Vaccine Equity & Access in Crisis

COVID-19 Vaccination Updates from Conflict-Affected and Fragile States

May 19, 2021
10 countries have administered 76% of all COVID-19 vaccines.
1.48 billion doses have been administered across 176 countries.
The global vaccination rate is 24.5 million doses per day on average.
Country Update: On March 31, Yemen received its first batch of 360,000 vaccine doses through the COVAX program.
Country Update: On April 22, Syria received its first batch of 250,000 vaccine doses through the COVAX program, including 53,000 which were delivered directly to the northwest.

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The world has entered the second year of the COVID-19 pandemic. After over 160 million global infections and nearly 3.4 million deaths from the virus, the growing number of COVID-19 vaccines offer a glimmer of hope. COVID-19 vaccines help to lead to 'herd immunity' when vaccine coverage of specific populations reaches sufficient levels, and reduces morbidity and mortality induced by the virus. However, while the availability of vaccines signals the beginning of the end of the pandemic, for the majority of the world the end is still a long way off. **A key component of the global vaccination campaign is missing: equity and access.**

Countries have experienced drastically unequal access to vaccines - 33% of all vaccines have gone to 27 of the world’s wealthiest countries, despite having only 10% of the global population. Around 90% of people in low-income countries are unlikely to receive a vaccine this year. For communities in conflict-affected and fragile states, the logistics of vaccine distribution - in addition to the financial constraints of purchasing adequate numbers of vaccines - create even more barriers to widespread vaccine access.

**MedGlobal was built on the vision of a world without healthcare disparity. Central to this vision is COVID-19 vaccine equity and access.**

The MedGlobal team has been leading critical COVID-19 responses in 11 countries around the world since March 2020, through direct health services, donations of essential equipment, building critical health infrastructure like oxygen generators, and virtual and in-person training and health education. Through these coordinated efforts, working with a diverse community of local health professionals and partner organizations, MedGlobal has learned about the local realities of some of the most vulnerable populations in the world facing the pandemic. This report dives into equity and access issues being faced in the global COVID-19 vaccination campaign; COVID-19 and vaccine accessibility updates from 7 of our countries of operation - Bangladesh, Colombia, Gaza, Lebanon, Sudan, Syria, and Yemen; and recommendations for vaccine delivery from a strategic and community perspective.
Global COVID-19 Vaccine Status

COVID-19, caused by the SARS-CoV-2 virus, continues to be a major threat to health. Since the outbreak of the COVID-19 pandemic, there have been over a hundred potential vaccines developed, but only a handful have been approved for use. The WHO and other trackers maintain updated lists of vaccines in the pipeline and provide the key data on vaccines which have demonstrated acceptable efficacy and tolerance to date. These vaccines vary in their composition from mRNA technologies to inactivated viruses to viral vectors, and include Pfizer-BioNTech, Moderna, Oxford University-Astrazeneca, Sinova, Sputnik V, Johnson & Johnson, and others.

Given this rapid development and production of vaccines, the planning for their purchase and delivery has been quite rapid. In April 2020, the WHO urged a global collaboration for COVID-19 diagnostics, therapeutics, and vaccines, as there were no platforms that ensured this collaboration of member states. In response, a mixed public-private-sector response came in the form of the Access to COVID-19 Tools Accelerator, or ACT Accelerator, which is a global collaboration to accelerate development, production, and equitable access to COVID-19 tests, treatments, and vaccines. The key vaccines pillar of the ACT Accelerator became COVAX, co-led by Gavi, the Coalition for Epidemic Preparedness Innovations (CEPI), and the WHO. COVAX acts as a platform to support the development and manufacturing of a range of COVID-19 vaccine candidates, and negotiate their pricing. All participating countries will have equal access to these vaccines once they are developed, working to ensure that no country, regardless of income level, is left behind in vaccine coverage. These points are laid out in the Gavi COVAX Advance Market Commitment (AMC), which supports access and delivery of timely vaccines to the 92 low-to-middle-income (LMIC) countries, and the humanitarian buffer plan, where a buffer of up to 5% of the total number of available COVAX doses will be set aside as a backstop to use if national vaccination campaigns processes fail to reach certain populations - like refugees, asylum seekers, and frontline workers.

