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Risk Communication and Community Engagement Guidance on COVID-19 Vaccines for Marginalised Populations

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Interim Guidance

**Collective
service** | Risk Communication and
Community Engagement

Produced by the Collective Service for Risk Communication and Community Engagement (RCCE) through the Inter-agency Sub-group on RCCE for Community Engagement in Low Resource Settings and the Inter-agency Sub-group on RCCE for Refugees, Migrants, IDPs, and Host Communities.

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* The USAID funded READY initiative aims to augment global capacity to respond to major outbreaks of infectious disease with epidemic or pandemic potential. READY is led by Save the Children in partnership with the Johns Hopkins Center for Humanitarian Health, the Johns Hopkins Center for Communication Programs, UK-Med, EcoHealth Alliance, and Mercy Malaysia.

PURPOSE OF THIS BRIEF

This brief aims to underscore inclusiveness in risk communication and community engagement (RCCE) for COVID-19 vaccines, vaccine plan prioritisation, and activities, and advocacy to national government decision-makers for fair and equitable access and distribution of vaccines to all people.

It supplements the [COVAX demand creation package](#)¹. We are defining marginalised populations as those who—largely because of public policy, social stigma, and historical marginalisation—may have less access to resources and services based on aspects of their circumstances and identities. While this definition is expansive, and may include certain ethnicities, religious affiliations, and socioeconomic groups based on country context, this brief focuses on specific populations who are the most consistently and most severely marginalised. This includes refugees, migrants, internally displaced persons (IDPs), asylum seekers, stateless individuals, people with disabilities, older people,² LGBTQI+ populations, people living in insecure

areas or areas not controlled by the government, people experiencing homelessness, indigenous populations, and people living in informal settlements.

This brief does not include all issues related to vaccine access, acceptance, and demand creation but highlights key challenges faced by marginalised people and presents recommendations. Any measurement or evaluation of vaccine uptake, hesitancy, and use, should be considered within the broader context of location-specific COVID-19 caseload and vaccine and vaccine information availability and accessibility, including policies and media coverage on the vaccine. Failure to do so risks placing blame and responsibility on already marginalised groups.



For more information on vaccines administered by country, see covid19.who.int/info/

THE HUMANITARIAN BUFFER AND ACCESS TO VACCINES

The [Humanitarian Buffer](#) is a mechanism established within the COVAX facility to act as a **measure of last resort** to ensure access to COVID-19 vaccines for *high-risk and vulnerable populations in humanitarian settings*.³ This buffer was approved by Gavi's Board of Directors on March 22, 2021 and enables the allocation and distribution of up to 5 per cent of the total number of doses procured through the COVAX facility. The aim is to have a targeted deployment reaching the highest-risk population subgroups in accordance with the WHO SAGE guidelines.⁴ Approximately 1.3 billion doses of vaccines for 92 low- and middle-income countries (LMICs) were reserved as part of this

buffer; this includes doses for at least 20 per cent of those countries' populations. The Humanitarian Buffer is only to be used where there are unavoidable gaps in coverage in national vaccination plans and micro-plans, despite advocacy efforts. According to an analysis conducted by the Global Health Cluster (GHC), bilateral procurement and donations from countries such as China, Russia, and India are also playing a significant role in vaccine procurement for LMICs.⁵ Yet even with these sources, the world's poorest, marginalised, and hard-to-reach communities are often missed out.

WHO SHOULD USE THIS BRIEF?



Multi-sectoral **government** ministry officials and **public health** and humanitarian personnel in charge of designing policy and delivering the health and multi-sectoral humanitarian response to COVID-19 in their local contexts.



Civil society groups working on human rights.



Communication and **community engagement professionals** active in the **pandemic response** working on vaccine rollouts.



Other **related institutions**.

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01

General Considerations



GENERAL CONSIDERATIONS FOR ALL MARGINALISED GROUPS

Part 1 includes key considerations that can be applied when designing RCCE programming for COVID-19 vaccine uptake across various marginalised population segments. See [Part 2](#) for considerations that are specific to certain marginalised groups.



Advocate for vaccination plans and related communication plans to be inclusive of all populations, without any discrimination (due to gender, legal status, age, religion, origin, location, or any other characteristic).

- **Advocate for vaccine supplies** where rollout is either slow or not occurring, engaging leaders from groups working with marginalised populations and representatives of marginalised populations, where feasible and safe.
- **Meaningfully engage representatives and leaders** from marginalised populations and groups working with marginalised populations in vaccination and communication plans. Advocate for these plans to **include barriers to vaccine acceptance and actions specific to marginalised groups** (as noted in [Part 2](#)).
- **Identify and develop plans to address the barriers and facilitators that specific marginalised groups may face.** These plans should understand their needs, beliefs, values and perceptions, preferred languages, communication channels and formats, concerns, questions, and motivations toward vaccine acceptance, and develop tailored behaviour change actions and messages accordingly. Advocate for strategies and engagement to support the maintenance of the other prevention behaviours such as face masks and social distancing, aligned with local contexts.
- Advocate for national vaccination and communication plans to ensure **information and the vaccine registration process is accessible** to people without digital skills or those who have lower levels of literacy, or may not speak the dominant language or do not have access to mobile phones, radios, televisions, and other forms of communication.
- In some cases, **micro-plans for specific, marginalised, underserved populations should be developed at the local level** that ensures meaningful participation of communities and empower marginalised groups in decision-making. See below the WHO resource for more specific advice on micro-planning for vaccinations.



Adopt a 'do no harm' approach and conduct a protection analysis when targeting populations at risk of exclusion. Develop strategies with an aim to avoid creating new risks, such as further stigmatisation.



Plan for different stages of community engagement at each point of the vaccine process, as information and perceptions will change.

- Design RCCE approaches locally by involving affected communities, who often have the best knowledge about what works to drive uptake. Involving them directly in the design contributes to generating ownership and sustainability of the eventual interventions. [See UNICEF's Human-Centered Design approach for Health and WHO's Tailoring Immunization Programmes (TIP) in the [Resources section](#) of this document for a cross-cutting and common approach that brings together a people-centered programme design.]
- Encourage community engagement teams to be **inclusive of marginalised populations specifically** making use of trusted leaders.
- **Do not assume "blanket legitimacy"** among local leaders and representatives, especially in conflict-affected communities where conflict dynamics influence the way communities perceive various leaders. For instance, a religious leader who is trusted in one locality might be rejected in another. Understand these dynamics when integrating leaders into planning and communication processes.



