Frequently Asked Questions (FAQ)
Immunization in the context of COVID-19 pandemic

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**These FAQs accompany WHO’s *Guiding principles for immunization activities during the COVID-19 pandemic*. As the COVID-19 pandemic evolves, these FAQ will be revised as necessary. **

Immunizations are an essential health service that protect susceptible individuals from vaccine-preventable diseases (VPD). By providing timely immunizations, individuals and communities remain protected and the likelihood of a VPD outbreak decreases. Preventing a VPD outbreak not only saves lives but requires fewer resources than responding to the outbreak and helps reduce burden on a health system already strained by the COVID-19 pandemic. While committing to sustaining immunization systems, countries should use approaches that respect the principle of do-no-harm and limit transmission of COVID-19 while providing immunization activities.

**Immunization services**

(1) Should routine immunization services continue as planned during the COVID-19 pandemic?

Immunization services should be maintained for the prevention of VPDs. The approach to maintain immunization services should be influenced by local mandates for physical distancing and be guided by the health system context, local burden of VPDs, transmission context of the COVID-19 virus (classified as no cases, sporadic cases, clusters of cases, or community transmission) and other factors such as population demographics, vaccine availability, service delivery design, and migration patterns. National Immunization Technical Advisory Groups (NITAGs) should be engaged in the decision-making of the country on sustaining immunization services and where necessary, restricting or temporarily suspending services.

As immunization services continue, attention to infection prevention and control measures to avoid transmission of the COVID-19 virus during the delivery of immunization services is essential. Even with continuation of services, there is a risk of diminished programme performance due to strained health systems, decreased workforce due to infection or deployment toward COVID-19, supply disruptions, and decrease in demand. In anticipation of this, planning for eventual catch-up vaccination activities should begin now.

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To sustain community demand for vaccination services during this unique period, a tailored communication strategy should be implemented to provide accurate health information, address community concerns, enhance community linkages and encourage continued use of immunization services.

(2) What are the recommendations for continuation of fixed, outreach and mobile sessions during the COVID-19 pandemic?

Every effort should be made to assure health system capacity is intact and essential health services are operational (e.g., adequate human resources, adequate vaccine supply). Fixed site immunization services should be executed while maintaining physical distancing measures and appropriate infection control precautions (e.g., protect health workers, adequately handle injection waste, and safeguard the public). Service delivery sites need to be equipped with the necessary supplies for infection control precautions.

The appropriateness of implementing outreach or mobile services for vaccine delivery, as well as activities requiring community interaction for VPD surveillance, must be assessed in the local context and should be adapted to ensure the safety of the health workers and the community. Immunization delivery strategies should not aggravate transmission of COVID-19; otherwise, they should be temporarily suspended.

For all immunization services, health workers may have concerns about the possible decreased number of children attending immunization sessions and increased levels of vaccine wastage. To address these concerns, the multi-dose vial policy should be reinforced, and health workers should be encouraged to provide vaccine to any eligible child in order to reduce missed opportunities.

Communities should be clearly informed about the continuation of services and strongly encouraged to maintain their scheduled visits within the constraints of physical distancing recommendations of local authorities. Health workers should be trained in infection prevention and control measures for COVID-19. Immunization visits should also be used as opportunities to disseminate messages to encourage behaviors to reduce transmission risk of the COVID-19 virus, to identify signs and symptoms of COVID-19 disease, and to provide guidance on what to do if symptoms emerge.

(3) How should immunization programmes prioritize if provision of only limited immunization services is feasible?

Where the provision of only limited services is feasible and where safety considerations are assured, prioritization should be given to the immunization of vulnerable populations at increased risk of morbidity and mortality due to VPDs (e.g. communities with low vaccination coverage rates against outbreak-prone diseases such as measles, polio, diphtheria, pertussis, meningococcus, and yellow fever; high risk populations for influenza in countries with influenza vaccination policy). However, in many contexts, trade-offs might require balancing the targeting of those most vulnerable compared to those most accessible (particularly at times when mobility is restricted). Local authorities and community leaders who may represent these population groups should be engaged and contribute to session planning. Careful consideration will be required regarding prioritization of reaching these populations based on

feasibility of the mode of service delivery (e.g. outreach, mobile) within the local context coupled with the ability to ensure the safety of the health workers and community.

