

Center for Strategic and International Studies

Online Event

“The State of Immunization Under COVID-19”

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FEATURING:

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Esther Nasikye,

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Jennifer Siler,

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Pierre Fontaine,

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Transcript By

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Katherine E. Bliss: Hello and welcome to CSIS. I'm Katherine Bliss, a senior fellow with the Global Health Policy Center. It's my pleasure to introduce this session on the state of immunization programs in the context of the coronavirus pandemic and efforts to plan for the rollout of COVID-19 vaccines on a global scale.

So here we are a little over a year into the pandemic. The first cases were reported in December of 2019, and this week we passed 100 million confirmed cases of COVID-19 worldwide. In between, a great deal has happened as far as immunizations are concerned. By March of 2020, countries in all regions had reported cases with many instituting lockdowns, curtailing economic activities, suspending transportation routes, and diverting health resources funds as well as care providers, including those dedicated to immunizations, to critical care. At the same time, with so much uncertainty about how COVID could be transmitted or treated, many parents were afraid to take their children into clinics for shots, fearful of being infected.

Recognizing that routine work could not carry on very well if the pandemic were not addressed, multilateral health assistance programs like the Global Fund and Gavi, the Vaccine Alliance allowed countries to request to divert a portion of their health system strengthening support to outbreak response. Even with intense attention diverted to the pandemic, it became clear that prioritizing routine services for children, as well as influenza vaccines for high-risk adult populations, remained critical. The World Health Organization issued guidance advising countries to schedule catchup programs if immunization services had to be suspended.

Nevertheless, in a relatively short period many countries did report widespread service disruptions. Surveys and anecdotal accounts documented interruptions to routine activities and campaigns, and follow-on research showed that immunization services were becoming more expensive because of personal protective equipment requirements and the additional handwashing stations and space for social distancing needed. By September 2020, though, there were signs that in some places things were beginning to recover lost ground on immunization, while others continued to report problems with supply, demand, or availability of protective gear for health workers.

But despite the ups and downs experienced in the immunization world, the past year was also one of unprecedented international scientific cooperation on vaccines, with plans for developing products to protect against infection with COVID gaining steam and dozens of efforts logged

into databases tracking the state of vaccine research and development. In April, governments, international organizations, and nonprofit groups organized to launch the Access to COVID-19 Tools Accelerator with the goal of scaling up and making available COVID-19 diagnostic tools, treatments, and vaccines.

COVAX, overseen by CEPI, Gavi, and the World Health Organization, is the ACT Accelerator's vaccine pillar. It supports efforts to develop, produce, and procure COVID-19 vaccines, and to make them affordable and available to all countries. COVAX now has at least 190 members, including self-financing high- and middle-income countries or blocs, as well as lower- and lower-middle-income countries.

In June at the Global Vaccine Summit, the COVAX Advance Market Commitment was launched as a financing instrument dedicated to securing funds to ensure lower- and lower-middle-income countries can access COVID-19 vaccines at the same time as the self-financing countries. There are 92 countries eligible for the AMC – that is, countries that have an annual gross national income per capita of less than \$4,000.

And in December, the United States Congress appropriated \$4 billion to Gavi to support COVID-19 vaccine procurement and distribution for the AMC countries. And on January 21st, U.S. officials affirmed plans for the country to join the COVAX facility.

With several vaccines having now been authorized for emergency use and in distribution, countries are developing plans for rebuilding or sustaining routine immunizations while creating plans to prioritize and ensure equitable distribution of COVID-19 vaccines.

Here to describe the state of immunization under COVID-19 and efforts to help countries maintain services while preparing for the rollout of COVID-19 vaccines is a great panel of experts. We're fortunate to have representatives from UNICEF, PATH Uganda, John Snow, Haiti, and the Sabin Vaccine Institute, all organizations which have been deeply involved in the effort of sustaining immunizations and preparing for COVID vaccines.

So before I introduce them, let me remind you that on the event page there is a button you can click to submit a question during the kind of second half, the discussion portion of the event, should you wish to do so.

So, first, it's really my pleasure to welcome Dr. Robin Nandy, principal adviser and chief of immunization services at UNICEF and based in New York. Robin actually spoke at one of the very last public events the Global Health Policy Center at CSIS hosted before everything abruptly shifted to

the virtual world, and I think this was February 24th of 2020, so almost a year ago.

It feels like it was really a long time ago, but I think at that meeting, Robin, you know, we talked about COVID and what it might mean for immunizations at the time, both the impact that the pandemic might have on routine services but also how immunizations should really be seen as a critical element of health security. So I'd like to ask you to start by talking about, you know, what you've observed, really, over the past 11 months about the impact of the pandemic on immunization programs worldwide and how UNICEF is working with countries to restore or strengthen services. And I'd also ask you to say, you know, what you're seeing in terms of country readiness to receive and distribute COVID vaccines and the role – you know, if you could tell us a bit about the role that UNICEF is playing in vaccine procurement and delivery. So, Robin, I'll turn it to you.

Robin Nandy,
M.D.:

Thanks, Katherine, and it's good to be at a CSIS event again. It was a different world when we were together in February of last year. A great deal has happened, but you know, what I want to do is try to tee us off and tee it – or tee it off also for the rest of the panel, but reflect on where we were prior to COVID-19, right?

You know, the latest data that we have in terms of global immunization coverage estimates is from 2019 and pre-COVID. We all know that immunization coverage, while having reached more children than most other child-survival interventions, have stalled in the mid-'80s at around 85, 86 percent – over the last decade, essentially. Approximately 20 million children we estimate globally do not receive the full complement of vaccines measured through, you know, measuring DTP3 coverage. Of these, 14 million kids don't receive any vaccine at all, and – what we call the so-called zero-dose children that we measure through DTP1 coverage as a proxy. Now, this has been a little bit intractable because we've not made huge gains among these zero-dose children.

