STUDY TO EXAMINE COVID-19 VACCINATION IN HUMANITARIAN SETTINGS

FINAL REPORT

Global Health Cluster
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AA</td>
<td>Autonomous Administration</td>
</tr>
<tr>
<td>AMC</td>
<td>Advanced Market Commitment</td>
</tr>
<tr>
<td>AVAT</td>
<td>African Vaccine Acquisition Trust</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>COVAX</td>
<td>COVID-19 Vaccines Global Access</td>
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<td>CoVDP</td>
<td>COVID-19 Delivery Partnership</td>
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<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>FA</td>
<td>Flash Appeal</td>
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<td>GHC</td>
<td>Global Health Cluster</td>
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<td>GHRP</td>
<td>COVID-19 Global Humanitarian Response Plan</td>
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<td>GIFMM</td>
<td>Inter-Agency Group on Mixed Migration Flows</td>
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<tr>
<td>HCT</td>
<td>Humanitarian Country Team</td>
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<tr>
<td>HCW</td>
<td>Healthcare Worker</td>
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<td>HICs</td>
<td>High-Income Countries</td>
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<tr>
<td>HNO</td>
<td>Humanitarian Needs Overview</td>
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<td>HRP</td>
<td>Humanitarian Response Plan</td>
</tr>
<tr>
<td>IAR</td>
<td>Intra-Action Review</td>
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<tr>
<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
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<tr>
<td>IDPs</td>
<td>Internally Displaced Persons</td>
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<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
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<tr>
<td>IPC</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>JRP</td>
<td>Joint Response Plan</td>
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<tr>
<td>KAP</td>
<td>Knowledge, Attitudes, and Practices</td>
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<tr>
<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>LICs</td>
<td>Low-Income Countries</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NDVP</td>
<td>National Deployment and Vaccination Plan</td>
</tr>
<tr>
<td>NES</td>
<td>North-East Syria</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NSAG</td>
<td>Non-State Armed Group</td>
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<tr>
<td>NWS</td>
<td>North-West Syria</td>
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<tr>
<td>OCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
</tr>
<tr>
<td>PIN</td>
<td>People in Need</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Healthcare</td>
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<tr>
<td>PHEIC</td>
<td>Public Health Emergency of International Concern</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>PoC</td>
<td>Population of Concern</td>
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<tr>
<td>RCCE</td>
<td>Risk Communication and Community Engagement</td>
</tr>
<tr>
<td>SAGE</td>
<td>Strategic Advisory Group of Experts on Immunization</td>
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SIG  Syrian immunisation group
UNHAS  United Nations Humanitarian Air Service
UNICEF  United Nations Children’s Fund
UNHCR  United Nations High Commissioner for Refugees
VPD  Vaccine-Preventable Diseases
WASH  Water, Sanitation, and Hygiene
WHO  World Health Organization
EXECUTIVE SUMMARY

INTRODUCTION

By 27 April 2022, roughly over two years after COVID-19 had been declared a pandemic, when this study was launched, the first COVID-19 vaccines had been in the market for more than a year and over 11.4 billion COVID-19 vaccine doses had been administered globally. At that time, it was estimated that less than 5% of vaccines doses had been administered in humanitarian settings, with the poorest and most fragile contexts the furthest behind. According to the Global Humanitarian Overview, which projects humanitarian needs for the coming year, there were 296 million people in need (PIN) in 69 countries, of which 31 had an inter-agency Humanitarian Response Plan (HRP), Joint Response Plan (JRP), or Flash Appeal (FA) in place.

As the target to vaccinate 70% of the world’s population by mid-2022 was set, the Global Health Cluster (GHC) COVID-19 Task Team at the World Health Organization (WHO) decided to conduct the present study to better understand good practices and challenges faced in COVID-19 vaccination of people affected by crises in humanitarian settings.

The purpose of the study is to better understand good practices as well as challenges faced in regard to the equitable deployment and administration of COVID-19 vaccines to reach affected populations in humanitarian settings, as well as to understand measures taken to mitigate the impact on essential health services (including routine immunisation).

The study objectives are threefold:

1. To understand and document successful practices as well as challenges faced in relation to reaching and administering COVID-19 vaccination in humanitarian settings.
2. To understand and document the successful strategies and enabling factors that allow governments and national task forces to best leverage the support of humanitarian actors to reach PoC.

To understand and document measures taken to mitigate the impact on the disruption of essential health services, including routine immunisation.

Humanitarian settings, for the purpose of this study, are the specific geographical locations affected by humanitarian crises where a Health Cluster has been activated. Populations of Concern (PoCs) are the specific populations affected by the humanitarian crisis.

METHODOLOGY AND LIMITATIONS

To meet the different objectives of the study the research team carried out a scoping review that aimed to collect all available information and evidence on COVID-19 vaccination in humanitarian settings. To complete this information, six case studies were carried out in six selected countries with humanitarian settings: Colombia, Cox’s Bazar in Bangladesh, Democratic Republic of Congo (DRC), Iraq, South Sudan, and Syria.

A participatory method involving stakeholders from a variety of backgrounds was used for interviews and workshops at different stages of the study. This approach helped to make sense of the data and to jointly develop recommendations for action, but also to provide feedback to those planning or implementing emergency operations, so that they could make improvements, encourage policies and make organisational and operational changes to increase the effectiveness and efficiency of the response to the COVID-19 pandemic in humanitarian situations.
FINDINGS AND CONCLUSIONS

The following points respond to the above study objectives and the research questions set out in the research framework. The conclusions relate to the findings presented in the report based on the scoping review and the six country case studies.

GOOD PRACTICES/CHALLENGES IN REACHING AND ADMINISTERING COVID-19 VACCINATION IN HUMANITARIAN SETTINGS

**RQ 1: What have been successful policies and strategic arrangements to reach and vaccinate eligible PoC?**

The **National Deployment and Vaccination Plans (NDVPs)** developed with support from the WHO, UNICEF, and Gavi, with inputs from some of the country-level partners, have evolved as more resources and supply became available. Early versions of the NDVPs, by and large, did not include PoCs as a target population. Humanitarian partners played an important advocacy role in favour of PoCs being included in the NDVPs. It is often with delays, at later stages of the pandemic, that PoCs were included as a target population in NDVPs.

Subsequent **decentralised planning** (micro-planning) was also developed at subnational level that took better account of both general population and vulnerable populations’ needs by better taking into consideration local humanitarian situations.

Strategies for accessing the population were regularly improved, depending on the initial results and resources available, drawing on the EPI strategies of **fixed sites** and then expanded through outreach and **mobile clinics and campaigns** that provided PoCs a better access to vaccination.

Different coordination mechanisms are reported for the implementation of the NDVPs, around the **Ministry of Health (MOH)** and local authorities, with varying degrees of humanitarian partner representations expressing their concerns for the PoC.

Different human resource strategies are reported depending on the ability to mobilise additional human resources for COVID-19 vaccination. Some countries rely on existing staff to cover COVID-19 immunisation, alternating between routine care and COVID-19 vaccination activities. Other countries mobilise additional human resources to cover COVID-19 vaccinations so that essential health services can continue to be provided.

**RQ2: What have been good practices and operational challenges for reaching and vaccinating populations of concern?**

Despite considerable experience gained from the EPI, infectious diseases outbreak management, and epidemic preparedness, low-resourced and volatile settings face significant and additional challenges compared to others in reaching PoCs.

Poor accessibility and further isolation of communities, resulting in additional costs and logistical constraints (transportation of vaccines and teams, cold chain, etc.), **limited funding capacity**, and **weaker health systems**, demanded efforts that were unprecedented, especially in fragile and conflict-affected settings.

Findings from the case studies highlighted that, while global-level guidance on COVID-19 vaccination may exist and, to different degrees, inclusive NDVPs have been developed, operationalisation of plans differed in reality and plans **did not always translate into equitable vaccine access** for PoC in practice. Due to the scale and urgency needed at national level in humanitarian contexts, where availability of vaccines was severely limited in the early stages and where logistics, operational constraints, and access issues were present, PoC were likely to be considered a lower priority in the deployment of COVID-19 vaccines, facing delays and gaps.
Various modalities of deployment of vaccines were considered to overcome technical and operational constraints and deliver vaccines in humanitarian settings, considering the different and volatile humanitarian situations and restricted access due to insecurity, or conflict. Combined modalities (fixed, outreach, and mobile services) coupled with strong community involvement and mobilisation proved to be an effective way to increase COVID-19 vaccination coverage in these settings. Vaccination teams supported the distribution and deployment of COVID-19 vaccines depending on contextual factors and national frameworks. Flexibility and adaptation were keys to success.

Negotiation and mediation efforts by humanitarian actors to unlock access barriers were key to providing vaccination services to otherwise restricted and isolated populations. In times where security conditions worsened during the pandemic due to lockdowns, the security of vaccination teams was jeopardised, the presence of humanitarian actors was limited, and communities were further isolated.

**RQ 3: Understanding specific needs of the population of concern.**

Vaccine demand among PoCs was found to fluctuate:

- In some countries, a very high demand was observed when the first batches of vaccines arrived but was followed by a drop in demand due to limited availability and access to vaccines, as well as to hesitation and reluctance.
- In some settings, demand was relatively low in general due to factors such as delayed arrival of the first vaccines, PoCs being already exposed to rumours and misinformation, the types of vaccine that arrived first, and mistrust in the source of vaccines (i.e., the implementers (governments) or the health system).
- In other countries, fluctuations in demand have been affected by the national pandemic trend, as each surge in positive cases of COVID-19 has been accompanied by an increased demand for vaccines, which then decreased when the number of positive cases dropped.

Variations were observed between countries in identifying demand-side barriers specific to PoC. In some countries specific mechanisms to closely monitor the factors affecting vaccination demand were implemented, including from PoCs (North-West Syria – NWS cross border response areas), while others had localised sporadic interventions monitoring many categories of the population (Colombia, DRC, and South Sudan).

Moreover, while various interventions were designed and implemented to understand demand-side barriers, few tools were developed for PoCs. The design and implementation of the RCCE was also challenging given that COVID-19 vaccination has led to targeting new types of eligible cohorts (primarily adults) that differ from those of routine vaccination (children under the age of five years), with different approaches consequently needed for demand generation and vaccination.

Another difficulty identified in understanding the obstacles on the demand side was related to incomplete data sources, especially for affected populations preventing the designers of the Risk Communication and Community Engagement (RCCE) from having a complete view of the situation of the country and the effect of the different determinants of demand.

In regard to factors affecting demand, a long list of factors was found through the scoping review and the various case studies. Many factors were cross-cutting between countries and PoC categories (such as hesitancy due to rumours and misinformation), while others were context related (e.g., mistrust in the rational for procurement of some vaccines in Syria) or specific to a PoC category/group (e.g., discrimination against migrants in Colombia).
RQ 4: To what extent have the PoC and the general population benefited equitably from vaccination with COVID-19?

Poor data quality or absence of data to specifically categorise PoCs in most humanitarian settings resulted in difficulties monitoring COVID-19 vaccination coverage for PoCs. These gaps mean there is insufficient evidence to establish an in-depth understanding and analysis of the extent to which the various categories of PoC have been reached.

However, the study showed that COVID-19 vaccination coverage varies regardless of the proportion of the total population who are in need of humanitarian assistance sub-nationally. The case studies also provided examples of situations where populations in humanitarian situations do not benefit from the same immunisation coverage as the general population. Differences in coverage in humanitarian settings are not necessarily due to inequitable planning and policy, but also due to the barriers and constraints found and the difficulty of mobilising resources in proportion to these constraints.

Despite having some NDVPs that were inclusive and strategies promoting a universal and equitable approach, when it comes to the availability and distribution of COVID-19 vaccines in humanitarian settings, the reality differs when compared to the rest of a nation’s population. Inclusion on paper in vaccine roll-out has not always translated into equitable vaccine access for displaced and affected populations in practice in the countries studied.

The overall limited supply of vaccinations and the urgency of scaling up with limited resources particularly affected humanitarian contexts and marginalised communities, with a noticeable tendency to prioritise populations that were easier to access such as those living in or close to urban areas, and nationals versus migrant populations.

Given current operational and logistical constraints, populations affected by humanitarian situations lack the same conditions in terms of equitable access as the rest of the population.

UNDERSTAND AND DOCUMENT SUCCESSFUL STRATEGIES, ENABLING FACTORS FOR GOVERNMENTS AND NATIONAL TASK FORCES TO BEST LEVERAGE THE SUPPORT OF HUMANITARIAN ACTORS TO REACH POPULATIONS OF CONCERN

A centrally managed national model allowed authorities to focus on speeding vaccination and scale-up at national level as a priority but has not always provided equitable access to COVID-19 vaccines, particularly to populations affected by humanitarian crisis.

The inclusion of humanitarian actors to support and/or administer COVID-19 vaccination differed depending on the strategies and operational modalities in which COVID-19 vaccination plans were implemented, but also on the political will.

Overall, NGOs’ capacities for vaccine deployment and support, including gaining and negotiating access and being present in humanitarian settings, were underutilised (due to them being vaccine/funding dependent). In addition, NGOs also faced significant operational and bureaucratic restrictions. Leveraging NGOs as a key partner from the outset would have helped drive a more efficient response, might have ensured marginalised populations were included, and increased vaccination coverage in fragile settings.

The participation of humanitarian actors remained dependent on the involvement and good will of national and local authorities. The significant advocacy efforts made by humanitarian partners achieved inclusive NDVPs as well as ensuring vaccination services, including administration of vaccines, have been provided in humanitarian settings.

National coordination mechanisms and platforms for COVID-19 vaccination planning and roll out, sometimes supported by Health Clusters, did not always provide an open and participatory space for humanitarian
dialogue and action for COVID-19 vaccination to reach PoC, which resulted in coordination opportunities, guidance being missed, impacting the ability to effectively reach PoCs in COVID-19 vaccination deployment.

Financing of COVID-19 vaccination was mostly an issue in settings and countries with lower resources, emergency humanitarian crises, and diverse priorities. **NGOs’ financing** for immunisation-related activities in humanitarian settings was an issue as it was often not well distributed among agencies, due to lack of transparency or to being dependent on standing implementation agreements and prior donor streams. This hinders the ability to secure funding for a wider range of partners potentially able to support COVID-19 immunisation activities.

**UNDERSTAND AND DOCUMENT MEASURES TAKEN TO MITIGATE IMPACT ON DISRUPTION OF ESSENTIAL HEALTH SERVICES, INCLUDING ROUTINE IMMUNISATION**

The decline observed at global level in routine immunisation during the initial phase of the COVID-19 pandemic is now changing in tandem with intensified effort to respond to health systems challenges, bottlenecks, and barriers related to COVID-19 and COVID-19 vaccination. Some exceptions to this initial decline are noted, such as in Cox’s Bazar, which shows an improvement in immunisation coverage over the three years of the pandemic, and with South Sudan, which shows stable immunisation coverage. It is noted that these countries retained the financial and human resources allocated to routine immunisation during the COVID-19 and COVID-19 immunisation phases.

There are several reasons for the decline of essential health services for the general population. These reasons are evolving and range from difficulties in accessing vaccination centres due to mobility constraints, to health workforce availability and capacities, to the decrease in resources allocated to routine vaccination in favour of COVID-19 and COVID-19 vaccination, to the fear of catching COVID-19 in health centres. These reasons also apply to PoCs and are likely to be exacerbated by humanitarian situations.

There is little disaggregated data to monitor routine immunisation coverage and service delivery gaps specifically for PoCs. At the global level, evidence is inconclusive on whether PoCs experienced overall lower immunisation rates and higher Vaccine Preventable Diseases (VPD) burdens compared with host populations.

Countries adopted short-term strategies and innovations to not only overcome disruptions and recover essential health services but also to scale up COVID-19 vaccination. **No common approach was found to address the decline in routine immunisation** specifically for PoCs or with a specific component for categories of PoCs.

**Different approaches** have been proposed by countries depending on the availability of resources. These adaptations evolved throughout the response to COVID-19. Infection Prevention and Control (IPC) protocols were (re-)publicised and strengthened. Routine immunisation modalities were changed from fixed to outreach, and specific intensified immunisation activities were implemented to address the most urgent needs. Door-to-door visits were proposed, while elsewhere alternate sequences of COVID-19 vaccination and routine immunisation were offered. The size of the immunisation teams was also reduced to allow more teams to respond to both COVID-19 and to routine immunisation. Recently, the integration of COVID-19 vaccination into routine immunisation activities was being considered in the majority of the countries studied.

**Some countries** were able to mobilise additional resources to conduct their COVID-19 vaccination campaigns, which meant that resources were not diverted away from routine immunisation.

Given the importance of maintaining essential health services, particularly routine immunisation, **communication efforts in favour of routine immunisation** were intensified in all the countries in the study.
Demand and mobilisation of the population through local leaders were promoted simultaneously for COVID-19 vaccinations and routine vaccinations alike.

**RECOMMENDATIONS**

### GOOD PRACTICES/CHALLENGES IN REACHING AND ADMINISTERING COVID-19 VACCINATION IN HUMANITARIAN SETTINGS

#### POLICIES AND STRATEGIC ARRANGEMENTS TO REACH AND VACCINATE POC

**To governments:** The principle of health equity should guide decision-making. Ensure that COVID-19 vaccination plans and strategies guarantee equitable access to vaccines for all persons within the national territory.

**To governments:** Ensure that NDVPs are based on sound microplanning that is representative of local realities, i.e., by local authorities with representative populations.

**To governments and local authorities:** Facilitate involvement of NGOs and community-based organisations in humanitarian settings in the strategic and operational planning of vaccination programmes at country and local level to enable locally appropriate and coordinated responses that will benefit PoCs.

**To the WHO:** Support the adaptation of a global vaccination policy model to specifically include affected populations in humanitarian settings in catch-up immunisation for COVID-19 vaccination, mass vaccination campaigns, and pandemic response plans.

**To governments and donors:** Increase the resources to deploy the NDVP as well as the means to enforce it at local levels.

**To governments and the WHO:** Provide resources to improve monitoring including vaccination coverage in real time and consider data disaggregated according to PoC status, to reach populations in humanitarian settings. This will consequently improve decision-making and resource management by identifying the barriers to and facilitators of vaccination services.

**To the WHO:** Perform a robust, large-scale study to identify what the value of consistently incorporating COVID-19 vaccination in HRPs would have been.

**To donors and United Nations (UN) agencies:** Soften and adapt funding requirements and procedures to allow for additional implementing partners to rapidly respond to pandemics in general, including integrating COVID-19 vaccination. Explore possibilities to have a country level mechanism to support rapid disbursement of NGO financing.

**To governments and the WHO:** Take opportunity of the situation of the current pandemic to strengthen national pandemic preparedness plans to prevent and respond to newly emerging infectious diseases (including with large-scale vaccination deployment) while maintaining quality essential health services. Plans should incorporate an improved surveillance and monitoring system to identify and monitor PoC health status.

#### OPERATIONALLY REACHING AND VACCINATING POC

**To governments and the WHO:** Capitalise on lessons learned during the pandemic and design operational guidelines for how to reach different categories of PoC with COVID-19 vaccination on timelines equivalent to the general population. The guidelines should be contextualised to the different humanitarian settings to address their operational and supply barriers and define targeted actions and modalities of vaccination. Operational guidelines should be disseminated, with quality data collected and published, so that success can be monitored.
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To governments and the UN: Support frontline staff involved in vaccination deployment in insecure environments by undertaking sufficient measures to mitigate potential attacks, ensuring the security and safety of vaccination teams, with a special emphasis on the protection of women and vulnerable teams.

To governments: Address the administrative barriers faced for PoC in accessing vaccines, including by taking a flexible approach to ID and documentation requirements by issuing temporary identity cards or allowing the use of identity documents from other countries and by ensuring that vaccination registration systems and vaccination centres are accessible to those without access to computers or the internet and to people who face language barriers.

To governments and donors: Provide sufficient support and funding for delivering vaccines, including in remote areas and areas with limited health infrastructure. These costs must be budgeted for by governments, UN agencies and NGOs, giving consideration not only to the cost of doses and delivery materials but also to transport and cold chain infrastructure, different models of care, the safety of frontline workers, training and logistics, and vaccine tracking and coverage.

To the UN: Include identification and availability of services to respond to future Public Health Emergency of International Concern (PHEIC) events or large epidemics services as part of the Humanitarian Needs Overview (HNO) planning process in each country.

UNDERSTANDING THE SPECIFIC NEEDS OF POCS

To governments, the WHO, UNICEF and NGOs: Develop communication and vaccination strategies based on contextualised understanding of the representations and perceptions of different PoCs regarding COVID-19 vaccination through a participative approach involving PoCs to co-create programs and delivery of services. Additionally, ensure accountability to all parts of the populations, including PoCs.

To governments, the WHO, and NGOs: Consider the changing epidemiology of the virus as well as changing evidence on vaccines affecting demand and adapt RCCE strategies accordingly for effective impact.

To governments, WHO and NGOs: Adapt communication tools to PoCs to reduce inequalities in vaccine information (including translation of information materials into relevant languages).

To governments: Compile and use the data generated by the different interventions aimed at understanding the barriers on the demand side to inform the decision-making process through a bottom-up evidence-based approach.

To governments and donors: Invest in consistent RCCE and messaging given the multitude of vaccines being developed, changing guidance, and evolution of misinformation.

SUCCESSFUL STRATEGIES AND ENABLING FACTORS FOR GOVERNMENTS AND NATIONAL TASK FORCES TO BEST LEVERAGE THE SUPPORT OF HUMANITARIAN ACTORS TO REACH POCS

To governments and the WHO: Strengthen coordination and leadership at national and subnational level (i.e., by those leading COVID-19 vaccination planning and implementation) from the outset to ensure that humanitarian partners are meaningfully engaged to enable an effective and aligned response in humanitarian settings and that everyone is reached. Humanitarian partners have a role in leading and co-leading groups, engaging in planning, providing technical assistance as well as being involved in implementation and administration of vaccination activities. In line with this, ensure that appropriate COVID-19 coordination mechanisms are in place with sufficient space for humanitarian actors to dialogue and to generate a greater impact and a speedy and effective humanitarian response to public health emergencies, including mass vaccination. Leverage existing partners and networks, invest in time and efforts to reach out and work with such networks such as the Health Cluster Partners and /or Coordinator.
Study to examine COVID-19 vaccination in humanitarian settings

To the Inter-Agency Standing Committee (IASC), WHO, Gavi and UN agencies: Provide operational guidance to humanitarian partners to ensure relevant actions are put in place for the provision of COVID-19 vaccination in humanitarian settings. Review and strengthen IASC protocols on public health emergencies to ensure robust inclusion of reaching populations affected by crisis with vaccines or other interventions including measures for leadership and financing.

To Health Clusters, WHO, UNICEF, Gavi and the Humanitarian Country Team (HCT): Invest in strong relations with government and local authorities to ensure buy-in and engagement for humanitarian response for equitable services and sufficient funding for pandemic response and to ensure sufficient dialogue and action for COVID-19 vaccination to reach PoCs takes place.

To Health Clusters and HCT: Consider WG in the Health Cluster and or HCT to at a minimum, track and discuss access to COVID-19 vaccination services by populations affected by crisis. Ensure issues are well understood by all members e.g., in HCT to ensure appropriate advocacy and response.

To donors, the WHO, and UNICEF: Provide timely funding mechanisms for COVID-19 immunisation in fragile and humanitarian settings that are sufficient to meet operational constraints, recognising that these may vary considerably depending on the situation.

To donors, the WHO, and UNICEF: Stimulate fundraising, soften and adapt funding requirements and procedures to allow for additional implementing partners to rapidly respond to pandemics, and increase transparency in funding allocation to implementing partners according to needs and with an eye to avoiding duplication of efforts for COVID-19 vaccination.

To donors and the UN: Facilitate NGO representation at all stages of the decision-making process and operational requirements (e.g., financing, access negotiations, importation, etc.) to ensure better access to PoCs.

MEASURES TAKEN TO MITIGATE THE IMPACT ON THE INTERRUPTION OF ESSENTIAL HEALTH SERVICES, INCLUDING ROUTINE IMMUNISATION

To governments and the WHO: Maintain and protect essential health services from disruption from the outset of the epidemic and ensure this is contextualised for populations facing humanitarian crises whose health needs may be different than the wider population.

To the WHO: Assess the implications of COVID-19 direct and indirect impact on the resurgence and the spread of VPDs, as well as the effect on infant and child healthcare, in humanitarian settings with disaggregated analysis on PoCs. This study on several countries with different routine immunisation coverage could inform priority setting during a future pandemic.

To governments and the WHO: Integrating COVID-19 vaccination with routine immunisation activities is a pragmatic way of reaching communities. However, given fragile health systems and challenges in the provision of routine immunisation for PoC, at national level, this option should be explored in a meaningful way with appropriate investments to further develop the approach, strategy, policy and resources (cold chain, human resources, finance, etc.) to reach PoC for the epidemic phase but also for the transition to an endemic phase.

To governments, the WHO and UNICEF: While respecting humanitarian principles and protecting PoCs, test the use of disaggregated data by PoC typology to better monitor routine immunisation coverage and gaps in service delivery for these populations.
1 INTRODUCTION

In January 2020, the World Health Organization (WHO) Director-General declared the outbreak of a new coronavirus (2019-nCoV) to be a Public Health Emergency of International Concern (PHEIC). On 11 March 2020, given the alarming levels of spread and severity of the disease, the WHO classified COVID-19 as a pandemic. Since then, it is estimated that 14.9 million additional deaths were associated with the COVID-19 pandemic in 2020 and 2021. The threat of another variant-induced wave of disease remains.

