Global Health Cluster Position on

COVID-19 vaccination in Humanitarian settings

12 key messages for advocacy

Acknowledgements

April 2021

Introduction

As the Inter-Agency Standing Committee (IASC) designated Cluster Lead Agency, the World Health Organization (WHO) hosts the Global Health Cluster (GHC) within the WHO Health Emergencies Programme (WHE). Global Health Cluster agencies[1] work collectively, in support of national authorities, to provide timely, effective, and appropriate actions to minimize the health impacts of humanitarian and public health emergencies through strengthening of service delivery, addressing gaps, and promoting effective leadership. Currently at country level there are approximately 900 Health Cluster partners working across 31 Health Clusters, to support 83.8 million people for humanitarian health assistance.[2]

The COVID-19 pandemic has been the greatest threat to world population health and socio-economic stability in a lifetime. Since the initial outbreak was declared in Wuhan, China on 31 December 2019, the pandemic has resulted in significant numbers of cases and deaths reported in over 200 countries, states and territories[3]. The global risk remains very high, overwhelming health system capacity in many countries with strict containment measures drastically impacting on individual livelihoods and national economies.

The development of safe and effective vaccines is a critical step towards mitigating the impact of the coronavirus pandemic, alongside therapeutics and diagnostics. By early December 2020, the first mass COVID-19 immunization campaigns had started[4] and in February 2021 the COVAX Facility delivered its first doses to Ghana[5]. By 29th April 2021 1.01billion doses had been administered but only 18.3million doses had been administered in countries with humanitarian settings[6], [7].

As such the Global Health Cluster reiterates its commitment to advocate and support equity across and within all countries and for all populations including access to and allocation of essential COVID-19 health products. This is in line with IASC commitments and the Health Cluster's mandate to relieve suffering and save lives during humanitarian and public health emergencies, while advancing the well-being and dignity of affected populations. These are guided by humanitarian principles of *neutrality, humanity, impartiality, and independence in the provision of humanitarian assistance*[8] and the '*right of every human being to the enjoyment of the highest attainable standard of health without distinction of race, religion, political belief, economic or any other social condition*'[9] *as well as international humanitarian law and international human rights law*[10]. As such to attain this right, access to therapeutics, vaccines, diagnostics, and other health products for COVID-19 must be considered as global public goods and thus made equitable, affordable, available, appropriate, safe and of assured quality for all of those who need them including populations of concern in humanitarian settings leaving no one behind.

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[1] The Global Health Cluster has 57 partners engaged at the global level https://www.who.int/health-cluster/about/en/

[2] Global Health Cluster. Health Cluster Dashboard Q1 2021 [accessed 16th April 2021]

[3] See World Health Organization WHO COVID-19 Dashboard for daily figures]

[4] 8 December 2021 in the UK (Pfizer-BioNTech); 5 December 2021 in Russia (Gamaleya) Our World in Data COVID-19 Vaccinations. [accessed 16th April 2021]

[5] Gavi, Gavi newsroom 24th February [accessed 16th April 2021]

[6] See the 30 countries with humanitarian appeals such as Humanitarian Response Plans, Flash Appeal Joint Response Plan

[7] World Health Organization WHO COVID-19 Dashboard [accessed 29th April 2021]

[8] UN General Assembly Resolution A/Res/58/114 of 5 February 2004. New York: United Nations; 2004 [accessed 16th April 2021]

[9] World Health Organization 1946 (updated 2005). Constitution of the World Health Organization [accessed 16th April 2021].

[10] Global Health Cluster Strategy 2017-2019

Purpose

This position paper provides key messages to guide global and country level health cluster partners to advocate and support equitable vaccine availability and uptake for populations of concern in humanitarian settings.

