

Interim Guidance for Routine and Influenza Immunization Services During the COVID-19 Pandemic

4/6/2021:

- Updates made to reflect the 2021-2022 influenza season.
- Updates made throughout to clarify guidance related to fully vaccinated people and quarantine guidelines.

The COVID-19 pandemic has caused healthcare personnel to change how they operate to continue providing essential services to patients. Ensuring immunization services are maintained or reinitiated is essential for protecting individuals and communities from vaccine-preventable diseases and outbreaks and reducing the burden of respiratory illness during the upcoming influenza season.

The following is a collection of federal resources designed to guide vaccine planning during the COVID-19 pandemic:

COVID-19 Vaccination Provider Requirements and Support



Vaccination providers participating in the COVID-19 Vaccination Program are required to follow the guidance outlined on this website for the safe delivery of vaccination services during the COVID-19 pandemic. Find information about requirements and resources for enrollment, ordering, and data in support of COVID-19 vaccination.

Interim Guidance for Immunization Services During the COVID-19 Pandemic

Purpose of Guidance

This interim guidance is intended to assist healthcare personnel in a variety of clinical and alternative settings in the safe administration of vaccines during the COVID-19 pandemic. This guidance will be continually reassessed and updated based on the evolving epidemiology of COVID-19 in the United States. This guidance focuses primarily on reducing the transmission of SARS-CoV-2, the virus that causes COVID-19, in vaccination settings. It outlines circumstances in which it is safest for people to go to a vaccination setting (particularly since any time a person leaves home there is an increased potential for SARS-CoV-2 exposure or transmission), or when it is safest for people who are already in healthcare or congregate settings to be vaccinated. Additionally, when deciding when to vaccinate individual patients, healthcare personnel should consider factors, such as presence and severity of acute illness, that might be precautions for vaccination, presence of underlying risk factors that might predispose a person to severe vaccine-preventable illness, likelihood that the person can or will return for vaccination at a later date, and the degree to which vaccine-preventable illnesses (such as influenza) are occurring in the community. Healthcare personnel who administer vaccines should also consult guidance from state, local, tribal, and territorial health officials and [vaccination statements from the Advisory Committee on Immunization Practices \(ACIP\)](#).

Importance of Immunization Services During the COVID-19 Pandemic

Efforts to reduce transmission of SARS-CoV-2 have led to a decrease in routine preventive medical services, including [immunization services](#). Ensuring that routine vaccination is maintained or reinitiated during the COVID-19 pandemic is essential for protecting individuals and communities from vaccine-preventable diseases and outbreaks. Routine vaccination prevents illnesses that lead to unnecessary medical visits and hospitalizations and further strain the healthcare system. For the 2021–2022 influenza season, influenza vaccination will be paramount to reduce the impact of respiratory illnesses attributed to influenza and resulting burdens on the healthcare system during the COVID-19 pandemic. Communicating the importance of vaccination to patients and parents/caregivers, as well as the safety protocols and procedures outlined in this guidance, can help reassure those who may otherwise be hesitant to present for vaccination visits.

Vaccine Recommendations During the COVID-19 Pandemic

Routine vaccination is an essential preventive care service for children, adolescents, and adults (including pregnant people) that should not be delayed because of the COVID-19 pandemic. Because of COVID-19-related reductions in people accessing vaccination services, it is important to assess the vaccination status of all children and adolescents at each patient visit to avoid missed opportunities for vaccination and ensure timely vaccine catch-up. All vaccines due or overdue should be administered according to the recommended [CDC immunization schedules](#) during each visit, unless there is a specific contraindication. This will provide protection as soon as possible and minimize the number of healthcare visits needed to complete vaccination.

Considerations for Routine Vaccination

- **Children and adolescents:** Healthcare personnel should identify children who have missed well-child visits and/or recommended vaccinations and contact parents to schedule in-person appointments, starting with newborns, infants and children up to 24 months, young children, and extending through adolescence. Additional guidance is available for the [prevention of mother-to-child transmission of hepatitis B during COVID-19-related disruptions](#).
- **Pregnant people:** If recommended maternal vaccines (tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis [Tdap] and influenza) have been delayed because of reduced or deferred in-person prenatal care visits, pregnant people should be scheduled for follow-up and receive vaccination during the next in-person appointment.
- **Adults:** Healthcare personnel—whether they administer vaccines or not—should take steps to ensure their patients continue to receive vaccines according to the [Standards for Adult Immunization Practice](#). If vaccination is deferred, older adults and adults with underlying medical conditions are at increased risk for complications of vaccine-preventable diseases.