(4) Should newborn vaccination programmes be continued as planned during the COVID-19 pandemic?

Given that institutional deliveries should be maintained in most situations, newborn vaccination (e.g. BCG, OPV, Hepatitis B) should remain a priority in these settings according to national immunization schedules.

(5) What measures can countries take to minimize the COVID-19 virus transmission during immunization sessions?

**Guidance for immunization service sites**
- Conduct vaccination sessions in well-ventilated areas, and disinfect the areas often.
- Ensure hand sanitizer or hand washing units with chlorinated water are available for public use at the entrance to the health facility.
- Display visual alerts in clinics, such as posters, with information about COVID-19 disease and reminders on individual prevention strategies. Specifically:
  - Handwashing and correct hand washing techniques;
  - Patient respiratory hygiene using alternatives to facemasks (e.g., use of tissues or flexed elbow to cover cough);
  - Physical distancing at all times (e.g. keep one meter apart).
- Limit the number of caregivers present at an immunization visit
- Avoid crowded waiting rooms. Some strategies for this could include:
  - Scheduled times for immunization appointments;
  - Bundling immunization activities with other essential preventive health services, as appropriate for age to limit the amount of time vaccinees and their caregivers are spending at health service centers;
  - Hold smaller and more frequent immunization sessions;
  - Use of outdoor spaces, if possible and adherence to physical distancing within the health care facility or site;
  - Establish immunization sessions exclusively for vaccination of older persons and those with pre-existing medical conditions (such as high blood pressure, heart disease, respiratory illness, or diabetes).
- Whenever possible, immunization services and waiting areas should be separated from curative services (i.e. separate times of the day or separate spaces depending on the facility).

**Guidance for immunization providers**
- Perform hand hygiene frequently as outlined in “My 5 Moments for Hand Hygiene”:
  - Before touching a patient
  - Before performing any clean or aseptic procedure
  - After being exposed to body fluids

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• After touching a patient
• After touching a patient’s environment
  • Hand hygiene consists of washing hands with soap and water or with a hand sanitizer that contains between 60% and 80% alcohol when hands are not visibly dirty
  • Avoid touching your eyes, nose and mouth
  • Practice respiratory hygiene by coughing or sneezing into a bent elbow or tissue and then immediately disposing of the tissue
  • Wear a medical mask when entering a room where patients with suspected or confirmed COVID-19 are admitted
  • If you are experiencing symptoms, such as cough or fever, you should self-isolate, contact your medical provider, and not be working

(6) Should school-based vaccination be continued as planned during the COVID-19 pandemic?

School-based delivery is an important mode of vaccine delivery for children and adolescents against several vaccines such as booster doses of tetanus and diphtheria, measles-rubella vaccines, HPV vaccine, meningococcal vaccines, and typhoid conjugate vaccines. School-based vaccination initiatives should continue only if infection prevention and control measures are implemented to avoid increased risk of transmission of the COVID-19 virus among the students, school personnel and health care providers.

However, when mass vaccination campaigns are under temporary suspension, school-based campaign strategies are to be avoided; alternative means should be sought to reach these school-aged children with the age-appropriate vaccines.

(7) Is adult vaccination recommended during the COVID-19 pandemic?

Countries with existing pneumococcal, influenza, or pertussis vaccination programmes for older adults and individuals with high-risk conditions should maintain those programs while implementing measures to avoid the spread of COVID-19, especially for those at higher risk of severe disease such as older adults. Preventing respiratory illness and hospitalization from pneumococcus, influenza, and pertussis through vaccination will allow respiratory medical equipment, medications, and health care workers to be more available to support patients with COVID-19. Influenza and other viral respiratory infections increase the risk for secondary bacterial infections such as from pneumococcus. While there is currently limited information on whether COVID-19 is associated with an increased risk of pneumococcal infection, pneumococcal vaccination can prevent both primary and secondary bacterial infections and the unnecessary use of antibacterial medications (antibiotics).

