National COVID-19 Vaccine Introduction and Deployment Plan
Ministry of Health, Wellness and the Environment
Saint Vincent and the Grenadines
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NATIONAL COVID-19 VACCINE INTRODUCTION AND DEPLOYMENT PLAN

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Abbreviations

AEFI  Adverse events following immunisation
ALBA  The Bolivarian Alliance for the Peoples of Our America
API   Agency for Public Information
ARDS  Acute respiratory distress syndrome
CARICOM Caribbean Community
CARPHA Caribbean Public Health Agency
CDB  Caribbean Development Bank
CDC  Centre for Disease Control and Prevention
CEPI  The Coalition for Epidemic Preparedness Innovations
COVAX COVID-19 Vaccines Global Access
COVID-19 Coronavirus disease 2019
CWSA Central Water and Sewage Authority
ECC  The Office for Eastern Caribbean Countries
EPI  Expanded Program on Immunisation
ESAVI Events Supposedly Attributable to Vaccination or Immunisation
EUA  Emergency Use Authorisation
Gavi  Global Alliance for Vaccines and Immunisation
HCW  Healthcare worker
HIDP  Highly Infectious Disease Plan
IPC  Infection, prevention and control
LLHC  Levi Latham Health Centre
LMIC  Low- and middle-income country
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<table>
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<tr>
<th>Abbreviation</th>
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<tr>
<td>MMDC</td>
<td>Modern Medical Diagnostic Centre</td>
</tr>
<tr>
<td>MOH</td>
<td>Medical Officer of Health</td>
</tr>
<tr>
<td>MoHWE</td>
<td>Ministry of Health, Wellness and the Environment</td>
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<tr>
<td>NCD</td>
<td>Noncommunicable disease</td>
</tr>
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<td>NEMO</td>
<td>National Emergency Management Organisation</td>
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<td>NTWG</td>
<td>National Technical Working Group</td>
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<tr>
<td>NVDP</td>
<td>National Vaccine Deployment Plan</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organisation</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase chain reaction</td>
</tr>
<tr>
<td>PHEIC</td>
<td>Public Health Emergency of International Concern</td>
</tr>
<tr>
<td>PHN</td>
<td>Public Health Nurse</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal protective equipment</td>
</tr>
<tr>
<td>SET</td>
<td>Supportive Education and Training</td>
</tr>
<tr>
<td>SVG</td>
<td>St. Vincent and the Grenadines</td>
</tr>
<tr>
<td>SXDX</td>
<td>Service DX Health Information System</td>
</tr>
<tr>
<td>UCC</td>
<td>Ultra-cold chain</td>
</tr>
<tr>
<td>VAERS</td>
<td>Vaccine Adverse Event Reporting System</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Background

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

The COVID-19 Pandemic has affected people of all ages throughout the world. The infectious disease has caused respiratory illness presenting with symptoms ranging from those of 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. As of February 21, 2023, there have been over 757 million cases and 6.8 million deaths globally. The pandemic has affected almost every country and territory in the world. Many vaccines continue to be developed and approved to provide protection against COVID-19. more than 13 billion vaccine doses have been administered globally as of February 23, 2023.

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. Immunisation 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 have been developed and made available to countries for the immunisation of their populations. These vaccines use various mechanisms (mRNA, vector or protein subunit) 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 continue to prepare and plan for their deployment by identifying key elements needed to ensure the country’s capacity to effectively and efficiently vaccinate their populations against COVID-19.

St. Vincent and the Grenadines recorded its first COVID-19 case on March 11, 2020, and confirmed community spread on February 5, 2021. As of February 18, 2023, there have been 9,589 confirmed cases of COVID-19 and 123 deaths in St Vincent and the Grenadines. Following the introduction of COVID-19 vaccines, efforts remain underway to improve the country’s vaccination rate among high-risk target groups and the general population. Local vaccine rollout has allowed for 73,418 vaccine doses to be administered to date.
Introduction

St. Vincent and the Grenadines (SVG) 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 is mountainous with fertile soils, lovely beaches, and active the La Soufrière volcano. A population of 110,872 people is served by an extensive health care system of thirty-two (32) health care centres, five (5) district hospitals, three (3) polyclinics, one (1) diagnostic and treatment centre and a major hospital. There is an excellent primary health care system and reliable referral into secondary and tertiary care. Currently there is 98-100% coverage for most vaccine preventable diseases.

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

On February 6, 2020, the Surveillance Committee and 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 off-island testing and development of protocols for the management of travellers to SVG. These measures led to the detection of the first case of 2019-nCoV in SVG on March 11, 2020 – imported from the United Kingdom. The WHO also declared the spread of 2019-nCoV virus as a pandemic on March 11, 2020.

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

The ‘battalion’ of port health staff – including health care workers (HCWs), police, airport staff, immigration and customs officers, and tourism sector workers – kept the country protected at the ports of entry. Furthermore, 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 capability. The COVID-19 taskforce continuously revised and implemented protocols to address rapidly
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changing external and internal environments. This strategy succeeded in keeping SVG without community spread of COVID-19 for nine (9) months except for six (6) cases in an import related cluster. Most cases of COVID-19 up to December 2020 were therefore imported.

During the early alert and serious response phases of the local outbreak, additional health care workers were employed, including ten (10) doctors and upwards of forty-five (45) registered nurses under the Supportive Education and Training (SET) Programme. A 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 generated with the taskforce’s 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 and 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 are now local with many clusters and some individuals not linked to any cluster.

The health services response must now 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 of protecting the health services from being overwhelmed.

The vulnerable populations in St. Vincent and the Grenadines have been identified as those with chronic noncommunicable diseases (NCDs) such as diabetes and hypertension. Additionally, frontline workers such as HCWs and security personnel must be prioritised for interventions aimed at preventing SARS-CoV-2 infection. The measures currently being implemented focus on aggressive surveillance to aide early detection of positive cases. This includes actively seeking confirmed cases in flu clinics, contact tracing, and targeted testing within at-risk populations.

Supportive measures encourage the use of face masks, proper hygiene and hand washing, reduced movement, and gatherings of any type outside the immediate home bubble. The capacity of the Molecular Lab to handle the growing volume of polymerase chain reaction (PCR) samples has been increased with the introduction of an automated extractor machine in January 2021. Additionally, private sector laboratories have been recognized to process exit screening for those travelling out of the country, 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 impact of COVID-19 in St. Vincent and the Grenadines. As such a National Technical Working Group (NTWG) has been established to ensure the efficient development and implementation of a COVID-19 immunisation program in SVG.
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SVG was incorporated by Gavi-CEPI-WHO into the list of 92 countries eligible for the Gavi-COVAX-AMC initiative for equitable access to the vaccine for low- and middle-income countries (LMICs). By being notified and ratified by Gavi as one of the countries that will receive benefits from this initiative, SVG will have access to vaccine donations to protect up to 20% of the population.

On January 6, 2021, COVAX announced its commitment to providing vaccines to Facility Participants as soon as possible within the first quarter of 2021. COVAX stated it may be able to initiate a "first wave" of small deliveries of the Pfizer vaccine between January and February 2021 if countries meet the strict criteria set. In this context, after having analysed each of the requirements, the Government of St Vincent and the Grenadines confirmed interest to COVAX on January 18, 2021. To access these vaccines, several requirements must be met, including having a national deployment and vaccination plan for the application of COVID-19 vaccine.