We've tried to understand this a little bit more – with a little bit more granularity and detail. And UNICEF, along with the Gates Foundation, chair what is called the Immunization Equity Reference Group, which is essentially a think tank to try and delve into some of the details of, you know, how to deal with these issues. And largely, the zero-dose children reside in three types of communities. They're either conflict-affected communities, they're in remote rural locations where the health system does not extend to, or they are in – among the urban poor populations largely in slums.

This has led us to really help, you know, ensure a laser focus on equity as we chart our vision for immunization in the next decade. This is articulated

in the Immunization Agenda 2030, and you'll also see it in the – in the new Gavi strategy for 2021 to 2025, a focus on not only zero-dose children but the communities there they're clustered in. Zero-dose children don't randomly – are not randomly distributed in populations; they are clustered in some of the most deprived communities. And this also provides an entry point that immunization can provide to broader PHC services. So these kids are not only lacking immunization, they are lacking other health system services, nutrition services, water, sanitation, and so on. So that's the spirit of Immunization Agenda 2030.

Then comes COVID. And what has COVID done to immunization? Just like COVID has turned out lives upside down, it has turned the world of immunization upside down as well.

We have had to temporarily and deliberately suspend campaign-style delivery of services. This was sage guidance back in March/April. And you know, we suspended campaign for the entire second quarter of 2020 until we then started reinstating campaign on a risk-benefit basis.

Outreach services were affected. People were not able to move out into the community to deliver vaccines.

Routine services were impacted, and we saw this through our very, you know, collective effort – WHO, UNICEF, Gavi, the Sabin Institute's Boost Initiative that Jennifer will talk to you about a bit later. We instituted what is called – what we call pulse service to identify the level of disruption. And we saw major disruptions across the globe in immunization services.

But important to note, even where services were being provided people were unable to access the services. As you mentioned, Katherine, there were various levels of lockdown, transport disruptions, and so on. UNICEF, as the largest procurement of vaccines for low- and low-middle income countries, saw a(n) 80 percent drop in vaccine shipments that we were sending out to countries, as well, due to transport disruptions.

You know, in – there were other factors that resulted in low immunization coverage. People, as you mentioned, were unwilling to go to health facilities to seek services for fear of COVID. Health workers themselves were worried about their own health and their own well-being.

You know, the good that came out of all this, you know, sad situation is how the immunization community rallied around, you know, developing, you know, approaches to reimagine immunization in the – you know, in the aftermath of, you know, as we concurrently dealt with the COVID-19 pandemic. And you know, I think, you know, this is really going to be important because, you know, new ways of delivering vaccines will have

been considered. Huge innovations in service delivery are reducing population mixing, for example, which has resulted in reduction in wait times for people seeking vaccinations. Separation of vaccination from curative services. Delivery of vaccine in open-air, you know, incorporating physical distancing. So a lot of innovation in more-developed countries. In the Latin Americas, you know, drive-in vaccinations, vaccinations at pharmacies. So a lot of innovation came about here.

And then, as we try to recover from this, we have both the good news of COVID-19 vaccines as you've said, Katherine, and – you know, which come with huge opportunities but with some new challenges as well. And I think it's really important for all our audience to understand that delivery of COVID vaccines will need very different approaches than what we normally are used to doing in low- and low-middle-income countries in the course of childhood vaccination. Vaccinating adults, vaccinating elderly, high-risk population, health workers, will take a very different approach than what programs are used to, and this will need programs to pivot in order to do that.

This will need planning. This will need investments, because one of my biggest fears where I sit – where I see it from is a further downturn in immunization coverage as we deliver COVID-19 vaccines because we're going to use the same infrastructure to deliver that. And we need to deliver it in a way that does not impact on normal childhood vaccination.

And then my final point, Katherine, is on complacency, is the fact that there is a vaccine should not lead to communities and governments taking their foot off the pedal on other prevention and mitigating activities like mask wearing, like distancing, like, you know, hand hygiene. Vaccines are going to be available in small doses to start with, not in enough doses to ensure herd immunity, at least in the first year of deployment. And so it will need to be in tandem with all the other activities.

UNICEF is the procurement coordinator, is the major procurer of COVID-19 vaccines for the ACT-A Initiative, the vaccine pillar, and are also co-leading with WHO the country readiness, which I'm sure we can – we can talk a little bit more after we hear from our country colleagues, because I'm sure they will bring up some of these issues as well. Thank you, Katherine.

Katherine E. Bliss: Robin, thank you. I mean, so really important to keep in mind that there was already some stagnation in terms of coverage with immunizations before COVID-19 hit. Saw that dip in the spring, some recovery, but you know, really important to keep in mind that, you know, the distribution of new vaccines will follow or build on the same platforms of existing ones, so important to strengthen those but also make sure that there's not sort of an

overwhelming of the routine services while the new work is going forward. Thank you.

It's my pleasure now to welcome Ms. Esther Nasikye, manager for advocacy and public policy with the PATH country office in Uganda. At the global level, Esther works with Immunization Agenda 2030 that we just heard a bit about, works with their communications and advocacy team. And in Uganda, she focuses with – on coordinating with the Ministry of Health in developing guidance for the delivery of COVID-19 vaccines during this critical period.

