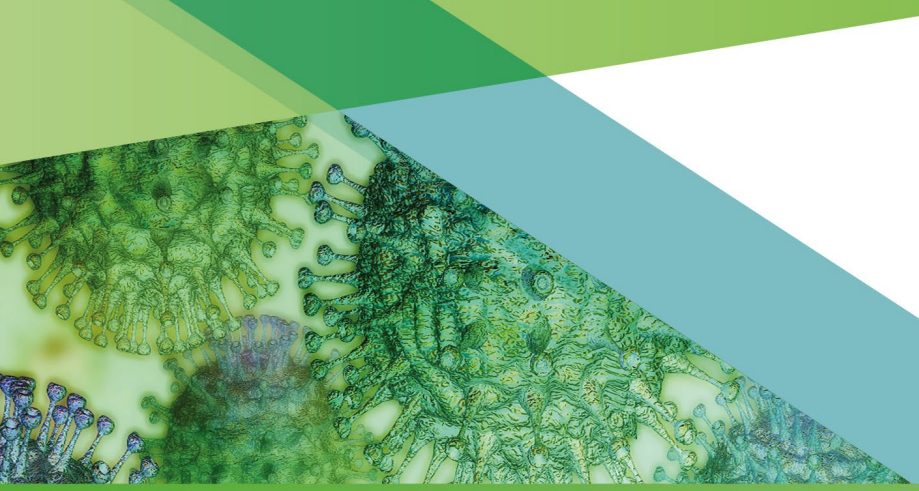

TECHNICAL REPORT

Stress test on logistical aspects of COVID-19 vaccination deployment plans: final report

3 February 2021

Summary

ECDC, together with the European Commission's Directorate-General for Health and Food Safety, organised a stress test of the logistical aspects of COVID-19 vaccination deployment plans. Twelve EU/EEA Member States participated in this stress test, a focused simulation exercise conducted in two rounds, one in mid-December 2020 and the second in early January 2021. Member States were asked to describe the deployment plans in place for delivering a vaccine with strict cold chain requirements to their target priority groups. All participating Member States were able to describe the process, albeit in varying levels of detail, reflecting that they were at different points in their planning. Most described bespoke cross-government governance arrangements where a task force had been convened to oversee the deployment. Electronic systems for logistics management and vaccination registries were described, some newly developed and others that had been used in previous vaccination programmes. Plans were also in place, or in development, to promote the vaccination campaign including using and monitoring social media to support the roll-out.

One of the most important aspects of the stress test, however, was to provide an opportunity for those involved in developing their vaccine deployment plan to test it against a realistic scenario, to work through all the elements of deployment and provide reassurance that the plan was robust and that any issues identified could be addressed. Feedback from those who took part in the stress test indicated that this was achieved. The stress test was completed when participants came together in a webinar to hear an overview of the results and share their experiences of vaccine roll-out to date.

Introduction

ECDC, together with the European Commission's Directorate-General for Health and Food Safety, organised a stress test of the logistical aspects of COVID-19 vaccination deployment plans. This stress test was highlighted as part of the Communication from the Commission to the European Parliament, the European Council and the Council on 28 October 2020:

> 'The Commission will put in place a common reporting framework so that Member States can work together and learn from each other. The European Centre for Disease Prevention will compile a first overview of national vaccination plans by the end of October 2020, to allow lessons to be drawn and experience to be shared. **A "test day" will be organised as an exercise to allow plans for strategy and deployment to be stress-tested.'**

The stress test was announced during Health Security Committee (HSC) meetings, and participation was actively sought from Member States. The HSC is a committee, chaired by the Commission's Directorate-General for Health

Suggested citation: European Centre for Disease Prevention and Control. Stress test on logistical aspects of COVID-19 vaccination deployment plans: final report. 3 February 2021. ECDC: Stockholm; 2021.

and Food Safety and attended by representatives of Member States, which has a role in coordinating national responses to serious cross-border threats to health such as COVID-19. Twelve Member States responded positively to the initial invitation and were included in the first round of the stress test. As can be seen from the Communication, the stress test was one element of a series of activities conducted by ECDC and the Commission's Directorate-General for Health and Food Safety in support of Member States as they prepare for this vaccination campaign, unprecedented in recent times.

Aim

To assist EU/EEA countries in assessing their preparedness for the deployment of vaccines, identifying gaps and follow-up actions.

