IOM UN MIGRATION | MIGRATION HEALTH

MIGRANT INCLUSION IN COVID-19 VACCINATION DEPLOYMENT

IOM Country Office Review

Updated March 2022

INTRODUCTION

The information presented here is **based on**:

- Data collected from 180 countries through **January and March 2022**
- The cross-examination of **various sources,** including IOM country offices direct observations, WHO/COVAX National Deployment and Vaccination Plan (NDVP) analysis, government websites and official communications by public authorities, media reports (in particular for countries where there is no IOM presence), the Global Health Cluster, UN OCHA's Humanitarian Data Exchange, and more.
- This year, we have introduced a new approach in data collection and management process with the support of IOM's **Community Response Map (CRM)*** where there is regional approvers validation component.

IOM direct reporting informed the data on 180 countries in this analysis, as of 31 March 2022. This report is a presentation of *what we know so far* and should **not** be considered a comprehensive document.

	Countries/Territories	Number of countries where IOM reported
Asia and the Pacific	40	40
Central and North America and the Caribbean	29	18
East Africa and the Horn of Africa	10	10
European Economic Area	35	31
Middle East and North Africa	18	17
South Eastern Europe, Eastern Europe, and Central Asia	20	19
South America	10	10
Southern Africa	15	15
West and Central Africa	23	20
TOTAL GLOBAL	**200**	**180**

Please note in this fast-changing context with contradictory reports, the information presented in this document is valid, to the best of IOM's knowledge, as of 31 March 2022

*CRM: web platform and mobile app that allows project managers to create customized surveys that can be used to collect qualitative and quantitative feedback from target audiences

MIGRANT INCLUSION: PLANS VERSUS PRACTICE

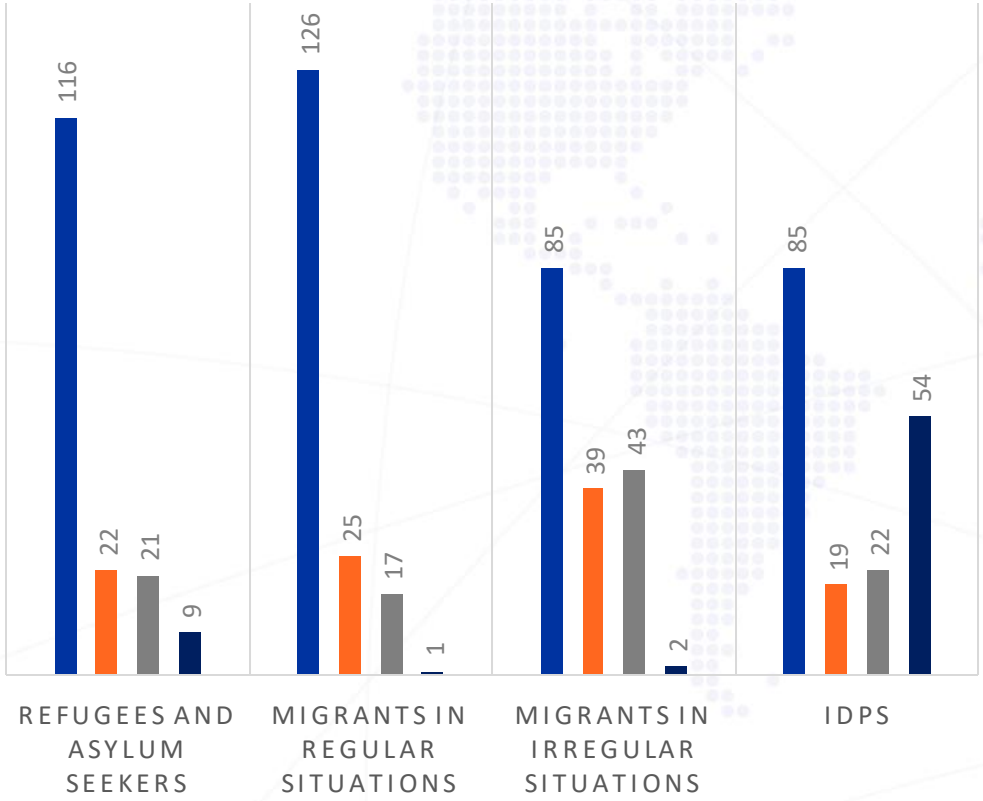
PLANS VERSUS PRACTICE: KEY NOTES

- **A lack of clarity remains and is reported in several countries** (More than 60 countries) regarding the level of access to the vaccine that different categories of migrants already have or will be able to have in practice. This can be due to :
  - Absence of NDVP in the country or NDVP was not shared with WHO, IOM or other partners
  - Many NDVPs mention priority groups without breaking down the various population categories within those groups, therefore getting clarity on the level of migrant inclusion can be challenging. In some cases, IOM's attempts to get the clear information directly from the vaccination focal authorities were not fruitful.
- **Discrepancies observed between the NDVP analysis, and the in-practice analysis** can be explained as follows:
  - There can be **differences in the terminology** used across NDVPs and potential lack of alignment with IOM's/WHO's terminology.
  - In some cases, **policies may intend to be migrant-inclusive, but realities may present aspects and processes** that policymakers did not consider as barriers for some categories of migrants.
  - Additionally, IOM has noted that some policymakers prefer to **avoid publicizing the intention to include migrants** in the campaigns for various reasons (for example to avoid xenophobic reactions in the general population).
- **IOM is monitoring the situation closely** at all levels and from various angles.