The COVID-19 pandemic presents a very serious threat to global public health and socio-economic stability. This is particularly the case in countries affected by humanitarian crises, where health systems are weak and large numbers of vulnerable people live in sub-optimal conditions that may accelerate COVID-19 transmission. The global response has been organised, considerable resources have been mobilised which have allowed the rapid development of various tools, such as vaccines. In December 2020 the first COVID-19 vaccine was authorised by WHO.3

The discovery and commercialisation of an effective COVID-19 vaccine was key in the response to the COVID-19 pandemic. Different initiatives were developed to deploy and administer COVID-19 vaccines for all. The COVAX Facility was launched in September 2020 with the goal of ensuring fair and equitable access to COVID-19 vaccines for every country.4 The WHO Strategic Advisory Group of Experts on Immunization (SAGE) offered guidance globally on the allocation and prioritisation of populations to receive COVID-19 vaccines,5 and several guidance updates have highlighted the importance of populations in humanitarian settings.6

A Humanitarian Buffer7 was established in 2021 within the COVAX Facility to prioritise reaching those considered the most vulnerable and at risk of being neglected by national vaccination efforts8 and to act as an important measure of ‘last resort’. It was created to ensure access to COVID-19 vaccines for populations in humanitarian settings that are not covered under national deployment and vaccination plans to ensure that the hardest-to-reach people are protected. As of 31 December 2022, the Humanitarian Buffer is no longer accepting new applications.9 Only eight applications were received with a total of 3,387,600 approved doses, with only two delivered.10 This is mainly due to operational challenges (application processes, regulations for humanitarian partners, and importation of vaccines).

In December 2021, the COVID-19 Delivery Partnership11 (CoVDP) between UNICEF, the WHO, and Gavi was created to accelerate uptake, aiming at reaching 70% vaccination coverage, and to coordinate in-country

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6 Ibid.
7 https://www.gavi.org/vaccineswork/covax-humanitarian-buffer-explained
8 Gavi Discussion Paper. Taking stock of humanitarian access to pandemic vaccines, 2022; and Joint Gavi–IASC statement on delivery: Gavi, Gavi and humanitarian agencies partner to deliver COVID-19 vaccines to the most vulnerable people in the world, 16 November 2021.
9 IASC. The Humanitarian buffer
10 Humanitarian Buffer Stakeholder Briefing, March 2022.
support with on-the-ground humanitarian partners as well as support from GHC as required. As at January 2022, 34 countries had been prioritised by the Partnership to boost vaccine delivery.\(^\text{12}\)

The WHO developed strategies to achieve global COVID-19 vaccination with a global target of 70% coverage by June 2022.\(^\text{13}, \text{14}\) As the IASC-designated Cluster Lead Agency, the WHO hosts the GHC within the WHO Health Emergencies Programme to relieve suffering and save lives during humanitarian and public health emergencies.\(^\text{15}\) The GHC currently supports 32 health clusters/sectors\(^\text{16}\) with over 900 partners in-country and 60 at global level.\(^\text{17}\) Health clusters support national authorities to provide timely, effective, and appropriate actions to minimise the health impacts of humanitarian and public health emergencies through strengthening of service delivery, addressing gaps, and promoting effective leadership.

As the global target to vaccinate 70% by mid-2022 was set, the GHC COVID-19 Task Team decided to conduct a study to better understand good practices and challenges faced in COVID-19 vaccination of PoC in humanitarian settings. The study’s findings will be used to generate lessons learned and for timely shared learning to help support and inform countries as they scale up to administer COVID-19 vaccines, and to help ensure no one is left behind. This study is the subject of this report and focuses on describing and analysing aspects of COVID-19 vaccination in humanitarian settings across countries. This study does not address the analysis of international mechanisms for procurement or supply of vaccines, although these are mentioned to describe the context.

### 1.1 PURPOSE AND OBJECTIVES

#### 1.1.1 PURPOSE

The purpose of the study is to better understand good practices as well as challenges faced in regard to the equitable deployment and administration of COVID-19 vaccines to reach PoC in humanitarian settings, as well as to understand measures taken to mitigate the impact on essential health services (including routine immunisation).

Findings will be used to help identify good practices for shared learning both across cluster settings and at regional and global level as well as identify challenges that mean further support from the global level should be provided.

#### 1.1.2 OBJECTIVES

The study objectives are threefold:

A. To understand and document successful practices as well as challenges faced in relation to reaching and administering COVID-19 vaccination in humanitarian settings.

B. To understand and document the successful strategies and enabling factors that allow governments and national task forces to best leverage the support of humanitarian actors to reach PoC.

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\(^{12}\) 34 countries had below 10% coverage and were not on track to meet the 70% coverage target (data correct as at 13 January 2022).


\(^{16}\) [https://healthcluster.who.int/countries-and-regions](https://healthcluster.who.int/countries-and-regions)

\(^{17}\) [https://healthcluster.who.int/partners](https://healthcluster.who.int/partners)
C. Understand and document measures taken to mitigate the impact on the disruption of essential health services, including routine immunization.

2 METHODOLOGY

2.1 APPROACH

To meet the different objectives of the study, a mixed methods approach was adopted. The team started by carrying out a scoping review that aimed to collect all available information and evidence on COVID-19 vaccination in humanitarian settings. To complete the information collected, and better understand the specificities of the different humanitarian contexts, six case studies were carried out in six different countries with humanitarian settings. The selection of countries was made to allow for a sufficiently wide variety of situations and humanitarian contexts so that the lessons and recommendations drawn from this study could be applied to other countries facing humanitarian crises when responding to emerging infectious diseases, including the equitable deployment of new vaccines. The humanitarian situations of the six countries are described in Annex 3.

A participative method was designed to provide feedback to those planning or implementing an emergency operation so that they can make improvements, foster policy, and achieve organisational and operational change to increase the effectiveness and efficiency of the overall response. This method brought a range of stakeholders together to make sense of the data and jointly develop recommendations for action, promoting greater ownership of and commitment to the findings and recommendations, in a way that explicitly addresses learning.
The study focuses on PoC in humanitarian settings. Humanitarian settings, for the purpose of this study, are the specific geographical locations affected by humanitarian crises where a Health Cluster has been activated. A humanitarian crisis is defined as any circumstance where humanitarian needs are sufficiently large and complex to require significant external assistance and resources (sudden-onset or protracted emergencies, natural disasters, public health emergencies, complex emergencies, international or internal armed conflicts, etc.) and where a multi-sectoral response is needed, with the engagement of a wide range of international humanitarian actors (IASC). PoCs are the specific populations affected by the humanitarian crisis. This term is used by COVAX, the WHO, GHC, and other actors involved in COVID-19 vaccination campaigns to refer to people affected by humanitarian crises. Depending on the different humanitarian situations, these populations may include (but are not limited to) Internally Displaced Populations (IDPs), returnees, refugees, migrants regardless of their legal status, those living in hard-to-reach or insecure areas, and those living in non-government-controlled areas.

2.2 RESEARCH MATRIX

A research matrix was developed for this study to be used as our overarching analytical tool. In the matrix, each objective was divided into a set of specific questions, for which an indicator – or set of indicators – has been defined. The information that was to be collected contributed to the indicator to respond to the question. Potential data sources/key informants and appropriate data collection methods were also elaborated for each question and mapped against the matrix (Annex 1).

2.3 SCOPING REVIEW

A scoping review was conducted to identify the variety of literature (both scientific and grey) on COVID-19 vaccination in humanitarian settings. The purpose of this review was to systematically collect and analyse published data and literature that is relevant to the components of the research matrix that guide the entire study. The scoping review, including the detailed methodology used for it, was submitted separately.

2.4 CASE STUDIES

2.4.1 APPROACH

For the purpose of this study, six different case studies were conducted in six countries: Colombia, Cox’s Bazar in Bangladesh, Democratic Republic of Congo (DRC), Iraq, South Sudan, and Syria.

The case studies enabled the documentation and capture data about the implementation of COVID-19 vaccination strategies and approaches, including challenges and enablers, which tend to be highly sensitive to context and to the different situations faced by PoC. They also enabled better understanding of the causal mechanisms that might influence COVID-19 vaccination approaches to reach PoC (i.e., context, the various steps taken and the importance of different operational details during decision-making and implementation, models and approaches used, and the management process in linking policy/strategy to COVID-19 vaccination). Finally, they also documented the disruption of other essential health services.

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18 https://healthcluster.who.int/countries-and-regions
19 https://www.corecommitments.unicef.org/ccc-1-1
20 Global Humanitarian Overview for country-specific humanitarian response plans, and people in need (PIN) of humanitarian assistance. https://hum-insight.info
The case studies drew on primary data obtained through qualitative data (i.e., key informant interviews (KII)), complementing secondary quantitative and qualitative data obtained from reports and other data sources.

2.4.2 SECONDARY DATA COLLECTION AND ANALYSIS

Document reviews were conducted for each of the case studies before starting the interviews in order to better understand the context and key information relating to vaccination against COVID-19. In addition, health cluster coordinators and other informants/participants were invited to share any relevant documentation relating to the objectives of the study in their respective countries.

2.4.3 KEY INFORMANTS AND GROUP INTERVIEWS

Semi-structured KIIIs with different categories of stakeholder were used to generate rich insights for the case studies. In consultation with the respective WHO country offices and health cluster coordinators, a complete list of potential stakeholders was developed for each country/setting. A purposive selection of informants was used to ensure representation of all key stakeholders and allow sufficient variation in views. Key informants’ categories included national authorities (such as ministry of health (MOH) representatives), UN agencies’ representatives, Humanitarian Country Team (HCT) members supported by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), international non-governmental organisations (NGOs), national NGOs and civil society organisations (CSOs), observers and (de facto) local health authorities’ representatives.

The team aimed to conduct about 15 interviews per country, with several KII per each category of stakeholder to ensure sufficient variation, as represented in the preliminary stakeholder mapping. A total of 88 KII was interviewed, broken down as follows: 11 in Iraq, 13 in Syria, 16 in South Sudan, 18 in DRC, 16 in Colombia, and 14 in Cox’s Bazar. In addition to these, some members of the Steering Group for the study and other key global stakeholders in COVID-19 (donors and other global stakeholders) were contacted to share their views to provide a global perspective or in-country experience for selected settings, as relevant.
A topic guide covering the different sections of the research matrix was developed for the semi-structured interviews. It covers the different sections of the matrix and was adapted by the study team based on the categories of key informants (see Annex 2).

### 2.4.4 COUNTRY LEVEL WORKSHOP

In regard to the case studies, one online co-learning and co-creation workshop was held at country level to discuss the study findings, agree on the conclusions, and jointly formulate the recommendations, except for Syria where four workshops were carried out. The complexity of the situation in the country, the differences in terms of findings as well as the sensitivities that exist between the different regions led to the organisation of the additional workshops in Syria. It was important that relevant stakeholders participate in the process as these workshops are considered to be useful occasions to stimulate discussion around key topics for learning, and to jointly validate the findings and recommendations. A total of 166 stakeholders participated in the workshops for the case studies, distributed as follows: 12 in Iraq, 77 in Syria (44 for HCT coordinated response areas, 14 for northeast Syria (NES) NGO coordinated response areas, and 19 for northwest Syria (NWS) cross border response areas), 20 in South Sudan, 26 in DRC, 18 in Colombia, and 13 in Cox’s Bazar.

### 2.4.5 COUNTRY CASE STUDY REPORT

Lastly, a draft report including both findings and feedback collected during the workshops was sent and shared at country level with key stakeholders. Upon reception of final comments and obtaining of clearance from the country health cluster coordinator, a final version of the case study report was shared with the GHC.

### 2.5 FINAL SYNTHESIS REPORT

In regard to the scoping review, preliminary findings were first presented to the Steering Group in an online meeting. Then, a draft report was submitted to the Steering Group members to allow them to comment on findings and give feedback. Lastly, a final version was produced along with a slide-deck for wider dissemination.

The findings from the scoping review and case studies were finally combined into this synthesis report, which highlights themes that are common across the studied settings as well as the successful strategies and good practices learned following the research questions. Examples are also given from country level to illustrate themes but are not exhaustive. Prior to submitting the synthesis draft report for feedback, a global co-creation workshop was held with the Steering Group to jointly formulate the main lessons learned and global recommendations. The draft report was submitted to global key stakeholders including the Steering Group for appraisal and feedback. The final report incorporating all received feedback will be produced along with slide-deck presentations to be used for wide dissemination. The study team will also support the dissemination of the results during three meetings with key stakeholders or public webinars, agreed upon jointly with the WHO/GHC and the Steering Group.

### 3 IMPLEMENTATION OF THE STUDY

#### 3.1 TIMELINE OF THE DIFFERENT PHASES

The study started on 28 March 2022 and lasted until mid-January 2023. The schedule and sequence of the different activities are as follows:

1. Inception phase (March - June 2022)
2. Scoping review (June-August 2022)
3. Case-studies (August-December 2022)
4. Final report development (December 2022-January 2023)

It should also be noted that the members of the Steering Group were closely involved in the project activities. For instance, several meetings and workshops were organized with the members of the Steering Group and aimed at (1) reviewing the terms of reference and the inception report, (2) discussing and validating the conclusions of the scoping review, (3) discuss and validate the conclusions of the case studies. In addition, members of the Steering Group were invited to review and comment on all project deliverables before validation and dissemination.

3.2 STRENGTHS AND LIMITATIONS

The adopted methodology combining a scoping review with case studies has several strengths and some potential limitations. In terms of strengths, to the researchers’ knowledge, this study includes the first scoping review to assess COVID-19 vaccination in humanitarian settings. This scoping review provided an in-depth understanding of the different factors influencing COVID-19 vaccination, which provided the background knowledge required prior to the case studies. Further, in addition to having acquired the necessary in-depth knowledge of the subject, the researchers were able to identify existing gaps in the literature related to evidence on COVID-19 vaccination and assess them in depth through the case studies. Therefore, the case studies complemented the scoping review and mitigated its methodological biases (see limitations below).

Another strength is the variety of humanitarian situations in the selected countries, which made it possible to study the impact of different humanitarian situations (displacement, conflict, political instability, etc.) on COVID-19 vaccination. Furthermore, the inclusive approach adopted through the selection of a wide variety of categories of key informant captured different perspectives on the factors influencing strategies to reach PoCs and the challenges faced.

The researchers identified a number of limitations in both the scoping review and the case studies. In regard to the scoping review, the main source of available data was the grey literature rather than peer-reviewed scientific articles. Moreover, there was a lack of evidence on some aspects of COVID-19 vaccination for PoCs due to the novelty of the topic, which prevented gathering sufficient information in order to respond to the different indicators in the research matrix.

Furthermore, the data uncovered by this review was mainly descriptive rather than analytical and not disaggregated by type of PoC, which impeded proper assessment of equity. This lack of disaggregated data combined with limited availability of documentation in certain contexts has made it impossible to conduct a unified quantitative analysis to assess equity in different countries. Additionally, the variety of humanitarian settings covered by this study (displacement, conflict, political instability, etc.), coupled with country specificities (such as areas of control and humanitarian response areas in Syria), precluded comparison of different settings to study the impact of context-related factors on COVID-19 vaccination.

Additionally, in the case studies, the political context of some countries combined with the collaborative approach of including, a variety of participants in the co-learning and co-creation workshops may be subject to bias resulting from the reduced spontaneity and participation of some participants due to pre-existing dynamics, relationships, as well as difficulties discussing sensitive topics in a multi-stakeholder group.

Finally, the qualitative approach may have led to information bias resulting from recall bias and positional bias of informants and participants, both of which can influence their perspectives and statements.

To mitigate these, an inclusive and participatory approach has therefore been adopted. For instance, a large sample including a wide variety of informants/participants was recruited, from the different countries, and
several methodologies were combined, including KII, group workshops, document review to reach data saturation.

4 KEY FINDINGS

4.1 OBJ. 1: UNDERSTAND AND DOCUMENT SUCCESSFUL PRACTICES AS WELL AS CHALLENGES FACED IN THE EQUITABLE DEPLOYMENT AND ADMINISTRATION OF COVID-19 VACCINES TO REACH POC IN HUMANITARIAN SETTINGS

4.1.1 WHAT HAVE BEEN SUCCESSFUL POLICIES AND STRATEGIC ARRANGEMENTS TO REACH AND VACCINATE ELIGIBLE POC?

The fair and equitable distribution of COVID-19 vaccines is both a strategic investment and a legal obligation for national governments, regardless of the legal status of PoC within the national territory. Ensuring legislation, strategic planning, and operational requirements are in place to secure equitable COVID-19 vaccination for all people in a given country is the responsibility of governments. Different strategic arrangements have been considered by governments in countries with humanitarian settings to procure, distribute, and administer vaccines in their territories, including for PoCs, depending on their respective political and humanitarian contexts and ability to do so.

Supply

Most countries with humanitarian settings received vaccines through COVAX and/or African Vaccine Acquisition Trust (AVAT) contracts and bilateral donations.

| Table 1. Vaccine supplies in 30 countries with dedicated humanitarian response plan (HRP, FA, or JRP) by income group as of 12 December 2022 |

22 WHO. WHO Director-General’s opening remarks at the UK high-level event on equitable access to COVID-19 vaccines in humanitarian settings. June 2021.
25 COVAX is the vaccines pillar of the Access to COVID-19 Tools (ACT) Accelerator, the global collaboration aiming to accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines. COVAX is co-led by the Coalition for Epidemic Preparedness Innovations (CEPI), Gavi, and the WHO, alongside key delivery partner UNICEF. Its aim is to accelerate the development and manufacture of COVID-19 vaccines, and to guarantee fair and equitable access for every country in the world.
26 African Vaccine Acquisition Trust (AVAT) acts as a centralised procurement agent on behalf of African Union (AU) member states to obtain the necessary vaccines, including blended funding resources to achieve the COVID-19 African Immunization Strategy, which aims to immunize a minimum of 60% of the African population based on a pan-African approach. AVAT was established by the COVID-19 African Vaccine Procurement Task Team (AVATT), which was set up in November 2020 by President Cyril Ramaphosa, President of the Republic of South Africa, in his capacity as Chairperson of the African Union (AU).
Low-income countries (LICs) are heavily dependent on the COVAX Advanced Market Commitment (AMC). For instance, in DRC 42.5% of COVID-19 vaccines are supplied by COVAX, 46.3% by AVAT, and 4.7% by bilateral donations (more than 6% unknown). Some countries such as Colombia also received COVID-19 vaccines through purchasing from COVAX as ‘self-financing participants’ or direct agreements with producers.

Most manufacturers supplying COVAX repeatedly downgraded the timelines for delivering their projected volumes to the COVAX Facility, which impacted the ability to organise regular distribution in-country and consequently to PoCs. For most of 2021, this was the situation in the six case study countries, where supply delays had an impact on the first phases of COVID-19 vaccination at the national level and consequently on the populations in humanitarian situations. The lack of availability was global; even though some of these six countries diversified their sources of supply, they do not seem to have been spared any more than the others. As at 13 May 2021, Colombia had only received 58.3% of the total amount expected by COVAX and 20.62% of bilateral commitments.

The supply at the global level improved in 2022 and CoVDP recently reported a median number of vaccine courses secured for 81% of the total population across 91 AMC participants (28 October 2022).

Despite the good intentions, sound rationale, and significant resourcing of the COVAX Humanitarian Buffer, since its inception in early 2021 it has reached only 1% of its intended target of 155 million people estimated to be excluded in humanitarian settings with COVID-19 vaccines. NGOs are a major, and sometimes the only, provider of health services to crisis-affected and marginalised populations; however, they have not been able to carry the significant operational, legal, and financial risks linked to this mechanism. The Humanitarian Buffer is too difficult to access for humanitarian agencies, thus limiting vaccination coverage of PoCs because of bureaucratic complexity, risk transfer, and liability costs.

Policies and strategic arrangements to reach and vaccinate eligible PoC

To respond to the COVID-19 pandemic, most countries developed Strategic Preparedness and Response Plans. These plans had to be adapted to build on what was being learned about the virus and the collective response, following WHO global standards and recommendations. The arrival of COVID-19 vaccines led to the development of specific plans, commonly called National Deployment and Vaccination Plans (NDVPs).

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29 GHC tracking. As at 10/01/2023.
31 ICVA. We need to fix the Humanitarian Buffer. If not for this pandemic, then for the next one.
32 ICVA. We need to fix the Humanitarian Buffer. If not for this pandemic, then for the next one.
35 The NDVP constitutes a country’s overall plan to deploy vaccines and deliver vaccination to identified target populations. The NDVP is considered the “one country plan” and main framework for a country’s COVID-19 vaccine deployment and vaccination effort. The plan can be used to work with donors such as the World Bank, other development banks, and the COVAX AMC for 92 eligible low- and middle-income economies (the AMC 92). WHO. January 2021.
There were global efforts, largely led by WHO, UNICEF, and Gavi, to standardise best practices in the national NDVP processes to identify target populations\textsuperscript{36} and to prioritise uses of COVID-19 vaccines.\textsuperscript{37,38}

PoC were not consistently included in the preparation of NDVPs, at least initially. A review conducted by the GHC COVID-19 Task Team in March 2021\textsuperscript{39} found that just over half (53\%) of NDVPs in countries where a cluster was activated explicitly included refugees and asylum seekers. This finding was supported by the United Nations High Commissioner for Refugees (UNHCR), which found that by the end of 2021, 162 countries included refugees in their national COVID-19 vaccine plans (inclusive of LICs as well as high-income countries (HICs)).\textsuperscript{40} The WHO systematic international policy analysis in February–March 2021 of 104 NDVPs submitted to the COVAX Facility\textsuperscript{41} found that most plans did not explicitly include migrants (72\%), while over half explicitly included refugees and asylum seekers and only 17\% explicitly included irregular migrants.\textsuperscript{42} The same GHC analysis found that, beyond refugees, other categories of PoCs were low priority in NDVPs (Figure 1).

\textbf{Figure 1. Prioritisation of vulnerable groups in the top 3–20%}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure1.png}
\caption{Prioritisation of vulnerable groups in the top 3–20\%}
\end{figure}

\textit{Source: GHC COVID-19 Task Team. Analysis of NDVPs from humanitarian settings. March 2021}

Only group 3 at 20\% was retained here because the within 3\% group targeted, in priority, the most at-risk groups: healthcare workers (HCW), elderly people and people with co-morbidities.

At the global level, different policies were developed and promoted by humanitarian partners to ensure the integration of refugees and migrants in COVID-19 vaccination.\textsuperscript{33,44,45} These initiatives were not developed

\begin{itemize}
  \item \textsuperscript{36} WHO/2019-nCoV/Vaccine deployment/2021.1. \url{https://www.who.int/publications/i/item/WHO-2019-nCoV-Vaccine-deployment-2021.1-eng}
  \item \textsuperscript{37} WHO. WHO SAGE Values Framework for the allocation and prioritisation for COVID-19 vaccination. September 2020.
  \item \textsuperscript{39} Global Health Cluster. C 19 Task Team. Analysis of NDVPs from humanitarian settings, 6 March 2021.
  \item \textsuperscript{40} UNHCR. UNHCR COVID-19 vaccine access report. 2021
  \item \textsuperscript{41} COVAX explained. Geneva: Gavi. 2020. \url{https://www.gavi.org/vaccineswork/covax-explained}
  \item \textsuperscript{42} WHO. COVID-19 immunization in refugees and migrants: principles and key considerations: interim guidance, 31 August 2021.
  \item \textsuperscript{43} WHO. World Health Organization. 2021. \url{https://apps.who.int/iris/handle/10665/344793}
  \item \textsuperscript{44} Wilbrink, F. A Study on Comparing Different COVID-19 Vaccine Allocation Strategies in the Rohingya Refugee Camps in Bangladesh | TU Delft Repositories. August 2021. \url{https://repository.tudelft.nl/islandora/object/uuid%3Adff38065-985c-4149-bc76-a4ff4f3f8c8e}
  \item \textsuperscript{45} WHO. WHO continues to support countries to fight COVID-19. June 2021.
  \item \textsuperscript{45} UNHCR. UNHCR - Vaccinating the world's 80 million forcibly displaced against COVID. February 2021.
\end{itemize}
simultaneously but in a dynamic way and contributed to a better consideration of PoCs. The COVAX Facility launched in September 2020 with the goal of ensuring fair and equitable access to COVID-19 vaccines for every country.\textsuperscript{46} Similarly, the WHO SAGE offered guidance globally on the allocation and prioritisation of populations to receive COVID-19 vaccines\textsuperscript{47} and several guidance updates highlighted the importance of PoCs.\textsuperscript{48} UNHCR and the International Organization for Migration (IOM) advocated for the inclusion of all migrants (including refugees, IDPs, and stateless populations) in national vaccination programmes and use of the COVAX Humanitarian Buffer.\textsuperscript{49} The GHC COVID-19 Task Team with over 28 partners including UN agencies and NGOs developed a position paper in May 2021 so key advocacy could be consistently messaged at global and country level for PoC to be held in equal regard to the wider population.\textsuperscript{50} Overall, the emerging picture is one of increasing inclusion of PoCs in the revised NDVPs.\textsuperscript{51}

in January 2022 WHO, UNICEF, and Gavi launched the CoVDP to support the COVAX AMC by focusing on the 34 countries that were at or below 10% coverage.