This document describes the strategies, and vaccination tactics to be taken for the introduction of COVID-19 vaccine.

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 Immunisation of Children Act Chapter 289 and the Public Health Act of 2020 are the existing legislations which could be utilised and or amended to provide legislative support to the introduction of any vaccines against COVID-19.

The Immunisation of Children Act Chapter 289 Act No. 16 of 1982 is an Act for the protection of children from certain diseases by immunisation, 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 immunisation 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 utilising vaccines recommended by the Minister of Health on the advice of the Chief Medical Officer.
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Regulation

The Ministry of Health, Wellness and the Environment of SVG will procure vaccines through the Expanded Program on Immunisation (EPI) using the PAHO Revolving Fund. The emergency or expedited regulatory pathways utilised by WHO PAHO for the approval of vaccines will be recognized as sufficient by the MoHWE. 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 pathways 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 authorised to sign on behalf of the Government of SVG.

The EPI Manager supported by the Drug Inspectorate will utilise the established system for the importation of vaccines, including the procurement, importation, customs clearance, storage and distribution in SVG, and will amend the procedures as necessary to accommodate the necessary conditions of the COVID-19 vaccines.

Target Population Vaccination Planning for SVG

The target population for COVID-19 vaccination was determined using two documents by the WHO Strategic Advisory Group of Experts on Immunisation (SAGE):

1. Updated WHO SAGE roadmap for prioritising uses of COVID-19 vaccines in the context of limited supply.
2. WHO SAGE values framework for the allocation and prioritisation of COVID-19 vaccination.

The initial vaccination phase, beginning February 2021, prioritised groups that were considered to have the highest level of risk by the National Technical Working Group (NTWG), guided by the WHO SAGE Roadmap. The rationale for selection of the following groups are as follows:

- Healthcare workers have high risk of acquiring severe infection or transmitting infection to patients. Healthcare workers are also integral to the continued functioning of the healthcare system and the COVID-19 response.
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- Adults 65 years and older are at greater risk for severe disease, hospitalisation, and death.
- Adults with comorbidities, independent of age, are associated with immunosuppression and are therefore at high risk for infection and severe disease. Comorbidities may include diabetes, hypertension, cardiac, lung and kidney diseases, and the effect of immunosuppression may be compounded by older age.
- Teachers have been selected given their importance in continuing the education, care and development of children. Their frontline exposure to many people puts them at greater risk for SARS-CoV-2 exposure and infection.

The NTWG has determined the first wave of vaccine roll out will target 3% of the population (110,872 as of February 2023). This translates to 3,326 persons, and the number of persons in the highest priority groups were distributed in the following manner:

- Healthcare Workers – 1000 individuals
- Adults 65 years and over – 1000 individuals
- Adults with comorbidities – 1000 individuals
- Teachers – 326 individuals

The delivery strategy for reaching these groups will be facilitated via selected clinics in each health district. These groups will be notified and will be required to register, following which they will be given appointments of the day and time to be vaccinated. This strategy was developed using the WHO SAGE Roadmap guidelines for the epidemiologic setting scenario for Sporadic Cases or Clusters of Cases.

The MoHWE continues to identify new cases of COVID-19 and monitors the prevalence of emerging variants of concern (e.g., Omicron and Delta). As the pandemic continued through 2021 and 2022, the epidemiologic scenario shifted to primarily community spread. Thus, the vaccine deployment strategy adjusted to achieve greatest coverage with the primary series for highest priority groups, followed by the remainder of the population. Lower risk groups were offered the COVID-19 vaccine, originally by appointment, then on a walk-in basis to prevent wastage at the various health centres and clinics.

Total Population: **110,872**

**Table 1** Proposed number of individuals to be vaccinated in the target population in order of priority.
<table>
<thead>
<tr>
<th>Target population in order of priority</th>
<th>Proposed number of individuals to be vaccinated to achieve herd immunity (70%)</th>
<th>Number of additional individuals to be vaccinated to achieve 100% vaccination rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Workers (High risk) in areas of high transmission</td>
<td>2022</td>
<td>933</td>
</tr>
<tr>
<td>Adults 65 years and older (in high transmission areas)</td>
<td>10236</td>
<td>5409</td>
</tr>
<tr>
<td>Emergency Reserve of vaccine</td>
<td></td>
<td>311</td>
</tr>
<tr>
<td>Health Care Workers (High risk) in the rest of the country</td>
<td>2022</td>
<td>311</td>
</tr>
<tr>
<td>Adults 65 years and older (in the rest of the Country)</td>
<td>10236</td>
<td>885</td>
</tr>
<tr>
<td>Comorbidity: Diabetes</td>
<td>9808</td>
<td>5595</td>
</tr>
<tr>
<td>Comorbidity: Hypertension</td>
<td>21042</td>
<td>5270</td>
</tr>
<tr>
<td>Front Line workers e.g., Police, Immigration, Customs and PAHO representatives</td>
<td>10111</td>
<td>1243</td>
</tr>
<tr>
<td>Teachers: Primary and Secondary</td>
<td>2022</td>
<td>1243</td>
</tr>
<tr>
<td>Essential workers outside of health and Education e.g., Taxi and Hotel personnel.</td>
<td>10111</td>
<td>1554</td>
</tr>
<tr>
<td>Rest of the population</td>
<td></td>
<td>10507</td>
</tr>
<tr>
<td>Total</td>
<td>77610</td>
<td>33262</td>
</tr>
</tbody>
</table>

**Table 2A** Distribution of vaccination goals in populations being targeted in order of priority: Stage I (very limited vaccine availability for 1-10% of the national population) using the WHO SAGE roadmap.
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<table>
<thead>
<tr>
<th>Description of target population</th>
<th>Distribution of 10% of population</th>
<th>Proposed number of individuals to be vaccinated in Stage I*</th>
<th>Proposed number of individuals to be vaccinated to achieve herd immunity (70%) (Table 1)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Workers (High risk) in areas of high transmission.</td>
<td>1.4%</td>
<td>1552</td>
<td>2,022</td>
<td>Vaccinating HCWs in high transmission areas protects the availability of essential services in the COVID-19 pandemic response. The prioritisation of HCWs is also supported by the principle of reciprocity.</td>
</tr>
<tr>
<td>Adults 65 years and older (in high transmission areas)</td>
<td>8.1%</td>
<td>8981</td>
<td>10,236</td>
<td>This group is at significantly higher risk of severe disease or death. The reasons for this prioritisation are grounded in the principles of equal respect and equity.</td>
</tr>
<tr>
<td>Emergency Reserve of vaccine</td>
<td>0.5%</td>
<td>554</td>
<td>311</td>
<td>In case of severe localized outbreak, the emergency reserve will be used for outbreak response or mitigation</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10.0%</strong></td>
<td><strong>11087</strong></td>
<td><strong>12,569</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Estimated at the maximum percentage of the stage.

