

Center for Strategic and International Studies

TRANSCRIPT

Online Event

**Equity in Immunization Services to Ensure “A Long Life
for All”**

DATE

Thursday, April 28, 2022 at 10:00 a.m. ET

FEATURING

Rebecca Fields

*Technical Lead for Immunization, USAID MOMENTUM Routine Immunization Transformation
and Equity Project*

Cathy Ndiaye

Senior Technical Officer for Immunization, PATH

Mireille Lembwadio

Global Vaccination Coordinator, International Organization for Migration

CSIS EXPERTS

Katherine E. Bliss

*Senior Fellow and Director, Immunizations and Health Systems Resilience, Global Health
Policy Center, CSIS*

*Transcript By
Superior Transcriptions LLC
www.superiortranscriptions.com*

Katherine E. Bliss:

Good morning. I'm Katherine Bliss, senior fellow at the CSIS Global Health Policy Center, where I direct our work on immunizations and health systems resilience. Welcome to this session on the state of global immunization programs as we move further into a third year of COVID-19.

The past two decades have really been characterized by significant improvements, gains, in global immunization coverage in many parts of the world, particularly in low and lower-middle income countries. And the past year has been characterized by the increased global distribution of COVID-19 vaccines as well. But since 2020, gaps in routine immunizations have widened in high, middle, and low-income countries alike. Due, in part, to the massive diversion of resources to outbreak response, starting in March of 2020, and also due to lockdowns and social distancing measures.

Today we'll be talking about what it takes – what it will take to close those gaps in routine programs in an equitable manner, ensuring that the most difficult to reach populations – be they migrants and refugees, adults and adolescent girls, or children living in remote or underserved communities – can access immunization services in the same way others can. Today's event takes place during World Immunization Week. And as many of you know, World Immunization Week is celebrated annually in the last week of April. It serves to raise awareness about vaccine preventable diseases, generate advocacy to support international immunization programs, stimulate political will to invest greater financial and human resources into vaccination campaigns as well.

And I believe that this year marks the 10th anniversary of the World Health Assembly's endorsement of World Immunization Week, formalizing the activities that many countries around the world had been undertaking at different times in kind of an ad hoc manner prior to 2012. Now, the theme this year is "A Long Life for All." And in recent months, CSIS has been working on issues related to equity in immunization services, with an emphasis on addressing gender-related barriers to access, extending immunizations to populations in fragile or conflict-affected settings, and considering how programs can expand in a sustainable way to better include adolescents and adults without sacrificing the focus on children.

And so we thought it would be relevant to this year's theme to host a discussion with a group of experts who bring considerable experience with program design, program implementation, and program oversight to their work. They also bring deep perspective with local level implementation, international development assistance and support, and multilateral agency coordination to their efforts to extend immunization services and really ensure "A Long Life for All."

I'm really pleased to welcome Rebecca Fields, technical lead for immunization with USAID's MOMENTUM Routine Immunization Transformation and Equity project. And she is based in Arlington, Virginia.

I'm also pleased to welcome Mireille Lembwadio, global vaccination coordinator at the International Organization on Migration in Geneva.

And Cathy Ndiaye, senior technical advisor at the Center for Vaccine Innovation and Access at PATH, based in Dakar, Senegal.

So let's get started. Now, the World Immunization Week theme of "Long Life for All" really encompasses a focus on equity and access to immunizations that has been at the heart of so much discussion related to vaccines and health services under COVID-19. It emphasizes the importance of ensuring broad geographic distribution of vaccines to high-, middle-, and lower-income countries. And it also emphasizes, I think, the necessity of ensuring access for people living in remote settings or hard-to-reach populations and reminds us of the relevance of immunizations for people of all ages across the life course – that is, children, adolescents, and adults.

So, Rebecca, let me – let me start with you. In the countries where you are working with JSI and the MOMENTUM project, to what extent have the social and economic disruptions of the pandemic accentuated gender-related barriers to vaccine deliveries, and including COVID-19 deliveries, over the past year, year-plus-months? What have you seen?

Rebecca Fields: Well, thank you so much for that question. And I think it's important to recognize that the gender barriers to immunization existed prior to the pandemic itself, but really were under-recognized. We had long – looked mostly at sex-disaggregated data around who is being vaccinated and didn't see big differentials between the number of girls and boys being vaccinated. And so the gender barriers for anybody to get vaccinated really had not been very well recognized.

In the lead up to the development of the immunization agenda 2030, IA 2030, as well as the Gavi 5.0 strategic plan for five years, much more attention has been devoted to really recognizing what some of those gender barriers are, and how they play out in terms of limiting access and utilization of immunization services. So again, this kind of predated a little bit the pandemic, but as the pandemic has progressed, we've developed – we've actually had the opportunities, in fact, to develop a far richer understanding of what those barriers are and how they affect immunization both for COVID and for routine immunization – routine childhood immunization.

And, you know, fortunately, we've seen some greater resources devoted to understanding what those barriers are, and also devoted to going into efforts

to address them. So those barriers – those standard sort of barriers that preexisted before the pandemic – included limited mobility for women to be able to access services, especially if those services were not offered at convenient times or places.

