SAINT VINCENT AND THE GRENADINES NATIONAL COVID-19 VACCINE INTRODUCTION AND DEPLOYMENT PLAN

MINISTRY OF HEALTH, WELLNESS AND THE ENVIRONMENT

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SAINT VINCENT AND THE GRENADINES
NATIONAL COVID-19 VACCINE INTRODUCTION AND DEPLOYMENT PLAN.

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BACKGROUND

COVID 19 is an infectious disease caused by the novel Corona virus 2 (Sars-CoV-2). This disease was first identified in Wuhan, China in December 2019. On 30 January 2020, WHO declared the COVID-19 outbreak a Public Health Emergency of International Concern (PHEIC). On March 11, 2020 WHO declared it a pandemic.

The COVID-19 Pandemic has affected lives throughout the world. It has caused illness which present with symptoms ranging from those like the common cold to more severe diseases such as Acute Respiratory Distress syndrome (ARDS). It is important to note that most of the people who were infected with this virus will experience mild to moderate respiratory illnesses and recover without any special treatment but older people and those with comorbidities are more likely to develop serious illness.

The devastating health, social and economic effects of the COVID-19 Pandemic demand a definitive effective intervention urgently to allow for the recovery of lives and livelihoods. Immunization is proven to be the most effective public health intervention against several communicable diseases and has prevented morbidity, disability, and death in populations. Various COVID-19 vaccines are currently available to countries for the immunization of their populations. These vaccines will used various mechanisms to provoke an immune response that will protect the person if he or she becomes exposed to the virus. Even as these vaccines are being developed, produced, and distributed, countries have been preparing and planning for their introduction by identifying key elements that are needed to ensure their capacity to vaccinate their populations effectively and efficiently against COVID 19.

St. Vincent and the Grenadines recorded its first COVID-19 case on March 11, 2020. As of February 3, 2021, there were 1067 confirmed cases of COVID-19 in St Vincent and the Grenadines, 142 of which were imported and 8 were import related. There were 918 local cases, some of which remain under investigation, while many have been linked to clusters of cases. There have been mostly asymptomatic cases, some moderate and few severe cases with three (3) deaths.
INTRODUCTION

St. Vincent and the Grenadines is a multi-island state of 32 islands and cays. Situated in the Caribbean the nation lies north of Grenada and south of St. Lucia. St. Vincent and Grenadines, with a volcano, is very mountainous with fertile soils and lovely beaches. A population of 107,000 people is served by an extensive health care system of 32 health care centers, five district hospitals, three polyclinics, one diagnostic and treatment center and a major hospital. There is an excellent primary health care system and good referral into secondary and tertiary care. Currently there is 98% - 100% coverage for most vaccine preventable diseases.

In late December 2019, CARPHA alerted CARICOM Member States for an increase in a respiratory viral illness in China. Throughout early January 2020, the Ministry of Health, Wellness, and the Environment reviewed existing surveillance systems and engaged in a prescheduled Emergency Supplies Chain training workshop aimed at enhanced pandemic response. The Highly Infectious Diseases Plan (HIDP) was also revised and updated. On Thursday, 30 January 2020, the World Health Organization declared that the outbreak of 2019-nCoV constituted a Public Health Event of International Concern (PHEIC).

On February 6, 2020, the Surveillance Committee/COVID-19 Taskforce as part of the Health Services Subcommittee was activated in keeping with the HIDP, the National Health Multi-Hazard Disaster Plan and the National Emergency Plan of NEMO. The guiding strategy during this alert phase was the rapid enhancement of the capacity of the Health Services to detect, contain and manage cases of the new virus. This enhancement took the form of aggressive risk communication interventions, training of various stakeholder groups, procurement of supplies, establishment an off-island testing mechanism and the development of protocols for the management of travelers to St. Vincent and the Grenadines. These measures lead to the detection of the first case of the 2019-nCoV in St. Vincent and the Grenadines on March 11, 2020, which was imported from the United Kingdom. March 11, 2020 was also the day that the WHO declared the spread of the novel virus a pandemic.

The Health Services Subcommittee of the NEMO followed the HIDP and implemented measures appropriate to the context of St. Vincent and the Grenadines
during the months of 2020 following the initial case in March 2020. Interventions continued to be focused on protecting the Health Services by keeping the virus out of St. Vincent through the controlled entry of travelers, quarantine, and testing. SVG was amongst the first to implement testing for asymptomatic COVID-19 travelers recognizing their importance in the transmission cycle.

Even as the ‘battalion’ of port health staff, health care workers, police, airport workers, immigration officers, custom officers and tourism sector workers kept the country protected at the ports of entry, the capacity to care for any COVID-19 patients was significantly enhanced by the creation of an isolation facility, increased staff and in country testing capacity. The strategy of implementing protocols which were continuously revised to address the rapidly changing external and internal environments was successful in keeping the St. Vincent and the Grenadines without local cases of COVID-19, except for six (6) cases in an import related cluster, for nine (9) months. Most cases of COVID-19 up to December 2020 were therefore imported.

Specifically, during these alert and serious response phases of the local outbreak, additional health care workers were employed, including ten (10) doctors and more than 45 registered nurses under the SET Programme. A staffed and equipped molecular lab capable of processing 200 PCR samples in a twenty-four (24) hour period was established and had processed more than 20,000 samples by December 2020. A data management system with supporting hardware was introduced to streamline the management of the enormous volume of data and information, including lab results associated with this response.

On December 28, 2020, a patient presented with symptoms of COVID-19 and a local cluster of seven (7) cases was subsequently confirmed. Between December 26, 2020 to January 16, 2021, three hundred and sixty-nine (369) COVID-19 cases were detected, three hundred and forty-four (344) of which are local. Most cases were local with many clusters and some individuals not linked to any cluster. On February 5, 2021, The Government declared Community Spread of COVID-19 in St. Vincent and the Grenadines.

The Health Services response was changed to focus on the protection of vulnerable populations, the early detection of cases in the communities and aggressive early
management of all high-risk cases of COVID-19. These measures though changed, still have the initial focus, that of protecting the health services from being overwhelmed.

The vulnerable populations in St. Vincent and the Grenadines have been identified as those persons with chronic noncommunicable diseases such as diabetes and hypertension. Additionally, frontline workers such as health care workers and security personnel were also prioritized for those interventions aimed at protecting them from being infected by the SARS-CoV-2 virus. The measures currently being implemented focus on aggressive surveillance to allow for the early identification of positive cases through actively seeking cases in flu clinics, contact tracing and targeted testing in at-risk populations.

Supportive measures encourage the use of masks by most persons, proper hygiene, reduced movement, and gatherings of any type outside the immediate home bubble.

The capacity of the Molecular Lab to handle the increased volume of PCR samples due to the in-country and external exponential increase in the number of cases, has been increased with the introduction of an automated extractor machine which was installed at the end of January 2021. Additionally, the private sector laboratories have been recognized to process exit screens, thus reducing the demand on the public lab.

The early and successful introduction of COVID-19 vaccines has been identified as one of the interventions capable of making the most significant impact on controlling and reducing the spread of covid-19 in St. Vincent and the Grenadines. A National Technical Working Group (NTWG) has been established to ensure the efficient development and implementation of a covid-19 immunization program in SVG.

Saint Vincent and the Grenadines was incorporated by Gavi-CEPI-WHO into the list of 92 countries eligible for the Gavi-COVAX-AMC initiative, mechanism for equitable access to the vaccine for low- and middle-income countries, being notified and ratified by Gavi, as one of the countries that will receive benefits from this initiative for access to vaccine donation to protect up to 20% of the population.

On January 6, COVAX notified that it is committed to providing vaccines to Facility Participants as soon as possible in the first quarter of 2021, and that it may be able
to initiate a "first wave" of small deliveries of the Pfizer vaccine between January and February, if countries meet the strict criteria set. In this context, after having analyzed each of the requirements, the Government of Saint Vincent and the Grenadines confirmed interest to COVAX on 18/01/2021. To access these vaccines, several requirements were to be met, including having a national vaccination deployment plan for the application of COVID-19 vaccine.

This plan describes the strategies, and vaccination tactics to be taken for the introduction of COVID-19 vaccine. The current coordination of the technical working group falls under the national COVID-19 Response which is coordinated by the health services subcommittee which is part of the overarching coordinating body NEMO. Within this structure there is collaboration with other sectors such as Ministry of foreign affairs, The Prime Minister’s Office, Ministry of Legal Affairs, Chamber of Industry and Commerce and Faith Based Organizations.

**LEGISLATION**

The policy position of the Ministry of Health, Wellness, and the Environment is that COVID-19 vaccinations should be voluntary rather than mandatory in the first instance. Therefore, no legislation with associated regulations is required. However, if necessary, the Immunization of Children Act Chapter 289 and the Public Health Act of 2020 are the existing legislations which could be utilized and or amended to provide legislative support to the introduction of any vaccines against COVID-19.

The Immunization of Children Act Chapter 289 Act No. 16 of 1982 is an Act for the protection of children from certain diseases by immunization, and for matters connected therewith. An amendment of this act could require that adults are required to be immunized. The inclusion of COVID-19 on the First Schedule as a disease against which immunization is required can be done by order of the Minister of Health to amend the schedule.

The Public Health Act of 2020 could also be amended to provide the legislation to support the mandatory vaccination against COVID-19 if such vaccination were made
mandatory. The Public Health Act, under the current state of a declared public health emergency, would allow for the legislation of vaccination against COVID-19 utilizing vaccines recommended by the Minister of Health on the advice of the Chief Medical Officer.

**REGULATION**

The Ministry of Health, Wellness and the Environment of St. Vincent and the Grenadines procures the vaccines which are distributed in the EPI through the PAHO Revolving Fund. The emergency or expedited regulatory pathways utilized by the WHO PAHO mechanisms for the approval of vaccines will be recognized as sufficient by the Ministry of Health of St. Vincent and the Grenadines. There are no regulatory requirements, special permits, or other expected restrictions for the importation of COVID-19 vaccines.

Therefore, the following will apply:

1. Local testing of the products approved through the WHO PAHO mechanism is not required prior to introduction.
2. The use of standard labels will be allowed.
3. The established import requirements under the Revolving Fund for specific products will apply.
4. Model Indemnity and liability agreements have been approved and the Chief Medical Officer has been approved as authorized to sign on behalf of the Government of St. Vincent and the Grenadines.

The EPI Manager supported by the Drug Inspectorate will utilize the established system for the importation of other vaccinations including the procurement, importation, customs clearance, storage and distribution in St. Vincent and the
Grenadines and will adjust and amend same as necessary to accommodate the peculiarities of the COVID 19 Vaccines.

**IPC MEASURES**

WHO guidelines will be followed during immunization sessions. Vaccinators will wear PPE consisting of a face shield, medical mask, disposable long sleeve gown and disposable gloves.

A specialized vaccine waste management program in keeping with WHO standards using bio safety boxes and biohazard bags is utilized.

Biohazard waste will be collected from the vaccination sites in biohazard bags/boxes and taken to the Hospital Services for incineration.

Prior to the start of vaccination, the teams will ensure that there are adequate bins lined with biohazard bags and sharps containers available to safely handle the projected volume of waste.

