COVID-19 Vaccine Delivery Partnership

Situation Report
February and March 2023

IN THIS EDITION

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• In-depth: Community health workers and vaccine delivery

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This report is produced by the COVID-19 Vaccine Delivery Partnership (CoVDP). It covers the months of February and March 2023.
SPOTLIGHT

• **Globally, primary series coverage has increased from 47% in January 2022 to 65% in March 2023.** Over the same period, it doubled in the 92 Advance Market Commitment (AMC92) entities, reaching 55%, and increased 9-fold to reach 27% across the 34 countries for concerted support (CCS).

• **13.3 billion doses have been administered across the globe,** of which 5 billion have been administered across the AMC92, including 2 billion doses in India alone.

• 186 WHO Member States have introduced booster or additional dose programs (3 more than in January 2023) and globally, **31% of the population has received at least one booster dose** (equivalent to 2.4 billion people).

• **Among the 34 CCS, 28 countries have now reached levels above 10%,** including 21 countries that have reached 20% or more. Tanzania and Sierra Leone are the first CCS to reach more than 50% vaccination coverage.

• **To date, more than US$178 million in quick-impact funding has been disbursed across 20 countries, contributing to more than 32 vaccination campaigns targeting 160 million people.** However, inequalities in global coverage persist. Only a quarter of the general population of low-income countries (LICs) have completed their primary series compared to three quarters in high-income countries (HICs).
• Among high-priority groups, there continues to be a significant coverage gap, especially among older adults (60+).

Only 34% of the elderly in LICs have completed their primary series compared to 92% in HICs.

• Booster dose coverage, which is essential to protect high-priority groups over the long-term, is also unequal.

Only 3% of the population in LICs have received at least one booster dose compared to 49% of the population in HICs.

• Absorption rates for COVID-19 vaccines are in decline, with 94 million doses administered globally over the past four weeks (compared to 112 million in the four-week period leading up to end of February)

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**Increase in coverage over time** – Global, AMC92 and 34 Countries for Concerted Support

- Share of global population with completed primary series
- Share of population with completed primary series in 92 Advance Market Commitment (AMC) entities
- Share of population with completed COVID-19 primary series in 34 countries for concerted support
Global Situation Overview

Since its peak in mid-December 2022, registered cases of COVID-19 have dropped dramatically across the globe. There has been a sustained decline in cases over the past 8 weeks with an average decline of 7.6% week-on-week since the beginning of February. Similarly, registered deaths from COVID-19 have also fallen dramatically. At the end of March 2023, 1,300 weekly deaths were registered globally – the lowest in 3 years.

Nonetheless, global deaths now stand at 6.9 million since the start of the pandemic. Seven countries alone account for more than half of all registered deaths: the United States of America, Brazil, India, Russia, Mexico, the United Kingdom, and Peru.

While testing rates have declined, the lower caseload and deaths registered are also due to the higher levels of immunization achieved primarily through the COVID-19 vaccine rollout, with more than 13.2 billion doses administered at the end of March 2023. Low and lower-middle income countries in particular, have seen a faster than average increase in vaccination uptake over the past few months.

Globally, 65% of the population have completed their primary series coverage – 1 percentage point more than at the end of January 2023. Sixty-eight countries have reached the global target of 70% primary series coverage. The vast majority of these are in the Western Pacific, Europe and the Americas.

The WHO African Region has seen a 2.5-fold increase in primary series coverage in the past twelve months. Five African countries have reached or surpassed the global target of 70%, including Mauritius, Seychelles, Rwanda, Liberia and Botswana. Nonetheless, only 30% of people in the WHO African Region have completed their primary series – the lowest rate among the WHO regions (up from 12% a year ago). This is followed by the WHO Eastern Mediterranean Region at 53% vaccination coverage (up from 34% a year ago).

While most WHO Member States have started to implement booster / additional dose programs, uptake of boosters is very uneven across regions and income groups. Globally, 31% of the population has received at least one booster dose but the proportion drops to just 5% in the WHO African region, 19% in the Eastern Mediterranean and 21% in South-East Asia.

FOR MORE ON THE GLOBAL SITUATION:

- WHO COVID-19 Weekly Epidemiological and Operational Updates
- WHO COVID-19 Dashboard
- UNICEF COVID-19 Vaccine Market Dashboard
- UNDP Global Dashboard for Vaccine Equity
- COVID-19 Vaccine Delivery Partnership Information Hub

1 Surveillance and testing continue to reduce globally, making it increasingly difficult to understand the epidemiology of COVID-19. Caution is required in interpreting current trends due to these reductions and persisting delays in reporting.
2 Countries mainly refers to WHO member states of which there are 194.
High-priority Groups

Globally, 89% of health care workers\(^3\) have completed their primary series coverage (unchanged since January 2023). The WHO South-East Asia and Americas Regions are reporting near total primary series coverage among healthcare workers (at 100% and 99%, respectively) whereas the WHO African Region\(^4\) has a coverage of 63% (two percentage points higher than two months ago).

Income group is the strongest predictor of disparities in healthcare worker coverage. Whereas all income groups except LICs have achieved coverage above 88%, LICs have a coverage of just 52% among healthcare workers (based on 26 reporting countries).