Other barriers included – certainly a very important one is limited autonomy by caregivers, who tend to be female, tend to be the mothers. Not exclusively, but that's commonly the case for childhood vaccination. Limited autonomy on the part of those mothers as to being able to access services and actually accessing the resources to be able to take the child for vaccination. Taking the child for vaccination means leaving behind temporarily some of the other responsibilities, household duties, income generation activities that mothers are also responsible for.

And in fact, it has been through some surveys that have been conducted in connection with COVID vaccination during this past year that we've come to recognize just how important it is to ensure that in communicating about vaccination we don't communicate just with the mothers, but that we communicate with the fathers, the male partners, the mothers-in-law, the grandparents, and so forth, because they have at least as much influence as the mothers in determining whether the mother can, in fact, take that child for vaccination.

We also have to recognize that some of the gender barriers – (coughs) – excuse me – some of the gender barriers that are face in immunization – sorry – (coughs) – affect the health workers themselves. Seventy percent of health workers – frontline health workers – are female. They have their own issues about their family responsibilities, their ability to move about. And of course, all of this has been exacerbated – all of these barriers have been exacerbated by the pandemic.

This has changed over time, right? I mean, at the start of the pandemic we were seeing very severe lockdowns, severe cuts to transportation. Services themselves were severely disrupted. Fortunately for immunization, there has been somewhat of a rebound – a relatively rapid rebound for restoring immunization services, but not necessarily making up for the disruptions to services that extended over several months in 2020. That means we have a lot of children now who are unprotected from vaccine-preventable diseases, and who we urgently need to look towards and help address their needs.

But we also saw with the pandemic, with regard to gender-related barriers, that women were really acutely affected in terms of their daily lives. They suffered a lot of severe secondary effects – loss of income, loss of jobs, taking on additional responsibility for childcare as schools were shut. We also saw an increase in gender violence. All of this has been exacerbated by some of the changes to the services themselves, including a shift towards really

emphasizing COVID vaccination as being critical, and sometimes diverting resources away from routine immunization or other essential services in order to make COVID vaccination – raise coverage for COVID vaccination as quickly as possible.

A couple of other things that we see with regard to the effects of the pandemic have to do with the specific circumstances that the COVID virus contributes to. We know that pregnant and lactating women have particularly elevated needs for COVID vaccination. But we also know that even as women often suffer from relatively limited access to accurate information, the rumor mill is still very active, and the circulation of misinformation and even deliberate disinformation is constant and needs to be dealt with on a constant basis. And we need to use a variety of channels for really trying to counter that misinformation, recognizing that interpersonal communication is extremely powerful.

The last thing I would just say here is that with regard to COVID vaccination itself, initially we were seeing in many countries that the proportion of COVID vaccine doses that were going to women was much lower than the proportion going to men. And so this has really required a lot of work to look at the disaggregated – sex-disaggregated data about COVID vaccination to see who really is getting vaccinated and who is not. And then, importantly, talking with women, finding out from them, hearing their voices as to what are the impediments that they are facing and what could be done to try to improve the situation?

And just as one example of where that has played out very well, we see that in South Sudan back last summer, in mid-2021, only about 26 percent of COVID vaccine doses were being administered to women. You know, we would expect that to be more about 50 percent. It was only about 26 percent. After implementing a combination of activities – of research with women, of developing specific interventions to try to reach them, we've seen that over the course of about six months that proportion has increased from about 26 percent to about 48 percent.

So this really gives us a sense that there are things that can be done. This is not an insurmountable issue. There are things that need to be done. But we need to hear from women as to what the issues are that they are facing, and what they view as the most important interventions that can help them in accessing both routine immunization for their children as well as COVID vaccination for themselves and their families.

Dr. Bliss:

Great. Thank you. I mean, it really sounds like – that last example that you gave, I mean, the issue of awareness, of checking the data and finding out what women themselves felt were some of the challenges to, you know,

really improving that 25 percent up to 50 percent, you know, really led to a redoubled effort to conduct outreach and really was able to move that – move that number forward. That’s a really inspiring story to hear.

Mireille, I want to turn to you in a second. You know, Rebecca at the outset talked about both the Gavi policy on gender and some of the focus within Immunization Agenda 2030 and Gavi 5.0 in terms of particularly, you know, reaching difficult and hard-to-reach populations. And Gavi, of course, also has the policy on fragility, emergencies, and refugees. That may not be the right order that I’m saying it. But has had that policy as well.

And I just wanted to ask you to say a little bit, kind of, about the state of efforts in terms of reaching migrant and refugee populations with immunizations before the pandemic. And, you know, to ask you to say, you know, what – how the pandemic has really shaped outreach to populations on the move during a period of health crisis and, you know, lockdowns, and the kind of social distancing that we really saw, particularly in 2020 and early 2021.

And if you could just say a bit about why it can be challenging to ensure that these communities, who – which, you know, may be in a different nation than their home nation or, you know, in between – in between communities, why is it particularly challenging to ensure that they have equal access to immunization services? And what has IOM in particular learned during the pandemic?

Mireille
Lembwadio:

Thank you so much, Katherine. Good morning.

