COVID-19 vaccination in humanitarian settings

Action plan from a joint convening and contributions to broader pandemic preparedness

unicef World Health Organization Gavi The Vaccine Alliance

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This plan does not necessarily represent the views, decisions or the stated policies of the participating organizations. It is a living document and some of the working groups will continue to meet to move forward implementation of actions.

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Abbreviations and acronyms

AAP	accountability to affected populations
AEFI	adverse events following immunization
AMC	advance market commitment
COVID-19	coronavirus disease
CoVDP	COVID-19 Vaccine Delivery Partnership
CSO	civil society organization
EPI	essential programme on immunization
GHC	Global Health Cluster
GHO	Global Humanitarian Overview
GHRP	Global humanitarian response plan
HC/RC	Humanitarian Coordinator/Resident Coordinator
HCT	Humanitarian Country Team
HeRAMS	Health Resources and Services Availability Monitoring System
HEPR	health emergency preparedness and response
HRH	human resources for health
HRP	humanitarian response plan
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IDP	Internally-displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
IOM	International Organization for Migration
MCM	medical countermeasure
MDB	multilateral development bank
MoH	ministry of health
MoU	memorandum of understanding
MSF	Médecins Sans Frontières
NDVP	national deployment and vaccination plan
NFC	no-fault compensation
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
NGO	nongovernmental organization
NRA	national regulatory authority
PHEIC	public health emergency of international concern
PoC	population of concern
PPE	personal protective equipment
PPR	pandemic prevention, preparedness, and response
RCCE	risk communication and community engagement

SDGs	Sustainable Development Goals
SOP	standard operating procedure
UHC	universal health coverage
UNHCR	United Nations Refugee Agency
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

Executive summary

The global rollout of coronavirus disease (COVID-19) vaccination has been marked by significant vaccine inequities, both between and within countries.

By mid-March 2023, completion of the primary series of COVID-19 vaccines was estimated at 65% of the world's population. However, across the 92 low- and middle-income countries that are eligible to participate in the COVAX Facility's Advance Market Commitment (AMC 92), primary series coverage by mid-March 2023 was only 54%. In low-income countries, which carry the greatest humanitarian needs, aggregate primary series coverage was only 25% by mid-March 2023. Notably, most of the countries that remain close to or below 10% primary series coverage have also been experiencing ongoing humanitarian emergencies.

Populations of concern (PoCs) – people in need of humanitarian assistance and other vulnerable groups – have had limited access to COVID-19 vaccines.

Many settings with high numbers of people identified in need of humanitarian assistance and vulnerable groups (e.g. internally-displaced persons, refugees, asylum seekers, stateless persons, minorities, detainees, vulnerable migrants, and people living in hard-to-reach areas) have lower vaccination coverage in comparison to the wider population. Across all countries with a humanitarian response plan 39.3% have completed the primary series by May 2023. However, for countries where more than 50% of the population are in need of humanitarian assistance only 27.5% of the population have completed the primary series. Although vaccination coverage has improved in some settings, vaccine delivery for PoCs has neither been timely nor regular, and persistent obstacles remain.

Inequitable access to vaccines and other medical countermeasures for PoCs must not happen again.

The COVID-19 global emergency has been declared over, and it is time to take stock of key challenges faced during the pandemic and to take bold steps to address them. *A joint convening on COVID-19 vaccination in humanitarian settings and the contribution to broader pandemic preparedness* was held on 14–15 February 2023 in Nairobi, Kenya to address the challenges encountered in implementing COVID-19 vaccination for PoCs and to prepare for future pandemics.

There are solutions that will improve vaccination delivery for PoCs during pandemic responses.

Stakeholders at the convening identified solutions and developed an action plan for improving vaccination delivery for PoCs during pandemic responses. While there is also a need to be prepared for future pandemic responses for PoCs more generally, this action plan focuses specifically on improving vaccination delivery. Future work can build on and broaden this plan to other public health measures.

These solutions are in three areas that represent key opportunities to strengthen effective vaccination delivery for PoCs:

1. Leveraging humanitarian architecture and humanitarian actors during pandemics.
2. Addressing upstream supply, regulatory and legal considerations impacting implementation of vaccination for PoCs during a public health emergency of international concern (PHEIC).
3. Strengthening health systems and pandemic prevention, preparedness, and response (PPR).

The action plan details the enablers, solutions, actions and potential owners of actions in these key areas.

A concerted global effort is urgently needed to implement these actions so that priority groups in PoCs have equitable access to COVID-19 vaccination and are not left out in future pandemics. Establishing these systems now is essential for ensuring equitable access to vaccines and other medical countermeasures during pandemics, and strengthens efforts to increase global health security and achieve universal health coverage.

Chapter 1

Summary of joint convening and action plans

1.1 How this action plan was developed

This report and action plan summarize the proceedings and outcome of a 2-day *Joint convening on COVID-19 vaccination in humanitarian settings* and the contribution to broader pandemic preparedness held on 14–15 February 2023 in Nairobi, Kenya.

The convening was organized by the COVID-19 Vaccine Delivery Partnership (CoVDP) and key partners from the Africa Centres for Disease Control and Prevention, Gavi, the Vaccine Alliance, the Global Health Cluster (GHC), International Committee of the Red Cross (ICRC), International Council of Voluntary Agencies (ICVA), International Federation of Red Cross and Red Crescent Societies (IFRC), INTERSOS, Médecins Sans Frontières (MSF), bilateral partners, and UN agencies (see Annex 1).

The goal of the joint convening was to address the challenges encountered in implementing coronavirus disease (COVID-19) vaccination for populations of concern (PoCs) and to prepare for future pandemics.

It connected health and humanitarian agencies and other actors, and stakeholders discussed lessons learnt as well as concrete steps to enable equitable responses during pandemics in which those affected by humanitarian emergencies and in need of humanitarian assistance have access to public health and medical countermeasures (MCMs), such as vaccines, therapeutics and diagnostics that can be used to diagnose, prevent or treat diseases in pandemics.

The global roll out of COVID-19 vaccination has been marked by significant vaccine inequities. By mid-March 2023, completion of the primary series of COVID-19 vaccines was an estimated 65% of the world's population. However, across the 92 low- and middle-income countries that are eligible to participate in the COVAX Facility's Advance Market Commitment (AMC 92), primary series coverage by mid-March 2023 was only 54%. In low-income countries, which have the greatest humanitarian needs, aggregate primary series coverage was only 25% by mid-March 2023.

Notably, most of the countries that remain close to or below 10% primary series coverage have also been experiencing ongoing humanitarian emergencies. Of the six countries that have less than 10% coverage for completed primary series, four countries have a humanitarian crisis (and have either a current Humanitarian Response Plan (HRP) or a 'Flash Appeal'): Burundi, Haiti, Yemen and Madagascar.[b]

There have also been significant vaccine inequities within countries. Many settings with large numbers of people identified in need of humanitarian assistance and vulnerable groups (e.g. IDPs, refugees, asylum seekers, stateless persons, minorities, detainees, vulnerable migrants and people living in hard-to-reach areas) have lower vaccination coverage in comparison to the wider population. The Global Health Cluster (GHC) reports that in areas where most of the population need humanitarian assistance (that is, the population in need is greater than 50%), only a few areas have more than 40% of people with primary series completion.[c]

In sum, for PoCs, there has been limited access to COVID-19 vaccines and although vaccination coverage has improved in some settings, vaccine delivery for PoCs has neither been timely nor regular, and persistent obstacles remain.

'Populations of concern' refers to those living under state-like control of non-state armed groups, populations in conflict settings, those affected by humanitarian emergencies or those in need of humanitarian assistance, including but not limited to refugees, asylum seekers, stateless persons, internally-displaced persons (IDPs), minorities, detainees and vulnerable migrants irrespective of their legal status.[a]

[a] This definition of PoCs is adapted from the definition that was endorsed by the Inter-Agency Standing Committee (IASC) Principals for the COVAX Humanitarian Buffer.

[b] The two countries are Senegal and Papua New Guinea, Democratic People's Republic of Korea and Eritrea are not vaccinating against COVID-19

[c] More data on COVID-19 vaccination setting can be found in: 2022 Covid-19 vaccination in humanitarian report. Geneva: Global health Cluster; 2022 (https://healthcluster.who.int/publications/m/item/2022-covid-19-vaccination-in-humanitarian-setting-report, accessed 25 September 2023)

Working group thematic areas

1	Leveraging humanitarian architecture and humanitarian actors in pandemic response *(Working Group 1).*
2	Upstream supply, regulatory and legal considerations impacting implementation of vaccination for PoCs during a public health emergency of international concern (PHEIC) *(Working Group 2).*
3	Health systems strengthening and pandemic preparedness and response in humanitarian settings *(Working Group 3).*