→ **Establish accessible two-way communication mechanisms.** Focus group discussions, interactive radio talk shows and other media platforms, or desk information points are examples of channels that can actively respond to people's questions and facilitate conversation about the vaccine and the vaccination process.

↳ Collect data on **drivers of behaviour** around COVID-19 vaccines. People will have different information needs, feelings, and experiences which influence their behaviours and practices. Understand what drives behaviour and use two-way communication to update people and respond to their concerns.

↳ Focus on **voluntary vaccine acceptance** and help normalise uptake by sharing stories and experiences from people, including trusted influencers who have had a COVID-19 vaccine and are still following other prevention behaviours, and peers within the community who can discuss the benefits. These could be stories from people who have just been vaccinated, as well as people who were vaccinated several weeks ago (the time period could be a key factor to indicate safety).

↳ **Address fears of criminalisation, retribution or removal because of social or citizenship status**, or misperceptions around lack of eligibility, by advocating for activities and messaging around these fears to be included in communication plans and in community discussions, which should be based on an analysis of barriers, government policy, and setting. Be careful not to over-promise, especially

where threats of violence may be carried out on marginalised populations.

→ Create or **use community feedback mechanisms** and a complaint mechanism for capturing regular community insights and concerns about the vaccines and vaccine rollouts, and to denounce and combat discrimination if it occurs.

→ To address **rumours and mis/disinformation**, train front-line staff on the basics of infodemic management and how rumours and mis/disinformation happen. Pivot the dialogue to the disease itself and the importance of protecting against the disease.⁶ Communicate in such a way that an individual perceives themselves at risk for disease (risk perception), believes there is an effective action (response efficacy), and has confidence (self-efficacy) that they are capable of taking that action.⁷ Encourage frontline workers to include their own motivations in the dialogue and to be transparent — to acknowledge fears, concerns, and side effects.

→ Understand who the trusted **local community influencers** are (for example, local musicians, trusted elders, athletes, religious leaders, etc.) to engage communities in dialogues about the vaccines. Keep in mind that delivering top-down messages has been shown to be less effective than tailoring messages to specific populations and linking those messages to social and behavior change approaches and community engagement.



Understand and use preferred and trusted communication channels that meet a range of different communication needs for people with disabilities, and those with literacy and cognition needs.

→ **Work with media and media development organisations** to develop creative, entertaining, and engaging communication that addresses marginalised people's priorities while exploring COVID-19 vaccine acceptance and other prevention behaviours. Refer to examples from BBC Media Action⁸ and Internews⁹ for more tips and on media communication for COVID-19 vaccines.

→ **Consider trusted media outlets that serve community needs in local languages.** Stories that show how peers from marginalised populations have overcome common barriers to accept and receive vaccines can be powerful. Support community radio stations in including marginalised populations in the **creation of programming**, and report on the experiences of marginalised groups, creating stories that directly target and meet their information needs.



Encourage partners to adapt and agree on harmonised communication goals and strategies, supported by harmonised messaging for marginalised populations.

Important information in vaccine communication content may include:

- when, where, and how to get a vaccine
- when, where, and how to get information on vaccination planning and registration
- how different COVID-19 vaccines work to prevent COVID-19, and their role in wider prevention measures / ending the pandemic
- eligibility (e.g., licensing for different age groups, use in pregnancy, etc.)
- explaining the time lag between vaccination and acquisition of a degree of immunity
- the importance of a second dose or boosters, where necessary

- a description of side effects, what they mean, how long they might last, and how to manage them.
- importance of maintaining protective measures (which may fluctuate over time), even after being fully vaccinated, which means two weeks after the last dose in the vaccine series. It is essential to communicate that vaccines do not work immediately, as the body needs approximately two weeks to build a full immune response after the first and second vaccination.
- why recommendations about COVID-19 vaccine delivery may change over time.
- potential interactions with other medications, including HIV ARVs, or assurances that there will be no interactions and vaccines are safe for people on chronic treatment.



Simplify and pretest messages with specific marginalised groups for easy understanding, adjust messages for literacy levels, and translate them into preferred languages, using local terms and concepts.¹⁰

- Use **continuous feedback, rumour tracking and assessment data** to adapt communication in response to this information. Prepare to continuously adapt messages to an evolving situation. For example; the arrival or approval

of new or different vaccines, the emergence of new data on efficacy and secondary effects, and the changes authorities are making to eligibility based on these new data, may all require adapted messaging.



Encourage discussion about on the lack of access or unavailability of the vaccine to avoid additional frustrations.

- **Be honest and clear** about the availability of vaccines otherwise unmet expectations could increase mistrust. Explain how vaccine rollout plans are made by governments (including eligibility and prioritisation criteria).¹¹ Explain how 'vulnerable' populations have been identified, and by whom, as well as what 'vulnerable' means in this context.¹² Sharing

country plans and acknowledging the delay or unavailability of the vaccine may avoid misinformation.¹³ In addition, emphasise what people *can* do: how the existing prevention measures work and then what vaccination does, so that people feel they can do something, which may help address some of their frustrations.



Understand that marginalised populations may have intersecting needs; for example, a migrant with a disability, or a community health worker (CHW) who is a refugee working in insecure areas.

- **Ensure services and delivery strategies are locally tailored**, with the inputs of the community, to be responsive to any specific needs and perspectives.



Consider the gender implications of COVID-19 vaccination programmes for all marginalised people.

- Potential barriers among women with intersecting elements of marginalisation may include: lack of agency, lower levels of literacy and education, childcare responsibilities, lack of financial resources for transport to vaccination centres or health services, and the inability to take the time to be vaccinated.
- For implementation planning, consider **gender disparities** in access to information, as women may have less access to media and communication and reliable information sources. This is particularly true for young women and girls, as information may be filtered through older women and men.
- For men, consider potential hesitation in seeking health care due to perceptions of masculinity, which may factor into vaccine hesitancy (some campaigns have linked vaccinations or other preventative behaviours to manhood).
- Develop content that addresses these barriers and discriminatory gender norms in order to help people reflect upon and support women's and girls' needs, including COVID-19 vaccination.



Include healthcare workers (HCWs) and community health workers (CHWs) as audiences in RCCE activities.

In many contexts, healthcare workers are prioritised for vaccination in the first phase of distribution. Specificities vary depending on the type of healthcare worker. Many countries include CHWs in the first stage of vaccination.