Our analysis of the six case study countries shows that initial NDVPs (from the first half of 2021) did not specifically consider PoCs as a target. That said, in Syria and Iraq IDPs were considered as a priority group and were included in NDVPs.

At national level, NDVPs were updated to take better account of the initial difficulties, the flow of available vaccines, and often the low national COVID-19 vaccination coverage, sometimes using intra-action reviews when available. In addition, humanitarian partners continued their advocacy to include PoCs in the national COVID-19 vaccination strategy. In the revised NDVP versions (often dating from the second half of 2021) PoCs were included as one of the targets for the DRC and South Sudan. In Colombia, the NDVP in February 2021 provided for “vaccination without barriers” and “for all”, with an approach based on principles of equity and universal, free access and utilising prioritisation focused on age and epidemiological risks, inclusive of migrants independently of their status. In Syria, the NDVP was developed by the MOH and addressed both vaccination in HCT and NES NGO coordinated response areas. With regard to the NWS cross border coordinated response areas, the DVP was developed by the WHO and UNICEF offices in Gaziantep (Turkey) under the WoS approach and approved by GoS, which ensured that the supply by COVAX is delivered simultaneously across Syria. NDVPs, therefore, evolved to include populations in humanitarian situations as target groups, but the plans developed predominantly focused on national populations and there was not sufficient detail or strategic considerations in the plans to describe how PoC were to be reached. Such considerations were often only present in subsequent exercises.

As COVID-19 immunisation coverage in some countries continued to remain low, new and more operational approaches were proposed to scale up vaccination. These included decentralisation and supportive supervision, enhancing communication and coordination with subnational levels, ensuring adequate financing, exemplary leadership and intersectoral solidarity, and clear national governance and coordination structures.\textsuperscript{52}

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\textsuperscript{48} Ibid.
Challenges associated with COVID-19 vaccination led to the development of micro-plans to ensure that local contexts, challenges, and specific requirements were considered. Global level guidance for the development of such micro-planning was created by the WHO from November 2021.\(^{53}\)

More attention was paid to vulnerable populations in the micro-plans that were developed. For instance, in DRC (from September 2021) and in South Sudan (from August 2021) the micro-plans better considered local needs for IDPs, returnees, and refugees, as well as hard-to-reach people. They therefore allowed for better consideration of local contexts and PoCs. It should be noted that planning depends on local leadership and partners for the last mile. Vaccination campaigns, set out in the micro-plans, accelerated immunisation coverage and reach to affected populations. In January 2022, the Colombian MOH reconfirmed its commitment to guarantee COVID-19 vaccination would reach the most dispersed and remote areas of the country, with a focus in mainly 92 municipalities, some of them affected by active conflict or under the control of Non-State Armed Groups (NSAG), and others with predominantly indigenous populations, which were below 60% vaccination coverage.\(^{54}\)

Overall, there appears to be a delay, depending on the country, in including PoCs in the plans as a target population, interestingly the timing of this occurred as the number of vaccines available at the global level increased\(^{55}\). Most countries ended up including these vulnerable populations in the revised NDVPs without developing a specific strategic approach for them. Vaccination coverage in South Sudan and DRC remains insufficient and it is ultimately decentralised planning (micro-planning) that best addresses PoCs. As will be seen in the following sections, limited resources and sometimes difficulties of access also contribute to vaccination of PoCs only commencing several months after the general population (for example in Iraq).

**National COVID-19 vaccination coordination structures and mechanisms**

Different coordination mechanisms for the implementation of the COVID-19 national plans and later for COVID-19 immunisation have been created in the six countries studied. The MOHs centralised the planning, coordination, and implementation of the NDVPs in their countries. These coordination mechanisms often include humanitarian partners who provide a voice for displaced populations, albeit to varying degrees.

However, it is especially at the decentralised level – for instance, the health zones in DRC, the counties in South Sudan, and in Cox’s Bazar – that coordination best helps vulnerable populations by taking better account of local humanitarian situations.

In Syria, the MOH was responsible for the vaccine supply and vaccination against COVID-19 in HCT and NES NGO coordinated response areas. However, micro-planning has not been sufficiently adapted to align with different contexts within the country. For example, government access to areas under the control of opposition parties in the NES NGO coordinated response areas is limited and coordination with local authorities to reach health facilities is complicated and has not been sufficiently supported during micro-planning. As for the Health Cluster and its partners operating in the NES, although involved in advocacy, operationally they were only involved in the activities of the RCCE.

In Iraq, COVID-19 vaccination planning has been primarily led by the Federal MOH while the largest proportion of PoCs is in the Kurdish region, which has its own MOH. More information sharing and

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\(^{54}\) The PDET territories are organised into 16 subregions, 170 municipalities, and 11,000 villages. That is, they represent 36% of the national territory. As indicated by official government figures, about 6.6 million Colombians live in these municipalities, or 24% of the rural population. In the country, it is worth mentioning that illiteracy in these territories is three times the national average. [https://www.edicionmedica.com.co/secciones/salud-publica/salud-implementa-estrategia-cooperativa-para-impulsar-la-vacunacion-covid-19-en-92-municipios-pdet-2104](https://www.edicionmedica.com.co/secciones/salud-publica/salud-implementa-estrategia-cooperativa-para-impulsar-la-vacunacion-covid-19-en-92-municipios-pdet-2104)

\(^{55}\) During the interviews some KIs reported their perception that NDVPs were becoming more inclusive as vaccine availability improved.
coordination were needed between the two ministries to allow for accurate estimation of the risks of the pandemic as well as the need among PoCs.

A lack of adherence to agreed-upon NDVP strategies and priorities has been reported in DRC and South Sudan, including amongst donor agencies, which could result in duplication of activities because of a lack of transparency and accountability on the part of partners and donors.

**Modalities**

The strategy for accessing populations in general (not specific to PoC) has been regularly modified according to the initial results and the resources available. In most of the countries, the initial COVID-19 vaccination roll-out strategy was planned through fixed sites and outreach and mobile clinics. This drew on Expanded Programme on Immunization (EPI) strategies and activities were expanded according to the available resources, which allowed dispersed (displaced) populations or areas affected by armed conflict to be reached. The strategy for the implementation of the plan was complemented by vaccination campaigns that allow more territories to be covered and thus reach more vulnerable populations. IDPs and refugees benefited from these modalities. These arrangements are mainly supported by the humanitarian implementing partners (NGOs) in health facilities in Cox’s Bazar or with mobile and campaign modalities in South Sudan, Syria, and DRC.

With the aim of reaching the entire population, the vaccination modalities of the EPI (facility-based and outreach) were replicated in Colombia, with the deployment of vaccination teams through different means of transport, which allowed reaching dispersed rural areas or areas affected by armed conflict. However, the NDVP followed a different strategy from the EPI, seeking a rapid and massive impact, with different needs in terms of logistics (cold chain, data collection, etc.) and having as its target the entire eligible population, which involved great efforts, more resources, and higher costs.

**Other deployment strategies for COVID-19 vaccine activities continue to be tested.** COVID-19 vaccination tends to be more integrated in EPI services and/or in primary healthcare (PHC) services. Options were also considered to expand COVID-19 vaccination by using opportunities of humanitarian activities such as nutrition and water, sanitation, and hygiene (WASH) services.

In NWS, doctors specialising in non-communicable diseases have recently been engaged in demand-generation activities and were given incentives for the investment in convincing people to get vaccinated.

**Operational costs**

The NDVPs in the six countries studied include a financial needs analysis but this analysis focuses on the national level and is not specific to populations in humanitarian settings. It is only at the level of the micro-plans that these needs might have been identified and covered with existing resources, and/or by additional resources from implementing partners present in the specific geographical areas or at national level.

The operational costs (logistics, incentives, training, demand generation, human resources, etc.) of delivering vaccines to populations in humanitarian situations in DRC, South Sudan, and Cox’s Bazar are mainly borne by implementing partners, funded with humanitarian donor funding, implemented by UN agencies and NGOs. The PoC in DRC and South Sudan are for the most part in contact with and even integrated into the host population. Thus, the COVID-19 vaccination campaigns supported by humanitarian partners do not specifically target PoCs but rather areas where these populations may be present to varying degrees. Access to COVID-19 vaccination, as well as to PHC services, is therefore chiefly limited by the capacity of partners to provide these additional resources.

In the case of Colombia, where vaccination was undertaken mostly by national health providers, the estimated cost for scheduling and applying the COVID-19 vaccine was different according to the region and
strategy used to stimulate COVID-19 vaccination. However, per diems were granted to vaccinate in more accessible rural areas and in more dispersed remote areas, which sometimes takes two to three days of travel to reach, and were only reimbursed if vaccination targets were achieved. Respecting the phases of the NDVP meant not being able to vaccinate everyone at once in some very remote areas or areas with restricted access, leading to excess costs and resources.

In Colombia and DRC, there have been (systemic) delays in payments to providers that have hampered vaccination efforts in general.

**Human resources**

The initial strategy for implementing the early stages of COVID-19 vaccination in the six countries was to use existing human resources for health such as health facility teams in Cox’s Bazar, the ward nurses in South Sudan, Health Area staff in DRC, and governmental health staff in Iraq. This was sometimes at the expense of other PHC activities.

With the increase in the availability of vaccines and the scaling up of vaccination activities, mobilisation of additional resources was necessary. This is the case in Colombia with the creation of new teams, in NWS with the implementation of additional vaccination teams, in South Sudan with newly trained human resources for COVID-19 vaccinations (including vaccinators, registration staff, and supervisors) to cover vaccination in fixed sites, mobile sites, and campaigns, and in DRC where the human resources for COVID-19 vaccination have been supplemented by the health cluster partners’ (NGOs) teams, particularly in humanitarian settings.

In South Sudan, vaccination against COVID-19 was initially carried out by the ward nurses because the vaccines were in the process of being approved by the Emergency Use Listing Procedures. Routine immunisation was thus not affected, but this was not the case for other essential health services such as malaria and TB programmes. For the second round of COVID-19 vaccination, new vaccinators were recruited (laymen/women who had already gained experience during measles campaigns) and received two weeks of training. This allowed nurses to resume their activities in essential healthcare services and the new vaccinators to deal solely with COVID-19 vaccination.

4.1.2 WHAT HAVE BEEN GOOD PRACTICES AND OPERATIONAL CHALLENGES IN REGARD TO REACHING AND VACCINATING POC?

Fragile economies and healthcare systems and volatile settings face greater and additional challenges compared to HICs despite their significant experience in accessing hard-to-reach populations with health services, including immunisation. While some of the initial challenges in reaching and vaccinating PoC were addressed as the situation evolved, and good and successful practices were implemented, others remained, and solutions need to be explored and put into practice for the future.

As vaccines became more available worldwide, additional challenges arose. As well as the already daunting difficulties in accessing and providing healthcare in humanitarian settings, the pandemic resulted in a new set of constraints. Hard-to-reach areas and regions with active conflict, insecurity, or limited mobility, as well as other populations cut off from humanitarian aid, became overall further isolated due to lockdowns. The limited presence of humanitarian organisations, especially during the first waves of the pandemic, made some locations further insecure and less accessible for vaccination.

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4.1.2.1 Operational challenges and enablers

Once the global supply issues improved, more local logistical challenges then caused domestic slow flows of vaccine supply and distribution. These were due to inadequate or limited storage and distribution systems and logistical capacity at country level, including issues affecting transport and cold chain capacity, human resources for health, and health systems as a whole, which lacked the support and infrastructure for the distribution – issues that were exacerbated in humanitarian settings.

In addition, other barriers such as administrative constraints as well as operational challenges in regard to accessing PoCs were also encountered. Countries with dispersed and rural populations reported limited capacity and heavy logistical burdens to reach populations in hard-to-reach areas, while some countries with active conflicts and insecurity reported attacks against health workers and limited access (e.g., Syria).

Logistical challenges

Most African countries are faced with challenges regarding inadequate medical facilities and infrastructure, which also applies to humanitarian settings in other regions.

Achieving effective delivery of quality COVID-19 vaccines requires a demanding supply and cold chain that meets specific requirements, with different temperature and large stock conditions, which can be difficult to provide and maintain in humanitarian settings. In large and populous countries like Nigeria, the organisation of the domestic cold chain involves five stages from national to primary healthcare level. With the added difficulty in keeping COVID-19 vaccines at the right temperature until administered, infrastructural challenges (including electricity) posed major logistical challenges in areas affected by armed conflict and violence in the northeast of the country. Delivering and storing vaccines in displaced camps and remote settlements proved complex due to limited infrastructure (e.g., Darfur in Sudan).

In the settings studied, in Cox’s Bazar the lack of an ultra-cold chain in the camps, which initially prevented the use of Pfizer vaccines Sinopharm vaccines were ultimately used and had to be stored at district level and brought to the vaccination points in the camps on a daily basis, which created initial delays and logistical constraints. In Damascus and NES, lack of cold chain equipment (including solar based), coupled with frequent electricity cuts, led to a very limited cold chain capacity, although this was overcome with WHO support. In DRC, the EPI used freezers and material for cold chain transport previously provided for the Ebola epidemic and relied on a solar-powered cold chain. As needs increased, the cold chain for COVID-19 vaccination was expanded with support from partners, including in terms of the storage capacity needed to reach remote areas. In South Sudan, outreach vaccination was carried out in remote areas within a perimeter compatible with the conservation of vaccines within the designated vaccination sites, which did limit the efficiency somewhat.

Better-resourced settings with stronger health and supply systems, such as Colombia and Iraq, had initial difficulties that were later overcome. In Iraq, early in the pandemic the cold chain system lacked the capacity to deliver due to the initial requirement for an ultra-cold chain for Pfizer vaccines. Once it was approved that vials could be preserved in a normal medical fridge for one week, distribution improved. In terms of infrastructure, no major gaps were mentioned; 80% of PHC centres were reported as having internet (for

References:

adequate follow-up) and equipment. No other important gaps in logistics related to transportation and cold chain capacity were reported.

Colombia had initial issues with ultra-cold chain storage and with equipment to transport vaccines rapidly to very remote areas, such as thermoses and portable refrigerators. With support from the Health Cluster partners, these became gradually more available.

Application of public health and social measures and the deteriorating access conditions had an impact on transport of vaccination staff, vaccines, and supplies both at domestic and international levels (for supplies), with some international borders (including physical crossings) closed at certain stages of the pandemic. People needing to be vaccinated and vaccination teams alike had limited access to vaccination points in humanitarian settings due to the previously mentioned obstacles. In contexts with disperse and mobile populations, the deployment of vaccination teams was undertaken by different means of transport including boats, donkeys, motorbikes, on foot, etc. This sometimes meant that it took several days to reach small pockets of populations, often those facing insecurity and violence (e.g., in South Sudan, Colombia, and DRC).

According to the literature review, some countries studied used the existing EPI system supply chain (South Sudan, DRC, HCT and NWS cross border coordinated response areas), whereas in other settings and according to literature reviewed (Darfur61) a parallel system was created, which required additional resources. Bringing vaccines to hard-to-reach areas became as such more costly and complex, and often resulted in delays. NES and South Sudan faced challenges related to domestic supply (among other causes): high costs of airlifting the vaccines, difficult land transportation due to insecurity, and required equipment for transportation of vaccines. Some countries relied on vaccines being airdropped by the UN Humanitarian Air Service (UNHAS) in Nigeria,62 South Sudan,63 and Libya64 to improve access to vaccination.

**Type of vaccine**

Even though approved WHO vaccines were available at national level, the choice of vaccines for humanitarian settings was limited due to transportation and cold chain requirements but also supply. Dosage and storage requirements for some vaccines guided preferences, with Pfizer and Moderna requiring, for example, ultra-freezers that were not available or were hard to maintain. In addition, initial guidance suggested a second dose within 21 and 28 days was required respectively before these vaccines offered protection. These logistical requirements made both vaccines infeasible for mass usage in most humanitarian settings. Instead, AstraZeneca’s vaccine was preferred as it can be stored in standard medical fridges, such as are already in use by EPI. However, other constraints arose. Although available through COVAX, distribution was heavily impacted by the AstraZeneca production issues in India during the Delta variant wave (June–October 2021) when exportation of the vaccine was halted. The vaccine also had a six-month shelf life after production, which resulted in large wastage due to expiration dates being passed (South Sudan, DRC, and Nigeria, often compounded by slow delivery to country),65 and was temporary halted in some countries due to initial safety concerns, which impacted acceptance (DRC and South Sudan). In some settings, there was a strong preference by the MOHs to use the J&J/Janssen vaccine, which can be administered as a single dose, providing a good option for highly mobile or hard-to-reach populations that

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62 [https://docs.wfp.org/api/documents/WFP-0000129673/download/](https://docs.wfp.org/api/documents/WFP-0000129673/download/)
might not be able to be reached again (South Sudan, DRC, and Colombia). However, availability of this type of vaccine was often an issue.

**Coverage data**

Disaggregated coverage data existed in some of the studied settings (i.e., refugee and IDP camps in South Sudan and other enclosed settings like refugee camps in Cox’s Bazar) but was not commonly available (e.g., Syria and Iraq). There is also insufficient disaggregated data, with only a few countries monitoring inequity by population group and by gender.\(^66\)\(^67\) This results in limited visibility and understanding and impedes efforts to advocate for higher and more strategic vaccination of PoC. Data was typically of better quality in settings such as refugee and IDP camps that are often able to rely on camp databases. In the case of Cox’s Bazar, COVID-19 vaccination data was linked to the UNHCR camp registration system, which resulted in accurate and up-to-date data and increased data protection. This allowed coverage issues to be identified, including women being less vaccinated than men, lack of acceptance of pregnant women, and vaccination site and camps being difficult to access physically. This data then allowed adjustments in planning and mobilisation to be made.

In settings where the health information systems were weaker, where there were mixed population flows or high mobility, and where people were affected by different humanitarian situations (e.g. mobile, static, host community, and highly volatile contexts), it became more complicated to capture socio-economic and demographic data with sufficient detail so that the different categories of PoC could easily be identified (and therefore recorded and targeted) to improve coverage (e.g. Colombia, Syria, South Sudan, and DRC). Continuous mobility and displacement presented specific challenges to follow-up for subsequent vaccine doses (Colombia and South Sudan). In Colombia, vaccination of over 2 million undocumented migrants was launched, with around 1 million in transit and therefore not easily traceable and 1 million with an expressed intention to stay in the country. A parallel system was created to register undocumented migrants, but this had inaccuracies in the estimation of both numerator and denominator, and only the number of doses could be accounted for and not coverage of this population in particular. This issue is also common with IDPs when they are hosted within the local community, as there is no specific data available.

Other limitations were a lack of specific indicators to collect disaggregated data for PoC (e.g. Chad, Somalia, and DRC), weak denominators or populations estimates that were not consistent between different sources due to outdated censuses and high mobility (e.g., Colombia, DRC, and NES), inconsistent application of definition for returnees in Iraq, issues with ID and registration of IDPs (most countries) or migrants (Colombia), and technical/connectivity issues (e.g. Colombia, DRC), among other issues.\(^68\) All of these shortcomings limited the availability of appropriate COVID-19 vaccination coverage data.

Overall, poor data quality and lack of disaggregated data resulted in difficulties measuring vaccination coverage, planning and monitoring vaccination, and consequently proposing specific measures to possibly improve COVID-19 vaccination coverage of PoC to the level of the general population.

**Funding for operational cost arrangements**

Delivering vaccines to hard-to-reach areas requires additional personnel, resources, and infrastructure. In South Sudan, delivery costs from “tarmac to arm” for vaccines in remote areas were estimated to be $9.97

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\(^66\) Ibid.

\(^67\) Health Cluster. COVID-19 vaccination in humanitarian settings report. 2022; Extract ‘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.’

\(^68\) COVID-19 Task Team Meeting. 13 October 2022.
per dose of vaccine administered or $22.22 per person fully vaccinated in 2021, which was six times more expensive than global estimates.\textsuperscript{69,70} For some actors providing vaccinations in South Sudan, the cost was as high as $20 per dose administered, including all costs.\textsuperscript{71} Some countries reported insufficient funding\textsuperscript{72} for vaccine delivery (e.g. Afghanistan, DRC, Ethiopia, Iraq, Niger, northeast Nigeria, Somalia, South Sudan, Sudan, and HCT coordinated response areas in Syria).\textsuperscript{72} In South Sudan, the start and continuation of vaccination was dependent on funding availability, as there were no resources from the government to cover operational costs. Lack of transparency and accountability on the part of partners and donors (including acting without prior consultation with the MOH or technical working group, or unwillingness on the part of partners to disclose available funds) often resulted in duplication of efforts.

**Administrative barriers**

In many countries, the registration process and documentation requirements included having a valid government issued ID, residence permit, or insurance card, which prevent migrants of different status from accessing COVID-19 vaccines. The Red Cross National Societies reported that migrants lacking the required documents faced barriers to access vaccines in 60% of 52 countries surveyed where national societies are operational.\textsuperscript{73} This was also reported in some of the countries in the study, including Venezuelan migrants in Colombia and conflict-affected people in Syria and Iraq. Globally, this was a particular challenge for stateless people, who often lack proof of citizenship or identity.\textsuperscript{74} The IOM also listed barriers affecting migrants’ access to services.\textsuperscript{75} Though varying across countries and across vaccination policies and roll-out strategies, some common challenges were shared by organisations\textsuperscript{76} and identified in the case studies:

- **PoC might fear arrest/deportation**, which was the case in Colombia. In NES, a high proportion of residents had difficulties registering for vaccination, either because of a lack of ID or due to fear of having their data shared with the government.

- **COVID-19 vaccines are in some cases prioritised for nationals**, especially given initial limited supply (Iraq), varying approaches between local and national government systems, and procedures relating to vaccine registration and access, among others.

- **Specific documents and/or registration through dedicated (online) systems** are often required prior to vaccination, which can be confusing and mean that other barriers can result in difficulties in identifying and reaching undocumented migrants (e.g. technological requirements, language barriers, fear of tracking tools that may lead to arrest or deportation, etc.).\textsuperscript{77,78} In February 2021, Colombia announced a policy shift toward undocumented migrants from Venezuela, facilitating regularisation and access to healthcare services, including COVID-19 vaccines. Despite inclusive


\textsuperscript{77} WHO. Strengthening COVID-19 vaccine demand and uptake in refugees and migrants. who.int, 2022.

\textsuperscript{78} PolicyCommons. Refugees and the Scope for Mandatory COVID-19 Vaccination. October 2021.
policy moves in some settings, however, migrants still faced constraints to access vaccinations due to issues around proving their identity and keeping track of people moving frequently within the country, particularly when newly arrived, which resulted in challenges in vaccine surveillance and monitoring.

4.1.2.2 Addressing operational barriers – modalities of vaccination

The ever-evolving context and nature of COVID-19 vaccination meant that constant adjustments were made in the operational roll-out of NDVPs, with the effect that different modalities to deliver vaccines were used. Campaigns-based vaccinations were launched in certain enclosed settings, such as refugee and IDP camps (e.g., Cox’s Bazar in Bangladesh and Al Hol camp in NES), or other remote settings (indigenous communities in Colombia). This meant that services were organised differently compared to the nationwide approach, and were often supported by humanitarian organisations and agencies with short time-bounded intensive one-off or series of campaigns, which required prior preparedness and mobilisation of eligible groups (by age/risk) following micro-plans and operational guidelines. Follow-up or catch-up campaigns were launched as a strategy to ensure all of the eligible population were included, with specific emphasis in attracting women, groups, or ages that were missed earlier (e.g., Cox’s Bazar). In South Sudan, the first round of COVID-19 vaccines was largely delivered out of health centres. As new vaccines became available organisations pivoted to mobile-based delivery models, in order to reach populations without access to a vaccination point.

In settings with populations facing mixed or diverse humanitarian situations (e.g., host, displaced, and/or migrant populations in Syria, Colombia, DRC, and South Sudan), combinations of fixed and mobile modalities running in parallel were used to increase coverage. The implementation of vaccination campaigns was found to be an effective way to increase vaccination coverage and reach additional populations, including PoC (Cameroun, South Sudan, and DRC). When mixed modalities and approaches were combined with adequate engagement of community leaders through trained and equipped community health workers, with intense preparation and mobilisation, often conducted house to house, this resulted in eligible high-risk groups and age groups being prioritised for COVID-19 vaccination in the countries studied (e.g., South Sudan, Colombia, and Cox’s Bazar). In Iraq, IDPs were a priority group (since August 2021) and those based in camps were targeted first, receiving optimal coverage with partner support (e.g., mobile vaccination teams visiting camps). Flexibility was key to reaching certain groups: populations in locations under the control of armed groups were exempted from providing IDs and universal vaccination was used when entering isolated indigenous communities, especially those affected by outbreaks, as was the case in Colombia.

COVID-19 vaccination services were sometimes integrated with other service packages provided in remote areas (outreach immunisation in Colombia). In some settings, once COVID-19 vaccination reached an optimal coverage, it was integrated within the EPI programme (Colombia and planned in Cox’s Bazar). In Iraq, mobile units (WHO and MOH) provided ID documentation together with COVID-19 vaccinations. This increased COVID-19 vaccination coverage.

