

ENSURING EQUITABLE ACCESS TO COVID-19 VACCINES

RECOMMENDATIONS

June 2021

About EPHA

EPHA is a change agent – Europe's leading NGO alliance advocating for better health. We are a dynamic member-led organisation, made up of public health civil society, patient groups, health professionals, and disease groups working together to improve health and strengthen the voice of public health in Europe.

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Introduction

The COVID-19 pandemic has devastated the lives of many, disproportionately affecting some individuals and communities more than others due to long standing health disparities, acting as an extrapolation of already existing vulnerabilities. It is important for the European Union to strive for global vaccine equity, making sure that people around the world benefit from equitable access to COVID-19 vaccines. Public health means protection of the population as a whole and health for all.

As solutions have been dispersed between restrictions promoting physical distancing and vaccination coverage, many limitations in these measures affect certain populations. Physical distancing has not been an option for everyone and priority to vaccination has not universally been given to those in greatest need.

Populations indicating vulnerable attributes, often not accounted for in the emergency response to the COVID-19 pandemic were identified as the following : persons experiencing homelessness, ethnic minorities including Roma and BAME (Black Asian and Minority Ethnic) communities, refugees, asylum seekers and undocumented migrants, prisoners, sex workers, persons at risk of poverty and social exclusion and persons with disabilities (physical, sensory, intellectual or psychosocial disabilities), together with their support network.¹

These groups are not only subjected to higher health risks linked to their socio-demographic and health status, but also face numerous obstacles to accessing basic healthcare and prevention services. Since the start of the pandemic, low political commitment to mitigate its effects on these groups has been observed in many countries, hindering their access to the new vaccines in addition to existing barriers to healthcare and prevention services in more general settings. Their exclusion from national vaccine rollout strategies, jeopardizing their chances for survival and good health and putting them at particular risk of morbidity and mortality, will also disproportionately shape their economic activity and stability, affecting generations to come.

Apart from low recognition of their needs in national vaccination campaigns, three systemic barriers exist:

- access to appropriate information
- physical access to the vaccines provision services
- structural impediments (such as administrative barriers).

Access to appropriate information

As communication campaigns around the pandemic, healthcare services, vaccines and vaccination usually target the general public, the absence of population-tailored messaging becomes a key access barrier. Linguistic and contextual adaptation of public information outreach is necessary to empower² vulnerable communities to seek the care they need. Additionally, information from health authorities needs to be available in alternative formats, such as braille, large print, videos, etc³ for persons with disabilities. The latter may also encounter difficulties in physically accessing facilities due to disability-unfriendly infrastructure and lack of assistance

¹ <https://www.ecdc.europa.eu/en/publications-data/guidance-medically-and-socially-vulnerable-populations-covid-19>

² RCCE, "COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement", 2020. https://reliefweb.int/sites/reliefweb.int/files/resources/COVID-19_CommunityEngagement_130320.pdf

³ United Nations Human Rights, "Human rights and access to covid-19 vaccines", 2020. https://www.ohchr.org/Documents/Events/COVID-19_AccessVaccines_Guidance.pdf

within the care provision (non-verbal communication, explanatory process for persons with learning disabilities, etc). People living in poverty and exclusion, as well as those living in rural and isolated areas may struggle to access vaccination centres due to their lower availability.

Physical access to vaccines provision services

Physical access includes geographical hurdles, as national and regional dispersion of healthcare facilities and traditional vaccination centres might be heterogeneous and therefore impose transportation costs on those seeking care. Inflexible opening hours also hinder vaccine access for those unable to attend during their working hours.

Structural barriers

Administrative - Access can be hindered by identification and insurance requirements. Stateless people, individuals without ID documents, social security numbers, health insurance nor the necessary (legal) documents may not be able to access health services and might not seek care for fear of being reported to migration authorities. Health insurance might also be a challenge for those in informal employment or those performing seasonal work, leaving many without health coverage. Furthermore, appointment booking requirements can be burdensome, if reservation options are not offered through different services - both digital and non-digital.

Financial - Healthcare costs might not be covered, therefore requiring out of pocket expenses, making it unaffordable for disadvantaged populations to benefit from healthcare services. This includes travel expenses to reach the nearest facility or vaccination centre.