- **Vaccine uptake among HCWs and CHWs trends is low in some regions**, and they have not always been prioritised for behaviour change. Anticipate which groups to prioritise with RCCE in line with the national vaccination plan. This approach has worked well in instances such as the Cross-River State situation in Nigeria, where professional medical and pharmaceutical groups mobilised healthcare workers toward greater acceptance of vaccines.¹⁴
- **Build capacity among healthcare and multi-sectoral frontline workers from other sectors such as agriculture, nutrition, education, etc., and community volunteers** to respond to marginalised populations' questions about vaccines.
 - ↳ Train frontline workers on the registration process and how to reach vulnerable and marginalised communities. They need to be updated with the latest information on the vaccine, including rollout and supply. Organise regular briefings and information-sharing sessions.¹⁵



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Other recommended actions include:

- Educate men that it is just as important for women and girls to be vaccinated as it is for men and boys.
- Educate communities on the importance for everyone to be vaccinated regardless of gender.
- Engage women and girls where they gather in community settings and at health services.
- Consider the role of home visits for engaging with women who may not be able to leave home easily.

↳ Information needs and concerns may vary from the vaccines themselves (e.g., dosage) or the rollout (e.g., comparing different rollout strategies of other countries). **Train frontline workers to listen and engage with people's questions and concerns about vaccines with empathy** and to be careful of dismissing concerns as simply false rumours to be corrected. The reasons why marginalised people may or may not accept a vaccine are complex, and hesitancy may be based on legitimate questions and negative past experiences with governments and health systems.

↳ Train frontline workers on how to avoid spreading rumours and misinformation. Teach them to be sensitive to the stigmatisation of marginalised groups and encourage community action to prevent and mitigate stigma.

02

Key Considerations



KEY CONSIDERATIONS FOR SPECIFIC MARGINALISED GROUPS

TABLE 1 | **REFUGEES, IDPS, ASYLUM SEEKERS, STATELESS PEOPLE, MIGRANTS, PEOPLE ON THE MOVE, AND RETURNEES**

The table below provides considerations for including specific marginalised populations in vaccinations plans and specifically in RCCE strategies for the COVID-19 vaccine.

KEY BARRIERS	RECOMMENDED ACTIONS
<p>Limited access to health services and high costs.¹⁶ Lack of knowledge of the health system or vaccination schedule, and relevant vaccination points in the host country. Even if some countries include migrants, refugees, and IDPs in their National Vaccination Plans, most vaccination efforts are carried out through health services.</p>	<p>Advocate for countries that are getting vaccines from COVID-19 Vaccines Global Access (COVAX) and other sources, such as bilateral donations and procurement, to explicitly include persons of concern and other marginalised populations.²¹</p> <p>According to the Global Health Cluster (GHC) position paper,²² national governments are responsible for vaccinating all within their territory regardless of legal status. Inclusive plans are a sound public health strategy to reduce morbidity and mortality. A related analysis determined that few national deployment and vaccination plans (NDVPs) have been explicit about supporting these populations, but operationally, the rollout to these populations varies. Consider advocating for inclusion in the country's "at-risk populations," following the existing technical guidance for prioritisation.²⁰</p>
<p>Fear of delays or prohibition in crossing checkpoints for security reasons, among others, when accessing vaccine centres outside the borders of their settlement camps, particularly for people with no documentation.</p>	<p>Advocate for information systems to capture vaccination coverage data for refugees, IDPs, and migrants, while ensuring data protection.</p> <p>Plan appropriate communication on access to vaccinations for refugees, IDPs, and migrant communities. Multiple communication strategies will be needed to address the different motivations and social and cultural practices behind vaccine acceptance. For example, in a study carried out with migrants and indigenous communities in Colombia, 80% of respondents reported the information provided during the pandemic was useful and helped meet basic needs. However, it was frequently reported in the study that prevention and support messages did not consider the social and cultural practices and channels used by their communities.²⁴</p>

EXAMPLE

In 2017, the Turkish government and partners conducted a mass vaccination campaign to provide missing doses of measles, mumps, and rubella (MMR) and oral polio vaccine to more than 400,000 refugee and migrant children under 5 years of age. Vaccines were provided in homes, communities, and health centres through a major coordinated effort with a team of more than 5,000 people. The team included trained Syrian refugee doctors and nurses who helped bridge the language gap and instill trust. Outreach teams went door-to-door offering vaccines in neighborhoods where many Syrian families lived. Additional communication channels included live radio broadcasts, mosques, and local health centres.¹⁷



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Mobility issues that include distance to vaccination points, lack of transportation, and time away from work.¹⁷ In settings such as refugee or IDP camps, limited ability to walk to get to sites to access information and vaccination services. Sometimes migrants are on the move, which is an issue for those vaccines that require a second dose.

Strengthen the capacity of healthcare providers to identify opportunities for vaccination among refugees, IDPs, and migrants. Advocate for mobile vaccination points and/or **expanded hours for vaccination services** that would improve accessibility, which may require increased mobilisation of volunteer steward/vaccinator support services. Given the importance of primary health care (PHC) services for refugee and migrant populations, **consider advocating for PHCs to be used as accredited vaccination centres**, provided access would not lead to deportation. It is important that non-state actors collaborate with the Ministry of Health to ensure people with legal issues will not be arrested if they show up to vaccination centres. It is critical that migrants receive precise information on vaccine side effects since they are on the move with limited access to health providers for follow-up questions and services.

Fear of stigma or violence. For example, a Red Cross Red Crescent Global Migration Lab report suggests that "Fear as a barrier was echoed by nearly 50 per cent of stakeholders interviewed. In the Sahel, a number of migrants - including undocumented migrants - are likely to remain 'invisible' and avoid seeking help during the pandemic, out of fear of stigma, violence or apprehension by the authorities."

Educate healthcare and frontline workers how of refugees, migrants, and IDPs can be stigmatised and encourage community action to prevent or mitigate stigma, particularly within vaccination points and health centres. **Improve training and awareness of healthcare workers** and other frontline workers on the needs and cultural, religious, and social perspectives of refugees, migrants, and IDPs. Involve the host community to defuse any potential conflict (vaccine nationalism discourse).

Mistrust, rumours, misinformation about the vaccines, which may be due to lingering negative experiences with government and health systems. Delays in sharing information with marginalised groups, perhaps due to a lack of information on access, is also increasing rumours and hesitancy.¹⁸

Mobilise refugees, IDPs, migrant-led organisations, and networks to have a meaningful role in COVID-19 response and vaccination rollout plans from their inception. Consider and respect the diversity within this population, as migrant communities even in the same area can be heterogeneous. If national healthcare workers are prioritised as part of vaccination rollout plans, advocate for refugee, migrant, and IDP healthcare workers to also be prioritised to support rollout plans. Partner with these groups to identify barriers, enablers, and behavioural factors, preferred and trusted communication channels, preferred languages, misinformation and questions about vaccination uptake.