Vaccination workforce

Vaccination teams were comprised of HCWs as well as logistics staff, which was more demanding for mobile teams. Some countries, like Colombia, required vaccinators to be newly recruited to maintain the provision

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81 Cameroun MOH. Plan national de déploiement et de vaccination. September 2021.
82 COVID-19 SPRP South Sudan 1Jun2022-31May2023
of other essential health services (including routine immunisation) but also specific certification to vaccinate for COVID-19. Overall, vaccinators needed complementary knowledge, skills, and consistent practice for infection prevention and control (IPC) and Adverse Events Following Immunisation strategies, which kept evolving. These training needs were exacerbated by limitations on people gathering for in-person training and the use of online training in humanitarian settings. Large investments were made in Cox’s Bazar and Colombia to train and enhance the capacity and supervision of vaccination teams, with strong support from humanitarian organisations and agencies. Some of them were women in Colombia, and these women often suffered from safety issues and additional vulnerabilities. Incentives were also foreseen, such as the provision of health insurance to ensure they would be cared for in the event that they fell ill from COVID-19 in Cox’s Bazar.\(^83\) HCWs’ capacity and availability were therefore enhanced, according to the literature reviewed (Cameroon, northeast Nigeria, Venezuela, etc.). Despite these efforts, attracting and retaining qualified health personnel to work in remote regions was an issue (e.g., in NWS).

In countries already affected by fragile health systems or enclosed settings (DRC, South Sudan, and Cox’s Bazar), the administration of COVID-19 vaccines was often supported by humanitarian agencies and organisations. Refugees and migrants living in closed settings (including camps, reception and detention centres, and formal and informal settlements) or in hard-to-reach areas significantly relied on the transportation and delivery of COVID-19 vaccination by the above-mentioned providers, in coordination with the national authorities and the Health Cluster. In other countries with higher incomes (Colombia), national authorities implemented the national vaccination roll-out, with the involvement of partners to complement vaccination services (planning, mobilising and registration tasks, as well as supplies, training, and capacity) but not as much in terms of vaccination administration per se. Engaging community health workers and members of the community, such as volunteers, women, and religious and cultural leaders, to support vaccination efforts was found to be essential in hard-to-reach and insecure areas.

**Negotiating and gaining access to PoC**

Access to populations affected by humanitarian crises was further hampered during the pandemic due to imposed restrictions, isolation measures, and fear of getting infected. Given that COVID-19 was declared a PHEIC and targeted mainly adult cohorts nationwide and thus was of high national interest, vaccination was often used as a tactical issue for NSAG to control access to territories and was often entangled in politics, which had an impact in terms of conflict dynamics and reaching areas with restricted access during the pandemic. In Syria, human rights organisations advocated against the government pattern of what they called ‘rewarding allies and punishing enemies when distributing vaccines’.\(^84\) Vaccination teams (run by MOH or humanitarian actors) had to find ways to negotiate and gain access using different approaches to those used in other public health interventions (e.g. routine immunisation for children).\(^85\) In Colombia, NSAGs managed to consolidate their control over local communities by imposing their own confinement and movement rules. Elsewhere, areas with indigenous communities facing humanitarian situations refused vaccination in their communities due to cultural beliefs. Humanitarian organisations helped to gain access for vaccination teams to restricted zones via mediation and negotiation in some of these areas. From the literature review, in large-scale and complex displacement settings, e.g., northeast Nigeria with over 2

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\(^83\) GHC-COVID-19-Task-Team-Klls, P. 17
Getting to areas not controlled by constituted authorities or the government, or with restricted access, brings additional problems in terms of logistics, the need to obtain a travel authorisation (which is usually complicated and time consuming), and reduced access to electricity and standard storage facilities. Such issues led to the exclusion of PoC from immunisation services (Colombia and some regions in Syria such as NWS, Ras Al Ain and Tell Aabadi), as well as difficulties for people trying to reach vaccination sites in locations suffering from insecurity (DRC and Syria). Moreover, challenges negotiating with NSAGs or opposition authorities were reported in many settings (e.g., Afghanistan, Colombia, Ethiopia, Somalia, Ukraine, Venezuela, and Yemen).

Attacks on medical teams increased during the pandemic either by armed groups or dissatisfied patients, or simply due to fear of transmission of the virus (e.g. Colombia and north-eastern states such as Borno, Adamawa, and Yobe in Nigeria). This limited the delivery of vaccination in fixed sites, which led to further inequities due to limited capacity to conduct outreach services and accessibility issues affecting vaccination sites (e.g. Somalia, South Sudan, and Yemen).

### 4.1.3 UNDERSTANDING THE SPECIFIC NEEDS OF THE POC

The cohorts eligible to be targeted by COVID-19 vaccines are very different from those for routine immunisation, which has caused difficulties for countries in regard to identifying the needs of eligible PoCs and in designing demand-generation activities. These difficulties were further exacerbated by specific considerations related to the social, economic, and cultural considerations of the PoC that needed to be identified in order to be addressed.

#### 4.1.3.1 Identification of demand-side barriers

Joint efforts at global and local levels have provided evidence to better understand the evolving barriers that prevent optimal coverage of COVID-19 vaccination. For instance, several tools were developed and used to assess factors affecting COVID-19 vaccination demand and uptake among PoCs:

- **RCCE collective service database and dashboard.** “The RCCE collective service database creates a public good, so we don’t have to use our own resources to get the same information. This saves us [as partners] so much time and money and means we can make more efficient use of funding” — Tom Black, Bill & Melinda Gates Foundation.

- **Scientific publications aimed at understanding the knowledge, attitudes, and practices (KAP) of populations vis-à-vis vaccination against COVID-19.**

- **Other surveys and needs assessments conducted at the national level by public institutions and local and international NGOs to assess demand-side barriers related to COVID-19 vaccination.** They

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87 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9087494/
93 https://www.rcce-collective.net/data/data-tracker/
Study to examine COVID-19 vaccination in humanitarian settings

include KAP surveys, third-party monitoring and evaluation, community-based discussions, and community-based surveillance tools such as hotlines, etc.

Not all the tools mentioned above provide the same level of evidence. Nevertheless, they allow real-time monitoring of trends and demand for vaccination as well as disaggregation of data for a better understanding of the social determinants linked to the behaviour of populations in regard to COVID-19 vaccination.

As for initiatives aiming at understanding the drivers of low demand that were identified through the different case studies, the relevant tools included:

- **KAP surveys** conducted by local or international NGOs or academic institutions aimed at understanding factors reducing vaccination demand and uptake and at initiating an evidence based RCCE approach (e.g., Iraq, DRC, South Sudan, and Colombia).
- **The community preparedness assessment tool** designed by WHO and used to measure the awareness of Rohingya refugees regarding the COVID-19 vaccination to better drive the risk communications strategy (e.g., Cox’s Bazar).
- **P-FIM approach (People first impact method)** to work upstream by raising awareness among populations so that they develop their own priorities based on their problems, perceptions, and fears, and subsequently to develop the messages that will be conveyed by the community itself (e.g., DRC).
- **Third-party monitoring** (NWS cross border response areas) conducted by the Syrian immunisation group (SIG) that involved monthly surveys and generated reports that included data on reasons for non-vaccination.
- **Community surveys** based on random samples with a focus on the migrant population in order to collect the specific data needed to reach this population (e.g., Colombia).
- **Field visits conducted by MOH staff** at vaccination facilities (e.g., Iraq), which were an opportunity to obtain insight into the views of both healthcare providers and beneficiaries to identify obstacles to vaccination.
- **House-to-house visits** (e.g., Syria, Cox’s Bazar, and Colombia) and house-to-house cluster surveys (NWS).
- **Involvement of community health workers** in demand-generation activities, which had a great impact on populations’ perceptions and behaviours related to COVID-19 vaccination (e.g., NWS and Cox’s Bazar).
- **Social listening** (e.g., DRC, and South Sudan), which consisted of capturing ongoing conversations in communities on the ground.
- **Community-based focus group discussions** with key political and religious figures, community leaders, and general community members (e.g., NWS and DRC).
- **Rumour-tracking mechanisms, including hotlines** such as the Drum platform in South Sudan, MOH/EPI services in DRC, and others (e.g., Cox’s Bazar).

It should be noted that variations were observed between countries in identifying demand-side barriers. Some such as NWS cross border response areas were closely monitoring the demand-side barriers of their

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communities, including PoC (through third-party monitoring), and some such as Colombia implemented localised interventions (where only three locations were covered and specific categories, including pregnant women), while others had no specific mechanism to specifically understand perceptions and determinants of acceptance of vaccination among PoCs (DRC and South Sudan). In NWS, besides the third-party monitoring tool including 15 reasons for not being vaccinated, qualitative methods were also used such as community-based focus group discussions to identify any emerging barriers not being assessed through third-party monitoring. Nevertheless, demand has remained low in these areas and efforts are in place to rethink the RCCE approach adopted.

4.1.3.2 Demand-side barriers

Vaccination coverage remains relatively low among PoCs. Besides difficulties on the supply side, the low demand in some countries from PoCs is still enormously affecting coverage despite the considerable efforts invested to overcome the operational challenges.

A wide range of demand-side barriers were identified through the scoping review. Some barriers identified among PoC were similar to those in the general community, while others were specific to PoC and related to their situation. Additionally, demand-side barriers were not only different across countries, but also evolved and changed since the start of vaccination roll-out within a single country or population. For example, some countries had very high demand when the first batches of vaccines arrived, followed by a drop in demand due to availability (including types of vaccines available), access, need, as well as hesitations and reluctance. For example, in 2021, COVID-19 surges were accompanied by increased demand and uptake of COVID-19 vaccines in Iraq, which decreased as infection rates declined.

The demand-side barriers identified through the scoping review included:

- **Barriers related to vaccines** such as the lack of information on vaccines, lack of acceptancy due to scepticism and mistrust, fear of side effects, and vaccine preferences.
- **Daily needs that compete with health priorities**, including immunisation. PoC are often struggling to secure basic needs such as electricity, livelihoods, and WASH, as a result of their socio-economic situation.
- **Administrative obstacles**, including ID requirements to register or receive vaccines and concerns among PoC around insufficient data protection.


98 Ibid.
• **Physical barriers affecting access to health services**, such as long and difficult travel to receive vaccination services, lack of transportation, and ongoing conflict.99

• **Financial barriers** related to transportation, possible loss of income, or costs of vaccines.100

• **Stigma and discrimination.**101 Fear of disease-related stigma if diagnosed as having COVID-19 when visiting health facilities and discrimination faced by PoCs in some countries has led to reduced demand and use of COVID-19 vaccines.

• **The perceived low risk of COVID-19** or the low importance placed on vaccination later during the pandemic.

As for the demand-side barriers identified through case studies, most were cross-cutting across the six countries. Some obstacles were, however, more context specific. The demand-side barriers identified were:

• **Widespread rumours that influenced the acceptance of the COVID-19 vaccine**

  o The “vaccines introduce a chip” theory was spread both among migrants (Government of Venezuela) and in areas under the control of armed gangs (where the chip was presented as a measure of control / infiltration by the Government or came from the US with the same motive).

  o Conspiracy theory, e.g., “vaccines as a means of extermination of migrants” (e.g., Colombia and Iraq).

  o Rumours about the impact of vaccines on virility and fertility (e.g., Colombia, South Sudan, DRC, and Iraq).

  o Rumours about the impact of vaccines on pregnancy (e.g., Syria and Cox’s Bazar).

  o Rumours about the side effects of vaccines, including death (e.g., Iraq, South Sudan, DRC, and Syria).

  o Stigmatisation of vaccinators who were not accepted because they were thought to be “sources of infection” (e.g., Colombia).

• **Availability of vaccines at the early stages of the pandemic (e.g., Syria, Iraq).** Vaccines arrived in waves and quantities were not sufficient to respond to the need, which finally led to reduced demand.

• **Types of available vaccines and vaccine preferences** (e.g., Syria, Iraq, DRC, South Sudan, and Cox’s Bazar). The perception of possible problems linked to certain vaccines (mainly AstraZeneca due to international controversies, or Sinopharm coming from China where the pandemic originated) led to an infodemic, although provision of different types of vaccine has helped alleviate this problem.

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100 iom.int. 2022.


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- **Lack of acceptance due to mistrust** in the government and/or the health system (e.g., Iraq and Syria).

- **Administrative obstacles** including the need to have legal status or an identity document to be able to register and be vaccinated thus limiting access for PoCs with no ID (e.g., Iraq, initially in Syria and Colombia); or PoCs who are afraid of having their identities and information shared with governments (e.g., due to opposing political affiliations).

- **Physical barriers**
  - Vaccines not being available in all health facilities or in all regions (e.g., NES, Iraq, and Colombia).
  - Long travel distances to receive vaccination services (e.g., Iraq, NES, DRC, and South Sudan).
  - Security concerns of PoCs when crossing checkpoints to reach vaccinating facility (e.g., Iraq and NES).
  - Financial barriers related to costs of transportation the need to pay out-of-pocket due to military checkpoints, and the cost to travel and receive vaccination certificates.
  - Lack of transportation means and transportation costs (e.g., Syria, Iraq, DRC, and South Sudan).
  - Limited mobility of PoCs who need special permits to exit camps (when vaccines were still not provided inside camps) (e.g., Cox’s Bazar and Iraq).
  - Mobilisation of the elderly and people with disabilities to vaccination sites (e.g., Cox’s Bazar). Some ambulances and transport were available, but some people had to be transported in wheelbarrows. There was no vaccination allowed outside the vaccination site.

- **Limited knowledge on the availability of vaccines and means of registration**, especially among non-working mothers, religious leaders, and elderly people (e.g., Iraq), or how to navigate the system in terms of registration, vaccination points, etc. (e.g., undocumented migrants in Colombia).

- **Insufficient/Inadequate RCCE strategies given multitude of new vaccines and new guidance issued as evidence emerged** (e.g., Syria, Iraq, DRC, and South Sudan).
  - Despite having an RCCE strategy in place, it was very similar to that covering routine immunisation and was not tailored to target PoCs (e.g., Colombia and Iraq).
  - RCCE implementors reported that many questions that emerged from the community on the safety of vaccines and management of side effects could not be properly addressed.

- **Daily needs that compete with health and humanitarian priorities** (e.g., Syria, Iraq, South Sudan, and DRC). In addition, in some settings people had higher priority health issues such as risk of suffering from cholera (e.g., Syria and South Sudan), hepatitis B, anthrax, meningitis, and typhoid and malaria during the rainy season, with COVID-19 coming last in the list (e.g., South Sudan).

- **The perceived low risk of COVID-19 combined with the low importance of vaccination** later on in the pandemic (e.g., Syria, Iraq, South Sudan, Colombia, and DRC) and in rural areas (Colombia).
The low presence or involvement of humanitarian organisations in COVID-19 vaccination in areas with security problems such as the territories of indigenous communities or those controlled by NSAG in e.g., Colombia.

Negative attitude of HCWs toward COVID-19 vaccination (e.g., Syria and South Sudan) and stigma against vaccines or PoCs.

Lack of ownership of vaccination from the side of national leaders (South Sudan and DRC).

Lack of motivation. For instance, some PoCs felt they did not need vaccination unless they had to travel abroad (e.g., Syria and Colombia), register for a scholarship (e.g., Colombia), or apply to a new job (in cities not in rural areas) (e.g., Colombia).

Cultural barriers such as the tendency to use traditional medicine among the indigenous population of Colombia, as well as their decision-making rites (e.g., health calendars consulted in coordination with spiritual guides, seeking vaccination authorisation, which delayed or prevented the process, etc.).

Burnout, low self-confidence, and low self-esteem resulting from the protracted crisis and the country context and resulting in reduced ability to make informed decisions.

Low user satisfaction due to stigma or discrimination at vaccination centres, mistreatment of beneficiaries, and vaccination services provided by staff perceived to be unqualified.

Evidence from the scoping review and case studies reveals that demand-side barriers vary from country to country or even from region to region within the same country. This implies that — to increase demand and uptake of vaccines — demand-side needs and barriers must be explored and addressed transparently in ways that consider the specificities of different contexts.

4.1.3.3 Measures taken to address demand-side barriers

Three elements are essential for successful immunisation outcomes: vaccine supply, capacity to vaccinate, and vaccine demand. Therefore, there is a continued need for well-tailored, timely interventions to mitigate demand-side barriers.

Extensive research since the introduction of COVID-19 vaccines has resulted in a set of guideline documents helping countries increase demand and uptake of COVID-19 vaccines to halt the spread of the virus. Some strategies and practices that succeeded in increasing vaccination demand can also be identified in the literature. Immense efforts have been made so far to increase vaccination literacy in an attempt to mitigate the rumours and infodemics that have accompanied the emergence of COVID-19 vaccines. RCCE activities included:

- Community mobilisation activities in which PoCs themselves, influencers, and religious leaders were approached, targeted by awareness activities, and involved in demand-generation activities.

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103 The website of the Collective Service for Risk Communication and Community Engagement provides a list of considerations for the implementation of communication strategies targeting marginalised groups. It includes guidelines on implementing protection analysis and communication strategies, and suggests strategies such as tailored RCCE activities and understanding and addressing barriers for different groups. [https://www.rcce-collective.net/?s=COVID-19+vaccination](https://www.rcce-collective.net/?s=COVID-19+vaccination)

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- Media mobilisation for information sharing and rumour tracking.
- Awareness-raising about vaccines through mass awareness campaigns, door-to-door awareness activities, and community-based discussions.
- Adoption of culturally adapted communication strategies.

Other strategies were also implemented to address other demand-side barriers (physical, financial, administrative, etc.) as they emerged. For instance, many countries scaled up mobile vaccination activities to reach and vaccinate PoC with reduced access to healthcare in underserved or hard-to-reach areas. Other countries waived the need for official documents for registration to overcome administrative challenges preventing people from receiving the vaccines.

As for the strategies adopted in the countries selected for the case studies in an attempt to overcome the barriers on the demand side and increase both demand and uptake, they included:

- **Mitigating physical accessibility issues**
  - Increasing access through expansion of vaccination points, provision of vaccination activities inside the camps, and increasing the numbers of mobile vaccination units targeting hard-to-reach or under-covered areas (e.g., Cox’s Bazar, Iraq, Syria, DRC, and South Sudan).
  - Extensions to opening hours, including evenings (e.g., Cox’s Bazar and Iraq).
  - Engagement of the protection sector (similar to protection cluster) with the Age and Disability Working Group to ensure access for these groups of PoCs.
  - Coordination with NSAGs to reach PoC in regions under their control (e.g., Syria, Colombia, DRC if we consider coordination with community).

- **Mitigating hesitancy due to misinformation and rumours through scaled-up RCCE**
  - Mass awareness campaigns (“Kermal el Kel” in NES and “Vaccination without barriers” in Colombia and DRC).
  - Distribution of messages around vaccine safety through a multi-channel strategy (community radio, interpersonal communication, and digital media) (e.g., Cox’s Bazar).
  - Promoting community mobilisation (e.g., Cox’s Bazar).
  - Engagement of community health workers (e.g., Cox’s Bazar, NWS, Iraq, and DRC) and leaders (Cox’s Bazar) in demand generation.
  - Organisation of awareness campaigns/sessions mainly targeting HCWs (e.g., Syria).
  - Delivering information on vaccines through group sessions and door-to-door activities (e.g., Cox’s Bazar and Syria).
  - Media mobilisation (e.g., Cox’s Bazar, Colombia, and Damascus and NES).

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105 UNICEF. Ensuring access to COVID-19 vaccines for all in South Sudan. October 2021.
Use of a culturally adapted communication strategy (designing of special flyers and brochures targeting illiterate PoCs) and coordination with community leaders, religious leaders, influencers, armed groups, etc. (e.g., Syria, Iraq, and DRC).

Vaccine hesitancy and rumour-tracking mechanisms (e.g., South Sudan, DRC, and Cox’s Bazar).

Release of a judiciary statement about the right to arrest and take legal actions against those who spread misinformation (e.g., Iraq).

**Mitigating administrative obstacles**

- Advocacy to allow people to register using an alternative identity document such as the camp registration card, UNHCR card, or phone number (e.g., Iraq).
- Waving the need to have an official ID to register for COVID-19 vaccination (e.g., NES).

**Mitigating hesitancy related to vaccine preferences**

- Providing more than one type of vaccine (Iraq, DRC, and South Sudan).

**Integrating COVID-19 vaccination into demand-generation activities**, which has proven to be an effective strategy to increase vaccination uptake (Syria).

- Engagement of other clusters in demand generation to increase mobilisation and outreach (WASH and education in NWS).

Evidence from the case studies showed that humanitarian actors and governments have shown great flexibility and made enormous efforts to vaccinate populations. In terms of mitigating emerging demand-side barriers, a wide range of interventions have been used. However, implementation, contextualisation, and timeliness of different interventions varied considerably from country to country.

**4.1.4 COVID-19 VACCINATION PERFORMANCE FOR POC AND THE WIDER POPULATION**

At global level, the COVID-19 vaccination implementation within countries has been very heterogeneous.\(^{107}\) Overall, marginalised groups including IDPs, refugees, migrants (regardless of status), and those living in insecure, non-government-controlled areas have been found to face inequities in terms of lower rates of vaccination.\(^{108,109}\) This was particularly evident during the early implementation of NDVPs. Overall, inequities were also observed between countries, with LICs receiving the lowest numbers of vaccines despite having the largest humanitarian caseloads\(^ {110}\).

Poor data quality or absence of data to specifically categorise PoCs in most humanitarian settings resulted in difficulties monitoring vaccination and in measuring coverage for PoCs. These gaps mean there is insufficient evidence to establish an in-depth understanding and analysis of the extent to which the various categories of PoC have been reached. However, the case studies provide examples of situations where populations in humanitarian situations do not benefit from the same immunisation coverage as the general population. Low levels of COVID-19 vaccination coverage achieved at national level had an impact on PoC vaccination, which in such a context will also remain low. Even in countries with higher coverage, volatile contexts and hard-to-reach areas were not reached at the same coverage rate or speed.

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\(^{107}\) UNHCR. Vaccinating the world's 80 million forcibly displaced against COVID. February 2021.


\(^{110}\) GHC advocacy and information brief Dec 2021 [https://healthcluster.who.int/publications/m/item/reaching-70-vaccine-coverage-for-covid-19](https://healthcluster.who.int/publications/m/item/reaching-70-vaccine-coverage-for-covid-19)
Data provided by the GHC COVID-19 Task Team was used to conduct a comparison between vaccination coverage and the PIN percentage in the different regions in the countries studied. Coverage is not proportional to the PIN percentage, with some regions having coverage that is higher than the coverage of other regions with fewer PIN. In Colombia, the COVID-19 vaccination coverage was 66.1% in February 2022 but despite high vaccination coverage at national level and to a certain degree at subnational level, this did not represent the reality found in some municipios (districts). Despite having COVID-19 vaccination coverage reported as high as 60% in some regions (Territorios) some of their municipios coverage could be as low as 10% in some cases. This illustrates the disparity of situations within one same region and difficulties to access certain municipalities with vaccination.

<table>
<thead>
<tr>
<th>Table 2. Disparities of vaccination coverage within “territories” and “municipios”</th>
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<tr>
<td><strong>Territorios with high percentage of PIN</strong></td>
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<tr>
<td>Range in municipios</td>
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Source: MoPHS Feb 2022

This example illustrates a potential inequity in vaccination distribution as well as sub-optimal coverage in some communities.

In South Sudan, only 15.36% of the general population was fully vaccinated in August 2022. PIN represent more than 80% of the population, and most are integrated in or are part of the host population. There are geographical disparities at state and county levels, but these disparities do not appear to be related to the percentage of PIN in the general population.

However, the rate of vaccination coverage for some categories of PoCs could be much lower than for the general population. The ODK data show that COVID-19 vaccination coverage for the general target population was 33.97% at the end of August 2022. Data for IDP camps show a vaccination coverage of 2.19% at the same date and 1.53% for the population in refugee camps. We note that the populations most vulnerable to COVID-19 (those with co-morbidity, the elderly, and HCWs) might also be significantly less well vaccinated in IDP or refugee camps than in the general population.

In DRC, the national coverage of fully vaccinated people was at 8.20% whereas the humanitarian provinces had lower vaccination coverage at 6.45% on average (October 2022). Insecurity problems affecting the organisation of campaigns and the lack of mobilisation of political and administrative authorities would explain a large part of this difference.

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111 The size of the bubble reflects the number of people vaccinated per 100 people. The provinces on the same line represent similar percentages of PoC. The lines are in descending order, with those at the top having the highest PoC percentage and those at the bottom having the lowest percentage of PoC.
In **Cox’s Bazar**, 94% of the total eligible population in the camps had received two doses of the vaccine by September 2022. Despite initial challenges and delays that would have risked a potentially large outbreak, a very high level of coverage was achieved, which showcases a positive example of how, when planning, coordination, resources, and informed decisions join together in an enclosed setting, within a relatively well “controlled” environment, high coverage can be achieved.

In **Iraq**, the COVID-19 vaccination coverage was at 18.3% as at August 2022. The reasons for differences in vaccination coverage were mostly similar for IDPs, refugees, and host populations. Vaccine hesitancy (80%) was a substantial factor, but also reduced access to health services and lack of information due to limited media coverage played a part. Despite national official data on COVID-19 vaccination being available via the IMOH dashboard (arcgis.com, 2022), it was not disaggregated to allow assessment of equity in terms of vaccination coverage. Nevertheless, COVID-19 vaccination data from the GHC COVID-19 Task Team for 2022 shows that the vaccination coverage varies by province regardless of the proportion of persons in need.