So we could really see that while the COVID-19 pandemic had affected everyone in the world, the response and related measures had initially created additional levels of exclusion of migrants, but also displaced populations and refugees. With regard to access to basic health-care services, including vaccination for COVID-19 when it became available, of course, but also other antigens, as routine services were highly disrupted.

So while pre-pandemic we were seeing a bit of progress in the consideration of migrants, displaced populations, and refugees into the different strategies but also the implementation plan as well as in actual targets and forecasts, the pandemic created a rupture of these steps. And we then witnessed a serious step back, requiring efforts and engagement to design and implement strategies and plans with host ministries of health, but also immigration, foreign affairs, interiors, and others to reach these groups, while ensuring their rights to health and protection are preserved.

So the challenge is to ensure these communities have equal access to immunization services related to COVID-19. As we know, most countries of

the world initially prioritized health-care workers, elderly persons, and people with comorbidities in what we call the national deployment and vaccination plan. And then they extended their eligibility criteria to additional prioritized groups, but primarily for the national citizens, leaving out vulnerable populations such as migrants, IDPs, and also, in many cases, refugees, that are all equally in needs to be catered for.

This was initially triggered by the limited availability of supply, when the vaccines became available, and then by the limited funding for personalization of the different plans and their deployment, as well as distribution down to the last mile. Which was obliging tough and discriminatory decisions to be made at very high level of the political engagements. But through different monitoring and observatory mechanisms, we noted also that while some of the plans could mention inclusion of vulnerable groups, there was no translation in practice when it came to implementation of those plans. And this, however, helped us shape and tailor advocacy and political will strategies and related interventions.

Nevertheless, beyond the target population prioritization that we easily mentioned as a key barrier, many others can be attributed to the challenge in ensuring migrants, IDPs, and refugees are – have access to immunization services. And this definitely applies to COVID-19, but also, to echo – to echo Rebecca, I would say these were also known as part of routine immunization services even pre-pandemic, and definitely with the pandemic that had disrupted all these services. So, we mainly talk about barriers related to administrative processes and policies.

In some countries, for example, you have certain laws and regulations that simply and really openly, really, ignore and bar some categories of migrants from having access to public health services. Vaccines are in some cases reserved only for nationals, especially when it comes to limited supply, as we have experienced with the COVID-19 pandemic, for example. We also have the issue of specific documents that might be required from the beneficiaries.

In some countries – fortunately, we have countries that accept any form of ID, valid or not, expired or not, and from any country. Only to verify the name and the identity. But then we have other countries that would require specific type of documents – for example, residencies, insurance cards – which really constitute a higher barrier for the beneficiaries. But those documents sometimes are accepted even if they've expired. And then we have countries, where documents that have to be presented have to be valid and not expired.

We also see a blurry or, let's say, an absence of firewall between health and immigration authorities. In some countries, health workers are required to

report to immigration authorities migrants that are coming for health services but that are in irregular situation. Which really leads for the beneficiary – for the migrants or people in vulnerable situations – to their fear of being arrested or deported. And then we also have faced the issue of registration that could be required to be done for different systems and often online prior to vaccination, which is really implementing another barrier for the beneficiary because of technological requirements, because of the language barrier as well. Again, fear of being tracked through these systems and then arrested or deported.

The migrants are also facing also financial barriers in some instances, because while the vaccine is free in most countries for people that are registered in national schemes or health insurance systems, in others it is really unclear the line on whether or not they should pay for it, or whether or not they should be enrolled before that into those different schemes. They face, as I mentioned, technical barriers like lack of internet connectivity, lack of access to information in the right language, and also mistrust is something that is really unclear among the different communities because of linguistic but also cultural barriers that we can have a very long list around it, and that we might have referred to all of us, during the pandemic especially.

We also see a lot of logistical hurdles for vaccine that are not reaching the last mile, like I mentioned, but also in terms of geographies. You mentioned the hard-to-reach areas, but there are also in urban areas people that are really hard to access. And then also where the conditions, seasonal situations where, for example, there are floods, and then the movements of population that really have to be constantly on the move. These are also difficult to monitor, to track, and then to reach. And more – and in the case of COVID-19, for example, the second doses were really difficult to make sure that those people would access these doses before the J&J vaccine became available, for example.

Some countries are also reporting as the barrier the effects of xenophobia and discrimination. Some host communities, host populations thinking that the migrant, the mobile population are the ones bringing the diseases among them. And then what we have learned really during this pandemic is the need to emphasize further on bottom-up approaches, really learning from the ground, learning from the context, learning from the beneficiaries, the target populations, and really tailor any guidance and strategies or plans to the reality, as well as the different messages that we share to really change the narrative and adapt them to the reality and the context, and have the right communication tools with us to make sure we achieve the right results.

Because these communications we have seen, when movements were restricted, where travels were completely banned, where people were confined, we've really seen – we've seen communication as being critical to

achieve any kind of result and to have an impact. Also, there is a real need to adapt to the actual situations in the field and its evolving nature, and manage to revise, replan, readapt as quickly as the situation changes.

Also, there is the need to clearly categorize, to clearly mention, to clearly identify the right populations in the plan, include migrants and other vulnerable populations from the start in the different national strategies and plans, to ensure that the related interventions do incorporate them and then they do target them. In theory, yes, of course. But more of it in practice, which was the main gap that we've seen throughout the pandemic.