Similarly, data on primary series coverage of people aged 60 or above\(^5\) show that 82% of older adults globally have been vaccinated. That coverage drops significantly

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\(^3\) Based on data reported by 143 out of 194 WHO member states.

\(^4\) Based on 38 reporting countries in the WHO African region.

\(^5\) Based on data reported by 158 out of 194 WHO member states.
among LICs which have vaccinated just 35% of their older adults (based on data from 24 reporting countries). The gap is significant even when compared to LMICs, which have now reached a primary series coverage of 76% among older adults.

Globally, 31% of healthcare workers and 57% of older adults have received at least one booster dose, but there are significant income-related disparities in booster uptake – some of them surprising. In LICs, only 6% of healthcare workers have received at least one booster shot compared to 68% in LMICs. However, in HICs – which have high levels of primary series coverage for healthcare workers (89%) – only 15% have taken a booster dose. Booster dose uptake among older adults is also lowest in LiCs (2%), followed by LMICs (28%). Among regions, the lowest booster uptake among older adults is observed in the WHO African, Eastern Mediterranean and European Regions.

**FIGURE 2**

**Booster coverage**

In the light of higher population-level immunity due to vaccination and previous infection, the WHO’s Strategic Advisory Group of Experts on Immunization (SAGE) updated its guidance for COVID-19 vaccination and revised the roadmap for prioritization in the use of COVID-19 vaccines at the end of March.
SAGE continues to recommend full primary series and booster doses for those at the greatest risk of death and severe illness from COVID-19 (i.e. older adults, younger adults with significant comorbidities, people with immunocompromising conditions, including children aged 6 months and older, pregnant persons, and frontline health workers), including additional booster doses either 6 or 12 months after the last dose.

For medium priority groups, SAGE recommends primary series and a first booster dose but does not recommend further doses given the low public health returns.

For low priority groups - primarily children and adolescents aged 6 months to 17 years - SAGE recommends that decisions to vaccinate should be guided by factors such as the disease burden, cost effectiveness, and other health or programmatic priorities and opportunity costs.

The full updates to the SAGE guidance can be found here.
Across the 92 Advance Market Commitment (AMC92) countries, primary series coverage has increased from 28% to 55% between January 2022 and March 2023 (a two-percentage point increase since January 2023). Vaccination coverage has increased at a faster rate than the global average: the vaccination gap compared to global levels has decreased from 19 percentage points in January 2022 to 10 percentage points in March 2023. Fourteen countries among the AMC92 (15%) have now reached the global goal of 70% vaccination coverage.

While the AMC92 have reached the milestone of 5 billion doses administered cumulatively since the start of the rollout, the rate of increase has slowed down with only 48 million doses absorbed in February and March 2023 compared to 104 million in the previous 2-month period. This represents the lowest level of dose absorption since March 2021 as is largely due to increases in vaccination coverage but also reduced risk perception.

The daily absorption rate stood at 0.02% pop./day at the end of March 2023 – significantly lower than the reference level for low absorption (at 0.65% pop./day). Given these low levels of absorption, there is a need for countries to start planning and implementing the integration of COVID-19 vaccination in primary healthcare services and combining this with sustained RCCE and demand generation activities to ensure continued uptake of primary series and booster doses especially among high-priority groups.

82% of healthcare workers and 69% of older adults have completed their primary series, representing a gap of 7 percentage points and 12 percentage points respectively vis-à-vis global coverage figures.

Among the AMC92 which report on booster coverage, 16% of the population have received at least one booster dose – a significant gap relative to the global booster coverage of 31% (and largely unchanged since January 2023).

![Figure 4: Doses administered across the AMC92](image-url)
Despite facing supply constraints during the early days of the vaccine roll-out and significant competing priorities, many of the 34 CCS have been able to catch up on vaccinations. Vaccine coverage has increased at a much faster rate in the 34 CCS than the global and AMC92 average, going from 3% in January 2022 to 27% by the end of March 2023: a 9-fold increase. Twenty-eight out of the 34 countries have coverage rates above 10%. In March 2023, Tanzania and Sierra Leone became the first CCS to surpass 50% coverage. A total of 14 countries now have coverage rates above 30%, with Afghanistan and Guinea being the latest countries to pass this threshold.
While tackling significant ongoing humanitarian challenges, several of the 34 CCS have managed to accelerate vaccine uptake despite competing priorities. Among the 14 countries with coverage rates of 30% or higher, six face significant ongoing humanitarian challenges: Afghanistan, CAR, Chad, Ethiopia, Nigeria, and Somalia.

Coverage among high-priority groups continues to increase but lags global and AMC92 figures. By the end of March 2023, 53% of healthcare workers and 48% of older adults have completed their primary series.

Similarly, booster uptake remains very low in the 34 CCS with only 4% of the population having received at least one booster dose. Only 7% of healthcare workers and 6% of older adults have received at least one booster dose.

However, some countries have made targeted efforts to move ahead with boosters: in Chad, 25% of the population has received at least one booster dose. The other two countries with booster coverage above 10% are Ghana (13%) and Côte d’Ivoire (12%).

