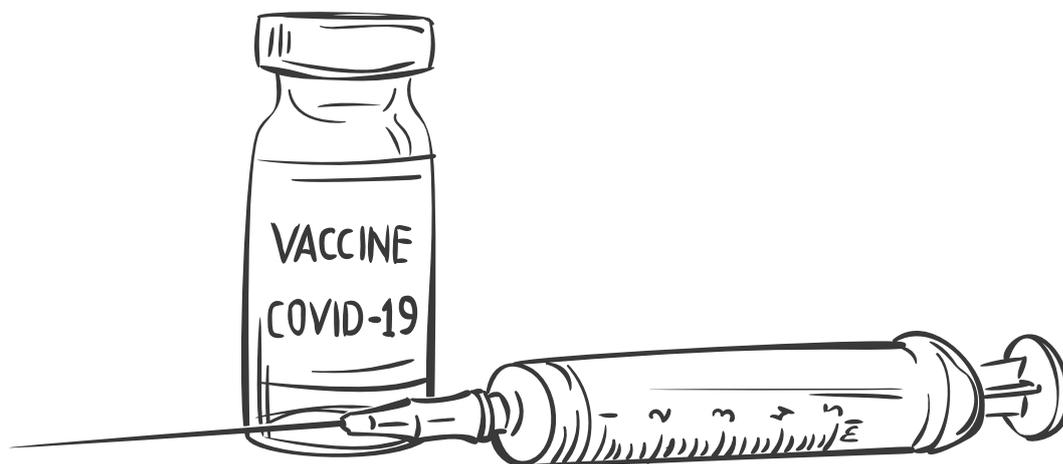


# Principles of effective COVID-19 vaccination response in Humanitarian contexts

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A GLOBAL NGO NETWORK  
FOR PRINCIPLED AND EFFECTIVE  
HUMANITARIAN ACTION



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# INTRODUCTION

Although the COVID-19 pandemic is still not over and the WHO continues to classify COVID-19 as a [Public Health Emergency of International Concern](#), the world has largely moved on. While much has been achieved, including the rapid development of safe and effective vaccines, a resounding failure of the response has been the lack of timely and effective pandemic response to communities living in fragile and humanitarian contexts.

The impact of COVID-19 on populations in low income and fragile settings has been much worse than generally assumed: WHO data highlights significantly more deaths occurred in countries with Humanitarian Response Plans (HRPs) between 1 January 2020 and 31 December 2021, with up to 2.2 million excess deaths attributable to COVID-19.<sup>1</sup> The WHO Africa region will likely experience 166 million COVID-19 infections in 2022, with severe implications for the elderly, health care workers, and people with comorbidities and underlying conditions.<sup>2</sup>

Much remains to be done to ensure adequate vaccination coverage: As of April 2022, just two out of thirty countries, Colombia and El Salvador, have met the WHO's 70% COVID-19 vaccination coverage target. While dose availability has improved, delivering COVID-19 vaccinations is an immense logistical exercise and requires significant financing, technical expertise, coordination and outreach. On top of initial financing gaps, low income and fragile countries have limited healthcare and transport infrastructure, some of which is damaged by conflict, overburdened or curtailed by budget shortages and limited health care workforce.

Funding for COVID-19 vaccines delivery is now increasing, primarily through the World Bank and GAVI.<sup>3</sup> According to OCHA's FTS, over USD 4.9 billion has been approved for covid vaccines, while the total funding approved for emergency health needs across all HRPs is just USD 761 million, 25.2% of requirements.<sup>4</sup> COVID vaccine financing comes at a time of enormous gaps in humanitarian funding, which have led to the reduction of health services, such as in South Sudan<sup>5</sup> and major cuts in food and nutrition supplies in the midst of a global food crisis.<sup>6,7</sup>

For many people living in fragile and conflict-affected states, COVID-19 is of low concern and while there were queues for vaccinations in 2021, in 2022 it is not considered a priority need. The international community now faces the challenge of how to effectively deliver a vaccine that is of low priority while also striving to put the needs and priorities of crisis affected people at the centre. On one hand, humanitarian and basic health needs are unmet due to financing shortfalls and COVID-19 vaccines are not perceived as a priority need by crisis-affected and marginalized populations; on the other hand, the virus remains a public health issue of concern

and financing is available to deliver the necessary vaccines. An effective response must grapple with these issues and leverage all available resources to ensure that COVID-19 vaccines are provided with or alongside humanitarian response and investments in health services.