Over 190 countries have either entered an agreement with or committed to joining COVAX. While COVAX is facing major funding shortfalls, it aims to deliver 2 billion vaccines in 2021, including at least 1.3 billion doses to the 92 LMICs. A country-by-country COVAX distribution forecast was released on February 3, showing an aim to provide participating countries with doses in proportion to their population size, reaching approximately 3.3% of each country’s population. Deliveries of these vaccines began in late February, but have been delayed across several regions. The ongoing COVID-19 crisis in India, a major vaccine manufacturer, will likely impact COVAX supplies and further disrupt vaccination efforts.
Refugees, asylum seekers, undocumented migrants, and stateless people face even more barriers to access vaccines. Across at least 103 countries, forcibly displaced people have faced the effects of COVID-19. However, less than 57% of countries developing national vaccination strategies have considered refugees in their vaccination planning. On February 3, the UNHCR and Gavi signed an agreement with the goal of ensuring refugees and forcibly displaced persons can access vaccines on par with nationals, but there is still much advocacy needed from the UN at the country-level to push for refugees and other vulnerable populations to be included in responses.

**Equity and Access**

The UN Secretary General has described the distribution of COVID-19 vaccines as “wildly uneven and unfair.”

The universal need for vaccines lays bare the inequality in healthcare access between wealthy and lower-income countries, with an even greater disparity for particularly vulnerable communities within conflict-affected and fragile states. Countries with the resources to fund vaccine development have been able to secure large numbers of vaccines for themselves while leaving a small supply of vaccines for others. Of the approximately 1.48 billion vaccine doses that have been administered as of May 19, nearly 76% of them were in just 10 countries. In the United States, more than 47% of the population has received one dose and the country is predicted to reach herd immunity in the coming months. In low-income countries, however, it is estimated that around 90% of people are unlikely to receive a vaccine this year, and widespread vaccine coverage for more than 85 lower-income countries is not expected before 2023.

Even when countries receive vaccines, disparities of distribution in-country are common. In the United States, communities of color, particularly Black, Latinx, and Indigenous communities, have been disproportionately harmed by COVID-19, but have far less access to vaccination sites during the vaccine rollout. Vaccination planning at
the country level - which varies country by country, particularly considering which populations are excluded from national plans and which groups are prioritized in the first phase of rollout - has the ability to lessen or exacerbate existing health disparities. According to UNHCR, only 94 out of the 130 countries it works in have committed to including forcibly displaced persons in national vaccine plans. In some countries, deliberate exclusion of specific areas or populations is feared as a weaponization of healthcare. For states with legacies of discrimination and mistrust between the state and certain populations, inclusion in vaccination plans may not be enough to ensure participation. Investment in outreach and education to both reduce stigmas surrounding vaccines and build trust are essential for effective and equitable vaccination campaigns.

In countries with weak health systems, especially those experiencing humanitarian emergencies, economic crises, or conflict, the lack of capacity of the national government to manage the vaccination program - as well as lack of funding, reduced numbers of health workers, and crumbling infrastructure - may seriously hinder a vaccine rollout. For many crisis-affected and fragile states, structural inequities and access issues will hinder potential vaccination campaigns. For rural communities in fragile states, even if the vaccine was available, access to vaccination sites and comprehensive information could be anticipated as common barriers. In many countries where health infrastructure has been destroyed by conflict, such as Syria, Gaza, or Yemen, health facilities often do not have the capabilities - such as cold chain technologies and ultra-cold freezers - or reliable electricity to store certain COVID-19 vaccines like Pfizer-BioNTech, leading to more limited supply options.

The inequitable distribution of COVID-19 vaccines is not only an ethical issue, but also an issue of global health security. Infectious diseases like COVID-19 do not respect borders, and leaving states behind in the vaccination response is a threat to global health. As said by WHO chief Tedros Adhanom Ghebreyesus, “Vaccine nationalism is self-defeating and would delay a global recovery.”

**Vaccination Updates: Key Countries**

MedGlobal supports comprehensive health services and trainings in many conflict-affected and fragile states, where COVID-19 has compounded existing vulnerabilities to create crises within crises. This section looks at 7 of MedGlobal’s countries of operation, and explores the current scale of the COVID-19 outbreak, the status of the vaccination response, and additional challenges facing vulnerable populations such as refugees or displaced people.
More than 900,000 Rohingya refugees live in the most densely populated refugee camps in the world in Cox's Bazar, Bangladesh. With limited access to water, sanitation, and hygiene, they live in low-lying areas that are prone to flooding and mudslides during the annual monsoon season.

In May, when health officials confirmed the first case of COVID-19 among the refugee population in Cox's Bazar, there were no ICU beds in any of the refugee camps. There have been 670 confirmed cases of COVID-19 among Rohingya refugees living in the camps and at least 11 have died after testing positive.