Structural deprivation - In some settings such as within prisons or correctional facilities, individuals might not be able to get the healthcare they need.⁴

Together with these obstacles to accessing healthcare come multiple health and social inequalities, increasing the health risks for vulnerable groups beyond COVID-19. The combination of lower access to healthcare, vaccine deprivation and socio-economic disadvantage, or environmental burdens makes it difficult to avoid clusters of infection within vulnerable groups. Increased risk of infection and therefore transmission and complications are often a consequence of numerous factors, frequently co-existing:

- Pre-existing conditions such as higher prevalence of non-communicable and communicable diseases and comorbidities among vulnerable groups increasing their exposure to ill-health.⁵
- The inability to work from home or physically distance due to poor living and work conditions: Individuals experiencing homelessness,⁶ living in shelters, shared accommodation and institutions (such as medical, psychiatric, correctional facilities), including persons living independently but requiring personal assistance as well as Roma living in segregated areas where they face substandard housing conditions, including poor access to clean water. It also concerns individuals in more precarious settings, who are not eligible for paid sick leave or financial aid if their job demands proximity with potentially infected individuals - this being the case for

⁴ Nadine Kronfli and Matthew J. Akiyama, "Prioritizing incarcerated populations for Covid-19 vaccination and vaccine trials". <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7772529/>

⁵ <https://epha.org/wp-content/uploads/2019/12/epha-health-inequalities-a-public-health-challenge-for-european-policy-makers.pdf>

⁶ https://www.feantsa.org/public/user/Resources/Position_papers/Vaccine_Statement_Feb_21.pdf

many sex workers, seasonal workers and undocumented migrants.

- Health literacy and vaccine hesitancy: Studies have shown that vulnerable and marginalised communities are less confident about the safety of vaccines.⁷ Literacy and uptake can indeed be related, without however being interdependent. Low health literacy may result from a lack of scientific knowledge and healthcare terms, lower educational skills or inequalities experienced in accessing healthcare, cognitive decline or learning disability.⁸ Hesitancy might arise from mistrust in authorities as a consequence of discrimination and neglect, including historical events of forceful medical procedures. The politicization of the COVID-19 pandemic and circulation of misinformation has also fuelled hesitancy in vaccine uptake. Vaccine confidence therefore depends on multiple environmental elements, including the healthcare system's structure.
- Health status prior to the pandemic: Access to healthcare, mistrust in health authorities and medical personnel, living and work conditions, behavioural risks, disability or co-morbidities increase the prevalence of chronic diseases and poor health (both physical and mental) lower life expectancy in the afore-mentioned populations, exponentially increases their vulnerability towards the COVID-19 virus.

These health threats, exacerbated by health and social inequalities represent an ethical dilemma as these populations also require COVID-19 vaccine coverage. Strategies in which these groups are not accounted for mean that communities as a whole cannot reach population herd immunity as high transmission within disadvantaged clusters represents a risk for the rest of the population as well. Moreover, non-inclusion increases a country's financial and economic burden, as emergency care and economic inactivity resulting from non-vaccination will lead to much higher costs in the longer -term.

The lack of consideration of the obstacles faced by these groups also represents a human rights issue, as Human Rights conventions and EU Treaties signed by all member states and approved by the Court of Justice of the European Union as within EU law, require their protection by the state in the face of disease and prohibit all forms of discrimination.⁹

In order to ensure vaccines are accessible to all population groups in national vaccine deployment strategies, the European Public Health Alliance (EPHA) and its members, many of whom work closely with vulnerable communities, recommend the following best practices:

Knowing who we are working with: Data Collection as a first step

- Assessment of needs and collection of data concerning the demographics of vulnerable and marginalized communities, as well as quantitative data measuring healthcare access, health status and qualitative data measuring the quality of services vulnerable groups receive and their experience within the social and healthcare systems, vaccination programmes and essential services.

⁷ Jamie Murphy and al, "Psychological characteristics associated with COVID-19 vaccine hesitancy and resistance in Ireland and the United Kingdom", 2021 Nature Communications <https://www.nature.com/articles/s41467-020-20226-9>

⁸ Health Literacy. NNLM. Available at: <https://nnlm.gov/initiatives/topics/health-literacy>

⁹ European Convention on Human Rights (Article 5 on the right to liberty and security, article 14 prohibiting discrimination), EU Charter on Fundamental Rights (Article 35 on access to healthcare), Convention on Human Rights and Biomedicine, the European Social Charter (Article 11 on the right to protection of health).

- Data collection should also ensure anonymity, with limited or no personal information and enforced data protected immunization information systems (as affirmed by the EU General Data Protection Regulation (GDPR)), restraining its use by migration and law enforcement authorities. In addition, apart from registration to indicate first-dose immunization for the double administration vaccines, firewalls should be created between the healthcare and migration control sectors, that ensure medical confidentiality and do not require medical personnel, medical administration nor accompanying social services to report on persons presenting irregular status seeking care.¹⁰ Authorities should be able to measure and compare vaccine uptake rates between vulnerable communities and the general population.