And lastly, we also learned that there is a need to support the health sector, as IOM we are really supporting with our expertise in multisectoral engagement and collaboration to define roles and responsibilities of the different sectors, but really upfront. And then negotiate at the right level for the consideration of migrants, of displaced population, but also refugees. And making sure, again, that their rights to health and protection is respected and applied. Thank you.

Dr. Bliss:

Thank you. I mean, you've really, you know, laid out a few of the challenges that go from, you know, governments really not wanting to put up the resources or sort of manage the finances addressing the health needs of displaced or migrant populations, you know, to legal considerations, requirements of nationality or residency, but also just some of the logistical hurdles around maneuvering in a new language or a new context, and, of course, the fear and just uncertainty about linkages between health authorities and migration and some kinds of enforcement. So really a very complicated situation that, you know, it sounds like has become even more complicated in some ways because of the intensity of the pandemic over the past few years.

Cathy, I want to turn to you. You know, both Rebecca and Mireille have, you know, laid out many of the challenges that different populations have faced over the course – you know, even before the pandemic, and then of course really with the move toward COVID-19 vaccines during the pandemic, and the need to sustain programs – routine programs that have been in place. I wanted to ask you to say a bit about PATH's work during this period, in particular looking at the challenge of reaching adolescents. I mean, we know that coverage rates for HPV vaccine have fallen off after successful rollouts, in many cases, over the previous decade.

I wonder if you could say a little bit about, you know, reaching adolescents during this period? And also, you know, what it's been like, you know, as you've seen programs kind of struggle to expand to reach out to adults who, in many places, are not the – you know, often the targets of immunization outreach in the same way that families and children are, as Rebecca was

mentioning earlier. What has it been like for some of the programs you work with to, you know, begin to reach out to adults to try to incorporate vaccinations for that older age group into the system? If could you say a bit about what PATH is learning during this period.

Cathy Ndiaye: Sure. Thank you, Katherine. And hello, everyone.

I think one vaccine I can clearly talk about is the HPV vaccine, which targets adolescent girls aged nine to 14. So the HPV vaccine, as you may know already, prevents cervical cancer. It can save thousands of lives. And during the pandemic, there was – so the pandemic really affected at different levels.

First of all, there was a shift in the focus on the EPI programs. It was really hard to get their attention during the pandemic to work on the HPV reduction activities because there was so much to be done for COVID vaccination. Like, applying for funding, training health workers. It was just a lot of work for them. And then HPV was not a priority at that time. There was also a shift in resources. So most of the financial resources were, again, shifted towards COVID vaccination. And because there's a contribution, Gavi, of course, pays a lot – a good part of the resources needed for the HPV introduction – vaccine introduction. But there was also a contribution from the government that we couldn't get at the time because, again, COVID was around, COVID was a priority.

So, and lastly, there was also a shift in strategy. So the most effective strategy when introducing the HPV vaccine is the school-based strategy. So for example, in Senegal 80 percent of the girls are vaccinated in schools. Most of them are in primary school, actually. But during the pandemic, schools were closed, we were not able to reach girls through that strategy. We had to shift and see – be innovative, see how we can do this actually differently. So we had to go towards the community, find the girls in their homes, and organize an intensification of vaccine during a week or two to try to reach girls who were in schools or out of school during the pandemic.

I think also a very important point was communication. When we were vaccinating during COVID, for example, in Mauritania, people were skeptical. They thought that it was a new COVID vaccine, and there were lots of rumors about it around the vaccine. They did not want to get the vaccine. And so last April, when I was in Mauritania – it was in April. So we had to – we didn't have a lot of communication activities. Coverage was really low, about 44 percent, which is considered low when it comes to HPV in general and other vaccines too. But a year later, like two months ago, we had a second campaign. We said, OK, this time we will really communicate around the vaccines. And, you know, all the rumors and misinformation, as Rebecca and Mireille mentioned earlier, we had to tackle those.

And we saw a big difference. We went from 44 percent to close to 90 percent coverage, just by really communicating about the safety of the vaccines and its efficacy, and how it can prevent cervical cancer. So I think for adolescents, even before the pandemic they were hard to reach. They were hard to reach because they're not usual target for immunization. So we had to do extra efforts in general to reach them, but even more so during the pandemic right now. And countries were affected at different levels. So countries who were preparing to introduce the vaccine had to stop. Countries already introducing – who had already introduced the vaccine had to rethink the programs, find new strategies. So the impact of COVID was, as you said earlier, really seen in the field and in terms of coverage.

But I think what we can learn from HPV vaccination and apply to other vaccines, when it comes to other vaccination – like, let's say, COVID vaccination – I think it's the fact that the strategy is mobile. We have to go towards the community. We cannot wait for them to come. I think for HPV, it's a lesson's learned. We said, OK, if we wait for girls to come to the health facilities we won't find – we won't reach them. So let's go towards them. Let's go to the schools, let's go to the community. I think for COVID vaccination also we saw that in DRC it also worked. Mobile teams were going to strategic places in the city, high-traffic areas, and offering the vaccine for those who couldn't go to the health facilities. And I think we saw the results. It was the most effective one. Thank you.