Key Messages

1. **National governments are responsible for ensuring that COVID-19 vaccination plans and strategies guarantee equitable access to vaccines for all persons within the national territory**
This includes populations of concern[11] regardless of legal status or documentation such as
    o Internally displaced populations (IDPs) living in camps, informal settlements or within host communities
    o Refugees and asylum seekers
    o Returnees
    o Migrants whether in regular or irregular situations (e.g., without legal status or stranded in vulnerable situations)
    o Those living in hard to reach areas due to e.g., insecurity, areas not under government control, geographic constraints
    o Stateless persons
    o Persons living in occupied territories
    o Mobile populations such as nomadic populations
    o Marginalized groups due to e.g., age, gender, disability, ethnicity, language, sexual orientation, indigenous populations, sex workers, persons being trafficked, people living with conditions potentially associated with stigma such as mental health conditions, HIV, survivors of gender based violence (GBV), people in detention and institutional settings

2. **Prioritisation and targeting of populations groups should be done in full accordance with the normative, technical guidelines developed by WHO and the SAGE Values Framework[12] and Roadmap[13].** When doing so populations of concern should be held in equal respect with the wider population within a country[16]. For example, increased risks for SARS-CoV-2 infection and developing severe COVID-19 illness faced by frontline health care workers, older people and those with comorbidities from populations of concern should be considered as equal as those in the wider population. Likewise special groups such as pregnant women and lactating[14] should also be equally considered. As such 'contextual parity' should be applied.

3. **Inclusive vaccine plans and strategies are essential to reduce the death and disease burden of COVID-19.** Ensuring equitable inclusion of persons at elevated risk of SARS-CoV-2 infection and severe COVID-19 illness from populations of concern is sound public health strategy to reduce morbidity and mortality. As well as biomedical factors (such as age or co-morbidity) that may increase risk, the societal, regulatory, and geographic risks faced by populations of concern should also be evaluated. In many humanitarian settings, vulnerable groups such as those living in hard to reach areas, IDPs, refugees or migrants, face practical or legal barriers to access health services, including inadequate physical access to health care services, linguistic or cultural barriers, or fear of detention

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[11] The term 'population of concern' will refer to all these groups throughout this position paper

[12] World Health Organization, September 2020, WHO SAGE Values Framework for the allocation and prioritisation for COVID-19 vaccination

[13] World Health Organization, November 2020. WHO SAGE Roadmap for prioritising uses of COVID-19 vaccines in the context of limited supply

[14] See World Health Organization Strategic Advisory Group of Experts on Immunization (SAGE) COVID-19 vaccines technical documents for recommendations of specific vaccines and use with pregnant and lactating women

or deportation when seeking health care. Insufficient access to coronavirus testing, places them and their communities at heightened risk of infection and illness. Furthermore, asylum seekers, refugees, internally displaced people, and vulnerable migrants may live in poor environmental conditions such as in crowded informal urban settlements, company housing, reception centers, camps, or immigration detention centers. This often means they are unable to physically distance, lack access to protective face masks, or water-sanitation facilities and are unable maintain basic public health and social measures to prevent transmission.

4. **COVID-19 vaccination of populations of concern should not be contingent on how vaccines are procured**. Contextual parity must inform the planning around vaccine roll out and ensure that populations of concern receive equal respect and consideration and therefore access to vaccines at the same time as the wider population. Noting that operational realities may hinder reaching populations of concern (e.g., those in insecure areas) national authorities should include procuring vaccines for populations of concern by the same mechanism and at the same time (from the same pool) as for the wider population. Vaccines for populations of concern should not be contingent upon waiting to receive donations or supplies, such as from the COVAX Facility for example, when the wider population are receiving vaccines procured by other means.

5. **Where multiple types of vaccines are being administered within a country, with varying characteristics and efficacy, the same safety and quality standards should be applied to the entire population including populations of concern without discrimination**. Acknowledging that the rate of vaccine availability and operational realities to reach populations of concern or choice of vaccine may affect implementation, the principles of equal respect and equity are critical to ensure vaccine allotment for populations of concern are guided by the same standards of safety and efficacy as the rest of the national population.

6. **Health care workers working for national and international non-governmental organizations (NGOs) and private providers should be prioritised equally and alongside public health care workers[15].** National plans should include all health care workers irrelevant of service provider, in accordance with risk as defined in the WHO SAGE Values Framework[15] and Roadmap[16]. Furthermore, potential elevated risks of SARS-CoV-2 infection and severe COVID-19 illness being faced by community health care workers (CHWs) should be carefully evaluated. Duties performed by CHWs may vary between service providers and their risk should be considered accordingly.