<table>
<thead>
<tr>
<th>Country</th>
<th>Coverage in January 2022</th>
<th>Coverage in March 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanzania</td>
<td>53.8%</td>
<td>52.6%</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td></td>
<td>47.8%</td>
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<tr>
<td>Zambia</td>
<td></td>
<td>46.9%</td>
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<tr>
<td>CAR</td>
<td></td>
<td>46.1%</td>
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<tr>
<td>Côte d’Ivoire</td>
<td></td>
<td>41.1%</td>
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<tr>
<td>Somalia</td>
<td></td>
<td>37.3%</td>
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<tr>
<td>Chad</td>
<td></td>
<td>36.0%</td>
</tr>
<tr>
<td>Guinea</td>
<td></td>
<td>36.0%</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td></td>
<td>35.8%</td>
</tr>
<tr>
<td>Afghanistan</td>
<td></td>
<td>35.5%</td>
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<tr>
<td>Djibouti</td>
<td></td>
<td>35.4%</td>
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<tr>
<td>Nigeria</td>
<td></td>
<td>33.9%</td>
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<tr>
<td>Ghana</td>
<td></td>
<td>32.7%</td>
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<tr>
<td>Ethiopia</td>
<td></td>
<td>32.6%</td>
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<tr>
<td>Sudan</td>
<td></td>
<td>30.6%</td>
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<tr>
<td>Uganda</td>
<td></td>
<td>28.5%</td>
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<tr>
<td>South Sudan</td>
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<td>27.9%</td>
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<tr>
<td>Niger</td>
<td></td>
<td>22.5%</td>
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<tr>
<td>Gambia</td>
<td></td>
<td>22.3%</td>
</tr>
<tr>
<td>Kenya</td>
<td></td>
<td>20.4%</td>
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<tr>
<td>Burkina Faso</td>
<td></td>
<td>19.8%</td>
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<tr>
<td>Malawi</td>
<td></td>
<td>19.4%</td>
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<tr>
<td>Guinea-Bissau</td>
<td></td>
<td>18.5%</td>
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<tr>
<td>Mali</td>
<td></td>
<td>16.0%</td>
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<tr>
<td>Syria</td>
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<td>12.9%</td>
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<tr>
<td>DR Congo</td>
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<td>12.8%</td>
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<tr>
<td>Gabon</td>
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<td>11.6%</td>
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<tr>
<td>Cameroon</td>
<td></td>
<td>10.9%</td>
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<tr>
<td>Madagascar</td>
<td></td>
<td>8.8%</td>
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<tr>
<td>Senegal</td>
<td></td>
<td>8.6%</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td></td>
<td>3.6%</td>
</tr>
<tr>
<td>Yemen</td>
<td></td>
<td>2.6%</td>
</tr>
<tr>
<td>Haiti</td>
<td></td>
<td>2.1%</td>
</tr>
<tr>
<td>Burundi</td>
<td></td>
<td>0.3%</td>
</tr>
</tbody>
</table>
TABLE 1: Vaccination coverage ranges among the 34 Countries for Concerted Support (as of 31 March 2023)

<table>
<thead>
<tr>
<th>Vaccination Coverage Ranges</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥50% (n=2)</td>
<td>Sierra Leone, United Republic of Tanzania</td>
</tr>
<tr>
<td>30-49% (n=12)</td>
<td>Afghanistan, Central African Republic, Chad, Côte d’Ivoire, Djibouti, Ethiopia, Ghana, Guinea, Nigeria, Solomon Islands, Somalia, Zambia</td>
</tr>
<tr>
<td>10-29% (n=14)</td>
<td>Burkina Faso, Cameroon, Democratic Republic of the Congo, Gabon, The Gambia, Guinea-Bissau, Kenya, Malawi, Mali, Niger, South Sudan, Sudan, Syria, Uganda</td>
</tr>
<tr>
<td>&lt;10% (n=6)</td>
<td>Burundi, Haiti, Madagascar, Papua New Guinea, Senegal, Yemen</td>
</tr>
</tbody>
</table>
Update On The Work Of The COVID-19 Vaccine Delivery Partnership

Country engagement

CoVDP has continued to support countries through high-level and technical missions with one high-level follow-up mission to the Democratic Republic of the Congo and three technical support missions to Guinea-Bissau, Djibouti and Madagascar having taken place in February and March 2023. This brings the total number of high-level political and technical missions to 32 across 20 different countries since the start of the Partnership.

As the Partnership prepares the transition of its core functions back to partner agencies, an increased focus will be put on capturing the lessons learnt from the COVID-19 vaccine roll-out, how it has contributed to strengthening health systems and how this can inform the next phase of the vaccine roll-out, which will be focused on the integration of COVID-19 vaccines with primary health care, and the essential immunization recovery efforts. To this effect, CoVDP partners, the Ethiopian Ministry of Health and the Africa CDC are organizing a country stock-take on 2nd and 3rd of May 2023 in Addis Ababa.

For a retrospective look at what the COVID-19 Vaccine Delivery Partnership has achieved in terms of country engagement in the past 15 months, please see here.

Country Stocktake – Addis Ababa
02-03 May 2023

To review COVID-19 vaccination efforts to date and support needed for the next steps, CoVDP, together with the Federal Ministry of Health of Ethiopia, Africa CDC, Gavi, UNICEF and WHO are arranging a Stock-Take of COVID-19 Vaccine Delivery, to be held on 2 and 3 May in Addis-Ababa, Ethiopia.