In **Syria**, big discrepancies in coverage were found between the different regions, with some of them having reached 34.2% but others having an average coverage of just 4.8%. However, coverage is not proportional to the percentage of PoCs, with some regions having coverage that is higher than the coverage of other regions with lower numbers of PoCs. In NWS, differences in coverage exist between governorates and not between PoCs and the local community. In Damascus and NES, a slightly higher level of coverage is observed in regions under the control of the government compared to regions with no governmental control (e.g., Aleppo and Idlib). It is noteworthy that these numbers might not represent the actual coverage, especially in NES. For instance, participants stated that figures reported about NES are not accurate because: (1) data shared by the government is based on estimations and does not reflect the actual need; and (2) many people do not have IDs in NES due to the war. Therefore, the denominator used to calculate coverage is based on estimations and is lower than the actual size of the population. Nevertheless, the latter shows that the current coverage is likely to be lower even lower than 4.8%, which emphasises the low performance in NES.

Low vaccination coverage in some settings is likely due to several factors. The initial scarcity of vaccines globally meant that there were simply not sufficient numbers of vaccines available at national level: in the first six months of 2021, 85% of vaccines went to wealthy countries while lower- and middle-income countries received only a fraction of the vaccine doses they required. The overall limited supply of vaccinations and the urgency of scaling up with limited resources particularly affected humanitarian contexts and marginalised communities, with a noticeable tendency to prioritise populations that were easier to access due to them living in or close to urban areas, and nationals versus migrant populations.

Despite being formally included in NDVPs, some PoCs received vaccines with a substantial delay: for example, refugees in Cox’s Bazar started receiving vaccines eight months later than the rest of the
The “vaccination for all” approach, which included migrants irrespective of their status, was launched in Colombia nine months after vaccinations started nationwide. In Iraq, vaccination of PoCs did not start until August 2021, whereas vaccination of the general population started in March 2021. Differences in coverage in humanitarian settings are not necessarily due to inequitable planning and policy, but also due to the barriers and constraints found and the difficulty of mobilising resources in proportion to these constraints. As explained above, countries with fewer resources and more fragile economies faced greater and additional challenges compared to HICs, despite their significant experience in accessing hard-to-reach populations with services such as EPI. While some of the initial challenges were addressed as the situation evolved, and good and successful practices were implemented, challenges remained, and solutions need to be explored and put into practice for the future. Despite having some NDVPs that were inclusive and strategies promoting a universal and equitable approach, when it comes to the availability and distribution of COVID-19 vaccines in humanitarian settings, the reality differs when compared to the rest of a nation’s population. Inclusion on paper in vaccine roll-out has not always translated into equitable vaccine access for displaced and affected populations in practice in the countries studied.

As vaccines became available worldwide, further issues arose. In addition to the already challenging difficulties surrounding access to healthcare in humanitarian settings, the pandemic resulted in a new set of challenges. Migration and forced displacement were major challenges for mobilisation, but also for setting targets, keeping records, and administering vaccines, especially the second dose. This was particularly prevalent in contexts with a high number of IDPs, porous borders, pendular migration, and mixed flows (Colombia and DRC, but also in Darfur in Sudan\(^\text{112}\)). Strict movement restrictions and isolation measures were imposed by national authorities (Iraq) but also by NSAGs (Colombia). Hard-to-reach areas and regions with active conflict, insecurity, or limited mobility, and thus populations cut off from humanitarian aid, became further isolated. Limited presence of humanitarian organisations, especially during the first waves of the pandemic, made some locations further insecure and less accessible for vaccination (Colombia and NES). Even though significant efforts were put in place to overcome operational and logistical constraints, populations affected by humanitarian situations lacked the same conditions to have equitable access as the rest of the population in the studied settings.

4.1.5 CONCLUSIONS

Policies and strategic arrangements

The NDVPs developed with support from the WHO, UNICEF, and Gavi, with inputs from some of the country-level partners, have evolved as more resources and supply became available. Early versions of the NDVPs, by and large, did not include PoCs as a target population. Humanitarian partners played an important advocacy role in favour of PoCs being included in the NDVPs. It is often with delays, at later stages of the pandemic, that PoCs were included as a target population in NDVPs. Subsequent decentralised planning (micro-planning) was also developed at subnational level that took better account of both general population and vulnerable populations’ needs by better taking into consideration local humanitarian situations.

Strategies for accessing the population were regularly improved, depending on the initial results and resources available, drawing on the EPI strategies of fixed sites and then expanded through outreach and mobile clinics and campaigns that provided PoCs a better access to vaccination.

\(^{112}\) ICVA. Principles of effective COVID-19 vaccination response in Humanitarian contexts, August 2022.
Different coordination mechanisms are reported for the implementation of the NDVPs, around the MOH and local authorities, with varying degrees of humanitarian partner representation able to express their concerns for the PoC.

Different human resource strategies are reported depending on the ability to mobilise additional human resources for COVID-19 vaccination. Some countries rely on existing staff to cover COVID-19 immunisation, alternating between routine care and COVID-19 vaccination activities. Other countries mobilised additional resources to cover COVID-19 vaccinations so that essential health services can continue to be provided.

**Operationally reaching and vaccinating PoC**

Despite considerable experience gained from the EPI, infectious diseases outbreak management, and epidemic preparedness, low-resourced and volatile settings face significant and additional challenges in reaching PoCs.

Poor accessibility and further isolation of communities, resulting in additional costs and logistical constraints (transportation of vaccines and teams, cold chain, etc.), limited funding capacity, and weaker health systems, demanded efforts that were unprecedented, especially in fragile and conflict-affected settings, which raised a number of operational challenges.

Findings from the case studies highlighted that, while global-level guidance on COVID-19 vaccination may exist and, to different degrees, inclusive NDVPs have been developed, operationalisation of plans differed in reality and plans did not always translate into equitable vaccine access for PoC in practice. Due to the scale and urgency needed at national level in humanitarian contexts, where availability of vaccines was severely limited in the early stages and where logistics, operational constraints, and access issues were present, PoC were likely to be considered a lower priority in the deployment of COVID-19 vaccines, facing delays and gaps.

Various modalities of deployment of vaccines were considered to overcome technical and operational constraints and deliver vaccines in humanitarian settings, taking into account the different and volatile humanitarian situations and restricted access due to insecurity, conflict, and the presence of NSAGs. Combined modalities (fixed, outreach, and mobile services) coupled with strong community involvement and mobilisation proved to be an effective way to increase COVID-19 vaccination coverage in these settings. Vaccination teams supported the distribution and deployment of COVID-19 vaccines depending on contextual factors and national frameworks. Flexibility and adaptation were keys to success.

Negotiation and mediation efforts by humanitarian actors to unlock access were key to providing vaccination services to otherwise restricted and isolated populations in times where security conditions worsened during the pandemic due to lockdowns, the security of vaccination teams was jeopardised, the presence of humanitarian actors was limited, and communities were further isolated.

**Understanding the specific needs of PoC**

Vaccine demand among PoCs was found to fluctuate:

- In some countries, a very high demand was observed when the first batches of vaccines arrived but was followed by a drop in demand due to limited availability and access to vaccines, as well as to hesitation and reluctance.

- In some settings, demand was relatively low in general due to factors such as delayed arrival of the first vaccines, PoCs being already exposed to rumours and misinformation, the types of vaccine that arrived first, and mistrust in the source of vaccines (i.e., the implementers (governments) or the health system), ID and documentation requirements for registration.
In other countries, fluctuations in demand have been affected by the national pandemic trend, as each surge in positive cases of COVID-19 has been accompanied by an increased demand for vaccines, which then decreased when the number of positive cases dropped.

Variations were observed between countries in identifying demand-side barriers. In some countries specific mechanisms to closely monitor the factors affecting vaccination demand were implemented, including from PoCs (NWS), while others had localised sporadic interventions monitoring many categories of the population (Colombia, DRC, and South Sudan).

Moreover, while various interventions were designed and implemented to understand demand-side barriers, few tools were developed for PoCs. The design and implementation of the RCCE was also challenging given that COVID-19 vaccination has led to targeting new types of eligible cohorts (primarily adults) that differ from those of routine vaccination (children under the age of five years), with different approaches consequently needed for demand generation and vaccination.

Another difficulty identified in understanding the obstacles on the demand side was related to the lack of complementarity of the sources of evidence preventing the designers of RCCE from having a complete view of the situation of the country and the effect of the different determinants of demand.

In regard to factors affecting demand, a long list of factors was found through the scoping review and the various case studies. Many factors were cross-cutting between countries and PoC categories (such as hesitancy due to rumours and misinformation, ID and documentation requirements), while others were context related (e.g., mistrust in the source of some vaccines in Syria) or specific to a PoC category (e.g., discrimination against migrants in Colombia).

**COVID-19 vaccination performance for PoC and the wider population**

Poor data quality or absence of data to specifically categorise PoCs in most humanitarian settings resulted in difficulties monitoring COVID-19 vaccination coverage for PoCs. These gaps mean there is insufficient evidence to establish an in-depth understanding and analysis of the extent to which the various categories of PoC have been reached.

However, the case studies showed that COVID-19 vaccination coverage varies regardless of the proportion of People in Need (PIN). The case studies also provided examples of situations where populations in humanitarian situations do not benefit from the same immunisation coverage as the general population. Differences in coverage in humanitarian settings are not necessarily due to inequitable planning and policy, but also due to the barriers and constraints found and the difficulty of mobilising resources in proportion to these constraints.

Despite having some NDVPs that were inclusive and strategies promoting a universal and equitable approach, when it comes to the availability and distribution of COVID-19 vaccines in humanitarian settings, the reality differs when compared to the rest of a nation’s population. Inclusion on paper in vaccine roll-out has not always translated into equitable vaccine access for displaced and affected populations in practice in the countries studied.

The overall limited supply of vaccinations and the urgency of scaling up with limited resources particularly affected humanitarian contexts and marginalised communities, with a noticeable tendency to prioritise populations that were easier to access such as those living in or close to urban areas, and nationals versus migrant populations.

Given current operational and logistical constraints, populations affected by humanitarian situations lack the same conditions in terms of equitable access as the rest of the population.
4.2 OBJ. 2: UNDERSTAND AND DOCUMENT SUCCESSFUL STRATEGIES AND ENABLING FACTORS FOR GOVERNMENTS AND NATIONAL TASK FORCES TO BEST LEVERAGE THE SUPPORT OF HUMANITARIAN ACTORS TO REACH POC

Governments are responsible for ensuring that COVID-19 vaccination plans and strategies guarantee equitable access to vaccines for all persons within the national territory.\textsuperscript{113,114} To be effective, vaccines must reach all individuals in society, including groups of people who are at risk of being overlooked or excluded from national vaccination plans either formally or at the implementation stage.

In countries facing humanitarian contexts, the Inter-Agency Standing Committee (IASC) is the international humanitarian forum led by UN and member states to ensure preparedness and a rapid and coordinated humanitarian response\textsuperscript{115}. Governments might request international assistance and the activation of the Cluster system, following certain criteria and procedures\textsuperscript{116}. Governments are therefore to be supported to leverage the humanitarian platforms and clusters once these are activated. National and international NGOs and humanitarian partners had thus a role in the different stages of vaccination rollout, to support and complement government efforts. In some settings, humanitarian actors were involved in the administration of vaccines (e.g., in Cox’s Bazar in Bangladesh, Chad, Colombia, DRC, Ethiopia, South Sudan, Iraq, Mali, Mozambique, Myanmar, northeast Nigeria, Sudan, and Syria).\textsuperscript{117}

In this context, national and international NGOs therefore have a key role to play in the different stages of vaccination roll-out to ensure affordable, timely, equitable, and universal access. NGOs are often the main or sole provider of health services in certain humanitarian settings and, as such, are usually well positioned and equipped to ensure that distribution of COVID-19 vaccines is provided equitably, and following a principled approach (i.e., following humanitarian principles of humanity, impartiality, neutrality and independence\textsuperscript{118}) especially relevant in conflict situations or volatile contexts. To be effective and to ensure equitable access, NGOs need to be able to operate in a collaborative, open, and transparent way, with the appropriate support from partners and agencies, such as UN agencies, the WHO, HCTs, and the Red Cross/Crescent movement to ensure sufficient representation, engagement, and participation in coordination mechanisms at national and subnational level.

4.2.1 INCLUSION OF HUMANITARIAN ACTORS IN THE COVID-19 VACCINATION TASK FORCE AND PLANNING

Vaccination is an essential step toward ending the pandemic. The humanitarian system and civil society together formed a strong pillar to ensure that PoCs were included in NDVPs but also in the distribution of COVID-19 vaccines in practice.\textsuperscript{119} Extensive advocacy work led by humanitarian partners urged health authorities and governments to shift their strategies to a more equitable approach,\textsuperscript{120,121} resulting in positive changes in Chad, Colombia, Iraq, DRC, Syria, Bangladesh, and north-east Nigeria, among others.\textsuperscript{122,123,124}

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\bibitem{121} UNHCR. Vaccinating the world’s 80 million forcibly displaced against COVID. February 2021.
\bibitem{122} UNHCR. Covid-19 vaccine access report. 2021.
\bibitem{123} UNHCR. Rohingya refugees and local Bangladeshi benefit from inclusive COVID-19 response. March 2021.
\bibitem{124} ReliefWeb. First COVID-19 vaccination unit opens in Domiz-1 refugee camp in Duhok. July 2021.
\end{thebibliography}
Vaccine scarcity in the early days the pandemic meant in general that less resources and vaccines were made available for PoC. As vaccines became available globally, migrants and hard-to-reach populations were included and prioritised for vaccination. Political will was a key enabler to allow humanitarian actors to be included in COVID-19 vaccination planning and decision-making, which in turn tended to be an element in favour to have PoC included in NDVPs, too.

In the countries studied, some of the initial versions of the NDVP did not specify the inclusion of PoCs or did not have a universal and equity-based approach in practice. These efforts were undertaken via existing coordination platforms, the Health Cluster and HCT, or via multilateral collaboration efforts between NGOs and UN agencies. Colombia launched in November 2021 “vaccination without barriers” to include all migrants regardless of their status. In February 2021, after significant advocacy efforts from multiple UN agencies and international NGOs, a revised version of the NDVP was released that included the Rohingya refugee population in Cox’s Bazar, to receive COVID-19 vaccination in a similar phased approach as was defined for the host community. Similar examples are found in DRC and South Sudan. Advocacy by key humanitarian actors, civil society and Health Cluster. for the inclusion of PoCs in NDVPs has proven to be a powerful driver to enable political will, bring about change and reach these populations, and to create a favourable environment and operational space for implementing partners to be further involved at the planning stages of the NDVPs. Some countries have proactively included humanitarian actors in planning processes. In studied countries there was no systematic involvement of civil society in the development of strategic and operational plans at national level, although there were some examples of participation which improved overtime due to advocacy efforts. Some governments included NGOs in immunisation working groups, but their engagement in the development and planning of NDVPs was not common. NGOs were overall more involved at local level in operational plans (DRC, South Sudan, Colombia) but it did depend on existing local dynamics for participation.

4.2.2 INCLUSION OF HUMANITARIAN ACTORS TO SUPPORT AND/OR ADMINISTER COVID-19 VACCINATION

A centrally managed model allowed authorities to focus on speeding vaccination and scale-up at national level as a priority, but it has not always provided equitable access to COVID-19 vaccines, particularly in humanitarian settings. The inclusion and participation of humanitarian partners at the service-delivery level helped access and reach PoCs with vaccination. In addition, the active engagement of humanitarian actors in understanding the needs of PoCs through RCCE activities, including KAP surveys, has led to intensified evidence-based advocacy. These efforts have resulted in the implementation of some successful measures in terms of registration, procurement and delivery methods, which has resulted in increased demand and uptake among PoCs. Overall, COVID-19 vaccine roll-out models had governments – represented by their MOH – guiding and leading national responses, with different levels of support from and coordination with other stakeholders. This could also include the humanitarian system (principally the WHO, including the Health Cluster, UNICEF, and other agencies such as UNHCR and IOM in displaced and migrant settings), local and international NGOs (mainly medical and humanitarian), and local authorities, including camp management in the case of IDP (under the cluster system) and refugee situations (under UNHCR). However, the role of non-governmental actors to administer COVID-19 vaccination differed depending on the

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125 https://www.minsalud.gov.co/Paginas/Vacunaci%C3%B3n%20Para%20todos%20sin%20barreras--.aspx#:~:text=Esta%20vacunaci%C3%B3n%20se%20dirige%20a%20que%20protegen%20contra%20enfermedades.
strategies and operational modalities in which COVID-19 plans were implemented, as well as on political will and the coordination mechanisms established.

Overall, there was no consistency in regard to including civil society in either national or community-level vaccination design, planning, and delivery exercises. Their role was often to support in geographical areas where they had existing operations or where they could expand, or to specific tasks related to vaccination (e.g., capacity building of human resources for vaccination, training, registration, tracking (including hidden population), transport, distribution, etc.). Humanitarian partners were also leveraged for RCCE which was a key element given vaccine misinformation. For NGOs that were delegated with vaccine roll-out, procurement and stocks were managed by the national authorities with support from UNICEF, so implementing partners were dependent on the national authorities’ capacity and willingness to supply vaccines. Communication was often an issue, with NGOs not knowing when vaccines would arrive, which meant there was a mismatch between mobilisation and rollout, leading to loss of confidence. Thus, the role and involvement of humanitarian partners were perceived as limited in comparison to their capacity and ability to be more involved. As some governments may not have access to or the acceptance of communities at subnational level, particularly in conflict-affected, non-government-controlled areas, hard-to-reach areas or communities with high mobility, the absence of humanitarian partners to support these efforts will have an impact in the ability to reach PoC and thus, the level of coverage in these areas.

In Iraq, there exists a division between the Kurdish area at the subnational level, with its own local governance structure, and the area under the control of the federal government. It was mentioned during an interview with a global stakeholder that “despite the apparent peace and coordination between the two regions, tensions persist. This had an impact as the federal government in Baghdad relies mainly on humanitarian agencies operating in the Kurdish area to reach the majority of PoCs and secure their needs related to health, including vaccination”. The NDVP by the federal government in Baghdad was developed for the roll-out nationwide and as such the Kurdish local MOH received vaccines from the federal government. The WHO and UNICEF supported the development of the NDVP, and, in the first stage, vaccination was led by the public sector and was the sole responsibility of the government. NGOs were not initially allowed to participate in COVID-19 vaccination besides providing RCCE. After intensified advocacy efforts from the WHO and UNICEF, vaccination of PoCs started in August 2021 (vaccination of the general population started in March), including in camps and settlements. Humanitarian agencies were then able to participate in vaccination, which also led to scaling up of funds. Humanitarian actors then had to seek ad hoc approval to support vaccination, regarding which the MOH was considered supportive.

In Colombia, except for some direct involvement administering vaccination by the National Red Cross and to a lesser degree some international NGOs, the government (via the MOH) was solely responsible for the COVID-19 vaccination roll-out and provision of services. Health Cluster partners and other stakeholders were mostly being involved in mobilisation and registration, which limited their role as part of the other health providers in the implementation and decision-making to roll out COVID-19 vaccines. Aside from not being able to participate in vaccination administration even in geographical areas of significant need where they were already operational during the first waves of COVID-19, there were no clear directives on how they could support other activities for vaccination (e.g., for mobilisation, registration, tracking, capacity building of vaccinators, etc.), especially in the early stages of the vaccination roll out. Their involvement was therefore perceived as limited as there was the capacity and willingness to do more and earlier. Despite reaching

128 The exception is NWS, where vaccination was managed and coordinated by humanitarian agencies located in Turkey (Gaziantep) with the support of the Turkish government. Implementation in NWS was led by the Syrian Immunisation Group.
129 A prior requirement to have acted as a provider of health services was required as well as a specific certification to deliver COVID-19 vaccinations by national authorities, which limited other NGOs from participating in COVID-19 vaccine distribution.
optimal vaccination coverage in regions at subnational level (>70%), when looking at specific districts (municipios) affected by humanitarian situations, coverage was much lower (sometimes below 20%).

In South Sudan, the EPI Technical Working Group was mandated to lead the planning and implementation of COVID-19 vaccination and included UN agencies and international and national NGOs. The government does not have sufficient means to ensure decentralised COVID-19 vaccine distribution, particularly to remote areas. The expansion of the COVID-19 vaccine deployment to remote areas, which meant vaccines were available throughout the country, was due to effective collaboration between EPI at the central level and UNICEF and UNHAS. For areas with high humanitarian needs, NGOs often took over at the county level to support the transport, distribution to, and administration of vaccines at vaccination sites. Support from local authorities to the transport and distribution of vaccines was uneven across counties, and sometimes depended on local political will. Context specific planning on the needs of the state and counties was done with the support of humanitarian partners who can report the needs of populations affected by humanitarian situations. For example, it may have been decided to vaccinate in a refugee or IDP camp or to strengthen a fixed site and its mobile clinic to better access the PoCs.

In the DRC, the vastness of the country and the multiplicity of humanitarian situations have led the authorities and partners to update the NDVP, in September 2021 and March 2022, by developing more local and contextualised approaches and modalities through micro-plans. Due to competing health priorities and emergencies, vaccination against COVID-19 may have been a lower priority at times for the population and national authorities. The national distribution of immunisation services (including COVID-19) is organised around the EPI architecture, logistics, and resources, from the national level to the most peripheral EPI depots. EPI logistics (transport, waste management, personal protective equipment (PPE), and cold chain) are supported by partners such as the World Bank or Gavi. This support mainly concerned reaching the general population, and little account was taken of the specificities of supply to reach populations in humanitarian situations. The distribution of vaccines at the most peripheral levels, from EPI centres to campaign or outreach immunisation sites, employed additional means provided by international NGOs such as Malteser, Save The Children, and MEDAIR. In terms of support, this can range from the financing of fuel transporting vaccines to the distribution of inputs and supervision of vaccination campaigns (e.g., Haut Uélé in the health zones of Aba, Watsa, or Faradje). This support was also seen to be provided in other provinces, particularly in Tanganyika. The COVID-19 vaccination roll-out for PoCs was highly dependent on external support, including NGOs and donors, however, and due to a limited number of NGOs being present on the ground for implementation the various emerging humanitarian situations and priorities only a few partners were involved in COVID-19 vaccination. These organisations were authorised to support COVID-19 immunisation and to support the distribution and administration of the vaccine according to their capacity. It was also reported that the participation of humanitarian actors was still inconsistent and remained dependent on the involvement and good will of local authorities.

4.2.3 COORDINATION WITH HUMANITARIAN ACTORS AND HEALTH CLUSTER TO REACH POCS

The role of the Health Cluster and other coordination mechanisms and platforms in COVID-19 vaccination varied according to each setting. The Health Cluster was leveraged to support coordination with humanitarian partners, identify missed populations and operating partners to administer vaccines in many settings (e.g., Cox’s Bazar, Colombia, DRC, South Sudan, Ethiopia, Iraq, Mali, Myanmar, northeast Nigeria, and Syria).
**Good practices**

In general, for COVID-19 response, Health Clusters that had, prior to the pandemic, a frequent and meaningful engagement with their partners and stakeholders and had effective leadership were reported to be more successful in their coordination efforts.\(^{131}\)

Effective and solid coordination for COVID-19 vaccination was highlighted in **Cox’s Bazar**, where the Health Sector\(^ {132}\) was reported to be strong and proactive in leading the health response before vaccination was rolled out in the refugee camps with mechanisms already in place to enhance coordination. COVID 19 vaccination had a strong support from the WHO, UNHCR, and UNICEF at the strategic and operational level. Vaccination points were run by MOH and NGOs for the roll-out of the vaccination plan in the camps, with a single operational plan developed by the WHO and support from working groups for complementary tasks such as mobilisation via community health workers, RCCE, and registration and other services supporting and administering vaccination.

In **Colombia**, the role of the health cluster was appreciated in identifying gaps and needs to be covered by the resources of the different aid organizations for COVID-19 vaccination, also noting MOH was co-lead of the Cluster. This was especially seen at subnational level. The Health Cluster (with the co-lead MOH) identified gaps e.g., for capacity building, RCCE, supply etc, for which cluster partners were requested to input funds or activities, accounted for in a “fund”, and then distributed to the regions as possible/needed. This was to help organise resources to be distributed.

In **South Sudan**, a National Steering Committee for the COVID-19 response was chaired by the MOH and co-chaired by the WHO, with a specific vaccination technical working group involving several partners, including some NGOs, IOM and UNHCR. The role of the Health Cluster was mainly to advocate with national authorities for the incorporation of the PoCs into the national strategy but also to facilitate coordination by exchanging information between humanitarian actors and development actors on COVID-19 vaccination.

In **DRC**, the Health Cluster helped to map PoC who had not benefited from COVID-19 vaccination humanitarian services, and also to share refugee registration data from the National Refugee Committee (Ministry of Interior) and UNHCR and conducted joint coordination meetings where challenges and advocacy for inclusion of refugees were discussed.

In **Iraq**, decision-making was centralised at the level of the Federal MOH, whereas the majority of humanitarian agencies addressing the health needs of PoCs are located in the Kurdish area. With regards to COVID-19 vaccination, the central government was leading the overall response and managed the vaccine supply chain relatively well with the support of UNICEF and the WHO.