7. **Throughout the National Deployment and Vaccination Plan efforts needed to reach populations of concern should be addressed.** This includes giving due consideration for
   - **Planning,** making the most effective use of existing health systems and for National EPI Task Forces, and national health clusters to coordinate based on contextual needs, leveraging support from humanitarian partners experienced in immunization activities, already operating with access to and acceptance from populations of concern, including them in national planning from the outset
   - **Vaccine delivery strategies** to safely reach all populations of concern including those in insecure areas or areas not under governmental control such as
     - Developing acceptable strategies with the community to engender trust, involving the engagement of marginalized groups
     - Conducting analysis of barriers to vaccine access including for gender[16]
     - Strategies that allow safe access of populations of concern to vaccines distribution points especially those in insecure areas, or from areas not under government control[17]

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[15] i.e., directly under the Ministry of Health

[16] See COVID-19 vaccine rollout – what do we know from past public health emergencies about gender-based violence risks and gender-related barriers to vaccine access? Gender Based Violence Area of Responsibility Help Desk 2021

[17] This may include joint planning with government and non-state armed actors or defacto authorities, or establishment of humanitarian corridors, cross line interventions, ceasefire 'days of tranquility' etc.

- o Using mobile or outreach strategies, rather than fixed site strategies,
- o Integrating vaccine delivery in other high demand humanitarian response services including from other sectors
- **Choosing contextually appropriate vaccines** if multiple safe and quality vaccine options exist e.g., single dose vaccines
- **Coverage of cold chain capacity** to reach all populations of concern including those in insecure areas or those not under governmental control
- **Adequate and appropriate safety and security measures** for health care workers especially in hard to reach or insecure areas recognising specific risks and needs of female health care workers[18], or those from populations of concern including
  - o Adequate PPE and infection prevention and control measures
  - o Attacks on health care workers (see point 8)
  - o Threats and stigma from the wider community[22]
- **Appropriate and transparent risk communication and community engagement strategies** that incorporate the specific needs and concerns from populations of concern
  - o noting the intersecting needs and concerns of health care workers who are female and/or from populations of concern. It is critical to engage, give messages and train these cohorts early to address their concerns given health care workers are most likely to be prioritised for vaccination first and have a critical role in disseminating health information to their community but amongst whom vaccine hesitancy is known[19]
  - o leveraging existing humanitarian 'communication with communities' or accountability to affected population platforms where they exist
  - o leveraging community health workers to support messaging
  - o ensure messaging from multisectoral humanitarian partners such as Protection actors, Camp Coordination Camp Management actors etc given their critical role in supporting COVID-19 response
  - o Messages should be in appropriate languages through varied medium and people that populations of concern trust
- **Monitoring coverage** and post immunisation impact evaluations specific to populations of concern including
  - o ensuring disaggregation of data to monitor equity including by
    - ▪ age, gender and disability
    - ▪ specific groups and/or by location e.g., IDPs, refugees, those living in hard-to-reach and insecure areas
  - o establishing sufficient measures for data protection to prevent identifiable data being shared with other government bodies such as on people from areas not under government control or irregular migrants, where risk of attack, detention or deportation may result, following IASC and WHO guidance on data sharing[20]
- Ensuring appropriate mechanisms for populations of concern to be able to report and be monitored for **adverse events following immunisation (AEFI) and adverse events of significant importance (AESI).** This includes receiving adequate health care and referral for higher level care, as well populations have the means to access relevant no fault compensation mechanisms in the event of an AEFI
- **Budgets are estimated and financed adequately** for possible higher operational (including security) costs to reach populations of concern including those living in hard to reach and insecure areas (see point 10)

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[18] See Emergency Support Query, Securing the safety and wellbeing of women frontline health care workers in the COVID-19 response Gender Based Violence Area of Responsibility Help Desk 2020
[19] See Health Cluster Study Findings: Key Informant Interviews from Six Countries, Global Health Cluster, November 2020, findings that determined health care workers need specific RCCE strategies
[20] See the IASC Operational Guidance on Data Responsibility in Humanitarian Action 2021, and WHO Policy Statement on Data Sharing by the World Health Organization in the Context of Public Health Emergencies, 2016