Bangladesh began an initial vaccine rollout in January after signing an agreement for 30 million doses of the AstraZeneca COVID-19 vaccine from India. In February, The Minister of Health announced that Bangladesh would also be receiving 68 million doses through COVAX. As of May 19, more than 9.5 million doses have been administered. However, India’s spike in COVID-19 infections and the disruption of vaccine exports has left Bangladesh facing vaccine shortages. In response, Bangladesh announced that it would further postpone vaccinations for Rohingya refugees—the only group in the country excluded. Among Rohingya refugees in Bangladesh, only 30,000 are above 60.

"It is important to remember that these are the most densely populated refugee camps in the world, and it is almost impossible to maintain physical distancing.”

Labib Tazone, Bangladesh Program Manager
Total Population: 50 million
Total Confirmed Cases: 3,118,426 (May 19)
Total Confirmed Cases among Venezuelans in Colombia: 32,747 (May 19)

Nearly 1.7 million Venezuelans are in Colombia as migrants, refugees, or asylum seekers. Local communities and health systems have struggled to manage the influx of displaced Venezuelans, many of whom have dealt with years of malnutrition and a lack of access to healthcare.

Despite initial successes in coping with the spread of COVID-19, the outbreak escalated to a peak in Colombia in January 2021. Colombia has recently been struggling to manage the virus due to weeks of massive anti-government protests across the country. Intensive care units in Colombia’s largest cities are hovering between 94-99% capacity and a new surge in cases is expected.

On February 8, Colombia announced it would grant temporary legal status for 10 years to all Venezuelan migrants who entered the country prior to 2021. This is a critical step, as it allows for Venezuelans to access national health services including the vaccination campaign. At this point, the Colombian government has made agreements to purchase enough vaccines for 29 million people as part of its goal to vaccinate 34 million people. Beginning on February 17, Colombia plans to vaccinate one million people in the first 30 days. Frontline health workers will receive the first vaccines, followed by people over 80 years of age.

“Here, especially on the Colombian-Venezuelan border, it has been a struggle to cope with COVID-19. In late January, the number of new daily cases reached its peak, with over 17,000 new cases across the country each day.”

Angela Restrepo, Colombia Program Manager
Gaza

Total Population: 1.9 million
Total Confirmed Cases: 104,871 (May 10)

The Gaza Strip is home to 1.9 million Palestinians, the majority of whom face poor living conditions and a lack of access to basic needs. Endemic poverty has significantly worsened over the past decade with over 80% of the population now living in poverty compared to 39% in 2011. Years of a blockade, lack of access to resources and aid, and the recent outbreak of violence between Israel and Hamas have eroded health infrastructure and brought the health system to a breaking point. On Monday, Gaza’s only lab processing COVID-19 tests was destroyed.

According to the Ministry of Health in Gaza, there have been 104,871 cases of COVID-19 and 956 deaths from the virus in Gaza as of May 10. The official number of cases is likely an underestimate due to a shortage of testing materials, issues related to access and freedom of movement, stigma related to the virus, and more.

The collapsed economy, weak health system, and total blockade of Gaza pose insurmountable challenges to purchasing and distributing vaccines without ongoing international support. An initial supply of 2,000 doses of Russia’s Sputnik V vaccine was delivered to Gaza from the West Bank on February 17. Gaza also received 20,000 doses of Sputnik V vaccine from the United Arab Emirates on February 21, with the vaccine rollout campaign beginning for health workers and people with chronic disease.

"The blockade and access issues we face will make it so difficult for us to access vaccines for the majority of our population. We know firsthand that the rollout of vaccines is not equitable or fair."

Rajaa, Gaza Program Manager
Lebanon

Total Population: 6.85 million
Total Confirmed Cases: 536,554 (May 19)
Total Confirmed Cases among Syrian Refugees: 5,624 (Mar 31)
Total Confirmed Cases among Palestinian Refugees: 10,510 (Mar 31)

**Confirmed cases among Syrian refugees reported by the UNHCR, and likely a dramatic underestimate of the real number.**

Prior to the outbreak of COVID-19, Lebanon was already dealing with a historic economic and political crisis that crippled the nation’s health system and pushed the majority of the population into poverty. The 1.7 million refugees in Lebanon, including 1.5 million Syrian refugees, experience an ongoing poverty crisis, with 88% of Syrian refugees living below the poverty line.

The damaged economy and health system were further devastated by the rapid spread of COVID-19. Lebanon’s struggle to pay for imports has led to countrywide shortages of medical supplies. Many health facilities lack sufficient medical oxygen and ventilators to treat patients and at least 2,300 health care workers have been infected with COVID-19 since the pandemic began.