**Table 2B** Distribution of vaccination small scale rollout of 275 individuals in populations being targeted in order of priority: Stage I (very limited vaccine availability for 1-10% of the national population) using the WHO SAGE roadmap.
### Description of target population

<table>
<thead>
<tr>
<th>Description of target population</th>
<th>Proportion of 10% population</th>
<th>Proposed number of individuals to be vaccinated in small scale rollout**</th>
<th>Proposed number of individuals to be vaccinated in Stage I* (Table 2A)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Workers (High risk) in areas of high transmission.</td>
<td>1.4%</td>
<td>39</td>
<td>1,522</td>
<td>Vaccinating HCWs in high transmission areas protects the availability of essential services in the COVID-19 pandemic response. The prioritisation of HCWs is also supported by the principle of reciprocity.</td>
</tr>
<tr>
<td>Adults 65 years and older (in high transmission areas)</td>
<td>8.1%</td>
<td>223</td>
<td>8,981</td>
<td>This group is at significantly higher risk of severe disease or death. The reasons for this prioritisation are grounded in the principles of equal respect and equity.</td>
</tr>
<tr>
<td>Emergency Reserve of Vaccine</td>
<td>0.5%</td>
<td>14</td>
<td>554</td>
<td>In case of severe localized outbreak, it will be used for outbreak response or mitigation, particularly for security forces and other essential government officers.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10.0%</strong></td>
<td><strong>275</strong></td>
<td><strong>11,057</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Estimated at the maximum percentage of the stage.

**Proposed number distributed among 275 individuals using proportions determined in Table 2A (Stage I)

Table 3 Distribution of vaccination goals in populations being targeted in order of priority: Stage I (very limited vaccine availability for 11-20% of the national population) using the WHO SAGE roadmap.
Description of target population | Distribution of 20% of population | Proposed number of individuals to be vaccinated in Stage II* | Proposed number of individuals to be vaccinated to achieve herd immunity (70%) (Table 1) | Rationale
---|---|---|---|---
Health Care Workers (High risk) in the rest of the country | 0.5% | 554 | 2022 | This group is at significantly higher risk of severe disease or death.
Adults 65 years and older (in the rest of the Country) | 1.3% | 1441 | 10,236 | This group is at significantly higher risk of severe disease or death.
Comorbidity: Diabetes | 8.4% | 9313 | 9,808 | This group is at significantly higher risk of severe disease or death.
Comorbidity: Hypertension | 7.9% | 8759 | 21,042 | This group is at significantly higher risk of severe disease or death.
Frontline workers e.g., Police, PAHO Immigration, Customs | 1.9% | 2107 | 10,111 | These workers are often the first line of contact at ports of entry.

Total | 20.0% | 22174 | 53219 | 

* Estimated at the maximum percentage of the stage.

Table 4 Distribution of vaccination goals in populations being targeted in order of priority: Stage I (very limited vaccine availability for 21-50% of the national population) using the WHO SAGE roadmap.

| Description of target population | Distribution of 50% of population | Proposed number of individuals to be vaccinated in Stage III* | Proposed number of individuals to be vaccinated to achieve herd immunity (70%) (Table 1) | Rationale
---|---|---|---|---
Teachers: Primary and Secondary | 4.8% | 5266 | 2022 | Their importance in continuing the education, care and development of children.
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<table>
<thead>
<tr>
<th>Description of target population</th>
<th>Distribution of 50% of population</th>
<th>Proposed number of individuals to be vaccinated in Stage III*</th>
<th>Proposed number of individuals to be vaccinated to achieve herd immunity (70%) (Table 1)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential workers outside of health and education e.g., taxi and hotel personnel.</td>
<td>5.8%</td>
<td>6375</td>
<td>10,111</td>
<td>Their frontline exposure to many people puts them at greater risk for SARS-CoV-2 exposure and infection.</td>
</tr>
<tr>
<td>Rest of the population up to 50%</td>
<td>39.5%</td>
<td>43794</td>
<td></td>
<td>Possible exposure to imported cases in the transport and hotel industry.</td>
</tr>
<tr>
<td>Total</td>
<td>50%</td>
<td>55436</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Estimated at the maximum percentage of the stage.

Conclusion

Using the WHO SAGE roadmap for prioritising uses of COVID-19 vaccines in the context of limited supply and the WHO SAGE values framework for the allocation and prioritisation of COVID-19 vaccination for Countries with Sporadic Cases or Clusters of Cases, the NTWG has determined the following vaccine deployment plan.

In Stage I, up to 10% of the population will be vaccinated (11,870 individuals):

- Health Care Workers (High risk) in areas of high transmission – 1,552
- Adults 65 years and older (in high transmission areas) – 8,981
- Emergency Reserve of Vaccine – 554

In Stage II, up to 20% of the population will be vaccinated (22,174 individuals):

Commented [PV2]: CDC guidelines (Oct 2022) now say that vaccination is recommended for everyone 6 months + including breastfeeding and pregnant women. Not sure what the recommendations are in SVG.
National COVID-19 Vaccine Introduction and Deployment Plan

- Health Care Workers (High risk) in the rest of the country – 554
- Adults 65 years and older (in the rest of the Country) – 1,441
- Comorbidity Diabetes – 9,313
- Comorbidity Hypertension – 8,759
- Front Line workers e.g., Police, Immigration, Customs - 2,107

In Stage III, up to 50% of the population will be vaccinated (55,436 individuals)

- Teachers (Primary and Secondary) – 5,266
- Essential workers outside of health e.g., taxi and hotel personnel – 6,375
- Rest of the population – 43,794

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:

St. Vincent and the Grenadines confirmed community spread on February 5, 2021.

Target population to achieve herd immunity is 70%.

Following the eruption of La Soufrière, individuals residing in the high hazard “red” zone of the country were prioritised for vaccination due to the increased risk infection in crowded shelters after evacuation.

All teachers were prioritised to receive available vaccines with an aim to restart in person school.

Vaccinations Strategies

The target population, as recommended, will be the most at-risk members of the Vincentian population. Thus, the initial target population includes all HCWs, adults older than 65 years, and adults with NCDs particularly diabetes and hypertension. Once COVID-19 vaccines become more readily available, as well as having achieved sufficient coverage in the high-risk population, immunisation of the general population will begin.

The target groups will be immunized in phases commencing with the HCWs. A comprehensive and efficient primary healthcare structure exists within SVG. Therefore, the main challenge will be to build capacity and confidence in the HCWs distributing the vaccines given the necessary storage
National COVID-19 Vaccine Introduction and Deployment Plan

requirements. HCWs will also need to be comfortable informing the recipients of the vaccines on important information such as the purpose of the COVID-19 vaccines and its potential side effects.

St. Vincent and the Grenadines, being only 389 km², is a relatively small country. This has allowed for a health care facility within approximately twenty (20) minutes of every home. Given the sensitive storage requirements of the vaccines, the preferred method for vaccine roll out is to have individuals come to identified healthcare facilities which will act as COVID-19 vaccination hubs.

The Government of SVG has sourced a specialized freezer vehicle which will support the transfer of vaccines between storage facilities and healthcare centres. The placement of ultra-cold chain (UCC) freezers at vaccination sites will likely reduce the requirement for transportation of vaccines after their initial placement.

Criteria for selection as a vaccination hub included additional space so that day-to-day operations of the health centre will not be impeded, and space for cold chain fridges and freezers. Additionally, these health facilities all have the capacity to respond to any case of severe anaphylactic reaction to the COVID-19 vaccine.