Additional Considerations for Influenza Vaccination

Annual influenza vaccination is recommended for all persons aged 6 months and older to decrease morbidity and mortality caused by influenza. Healthcare personnel should consult current [influenza vaccine recommendations](#) for guidance around the timing of administration and use of specific vaccines.

During the COVID-19 pandemic, reducing the overall burden of respiratory illnesses is important to protect vulnerable populations at risk for severe illness, the healthcare system, and other critical infrastructure. Thus, healthcare personnel should use every opportunity during the influenza season to administer influenza vaccines to all eligible persons, including:

- **Essential workers:** [Healthcare personnel](#), including staff in post-acute and long-term care facilities, as well as pharmacy staff, and other [critical infrastructure](#) workforce

- *Persons at increased risk for severe illness from COVID-19:* Including adults aged 65 years and older, residents in post-acute and long-term care facilities, and persons of all ages with certain underlying medical conditions. In addition, severe illness from COVID-19 disproportionately affects members of certain [racial and ethnic minority groups](#).
- *Persons at high risk for influenza complications:* Including infants aged 6 months and older and young children less than 5 years of age, children with neurologic conditions, pregnant people, adults aged 65 years and older, and other persons with certain underlying medical conditions

It is important to counsel patients about the risk of self-limited side effects after influenza vaccination, including local reactions, such as redness, pain, or swelling at the injection site, and systemic reactions, which include fever, chills, headache, and body aches. If they occur, such side effects normally resolve within 72 hours after vaccination. Because of concerns about COVID-19, if a vaccine recipient develops fever after vaccination, they should stay home until they have been fever-free for 24 hours without the use of fever-reducing medications. Influenza vaccination does not cause [respiratory symptoms common in COVID-19](#), such as cough or shortness of breath. If the vaccine recipient develops new symptoms of COVID-19 (e.g., cough or shortness of breath), or if fever does not resolve within 72 hours of vaccination without the use of fever-reducing medications, the recipient should contact their healthcare provider. If the patient [develops emergency warning signs for COVID-19](#), they should seek emergency medical care immediately.

There are no data to inform optimal timing of influenza vaccination for vaccine effectiveness in persons with COVID-19 or who are recovering from COVID-19. Additionally, some patients with COVID-19 are treated with medications that can suppress the immune system (e.g., IL-6 inhibitors, high-dose steroids). It is possible that these medications may diminish immune response to influenza vaccination, but the ideal time to vaccinate after discontinuation of these medications is not known. These persons might also be at increased risk for severe illness from influenza as a result of immunosuppression. Timing of vaccination for these individuals should be guided by considerations of the individual's underlying risk of medical complications due to influenza and the degree of influenza circulation in the local community.

Deferring Routine Vaccination Visits for Persons with Suspected or Confirmed COVID-19 Who Are in Isolation or Persons with a Known COVID-19 Exposure Who Are in Quarantine

Visits for routine vaccination should be deferred (postponed) for asymptomatic and presymptomatic persons who have tested positive for SARS-CoV-2, the virus that causes COVID-19, until the isolation period has ended. For symptomatic persons with suspected or confirmed COVID-19, visits for routine vaccination should be deferred until [criteria](#) have been met for them to discontinue isolation and until the person is no longer moderately to severely ill. Consider further deferring the vaccination visit until the person has fully recovered from acute illness. Persons who have not completed the COVID-19 vaccination series (waiting a full two weeks after the final dose) and who have had a known exposure to a person with COVID-19 should not seek outpatient care solely for routine vaccination until their quarantine period has ended. Postpone vaccination visits for all of these individuals to avoid exposing healthcare personnel and other patients in the vaccination setting to SARS-CoV-2. When scheduling or confirming appointments for vaccination, patients should be instructed to notify the provider's office in advance if they currently have or develop any symptoms of COVID-19. However, if patients with symptomatic COVID-19 seek care in a healthcare setting and are still under isolation [criteria](#), deferral of vaccination may be warranted, depending upon the degree of illness and other individual factors. Moderate to severe illness with or without fever is a precaution for all vaccines. Additional considerations for influenza vaccination of persons who are already in healthcare or congregate settings are discussed below.