Dr. Bliss: So it strikes me – I mean, all of you in different ways have really focused on the challenge of trust, and really tailoring strategies for outreach to conditions at the local level. Really talking to people, understanding what their needs are, and focusing on developing a strategy that will meet those needs. And, you know, what's really become clear over the course of the pandemic as well, you know, I think is the importance of delivering those health services within the primary health-care framework, with care really being people-centered, and delivered – you know, building that trust and delivering that care by trusted people at the local – you know, at the community level.

So, Rebecca, I wanted to go back to you for a second, just to ask you to say a big about how the programs or the projects that you're involved with define PHC, you know, define primary health care? And how important do you see the PHC model or framework for delivering immunization services? And what – can you say a little bit more about what's gained, you know, kind of beyond some of the gender-related issues you were talking about. What's gained by, you know, really focusing on community engagement and delivering those services at the community level?

Ms. Fields: Yeah. Absolutely. Thank you so much for that.

Well, I think, for starters, I just want to note that despite the circumstances that we're in right now with COVID vaccination, where some very unusual strategies have been used – you know, the mass campaigns at stadiums in some instances, things like that – by and large immunization is a cornerstone of primary health care. You know, it's always been a cornerstone of primary health care. It plays out differently for certain diseases, perhaps vaccine-preventable diseases such as polio and measles, at different points in time. But it really is a cornerstone of primary health care. And one of the really important attributes of childhood vaccination is that we are trying to reach every single child.

This is particularly prominent in the current environment – policy environment with the emphasis on trying to reach zero dose children. And I think we've come to recognize just how critical it is to try new and different approaches, but also expand some of those approaches that have worked over the past several years to get coverage to the point where it was at least prior to the pandemic. We're trying to reach every child. And one way that – not just those that come to the health facility. You know, and as Cathy was just saying, we need to make sure that those services are made convenient and available to those who are expected to use them. So we are trying to reach every child.

And one of the most powerful tools that we have for enabling that process is something called microplanning. This is really quite a detailed process that happens at health facility level, or it happens maybe a level up within the health system, to really try to identify where are people? Where are they located? How can we get services to them in a way that meets their needs? And what are the resources that are required to do so? So as we're thinking about that, we're applying that now for COVID vaccination as well. I mean, again, it was originated for childhood vaccination, but we're certainly seeing that it's highly applicable for COVID vaccination.

So here's the thing, if we're trying to do microplanning to reach every child, you know, we have to recognize that every child is born to a woman who needs other services. She needs anti-natal care, she needs safe delivery care, she needs postpartum care, she needs access for her family, for other aspects of primary health care. And so what we've been seeing is that that process – that approach of microplanning – (coughs) – excuse me – with some adaptation, can be highly useful for serving other health interventions within primary health care as well.

I think one of the other things that we've come to realize, just thinking about how immunization is embedded within primary health care, is, you know, we have new vaccines that have been introduced over the course of the past several years or are going to be introduced in the years to come. Cathy was just mentioning HPV vaccine. And what we see with some of these vaccines

is that they are extremely powerful tools, but they are just one tool in a toolkit, you know? So for example, with rotavirus vaccine, rotavirus vaccine is highly effective in preventing a certain type of diarrheal disease. But we have to look at how to prevent and manage diarrheal disease in a broader sense, recognizing that, again, the vaccine is one very important tool, but it needs to be used together with other tools.

The same is true with the very exciting developments around RTSS vaccine for malaria. This is a fantastic development. It holds great promise. It's going to be able to reach people who may not have access to other interventions for malaria. And that has been demonstrated. But we also recognize that it is one tool for malaria prevention and control, that has to be used in conjunction with other tools that are part of that primary health-care model overall.

Just going back for a minute to microplanning, one of the things that we've really seen over the years, and which we see right now in our work under MRITE in Mozambique and in DRC and in Kenya, is how important it is to have community engagement – active community engagement as part of a microplanning. This is the way of ensuring that the plans that are developed actually capture the needs of those clients who are to be served and reached with vaccination services. You know, they are the ones who can provide the input as to what time of day to provide the services, and where exactly to provide them. Is it OK to do it in a school during certain times? Is it OK to do it in a – to provide outreach services in a church as opposed to a mosque? I mean, again, this has highly contextual aspects to it, for which the community voices are really critical.

And I just want to mention that back several years ago at JSI we conducted a series of studies to try to understand what is it that drives improvements in routine immunization – childhood immunization, this was at the time. And in our analyses in Ethiopia, Cameroon, and Ghana, what we found was that – we identified about six drivers. And really about half of them clustered around building strong partnerships between health systems and communities, so that people see themselves as being on the same page and working towards the same goal. Immunization is relatively countable. It's relatively a constant kind of primary health-care service. It's tangible. People understand the value of it.

And that's where we found that really forging those links between health system personnel – whether it's frontline health workers, or whether it's supervisors – and those representatives from the communities and, of course, the mothers themselves is critically important for figuring out where, when, and how to provide those services in a way that is mutually agreeable, and which also brings in some mutual accountability. Communities have

their own contributions that they can make to help enable things like outreach to happen.

