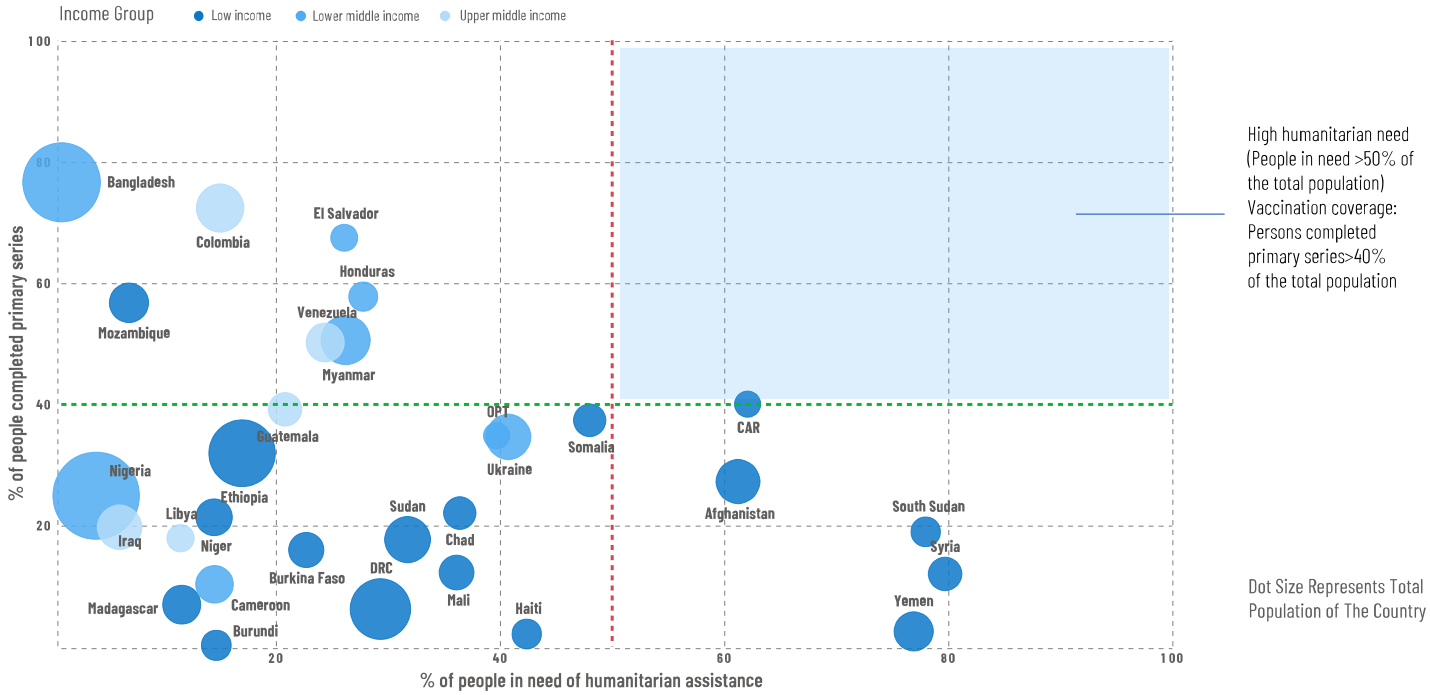
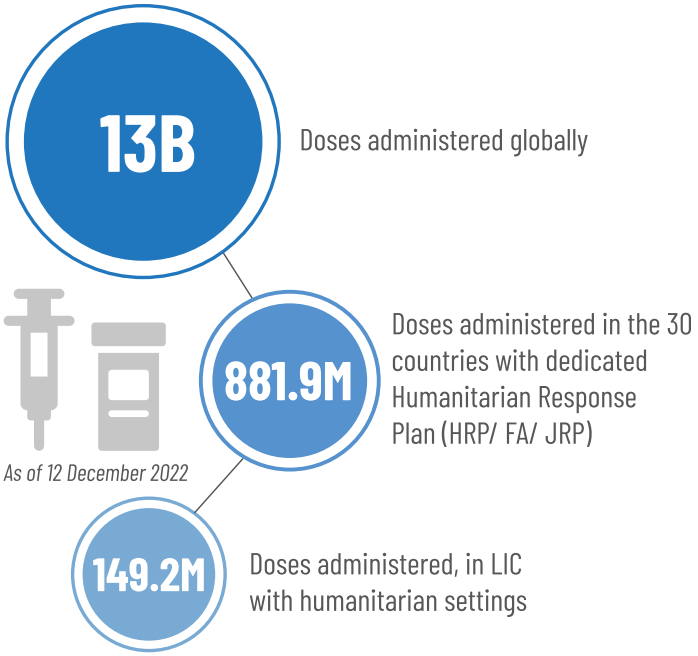


Figure 4. Countries with dedicated humanitarian response plan (HRP, FA, or JRP), percentage of population in need of humanitarian assistance and national vaccination coverage (% completed primary series) as of 12 December 2022 (Source; WHO, GHO, World Bank)

Countries with higher humanitarian need have lower coverage and are reached the least. In 2022, while many countries with humanitarian crisis have achieved coverage where more than 40% of the total population have completed the primary series, only one country with high humanitarian need (where more than 50% of the country population has been identified as in need of humanitarian assistance) has achieved this, the Central African Republic (see figure 4). Note also 40% coverage was the global target for December 2021. Additionally, no country with high humanitarian need has vaccinated 70% of their population (the mid-2022 target).