Vaccine Administration During the COVID-19 Pandemic

Vaccination in the [medical home](#) [🔗](#) is ideal to ensure that patients receive other preventive services that may have been deferred during the COVID-19 pandemic. However, vaccination at locations outside the medical home may help increase access to vaccination in some populations or situations, particularly when the patient does not have a primary care provider or when care in the medical home is not available or feasible. Regardless of vaccination location, healthcare providers should follow [best practices for storage and handling of vaccines](#) and [vaccine](#)

administration. In addition, information on administered vaccines should be documented (e.g., through the state-based immunization information system [IIS], patient's electronic medical record, client-held paper vaccination record) so that healthcare personnel have accurate and timely information on their patients' vaccination status and to ensure continuity of care during COVID-19-related disruptions to routine medical services.

General Practices for the Safe Delivery of Vaccination Services



The potential for asymptomatic transmission of the virus that causes COVID-19 underscores the importance of applying infection prevention practices to encounters with all patients while in a healthcare facility. These include physical distancing, respiratory and hand hygiene, surface decontamination, and source control. Vaccination providers should refer to the guidance developed to prevent the spread of COVID-19 in [healthcare settings](#), including [outpatient and ambulatory care settings](#).

To help ensure the safe delivery of care during vaccination visits, providers should:


- Minimize chances for exposures, including:
 - Screen for [symptoms](#) of COVID-19 and contact with persons with possible COVID-19 [prior to](#) and upon arrival at the facility and isolate symptomatic patients as soon as possible.
 - Limit and monitor points of entry to the facility and install barriers, such as clear plastic sneeze guards, to limit physical contact with patients at triage.
 - Implement policies for the use of [cloth face coverings](#) in persons over the age of 2 years (if tolerated).
 - Ensure adherence to respiratory hygiene, cough etiquette, and [hand hygiene](#).
- Ensure all staff adheres to the following infection prevention and control procedures:
 - Follow [standard precautions](#), which include guidance for hand hygiene and cleaning the environment between patients.
 - Wear a medical face mask at all times.
 - Use [eye protection](#) based on [level of community transmission](#):
 - Moderate to substantial: Healthcare personnel should wear eye protection given the increased likelihood of encountering asymptomatic COVID-19 patients.
 - Minimal to none: Universal eye protection is optional, unless otherwise indicated as a part of [standard precautions](#).
 - Additional considerations for vaccine administration:
 - Intranasal or oral vaccines:
 - Healthcare personnel should wear gloves when administering intranasal or oral vaccines because of the increased likelihood of coming into contact with a patient's mucous membranes and body fluids. Gloves should be changed and hand hygiene should be performed between patients.
 - Administration of these vaccines is not considered an [aerosol-generating procedure](#) and, thus, the use of an N95 or higher-level respirator is not recommended.
 - Intramuscular or subcutaneous vaccines:
 - [If gloves are worn during vaccine administration](#), they should be changed and hand hygiene should be performed between patients.
 - Ensure physical distancing by implementing strategies, such as:
 - Separate sick from well patients by scheduling these visits during different times of the day (e.g., well visits in the morning and sick visits in the afternoon), place patients with sick visits in different areas of the facility, or schedule patients with sick visits in a different location from well visits (when available).
 - Reduce crowding in waiting areas by asking patients to remain outside (e.g., stay in their vehicles, if applicable) until they are called into the facility for their appointment.
 - Ensure that physical distancing measures, with separation of at least 6 feet between patients and visitors, are maintained during all aspects of the visit, including check-in, checkout, screening procedures, and postvaccination monitoring. Use strategies such as physical barriers, signs, ropes, and floor markings.

- Utilize electronic communications as much as possible (e.g., completing paperwork online in advance) to minimize time in the office as well as reuse of materials (e.g., clipboards, pens).

Additional Considerations for Alternative Vaccination Sites

Guidance has been developed for the administration of vaccines at [pharmacies](#), [temporary, off-site, or satellite clinics](#)  , and [large-scale influenza vaccination clinics](#). Other approaches to vaccination during the COVID-19 pandemic may include drive-through vaccination services at fixed sites, curbside clinics, mobile outreach units, or home visits.