And finally, the last point I just want to bring up is often missed or not fully recognized, is now important and powerful it can be to bring in local non-health actors within the local government – that is to say, outside of the health system but operating at the local level of government. You know, general assemblymen, local political figures, local civil authorities who make budget allocation decisions. They have critically important roles to play, but only if they know that they have those roles to play around immunization.

Typically, in immunization we haven't done a great job in reaching out to them. And some of our prior work under a previous USAID-funded project called Maternal and Child Survival Program, we did quite a bit of work in Uganda to really try to bring the health personnel together with those local non-health actors, with some very tangible outcomes from those collaborations. And just to mention one example, in one particular district, in Bulambuli district in Uganda, where about half of the population had not been vaccinated at all, by bringing those local non-health actors into the microplanning process, they became aware of the fact that about a third of the population did not have access – did not have physical access to immunization or primary health-care services overall. There were no health facilities nearby.

And as a result of their involvement in that microplanning process, they charged other officials, other administrators, to repurpose six buildings – government buildings as health facilities – primary health-care facilities that were then staffed and equipped. And that led to a doubling of the number of villages that could be served, not just with immunization but with other primary health-care services, from about 340 to almost 700 villages that then could be reached. And it was because of that reaching out, not regarding immunization as its own standalone program but really situating it very well within immunization – excuse me – within primary health care overall.

This is exactly what we're trying to do now with MRITE in our country programs, particularly in Mozambique, and in DRC, as Cathy notes so well, and in Kenya. Trying to ensure that we really recognize the opportunities for integrating immunization, service delivery, and other management functions within primary health care more broadly, for the mutual benefit not just of immunization but for other services – other primary health-care services as well. Thank you.

Dr. Bliss:

So, Mireille, you know, Rebecca has really emphasized the importance of embedding immunization in a primary health-care model within a community where you can bring in elected officials or known civil authorities and other leaders, which strikes – and really engage in a level of

microplanning with the community to determine needs and design strategies. But it strikes me that, in talking about mobile populations that may have relocated from one place to another, whether within a country or between countries, and particularly if moving because of political or – political issues or conflict, that building that sense of community and creating that sense of trust that would allow for the kinds of engagements and planning that Rebecca has described, may be slightly more challenging.

And so I wanted to ask you to talk a little bit about what it takes to kind of build those relationships of trust and community around health and around immunizations within migrant communities and, you know, really how can some of the – you know, some of these lessons about people-centered, locally rooted health services be applied within the context of serving migrant populations?

Ms. Lembwadio: Thank you, Katherine.

I guess building trust requires really to be able to address multiple factors and needs. And this is exactly the same for migrants and the host communities, to ensure that we really create an atmosphere that make them feel really in a safe environment that we could navigate in and interact with them in. So these are related.

I would start by saying that these are related by knowing your audience, first of all. Wherever they are, you need to know who you're talking to, right? So while referring to migrants, IDPs and refugees in general maybe as vulnerable populations or groups, within these we also have specific groups with different type of vulnerabilities, but also needs, that are present. So I'm talking about children, women, adolescent girls, for example, people living with disabilities, with HIV or other diseases. These are all examples, again.

And those targets, those groups, do have specific and targeted needs, and different attentions that you have to really apply, as well as the related sensitivities and discretions that you might need when you address the different groups. So first of all, really to create that environment by knowing your audience, then to know the environment these population do evolve in, do move through the different mobile path that they have to follow, depending on where they're coming from, the reason why they had to move, they had to leave their homes.

All the legal implications also of interacting with the different populations, as I mentioned earlier, that could be related to fear of being deported, of being returned to their homes. So all these have to be – to be factored in, to be taken into account, as well as the different access issues that we also mentioned through the different barriers and limiting factors. And these are to be also considered in the different – in the different messages and

interventions that we do throughout building this trust with those communities.

We need to know the different communication tools and channels that we can use with the audience, but also what kind of information we could share, as well as the social behavior challenges such as the language. So as Rebecca was mentioning, to really involve the right people, together with those people that are part of the community, that would know the language but also know the level of literacy of those people, whether or not they have access to the different media, information. And then practices and norms when it comes to social and behavioral areas.

So this also – again, I will also reiterate the point and emphasize on the need to really involve the different influencers, the different community leaders, but the different people that could – like, religious leaders as well. And anybody that could really help create that link with the target audience, and then with the population. Among groups we've seen in different area, in different gathering, in different contexts. Even among a group of people that had to flee, among a group of people that had to really leave their homes because of war, you will always find a leader, someone who is really leading the group. So you really need to identify that person and address the communication, address the needs to that person that people will really follow, and that really trust already.

Also we need to know their fears and how these could be addressed, how these could be really taken into account in the different interventions, in the answers also that we give to them. And also point of clarification for the stigma and the discrimination that they're also facing, how we can really help them overcome these, how we could really create that safe environment that I was speaking about and avoid community rumors or dis or misconceptions to really evolve and expand further, by really trying to help them throughout the whole process. All of these are definitely done.