Low-income countries facing humanitarian crises have further challenges



Low Income Countries (LICs) carry the greatest humanitarian caseload, but the lowest vaccination coverage

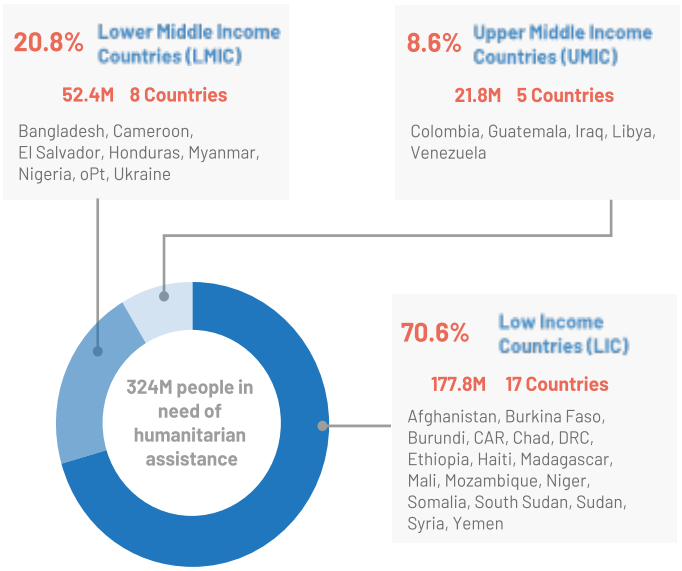


Figure 5. People in need of humanitarian assistance by income group of the 30 countries with dedicated humanitarian response plan (HRP, FA, or JRP) as of December 2022 (Source, GHO, World Bank)

Of the 30 countries with a dedicated Humanitarian Response Plan (HRP / FA / JRP), 17 are low-income countries (LICs) and carry 70.6% of the total population in need (PiN) of humanitarian assistance, i.e. 177.8M (see figure 5)[5]. However, LICs still have the lowest supply, vaccine administration and absorption with an overall supply of 50.7 total doses per 100 population and 20.4% people having completed primary series (see figure 6). Of note, LMICs and UMICs have high overall numbers of 108.7 and 127.7 doses administered per 100 population due to the provision of booster doses, e.g., 3rd or 4th doses.

LICs are reliant on COVAX doses (as Advanced Market Commitment countries) as well as bilateral donations and are therefore reliant on a limited supply chain, making it difficult to diversify risk or procure from different vaccine suppliers (See figure 7).

[5] *Of the 69 countries within the GHO 2022, 21 are LICs and carry 55.9% of the total population in need (PIN), i.e. 181.4M, whereas 19 LMICs have 83.9M (25.9%), 19 UMICs have 49.6M (15.3%), 10 HICs have 5.0M (1.5%) PIN, respectively. 4.3M (1.3%) of the total PIN in GHO 2022 (324.3M) cannot be easily atributed to income groups due to lack of disagregated data in the GHO (e.g. in RMRP for Venezuela).*

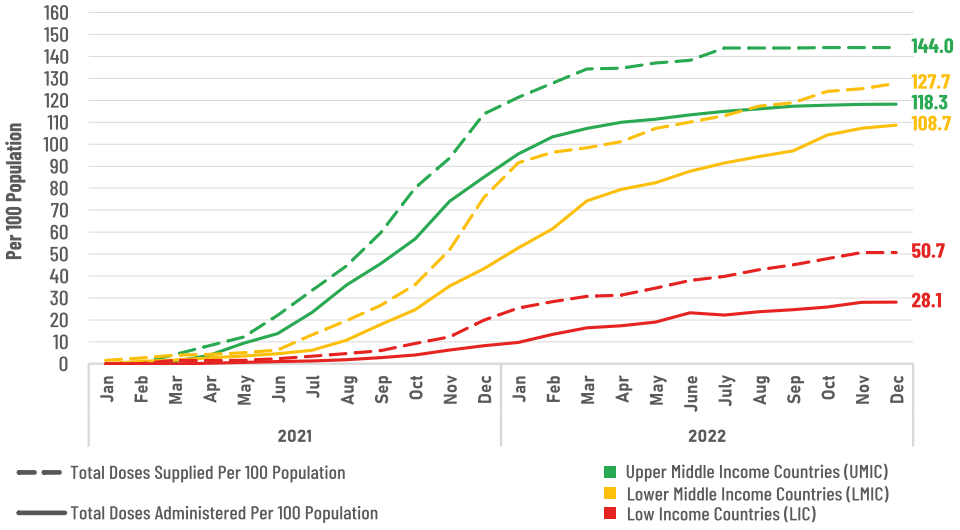


Figure 6. Total COVID-19 vaccine doses supplied and administered per 100 population of the 30 countries with dedicated humanitarian response plan (HRP, FA, or JRP) as of 12 December 2022 (Source, WHO, UNICEF, World Bank, other)

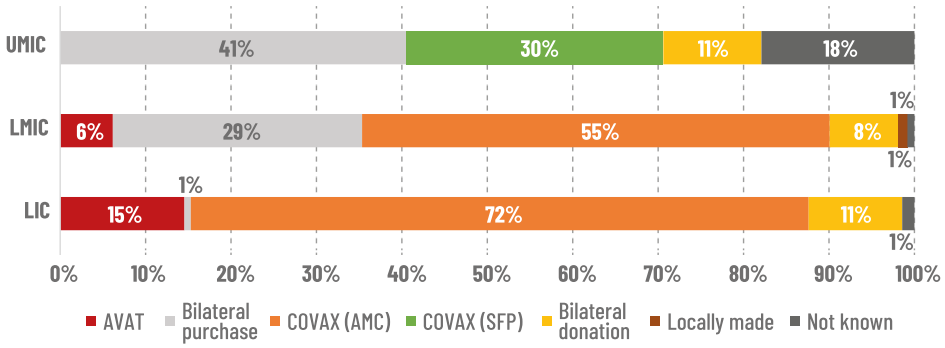


Figure 7. Vaccine supplies in 30 countries with dedicated humanitarian response plan (HRP, FA, or JRP) by income group as of 12 December 2022 (Source, UNICEF, World Bank, other)