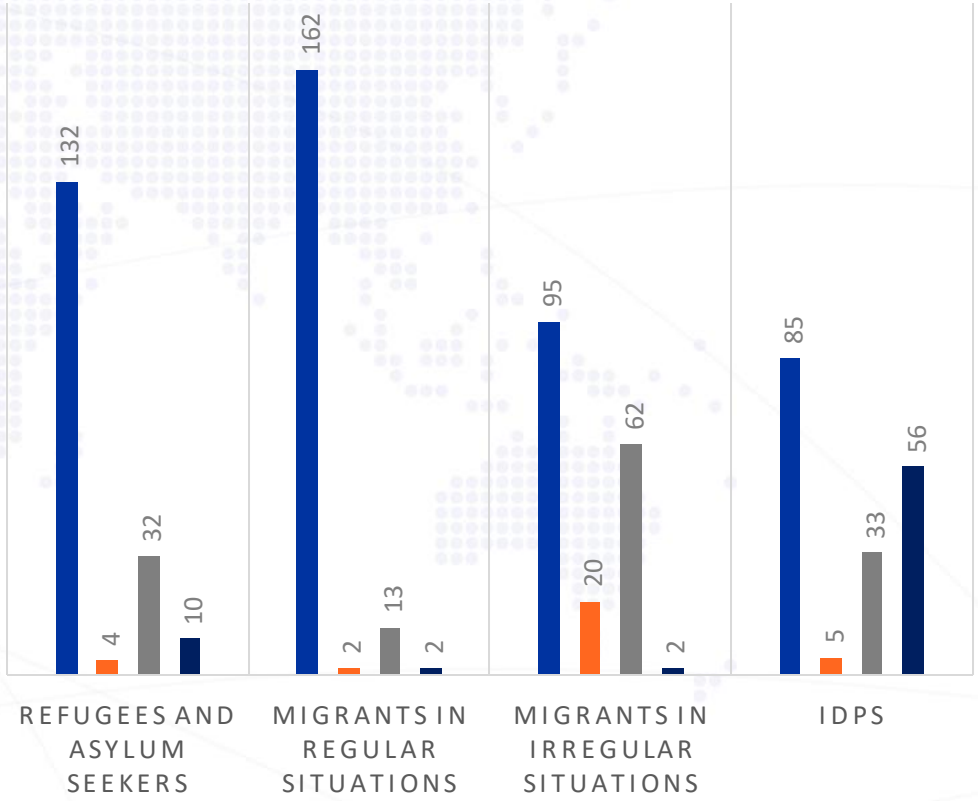
PLANS VERSUS PRACTICE: GLOBAL OVERVIEW

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP



INCLUSION IN PRACTICE



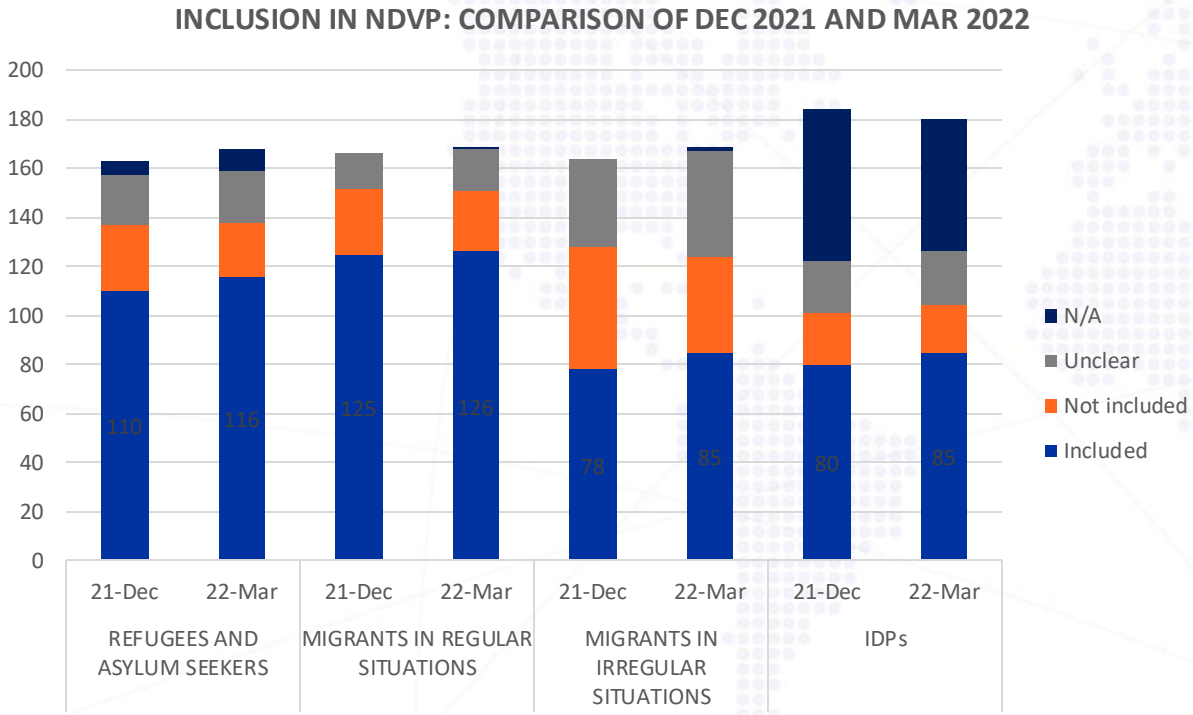
This analysis is based on the 180 country plans and practices observations.

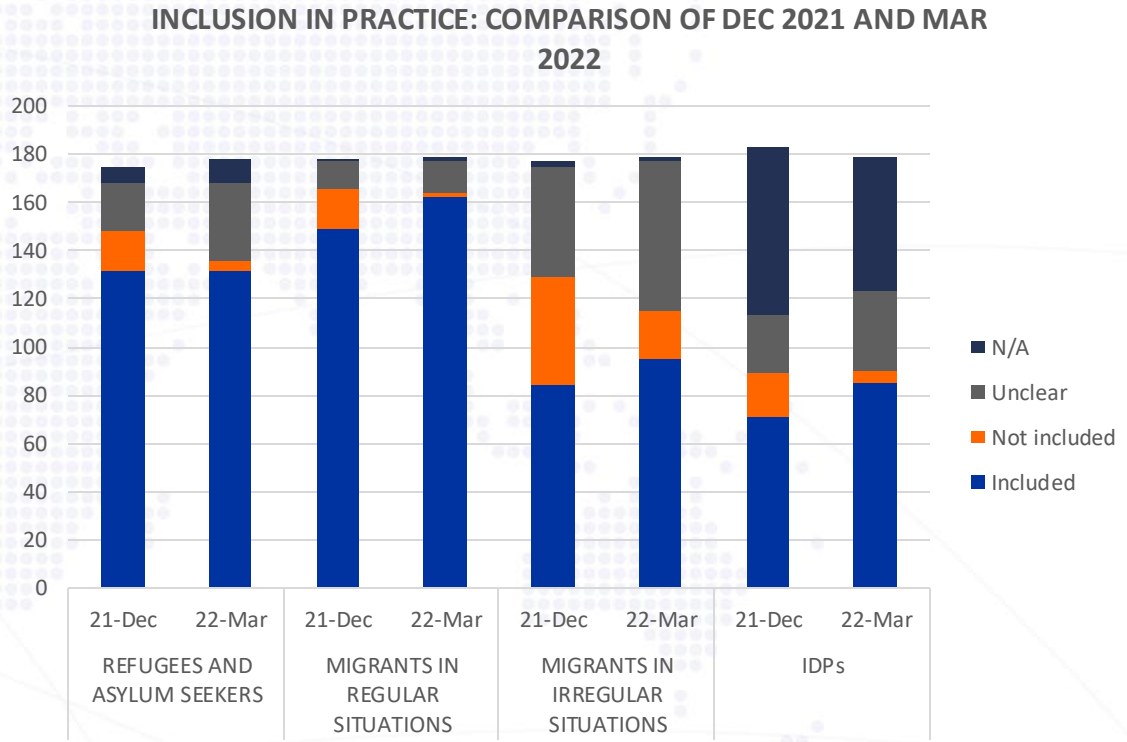
HIGHLIGHTS: AS OF 31 March 2022

- Of the 180 country that IOM offices providing data, 162 (90%) reported that migrants in regular situations have access to COVID-19 vaccines in practice.
- Of the 180 country that IOM offices providing data, 95 (53%) reported that migrants in irregular situations have access to COVID-19 vaccines in practice.
- Of the 180 country that IOM offices providing data, 85 (47%) reported that IDPs have access to COVID-19 vaccines in practice.
- Of the 180 country that IOM offices providing data, 132 (73%) reported that refugees and asylum seekers have access to COVID-19 vaccines in practice.

PLANS VERSUS PRACTICE: GLOBAL COMPARISON OF DECEMBER 2021 and March 2022

This graphic compares December 2021 and March 2022 vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*





This analysis is based on 180-country plan and practice observations.

COMPARISON BETWEEN DECEMBER 2021 AND MARCH 2022: HIGHLIGHTS

- In the first quarter of 2022, we noted a slow but progressive improvement in the number of countries making plans for migrants in regular and irregular situation in their NDVPs and in practice.

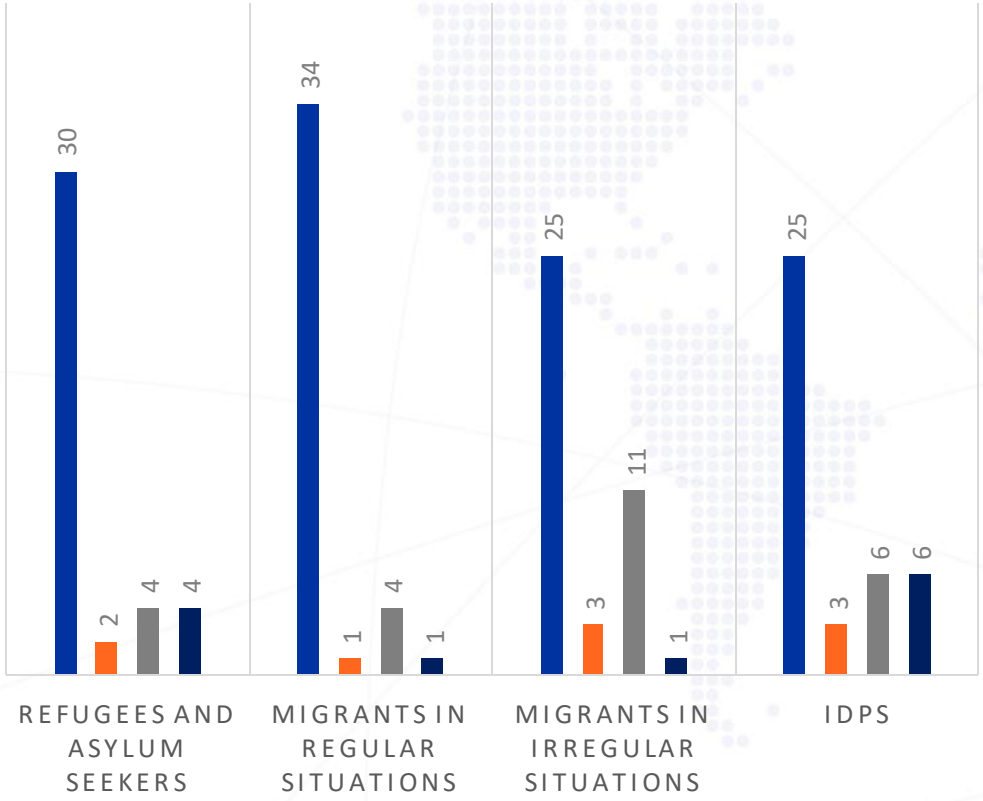
- 1 country (1% increase) started including migrants in regular situations in their NDVP while 7 countries (8% increase) started including migrants in irregular situations in their NDVP.

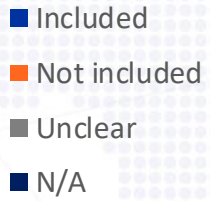
- In practice , 13 countries (8% increment) expanded access to COVID-19 vaccination to migrants in regular situation between December 2021 and March 2022, while 11 countries (12% increment) expanded access to COVID-19 vaccination for irregular migrants in the same timeframe.