Objectives

- To explore the efficient distribution of vaccines, in particular for a vaccine requiring high maintenance cold-chain and storage requirements;
- To explore the timely distribution and delivery of a COVID-19 vaccine to the identified priority groups according to the country-specific plan;
- To consider flexibility in planning arrangements and mitigation strategies;
- To identify key priority areas where there are gaps, as well as identifying areas of good practice;
- To explore issues around risk communication.

Methodology

The stress test was a one-day event, starting at 0900 CET and finishing at 1700 CET. This was not a complex simulation exercise but rather a short and focused exercise on the current level of readiness of Member States, to understand if they have mechanisms in place to coordinate the vaccination campaign, with clear lines of command, processes to receive, store and allocate vaccines to vaccination sites, a vaccination delivery strategy, and proactive and reactive communication plans in place.

A single scenario document was sent to a single point of contact in each country at 0900 CET (Annex A). A template to respond was also provided to capture their responses (Annex B). Participants were encouraged to consult colleagues both inside and outside their organisation involved in all aspects of the planned COVID-19 vaccination campaign, including logistics and communications experts, to get as comprehensive a view as possible.

The scenario described the arrival of a single vaccine, Vaccine A, into countries at their pre-designated arrival point. The focus was specifically placed on this as the first vaccine to be granted an authorisation for use in the EU to add realism. The vaccine was only available in very limited quantities, reflecting enough for 1% of the population, and with very strict cold chain requirements requiring ultra-cold conditions (-70°C). Participants were asked to consider what needed to be in place pre-deployment and during deployment of the vaccine to ensure a successful vaccination campaign. Participants were also asked to consider what risk communication and media monitoring strategies were in place to support the campaign.

Additionally, participating Member States were asked to complete a short evaluation form, in which they were asked to highlight what they considered worked well and where there were issues in their countries identified during this stress test (Annex C).

Findings

Two rounds of the stress test were run on two separate dates: 15 December 2020 and 12 January 2021. In total, 12 Member States completed the stress test by submitting a written response, 10 on 15 December and three on 12 January (one Member State attended both dates). These Member States were Austria, Belgium, Croatia, France, Germany, Greece, Ireland, Lithuania, Malta, Portugal, Romania and Spain. This was out of a total of 18 Member States who had indicated that they wished to participate and were sent the material on the day. Five did not return a completed response. There was minimal difference between the two rounds to allow comparability of responses. However, the scenario was updated for the second round to reflect the initial deployment of COVID-19 vaccines to Member States in late December 2020 and some changes other countries outside of the EU had made to their vaccine delivery processes based on their more advanced campaigns. As a result, there was an additional section on the response template, 'other', for the second round (Annex B).

The test was deliberately run over a fixed time period (eight hours), addressing specific areas that dedicated focal points in Member States should be aware of ahead of the launch of the vaccination campaign. It was reassuring that the crucial activities were known and that the level of detail in many of the responses was fairly advanced.

Overall, the outcome indicated that there is a high sense of urgency in Member States in putting a vaccine distribution campaign in place, and a lot of associated effort. The majority recognised that this is unlike any previous vaccination campaign and have put bespoke arrangements in place to assure a successful campaign.

The stress test was articulated around three areas in the response template, and the initial findings have been grouped accordingly:

1. Pre-deployment

Participants were invited to describe their pre-deployment process under five headings: governance of the programme; planned training; planned distribution in country from national to local level; which priority groups were identified for the initial phases; and how the process for invitation to be vaccinated was to be managed.

Governance

Ten Member States described establishing a specific multiagency task force, often led by the Ministry of Health with cross-sectoral collaboration at ministerial level, some supported by the military, reflecting their expertise in logistics. Federal countries included representatives from all the federated states to ensure representation of the whole country. Below this task force structure, working groups were established to represent the broad remit of the task force.

Working groups described by the Member States operating under the the task force included strategy (identification of priority groups, vaccination phasing and vaccine choice if required), vaccination process and workforce (nursing homes, hospitals, large-scale vaccination centres, etc.), supply chain and logistics (distribution of all required materials from national to regional to local centres and onwards to specific vaccine settings), monitoring (vaccination data and inventory management),enabling technology (web application and database development and management), surveillance (monitoring and follow up of side effects) and communication (public engagement and campaign). An additional cross-cutting workstream covered regulatory matters and funding.