Trained waste haulers will be identified to carry the waste to the incinerators.

Supportive supervision system

The current supportive system used to manage the Immunization Program is quite efficient. At the National level the EPI Manager reports to the Senior Nursing Officer (SNO) of Community Health Services and the SNO Community Health Services reports to the Chief Nursing Officer. At the Local level the District Nurse who is the manager of the facility reports to the Health Nursing Supervisor of the Health District who informs the Health Nursing Supervisor /EPI Manager. This mechanism will ensure that strict supervision is carried out during the roll out of the vaccine
STRATEGIES

The vaccination strategies are employed to cover all aspects of the National Vaccine Introduction and Deployment Plan to achieve greater success of the implementation process. A standard Operations Procedure Manual has been developed and will be made available at all vaccination sites to maintain the standard throughout, refer to SOP ANNEX 5. To achieve this goal, we have classified all the strategies into three concise categories which are mentioned as follows.

1. VACCINES

❖ Cold chain capacity

The cold chain plays an integral part in storage of COVID-19 vaccine thus allowing the achievement of immunization targets. The Ministry of Health, Wellness, and the Environment (MOHWE) in St. Vincent and the Grenadines has considered the local conditions which will affect the distribution system as well as the maintenance of the vaccine’s efficacy.

Ultra-cold chain storage

- Given the urgency and the wide-ranging consequences of the present pandemic, four (4) facilities have been earmarked for ultra-cold storage of the vaccines while the other facilities be equipped with 2°C - 8°C Refrigerators.

. The approximate dimensions of the freezers that they will accommodate are: 3.51ft. (L) x 3.13 ft. (W) x 6.5 ft. (H)
The MOHWE is in the final stages of procuring the required ultra - cold freezers (-70 and -90 degrees Celsius). Based on the total number of doses required for the target population, the size of the freezers ordered will adequately accommodate the number of vaccine doses required.

There are no gaps identified in the human resource for cold chain management. The existing EPI Programme under its framework has a mechanism for the management of Cold chain which includes adequate human resources, cold chain equipment and source distribution and logistics.

❖ Vaccine Storage Requirements.

Cold chain equipment is an essential component of the supply chain which is required to ensure the safe and timely delivery of the COVID-19 vaccine to target populations. Of the several types of COVID-19 vaccines expected to be available, each vaccine will require one of three storage temperatures: \(2 \text{°C} - 8 \text{°C}\), \(-20 \text{°C}\) or \(-70 \text{°C}\).

<table>
<thead>
<tr>
<th>VACCINE TYPE</th>
<th>STORAGE TEMP. REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>AstraZeneca</td>
<td>(2 \text{°C} - 8 \text{°C})</td>
</tr>
<tr>
<td>Johnson &amp; Johnson</td>
<td>(2 \text{°C} - 8 \text{°C})</td>
</tr>
<tr>
<td>Moderna</td>
<td>(-20 \text{°C})</td>
</tr>
<tr>
<td>Pfizer</td>
<td>(-70 \text{°C})</td>
</tr>
<tr>
<td>Sputnik V</td>
<td>(2 \text{°C} - 8 \text{°C}) (dry), (-18 \text{°C}) (liquid)</td>
</tr>
</tbody>
</table>

The possibility exists of receiving in Country any of the different vaccine types due to that fact, the Ministry of Health, Wellness, and the Environment is making the necessary arrangements to be able to store any or all the available vaccine types. Accordingly,
arrangements are being made to procure seven (7) dedicated vaccine storage units to be used to store COVID-19 vaccines:

- One x Ultra Cool Freezers: -90°C
- Two x Ultra Cool Freezers: -40°C
- One x Commercial Freezer: -20°C
- Three x Medical Refrigerators: 2°C - 8°C

❖ Placement of Vaccine Storage Freezers

Storage sites for vaccine storage may vary from designated vaccination sites. To reduce logistic complications all cold chain equipment will be strategically placed at different vaccine storage sites throughout the Island to accommodate accessibility to the different vaccination sites.

❖ Vaccination Sites

St. Vincent and the Grenadines is 389 km² relatively small with a health care facility within twenty (20) minutes of every home. The option to have the target population come to identified fixed points where the immunization will be done to allow for the maintenance of safe storage is the preferred option and is in keeping with the existing system.

The following health facilities are proposed as designated vaccination sites. These sites were selected throughout the Islands from the nine (9) health district based on their location – to ensure accessibility by the population in all geographic locations, and the presence of supporting facilities or their state of readiness to accommodate the supporting facilities necessary to perform vaccination functions adequately.

1. Buccament Polyclinic.
2. Chateaubelair Hospital.
5. Modern Medical Diagnostic Centre (Georgetown).
6. Sandy Bay Clinic (North Windward).
7. Port Elizabeth Health Centre (Bequia).
8. Stubbs Polyclinic.

❖ Waste Management

In this Mass vaccination effort, the generation of waste and its management must be taken into consideration and accounted for. It must be noted that his process is governed by the established protocol which allows for disposal of medical waste by the Solid Waste Management Unit in the Central Water and Sewage Authority, under the guidance of Environmental Health.

❖ Vaccine Sources

St. Vincent and the Grenadines in our response to the COVID-19 pandemic will be administering available COVID-19 vaccines to the population. We have already identified various sources of vaccine supply and are in the process of negotiation with these sources. We will make all attempts to speedily acquire the vaccines.

<table>
<thead>
<tr>
<th>Sources and Types of Vaccines</th>
<th>Source</th>
<th>Type</th>
<th>Quantity</th>
<th>Cost</th>
<th>Estimated Arrival</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government of Dominica</td>
<td>AstraZeneca/Covishield</td>
<td>5000</td>
<td>Donation</td>
<td>Arrived February 11, 2021</td>
</tr>
</tbody>
</table>
Several vaccines were received (5000 doses of AstraZeneca Covishield), from the Commonwealth of Dominica on February 11, 2021. The allocation of these vaccines among the priority groups based on the SAGE roadmap was as follows:

- Health care workers - 750 doses.
- Persons 65 years and older, younger persons with NCD's and those living with persons with NCD's - 4000.
- Essential services workers including teachers and security personnel - 250.

**Risk Communications**

The success of the vaccination with the COVID vaccines will require a strong and comprehensive risk communication program guided by a risk communications plan which utilizes gate keepers of the various target groups. Teachers, Church Leaders, Political Party Leaders, Trade Union Leaders, Talk Radio Personalities, Entertainers, private and public sector HCWs must be coopted to take the message to the entire population to ensure the required vaccine acceptance and uptake. Early and consistent messaging utilizing all available media and appropriate in person sessions will be utilized. Persons who request the vaccine even if outside the target groups should be considered as a mechanism to build positive reinforcement experiences.

Appropriate messages and jingles will be developed for the media providing accurate information for the target population. Interactive Sessions, power point presentations...
are some things that will be done to inform people about the vaccine. The capacity of the frontline workers will be built by doing presentations and providing reading materials, answer their questions about the vaccines to support their roles as recipients and vaccinators.

The Health Promotion Unit within the Ministry of Health Wellness, and Environment, Agency for Public Information (API) and external partners have commenced the implementation of a communication plan aimed at sensitizing the population regarding the COVID-19 vaccine. The Communication Plan’s strategy for introduction of the COVID-19 vaccine includes the following:

1. Engagement of a communication specialist

2. Ongoing pre-vaccination communication

3. General information public awareness ongoing with various media houses:
   a. Create Fact sheets
   b. Television programs

4. Target group first 20,000 including healthcare workers as a critical target group, vulnerable population front line workers.

5. Preparing messages and jingles for the media and providing accurate information for the target population.

6. Conduct interactive sessions, power point presentations, press conferences to inform people about the vaccine.

7. Conduct capacity building session with the frontline workers, provide reading materials, and answer their questions about the vaccines to support their roles as recipients and vaccinators.
8. Online training and sensitization of healthcare worker to champion the COVID-19 vaccine uptake and dispel myths to build confidence in the vaccine:

❖ **Vaccine Safety Monitoring and Management of AEFI**

Vaccine specific IPC protocols are in place, and extensive training accompanied by the provision of adequate PPEs and other specially indicated equipment and supplies will be ensured.

Adverse Effects Following Immunization (AEFI) are the true adverse reaction which are intrinsic to the vaccine. The reaction may be caused by the way the vaccine is administered vaccine or they may be related to underlying condition in the recipient. However, some AEFI may be coincidental and would have occurred regardless of vaccination.

The Public Health Nurse will investigate including full documentation of the patient’s medical history, the steps taken by the vaccinator, the product information and status and will complete the appropriate reporting forms. The individual must be seen and assessed by the doctor.

The structure of the line of reporting is such that the Registered nurse is usually the first person who gets the report of an AEFI. Her role is to report to pharmacovigilance then report to the Public Health Nurse. The Public health Nurse then reports it to the EPI manager and will investigate using PAHO stipulated form. The EPI manager provides guidance and assistance. The Public Health Nurse will submit the report to the EPI Manager, the Epidemiologist, the MOH and CMO. The EPI manager will report to PAHO. The Epidemiologist, MOH, and COM provide guidance and use the report for decision making. See **ANNEXII** – AEFI Forms
A vaccine specific Anaphylactic Plan has been developed (refer to ANNEX 3.) and will be utilized in the specialized training session to ensure all vaccinators can efficiently manage AEFI.

AEFI active surveillance will be achieved through monitoring by the Health Promotion unit of social media pages, call in programs, the COVID-19 Hotline.

The Ministry of Health has adapted the COVID-19 case monitoring form which would include a section stating whether persons were vaccinated or not and the dated when the first and second doses were given. See ANNEX 4.

❖ Monitoring and Evaluation

A comprehensive monitoring and evaluation system will be utilized throughout the entire implementation of the COVID-19 vaccination plan. The existing vaccination monitoring and evaluation system is paper based, however there is an extensive effort underway to utilize existing IT platforms to link and monitor the COVID-19 Pandemic in SVG. The vaccination against COVID-19 will also be incorporated into an electronic surveillance system. The Government of SVG including the MOHWE is moving towards a Multi-purpose ID which will simplify the monitoring and evaluation of the immunization program. Additionally, the existing SXDX system allows the early reporting and therefore identification of adverse effects through patient feedback modules. The system is currently being developed and would be used for feedback.

This SXDX system also allows for the registration, structuring of appointments, allows for the follow up to patients to be made via message prompts and also keeps tract of the dates of the first and second doses to be given or given.

Added to this system we would also explore the use of a google sheet that keeps tract of all vaccine request registrations, appointments and a list of all persons vaccinated.
2. VACCINATORS

❖ Human Resource Management and Training

An Implementation team has been formed to operationalize the deployment component of the National Vaccine Introduction and Deployment Plan. This team comprises the Expanded Programme for Immunization (EPI) manager, the Epidemiologist a Health Promotion/Communication Officer, and an Information Technology Officer. The scope of objectives for this team includes overseeing the entire deployment process, coordination of the vaccination process at the various vaccine sites and managing reports related to the vaccination process.