And knowing also the host communities. So we know the migrant, we know the mobile population. But we need to know also the host communities as well, which may also in some instances face similar challenges and barriers, and who can jointly benefit from the related interventions, which is also creating some sort of synergies among them, and then inter-ethnic or inter-cultural tolerance and understanding of each other. I would say, like, for – and also, I think Cathy, she raised a very critical point of the need to really be close to the community, close to the population, really avoid having only general, standardized approaches or maybe centralized, but really go to the lowest levels and be part of the community.

I've seen an example from recent interventions, recent field missions. In Nigeria, for example, we went to the northeast, Maiduguri, and Monguno,

where we really had to go through the IDP camps and really be part of the population. We used – first of all, as I mentioned, identified the community leader, the camp leader, I would say something who could really translate what we were doing. But we had also among the host communities someone who knew the language, and we were communicating in their language, even using even myself some of the words that I managed to learn to really approach those population, talk about vaccination in their own language in a way they could – they could understanding – understand it – sorry – but also any other health – essential health intervention that they could benefit from.

And that same day, we really – we've really seen an increase also in vaccine uptake. In that case, that was the campaign for COVID-19 vaccination. But I would say 95 percent of the camp eligible population were vaccinated that same day, just after the intervention, and really to the conversation that we'd had together. Same with DRC, as Cathy also mentioned. By really going down to the community and having involved the community leaders, but also community actors, community youth, who would talk to their population but also around their communities, and who will make them understand the benefits of vaccination, but the benefit also of accessing health-care services really helped also in our case, because we are present in most of the priority point of entries. This has helped also with the vaccinate acceptance and the vaccine uptake at that moment.

And using these – all these strategies, all these experience, all these lessons, we used that as part of our risk communication and community engagement strategy to help us really navigate through the difficult barriers that the community are facing. And this helped us really to build community trust, to reduce hesitancy which is fairly high, but ultimately improve vaccine uptake among migrants and vulnerable population. Also to mention the need and to also emphasize the need to really integrate also the different interventions and services who would really help to make population accept the vaccine and really go forward as a nation.

Because now we are really in some part of the world – really lightening, I would say, the related measures to COVID-19, for example, and going back to what we call the normal times, where routine immunization will literally be – recover from the impact that it has had during the pandemic. But then, other countries are still facing a very low coverage of COVID-19 vaccine, but very, very extremely high hesitance. So the need to really integrate messages for people with different health priorities is very key there as well, and important. Thank you.

Dr. Bliss: Thank you.

So, Cathy, I want to turn to you for a second. You know, both Rebecca and Mireille have emphasized the importance of tailored strategies,

microplanning, you know, really the kind of outreach to the community that can help understand the needs and deliver the best services. And of course, a lot of this effort linking with the community relies on community health workers.

But we know that over the course of the pandemic, health workers have experienced multiple burdens. They themselves have faced illness, lack of personal protective equipment. They've seen colleagues die – become sick and die. And, you know, they've had to take care of their families at the same time that they're working in health centers. And there's, you know, been – there have been numerous reports of burnout and just mental stress and fatigue on the part of health workers, and community health workers in particular.

So I just wanted to ask you to say a little bit about the role of community health workers in ensuring equitable immunization services, and in addressing some of the rumors and misinformation and some of the challenges that Rebecca and Mireille have talked about. And really, what more can be done to support community health workers who are facing so many of these different burdens, and yet upon whom so much is really depending for the success of these programs?

Dr. Ndiaye:

Mmm hmm. Yes, thank you, Katherine.

Yes, I think all of us would agree that community health workers are essential when it comes to immunization for the planning and implementation of vaccines. They contribute, as I said, planning – microplanning, as Rebecca mentioned earlier. They work closely with the EPI programs before even the vaccination starts. Before vaccination starts, also they have identified the target groups. They are the best-positioned person in the community to know whether – when it comes to HPV where the adolescent girls live, and when it comes to routine immunization for infants also they know the parents. They are the best placed to help us identify and vaccinate target groups.

For HPV vaccine also, we need, for example, to do this. Tracking the girls is quite challenging. But with the help of community health workers, it was feasible to find the girls, six months later, one year later, and give them the vaccine. So in general, for me, for all types of vaccines, it is essential to work with them. They do a great work. And the question now is – you ask, how can we improve their contribution? How can we give them the tools they need to do better? I think that's a great question. I wouldn't say that we have the answers yet, because the thing is they work not only on immunization activities, but they also do malaria work. They do nutrition work.

So it's a lot of programs that rely a lot on community health workers. I think what we could do is sit together and talk together how we can strengthen their role and give them the tools they need. Because the thing is, by definition, community health workers are volunteers. So when – even when some parents attempted to pay them, people are reticent. And they say, OK, let's think about the carefully. Can we give them money? Should we – should we not? So there was a lot of discussion around it. We haven't found the right solution. But what we can do at least is give them incentives. Sometimes it doesn't – they don't ask for much. Just, like, a raincoat for when it rains, or boots just to walk around the community would suffice.

So we can probably continue the conversation where we are thinking about how to do it. But we know for sure – (audio break) – many programs. And we need to – (audio break) – hello?

Dr. Bliss: I think we lost you for a second, but –

Dr. Ndiaye: Oh, sorry, sorry. (Laughs.) Can you hear me now?