INEQUITY WITHIN COUNTRIES STILL EXIST

Areas sub-nationally with the highest humanitarian needs are vaccinated the least

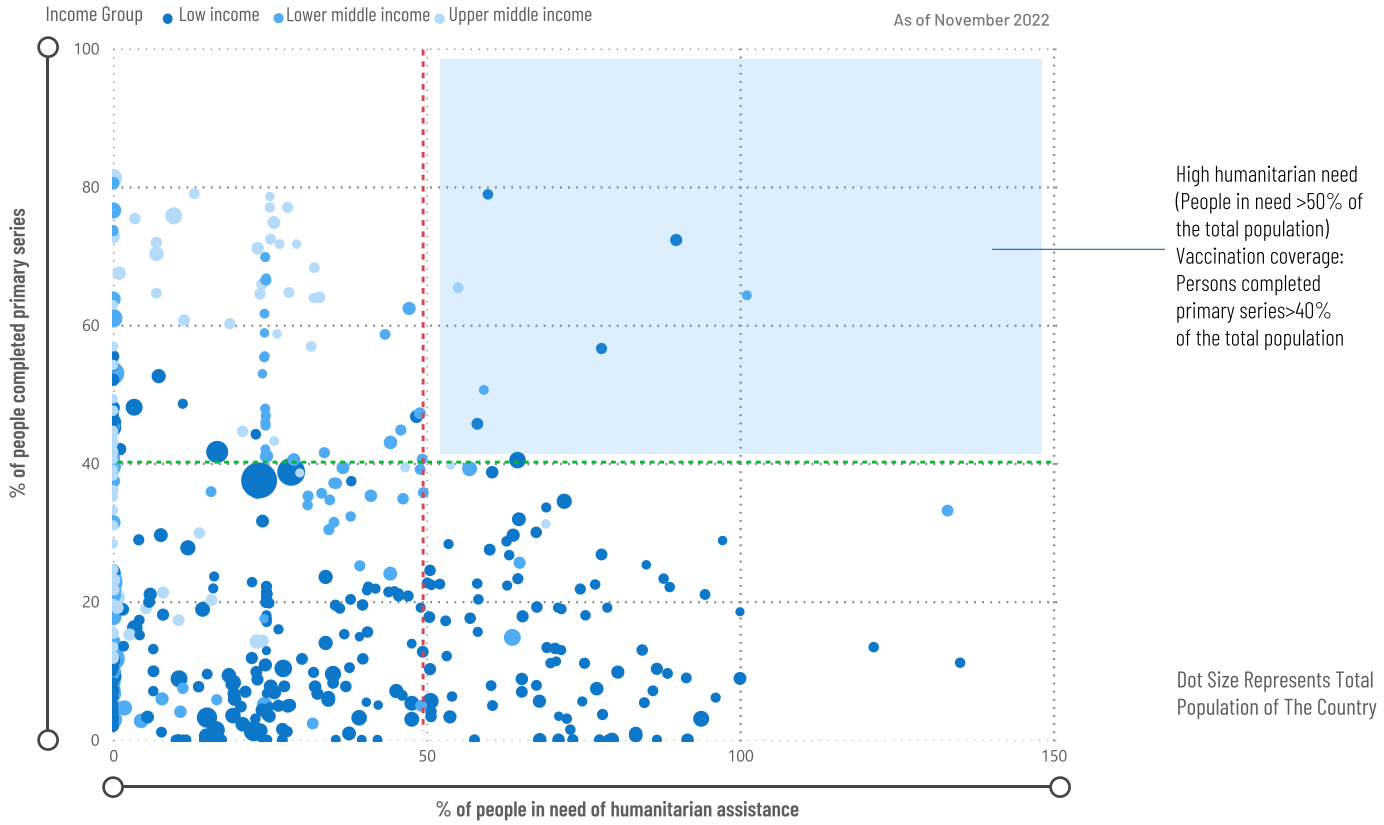


Figure 8. graph to show sub-nationally within countries with dedicated humanitarian response plan (HRP, FA, or JRP), percentage of population in need of humanitarian assistance and national vaccination coverage (% who have completed the primary series) using available evidence, with data de-identified, as of November 2022 (Source, Health Cluster, GHO, World Bank, other)[6]

Sub-nationally, further inequity is seen, with the most vulnerable being missed, as few areas with high humanitarian need have adequate vaccination coverage for COVID-19. While overall, national vaccination coverage rates are improving, in areas where most of the population are in need of humanitarian assistance (PiN is >50% of total population), only a few areas (8) have >40% people fully vaccinated, as seen in figure 8. Many areas are suffering due to insecurity, being operationally hard to reach, and having marginalized groups such as Internally Displaced People (IDPs), refugees, migrants. As such, sub-national vaccination coverage should not be overlooked.

[6] *Percentage of people in need of humanitarian assistance exceed 100 in some instances as may reflect recent population movements. Population estimates used are those used by national COVID-19 vaccination planning.*

1) WHO / Arete/Ismail Taxta

Somalia: 20 April 2022, health workers prepare to go to IDPs camps for house-to-house visits in Kismayo.

Further challenges for vulnerable groups affected by humanitarian crisis

Gender disparities

Even though women make up half of the world's population, barriers faced by women are not always understood. Only 18 out of 28 countries with activated Health Clusters are reporting vaccination coverage by gender, nearly half of which show gender disparity: 8 settings still show women are less likely to be vaccinated.