The exiting Community Nursing personnel of the Community Nursing Service will be the main vaccinators. Thirty (30) set workers (Nurses) are to be recruited to serve as additional vaccinators. The vaccinators will be supervised by Health Nursing Supervisors and Family Nurse Practitioners.

The EPI Manager will be responsible for monitoring the entire process with particular emphasis on Adverse Effects Following Immunization (AEFI) and ensuring that all quality control measures are maintained. Specially designed training programmes which include a strong risk communication component will be implemented for the expanded teams.

<table>
<thead>
<tr>
<th>No</th>
<th>Category of Staff</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Public Health Nurse</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>Family Nurse Practitioners</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>District Nurses</td>
<td>40</td>
</tr>
</tbody>
</table>
All categories of staff involved in the COVID-19 vaccination introduction program are to be trained in the safe and efficient handling and management of the COVID-19 vaccines. Small group sessions and virtual modalities will be utilized to ensure comprehensive learning and competencies are achieved. Specialized training will be coordinated with support from the manufacturers and PAHO ECC.

<table>
<thead>
<tr>
<th>No</th>
<th>Category</th>
<th>Training Need</th>
<th>Time Frame</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vaccinators</td>
<td>• Background information on COVID-19&lt;br&gt;• Importance of immunization&lt;br&gt;• Characteristics of the vaccine and its effectiveness&lt;br&gt;• Cold chain management&lt;br&gt;• Handling of the waste products&lt;br&gt;• Management of AEFI&lt;br&gt;• Safety during immunization</td>
<td>Initial January – February 2021&lt;br&gt;Ongoing February -June 2021</td>
<td>EPI Manager, Epidemiologist, Drug Inspector, Chief laboratory Technologist</td>
</tr>
<tr>
<td>2</td>
<td>Brokers</td>
<td>• How to Handle vaccines from Port of Entry to national store</td>
<td></td>
<td>EPI Manager, Epidemiologist, Drug Inspector</td>
</tr>
</tbody>
</table>
3. VACCINEES

❖ Target population Vaccination planning

The WHO SAGE roadmap for prioritizing uses of COVID-19 vaccines in the context of limited supply and WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination was used to determine the target population. https://www.who.int/immunization/sage/covid-19_documents/en/

Following the identification of new cases of COVID-19 in St. Vincent and the Grenadines, the Epidemiologic setting scenario initially applied was: (b), for Sporadic Cases or Clusters of Cases. Please refer to The Target population planning Annex1.

Please note that the SAGE Roadmap and Framework only allows for the allocation of vaccines to cover up to 50% of the population.

On the 5th of February St. Vincent and the Grenadines declared Community spread in the Island and subsequently The Target Population plan status was again updated according to the guidelines outlined in the WHO SAGE roadmap and WHO SAGE Framework, The Epidemiologic setting scenario (a) for Community Spread was applied. Refer to Annex 2.
The Updated Target Population plan also took into consideration our country’s proposal to immunize 70% of the population with the aim of achieving Herd Immunity.

**First Wave roll out for 3% population.**

For this initial vaccination phase according to requirements by the COVAX facility the highest priority groups were considered on recommendations by the National Technical Working Group (NTWG).

3% translates to 3210 persons, and the number of persons in the priority categories would be distributed in the following manner.

- Healthcare Workers- 1000
- 65 years and over- 1000
- Comorbidities- 1000
- Teachers- 210

Under the COVAX facility the total amount of vaccines to be supplied to this country would cover 20% of the population, to this end the appropriate target population and allocation of vaccines have been calculated and presented in our target population plan. See ANNEX 1.

The delivery strategy for reaching these groups will be facilitated via selected clinics in each health districts. These groups are to be notified and will be required to register, following which they will be given appointments of the day and time to be present for vaccination.

❖ **Anaphylactic Reactions**

Anaphylaxis is a severe, life-threatening allergic reaction that occurs rarely after vaccination. Locations administering COVID-19 vaccines should adhere to CDC guidance for use of COVID-19 vaccines, including screening recipients for contraindications and precautions, having the necessary supplies available to manage anaphylaxis, implementing the recommended post vaccination observation periods, and immediately treating suspected cases of anaphylaxis with intramuscular injection
of epinephrine. Please refer to the complete ST. Vincent and the Grenadines COVID-19 vaccine Anaphylactic Plan in ANNEX 3.

**VACCINATION BUDGET**

The immunization of the population of St. Vincent and the Grenadines against the SARS-CoV-2 virus which causes COVID-19 has been identified as critical to the preservation of the social, economic and health status of the population. Financing of the procurement and introduction of vaccines will include funding from the government of SVG, COVAX support, friendly allies, and developmental partners.

To achieve Heard Immunity, we hope to vaccinate 70% of the population, thus beyond the 20% being provided through the COVAX facility, we have identified the need to purchase vaccines for a further 50% population, 53,500 persons.

Presently our existing staffing allows for the smooth functioning of staff to be allocated duties of vaccinators, Transportation cost, meals etc. of vaccination by outreach activities would be covered by local Government funding.

Our strategy to address the gap of $789,380.00 include.

- CDB Loan – US $100,000
- Mustique Charitable trust – US $368,000
- Alba Grant – US$200,000
- Friendly Government Source – US $ 600,000
Budget for St. Vincent and the Grenadines vaccine deployment.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Total Cost (US $)</th>
<th>Government estimated funding</th>
<th>Funding from External Sources</th>
<th>Funding Required (US $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and coordination</td>
<td>50,000.00</td>
<td>5,000.00</td>
<td>$15,000 USD (GAVI/COVAX TA)</td>
<td>30,000.00</td>
</tr>
<tr>
<td>Training of health care workers</td>
<td>15,000.00</td>
<td>15,000.00</td>
<td></td>
<td>15,000.00</td>
</tr>
<tr>
<td>Vaccines (purchase and delivery)</td>
<td>1,000,000.00</td>
<td>100,000.00</td>
<td>410,000.00 (Friendly Government Source)</td>
<td>490,000.00</td>
</tr>
<tr>
<td>Supply chain and cold chain (2x UCC)</td>
<td>100,000.00</td>
<td></td>
<td>$15,000 USD (GAVI/COVAX TA)</td>
<td>85,000.00</td>
</tr>
<tr>
<td>IPC – PPEs and Waste management</td>
<td>55,000</td>
<td>5,000.00</td>
<td></td>
<td>50,000.00</td>
</tr>
<tr>
<td>Syringes 1ml, 1000/box</td>
<td>11,000.00</td>
<td>11,000.00</td>
<td></td>
<td>11,000.00</td>
</tr>
<tr>
<td>Voltage regulators for freezers</td>
<td>12,900.00</td>
<td>12,900.00</td>
<td></td>
<td>12,900.00</td>
</tr>
<tr>
<td>Other (Generator, Site preparation, etc.)</td>
<td>15,480.00</td>
<td>15,480.00</td>
<td></td>
<td>15,480.00</td>
</tr>
<tr>
<td>EPI-pen (epinephrine autoinjector)</td>
<td>20,000.00</td>
<td>20,000.00</td>
<td></td>
<td>20,000.00</td>
</tr>
<tr>
<td>Refrigerated Truck</td>
<td>40,000.00</td>
<td>40,000.00</td>
<td></td>
<td>40,000.00</td>
</tr>
<tr>
<td>Communication and Public Information</td>
<td>50,000.00</td>
<td>10,000.00</td>
<td>$20,000 (GAVI/COVAX TA)</td>
<td>20,000.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,369,380</strong></td>
<td><strong>234,380</strong></td>
<td><strong>460,000</strong></td>
<td><strong>789,380.00</strong></td>
</tr>
</tbody>
</table>
ANNEX 1. 50% Target population Vaccination planning for

St. Vincent and the Grenadines

Total Population: **107,000**

Table 1. Total number of Individuals estimated in the target population in order of Priority, in SVG.

<table>
<thead>
<tr>
<th>Target Population in order of Priority</th>
<th>Number of additional individuals to be vaccinated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Workers (High risk) in areas of high transmission.</td>
<td>1,500 of 2000 proposed</td>
</tr>
<tr>
<td>Adults 65 years and older (in high transmission areas)</td>
<td>8,700 of 10,124 proposed</td>
</tr>
<tr>
<td>Emergency Reserve of Vaccine</td>
<td>500 (estimated)</td>
</tr>
<tr>
<td>Health Care Workers (High risk) in the rest of the country</td>
<td>500 of 2,000 proposed</td>
</tr>
<tr>
<td>Adults 65 years and older (in the rest of the Country)</td>
<td>1,424 of 10,124 proposed</td>
</tr>
<tr>
<td>Comorbidity Diabetes</td>
<td>9,000 of 9,700 proposed</td>
</tr>
<tr>
<td>Comorbidity Hypertension</td>
<td>8,476 of 20,811 proposed</td>
</tr>
<tr>
<td>Front Line workers e.g., Police, Immigration, Customs and PAHO representatives</td>
<td>2,000 of 10,000 proposed</td>
</tr>
<tr>
<td>Teachers (Primary and Secondary)</td>
<td>2000 proposed</td>
</tr>
<tr>
<td>Essential workers outside of health and Education e.g., Taxi and Hotel personnel.</td>
<td>2500 of 10,000 proposed</td>
</tr>
<tr>
<td>Rest of the population up to 50%</td>
<td>16,900 (Sum of 10,700+21,400)</td>
</tr>
</tbody>
</table>
Table 2. Groups being targeted for vaccination in order of priority: Stage I. WHO SAGE roadmap.

<table>
<thead>
<tr>
<th>Vaccine supply scenario</th>
<th>Target population (description) (Prioritised using SAGE Roadmap)</th>
<th>Number of individuals to be vaccinated</th>
<th>Rational</th>
<th>Proportion of total population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Health Care Workers (High risk) in areas of high transmission.</td>
<td>1,500 of 2000 proposed</td>
<td>protecting these workers protects the availability of a critical essential service in the COVID-19 pandemic response. Prioritization of these workers is also supported by the principle of reciprocity</td>
<td>1.4</td>
</tr>
<tr>
<td></td>
<td>Adults 65 years and older (in high transmission areas)</td>
<td>8,700 Of 10,124 proposed</td>
<td>This group is at significantly higher risk of severe disease or death. The reasons for this prioritization are grounded in the principles of equal respect and equity.</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>Emergency Reserve of Vaccine</td>
<td>500 (estimated)</td>
<td>In case of severe localized outbreak, it will be used for</td>
<td>0.5</td>
</tr>
</tbody>
</table>
Table 2A. Groups being targeted for vaccination in order of priority: Stage I. WHO SAGE roadmap. (edited to include small scale first wave subgroup targeted population)

<table>
<thead>
<tr>
<th>Vaccine supply scenario</th>
<th>Target population (description) (Prioritised using SAGE Road map)</th>
<th>Number of individuals to be vaccinated</th>
<th>Number of individuals to be vaccinated during small scale rollout with 275/2500 persons</th>
<th>Rational</th>
<th>Proportion of total population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Health Care Workers (High risk) in areas of high transmission.</td>
<td>1,500 of 2000 proposed</td>
<td>275/1500 of 1500 of 2000 proposed</td>
<td>protecting these workers protects the availability of a critical essential service in the COVID-19 pandemic response. Prioritization of these workers is also supported by the principle of reciprocity</td>
<td>1.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Number of individuals to be vaccinated in total (description)</th>
<th>Number of individuals to be vaccinated during small scale rollout with 275/2500 persons</th>
<th>Rational</th>
<th>Proportion of total population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td>1,070 - 10,700</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>
 Adults 65 years and older (in high transmission areas)  8,700 Of 10,124 proposed  0/450 of 8,700 of 10,124 proposed  This group is at significantly higher risk of severe disease or death. The reasons for this prioritization are grounded in the principles of equal respect and equity.  8.1

| Emergency Reserve of Vaccine | 500 (estimated) | 0/550 for security forces and other essential government officers | In case of severe localized outbreak, it will be used for outbreak response or mitigation | 0.5 |

| Total | 1,070 - 10,700 | 275/2500 | 10% |

**Table 3. Groups being targeted for vaccination in order of priority: Stage II. WHO SAGE roadmap.**
Table 4. Groups being targeted for vaccination in order of priority: Stage III. WHO SAGE roadmap.