Language barriers, literacy, and access to communication channels or lack of funds to access communication services (e.g., inability to maintain mobile phone credit).

EXAMPLE

Applying the WHO-developed [Guide to Tailoring Immunization Programmes \(TIP\)](#)²⁵, the Swedish government developed tailored responses to the under vaccination of the Somali migrant community within the two areas of Rinkeby and Tensta in northern Stockholm (2015–2016). Interventions included "vaccine champions" and peer-to-peer education projects using educators from a Somali community. These channels reached key Somali informants who could forward information about vaccinations to Swedish-Somalis in Rinkeby and Tensta. Information about vaccines was provided to Swedish-Somalis in the target group's own language and considering cultural aspects.²⁶



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Being vaccinated and preventative behaviours can be low on people's list of priorities, especially in humanitarian contexts or contexts with low burden of disease.¹⁹

Fatigue due to the additional socio-economic burdens that outbreak and measures have caused.

Fear of legal consequences or discrimination when registering for vaccine appointments, particularly for people who are undocumented and criminalised.²⁷

Practise **bottom-up approaches in developing community engagement strategies** to emphasise the participation of the local community in developing initiatives and to ensure community ownership, commitment, and accountability. Engage existing volunteer groups to use their creativity to raise awareness, or help to arrange for registration. Depending on the context and audience, consider engaging the following as well:

- community and religious leaders and groups, peer groups, youth associations, traditional healers, and healthcare workers
- media outlets, including local media that are trusted and serve community needs in local languages
- established diaspora groups outside the country of focus.

EXAMPLE

The Communications with Communities/ Communication for Development (CwC/C4D) Working Group of the Regional Interagency Coordination Platform for Refugees and Migrants from Venezuela (R4V) conducted a **regional survey**²⁷ to identify communication needs and channels. Then using questions from the **RCCE Collective Service questions bank**²⁸, the group conducted another survey on COVID-19 vaccine perceptions, with an estimated 200 participants.

According to the study, 48 per cent of participants believed that the COVID-19 vaccine provides protection, with 61 per cent saying they would get the vaccine, and an equal percentage believing the vaccine is safe; however, 34 per cent said they did not know if they would have access to it. Equipped with this information, a Regional Reference Group with refugees and migrants from Venezuela was convened to review and draft key messages on the COVID-19 vaccines.



TABLE 2 | PERSONS WITH DISABILITIES

GENERAL RECOMMENDED ACTIONS	
<p>Advocate for inclusion in vaccination and communication plans and to be included in early phases of the rollout (if vaccine rollouts have not already begun). May require advocating for specific micro-plans for people with disabilities, given that the needs, and particularly the communication needs, are specific. Develop or review plans with an eye toward all persons with disabilities, including persons with psychosocial disabilities.</p> <p>In these plans, consider that some people with disabilities are clinically more vulnerable to COVID-19. Consider also the intersectionality with other population segments, e.g. migrants, older people.</p>	
<p>Track levels of coverage for persons with disabilities with disaggregated data by gender, age, and disability at each stage of the process, from assessment to evaluation.</p>	
KEY BARRIERS	RECOMMENDED ACTIONS
<p>Some vaccination sites are not functional for people who use mobility devices such as wheelchairs.</p> <p>Some people with lower and/or upper body mobility issues are less able to walk or use public transport (e.g., if using wheelchairs) to get to sites to access information and vaccination services.</p> <p>Limited access to language aids or communication formats for the hearing, sight, or cognitively impaired.</p>	<p>To identify persons with disabilities and understand the preferred and trusted communication channels and formats, consider conducting assessments using the Washington Group of Questions³⁰. The disaggregation of that data by functional impairment will tell you the percentage per impairment, which is helpful to take into account for planning and communication.</p> <p>Engage with and support persons with disabilities’ networks/organisations, and trusted influencers, which may include health workers, peers (other people with disabilities), carers, family members or religious, community leaders.³¹ These individuals and groups can inform plans on specific barriers and facilitators to vaccine acceptance, speak to the needs of people with disabilities and help arrange for registration, participate in the development and testing of messages and activities, and can play an active role in designing and spreading messages.</p>
<p>Due to discrimination, marginalisation, and accessibility issues, some people with disabilities may have low or lower literacy levels and limited access to or use of technologies.</p> <p>Some disabilities cause cognitive issues that may impede understanding of vaccination information, disease prevention, and the pandemic more broadly.</p> <p>Reliance on others (carers) and services for health decisions.</p> <p>Carers may be vaccine hesitant or have their own challenges in accessing information and services that support coronavirus prevention and COVID-19 vaccine uptake.</p>	<p>Advocate for accessible/mobile vaccination centres or provide/facilitate accessible transport.</p> <p>Design and share disability-sensitive information on COVID-19 vaccine through diverse and accessible formats and technologies to reach people with visual, hearing, cognitive, and psychosocial disabilities (sign language, easy read, plain language, audio, captioned media, Braille).³² Consider a mix of verbal and non-verbal messages as part of the communication strategies targeting lower literacy levels among this group.</p>

Lack of empathetic provider/client communication and interaction.

Fear of stigma and discrimination: self-discrimination and societal stigma.

Limited access to information on their rights.

Train health workers in patient-centered care and interpersonal communication to support more empathetic vaccine services for people with disabilities. In addition, train them to respect the freedom of choice of people with disabilities or psychosocial disabilities, respecting their bodily autonomy, with a rights-based approach to the healthcare of people with disabilities.



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TABLE 3 | **OLDER PERSONS**

KEY BARRIERS	RECOMMENDED ACTIONS
Literacy and cognitive issues among some older people, which may result in a limited understanding of vaccination information.	Make messages about how to access vaccines appropriate for particular living conditions (including assisted living facilities). Use simple, clear facts in words older people with or without cognitive impairment can understand. Use visuals to support messages. Address specific feedback.
Limited access to or use of technologies , particularly among less resource-rich populations.	Understand trusted and familiar communication channels and influencers, e.g., television, radio, or written information materials (e.g. flyers). Channels may also include health workers, peers (other older people), carers, family members, or religious and community leaders who can demonstrate their own willingness to get the vaccine and talk about the benefits and potential consequences of not getting a vaccine. ³³
Lack of outreach to identify and engage older people. Exclusion and discrimination by healthcare and other frontline workers and invisibility by humanitarian actors.	Engage older people in the planning of vaccine communication for older people. Link to older person's groups or other relevant groups or people working with older people in the community. Ensure open communication and dialogue to address questions and concerns about the safety and benefits of vaccination.
Mobility issues that limit the ability to visit sites for information and vaccination services with limited access to health services .	As noted in the <i>General Recommendations</i> above, it is important to provide information on age-related eligibility, which in some countries differ per vaccine type and policies relating to vaccine distribution in contexts where volume of doses is limited.