In the initial vaccine roll out, when supply is limited, vaccines will be administered by appointment only. Appointments will be managed by the individual facilities to avoid duplications and to ensure a smooth process. It is estimated that approximately 50 – 75 vaccines will be administered per day at each facility. As supply increases and becomes more reliable, individuals can receive vaccines on a walk-in basis as well as by appointments.

Individuals residing in the Grenadines will also be able to easily access the COVID-19 vaccine. The vaccines will be transported in a cold storage carrier by a community nurse via sea (a 1-hour voyage) for the Northern Grenadines (Bequia and Mustique) and via air (a 20-minute flight) for the Southern Grenadines (Union Island, Canouan and Mayreau) on the days of vaccination. Vaccination will be done at one health centre per island for immediate inoculation of clients. All individuals to be vaccinated will be given appointments and must be present at the clinic before the arrival of the vaccines to expedite its deployment and prevent wastage.

All individuals, regardless of vaccination centre, must indicate their agreement to receive the vaccine prior to finalising their appointment date. Each vaccinated person will be given a certificate of vaccination (see sample in ANNEX) and will be registered in a country database.

Infection, Prevention and Control Measures

WHO guidelines for infection, prevention and control (IPC) will be followed during immunisation sessions to prevent HCWs and patients from being harmed. Vaccinators will wear personal protective equipment (PPE) consisting of a face shield, medical mask, disposable long sleeve gown, and disposable gloves.
National COVID-19 Vaccine Introduction and Deployment Plan

A specialized vaccine waste management program in keeping with WHO standards using biosafety boxes and biohazard bags is utilised. 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 health centre 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. This process is governed by the established protocol which allows for disposal by Solid Waste Management by the Central Water and Sewage Authority (CWSA), under the guidance of Environmental Health.

Supportive Supervision System

The current supportive system used to manage the Immunisation Program is quite efficient. At the national level, the EPI Manager reports to the Senior Nursing Officer (SNO) of Community Health Services who subsequently reports to the Chief Nursing Officer. At the local level the District Nurse, who is the manager of the health facility, reports to the Health Nursing Supervisor of the health district. The Health Nursing Supervisor and the EPI Manager are then informed. This mechanism will ensure that strict supervision is carried out during the roll out of the vaccine.

Figure 1 National and local pathways for the reporting of COVID-19 vaccine roll out.
Human Resource Management and Training

The existing core members of the existing EPI team and other HCWs will be trained to deploy and administer the vaccines in their districts. Specially designed training programmes, which include a strong risk communication component, will be implemented for the expanded teams.

Table 5 Staff to be trained for the implementation of COVID-19 Vaccination.

<table>
<thead>
<tr>
<th>Category of Staff</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Nurse</td>
<td>9</td>
</tr>
<tr>
<td>Family Nurse Practitioners</td>
<td>7</td>
</tr>
<tr>
<td>District Nurses</td>
<td>40</td>
</tr>
<tr>
<td>Supply Chain Management</td>
<td>2</td>
</tr>
<tr>
<td>Community Mobilization</td>
<td>1</td>
</tr>
</tbody>
</table>

All categories of staff involved in COVID-19 vaccination program will be trained in the safe and efficient handling and management of the COVID-19 vaccines. Small group sessions and virtual modalities will be utilised to ensure that comprehensive learning and competencies are achieved. Specialized training will be coordinated with support from the vaccine manufacturers and PAHO’s Office for Eastern Caribbean Countries (ECC).

Table 6 Framework and timeline for training to implement COVID-19 vaccination.

<table>
<thead>
<tr>
<th>Category</th>
<th>Training Need</th>
<th>Time Frame</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccinators</td>
<td>Background information on COVID-19</td>
<td>Initial January – February 2021</td>
<td>EPI Manager</td>
</tr>
<tr>
<td></td>
<td>Importance of immunization</td>
<td>Ongoing February - June 2021</td>
<td>Epidemiologist</td>
</tr>
<tr>
<td></td>
<td>Characteristics of the vaccine and its effectiveness</td>
<td></td>
<td>Drug Inspector</td>
</tr>
<tr>
<td></td>
<td>Safety during immunization</td>
<td></td>
<td>Chief laboratory Technologist</td>
</tr>
<tr>
<td></td>
<td>Cold chain management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Management of AEFI</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Handling of the waste products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brokers</td>
<td>Handling of vaccines from port of entry to national storage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Handling of vaccines from storage to vaccination centres</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vehicle Drivers</td>
<td>Handling of vaccines from storage to vaccination centres</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cold Chain Capacity

The cold chain plays an integral part in storage of COVID-19 vaccine. The MoHWE in SVG has considered the local conditions which will affect the distribution system as well as the maintenance of the vaccine’s efficacy. Regular 2-8 degrees Celsius (°C) vaccine freezers have been purchased. Some COVID-19 vaccines require ultra-cold storage (between -70°C and -90°C), and these freezers have also been acquired by the MoHWE.

Given the urgency and the wide-ranging consequences of the present pandemic, five (5) facilities were earmarked for ultra-cold storage of the vaccines. The approximate dimensions of the freezers that they accommodate are: 3.51ft. (L) x 3.13 ft. (W) x 6.5 ft. (H). The first two freezers arrived in the second half of February 2021. Based on the total number of doses required for the target population, the size of the freezers ordered will adequately accommodate the number of vaccines required.

Cold chain equipment is an essential component of the supply chain required to ensure the safe and timely delivery of the COVID-19 vaccine to target populations. The several types of COVID-19 vaccines available in SVG require one of three storage temperatures: 2 – 8°C, -20°C or -70°C.

Table 7 Storage temperature requirements for available COVID-19 vaccines.

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Storage Temperature Required (°C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AstraZeneca</td>
<td>2–8</td>
</tr>
<tr>
<td>Johnson &amp; Johnson</td>
<td>2–9</td>
</tr>
<tr>
<td>Moderna</td>
<td>-20</td>
</tr>
<tr>
<td>Pfizer</td>
<td>-70</td>
</tr>
<tr>
<td>Sputnik V</td>
<td>2 – 8 (dry) or -18 (liquid)</td>
</tr>
</tbody>
</table>

In the initial stages of global vaccine rollout, it was unclear which vaccines the MoHWE would receive. To be prepared for all scenarios, arrangements were made to store all the major available vaccines. The MoHWE procured seven (7) dedicated vaccine storage units to be used to store COVID-19 vaccines:

- Two (2) ultra-cold freezers: -90°C
- Two (2) ultra-cold freezers: -40°C
National COVID-19 Vaccine Introduction and Deployment Plan

- One (1) commercial freezer: -20°C
- Two (2) medical refrigerators: 2°C-8°C

One commercial freezer and one refrigerator were already on location at the Levi Latham Health Centre and continues to be used for COVID-19 vaccine storage.

Vaccination Sites

The following health facilities were proposed and approved as designated vaccination sites. These sites were selected based on their location to ensure accessibility by the population in all geographic locations. These sites also had the capacity or the ability to be readied to support high volume of vaccinations. Ideally, all vaccination sites should have 2-8°C storage capacity.