The key objectives include:
2. Identify needs for continued support into the next phase of the response including support for integration of COVID-19 into RI/PHC.

Meeting outputs will include:
- A report on the best practices and lessons learnt in COVID-19 vaccine delivery in participating countries
- Timebound recommendations for WHO/UNICEF/Gavi and other key immunization stakeholders to support for integration of COVID-19 into RI/PHC
- Broad consensus on the pathway for integration for COVID-19 activities in PHC and essential immunization
CoVDP conducted its fourth mission to the Democratic Republic of the Congo (DRC) in February/March 2023. This high-level mission enabled government and partners to take stock of the different efforts and support activities undertaken in the past few months to increase the vaccination coverage which stood at 12% by the end of March 2023 – compared to 0.1% in January 2022.

Together with Africa CDC, UNICEF and WHO, the mission took stock of what strategies, approaches and actions have been successful at increasing coverage and which have not (and why). The mission also discussed the government’s immediate plans to continue to increase coverage and explored what support would be needed for the next phases of vaccine delivery, in particular the integration of COVID-19 vaccination with routine health services. The mission included a significant technical component focused on identifying and addressing gaps in the country’s data & monitoring systems for COVID-19 vaccination, and developing a way forward on persistent data backlogs affecting coverage figures.

The mission noted the following about the current status of vaccine delivery:

- Sufficient resources are available to implement the next vaccination campaigns and the integration roadmap;
- The country has national plans in place for accelerating COVID-19 vaccination coverage and a roadmap for integrating COVID-19 vaccination, successful partnerships with non-traditional EPI partners including religious institutions, strengthened community engagement structures and social listening capacity, identified ‘humanitarian’ provinces and developed tailored strategies in collaboration with humanitarian partners to reach populations of concern and track their vaccination coverage;
- COVID-19 vaccination data management, analysis, and use face considerable challenges. Persistent backlogs of vaccination records in ‘routine’ aggregate data systems result in misleading recorded coverage levels. These challenges have prevented the full deployment of the individualized, electronic COVID-19 vaccination registry;
- The expansion of access to digital tools for data entry and analysis – providing an opportunity to strengthen data and monitoring systems more broadly – needs to be repurposed from their original intended use as an individualized, electronic vaccination registry given the above-described data challenges.

To further support the government of the DRC in the next steps of vaccine delivery, the mission recommended the following:

- Clarifying the role of the national institute of public health (INSP) and the General Secretariat of the Ministry of Health in the vaccine roll-out and its planned integration with PHC;
- Developing and implementing a booster policy;
- Mobilizing the Ministry of Interior in order to strengthen the role, visibility and ownership of vaccine delivery among the governors of the regions;
• Improving the coordination with humanitarian partners in the eight humanitarian regions to ensure that vaccines are available in the last mile and for populations of concern;
• Continuing coordination and alignment among partners to ensure that available funds are used in the most effective way and any obstacles to disbursements are dealt with promptly;
• Implementing two additional campaigns focused on the regions where coverage among high-priority groups is the lowest;
• Prioritizing clearing the existing backlog of data in the routine aggregate data system to enable more accurate estimation of real coverage levels in the country;
• Evaluating real risks against the possible benefits of establishing an electronic immunization registry both for COVID-19 and routine immunization, making use of available tools from WHO and partners to assess the state of foundational requirements necessary for the implementation of such systems.

The stocktake conducted during this mission was an important step in understanding and being accountable for the support that has been provided to DRC by partners over the past 15 months. A total of more than US$8.5 million was facilitated during that time, including US$3.5 million to fund campaigns in the 11 provinces with the lowest vaccination rate and US$5 million channeled through IOM for vaccination of IDPs, refugees and other populations of concern.

**Guinea-Bissau**

10-17 March 2023

A technical mission led by CoVDP jointly with WHO AFRO and the UNICEF regional office for West and Central Africa (WCARO) was organized to support preparations for an integrated C-19 and routine vaccination campaign in Guinea-Bissau and to review the level of implementation of recommendations that were made following the high-level CoVDP mission in July 2022 which resulted in US$1.9 million of funding being made available to the country for its vaccination campaign in February 2023.

Working sessions were organized with WHO and UNICEF country offices and the EPI team of the Ministry of Health. Together with the country team, support was provided to expedite the disbursement of funds required to speed up preparatory activities and strengthen the commitment of religious, traditional, and community organizations towards the integrated campaign. The mission also took part in the launch ceremony of the integrated C-19 and routine vaccination campaign on March 15th, 2023, combining this with a visit of a vaccination site in the Bissau Autonomous Sector.

Based on the discussions, observations and insights collected during the mission, it was recommended that a risk communication and community engagement (RCCE) plan be developed to strengthen the inclusion of community leaders towards C-19 and routine vaccination and to implement this plan to support the ongoing campaign. Key recommendations made during the last high-level CoVDP mission - including the designation of NITAG members as a governance tool for immunization and the payment of risk subsidies of HCW to improve operational support during campaigns - were in their final phases of implementation. A high-level online meeting is scheduled by the end of April to review gains made and to identify areas for additional support.
Madagascar
14 March – 4 April 2023

CoVDP conducted a technical follow-up mission to Madagascar six months after the high-level advocacy mission in September 2022 in order to follow-up on action points stemming from the mission and evaluate changes in the vaccination context. The mission included meetings with One Country Team partners – EPI, WHO, UNICEF, USAID, World Bank – on capital level and field visits to integrated COVID and routine catch-up activities on community level in Sava, Diana, and Vakinankaratra regions.