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TABLE 4 | LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, INTERSEX+ (LGBTQI+)* PEOPLE

KEY BARRIERS	RECOMMENDED ACTIONS
<p>Invisibility can be a strategy for LGBTQI+ people to maintain safety. Scrutiny of documents may be problematic for some people. This can lead to exclusion from outreach efforts targeted at people who are less visible.</p>	<p>Seek out and consult with civil society actors, NGOs or other civic organisations to identify LGBTQI+ persons and engage with them. Listen to their perceptions of risks in accessing vaccines, and learn where they already seek services, information, and support and what ideas they have about how to conduct outreach and encourage vaccination acceptance.</p>
<p>Medical documentations and IDs containing the birth gender and name, which for transgender people can be a barrier to health care or vaccination registration given the inconsistency between their birth gender and their gender expression.</p>	<p>Develop FAQs in consultation with the LGBTQI+ community that respond to specific vulnerabilities and concerns.</p>
<p>EXAMPLE</p> <p>Based on Internews' experience working with LGBTQI+ migrants in Colombia, trusted information sources often came from the broader LGBTQI+ community (LGBTQ+ influencers on YouTube in the LAC region, for instance), rather than necessarily being local sources in the town. Recognise that trusted information sources from the wider LGBTQI+ community may need to be engaged in communication plans.</p>	
<p>Previous negative experiences with healthcare workers or vaccination point staff who may not be trained to work with LGBTQI+ people in a respectful way, can lead to vaccine hesitancy.</p>	<p>Train staff, outreach workers, and healthcare workers to be sensitive to the needs of LGBTQI+ people and the risks they face. All of these activities should be based on local knowledge and conversation with local actors and NGOs, especially to validate safe or appropriate activity in countries and/or regions with high levels of anti-LGBTQI+ sentiment. This should include, in particular, the need to recognise families of LGBTQI+ persons, for example, when partners are coming to a vaccination center together and/or bring their child with them, or when one partner indicates the other as an emergency contact. This should also reflect the need to respect gender identity and expression of transgender persons, including their preferred names and gender pronouns.</p>
<p>Fear of visibility, arrest, violence, or discrimination at information points, health centers, or vaccination points with general access hours, which may stop some individuals from registering for vaccines.³⁴ LGBTQI+ families, especially when not recognised by law, may be stigmatised or not appear 'visible' to the authorities. They may not be provided with the rights and opportunities normally accessible to partners and parents with children. They may also live in settings where their identities or behaviours are criminalised.</p>	<p>Develop proactive, targeted strategies for addressing the risks of visiting information and vaccination points, and linking with protection staff.</p>

* L, G, B, T, Q, I are each different identities with specific exclusion/vulnerability factors.

TABLE 5 | POPULATIONS LIVING IN INSECURE AREAS OR AREAS NOT CONTROLLED BY THE GOVERNMENT

The ICRC estimates that more than 60 million people live in areas controlled by non-state armed groups who risk not being included in national vaccine distribution frameworks.³⁵

KEY BARRIERS	RECOMMENDED ACTIONS
<p>Reaching frontlines and areas controlled by non-state armed groups brings complications such as difficult logistics, the need for travel permissions, and reduced availability of electricity and refrigeration. For instance, there may be a breakdown of health services, a lack of supplies, infrastructure, and personnel, including health personnel who are unable to reach people living in these complex environments. Disputed borders might hamper vaccine distribution.³⁶</p>	<p>Following the general recommendations above, when advocating for inclusion in national vaccination frameworks, ensure that plans cover populations living in insecure areas or areas not controlled by the government.⁴²</p>
	<p>Engage community health workers, community members, volunteers, and religious and community leaders to help design and implement vaccine mobilisation plans. Plan communication on access to vaccinations so they understand how to get them, with communication strategies to address the different barriers and motivations, including social and cultural practices driving vaccine acceptance.</p>
	<p>Consider digital technology such as interactive voice recording (IVR), SMS, etc. to reach geographically dispersed or insecure populations.</p>
	<p>Track levels of vaccine coverage for people by community status: IDP, refugee, host community, returnee, stayee, etc.</p> <p>Depending on the context, be mindful that creating a heightened demand for the vaccine when supplies are low could have unintended consequences, as some people may not have access to the vaccine for a prolonged period of time.</p>
<p>Militarisation of vaccine rollout: For example, the military presence around vaccination sites created a lot of fear and hesitancy among groups during the Ebola outbreak in DRC. Some communities affected by conflict may interpret military/security presence and involvement in vaccination as a potential threat, which may create fear to seek the vaccine.</p>	<p>Advocate for non-state affiliated health care centres and/or mobile vaccination services to support vaccination rollout plans and encourage trust with people affected by conflict. Some proposed additional points:</p> <ul style="list-style-type: none"> → Conduct protection analyses when developing strategies for vaccination in order to mitigate further risk exposition (for targeted population and health care providers). → Advocate that all parties in conflict should allow and facilitate safe and unhindered access for vaccinations, and ease restrictions. → Advocate for respect of humanitarian personnel (#notatarget).
<p>Mistrust, rumours, misinformation about the vaccines due to negative experiences with government and health systems.³⁸ Mistrust in the vaccine, especially if the administering NGO or Ministry of Health is seen as not neutral or impartial.³⁹ Rumours, misinformation and disinformation based on inter-group conflict or other root causes of conflict, which may increase vaccine hesitancy.⁴⁰</p>	<p>Engage community health workers, community members, volunteers, and religious and community leaders to help design and implement vaccine mobilisation plans. Plan communication on access to vaccinations so they understand how to get them, with communication strategies to address the different barriers and motivations, including social and cultural practices driving vaccine acceptance.</p>
	<p>Remain flexible and adaptable to the operating environment, adjusting to the local situation.</p> <p>People have very real concerns about vaccination: its safety, efficacy, long-term implications, whether it's a tool for advancing conflict agendas, etc. Create an empathetic environment to improve confidence and trust in the vaccination process. Coercive methods and messaging (especially from the government) can create greater resistance and reluctance.</p>

Fear of attack among populations who feel unsafe traveling to and from a health facility or vaccine distribution point. **Fear of detention** if having to cross government-controlled areas to receive a vaccine, or from providing data when registering for vaccination. Restrictive measures and sanctions may impede access to insecure areas.