PLANS VERSUS PRACTICE: ASIA AND THE PACIFIC

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVPS





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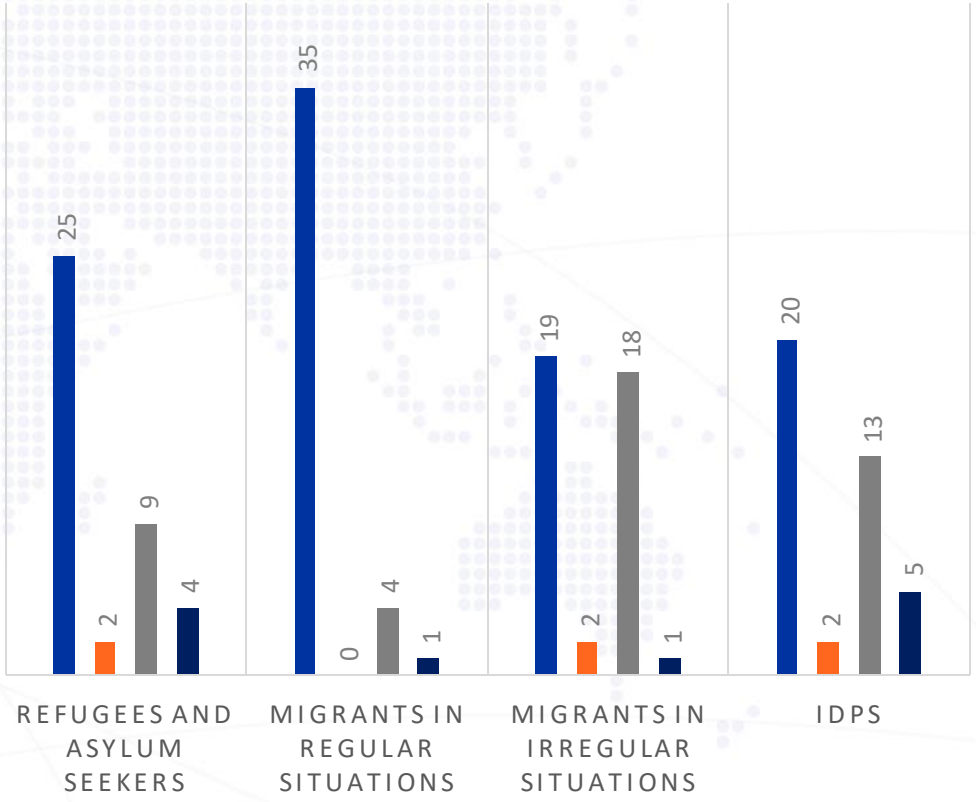
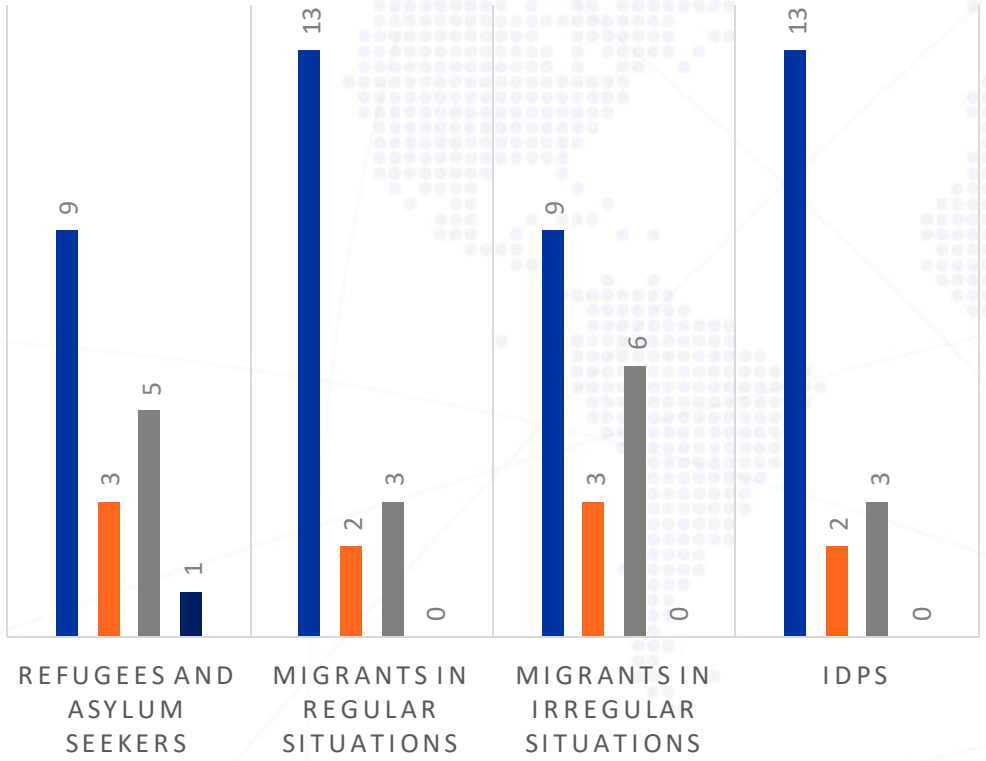


This analysis includes all 40 countries in the region.