While reported vaccination coverage in Madagascar remains under 10%, recommendations made during the September 2022 mission have contributed to a positive trend in vaccination coverage on a community level:

- CoVDP and partners visited Toamasina in 2022 where the mission met with the governor of Atsinanana region to propose a social contract with him to champion COVID-19 vaccination. Since then, vaccination coverage has jumped in the region and it now reports the highest vaccination coverage in the country with nearly 30% of the target population having received a full primary series. Partners plan to replicate the social contract with governors in other regions;
- Successful partnership with the Ministry of Tourism to ensure people working in the tourism sector have access to COVID-19 vaccination, helping to increase tourists’ confidence in returning to Madagascar and boosting the economy;
- In December 2022 and January 2023, the country conducted an integrated COVID-19 vaccination campaign in 72 districts where more people were vaccinated in just one week than in all of the previous 100-day campaign;
- WHO AFRO consultants deployed to Madagascar have supported the development of integrated microplans for COVID-19 and routine vaccinations;
- Coordination between the EPI and partners has strengthened, with coordination meetings being conducted more regularly;
- Prioritizing outreach activities including door-to-door vaccination for populations living 3-5 km or more than 5 km from the nearest primary care facility is positively impacting vaccination coverage at the district level.

The mission additionally noted several remaining challenges:

- Despite advocacy efforts from partners, COVID-19 vaccinations have not been prioritized in the national agenda, resulting in limited political support for vaccine delivery activities;
- Disbursement of funding from the unité de coordination des projets (UCP) to allow for the implementation of vaccination activities continues to be inefficient (e.g. disbursement of funding for vaccination cards was blocked leading to stockouts in the field);
- Guidance and protocols on high priority groups are not sufficiently disseminated from central and regional level to district level and there is no operational strategy to reach priority populations;
- Some primary care facilities expressed confusion about the target population and there was a need to strengthen knowledge, understanding and application of the latest SAGE guidance on identifying/targeting high priority groups at the district level;
- Despite steer from Ministry of Health to integrate COVID vaccination since 2022, the country does not yet have a roadmap, plan, or technical guidance for implementing integration.
Madagascar is currently planning for a national push on polio with inter-campaign acceleration of routine catchup, reaching zero dose children and COVID-19. Partners in-country are working on mapping the funding available for integrated COVID-routine catchup activities and will share any gaps/needs for rapid impact funding with CoVDP as soon as possible. CoVDP will additionally provide technical assistance on addressing the data backlog and will work together with Gavi colleagues to identify action points for ensuring disbursement is smoother for CDS3.

### Political engagement and advocacy

CoVDP has used several public platforms to continue political advocacy around vaccine delivery and the strengthening of community health, with a focus on ensuring that the learnings from the COVID-19 vaccine roll-out inform not only the next phases of vaccine delivery, but also future platforms for the delivery of different types of medical countermeasures.

- **The G7, under the presidency of Japan**, is laying the ground for a medical countermeasures partnership for delivery to be part of any future medical countermeasures platform and pandemic response architecture. Lessons learnt from CoVDP have fed into the initial consultations on this, reflecting several of its core principles, including putting countries at the center, collaboration and complementarity between partners, inclusion of LICs and LMICs, consideration of the specific needs of countries facing humanitarian emergencies, and building on and strengthening the primary care systems.

- **During the Community Health Worker Symposium** in Liberia, CoVDP advocated for paid, trained, motivated, protected and adequately supplied community health workers (CHWs) as a key component of pandemic preparedness and response, building on country case studies that showed CHW's critical role in vaccine delivery. CoVDP emphasized in particular the critical gap that CHWs fill in countries affected by disasters and conflict where they often constitute the main link with the formal health system. A formal call for action laying out the main steps governments and partners are expected to take to advance community health worker programs globally was launched at the end of the symposium.
Technical assistance

Two events were organized or co-convened by CoVDP between February and March, each with an emphasis on consolidating the technical knowledge and learnings from the COVID-19 vaccine roll-out for different aspects of vaccine delivery, specifically: vaccine delivery in humanitarian settings, and vaccine data and monitoring systems. Each brought together international and regional experts in their field as well as country-level representatives that highlighted the specific challenges faced at the country-level and actions or strategies deployed to address these.

Joint Convening on COVID-19 Vaccinations in Humanitarian Settings and the Contribution to Broader Pandemic Preparedness
14-15 February 2023

COVID-19 vaccine delivery in contexts of humanitarian crises has posed a particular challenge due to the legal, operational and logistical barriers involved in getting vaccines to areas affected by conflict, political instability or disaster. As a result, countries with ongoing humanitarian emergencies represented about half of all countries that were at or below 10% vaccination coverage in January 2022.