This paper lays out six principles that will strengthen effective and timely pandemic response in humanitarian settings for both this pandemic and the next.

- 1 Strengthen health services: Effective pandemic preparedness & response requires a functioning health system**
- 2 Leverage partnerships: Engage local, national and international NGOs**
- 3 Provide timely and sufficient financing and suitable financing mechanisms for vaccine delivery and outreach**
- 4 Streamline interventions: Ensure vaccine delivery, financing and demand move in tandem**
- 5 Respect & engage communities: Take a bottom-up approach to vaccine delivery**
- 6 Be inclusive: Tailor approaches to be gender responsive and inclusive of vulnerable or marginalised groups**

The principles are not new; they largely underscore the lessons learned during the Ebola and HIV pandemics. NGOs will need to work together with communities, governments, donors, UN agencies, the World Bank, and the private sector at all levels from local to global to ensure that these principles are incorporated into the COVID-19 response and are the foundation of future response models in humanitarian and fragile contexts.

# PRINCIPLE 1

## Strengthen existing health services: Effective pandemic preparedness & response requires a functioning health system

Health systems have been severely overwhelmed by COVID-19. Three years into the pandemic, essential health services continue to be disrupted in 90% of countries<sup>8</sup> with severe consequences: Emerging data suggests that twice as many women and children have died from health service disruption as from COVID-19 itself.<sup>9</sup> Routine immunization campaigns have also been delayed impacting more than 198 million people across 14 countries.<sup>10</sup> The burden on health workers, both in terms of workload and health, has been enormous.

In humanitarian and low-income settings, the limited health infrastructure, a lack of testing, and insufficient support for frontline healthcare workers hampered the pandemic response and overwhelmed essential service provision.<sup>11</sup> Cuts in donor financing have led to the closures of essential health services in fragile settings, such as in South Sudan where 220 Primary Health Care Centres have been forced to close, with serious consequences for the ability of marginalised communities to access care and undermining vaccine delivery.

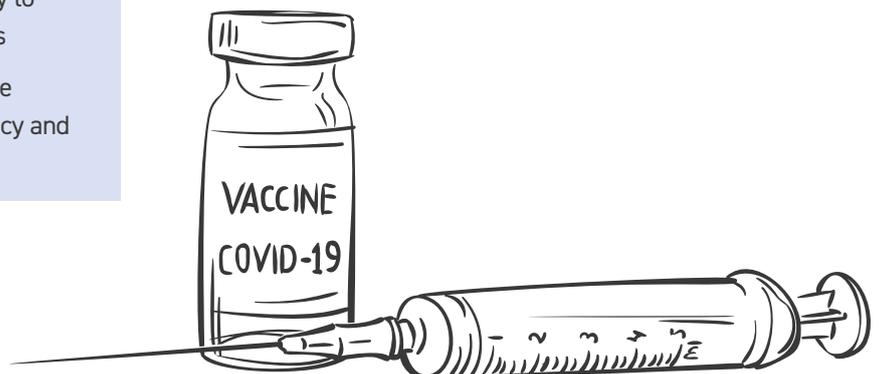
If not properly resourced, pandemic response can further erode health service delivery. Mass vaccination campaigns in fragile settings often redeploy the few available health staff to do outreach. This has consequences for timely treatment and referral. In some locations, NGOs report refugee health services have been suspended for weeks as health staff are deployed to conduct COVID-19 vaccination outreach campaigns. If resources are available, one solution is to add additional staff for vaccine campaigns, however the focus should not only be on COVID vaccinations.