- Civil society and community-led organizations should be involved in the contribution of population-specific data, as well as in national and regional decision-making on vaccine deployment because of their expertise in the hurdles and needs that the communities they represent face.

Access to information: Inclusive information and education campaigns reflecting the diversity of vulnerable communities

- Vaccine information campaigns and health education outreach need to be delivered in accessible languages and formats¹¹ (braille, easy-to-read material, large print, videos, sign language). They should address both vaccine safety and vaccine access: **who** has priority and **where** they can get vaccinated, rights to healthcare and prevention, most frequently asked questions and concerns (for example: If the vaccine is free of charge, safe, when they can get vaccinated, etc.).

Additional information on incentives as well on the functioning of the healthcare system or vaccination site amenities: disability-friendly infrastructure and services, languages spoken by the health professionals working in vaccination centres should be included. Vaccination registries can be used as a facilitator to more general healthcare access for these groups in the future.

- Targeted information campaigns should be communicated through numerous channels: social media, public areas and locations where certain communities gather (homeless shelters for persons experiencing homelessness, specific institutions for persons internalized for mental illness or disability, prisons, isolated areas). They should be delivered both digitally and non-digitally and avoid any type of discrimination.¹²

- Outreach initiatives can be facilitated by community-led organisations which have worked with their respective communities in the past and therefore are trusted by them.

- Targeted information exchange initiatives based on discussions between patients and healthcare providers were found to be very effective¹³ (ECDC, 2017).

- Health mediators and community representatives as ‘Vaccines Ambassadors’¹⁴ need to be involved in vaccine-related discussions. To this end, community representation should be encouraged in future workforce recruitment.

10 https://picum.org/wp-content/uploads/2020/07/PICUM-Briefing_Data-protection-and-the-fire-wall_health.pdf

11 <https://www.verywellhealth.com/people-with-disabilities-barriers-covid-19-vaccine-5115883>

12 “Building Vaccine Confidence Through Community Engagement” American Psychological Association <https://www.apa.org/topics/covid-19/equity-resources/building-vaccine-confidence.pdf>

13 “Catalogue of interventions addressing vaccine hesitancy” European Centre for Disease Prevention and Control, *Technical report* 2017. <https://www.ecdc.europa.eu/en/publications-data/catalogue-interventions-addressing-vaccine-hesitancy>

14 <https://www.urban.org/urban-wire/five-ways-communities-can-ensure-covid-19-vaccines-reach-people-experiencing-homelessness>

Getting vaccinated: Facilitating the trip

- Geographical obstacles: Medical facilities and “hospital deserts” need to be resolved in homogenising vaccination centres throughout regions. This can be achieved by using “non-traditional” locations to carry out vaccinations (for example: shelters, ...) whilst guaranteeing the optimal conditions for vaccine safety.
- Vaccination centres should consider extending their opening hours and vaccinating outside typical working hours.
- Free transportation enabling people to reach the vaccination centres must be ensured for those living in isolated and rural areas to avoid financial hardship for those already living in a disadvantaged situation.
- Alternatively, transportation amenities can be organized, which might facilitate the travel for individuals with physical/mental disabilities.
- Bringing vaccines to the people in enabling environments: Mobile Vaccination Teams, covering geographically remote areas and highly-frequented locations. In the administration of a two-dose vaccine, a secondary date needs to be fixed for the second dose administration. Therefore, depending on doses’ availability, the administration of single-dose vaccines (when and where possible) to vulnerable populations must be considered whilst safeguarding the rights of vulnerable groups to choose the vaccine they receive.^{15,16}

Administration services: cutting red tape, encouraging communities to seek vaccination

- Services for specific groups should be ensured:
 - Provision of translators and Interpreters for patients who do not speak the host-country’s language(s)
 - Personal assistants for patients presenting a disability
- Where possible, encourage expert healthcare workers or health mediators to accompany vulnerable patients during the vaccination process (for example: nurses trained in learning disabilities nurse in case of anxiety around needles).
- Vaccines provision should take into account user-friendly infrastructure to facilitate movement and access for persons with physical disabilities (ramps, elevators, handrails, priority parking spaces).
- Possible incentives for hesitant populations: free meal distribution for persons in precarious situations, personal protective equipment (disinfectant gel, masks), redirection to social services for lodging issues, financial incentives such as tax credits, etc.
- Vaccination registration systems should be as simple as possible with limited or flexible documentation requirements: documents such as identification and social security numbers, health insurance adherence or proof of residency should not be a

¹⁵ <https://apnews.com/article/world-news-pandemics-coronavirus-pandemic-london-coronavirus-vaccine-657f8e9f454e9017b11a7489bb415f59>

¹⁶ <https://www.infomigrants.net/fr/post/31172/covid-19-la-serbie-commence-a-vacciner-les-migrants-et-etrangers>

prerequisite.