The general principles outlined for [healthcare facilities](#) should also be applied to alternative vaccination sites, with additional precautions for physical distancing that are particularly relevant for large-scale clinics, such as:

- Providing specific appointment times or using other strategies to manage patient flow and avoid crowding
- Ensuring sufficient staff and resources to help move patients through the clinic flow as quickly as possible
- Limiting the overall number of attendees at any given time, particularly for populations at increased risk for [severe illness from COVID-19](#)
- Setting up a unidirectional site flow with signs, ropes, or other measures to direct site traffic and ensure physical distancing between patients
- When feasible, arranging a separate vaccination area or separate hours for persons at increased risk for severe illness from COVID-19, such as older adults and persons with underlying medical conditions
- Reminding persons who have not been fully vaccinated and had a close contact exposure to a person with COVID-19 or persons who are positive for COVID-19 that they should not visit a pharmacy or a temporary, off-site, or satellite vaccination clinic solely for vaccination:
 - Until their [quarantine](#) period has ended (for persons with close contact with a person with COVID-19). Quarantine is only necessary for unvaccinated persons, partially vaccinated persons, or those for whom it has not been two weeks since completing the COVID-19 vaccine series.
 - Until their [isolation](#) period ends (for asymptomatic or presymptomatic COVID-19 patients) for persons who are positive for COVID-19
 - Until the [isolation](#) period ends AND they are no longer moderately to severely ill. Consider further deferring the vaccination visit until the person has fully recovered from acute illness (for symptomatic COVID-19 patients).
- Selecting a space large enough to ensure a minimum distance of 6 feet between patients in line or in waiting areas, between vaccination stations, and in postvaccination monitoring areas (the Advisory Committee on Immunization Practices [recommends that providers consider observing patients for 15 minutes after vaccination](#)  to decrease the risk for injury if they faint).

Additional Considerations for Influenza Vaccination of Persons in Healthcare Facilities and Congregate Settings During the COVID-19 Pandemic**

Patient Setting	Patient who is fully vaccinated against COVID-19* or with no known close contact exposure to a person with confirmed COVID-19	Patient (who is not fully vaccinated against COVID-19*) with close contact exposure to a person with COVID-19	Patient with asymptomatic or presymptomatic COVID-19†	Patient with symptomatic COVID-19

Patient Setting	Patient who is fully vaccinated against COVID-19* or with no known close contact exposure to a person with confirmed COVID-19	Patient (who is not fully vaccinated against COVID-19*) with close contact exposure to a person with COVID-19	Patient with asymptomatic or presymptomatic COVID-19†	Patient with symptomatic COVID-19
Outpatient Care (urgent care, outpatient clinics, community influenza vaccination events)	Vaccinate	Can vaccinate during quarantine period, particularly if they might not have another opportunity to be vaccinated.†‡ However, patient should not seek outpatient care solely for vaccination until quarantine period ends.	Can vaccinate during isolation period.‡ However, patient should not seek outpatient care solely for vaccination until isolation period ends.	Should consider deferring (postponing) vaccination for at least the isolation period ** AND until no longer moderately or severely ill. Consider further deferring vaccination until fully recovered from acute illness.
Emergency Department	Vaccinate	Can vaccinate during quarantine period, particularly if they might not have another opportunity to be vaccinated †‡	Can vaccinate during the isolation period ‡	Should consider deferring (postponing) vaccination for at least the isolation period ** AND until no longer moderately or severely ill. Consider further deferring vaccination until fully recovered from acute illness.
Inpatient Acute Care	Vaccinate at discharge	Can vaccinate at discharge.†‡	Can vaccinate at discharge‡	Should consider deferring (postponing) vaccination for at least the isolation period** AND until no longer moderately or severely ill. Consider further deferring vaccination until fully recovered from acute illness.
Congregate Healthcare Setting (e.g., post-acute or long-term care facility; group home; mental health inpatient facility; inpatient substance use disorder treatment centers)	Vaccinate	Can vaccinate.†	Can vaccinate	Should consider deferring (postponing) vaccination for at least the isolation period ** AND until no longer moderately or severely ill. Consider further deferring vaccination until fully recovered from acute illness.

Patient Setting	Patient who is fully vaccinated against COVID-19* or with no known close contact exposure to a person with confirmed COVID-19	Patient (who is not fully vaccinated against COVID-19*) with close contact exposure to a person with COVID-19	Patient with asymptomatic or presymptomatic COVID-19†	Patient with symptomatic COVID-19
Correctional or Detention Facility	Vaccinate	Should consider deferring (postponing) vaccination until quarantine has ended††	Can vaccinate‡‡	Should consider deferring (postponing) vaccination for at least the isolation period** AND until no longer moderately or severely ill. Consider further deferring vaccination until fully recovered from acute illness.
Shelters or Receiving Homeless Services	Vaccinate	Should consider deferring (postponing) vaccination until quarantine has ended††	Can vaccinate‡‡	Should consider deferring (postponing) vaccination for at least the isolation period** AND until no longer moderately or severely ill. Consider further deferring vaccination until fully recovered from acute illness.