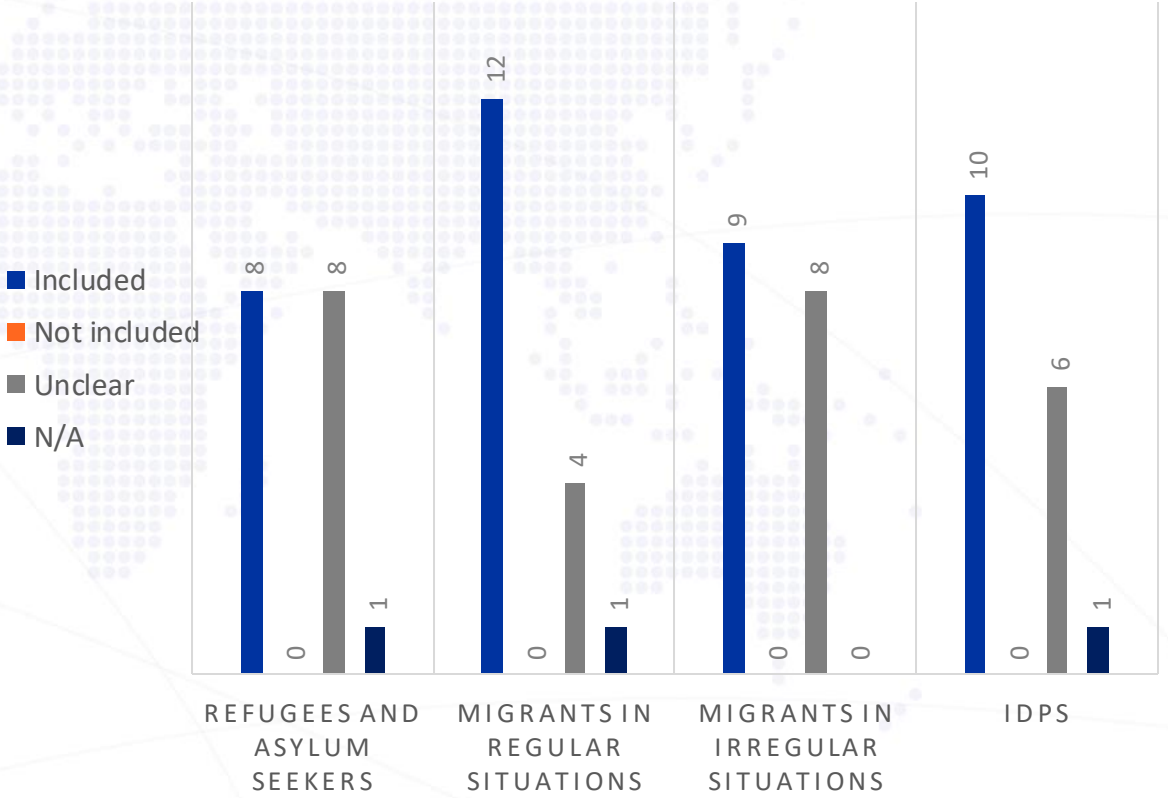
PLANS VERSUS PRACTICE: CENTRAL AMERICA, N. AMERICA, CARIBBEAN

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP



INCLUSION IN PRACTICE

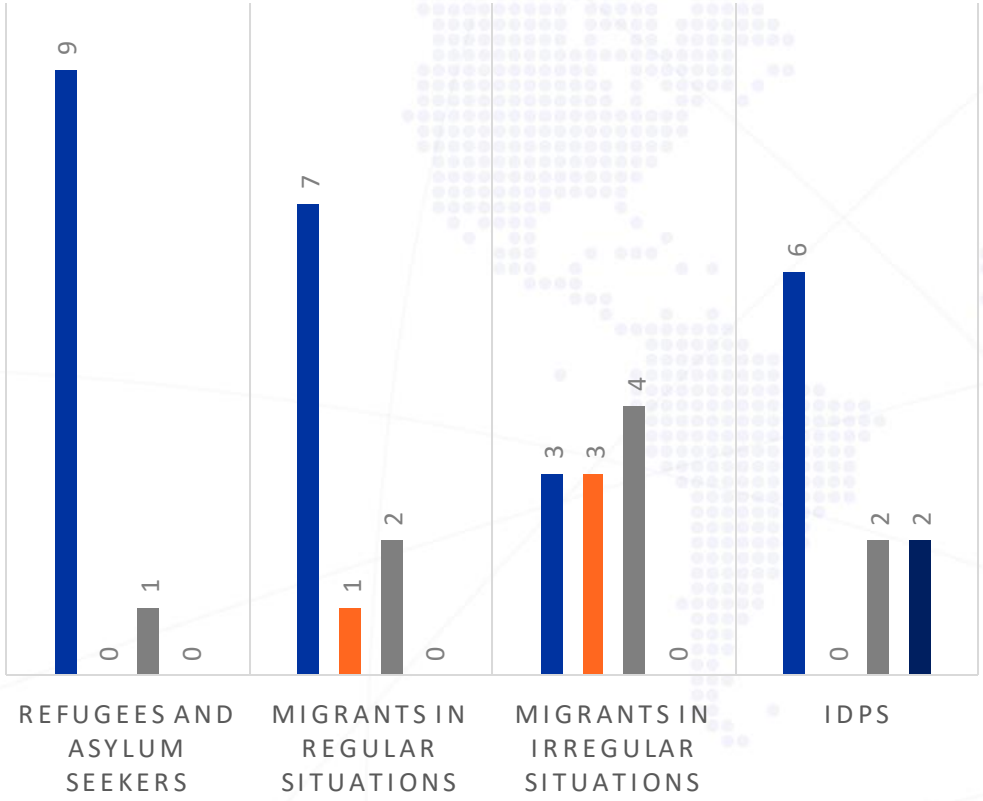


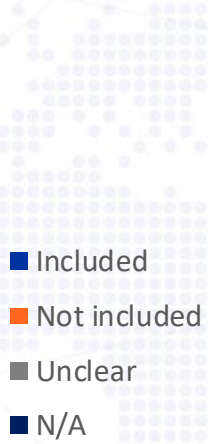
This analysis includes 18 countries, 4 countries with no change reported from the previous report and lacks information from 11 countries.

PLANS VERSUS PRACTICE: EAST AFRICA AND HORN OF AFRICA

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP





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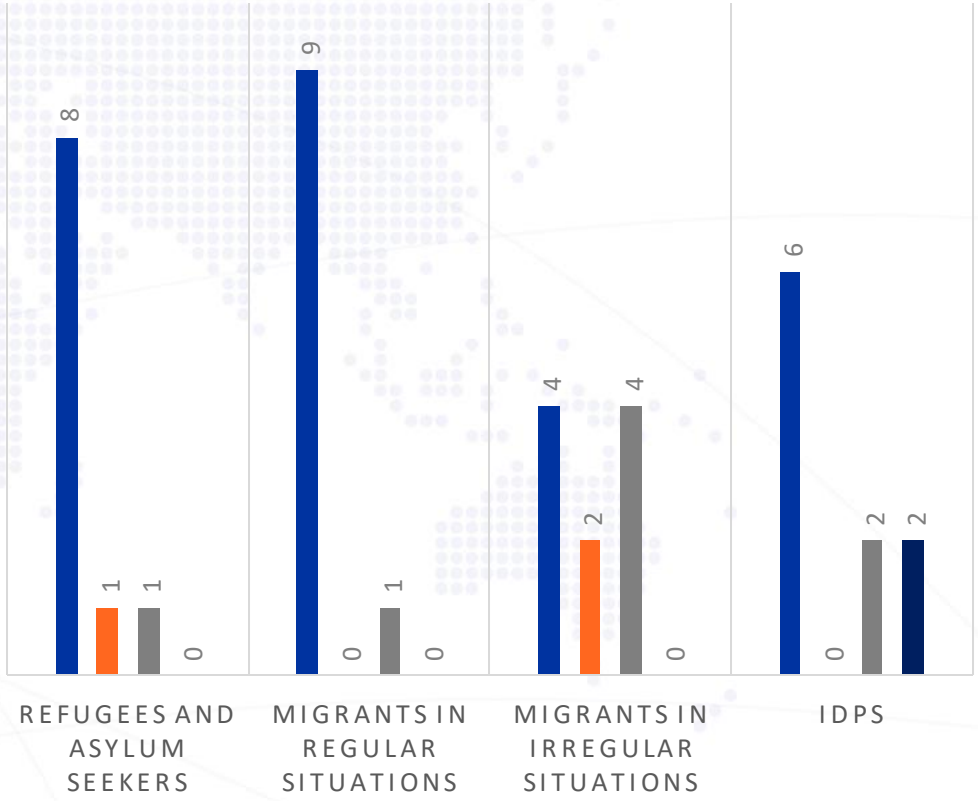
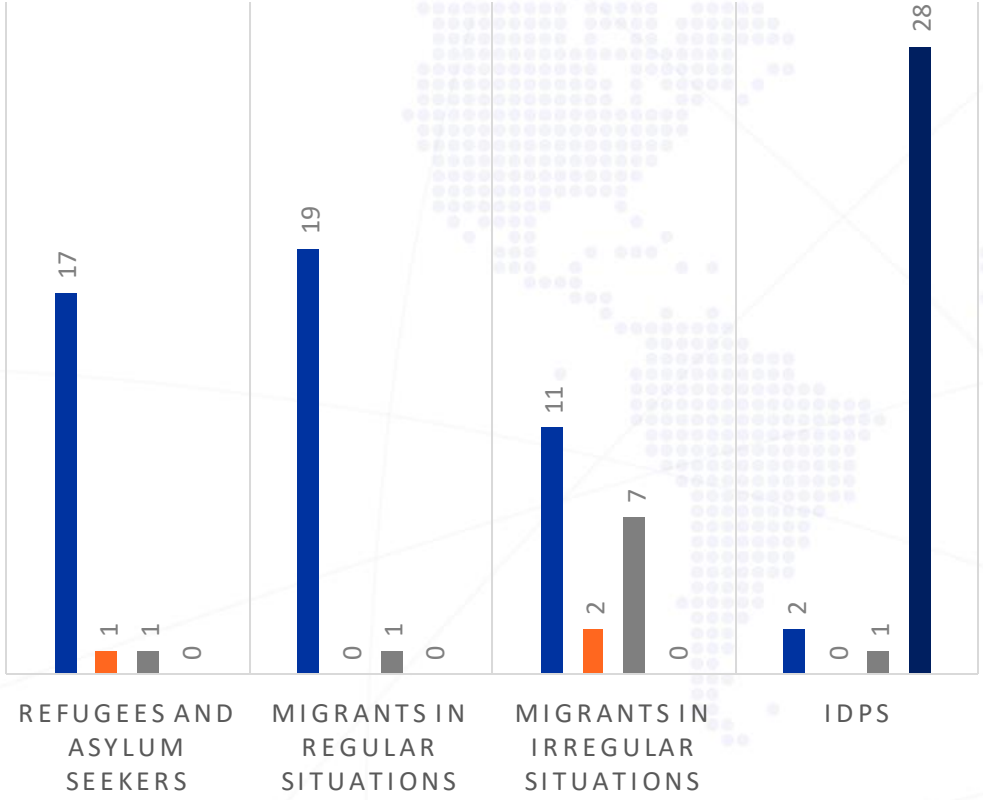


This analysis includes all 10 countries in the region, 1 with no change reported from the previous report.

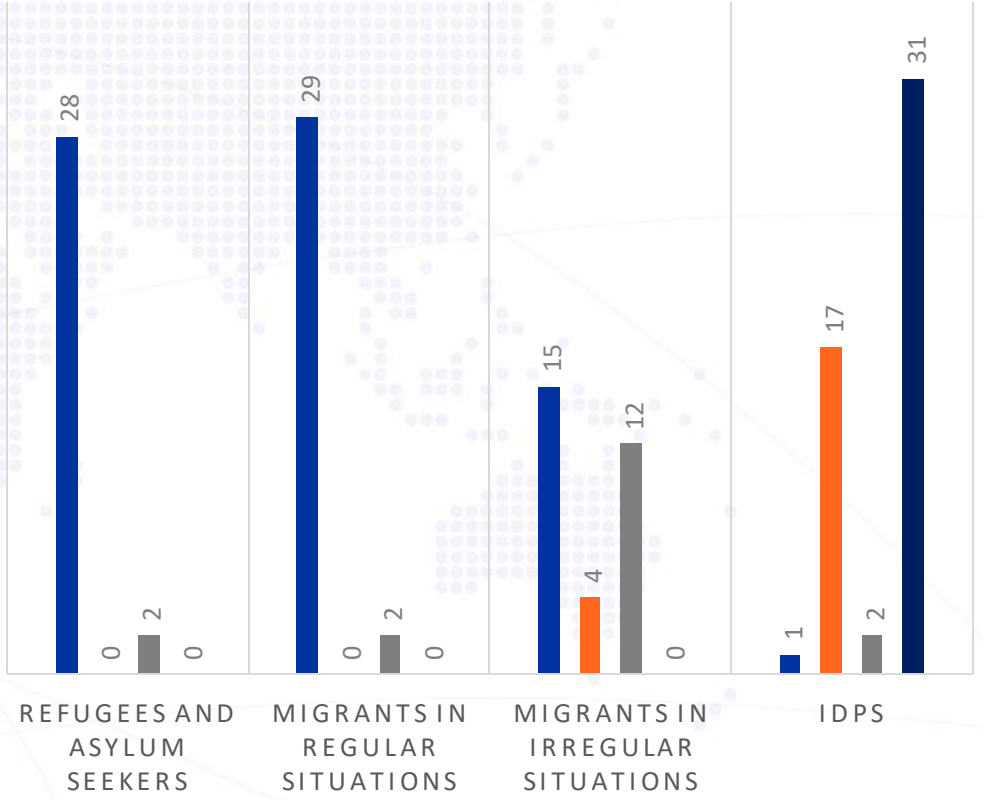
PLANS VERSUS PRACTICE: EUROPEAN ECONOMIC AREA