RCCE plans should ensure we understand local conflict dynamics, not only to avoid harm but also because these communities will interpret vaccination campaigns within the wider context of the ongoing conflict, which might create additional barriers to vaccination (e.g. if mistrust in government is rampant or the government is a party to the conflict and they are leading vaccination efforts). As conflict dynamics can vary drastically from community to community, multi-track, tailored approaches are required for communities affected by conflict.

Recommendations from Search for Common Ground's [Trust in Authorities - the golden ticket to successful COVID-19 vaccine rollout in conflict settings](#)⁴⁵, and Mercy Corps' [Peace and Stability in COVID-19: Our Agency Approach](#)⁴⁶ include:

- Conduct research and analysis to better understand the causality between trust and mistrust in government and how mistrust contributes to response and recovery across conflict settings. This will help refine how to support governments to carry out trusted interventions.
- Monitor information, rumours, or misinformation that could exacerbate existing tensions, and identify trusted sources of information.
- Address escalatory mis/disinformation that politicises the pandemic and/or vaccine, exacerbates divisions among different groups in society, and erodes the relationship between communities and leaders, thus increasing the likelihood for conflict.

From WHO's [Joint note on means to protect health care from acts of violence in the COVID-19 vaccination rollout in fragile, conflict-affected and vulnerable settings](#),⁴⁷ **sufficient measures should be taken to mitigate attacks on healthcare workers and support staff** working in insecure settings involved in the vaccination rollout.

For example:

- Conduct a risk assessment in each context before the vaccine rollout.
- Establish an agile system for situation monitoring and adjustment of programme rollout to changing security situations.
- From the beginning, conduct community engagement based on risks analysed involving communities.
- Adopt measures for active and continuous social listening (feedback and perceptions), adapting programmes accordingly.
- Use community accepted modalities for vaccine delivery including vaccine strategy adaptation.
- Ensure security measures for staff (not just supplies or assets) including appropriate measures to respond to risks dependent on context e.g. where enhanced visibility is appropriate or not.
- Negotiate for humanitarian space, such as through a Humanitarian Coordinator / Resident Coordinator, civilian-military coordination platforms, communities, and key stakeholders.
- Train health staff in communication skills, cultural sensitivities, and ethical standards.
- Have duty of care protocols that include:
 - ↳ organisational support in case a staff member is injured
 - ↳ adequate mental health and psychosocial support for those that may experience distress due to occupational risk
 - ↳ addressing risks faced by female healthcare workers and/or those from populations of concern e.g., gender-based violence (GBV), stigmatisation by their communities
 - ↳ creating a supportive work environment to discuss challenges or ethical dilemmas healthcare workers may face and discuss with supervisors or peers.

Being vaccinated could be a low priority for individuals in humanitarian contexts or contexts with low burden of disease.⁴¹

Ensure the vaccine response is integrated with other life-saving needs. Conflict-affected communities face immense pressures and competing priorities. Therefore, reducing opportunity costs to vaccination and having an integrated response that meets the full needs of the individual is critical.

TABLE 6 | INFORMAL WORKERS AND SETTLEMENTS

These populations represent a population size greater than the allocated doses of COVAX itself. Common disease control measures such as safe distancing, ventilation, and frequent hand washing are challenging in these settlements making vaccination even more important. They remain high-risk areas for disease spread.

KEY BARRIERS	RECOMMENDED ACTIONS
Limited coverage of regulated or official health centres or other vaccination points.	Advocate for the inclusion of civil society platforms and active community-based organisations (CBOs) and NGOs, such as slum dweller federations and community saving groups, groups represented the poor and people experiencing homelessness, and religious charitable groups, in the development of COVID-19 vaccination and communication plans.
Proliferation of unregulated health centres , local medicine shops, self-styled healthcare providers that often offer counterfeit medications including vaccines.	
Deep mistrust of the state as a result of constant threats of eviction and confiscation of informal economy goods.	
Stigma when accessing services , particularly services outside of coverage areas.	
Limited mobility to vaccination sites particularly for women and girls in insecure environments.	Map and liaise with local NGO and CBO networks to access information and monitor the prevalence of the disease and the rollout of vaccination campaigns.
Not being included in official registries and population data risks exclusion and falsely increases the vaccination rate in official estimates creating the impression of coverage.	In coordination with COVID-19 vaccine task forces, local governments, slum dweller federations, and formal/informal community leaders and members, conduct settlement profiling and mapping of WASH infrastructure, contagion risk hotspots and facilities that can be used as vaccination points, such as schools, places of worship, and health centres , and share this information for consideration in plans and with the community. Logistical support can also be provided in partnership with local organisations and community groups and networks.
Potentially lower literacy levels in some areas.	Advocate for mandatory mobile vaccination services to the doorsteps of homes and expanded hours of services, including weekends , for vaccination services as well as for psychosocial support to slum dwellers. This is important for achieving effective vaccination coverage and reaching the most vulnerable.
Lack of access to information around COVID-19 contagion and prevention.	Recruit local youth and volunteers to serve as community mobilisers and community health workers for vaccination campaigns.
Lack of community health volunteer coverage , and a lack of fixed addresses needed for vaccine-related appointments.	Educate and inform all health providers/medicine vendors about the importance of vaccination in their communities so that they may remind their customers and direct them to the appropriate vaccination facilities.



Digital gap in vulnerable urban areas.

Advocate for short-term investments to expand access to Wi-Fi and technology devices in informal settlements and markets to enable access to information and services.