**“If we are to be resilient as a global community, then all countries need to have access to the basic services that underpin communities’ ability to respond to inevitable shocks that will come along”**

**BOND** 

### Recommendations:

- Governments, donors, COVAX, the UN, in discussion with NGOs and community leaders, must ensure pandemic response takes a holistic, community-centered and integrated approach such that health systems are strengthened in tandem with pandemic interventions.
- Donors must soften the earmarking of COVID-19 financing to allow for these significant resources to both support vaccination efforts and stabilise - and where possible strengthen - routine immunisation and primary health care services.
- NGOs, governments and UN agencies must support health care workers to get vaccinated to protect them from infection, severe disease and death This is key to maintaining sufficient personnel for health services
- NGOs and health clusters must (continue to) ensure health system strengthening is a priority in advocacy and operations.



## PRINCIPLE 2

### Leverage partnerships: Engage local, national, and international NGOs

The COVID-19 response model has governments squarely at the centre of driving their national response, with support from the UN. In humanitarian settings this focus is too narrow: authorities may not have access to or the acceptance of all communities, particularly in conflict-affected areas.

The state-centered response model has largely overlooked the central role NGOs can play in reaching marginalised and crisis-affected populations. This has had consequences for achieving vaccination coverage targets and for ensuring no one is left behind. In part this is due to a lack of understanding of humanitarian contexts, but also due to a lack of understanding of government-NGO relationships and NGO capacity. NGOs understand local contexts and barriers to delivery, have communities' trust and acceptance, and can reach remote and underserved areas where the UN and government may not have access. Local NGOs often have access to communities no one else can reach due to security constraints. In some contexts, NGOs are the main provider of health services.

UN agencies and GAVI rely heavily on their NGO partners for response implementation. UN agencies and GAVI can encourage governments to leverage all partners available and play a stronger role in ensuring NGOs are meaningfully engaged in vaccine delivery in humanitarian contexts from the strategic planning level to the local level.

Some governments, recognising the expertise and capacity available, have included NGOs in immunisation working groups, engaged them in the development of national vaccination deployment plans and delegated vaccine rollout to NGOs. This has worked well in moving coverage targets forward and enabling crisis-affected and marginalised communities to access vaccines.



Overall however, discussions with NGOs in humanitarian contexts indicate limited engagement of NGOs in national level and district level (microplanning) vaccine delivery planning exercises. There remains a lack of consistency in including NGOs at both country level and local level vaccination delivery planning exercises. This has been a significant missed opportunity. Leveraging NGOs as a key partner from the outset would have helped drive a more efficient response, ensured marginalised populations were included and increased vaccination coverage in fragile settings.

Compared to other stakeholders, NGOs are often able to be more agile and adaptive, including to integrate interventions such as COVID-19 vaccines into ongoing service delivery. Identifying NGOs can easily be done through the Health Cluster or the NGO Forum, which is present in many humanitarian contexts and is an excellent entry point for engaging with and mobilising NGO leadership.

#### Recommendations:

- Governments and COVAX must ensure that NGOs are meaningfully engaged from the outset to enable locally appropriate and coordinated response, examples include NGO representation at “COVAX Vaccine Delivery Partnership One Plan” meetings at national and microplanning level, and National Disaster Preparedness & Prevention Committees.
- NGOs should negotiate NGO representation at strategic decision-making tables to ensure that crisis-affected and marginalized populations are included in the response, and the response meets other identified needs.
- Given NGOs' leading role in health service provision in many humanitarian contexts and ability to influence community engagement, UN agencies must facilitate NGO representation and NGOs' legitimate operational requirements (e.g financing, access negotiations, importation) to ensure that everyone is reached.
- COVAX and future response models must connect into existing coordination architecture: COVID-19 vaccination efforts and structures should make full use of and communicate comprehensively with health clusters, NGO fora and other existing coordination structures as relevant.

## PRINCIPLE 3

### Provide timely and sufficient financing and suitable financing mechanisms

COVID-19 vaccine doses are of little use in fragile and humanitarian settings without adequate financing for delivery and demand generation: Many low-income nations were severely impeded in conducting vaccine delivery by their inability to access timely financing when COVID-19 vaccines arrived. The lack of infrastructure and overstretched healthcare systems also makes vaccine rollouts more difficult and expensive, as additional capacity must be deployed.<sup>12</sup>

While delivery funding is coming online at scale in 2022, the delay means there has been a significant shift in focus from COVID-19, to rising global hunger and the cost of living, spurred in part by the pandemic's secondary effects. Financing must be made available when the attention and appetite is there – we've learned this moves on quickly.