[Show More](#)

* A person is considered fully vaccinated 2 weeks (14 days) after completing a vaccination series, either 2 weeks after the 2nd dose of a 2-dose series, or 2 weeks after receiving a 1-dose series vaccine.

†It is also acceptable to wait to vaccinate until quarantine or isolation is over if healthcare personnel are confident patient will return for vaccination or seek vaccination elsewhere when their quarantine or isolation period ends.

‡However, if there are concerns that postvaccination symptoms might be mistaken for COVID-19 symptoms and cause diagnostic confusion, vaccination can be deferred until quarantine or isolation has ended.

**The “gating criteria” for ending isolation that is hyperlinked here, in addition to waiting until the patient with suspected or confirmed COVID-19 is no longer moderately or severely ill (since moderate to severe illness can outlast the gating criteria), reflect the soonest that it would be safe for a patient to come in and receive vaccination. However, as data on vaccination of patients with COVID-19 are limited, consider further deferring vaccination for those who have suspected or confirmed COVID-19 until the patient has fully recovered from acute illness.

‡‡Delaying vaccination until the end of the quarantine period prevents quarantined persons from potentially exposing people in other parts of the facility/shelter if receiving vaccination would require them to leave the quarantine area. It also prevents possible mild side effects from vaccination from being mistaken for COVID-19 symptoms, which has broader implications in this type of setting.

††Can vaccinate if it can be done without leaving the isolation area (e.g., so they do not potentially expose people in other parts of the facility/shelter to SARS-CoV-2)

Vaccinating patients who are already in a healthcare setting (e.g., patients in outpatient settings, including urgent care, outpatient clinics, or community influenza vaccination events; patients presenting at an emergency department; or hospital inpatients in acute care) does not necessarily introduce additional risk to healthcare personnel or other patients. In the healthcare setting, assuming proper infection control precautions can be taken, healthcare personnel should take advantage of opportunities to vaccinate patients to the extent possible, with the following considerations:

- Patients who are fully vaccinated or who have no known recent exposure to a person with COVID-19 are recommended to receive influenza vaccine.
- Patients in quarantine due to a [close contact](#) exposure to a person with COVID-19 can receive influenza vaccine, particularly if they might not have another opportunity to be vaccinated. However, if there are concerns that postvaccination symptoms might cause diagnostic confusion, vaccination can be deferred until quarantine has ended.
- Patients with suspected or confirmed COVID-19 who are asymptomatic or presymptomatic, or who have recovered and are now asymptomatic, can receive influenza vaccine, even if criteria for discontinuation of isolation are not yet met. For example, an asymptomatic person being discharged from the hospital can receive influenza vaccine before discharge, since they might not have another opportunity to be vaccinated once they are discharged.
- For patients with suspected or confirmed COVID-19 who are [symptomatic](#), healthcare personnel should consider deferring (postponing) influenza vaccination for at least the isolation period AND until COVID-19 symptoms are improving AND the patient is no longer moderately to severely ill. Consider further deferring vaccination until the patient has fully recovered from acute illness.

Residents in congregate healthcare settings (e.g., post-acute and long-term care facilities, group homes, mental health inpatient facilities, and inpatient substance use disorder treatment centers)

CDC recommends that residents in congregate healthcare settings, such as post-acute and long-term care settings, group homes, mental health inpatient facilities, and inpatient substance use disorder treatment centers offer influenza vaccine to all residents and healthcare personnel throughout the influenza season. In these facilities, direct exposure and transmission of SARS-CoV-2 can occur repeatedly for long periods of time. Therefore, residents fully vaccinated against COVID-19, residents with close contact with someone with COVID-19, as well as residents in isolation who are asymptomatic and presymptomatic with SARS-CoV-2, can be vaccinated. In these settings, healthcare personnel are already entering residents' rooms to deliver medications or conduct health assessments, so administering influenza vaccine should not result in additional exposures. However, for residents with suspected or confirmed COVID-19 who are [symptomatic](#), healthcare personnel should consider deferring (postponing) vaccination until criteria for discontinuing isolation are met (i.e., for at least the isolation period AND until the person is no longer considered moderately or severely ill). Consider further deferring vaccination until the person has fully recovered from acute illness.