So, Esther, you know, as I turn to you, I want to ask you to say a bit about the extent of the impact of COVID on immunization programs in Uganda over the past year. You know, to what extent were services disrupted? How has, you know, recovery of – or rebuilding of some of those services taken shape? And in particular, you know, if you could tell us how the ministry and partners like PATH and others have been working to develop plans for the distribution of COVID vaccines, both in terms of procuring those through the COVAX AMC but also beyond, you know, as looking at, you know, additional supplies of vaccines for that other portion of the population. Thank you.

Esther Nasikye: Thank you so much, Katherine, and I'm really excited to be a part of this CSIS conversation. And I'm excited to share exactly what is happening at country level.

It's interesting that some of the points that Robin raises as what he sees as the global level is exactly what is mirrored at the – at the country level. You know, just touching off in terms of impact of COVID on routine immunization services, you know, I mean, we've seen impact in terms of access to services and uptake of immunization services at country level. When the country first – our first cases, our first COVID cases, were reported in March 2020 and the country went into total lockdown, so there were limitations in terms of movement that were instituted as part of measures to cap the spread of COVID. But those measures, the limitations in movement, meant that community members could not access routine services like immunization. And also – and also, for them to access services, they had to seek permission from local authorities, and you can understand how bureaucratic that can be in some of our settings. So most of the caregivers and, you know, parents, opted not to take their children for immunization at all. So during those periods we saw a drop in terms of – in terms of services that were – in terms of uptake of immunization services.

But like Robin mentioned, following the guidance from WHO we had campaigns – immunization campaigns suspended. We had outreaches suspended in the country. So services were only offered at static points.

But with that, you know, when you kind of put it in a gender lens to it, it meant that women had to – because most – in most cases women are the caregivers, so it meant they had to walk long distances for them to be able to access services. And you know, most of their homes are not within the five-kilometer radius of a health facility. So you think about almost an eight-kilometer journey, 10-kilometer journey with a child on their back for a woman to be able to access services, which becomes really problematic. So most of them opted not to.

But the limitation in terms of access to health service facilities did not actually affect – maybe just before I talk about health workers, let me mention this. A survey that was conducted by Makerere School of Public Health in October/November indicated that of the districts that they surveyed, 31 percent of them did not even only cancel the outreaches and the campaigns; they even canceled services at the static points because there were no parents that were bringing children for immunization at all, so they saw no need to run or to open for the service. So they ended up closing even the static – the static sites, so there were no immunization services that were being offered at all in some of the places.

But you know, when we talk about access and we talk about, you know, the community, sometimes we forget that the health workers were also impacted. In this – in this survey by Makerere University, they – 55 percent of the districts actually reported that the lockdowns and the limitations in transport had impact on human resources because the health workers could not move to and from the health facility. I know at a district about 200 kilometers from our capital, Kampala, where health workers were stranded at the – at the facility. They could not go back home and yet, you know commit members also not coming to them because of the limitations in terms of movement because they had to adhere to the curfews that had been put in place. So there have been challenges in terms of uptake.

But I also want to talk about, you know, the increased cost. I know Robin, you know, alluded to this, the increased cost in terms of access to health services, including immunization. Immunization services are for free, but you know, you need to look at the associated costs that come with that, that you know, someone has to find transport, you know, to take them to the facility with their child. But in addition now, we even have – we even have already a mask that is a requirement for one to be able to, you know, reach a health facility. Now, we are talking about – when you look at the World Bank statistics, we are talking about close to 40 percent of the population that lives on \$2 or less a day, and now we are saying they need an extra dollar for them to be able to procure a mask so that they can access services. So definitely that affected – rather increased the cost of access to some of these services and, you know, ultimately we saw that people were

not accessing services, you know, at all. And already, our out-of-pocket expenditure is also astronomical, so it only wasn't the problem.

But whilst we talk about that, I mean, there are the obvious things that can be measured, for example the increase in the number of zero-dose children. Definitely, when you have limitations in movement you know very well that in a – in most of our communities women are going to be delivering in the facility – rather, in the community with the support of traditional birth attendants. They have been outlawed, but still the practice exists. So during those phases, women were seeking services with traditional birth attendants not linked to a facility at all. So we see that there are quite a number of children that have not been immunized.

But while that one is obvious, I also want to talk about, you know, the missed-dose children that has increased. We don't have the exact statistics yet, but we know that that figure is quite high because when it comes to, for example, the HPV vaccination, the catchment areas were usually the schools. And now in Uganda the schools have been closed since March 2020. So, you know, this mobilization – the adolescent girls have not been mobilized at all. You know, there are certain measures that have been put in place now to try to track them through VHTs or through some of the health facilities, but you know, it is – it has not been very well coordinated. So we have quite a number of girls that have missed some of the services.

But you know, with the time that is limited, let me talk about what is being done. So what we've been doing, also, as partners working with the government is to peg backwards some of the immunization days that have been set in place. Specifically, for us it was the October ICH day, the International Child Health days that were put in place for us to invigorate the campaign for uptake of services, you know. So running media campaigns, you know, TV, radio messages, supporting a lot of social mobilization, working with the VHTs to track some of the children, some of the – you know, for them to come back to the facility for services, you know, we were doing that – we were doing that quite a bit. But also, what we were doing was – also, what we were doing – of course, still working with the VHTs, because we know these are the closest people to the – to the households, so ensuring that they were mapped and then they could report back.

In terms of – let me – in the minute that is left, let me talk about how – our preparedness as a country for the COVID vaccine. Now, I already mentioned that our first case was reported in March. So what we did as a country, I think we've made good strides in the sense that by the end of April 2020 we already had a leadership or governance structure in place. So we had our National Coordination Committee that was instituted working closely with the NITAG – the National Immunization Technical

Advisory Group – working closely with the EPI Technical Working Group to give guidance to the country in terms of, you know, the next steps to prepare for the – for potential introduction of a vaccine.