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP



INCLUSION IN PRACTICE

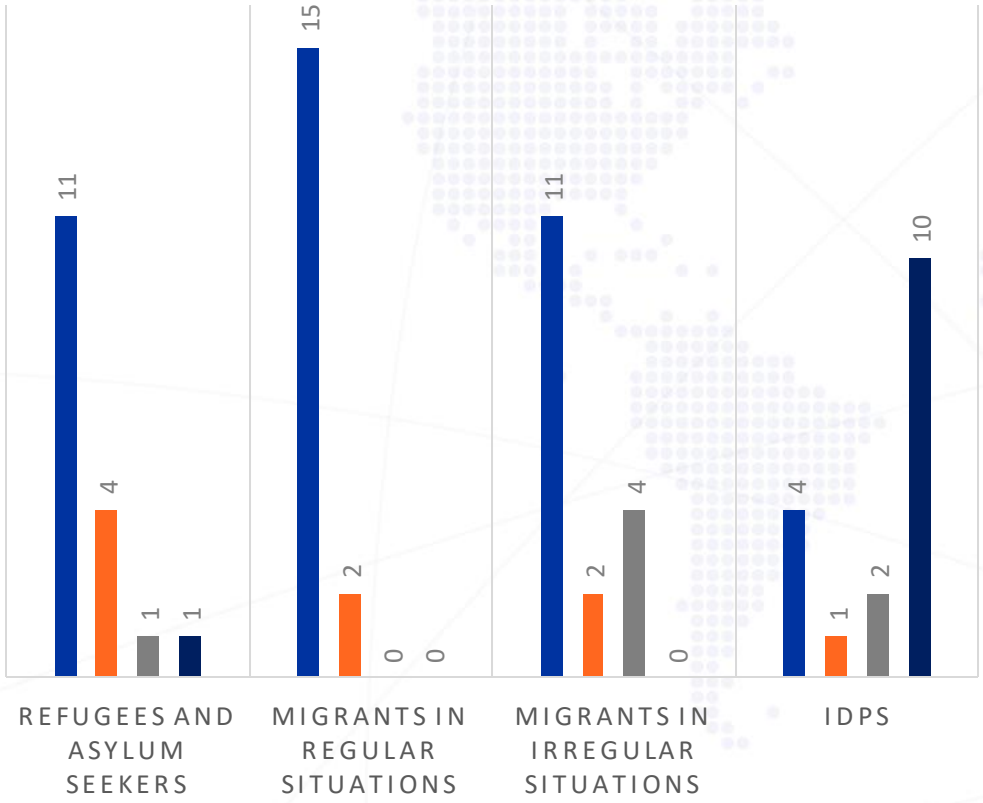


This analysis includes 31 countries, 17 countries with no change reported from the previous report and lacks information from 4 countries.

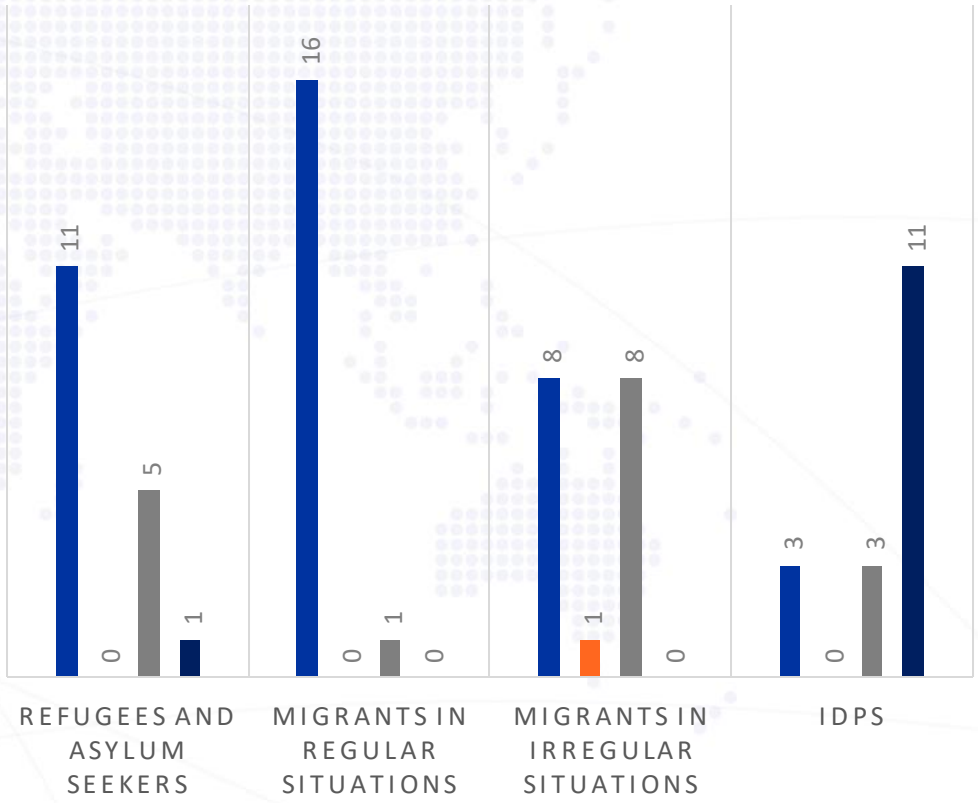
PLANS VERSUS PRACTICE: MIDDLE EAST AND NORTH AFRICA

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP



INCLUSION IN PRACTICE

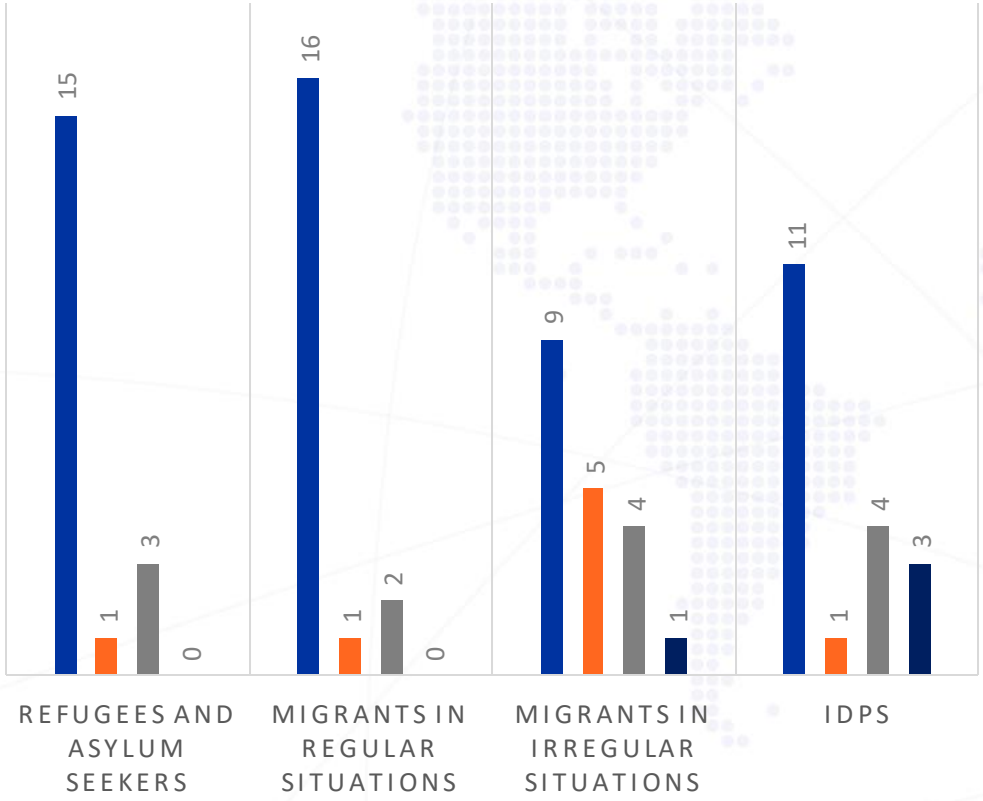


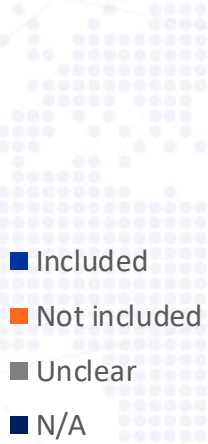
This analysis includes 17 countries, one with no change reported from the previous report and lacks information from one country.