Sufficient flexibility must also be built in to available funds to ensure that responders can modify plans and approaches to changing operational contexts and continue to meet the greatest need of communities as effectively as possible.

The humanitarian response system, which was already under resourced, was unable to mobilise sufficient additional resources when faced with a global shock and COVID-19 response was consistently underfunded: The COVID-19 Global Humanitarian Response Plan (GHRP) only raised 40.2% of the USD\$9.5 billion in requirements in the plan.<sup>13</sup>

#### NGO Financing

A key issue for effective pandemic response in humanitarian settings has been the lack of NGO financing: Most of the funding for COVID-19 vaccine rollout in humanitarian contexts was channelled through governments. The initial COVID-19 GHRP only allocated USD\$100 million to NGOs of 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 FTS (20%), it took months for funding flows to reach frontline responders. Little of this funding went directly to local and national partners: only USD\$64.6 million (1.6%).

Overall, donor financing for COVID-19 response for NGOs did not meet established goals, meaning many NGOs could not sustain their engagement in COVID-19. The funding that was established for NGOs to engage in vaccine delivery was unsuitable: [The COVAX Humanitarian Buffer](#) was designed to enable NGOs to access vaccines and financing, but has generated low interest as it does not align to NGOs' ways of working and carries significant operational, legal and financial risks.<sup>14</sup>

NGOs need access to financing, both for vaccination delivery and to cover the costs of their infrastructure, which is used for overseeing and facilitating effective delivery. It has not been easy for NGOs to access timely and consistent financing, in some cases

resulting in inefficient stop-start vaccination campaigns leading to a loss of community confidence in vaccines.

Several host governments have donated vaccines – but not financing – to NGOs to meet the needs of crisis affected populations. NGOs without donor financing to cover their basic core functions have had to do so with their own internal resources (if available), which means diverting funding from other humanitarian or development interventions.

#### Delivery Costs

Another challenge for NGOs for vaccine delivery is the cost of delivery. UNICEF's 2022 global costing models estimate that it costs between USD\$3.70 and USD\$4.45 per person fully vaccinated.<sup>15</sup> The real cost of delivery can be significantly higher:<sup>16</sup> In Nepal – a country with relatively strong health system – the real cost of last mile COVID-19 vaccine delivery is USD\$18.<sup>17</sup> In South Sudan it was USD\$22 per fully vaccinated person.<sup>18</sup>

The COVAX humanitarian buffer initially provided just USD\$3 per dose in delivery funding; this cap has since been removed and the actual costs of vaccine delivery based on the context are now supported. This must be the default approach for all future pandemic response models. With the current financial outlook foretelling significant increases in inflation, particularly food and fuel costs, ensuring a funding approach that incorporates coverage for the real costs of delivery is increasingly important.

#### Recommendations:

- Donors and the UN must ensure that sufficient and timely financing for the real cost of delivery and outreach that responds to the operational environment recognising that this will vary significantly by context. In many cases, this will require modification to current definition of direct and indirect costs as well as limitations on the coverage of indirect costs that are essential to operations.
- COVAX, donors and the UN must finance NGOs for pandemic preparedness and response, including for providing community outreach, logistics and capacity building to support effective vaccine delivery. Funding should be channelled through existing mechanisms.
- NGO partners should clearly define and present direct and indirect costs in early stage donor budgets. Incorporating these costs into the "ask" is an important step to push for better quality financing from donors.
- Donors and UN agencies, should incorporate crisis modifiers into their financing streams to allow for rapid adaptation and response to pandemics, including integrating COVID-19 vaccination into ongoing activities.