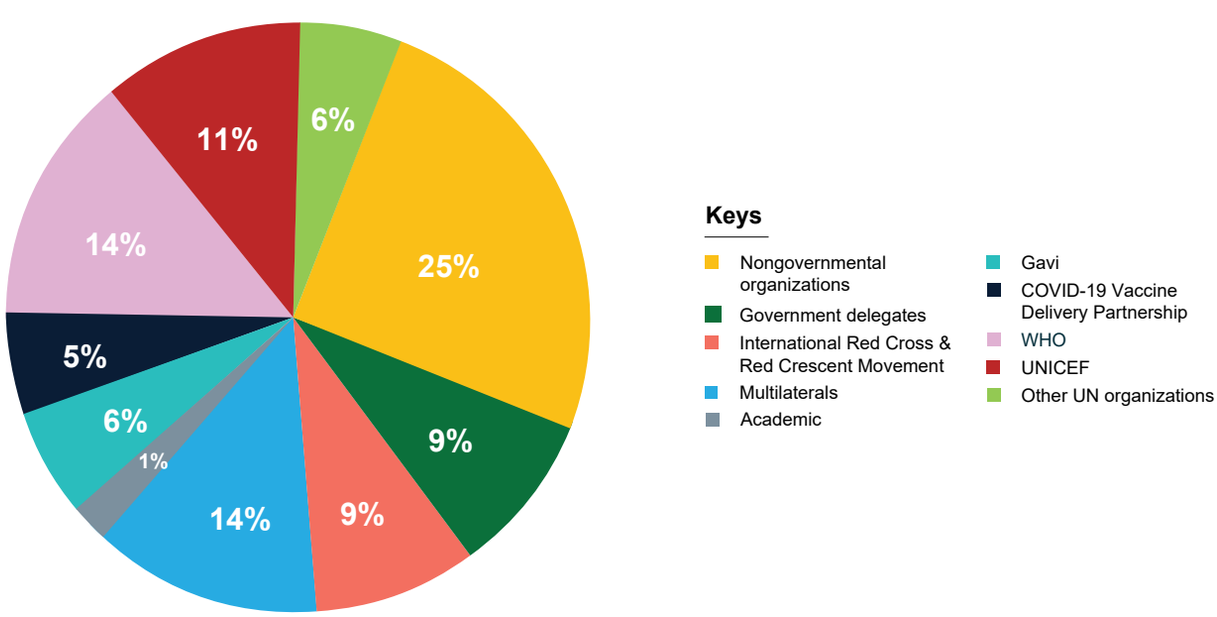
In preparation for the joint convening, working groups across three thematic areas were established (see Annex 1). These three areas were identified as particularly problematic and represented key opportunities to strengthen effective vaccination delivery for PoCs. Discussions were held over seven sessions per working group between November 2022 and February 2023, with participants identifying challenges to COVID-19 vaccination for PoCs in each thematic area, how challenges were addressed where possible and lessons learnt, and key principles, guiding statements, and potential enablers, solutions and actions for addressing these challenges now for COVID-19 as well as for future pandemics.

The joint convening brought together 121 participants from multiple countries and many different types of organizations (see Fig. 1) and areas of expertise (e.g. humanitarian, immunization, public health etc.) to review the current global situation of COVID-19 vaccine delivery for PoCs, identify lessons learnt and share good practices. A detailed participant list can be found in Annex 2.

A key background document was prepared as a pre-read for the convening (an overview of the document is included as Annex 3).

Building on the work conducted by the working groups prior to the convening, attendees identified and addressed areas of overlap, and developed concrete solutions and an overarching action plan to both guide the COVID-19 vaccination response and inform planning during future pandemics.

Fig. 1. Attendee representation



The agenda for the two-day convening broadly comprised the following:

Day 1

Setting the scene, including: presentation of available data on progress in reaching PoCs with COVID-19 vaccination and sharing experiences from government ministries and nongovernmental organizations (NGOs) with experience in provision of vaccination for PoCs; presentation of preliminary work done to identify critical bottlenecks and emerging solutions; breakout sessions for each working group to deepen discussions on key obstacles and agree on solutions.

Day 2

Marketplace, in which: working groups presented to other groups to gather feedback on proposed solutions; breakout sessions were held for each working group to fine-tune solutions and develop an action plan; working groups reported back to the full group on their updated action plan and next steps; and closing remarks with a summary of key take-aways.

This report is a summary of the joint convening proceedings, with a particular focus on the resulting action plan that provides a concrete roadmap for next steps.

1.2 Key takeaway messages

Several key points were reiterated by speakers and attendees. The first is that in pandemics such as COVID-19, **no one is safe until everyone is safe.** Promoting the safety of all will decrease the likelihood of new mutations of the virus, increase global health security, and strengthen commitments to achieving universal health coverage (UHC). While the initial focus of the meeting was on vaccines and pandemic preparedness, it was highlighted that response and recovery phases also require diagnostics and therapeutics.

Another point emphasized was that humanitarian contexts are not all the same and vary widely across and within countries. Governments are encouraged to take responsibility for all populations within their borders including PoCs. **Therefore, in the vast majority of settings, delivery of vaccines and other public health measures for PoCs during pandemics is government-led and coordinated,** and includes partnering with health and humanitarian agencies for an effective response.

However, in a small number of cases, governments are unable to reach PoCs, such as in non-government-controlled areas, and where humanitarian assistance needs to be provided directly by humanitarian agencies, and these contexts require different strategies for access. Reaching PoCs with vaccination and other public health measures during pandemics requires solutions and actions for these different contexts, so that no one is left behind.

Another critical point raised was recognition of **the deep commitment and tireless efforts of health, humanitarian and frontline workers** implementing COVID-19 vaccination in the context of scarce resources. This highlights the need for resources to be leveraged in the future for more timely and sufficient support.

The **importance of localization for improved efficiency and effectiveness of vaccine delivery** for PoCs was also reiterated, since in many crisis-affected settings local NGOs and civil society organizations (CSOs) are the best placed (and in many cases, only) agencies for accessing communities. Equally important is the **contextualization of vaccination responses for PoCs** since these contexts vary significantly and require tailored approaches.

Stakeholders shared their experiences of implementing COVID-19 vaccination in humanitarian settings. Several countries with humanitarian emergencies have made impressive gains in improving COVID-19 vaccination coverage, and both government and partners with experience in provision of vaccination for PoCs in these countries highlighted **challenges encountered as well as success factors.**

These challenges and success factors shared by governments and partners are detailed in Table 1.

Table 1. Challenges and success factors shared by governments and partners

Challenges

There has been a **mismatch between vaccine supply and demand.** Countries with humanitarian emergencies were often among the last to access COVID-19 vaccines, and subnationally PoCs within these countries received access even later. This meant that those people in PoCs most at risk of severe illness due to the SARS-CoV-2 virus (e.g. older people, health workers, or those with comorbidities) were left unprotected. By the time vaccines were finally available for PoCs, risk perception and demand had dropped significantly. Future efforts must ensure alignment of supply and demand, as well as addressing upstream supply, regulatory and legal issues.
In PoCs, **there are many competing health needs and pressing basic needs** including food security and livelihoods, and community priorities do not necessarily include COVID-19 vaccination. Future efforts must listen more closely to communities and address their priorities, including through integrating COVID-19 vaccination with other health and humanitarian services.
Insecurity and poor accessibility in many settings where PoCs are located have led to access constraints and logistical challenges, and have had a significant impact on related costs. This has contributed to a **lack of sufficient funds for the operational costs of COVID-19 vaccination for PoCs** in many settings and/or a **disconnect between humanitarian and pandemic responses** in some countries. Future efforts should leverage humanitarian partners, working closely with CSOs where possible, to help address access constraints and ensure funding mechanisms provide sufficient, adaptable, and timely funding for vaccine delivery for PoCs.
In many PoCs settings, there are insufficient **trained human resources for health (HRH), as well as a shortage of health facilities** with sufficient cold vaccine chain infrastructure and means of transportation. This was exacerbated during the pandemic when health workers became ill, lost their lives, or were forced to leave jobs to care for their own families. Some health workers were also stigmatized and at increased risk of aggression and violence. Future efforts should strengthen health systems in PoCs settings, in particular investing in community level HRH.
Political barriers, for example when a government does not support vaccination for the population, create significant access barriers for PoCs. Future efforts should focus on political engagement for access and equity, including specific mechanisms for ensuring access for PoCs in non-government-controlled areas.

Table 1. Challenges and success factors shared by governments and partners

Success factors

Being intentional in identifying inequities and acting upon them. This requires advocacy and political commitment at national and subnational levels to ensure COVID-19 vaccination for PoCs. It also requires including PoCs in national deployment and vaccination plans (NDVPs) and in microplans targeting populations with specific outreach strategies.

Building trust by taking community-led, bottom-up approaches, engaging community and religious leaders, and conducting community listening efforts and responsive communications (tailored to age and gender). This is particularly important among PoCs where basic needs are often not being met and there is limited trust, which was further compounded by the lack of timely provision of COVID-19 vaccines.

Providing people-centred-services that work to understand the needs of PoCs, ensuring dignity in health care and humanitarian responses, and providing appropriate accountability mechanisms.

Investing in primary health care in settings with PoCs, as part of building trust and providing people-centred services.

Coordinating all stakeholders and sectors, including the involvement of NGOs and CSOs at the earliest moment to ensure they are part of planning and implementation.

Employing dedicated resources as well as mixed delivery approaches tailored to specific PoCs settings. Approaches include mobile vaccination teams, door-to-door outreach, engagement of community, traditional and religious leaders, partnerships with NGOs and CSOs, and integration of COVID-19 vaccination with other health and humanitarian services. For all these approaches, health workers need to be supported with appropriate training.

Using evidence and data-driven approaches throughout planning and implementation.

1.3 Summary of action plans to improve vaccination delivery for populations of concern during pandemic responses

Stakeholders fine-tuned solutions and developed action plans for improving vaccination delivery for PoCs. While there is also a need to be prepared for future pandemic responses for PoCs more generally, this action plan focuses specifically on improving vaccination delivery for PoCs. Future work can build on and broaden this plan to other public health measures.

This action plan is guided by key principles and organized around three objectives, and includes enablers (Objective 2 only), solutions, actions and potential owners of actions.