<table>
<thead>
<tr>
<th>Vaccine supply scenario</th>
<th>Target population (description) (Prioritised using SAGE Road map)</th>
<th>**proposed Number of individuals to be vaccinated</th>
<th>Rational</th>
<th>Proportion of total population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers</td>
<td>2000 proposed</td>
<td>Because of the critical</td>
<td>1.9</td>
<td></td>
</tr>
</tbody>
</table>
### SAINT VINCENT AND THE GRENADINES NATIONAL COVID-19 VACCINE INTRODUCTION AND DEPLOYMENT PLAN

<table>
<thead>
<tr>
<th>Stage III</th>
<th>(Primary and Secondary)</th>
<th>developmental stage of the children, they teach.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(moderate vaccine availability for 21–50% nat. pop.)</td>
<td>Essential workers outside of health and Education e.g., Taxi and Hotel personnel.</td>
<td>Because of possible exposure in the Transport and Hotel industry.</td>
</tr>
<tr>
<td></td>
<td>2500 of 10,000 proposed</td>
<td>2.3</td>
</tr>
<tr>
<td>Total</td>
<td>4500</td>
<td></td>
</tr>
<tr>
<td>Rest of the population up to 50%</td>
<td>16,900 (Sum of 10,700+21,400 +4,500=36,600 53,500-36,600 =16,900)</td>
<td>Adults who are not included in the previous categories. Not approved for Children, Pregnant and Lactating mothers</td>
</tr>
<tr>
<td>Total</td>
<td>21,400 (16,900+4500)</td>
<td>20%</td>
</tr>
<tr>
<td>Grand total</td>
<td>22,470-53,500</td>
<td>50%</td>
</tr>
</tbody>
</table>

** Estimated at the maximum percentage of the stages.

**Conclusion:**

Using the WHO SAGE roadmap for prioritizing uses of COVID-19 vaccines in the context of limited supply and WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination for Countries with Sporadic Cases or Clusters of Cases.

In Stage I. 10% of the population to be vaccinated will be 10,700 persons

- Health Care Workers (High risk) in areas of high transmission. 1,500
- Adults 65 years and older (in high transmission areas) 8,700
- Emergency Reserve of Vaccine 500 (estimated)

In stage II. 20% of the population to be vaccinated will be 21,400 persons.

- Health Care Workers (High risk) in the rest of the country 500
- Adults 65 years and older (in the rest of the Country) 1,424
- Comorbidity Diabetes 9,000
Comorbidity Hypertension 8,476
❖ Front Line workers e.g., Police, Immigration, Customs 2,000

In stage III. 50% of the population to be vaccinated will be 53,500 persons.
❖ Teachers (Primary and Secondary) 2000
❖ Essential workers outside of health e.g., Taxi and Hotel personnel. 2500
❖ Rest of the population up to 50% 16,900.

For each stage, the maximum percentage of that stage was considered to estimate the distribution of the total among the target population as demonstrated in the tables.

NOTE:

Updated on 6th February

2. Target population for sufficient immunity is 70%.
3. Prioritizing persons in the Volcano red zone of the country due to the increased risk of an explosive volcanic eruption and the evacuation this would trigger.
4. Prioritizing all teachers to receive available vaccines with an aim to restart in person school.
ANNEX 2. 70% Target population Vaccination planning for

St. Vincent and the Grenadines

Total Population: 107,000

Status: Community Spread

Target Population 70%

The WHO SAGE roadmap for prioritizing uses of COVID-19 vaccines in the context of limited supply and WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination was used to determine the target population. https://www.who.int/immunization/sage/covid-19_documents/en/

To date 9.2.20 (St. Vincent and the Grenadines has recorded a total of 1174 cases of SARS-COV-2. On the 3rd of February 2021 St. Vincent declared community transmission, Due to this fact, we have applied the guidelines outlined in the WHO SAGE roadmap, Epidemiologic setting scenario: (a), for Community Spread.

On Tuesday 29th Prime minister Hon. Dr. Ralph Gonsalves and representatives of the UWI Seismic research Unit held a press briefing and confirmed An Effusive Eruption of the La Soufriere Volcano. The volcanic dome is currently expanding daily with slow emission of magma and gases and the alert level has been elevated to Orange.

To date no evacuation order has been given to the persons residing in the red and orange zones however we have taken into consideration the prioritization of these zones to be vaccinated against COVID-19. This is to mitigate a super spread in the likelihood of these populations being displaced due to evacuation. Refer to Table 2.
<table>
<thead>
<tr>
<th>Target Population in order of Priority</th>
<th>Number of additional individuals to be vaccinated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Workers (High risk) in areas of high transmission.</td>
<td>1,500 of 2000 proposed</td>
</tr>
<tr>
<td>Adults 65 years and older (in high transmission areas)</td>
<td>8,700 Of 10,124 proposed</td>
</tr>
<tr>
<td>Teachers</td>
<td>500 Of 2000 estimated</td>
</tr>
<tr>
<td>Health Care Workers (High risk) in the rest of the country</td>
<td>500 of 2,000 proposed</td>
</tr>
<tr>
<td>Adults 65 years and older (in the rest of the Country)</td>
<td>1,424 of 10,124 proposed</td>
</tr>
<tr>
<td>Teachers (Primary and Secondary)</td>
<td>1500 of 2000 proposed</td>
</tr>
<tr>
<td>Comorbidity Diabetes</td>
<td>9,000 of 9,700 proposed</td>
</tr>
<tr>
<td>Comorbidity Hypertension</td>
<td>8,476 of 20,811 proposed</td>
</tr>
<tr>
<td>Front Line workers e.g., Police, Immigration, Customs</td>
<td>2,000 of 10,000 proposed</td>
</tr>
<tr>
<td>Essential workers outside of health and Education e.g., Taxi and Hotel personnel.</td>
<td>2500 of 10,000 proposed</td>
</tr>
<tr>
<td>Government workers not previously covered.</td>
<td>14,900 estimated</td>
</tr>
<tr>
<td>Prisons, Geriatric Homes, homeless Psychiatric Hospital.</td>
<td>2000 estimated</td>
</tr>
<tr>
<td>Rest of the population over sixteen years of age not included in the previous priority categories.</td>
<td>21,400</td>
</tr>
</tbody>
</table>

**Table 1. Priority for Vaccination by Target Groups in St. Vincent and the Grenadines**
Table 2. Priority for Vaccination by Volcanic Hazard Zones in St. Vincent and the Grenadines

<table>
<thead>
<tr>
<th>Zones</th>
<th>Order of Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Zone</td>
<td>1</td>
</tr>
<tr>
<td>Orange Zone</td>
<td>1</td>
</tr>
<tr>
<td>Yellow Zone</td>
<td>2</td>
</tr>
<tr>
<td>Green Zone</td>
<td>2</td>
</tr>
</tbody>
</table>

1= First Priority, 2= Second Priority

Table 3. Groups being targeted for vaccination in order of priority: Stage I. WHO SAGE roadmap.

<table>
<thead>
<tr>
<th>Vaccine supply scenario</th>
<th>Target population (description) (Prioritised using SAGE Road map)</th>
<th>Number of individuals to be vaccinated</th>
<th>Rational</th>
<th>Proportion of total population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Health Care Workers (High risk) in areas of high transmission.</td>
<td>1,500 of 2000 proposed</td>
<td>protecting these workers protects the availability of a critical essential service in the COVID-19 pandemic response. Prioritization of these workers is also supported by the principle of reciprocity</td>
<td>1.4</td>
</tr>
<tr>
<td></td>
<td>Adults 65 years and older (in high transmission areas)</td>
<td>8,700 Of 10,124 proposed</td>
<td>This group is at significantly higher risk of severe disease or death. The reasons for this prioritization are grounded in the principles of equal respect and equity.</td>
<td>8.1</td>
</tr>
<tr>
<td></td>
<td>Teachers</td>
<td>500 Of 2000 (estimated)</td>
<td>Because of the critical developmental stage</td>
<td>0.5</td>
</tr>
<tr>
<td>Vaccine supply scenario</td>
<td>Target population (description) (Prioritised using SAGE Road map)</td>
<td>**proposed Number of individuals to be vaccinated</td>
<td>Rational</td>
<td>Proportion of total population (%)</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Stage II</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(limited vaccine availability, for 11–20% nat. pop.)</td>
<td>Health Care Workers (High risk) in the rest of the country</td>
<td>500 of 2,000 proposed</td>
<td>This group is at significantly higher risk of severe disease or death.</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Adults 65 years and older (in the rest of the Country)</td>
<td>1,424 of 10,124 proposed</td>
<td>This group is at significantly higher risk of severe disease or death.</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>Teachers (Primary and Secondary)</td>
<td>1500 of 2000 proposed</td>
<td>Because of the critical developmental stage of the children, they teach.</td>
<td>1.4</td>
</tr>
<tr>
<td></td>
<td>Comorbidity Diabetes</td>
<td>9,000 of 9,700 proposed</td>
<td>This group is at significantly higher risk of severe disease or death.</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>Comorbidity Hypertension</td>
<td>8,976 of 20,811 proposed</td>
<td>This group is at significantly higher risk of severe disease or death.</td>
<td>8.4</td>
</tr>
<tr>
<td>Total (stage II)</td>
<td></td>
<td>21,400</td>
<td></td>
<td>20%</td>
</tr>
</tbody>
</table>

Table 4. Groups being targeted for vaccination in order of priority: Stage II. WHO SAGE roadmap.