In order to take stock of the efforts deployed to date to immunize populations of concern against COVID-19 in humanitarian contexts, identify key obstacles and promising long-term solutions to vaccine delivery in humanitarian settings, CoVDP hosted a joint convening in Nairobi on 14th and 15th February.

The event brought together key stakeholders from government, public health and the humanitarian sectors and was structured around three technical working groups, tasked to collect, analyze and discuss evidence addressing the main pain points in vaccine delivery in humanitarian settings, namely: (i) how to leverage the humanitarian architecture and humanitarian actors in pandemic response; (ii) upstream supply, regulatory and legal considerations impacting implementation in humanitarian settings; and (iii) health systems strengthening and pandemic preparedness and response in humanitarian settings.

From this event and the work of the technical working groups, several key recommendations were formulated:

1. Response plans that detail strategy to reach populations of concern and outline steps to link up humanitarian and public health actors from the onset of public health emergencies.
2. Dedicated community outreach in humanitarian settings, focused on the delivery of a bundle of humanitarian and public health interventions to build and maintain trust in public health measures.
3. Design and establish national, regional and/or international no-fault compensation scheme(s) for or inclusive of humanitarian populations of concern.
4. Support Human Resources for Health and capacity strengthening in humanitarian settings (e.g. through incentives, better working conditions).

A report with a full set of recommendations will be published in May 2023.
Global Convening on COVID-19 Vaccination Monitoring and Related System Strengthening  
13-15 March 2023

The COVID-19 vaccine rollout has required unprecedented levels of in-depth and near real-time implementation data to support programmatic decision-making. Governments, international agencies, and other partners have made every effort to make sure these needs have been met. As the pandemic and vaccine rollout have evolved, however, data needs have shifted. Now, as countries move to routinize COVID-19 vaccines and as many end states of emergency for COVID-19, monitoring activities will need to merge with existing practices, while exploring opportunities to enhance of such practices where feasible, while adjusting the breadth, depth, and frequency of monitoring.

Given this changing landscape and the need for alignment on the way forward, WHO with Gavi, UNICEF, and the CoVDP, organized a three-day global technical workshop from 13-15 March in Geneva to a) take stock of recent developments, b) align on the way forward on both COVID-19 vaccination monitoring and related system strengthening, and c) plan phase-over to and enhancement of existing processes. The event reassembled technical experts on vaccine monitoring from the global, regional, and national, regional and global levels, including partner agencies and select countries.

The meeting was a pivotal moment in the COVID-19 vaccination monitoring and systems strengthening space, as an important opportunity to bring together different stakeholders and experts to conduct a comprehensive stock take and jointly plan a way forward. Coming out of the meeting, the participants made a series of recommendations for country-, regional-, and global-level actors to establish and advance key monitoring and systems strengthening priorities on the way to COVID-19 vaccine integration. The participants agreed to action the recommendations made by establishing several task-specific, time-limited working groups working on a time-horizon of end of Q3 2023.

Highlighted recommendations coming out of the convening include:

1. Begin transition to an “influenza-like” model of monitoring uptake of COVID-19 vaccines, both at country and regional/global levels.
2. Proceed with a more modest reporting frequency for uptake & other indicators at global level, transitioning from weekly & monthly to quarterly.
3. Continue to use uptake in certain priority groups as proxy measures for capacity to target priority groups generally.
4. There is not an urgent need to accelerate transition to electronic immunization registries (EIRs) for COVID-19 vaccination to satisfy monitoring requirements, recognizing however that they have other benefits.
5. Develop guidance and tools to support Member States exploring the feasibility of transitioning from an aggregate monitoring system to an electronic one.

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7 The below summary is the Executive Summary of the event’s Meeting Report which will be published shortly on the WHO website.
Funding

By the end of March 2023, CoVDP had facilitated the disbursement of **US$178 million** across 20 countries and contributing to 32 vaccination campaigns targeting a total of more than 160 million people. In February and March, an additional **US$9.8 million** was released, including:

- **US$6.1 million for Sudan** to launch a mass vaccination campaign before Ramadan which has reached more than 7 million people and pushed the vaccination rate to 31%;
- **US$2.3 million for Ethiopia** for an integrated campaign with measles and vitamin A distribution in Tigray;
- **US$1.4 million for Sierra Leone** for an additional campaign targeting 1 million people.

IN-DEPTH:
The role of community health workers in vaccine delivery

Community health workers (CHWs) are an essential component of a country’s health workforce, providing essential curative, consultative and preventive health services outside of formal health facilities. Given the large number of CHWs in many low- and lower-middle income countries, CHWs have the potential to significantly increase the pool of available health personnel in a country and could be mobilized at scale for pandemic prevention, preparedness, and response activities.

During the COVID-19 pandemic response, the role of CHWs has generally centred on three main activities:

- **RCCE:** CHWs inform and educate the community about the benefits of vaccines, esp. among high-priority groups that are at a greater risk of severe illness, hospitalization and death. They mobilize the local populations in favour of vaccination, encouraging them to get vaccinated and directing them to the nearest vaccination site.

- **Identification and referral of high-priority groups:** CHWs play a role in identifying high-priority groups, for instance through door-to-door outreach strategies. They refer and in some cases transport people to the nearest vaccination site. They have also helped identify “second dosers” that might have missed their appointments, and in some cases identified zero dose children during their outreach activities.

