Proposal for Further Refinement to Sequencing and Prioritisation in WC in light of the Sisonke Implementation study

1. Purpose:

To **refine the suggested criteria for sequencing** to date in the light of the Sisonke Implementation Study and the limited doses arriving in tranches.

2. Context:

The Johnson & Johnson vaccine has **shown efficacy against the new variant (501.Y.V2) of Covid** - 57% efficacy against mild to moderate disease and 85% efficacy against severe disease. So the **Sisonke Implementation study is not to prove its efficacy**, which has been proven already. It is about enabling access and assessing an implementation programme.

We will be receiving **80 000 doses every two weeks** and possibly 60 000 in the last tranche towards the last week of March. This will mean about 300 000 doses in total for the country. A further 200 000 doses is still being negotiated. Our efficient uptake of the first 300 000 doses will incentivize the further negotiations.

Approx. **13 000 doses have been allocated to WC (7400 to TBH and 5760 to GSH)** in the first round which is expected to land in the province in latter half of this week. This allocation is for both the private and public sectors. **It is unclear what rationale and criteria is being used to allocate doses to the province.** We also unsure of future allocations to provinces.

3.Approach to Sequencing:

3.1. There is agreement of a 2:1 **(⅔: ⅓) split between public and private health sectors, at a NDoH level for the J&J vaccine.** This is in keeping with the direction of the EAC recommendation as well. This has been tabled with the research team as well as with private health sector and no opposition was tabled.

3.2. In the first round, a set of 17 hospitals nationally were identified to launch the initiative. **In WC, TBH and GSH were identified.** These sites have been chosen by NDOH and the Ensemble team.

3.3. **NDOH is of the view that staff at these hospitals should be prioritised** in this first round given the high prevalence of Covid HCW infections at these sites.

3.4. We have tabled the **need for equitable access and flexibility for provinces**, given that we need to own this process and will be accountable to public, staff and stakeholders on sequencing. This was accepted by NDOH.

3.5. The research team has accepted that **WCGH take responsibility for who gets vaccinated at GSH and TBH.**

3.6. The hospital CEOs from TBH and GSH have supported that **sequencing and deciding the access should be a provincial decision** as they are merely a chosen vaccination site.

3.7. The **research team has also accepted that our vaccination sites could be used going forward**.

However, the **rate limiting step is the physical presence of their members** to ensure supply and monitor vaccine administration.

3.8. From several engagements to date, the ff preliminary perspective seems to be emerging:

a) The principle of **equitable access is supported,** and this principle must be seen to be addressed even in first round.

b) **Recognise the limitation of not having a rural site in the first round** and this must be remedied from the second round onwards.

c**) The TBH and GSH sites be seen as Metro East and Metro West sites**

d) Given the small no of doses in first round, the **immediate sub district of Tygerberg, and Southern/ or Western be focussed** upon to ensure pragmatic quantum of doses per facility, and not to thinly scattered across too many facilities. **This will enable access to staff at these facilities from acute hospitals to EMS and PHC both within WCGH and COCT.**

e) A **roadmap of defined areas with vaccination sites to be developed, in consultation with the research team and rationale for sequencing to be explicitly described** for subsequent rounds. This **must be rapidly consulted with relevant stakeholders** including internal service mx, as well organised labour and COCT.

f) The **no of doses will be allocated pro rata to the number of staff at identified facilities** within the defined sub district. **The number of doses per facility is being finalised.**

g) From the pro rata allocated doses to a facility, **a further prioritisation needs to happen within facilities**. The ff. approach / factors could be considered:

- **individual vulnerability by age**
- **individual vulnerability by co morbidities** if data is available and can be fairly applied.
- **risk of exposure by category of staff (patient facing vs non patient facing)** as suggested by the EAC I.e. nurses, doctors etc
- **criticality of setting within facility**- critical care, Covid wards, ECs, Theatres etc

4. **The private sector:**

- will develop its own approach to sequencing
- in the first round they may choose to use GSH and TBH as sites for their staff
- they will have to assist with provision of vaccinators.
- going forward, sites for private sector staff will be negotiated with the Ensemble team.
- the private sector will be invited to nominate a representative onto the EAC especially given the discussion on sequencing and prioritisation

5. Next Steps

A defined approach to sequencing needs to be finalised as a matter of urgency. The **next steps** will include:
a) getting a final set of recommendations from the EAC.
b) consulting with organised Labour, COCT, and own service mx across the province

c) In parallel, we should initiate rapid assessments of HCW willingness for uptake.
d) Strongly encourage all HCWs, who are willing to accept the vaccine, to register on EVDS

15 Feb 2021