(8) Can a person with COVID-19 (confirmed or suspected) infection be vaccinated?

Currently, there are no known medical contraindications to vaccinating persons who have COVID-19.

To minimize risk of COVID-19 transmission, individuals with suspected or confirmed COVID-19 should be isolated and cared for according to WHO guidance.8

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If a person with confirmed or suspected COVID-19 is not in a health care facility (e.g. at home), the act of seeking immunization may increase spreading infection to others. For that reason, this individual should defer vaccination until symptoms resolve, preferably following two consecutive tests negative for COVID-19 (conducted 24 hours apart).\(^9\) If testing is not feasible, WHO recommends deferring vaccination for 14 days after symptom resolution.

If a person with confirmed or suspected COVID-19 is under care in a health care facility (e.g. inpatient) this individual should be vaccinated according to the national immunization schedule upon recovery and prior to discharge, assuming appropriate infection prevention and control measures are respected.

The duration of viral shedding and transmissibility of COVID-19 is not yet well understood. As these studies become available, this guidance will be updated.

(9) Can a person exposed to a COVID-19 case be vaccinated (a contact)?

Currently, there are no known medical contraindications to vaccinating persons who have COVID-19.

If a person exposed to a COVID-19 case is not in a health facility (e.g. home), this individual should first complete 14 days of self-isolation to prevent risk of COVID-19 virus transmission to others. If the contact does not develop symptoms of COVID-19 after 14 days of self-isolation, then this person can be vaccinated.

If a person exposed to a COVID-19 case is under care in a health care facility (e.g. inpatient) this individual should be vaccinated according to the national immunization schedule upon recovery and prior to discharge, assuming appropriate infection prevention and control measures are respected.

(10) If immunization is suspended or reduced, what should be communicated to concerned parents who are worried about their children missing vaccine doses?

In the context of COVID-19, parents can be informed that although it is important to provide timely vaccinations, there is also a need to follow guidance by national and local governments on COVID-19 preventive measures, including physical distancing. This means that there may be temporary interruption of vaccination services. Consequently, it may be challenging to seek immunizations due to physical distancing and the need to reduce crowding at health facilities. In these instances, it will be important to advise parents to seek immunization for children as soon as vaccination services resume.

In these interactions with parents and communities, it will also be important to listen to and acknowledge their concerns about any missed vaccines and affirm their desire to vaccinate. Parents should also be reassured that as soon as vaccination services are again available they will be informed about how to catch up the missed doses. This message should be adapted locally and context specific.

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Mass Vaccination Campaigns

(11) Should preventive mass vaccination campaigns be conducted?

Based on the current understanding of the transmission modes of COVID-19 and the recommended prevention measures of physical distancing, it is advised to temporarily suspend preventive mass vaccination campaigns due to the increased risk of promoting community circulation of the virus responsible for COVID-19. Countries should re-evaluate, at regular intervals, the necessity for the delay of preventive mass vaccination campaigns.

(12) Should mass vaccination campaigns for outbreak response to VPD diseases be conducted?

Under circumstances of a VPD outbreak, the decision to conduct outbreak response mass vaccination campaigns is complex and will require a risk-benefit assessment that is conducted as urgently as possible. This assessment must factor in the health system’s capacity to effectively conduct a safe and high-quality mass campaign in the context of the current COVID-19 pandemic and weigh critical public health trade-offs. The assessment should evaluate the risks of a delayed response against the risks associated with an immediate response, both in terms of morbidity and mortality for the VPD and the potential impact of further transmission of COVID-19.

