Some Issues to be Considered in the Roll Out of COVID-19 Immunization in Conflict, Security Compromised, or Difficult Access Areas | Tom Gregg

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The delivery of COVID-19 vaccines in complex and conflict settings will present a unique set of challenges to the global health community. This paper introduces some of the issues that are likely to be encountered; describes various contexts and countries where they will be encountered; and proposes some practical next steps.

There is currently no definitive data on the collective population size or demographic composition of non-state spaces and other known access compromised areas. These areas exist across the globe and can be broadly divided into the following categories:

- Non-state spaces controlled or contested by armed opposition: examples include Taliban controlled parts of Southern and Eastern Afghanistan, al-Shabab controlled areas in South-Central Somalia and armed opposition (there are multiple) controlled pockets in CAR etc…
- Inaccessible communities due to religious or ethnic discrimination: examples include Rohingya (Myanmar) and Muslim communities in Northeast Kenya
- Situations where *de jure* authority remains with the Central government but *de facto* the authority rests with local actors: examples include South Yemen and areas controlled by Popular Mobilization Units (PMUs) across Iraq
- Reduced or failed state capacity: examples include North Korea, Venezuela
- Spaces controlled by self-declared administrations and not accessible to the global health community: examples include Northeast Syria
- Emerging conflicts that will impact routine access and are not yet widely understood: examples include Cabo Delgado, Mozambique (1/2 million people currently displaced)
- Refugee Camps, examples include: Al-Hol refugee camp near the Syria-Iraq border among countless others camps in multiple countries.

What all of these contexts have in common is that the traditional state centric/multilateral approach, whereby delivery is dependent upon a partnership with the local health ministry, will not result in securing access to the target communities. Therefore, there is an urgent need for special planning on immunization allocation and delivery for these populations.

The specific set of challenges these places present to the global health community include:

- *Ensuring access to populations:* The obvious issue is ensuring that once a vaccine becomes available, populations in complex settings can be accessed; *this is not referring to the operational challenges of reaching people but rather the political considerations.* In many if not most conflict settings, ensuring access will involve engaging local authorities, whether government, community, or non-state groups or entities, to enable local actors and partners to reach communities with vaccines. Current and recent experience in complex settings in Afghanistan, Syria, Somalia and other countries strongly support the conclusion that *this work to obtain the agreement and support of local authorities should commence immediately in conflict and other known access compromised situations*, so that as the vaccine comes online, it can be used as extensively as possible.
- *Community engagement:* Recent lessons from the COVID pandemic as well as lessons from polio eradication in complex settings, point to the critical importance of early work to engage communities and establish trusted channels of communication

to discuss risks, explain approaches, address questions, and identify mutual solutions for community concerns. Even before the principle of access has been established work on community engagement should commence. *It is highly dangerous to underestimate the importance of this issue in ultimately ensuring that communities accept and actively participate in the immunization process.* This is particularly important given that the target groups for immunization will likely be different to the usual pattern for other vaccines.

- *Lack of partners on the ground with requisite capacity and experience:* The COVID vaccine campaign will be a population level public health exercise. Most actors on the ground in these areas are not equipped to undertake such a large-scale activity. The WHO typically can carry out such population level campaigns but not in areas that are inaccessible. Other actors, such as MSF, ICRC et al. are not necessarily well placed for such population level campaigns. What they do typically do best are point of service – fixed point or mobile point clinics etc.
- *Operational and logistical planning:* While there is considerable operational and logistics planning experience from polio, measles and other immunization campaigns in complex settings, the COVID immunization campaigns present additional and unique challenges due to differences in:
    - target groups for immunization,
    - possible differences in storage and transport requirements for vaccines,
    - the need for two doses for most currently available vaccines and therefore the need to track who is immunized and with which vaccine,
    - and potential operational challenges of the roll out due to the staggered availability of vaccines.
- These issues will be compounded by an absence of any established cold chain capacity in most complex and conflict settings. Further, establishing a cold chain in complex and conflict settings is both access dependent but importantly, infrastructure dependent. In the majority of such areas, even the most basic utilities, such as electricity, are absent for some or all of the day. In these areas, cold chains will rely upon additional equipment such as generators and fuel, which as a lucrative commodity, can be easily diverted. While some of this planning cannot be done too far in advance until the details of target groups, vaccine type, and vaccine availability are available, many of the principles should be addressed early.
- *Taking advantage of integration possibilities with other health interventions:* In the unique circumstances of complex settings, it makes a great deal of sense to look for possibilities of integrating, or partnering, COVID immunization activities with other public health interventions. In many complex settings there are other public health activities being implemented, including polio and measles immunization campaigns, which offer not only experience but opportunities for partnering; additionally, COVID immunization activities could provide a bridge to facilitate broader sustained public health interventions.
- *Vaccine introduction and roll out is likely to be highly uneven globally.* Developed, wealthy countries have already begun to introduce the vaccine and will continue to do so more quickly and more extensively than middle income and especially lower income countries, despite the best efforts of international initiatives, including the COVAX partnership, to ensure the widespread availability of safe, effective, and affordable vaccines.
- *Vaccine nationalism/competition.* It is highly likely that any sort of rational vaccine distribution/allocation mechanism will be further impeded by national/geopolitical considerations of whose vaccines to use – e.g., in Myanmar, they are going be under

pressure to use the Chinese vaccine, even if for various reasons they would prefer an alternative one. Vaccine nationalism will make roll out and equitable distribution more complex.

- Given the likely unevenness of the global vaccine rollout, it should be assumed, for planning purposes, that populations in conflict affected areas, security compromised areas, and areas of difficult access for geographic, social, or political reasons, will be among the last to have access to COVID vaccines. Despite the inequity of this scenario, given the complexities of effectively introducing vaccines in these areas and populations, *it is essential to begin preparing now* for the time that vaccine does become available.

Structural Obstacles to Access

- Some communities in conflict, security compromised, or difficult access areas are controlled by armed opposition groups and parties that have been placed on the U.S. Treasury's List of Specially Designated Nationals and Blocked Persons or in countries under Comprehensive Sanctions. To date, this issue is viewed through the prism of individual or an organisation's appetite for risk (few NGOs have secured OFAC licenses to legally engage with such groups). However, COVID-19 immunization provides a clear example, as has polio eradication efforts, that in order for the international community to fulfill its commitment to vaccinations, some engagement and coordination with non-state actors on the list of Specially Designated Nationals and Blocked Persons or in countries under Comprehensive Sanctions will be required. This raises important questions regarding the current posture of the Global Health Community, and its international donors.

Proposed way forward

Last week, President Biden announced that he has reached an agreement with Pfizer and BioNTech to provide 500 million doses of coronavirus vaccine to about 100 countries over the next year. As these, and other COVID-19 vaccines are used in developed countries the likelihood is that vaccine supply also improves and will continue and accelerate throughout 2021 and 2022. Allocation of COVID vaccine supplies internationally is currently entirely mediated between Governments and vaccine manufacturers or cooperative efforts among Governments like COVAX. Communities either in direct opposition to Government entities or caught in the midst of a conflict between other entities in opposition to a Government entity are not represented. Furthermore, distribution of COVID vaccine supplies within a country is also entirely dominated by state structures. Finally, planning for the delivery of COVID vaccines is similarly being done by state structures. Given these dynamics, it is still not at all clear how these very vulnerable populations will obtain access to COVID vaccines.

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