Vulnerable groups are not always regularly reached

Concerns remain high for reaching other vulnerable groups. Although IDPs, refugees and migrants with legal status have been reported to have been vaccinated at some point, they are not always reached regularly, and coverage data is frequently unavailable. Where known, vaccination coverage is low in most cases compared to the overall population. Returnees, migrants without legal status, prisoners, and those in non-government-controlled areas are shown to be reached the least. Figure 9 highlights key groups, whether these groups have been reached before, and what percentage of countries are reporting this vaccination data.

Vulnerable groups are not always prioritized with equal regard compared to the wider population

Concern for vulnerable populations such as IDPs, refugees, people living in hard-to-reach areas, and other groups listed in figure 9 below, remains. In some areas, they are not given the same priority or eligibility compared to the general population. For example, of the 30 countries with a dedicated humanitarian response plan, 3 countries are vaccinating 5+ years children and 9 are vaccinating children 12+ years. In addition, booster doses are ongoing in many settings (21 countries). However, the same national criteria (e.g., COVID-19 vaccination for children or booster doses) are not always applied to vulnerable groups. In some contexts, this is due to operational challenges, such as the need for an ultra-cold chain (UCC) for vaccines used for children or booster doses.

Data limitations compound vulnerability

Lack of vaccination coverage data of vulnerable and marginalized groups compounds their vulnerability further as true status and needs are not adequately able to be understood or thereby responded too. Only a few countries are monitoring inequity and vaccination of vulnerable groups affected by humanitarian crisis. Good examples include Afghanistan, Cameroon, Chad, Niger, Somalia, South Sudan and Yemen. Many countries have not yet incorporated data disaggregation into their reporting forms or their databases. Some have reported that though the willingness is there, the investments and resources needed to do so, such as funding and training, remain a challenge.

Other constraints exist

Populations estimates are not consistent: Ministry of Health / government estimates do not always align with humanitarian data or mapping done by OCHA, IOM and UNHCR. For example, census surveys may not be recent and do not include recent movement of populations through displacement or number of people living in non-government-controlled areas. In certain countries definition of IDP or refugee may vary or does not include IDPs living in informal camps or within the host community.

Even when vulnerable groups are vaccinated, not all have the appropriate ID to prove their ´vulnerability´ for their vaccination status to be documented. e.g., people identified as in need of humanitarian assistance in the general population, IDPs living in informal camps or in the host community. Conversely, having an ID to 'prove their vulnerability' can be a protection risk for detention, deportation, or attack. e.g., people receiving vaccinations in non-government-controlled areas, migrants without legal status.

Conducting post-vaccination evaluation surveys specific to understanding vaccination coverage of populations affected by humanitarian crisis is therefore critical.