As for the Health Cluster in Iraq – which only operated in the regions covered by the HRP and was to be deactivated in December 2022 – it played a key role in the management of the pandemic and contributed to the inclusion of the humanitarian actors in the coordination process. Support to the partners took place from the outset, the health cluster developed several Standard Operating Procedure (SOPs) and guidelines in collaboration with other relevant clusters, designed and sent out bulk SMS messages through the Iraq Information Centre, incorporated COVID-19 into every cluster meeting nationally and sub-nationally, developed specific interactive 4Ws (Who, What, When, Where tools) for partners providing COVID-19 services, supported the adjustment of the humanitarian response plan (HRP) to include COVID-19

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\(^{132}\) In Cox’s Bazar, the Health Sector is led by the Government of Bangladesh (Civil Surgeon’s office) with the support of the WHO, to the equivalent of a “Health Cluster-like coordination system” in other settings. [https://healthcluster.who.int/countries-and-regions/bangladesh](https://healthcluster.who.int/countries-and-regions/bangladesh)
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requirements, and facilitated the Iraq Humanitarian Fund's COVID-19 allocation for partners. As for WHO, it also played an important role since the beginning of the pandemic and throughout COVID-19 vaccination implementation by providing strategic direction to the MoH, contextualizing global IEC material to Iraqi context and distributing them, etc.

The Government of Syria was managing the overall response in both HCT and NES NGO Coordinated response areas including the vaccine supply chain, with the support of UNICEF and the WHO. Participants considered the Health Cluster in NES to have played a key role in advocacy as it was seen as an important spokesperson, continuously highlighting the ever-increasing needs in NES. Moreover, the Health Cluster played a role in bridging the gap and facilitating coordination between the government and MOH and the local health authorities, which resulted in increased availability of and accessibility to vaccines for people in NES.

In NWS, the Health Cluster was vital in coordinating the response between humanitarian actors providing cross border support through Turkey, the SIG (the main implementing partner) and local NGOs implementing activities on the ground. The coordination process was in place in the NWS. For instance, bi-weekly health cluster meetings bringing together the various stakeholders and during which the SIG presented updates on vaccination activities were organized. Informants described the coordination process as very inclusive with all actors being invited to participate in the bi-weekly meetings.

**Challenges**

Some coordination challenges identified were closely linked to poor transparency, lack of appropriate, specific, and detailed coverage data in humanitarian settings (necessary to be able to identify the various categories of PoC and to inform decision-making in these areas), ineffective coordination mechanisms, and inadequate leadership.

In Colombia, despite the efforts mentioned above, the Health Cluster’s mandate and responsibilities were not always clear nor effective at national level due to both the existence of two parallel coordination platforms (OCHA / Humanitarian Country Team (HCT) and Inter-agency Group on Mixed Migration Flows (GIFMM) (UNHCR/IOM), responding to migration issues nationwide) and having the cluster co-led between Pan American Health Organization and the MOH. The cluster at national level was perceived as a platform for updates and presentations of the MOH on the COVID-19 situation, and not so much a space for consultations and dialogue between cluster partners to specifically reach PoC. There was a perceived need to generate more dialogue on how to reach communities with vulnerabilities and less access, with an approach based on humanitarian principles (independent of political agendas, mandates of organisations, or provision of donor funds). At subnational level, COVID-19 vaccination coordination varied according to each health committee (Mesas de Salud) in each departamento (regional administration), depending on the dynamics, leadership, and context. In some departamentos, strong coordination was perceived and in others it was deemed to be less effective, which meant there was also a tendency toward coordination occurring between partners outside of these committees. Some organisations mentioned not having the necessary and timely information and data at lower/district level. The Health Cluster had a person dedicated to the coordination between the MoH and aid organisations, who helped identify some needs, including locations with lowest coverage in the NDVP, and prepared a strategy for the territories through the health committees. As such, one of the main gaps related to vaccinating migrants in Colombia was the poor coverage data (relying on doses administered but no clear numerator or denominator for undocumented migrants) and insufficient coordination between subnational authorities and humanitarian actors. This resulted in a lack of specific integrated responses for civil society to be better placed to respond to vaccination of migrants. Thus, the role and participation of humanitarian organisations in coordination at national level but also during implementation was perceived as limited. There is currently the annual
consultation/evaluation (Cluster Coordination Performance Monitoring) exercise in Colombia ongoing by the cluster to clarify some of these issues, as well as another GHC study to evaluate the coordination of the COVID-19 response, which will hopefully assist improving some of these processes.

In **South Sudan**, implementation of the NDVP was somewhat uneven at state and county level, with national and state authorities lacking the resources to monitor the proper implementation of the plan at local levels, or support to partners to access populations in humanitarian situations. It was pointed out that the Health Cluster could, in addition to its work with the EPI and the MOH, become more involved with state ministries and county authorities in order to facilitate the work of humanitarian actors in the field in terms of administrative, logistical, and security aspects.

In **DRC**, as in other countries with humanitarian settings, the HRP didn’t include vaccination and so the Health Cluster did not have an active leadership role in the organisation of COVID-19 vaccination.

The coordination of the COVID-19 vaccination campaign was initially carried out in the health zones by the EPI, but without any specific attention on PoCs. In North Kivu, while there was active participation of certain organisations in the administration of vaccines (Medair, IMA, and UNHCR), it was reported that not all stakeholders were involved in the coordination and operational deployment.

A new humanitarian architecture was put in place in January 2022 in DRC, based on Provincial Operational Humanitarian Coordination, but this was not activated to support COVID-19 vaccination until October 2022. The lack of transparency and coordination between the EPI and humanitarian organisations affects the provision of immunisation services in support of the COVID-19 vaccination programme by the latter. The involvement and representation of humanitarian partners within the COVID-19 vaccination coordination groups seems insufficient, restricting the ability to better consider PoCs.

In **Iraq**, the above-mentioned tensions between Kurdish and central authorities affect health system governance. The government was not highly involved in humanitarian aspects and did not help coordinate COVID-19 vaccination activities in humanitarian settings. Informants considered the government to have been supportive and not obstructive, but it was not leading COVID-19 vaccination for PoCs. Its role was limited to indirect supervision.

In addition, and regarding WHO, some informants considered that WHO’s support for the Health Cluster should have been larger in bridging the gap between the humanitarian actors and the government.

Overall, coordination mechanisms that had previously suffered from bottlenecks or other issues preventing smooth coordination, translated into persisting dynamics and defaults, at times where physical meetings were not possible due to restrictions and speedy decisions for massive scale-up were needed. Health clusters in-country were often the only mechanism available for coordination between humanitarian partners in the COVID-19 response, including vaccination. However, communications and meetings where at times politicised or followed formalities and protocols, especially in countries where the clusters were co-led by the MOH, thus limiting them to sharing epidemiological information and updates on the pandemic. Communication lines and mandates were not always clear, and dialogue and specific and effective action were missing. The cluster had a role in identifying gaps and needs to be covered with the resources of different organisations and donors for COVID 19 vaccination. However, it missed the opportunity in some instances to provide a more systematic and strategic platform to share priorities and needs identified at national and subnational levels, as well as for cross-border cooperation, in the case of Colombia, for

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133 HRP DRC 2022. Health cluster objectives: (i) Access to prevention services and medical and psychosocial care for people affected by an epidemic (cholera, measles, malaria, COVID-19); (ii) the vital needs of people affected by recent population movements are covered.
example. This was more persistent at national level, whereas at subnational level dynamics changed depending on contexts and capacities. Often, partners had bilateral and multilateral coordination outside of cluster meetings to address COVID-19 vaccination reaching populations of concern, or the cluster formed sub-groups and side-meetings to expand beyond protocols and formalities and to ensure swift and relevant action, which limited participation. Although in some contexts and to some extent the WHO tended to be more “operational” at country level, structural and mindset limitations prevented expansion of their role beyond that of a technical adviser to the MOH to have a focus on humanitarian settings. Other limitations included prioritisation of responding to other humanitarian and emergency needs, focusing on the overall population but not always a specific focus on PoCs needs and vulnerabilities, and insufficient hands-on capacity on the ground. All these constraints, to varying degrees, left partners without de facto leadership or space for humanitarian dialogue and action to ensure equitable COVID-19 vaccination for populations affected by crisis, which resulted in missing coordination opportunities, guidance, and direction, impacting the ability to effectively reach PoCs through the COVID-19 vaccination deployment.

4.2.4 SUPPORT TO HUMANITARIAN ACTORS TO FUND VACCINE ADMINISTRATION

A lack of infrastructure and overstretched healthcare systems in humanitarian settings make vaccine roll-outs difficult and expensive. Moreover, additional capacity must be deployed. Initially, the COVID-19 Global Humanitarian Response Plan (GHRP) (April–December 2020) allocated just USD$ 100 million to NGOs from a USD$ 2 billion funding request (5%). Although the final funding numbers for NGOs under the GHRP did improve, with NGOs directly receiving USD$ 769 million of the USD$ 3.8 billion recorded through OCHA Financial Tracking Service (20%), it took months for funding flows to reach frontline responders. Only USD $64.6 million (1.6%) of this funding went directly to local and national partners. Overall, most of the funding for COVID-19 vaccine roll-out in humanitarian contexts was channelled through governments or to existing implementing agreements. As per IASC guidance needs response and funds required to ensure COVID-19 vaccination for populations affected by crisis was not included in HRPs beyond 2021. Of the countries studied, those with higher income levels (Iraq and Colombia) had fewer issues with financing.

In Colombia, funding for vaccination was provided at the central level through the existing allocation system, which channels funds from the state to private insurance companies, who in turn reimburse health providers (public and private) for their services according to pre-established fees. As such, it was a requirement to have a health provider status, which most international/national NGOs did not have. The National Red Cross was one of the exceptions, and they manage to receive funds for their vaccination services in humanitarian settings as a health provider. The main issue in Colombia related to delays in the payments of fees, sometimes for months, which compromised the ability of health providers to continue with vaccination efforts, especially in dispersed and hard-to-reach areas where costs were higher. Funds for complementary efforts (capacity building, equipment, supplies, RCCE etc.) for COVID-19 vaccination of PoC were provided by each agency or organisation, in coordination with the Health Cluster, which organised a pool of funds as well as in-kind activities and assisted in identifying gaps and mobilised further funding and resources to reach PoC.

In Iraq, study participants reported that funding should not have been an issue given the resources of the government to support the health system nationwide. However, the health system in Iraq remains underfunded and fragile, with routine immunisation facing shortages in essential vaccines and a COVID-19 response that was generally weak. It was also reported that, starting from 2023, humanitarian funds will be decreasing with the objective of resilience and self-funding, but also due to reprioritisation to other global

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humanitarian crises. The government assisted with deployment of human resources to support vaccination of PoCs, which alleviated some of the costs.

In Cox’s Bazar, funding was provided via existing implementing partnerships (principally UN) or regular donor streams. Some funds were reprioritised to the COVID-19 response, including vaccination, or allowed for flexibility, especially since the restrictions imposed put on standby most of the health services considered to be non-essential.

In South Sudan, while sufficient funding was available for COVID-19 vaccination, it was unequally distributed to implementing partners. This resulted in difficulties in scaling up and securing incentives for vaccinators and some partners being unable to continue vaccination because of funding gaps. Additionally, partner-specific funding gaps resulted in interrupted COVID-19 vaccination that potentially affected populations in humanitarian situations (lack of transparency and accountability by partners and donors).

In DRC, the lack of funding for COVID-19 vaccination or issues accessing such funding for humanitarian providers was a factor limiting uptake. The budget for the NDVP in DRC is built around the pillars for vaccination. Several development partners contribute to cover the operational costs of the National Plan, with some humanitarian donors also contributing to this budget. Multilateral donors, the World Bank, and Gavi contribute to support the EPI plan for COVID-19 vaccination, although this is mainly for the general population and has no specific allocation for PoCs. Bilateral donors supported UN agencies, such as the WHO and UNICEF, as well as international NGOs working at the more peripheral level for COVID-19 vaccination. Bilateral funding for NGOs was mostly linked to ongoing humanitarian or development projects, and part of these resources have been directed toward supporting the implementation of the COVID-19 Local Plan (the micro-plan) in areas such as planning, communication plans, fuel, input distribution, supervision, etc. The Local Plan considers the populations in the area, including PoCs when appropriate. NGO funding at the local level for humanitarian settings appeared to be constrained by the financial volume of the ongoing humanitarian projects and the possibility of diverting part of the resources for COVID-19 vaccination (crisis modifiers), which was also an issue in South Sudan. In addition, the funding procedures of some donors are perceived as too restrictive by some NGOs in DRC, who report that they have not been able to support vaccination against COVID-19 due to a lack of funding.

4.2.5 CONCLUSIONS

A centrally managed national model allowed authorities to focus on speeding vaccination and scale-up at national level as a priority but has not always provided equitable access to COVID-19 vaccines, particularly to populations affected by humanitarian crisis.

The inclusion of humanitarian actors to support and/or administer COVID-19 vaccination differed depending on the strategies and operational modalities in which COVID-19 vaccination plans were implemented and political will.

Overall, NGO’s capacities for vaccine deployment and support, including gaining and negotiating access and being present in humanitarian settings, were underutilised (due to them being vaccine/funding dependent. In addition, NGOs also faced significant operational and bureaucratic restrictions).

Leveraging NGOs as a key partner from the outset would have helped drive a more efficient response, might have ensured marginalised populations were included, and increased vaccination coverage in fragile settings.

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The participation of humanitarian actors remained dependent on the involvement and good will of national and local authorities. The significant advocacy efforts made by humanitarian partners achieved inclusive NDVPs and distribution as well as ensuring vaccination services were provided in humanitarian settings.

Overall, national coordination mechanisms and platforms, supported by health clusters, in relation to COVID-19 vaccination planning and roll out did not always provide an open space for humanitarian dialogue and action for COVID-19 vaccination to reach populations affected by crisis, which resulted in coordination opportunities and guidance being missed, impacting the ability to effectively reach PoCs in COVID-19 vaccination deployment.

Financing of COVID-19 vaccination was mostly an issue in settings and countries with lower resources, emergency humanitarian crises, and diverse priorities. NGOs’ financing for immunisation-related activities in humanitarian settings was an issue. The operational costs (logistics, incentives, training, demand generation, human resources, etc.) of delivering vaccines to populations in humanitarian situations were often borne by implementing partners, funded with humanitarian donor funding, implemented by UN agencies and NGOs.

Financing was often not well distributed among agencies, due to lack of transparency or to being dependent on standing implementation agreements and prior donor streams. This hinders the ability to secure funding for a wider range of partners potentially able to support COVID-19 immunisation activities.

4.3 OBJ. 3: UNDERSTAND AND DOCUMENT MEASURES TAKEN TO MITIGATE IMPACTS IN TERMS OF DISRUPTION OF ESSENTIAL HEALTH SERVICES, INCLUDING ROUTINE IMMUNISATION

4.3.1 IMPACT ON ROUTINE IMMUNISATION SERVICES AND RESOURCES

The impact of the COVID-19 pandemic coupled with existing poor access to healthcare in humanitarian settings, particularly in those areas affected by conflict, has caused severe disruptions to the provision of essential health services, especially routine immunisation, as well as the emergence of additional threats in terms of communicable diseases.136, 137, 138

The pandemic, and in particular the intensive global efforts dedicated to vaccination against COVID-19, had a negative impact on the provision and uptake of routine immunisation services in most countries, especially for infants (Colombia, Ethiopia, and Yemen).139

The WHO’s global pulse surveys on continuity of essential health services during the COVID-19 pandemic show that, despite early evidence of service recovery, 92% of 129 countries participating in the third round of the survey still affected by the COVID-19 pandemic reported some kind of disruption to services during

136 A comprehensive explanation of the effects of the pandemic on health service provision specific to populations affected by humanitarian crisis is not possible here, since this was not a primary objective of the study and different methods and approaches would be necessary to capture the direct and indirect effects of the pandemic on the continuum of care provision.


the preceding six months from the date of survey submission (June–November 2021). This was similar to the findings reported in previous rounds of the survey (Q1 2021 and Q3 2020). As COVID-19 vaccination has scaled up, disruptions in routine immunisation services have increased, with almost half of 82 countries reporting service disruptions.

Some organisations, such as Médecins Sans Frontières, highlighted the detrimental impact of the pandemic on the delivery of measles vaccines and the ability of health systems to tackle ongoing measles outbreaks in the Central African Republic, Chad, and DRC.

Mass vaccination campaigns, a modality used mainly in hard-to-reach areas and humanitarian situations, were disrupted heavily by COVID-19. The main reasons reported early in the pandemic for the disruption of preventive campaigns services were insufficient PPE for HCWs, unclear public health protocols for safe administration of vaccines in a mass campaign environment, low availability of HCWs, extensive lockdown measures, and closure of health facilities and services. Starting from mid-July 2020, the implementation of routine vaccination campaigns regained momentum, despite the challenges brought by the pandemic. The proportion of campaigns postponed or cancelled because of COVID-19 decreased from 57% in May 2020 to 16% in December 2021.

Early in the pandemic the WHO recommended temporarily suspending mass vaccination campaigns and in May 2020 provided a framework for decision-making to implement mass vaccination campaigns in the context of COVID-19.

The third Global Evidence Review on Health and Migration in 2022 showed that displaced and mobile populations might encounter additional difficulties in accessing basic health services, including immunisation services, facing discrimination and social exclusion from host governments and communities. Many countries still do not specify a clear policy on refugees’ and migrants’ entitlement to routine vaccination, and even when they do there are often gaps in implementation. As a result, far too many PoCs globally are under-immunised, especially those who lack legal status. These inequities have been exacerbated by the COVID-19 pandemic.

For the six countries in the study, the impact of COVID-19 on essential health services and routine immunisation in particular is more nuanced. For South Sudan and DRC, there is little or no evidence of disruption to routine immunisation services in the WHO Global Pulse Survey, although disruptions to other essential health services are reported in DRC (nutrition and communicable diseases). Iraq, Syria and Colombia reported disruptions to their routine immunisation services. Numerous disease outbreaks have taken place in the camps in Cox’s Bazar over the years, including diphtheria, measles, cholera, and varicella, due to the low immunisation coverage of the Rohingya community. Despite a pronounced improvement in immunisation records, the acute phase of the pandemic jeopardised efforts that had been put in place.

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144 For cholera, measles, meningitis A, polio, tetanus-diphtheria, typhoid, and yellow fever.
146 Ibid.
In the case of South Sudan, the protection and continuation of other non-COVID-19 health services is central to the Strategic Preparedness and Response Plan, which emphasised the importance of continuing essential health services.

The reasons for the negative impact on essential services and on routine immunisation found for the six countries in this study are consistent with those discussed above: people’s reluctance to visit health facilities due to the fear of getting infected (Syria and Colombia), lockdown and isolation measures issued by the government at the national level (Colombia), the financial, human, and medical and operational material resources prioritised for COVID-19 response including vaccination, overburdened health workforces, or rumours related to the integration of the COVID-19 vaccine with routine immunisation vaccines without obtaining the consent of caregivers.

4.3.2 ROUTINE IMMUNISATION COVERAGE

The WHO and UNICEF report that ‘the Covid-19 pandemic, associated disruptions, and Covid-19 vaccination efforts have strained health systems in 2020 and 2021, resulting in 25 million children missing out on vaccination, 2 million more than in 2020, 6 million more than in 2019 and the highest number since 2008. The number of children missing out on any vaccination – “zero-dose children” – increased by 5 million in 2021 compared with 2019, going from 13 to 18 million’. Ten countries account for 11 of the 18 million zero-dose children in the world (62%) and this list is dominated by low- and middle-income countries, including DRC.

Essential immunisation service coverage dropped in all WHO regions. The South-East Asian Region was most affected, with a drop of 9% over two years. The Region of the Americas, the African Region, and the Western Pacific Region all dropped 4%, while the Eastern Mediterranean Region dropped 3% and the European Region limited its drop to 1%.

Coverage of the third dose of diphtheria, tetanus, and pertussis vaccine (DTP-3) dropped a further 2% compared 2020, to 81% in 2021, leaving 25 million children vulnerable to vaccine-preventable diseases (VPD).

First dose measles (MCV-1) coverage dropped to 81% in 2021, which was the lowest level since 2008, leaving 5 million more children unvaccinated compared to 2019. An additional 15 million children received only a first dose. Supplemental immunisation activities (including campaigns) continue to be required to ensure that all children receive the two doses that will protect them from measles.

Few countries achieved improvements in coverage during the pandemic. Thirty-nine countries recovered to some extent in 2021, but over two years only 24 countries achieved higher coverage in 2021 than in 2019.

At global level, the evidence is inconclusive on whether migrant and refugee populations experienced overall lower immunisation rates and higher VPD burdens compared with host populations. Undoubtedly, some refugee and migrant populations are under-immunised, and the drivers of under-immunisation and vaccine hesitancy in refugee and migrant populations are likely to be complex and highly context dependent. Furthermore, the COVID-19 pandemic has disrupted routine immunisation services and supplemental immunisation activities.

150 “Zero-dose children” are those who lack any dose of DTP. “Under-vaccinated” are those who received one dose, but not a third protective dose. The number of zero-dose children – those never vaccinated with even a first dose of DTP-containing vaccine – indicates that they are not served through routine services, although they may be reached through disease-specific Supplemental Immunisation Activities.


immunisation activities for the general population, and it is expected to have worsened pre-existing vulnerabilities and increased inequities for refugees and migrant populations.\textsuperscript{153}

Routine immunisation results varied across the countries considered in the study.

In Cox’s Bazar, routine vaccination coverage in refugee camps increased over the three years of the COVID-19 pandemic (Figure 3). However, the Rohingya response coverage rates in the camps remained below the recommended targets in refugee health\textsuperscript{154} despite significant immunisation efforts and outbreaks of infectious diseases still happening.

![Figure 3. Comparative monitoring coverage for the year 2020, 2021 and 2022 in Cox’s Bazar](image)

Routine immunisation coverage declined in Colombia in 2020, with an average reduction of 14.4\% in 2020 compared to 2019 but with a minor increase in 2021. Colombia was recertified as a country free of measles, rubella, and congenital rubella syndrome (January 2022).\textsuperscript{155} Certain regions, such as the Amazonia, Orinoquia, and the Pacific (which include areas with high numbers of PIN\textsuperscript{156} such as Chocó, Cauca, Vichada, Arauca, etc.), showed statistically significant reductions in coverage compared to other regions.\textsuperscript{157}


\textsuperscript{154} Sphere Handbook 2018. [https://spherestandards.org/handbook/editions/] The recommendation is to conduct a mass measles vaccination campaign for children aged six months to 15 years when estimated measles coverage is less than 90 per cent or unknown, to achieve >95\% coverage.

Routine EPI should be established as soon as possible where at least 90\% of children aged between 0 and 12 months have received three doses of DPT.

\textsuperscript{155} [https://www.minsalud.gov.co/Paginas/Colombia-recertificada-por-GPS-OMS-como-pa%C3%ADs-libre-de-sarampi%C3%B3n-aspx]

\textsuperscript{156} PIN according to Humanitarian Needs Overview in Colombia 2022.

\textsuperscript{157} Impact of the COVID-19 pandemic on routine childhood immunisation in Colombia Jose Moreno-Montoya, J Silvia Marcela Ballesteros, Jaid Constanza Rojas Sotelo, 2 Clara Lucia Bocanegra Cervera, 2 Pedro Barrera-López, 1 José A De la Hoz-Valle. Results Vaccination coverage showed an overall decline of approximately 14.4\% from 2019 to 2020 (2019 coverage=76.0, 2020 coverage=61.6\%). The greatest reduction in proportion vaccinated was observed in children <12 months of age for pneumococcal vaccine (second dose) (2019 coverage=81.4\%; 2020 coverage=62.2\%; 2019–2020 absolute difference, 19.2\%; 95\%CI 14.8\% to 23.7\%). For children aged 12–23 months, the proportion vaccinated for yellow fever declined by 16.4\% (12.4\% to 20.9\%) from 78.3\% in 2019 to 61.8\% in 2020. Among children 5 years of age, the biggest decrease occurred for the oral polio vaccine (second dose), with a difference of 11.4\% (7.1\% to 15.7\%) between 2019 and 2020 (73.1\% and 61.7\% for 2019 and 2020). We observed a statistically significant effect on vaccine coverage in rural versus urban areas for children <12 months and 5 years of age.
The data displayed by WHO/UNICEF Estimates of National Immunisation Coverage shows no decrease in the trends in vaccination coverage for South Sudan by selected antigens during the last five years (up to 2021). The analysis of national immunisation coverage estimates in DRC shows that, despite a relatively small disruption to immunisation services, there has been a decline in all coverage except for RotaC. In Iraq, data from WHO and UNICEF pertaining to national immunisation coverage for different vaccines show lower coverage rates for most vaccines in 2020 and 2021. The same is true for Syria, where data shows a continued increase in the number of unvaccinated one-year-olds against diphtheria, pertussis, tetanus, measles, poliomyelitis and hepatitis B since 2019.

4.3.3 STRATEGIES TO MITIGATE DISRUPTION OF ESSENTIAL HEALTH SERVICES FOR POCs

The impact of the COVID-19 pandemic, coupled with existing poor access to healthcare in humanitarian settings, particularly in those areas affected by conflict, caused severe disruptions to the provision of essential health services, especially routine immunisation. At the beginning of the pandemic, rapid strategies were used to reduce the burden on already fragile healthcare systems and to mitigate potential disruptions to essential health services in some countries. These strategies have mainly been oriented toward prompt and effective curtailment of the COVID-19 pandemic and aimed at increasing COVID-19 vaccination resources in general.