Objectives

1 Leverage humanitarian architecture and humanitarian actors during pandemics.

2 Address upstream supply, regulatory and legal considerations impacting implementation of vaccination for PoCs during a public health emergency of international concern (PHEIC).

3 Strengthen health systems and pandemic prevention, preparedness, and response.

Because many of the solutions and actions related to **Objectives 1 and 3** are cross-cutting, the related solutions and actions are combined into one component of the action plan. The solutions and actions related to **Objective 2** are presented in the second part of the plan. Table 2 provides a summary of these solutions. The principles guiding the action plan can be found in Sections 2.1 and 2.2.

The action plan is a living document and some working groups will continue to meet to support implementation of actions. The solutions feed into the five interconnected core sub-systems for health emergency preparedness and response (HEPR): collaborative surveillance; community protection; clinical care; access to countermeasures; and emergency coordination.

Many of the actions are linked with and informed by ongoing processes and strategies such as the Immunization Agenda 2030 (IA2030), the proposed HEPR architecture, negotiations to establish an international pandemic accord, proposed MCM coordination mechanisms, the International Health Regulations (IHR) review, and other global policies, frameworks, and agreements being developed to protect the world from future pandemic emergencies.

Table 2. Summary of action plan objectives and solutions

Objective	Solutions	
Part 1 **Objective 1** Leverage humanitarian architecture and humanitarian actors during pandemics **and** **Objective 3** Strengthen health systems and pandemic prevention, preparedness, and response (PPR)	**1.1**	Strengthen and align policies, frameworks and global instruments at global, national, sub-national and community levels so that PoCs are systematically included in public health responses during pandemics from the outset
	1.2	Reflect, improve and strengthen global and national stakeholder coordination, planning and budgeting
	1.3	Conduct early, consistent and respectful engagement with communities and PoCs to strengthen delivery and uptake of public health measures in line with the primary health care model
	1.4	Seek to ensure that financing models for pandemic responses cater to the needs of fragile and humanitarian contexts, and that financing continuously invests in health systems
	1.5	Support timely and adequate supply of regional and national equipment/stocks during a pandemic response
	1.6	Strengthen integrated service delivery approaches for PoCs during pandemic periods
	1.7	Strengthen national/sub-national human resource systems to be robust and agile, and to provide pandemic responses in support of national health systems
	1.8	Improve data systems to support integrated data on PoCs for evidence-based decision-making

Objective	Solutions	
Part 2 **Objective 2** Address upstream supply, regulatory and legal considerations impacting implementation of vaccination for PoCs during pandemics	**2.1.1**[d]	Existence of no-fault compensation (NFC) schemes that include people in humanitarian PoCs who suffer serious adverse events resulting in permanent injury or death associated with a novel vaccine administered by a humanitarian agency
	2.2.1	Inter-Agency Standing Committee (IASC) principles that reflect acceptable risk-transfer and -sharing principles between relevant parties
	2.2.2	Voluntary commitment by manufacturers to provide indemnification and liability (IL) waivers for humanitarian agencies with respect to novel vaccines, where possible in advance of the next PHEIC
	2.2.3	Without prejudice to Principle 6, seek to secure that indemnification for product liability, if any, afforded to manufacturers of novel vaccines during a PHEIC is limited in time from the outset (taking into account factors such as the establishment of the safety profile of such vaccines and/or the possibility for manufacturers to make the usual insurance and/or self-insurance arrangements for such vaccines)
	2.2.4	Robust and transparent end-to-end cargo and last mile insurance
	2.3.1	Workable and simplified model legal contracting framework and clauses between partners (other than manufacturers and governments) directly engaged in the procurement and supply of vaccines and humanitarian agencies engaged in vaccination programmes
	2.3.2	Enabling environment for importation directly by humanitarian agencies, or government-facilitated importation on behalf of humanitarian agencies, for vaccinating humanitarian PoCs

Objective	Solutions	
	2.3.3	National regulatory authorities (NRAs) and/or ministries of health (MoH) to implement (and in absence of, develop) emergency procedures that allow for accelerated regulatory approvals for pandemic vaccine products (and aligned with WHO safety guidance)
	2.4.1	Position that is supportive of these principles and enablers is incorporated into language in the pandemic accord as a priority, and other relevant agreements/instruments
	2.4.2	Broad support by relevant actors of these principles and enablers

[d]The numbering of solutions in Part 2 varies slightly from Part 1 since its solutions and actions are structured around a set of four enablers.

Chapter 2

Detailed action plans

2.1 Action plan for Objectives 1 and 3

Participants developed an action plan for Objective 1: Leveraging humanitarian architecture and humanitarian actors during pandemics. Solutions and actions focused on three areas: strengthening policies and coordination at global, national, sub-national and community levels; engaging communities and linking bottom-up with top-down approaches; and integrating financing models for pandemic response in fragile and humanitarian contexts.

Participants also developed solutions and actions for Objective 3: Strengthening health systems and pandemic prevention, preparedness, and response (PPR). Solutions and actions focused on strengthening the building blocks of the health systems relevant to vaccination for PoCs in pandemics (i.e. service delivery, human resources for health, data, governance and financing) as well as on global instruments and policies for PPR.

Stakeholders identified five key principles that must be upheld to enable an effective pandemic response for PoCs, and that guide Part 1 of the action plan. These principles reiterate existing commitments to UHC as well as quality humanitarian health responses, as defined by Quality of care in fragile settings, the Inter-Agency Standing Committee (IASC) statement Centrality of protection and accountability to affected populations, and the Core humanitarian standard on quality and accountability.

These principles also align with: the proposed HEPR architecture's key principles of equity, coherence and inclusion; the text of the Pandemic Accord that is still under negotiation; the humanitarian principles of neutrality, humanity, impartiality and independence in the provision of humanitarian assistance;[e] commitments to do no harm; the right to health enshrined in international human rights law; and international humanitarian law provisions that provide critical safeguards during pandemics.

[e] As per United Nations General Assembly Resolutions 46/182 and 58/114.

Table 3. Five key principles

1. Equity. Vaccination responses in pandemics must ensure equitable and timely access, among and within countries, including for PoCs in humanitarian settings. In the interest of PoCs and other vulnerable populations, priority groups for vaccination should be defined according to their vulnerability. In addition to prioritization based on high-risk status, equitable access to vaccination should also consider gender-transformative and -inclusive initiatives and, lastly, allocate additional funds to effectively achieve equity for these populations, with the understanding that it may cost more to reach vulnerable populations.

2. Integration and sustainable responses. During a pandemic response, vaccines should be deployed in ways that sustain the need for delivery of other essential health services for all populations including PoCs. To achieve this, vaccination roll out and the broader pandemic response should be integrated, and should strengthen health systems and essential health services. The sustainability of this vital infrastructure for both effective pandemic responses and the management of ongoing health needs must be prioritized in all pandemic response efforts.

3. Protected health workforce. During pandemics, measures should be taken to ensure the protection, well-being, and safety of the health workforce. Specifically, health workers must be prioritized in vaccination and the provision of protective equipment, support must be put in place to protect their health, and measures must be implemented to prevent and mitigate violence against health care.

4. People-centred. Vaccination responses during pandemics must be accountable to communities, twinning top-down with bottom-up approaches: community representatives must be engaged in the development of vaccine delivery mechanisms and their ongoing health needs must also be met. From the outset of the design, management and delivery of vaccination plans and campaigns during pandemics, the needs and concerns of all people should be placed at the centre, regardless of residency and legal status, age, gender or community. This entails recognition that *different* barriers are faced by *different* vulnerable and at-risk groups and thus a *differentiated* approach needs to be integrated into the response to ensure it is relevant and acceptable. It also emphasizes a commitment to do no harm, identifying and minimizing potential negative effects of assistance and services while increasing trust in health services, and providing access to information on redress mechanisms.

5. Partnership and coordination. Stakeholders should work with Member States to ensure that vaccination plans and strategies during pandemics enable equitable access to vaccines for all persons within the national territory and, in vaccination responses, should uphold the purpose of existing health and humanitarian laws, regulations, agreements and commitments, including to Sustainable Development Goal 3 (SDG3) and UHC. To reach those furthest behind, humanitarian partners, CSOs and local NGOs should be leveraged for effective vaccination response, and decision-making at the subnational level should be reinforced to ensure their needs are reflected in national-level plans.

