Reaching People in Fragile and Conflict-Affected Settings with Immunization Services

By Katherine E. Bliss and Mackenzie Burke

THE ISSUE
Conflict, political instability, natural disasters, and humanitarian crises can disrupt the provision of primary healthcare, including immunizations, limiting vulnerable populations’ access to essential services and increasing the likelihood of disease outbreaks.

During the Covid-19 pandemic, when access to routine healthcare has become more difficult due to quarantines, economic instability, and the diversion of resources to outbreak response, people living in fragile and conflict-affected settings have faced acute challenges in accessing preventive care, such as immunizations. The circulation of misinformation and disinformation about Covid-19 vaccines has also undermined confidence in immunizations overall, contributing to decreased vaccine coverage and increased outbreaks of measles, polio, and other infectious diseases.

Engaging vulnerable communities—including refugees, migrants, and displaced people—in the design of immunization programs; ensuring that health services for people living in fragile and conflict-affected settings are tailored to be culturally, linguistically, and socially relevant; and allowing for innovations and flexibilities in the financing and delivery of services within fragile and humanitarian contexts are all steps that can improve trust in disease-prevention measures, reach global goals regarding access to immunizations, and protect health security.

INTRODUCTION
The 2022 World Health Organization (WHO)/UNICEF estimates of national immunization coverage (WUENIC) revealed that in 2021, 5 of the 10 countries with the lowest coverage for the three recommended doses of the diphtheria, tetanus, and pertussis vaccine (DTP3), which are typically given during a child’s first year of life, are also among the top 10 countries on the Fragile States Index—a database that highlights the many social, economic, and political factors that make states particularly vulnerable to crises, violence, and natural disasters. Myanmar, Central African Republic, Somalia, Syria, and South Sudan saw their DTP3 coverage decrease or languish at a low level between 2019 and 2021. While it is true that many countries around the world documented decreased DTP3 coverage during the first two years of the pandemic, in none of these five countries is more than 50 percent of the population fully protected from the three infections. These same countries also have Covid-19 vaccination coverage rates well below the global average, with South Sudan reporting that only 20 percent of adults have completed the full set of doses and Syria reporting that just 10 percent of the population is considered fully
immunized. These data points regarding recommended vaccine coverage suggest that significant numbers of children and adults living in fragile settings are missing out on critical services to protect their health, and that of their communities.

Ensuring universal access to recommended vaccines has been considered a critical driver of sustainable development, child health, and health security since the WHO launched the Expanded Program on Immunization in 1974. Although technical support from the WHO and UNICEF, along with other multilateral and bilateral agencies, certainly helped national governments increase the proportion of children reached with vaccines, by 1990 there were still many millions of children in low- and middle-income countries who were not benefitting from access to immunizations. Experts concluded that in addition to the technical challenges governments faced in building high-performing immunization programs, financial obstacles were also at play, with health ministries in low-income countries struggling to secure sufficient funding for vaccines. This led to significant delays in populations’ access to new products and deepened their vulnerabilities to infectious disease outbreaks. In 2000 at the World Economic Forum meeting in Davos, Switzerland, a coalition of donor governments, international organizations, foundations, and pharmaceutical industry representatives launched Gavi, the Vaccine Alliance, to enable governments in the lowest-income countries to purchase vaccines at a deep discount.

Yet even with reduced prices and intensified global support for strengthening health and immunization systems, in the early 2000s, many populations worldwide were still missing some or all of the recommended vaccine doses. People living in conflict zones or other fragile settings were at particular risk. Over the next decade, Gavi, the WHO Strategic Advisory Group of Experts, and the Global Compact on Refugees all emphasized the importance of ensuring that migrants, refugees, displaced people, and those living in humanitarian crises can access health services. Immunization Agenda 2030, which was developed over several years of consultations and endorsed by UN member countries in 2020, highlights the importance of reaching “the most marginalized communities, those living in fragile and conflict-affected settings, and mobile populations, especially those moving across borders.” Despite increased understanding of how important it is to global health security to ensure that migrants, refugees, displaced people, and people living in conflict-affected settings can benefit from enhanced access to vaccines, the approaches national governments have adopted to make immunizations available to vulnerable populations vary considerably. Some governments provide specific guidance on ensuring access to vaccines for refugee and migrant populations, for example, while others finance or co-finance purchases only for specific groups, such as children of migrants or refugees living in specified camps.