PLANS VERSUS PRACTICE: SOUTH EASTERN AND EASTERN EUROPE, AND CENTRAL ASIA

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP





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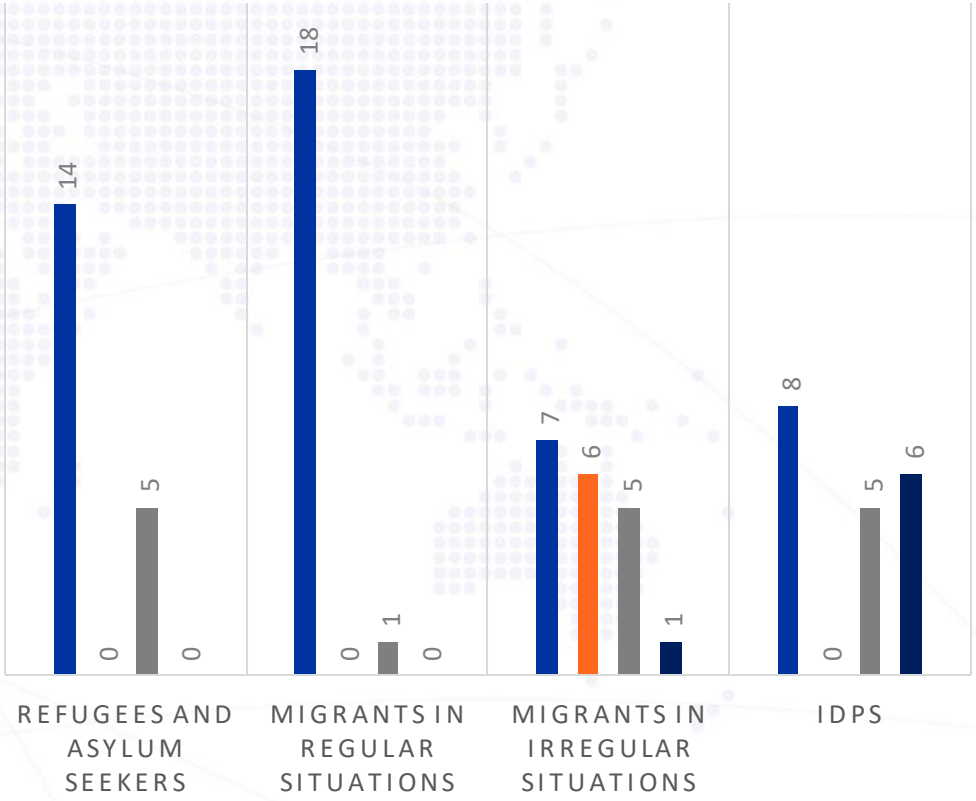
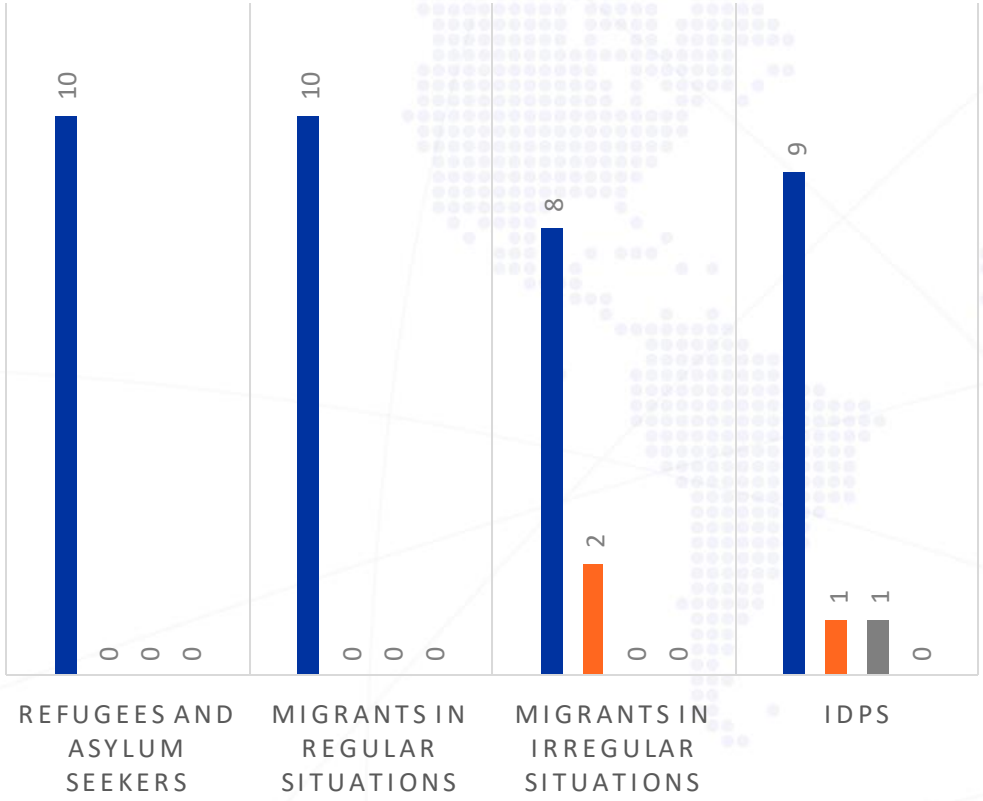


This analysis includes 19 countries in the region and lacks information from one country.

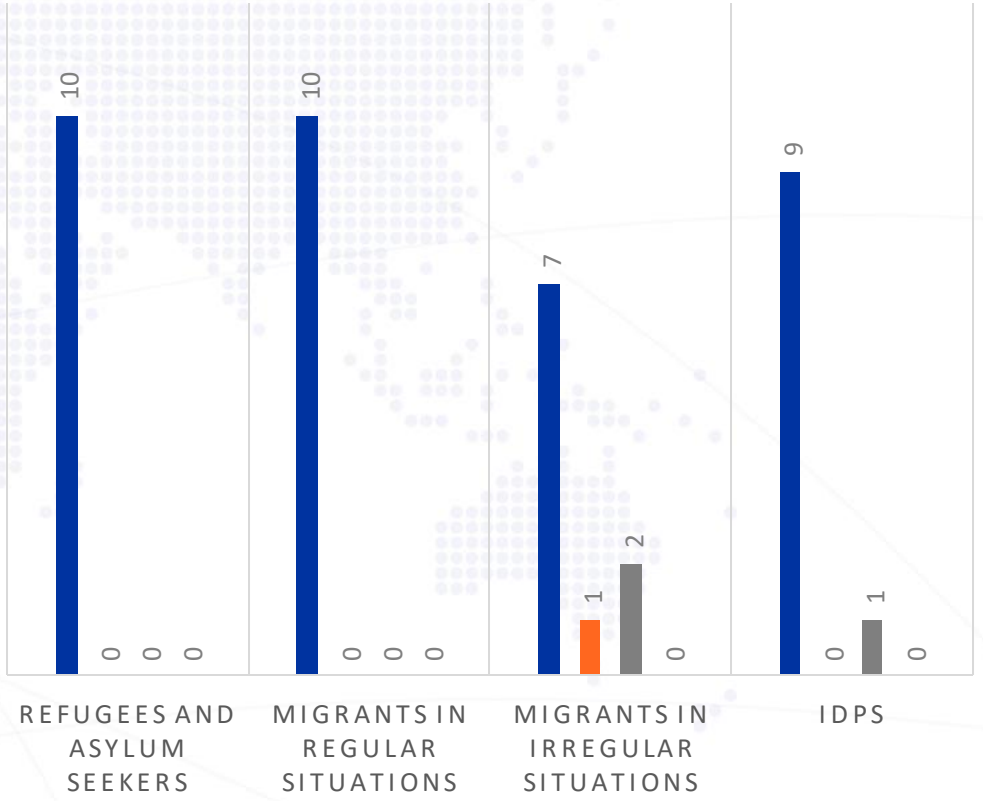
PLANS VERSUS PRACTICE: SOUTH AMERICA

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP



INCLUSION IN PRACTICE

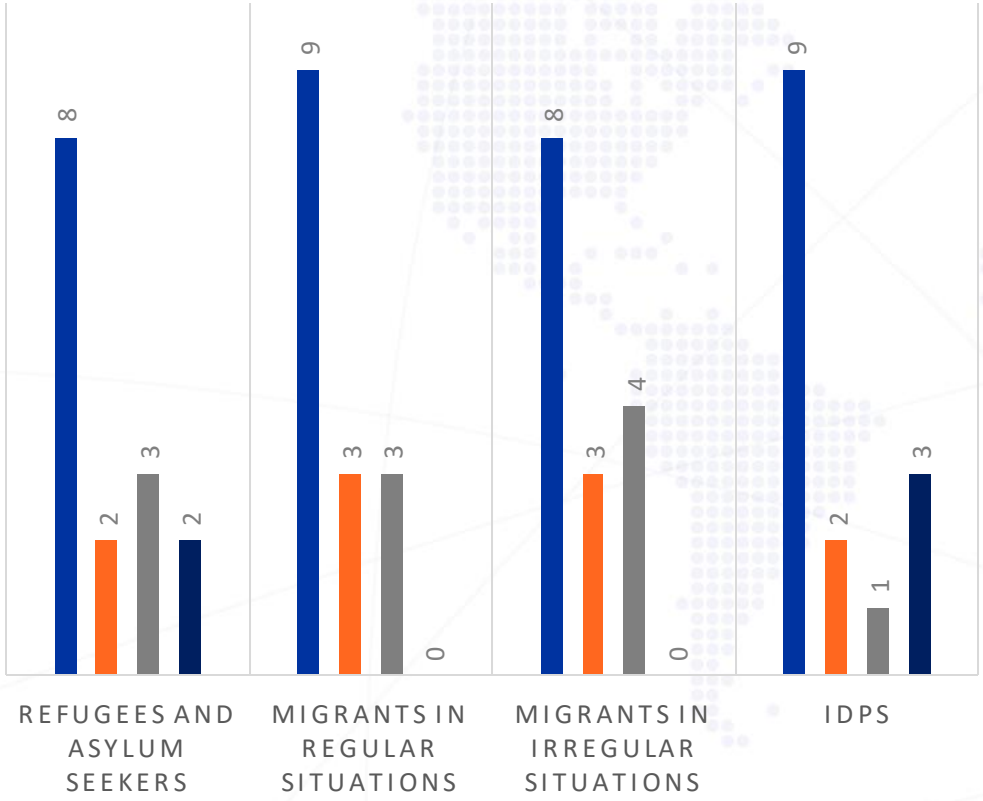


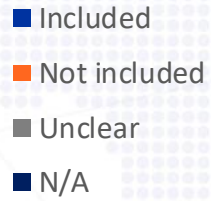
This analysis includes all 10 countries in the region and one country with no change reported from the previous report.