Table 4. Action plan (part 1): Objectives 1 and 3

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
Solution 1.1. Strengthen and align policies, frameworks and global instruments at global, national, subnational and community levels so that populations of concern (PoCs) are systematically included in public health responses during pandemics from the outset.		
Action 1.1.1 Seek to ensure the inclusion of specific provisions related to the inclusion of PoCs and humanitarian principles in the pandemic accord, medical countermeasures (MCM) mechanisms and platforms, the proposed WHO health emergency preparedness and response (HEPR) architecture, and the UN General Assembly resolution to be adopted at the high-level meeting on pandemic prevention, preparedness and response (PPR) (as relevant).		
Sub-action 1.1.1.1 Specific advocacy actions on: • Equitable and timely access for PoCs to MCMs. • Early identification of humanitarian contexts for concerted support focusing on contextual and situational issues. • Commitment by all Member States to uphold humanitarian principles, facilitate humanitarian access, and uphold international human rights law and international humanitarian law to promote timely and equitable access to MCMs for PoCs. • Centrality of humanitarian agencies and CSOs in pandemic responses, including: • Access to novel MCMs for humanitarian agencies and NGOs to reach PoCs. • Establishment of planning, financing and coordination mechanisms that facilitate meaningful community and CSO engagement in humanitarian contexts.	Medium-term	Governments, WHO, UNICEF, other key UN entities, and nongovernmental organization (NGO) consortia (to find humanitarian NGO representatives)
Action 1.1.2 Strengthen joint agreements and ways of working between public health, development, and humanitarian sectors, agencies and actors to promote equitable reach for PoCs and to facilitate the inclusion of humanitarian and development partners in pandemic response coordination at global and country levels.		
Sub-action 1.1.2.1 Review and propose updates to the: • Inter-Agency Standing Committee (IASC) Protocol for the control of infectious disease events.	Medium- to long-term	WHO, United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and United Nations Children's Fund (UNICEF) with support from other IASC members

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
• Humanitarian system-wide Activation 2019 and subsequent IASC system-wide scale-up protocols to respond to the COVID-19 pandemic		
Sub-action 1.1.2.2 Undertake coordinated mapping of NGO and partner capacity along the vaccine value chain, to identify and document capacities and gaps, with a view to annually updating/ maintaining mapping and making it publicly available where possible.	Ongoing	Gavi, WHO and UNICEF, with support from health clusters, NGOs and NGO fora
Sub-action 1.1.2.3 Identify the best placed UN agency or other actor to facilitate the importation and/or act as consignee, of novel vaccines when PoC coverage is inequitable, delayed or access is heavily restricted.	Long-term	OCHA, with support of IASC Principals
Sub-action 1.1.2.4 Develop guidance for the international community and humanitarian architecture to support the pandemic response for PoCs, specifically: • For monitoring the public health emergency of international concern (PHEIC) response and gaps for PoCs. • On best practice for facilitating the inclusion of humanitarian NGOs in government-led coordination structures where appropriate. • For integrated strategies to reach PoCs. • For ensuring in-country humanitarian leadership bodies assess risks, leverage expertise and comparative advantages to response and problem-solving, and communicate as one.	Medium-term	Working Group 1 (WG1) in collaboration with OCHA, WHO, UNICEF, Gavi, with support from health clusters, NGO fora where relevant
Sub-action 1.1.2.5 Advocate with the World Bank to consider utilizing its observer status at IASC and the Humanitarian Country Team (HCT) to facilitate strengthened coordination on financing of pandemic responses in humanitarian contexts.	Medium-term	WHO and IASC colleagues

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
Solution 1.2. Reflect, improve and strengthen global and national stakeholder coordination, planning and budgeting.		
Action 1.2.1 Capture key lessons from programmes, models and approaches used to reach PoCs to inform ongoing/future pandemic vaccination responses.		
Sub-action 1.2.1.1 Seek to ensure that the various evaluations and lesson learnt exercises on COVID-19 vaccines delivery include PoC considerations, including: • Review COVID-19 financing mechanisms and their effectiveness for reaching PoCs in humanitarian settings. • Evaluate at the national and subnational levels the achievements and challenges in the national deployment and vaccination plan (NDVP)/One Plan implementation for reaching PoCs.	Medium-term	WHO, UNICEF, Gavi and UN Crisis Management Team/UN Secretary General (where indicated)
Sub-action 1.2.1.2 Develop best practice for a coordination model, building on the CoVDP 'One Team, One Plan, One Budget' approach, including analysis on performance reaching PoCs specifically.	Short-term	WG1 and 3, UNICEF and WHO, in consultation with: MoH national vaccination planners/essential programme on immunization (EPI), with support from WHO, UNICEF, Gavi, Donors, Red Cross/Red Crescent, Health Clusters and NGO fora
Sub-action 1.2.1.3 Ensure key documents, analysis, guidance and tools are easily and publicly accessible for future responses.	Short-term	All WG1 and 3 members
Action 1.2.2 Develop transition plan, implementation guides or blueprints that support stakeholder coordination, planning and budgeting.		

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
Sub-action 1.2.2.1 Implement transition plans from CoVDP to future mechanisms, and articulate how HCT members, NGOs and country-level resources can/should engage.	Short-term	CoVDP, UNICEF, WHO and Gavi
Sub-action 1.2.1.2 Support the establishment of a global partnership mechanism at the immediate onset of the next global pandemic, drawing on the CoVDP approach, (leaning on best practice/lessons learnt, see Action 1.2.1), to facilitate high-level engagement at global and national levels to support countries with humanitarian contexts (and those with inter-agency humanitarian appeals) to integrate and budget for PoCs to access vaccination and other MCMs.	Medium-term	CoVDP, UNICEF, WHO and Gavi
Action 1.2.3 Support governments to implement recommendations on coordination, planning and budgeting.		
Sub-action 1.2.3.1 Support governments to embed Inter-Agency Humanitarian Evaluation of the COVID-19 humanitarian response[f] and other recommendations into national and subnational health strategies, policies and operations.	Long-term	WHO and UNICEF
Sub-action 1.2.3.2 Develop guidance to support developing a costed PPR plan (based on scale, severity and type of outbreak).	Medium- to long-term	WG1&3
Solution 1.3. Conduct early, consistent and respectful engagement with communities and PoCs to strengthen delivery and uptake of public health measures in line with the primary health care model.		
Action 1.3.1 Seek to ensure early engagement with communities and PoCs, including in microplanning, risk communication and community engagement (RCCE), and accountability to affected populations (AAP) measures.		

[f] See: https://interagencystandingcommittee.org/inter-agency-humanitarian-evaluations/inter-agency-humanitarian-evaluation-covid-19-humanitarian-response, accessed 25 September 2023.

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
Sub-action 1.3.1.1 Implement the recommendations outlined In the Inter-Agency Humanitarian Evaluation of the COVID-19 humanitarian response, taking into account the needs of vulnerable groups.	Medium- to long-term	Governments and IASC members
Sub-action 1.3.1.2 Develop pathways to provide early funding to governments and partners to support subnational coordination and planning capacity, which at the onset of a pandemic can strengthen inclusive strategic and operational microplanning and RCCE planning: • This includes strong community engagement and adaptation of global RCCE approaches that understand community needs and co-creation of interventions for increased acceptability and engagement.	Medium-term	Donor governments and international organizations
Sub-action 1.3.1.3 • Consistent with AAP frameworks, strengthen complaints and feedback (and potentially compensation) mechanisms that ensure pandemic responses are community-led and protective of vulnerable populations.	Medium- to long-term	AAP focal point in-country and in the IASC
Solution 1.4. Seek to ensure that financing models for pandemic responses cater to the needs of fragile and humanitarian contexts, and that financing continuously invests in health systems.		
Action 1.4.1 Identify opportunities with remaining COVID-19 response funding to reach PoCs and stabilize health systems, and: • Map and publish remaining funding available from COVID-19 programmes in response to COVID-19-induced childhood vaccination and health system backsliding. • Advocate for donors to allow for remaining COVID-19 financing to also support integrated health and immunization programming in humanitarian settings through governments and humanitarian agencies.	Short-term	WG1 and 3, with support from donors and international organizations[g]
Action 1.4.2 Consider measures to apply during a PHEIC in order to mitigate the impacts of widespread redirecting of resources from humanitarian programming to pandemic response.	Medium- to long-term	WG1 and 3, with support from OCHA and IASC

[g]The G20 is reportedly doing this mapping.

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
Action 1.4.3 Evaluate the determination by the IASC decision to exclude COVID-19 vaccinations delivery financing in humanitarian response plans (HRPs), and provide recommendations for future pandemics.	Medium-term	WG1 and 3, with support from OCHA
Action 1.4.4 Develop principles that emphasize specific needs of humanitarian agencies and PoCs in PPR financing mechanisms, that consider: • Including and covering the costs of reaching PoCs, while maintaining health services and routine immunization. • Promoting integrated interventions (see Solution 1.6) that address community priorities. • Access to quality, flexible, multi-annual funding for NGOs for pandemic responses. • Advocacy to donors on the need for flexibility to enable integration, and how to balance reporting, accountability and transparency. • Earmarked donor funds that include sectoral and programme investments alongside system support but remain flexible to variations in national and subnational government and NGO needs. • Sufficient support for indirect programming costs, such as security and coordination. • Upholding World Humanitarian Summit and Grand Bargain Commitments on localization, including 25% funding to local NGOs.	Medium-term	WG1 and 3 in conjunction with UNICEF, Gavi, World Bank and WHO
Action 1.4.5 Based on mapping of NGO and partner vaccine supply chain capacity (see Sub-action 1.1.2.2), international organizations to increase pathways and partners for rapid and/or emergency procurement, for example contractual framework agreements, memoranda of understanding (MoUs), etc.	Medium-term	Gavi, UNICEF and World Bank
Action 1.4.6 Explore the viability and value of a Global Emergency Health Response Pool fund for humanitarian actors and CSOs (or utilize country-based pooled funds), that can provide ‘day zero’ funding once a PHEIC is pronounced, with new funding rolled out to the country level based on an impartial needs analysis:	Medium- to long-term	WHO in liaison with other key international organizations