## PRINCIPLE 4

### Streamline interventions: Ensure vaccine delivery, financing and demand move in tandem

The frequent disconnect between vaccine deliveries to a country, country readiness, the availability of vaccine delivery financing, and community outreach undermines successful administration. Countries are receiving multiple types of vaccines, each with their own technical handling requirements and are often given little notice on when to expect shipments. The doses received are often less than expected and too often, close to their expiration dates.<sup>19</sup>

While many countries are now rejecting vaccines with short shelf-lives, they are still heavily impacted by the lack of clear scheduling, which is foundational to effective planning, outreach, and absorption. In some instances, NGOs have noted delays in the delivery of the second doses of the primary vaccination schedule have undermined the achievement of full coverage, as people could not receive their second dose within the appropriate time.

NGOs engaged in vaccine delivery have highlighted the lack of transparent vaccine scheduling as detrimental to their ability to plan campaigns and conduct effective community outreach. Some agencies have found that if mobilisation is conducted too close or too long after vaccines become available, then uptake is markedly lower. It is critical that clear and regular vaccine scheduling is provided.

Coordinated efforts need to be made to match the needs of countries facing humanitarian situations with the type of vaccines provided, the timing of deliveries, and the finance needed to administer them and generate demand. While these elements remain mismatched, it creates a huge hurdle for these countries to organise successful vaccine delivery, especially to remote and crisis-affected populations.

#### Recommendations:

- COVAX and donors must ensure that supply, demand, absorption capacity and financing move in tandem: All must be in place for successful vaccine rollout.
- COVAX and donors must provide clear and manageable delivery schedules, contextually appropriate vaccines, and vaccines with long expiry dates.



## PRINCIPLE 5

### Respect & engage communities: Take a bottom-up approach & ensure duty of care

Community engagement and dialogue is a vital part of an effective pandemic response. Vaccine campaigns have low uptake if they neglect community outreach. In humanitarian settings centralized, top-down approaches to vaccination are unlikely to be successful and can even break trust and credibility, putting staff at risk.

Pandemic fatigue and the lack of development and humanitarian financing are problematic for vaccine rollout, as an agency's community acceptance is grounded in its ability to provide services that are felt community needs. While good risk communication and community engagement can help, providing vaccines to communities who are acutely affected by hunger or a lack of health services does not demonstrate good solidarity or accountability, and can even result in security issues.

Two-way communication is vital to build trust and acceptance with communities when responding to disease outbreaks. This was a key lesson learned from the 2014-2016 Ebola outbreak in West Africa, when fear, anger, and lack of trust of authorities impeded the medical response. Community engagement was identified as a crucial enabler.<sup>20</sup>

The importance of a community-centred approach is not limited to addressing vaccine hesitancy. Engaging in two-way dialogue with communities and putting crisis-affected people at the centre of the vaccine response enables the identification of specific concerns and barriers to accessing vaccines, and the inclusion of unseen and excluded groups.

**'A key lesson from the Ebola response, was the narrow, Ebola-centric approach initially adopted to contain the outbreak ignored community priorities and therefore failed to earn the trust of the communities.'**

MSF 



The need to ensure a complaints and feedback mechanism is also critical. While surveillance mechanisms are in place for the rare adverse reactions to a COVID-19 vaccine, it is important that these are rapidly followed up on to maintain community confidence. Information on redress options for in the event of a severe adverse reaction, such as the no fault compensation programme,<sup>21</sup> must also be provided in these instances.

Finally, while some NGOs made excellent progress in promoting full vaccination coverage among staff, this was not the case everywhere and in some instances, NGO staff were responsible for sharing misinformation about vaccines in vulnerable populations. NGOs who treated vaccination from a health and safety or duty of care perspective, and invested in staff engagement made the best progress, even in contexts with high vaccine scepticism. Others made limited efforts to ensure their staff were vaccinated and quickly disengaged when faced with push-back. In most contexts vaccine availability was not an issue from late 2021 onwards due to the UN systemwide vaccination programme, so the issue was largely effective staff engagement.