And it's because of efforts like that that Uganda is now a member of the COVAX Facility. And with that, we also have already drafted our National Vaccination Deployment Plan. And we have received recently technical assistance from COVAX to support, you know, the – some of the activities that are going to lead to the introduction of the – of the vaccine at country level.

But in the 10 seconds that – (laughs) – that I have left, let me just mention, of course, that even with the assurance that COVAX will cover 20 percent of the population, we know that we still need to do a lot of advocacy for us to be able to meet the doses for the remaining 80 percent. So funding is still a challenge and there is still a lot of advocacy that we can talk about here. We can talk about – I've had, you know, conversation – we've had conversations around how we can leverage, you know, the World Bank support, but we are already a country that is sinking in public debt. So how do we manage and, you know, navigate situations like that? But conversations are ongoing to look at beyond the 20 percent that COVAX, you know, is offering. How about the private sector? And then, you know, what else can government bring in terms of domestic resources? So that is how we are prepared in terms of the introduction of the – of the vaccine.

Thank you, Katherine. In case there are any more questions, I can respond, too.

Katherine E. Bliss: Esther, thank you very much. And you know, really an important reminder to, you know, be conscious of the gender dynamics both in terms of seeking vaccinations but also just the – you know, the ways in which the impacts of the pandemic, you know, beyond the health sector – you know, on the education sector – have really affected girls' access to, you know, vaccines kind of out of the normal clinic schedule. So important reminders there. And also, you know, just the – you know, the challenges posed by seeking access to vaccines kind of beyond the COVAX model, you know, how some of those conversations will take shape.

I want to turn now to Dr. Pierre Fontaine, lead technical advisor for the Haiti Urban Immunization Program led by John Snow, Inc., and with funding from Gavi, the Vaccine Alliance. Pierre's work is very much focused on efforts to bolster immunization coverage in the peri-urban settlement of Cité Soleil outside of Port-au-Prince in Haiti.

And you know, Pierre, the Americas have really been one of the regions hardest hit by COVID – high caseloads and high death rates in a number of countries. You had just a little over 11,000 cases and less than 250 deaths.

Haiti seems to have been spared some of the problems faced by Brazil and Peru and Mexico and some of the other very high-population countries in the region. But I – you know, I want to ask you, you know, despite that, how has COVID impacted immunization services in Cité Soleil and in the urban context in Haiti? And what are you seeing in terms of opportunities both to strengthen routine services while preparing for the introduction of COVID vaccines and preparing for other introductions as well? So over to you.

Pierre Fontaine: Hi, everyone. Thank you, Katherine, for introducing me. I am pleased and I'm proud, as well, to be part of this panel to discuss on how COVID-19 has impacted our work in Haiti and especially in Cité Soleil.

So I will be raising three points. The first one, it just – the first point, it will be just about the situation of vaccination in Cité Soleil, which is a very dense and populated city with 300,000 inhabitants. Cité Soleil is like 30 minutes' drive from the capital city, which is Port-au-Prince, and people in Cité Soleil have low social and economic condition. And as well, they have poor health condition. About health condition, there are, like, three main challenges that have been – that have been existed there. So the first one is the low immunization coverage, and the second one is the high number of zero-dose children.

So the map – the first image is a map that shows the distribution of numerous children that were partially vaccinated, and they are indicated with yellow dots. And the next graph is show, like, DTP coverage in Haiti. It's like – it's called ten-dot-three (ph). This shows the DTP coverage that remain below 45 percent from the period 2012 to 2018.

Maybe you can move to the next slide.

And the second point I will be raising, it's about how the modeler – urban model was going where in Cité Soleil and since COVID – (inaudible) – how this has impacted the model intervention and how we are starting adapt ourself to the new environment. For this we are choosing to assess three parameters.

The first one is community participation. And before COVID-19, we have people, they organize and they created committee – health committees, and those committees are meeting on a regular basis.

Then, about access to services, access was also improved since we can see DTP1 was increasing and numbers of outreach strategy was – were also going well.

And about use of services, we can see that service use was also improving since we can see DTP3 was increasing and the estimated time for parents to get the vaccine and go back home was less than 45 minutes.

But since COVID occurred, so within the first six month(s) of COVID, we have experienced some important changes in term of performance. And using the same parameters, we can see that about committees that were – that were meeting regularly, so those meeting didn't happen anymore. Even if they were scheduled, they had to be canceled after.

And also, about access to services, we could see that data were going down with DTP was decreasing and outreach strategy were no longer taking place since people were not coming because of fear of being infected.

And about service use, we could see, as well, that DTP was going down and the estimated time for – to get the service was increasing, as well, like one hour and 30 minutes due to – with respect for the guidelines about social distancing.

But since this happened and six months after COVID, we have started to adapt ourselves to the new environment. So we switch from traditional meeting to Zoom meetings, so all of the people in the group have committed. Now they have smartphone with data, too, and they have some great software like Zoom or WhatsApp or Messenger, and they organize who posts – (inaudible). And the main way that is being used now, it's Zoom meeting.

And about access to service, we conducted advocacy. So all personal protection equipment become available. And providers, they feel comfortable, they feel protected, and they are ready to be – to be in the facility and to provide services. The same for those who have to supply vaccine. Since they have PPE, they feel protected and they come and they work and vaccine become available.