Table 5. Groups being targeted for vaccination in order of priority: Stage III. WHO SAGE roadmap.
## Conclusion:

<table>
<thead>
<tr>
<th>Vaccine supply scenario</th>
<th>Target population (description) (Prioritised using SAGE Road map)</th>
<th><strong>proposed Number of individuals to be vaccinated</strong></th>
<th>Rational</th>
<th>Proportion of total population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage III</strong> (moderate vaccine availability covers up to 50% nat. pop.)</td>
<td>Front Line workers e.g., Police, Immigration, Customs</td>
<td>2,000 of 10,000 proposed</td>
<td>First line of contact at the ports of entry</td>
<td>1.9</td>
</tr>
<tr>
<td></td>
<td>Essential workers outside of health and Education e.g., Taxi and Hotel personnel.</td>
<td>2500 of 10,000 proposed</td>
<td>Because of possible exposure in the Transport and Hotel industry.</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Government workers not previously covered.</td>
<td>14,900 estimated</td>
<td>Those essential to the critical functioning of the state, not covered by other categories.</td>
<td>13.9</td>
</tr>
<tr>
<td></td>
<td>Geriatric Homes, Prisons, Homeless Psychiatric Hospital.</td>
<td>2000 estimated</td>
<td>Those Institutionalised and Homeless who are vulnerable to spread.</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total (stage III)</strong></td>
<td></td>
<td>21,400</td>
<td></td>
<td>20%</td>
</tr>
</tbody>
</table>

**Accumulative Total** (Sum of Stage I, II, & III using the upper percentage limits):

| | | 53,500 | | 50% |
| | | (10,700+21,400+21,400) | | (10%+20%+20%) |

**IF Availability of vaccines to cover 51-70% Nat. pop**

| | | 21,400 | | EXTRA 20% |
| | | (74,900-53,500) | | |

**Grand Total** (Sum of Stage I, II, & III using the upper percentage limits + extra 20%)

| | | 74,900 | | 70% |
| | | (53,500+21,400) | | (50%+20%) |
Using the WHO SAGE Road map for prioritizing uses of COVID-19 vaccines in the context of limited supply and WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination for Countries with **Community Transmission**.

In Stage I. 10% of the population to be vaccinated will be 10,700 persons

- Health Care Workers (High risk) in areas of high transmission. 1,500
- Adults 65 years and older (in high transmission areas) 8,700
- Teachers 500

In stage II. 20% of the population to be vaccinated will be 21,400 persons.

- Health Care Workers (High risk) in the rest of the country 500
- Adults 65 years and older (in the rest of the Country) 1,424
- Teachers (Primary and Secondary) 1,500
- Comorbidity Diabetes 9,000
- Comorbidity Hypertension 8,976

In stage III. Up to 50% of the population to be vaccinated will be a total of 53,500 persons. Tt is the accumulative total of stage I, II and III.

- Front Line workers e.g., Police, Immigration, Customs 2,000
- Essential workers outside of health and Education e.g., Taxi and Hotel personnel 2,500
- Government workers not previously covered 14,900 estimated
- Prisons, Geriatric Homes, homeless Psychiatric Hospital 2,000 estimated
- Rest of the population over sixteen years of age, up to 70% 21,400

To achieve Herd Immunity our proposed Target is 70% of the population to be vaccinated, that translates to 74,900 persons. To obtain this goal, an extra 20% of the population (21,400 persons) will need to be vaccinated. This corresponds to adults who were not included in the previous priority categories.
ANNEX 3. COVID-19 Vaccine Anaphylactic Plan

ST. VINCENT AND THE GRENADINES COVID-19 VACCINE ANAPHYLACTIC PLAN

FEBRUARY 2021
Contents

Contents  Error! Bookmark not defined.

Background  Error! Bookmark not defined.

Adverse event following immunization (AEFI)  Error! Bookmark not defined.

Classification of AEFI  Error! Bookmark not defined.

AEFI Communication plan  Error! Bookmark not defined.

Clinical Considerations for Use of mRNA COVID-19 Vaccines  Error! Bookmark not defined.

Reporting of vaccine adverse events  Error! Bookmark not defined.

Clinical Considerations for Use of all other COVID-19 Vaccines  Error! Bookmark not defined.

COVID-19 Vaccination Measures  Error! Bookmark not defined.

Management of anaphylaxis at a COVID-19 vaccination site.  Error! Bookmark not defined.

Reporting of anaphylaxis  Error! Bookmark not defined.

REFERENCE Error! Bookmark not defined.
Background

St. Vincent and the grenadines Is presently preparing to roll out COVID-19 vaccines to the population. With this comes the concerns of the management of (AEFI). To ensure safe delivery and effective timely management of any adverse event we outline our plan for risk communication and response to serious (AEFI).

The ministry of Health Wellness and the Environment is dedicated to provides support in education and training and legislative framework these commitments include but not limited to:

- Providing, as far as practicable, a safe and supportive environment in which clients at risk of anaphylaxis can be educated, monitored, and treated in a timely manner.
- raising awareness about allergies and anaphylaxis in the school community
- actively involving the clients and caregivers at risk of anaphylaxis in assessing risks and developing risk minimization and management strategies for the client
- ensuring that every staff member and vaccinators has adequate knowledge of allergies, anaphylaxis, and emergency responses.
- ensuring that all health care facilities have policies and procedures in place to identify and minimize the risks associated with severe AEFI

Adverse event following immunization (AEFI)

An Adverse event following immunization (AEFI) is any untoward medical occurrence which follows immunization, and which does not necessarily have a causal relationship with the usage of the vaccine. The adverse event may be any unfavorable or unintended sign, abnormal laboratory finding, symptom or disease.

Anaphylaxis is a severe, life-threatening allergic reaction that occurs rarely after vaccination. Locations administering COVID-19 vaccines should adhere to CDC guidance for use of COVID-19 vaccines, including screening recipients for contraindications and precautions, having the necessary supplies available to manage anaphylaxis, implementing the recommended postvaccination
observation periods, and immediately treating suspected cases of anaphylaxis with intramuscular injection of epinephrine.

Classification of AEFI

- Vaccine product-related reaction
- Vaccine quality defect-related reaction
- Immunization error-related reaction
- Immunization anxiety-related reaction
- Coincidental event

**Serious event**

An AEFI will be considered *serious* if it:

- results in death,
- is life-threatening,
- requires in-patient hospitalization or prolongation of existing hospitalization,
- results in persistent or significant disability/incapacity,
- is a congenital anomaly/birth defect,
- requires intervention to prevent permanent impairment or damage.

**AEFI Communication plan**

The purpose of this communication plan is to clarify the relationships between audiences, messages, channels, activities, and materials.

The Ministry has adapted a strategic approach that covers the frequent, proactive, and multipronged public education to promote awareness and understanding of the COVID-19 vaccines. The intervention is also designed to provide information regarding the possible adverse events and how to respond to these events in a timely matter.

Elements of the communication Plan:
1. **Health communication team:**
   This team comprise of the Chief Medical Officer, Medical Officer of Health, Health promotion, Psychosocial team, and members of the National Technical Working Group.

2. **Objectives:**
   a) to ensure all target populations have relevant and credible information in a timely manner on COVID-19 vaccines and possible adverse events following immunization.
   b) to build vaccine confidence and dispel myths and rumors among the general population
   c) to positively influences vaccine uptake among the target population.
   d) to provide regular updates on benefits, safety, effectiveness and clearly communicate what is known about the vaccine.

3. **Situational analysis:**
   A survey on attitudes of healthcare workers to COVID-19 vaccine was developed and applied among the healthcare workers with the aim of identifying the public’s perception regarding the uptake of the vaccine.

4. **Topics to cover:**
   a) COVID-19 vaccine types, and how they work.
   b) COVID-19 Vaccine efficacy, safety, and benefits.
   c) Rumors and myths
   d) Adverse effects following Immunization. (precaution, signs, and symptoms)
   e) Response and management of an AEFI.

5. **Target population:**
   St. Vincent and the grenadines has outlined our target population in our NVDP based on the WHO SAGE roadmap recommendations. This includes, healthcare workers, Persons over 65 years of age, Frontline workers, Persons with co-morbidities, Teachers and the institutionalized, among others.

6. **Activities:**
   The communication team will implement and deliver virtual educational /sensitization sessions, medical Education, webinars, distributing IEC materials (posters, brochures),
Testimonials, production of commercials and infomercials, public service announcements /jingles, live talk shows, newspaper articles, vaccine endorsement messages from Government and influencers, Question and answer segment and myth busters, virtual press conferences, press releases and feature articles.

7. **Communication Channels:**
   
   a) Social media and Electronic media (Facebook, WhatsApp, emails, Government websites.
   
   b) Print media (newspapers, brochure, posters flyers)
   
   c) Broadcast media (radio, television)
   
   d) Other (edutainment, text blast, overhead banners indoor and external digital screens, jingles etc.)

8. **Monitoring and Evaluation:**
   Monitoring will be done via responses from the COVID-19 hotline, Social media insights, reports from health districts, rumour tracking tool, call in radio and televised programme and surveys.

   The results will be evaluated and reported on a daily, weekly, and monthly basis.
Clinical Considerations for Use of mRNA COVID-19 Vaccines

Triage of persons presenting for mRNA COVID-19 vaccination.

<table>
<thead>
<tr>
<th>MAY PROCEED WITH VACCINATION</th>
<th>PRECAUTION TO VACCINATION</th>
<th>CONTRAINDICATION TO VACCINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONDITIONS</td>
<td>CONDITIONS</td>
<td>CONDITIONS</td>
</tr>
<tr>
<td>Immunocompromising conditions</td>
<td>Moderate/severe acute illness</td>
<td>None</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Risk assessment</td>
<td>N/A</td>
</tr>
<tr>
<td>Lactation</td>
<td>Potential deferral of vaccination</td>
<td></td>
</tr>
<tr>
<td>ACTIONS</td>
<td>15-minute observation period if vaccinated</td>
<td></td>
</tr>
<tr>
<td>Additional information provided*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 minute observation period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Triage of persons presenting for Pfizer-BioNTech COVID-19 vaccination.

<table>
<thead>
<tr>
<th>MAY PROCEED WITH PRECAUTION TO CONTRAINDICATION TO VACCINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>VACCINATION</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### ALLERGIES

History of allergies that are unrelated to components of an mRNA COVID-19 vaccine†, other vaccines, injectable therapies, or polysorbate, such as:

- Allergy to oral medications (including the oral equivalent of an injectable medication)
- History of food, pet, insect, venom, environmental, latex, etc., allergies
- Family history of allergies

### ACTIONS

- Risk assessment
- Consider deferral of vaccination and/or referral to allergist-immunologist
- 30-minute observation period if vaccinated

### ALLERGIES

- History of any immediate allergic reaction‡ to vaccines or injectable therapies (except those related to component of mRNA COVID-19 vaccines† or polysorbate, as these are contraindicated)
- History of the following are contraindications to receiving either of the mRNA COVID-19 vaccines‡:
  - Severe allergic reaction (e.g., anaphylaxis) after a previous dose of an mRNA COVID-19 vaccine or any of its components
  - Immediate allergic reaction‡ of any severity to a previous dose of an mRNA COVID-19 vaccine or any of its components (including polyethylene glycol)#
  - Immediate allergic reaction of any severity to polysorbate#
Triage of persons presenting for Pfizer-BioNTech COVID-19 vaccination.