- Should an outbreak response vaccination campaign be pursued, stringent measures are required to uphold standard and COVID-19 infection prevention and control, protect health workers, adequately handle injection waste, and safeguard the public. Communications should be well-planned and executed to reassure the health workforce and public that all appropriate safety measures have been taken, and to emphasize the necessity of vaccination.
- Should an outbreak response vaccination campaign be delayed, a periodic assessment based on local VPD morbidity and mortality, as well as regional and international epidemiology will be required to evaluate risk of further delay.

Resumption of Immunization Services

(13) If immunization services are suspended, when can immunization activities resume?

Suspended immunization services should resume as soon as the risk of COVID-19 transmission is reduced and the health system capacity is capable to resume immunization services. It is likely that there will still be some risk of COVID-19 transmission when services resume. Stricter infection prevention and control measures and physical distancing practices for waiting areas will still be needed in the initial phases of reinstating immunization services.

NITAGs should be engaged to advise the Ministry of Health on when and how to resume immunization services and which service delivery strategy and populations to prioritize.

In preparation for the reinstatement of services, a communication strategy should be developed and implemented at the appropriate time; this strategy should adequately inform and prepare health workers, clearly announce the reinstatement of immunization services, and encourage the public to seek vaccination.
What activities need to be conducted to successfully implement catch up vaccination strategies?

Countries will need to reinstate and reinvigorate immunization services at the earliest possible time. Even if routine services have continued throughout the COVID-19 pandemic, service delivery may have been sub-optimal, or beneficiaries may not have been able or willing to access services. Therefore, intensification of immunization services and demand generation activities will be a priority. The following activities should be conducted for successful catch-vaccination to occur on a large scale:

- Planning of catch-up vaccination activities should begin early, during the time of suspension of immunization activities, and not wait for their resumption.
- Review of vaccine registers, defaulter listings and newborn tracking should be continuously updated, during the time of suspended or reduced immunization activity and used for catch-up planning.
- Vaccine stocks and injection supplies should be assessed and compared to vaccine forecasting and immediately updated to ensure adequate supplies are in place.
- Planning for rapid vaccination coverage assessments in affected areas after COVID-19 transmission has decreased may be necessary to identify higher risk communities for prioritization.
- Periodic intensification of routine immunization services (PIRIs) may need to be considered for rapidly catching up children and adolescents.\(^\text{10}\)
- Additional outreach and/or mobile sessions should be considered.
- Prioritization of catch-up activities should be based on local epidemiology and outbreak-prone VPDs in the area such as measles, polio, diphtheria, pertussis, meningococcus, and yellow fever.
- NITAGs should be engaged to advise the Ministry of Health if recommendations for modified catch up policies (e.g. adjusting policies to extend age eligibility) or revised immunization schedules (e.g. minimum interval between doses of vaccine) can facilitate catch-up activities.\(^\text{11}\)
- Microplanning will need to be reassessed, particularly if services were disrupted for an extended period of time.
- Health workers will need to be trained on catch-up vaccination schedules and reminded of the safety and importance of multiple injections toward rapidly getting children caught-up.
- Community engagement should involve local leaders in planning of catch-up activities to support their role in advocating for vaccination, to inform communities of services being resumed, and to emphasize the importance of vaccination, the need to catch-up children who missed their vaccination, and the safety of multiple injections.

What are the considerations for vaccination acceptance and uptake to improve catch-up vaccination?

To evaluate the suitability of various service delivery options to catch-up missed cohorts, it may be important for decision-makers to assess the factors that drive vaccination acceptance and uptake of

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\(^\text{10}\) Periodic Intensification of Routine Immunization.  
https://www.who.int/immunization/programmes_systems/policies_strategies/piri_020909.pdf

\(^\text{11}\) WHO. Table 3: Recommendations* for Interrupted or Delayed Routine Immunization - Summary of WHO Position Papers. 
routine immunization in a community. To guide these tailored strategies, it will be crucial to monitor possible barriers to vaccination among the public and vulnerable groups to identify insights to guide programme strategies.