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
• Funding appeals to include specific support for humanitarian systems, delivery responses, and health systems strengthening. • Allow for cross-sectoral use as epidemiology or needs arise.		
Action 1.4.7 Develop guidance on bundling of vaccination services with other assistance into costing of NDVPs for governments to consider.	Short- to medium-term	UN agencies, NGOs, CSOs and Gavi
Solution 1.5. Support timely and adequate supply of regional and national equipment/stock during a pandemic response.		
Action 1.5.1 Consider how best to have adequate regional and national stocks of MCM equipment and supplies for governments and humanitarian agencies to enable rapid service delivery for PoCs.	Medium-term	Governments and partners, UNICEF and logistics cluster
Action 1.5.2 Support the establishment of agreements between governments and the private sector to strengthen the laboratory system and manufacturing of personal protective equipment (PPE) and tests.	Medium-term	Governments and partners, UNICEF and logistics cluster
Solution 1.6. Strengthen integrated service delivery approaches for PoCs during pandemic periods.		
Action 1.6.1 Develop best practices, standard operating procedures and guidance for national governments (recognizing the importance of government-led integrated pandemic response plans) to promote: • Service integration of pandemic response activities for PoCs in the health sector (alongside other health services, for example essential maternal, newborn, child and adolescent health interventions and other context-specific services). • Integration of vaccination and other MCMs with services beyond the health sector (e.g. nutrition services) given the multisectoral nature of the humanitarian response architecture.	Medium-term	WHO to lead, with support from other technical partners

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
• Reaching people in PoCs who have specific vulnerabilities (e.g. older populations, the mobility impaired).		
Solution 1.7. Strengthen national/subnational human resource systems to be robust and agile and to provide pandemic responses in support of national health systems.		
Action 1.7.1 Create an enabling work environment for human resources for health (HRH), which adequately compensates and protects staff working in humanitarian settings and/or other high-risk locations. This includes: • Review of barriers to health workers in remote/fragile settings (including financial remuneration, working conditions, retention and security environment); and identifying and implementing solutions, where possible.	Medium-term	Governments, UN agencies, NGOs, CSOs, donors and multilateral development banks (MDBs)
Action 1.7.2 Support governments to train health workers/ managers on routine services in emergency response settings in the areas housing PoCs, for better retention of HRH in humanitarian settings.	Short- to medium-term	WHO to lead, with support from other relevant partners
Action 1.7.3 Strengthen capacity for governments to: • Build a national database of HRH workers if there are no protection concerns and in line with data protection policies, and with their informed consent. • Develop capacity needs assessment tools to identify the skills and competencies of HRH in humanitarian settings. • Update and where necessary create a comprehensive HRH plan using a bottom-up and gender transformative approach for future HRH planning and deployment, with consideration to developing a separate community health worker strategy with appropriate workforce remuneration/incentives. • Identify gaps and build capacities of HRH (both quantitative as well as qualitative) and potentially link to the Health Resources and Services Availability Monitoring System (HeRAMS).[h]	Short-to long-term	UN agencies, humanitarian actors

[h] See:https://www.who.int/initiatives/herams.

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
Action 1.7.4 Advocate with governments on the importance of prioritizing dedicated human and financial resources in annual health budgets to enable supportive supervision[i] of HRH, in particular extending supportive supervision to community health workers in humanitarian settings.	Continuous, long-term	UN agencies, humanitarian actors
Action 1.7.5 Develop best practice, in order to prioritize the physical protection of HRH in areas supporting PoCs or in areas where training has been minimal to date, for: • Providing personal protective equipment (PPE) and specific equipment needed to protect HRH from infections and diseases. • Training HRH on the use of PPE and other preventive measures for disease and infections. • Supporting health workers to get vaccinated (where applicable) to protect them from infection in pandemics. • Training HRH on measures to prevent and protect against harm and violence.	Continuous, long-term	UN agencies, humanitarian actors
Solution 1.8. Improve data systems to support integrated data on PoCs for evidence-based decision making.		
Action 1.8.1 Integrate and utilize humanitarian data and analysis to better contextualize policies, strategies and operational support for PoCs including for COVID-19 and future novel vaccines.	Short-term	Gavi, WHO, UNICEF and other global level partners
Action 1.8.2 Advocate for all health actors/partners to work together and use the same data platform (e.g. DHIS2, HMIS), while respecting informed consent of PoCs: • Link existing humanitarian data sources with MoH health information systems, consistent with data protection best practices and protecting PoCs, and other potential data sources to strengthen analysis related to vaccination of PoCs, leveraging UN agencies' technical support as needed.	Medium-term	Governments, donors, health actors/partners, NGOs and CSOs

[i] See: https://apps.who.int/iris/bitstream/handle/10665/337056/9789240015692-eng.pdf.

Actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 1–5 Years	Potential owner(s) of action
Action 1.8.3 Provide best practices to inform how to monitor and analyse vaccination responses for PoCs in line with WHO guidelines (by subnational area and by group).	Medium-term	WHO and health actors/partners
Action 1.8.4 Advocate for disaggregation in country databases (e.g. broken down by PoC status, age and gender), if there are no protection concerns and given informed consent from PoCs, to strengthen evidence-based decision making and address inequities in PoCs as well as gender-vaccine equity and intersectional analysis.	Short-term	WHO, donors, health actors/ partners, CSOs and NGOs

2.2 Action plan for Objective 2

The convening provided a unique opportunity for key stakeholders to meet and identify upstream constraints to vaccination for PoCs and agree on a joint workplan for addressing these constraints.

Stakeholders emphasized seven key principles related to upstream supply, regulatory and legal aspects, with a primary focus on the vaccine response during a PHEIC. One of these principles underscored the importance of ensuring that no one is left behind in the response to a pandemic.

Proposed programmatic enablers, solutions, and actions for this objective addressing upstream supply, regulatory and legal constraints were focused on those settings where assistance is provided largely by humanitarian agencies.

It was generally agreed that the issues addressed by Working Group 2 are complex and would require further reflection and coordination work, in coordination with other working group and stakeholders where necessary.

This Action Plan does not necessarily represent the views, decisions or stated policies of, and should not be considered as endorsed by, any or all of the organizations participating in Working Group 2.

Table 5. Seven principles on upstream supply, regulatory and legal considerations

1.	No one should be left behind during a pandemic response.
2.	All humanitarian PoCs should have access to the broadest range of vaccines possible.
3.	All humanitarian PoCs should have access to vaccine products in a timely manner.
4.	All humanitarian PoCs require accessible, people-centred redress mechanisms during a PHEIC.
5.	Each humanitarian agency should be responsible only for its own actions or inactions, with due regard to the other principles and enablers set forth in this document.
6.	Humanitarian agencies should not bear the burden of product liability risks arising from any vaccine administered to humanitarian PoCs.
7.	Without prejudice to Principle 6, manufacturers should assume full product liability for their vaccines, apart from exceptional, last resort, time-bound arrangements during public health emergencies – with the cut-off points for the latter expressly defined.

Table 6. Action plan (part 2): Objective 2

Programmatic enablers, solutions and actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 12–18 months	Potential owner(s) of actions WG2 members will work collaboratively, with expert/consultant support, as needed.
Enabler 2.1. Make available appropriate redress mechanisms for serious adverse events following immunization (AEFIs) that result in permanent injury or death associated with novel vaccines administered by humanitarian agencies to PoCs in a PHEIC context.		
Solution 2.1.1. Existence of no-fault compensation (NFC) schemes that include people in humanitarian PoCs who suffer serious adverse events resulting in permanent injury or death associated with a novel vaccine administered by a humanitarian agency.		
Action 2.1.1.1 Put forward proposals for relevant actors to design and establish national, regional and/or international NFC scheme(s) for or inclusive of humanitarian PoCs, including by drawing on available models and lessons learnt from existing NFC schemes. Should address core needs, practical limitations, duration in time, and financing options, etc.	Long-term	WG2 members
Action 2.1.1.2 Put forward proposals for relevant actors to undertake advocacy to WHO Member States to establish national and/or regional NFC schemes, that extend to cover all humanitarian PoCs within their respective countries.	Long-term	WG2 members
Action 2.1.1.3 Identify appropriate organizations that might, upon request, be willing and able to provide technical support to Member States with humanitarian PoCs and/or to relevant regional bodies, to establish NFC scheme(s) for all persons (including humanitarian PoCs) in their territory.	Long-term	WG2 members
Enabler 2.2. Robust risk mitigation measures that respond to vaccine delivery concerns for humanitarian agencies and reflect acceptable risk transfer and risk sharing principles between relevant parties.		
Solution 2.2.1. IASC principles that reflect acceptable risk transfer and risk sharing principles between relevant parties.		

Programmatic enablers, solutions and actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 12–18 months	Potential owner(s) of actions WG2 members will work collaboratively, with expert/consultant support, as needed.
Action 2.2.1.1 Propose principles to the IASC with the aim of having them endorsed as broadly as possible.	Medium-term	WG2 members
Action 2.2.1.2 Put forward proposals to relevant actors to broaden exposure to and awareness of these principles and share with relevant stakeholders.	Medium-term	WG2 members
Solution 2.2.2. Voluntary commitment by manufacturers to provide indemnification and liability (IL) waivers for humanitarian agencies with respect to novel vaccines, where possible in advance of the next PHEIC.		
Action 2.2.2.1 Draft main principles for model IL waivers.	Long-term	WG2 members
Action 2.2.2.2 Develop recommendations for relevant actors in respect of a multi-stakeholder engagement and advocacy plan to engage manufacturers' associations ahead of the next PHEIC.	Medium-term	WG2 members
Solution 2.2.3. Without prejudice to Principle 6 (Table 5), seek to secure that indemnification for product liability afforded to manufacturers of novel vaccines during a PHEIC, if any, is limited in time from the outset (taking into account factors such as the establishment of the safety profile of such vaccines and/or the possibility for manufacturers to make the usual insurance and/or self-insurance arrangements for such vaccines).		
Action 2.2.3.1 Propose time-bound considerations and corresponding definition(s) that can be integrated by relevant actors into negotiation strategies for manufacturers.	Long-term	WG2 members