Due to Lebanon’s financial crisis, the World Bank has paid for enough vaccines for 2 million people. The first vaccinations began on February 13 for frontline workers followed by people over the age of 75.

Human rights groups are raising important concerns that migrant workers are being excluded from the vaccination campaign. While the Lebanese government has said that it will vaccinate Syrian and Palestinian refugees along with the rest of the population, registration is extremely low among refugees. The UN recently released data showing that Palestinian refugees in Lebanon are three times more likely to die from COVID-19 than the population as a whole, underscoring the importance of accessible vaccinations for refugees. With the high rates of poverty, Palestinian and Syrian refugees tend to have poorer baseline health conditions, making them more susceptible to the effects of COVID-19 coupled with co-morbidities.

"It is essential that everyone in Lebanon, including Syrian refugees, the Palestinian population, and migrant workers, have access to COVID vaccines when they become more widely available in the country."

Tania Baban, Lebanon Program Manager
In 2020, Sudan faced record-breaking floods, internal displacement, and the beginning of a humanitarian emergency as more than 60,000 Ethiopian refugees fled into eastern Sudan. The transitional government’s ability to respond to these crises has been severely hindered by a struggling economy and the outbreak of COVID-19 that has overwhelmed the fragile health system. Though the country has reported nearly 35,000 cases, the real number is likely much higher according to a report by Imperial College London that estimated 98% of COVID-19 related deaths in the capital were unreported.

In December, the Ministry of Health announced that it expects to receive 8.4 million doses of COVID-19 vaccines through COVAX in the first quarter of 2021. The United Arab Emirates announced in January that it plans to supply Sudan with vaccines as well. However, it is not expected that Sudan will receive sufficient doses to vaccinate the majority of the population in 2021. With a growing displacement crisis in the Darfur region and uncertainty about the future for Ethiopian refugees now crowded in refugee camps in the east, there are numerous populations in Sudan that are not able to effectively socially distance and are particularly at-risk.

“Sudan will be receiving COVID vaccines through COVAX, but it may be several years until there are enough doses to vaccinate the majority of the population. People here in Sudan deserve the same access to vaccines and healthcare as all other countries in the world.”

Abdelsamad Abdalla, Sudan Program Manager
Syria

Total Population: Around 17 million
Total Confirmed Cases in Government-Held Areas: 23,788 (May 19)
Total Confirmed Cases in Northwest: 22,405 (May 19)
Total Confirmed Cases in Northeast: 15,000 (April 26)

**Confirmed cases are likely a dramatic underestimate of the real number.**

The decade-long conflict in Syria has killed hundreds of thousands of people and created the world’s largest displacement crisis. Destruction of health facilities across Syria has exacerbated the humanitarian situation and severely crippled local and national capacities to respond to the COVID-19 pandemic.

The scope of the COVID-19 outbreak in Syria is unknown due to underreporting, limited testing capacity and entrenched stigmas associated with the virus. Across all areas, the official COVID-19 caseloads are likely major underestimates. Local health systems lack the capacity to effectively treat cases as 70% of health workers have fled and there is a dire lack of personal protective equipment, medical oxygen, and ventilators across the country.

On April 22, Syria received its first batch of 250,000 vaccine doses through the COVAX program, including 53,000 which were delivered directly to the northwest. Across Syria, there are also concerns about a lack of equipment and continuous access to electricity needed to properly handle and store certain COVID vaccines. Beyond logistical barriers, it is critical to address growing misinformation and stigma associated with COVID-19 to implement an effective vaccination campaign. Particularly with the uniquely decentralized distribution plans, ensuring equitable access to vaccines in Syria will be a difficult undertaking.

"Syria has been overwhelmed by COVID. Many hospitals were unable to even receive patients, and many patients were treated and died at home. Many healthcare providers died after getting infected. We think the official numbers represent less than 5% of the actual case and mortality numbers."

**Dr. Zaher Sahloul**, MedGlobal President and Co-Founder
**Yemen**

Total Population: Around 29 million  
Total Confirmed Cases: 6,572 (May 19)  
**Confirmed cases are likely a dramatic underestimate of the real number.**

After more than 5 years of conflict, 80% of Yemen’s population is in need of humanitarian aid and less than half of all health facilities are fully functioning. The hunger crisis in Yemen is now at the point of famine, as 16 million face food insecurity, including five million who are acutely food insecure.