<table>
<thead>
<tr>
<th>MAY PROCEED WITH PRECAUTION TO CONTRAINDICATION TO VACCINATION</th>
<th>VACCINATION</th>
<th>VACCINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 30-minute observation period: Persons with a history of anaphylaxis (due to any cause)</td>
<td></td>
<td>ACTIONS</td>
</tr>
<tr>
<td>• 15-minute observation period: All other persons</td>
<td></td>
<td>• Do not vaccinate#</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider referral to allergist-immunologist</td>
</tr>
</tbody>
</table>

**Authorized age groups.**

Under the EUAs, the following age groups are authorized to receive vaccination:

- Pfizer-BioNTech: ages ≥16 years
- Moderna: ages ≥18 years

Children and adolescents outside of these authorized age groups should not receive COVID-19 vaccination at this time.

**Administration**

The mRNA COVID-19 vaccine series consist of two doses administered intramuscularly:

- Pfizer-BioNTech (30 µg, 0.3 ml each): 3 weeks (21 days) apart
- Moderna (100 µg, 0.5 ml): 1 month (28 days) apart

Persons should not be scheduled to receive the second dose earlier than recommended (i.e., 3 weeks [Pfizer-BioNTech] or 1 month [Moderna]). However, second doses administered within a grace period of 4 days earlier than the recommended date for the second dose are still considered valid. Doses inadvertently administered earlier than the grace period should not be repeated.
The second dose should be administered as close to the recommended interval as possible. However, if it is not feasible to adhere to the recommended interval, the second dose of Pfizer-BioNTech and Moderna COVID-19 vaccines may be scheduled for administration up to 6 weeks (42 days) after the first dose. There are currently limited data on efficacy of mRNA COVID-19 vaccines administered beyond this window. If the second dose is administered beyond these intervals, there is no need to restart the series.

**Patient counseling**

**Vaccine efficacy**

Preliminary data suggest high vaccine efficacy in preventing COVID-19 following receipt of two doses of mRNA COVID-19 vaccine (Pfizer-BioNTech: 95.0% [95% CI: 90.3%, 97.6%]; Moderna: 94.1% [95% CI: 89.3%, 96.8%]). Limited data are currently available regarding the efficacy of a single dose. Patients should be counseled on the importance of completing the two-dose series (of the same vaccine product) to optimize protection.

**Reactogenicity**

- Before vaccination, providers should counsel mRNA COVID-19 vaccine recipients about expected local (e.g., pain, swelling, erythema at the injection site, localized axillary lymphadenopathy on the same side as the vaccinated arm) and systemic (e.g., fever, fatigue, headache, chills, myalgia, arthralgia) post-vaccination symptoms. Depending on vaccine product, age group, and vaccine dose, approximately 80–89% of vaccinated persons develop at least one local symptom and 55–83% develop at least one systemic symptom following vaccination.

- Most systemic post-vaccination symptoms are mild to moderate in severity, occur within the first three days of vaccination, and resolve within 1–3 days of onset. These symptoms are more frequent and severe following the second dose and among younger persons compared to older persons (i.e., >55 or ≥65 years [for Pfizer-BioNTech or Moderna vaccines, respectively]). Unless persons develop a contraindication to vaccination (see below), they should be encouraged to complete the series even if they develop local or systemic symptoms following the first dose to optimize protection against COVID-19.

- In clinical trials, hypersensitivity-related adverse events were observed in 0.63% of participants who received the Pfizer-BioNTech COVID-19 vaccine and 1.5% of participants
who received the Moderna COVID-19 vaccine, compared to 0.51% and 1.1%, respectively, in the placebo groups. Anaphylaxis following vaccination was not observed in the Pfizer-BioNTech or Moderna COVID-19 vaccines clinical trials. However, anaphylactic reactions have been reported following receipt of mRNA vaccines outside of clinical trials.

- Antipyretic or analgesic medications (e.g., acetaminophen, non-steroidal anti-inflammatory drugs) may be taken for the treatment of post-vaccination local or systemic symptoms, if medically appropriate. However, routine prophylactic administration of these medications for the purpose of preventing post-vaccination symptoms is not currently recommended, as information on the impact of such use on mRNA COVID-19 vaccine-induced antibody responses is not available at this time.

### Potential characteristics of allergic reactions, vasovagal reactions, and vaccine side effects following mRNA COVID-19 vaccination.

In patients who develop post-vaccination symptoms, determining the etiology (including allergic reaction, vasovagal reaction, or vaccine side effects) is important to determine whether a person can receive additional doses of mRNA COVID-19 vaccines. The following table of signs and symptoms is meant to serve as a resource but may not be exhaustive, and patients may not have all signs or symptoms. Providers should use their clinical judgement when assessing patients to determine the diagnosis and management.

### Potential characteristics of allergic reactions, vasovagal reactions, and vaccine side effects

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Immediate allergic reactions (including anaphylaxis)</th>
<th>Vasovagal reaction</th>
<th>Vaccine side effects (local and systemic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing after vaccination</td>
<td>Most occur within 15-30 minutes of vaccination</td>
<td>Most occur within 15 minutes</td>
<td>Median of 1 to 3 days after vaccination (with most occurring day after vaccination)</td>
</tr>
</tbody>
</table>

**Signs and symptoms**

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Feeling of impending doom</th>
<th>Feeling warm or cold</th>
<th>Fever, chills, fatigue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutaneous</td>
<td>Skin symptoms present in ~90% of people with sensation of facial warmth, anaphylaxis, including pruritus, urticaria, flushing, angioedema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pallor, diaphoresis, clammy skin, pain, erythema or swelling at injection site; lymphadenopathy in same arm as vaccination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td>Confusion, disorientation, dizziness, lightheadedness, syncope, dizziness, lightheadedness, (often after prodromal symptoms for a weakness, loss of few seconds or minutes), weakness, changes in vision (such as spots of flickering lights, tunnel vision), changes in hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>Shortness of breath, (variable: if accompanied by anxiety, N/A wheezing, bronchospasm, may have an elevated respiratory rate stridor, hypoxia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Hypotension, tachycardia, variable; may have hypotension or bradycardia during syncopal event</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Nausea, vomiting, abdominal cramps, diarrhea, Nausea, vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>N/A, N/A, Myalgia, arthralgia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine recommendations</td>
<td>Recommended to receive 2nd dose of mRNA COVID-19 vaccine?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Reporting of vaccine adverse events

Adverse events that occur in a recipient following mRNA COVID-19 vaccination should be reported to the EPI manager. Vaccination providers are required to report the following that occur after mRNA COVID-19 vaccination:

- Vaccine administration errors
- Serious adverse events
- Cases of Multisystem Inflammatory Syndrome
- Cases of COVID-19 that result in hospitalization or death.

Reporting is encouraged for any other clinically significant adverse event even if it is uncertain whether the vaccine caused the event.

Clinical Considerations for Use of all other COVID-19 Vaccines

The precautionary measures outlined in the previous mRNA vaccines application would also apply to the application of all other COVID-19 Vaccines to be administered. The precautionary measured are the standard procedures to be observed and monitored in any vaccine application process.

COVID-19 Vaccination Measures

**Observation period following COVID-19 vaccination.**

CDC currently recommends that persons without contraindications to vaccination who receive an mRNA COVID-19 vaccine be observed after vaccination for the following time periods:

- 30 minutes: Persons with a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy and persons with a history of anaphylaxis due to any cause.
- 15 minutes: All other persons
Early recognition of anaphylaxis

Because anaphylaxis requires immediate treatment, diagnosis is primarily made based on recognition of clinical signs and symptoms, including:

- Respiratory: sensation of throat closing, stridor (high-pitched sound while breathing), shortness of breath, wheeze, cough
- Gastrointestinal: nausea, vomiting, diarrhea, abdominal pain
- Cardiovascular: dizziness, fainting, tachycardia (abnormally fast heart rate), hypotension (abnormally low blood pressure)
- Skin/mucosal: generalized hives, itching, or swelling of lips, face, throat.

Symptoms of anaphylaxis might be more difficult to recognize in persons with communication difficulties, such as long-term care facility residents with cognitive impairment, those with neurologic disease, or those taking medications that can cause sedation. Persons with communication difficulties should therefore be monitored closely for the signs and symptoms of anaphylaxis listed above after receiving an mRNA COVID-19 vaccine and should also be monitored for more nonspecific signs of possible anaphylaxis including flushing, sudden increase in secretions (from eyes, nose, or mouth), coughing, trouble swallowing, agitation, or acute change in mental status.

Symptoms often occur within 15-30 minutes of vaccination, though it can sometimes take several hours for symptoms to appear.

Early signs of anaphylaxis can resemble a mild allergic reaction, and it is often difficult to predict whether initial, mild symptoms will progress to become an anaphylactic reaction. In addition, not all symptoms listed above are necessarily present during anaphylaxis, and not all patients have skin reactions.

Symptoms are considered generalized if there are generalized hives or more than one body system (e.g., cardiovascular, gastrointestinal) is involved. If a patient develops itching and swelling confined to the injection site, the patient should be observed closely for the development of generalized symptoms (beyond the recommended observation periods noted above, if necessary).

If symptoms are generalized, epinephrine should be administered as soon as possible, emergency medical services should be contacted, and patients should be transferred to a higher level of medical
care. In addition, patients should be instructed to seek immediate medical care if they develop signs or symptoms of an allergic reaction after their observation period ends and they have left the vaccination site.

**Medications and supplies for assessing and managing anaphylaxis.**

The following medications and supplies are important for evaluating and managing of anaphylaxis and are recommended for COVID-19 vaccination sites.

The following emergency equipment should be immediately available to the clinical team assessing and managing anaphylaxis.

**Medications and supplies for assessing and managing anaphylaxis**

<table>
<thead>
<tr>
<th>Should be available at all sites</th>
<th>If feasible, include at sites (not required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epinephrine prefilled syringe or Pulse oximeter autoinjector*</td>
<td>H1 antihistamine (e.g., diphenhydramine)†</td>
</tr>
<tr>
<td>Oxygen</td>
<td>H2 antihistamine (e.g., famotidine, cimetidine)</td>
</tr>
<tr>
<td>Blood pressure cuff</td>
<td>Bronchodilator (e.g., albuterol)</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>Intravenous fluids</td>
</tr>
<tr>
<td>Timing device to assess pulse</td>
<td>Intubation kit</td>
</tr>
<tr>
<td>Adult-sized pocket mask with one-way valve (also known as cardiopulmonary resuscitation (CPR) mask)</td>
<td></td>
</tr>
</tbody>
</table>

COVID-19 vaccination sites should have at least 3 doses of epinephrine on hand at any given time. †Antihistamines may be given as adjunctive treatment but should not be used as initial or sole
treatment for anaphylaxis. Additionally, caution should be used if oral medications are administered to persons with impending airway obstruction.

**Management of anaphylaxis at a COVID-19 vaccination site.**

If anaphylaxis is suspected, take the following steps:

- Rapidly assess airway, breathing, circulation, and mentation (mental activity).
- Call for emergency medical services. (Ambulance).
- Place the patient in a supine position (face up), with feet elevated, unless upper airway obstruction is present, or the patient is vomiting.
- Epinephrine (1 mg/ml aqueous solution [1:1000 dilution]) is the first-line treatment for anaphylaxis and should be administered immediately.
  - In adults, administer a 0.3 mg intramuscular dose using a premeasured or prefilled syringe, or an autoinjector in the mid-outer thigh.
  - The maximum adult dose is 0.5 mg per dose.
  - Epinephrine dose may be repeated every 5-15 minutes (or more often) as needed to control symptoms while waiting for emergency medical services.
  - Because of the acute, life-threatening nature of anaphylaxis, there are no contraindications to epinephrine administration.