But about – what about use? How did we adapt to increase service use? We have observed that because of COVID – (inaudible) – in Haiti, it's like health workers in the community. They call them ASCP. They are working with MSPP for Cité Soleil people about the guideline to be followed with regard to COVID-19 infection pandemic. And we say, ah, they are the same people who are doing vaccination and the same doing this immunization campaign, so it's a great opportunity for us to tell to those people that it's good to – it's good to profit – to take profit off COVID-19 sensitization to promote service use. And that's what we did.

And maybe the past point I will be raising, it's about the results that have been achieved despite COVID-19. The next side, we can see.

The first one, in your left side, it's a graph, and that shows the progression of some antigen during the last three years. For instance, the DTP three-year ten-dot-three (ph) started from 45 percent in 2018 and progressed to 60 percent in 2019, and finally reached 86 percent in 2020.

And the second graph is showing, as well, DTP3 progression within the last eight years, starting from 2012 to 2020. And in 2012, it was 13 percent. And to 2020, which is 86 percent. So we – you can see that we still have some work to do because we are not yet at 100 percent coverage. But as you can see, as well, we have – we are coming from so far.

So thank you very much for attention. So I'm ready to discuss about it with your questions and suggestions. Thank you.

Katherine E. Bliss: Pierre, thank you very much. Really clear overview and depiction of the impact on the one hand of COVID, you know, on access to services in a particular context – in the very specific context of Cité Soleil – but also some, you know, interesting sort of I guess bright spots in terms of the new adaptation of different kinds of technologies, greater use of SMS and Zoom, you know, in terms of some of the sort of, I guess, telehealth discussions, and really improvements, you know, over the longer, you know, period of the year in terms of wait times, and then also improvements in terms of coverage, you know, despite all of the crisis that's happening.

So now, to take us back to a global discussion, let me ask Jennifer Siler, vice president for community engagement at the Sabin Vaccine Institute who leads Boost, a global network of immunization professionals involved in some of those early surveys that have been discussed – you know, that documented the impacts of COVID on immunization services in diverse countries. Jen oversees Boost and is also involved in CVEP, the COVID Vaccine Equity Program, which also includes JSI.

Jen, if you would tell us, you know, how is Boost helping countries share information and experience about sustaining or reigniting services under COVID? And what are you seeing as the key challenges around preparing countries for COVID-19 vaccine introductions while continuing to support them on routine programs? What are you hearing from your members? And how are they networking about the lessons that they're learning over this process?

Jennifer Siler: Thank you, Katherine. So, many of the themes and findings that Robin and Esther and Pierre just mentioned I'm going to be highlighting as well.

So Boost – our Boost community, which Katherine just mentioned, actually launched a year ago nearly today. And before our launch, we spent most of

2019 interviewing dozens of immunization professionals in low- and middle-income countries across the globe, and then also spent a few months in East Africa really speaking with immunization professionals at every level, so from national to county to district all the way to facility, to really understand what are the gaps and needs in their everyday work. And so this was honestly completed, you know, just a few months before COVID-19 hit.

What we heard then, and we know is still the case now and is just exacerbated in a lot of ways, was that subnational staff did not have good channels to communicate with one another – so to understand, hey, I'm doing this in my community, what are you doing with this; staff were working very long hours, getting burned out quickly, so there was a lot of turnover; and that many national immunization program decisions were frequently political, and so folks were not feeling at a local level incentive and empowered to really try to change the status quo.

And so with this feedback, we shaped our Boost platform with a focus on really enabling those connections, and between immunization professionals and with experts, and providing opportunities for these immunization professionals to have foundational learnings – so around leadership and management and advocacy and community building. We feel like, you know, all these technical pieces come in, but this foundational learning is essential in a world where things are changing every day.

And so there were two key underlying aspects of our initial findings that were interesting. One – something that is just like I'm going to say it multiple times – but really need to give local immunization staff at levels under national, even subnational levels and subcounty levels, voices. They need a seat at the table. We need to understand what their needs are and we consistently need to understand that. I think, Esther, you mentioned this, too, right? It's what's happening at the local community level. We need to understand what's going on and what the challenges are, and that these communities that are zero-dose, these are the ones that – you know, these are the – we know why they're zero-dose, because we haven't been able to reach them. And so we need to understand what's going on there. And the second piece is just that we knew that with Boost we needed our model and platform to be super iterative and adaptive, and appreciating that the challenges were – none of the challenges were static.

And so we launched Boost in January of last year, you know, just before COVID reached all of our shores. We appreciated very quickly that we needed to understand with COVID now what are the challenges, what are folks needing. And so we worked with UNICEF and WHO and other to launch a set of pulse surveys, and that happened in April and May of last year, and we heard a lot of things from these surveys. Some of the biggest

themes that came out were challenges around infection prevention control, vaccine demand and hesitancy, returning to routine immunization, and the COVID-19 vaccine, which at the time was still, you know, unclear what that would look like.

Another piece that really came out of this was people didn't know where to go for consistent information that was the most up to date, whether that was local or global. And so we worked with UNICEF, WHO, CDC to kind of help fill these gaps, build some content, try to make it easier for folks to find information. And I feel like partnership at a local level has been very important. Partnership at a global level, as Robin mentioned, has been essential and has been really fantastic.

I think that, you know, from the work that we did in building out these global goods to kind of meet some of the gaps and challenges people talked about, we saw that one of the largest gaps was supervisors. And many folks in the immunization space are supervisors, whether that's of health-care workers, voluntary or otherwise, or other staff members really wanting to – you know, no longer being able to kind of see all the staff that they're managing, so needing to figure out a way of how do I support my staff and how do I manage them when I am not, you know, able to go visit them. And so we really tried to institute and provide support around that.