The true extent of COVID-19’s spread among the population is unknown due to limited testing, social stigma, misdiagnosis of symptoms, and more. In northern Yemen, COVID-19 cases are not being tracked or fed into the overall COVID-19-related data. Though it is a large underestimate, as of May 19, there have been 6,572 COVID-19 cases confirmed in Yemen and 1,295 official deaths from COVID-19. This amounts to nearly 20% mortality rate among confirmed COVID-19 patients, more than 10 times the global average. MedGlobal worked with a group of local doctors in Yemen to track the deaths of health providers from COVID-19, and found that over 100 health workers across the country reportedly died of COVID-19 within four months after the first recorded case.

On March 31, Yemen received its first batch of 360,000 vaccine doses through the COVAX program. Storing, transporting, and distributing vaccines across the country will be challenging due to the ongoing conflict, damaged infrastructure, and difficulty accessing communities, particularly those in northern Yemen.

“Among those confirmed to have coronavirus [in Yemen], the mortality rate was extremely high. At one point, the official COVID mortality rate was the highest in the world.”

**Dr. Mohammed Abass**, Yemen Program Manager
Key Recommendations

Moving into the rest of 2021, it is essential that the global vaccination response prioritize equity and access. Based on feedback from our in-country, program, and medical experts we provide the following essential recommendations and advocacy points, specifically from the standpoint of refugees and displaced populations:

To Middle and Upper-Income Countries:

- Countries should increase contributions to the COVAX facility and to share doses with COVAX in parallel with their national vaccine rollouts.
- Countries should prioritize supplying to COVAX over new bilateral deals.

All Governments:

- All governments should ensure that COVID-19 vaccines are distributed for free.
- Vaccine rollouts should begin with health workers and those people at greatest risk of COVID-19. It is critical to prioritize the most affected communities.
- The principle of health equity should guide decision-making. Essential workers and the most affected communities - including refugees and displaced people themselves when applicable - should be involved in the strategic planning of vaccine programs.

UN and COVAX Facility:

- COVAX, and particularly the humanitarian buffer and AMC branch, are critical in addressing equity of the vaccine distribution. However, COVAX does not address equity in the phase 1 distribution at the country level, specifically for special populations like refugees and displaced persons, which constitute over 80 million individuals globally. Healthcare systems for refugees and displaced are already scarce and fragile, and outbreaks in these communities have dire consequences on the health, social, and economic situation of the individuals and their families. A ‘fair priority model’, as presented by Emanuel et. al, which prioritizes vulnerable populations should be incorporated into COVAX agreements, at least for the initial vaccines distributions. This is a cost-effective approach, as it could help to prevent “aggregate economic damage” ensued by an uncontrolled outbreak in refugee and displaced communities.
A global collaboration by the humanitarian, social justice, and public sectors should further push the proposal set at the World Trade Organization (WTO) to waive the intellectual property on COVID-19 vaccines.

**Vaccine Manufacturers:**

- Vaccine manufacturers should increase their commitment to COVAX to guarantee access to vaccines of the most vulnerable populations and communities, including refugees and displaced people. NGOs experienced in vaccination programs for refugees should be consulted, so that the process of vaccination is safeguarded, especially with the technical aspects of vaccines.

**At the country level:**

- Local NGOs and civil society organizations need to be involved in the strategic planning of vaccine programs at the country-level.
- Health education and awareness programs with clear, simple, and culturally salient information about vaccines should be conducted in camps, informal settlements, and vulnerable community settings to provide communities.
- Health education and training sessions for health personnel on the frontlines with refugees and displaced people should be conducted to ensure they are familiar with vaccine data and can accurately convey information.
- Surveys and focus group discussions should be conducted with populations where there is particular resistance to COVID-19 vaccination campaigns. Understanding the specific concerns of local communities is critical to countering misinformation and incorporating local knowledge into vaccine rollouts.
- The pillars of resilient health systems, global health equity, and social justice are essential in the planning and implementation of vaccination programs for displaced populations and refugees.
- Mechanisms for the follow-up of individuals vaccinated, including reporting of adverse effects, should be in place prior to implementation of vaccinations.
- The study of the efficacy of the vaccines in the refugee and displaced populations should be led by the UNHCR, with special considerations surrounding research on refugees and displaced people.
Resources

- The People’s Vaccine
- Bloomberg Global COVID Vaccine Tracker
- COVID-19 WHO Dashboard
- UNHCR Global COVID-19 Emergency Response
- Delivery of immunization services for refugees and migrants: technical guidance
- Call to Action: WHO Vaccine Equity Declaration
- COVAX - List of participating economies
- Q&A: 'Including refugees in the vaccine rollout is key to ending the pandemic'
- Are asylum seekers, refugees and foreign migrants considered in the COVID-19 vaccine discourse?
- People’s Health Movement - COVID and Governance
- An ethical framework for global vaccine allocation

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