Dr. Bliss: Yes.

Dr. Ndiaye: OK. OK. Where did you – oh, I have – where did I stop? Where did you stop hearing me?

Dr. Bliss: I think you were emphasizing the ways that we can identify support for community health workers in the future.

Dr. Ndiaye: Yes. OK. Yeah, sorry, I didn't know where I got cut off. But I was just saying, yes, we need to find ways to support the community health workers by giving them incentives. Even if they are not paid monthly, but we can provide find tools like just giving them a raincoat for when it rains or boots to walk around the community may be a good start, until we find a consensus between all the partners on how to compensate these people for their work. Thank you.

Dr. Bliss: Thank you.

So we're coming to the end of our session. And this has been a really rich discussion with a lot of important points raised. And I know we could take each one of these points and have a future discussion around each one of them. But I just want to ask each of you in just the short time that remains for us to offer some final reflections on lessons from the pandemic that your organization has, you know, really learned over the past two years in particular.

And steps – just if you would kind of identify one priority step that you think local – depending on your perspective – local organization, the development assistance programs where multilateral agency can take to really strengthen the delivery of immunizations across countries, but really across the life cycle, across the life course. You know, just lessons from the pandemic and really one step that can be taken today to, you know, increase the awareness and reach across the life course for – or, for – you know, to improve equity within the populations with which you work.

So let's see. Mireille, let me start with you.

Ms. Lembwadio: Thank you, again, Katherine. And thank you, everyone.

I think what we really need to continue doing is to join forces. Something that we really learned to do further during the pandemic. And strengthen really the stakeholders, collaboration, and coordination at all levels. I'm thinking about the health sector, definitely, but also with other sector that we've seen that we really need their involvement if we want to achieve better results.

And we – something that I think that we should take immediately as a first step is to really contextualize our different interventions, but also strategies, and have them really build, develop, and state at the sub-national levels – really, like, targeting sub-national levels and the right context, and the field situation as it is. I think this is my main take for – and definitely, from our area of work, for our mandate but also expertise, would be to have from the very start of all these interventions, all these strategies, to have all types of populations included in the plans from the very beginning. Thank you.

Dr. Bliss: All right. Thank you. So multisectoral engagement and, you know, really collaboration across many different fields within the health sector and beyond. Let's see, Cathy, let me – let me turn to you. What's your top priority or recommendation?

Dr. Ndiaye: Yes. Recommendation? In addition to what Mireille said, I think reducing vaccine hesitancy is really important. I think when it comes to at least the vaccines I know most, the HPV vaccine and the COVID vaccine, vaccine hesitancy plays a big role. So and second, improve accessibility of that – of services. How do we make vaccination services more mobile, closer to the community? I think that's a major barrier that if we can address we will get better results. And finally, finally, as you mentioned, community health workers, how do we support them to better do the work they are doing? They are essential to get also better results. Thank you.

Dr. Bliss: Thank you. So better address vaccine hesitancy, improve accessibility, and continue to support community health workers.

All right, Rebecca, the last word is yours.

Ms. Fields: (Laughs.) OK. Thanks.

So, first, I want to say how much I agree with the points that Mireille and Cathy have just raised. Really critical points. I would say that the pandemic has forced us, in a way, into life course vaccination in a way that previously had been stalled, frankly. And with this attention to life course vaccination, we have some opportunities here. We've got lessons that we are learning in real time right this minute.

One of them is about new types of partnerships – reaching out to different types of people that we haven't worked with previously – professional associations, other organizations, employers, and so forth. And we've also come to realize that we have new points of entry for immunization. For example, through HIV/AIDS programs in southern and eastern Africa, where we've seen those programs as an opportunity for reaching people with comorbidities and who are immunocompromised – to reach them with vaccination.

The other point, just getting back to what Cathy was saying, is that the issue of vaccine hesitancy has been front and center in terms of attention. And with that concern has come a rapid implementation of better methods and tools and acceleration of work to understand the reasons for low vaccination uptake. We've got new tools and models that have proven to be very, very effective that we need to continue using. Because the issue of vaccine hesitance, as well as its counter, to that point, vaccine acceptance, which is what we're after, is going to continue to be an issue in perpetuity.

Finally, I would say that we are seeing enhanced use of data across the board to try to figure out where and how to provide those kinds of tailored services and strategies that both Mireille and Cathy were just talking about. Those are all some gains that we have made during this very, very difficult period of the pandemic, that we certainly should build upon and not lose what we've learned from them. Thank you.

Dr. Bliss: Great. Well, thank you. So new partnerships, better integration with other areas of health services and other social services, and really better use of data to target populations and understand the kind of outreach that's needed.

I want to thank the three of you for taking the time to join me today to share your perspective on the state of global immunization programs, and what it takes to reach difficult to reach populations, and to reach populations really at all different ages, whether they be migrants and refugees, adolescent girls,

or people living in remote or just underserved communities maybe in urban centers. I also want to thank Mackenzie Burke and Maclean Sperer, and the AV staff here at CSIS for their work in putting this livestream together today. And I also want to thank you, the audience, for joining this session, and wish everyone a good remainder of World Immunization Week. Thank you all very much.

(END)