As the COVID-19 pandemic took hold, new strategies had to be adopted to ensure that essential health services were maintained during vaccine deployment. Measures had to be designed to ensure COVID-19 immunisation activities do not divert resources from or interrupt the safe provision of essential health services, including other life-saving vaccinations. Examples include the sustained redeployment of HCWs, redistribution of stocks of PPE, or diversion of funds from other routine services (e.g., chronic care, reproductive, maternal, newborn and child health services, and routine immunisations).

i) Health personnel and community health workers were prioritised for vaccination

Vaccination of HCW for COVID-19 helps protect front line workers most likely to be exposed to SARS-CoV-2 infection and as such was recommended by WHO SAGE as a priority group for vaccination, and was also a critical part of protecting health systems and services as defined in the WHO Global COVID-19 Vaccination Strategy for 2022. The six case studies show that the initial SAGE and WHO recommendations for prioritisation of COVID-19 vaccination were followed in the NDVPs for HCWs. They were included in the priority lists for COVID-19 vaccination.

However, there are examples, such as in Colombia, that other frontline staff from NGOs and UN agencies, doing registration or RCCE for instance, were only vaccinated as normal groups, even if they were highly exposed.

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158 BCG; DTP-containing vaccine, 1st dose; DTP-containing vaccine 3rd dose; HepB3; Hib3; Inactivated polio-containing vaccine, 1st dose; Measles-containing vaccine, 1st dose; Polio, 3rd dose.
Data from CoVDP\textsuperscript{164} as of 28 October 2022, show a percentage of HCW fully vaccinated of 59% for DRC, 93% for South Sudan and 36% for Syria. The low HCWs demand to be vaccinated helps to explain this low result. In DRC HCW did not want to be vaccinated with the initial vaccine available (AZ).

Poor data quality or absence of data to specifically categorise PoCs in most humanitarian settings resulted in difficulties monitoring COVID-19 vaccination coverage for PoCs.

In South Sudan, the populations most vulnerable to COVID-19 (co-morbidity, elderly, HCW) were significantly less well vaccinated in IDP or refugee camps than in the general population.\textsuperscript{165} The percentage of HCW fully vaccinated in the country would be 91.26% against 0.45% and 1.61% respectively in IDP and refugee camps (October 2022).

\begin{itemize}
  \item [ii)] **Appropriate physical organisation of services considering IPC**
  
  There were limited findings with regard to whether services were physically organised to take into account IPC, to mitigate disturbances to essential health services during COVID-19 vaccination roll out. Previously it was reported that essential health services that were usually provided in health facilities were affected by movement restrictions and the reductions in the provision of PPE. Lack of PPE and poor IPC practices were reported to contribute to HCWs getting infected and persistent fears of HCWs being infected were reported to at times affect their willingness to continue working and thus staff retention.\textsuperscript{166}

  For South Sudan, the importance of PPE and IPC was underlined at the level of the HRP, with the Health Cluster encouraging and supporting infection prevention and control and WASH measures including appropriate COVID-19 prevention and management activities to protect both patients and HCWs.\textsuperscript{167}

  \item [iii)] **Adaptation of service modalities (e.g., switch to outreach, mobile clinics, integrated vaccination sessions, etc.)**
  
  The countries studied had various ways of adapting healthcare and routine immunisation services.

  In the case of Cox’s Bazar, service providers put in place several programme adaptations throughout the 18 months of COVID-19 restrictions to mitigate the impact on essential health services (i.e. conducting door-to-door visits, maintaining IPC protocols, etc.) the Health Sector partners maintained access and delivery of healthcare services through existing networks, guaranteeing the continuation of routine immunisation at fixed sites and via outreach sessions, when the lockdown restrictions were lifted in 2021.

  In Iraq and Syria (HCT and NES NGO coordinated response areas), different sequences have been used for COVID-19 and routine immunisation activities. COVID-19 vaccination activities have been implemented only two days per week in some health facilities in Iraq to avoid disrupting routine vaccination. Interrupting COVID-19 vaccination for a few days allows routine vaccination services to be provided and vice versa in Damascus. This modality avoids mixing different patients (as the target categories for COVID-19 and routine immunisation are different).

  In NWS cross border response areas, in an attempt to use available resources efficiently given the scarcity of health personnel, the size of the vaccination teams was cut into smaller units that were able to continue COVID-19 and routine immunisation at the same time.
\end{itemize}

\textsuperscript{164} CoVDP. COVID-19 vaccination implementation: Analysis and insights. 28 October 2022

\textsuperscript{165} ODK as at October 2022


\textsuperscript{167} HRP South Sudan 2022 (30 March 2022)
Specific immunisation intensification activities (e.g., a series of national immunisation days and weeks) aimed at reaching and immunising children and raising awareness of the importance of routine immunisation, with support from the WHO and UNICEF, were organised in Syria (HCT and NES NGO coordinated response areas) to complement immunisation campaigns. Mobile immunisation units have been deployed to increase coverage in camps and informal settlements with limited access to routine vaccination services.

Integrating COVID-19 vaccination with EPI is a pragmatic way of reaching communities for both COVID-19 and VPD. Based on the context, different options are being explored to develop the approach, strategy, and policy, and to mobilise resources (cold chain, HR, financial) adequately. Further, integration of COVID-19 vaccinations with PHC services rather than with routine immunisations should also be considered as there are more opportunities to reach the main target through PHC services than through routine immunisation service integration only. However, one limitation could be that there might be confusion if health centres and vaccination centres are the same as the centres perceived to be places for people who are sick.

COVID-19 and routine immunisation activities have already been integrated in Colombia. The integration of COVID-19 vaccination into EPI was a resource mobilisation opportunity developed in Colombia that allows for strengthening epidemiological surveillance and for improving vaccination coverage (for both routine and COVID-19 vaccination). This approach is being explored in NWS and in other settings, with the limitation that this action could impact the uptake of routine vaccination due to people’s reluctance toward COVID-19 vaccines. In Iraq, COVID-19 vaccination services have been integrated into routine childhood vaccination efforts through a community mobilisation outreach approach (Intensifying Integrated Immunisation). IDPs and returnees in Iraq in camps, informal settlements, or mixed with the community were targeted by these activities (Nadia Butler, 2022).

iv) Resources required (e.g., HR, logistical, financial, etc.)

In terms of human resources, particularly at the beginning of the pandemic, existing staff were used for COVID-19 vaccination, whether it was staff from other health services such as malaria, pneumonia in the case of South Sudan, or EPI vaccination staff as in DRC. This additional activity stressed already limited resources and could have affected the quality of these services.

Depending on the context, resources were mobilised differently. In South Sudan, vaccination against COVID-19 was initially carried out by the ward nurses because the vaccines were in the process of being approved by the Emergency Use Listing Procedures. Routine immunisation was thus not affected, but this was not the case for other essential health services such as malaria and TB programmes. For the second round of COVID-19 vaccination, new vaccinators were recruited (laymen/women who had already been used in the measles campaigns) and received two weeks of training. This allowed nurses to resume their activities in essential healthcare services and the new vaccinators to deal solely with COVID-19 vaccination.

In Iraq, health staff were deployed from other programmes to support both COVID-19 and EPI with support from partners.

Countries also capitalised on activities deployed for COVID-19 immunisation. In Iraq, mobile teams integrated routine immunisation into demand-generation activities. Epidemiological surveillance, including for routine immunisation, was strengthened in Colombia.

Countries strengthened existing human resources through training and refreshment programmes in the surveillance of VPDs (Iraq and Syria).

Although this was described as a systematic approach, COVID-19 cold chain resources were also used for routine immunisation. Cold chain capacity was improved, which also benefited routine immunisation.
In Colombia, the deployment of resources for COVID-19 vaccination strengthened certain essential components, such as the cold chain, development of human resources in hospitals, and strengthening of intensive care units, including in more remote areas. Likewise, surveillance in public health and epidemiology was strengthened (although not sufficiently).

**v) RCCE activities**

Given the importance of maintaining essential health services, particularly routine immunisation, communication in favour of routine immunisation is intensifying in all the countries in the study. This communication relies on different means depending on the context, and is often supported technically by the WHO, UNICEF, and humanitarian partners.

BBC media action series were produced with technical support from the WHO, which raised awareness on maternal, neonatal, and child health and nutrition in Cox’s Bazar. Community health workers and communities, including Imams and other local leaders, were engaged in several community outreach initiatives to disseminate messages on COVID-19 and essential health services.

This community-based approach to getting messages closer to the people is found in other countries too. Community health workers have had to develop a key information package on health and COVID-19 that is delivered during awareness campaigns where routine vaccinations and COVID-19 vaccinations are delivered (South Sudan).

In Colombia, induced demand and mobilisation of the population through local and indigenous leaders was promoted simultaneously for COVID-19 vaccinations and routine vaccinations, sometimes with support from organisations such as ICRC and CRC. In addition, other health services were also offered as an opportunity, through modalities such as mobile medical units. More recently, it has been possible to integrate COVID-19 vaccination into EPI, with the objective of strengthening epidemiological surveillance and improving vaccination coverage after the two-year lag.

In Syria and Iraq, RCCE activities were intensified to increase awareness about the importance of routine immunisation but also to keep caregivers alerted about the need to get their children vaccinated.

### 4.3.4 ENABLERS

- Tailored and targeted interventions have been shown to improve vaccination uptake in refugee and migrant populations. These include door-to-door vaccination initiatives, mobile vaccination teams, media and health promotion campaigns, social mobilisation activities, patient reminder letters, culturally and linguistically tailored community outreach and engagement, and strengthened partnership working and coordination.\(^{168}\)

- When access and delivery of healthcare services are maintained,\(^{169}\) which is the case in Cox’s Bazar with health sector partners.

- Support to government by humanitarian actors for routine vaccination including vaccination campaigns and accelerated vaccination activities.

- Intensifying communication for routine immunisation to keep it as a priority. Having its own separate budget and maintaining resources (vaccinators) for routine immunisation during the pandemic (Colombia, South Sudan).

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\(^{168}\) WHO. Global Evidence Review on Health and Migration (GEHM) series; Ensuring the integration of refugees and migrants in immunization policies, planning and service delivery globally. July 2022.

4.3.5 CHALLENGES

Their high mobility, both within countries and across borders, is a key logistical barrier to delivering all doses of key vaccines and healthcare services to some refugee and migrant groups. These constraints may have been compounded by the COVID-19 pandemic.

The challenges described below have evolved dynamically. The challenges experienced when COVID-19 vaccination first rolled out are not necessarily the same today.

- Overburdened and already fragile health systems conducting COVID-19 vaccination activities: PPE shortages, low availability of health workers due to refocusing on COVID-19 vaccination, and chronic shortages in skilled HCWs due to huge migrations of the health workforce (Syria).
- Low demand for routine immunisation services due to fear of being infected with COVID-19, such as in DRC.
- Difficulties in access due to the humanitarian situation, containment measures, and other movement restrictions related to COVID-19: movement restrictions in Cox’s Bazar camp, in Syria the current security situation in the country affecting access to health services and the mobility of vaccinators and humanitarian staff.
- A study on Refugees in Cox’s Bazar in 2021 (Bangladesh) indicates that 30% of this population experienced difficulties in accessing routine medical care. Contributing factors included poor literacy, language barriers, and long walking distances to clinics.\(^{170}\)
- Financial, human, and operational material resources in general were prioritised for COVID-19 medical care and vaccination: in Cox’s Bazar, the WHO repurposed its field staff working in other programmes in addition to deploying medical officers specialising in VPDs to prioritise supporting the smooth roll-out of COVID-19 vaccination. The same strategies were reported in Iraq, Colombia, and DRC.
- The use of stronger incentives or fees for services to support COVID-19 vaccination has certainly had positive effects in terms of motivation and prioritisation of services. However, since vaccination teams accessed better incentives for COVID-19 vaccination or service providers received higher fees, it had a counter-productive impact on the motivation and retention of HCW and the delivery of essential health services such as regular routine immunisation (South Sudan, DRC, and Colombia).

4.3.6 CONCLUSIONS

The decline observed at global level in routine immunisation during the initial phase of the COVID-19 pandemic is now changing in tandem with intensified effort to respond to health systems challenges, bottlenecks, and barriers related to COVID-19 and COVID-19 vaccination. Some exceptions to this initial decline are noted, such as in Cox’s Bazar, which shows an improvement in immunisation coverage over the three years of the pandemic, and with South Sudan, which shows stable immunisation coverage. It is noted that these countries retained the financial and human resources allocated to routine immunisation during the COVID-19 and COVID-19 immunisation phases.

There are several reasons for the decline of essential health services for the general population. These reasons are evolving and range from difficulties in accessing vaccination centres due to mobility constraints, to health workforce availability and capacities, to the decrease in resources allocated to routine vaccination.

\(^{170}\) Mistry, S. Difficulties faced by older Rohingya (forcibly displaced Myanmar nationals) adults in accessing medical services amid the COVID-19 pandemic in Bangladesh. 2021. https://gh.bmj.com/content/bmjgh/6/12/e007051.full.pdf
in favour of COVID-19 and COVID-19 vaccination, to the fear of catching COVID-19 in health centres. These reasons also apply to PoCs and are likely to be exacerbated by humanitarian situations.

There is little disaggregated data to monitor immunisation coverage and service delivery gaps specifically for PoCs. At the global level, evidence is inconclusive on whether PoCs experienced overall lower immunisation rates and higher VPD burdens compared with host populations.

Countries adopted short-term strategies and innovations to not only overcome disruptions and recover essential health services but also to scale up COVID-19 vaccination. No common approach was found to address the decline in routine immunisation specifically for PoCs or with a specific component for categories of PoCs.

Different approaches have been proposed by countries depending on the availability of resources. These adaptations evolved throughout the response to COVID-19. IPC protocols were (re-)publicised and strengthened. Routine immunisation modalities were changed from fixed to outreach, and specific intensified immunisation activities were implemented to address the most urgent needs. Door-to-door visits were proposed, while elsewhere alternate sequences of COVID-19 vaccination and routine immunisation were offered. The size of the immunisation teams was also reduced to allow more teams to respond to both COVID-19 and to routine immunisation. Recently, the integration of COVID-19 vaccination into routine immunisation activities was being considered in the majority of the countries studied.

Some countries were able to mobilise additional resources to conduct their COVID-19 vaccination campaigns, which meant that resources were not diverted away from routine immunisation.

Given the importance of maintaining essential health services, particularly routine immunisation, communication efforts in favour of routine immunisation were intensified in all the countries in the study. Demand and mobilisation of the population through local and indigenous leaders was promoted simultaneously for COVID-19 vaccinations and routine vaccinations alike.

5 RECOMMENDATIONS

5.1 SUCCESSFUL PRACTICES/CHALLENGES IN REACHING AND ADMINISTERING COVID-19 VACCINATION IN HUMANITARIAN SETTINGS

5.1.1 POLICIES AND STRATEGIC ARRANGEMENTS

To governments: The principle of health equity should guide decision-making. Ensure that COVID-19 vaccination plans and strategies guarantee equitable access to vaccines for all persons within the national territory.

To governments: Ensure that NDVPs are based on sound microplanning that is representative of local realities, i.e., by local authorities with representative populations.

To governments and local authorities: Facilitate involvement of NGOs and community-based organisations in humanitarian settings in the strategic and operational planning of vaccination programmes at country and local level to enable locally appropriate and coordinated responses that will benefit PoCs.

To the WHO: Support the adaptation of a global vaccination policy model to specifically include affected populations in humanitarian settings in catch-up immunisation for COVID-19 vaccination, mass vaccination campaigns, and pandemic response plans.

To government and donors: Increase the resources to deploy the NDVPs as well as the means to enforce it at local levels.
Study to examine COVID-19 vaccination in humanitarian settings

To governments and the WHO: Provide resources to improve monitoring including vaccination coverage in real time and consider data disaggregated according to PoC status, to reach populations in humanitarian settings. This will consequently improve decision-making and resource management by identifying the barriers to and facilitators of vaccination services.

To the WHO: Perform a robust, large-scale study to identify what the value of consistently incorporating COVID-19 vaccination in HRPs would have been.

To donors and UN agencies: Soften and adapt funding requirements and procedures to allow for additional implementing partners to rapidly respond to pandemics in general, including integrating COVID-19 vaccination. Explore possibilities to have a country level mechanism to support rapid disbursement of NGO financing.

To governments and the WHO: Take opportunity of the situation of the current pandemic to strengthen national pandemic preparedness plans to prevent and respond to newly emerging infectious diseases (including with large-scale vaccination deployment) while maintaining quality essential health services. Plans should incorporate an improved surveillance and monitoring system to identify and monitor PoC health status.

5.1.2 GOOD PRACTICES AND OPERATIONAL CHALLENGES

To governments and the WHO: Capitalise on lessons learned during the pandemic and design operational guidelines for how to reach different categories of PoC with COVID-19 vaccination on timelines equivalent to the general population. The guidelines should be contextualised to the different humanitarian settings to address their operational and supply barriers, and define targeted actions and modalities of vaccination. Operational guidelines should be disseminated, with quality data collected and published, so that success can be monitored.

To governments and the UN: Support frontline staff involved in vaccination deployment in insecure environments by undertaking sufficient measures to mitigate potential attacks, ensuring the security and safety of vaccination teams, with a special emphasis on the protection of women and vulnerable teams.

To governments: Address the administrative barriers faced for PoC in accessing vaccines, including by taking a flexible approach to ID and documentation requirements by issuing temporary identity cards or allowing the use of identity documents from other countries and by ensuring that vaccination registration systems and vaccination centres are accessible to those without access to computers or the internet and to people who face language barriers.

To governments and donors: Provide sufficient support and funding for delivering vaccines, including in remote areas and areas with limited health infrastructure. These costs must be budgeted for by governments, UN agencies and NGOs, giving consideration not only to the cost of doses and delivery materials but also to transport and cold chain infrastructure, different models of care, the safety of frontline workers, training and logistics, and vaccine tracking and coverage.

To the UN: include identification and availability of services to respond to future PHEIC events or large epidemics as part of the Humanitarian Needs Overview (HNO) planning process in each country.

5.1.3 UNDERSTANDING THE SPECIFIC NEEDS OF POCS

To governments, the WHO, UNICEF and NGOs: Develop communication and vaccination strategies based on contextualised understanding of the representations and perceptions of different PoCs regarding COVID-19 vaccination through a participative approach involving PoCs to co-create programs and delivery of
services they will be able to reach. Additionally, ensure accountability to all parts of the populations, including PoCs.

To governments, the WHO, and NGOs: Consider the changing epidemiology of the virus as well as changing evidence on vaccines affecting demand, and rethink and adapt RCCE strategies accordingly for effective impact.

To governments, WHO and NGOs: Adapt communication tools to PoCs to reduce inequalities in vaccine information (including translation of information materials into relevant languages).

To governments: Compile and use the data generated by the different interventions aimed at understanding the barriers on the demand side to inform the decision-making process through a bottom-up evidence-based approach.

To governments and donors: Invest in consistent RCCE and messaging given the multitude of vaccines being developed, changing guidance, and evolution of misinformation.

5.2 SUCCESSFUL STRATEGIES AND ENABLING FACTORS FOR GOVERNMENTS AND NATIONAL TASK FORCES TO BEST LEVERAGE THE SUPPORT OF HUMANITARIAN ACTORS TO REACH POCS

To governments and the WHO: Strengthen coordination and leadership at national and subnational level (i.e., by those leading COVID-19 vaccination planning and implementation) from the outset to ensure that humanitarian partners are meaningfully engaged to enable an effective and aligned response in humanitarian settings and that everyone is reached. Humanitarian partners have a role in leading or co-leading groups, engaging in planning, providing technical assistance as well as being involved in implementation and administration of vaccination activities. In line with this, ensure that appropriate COVID-19 coordination mechanisms are in place with sufficient space for humanitarian actors to dialogue and to generate a greater impact and a speedy and effective humanitarian response to public health emergencies, including mass vaccination. Leverage existing partners and networks, invest in time and efforts to reach out and work with such networks like the Health Cluster Partners and/or Coordinator.

To IASC, WHO, Gavi and UN agencies: Provide operational guidance to humanitarian partners to ensure relevant actions are put in place for the provision of Covid-19 vaccination in humanitarian settings.

To Health Clusters and HCT: Invest in strong relations with government and local authorities to ensure buy-in and engagement for humanitarian response for equitable services and funding for pandemic response to ensure sufficient dialogue and action for COVID-19 vaccination to reach PoCs takes place. Ensure there is an enabling environment for equitable immunisation services and sufficient funding for pandemic response.

To Health Clusters and HCT: Consider WG in the Health Cluster and or HCT to at a minimum, track and discuss access to COVID-19 vaccination services by populations affected by crisis.

To donors, the WHO, and UNICEF: Provide timely funding mechanisms for COVID-19 immunisation in fragile and humanitarian settings that are sufficient to meet operational constraints, recognising that these may vary considerably depending on the situation.

To donors, the WHO, and UNICEF: Stimulate fundraising, soften and adapt funding requirements and procedures to allow for additional implementing partners to rapidly respond to pandemics, and increase transparency in funding allocation to implementing partners according to needs and with an eye to avoiding duplication of efforts for COVID-19 vaccination.
To donors and the UN: Facilitate NGO representation at all stages of the decision-making process and operational requirements (e.g., financing, access negotiations, importation, etc.) to ensure better access to PoCs.

5.3 MEASURES TAKEN TO MITIGATE THE IMPACT ON THE INTERRUPTION OF ESSENTIAL HEALTH SERVICES, INCLUDING ROUTINE IMMUNISATION

To governments and the WHO: Maintain and protect essential health services from disruption from the outset of the epidemic and ensure this is contextualised for populations facing humanitarian crises whose health needs may be different than the wider population.

To the WHO: Assess the implications of COVID-19 direct and indirect impact on the resurgence and the spread of VPDs, as well as the effect on infant and child healthcare, in humanitarian settings with disaggregated analysis on PoCs. This study on several countries with different routine immunisation coverage could inform priority setting during a future pandemic.

To governments and the WHO: Integrating COVID-19 vaccination with routine immunisation activities is a pragmatic way of reaching communities. However, given fragile health systems and challenges in the provision of routine immunisation for PoCs, at national level, this option should be explored in a meaningful way with appropriate investments to further develop the approach, strategy, policy, and resources (cold chain, HR, finance, etc.) to reach PoCs for the epidemic phase but also for the transition to an endemic phase.