Even so, gaps in the public provision of comprehensive health services for migrants, refugees, and displaced people explain only a small part of the challenge to ensure vaccine access in situations of fragility. Beyond the reality that some missed populations may live in remote or hard-to-reach areas, the factors limiting the delivery of healthcare to displaced people, mobile groups, and those experiencing conflict and crisis include a complex set of economic, political, and cultural barriers. Economic sanctions imposed by governments on regimes they consider to be illegitimate or in violation of international laws can limit the flow of needed humanitarian supplies. Conflict and insecurity can make it difficult for international organizations and nongovernmental organizations (NGOs) to protect personnel and support the delivery of healthcare services. At the same time, governments that fail to deliver health services to all within their borders may also seek to prevent external NGOs from offering care to local populations, and armed non-state actors may also attempt to prevent the delivery of humanitarian assistance to the population in areas under their control. Finally, negative experiences with public officials or fear of deportation may cause refugees, migrants, and other vulnerable populations in fragile settings to mistrust public services, leading them to avoid or reject services even when they are offered.

Three years into the Covid-19 pandemic, with consecutive years of declines in immunization coverage, as well as new outbreaks of measles and other vaccine-
preventable diseases, getting back on track toward reaching global immunization goals and protecting health security requires greater attention to the populations living in the most challenging settings. Allowing for flexibility with respect to the financing and guidelines for delivery of healthcare in fragile or conflict situations; engaging communities themselves in the design of health programs in fragile and conflict settings; and ensuring that the health services provided are culturally, linguistically, and socially relevant to the recipient communities are all steps that can improve access to disease-preventing measures, reach global goals regarding immunizations, and strengthen trust and protect health security in the long term.

**THE PRE-COVID-19 POLICY LANDSCAPE**

For the past 40 years, ensuring all people, including marginalized populations, are protected against outbreaks of vaccine-preventable disease has been an important aspect of global immunization programs and a key element of global health security approaches. The institutions involved in developing guidance for, setting policy on, and delivering vaccines in fragile or humanitarian contexts include national immunization programs, multilateral agencies, and NGOs. When supporting national governments in making sure all people within their borders can access preventive services such as immunizations, the WHO and UNICEF, along with Gavi, donor agencies, and NGOs all draw on experience gained over several decades of work delivering vaccines in fragile settings.

Following the launch of the Expanded Program on Immunization in the mid-1970s, civil wars and internal conflicts in several regions fueled concerns among health authorities that children living in disputed zones or areas controlled by non-state armed groups might be missing out on critical health services, including routine immunizations. For example, the violence that characterized the conflict between government and revolutionary forces in El Salvador following the 1980 assassination of Archbishop Óscar Romero prevented health officers from delivering routine services in many affected regions. In response, UNICEF, in collaboration with the Pan American Health Organization (PAHO),

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### Figure 1: Policies Promoting Immunizations in Fragile and Conflict-Affected Settings