- **Administration of vaccines:** in some countries, CHWs were trained to directly administer vaccines, including in Ethiopia, Ghana, Kenya, Malawi, Mali, Nigeria, Pakistan, Papua New Guinea, and Zambia (among others).
The experience showed that there is a significant potential in training-up and deploying CHWs to administer vaccines during routine and emergency times. Despite the challenges CHWs are facing in vaccine administration, including difficult or inadequate access to supplies, inadequate cold chain equipment, lack of transportation, a heavy workload, irregular payment, and insufficient supervision, the experience of deploying CHWs for vaccine administration demonstrates a huge potential for addressing the recent decline in routine immunization. Country examples cited in Gibson et al. demonstrate the feasibility of task-shifting the administration of vaccines to CHWs as many CHWs with limited clinical training and experience can be trained to administer COVID-19 vaccines. CHWs could therefore be deployed en masse to reach under-immunized and zero-dose children since they have the added advantage of being, in many cases, embedded in the community, and thereby potentially able to reach pockets of populations that are consistently missed in routine immunization (eg. hard-to-reach rural areas, conflict-affected areas, informal urban settings).

The expansion, professionalization and integration of the community health workforce into the formal health system is a pre-requisite for stronger pandemic preparedness and response capacities. During the COVID-19 response, CHWs fulfilled a number of critical response functions while at the same time ensuring the continuation of basic health services at a time when populations were unable or unwilling to seek services in formal health facilities. In some countries, such as Liberia and Guinea, CHWs already play a critical preparedness function by conducting syndromic surveillance and thus contributing to the early detection of diseases with epidemic potential. Given the scale of many national CHW programs but also the increased risk of disease outbreaks, it is therefore essential that CHW programs be scaled-up and professionalized, including through the offer of formal training on the prevention, preparedness and response to outbreaks, payment of salaries, development career pathways, provision of adequate protective equipment, and investment in reliable supplies, transportation and supervision.

**FIGURE 7**
Countries with community health workers administering vaccines

- 34 countries for concerted support
- AMC 92
- Other

- **34 countries for concerted support**
  - Afghanistan, Ethiopia, DRC, Ghana, Kenya, Malawi, Mali, Niger, Nigeria, Papua New Guinea, Zambia

- **AMC 92**
  - Bangladesh, India, Indonesia, Nepal, Pakistan

- **Other**
  - Brazil, China, Iran, United States
Country snapshots

Pakistan

Lady Health Workers (LHWs) played a critical role in the response to COVID-19 in Pakistan, particularly in rural and marginalized communities. These workers are typically from the local communities and have a deep understanding of the social and cultural dynamics of the areas they serve. LHWs are trained female community health workers who provide basic health services and health education to families in their homes.

In the context of COVID-19, LHWs in Pakistan were trained in large numbers (around 46,000 LHWs) to provide home-based care and have been involved in several key activities in response to the virus. Firstly, they have been providing information and education about the virus to families in their communities. This includes educating people on the importance of hand hygiene, wearing masks, and social distancing. Secondly, LHWs have been involved in contact tracing efforts. They worked with health authorities to identify individuals who have come into contact with COVID-19 positive patients and follow up with them to ensure they are tested and monitored for symptoms. Finally, LHWs have been involved in the distribution of PPE to frontline health workers and vulnerable communities. They have also been working with local authorities to set up isolation and quarantine centers.

Beyond the immediate response to the outbreak, LHWs have also been involved in the mass campaign of COVID-19 vaccination in Pakistan. They have been involved in several aspects of the vaccination campaign, including registering people for the vaccine, providing information about the vaccine’s safety and effectiveness, and ensuring that people receive their second dose. They have also been working closely with health authorities to ensure that vaccine doses are available in their communities and that vaccination sites are accessible to everyone, particularly those living in remote and underserved areas.

Despite the critical role they play, LHWs in Pakistan have faced several challenges during the pandemic, including limited resources, inadequate training, and perhaps a lack of recognition and support. However, their tireless efforts have undoubtedly helped to mitigate the impact of COVID-19 on local communities and their involvement has been crucial in reaching underserved and marginalized communities and ensuring that everyone has access to the vaccine.

Liberia

Liberia represents a remarkable example of how CHWs can support the provision of basic health care while playing a central role in the prevention, preparedness and response to public health emergencies in low-resource settings. The origins of the CHW program date back to 2008 when the country first launched its National Policy and Strategy on Community Health. At the time, the country only had 51 doctors serving a population of 3.7 million people, including 1 million people that lived further than 5 kilometers from the nearest health facility. 8

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8 World Bank Open Data; Last Mile Health/ Exemplars in Global Health, Community Health Workers in Liberia, 2019.
Liberia gradually increased the corps of CHWs, transitioning from small-scale pilot programs to a nationwide community health assistant program after Ebola. Initially, the country relied primarily on volunteers divided into five different cadres each with their own training, incentives, package of services and skills. A majority of these cadres were funded and supervised by NGOs and other donors, but a lack of planning and coordination resulted in the absence of a coherent and standardized package of services, a duplication of services, inconsistency in the delivery and quality of services, low retention, and other challenges. The weaknesses of the system were exposed during the West African Ebola outbreak, from 2014-2016, during which the country lost 8% of its health workforce to the disease.