1. Levi Latham Health Centre (LLHC)
2. Kingstown Health Clinic
3. Modern Medical Diagnostic Centre (MMDC)
4. Clifton Health Facility
5. Buccament Polyclinic
6. Stubbs Polyclinic
7. Bequia Casualty Hospital

Storage sites for vaccine storage are also designated as vaccination sites to reduce the logistic complications of transportation and maintenance of the cold chain that would otherwise have to be considered.

<table>
<thead>
<tr>
<th>Vaccination Site</th>
<th>Cold chain storage present prior to rollout</th>
<th>Space available</th>
<th>Cold chain storage currently present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bequia Casualty Hospital</td>
<td></td>
<td></td>
<td>Ultra-cool freezer (-90°C) Refrigerator (2-8°C)</td>
</tr>
<tr>
<td>Buccament Polyclinic</td>
<td>No</td>
<td>1 unit</td>
<td>Refrigerator (2-8°C)</td>
</tr>
<tr>
<td>Clifton Health Facility</td>
<td>No</td>
<td>1 unit</td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Availability of cold chain storage of COVID-19 vaccines in selected vaccination sites prior to rollout and currently.
National COVID-19 Vaccine Introduction and Deployment Plan

<table>
<thead>
<tr>
<th>Facility</th>
<th>Storage Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingstown Health Clinic</td>
<td>Yes, 1 unit Ultra-cold freezer (-40°C)</td>
</tr>
<tr>
<td>LLHC</td>
<td>Yes, 1 additional unit Commercial freezer (-20°C)</td>
</tr>
<tr>
<td>MMDC</td>
<td>No, 1 unit Ultra-cold freezer (-40°C)</td>
</tr>
<tr>
<td>Stubbs Polyclinic</td>
<td>Ultra-cold freezer (-90°C) Ultra-cold freezer (-40°C)</td>
</tr>
</tbody>
</table>

The LLHC is equipped to store vaccines of all storage temperature requirements since the facility has a refrigerator (2°C-8°C) and a commercial freezer -20°C on site. The Pfizer vaccine (-70°C) will need to be transferred to LLHC after ultra-cold storage at either the Buccament or Stubbs Polyclinics. The LLHC has a backup generator installed.

The Kingstown Health Clinic had a refrigerator (2°C-8°C) prior to deployment, and one ultra-cold freezer (-40°C) has been installed to increase capacity. The Pfizer vaccine will need to be transferred to Kingstown from either the Buccament or Stubbs Polyclinics.

**Risk Communications**

**Vaccine Acceptance, Demand and Uptake**

The success of the COVID-19 vaccination requires a strong and comprehensive risk communication program which utilises respected members of various target groups. Teachers, church leaders, politicians, trade union leaders, radio talk show personalities, entertainers, and private and public sector HCWs must be co-opted by the MoHWE to assist with positive publicity for vaccination. Community leaders should be able to educate the population about the importance of COVID-19 vaccines and increase acceptance of novel vaccine types (e.g., mRNA vaccines), ensuring the required vaccine uptake. The MoHWE Health Promotion team and COVID-19 Taskforce will utilise early and consistent messaging via available media and appropriate in-person sessions. Individuals who request the vaccine should be considered as a mechanism to promote positive experiences.

The MoHWE Health Promotion Unit, Agency for Public Information (API) and external partners have implemented a communication plan aimed at sensitizing the population regarding the COVID-19 vaccine. The communication plan for the introduction of COVID-19 vaccines includes the following:

- Engaging a communication specialist.
- Education and sensitisation prior to vaccine rollout.
National COVID-19 Vaccine Introduction and Deployment Plan

- Public awareness campaigns with the creation of graphic fact sheets for print and digital publication, and television programming.
- Preparing messages and jingles for the media and providing relevant information for the target population.
- Targeting high priority groups which are inclusive of the 65+ years population, HCWs and other frontline workers.
- Conducting interactive sessions, PowerPoint presentations and televised press conferences.
- Hosting capacity building and Q&A sessions with frontline workers alongside reading materials to support their roles as vaccinators and recipients.
- 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

To ensure safety for individuals receiving and distributing the COVID-19 vaccine, vaccine specific IPC protocols are in place. Extensive training for vaccinators accompanied with adequate PPE and other indicated supplies will be provided for frontline workers.

Events supposedly attributable to vaccination or immunisation (ESAVI) are clinical symptoms that may be temporally associated with receiving a vaccine, but do not imply a causal relationship between the ESAVI and the vaccination. Adverse events following immunisation (AEFI) are the true adverse reaction which are intrinsic to the vaccine. The reaction may be caused by the way the vaccine is administered or they may be related to underlying condition in the recipient. However, some AEFI may be coincidental and would have occurred regardless of vaccination.

AEFI can be classified into 4 main categories:

1. Programme-related
2. Vaccine-induced
3. Coincidental
4. Unknown

Programme-related AEFI may result from inappropriate practices in the provision of vaccines by vaccinators. Some of the harmful practices include:

- Incorrect dose of vaccine.
National COVID-19 Vaccine Introduction and Deployment Plan

- Vaccine used beyond indicated expiry date.
- Vaccine administered at inappropriate intervals.
- Inappropriate route, site, or technique of administration.
- Vaccine constituted with incorrect diluent.
- Incorrect quantity of diluent used to constitute vaccines.
- Drugs substituted for vaccine or diluent.
- Contaminated vaccine or diluent.
- Vaccine or diluent stored incorrectly (not at required temperatures).
- Inadequate effort to identify and acknowledge contraindications.
- Reconstituted vaccine kept beyond the recommended period.

Vaccine-induced AEFI may be brought on by the components of the vaccine or by an underlying medical condition leading to an unexpected response in the recipient. AEFI induced by direct effects of vaccine components include local reaction (redness, swelling or site pain) and fever with 48 hours of vaccination.

Anaphylaxis can occur immediately after vaccination. When there has been a confirmed anaphylactic reaction to a previous dose of the same vaccine, this contraindicates further vaccination with the same vaccine or a component of that vaccine. Contraindication also includes conditions are likely to occur sometime in the future that may be triggered by the vaccine.

Coincidental AEFI are adverse reactions determined to not have causal relationships with the vaccine but are temporally associated.

AEFI or ESAVI for which there is insufficient evidence to classify as one of the three definitive categories are classified as unknown.

AEFI Surveillance and Reporting

Any AEFI related to the COVID-19 vaccine must be reported to the Public Health Nurse (PHN) immediately by vaccinators. The PHN will notify the EPI manager and the Medical Officer of Health (MOH). The PHN will record the following information in the AEFI Register:

- Name of vaccine recipient
- Address
National COVID-19 Vaccine Introduction and Deployment Plan

- Age
- Sex
- Date of vaccination
- Name of vaccine
- Expiry date
- Batch number
- Date of AEFI
- Details of the AEFI

The PHN investigation will include a full review of the patient’s medical history, the steps taken by the vaccinator, the product information, current patient status, and will complete the appropriate reporting forms. The individual must be seen and assessed by the doctor. The investigative report will then be submitted to the EPI manager, the epidemiologist, and the MOH. Community nursing service will monitor and follow up on the status of the AEFI patient.

A COVID-19 vaccine specific AEFI manual will be utilised in the specialized training session to ensure all vaccinators can efficiently manage AEFI.