Persons in correctional or detention facilities

CDC recommends that correctional and detention facilities offer influenza vaccine to all incarcerated/detained persons and staff throughout the influenza season, especially those who are at higher risk of severe illness from influenza. Influenza vaccination is always important in congregate settings, where large numbers of persons are in close contact for prolonged periods of time without opportunities for physical distancing. During the COVID-19 pandemic, influenza vaccination will be even more critical to maintain population health and help reduce strain on healthcare resources.

For incarcerated or detained persons who are under quarantine precautions because of a close contact exposure to a person with COVID-19, healthcare personnel should consider deferring (postponing) influenza vaccination until after the quarantine period ends. Delaying vaccination until the end of the quarantine period prevents the quarantined person from potentially exposing people in other parts of the facility if receiving vaccination would require them to leave the quarantine area. Deferring vaccination also prevents possible mild vaccination side effects

from being mistaken for COVID-19 symptoms, which has broader implications in this type of setting. Note that if a person is in routine, administrative quarantine that happens either at intake before being assigned housing with the rest of the facility's population, or before transfer or release (rather than quarantine because of exposure to someone with COVID-19), they can be vaccinated during this period.

For incarcerated or detained persons in medical isolation as confirmed or suspected COVID-19 cases with [symptoms](#) of COVID-19, healthcare personnel should consider deferring (postponing) vaccination until criteria to discontinue isolation are met (i.e., for at least the isolation period, AND until the person is no longer considered moderately or severely ill). Consider further deferring vaccination until the person has fully recovered from acute illness. Persons in medical isolation for COVID-19 who are asymptomatic or presymptomatic can be vaccinated if it can be done without leaving the isolation area (e.g., so they do not potentially expose people in other parts of the facility to SARS-CoV-2). Healthcare personnel providing vaccination should always wear recommended PPE.

Sometimes incarcerated or detained persons in quarantine or isolation are transferred to other facilities during their quarantine or isolation period. In addition, some persons may be released from the facility into the community during their isolation or quarantine period, since they cannot legally be held beyond their release date. In these instances, the decision to vaccinate prior to transfer or release should be left to the facility's discretion.*

Footnote

*When deciding whether to vaccinate, facilities should consider availability of PPE for healthcare personnel providing vaccination, the likelihood the incarcerated or detained person will have the opportunity to be vaccinated at the receiving facility after transfer or release, and the degree to which influenza viruses are circulating within the facility and in the community.

Correctional and detention facilities should have a plan to ensure vaccination opportunities for staff, as well as incarcerated or detained persons for whom influenza vaccination was deferred because of isolation, quarantine, or transfer.


Persons in shelters or who are receiving homeless services

Shelters and homeless service providers should consider ways to offer influenza vaccination to people experiencing homelessness, as well as staff, throughout the influenza season, especially those who are at [higher risk of severe illness from influenza](#). Influenza vaccination is always important in congregate settings, where large numbers of people are in close contact for prolonged periods of time with limited opportunities for physical distancing. During the COVID-19 pandemic, influenza vaccination continues to be critical to maintain population health.




For people experiencing homelessness who are under quarantine precautions because of a close contact exposure to a person with COVID-19, healthcare personnel should consider deferring (postponing) influenza vaccination until after the quarantine period ends. Delaying vaccination until the end of the quarantine period prevents the quarantined person from potentially exposing people in other parts of the shelter if receiving vaccination would require them to leave the quarantine area. Deferring vaccination also prevents possible mild side effects from vaccination from being mistaken for COVID-19 symptoms, which has broader implications in this type of setting.

For people experiencing homelessness with suspected or confirmed COVID-19 who are [symptomatic](#), healthcare personnel should consider deferring (postponing) vaccination for at least the isolation period AND until the person is no longer considered moderately or severely ill. Consider further deferring vaccination until the person has fully recovered from acute illness. People in isolation for COVID-19 who are asymptomatic or presymptomatic can be vaccinated, if accessing vaccination does not compromise their ability to isolate (e.g., having to travel to a healthcare facility solely to be vaccinated). When deciding whether to vaccinate persons who are asymptomatic for COVID-19 in these settings, facilities should consider the availability of healthcare personnel to provide vaccination on site, in addition to the availability of PPE for these healthcare personnel, and the degree to which influenza is circulating within the facility and in the community. Healthcare personnel providing vaccination should always wear recommended PPE.