Recognizing that the devastation caused by the Ebola outbreak was due to the absence of paid and trained health care workers, the country has taken bold steps to improve its community health systems. Liberia’s community health worker program is composed of more than 4,300 community health assistants (CHAs) and 469 supervisors and was developed after the end of the Ebola crisis. Each CHA covers between 40 and 60 households and each household receives at least one monthly visit. The program includes a standardized integrated package of services (including events-based surveillance of infectious diseases) and incorporates uniform standards for recruitment, training, remuneration, supervision, and M&E. Strong political will and leadership at the highest level of government have been central to the development and expansion of the program. New systems set in place to identify funding needs down to the county level while simultaneously mapping available funding from partners has resulted in a more efficient system of resource and funding allocation to implement the national CHA program. Critical support systems were set up to enable more data-driven decision making, including systems to track routine service delivery and disease monitoring, community- and health facility level surveys to assess performance issues, and evaluations and ad hoc research.

As a result of these improvements, the country was able to leverage its community health workforce in the response to COVID-19 which has contributed to the country reaching one of the highest levels of vaccination coverage on the continent. At the end of March, Liberia had reached 74% primary series coverage. During the COVID-19 pandemic, CHAs made sure that people continued to have access to basic health services while playing a critical role in informing, education and mobilizing local communities about the virus and the vaccine. All CHAs were equipped with a Community Based Health Surveillance Handbook specific to COVID-19 with clear instructions and decision trees designed to guide CHAs in detecting suspect cases, referring any suspect cases to health facilities, conducting contact tracing, and monitoring those in home-based isolation or care.

A key contributing factor to the effectiveness of CHAs during the COVID-19 and more broadly in health service provision, is the integration of CHAs with the formal health sector. Referrals are made to the health facility and vice versa, supervisors are based at the nearest health facility, CHAs receive supplies through the same supply chain as formal health facilities, and can collect and share data via the community health information system which is integrated into the government health management information system.

9 Last Mile Health/ Exemplars in Global Health, Community Health Workers in Liberia, 2019.
RESOURCES

- COVID-19 Vaccine Delivery Partnership web page
- Vaccine Delivery Partnership FAQ
- COVID-19 vaccine delivery stories
- COVID-19 vaccine delivery toolkit
- Strategic Advisory Group of Experts on Immunization (SAGE) updated COVID-19 vaccination guidance
- Global COVID-19 Vaccination Strategy in a Changing World: July 2022 update
- Updated WHO SAGE Roadmap for prioritizing uses of COVID-19 vaccines
- COVID-19 Vaccine Delivery Partnership Information Hub
- COVID-19 Vaccine Implementation Analysis & Insights Report archives
- Considerations for choosing COVID-19 vaccine products Eng | French
- Microplanning guide
- Considerations to inform country COVID-19 vaccine decision-making
- Good practice statement on the use of variant-containing vaccines
- Management and safe disposal of COVID-19 vaccination waste at health facility level
- WHO/UNICEF guidance document on programmatic considerations for C-19 integration into PHC

For all countries, various tools and guidance and vaccine confidence and uptake are available here, including:
- Demand planning guide
- Planning and budgeting template (Excel)
- Behavioural and social drivers: tools and guidance to assess and address low uptake
- Conducting community engagement guide
- Misinformation management guide
- Vaccine safety surveillance manual, communications chapter
- Health worker conversation guide
- Communicating on Covid 19 Vaccines in a Changing Environment
- Explainers
- Integrating gender into immunization demand
- Gender and immunization demand checklist

For all countries monitoring tools and guidance available here including:
- Monitoring COVID-19 vaccination: Considerations for the collection and use of vaccination data

Global compendium of country knowledge on COVID-19 vaccination
- Ethiopia Case Study – Digital health English | French
- India Case Study – Digital solutions English | French
- Nepal Case Study - Waste management English | French
- Pakistan Case Study – Vaccination of refugees English | French
- Rwanda Case Study – Digital solutions English | French
- Zambia Case Study – Demand generation English | French
- Other case studies
Sabin Vaccine Institute in collaboration with UNICEF and GAVI will be hosting the second Vaccination Acceptance Research Network (VARN) Annual Conference.

The conference focus on three main themes:

1. **Vaccine equity:** setting a new course for reaching marginalized and zero-dose communities, conflict-settings, and reducing gender barriers

2. **Reimagining essential childhood immunization:** a reversal of current trends and improved integration into comprehensive health service delivery programs (from policy to community-level responses)

3. **Life-course immunization:** extending the opportunities of COVID-19 vaccination investments to integrate, expand and strengthen LCI (HPV vaccination, future pandemic preparedness, and healthy aging).

The conference will place special emphasis on vaccine demand generation and social listening/misinformation as cutting across with a special focus on COVID-19 Vaccine Delivery Partnership priority countries. The conference has drawn participation from multi-sectoral and multidisciplinary stakeholders across the vaccine acceptance, demand, delivery, and decision-making ecosystem.

Registration for the conference is open until 12 May 2023. Please see this link for more information.
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