Sustaining trust in vaccination and the health system is essential. Therefore, any changes to the operations of immunization services following the COVID-19 pandemic must be clearly communicated to the health workforce and the community. This should include skills for health workers on infection prevention and control, ability to communicate with caregivers and communities, messaging on the rationale for vaccination as a priority health service, the risks of VPDs and the benefits of vaccination.

(16) What strategies need to be in place to conduct the mass vaccination campaigns that were temporarily suspended?

Prior to the COVID-19 pandemic, immunity gaps likely existed which necessitated mass vaccination campaigns. As these immunity gaps are still present or have widened, mass vaccination campaigns that were suspended (especially for outbreak response) should be reinstated as soon as possible to minimize the risk of VPD outbreaks. The following should be given considerations:

- Target age groups of campaigns may need to be adjusted to account for the increased number of age cohorts with sub-optimal immunity.
- When feasible, mass vaccination campaigns should become integrated with other vaccines and health interventions to maximize health benefits, improve community uptake, facilitate catch-up, and minimize burden of multiple campaigns.
- Clear communications to communities and to the media should be targeted to support health workers during the campaign and to inform the eligible populations of the safe resumption of services.
- To counter negative press or misinformation on social media platforms, media should be engaged from the onset and kept informed of developments.

**VPD Surveillance and Reporting**

(17) Should surveillance for VPDs continue during the COVID-19 pandemic?

Surveillance systems should continue to enable early detection and management of VPDs, at a minimum for diseases with global surveillance mandates and elimination and eradication goals: polio, measles, neonatal tetanus, and, in countries with regional elimination goals, rubella. Countries should also prioritize surveillance for VPDs with epidemic potential: influenza, meningococcus, yellow fever, typhoid, cholera, and diphtheria12. Ongoing surveillance for other VPDs should continue as much as possible.

If COVID-19 does not allow for existing VPD surveillance systems or a component of VPD surveillance systems to continue as normal, critical functions should be identified and maintained, such as active surveillance for acute flaccid paralysis cases, polio environmental surveillance, surveillance for outbreaks, and shipment of urgent specimens and laboratory confirmation of priority VPDs. To decrease the risk of exposure to COVID-19, active surveillance for VPDs such as polio can continue at a limited number of

12 **WHO** Vaccine Preventable Diseases Surveillance Standards. 
priority hospitals, as long as the surveillance officer wears appropriate personal protective equipment (PPE). If this is not possible, active surveillance should be done remotely (e.g. by internet, phone) as much as possible.

If surveillance activities are temporarily stopped due to the COVID-19 pandemic, countries should include surveillance in the post-COVID-19 recovery plans.

(18) How can continuity of laboratory-based surveillance for VPDs be ensured?

Many VPD network laboratories are becoming involved in testing for the virus that causes COVID-19, drawing laboratory resources away from VPD testing. COVID-19 response has also led to shortages of reagents and supplies because of repurposing for COVID-19 testing, limited supply routes from reduced air transportation, and challenges for global production to keep up with the increased demand.

Ministries of Health are encouraged to retain a sufficient level of routine capacity to test for VPDs, albeit potentially with decreased frequency of testing for priority VPDs as described in question 19. When laboratory testing is not possible, specimens should be stored appropriately for confirmation when laboratory capacity allows. Countries should ensure enough storage capacity at provincial and central level and monitor it on a regular basis.

Laboratory testing algorithms may need to be adjusted to meet the demand for laboratory confirmation. Specifically, based on WHO Surveillance Standards for Measles in an outbreak situation, new clusters of suspect cases can be confirmed by testing five to ten suspect cases. Additional measles suspect cases can be linked epidemiologically instead of confirming with laboratory testing. For domestic specimen transportation for COVID-19, VPDs, and other diseases, the same infrastructures could be used to facilitate timely transportation to testing laboratories.

(19) What are implications and ways to minimize workload on laboratories during the COVID-19 pandemic as reference laboratories often conduct testing for COVID-19 and other VPDs, such as measles?