**Line of Reporting for AEFI**

The Registered Nurse is usually the first person who receives report of an AEFI. Their role is to report to pharmacovigilance then to the PHN. The PHN then reports it to the EPI manager and will investigate using PAHO stipulated form. The EPI manager provides guidance and assistance. The PHN 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 ANNEX Figures 2-3 for reporting forms.

**Figure 2** Line of reporting for AEFI
Management of an Anaphylactic Reaction

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 but not limited to:

- screening recipients for contraindications and precautions.
- having the necessary supplies available to manage anaphylaxis.
- implementing the recommended post vaccination observation periods.
- immediately treating suspected cases of anaphylaxis with intramuscular injection of epinephrine.

Please refer to the complete National COVID-19 Vaccine Anaphylaxis Plan in the ANNEX.

Monitoring and Evaluation

A comprehensive monitoring and evaluation system will be utilised throughout the implementation of the COVID-19 vaccination introduction and deployment plan. The existing vaccination monitoring and evaluation system is paper-based, however there is extensive effort underway to
National COVID-19 Vaccine Introduction and Deployment Plan

utilise existing electronic platforms to link and monitor the COVID-19 Pandemic in SVG. The COVID-19 vaccination campaign will also be incorporated into an electronic surveillance system. The Government of SVG is moving towards a multi-purpose identification card which will simplify the monitoring and evaluation of the immunisation program. Additionally, the existing SXDX system allows for the early reporting and identification of adverse effects through patient feedback modules. Efforts are underway to improve utilisation of the SXDX system for COVID-19 monitoring and evaluation.

COVID-19 Vaccine Introduction Funding

The immunisation 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 for the procurement and introduction of vaccines will include funding from the Government of SVG, COVAX support, friendly allies, and developmental partners.

To achieve herd immunity, the MoHWE aims to vaccinate at least 70% of the population. COVAX has committed to providing vaccines for 20% of the population. Therefore, the MoHWE has identified need to purchase vaccines for a further 50% of the population (55,436 individuals).

The existing staffing of HCWs allows for feasible allocation of duties as vaccinators. Other associated costs such as transportation of vaccinators to outreach activities will be covered by local government funding.

Our strategy to address the gap of USD$789,380 include:

- Caribbean Development Bank (CDB) Loan – USD$100,000
- Mustique Charitable Trust – USD$368,000
- The Bolivarian Alliance for the Peoples of Our America (ALBA) Grant – USD$200,000
- Friendly Government Source – USD$600,000

A total of USD$1,268,000 has been pledged to the Government of SVG for the introduction of COVID-19 vaccination.

COVID-19 Vaccine Deployment Budget

Table 9 Distribution of budget for deployment of COVID-19 vaccines in US$
### National COVID-19 Vaccine Introduction and Deployment Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Total Cost</th>
<th>Government estimated funding</th>
<th>Funding from External Sources</th>
<th>Funding Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and coordination</td>
<td>50,000</td>
<td>5,000</td>
<td>15,000 (GAVI/COVAX TA)</td>
<td>30,000</td>
</tr>
<tr>
<td>Training of HCWs</td>
<td>15,000</td>
<td>15,000</td>
<td></td>
<td>15,000</td>
</tr>
<tr>
<td>Vaccines (purchase and delivery)</td>
<td>1,000,000</td>
<td>100,000</td>
<td>410,000 (Friendly Government Source)</td>
<td>490,000</td>
</tr>
<tr>
<td>Supply chain and cold chain (2x UCC freezers)</td>
<td>100,000</td>
<td></td>
<td>15,000 (GAVI/COVAX TA)</td>
<td>85,000</td>
</tr>
<tr>
<td>IPC – PPEs and waste management</td>
<td>55,000</td>
<td>5,000</td>
<td></td>
<td>50,000</td>
</tr>
<tr>
<td>Syringes 1ml, 1000 per box</td>
<td>11,000</td>
<td>11,000</td>
<td></td>
<td>11,000</td>
</tr>
<tr>
<td>Voltage regulators for freezers</td>
<td>12,900</td>
<td>12,900</td>
<td></td>
<td>12,900</td>
</tr>
<tr>
<td>EPI-pen (epinephrine autoinjector)</td>
<td>20,000</td>
<td>20,000</td>
<td></td>
<td>20,000</td>
</tr>
<tr>
<td>Refrigerated truck</td>
<td>40,000</td>
<td>40,000</td>
<td></td>
<td>40,000</td>
</tr>
<tr>
<td>Communication and public information</td>
<td>50,000</td>
<td>10,000</td>
<td>20,000 (GAVI/COVAX TA)</td>
<td>20,000</td>
</tr>
<tr>
<td>Other (generator, site preparation, etc.)</td>
<td>15,480</td>
<td>15,480</td>
<td></td>
<td>15,480</td>
</tr>
<tr>
<td>Total</td>
<td>1,369,380</td>
<td>234,380</td>
<td>460,000</td>
<td>789,380</td>
</tr>
</tbody>
</table>
ANNEX COVID-19 Vaccine Anaphylaxis Plan

National COVID-19 Vaccine Anaphylaxis Plan

Ministry of Health, Wellness and the Environment
Saint Vincent and the Grenadines

Updated March 2023
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National COVID-19 Vaccine Anaphylaxis Plan

Background

The Government of St. Vincent and the Grenadines has introduced COVID-19 vaccines to the population as of February 2021. The introduction of a new vaccine raises concerns of AEFI management. To ensure safe delivery of vaccines and efficient management of any adverse event, this annex outlines the plan for risk communication and response to serious AEFI.

The MoHWE provides support in education, training and legislative framework. These commitments include but are not limited to:

- Providing, as far as is practical, 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 vaccinator 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 Events Following Immunisation (AEFI)

An AEFI is any untoward medical occurrence which follows immunisation, and which does not necessarily have a causal relationship with the usage of the vaccine. The adverse event may be any unfavourable 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 Centre for Disease Control and Prevention (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

The classifications of AEFI can be furthered broken down into:

- Vaccine product-related reaction
National COVID-19 Vaccine Anaphylaxis Plan

- Vaccine quality defect-related reaction
- Immunisation error-related reaction
- Immunisation anxiety-related reaction
- Coincidental 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 MoHWE has adapted a strategic approach that covers frequent, proactive, and multipronged public education to promote awareness and understanding of COVID-19 vaccines. The communication plan is designed to provide information regarding possible adverse events associated with vaccination and how to respond to these events in a timely matter.

The elements of the AEFI communication plan include:

1. The health communication team: This team comprises of the CMO, MOH, health promotion team, psychosocial team, and members of the NTWG.

2. Objectives:
   a) to ensure all target populations have relevant and credible information in a timely manner on COVID-19 vaccines and possible AEFI.
National COVID-19 Vaccine Anaphylaxis Plan

b) to build vaccine confidence and dispel myths and rumours among the general population.

c) to positively influence vaccine uptake among the target population.

d) to provide regular updates and clear communication on the benefits, effectiveness, and safety of approved COVID-19 vaccines.

3. Situational analysis: A survey on attitudes of HCWs towards COVID-19 vaccine uptake was developed and distributed.

4. Primary areas of focus:

a) Vaccine types and mechanisms.

b) Vaccine efficacy, safety, and benefits.

c) Dispelling common rumours and myths.

d) AEFI including precautions, signs, and symptoms.

e) Response and management of an AEFI.