An example of kind of one of the challenges that we heard a few different times was how to manage kind of an overall increase in vaccine hesitancy in a community because of contradicting information about the forthcoming COVID-19 vaccine. And I think the hard part about this was we couldn't provide just one answer, right? There were – there are many answers, right, and there's a lot of different ways you can look at the challenge. And so I think that was something where we started, then, from this to launch our adaptive leadership program. And we worked with Adaptive Change Advisors and the Geneva Learning Foundation to launch this, which is a six-week adaptive leadership course with 300 or so participants really focused on enabling staff to feel connected and empowered and able to drive change. And the challenges that arose during that course from immunization staff were ones that didn't have, you know, again, one right answer, maybe even 10 right answers. A lot of the challenges these folks are facing were extremely complex.

It was during this same time, in early summer, that we began to understand an underlying challenge that immunization staff were anticipating, which was that there was going to be real difficulty in rolling out the COVID-19 vaccine equitably within countries and local communities. So we've had a lot of important talk about kind of getting the vaccines to countries, but once they're there, how are we going to reach – Robin mentioned this – you

know, these populations when we haven't done life-course immunization in many of these countries previously?

And so alongside JSI and Dalberg we launched the COVID-19 Vaccine Equity Project, or CVEP, in October of last year. And we worked with the Boost community, which is now 1,300 members in 125 countries, to really understand what the core priorities were for folks locally in terms of driving local equity. And the five gaps that arose that are now kind of CVEP's core focal areas are: effective and inclusive planning and coordination to reach priority populations; transparent, data-driven approaches to identify and track vaccine recipients; equitable and data-driven immunization supply chain and cold-chain management; health-care worker and community health worker engagement and training; and then lastly community engagement mobilization, demand generation, and acceptance.

And so the challenges that these countries are grappling with to really prepare for the arrival of the COVID-19 vaccine are extremely real, and CVEP is currently working with four pilot countries offering technical support around those five areas I just mentioned. We're hoping to scale to additional countries and also build out, really, a community of practice with global goods so that we can honestly have a bottom-up approach, not a top-down approach, in really sharing out these learnings in real time. Katherine, you mentioned bright spots a moment ago, and we actually have a series that we've begun in the past and will continue just highlighting, you know, as quickly as in real time of what are the bright spots that we're seeing.

So, in closing, I'm going to share my list of four key messages we keep hearing on the Boost – the Boost platform, and I just kind of went through and pulled these with the team that we know as global-local immunization community. These are needs that keep coming up.

And so one is addressing challenges related to vaccine hesitancy resulting both from mistrust in the vaccine, but also misinformation.

Two, how important community engagement will be to ensure a successful rollout of the vaccine – COVID-19 vaccine.

How to prepare for the COVID-19 vaccine and the uncertainties there.

Wow, we've heard it: Maintaining routine immunization activities.

And then, lastly and I think one of the points that we're trying to really own and help support, which is the need to include members of the community, those at the lowest levels of the system, in the planning and coordination,

giving them a seat not just at one table but at every table, and moving again this top-down approach to one that is bottom-up.

So thank you.

Katherine E. Bliss: Jen, thank you very much. You know, really, you know, bringing home that message that the voices of, you know, health workers and the community about immunizations need to be taken into account at every level of the discussion and not just kind of brought in at the end like, oh, yeah, then we talk to them, but really, really incorporated to enrich and improve service delivery at every level.

We have a number of questions that come in – have come in through the chat, and I would encourage other people who have them to go ahead and submit them. But I want to pose a couple to the panelists to kind of – I’m going to combine a couple of them and pose them to the panelists.

You know, one is, you know, from – let’s see – James Goodson at the Centers for Disease Control and Prevention here in the U.S., you know, that is really around, you know, we’re at a moment here where we’re starting to, you know, look at the rollout of COVID vaccines and people, you know, becoming more complacent. You know, this is really kind of a risky time with the perhaps declining immunization coverage. You know, we may, you know, really see a risk for the resurgence of diseases like measles and others that – you know, once some of these restrictions around travel and lockdown are lifted. You know, do we really see that? And what are – what can be done now to mitigate those risks and prevent, you know, outbreaks of vaccine-preventable disease?

And you know, another question that some of you have begun to raise a bit, but you know, I think this is – Laura Shimp from JSI posed is, you know, how are countries looking at, you know, really shifting from a focus on child immunizations to, you know, addressing adult populations – you know, which are not necessarily accustomed to kind of walking through the pediatric wards to, you know, the immunization clinic. And so how as – you know, how can we ensure that all antigens are prioritized and, you know, really look at addressing issues across the life course as we integrate COVID vaccines into the process?

So, Robin, maybe I can start with you, and then ask each of the panelists to take up a portion of these questions.

Robin Nandy,
M.D.:

Absolutely, Katherine. I’m happy to take a stab at the first two questions from my esteemed colleagues Jim Goodson and Laura Shimp, who I know very well.

Jim, your question is really a good one. You know, the COVID-related mitigation actions and so on is obviously aimed to cut down COVID-19 transmission. It has probably contributed to cutting down transmission of every other virus and pathogen that is transmitted through the respiratory group. And the – you know, the disruption that we face obviously has contributed to reducing population immunity, increasing the number of susceptibles in the population. So and I mentioned that. And I think I – you know, we all are really concerned that unless we catch up on the missed doses and close the immunity gaps that have resulted in – resulted from the COVID-related disruptions, we will face risk – increased risk of outbreaks, you know, once people start moving around and – you know, and so on.