## Recommendations:

- Local vaccine delivery planning, whether led by governments, UN or NGOs, must ensure the voices of different groups - including community or religious leaders, women- and refugee -led organisations, and local NGOs – are meaningfully included in planning and activities.
- Plans must address the legitimate concerns communities have about accessing vaccines (e.g. travel distance, safety), as well as providing education and information to combat myths and misinformation.
- Embed complaint and feedback mechanisms in campaigns to assess and rapidly respond to community concerns, and respond rapidly to issues to maintain community confidence.
- NGOs must invest in engaging their staff, particularly frontline staff that engage with communities, both as a duty of care issue and also as NGO staff have significant influence in vulnerable communities.



# Vaccine Hesitancy

'Vaccine hesitancy' is a catch-all term for the reasons why an individual may not choose to receive a vaccine. Its determinants can include a wide range of factors from physical barriers such as transportation and security, concerns about vaccine efficacy and side-effects, complacency, myths and rumours, to refusals on the grounds of bodily autonomy and civil liberties.



**While much has been made of vaccine hesitancy, data compiled by the RCCE collective shows that globally the proportion of people who would accept a vaccine if recommended and available has risen from 69% in January 2021 to 91.2% by the end of 2021.**

NGO surveys find many of reasons for “vaccine hesitancy” are practical and legitimate – the vaccine site is closed on a person’s day off work, the transport costs are too high, there are fears of being rejected or arrested due to the lack of correct paperwork, or there are frequent stock-outs at the facility.

## PRINCIPLE 6

### Be inclusive: Tailor approaches to be gender responsive and inclusive of vulnerable or marginalised groups

To reduce further pandemic-induced losses, and lower the risk of a more deadly variant developing, it is important everyone, everywhere has equitable and swift access to COVID-19 vaccines. To achieve this, we need to take active steps to ensure that no groups of people continue to be excluded from vaccine coverage.

A range of groups of people within larger populations often have difficulties accessing vaccines, whether due to their gender, ethnicity, disability, nationality, status, religion or sexuality. It is vital that pandemic response mechanisms understand and address these specific challenges, leveraging partners when needed, so that no one is left out.

#### Ensure a gender-responsive approach

Misinformation, social and cultural norms, and a range of other systemic factors have contributed to gender disparities in vaccination rates in many humanitarian contexts – with women and girls often being left behind. Of the 30 countries included in the Global Humanitarian Overview, nine reported that women were less likely to be vaccinated than men.<sup>22</sup> Women are heavily represented among frontline healthcare workers, and need additional considerations for support and protection as they respond to the pandemic and carry out vaccinations. The pandemic has also increased gender-related risks, with restricted access to maternal health and sexual health and reproductive services, and GBV cases increasing over the course of the pandemic in many areas.

In South Sudan women initially represented only 26% of those vaccinated, even though they represented 70% of those who tested positive for COVID-19.<sup>23</sup> This has now been rectified – as of June 2022, over 50% of people vaccinated in South Sudan are women, showing gender parity can be achieved. The arrival of J&J vaccines played a major part in this – it is critical to identify concerns women have about vaccines (such as sterility) and either counter the rumours or provide more acceptable types.

#### Identify and support vulnerable or marginalized groups

Refugees, IDPs, and migrants might face additional difficulties in accessing vaccines even when, on paper, they are included in vaccine rollouts.<sup>24</sup> People within these groups with additional vulnerabilities and mobility difficulties – the elderly, people with disabilities – experience even greater barriers.

These difficulties can come from deliberate exclusion or discrimination, but also from programs that inadvertently exclude certain groups or are not designed to cater to everyone's needs. These barriers can be administrative (e.g. I.D requirements, lack of firewalls), discrimination by health staff despite inclusive government policies, logistical barriers (e.g. travel costs and safety), and a lack of information.

#### Recommendations:

- National vaccine delivery plans and local level planning exercises whether led by government or UN must embed gender and vulnerability analysis as standard and address gender and vulnerability-related gaps and barriers.
- Proactive approaches should be taken to ensure the most vulnerable are reached might include decentralising vaccination and care to household level or leveraging partners, such as NGOs, that have good community acceptance.
- Ensure local NGOs are included in planning and decision-making forums, and in implementation.
- Ensure direct representation of minority, marginalised and women's groups at planning and decision making tables to ensure effective outreach.



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