5. Target population: SVG has outlined our target population in our NVDP based on the WHO SAGE roadmap recommendations. This includes HCWs, persons over 65 years of age, frontline workers, persons with co-morbidities, teachers and the institutionalised, and the remainder of the population.

6. Activities: The communication team will implement and deliver sensitisation sessions, medical education, webinars, distributing IEC materials (posters, brochures), testimonials, production of commercials and infomercials, public service announcements, jingles, live talk shows, endorsement messages from the Government and influencers, question and answer segments, myth busters, virtual press conferences, press releases and feature articles.

7. Communication Channels:

a) Social media and electronic media (Facebook, WhatsApp, Instagram, email newsletters, Government websites).

b) Print media (newspapers, brochure, posters flyers).

c) Broadcast media (radio, television).
National COVID-19 Vaccine Anaphylaxis Plan

d) Other (edutainment, blast text messages, overhead banners, indoor and exterior 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, monitoring call-in radio and televised programming, and surveys.

The results will be evaluated and reported on a daily, weekly, and monthly basis.

Clinical Considerations for the Use of mRNA COVID-19 Vaccines

Annex Table 1 Triage of individuals requesting vaccination with Pfizer-BioNTech COVID-19 vaccine.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>MAY PROCEED WITH VACCINATION</th>
<th>PRECAUTION TO VACCINATION</th>
<th>CONTRAINDICATION TO VACCINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunocompromising conditions</td>
<td></td>
<td>Moderate or severe acute illness</td>
<td>None</td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional information requested by vaccinator</td>
<td></td>
<td>Risk assessment</td>
<td>N/A</td>
</tr>
<tr>
<td>15-minute observation period</td>
<td></td>
<td>Potential deferral of vaccination</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>15-minute observation period if vaccinated</td>
<td></td>
</tr>
<tr>
<td>ALLERGIES</td>
<td></td>
<td>History of any immediate allergic reaction() to vaccines or injectable therapies (except those related to component of mRNA COVID-19 vaccines)</td>
<td>History of the following are contraindications to receiving either of the mRNA COVID-19 vaccines:</td>
</tr>
<tr>
<td>History of allergies that are unrelated to components of an mRNA COVID-19 vaccine, other vaccines, injectable therapies, or polysorbate, such as:</td>
<td></td>
<td>History of allergies that are unrelated to components of an mRNA COVID-19 vaccine, other vaccines, injectable therapies, or polysorbate, such as:</td>
<td></td>
</tr>
<tr>
<td>Allergy to oral medications (including the oral equivalent of an injectable medication)</td>
<td></td>
<td>Severe allergic reaction (e.g., anaphylaxis) after a previous dose of an mRNA COVID-19 vaccine or any of its components</td>
<td></td>
</tr>
</tbody>
</table>

Commented [PV5]: Is this table applicable to all mRNA COVID vaccines?
National COVID-19 Vaccine Anaphylaxis Plan

<table>
<thead>
<tr>
<th>MAY PROCEED WITH VACCINATION</th>
<th>PRECAUTION TO VACCINATION</th>
<th>CONTRAINDICATION TO VACCINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of food, pet, insect, venom, environmental, latex, etc.</td>
<td>Immediate allergic reaction of any severity to a previous dose of an mRNA COVID-19 vaccine or any of its components (including polyethylene glycol)</td>
<td>Immediate allergic reaction of any severity to polysorbate</td>
</tr>
<tr>
<td>Family history of allergies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ACTION**

<table>
<thead>
<tr>
<th>30-minute observation period: Persons with a history of anaphylaxis (due to any cause)</th>
<th>Risk assessment</th>
<th>Do not vaccinate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider deferral of vaccination and/or referral to allergist-immunologist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>15-minute observation period: All other individuals</th>
<th>30-minute observation period if vaccinated</th>
<th>Consider referral to allergist-immunologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider referral to allergist-immunologist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Administration of mRNA COVID-19 Vaccines**

Under the Emergency Use Authorisation (EUA), the following age groups are authorized to receive COVID-19 vaccination:

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

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

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

Individuals should not be scheduled to receive the second dose earlier than recommended (i.e., 3 weeks for Pfizer-BioNTech or 1 month for 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. If it is not feasible to adhere to the recommended interval, the second dose of Pfizer-BioNTech or
National COVID-19 Vaccine Anaphylaxis Plan

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.

Vaccine Efficacy

Preliminary data suggest high vaccine efficacy in preventing COVID-19 following two doses of an 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 counselled on the importance of completing the two-dose series (of the same vaccine product) to optimize protection.

Reactogenicity

Prior to 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 (3) 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 recipients compared to older recipients (i.e., >55 or ≥65 years for Pfizer-BioNTech or Moderna vaccines, respectively). Unless persons develop a contraindication to vaccination (see Annex Table 1), 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 response is not yet available.

In patients who develop post-vaccination side effects (including allergic reaction, vasovagal reaction, or vaccine side effects), determining the aetiology is important to establish 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.

**Annex Table 2** Potential characteristics of allergic reactions, vasovagal reactions, and vaccine side effects following mRNA COVID-19 vaccination.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Immediate allergic reactions (including anaphylaxis)</th>
<th>Signs and Symptoms</th>
<th>Vaccine side effects (local and systemic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing after vaccination</td>
<td>Most occur within 15 to 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>
<tr>
<td>Constitutional</td>
<td>Feeling of impending doom</td>
<td>Feeling warm or cold</td>
<td>Fever, chills, fatigue</td>
</tr>
<tr>
<td>Cutaneous</td>
<td>Skin symptoms present in ~90% of people with anaphylaxis, including pruritus, urticaria, flushing, angioedema</td>
<td>Pallor, diaphoresis, clammy skin, sensation of facial warmth</td>
<td>Pain, erythema or swelling at injection site; lymphadenopathy in same arm as vaccination</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Shortness of breath, wheezing, bronchospasm, stridor, hypoxia</td>
<td>Variable: if accompanied by anxiety, may have an elevated respiratory rate</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### National COVID-19 Vaccine Anaphylaxis Plan

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Signs and Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Variable; may have hypotension or bradycardia during syncopal event</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Dizziness, light-headedness, syncope (often after prodromal symptoms for a few seconds or minutes), weakness, changes in vision (such as spots of flickering lights, tunnel vision), changes in hearing</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Nausea, vomiting or diarrhoea may occur</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Myalgia, arthralgia</td>
</tr>
</tbody>
</table>

#### Reporting of Adverse Events Following Vaccination

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 association with the vaccine cannot be confirmed.
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 measures are the standard procedures to be observed and monitored in any vaccine application process.

COVID-19 Vaccination Measures

Observation Period Following COVID-19 Vaccination

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

- **30 minutes**: individuals with a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy, and individuals 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, diarrhoea, 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. These individuals should also be monitored for more non-specific 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.
National COVID-19 Vaccine Anaphylaxis Plan

Symptoms often occur within 15 to 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 generalised if there are generalised 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 generalised symptoms (beyond the recommended observation periods noted above, if necessary).

If symptoms are generalised, 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, if patients have left the vaccination site, they should be instructed to seek immediate medical care if they develop signs or symptoms of an allergic reaction after their observation period.