8. **Sufficient measures should be taken to mitigate attacks on health care workers and support staff working in insecure settings involved in the vaccination roll out [21].** This includes appropriate
   - Risk assessment in each context before vaccine rollout
   - Establishment of an agile system for situation monitoring and adjustment of program rollout to changing security situation
   - Community engagement, based on risks analyzed involving communities from the beginning
   - Measures for active and continuous social listening (feedback and perceptions) adapting programmes accordingly
   - Community accepted modalities for vaccine delivery including vaccine strategy adaptation
   - Security measures for staff (not just supplies or assets) including appropriate measures to respond to risks dependent on context e.g., where enhanced visibility is appropriate vs not
   - Negotiating for humanitarian space such as through Humanitarian Coordinator / Resident Coordinator, civ-mil coordination platform[22], communities, and key stakeholders
   - Training of health staff in communication skills, cultural sensitivities, and ethical standards
   - Duty of care including
     - Organisational support should a staff member be injured
     - Adequate mental health and psychosocial support for those that may experience distress due to occupational risk[23]
     - Addressing risks faced by female health care workers[24] and/or those from populations of concern e.g., GBV, stigmatization by their communities
     - Creating a supportive work environment to discuss challenges or ethical dilemmas the health care workers may face and discuss with supervisors or peers[25]

9. **COVID-19 vaccines are a global public good and all people including populations of concern should receive vaccinations free of charge, without discrimination and free from sexual exploitation and abuse (SEA).** Measures should be articulated within national plans and consistently implemented ensuring adequate training of staff, communication with communities and reporting systems are in place to ensure allegations of SEA are responded to in a timely and appropriate manner.

10. **National COVID-19 vaccination plans must be adequately funded in a timely manner.** Operational constraints including limited vaccine availability and short shelf life of different vaccines, require donors and the international community ensure that vaccine deployment plans in low resourced countries and those facing humanitarian emergencies are adequately financed in a timely manner and without delay. Furthermore, potential increased operational costs to reach populations of concern within countries, should be adequately estimated and funded within national plans with planning occurring from the start alongside that for the wider population to avoid delay holding them in equal respect. However, **funding should not be diverted from supporting humanitarian response** defined in Inter Agency Appeals[26] for example which would further deprive affected populations of other essential and life-saving services.

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[21] For further guidance see WHO, ICRC, IFRC 2021 Guidance Note on Means to protect Health Care from Acts of Violence in the COVID-19 Vaccination Rollout [placeholder], and ICRC Health Care in Danger,

[22] See GHC Position Paper February 2011 Civil Military Coordination during Humanitarian Health Action

[23] World Health Organization November 2020 Health workforce policy and management in the context of the COVID-19 pandemic response

[24] Ibid 21

[25] Global Health Cluster December 2020, Ethics: key questions to ask when facing dilemmas during COVID-19 in humanitarian settings

[26] See Global Humanitarian Overview 2021

11. **Ensure that essential health services are maintained during vaccine deployment.** Measures must be taken to ensure COVID-19 immunization activities do not divert resources from or interrupt the safe provision of essential health services including other life-saving vaccination. For example, the sustained redeployment of health care workers, redistribution of stocks of PPE or diversion of funds from other mass vaccination campaigns or other routine services (e.g., chronic care, reproductive, maternal, newborn and child health services and routine immunizations).[27]

12. **The humanitarian buffer is considered a *measure of last resort* to ensure vaccine availability for vulnerable and marginalised group in humanitarian settings[28].** Governments are accountable for the health needs of all individuals and populations within their national territory, independent of their residency and legal status and all **efforts should first be** to ensure reaching populations of concern through national plans and campaigns.

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[27] See Global Health Cluster Guidance note: How to prioritise and plan essential health services during COVID-19 in humanitarian settings, Global Health Cluster, 2020.
[28] See Inter-Agency Standing Committee Frequently asked questions: the COVAX Humanitarian Buffer [accessed 29 April 2021]