Programmatic enablers, solutions and actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 12–18 months	Potential owner(s) of actions WG2 members will work collaboratively, with expert/consultant support, as needed.
Solution 2.2.4. Robust and transparent end-to-end cargo and last mile insurance.		
Action 2.2.4.1 Mapping of end-to-end process (procurement to administration) to understand coverage and identify gaps in risk mitigation during transportation and storage.	Short-term	WG2 members
Action 2.2.4.2 Develop proposals aimed at ensuring that humanitarian agencies: (a) would not bear exceptional liability/risks vs a standard immunization programme; and (b) have an enhanced understanding and insight.	Medium-term	WG2 members
Enabler 2.3. Enabling environment for humanitarian agencies to deliver during a PHEIC.		
Solution 2.3.1. Workable and simplified model legal contracting framework and clauses between partners (other than manufacturers and governments) directly engaged in the procurement and supply of vaccines and humanitarian agencies engaged in vaccination programmes.		
Action 2.3.1.1 Drafting and collaborative review of main principles for model contracting framework and underlying assumptions.	Medium-term	WG2 members
Solution 2.3.2. Enabling environment for importation directly by humanitarian agencies, or government facilitated importation on behalf of humanitarian agencies, for vaccinating humanitarian PoCs.		
Action 2.3.2.1 Map existing and proposed mechanisms that allow swift humanitarian responses, including directly by humanitarian agencies in hard-to-reach areas.	Long-term	WG2 members

Programmatic enablers, solutions and actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 12–18 months	Potential owner(s) of actions WG2 members will work collaboratively, with expert/consultant support, as needed.
Action 2.3.2.2 Make proposals aimed at promoting the development of a mechanism for vaccines to be offered to hard-to-reach populations in government and non-government-controlled areas.	Long-term	WG2 members
Action 2.3.2.3 Mapping and analysis of importation and regulatory obstacles regarding humanitarian agencies' capacity to import and deploy COVID-19 vaccines to-date.	Medium-term	WG2 members
Action 2.3.2.4 Put forward proposals for relevant actors to undertake advocacy and provide technical support on country-by-country basis to facilitate importation requirements (support from in-country health cluster and logistics cluster).	Long-term	WG2 members
Solution 2.3.3. National regulatory authorities (NRAs) and/or ministries of health (MoH) to implement (and in absence of, develop) emergency procedures that allow for accelerated regulatory approvals for pandemic vaccine products (and aligned with WHO safety guidance).		
Action 2.3.3.1 Make proposals for appropriate actors to advocate with MoH/NRAs for potential solutions to the regulatory barriers identified under action 2.3.2.3.	Long-term	WG2 members
Enabler 2.4. International pandemic prevention, preparedness and response commitments reflect these principles and enablers to improve timely vaccine access and coverage in humanitarian PoCs.		
Solution 2.4.1. Position that is supportive of these principles and enablers is incorporated into language in the Pandemic Accord as a priority, and other relevant agreements/instruments.		

Programmatic enablers, solutions and actions to be implemented	Timeframe Short-term: 6 months Medium-term: 12 months Long-term: 12–18 months	Potential owner(s) of actions WG2 members will work collaboratively, with expert/consultant support, as needed.
Action 2.4.1.1 Develop proposals for relevant actors to advocate with Member States to reflect these principles and enablers in the text of the Pandemic Accord that is currently under negotiation, and in other relevant agreements/instruments.	Short-term	WG2 members
Solution 2.4.2. Broad support by relevant actors of these principles and enablers.		
Action 2.4.2.1 Put forward proposed key advocacy messages for relevant actors to disseminate.	Short-term	WG2 members

2.3 Next steps

The convening brought together key stakeholders from across countries, agencies and sectors to address the challenges encountered in implementing COVID-19 vaccination for PoCs and to plan for future pandemics. In so doing, it provided an unprecedented opportunity to: share experiences; identify lessons learnt; and to work in tandem to develop concrete solutions and actions. Hopefully, this will enable those affected by humanitarian emergencies and those in need of humanitarian assistance to access vaccines and other public health measures during pandemics.

Despite these significant achievements, more efforts are needed to move solutions and actions forward, and thus the work continues, and the action plan will be further elaborated to reflect tangible results, timelines, potential owners and ultimately a monitoring and evaluation mechanism. Vital to this ongoing work will be linking health and humanitarian efforts, both between and within entities. Equally important will be tracking and coordinating ongoing work in the development and revision of PPR policies and practices such as the proposed HEPR architecture, IA2030, and various proposed MCM mechanisms and platforms as well as instruments including the proposed Pandemic Accord and the IHR review.

Chapter 3

Key documents

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Chapter 4

Annexes

Annex 1. Members of the steering committee for the joint convening on COVID-19 vaccination in humanitarian settings and the contribution to broader pandemic preparedness and the three working groups

Steering Committee

Africa Centres for Disease Control and Prevention (CDC); COVID-19 Vaccine Delivery Partnership (CoVDP); United Kingdom Foreign Commonwealth & Development Office (FCDO); Gavi, the Vaccine Alliance; German Federal Foreign Office (FFO); German Federal Ministry for Economic Cooperation and Development (BMZ); Gesellschaft für Internationale Zusammenarbeit (GIZ); Global Affairs Canada; International Committee of the Red Cross (ICRC); International Council of Voluntary Agencies (ICVA); International Federation of Red Cross and Red Crescent Societies (IFRC); INTERSOS; International Organization for Migration (IOM); Médecins Sans Frontières (MSF); The Global Fund; The World Bank (WB); UN Refugee Agency (UNHCR); UN Children's Fund (UNICEF); United States Agency for International Development (USAID); World Health Organization (WHO).

Working Group 1

Chairs: ICVA and WHO

Project Manager: CoVDP/IFRC

Members: Africa CDC; Amel Foundation Lebanon; CARE South Sudan; ECHO; Gavi; ICRC; International Medical Corps (IMC); ISGLOBAL; MSF; NGO Forum coordinator (Uganda); Save the Children; Tamdeen Youth Foundation Yemen; UNICEF; USAID; Bureau of Humanitarian Assistance; WFP; World Vision International; WHO.

Working Group 2

Chairs: MSF and Gavi

Members: BMZ/German Development Cooperation; Federal Foreign Office Germany; Gavi; ICRC; IFRC; IOM; MSF; UNICEF; USAID; WHO.

Working Group 3

Chairs: INTERSOS and BMZ/German Development Cooperation

Project Manager: Gavi

Members: Action Contra le Faim; Africa CDC; BMZ/German Development Cooperation; CARE South Sudan; CoVDP; Gavi; Global Fund; Global Affairs Canada; HelpAge International; ICRC; ICVA; IFRC; IMC; INTERSOS; IRC; MSF; UNICEF; USAID; WB; WFP; WHO.

Annex 2. List of attendees at the joint convening

Geneviève Begkoyian	Academic
Miguel Suarez	Action Contre La Faim (ACF)
Seema Masoumi Ghani	Afghan Family Guidance Association
Neema Kamara	Africa Centres for Disease Control and Prevention
Henok Minas Brook	Africa Centres for Disease Control and Prevention
Ezinne Victoria Chinemerem Onwuekwe	Africa Centres for Disease Control and Prevention
Huntuwa Maji	American Red Cross
Virginie Lefevre	Amel Foundation (Lebanon)
Anthony Ombara	Amref Health Africa
Mary Wambui Mathenge	Amref Health Africa
Hanan Boudart	arcenciel NGO
Lisa-Marie Ouedraogo	BMZ/GIZ
Katharina Maria Prinz	BMZ/GIZ
Emmanuel Ojwang	CARE (South Sudan)
Abhijeet Anand	US Centers for Disease Control & Prevention (CDC)
Rachel Eidex	US Centers for Disease Control & Prevention (CDC)
Sheetal Sharma	Core Group
Elia Badjo	COSAMED
Violeta Isabel Perez Nueno	COVID-19 Vaccine Delivery Partnership
Benjamin Schreiber	COVID-19 Vaccine Delivery Partnership
Ted Chaiban	COVID-19 Vaccine Delivery Partnership
Adelaide Margaret Davis	COVID-19 Vaccine Delivery Partnership
Ann Lindstrand	COVID-19 Vaccine Delivery Partnership
Alice Wimmer	COVID-19 Vaccine Delivery Partnership
Yume Yorita	Embassy of Japan
Elena Velilla	European Civil Protection and Humanitarian Aid Operations
Louisa Singer	Federal Foreign Office Germany
Harpal Dhillon	Gavi, the Vaccine Alliance
Hannah Kettler	Gavi, the Vaccine Alliance
Denis Kongere	Gavi, the Vaccine Alliance
Amy LaTrielle	Gavi, the Vaccine Alliance
Caitlin Longden	Gavi, the Vaccine Alliance
Temidayo Ogunrinu	Gavi, the Vaccine Alliance
Geena Zimbler	Gavi, the Vaccine Alliance
Gillian Harris	Global Affairs Canada
Abdur Razzaque Khan	Gonoshasthaya Kendra Cox's Bazar
Christiana Oluwatobi Fashola	Helpage International
Gideon Mwawasi	HIAS Kenya