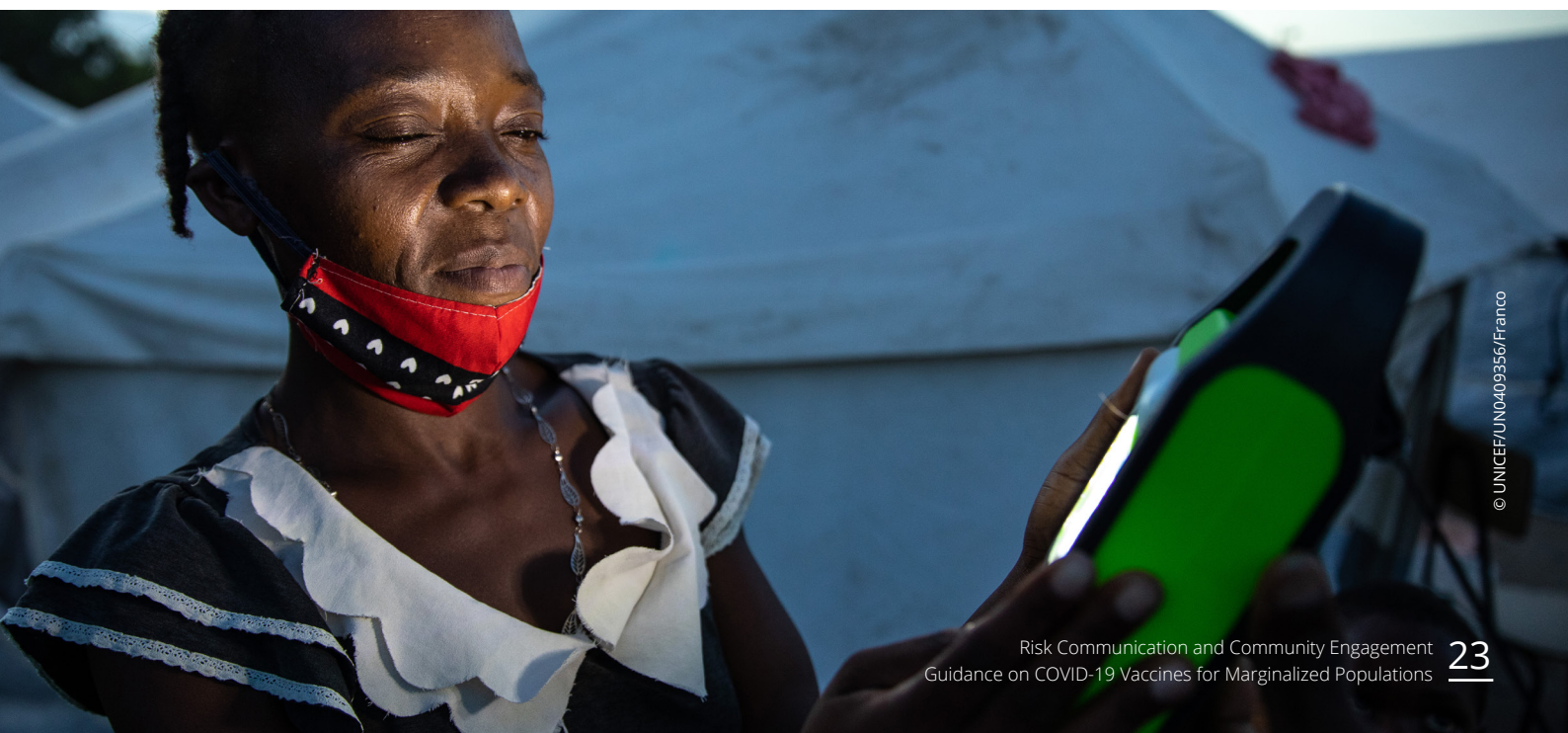
Low priority compared to other issues, such as securing livelihoods, especially for those relying on daily income. Informality of labour, low income prevalence, and income disruption as an impediment for acquisition of PPEs and hygiene kits, and often food.

Ensure that public health measures are underpinned by interventions guaranteeing safety, livelihoods, food security, mental health and psychosocial support, for example, in the form of personal protective equipment (PPE), hygiene kits, food packages and referrals to services. Some cities and national governments are offering cash assistance to informal workers and households lacking income and under the poverty line.

Mental health and psychosocial issues, particularly among homeless populations.

TABLE 7 | PEOPLE EXPERIENCING HOMELESSNESS

GENERAL RECOMMENDED ACTIONS	
<p>Involve people experiencing homelessness in planning and distribution, all of which should be grounded in local available data and input from frontline workers.</p>	
<p>Connect with trusted communicators, such as people with lived experience of homelessness, who can provide vaccination education and information to people experiencing homelessness. These individuals could also serve as vaccine ambassadors to help increase trust and uptake, and provide feedback throughout the process. Engage them in planning and implementation of vaccination events.</p>	
<p>Homeless service providers should continue encouraging all precautions, including wearing a well-fitting mask that covers your mouth and nose when around others, staying at least six feet away from others, avoiding crowds, avoiding poorly ventilated spaces, and washing your hands often.⁴⁹</p>	
KEY BARRIERS	RECOMMENDED ACTIONS
<p>Lack of a fixed address makes locating floating populations challenging, even for mobile services.</p>	<p>Shelters or encampments may be a good starting point, but they will not reach everyone. Identify common congregating points such as free meal providers (charities, places of worship), public restrooms used by the homeless, overnight parking lots used by those housed in vehicles, public parks and sheltering sites to target vaccination efforts through mobile services or post information about vaccination services. Advertise in advance of these vaccination events.</p>
	<p>Avoid use of police or uniformed security services when engaging within homeless encampments.</p>
<p>High correlation of homelessness with mental health issues and/or substance abuse, which can be complex patient profiles for untrained health providers and barriers to effective communication.</p>	<p>Combine social services with vaccination efforts to meet complex needs and encourage vaccination and improve retention for second doses. Offer monetary or other incentive to complete vaccination.</p>
	<p>Adequately train vaccine providers on the complex needs of patients and how to recognise and respond to mental health issues, substance abuse, and legal concerns.</p>
<p>Difficulty returning to get a second dose of 2-dose COVID-19 vaccine series.</p>	



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TABLE 8 | **INDIGENOUS POPULATIONS**