So I think it is extremely imperative that there is a catch up on missed doses. And please don't misunderstand my use of the word "catch up" to mean catch up campaigns. I'm not talking about a unidimensional. We need to use everything in our armory, all the tools – whether it's outreach, intensification of routine campaigns, a combination to catch up and cover the immunity gaps – or else, you know, come later on in 2021 we will see outbreaks of vaccine-preventable diseases, which would be extremely damaging for countries that are – now are trying to recover from COVID-related disruptions.

I think the related point now, to Laura's comment, is, Laura, absolutely agree that we need to look at all the vaccines in the continuum and across the life course, whether it's against vaccine-preventable diseases, whether it's antigens like HPV vaccine. And here again, you know, I have to emphasize that, in response to both questions, is we need to both catch up on the missed doses, but also address the immunity gaps that we had pre-COVID, because some of those immunity gaps have increased. Most of the disadvantaged population will face disproportionate impact on the COVID-related disruption. So we need to not look at it piecemeal antigen by antigen. And when we look at the zero dose agenda, we are not talking about coveting a DTG0 to a DTG1.

Our aim – this is the part of the continuum toward a fully vaccinated child. And that's the spirit of IA 2030, is that we stop going antigen by antigen. So the measles folks want to, you know, do a campaign because, you know, they want to cover their immunity gaps. But so do the yellow fever folks, so do the polio folks. And we need to do this together. We need to get efficiencies out of it, because there will not be resources to rebuild immunization antigen by antigen. We have to do it in an integrated fashion, and along with primary health care services. Remember, immunization is not the only service that has been disrupted. All other sorts of services, including nutritional services, have been disrupted. Thank you.

Katherine E. Bliss: Robin, thank you.

Esther, can I turn to you for your perspective on, you know, what's, you know, happening in Uganda around, you know, kind of focusing on immunizations over the life course, you know, kind of beyond just the focus on children, and how you see the potential for, you know, vaccine-preventable diseases to really, you know, kind of come back and resurge in a big way when some of these restrictions are taken down?

Esther Nasikyee: Yeah. Thank you so much, Katherine.

For me, what that means – or, what that calls us to do is really to rethink our whole idea of social mobilization. Many times, you know, that has been looked at as a type of a downstream activity, but, you know, when we have, I mean, a situation like now, where we need to focus on everybody, the adults that traditionally have not been the focus of immunization campaigns, it means we need to rethink how we – how we support special mobilization across the board.

We need to think about it as – you know, as an upstream activity as well. We need to see more champions. People are talking about this. And, you know, having strong messages that are ready, whether it's the adults or the children, you know, the combination of that for increased uptake, so that we don't have, you know, children being left out, or focusing on only the adults or, in some cases, focusing on only the children, and then we have the adults hesitating to take up these services. So we need to rethink that.

But then also the second point, and in the interests of time, it's really rethinking the human resource. That as countries, we need to think, you know, how we expand that, because the current human resource is not even enough to cover the children alone. How much more when we expand, you know, the vaccine schedule? So we need to rethink how we bring in more people, how we support that, how we train. You know, could the health workforce that we have presently, you know, to even reach the number that we need them to reach. So we need to have some conversations and thinking around that as well.

And then, of course, you know, like I think I think that they say it is Nandita (ph) from Columbia University who is saying – you know, who is thinking about the other challenges in terms of new vaccine introduction. And of course, there are all the issues around the cold chain. You know, now, for us in Uganda, we are thinking about whatever vaccine we get for COVID, for example, what temperature range is that going to be? Is it going to be the plus-two to -eight? Then that the available cold system can handle. But if it is minus-70, like some of the vaccines we are seeing in other countries, it means, you now, that is going to be overhauled. The cold chain system will need an overhaul. And that comes with its own challenges. So thinking

through all these things are going to be important. But in terms of mobilization, for me my key point is we need to rethink social mobilization and the strategies.

Katherine E. Bliss: Esther, thank you.

Pierre, let me – let me turn to you, you know, around this question of focusing on – particularly on the Cité Soleil context where you’ve been working. You know, how – what are the – what is the experience in terms of implementing vaccines kind of beyond the focus on child vaccines? And, you know, as you contemplate the introduction of COVID vaccines in particular, I guess, you know, I would also ask you to say a little bit about not just community mobilization but also some of the questions around vaccine confidence that have been raised and, you know, certainly we’re seeing here in the United States with the, you know, sort of uneven rollout of the – of the vaccines in the different states.

What are you seeing in terms of, you know, these efforts to reach the zero dose families or the zero dose children? How do you see the prospects for kind of implementing immunizations for adults in that context, and what do you hear from the families that you’re interacting with about these confidence and trust questions? I think you’re still on mute – (laughs) – sorry.

Pierre Fontaine: Thank you. So in Haiti, in Cité Soleil, people were not really confident of the vaccine. Some of them didn’t even believe that COVID-19 exists. Some say that it’s just a rumor, and others say it’s true because I got a family or friend who got sick from it. So in Haiti, some people are at the – (inaudible). For instance, in some country they have started vaccination and they keep promoting social distancing. But in Haiti, we are a different stage, only – we are only promoting social distancing. Why we aren’t working for introducing COVID vaccine?

So what we do, we take opportunity of sensitization for social distancing and we try to anticipate for a vaccine, to say that the vaccine is also upcoming. So while we are keeping social distancing guidelines, we have to keep in mind that the vaccine would help us to avoid to be sick of COVID disease. So this will help us to fight against any kind of misinformation about COVID vaccine. And one of the reason they mention, that how can you have a vaccine so fast? Do you think it could be a right thing? Just do you think it can help? Because you didn’t need like two years to get a vaccine done. So this is one thing we can – we can mention.