Joyce Kimita	HIAS Kenya
Amos Chweya	inSupply / JSI
Charles Deutscher	International Committee of the Red Cross (ICRC)
Heather Pagano	International Committee of the Red Cross (ICRC)
Eileen Morrow	International Council of Voluntary Agencies (ICVA)
Tatiana Alvarez Marin	International Federation of Red Cross and Red Crescent Societies (IFRC)
Walter Cotte	International Federation of Red Cross and Red Crescent Societies (IFRC)
Carrie Nielsen	International Federation of Red Cross and Red Crescent Societies (IFRC)
Frederique Protin	International Federation of Red Cross and Red Crescent Societies (IFRC)
Beldina Gikundi	International Organization for Migration (IOM)
Mireille Lembwadio	International Organization for Migration (IOM)
Andrew Mbala	International Organization for Migration (IOM)
Steven Malinga	International Rescue Committee (IRC)
Andrea Accardi	INTERSOS
Konstantinos Moschochoritis	INTERSOS
Abdirashid Aden	Kenya Red Cross
Miriam Ngure	Kenya Red Cross
Miranda Brown	Médecins Sans Frontières (MSF)
Nicaise Eloi Mboufoungou	Ministry of Health, Central African Republic
Luc Salva Heredeibona	Ministry of Health, Central African Republic
William Alberto Robles Fonnegra	Ministry of Health, Colombia
Jean Crispin Mukendi	Ministry of Health, Democratic Republic of the Congo
Audry Mulumba wa Kamba	Ministry of Health, Democratic Republic of the Congo
Eid Azar	Ministry of Health, Lebanon
Taiwo Adebesin	Ministry of Health, Nigeria
Bassey Bassey Okposen	Ministry of Health, Nigeria
Mukhtar Abdi	Ministry of Health, Somalia
Ubah Farah Ahmed	Ministry of Health, Somalia
Udoh Ibanga Idaraobong	Nigerian Red Cross Society
Laura Cardinal	READY Initiative
Mirabelle Enaka	Red Cross of the Democratic Republic of the Congo
Michael Geoffrey Bruce	Save the Children
Rachael Helen Cumming	Save the Children
Karrar Karrar	Save the Children
Alex Yogolelo Mutanganayi	Save the Children
Nimo Hassan	Somalia NGO Consortium
Eustakious Abraham Masson Guma	South Sudan Health Association (SSHA)
Jameel Abdo	Tamdeen Youth Foundation (Yemen)
Abdisalam Ahmed Bahwal	The World Bank
Gloria Modong Soma	Titi Foundation & NGO Forum South Sudan
Amboko Buhozozo	UN High Commissioner for Refugees

Nathalie Fol	UNICEF
Abdoul Aziz Gbaya	UNICEF
Samuel Kweku Ocran	UNICEF
Adjowii Jolin Leinonen	UNICEF
James McQuen Patterson	UNICEF
Ahmadu Yakubu	UNICEF
Zoulikha Faraj	UNICEF Democratic Republic of the Congo
Eleanore Marie Antoinette Ba	UNICEF Eastern & Southern Africa Regional Office
Mohamed Malick Fall	UNICEF Eastern & Southern Africa Regional Office
Paul Ngwakum	UNICEF Eastern & Southern Africa Regional Office
Mekonnen Tadesse Hagos	UNICEF Eastern & Southern Africa Regional Office
Landry Dongmo Tsague	UNICEF Europe & Central Asia
Altaf Musani	World Health Organization
Naor Bar-Zeev	World Health Organization
Stefanie Benitez	World Health Organization
Alya Dabbagh	World Health Organization
Amira Eapen	World Health Organization
Rafael La Rotta	World Health Organization
Anne Mazur	World Health Organization
Katherine O'Brien	World Health Organization
Eba Al-muna Pasha	World Health Organization
Elisabeth (Isis) Pluut	World Health Organization
Mutale Mumba	World Health Organization Eastern and Southern Africa
Oniovo Efe-Aluta	World Health Organization IST/WA
Phionah Atuhebwe	World Health Organization Regional Office for Africa
Thierno Balde	World Health Organization Regional Office for Africa
Oluchi Bassey	World Health Organization Regional Office for Africa
Sheba Loy Nakimera	World Health Organization Regional Office for Africa
Gilson Paluku	World Health Organization Regional Office for Africa
Ambrose Talisuna	World Health Organization Regional Office for Africa
Sk Md Mamunur Rahman Malik	World Health Organization Somalia
Vianney Rusagara	World Vision International
Laura Frost	Writer (Consultant)

Annex 3. Summary of protecting populations of concern against this pandemic and the next: Key document

Purpose of the key document[a]

The global rollout of COVID-19 vaccinations has been marked by vaccine inequities between and within countries. For populations of concern (PoCs) in humanitarian settings, there has been limited access to vaccines and although vaccination coverage has improved in some settings, persistent obstacles remain.

PoCs include those living under the state-like control of non-state armed groups, populations in conflict settings, those affected by humanitarian emergencies and those in need of humanitarian assistance, including but not limited to refugees, asylum seekers, stateless persons, internally displaced persons, minorities, detainees, and vulnerable migrants irrespective of their legal status.[b]

To address the challenges encountered in implementing COVID-19 vaccination in high-risk groups within PoCs, the COVID-19 Vaccine Delivery Partnership (CoVDP) and key partners from UN agencies, Gavi, the Vaccine Alliance, the Global Health Cluster, Africa CDC, International Council of Voluntary Agencies (ICVA), International Federation of Red Cross and Red Crescent Societies (IFRC), International Committee of the Red Cross (ICRC), INTERSOS, Médecins Sans Frontières (MSF), and bilateral partners have led the preparation of a joint convening on COVID-19 vaccination in humanitarian settings and the contribution to broader pandemic preparedness on 14–15 February 2023 in Nairobi, Kenya.

A central part of these preparations has been the establishment of working groups across three thematic areas, which were identified as the key opportunities to strengthen effective vaccination delivery in humanitarian settings.

Working Group 1: Leveraging humanitarian architecture and humanitarian actors in pandemic response.

Working Group 2: Upstream supply, regulatory and legal considerations impacting implementation in humanitarian settings.

Working Group 3: Health system strengthening and pandemic preparedness and response in humanitarian settings.

[a] This key document was developed as a background paper for the joint convening.

[b] This definition of populations of concern (PoCs) was endorsed by the Inter-Agency Standing Committee (IASC) Principals for the COVAX Humanitarian Buffer.

Working group participants represent a range of organizations including UN agencies, nongovernmental organizations (NGOs), civil society organizations (CSOs), the International Red Cross and Red Crescent movement, bilateral partners, and academic entities. In discussions over seven sessions per group, participants identified challenges to COVID-19 vaccinations in PoCs in each thematic area, how challenges were addressed and lessons learnt, and key principles and potential solutions for addressing these challenges now for COVID-19 for future pandemics.

This document is a working draft that summarizes the key issues and emerging principles, solutions, and actions identified in the working groups as a basis for further consultation, consensus-building, and development of an action plan.

Stakeholders at the convening will critically review the current global situation of COVID-19 vaccine delivery in PoCs, identify lessons learnt, and share good practices. Drawing from the work already conducted by the working groups, stakeholders will develop more concrete solutions and an action plan to guide the rest of the COVID-19 vaccination response and inform future planning during pandemics.

In doing so, they will address areas of overlap between the working groups and ensure harmonization. A public report with joint commitments from stakeholders on actionable solutions will provide a concrete roadmap for next steps.

Key principles

Participants across the working groups identified key principles that should underpin vaccination efforts for PoCs in humanitarian settings during pandemics. These principles are detailed in Sections 2.1 and 2.2 of this report.

Background on COVID-19 vaccination in POCs in humanitarian settings

By early February 2023, completion of the primary series of COVID-19 vaccines was an estimated 65% of the world's population. Across the 92 low- and middle-income countries that are eligible to participate in the COVAX Facility's Advance Market Commitment (AMC 92), however, primary series coverage was only 53% (by 9 February 2023).

In countries in the WHO African Region, aggregate primary series coverage was 28% and in low-income countries, aggregate primary series coverage was 23% (by 9 February 2023). Thus, there is still a global vaccine equity gap between countries, although this gap has been decreasing. Among the 34 Countries for Concerted Support (34 CCS) from the CoVDP and partners (countries that were at or below 10% coverage in January 2022), average vaccination coverage increased significantly from 3% in January 2022 to 25% by 9 February 2023.

Notably, most of the countries that remain close to or below 10% coverage have also been experiencing an ongoing humanitarian emergency. Of the eight countries that have yet to achieve 10% coverage, five of these had humanitarian crises prior to the pandemic that threaten the health, safety, or well-being of communities within the country. The humanitarian response architecture in place for delivering essential services to PoCs differs by each context; there is no one size fits all.

It varies depending on whether there is an interagency appeal launched at the request of or acceptance from the government as part of the Global Humanitarian Overview (GHO), whether there is a UN Humanitarian Coordinator (HC) and Humanitarian Country Team (HCT), and whether there is a cluster system involving humanitarian organizations in each of the main sectors of humanitarian action, designated by the Inter-Agency Standing Committee (IASC, the highest-level humanitarian coordination forum of the UN system) with clear responsibilities for coordination.

These humanitarian settings also differ in terms of whether there is access to PoCs by the government or humanitarian partners either due to security and physical constraints, or bureaucratic and administrative barriers faced by humanitarian partners. As there are many other risks affecting PoCs, public health measures need to be carefully balanced with other pressing needs.

For COVID-19 vaccination, governments in some countries reached PoCs by including them in national deployment and vaccination plans (NDVPs), working through health systems and, in some settings, in partnership with humanitarian agencies. However, NDVPs, particularly the early versions of these plans, did not always include PoCs as a target population with specific strategies for reaching them. To support vaccine delivery to populations in humanitarian settings, the COVAX Humanitarian Buffer was established as a mechanism of last resort, dedicating up to 5% of COVAX Advanced Market Commitment (AMC) funding for doses to be deployed via the COVAX Humanitarian Buffer for these populations.