PLANS VERSUS PRACTICE: SOUTHERN AFRICA

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP





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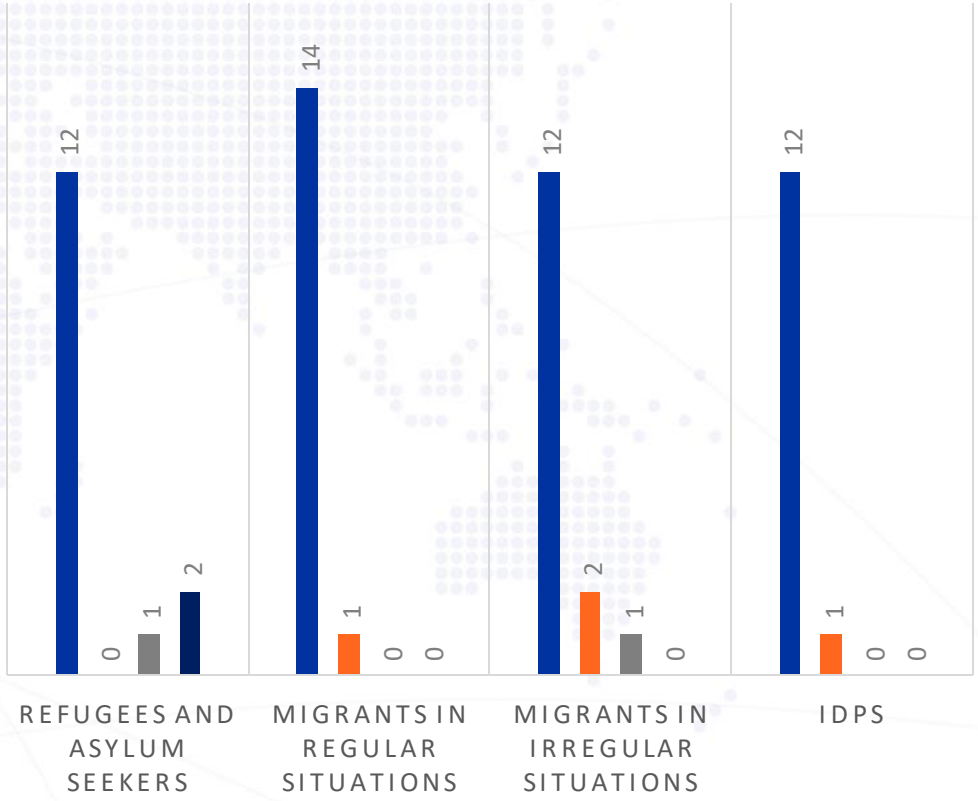
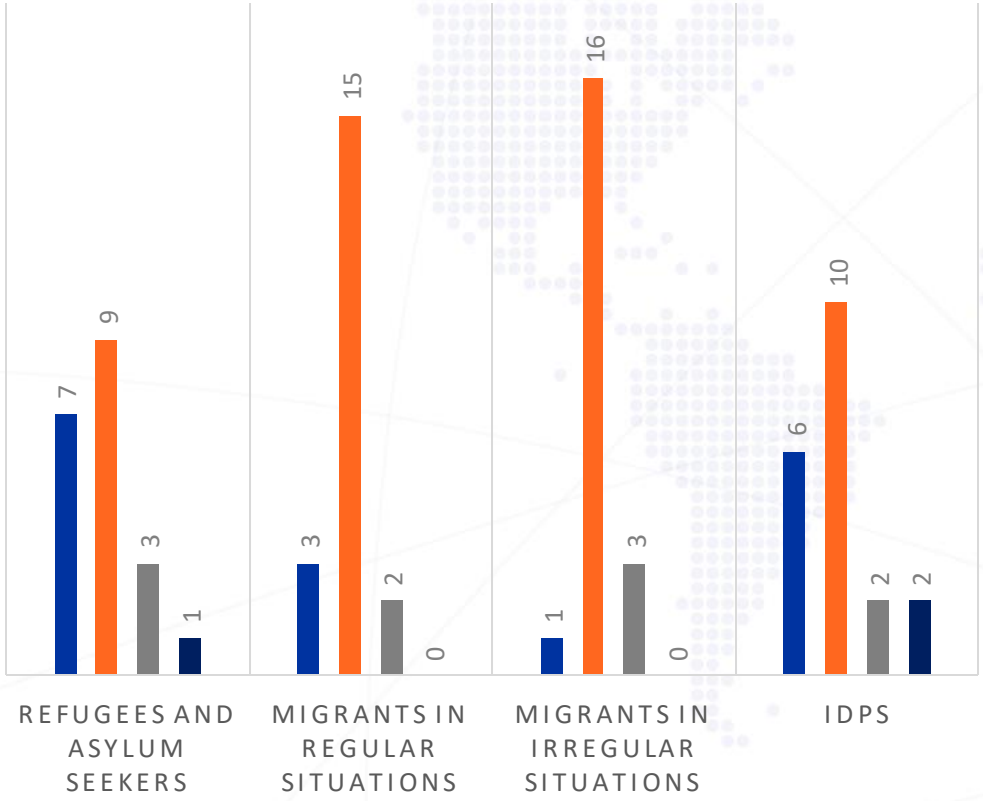


This analysis includes all 12 countries in the region and 3 countries with no change reported from the previous report.

PLANS VERSUS PRACTICE: WEST AND CENTRAL AFRICA

This graphic compares vaccine access for migrants as stated *on National Deployment and Vaccination Plans* (NDVPs) – based on WHO analysis, where available, or IOM analysis – against observations made by IOM regarding access *in practice.*

INCLUSION IN NDVP



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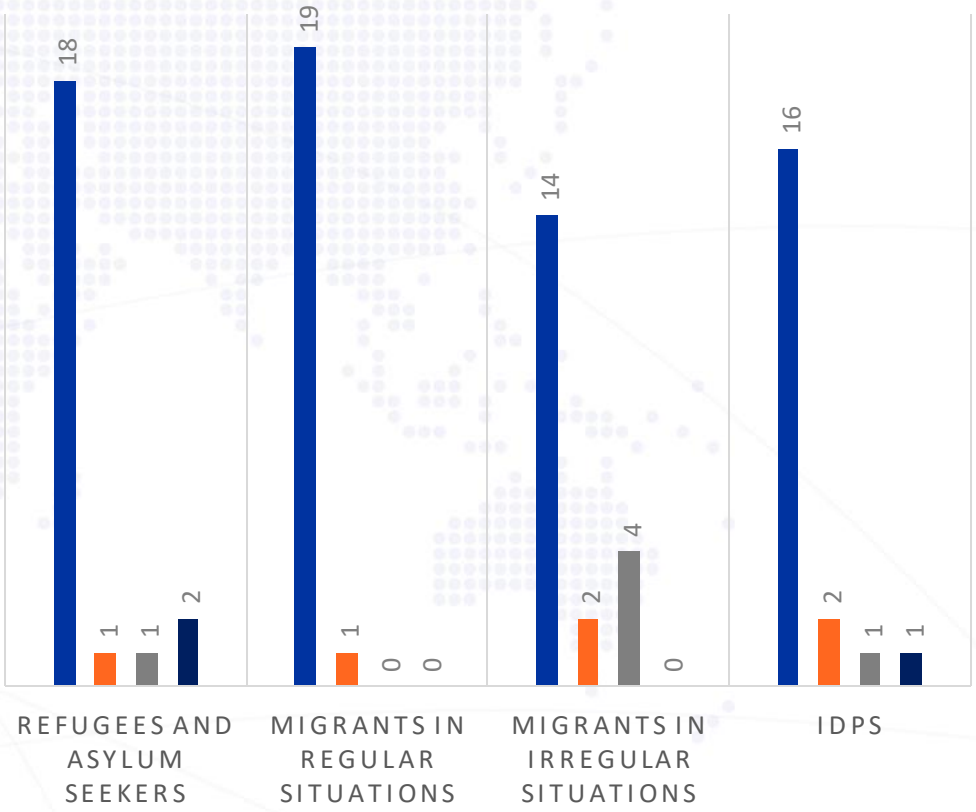


This analysis includes all 20 countries in the region and lacks information from 3 countries.