To governments, the WHO and UNICEF: While respecting humanitarian principles and protecting PoCs, test the use of disaggregated data by PoC typology to better monitor routine immunisation coverage and gaps in service delivery for these populations.
# ANNEX 1. RESEARCH MATRIX

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| Understand and document successful practices as well as challenges faced in the deployment and administration of COVID-19 vaccines to reach PoC in humanitarian settings | NDVP: COVID-19 vaccination plans consider equitable access to vaccines for all persons within the national territory (both in NDVPs and in microplans)  
- Inclusive vaccine plans and strategies that ensure equitable inclusion of persons at elevated risk of SARS-CoV-2 infection and severe COVID-19 illness from PoC  
- Adapted to the humanitarian settings contexts and access barriers for PoC  
- The type of vaccine to be used for PoC has been determined and adopted  
- Costs required to reach PoC estimated  
- Strategies aiming at ensuring equitable access to COVID-19 vaccines across populations  
- Modality in which vaccines are delivered (e.g., mobile clinics, outreach, etc.)  
- Reducing discrepancies in vaccine delivery within countries with humanitarian settings (sub-nationally, in areas with high humanitarian caseload (people in need)) | Key country documents, including national COVID-19 response plan, NVDP, COVID-19-related survey reports, COVID-19 vaccine mini–Post-Introduction Evaluation (mini-cPIE) reports, Availability Mapping System (HeRAMs) and the Health Cluster Public Health Information Services, and any other relevant country document. Analysis conducted by WHO, GHC, RCCE Collective Service, such as NDVP review, monthly tracking report, country reports | Literature review  
Key informant and group interviews  
Data extraction from available databases  
Mixed-methods data analysis at global, national, and at local level |
| 1. What have been successful policies and strategic arrangements to reach and vaccinate eligible PoC?  
- What policies have been adopted and what strategies have been planned to reach and vaccinate eligible PoC? | Design / performance monitoring / data  
- Availability of disaggregated data for access indicators for PoC groups  
- Percentage of vaccines administered among PoC | | |
| b. How did each of these contribute to reaching and vaccinating PoC? | | | |
| c. To what extent have the immunisation delivery systems and structures needed to secure COVID-19 vaccines been designed to ensure access to priority populations among PoC? | | | |
### 2. What have been good practices for, and operational challenges faced in, reaching and vaccinating PoC?

| Enabling factors and challenges in terms of ensuring adequate coverage and resources for reaching and vaccinating PoC: i) health workforce/human resources; ii) vaccination service coverage (health facility/vaccination point), including cold chain management and transportation arrangements; iii) information (continuous surveillance, availability of data, availability of timely and disaggregated data); and iv) funding for operational costs of reaching PoC, including in hard-to-reach or insecure areas, mobile or hidden populations, etc. Needs assessments undertaken to approach PoC for COVID vaccination in specific humanitarian settings | Key documents, including COVID-19 vaccination operational plans, budgets, survey reports, administrative reports. Analysis conducted by WHO, GHC, RCCE Collective Service, such as NDVP review, monthly tracking report, country reports. Ministry of Health (MoH) representatives at various levels, representatives of national and international NGOs, partners providing health services or COVID-19 vaccination to PoC, representatives of United Nations agencies supporting health services or COVID-19 vaccination for PoC, relevant humanitarian and development donors, members of the United Nations Humanitarian Coordination Team | Literature review | Key informant and group interviews | Data extraction from available databases | Mixed-methods data analysis |

| Measures to understand demand-side barriers specific to different PoC present within the setting: | Key documents, including COVID-19 vaccination operational plan, COVID-19 vaccination data, administrative reports, survey reports. Analysis conducted by WHO, GHC, and RCCE Collective Service, such as NDVP review, monthly tracking report, country reports. MoH representatives at various levels, representatives of national and international NGOs, partners providing health services or COVID-19 vaccination to PoC, representatives of United Nations agencies supporting health services or COVID-19 vaccination for PoC, representatives of elders and women among PoC | Literature review | Key informant and group interviews | Data extraction from available databases | Mixed-methods data analysis |

#### a. What are the enablers and the challenges faced when working in humanitarian contexts to reach PoC?

#### b. How is funding for operational costs to reach PoC mobilised?

### 3. Understanding specific needs of PoC:

| Measures to address demand-side barriers for different PoC present within the setting: | | | | | |
| healthcare workers from PoC? | • Participative governance and decision-making (involvement of community leaders, influencers, etc.)  
• Access to appropriate RCCE  
• Availability of appropriate and transparent RCCE strategies  
Measuring inequity through the following:  
• Monitoring availability and equitable supply of vaccines (vaccine shortages, the same safety and quality standards should be applied to the entire population including PoC without discrimination)  
• Monitoring coverage (ensuring disaggregation of data to monitor equity by age, gender, and disability; specific groups and/or by location – e.g., IDPs, refugees, those living in hard-to-reach and insecure areas)  
• Assessing access inequity |
| --- | --- |

**Understand and document successful strategies and enabling factors for governments and national task forces seeking to best leverage the support of humanitarian actors to reach PoC**

| 4. What strategies are used by governments and national task forces to best leverage the support of humanitarian actors to reach PoC? | Coordination with humanitarian actors/health cluster on issues related to vaccination of PoC, including identification of PoC to be vaccinated and partners able to reach them  
Inclusion and engagement of humanitarian actors in the COVID-19 vaccination task force and planning at various levels of the health pyramid  
Inclusion of humanitarian actors to support and/or administer COVID-19 vaccination (e.g., as implementing partner)  
Support to humanitarian actors to fund vaccine administration and potential increased operational costs | Key documents, including COVID-19 vaccination operational plan, reports from humanitarian actors. Analysis conducted by WHO, GHC, and RCCE Collective Service, such as NDVP review, monthly tracking report, country reports  
MoH representatives at various levels, health clusters and their members, and other international and local organisations supporting relevant health services or COVID-19 vaccination to PoC that are present and active in humanitarian settings, and relevant humanitarian and development donors |
| --- | --- |

**Literature review**  
**Key informant and group interviews**  
**Qualitative data analysis**
5. **What are the enabling factors for best leveraging the support of humanitarian actors to reach PoC?**

<table>
<thead>
<tr>
<th>Elements in favour or challenges for humanitarian organisations in regard to being able to effectively and timely identify, access, and reach PoC in supporting vaccination, including but not limited to political will, appropriate space for humanitarian response in place, capacity, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoH representatives at various levels, representatives of national and international NGO, partners providing health services or COVID-19 vaccination to PoC, representatives of United Nations agencies supporting health services or COVID-19 vaccination for PoC, relevant humanitarian and development donors, coordination mechanisms/clusters</td>
</tr>
</tbody>
</table>
| Literature review  
Key informant and group interviews  
Qualitative data analysis |

6. **What strategies have been used to mitigate potential disruption to essential health services delivery?**

| Health personnel and community health workers were prioritised for vaccination  
Specific resources (human, PPE, funds, equipment, etc.) for COVID-19 vaccination  
Adaptations made to ensure both COVID-19 vaccination and essential services are provided to PoC: i) appropriate physical organisation of services considering IPC; ii) service modalities adaptation (e.g., switch to outreach, mobile clinics, integrated vaccination sessions, etc.); iii) frequency of routine immunisation sessions and other essential health services; iv) resources required – e.g., human resources, logistics, finance; v) RCCE activities  
Routine immunisation coverage performance |
| --- |
| Essential health service planning, administrative reports, database capturing the outputs of essential health services  
Key persons at central level (including partners at national level, Gavi, implementing partners, and other agencies)  
MoH representatives at various levels, representatives of national and international NGO, partners providing health services or COVID-19 vaccination to PoC, representatives of United Nations agencies supporting health services or COVID-19 vaccination for PoC, relevant humanitarian and development donors |
| Literature review  
Key informant and group interviews  
Data extraction from available databases  
Mixed-methods data analysis |

7. **What were the enablers and challenges faced in mitigating potential disruption to essential health services delivery?**

| Enablers for the implementation of measures to mitigate potential disruption to essential services for PoC  
Challenges to the implementation of mitigation measures |
| --- |
| Essential health service planning, administrative reports, database capturing the outputs of essential health services, Availability Mapping System (HeRAMs), Health Cluster Public Health Information Services, and any other relevant documents  
MoH representatives at various levels, representatives of national and international NGO, partners providing health services or COVID-19 vaccination to PoC, representatives of United Nations agencies supporting health services or COVID-19 vaccination for PoC |
| Literature review  
Key informant and group interviews  
Data extraction from available databases  
Mixed-methods data analysis |
Thank you - Thank you for the interviewee and for your time today.

Intro - My name is ............, and I work as an external consultant for Hera. Hera is an international partnership of health sector experts committed to evidence-based evaluation and advice.

Purpose - We are conducting a study to examine Covid-19 vaccination in humanitarian settings for the GHC. This study is designed to identify and analyse good practices and challenges in COVID-19 vaccination for PoCs in humanitarian settings where the HC is activated. A report will be published.

We would appreciate if you could provide as many examples as you can, according to your own experience and if you can also refer us to any documentation or other key contacts.

Duration – I expect the interview to take approximately 60 minutes. We have prepared different questionnaires to different groups of stakeholders, and I hope the following questions are relevant to your activities. It’s absolutely fine if you do not know the answer to a question or prefer not to answer or the question is not relevant to your role.

Confidentiality: please note that this interview is confidential and your name and data will remain anonymous. For the purpose of taking minutes afterwards while now focusing on our conversation, would it be Ok if it is recorded? (Note: if possible, make sure that verbal agreement is already recorded)

Opportunity for questions – Do you have any questions before we start? You are welcome to interrupt me at any time if you have questions or if there are any elements that did not come up during the interview feel free to share them near the end.

We will start the interview with some questions about (1) successful practices as well challenges to reach and administer vaccination to PoCs in humanitarian settings (2) successful strategies, enabling factors for governments and national task forces to best leverage the support of humanitarian actors to reach PoCs followed by (3) strategies that have been used and challenges faced to mitigate potential disruption to essential health services delivery while ensuring COVID-19 vaccination is effectively rolled out to reach populations of concern.

<table>
<thead>
<tr>
<th>INTRODUCTION</th>
<th>Global KII</th>
<th>Country KII</th>
<th>Locally based KII</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could you please you introduce yourself, your background, job title, organisation, and your role?</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>How many years have you been in this role? How long have you been with this organisation?</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>What is your involvement with respect to the Covid-19 Vaccination in Humanitarian settings?</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
## INTRODUCTION

<table>
<thead>
<tr>
<th>1. Successful practices and challenges in the deployment and administration of Covid-19 vaccines to PoCs</th>
<th>Global KII</th>
<th>Country KII</th>
<th>Locally based KII</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1. What have been successful policies and strategic arrangements to reach and vaccinate eligible PoC?</strong></td>
<td></td>
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<tr>
<td>What policies have been adopted and what strategic arrangements have been planned to reach eligible PoC for Covid-19 vaccination? (descriptive)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Probes: Plans (i.e., NDVP), policies, microplans, strategies and resource mobilisation (referring to government-led initiatives including financial and HR) that have been adopted, planned, implemented for the general population but including PoC or for specific PoC groups nationwide or sub-nationally to reach PoCs for vaccination? What are the challenges/enablers to develop and implement these? Modalities in which vaccines are delivered, e.g., mobile clinics, outreach, other adapted means (descriptive). How were vaccination high-risk priority groups identified? (Age, health, exposure risk, transmission risk, Status, (equity focus)) Strategy to address specific PoCs needs in relation to vaccine types. Risk Communication and Community Engagement (RCCE) strategy?</td>
<td></td>
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<tr>
<td>To what extent these policies, strategies, and resource mobilisation have contributed to reach PoCs with C19 vaccination (increasing coverage)? (analytical)</td>
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</tr>
<tr>
<td>Probes: Are they successful (check numbers, reports, examples etc to describe success)? Disaggregated data – age, gender, geo location, etc- Indicators used to assess access, performance of immunization service delivery and immunization uptake. To what extent each of these policies, arrangements and resource mobilisation have contributed to reaching PoCs with vaccination? Are these policies/plans successful (check numbers, reports, examples etc to describe success (calculation of estimated PoCs needs, PoC vaccinated against estimated needs, vax coverage data for PoCs compared to wider population (nationally/sub nationally/hum settings))?</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>1.2. What have been good practices and operational challenges for reaching and vaccinating populations of concern?</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>What are good practices and operational challenges (supply side) for vaccination of PoCs in humanitarian settings where the HC is activated?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Areas to explore (if not available via desk review)</td>
<td></td>
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</tr>
<tr>
<td>• Geo areas/locations covered by HC in each country, in particular: hard to reach, active conflict or insecure areas, areas with limited mobility or cut off from humanitarian aid. • Categories of PoC/affected population (mobile or hidden populations (IDPs, refugees, nomads, migrants of any status) people affected by crises or living in areas above). • Good practices and challenges: Logistics (transport, cold chain, distribution), Adequacy of Operational arrangements for vaccination as described in 1.1 (health workforce/HRs, health facility/vaccination point/mobile, ability to scale up) • Operational challenges: Negotiation with Non-State Armed Groups (NSAG) or opposition, counterterrorism measures, strategy and plans to reach PoC, ability to reach populations in hard to reach / insecure areas, ability to reach specific groups, such as women (specific to certain contexts where women are excluded from healthcare/vaccination) or other marginalised and discriminated groups, and bureaucratic and political constraints. Existing data of PoC vaccinated (sufficient, disaggregated (as per 1.1.), timely, etc) Vaccine availability and distribution in humanitarian settings (safety standards, shortages, equitable distribution, etc compared to rest of population same country)</td>
<td></td>
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</tbody>
</table>
### INTRODUCTION

<table>
<thead>
<tr>
<th>Funding estimations (needs assessments) and availability to reach PoC.</th>
<th>Global KII</th>
<th>Country KII</th>
<th>Locally based KII</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existence of a need assessment to approach PoCs for Covid vaccination in specific humanitarian settings</td>
<td></td>
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</tbody>
</table>

How is funding for operational costs to reach populations of concern done?

| Is the cost to reach and vaccinate population of concerns estimated? | x | x | x |
| What are the arrangements for funding? Co-financing? |  |  |  |
| Is the funding adequate? funding arrangement and amount? examples? |  |  |  |

### 1.3. Understanding specific needs of the population

**What measures have been taken to understand demand-side barriers specific to PoC?**

**Probes:**
- Categories of PoC and possible demand-side barriers for each (also for women, men, children, aged, disabled, marginalised groups, etc.). Focus in perception of PoC (each category) towards C-19 vaccines
- Availability of surveys/data collection (acceptance, awareness, identify barriers, feedback and perception).
- Training of health staff (communication skills, cultural sensitivities, ethical standards)
- Existence of CBOs or representatives of the community of PoC raising the voice of behalf of PoC in vac c- 19 related issues
- Examples of barriers (non-exhaustive list): geographic or bureaucratic access constraints such as distance from health facility, registration with ID, or marginalisation and mistrust of authorities.

| What measures have been taken to address these demand-side barriers? | x | x | x |
| Probes: |  |  |  |
| Mechanisms (health authorities, NGOs/CSOs) to address these barriers (Participative governance and decision-making (involvement of representatives of PoC, community leaders, influencers, etc.) |  |  |  |
| Assess RCCE |  |  |  |

### How is vaccination inequity for PoC being measured?

**Probes:**
- Mechanisms to measure differences between vaccines needs and coverage in PoC priority groups (comparison between subnationally/nationally vaccination guidelines for general population and PoC)

| How is vaccination inequity for PoC being measured? | x | x | x |
| Probes: |  |  |  |
| Mechanisms |  |  |  |

### 2. Understand and document successful strategies, enabling factors for governments and national task forces to best leverage the support of humanitarian actors to reach populations of concern

#### 2.1. What are strategies used by governments and national task forces to best leverage the support of humanitarian actors to reach populations of concern?

| What are the strategic arrangements (policies and resource mobilisation) and coordination mechanisms with hum actors/health cluster for vaccination of PoCs used by national authorities to best leverage the support of humanitarian actors to reach PoCs? | x | x | x |
| Probes: |  |  |  |
| Performance of existing COVID-19 vaccination National Task Force and Health Cluster, existence and inclusion of humanitarian actors for C-19 vaccination (coordination, reporting, engagement, etc.), support/barriers for these actors to identify and reach PoC. |  |  |  |
| Mechanisms for subcontracting (funding) organisations and potential increased operational costs due to vaccination. |  |  |  |

#### 2.2. What are the enabling factors and challenges to best leverage the
INTRODUCTION

**support of humanitarian actors to reach populations of concern?**

Describe enabling factors and challenges

**Probes:**
Presence /access of humanitarian actors in areas with high caseload of humanitarian needs (PIN) with also vaccination needs (vaccination coverage, ability/willingness of government to vaccinate)
Perception/support/barriers of government towards organisations that access areas with PoC associated with opposition/others side of the conflict/neglected/discriminated population
Examples of enables and challenges

<table>
<thead>
<tr>
<th></th>
<th>Global KII</th>
<th>Country KII</th>
<th>Locally based KII</th>
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</thead>
<tbody>
<tr>
<td><strong>3. Understand and document measures taken to mitigate impact on disruption of essential health services, including routine immunization in humanitarian settings</strong></td>
<td></td>
<td></td>
<td>x x</td>
</tr>
<tr>
<td>How were routine immunisation resources (HWF, facilities, equipment, funding) impacted due to covid vaccination at national/subnational level (focus in humanitarian settings)?</td>
<td></td>
<td></td>
<td>x x</td>
</tr>
<tr>
<td><strong>Probes:</strong></td>
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<tr>
<td>If not available during desk review: Disruptions of services and impact in coverage (compare pre- and post-pandemic coverage rates for DPT3 (3 doses of diphtheria-tetanus-toxoid-pertussis as a prox for routine immunisation) nationally/subnationally using WHO/UNICEF Estimates of National Immunization Coverage (WUENIC) data), national reports on disruption of essential services (GAVI/MoH)</td>
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<tr>
<th></th>
<th>Global KII</th>
<th>Country KII</th>
<th>Locally based KII</th>
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</thead>
<tbody>
<tr>
<td><strong>3.1. What strategies have been used to mitigate potential disruption to essential health services delivery?</strong></td>
<td></td>
<td></td>
<td>x x</td>
</tr>
<tr>
<td>Adaptations, flexibility and “resilience of the health system” to ensure both Covid vax and essential services are provided to PoCs?</td>
<td></td>
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<td>x x</td>
</tr>
<tr>
<td><strong>Probes:</strong></td>
<td></td>
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<tr>
<td>Appropriate physical organisation of services considering Infection Prevention Control (IPC)? For COVID-19 vaccination? For other essential services performed among PoCs?</td>
<td></td>
<td></td>
<td>x x</td>
</tr>
<tr>
<td>Modalities adaptations (outreach, mobile, integrated vax sessions, ...)?</td>
<td></td>
<td></td>
<td>x x</td>
</tr>
<tr>
<td>Resources required (HR, funds, logistics, ...)</td>
<td></td>
<td></td>
<td>x x</td>
</tr>
<tr>
<td>Risk communication and community engagement (RCCE) activities being performed among PoCs?</td>
<td></td>
<td></td>
<td>x x</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Global KII</th>
<th>Country KII</th>
<th>Locally based KII</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.2. What were the enablers and challenges faced to mitigate potential disruption of essential health services delivery</strong></td>
<td></td>
<td></td>
<td>x x</td>
</tr>
<tr>
<td><strong>Probes:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Reports, organisations involved in provision of essential services, funding and prioritisation at national/subnational level, etc</td>
<td></td>
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<td>x x</td>
</tr>
</tbody>
</table>

We have come to the end of this interview. Is there anything else you haven’t mentioned yet that you would like to add? Wrap up of key points from your side? Is there anything you would like to ask us? Any documentation/key contacts you can provide?

Also, if you would be interested in receiving a copy of the study report you could do so by contacting GHC Covid 19 task team.

*Thank you very much and wishing you a good day.*
### ANNEX 3: CONTEXTS OF THE COUNTRIES SELECTED FOR THE CASE STUDIES AND CATEGORIES OF TARGETED POCS

<table>
<thead>
<tr>
<th>Country</th>
<th>Context</th>
<th>Total population, and population in need PoCs</th>
<th>PoCs’ description/comments</th>
</tr>
</thead>
</table>
| Colombia  | - Colombia has multiple humanitarian situations and contexts, with populations living in conflict and insecurity, marginalised, in dispersed and hard-to-reach areas, in situations of displacement and mixed migration, as well as affected by natural disasters. There are also indigenous communities.  
- It is the second country in the world, after Syria, with the highest number of displaced people due to violence and conflict, and the largest recipient of Venezuelan migrants. 24% of the population lives in rural areas, where there are high socio-economic inequalities and where populations face serious disparities and barriers to access health services.  
- After the signing of the peace agreement between the Colombian government and the FARC in 2016, the conflict has become atomised, with the appearance of dissidents and the presence of former armed groups, such as the ELN, or the transformation of paramilitaries into criminal gangs such as the Clan del Golfo.  
With the pandemic, some armed groups have managed to consolidate their control over local communities via their own confinement and movement rules. | - Population: 48.2M  
- Population in need: 7.7M distributed as follows:  
  - Residents in areas with armed groups: 5.8M  
  - Refugees: 1.8M  
  - Migrants: 7M | - As for the PoCs covered by this study, they include: Approximately 5.8 million of PoCs live in areas with armed groups. In addition, there are 1.8 million refugees and migrants from Venezuela, with 1 million migrants in irregular situations with an intention of permanence, more than 5 million Venezuelans possessing a Border Migration Card, and 1 million migrants in transit who are not easily identifiable, making them difficult to trace. |
| Cox’s Bazar | - Since 1978, Bangladesh has received successive waves of Rohingya refugees. Before August 2017 most refugees had returned to Myanmar  
- Following a large violent military crackdown in Rakhine state in August 2017, more than 700,000 Rohingya were forced to flee to Bangladesh within a few days. | - Population: >900,000  
- Population in need: 1.4M distributed as follows:  
  - Residents of the host community: 540K  
  - Refugees: 900K | - As for the PoCs covered by this study, they include: More than 900,000 refugees are currently living in 33 camps of Ukhia and Teknaf Upazilas of Cox’s Bazar, Bangladesh and more than 540,000 people targeted for assistance in the host community in the JRP 2022 |

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<table>
<thead>
<tr>
<th>Study to examine COVID-19 vaccination in humanitarian settings</th>
</tr>
</thead>
</table>

weeks\(^{173}\). Over 900,000 refugees remain currently in Cox’s Bazar, the largest camp in the world. Around 26,000\(^{174}\) were moved to Bhasan Char Island\(^{175}\). By mid-2020, the COVID-19 had reached the camps. While there has been continuous humanitarian support for the refugee, restrictions imposed in response to COVID-19 interrupted some humanitarian activities and forced the scaling down of others. Humanitarian activities had fully resumed by mid-2021, but the negative impacts of COVID-19 restrictions persist\(^{176}\).

### DRC

- Acute humanitarian needs remain concentrated in the eastern provinces of the country (Ituri, North Kivu, South Kivu, and Tanganyika) and in the Kasai region. Eastern DRC is characterised by a complex humanitarian situation due to the presence of numerous armed groups (violence and state of siege in North Kivu and Ituri), inter-community tensions, epidemics, natural disasters, and chronic poverty.
- The sub-regional political context continues to impact the situation in DRC. For example, the December 2020 presidential elections in the Central African Republic led to the arrival of more than 70,000 Central African refugees in the North and South Ubangi provinces between.
- Humanitarian needs have continued to increase in recent years, particularly in 2018 following the crisis in the Kasai region and during the years 2020 and 2021 due to outbreaks of COVID-19, Ebola virus disease, and worsening food insecurity figures.

The HNO indicates an increase of humanitarian assistance in 2022. This increase is explained by the deterioration in the humanitarian situation in certain areas and especially by the increase in the number of people in acute food insecurity.

| Population: 95.8M\(^{178}\) |
| People in need\(^{179}\): 27M distributed as follows: |
| IDPs: 4.86M |
| Returnees: 1.94M |
| Refugees: 533K |

### Iraq

- Iraq is still undergoing massive reconstruction and rehabilitation efforts following large-scale military operations against Islamic State in Iraq and the Levant, which came to an end in 2017.

| Population: 43.5M (as of 2021)\(^{180}\) |
| PoCs that have been covered by this study include the internally displaced (in camps or mixed with the |

\(^{173}\) OHCHR 11/09/2017  
\(^{174}\) UNHCR 12/07/2022  
\(^{175}\) In 2020, Rohingya refugees were transferred to Bhasan Char, a previously uninhabited island in the Bay of Bengal. In October 2021, the UN and the GoB signed a MoU to provide services to these refugees (UN 09/10/2021). As of February 2022, only over 20,000 refugees were relocated (UNHCR 24/03/2022).  
\(^{176}\) ISCG 04/11/2021  
As a result, humanitarian needs and displacement persist in Iraq, deeply affecting and increasing the vulnerability of an important proportion of the population.

- People in need\(^{181}\): 2.5M distributed as follows:
  - Residents/ Host community: 9.2M
  - IDPs out of camps: 549K
  - IDPs in camps: 180K
  - Returnees: 1.7M
  - Refugees: 300K\(^{182}\)

It is to be noted that refugees in Iraq are mostly Syrian (280K) and are located in the Kurdistan region and mixed with the local population.

### South Sudan

- The country has been confronted by social and political instability due to violence and a series of interconnected shocks, including conflict, persistent and unprecedented flooding, inflation, and the impact and economic weight of COVID-19. This has led to massive internal and cross-border displacement, further straining of scarce resources, livelihoods, and basic services, and increasing protection risks, particularly for the most vulnerable groups. 2021 saw a deterioration in the humanitarian situation in South Sudan.
- Insecurity, fuelled by subnational intercommunal violence, crime, and widespread impunity, continued to hamper the country’s roadmap to peace. The conflict and violence that erupted in South Sudan after December 2013 increased the number of IDPs, with repercussions for the displaced populations still relevant today.
- More than half of South Sudan’s population is expected to face acute food insecurity at the height of the annual hunger season between May and July. According to projections made before the impacts of COVID-19, plummeting oil prices and desert locust infestation worsen food insecurity. With COVID-19 and related food price increases, some 1.6 million people have become newly vulnerable due to their dependence on markets. An estimated 8.3 million people, including refugees, were expected to experience severe food insecurity at the peak of the 2022 lean season (May–July).

- PIN represent more than 80% of the population and are found throughout the country, although larger concentrations are found in Upper Nile and Jonglei states. The host community represent 6 million PIN, whereas IDPs and returnees represent 1.4 million and 1.2 million, respectively. IDPs are for the most part integrated in host communities. These figures may fluctuate depending on the evolution of the security situation and subsequent population movements. Refugees number some 350,000\(^{185}\). Most of the refugees are Sudanese in the Upper Nile and Unity states. The highest presence of IDPs is in Warrap.

- Challenges cut across populations and are not specific to a population. For most part, IDPs and host communities live together.


Climate change has affected the variability of weather, exposing the country to torrential rains and seasonal flooding. Usually, the flooding pattern is predictable but not its impact. In 2021, the impact of flooding was on an east–west axis, which was more unpredictable. The water may remain stagnant all year, preventing a possible return.

**Syria**

- Civil war leading to fragmentation of power and territorial integrity, with some areas remaining under the mandate of the government put in place by the regime while others are now under the mandate of the various opposition parties.
- For this case study, and given the complexity of the context and the fragmentation of the response, each of the three regions below has been approached separately:
  1. Damascus, which is under the control of the Government of Syria (GoS)
  2. North-east Syria (NES), which has 5% of its territories under government control while other areas fall under the Kurdish governance of the Syrian Democratic Forces (SDF) working with the Autonomous Administration (AA) which is still not accepted by some communities in NES\(^{186}\)
     It receives humanitarian aid through crossline support from Damascus.
  3. North-west Syria (NWS), which has highly fragmented governance as it is home to several NSAGs such as the Third Legion and Hayat Tahrir al-Sham\(^{187}\). In regard to humanitarian aid, it receives cross-border support from Turkey via “remote management” as per the UN security council (SC) resolution 2642 that needs to be regularly ratified and approved by SC.

- PoCs that have been covered by this study include the internally displaced (in camps or mixed with the community), returnees, and a large part of the host population or non-displaced residents in Syria. For instance, the definition of PoC also applies to local populations in NES NGO coordinated response areas and NWS cross border response areas given the context of insecurity in these areas and the increased need for humanitarian assistance as defined in the Whole of Syria HRP 2022.
- As for the distribution of IDPs and returnees, they constitute 32% of the total population in Syria (24% IDPs out of camps, 7% IDPs in camps, and 1% returnees). Camps and settlements are only found in NWS and NES, with no camps in government-controlled areas\(^{189}\).

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