Limiting and prioritizing testing in laboratories will be critical. If COVID-19 becomes a priority for testing, VPD samples should be tested if there is assurance that it does not compromise testing capacity for COVID-19. There is a risk of limited availability of reagents and supplies for laboratory testing due to a disruption in the production or limited capacity for the international transportation of them.

WHO will be providing guidance to address this laboratory testing surge to ensure priority VPD surveillance programmes with eradication and elimination goals are affected as little as possible. New testing protocols are being developed, including rapid diagnostic testing or point-of-care testing for COVID-19.

(20) What are the possibilities to integrate COVID-19 surveillance with the existing VPD surveillance?

Reporting for VPDs should remain as currently recommended to allow for timely identification of outbreaks and monitoring control, elimination, and eradication goals. Whenever possible, comprehensive VPD surveillance systems should be integrated with surveillance systems for COVID-19, taking advantage of shared infrastructure for laboratory capacity, data management systems, and reporting. Integration
with COVID-19 laboratory surveillance is possible for specimen collection, transportation and processing (which is similar to influenza and measles) and for testing platforms, and protocols (which are mostly PCR-based, using the same RNA extraction kits and enzymes).

(21) Should community-based surveillance be continued?

Activities involving in-person visits or group sensitization are strongly discouraged. However, when community-based surveillance (CBS) for polio is ongoing, persons conducting such surveillance should still be encouraged to report acute flaccid paralysis cases and call patients to encourage them to go to the nearest hospital. CBS for neonatal tetanus, if possible, can also be conducted remotely. WHO does not recommend CBS for other VPDs. However, if persons conducting CBS are made aware of potential outbreaks, they should inform public health authorities immediately and not conduct any in-person investigations or community/group sensitizations until otherwise directed by health authorities.

Cold Chain and Supplies

(22) What implications does COVID-19 have on the vaccine supply chain?

Global disruption of vaccine shipments that can cause vaccine shortages at country level are currently occurring. These are a result of travel restrictions imposed by governments and other public health measures that have put vaccine supply chains under strain. In addition, there may be an adverse impact on production levels due to delays in delivery of commodities used in the manufacturing process, in stalled shipments leading to excess stock remaining with manufacturers, or in slower manufacturing pace due to absenteeism of skilled staff. Therefore, countries are advised to monitor their current stock levels, assess changes in consumption if programs are suspended, and review cold chain capacity. If and where possible, front-loading supply chains is advised to ensure the country has sufficient stock to manage ongoing programs, and can resume programs quickly, particularly if services have been suspended.

Some countries have set up sub-national labs to support testing for the virus that causes COVID-19. The test kits, reagents and other lab supplies that require cold storage may likely use the existing national and sub-national cold chain facilities and equipment to accommodate this surge. In such circumstances cold chain or supply officers should a) allocate a temporary dedicated space for such laboratory products distinct from vaccines b) regularly assess storage capacity and c) modify vaccine receipt and distribution schedules where required to avoid excess burden on the cold chain.

Should a COVID-19 vaccine become available, the conduct of cold chain capacity assessments will be critical to the preparedness and planning for implementation.

(23) What actions can be taken to ensure availability of vaccines and related supplies for routine immunization programme at all levels?

The capacity of the existing vaccine cold chain may be stretched, with excess vaccines from anticipated shipments and/or low consumption due to unexpected decrease in immunization services. Countries should maintain an updated list of all potential facilities (public and/or private) with functional cold chain to ensure surge capacity. The National Logistics Working Group should make use of latest assessments
such as the WHO-UNICEF Effective Vaccine Management Assessment, or conducted during the Cold Chain Equipment Optimization Platform, or from other cold chain mapping exercises. In the absence of these, a rapid assessment should be conducted to ensure compliance with vaccine storage temperature requirements.