Vaccination of Key Groups

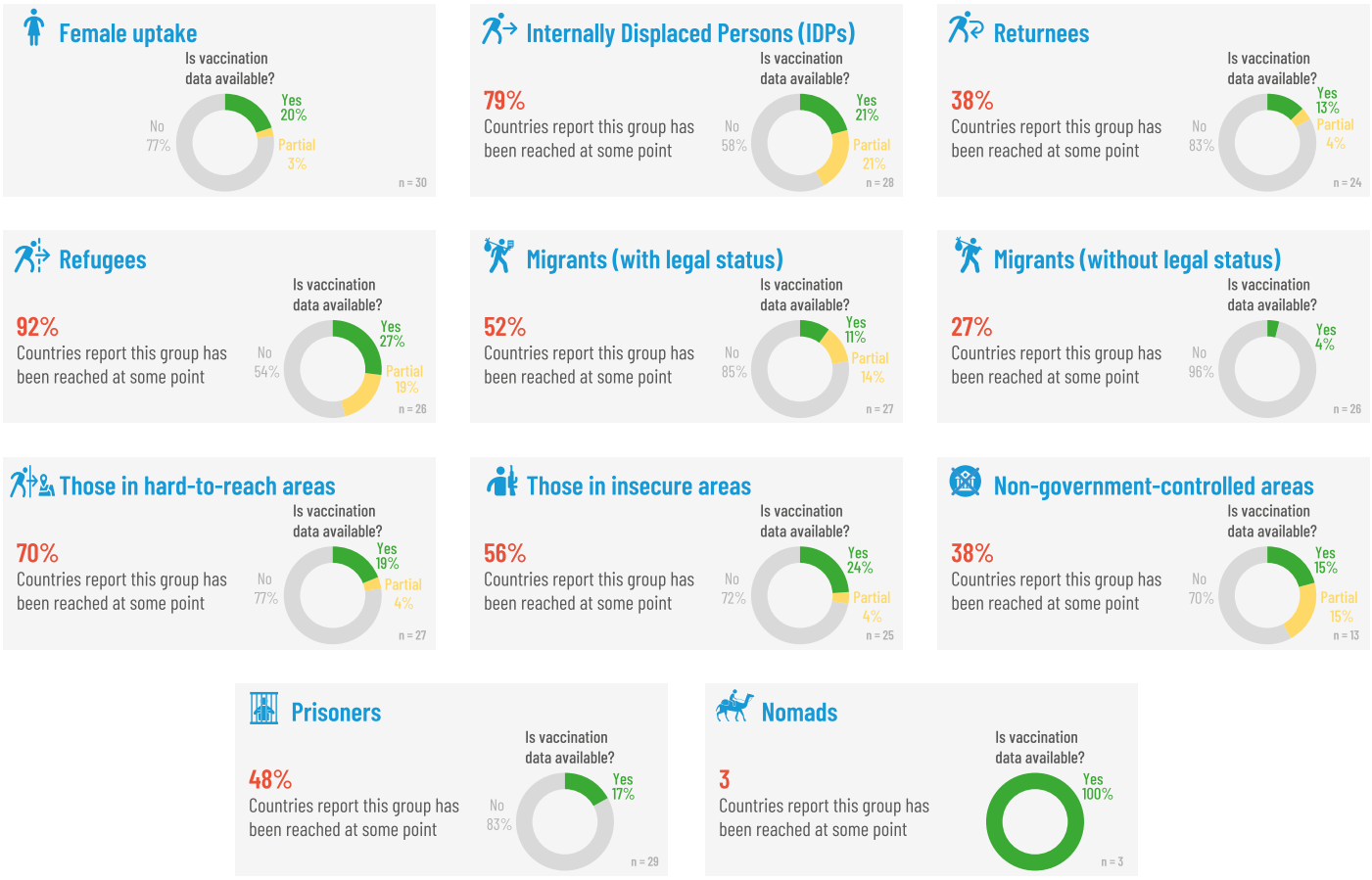


Figure 9. Vaccination status and data availability of populations affected by humanitarian crisis in countries with dedicated humanitarian response plan (HRP, FA, or JRP) as of November 2022 (Source, Health Cluster, other)

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OTHER KEY TRENDS

Leveraging of humanitarian architecture and Health Cluster partners is occurring but needs strengthening

The Health Cluster is activated in 28 humanitarian settings and has around 900 partners working to support the provision of health services to populations affected by humanitarian crisis. This includes hard to reach areas, insecure areas and those not under the control of the government.

Work is being done in countries by the Health Cluster and, Ministry of Health at national and sub-national level as well as key actors, such as the COVID-19 Vaccine Delivery Partnership (CoVDP) to identify and support Health Cluster partners to reach vulnerable populations and areas affected by humanitarian crisis with COVID-19 vaccination. However, the need for continued strong advocacy, commitment, will and investments by all stakeholders to address inequities exists. This includes supporting tailored strategies as well as the higher operational costs associated to reach populations affected by humanitarian crisis.

In most settings Health Clusters are being leveraged to support different aspects of COVID-19 vaccination activities. Partners are involved in risk communication and community engagement (RCCE) in many settings and multisectoral messaging is also occurring by partners, including those in the Protection Cluster, WASH Cluster, Nutrition Cluster, and Camp Coordination and Camp Management Cluster, thereby leveraging the cluster system as a whole. However, Health Cluster partners have been reported to be involved in the administration of vaccines in only 12 settings; and the Health Cluster is being leveraged to support coordination and to identify missed populations and/or operating partners able to administer vaccines in only 9 settings. With less than half of Health Clusters being engaged for each of these activities, given the role of the Health Cluster and operational reach of Health Cluster partners to reach the most marginalized and vulnerable, capitalizing existing platforms and partners must be strengthened.

Insecurity remains a concern

Insecurity has been reported as a continuing barrier for populations to access vaccination services (17 countries). Fear of attack, detention, or deportation has been reported (8 countries) and coordination/negotiating with non-state armed groups / opposition governments / de-facto authority reported as a challenge (10 countries)

Campaigns and strategies to reach populations affected by crisis exist but face challenges

Since August, recent campaigns have demonstrated success in improving coverage in settings affected by humanitarian crisis (e.g. 9 settings). However, low uptake occurs either in between or after campaigns (reported in 12 settings since June). In some instances, though a relatively high coverage for the primary series has been achieved, low uptake for booster doses by populations affected by humanitarian crisis is seen (2 countries). Most countries report some tailored strategies to reach populations affected by humanitarian crisis have been implemented for example through outreach, such as mobile clinics. However, the vast majority of vaccination services are provided through fixed health facilities, and availability and coverage of special strategies and outreach services are often low. As such, challenges still remain for populations affected by humanitarian crises to be reached by and therefore access COVID-19 vaccination services.

Insufficient funding to reach IDPs, refugees, migrants, those in hard-to-reach areas still a challenge

Challenges have been reported with operational costs to reach populations affected by humanitarian crisis with COVID-19 vaccination given the higher operational costs for vaccine administration, and the additional strategies and resources needed, which may not have always been outlined in national vaccination plans. (12 countries).

Integration of COVID-19 vaccination into routine immunization or other health services is occurring

The epidemiology, trajectory, and timing of the COVID-19 pandemic remain uncertain. Recognizing the need for sustainability and as such the diminishing returns of vertical COVID-19 vaccination campaigns[7], planning is occurring at a national level for the transition of COVID-19 vaccination into routine services and has been reported in at least 8 settings. 2023 will see the transition from vertical COVID-19 campaigns into national plans for routine immunization and primary health care. However, it remains to be seen what these integration strategies will look like for populations affected by humanitarian crisis and advocacy is still needed to ensure these populations have access to services.

Availability of vaccination services close to populations affected by crisis is low

Most settings have reported that coverage of vaccination points to reach populations affected by humanitarian crisis is low, and likewise physical barriers are faced by such populations to reach vaccination points (21 countries). Long distances to reach vaccination points, living in hard-to-reach areas, or areas affected by natural hazards have been reported as challenges.

Insufficient human resources for vaccination

Insufficient numbers of health care workers (HCWs) to reach populations affected by humanitarian crisis has been reported (14 countries) with reports of insufficient salary or disruptions to pay HCWs (8 countries).

Concerns of unclear data protection

In some settings a lack of clear protocols on data protection between health authorities and other departments such as the military remain a concern.

ID requirements to register

Some countries have reported ID is still required for vaccination thus potentially excluding those with irregular status, from non-government-

7 Considerations for integrating COVID-19 vaccination into immunization programs and primary health care for 2022 and beyond WHO, UNICEF 2022, and COVID-19 Delivery Partnership SitRep

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controlled areas, or those with political affiliation.