- Informed consent should be ensured for all individuals that agree to get vaccinated. Vaccines should remain non-mandatory and free of charge.
- Vulnerable groups must be provided with optimal conditions for accessing equally COVID-19 vaccination mainstream measures. In addition, they must be provided with targeted measures taking into consideration Principle 3 of the European Pillar of Social Rights which states that “[...] equal opportunities for under-represented groups should be fostered.”

Vaccination follow-up

- Administering a second vaccine dose when necessary can be troublesome due to various reasons including limited access to the internet as well as low digital literacy. Various means of outreach therefore need to be identified for vaccine reminders.
- Vaccination cards need to be provided, indicating administration of 1 or more doses.
- For individuals deemed difficult to reach for a second dose, notably mobile workers and communities, people without permanent residence such as persons experiencing homelessness, single-dose vaccines should be prioritized.
- Medical follow-ups should be organized in case of vaccination secondary effects.

Partnering with civil society organisations

Collaboration with civil society and community-based organizations needs to be nurtured to bring about solutions to ensure access to vaccination for vulnerable groups. Civil society stakeholders can contribute to data sharing and collection, involvement in policy development, direct outreach to vulnerable groups (through the design of easily accessible awareness-raising campaigns), as well as provision of supportive essential services and assistance.

Looking ahead, in addition to these recommendations,

The European Commission should:

- 1) Highlight the risks faced by disadvantaged population groups confronting distinct as well as overlapping barriers to accessing mainstream health systems and issue guidance accordingly, supported by the legal frameworks of international Human Rights treaties and obligations that ensure protection for vulnerable groups across Europe.¹⁷
- 2) Allocate EU COVID-19-related recovery funds to vaccination information campaigns targeting groups who may be left behind, such as the following: EU4Health programme, Coronavirus Response Investment Initiative (CRII Plus), European Social Fund (ESF) and the Fund for European Aid to the Most Deprived (FEAD).
- 3) Extend the mandate of the European Centre for Disease Prevention and

¹⁷ Article 35 of the EU Charter of Fundamental Rights, Europe, Article 14 of the European Convention on Human Rights, EU member states' adoption of SDGs

Control (ECDC) to support the exchange of knowledge and experience between Member States and improve the quality of data to monitor access for key populations, by using relevant equity-related indicators.

- 4) Review and track implementation of European national vaccination strategies and provide further guidance to Member States, as appropriate.

The European Centre for Disease Prevention and Control should:

- 1) Monitor health inequities and conduct research on long-standing health inequalities, with a view to improving access to COVID-19 vaccines and to healthcare, for vulnerable communities
- 2) Engage with EU Member States to collect data on the vaccine deployment to hard-to-reach populations and facilitate exchange of best practices among public health authorities in the Member States on these issues, in order to track vaccine uptake and facilitate exchanges between national vaccination committees
- 3) Action-driven strategies should be supported by disaggregated data and by the development of simple and relevant equity-related indicators, in order to provide consideration for intersecting factors that may place certain groups in high-risk categories;
- 4) We encourage the ECDC to issue guidance accordingly, on integrative and population- adapted health emergency preparedness and response during the COVID-19 pandemic, while considering its relevance for future public health crises and crisis response.

Vaccine Equity as a pathway to systemic equity in health

The current pandemic has highlighted gaps in national healthcare delivery systems, as well as within EU health systems governance. This global experience of urgent vaccination deliveries needs to become a turning point for better health emergency preparedness and more inclusive health systems in the future.

