

The Immunization Program in the Context of the COVID-19 Pandemic

(26 March 2020)

Objective

- Provide guidance regarding the operation of immunization programs in the context of the COVID-19 pandemic.

Key Considerations

- In December 2019, a new coronavirus (SARS-CoV-2) was identified as the causative agent of a severe acute respiratory disease (COVID-19) in Wuhan, China. (1,2) The virus spread to different countries and the World Health Organization (WHO) declared a pandemic on 11 March 2020. (3)
- There are still some uncertainties in the natural history of SARS-CoV-2, including sources, transmission mechanisms, and persistence of the virus in the environment. Person-to-person transmission has been documented, with an incubation period of 2 to 14 days.
- There is currently no vaccine available against SARS-CoV-2. WHO has launched a project (4), which aims to coordinate and accelerate the development of this vaccine. As of 26 March, there are 2 candidate vaccines that have already started clinical trials and 52 that are in the preclinical phase. (5)
- Meanwhile, in the context of the COVID-19 pandemic, health systems are facing a rapid increase in demand. When health systems are overwhelmed, both direct outbreak mortality and indirect mortality from preventable and treatable conditions, such as vaccination, increase dramatically. In fact, an analysis of the 2014-2015 Ebola epidemic suggests that the increase in the number of deaths caused by measles, malaria, HIV/AIDS, and tuberculosis attributable to health system failures outnumbered deaths from Ebola. (6)
- Therefore, WHO recommends that vaccination should be considered an essential health service that should not be interrupted.

Recommendations

- The following are recommendations on vaccination and epidemiological surveillance for vaccine-preventable diseases (VPDs) in the context of the COVID-19 pandemic, in the Region of the Americas, which were consulted on by members of PAHO's Technical Advisory Group (TAG) on Vaccine-preventable Diseases, and are aligned with recommendations from WHO's Strategic Advisory Group of Experts (SAGE) on immunization. (7)
- These recommendations are preliminary and are subject to review as new evidence becomes available.¹

1. Routine Vaccination during the COVID-19 Pandemic

- Involve the National Immunization Technical Advisory Group (NITAG) in making decisions about continuing vaccination services.
- The decision to maintain immunization services will be determined by national guidelines on social distancing, the health system situation, the burden of vaccine-preventable diseases (VPDs), the context of local SARS-CoV-2 transmission (without cases, sporadic cases, conglomerates or community transmission),

¹ Updated information on COVID-19 is available at: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

as well as other factors, such as demographic data and the availability of vaccines and supplies. Possible scenarios to consider are the following:

Scenario	Recommendation
1. If the capacity of the health system is intact and the provision of essential health services continues	Vaccination should be conducted through fixed posts, mobile posts, and coverage extension activities, guaranteeing fulfillment of the recommended measures for infection prevention and control (8,9) and safe vaccination. The population should be informed on the continuation of vaccination services, and the importance of attending scheduled vaccination appointments.
2. When only limited service provision is available	Prioritize vaccination of vulnerable populations with the highest risk of morbidity and mortality from VPDs (for example, older adults, people with chronic diseases, health personnel, pregnant women, children under 5 years of age, communities with active outbreaks of measles, diphtheria, yellow fever).
3. If vaccination cannot be performed safely, and the risk of SARS-CoV-2 transmission increases	Suspend vaccination activities until the risk of SARS-CoV-2 transmission has been reduced and the capacity of the health system has recovered sufficiently to resume these activities.

- In scenarios 1 and 2, vaccination against influenza and measles should be prioritized:
 - *Influenza*: The recommendation to vaccinate against influenza applies primarily to countries that, following WHO recommendations for the southern hemisphere, will apply the flu vaccine in the coming months. Vaccination of health personnel, older adults, people with chronic diseases, and pregnant women should be prioritized.
 - *Measles*: Consider applying the zero-dose strategy for children aged 6-11 months in municipalities with active outbreaks.
- In health establishments where vaccination activities are to be carried out, it is essential that health professionals be alert to signs and symptoms of respiratory illnesses and offer patients with flu symptoms a surgical mask and refer them for medical evaluation according to local protocols for initial approach to patients with suspected COVID-19.
- Routine use of medical masks by health professionals in the context of routine vaccination during the COVID-19 pandemic is not recommended.
- As institutional births will continue, vaccination of newborns must remain a priority in all settings.
- Countries with pneumococcal vaccination programs for older adults and people with high-risk conditions should maintain these programs whenever the administration of this vaccine is possible.

2. Vaccinating People Diagnosed with COVID-19 and their contacts

- Although there are currently no known medical contraindications to vaccinating a person with COVID-19, it is recommended to defer all vaccination until complete recovery, according to established criteria.
- Although there are currently no known medical contraindications to vaccinating a person who has had contact with a COVID-19 case, it is recommended to defer vaccination until quarantine has been completed (14 days after the last exposure).

3. Conducting Vaccination Campaigns

- Based on current knowledge of SARS-CoV-2 transmission, and recommended prevention measures for social distancing, it is recommended to temporarily suspend mass vaccination campaigns due to the risk of strengthening transmission in the community and in health establishments.
- If a VPD outbreak occurs, the risk-benefit of conducting outbreak response vaccination should be evaluated while considering the health system's ability to safely carry out this activity in the context of the current COVID-19 pandemic. This evaluation should assess the risk of a late response against the associated risks of an immediate response, both in terms of VPD morbidity and mortality, and the potential impact of increased SARS-CoV-2 transmission. If the decision to conduct a vaccination campaign is made, strict measures must be followed to protect health workers, safeguard the population, and ensure solid waste management. If the decision is to delay the outbreak response vaccination campaign, a periodic assessment of VPD morbidity and mortality will be required and the risk of further delaying a response will be considered.
- The countries that had planned this year to conduct follow-up campaigns against measles, rubella or human papillomavirus (HPV) should continue the micro-planning phase and postpone the implementation phase until conditions permit.