Medications and Supplies for Assessing and Managing Anaphylaxis

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

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

Annex Table 3 Medications and supplies for assessing and managing anaphylaxis at vaccination sites.

<table>
<thead>
<tr>
<th>Available at all sites</th>
<th>Available at sites if feasible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epinephrine prefilled syringe or autoinjector*</td>
<td>Pulse oximeter</td>
</tr>
<tr>
<td>H1 antihistamine (e.g., diphenhydramine)†</td>
<td>Oxygen</td>
</tr>
<tr>
<td>Blood pressure cuff</td>
<td>Bronchodilator (e.g., albuterol)</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>H2 antihistamine (e.g., famotidine, cimetidine)</td>
</tr>
<tr>
<td>Timing device to assess pulse</td>
<td>Intravenous fluids</td>
</tr>
<tr>
<td></td>
<td>Intubation kit</td>
</tr>
</tbody>
</table>
National COVID-19 Vaccine Anaphylaxis Plan

<table>
<thead>
<tr>
<th>Available at all sites</th>
<th>Available at sites if feasible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult-sized pocket mask with one-way valve (also known as cardiopulmonary resuscitation (CPR) mask)</td>
</tr>
</tbody>
</table>

*COVID-19 vaccination sites should have at least three (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 after vaccination is suspected, HCWs should take the following actions:

- 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. Anaphylaxis may recur after patients begin to recover, therefore monitoring in a medical facility for at least several hours is advised, even after complete resolution of symptoms and signs.
National COVID-19 Vaccine Anaphylaxis Plan

Patient Counselling

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

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 HCWs administering vaccines have been trained in the proper reporting mechanism, i.e., utilising the reporting forms. The EPI manager is to be immediately notified of all adverse effects.
COVID-19 Vaccination Certificate and Reporting Forms

**Annex Figure 1** Certificate of COVID-19 Vaccination to be given to all individuals vaccinated against COVID-19 in SVG.

<table>
<thead>
<tr>
<th>CERTIFICATE OF COVID-19 VACCINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>ID Type:</td>
</tr>
<tr>
<td>Nationality:</td>
</tr>
<tr>
<td>1st Dose Date:</td>
</tr>
<tr>
<td>Manufacturer:</td>
</tr>
<tr>
<td>Expiry Date:</td>
</tr>
<tr>
<td>Vaccinator (PRINT):</td>
</tr>
<tr>
<td>Health Institution Stamp:</td>
</tr>
</tbody>
</table>

Appointment for 2nd Dose:

| 2nd Dose Date: | (dd/mm/yyyy) | Time: AM/PM | |
| Manufacturer: | Batch/Lot No.: | |
| Expiry Date: | (mm/yyyy) | Place of Vaccination: | |
| Vaccinator (PRINT): | Signature: | |
| Health Institution Stamp: | | |
National COVID-19 Vaccine Anaphylaxis Plan

Contact Information:
Community Health Services
Ministry of Health, Wellness and the Environment
St. Vincent And the Grenadines
1-784-456-199

Commented [PV6]: Incomplete phone number. Could not find online.
Annex Figure 2 AEFI reporting form to be filled out by the PHN for any adverse event.

REPORTING FORM FOR ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI)

<table>
<thead>
<tr>
<th><em>Patient Name:</em></th>
<th><em>Reporter’s Name:</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s full address:</td>
<td>Institution:</td>
</tr>
<tr>
<td>Telephone:</td>
<td>Designation &amp; Department:</td>
</tr>
<tr>
<td>Sex: ☐ ☐</td>
<td>Address:</td>
</tr>
</tbody>
</table>

**Date of birth:** ☐ ☐ ☐ ☐

**OR Age at onset:** ☐ ☐ ☐ ☐ Months ☐ ☐ ☐ Days

**OR Age Group at onset:** ☐ 1 Year ☐ 1 to 5 Years ☐ >5 Years

**Date patient notified event to health system:** ☐ ☐ ☐ ☐ ☐ ☐

**Today’s date:** ☐ ☐ ☐ ☐ ☐ ☐

**Health facility (place or vaccination centre) name & address:**

**Vaccine**

<table>
<thead>
<tr>
<th>Name of vaccine</th>
<th>*Date of vaccination</th>
<th>*Time of vaccination</th>
<th>Dose (1st, 2nd, etc.)</th>
<th>*Batch/Lot number</th>
<th>Expiry date</th>
</tr>
</thead>
</table>

**Diluent (if applicable)**

<table>
<thead>
<tr>
<th>Name of diluent</th>
<th>*Batch/Lot number</th>
<th>Expiry date</th>
<th>Date and time of reconstitution</th>
</tr>
</thead>
</table>

**Adverse event(s):**

☐ Severe local reaction ☐ >3 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*
National COVID-19 Vaccine Anaphylaxis Plan

Annex Figure 3 AEFI investigation form for serious adverse events only (death, disability, hospitalisation)
# AEFI INVESTIGATION FORM

**Section A**

Basic details

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

**Address of vaccination site:**

- Name of Reporting Officer: [Name]
- Date of investigation: [Date]
- Date of filling this form: [Date]
- Designation / Position: [Position]
- Telephone #: [Number]
- Mobile #: [Number]
- E-mail: [Email]

**Patient’s full address with landmarks:**

- Address: [Address]
- Date of birth (DD/MM/YYYY): [Date]
- Sex: [Male/Female]

**Type of site:**

- Fixed
- Mobile
- Outreach
- Other

**Name of vaccine/doses received by patient:**

<table>
<thead>
<tr>
<th>Name of vaccine/doses received by patient</th>
<th>Date of vaccination</th>
<th>Time of vaccination</th>
<th>Dose (e.g. 1st, 2nd, etc.)</th>
<th>Batch/Lot number</th>
<th>Expiry date</th>
</tr>
</thead>
</table>

**Date of first key symptom (DD/MM/YYYY):** [Date]

**Time of first symptom:** [Time]

**Date of hospitalization (DD/MM/YYYY):** [Date]

**Status on the date of investigation:**

- ✔️ Died
- Discharged
- Recovered
- Recovered completely
- Unknown

**If died, date and time of death:** [Date]

**Autopsy done?**

- Yes
- No

**Attach report (if available):**

**Section B**

Relevant patient information prior to immunization

**Past history of similar event:**

- Yes
- No
- Unknown

**Adverse event after previous vaccination(s):**

- Yes
- No
- Unknown

**Pre-existing illness (30 days) / congenital disorder:**

- Yes
- No
- Unknown

**History of hospitalization in last 30 days, with cause:**

- Yes
- No
- Unknown

**Patient currently on concomitant medication:**

- Yes
- No
- Unknown

**Family history of any disease relevant to AEFI or allergy:**

- Yes
- No
- Unknown

**For adults:**

- Currently pregnant? Yes / No / Unknown
  - (Weeks)
- Currently breastfeeding? Yes / No

**For infants:**

- The birth was
- Full-term
- Pre-term
- Post-term
- Birth weight:

- Delivery procedure was
- Normal
- Caearean
- Assisted (forceps, vacuum etc.)
- With complication (specify)
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References

2. https://www.who.int/publications/i/item/10665337553