Limited vaccine acceptance

Most countries still report this as an issue with persisting rumors and misinformation (24 settings).

Low priority for populations affected by humanitarian crisis to be vaccinated

Competing priorities for populations such as food, water sanitation, safety, and other health threats such as cholera have been reported (15 countries), therefore contributing to diminishing demand and uptake. The need for consistent and strengthened RCCE specific to populations affected by humanitarian crises has been highlighted (5 countries) as well as need for integrated services e.g., with other multisectoral humanitarian services.

However tailored strategies and RCCE, bringing vaccination services closer to populations affected by humanitarian crises have proven successful

As demonstrated through recent interventions in DRC and Somalia. Involving communities and whole government can increase demand despite competing priorities or initial vaccine hesitancy.

Country Spotlights

Mali

Mali has steadily increased its vaccination coverage during 2022. Four campaigns conducted have increased those having completed the primary series from 3.1% in January 2022 to 11.1% in November 2022. However, the national coverage still remains low. To address this high-level political mobilization, increased coordination with Health Cluster partners and other NGOs, as well as the opening of funding for NGOs to reach populations affected by humanitarian crisis (e.g., COVID-19 Vaccine Delivery Support (CDS) funding) is ongoing and a fifth vaccination campaign is underway as of December 2022.

For a COVID-19 Vaccine Delivery Partnership (CoVDP) mission in October 2022, and to strengthen engagement and leverage humanitarian partners, the Health Cluster Coordinator, Dr. Allé Baba Dieng, convened 26 Health Cluster partner organizations and 7 civil society organizations, and stakeholders, with national representatives and stakeholders to determine how to further support vaccination and improve vaccine coverage for populations affected by humanitarian crisis..

"Just making sure that everyone was on the same page, and really working together as one team was important. It was a big win to have the partners meeting and communicating more with each other." – Adelaide Davis, CoVDP Desk Officer

After the mission and engagement with the Ministry of Health, NGOs and CSOs were added to the CDS application indicating a strong willingness by the government to engage and work with Health Cluster and humanitarian partners.

"The Health Cluster partners are very involved working with the government at different levels including Regional Health Directorates, and in all parts of the process. Local and international NGOs are involved in the organization and coordination of meetings, sensitization to increase demand, proximity communication with community workers to engage leaders and other community members, and training of vaccinators and other health staff." – Dr. Allé Baba Dieng, Health Cluster Coordinator

Two strategies are used for COVID-19 vaccines: Vaccinations are offered combined with routine immunization or during campaigns. For campaigns, mobile teams are used to reach remote communities, but also mobile clinics are used by NGOs which provide a package of health services in addition to vaccines.

In regions that have high insecurity, such as Menaka, the Regional Health Directorate organize mobile teams to go into districts to reach IDPs and other populations in need. The Health Cluster partners involved in COVID-19 vaccination already have experience in these areas and are known and accepted by the community. All vaccination teams include at least one member of the local community to facilitate access to the communities and increase vaccine uptake and coverage.

This strategy has led to areas, like Menaka, with a high percentage of its population in need of humanitarian assistance, having improved coverage with an increase from 5.0% in March 2022 to 28.8% in November 2022 of those having completed primary series.

"Hopefully, development and public health partners understand the added value of working with humanitarian partners moving forward and the collaboration and progress seen with COVID-19 vaccination serves as a model for strengthening other health systems." – Adelaide Davis, CoVDP Desk Officer

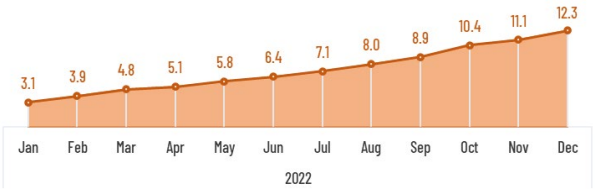

Figure 10. Progress of national vaccination coverage (% who have completed the primary series) in 2022 in Mali as of 12 December 2022 (Source, WHO)