4. Guidance for Vaccination Posts

- Conduct vaccination sessions in well-ventilated areas that are frequently disinfected. (10)
- Ensure the availability of hand sanitizer or a hand washing station with chlorinated water for use by users at the entrance of the health facility. (10)
- Limit the number of family members accompanying the person to be vaccinated (one companion).
- Perform triage of persons presenting respiratory symptoms before admission to the vaccination posts to prevent the spread of SARS-CoV-2. If patient presents respiratory symptoms, offer medical mask, do not vaccinate, and refer to service for evaluation.
- Avoid crowded waiting rooms. Some strategies for this could include:
 - Scheduled times for vaccination appointments;
 - Integrate vaccination activities with other essential preventive health services, as appropriate;
 - Carry out small and frequent vaccination sessions;
 - Utilize outdoor spaces and adhere to the recommendation of social distance within the facility, or vaccination post;
 - Establish exclusive vaccination sessions for older people and people with pre-existing medical conditions (such as high blood pressure, heart disease, respiratory disease, or diabetes).
- Whenever possible, the vaccination post must be separate from healing services (i.e., different hours, different spaces);
- Recommendations for vaccinators:
 - Frequently maintain hand hygiene as described in "My 5 Moments for Hand Hygiene": i) Before touching a patient; ii) Before clean or aseptic procedures; iii) After body fluid exposure/risk; iv) After touching a patient, and v) After touching patient surroundings. (11)
 - Hand hygiene consists of washing hands with soap and water or with a hand sanitizer that contains between 60% and 80% alcohol.
 - Comply with guidelines on clothing: i) Use a uniform, which should be not used outside the health facility; ii) Use closed shoes; iii) Do not use accessories (for example: earrings, rings, chains, watch).
 - Clean cell phones properly. Do not use cell phone while providing medical attention.
 - If you experience symptoms, such as cough or fever, you should not be working and should seek medical attention.

5. Reestablishing Vaccination Services

- Vaccination services should be restored when the risk of transmission of SARS-CoV-2 has been reduced and the capacity of the health system has recovered enough to resume these activities. There will probably still be some level of SARS-CoV-2 transmission when services resume. It is likely that stricter IPC measures and social distancing practices are still needed in the early stages of resuming vaccination services. The NITAG should advise the country on how to resume service and what populations to prioritize.
- Once health services go back to normal, countries should intensify vaccination as soon as possible, even if routine vaccination has continued throughout the entire pandemic, since it is possible that the service delivery level was not optimal or the population was unable or unwilling to access the service. Therefore, the intensification of vaccination services should be a priority. Furthermore, the mass vaccination campaigns that were suspended due to the pandemic should be prioritized. It may be necessary to adjust the target age groups of the campaigns to consider the largest number of age cohorts with low immunity. Where feasible, other vaccines and health interventions should be integrated to maximize health benefits, facilitate recovery and minimize the burden of multiple campaigns. Micro-planning will need to be reevaluated, especially if services were interrupted for an extended period.
- The decision to establish vaccination services should be communicated in a timely manner to health personnel and the population.

6. Cold Chain and Vaccine and Supply Stock

- It should be noted that interruption of flights and the manufacturing of vaccines and supplies can affect delivery plans.
- Monitor the stocks of vaccines and supplies, as well as the functionality of the cold chain.
- The existing cold chain storage capacity may need to be expanded if excess vaccines exist due to anticipated shipments and/or low use due to an unexpected decline in vaccination services. Countries should maintain an updated list of all potential facilities (public and/or private) with a functional cold chain to expand capacity if necessary.

7. VPD Epidemiological Surveillance

- Surveillance systems should continue with early VPD detection and case management, at least for diseases with global surveillance mandates and elimination and eradication objectives: measles, rubella, neonatal tetanus, polio.
- Countries should also prioritize surveillance of VPDs with epidemic potential: influenza, meningococcus, yellow fever, measles, rubella, diphtheria, and polio.
- Routine surveillance for other VPDs should continue as long as possible; when laboratory testing is not possible, samples should be stored appropriately for confirmation when laboratory capacity allows. Countries should ensure enough sample storage capacity at the provincial and central levels and monitor it regularly. It is recommended to review the conservation conditions for samples, according to the type of sample and event.
- If it is not possible that VPD surveillance systems continue to function normally, identify and maintain critical functions, such as active acute flaccid paralysis (polio) surveillance, outbreak monitoring and sending of urgent samples and laboratory confirmation of priority VPDs. To reduce the risk of exposure to SARS-CoV-2, active surveillance for polio can continue in a limited number of priority hospitals, provided the

surveillance officer uses the appropriate personal protective equipment (PPE). If this is not possible, active surveillance should be carried out remotely (for example, via internet, telephone) as much as possible.

- If epidemiological surveillance activities are temporarily suspended due to the COVID-19 pandemic, countries should implement necessary actions to ensure continuity of activities and plan recovery measures, if necessary (for example: active searches for suspected measles/rubella cases).
- Since the laboratories performing tests to detect VPDs may also be responsible for conducting SARS-CoV-2 tests, it is important that countries retain the ability to identify priority VPDs, although potentially at reduced levels, with a decreased frequency.
- Optimizing and prioritizing the use of laboratory tests will be essential to ensure the sustainability of laboratory surveillance during the time of the pandemic and in the months immediately following. There is a risk of limited availability of reagents and laboratory supplies due to an interruption or decrease in production, and limited capacity for their international transportation.

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