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>The UNICEF Core Commitments for Children in Humanitarian Action 2.0 outlines a framework for upholding the rights of children in crises; one of the strategic goals focuses on health and immunizations.</td>
</tr>
<tr>
<td>2013</td>
<td>The Gavi Alliance Fragility and Immunizations policy outlines options for supporting eligible countries experiencing chronic fragility or acute emergencies with tailored interventions to reach zero-dose children.</td>
</tr>
<tr>
<td>2017</td>
<td>The Gavi Alliance Fragility, Emergencies, and Refugees policy version 2.0 recognizes the challenges refugees and people in emergency contexts face in securing access to vaccines and outlines flexibilities for Gavi-supported countries that host refugees.</td>
</tr>
<tr>
<td>2018</td>
<td>The Gavi Alliance Fragility, Emergencies, and Displaced Populations policy version 3.0 emphasizes transparency of selection criteria, improving the processes for prioritizing countries facing fragility, and flexibility in adapting Gavi’s policies and practices.</td>
</tr>
<tr>
<td>2020</td>
<td>Gavi announces the COVAX Advance Market Commitment (AMC), an innovative financing mechanism to enable 92 low- and middle-income economies to procure Covid-19 vaccines regardless of their ability to pay.</td>
</tr>
<tr>
<td>2021</td>
<td>The COVAX Humanitarian Buffer is established as a “last resort” measure for ensuring delivery of Covid-19 vaccines to high-risk and vulnerable populations in humanitarian settings with a reserve of 5 percent of COVAX-available doses.</td>
</tr>
<tr>
<td>2022</td>
<td>Gavi partners with the International Rescue Committee and World Vision to launch the Zero-Dose Immunization Program (ZIP) to reach zero-dose children living in fragile and conflict-affected settings.</td>
</tr>
</tbody>
</table>

**Source:** Authors’ own analysis based on multiple sources. Please reference the endnote section for complete citations.

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the regional arm of the WHO, the Catholic Church, and the International Committee of the Red Cross, negotiated one-day cease-fires between the Farabundo Martí National Liberation Front and the state security forces in order to deliver immunizations to children living in the conflict zones. These cease-fires became known as “Days of Tranquility” and enabled vaccinators
to enter areas otherwise embroiled in fighting to reach vulnerable populations with immunizations against polio, measles, diphtheria, tetanus, and whooping cough. Between 1985 and 1991, as the conflict wore on, more than 200,000 Salvadoran children who had missed vaccines because of the conflict were successfully immunized, contributing to the elimination of polio from the Americas and to decreased numbers of measles and diphtheria cases throughout the region.

Building on the successes of the Days of Tranquility framework in Central America, in the 1990s, the WHO adopted the model for promoting the distribution of vaccines in other conflict zones, such as Afghanistan, Lebanon, the Philippines, Tajikistan, and Sudan. In Lebanon, for example, an immunization campaign during several four-day cease-fires in the fall of 1987 was credited with helping to avert a measles outbreak.

UN-brokered cease-fires in Afghanistan in 1999 enabled UNICEF, the WHO, the Ministry of Health, and volunteers to reach 4 million children with polio vaccines. In Sudan, which faced a polio outbreak in 2005, cease-fires over several months, including in areas controlled by the Sudan People’s Liberation Movement, enabled vaccinators to reach more than 5 million children with polio vaccines and limit further transmission of the virus in the region.

Although negotiated Days of Tranquility proved to be an important innovation in ensuring vaccine delivery to communities in active war zones or those affected by civil conflict, by the early 2000s, it also became clear that other populations—including refugees, displaced people, and mobile populations—were not always being served during the cease-fires and were still missing vaccines. In 2013, Gavi’s Fragility and Immunization policy outlined conditions for providing “vaccines to governments for refugees and internally displaced populations in Gavi-supported countries,” which included low-income countries with an annual gross national income per capita below the Gavi eligibility threshold. A 2017 revision of the approach, which was renamed the Fragility, Emergencies, and Refugees policy offered guidance on engaging with non-state actors to ensure delivery of vaccines in conflict-affected settings, as well.

Assessing the impacts of conflict on children over the last two decades has also pointed to other factors that impede immunization delivery in fragile settings. In 1996, the Graça Machel report on children in conflict found that “Sanctions on regimes in a number of countries were having devastating effects on child mortality and the maintenance of basic services.”

A follow-up assessment released in 2009 found that some progress had been made and noted that “Sanction measures by the Security Council are more targeted, and the humanitarian impact is assessed.” An important trend with respect to the imposition of sanctions by the United Nations and governments was the allowance of exemptions that may permit the flow of medical supplies, even if the movement of other goods is prohibited. But however well-intended exemptions may be, imposed sanctions may nevertheless inhibit peoples’ access to care by restricting activities related to transportation, energy supply, or water infrastructure, all of which may be critical for the delivery of health services.