COVID-19 vaccination in countries with a humanitarian emergency improved throughout 2022. Of the 30 countries with dedicated humanitarian response plans (HRPs) in the GHO, completion of primary series for COVID-19 vaccination increased from 13.5% in December 2021 to 34.4% a year later. Several countries with humanitarian emergencies have made impressive gains in improving COVID-19 vaccination coverage. Despite an ongoing humanitarian emergency, the Central African Republic, for example, was one of the first countries among the 34 CCS to achieve primary series coverage above 20%, with the current percentage of persons with primary series coverage at 40.1%.

Additionally, Somalia increased primary series coverage from 5% in January 2022 to 37.4% in December 2022, with significant gains made through the government's national phased campaign. Despite impressive gains in some countries, data on vaccination coverage at the national level should be interpreted with caution, as these may mask inequities within countries. Therefore, improvements in vaccination coverage at the national level do not mean that vaccination coverage for PoCs has also improved.

Achieving success in these countries has shown the importance of: political commitment at national and subnational levels; leveraging of humanitarian partners; effective microplanning; strong engagement with communities; training of vaccination teams; and evidence and data-driven approaches to identifying and reaching priority groups. Countries have utilized a combination of approaches including mobile vaccination teams, door-to-door outreach, engagement of community, traditional, and religious leaders, partnerships with NGOs and CSOs, bundling of interventions with other health and humanitarian interventions, and other approaches tailored to specific contexts.

Despite these successes, persistent obstacles to reaching PoCs remain. There is significant inequity within countries and the Global Health Cluster reports that in areas where most of the population need humanitarian assistance (that is, the population in need is greater than 50%), only a few areas have more than 40% people with primary series coverage. Reaching these populations appropriately means higher cost of vaccine delivery, sufficient human resources for health in areas that sometimes have greater risk to health workers, and adequate cold chain capacity for COVID-19 vaccines.

Countries with humanitarian emergencies were among the last group to access vaccines, and subnationally, PoCs within these countries received access even later. Humanitarian NGOs faced systemic, legal and regulatory barriers to accessing COVID-19 vaccines and at the outset of the pandemic, humanitarian architecture was often not adequately leveraged and financed for the COVID-19 vaccination response, particularly of CSOs and NGOs that are essential to humanitarian response in these settings. These challenges have meant that strategies to deliver vaccines were not always developed to address the challenges faced by PoCs including combining, or bundling, of COVID-19 vaccination with other humanitarian services.

These issues were compounded by insecurity and poor accessibility, which has led to additional costs and logistical constraints, administrative barriers such as documentation required to register for /receive vaccines, rumours and misinformation in some settings, and low demand and low risk perceptions, as well as many other competing priorities in humanitarian settings. Overall, the lack of timely provision of COVID-19 vaccination for PoCs led to further distrust and perceptions of marginalization, as well as a decrease in risk perceptions within these communities.

A concerted effort that leverages governmental, humanitarian, health and development stakeholders at all levels is urgently needed to address these barriers to COVID-19 vaccination for PoCs. It is also essential for broader PoCs and priority at-risk groups within PoCs (e.g. health workers, older populations, and others) to be held in equal regard to other populations. This effort will also decrease the likelihood of new mutations of the virus leading to new variants, increase global health security, and strengthen commitments to achieving universal health coverage. Establishing these systems now is not only important for COVID-19 vaccination but is also essential to ensuring that PoCs are not left out in future pandemics.

Leveraging humanitarian architecture and humanitarian actors in pandemic responses

Recognizing the gaps in vaccination coverage in humanitarian contexts, Working Group 1 examined the humanitarian architecture and actors could be leveraged for COVID-19 vaccination and future pandemic responses.

Participants discussed the following sub-topics in seven meetings:

- Leveraging existing coordination systems and building understanding of the humanitarian system and mandate for public health and development partners.
- Political engagement to ensure equity and humanitarian access.
- Meaningful engagement of humanitarian partners including NGOs.
- Navigating NGO importation of vaccines.
- Accountability and inclusion.
- Funding/financing beyond preferred partners.

Prior to the convening the working group identified five emerging solutions and related actions, detailed on the next page.

Table A1. Emerging solutions and related actions

1	Action at global, national, subnational and community levels across all actors to ensure equitable access to vaccination for PoCs, leveraging humanitarian architecture and actors at the outset of vaccination in pandemic response.
2	Engage early, consistently and respectfully with communities to ensure a bottom-up approach in vaccination response.
3	Prioritize localization as well as working with and funding national and local NGOs and CSOs.
4	Provide timely, sufficient, predictable and flexible funding for humanitarian agencies.
5	Ensure conducive environment for NGO access to vaccines.

Table A2. Guiding questions for continued development of solutions at the joint convening

For each of the five emerging solutions and actions, what could work, what is not possible and why not, and who should take it forward?
What steps (in a checklist or standard operating procedure (SOP)) need to be taken for national planners for COVID-19 vaccinations (i.e. MoH with WHO, UNICEF, and Gavi, etc.) to link with existing humanitarian architecture or coordination platforms (i.e. RC/HC, Humanitarian Country Team, Health Cluster, NGO fora) to ensure humanitarian partners are meaningfully engaged from the outset in pandemic responses?
Discuss how to safeguard frontline workers (not just health workers) in humanitarian settings (and ensure alignment with WG3).
Was having two separate appeals for COVID-19 vaccinations and humanitarian response during the pandemic the most effective approach? What would a joint appeal look like?
Are WG1 solutions aligned with those of the other working groups, particularly regarding financing and governance (WG3), and NGO access to vaccines and framework agreements and templates (WG2), and global instruments and policies (WG2 and WG3)?

Upstream supply, regulatory and legal considerations impacting implementation in humanitarian settings

Working Group 2 discussed the upstream supply, regulatory and legal considerations that influenced the implementation of COVID-19 vaccinations for PoCs in humanitarian settings.

Participants discussed the following sub-topics:

- Manufacturers' limited product liability and other liabilities.
- Impact of risk transfer.
- Mitigation measures.
- Import and regulatory issues.
- Deep dives on possible solutions.

The working group identified seven principles for vaccination by humanitarian agencies of PoCs, four programmatic enablers and a series of related solutions and actions.

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Table A3. Guiding questions for continued development of solutions at joint convening

What is the action plan for implementing these principles, including actions, roles, responsibilities and timing of next steps?
Are WG2 solutions aligned with those of the other working groups, particularly regarding humanitarian NGO access to vaccines, framework agreements and templates, and global instruments and policies (WG1 and WG3, as applicable)?

Health system strengthening and pandemic preparedness and response in humanitarian settings

The discussions in Working Group 3 centred on health system strengthening and pandemic preparedness and response in PoCs in the context of COVID-19 vaccinations.

Over seven sessions, participants discussed the following sub-topics:

- Health system strengthening.
- Integration.
- Improving workforce and human resources for health.
- Financing and resource earmarking.
- Governance.
- Pandemic prevention, preparedness, and response (PPR) and global health security.
- Enablers and recommendations.

The working group identified guiding principles, emerging solutions and associated actions in six thematic areas:

- Service delivery.
- Human resources for health.
- Data.
- Financing.
- Governance.
- Global instruments and policies for PPR.

Table A4. Guiding questions for continued development of solutions at the joint convening

How can human resources for health (HRH) plans for vaccination responses in humanitarian settings during pandemics be developed and costed to ensure that countries can cope with future shocks, while maintaining essential services? What elements should these plans include (e.g. gender representation of health workers, incentives, training, appropriate costing, transition plans and career tracks, etc.).
Is there a checklist of capacity transfers/strengthening that could be developed to strengthen HRH for vaccination response for PoCs?
What are best practices for incentivizing health workers in PoCs (and ensuring incentives do no harm)?
Is there agreement among donors to fund integration of services or bundling in humanitarian settings? Is there a package to present to donors on bundling?
How can the funding channels be more flexible and adaptable to the ongoing needs that arise during the pandemic during the acute and latent phases? How can we address the blockage from central level to frontline workers?
What complementary humanitarian data sources exist that can help with analysis for a vaccination response for PoCs? How can MoHs integrate these humanitarian data sources into their systems of analysis for pandemic response?
What textual suggestions to the Pandemic Accord negotiations, IHR, and HEPR processes can be collectively agreed and put forward to ensure equitable access to vaccination for PoCs during pandemic responses?
What coordinating structures need to be implemented to ensure the management and oversight of vaccine-related pandemic response in PoCs for COVID-19 vaccinations and for future pandemics? Who should oversee and manage this structure? What should their SOPs look like?
How can we more sufficiently cover requirements that are specific to, or amplified in, PoCs? How can women, children, older people, people with disabilities, and other vulnerable populations in PoCs be reached safely and efficiently with COVID-19 vaccinations?
How can we address the mental health risks in PoCs and how might this affect vaccine delivery or acceptance?

Table A4. Guiding questions for continued development of solutions at the joint convening

How can we ensure communication and escalation when there is exclusion of PoCs or gaps in service delivery?
What strategies from the COVID-19 vaccinations campaign for PoCs can be maintained/kept in place that can be helpful in future pandemic preparedness and response?
Are WG3 solutions aligned with those of the other working groups, particularly regarding financing and governance (WG1) and global instruments and policies (WG1 and WG2)?

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Gavi
The Vaccine Alliance