Strategies for Catch-Up Vaccination


With reduced vaccine administration during the COVID-19 pandemic, unvaccinated or undervaccinated patients are susceptible to preventable illness and communities are at risk for outbreaks. Thus, it's important to implement strategies to promote vaccination schedule adherence and ensure catch-up vaccination, especially for children. [Reminder and recall systems](#) should be implemented to identify patients who are due for or who have missed vaccine doses. Immunization information systems and electronic health records may be able to support this work. In addition, the vaccination status of all patients should be assessed at every healthcare visit to reduce missed opportunities for vaccination, including COVID-19 vaccination. Use of [standing orders](#)  may further improve efficiency of catch-up vaccination.

Additional Resources

- [Interim CDC Guidance on Handling Non-COVID-19 Public Health Activities that Require Face-to-Face Interaction with Clients in the Clinic and Field in the Current COVID-19 Pandemic](#)
- [Repository of Resources for Maintaining Immunization during the COVID-19 Pandemic](#) 
- [Resources for Hosting a Vaccination Clinic](#)
- [Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic](#)
- [Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission](#)
- [Vaccine Recommendations and Guidelines of the ACIP](#)
- [Community Preventive Services Task Force – Findings for Increasing Vaccination](#) 
- [VaccineFinder](#) 
- [Vaccines for Children program](#)
- [Vaccine information statements](#)
- [Vaccinate with Confidence](#)
- [Immunization information systems](#)
- [Epidemiology and Prevention of Vaccine-Preventable Diseases, 13th ed.](#)
- [Vaccine Administration Resource Library](#)

Vaccination Recommendations during the COVID-19 Pandemic

General Information on Childhood Immunizations

The COVID-19 pandemic has resulted in declines in outpatient pediatric visits and [fewer vaccine doses being administered](#), leaving children at risk for vaccine-preventable diseases. Healthcare providers are encouraged to **work with families to keep or bring children up to date with their vaccinations**. Primary care practices in communities affected by COVID-19 should continue to use [strategies to separate well visits from sick visits](#) . Examples include:

- Scheduling sick visits and well-child visits during different times of the day
- Reducing [crowding in waiting rooms](#) by asking patients to remain outside (e.g., stay in their vehicles, if applicable) until they are called into the facility for their appointment, or setting up triage booths to screen patients safely
- Collaborating with healthcare providers in the community to identify separate locations for providing well visits for children

Healthcare providers should **identify children who have missed well-child visits and/or recommended vaccinations** and contact them to schedule in-person appointments, starting with newborns, infants up to 24 months, young children, and extending through adolescence. State-based immunization information systems and electronic health records may be able to support this work.

All newborns should be seen by a pediatric healthcare provider shortly after hospital discharge (3 to 5 days of age). Ideally, **newborn visits should be done in person** during the COVID-19 pandemic to evaluate for dehydration and jaundice, ensure all components of newborn screening were completed and appropriate confirmatory testing and follow-up are arranged, and evaluate mothers for postpartum depression. **Developmental surveillance and early childhood screenings**, including developmental and autism screening, **should continue**, along with referrals for [early intervention services](#) and further evaluation if concerns are identified.



Measles & Rubella Initiative

More than 114 million children at risk of missing out on measles vaccines, as COVID-19 surges





The Measles & Rubella Initiative (M&RI) is a global partnership, founded by the American Red Cross, the Centers for Disease Control and Protection, the United Nations Foundation, UNICEF, and the World Health Organization, that is committed to achieving and maintaining a world without measles, rubella, and congenital rubella syndrome. Founded in 2001, the Initiative has helped vaccinate over 2.9 billion children and save over 21 million lives by increasing vaccination coverage, improving disease response, monitoring and evaluation, and building public confidence and demand for immunization. The Initiative works closely with Gavi, the Vaccine Alliance, to achieve these goals.

During this challenging period, M&RI partners recognize the world's response to the pandemic requires a coordinated effort and commitment of resources to ensure our staff and frontline health workers around the world are protected as they face and respond to this new threat. At the same time, it is important to recognize millions of children may be missing essential immunization services. M&RI partners have urged leaders to intensify efforts to track unvaccinated children, so that the most vulnerable populations can be provided with measles vaccine as soon as it becomes possible to do so.

The World Health Organization (WHO) has issued interim [guidelines—endorsed by the Strategic Advisory Group of Experts on Immunization \(SAGE\)—to help countries sustain immunization activities during the COVID-19 pandemic.](#)

  The guidelines recommend that governments temporarily pause preventive immunization campaigns where there is no active outbreak of a vaccine-preventable disease. M&RI partners strongly agree with these recommendations and urge countries to continue routine immunization services, while ensuring the safety of communities and health workers. The recommendations also ask governments to undertake a careful risk-benefit analysis when deciding whether to delay vaccination campaigns in response to outbreaks, with the possibility of postponement where risks of COVID-19 transmission are deemed unacceptably high.