On the eve of the Covid-19 pandemic, data showed that gains in immunization coverage in the fragile states eligible for Gavi support had plateaued since 2012. Indeed, there was a trend of increasing numbers of measles cases, with a global outbreak in 2019 killing more than 200,000 people. The same year, the WHO named both fragile and vulnerable settings, as well as vaccine hesitancy, to be among the top 10 threats to global health, making it clear that tailored approaches addressing the unique social, cultural, and political aspects of healthcare in fragile settings will be required.

**DELIVERING VACCINES IN THE COVID-19 CONTEXT**

As news of the novel coronavirus began to circulate in 2020, stagnating global coverage of DTP3 and other routine immunizations was already a concern to public health officials. When the WHO declared the SARS-CoV-2 outbreak a pandemic, countries began to impose travel restrictions and quarantine measures, leading to considerable concern over the potential of these nonpharmaceutical interventions to interrupt immunization campaigns and routine immunization services. Optimistic projections that service delivery
would recover lost ground proved to be unfounded, however, and by the release of the WUENIC data in July 2021, it was clear that the percentage of children who had received all recommended doses of the DTP3 vaccine in 2020 had dropped from 86 percent to 83 percent. A considerable proportion of the children missing all immunizations were found to be living in fragile settings.30

Research to develop vaccines for preventing coronavirus infection started in early 2020, and by May of that year, the European Union, along with international organizations, launched the Access to Covid-19 Tools Accelerator (ACT-A) to promote equitable access to diagnostics, treatments, and vaccines globally.31 COVAX—co-led by Gavi, WHO, and the Coalition for Epidemic Preparedness Innovations—is the ACT-A vaccine pillar, and the COVAX Facility, led by Gavi, serves as a mechanism for procuring and coordinating the delivery of Covid-19 vaccines to member countries.32 But even prior to the emergency use authorization of new Covid-19 vaccines, the effort to secure doses of them for low- and middle-income countries proved challenging, as high-income countries negotiated advance access to the most promising vaccine candidates, leaving others at a disadvantage in terms of securing doses for the most vulnerable. Through the COVAX Advance Market Commitment (AMC), a set of Gavi-eligible countries, along with a group of additional lower-income candidates, were made eligible for low- or no-cost doses of the new vaccines, but several challenges remained.33 Once the Covid-19 vaccines became available in late 2020 and early 2021, the initial scarcity of supplies led some countries to impose limits on who could access them. Faced with decisions on which populations to prioritize, some governments initially stated that migrants or others living in the country on a temporary basis would not be eligible for the Covid-19 vaccines. In 2020, then president of Colombia, Iván Duque, stated that the undocumented Venezuelans living in Colombia would not be eligible.34 But eight months later, as supplies increased, the Ministry of Health issued a resolution declaring that people without formal identification or migration status could access vaccines that had been donated to Colombia specifically for that purpose.35

Recognizing the uncertainties faced by the nearly 170 million people worldwide living in fragile, crisis, or conflict-affected situations in terms of receiving Covid-19 vaccines once they became available, COVAX launched the Humanitarian Buffer to facilitate the provision of vaccines to populations at greatest risk of missing out. Under the plan, 5 percent of vaccine doses available to the COVAX Facility were set aside to supplement state efforts and provide vaccines for vulnerable populations considered likely to miss out on receiving Covid-19 vaccines through national programs, with as many as half living in areas controlled by non-state armed groups.36 All participating countries were deemed eligible to apply for funding to cover temporary, displaced, or hard-to-reach populations.37 Governments or nongovernmental humanitarian aid agencies could apply to the Inter-Agency Standing Committee for funds to purchase vaccine doses, as well as funds for supplies and vaccine delivery. But the Humanitarian Buffer has faced numerous challenges, including liability and indemnification challenges. An external review of the ACT-A found that COVAX itself had supplied the majority of Covid-19 vaccines administered in “28 countries with a humanitarian response plan.”38