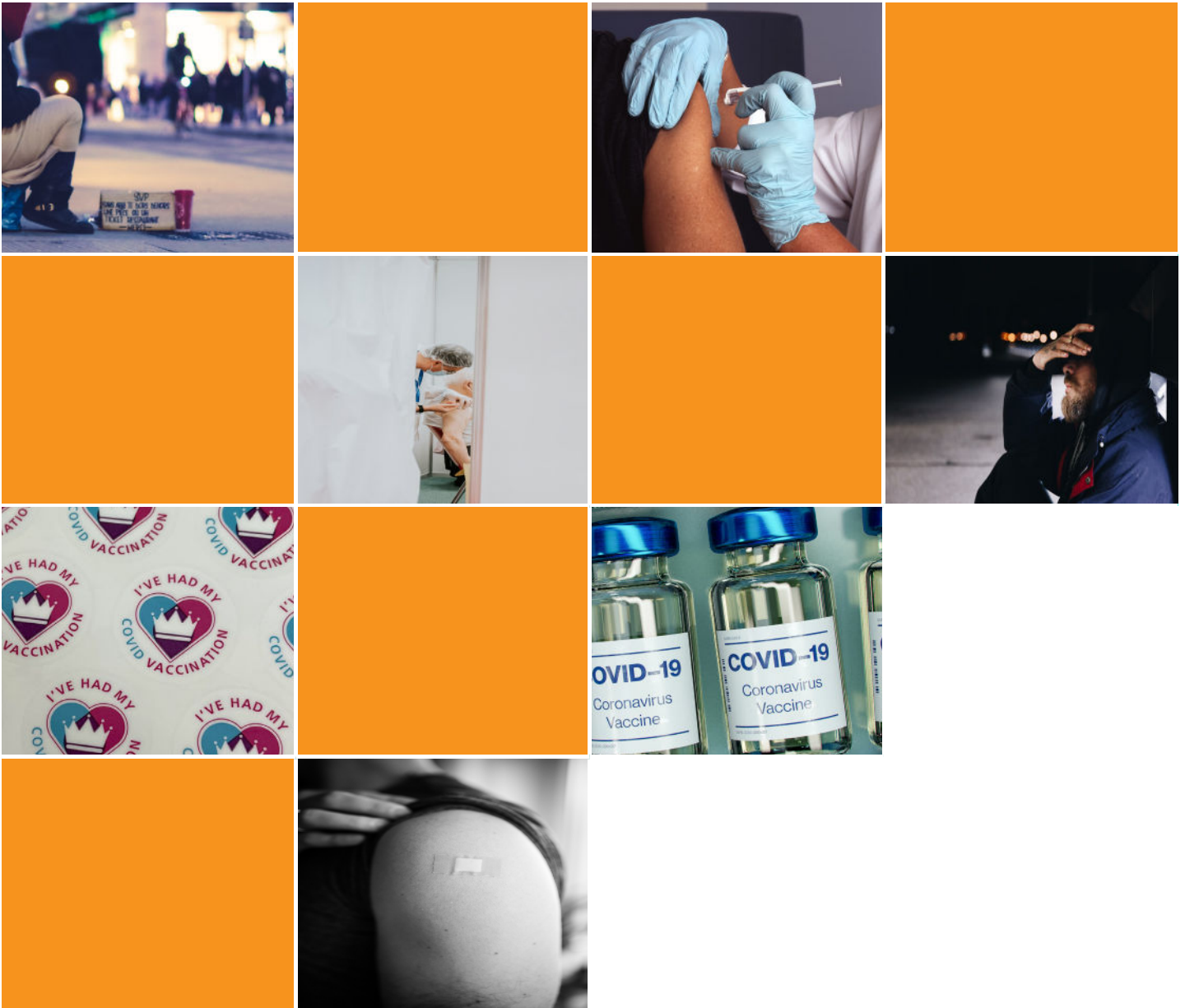
We therefore highlight the importance of the following points:

- In achieving more inclusive, better adapted healthcare systems and an enhanced health preventive culture in general, we value equal access to quality healthcare as a crucial turning point to be addressed for vulnerable populations, whether it delivers preventive or curative care.
- Health authorities should work more closely with civil society organizations to develop more inclusive and comprehensive policies. In this view, public-private and local-regional-national partnerships will also lead to a more cohesive and effective response towards public health issues.
- The EU and its Member States need to focus on developing a more reactive and cohesive approach to public health emergency response, that

These recommendations represent a basis for a healthier and equitable Europe. Many hurdles faced by vulnerable groups still need to be addressed, beyond their inclusion in vaccine deployment strategies, as holistic approaches are needed to resolve the lower inclusiveness of healthcare and vaccination campaigns. Vaccines have been identified as public goods and equitable access to medicines and healthcare for to vulnerable groups is necessary for the achievement of many of the Sustainable Development Goals (n°3 - Good Health and Wellbeing; n°10 - Reducing Inequalities; n°17 - Partnerships for the Goals).¹⁸

Finally, health is a human right, and healthcare and prevention services should be available for all, regardless of physical and mental ability, revenue, legal status or ethnicity.

¹⁸ <https://sdgs.un.org/goals>



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