Antihistamines (e.g., H1 or H2 antihistamines) and bronchodilators do not treat airway obstruction or hypotension, and thus are not first-line treatments for anaphylaxis. However, they can help provide relief for hives and itching (antihistamines) or symptoms of respiratory distress (bronchodilators) but should only be administered after epinephrine in a patient with anaphylaxis. Because anaphylaxis may recur after patients begin to recover, monitoring in a medical facility for at least several hours is advised, even after complete resolution of symptoms and signs.

**Patient counseling**
Patients who experience anaphylaxis after the first dose of COVID-19 vaccination would be instructed not to receive additional doses. In addition, patients would be referred to an allergist-immunologist for appropriate work-up and additional counseling.

**Reporting of anaphylaxis**

Any adverse events that occur in a recipient following COVID-19 vaccination, including anaphylaxis, should be reported to the Vaccine Adverse Event Reporting System (VAERS) as outlined. All Health care providers administering vaccines have been trained in the proper reporting mechanism, utilizing the reporting forms. The EPI manager is to be immediately notified of all adverse effects.
ANNEX 4. Vaccine certificate and reporting forms

CERTIFICATE OF COVID-19 VACCINATION

<table>
<thead>
<tr>
<th>NAME:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td>(dd/mm/yyyy)</td>
<td></td>
</tr>
<tr>
<td>ID no.:</td>
<td>ID Card  Passport  Drivers Lic.</td>
<td></td>
</tr>
<tr>
<td>Nationality:</td>
<td>Tel. no.:</td>
<td></td>
</tr>
<tr>
<td>1st Dose</td>
<td>Date: (dd/mm/yyyy)</td>
<td>Time: am/pm</td>
</tr>
<tr>
<td>Manufacturer:</td>
<td>Batch/Lot no.:</td>
<td></td>
</tr>
<tr>
<td>Expiry date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place of vaccination:</td>
<td>(mm/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Vaccinator:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name (Block letters)  Signature

Health Institution Stamp:
**Appointment for 2\textsuperscript{nd} Dose:** 

(\text{dd/mm/yyyy})

Place of Vaccination

Time

\textbf{2\textsuperscript{nd} Dose} \hspace{1cm} Date: \textbf{……………….} \hspace{1cm} Time: \textbf{……………….}\textbf{am/pm}

(\text{dd/mm/yyyy})

Manufacturer: \textbf{……………….} \hspace{1cm} Batch/Lot no.: \textbf{……………….}

Expiry date: \textbf{……………….} \hspace{1cm} Place of vaccination: \textbf{……………….}

(\text{mm/yyyy})

Vaccinator \textbf{……………….}

\textbf{………………………………………...}

Name (Block letters) \hspace{1cm} Signature

Health Institution Stamp:

---

**Contact Information**

COMMUNITY HEALTH SERVICES

MINISTRY OF HEALTH, WELLNESS AND THE ENVIRONMENT

ST. VINCENT AND THE GRENADINES

784-456-199
SAINT VINCENT AND THE GRENADINES NATIONAL COVID-19 VACCINE INTRODUCTION AND DEPLOYMENT PLAN

**AEFI reporting ID number:**

**REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)**

*Patient Name:
*Patient’s full Address:

Telephone:  
Sex: □ M  □ F

*Date of birth : ___/___/____  
OR Age at onset: □□□ Years □□ Months □□□ Days  
OR Age Group at onset: □ <1 Year □ 1 to 5 Years □ >5 Years

*Reporter’s Name:
Institution:  
Designation & Department:  
Address:  

Telephone & E-mail:  
Date patient notified event to health system: ___/___/____

Today’s date : ___/___/____

<table>
<thead>
<tr>
<th>Health facility (place or vaccination centre) name &amp; address:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccine</strong></td>
<td><strong>Diluent (if applicable)</strong></td>
</tr>
<tr>
<td><em>Name of vaccine</em></td>
<td><em>Date of vaccination</em></td>
</tr>
<tr>
<td><em>Time of vaccination</em></td>
<td><em>Batch/Lot number</em></td>
</tr>
<tr>
<td><em>Dose (1, 2nd, etc.)</em></td>
<td>Expiry date</td>
</tr>
<tr>
<td><em>Batch/Lot number</em></td>
<td>Name of diluent</td>
</tr>
<tr>
<td>Expiry date</td>
<td><em>Batch/Lot number</em></td>
</tr>
<tr>
<td>Date and time of reconstitution</td>
<td>Expiry date</td>
</tr>
</tbody>
</table>

*Adverse event(s):*

☐ Severe local reaction ☐ >5 days ☐ beyond nearest joint
☐ Seizures ☐ febrile ☐ afebrile
☐ Abscess  
☐ Sepsis  
☐ Encephalopathy  
☐ Toxic shock syndrome  
☐ Thrombocytopenia  
☐ Anaphylaxis  
☐ Fever ≥38°C  
☐ Other (specify)…………………………………………………………

Date AEFI started : ___/___/____

Time ___ : ___ : ___

Describe AEFI (Signs & Symptoms):

*Serious: Yes / No: ★ If Yes ☐ Death ☐ Life threatening ☐ Persistent or significant disability ☐ Hospitalization ☐ Congenital anomaly  
☐ Other important medical event (specify)………………………………………………………………………………………………………..

*Outcome: ☐ Recovering ☐ Recovered ☐ Recovered with sequelae ☐ Not Recovered ☐ Unknown

☐ Died If Died, date of death : ___/___/____  
Autopsy done: ☐ Yes ☐ No ☐ Unknown

Past medical history (including history of similar reaction or other allergies), concomitant medication and other relevant information (e.g. other cases). Use additional sheets if needed:

First Decision making level to complete:

Investigation needed: ☐ Yes ☐ No  
If Yes, date investigation planned : ___/___/____

National level to complete:

Date report received at National level ___/___/____  
AEFI worldwide unique ID :

Comments:

*Compulsory field

Page 1 of 2  
January 2016
### AEfi Investigation Form

(Only for Serious Adverse Events Following Immunization – Death / Disability / Hospitalization / Cluster)

#### Section A

**Basic details**

<table>
<thead>
<tr>
<th>Province/State</th>
<th>District</th>
<th>Case ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Place of vaccination (✓):**
- [ ] Govt. health facility
- [ ] Private health facility
- [ ] Other (specify) __________

**Vaccination in (✓):**
- [ ] Campaign
- [ ] Routine
- [ ] Other (specify) __________

**Address of vaccination site:**

**Name of Reporting Officer:**

**Date of investigation:** __ __ / __ __ / __ __

**Date of filing this form:** __ __ / __ __ / __ __

**Designation / Position:**

**This report is:**
- [ ] First
- [ ] Interim
- [ ] Final

**Telephone # and landline (with code):**

**Mobile:**

**e-mail:**

**Patient Name**

(use a separate form for each case in a cluster)

**Date of birth (DD/MM/YYYY):** __ __ / __ __ / __ __ __ __

**OR Age at onset:** __ __ years __ __ months __ __ days

**OR Age group:**
- [ ] < 1 year
- [ ] 1-5 years
- [ ] > 5 years

**Patient’s full address with landmarks (Street name, house number, locality, phone number etc.):**

#### Section B

**Relevant patient information prior to immunization**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Finding</th>
<th>Remarks (if yes provide details)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past history of similar event</td>
<td>Yes / No / Unkn</td>
<td></td>
</tr>
<tr>
<td>Adverse event after previous vaccination(s)</td>
<td>Yes / No / Unkn</td>
<td></td>
</tr>
<tr>
<td>History of allergy to vaccine, drug or food</td>
<td>Yes / No / Unkn</td>
<td></td>
</tr>
<tr>
<td>Pre-existing illness (30 days) / congenital disorder</td>
<td>Yes / No / Unkn</td>
<td></td>
</tr>
<tr>
<td>History of hospitalization in last 30 days, with cause</td>
<td>Yes / No / Unkn</td>
<td></td>
</tr>
<tr>
<td>Patient currently on concomitant medication?</td>
<td>Yes / No / Unkn</td>
<td></td>
</tr>
<tr>
<td>(If yes, name the drug, indication, doses &amp; treatment dates)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history of any disease (relevant to AEfi) or allergy</td>
<td>Yes / No / Unkn</td>
<td></td>
</tr>
</tbody>
</table>

**For adults**
- [ ] Currently pregnant? Yes (weeks) ____________ / No / Unknown
- [ ] Currently breastfeeding? Yes / No

**For infants**
- [ ] The birth was
  - [ ] full-term
  - [ ] pre-term
  - [ ] post-term.

**Birth weight:**

**Delivery procedure was**
- [ ] Normal
- [ ] Caesarean
- [ ] Assisted (forceps, vacuum etc.)
- [ ] with complication (specify)
ANNEX 5. STANDARD OPERATING PROCEDURES COVID-19 TESTING, VACCINATION AND REPORTING ST. VINCENT AND THE GRENADINES

PURPOSE
This Standard Operating Procedure (SOP) is for all Ministry of Health, Wellness and the Environment officers involved in the COVID-19 response. This document provides guidance on how to initiate and support the implementation of the COVID-19 protocols for testing and reporting of suspected or confirmed COVID-19 patients. The document also provides guidance on the process of vaccination for eligible persons as per the National Vaccine Introduction and Deployment Plan. This procedure will be regularly reviewed and updated in line with ongoing guidance and directions from the Ministry of Health, Wellness and the Environment.

COVID-19 TESTING
COVID-19 testing is useful for finding out if people are infected with the SARS-CoV-2 virus. Testing is done for persons with or without symptoms as both groups can spread the infection to others. There are three types of tests currently available in St. Vincent and the Grenadines:
1. (Rapid) Antibody or serologic tests
2. (Rapid) Antigen tests
3. Polymerase Chain Reaction (PCR) tests
PCR and antigen tests tell you if you have the virus now. Antibody tests tell you if you had the virus in the past (Figure 1).

Figure 1 Summary of COVID-19 test types
For ease of COVID-19 testing, twelve (12) Flu Clinics have been operationalized across St. Vincent and the Grenadines. These Flu Clinics are:

- Flu Clinic Contact Number
- Kingstown Health Center 485-6133
- Coull’s Hill Health Center 458-2218
- Levi Latham Health Complex 458-5245
- Georgetown Health Center 458-6652
- Port Elizabeth Hospital 457-3328
- Mayreau Health Center 485-8215
- Layou Health Center 458-7245
- Calliaqua Health Center 458-4280
- Biabou Health Center 458-0217
- Owia Health Center 457-6837
- Celena Clouden Hospital 458-8339
- Canouan Health Center 458-8305

Who should be part of the core COVID-19 District Testing Team?