By March 2022, according to a report from the United Nations High Commission on Refugees (UNHCR), a majority of countries were including refugees in national Covid-19 vaccination plans.39 However, a subsequent UNHCR evaluation in July 2022 revealed that many countries were failing to protecting refugees’ rights to vaccines.40 More than 30 countries were reported to restrict health service access for refugees, asylum seekers, and others fleeing violence, with refugees reported to have faced “specific obstacles in accessing vaccines and other Covid-19-related services.”41 Even when national policies do include refugees, building and sustaining community trust in vaccines can be daunting. In Lebanon, which hosts the largest number of refugees in the world relative to its population and which early on adopted an inclusive policy with respect to Covid-19 vaccines, rumors fueled hesitancy among refugee populations, requiring tailored communications that assured members of the diaspora that they would be safe from abuse by security forces.42

The COVID-19 Vaccine Delivery Partnership was established at the beginning of 2022 to support the 34
COVAX AMC countries that reported below 10 percent coverage at the time. An alliance of UNICEF, the WHO, and Gavi, it offers countries support and technical guidance to boost immunization rates, including by addressing rumors and misinformation, as well as by developing plans to bring services to hard-to-reach communities in conflict-affected settings.43 By August 2022, two-thirds of the countries had increased Covid-19 vaccine coverage beyond 10 percent, but gaps remain.44

Innovative approaches have enabled providers to reach remote populations living in insecure situations. In the Horn of Africa, for example, where pastoralists move across the borders between Ethiopia, Somalia, and Kenya to graze their livestock, service providers have adopted the use of digital tools to locate and share information about clusters of unimmunized adults, while also working with religious leaders and community mobilizers to answer questions about and build trust in the new vaccines.45 In Cameroon, conflict since 2015 in the southeast region along the border with Central African Republic has left many health facilities closed, with people fleeing their communities to find shelter in “safe havens.” Even when Covid-19 vaccines have been available, however, rumors and mistrust have fueled many communities’ hesitancy to get them.46 By working with religious groups, such as the Christian Health Association and the Muslim Women’s Association, as well as mother’s groups, public officials have begun to counter rumors and negative messages spread on social media to build trust in vaccines, but much work remains to be done to ensure widespread access and uptake in these conflict-affected areas.47

Unfortunately, lower rates of vaccine confidence, the diversion of personnel from routine immunization to outbreak response, and decreased availability of resources for health services overall have contributed to fresh outbreaks of measles in Somalia, Yemen, Afghanistan, Nigeria, and Ethiopia in 2022. This signals that immunization systems remain weak and points to the importance of building health systems over the long term.48
TOWARD A MORE EQUITABLE APPROACH TO PANDEMIC PREPAREDNESS AND RESPONSE

As the world enters a fourth year of the Covid-19 pandemic, there is hope that the outbreak will begin to transform from a crisis to an endemic situation. In this context, there is a possibility that Covid-19 vaccines could eventually be incorporated into routine immunization services, with the Gavi Board recently agreeing “in principle” to consider such a shift by 2024. This change could create challenges for health systems in terms of training staff and developing communications to ensure outreach on routine immunizations—services typically viewed as aimed at children—to adult and adolescent populations, but it could also open opportunities for extending healthcare to these often missed groups, as well.

Preparing for future pandemics means making sure all potential countermeasures, including diagnostics, treatments, and vaccines, are available to all populations—regardless of their status or where they live—in an equitable and timely manner. People living in situations of fragility or who are affected by conflict are especially vulnerable to being overlooked in immunization plans. They may also mistrust public officials and be reluctant to accept vaccines even if they are offered. Incorporating refugees, migrants, displaced people, and mobile populations, including those affected by conflict, into routine immunization plans can protect their health, as well as that of the communities in which they live. It can also strengthen immunization systems to ensure equitable and timely access to new vaccines in future health emergencies.

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ENDNOTES


Zoë Pelter, Camila Teixeira, and Erica Moret, United Nations Children’s Fund (UNICEF), Ibid.


Ibid.


Priya Joti, “How Can We Boost COVID-19 Vaccine Coverage in...


**GRAPHICS**

**FIGURE 1**


**FIGURE 2**