MIGRANT INCLUSION:
MAIN GAPS AND BARRIERS

MIGRANT INCLUSION: SEVEN MAIN BARRIERS IDENTIFIED (1/3)

IOM country offices have observed and reported the following barriers to COVID-19 vaccinations:

1. ADMINISTRATIVE/POLICY BARRIERS:

a. **In some countries, certain laws and regulations simply/openly bar some categories of migrants** from having access to public health services. The COVID-19 vaccines are in some cases reserved for nationals, especially given the current limited supply.

b. **Specific documents are often required**, creating a spectrum of barriers that can be categorized from low to high:
> LOW: some countries will accept *any form of ID*, valid or not, expired or not, and from anywhere, only to verify the identity;
> MEDIUM: other countries require *specific types* of documents (e.g. residence permit, host country insurance cards), which constitutes a higher barrier, but those documents are accepted even if expired;
> HIGH: other countries require *specific types* of documents that are *still valid / have not expired*.

c. **Blurry or absence of firewall between health and immigration authorities:** In some countries, health workers are required to report to immigration authorities migrants in irregular situations attempting to access health services, which leads to fear of arrest/deportation.

d. **Registration through dedicated (online) systems** are often required prior to vaccination, which can be confusing, and which often also imply other barriers (technological requirements, language barriers, fear of tracking tools that may lead to arrest or deportation…).

MIGRANT INCLUSION: SEVEN MAIN BARRIERS IDENTIFIED (2/3)

IOM country offices have observed and reported the following barriers to COVID-19 vaccinations:

2. FINANCIAL BARRIERS:

While the vaccine is free in many countries for people registered in national health insurance plans for example, in some countries, there is a **lack of clarity on whether there is a cost/fee** for people who are not enrolled in such schemes.

3. TECHNICAL BARRIERS:

Lack of internet connectivity is reported as a barrier in countries where vaccine bookings have to be made online. *Note: this is linked to Barrier 1d.*

4. INFORMATIONAL BARRIERS and MISTRUST:

a. In some countries, **a lack of outreach and reliable information targeting migrants** is reported, contributing to reducing trust, and vaccine hesitancy is reported to be high among migrant populations in those countries.
b. In others, **linguistic and cultural barriers** are listed as major concerns for migrant participation/access leading to dis- and misinformation.

MIGRANT INCLUSION: SEVEN MAIN BARRIERS IDENTIFIED (3/3)

IOM country offices have observed and reported the following barriers to COVID-19 vaccinations:

5. BARRIERS LINKED TO OVERALL LACK OF VACCINE AVAILABILITY:

a. The overall **limited supply of doses across the world** continues to makes it difficult *de facto* for many people to have access to vaccinations, including nationals, but this affects particularly marginalized communities, for example migrants in irregular situations.
b. One country reported that vaccines approved by the national Government and vaccines approved by the COVAX Facility are not aligned which complicates the supply situation.
c. Government made a **choice not to carry out a COVID-19 vaccination campaign**
d. Complex **ongoing crisis** limits the country's ability to focus on COVID-19 vaccination campaign

6. LOGISTICAL HURDLES FOR DELIVERY, CONTINUED MOBILITY OF PEOPLE:

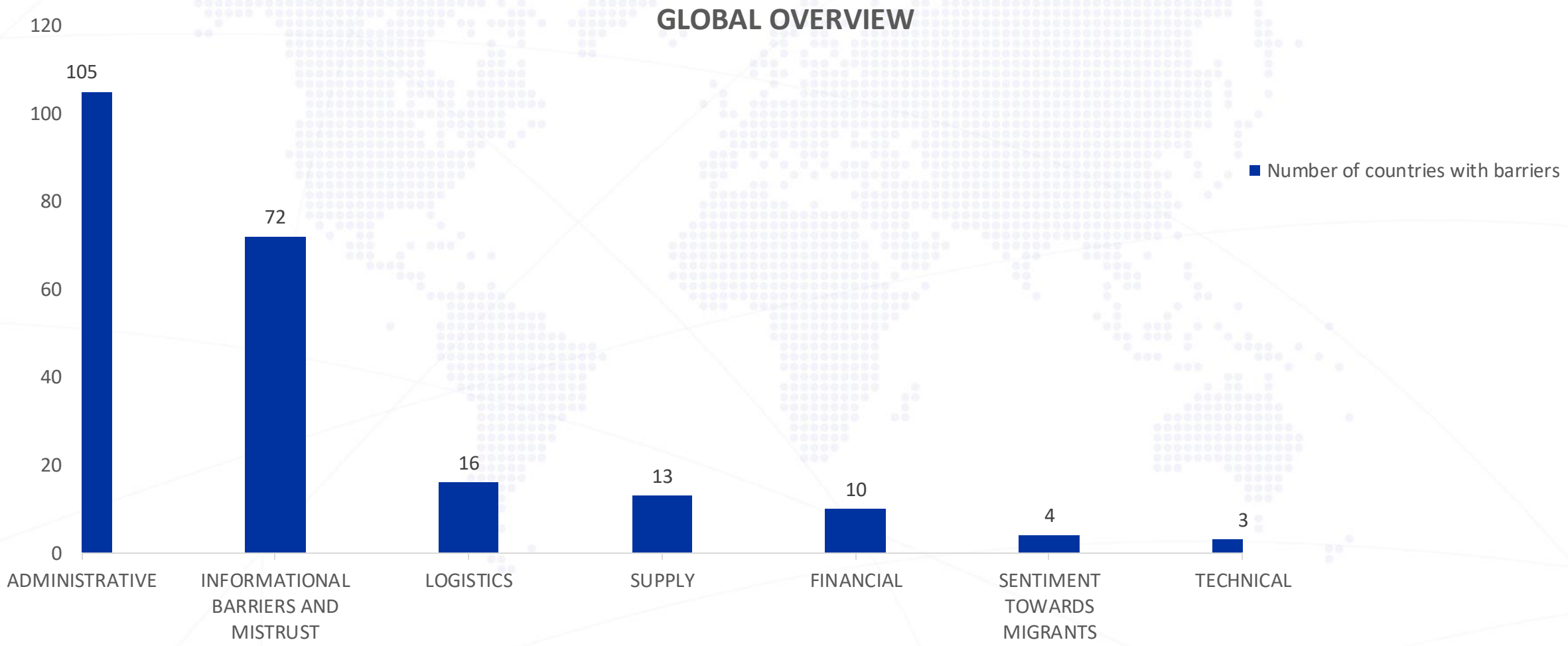
Logistical hurdles make it difficult to deliver vaccines in some countries. Also, **continued mobility** is reported as a major challenge for the administering the second dose. The concern is particularly prevalent in emergency contexts where there is a high number of IDPs.

7. EFFECTS OF XENOPHOBIA AND DISCRIMINATION:

Three countries reported this as a barrier.

MIGRANT INCLUSION: MAIN BARRIERS IDENTIFIED

IOM country offices have observed and reported the following barriers to COVID-19 vaccinations:



MIGRANT INCLUSION: SOME EXAMPLES OF BEST PRACTICES

Good initiatives, identified by IOM, with which countries reduce barriers for migrants to access to COVID-19 vaccines:

1. No form of identification required as a pre-requisite for COVID 19 vaccination .
2. Firewall between health and immigration authorities to guarantee that will not be turned up if they try to access vaccination services
3. Making vaccine free to all or universal (including foreigners, migrants, displaced people) at all clinics.
4. Clear categorization of migrant typologies in NDVPs, or as separate priority group.
5. Pro-actively reaching out to migrant communities, in tailored languages and through trusted communication channels to create vaccine demand.
6. Deploying mobile vaccination teams to reach migrants and other vulnerable population in remote areas where primary health services remain scarce.

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MIGRANT INCLUSION:
IOM'S INTERVENTIONS TO FACILITATE VACCINE ACCESS FOR MIGRANTS

IOM ONGOING ACTIVITIES TO FACILITATE MIGRANT INCLUSION

Across all regions, IOM is pro-actively working to help ensure COVID-19 vaccines reach migrants, including forcibly displaced people, and is engaging with governments to implement the following interventions:

a. Sustained advocacy for inclusion and removal of barriers to access
b. Capacity-building for partners and staff
c. Triangulation and utilization of accurate data on migrant typology and for planning
d. Continued social mobilization and outreach to assist in addressing vaccine hesitancy
e. Operational and logistics support (transport, HRH support, storage…)
f. Establish and strengthen monitoring and learning systems
g. Facilitate special campaigns and vaccination drives to (migrant) communities
h. Countries must explore the option of requesting for the Humanitarian Buffer systems
i. Target identification and reach/vaccine administration

IOM missions are currently focusing mainly on vaccination delivery, advocacy, capacity-building, supply/cold chain enhancement, data provision in line with privacy principles and regulations, as well as social mobilization and outreach.