1. Clinical staff responsible for:
   a. Sample collection
   b. Issuing Medical Officer’s Order
   c. Issuing sick leave certificate
   d. Issuing Fit to Resume Work letters

2. Administrative (SET) staff on instruction from the COVID-19 Team Leader will:
   a. Inform clients of negative and positive results
   b. Document contacts of positive cases for contact tracing
   c. Report daily Rapid Antigen results to Epidemiologist
   d. Clear via telephone calls positive cases once deemed recovered by COVID-19 Team Leader

3. Psychosocial support team for regular follow up with patients ALL clients cleared from quarantine/isolation must be provided with a physical or
electronic copy of their NEGATIVE PCR test result OR a Fit To Resume Work letter.

Who should be tested?
• Any person who meets the following clinical or epidemiological criteria:
  o Acute onset of fever AND cough; OR
  o Acute onset of ANY THREE OR MORE of the following signs or symptoms:
    Fever, cough, general weakness/fatigue, headache, myalgia, sore throat, coryza, dyspnoea, anorexia/nausea/vomiting, diarrhea, altered mental status, loss of taste and smell
  o Residing or working in an area with high risk of transmission of SARS-CoV-2 virus: closed residential settings, anytime within the 14 days prior to symptom onset; or
  o Residing or travel to an area with community transmission anytime within the 14 days prior to symptom onset; or
  o Working in any health care setting, including within health facilities or within the community; any time within the 14 days prior of symptom onset.
  o A patient with severe acute respiratory illness: (SARI: acute respiratory infection with history of fever or measured fever of $\geq 38^\circ C$; and cough; with onset within the last 10 days; and requires hospitalization).
  o Asymptomatic person with history of contact with a laboratory confirmed or positive SARS-CoV-2 Antigen case.
• Persons requiring a PCR or Rapid Antigen test for travel purposes.
  Appointments are
scheduled through the COVID-19 Taskforce using the PCR test request form available on health.gov.vc.

What tests should be done?
Clients presenting to flu clinics or contacts of known COVID-19 positive cases will be tested as per the algorithm (Figure 2) below.

Figure 2 COVID-19 Testing Algorithm
All samples for PCR testing, especially exit screens, should be transported to the Molecular Laboratory Unit before 4:00 pm daily.

What should be done when a positive case is identified?
RAPID ANTIBODY POSITIVE – This is NOT counted as a confirmed case of COVID-19.
• The patient must be given a PCR test for confirmation.
• Complete Syndromic Surveillance Form (Appendix 1) and send properly labelled sample for PCR testing to the Molecular Laboratory Unit.
• Advise the patient to quarantine until the PCR test result is available.
• Once results are returned, the client must be informed via telephone by a designated team member.
• If client is PCR positive, advise further isolation, grant 14 days sick leave and collect information regarding close contacts.
• If client is PCR negative, clear from quarantine and provide fit to resume work documentation (See Appendix 2) as necessary.

RAPID ANTIGEN POSITIVE – This is NOT counted as a confirmed case of COVID-19.
- The patient must be given a PCR test for confirmation.
- Inform client immediately of positive rapid antigen results
- Complete Syndromic Surveillance Form (Appendix 1) and send properly labelled sample for PCR testing to the Molecular Laboratory Unit.
- Advise the patient to isolate until the PCR test result is available.
- Once results are returned, the client must be informed via telephone by a designated team member.
- If client is PCR positive, advise further isolation, grant 14 days sick leave and collect information regarding close contacts.
- If client is PCR negative, clear from quarantine and provide fit to resume work documentation (See Appendix 2) as necessary.
- Inform Chief Medical Officer, Medical Officer of Health and Epidemiologist of patient recovery within 24 hours of clearance.

PCR POSITIVE – This is counted as a confirmed case of COVID-19.
- Inform client immediately of results
  - Advise the patient to isolate
  - Serve patient with Medical Officer Order
- Grant 14 days sick leave and collect information regarding close contacts.
- Re-test patient 14 days after first positive result. If negative, clear from isolation and provide fit to resume work documentation (See Appendix 2) as necessary.
- Inform Chief Medical Officer, Medical Officer of Health and Epidemiologist of patient recovery within 24 hours of clearance.

Covid-19 Contact Tracing
Contact tracing should be conducted for close contacts (any individual within 6 feet of an infected person for a total of 15 minutes or more if asymptomatic or 48 hours prior to symptom onset) of laboratory-confirmed or probable COVID-19 patients. Close contacts may exist in a variety of settings outside of the household including work, school, visitors to home, volunteer activities; daycare; religious activities; social activities (restaurants, shopping); sports; visits to acute care settings, long-term care homes, retirement homes, medical labs, dentists, and other health care providers; contact with ill persons. Contacts should be documented on the Close Contact Tracing Worksheet (Appendix 3).

If a person is identified as a close contact of a COVID-19 patient the following steps should be taken:

- Advise client that they have been identified as a close contact of a positive COVID-19 case
- Advise contact to immediately enter quarantine
  - Serve contact with Medical Officer Order
  - Grant 7 days sick leave in the first instance
  - PCR Test contact on day 5 of quarantine
- If contact is PCR positive, advise further isolation, grant 14 days sick leave and collect information regarding close contacts.

If client is PCR negative, clear from quarantine and provide fit to resume work documentation (See Appendix 2) as necessary.

Where can I get supplies and materials for my team?
• Supplies and materials such as Personal Protective Equipment (PPEs) can be secured through the regular channels including the Central Medical Stores and the Health Disaster Management Unit.

• Copies of relevant forms for daily COVID-19 operations can be requested through the Health Emergency Operations Center (HEOC) housed at the National Emergency Management Organization Headquarters. Requests can be made by the COVID-19 Team Leader or his/her designate via telephone number 458-6366.

COVID-19 VACCINATION
St. Vincent and the Grenadines has commenced the introduction of COVID-19 vaccines as a key intervention in reducing transmission of COVID-19 in St. Vincent and the Grenadines.

Health District Vaccination Center Contact Number
Chateaubelair Chateaubelair Smart Hospital 458-7860
Pembroke Buccament Polyclinic 458-7191
Calliaqua Stubbs Polyclinic 458-0743
Marriaqua Levi Latham Health Complex 458-5245
Georgetown Sandy Bay Health Center 457-6836
Georgetown Modern Medical and Diagnostic Center 532-1400
Kingstown Planned Parenthood Association 456-1793
Northern Grenadines Port Elizabeth Health Center 457-3328
Southern Grenadines Union Island Health Center (Mayreau, Canouan) 458-8339

Who should be part of the core COVID-19 District Immunization Team?
1. Clinical staff for:
SAINT VINCENT AND THE GRENADINES NATIONAL COVID-19 VACCINE INTRODUCTION AND DEPLOYMENT PLAN

a. Vaccine administration
b. Issuing of vaccination certificates
c. Monitoring for adverse reactions to the vaccine post administration
d. Reporting of adverse reactions to Expanded Program of Immunization (EPI) Manager

2. Administrative (SET) staff for:
a. Scheduling appointments for vaccine administration via phone
b. Keeping a register of all vaccinated clients
c. Reporting vaccinated clients daily to EPI Manager and Epidemiologist via email using established electronic forms (Appendix 4)
d. Issuing reminders for second vaccine dose to clients

What is the COVID-19 vaccine application process?
Clients interested in receiving the COVID-19 vaccine must register by sending an email to vaccine@gov.vc with their name, age, sex, address, telephone number and underlying conditions including known allergies. Once this information is received, clients will be sent a form which they must fill to be scheduled for their appointment. District Health Team will contact persons to inform of their appointment day and time. Interested clients may also contact the vaccination center directly to schedule their appointment.

Can recovered COVID-19 cases be vaccinated?
Yes. Once COVID-19 cases have been deemed cleared by their district medical teams, the client can be administered a COVID-19 vaccine.

Who should not receive the vaccine?
• Prospective clients with a history of severe allergic reaction following vaccination or to ingredients in vaccines
  • Clients who are experiencing hyperglycemia or hypertensive emergencies

How should the vaccination center prepare for a severe allergic reaction to a COVID-19 vaccine?

• Healthcare personnel who are trained and qualified to recognize the signs and symptoms of anaphylaxis as well as administer intramuscular epinephrine should be available at the vaccination location at all times. Vaccination locations that anticipate vaccinating large numbers of persons (e.g., mass vaccination clinics) should plan adequate staffing and supplies (including epinephrine) for the assessment and management of anaphylaxis.

• The following emergency equipment should be immediately available for the assessment and management of anaphylaxis:
  o Epinephrine (e.g., prefilled syringe, autoinjector)*
  o H1 antihistamine (e.g., diphenhydramine, cetirizine)†
    o Blood pressure monitor‡
    o Timing device to assess pulse

**COVID-19 vaccination locations should have at least 3 doses of epinephrine available at all times, and the ability to quickly obtain additional doses to replace supplies after epinephrine is administered to a patient.

†Antihistamines may be given as adjunctive treatment but should not be used as initial or sole
treatment for anaphylaxis. Additionally, caution should be used if oral medications are administered to persons with impending airway obstruction.

‡Either an automated or a manual blood pressure monitor, with appropriate cuff sizes, is acceptable. If a manual blood pressure monitor is used, a stethoscope should also be available.

What should be done immediately after vaccine administration?

• Routine observation following COVID-19 vaccination is recommended as follows:
  o 30 minutes for persons with a history of an immediate allergic reaction of any severity to another (non-mRNA COVID-19) vaccine or injectable therapy AND persons with a history of anaphylaxis due to any cause
  o 15 minutes for all other persons

Note: Persons may be observed for longer, based on clinical concern. For example, if a person develops itching and swelling confined to the injection site during their post-vaccination observation period, this period may be extended to assess for development of any hypersensitivity signs or symptoms consistent with anaphylaxis (described below).

What are the early clinical signs and symptoms of anaphylaxis?

1. Respiratory: sensation of throat closing or tightness, stridor (high-pitched sound while breathing), hoarseness, respiratory distress (such as shortness of breath or wheezing), coughing, trouble swallowing/drooling, nasal congestion, rhinorrhea, sneezing

2. Gastrointestinal: nausea, vomiting, diarrhea, abdominal pain, or cramps
3. Cardiovascular: dizziness; fainting; tachycardia (abnormally fast heart rate); hypotension (abnormally low blood pressure); pulse difficult to find or “weak”; cyanosis (bluish discoloration); pallor; flushing
4. Skin/mucosal: generalized hives; widespread redness; itching; conjunctivitis; or swelling of eyes, lips, tongue, mouth, face, or extremities
5. Neurologic: agitation; convulsions; acute change in mental status; sense of impending doom (a feeling that something bad is about to happen)
6. Other: sudden increase in secretions (from eyes, nose, or mouth); urinary incontinence

If anaphylaxis is suspected, administer epinephrine as soon as possible, contact emergency medical services, and transfer patients to a higher level of medical care. In addition, instruct patients to seek immediate medical care if they develop signs or symptoms of an allergic reaction after their observation period ends and they have left the vaccination location.

Report any adverse events, including anaphylaxis, that occur in a recipient following COVID19 vaccination to the EPI Manager immediately.

How can immobile clients be administered their vaccines?
Arrangements can be made for vaccination visits to immobile or shut-in clients in your health district. If transportation is not available at your vaccination center, contact the Senior Nursing Officer, Community Health Services, to make the necessary arrangements.
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