KEY BARRIERS	RECOMMENDED ACTIONS
<p>Lack of access to health services and supplies, with a dependency on outside supplies not being included in official records of the population.</p>	<p>Include indigenous leaders and/or coalitions and civil society platforms representing indigenous populations in COVID-19 vaccine task forces at country and local level, if feasible, and/or develop a micro-plan for RCCE for COVID-19 vaccinations with indigenous people. Provide appropriate and culturally adjusted materials and ensure messages about the vaccines are produced in local indigenous languages.</p>
<p>Denial or different interpretations of the COVID-19 pandemic and related measures, including vaccines.</p>	<p>Work with the government to recognise ancestral and traditional medicine and the work of community health workers to build trust between the government and indigenous populations. Consider including ancestral medicine in healthcare protocols and training professionals on these practices.</p>
<p>Mistrust in health systems due to impacts of historical medical racism.</p>	
<p>EXAMPLE</p> <p>A COVAX short video shows how teams traveled to Colombia’s Amazon to deliver COVID-19 vaccines to indigenous populations. Vaccines were offered to all age groups to increase participation, and front-line workers went door-to-door in some areas to provide vaccines on the spot.</p>	 <p style="text-align: right; font-size: small;">© UNICEF video</p>
<p>Lack of mobility and transportation to health centres or other vaccination sites. Insecurity for women and girls to travel even short distances.</p>	<p>Engage indigenous groups to identify barriers and facilitators around vaccination update and experiences with vaccination, support them in identifying how to address these barriers. Engage them to select accessible, safe, and trusted vaccination sites. Considerations may include staffing these sites with respected traditional leaders and others from the communities who are trained to answer questions about the vaccine. Give consideration to traditional ceremonies and people’s cultural definitions of illness, diagnostics, and treatment.</p>
<p>Low connectivity for remote indigenous groups, limiting access to engagement and information via remote and digital approaches.</p>	
<p>Information overload and fatigue. Some indigenous communities have expressed dissatisfaction with the influx of information being pushed toward their communities by external actors, choosing instead to ignore it.</p>	
<p>Mistrust in government agencies and large media conglomerates. This is often as a result of histories of conflict between indigenous populations and oppressive governing bodies and the lack of representation of indigenous issues and concerns in the mainstream media.</p>	<p>With consideration to drivers of vaccine uptake, work with community and indigenous-owned radio and trusted sources of information to engage communities in dialogues about the vaccine and the impacts of the disease.</p> <p>Connect with indigenous people’s organisations (IPOs) to share experiences and lessons learned about vaccine uptake across regions and countries. Increase the opportunities for networking and connection among indigenous groups with similar experiences.</p>

03

Additional Resources



ADVOCACY FOR EQUITABLE ACCESS TO VACCINES

[Global Health Cluster, Position on Covid-19 Vaccination in humanitarian settings: 12 key messages for advocacy.](#)

[Migrants: Guidance on equitable access to Covid-19 vaccine.](#)

– OHCHR 8 March 2021

[Vaccine: Why vaccine inequality is our biggest COVID-19 communication challenge yet.](#)

– Internews

FACTS ABOUT COVID-19 VACCINES

[Coronavirus Disease \(COVID-19\): Vaccine Q&A.](#)

– WHO

[COVID-19 advice for the public: Getting vaccinated.](#)

– WHO

[Vaccinations in Humanitarian Emergencies Implementation Guide.](#)

– WHO

COVID-19 VACCINE-RELATED DATA

[COVID-19 Data Explorer: Global Humanitarian Operations.](#)

– OCHA, HDX

[COVID-19 Data & Dashboards for RCCE.](#)

– WHO, IFRC, UNICEF, GOARN

VACCINE DISTRIBUTION PRIORITISATION AND THE HUMANITARIAN BUFFER

[WHO SAGE Roadmap for Prioritizing Uses of COVID-19 Vaccines in the Context of Limited Supply.](#)

– WHO, SAGE

[IASC Frequently Asked Questions: The COVAX Humanitarian Buffer.](#)

– IASC

GENDER AND COVID-19 VACCINES

[Guidance Note and Checklist for Tackling Gender-Related Barriers to Equitable Vaccine Deployment.](#)

– UN agencies and partners

[WHO recommendations related to vaccination of pregnant women.](#)

– WHO

INTERPERSONAL COMMUNICATION FOR FRONTLINE WORKERS

[Interpersonal Communication for Immunization Kit.](#)

– UNICEF

RCCE TOOLS AND GUIDANCE FOR COVID-19 VACCINES

[Data for action: achieving high uptake of COVID-19 vaccines, Interim guidance.](#)

– WHO, UNICEF

[Human-Centered Approach for Health.](#)

– UNICEF

[Tailoring Immunization Programmes \(TIP\): An introductory overview.](#)

– WHO

[Communicating around Covid-19 Vaccines: A Technical Brief.](#)

– Johns Hopkins CCP/ Breakthrough ACTION

[Pocket guide for community engagement and accountability practitioners: The Essential COVID-19 Vaccine Resources.](#)

– IFRC

[Handbook for media: the coronavirus and COVID-19.](#)

– BCC Media Action *April 2021*

[COVID-19 Vaccination Communication Toolkits.](#)

– CDC

[COVID-19 Communication Network Vaccine Resources.](#)

– Johns Hopkins CCP

[10 Steps to Community Readiness.](#)

– WHO, IFRC, UNICEF, GOARN

[Generating acceptance and demand for COVID-19.](#)

– COVAX/WHO

[Building trust in vaccination.](#)

– Johns Hopkins University

[The Little Jab Book, 18 Behavioral Science Strategies for Increasing Vaccination Uptake.](#)

– Busara, Common Thread, Save the Children

[RCCE Collective Service Questions Bank for COVID-19 \(including vaccine\).](#)

– WHO, UNICEF, IFRC

ADDITIONAL RESOURCES RELATED TO SPECIFIC HUMANITARIAN SETTINGS AND MARGINALISED OR UNDERSERVED GROUPS

[Trust in authorities – the golden ticket to successful COVID-19 vaccine rollout in conflict settings.](#)

– Search for Common Ground

[Peace and Stability in COVID-19: Our Agency Approach.](#)

– Mercy Corps

[Joint note on means to protect health care from acts of violence in the COVID-19 vaccination rollout in fragile, conflict-affected and vulnerable settings.](#)

– WHO

[Training manual for facilitators: Working with Lesbian, Gay, Bisexual, Transgender and Intersex \(LGBTI\) Persons in Forced Displacement and the Humanitarian Context.](#)

– IOM *January 2017*

[The European Commission, Trainers' manual: Reducing health inequalities experienced by LGBTI people: What is your role as a health professional?](#)

– European Commission

[Gay & Lesbian Medical Association, Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients.](#)

– GLMA

[United Nations Independent Expert on sexual orientation and gender identity, An LGBT-inclusive response to Covid-19.](#)

– OHCHR

[Practical Guidance for Risk Communication and Community Engagement \(RCCE\) for Refugees, Internally Displaced Persons, Migrants and Host communities Particularly Vulnerable to Covid-19 Pandemic.](#)

– UNHCR, IOM, UNICEF, JHUCCP, WHO, UNODC, IFRC

[Washington Group Set of Questions.](#)

– Washington Group on Disability Statistics

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