So as a last thing, that we can see that COVID-19 wants people to stay at home, for instance, to avoid to be sick. And with immunization we want them to go out to the clinic and get the vaccine. So it’s like opposed. Those

two are opposed. What we try to find a common factor, which is sensitization. Sensitization for COVID gives us an opportunity to try to increase the use of services by specifically, like, decreasing the gap that has created COVID-19, and also to reduce the gap – the existing gap just before COVID-19.

Katherine E. Bliss: OK, well, thank you.

You know, Jen, I just wanted to return to your comments about the importance of community engagement and, you know, really locating services. I mean, everybody has mentioned this one or the other, but really having that important relationship between families and providers at the community level, and the trust that's so important to the immunization enterprise there. Just, you know, wanted to ask, you know, if within the Boost community or the other works that you're working with across the board, you know, the extent to which this issue of confidence and COVID-19 vaccines comes up. You touched on this a little bit, but, you know, kind of where you see that developing over the next few months.

Jennifer Siler: Yeah. Thanks, Katherine.

It has come up a lot from the adaptive leadership course that I mentioned. And we've posted a few of those now, which are kind of intensive six-week programs. There are a number of the members of those programs who are focusing on hesitancy challenges they're experiencing right now. We know that this is going to be a huge issue, and it's also going to be quite localized in terms of what the misinformation is. And so I think – (laughs) – it's something that we're all going to have to grapple with, and I know we're very focused on with the – Robin, you know, the demand hub, and a lot of other pieces that are moving to help support this.

We feel like at Boost having some of these foundational schools around adaptive leadership and community building and some of these other pieces will allow bringing that skillset down into, you know, subnational and county-level folks will allow some of these – you know, mapping out: What do I do with this – with this challenge of vaccine hesitancy in a specific way, and will allow, you know, folks to have some of those creative thinking skills too to say, all right, let's think about this. And I think we're hoping that on Boost too we can provide that space where people can talk about what they've been trying, what's been working.

I think someone – a concerned pediatrician in the Bronx asked a question kind of about, you know, what can the U.S. learn? And I think there's a lot of shared learning that can happen here. And we're hoping to do some of that global good pulling. But not everything is – you know, I think there's a lot of transferable ideas here. And it would be interesting to see what's working,

and finding that in real time of, hey, we're seeing this working over here for hesitancy, can I try it in this context? So, yeah.

Katherine E. Bliss: All right. Well, thank you.

I know we're coming to the end of our time here. But, Robin, if I could turn back to you for some just kind of final reflections on – you know, as you've looked over the past year and really seen the development and the impacts of COVID on the state of immunization, and as you look ahead around, you know, the – helping countries prepare for implementing COVID immunizations, what are you, you know, kind of most hopeful for? You know, one or two, you know, things that you're really optimistic about in the next six to 12 months or so.

Robin Nandy,
M.D.:

Well, in the interests of time I'm going to – I'm going to be very brief and limit to three points. Number one, a follow up to my response to Laura Shimp is that, yeah, we've got to get the political attention that these outbreaks cause to actually improve the system. So while we can use measles outbreak as an opportunity to raise the political – raise the immunization and the political agenda, we need to then use that momentum to cover all antigens and other essential services, including everything to do with primary health care.

My second point is on this whole issue of vaccine hesitancy. You know, I think it's really important to be measured in how we look at vaccine hesitancy. Sometimes the word "vaccine hesitancy" is thrown around willy-nilly. And I would like to caution against that. I think, you know, vaccine hesitancy doesn't – and vaccine misinformation does not automatically result in people rejecting vaccine. People reject vaccine when misinformation is layered on mistrust in the system. And I think we need to get the trust back.

The way governments have dealt with the COVID-19 pandemic has raised a lot of distrust and makes people much more likely to believe the misinformation. We need to, on one hand, get the trust back and make sure that evidence is shared, and information is easily – more easily accessible than misinformation.

And then, you know, my final point is, again, reiterating the points made by Jennifer, Esther, and Pierre, that the COVID-19 vaccine rollout will need to be adequately resourced in terms of finances, in terms of human resources. And if we don't do that, the immunization program and other health services will suffer. There's no two ways about this, because we're going to use the same system to deliver vaccines to a completely different age group that are not normally targeted. This will require very, very careful planning. And the national vaccine deployment plans that the governments

are working on will need to incorporate these elements so that the routine services are not compromised.

Katherine E. Bliss: Thank you. I think I see at least four or five additional meetings, you know, and sessions we could hold to discuss a lot of these – a lot of these topics. And speaking of that, you know, COVID has interrupted immunization services. It's also disrupted immunization conferences. And normally at CSIS, at least for the past few years, we've had an annual conference, kind of an all-day event that really brings people together in one place to talk about a lot of these issues. We're not able to do that this year. So this is one of a series of public virtual conversations that we will be hosting around these important topics over the next several months. So I encourage you to look at our event page and sign up for notices if you – if you would like to continue to engage in the discussions.

I want to thank all of our speakers for taking time to join us today from near and far. And Esther in Uganda, where it's already nighttime. So thank you all very much. I want to thank our team at CSIS, our conferencing team and audio/visual team, as well as Michaela Simoneau from the Global Health Policy Center, who's really been essential in putting all of this together. And very much appreciate those of you from the audience who joined us today, and online, and submitted questions. And look forward to additional discussion in the future. So thank you all very much.

(END)