To anticipate any possible disruptions in supply, vaccine availability should be ensured for at least three months at national level. If this is not possible, vaccine availability should be ensured at sub-national level for three months, if storage capacity exists. Otherwise, consider shipping vaccines to the sub-national level more frequently, e.g. monthly or depending on previous stock level.

The vaccine stock monitoring system should be reinforced to ensure that all antigens are available and potent (e.g., vaccine stock quantities, adequate expiry date, vaccine vial monitor status where applicable). The stock levels for ancillaries (syringes and safety boxes) should be closely monitored to ensure that bundling of vaccines and related commodities is respected. A close watch on ancillary materials is needed, particularly for dilution syringes, as these products may be used for therapeutic purposes in times of shortage.

As countries prepare for reinstatement of suspended immunization services, front-load supply of shipments when possible to secure availability. Vaccine suppliers will continue efforts to meet planned demand, and as flights are scheduled and shipments are able to proceed, countries should ensure adequate cold chain space to receive vaccines.

(24) **What are the recommendations on forecasting, stock management and shipping supplies?**

Countries should make rational forecasting of vaccines and ancillary items, based on anticipated consumption from routine immunization services and possible supplementary immunization activities (SIAs). If immunization activities are stopped, special care should be placed on regularly monitoring supplies (including gas and other fuel). When appropriate (and determined by vaccine vial monitor status and shelf life), consider using vaccines that were previously planned for mass vaccination campaigns on routine immunization.

Vaccine orders and shipments should include adequate safety stock levels. Stock monitoring systems, stock management and reporting systems should be strengthened to ensure timely visibility of in-country stock levels to guide decisions on resupply.

Programmes should check systematically with supplier(s) regarding vaccine supply availability and the shipment schedule; budget availability and fund allocation should be aligned with this supply schedule.

**Miscellaneous**

(25) **Should other activities such as immunization trainings and coverage surveys continue?**

Activities that facilitate immunization programmes should be carefully considered against the risk of further aggregating transmission of COVID-19. In-person trainings, which congregate groups of people should be temporarily suspended when they are not compliant with physical distancing...
recommendations. Existing digital health platforms may be leveraged for training, information access, and dialogue with the communities who seek immunization services. Such platforms may help refer families to appropriate sources of health information or other social services.

(26) Should new vaccine introductions continue?

Planned new vaccine introductions should be carefully reconsidered and will likely need to be postponed. Often new vaccine introductions include a launch that would not comply with physical distancing recommendations. Furthermore, health care capacity will likely be diverted toward COVID-19 and community demand too low to warrant a new vaccine introduction.

(27) Should verification exercises of measles-rubella elimination continue during the COVID-19 pandemic?

Measles rubella elimination verification activities could continue during the COVID-19 outbreak but should be aligned with the country response capacity to COVID-19, or otherwise postponed. Any delayed measles-rubella verification activities should be included in the post-COVID-19 recovery plans.

(28) Should MNTE assessments continue during the COVID-19 pandemic (e.g., pre-validation assessments, validation surveys and post-validation assessments)?

Given the intense engagement and personal interactions required during these assessments, particularly between communities and assessment teams, these exercises should be postponed and resumed once physical distancing restrictions have been lifted.

(29) Are there vaccines that are recommended for health care workers in the context of COVID-19?

Since there may be other vaccine preventable diseases, such as influenza and measles, circulating in a country along with COVID-19, all health care workers should receive vaccines according to their national schedule.\(^\text{(13)}\)

(30) Is there a vaccine against COVID-19?

As of date of the issuance of these FAQs, there are over 40 vaccine candidates under development and the first clinical trial with an experimental vaccine began in March 2020. It is the first time in history that only 60 days passed between genome sequencing of the virus and the accelerated development of the vaccine. However, WHO does not expect to have a safe, effective vaccine available against COVID-19 earlier than 18 months from the issuance of these FAQs.

\(^{13}\) WHO recommended vaccines for health care workers [https://www.who.int/immunization/policy/Immunization_routine_table4.pdf](https://www.who.int/immunization/policy/Immunization_routine_table4.pdf)