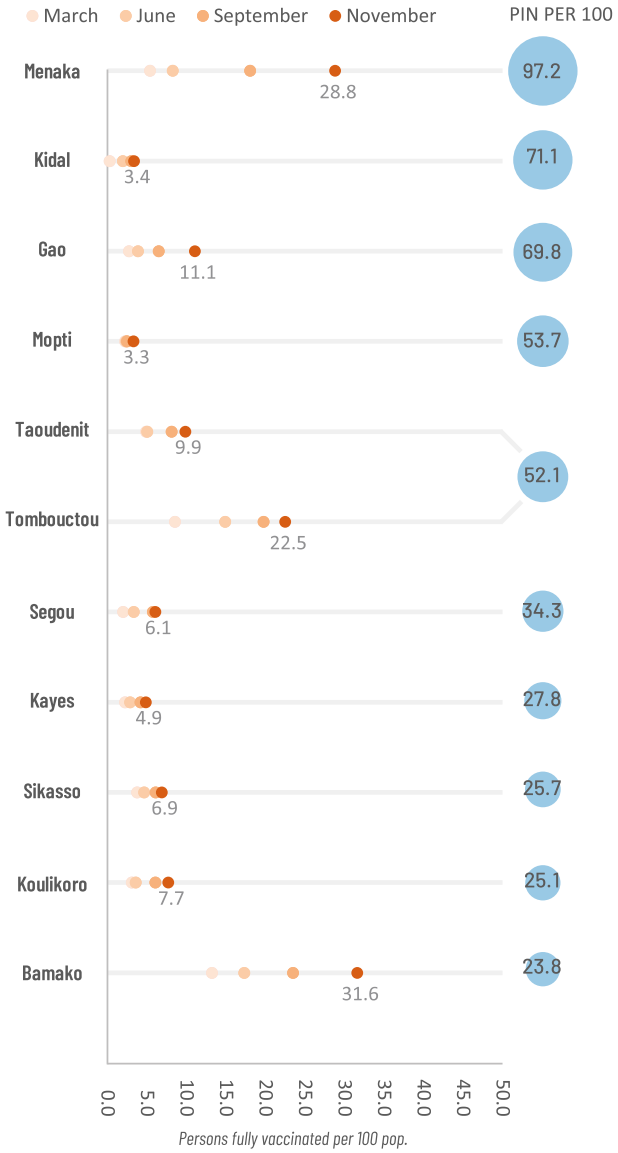

Figure 11. Graph to show progress of subnational vaccination coverage (% who have completed the primary series) and percentage of those in need of humanitarian assistance (PIN) in 2022 in Mali as of 13 November 2022 (Source, WHO, GHO)

Somalia

The recent nationwide campaign targeting 3.5M in Somalia has shown considerable success with 3.4M persons vaccinated with Janssen (J&J), and the national average of those having completed the primary series rising from 15.3% in August 2022 to 37.4% in November 2022. Sub-nationally, even areas with high humanitarian need have improved such as Banadir, Hirshabele, Galmudug and Jubaland. South-West State, though much improved, still has lower vaccination coverage compared to others. 2.4M IDPs have been fully or partially vaccinated, with recent estimates of 45% of IDPs being fully vaccinated. The deteriorating humanitarian situation including drought and food insecurity is displacing more people internally making targeting all IDPs a challenge. Concerns remain for low vaccination coverage of nomads and migrants regardless of legal status (noting that Somalia is part of the Horn of Africa Migrant Response Plan 2022)

1) WHO / Ismail Taxta

Somalia: 13 August 2022, vaccination awareness campaign for COVID-19 vaccination for vulnerable communities.

The recent campaign mobilized 5000 teams and 37,000 health care workers for a 10-day campaign during September and October (roll out at subnational level affected timeline and duration), with coordinated messaging and communication. Strong pollical will, coordination and planning since June 2022 across all levels occurred with detailed microplanning, mapping of populations affected by humanitarian crisis and coordination with different platforms including the Health Cluster and Camp Coordination and Camp Management Cluster. Since March 2022, integrated outreach teams have provided routine immunization, Vitamin A, deworming, Zinc and basic consultations, as well as identifying Zero-Dose children for immunization

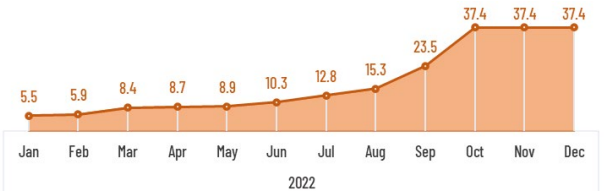

Figure 12. Progress of national vaccination coverage (% who have completed the primary series) in 2022 in Somalia as of 12 December 2022 (Source, WHO)

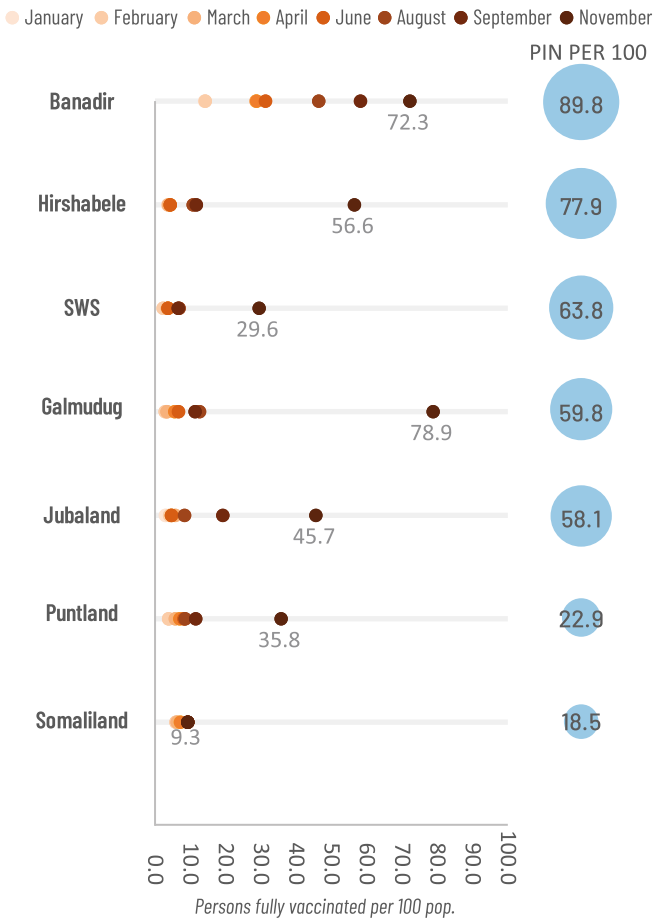

Figure 13. Progress of subnational vaccination coverage (% who have completed the primary series) and percentage of those in need of humanitarian assistance (PIN) in 2022 in Somalia as of 12 November 2022 (Source, WHO, GHO)

The Democratic Republic of Congo (DRC)

COVID-19 vaccination coverage in DRC increased from 1.2% in April 2022 to 6.2% in December 2022 for those who had completed the primary series. Strong efforts are currently being taken to increase vaccination coverage, especially for areas affected by humanitarian crisis. DRC has identified 8 regions as 'humanitarian provinces' to prioritize increasing COVID-19 vaccination coverage. These include Haut Uélé, Ituri, Nord Kivu, Sud Kivu, Kasai, Kasai Oriental, Lomami, and Tanganyika. These provinces were identified using humanitarian data provided by Health Cluster and other humanitarian partners. Strong collaboration with the Health Cluster and Health Cluster partners ongoing.