More information

- Measles information
 - WHO [factsheet](#) 
 - CDC [measles pages](#)
- Latest WHO measles [surveillance data](#) 
- [New interim recommendations for immunization programmes](#) 
- [The Measles & Rubella Initiative](#) 

For more details, please contact:

Priyanka Khanna, M&RI Communications Specialist, at pkhanna@unicef.org

Interim Guidance to Prevent Mother-to-Child Transmission of Hepatitis B Virus

Interim guidance to prevent mother-to-child transmission of hepatitis B virus during COVID-19 related disruptions in

Interim guidance to prevent mother-to-child transmission of hepatitis B virus during COVID-19-related disruptions in routine preventive services

This guidance is provided to ensure that certain safety nets are in place to prevent mother-to-child hepatitis B virus (HBV) transmission if there are significant COVID-19-pandemic-related disruptions in routine preventive services before, during, and after labor and delivery. The guidance is intended to be used by obstetric and pediatric care staff for consideration while prioritizing the Advisory Committee on Immunization Practices (ACIP) recommendations for prevention of mother-to-child transmission of HBV infection (see <https://www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm>).

Prenatal care of hepatitis B surface antigen (HBsAg)-positive women

Ensure that HBsAg-positive pregnant women are able to advocate for the proper care of their HBV-exposed infants in case labor and delivery occurs at an unplanned facility or is attended by staff that is not knowledgeable about managing HBV-exposed infants:

- Educate HBsAg-positive women on their HBsAg status and the importance of proper preventive care for their infant, including hepatitis B immune globulin (HBIG) and single-antigen hepatitis B vaccine at birth, hepatitis B vaccine series completion at 6 months of age, and postvaccination serologic testing.
- Supply HBsAg-positive women with documentation of HBsAg laboratory results and ask them to provide this documentation to labor and delivery staff at the time of delivery.

Labor and delivery care

- Identify HBsAg status of all women presenting for delivery.
- If a woman's HBsAg status is positive, administer HBIG and single-antigen hepatitis B vaccine to her infant within 12 hours of birth.
- If a woman's HBsAg status is unknown, administer single-antigen hepatitis B vaccine to her infant within 12 hours of birth. Determine administration of HBIG per ACIP recommendations (see <https://www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm>). Infants weighing <2,000 grams should receive HBIG if the mother's HBsAg status cannot be determined within 12 hours of birth.
- Provide the birth dose of hepatitis B vaccine to all other newborns within 24 hours of birth to prevent horizontal hepatitis B virus transmission from household or other close contacts.

Pediatric care of HBV-exposed infants

- Every effort should be made to ensure HBV-exposed infants complete the hepatitis B vaccine series following ACIP recommendations (see <https://www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm>). Providers using single-component vaccine who are experiencing immunization service disruption should administer hepatitis B vaccine as close to the recommended intervals as possible, including series completion at 6 months, and follow ACIP recommendations for postvaccination serologic testing.
- If postvaccination serologic testing is delayed beyond 6 months after the hepatitis B series is completed, the provider should consider administering a "booster" dose of single-antigen hepatitis B vaccine and then ordering postvaccination serologic testing (HBsAg and antibody to HBsAg [anti-HBs]) 1–2 months after the "booster" dose.

COVID-19 Operational Guidance



State and Local Health
Departments

Deliver vaccines safely during the COVID-19 pandemic

- [Administration of vaccines](#) is an essential medical service.
- Assess the vaccination status of all patients across the life span at every healthcare visit.
- Administer [routinely recommended](#) vaccines to children, adolescents, and adults (including pregnant



Clinical Care



Long-Term Care Facilities

people). [COVID-19 vaccines](#) may be coadministered with other vaccines – on the same day, as well as within 14 days of each other.

- Follow [guidance](#) to prevent the spread of COVID-19 in healthcare settings.
- Encourage vaccination at the patient’s medical home.
- Implement effective strategies for [catch-up vaccination](#).
- Communicate with patients/families about how they can be safely vaccinated during the pandemic.

Federal Resources on Influenza Pandemic Vaccine Planning



[Pandemic Vaccine Program Distribution, Tracking, and Monitoring](#)

[Implementing Pandemic Influenza Vaccination of Critical Workforce](#)

[Allocating and Targeting Pandemic Influenza Vaccine Guidance](#)

[Pandemic Influenza Vaccine Targeting Checklist](#)

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