"At the level of the Health Cluster Coordination, we did everything to try to bring all the health cluster partners around overall national coordination. It was impactful for us and the partners to align." – Dr. Alou Badara Traore, Health Cluster Coordinator

The Health Cluster Coordinator, Dr. Alou Badara Traore, successfully convened 35 Health Cluster partner organizations for the CoVDP missions, with over 80% attendance. Partners attended the meeting looking for a clear vision on what is being done by the CoVDP team and how they could contribute. In general, most partners that benefited from COVID-19 vaccine fund allocations at the start of the national COVID-19 response were those that had experience in vaccination in humanitarian settings and many are still actively contributing or willing to contribute to vaccination. Humanitarian partners involved in COVID-19 vaccination include World Vision, Alima, and Save the Children.

The Health Cluster further supports the Ministry of Health at the different levels, from national and provincial level to health zones and at the community level. Health Cluster partners supported a variety of interventions including, developing strategies and guidelines, resource mobilization, microplanning sessions organized at the provincial level, training of health care workers on different vaccination tools, how to administer vaccines, communication and mobilization efforts, mapping existing humanitarian services to be integrated into vaccinations plan as well as vaccine administration, monitoring, evaluation and data quality improvement.

To ensure disaggregated data, the government and partners have worked together to develop monitoring tools to better track vaccination coverage of displaced persons. Displacement and refugees' status is now included on vaccination sheets for when teams go into health zones. This data provides better visibility for ensuring equity and that last mile marginalized and vulnerable communities are getting access to vaccines.

"This was exciting, that humanitarian partners were providing technical support to make sure that we have better visibility on whether these target population are being reached. The government is focusing on IDPs, refugees and returnees living in camps because they, through CoVDP's and humanitarian partner's influence, identified them as high priority." – Adelaide Davis, CoVDP Desk Officer

The government, Health Cluster Coordinator, and in-country WHO and UNICEF offices identified partners to work with and fund through CoVDP's ability to rapidly mobilize quick impact funding. IOM was identified as an important partner for IDP vaccination coverage and received adequate funding to support a campaign. Working with Health Cluster partners and a consortium of NGOs, vaccination is now occurring in 3 humanitarian provinces, Ituri, South Kivu, and Tanganyika, and more than 70% of the campaign target populations have been covered. UNHCR is working with the government on a plan to reach refugee populations, working with implementing partners.

17 campaigns have been conducted across the country in different provinces at different times. Currently campaigns are being planned and conducted, including in the humanitarian provinces.

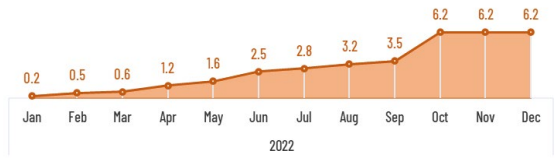

Figure 14. Graph to show progress of national vaccination coverage (% who have completed the primary series) in 2022 in DRC as of 12 December 2022 (Source, WHO)

Figure 15. Graph to show progress of subnational vaccination coverage (% who have completed the primary series) and percentage of those in need of humanitarian assistance (PIN) in 2022 in DRC as of 3 December 2022 (Source, WHO, GHO)

LOOKING AHEAD

Equity is more than just increasing national coverage rates

While improvements can be seen in 2022 true equity lies in also improving sub-national coverage rates and that of vulnerable groups to ensure all people in a country have access to vaccination.

Understanding the barriers, needs and developing tailored solutions for populations affected by humanitarian crisis needs consistent investment

COVID-19 vaccination has provided considerable insight into the challenges specific to reaching populations affected by humanitarian crisis. Recent successes and good practice such as Somalia and DRC highlight that despite competing priorities faced by populations, through strong political will, engagement across all levels from national to local, and leveraging existing actors, uptake can be achieved.

Integration of COVID-19 into routine services needs special attention for people affected by humanitarian crisis

Challenges will remain in reaching populations in need of humanitarian assistance with COVID-19 vaccination as it integrates into other routine services. Countries with fragile systems already face challenges in providing health services for these populations. Therefore, as transition occurs, all stakeholders need to mainstream reaching populations affected by humanitarian crisis by strengthening health systems, but also by leveraging existing humanitarian platforms and health actors. The Health Cluster, and interagency humanitarian response plans, are established at the request of the government to support the provision of life-saving essential health services for populations affected by humanitarian crisis. As such and by continuing to use a multi-hazard approach to health response, support and advocacy for the equitable provision of COVID-19 services including vaccination will remain a priority.

Joint convening to be held on COVID-19 vaccination in humanitarian settings

In February 2023, a Joint Convening led by COVID-19 Vaccine Delivery Partnership with key partners (e.g. UN agencies, Africa CDC, GHC, ICVA, IFRC, ICRC, MSF, and bilateral partners) will take place in Nairobi, Kenya to take stock of the current global situation of COVID-19 vaccine delivery in humanitarian settings, identify lessons learned, and share good practices. Critical actionable recommendations will be developed to improve vaccination efforts in COVID-19 and broader pandemic preparedness to ensure that no one is left behind.

2) WHO / Motherland production
South Sudan: 29 April 2022, a vaccinator preparing the COVID-19 vaccine in Juba, near the banks of the White Nile, during a vaccine campaign targeting the residents of settlements in Mangalla. Lilian Hilary, 26, the mother of two, says: "Today I am very happy that the services have been brought closer to our homes for women who cannot leave their children alone to also benefit from vaccines. We are happy that vaccines will now help protect us from getting sick from COVID-19."