One Member State specifically mentioned the use of existing structures utilised in the normal annual vaccination programme for influenza and building on those to deliver the COVID-19 vaccination programme. Others mentioned the use of established coordination mechanisms between national and regional structures in countries where vaccination will be under the remit of local authorities.

Training

It was recognised within Member States that a significant workforce would need to be deployed to appropriately staff the vaccination programme, including clinical staff, administrative and logistics staff. Hence, a broad range of training was required to support the different roles. Many vaccinators already have specialist experience and there was no need for extensive additional training in that aspect. Others will need specific training on the different vaccines and the different settings. Given the scope of training required, Member States reported that online programmes (e-learning, online lessons and workshops) have been developed and in many cases complimented by written guidance (standard operating procedures and illustrated guidance documents). These are supplemented by webinars on specific topics to enable more in-depth discussion and clarification of specific issues. Some Member States mentioned specific standard operating procedures and guidance tailored to the different vaccines and their different handling characteristics. Many newly developed training programmes have been built on the material used in previous vaccination programmes, as well as international best practice. Included in the training, wherever possible, Member States have taken the opportunity to conduct dry runs and rehearsals (for example, with healthcare workers in place of the general population), simulation exercises and drills. One Member State mentioned that a non-governmenal organisation is supporting their training activity.

Vaccine cold chain and distribution

The scenario used in the stress test was fictitious, but the vaccine described was closely based on the first vaccine expected to be available in the EU. When Member States responded to the stress test they pointed out that the manufacturer of this vaccine was willing to deliver their vaccine consignments to regional hubs within countries when requested to do so. This will probably not be an option for all COVID-19 vaccines as more become available. However, it illustrates the possibility of a degree of flexibility with some manufacturers and points to the fact that, as some Member States mentioned, close liaison with vaccine manufacturers in terms of delivery destination and scheduling of vaccine deliveries is possible and will be very helpful in planning.

In terms of distribution, many Member States described that distribution from hubs by dedicated logistics organisations were in place to ensure that timely distribution and the cold chain is maintained throughout the process. Some Member States planned to use the military in support of the distribution of the vaccine, while others planned to engage specialised companies, but all recognised the scale and complexity of the task.

One Member State noted that the schedule of deliveries to vaccination centres is foreseen according to the capacities for storage of cold chain products locally, and planned accordingly. This relies on up-to-date reporting and inventory management at all points in the supply chain.

Several Member States mentioned that they would adapt the supply chain to the expected different cold chain requirements of the different vaccines as they become available from the manufacturers.

Priority groups

The consideration of priority groups was well described in all countries participating in the stress test. Given the limited availability of vaccine in the initial roll-out, residents and workers in long-term care facilities (LTCFs) were the initial target for vaccination mentioned by Member States. Other groups mentioned as high on the list of priorities were frontline healthcare workers, people over 80 years of age and those with underlying health conditions.

Invitation to vaccination

Many Member States identified that organising an invitation system was not a problem for residents in LTCFs as the vaccine would be taken to the facility and all who were present and wished to be vaccinated would be.

For successive priority groups, the systems described were more complex. Many Member States plan to use electronic systems that have been used in vaccination programmes previously, while others are developing bespoke electronic systems. Member States referred to online booking systems linked to records (health or national insurance records) and a combination of post/email/SMS to contact target groups identified at local level. There was a recognition of the need to use multiple approaches to contact individuals, given that some are hard to reach and may not have access to electronic devices.

2. Distribution

In this stress test, distribution refers to distribution of the vaccine once it has arrived in local vaccination centres. Participants were invited to describe this process under five headings: vaccination allocation; vaccination settings; recording vaccinations; follow-up; and strategies to minimise waste.

Vaccine allocation

For LTCFs, Member States plan to use mobile vaccination teams whenever possible to take the vaccine to the care facility. Hence, allocation is a simple process in which vaccination teams collect the required amount of vaccine from the local distribution centre or larger healthcare facility, whichever was nominated as holding the local supply. The demand for vaccine allocation is therefore driven in this instance by the needs of individual LTCFs.

In order to ensure that the correct volume of vaccines are received by each vaccination location at the right time for other settings, some Member States noted that a robust, accurate, real-time inventory management system would need to be in place to assure the availability and maintenance of adequate supplies, minimise potential wastage and accurately forecast demand. Several Member States mentioned a "control tower" approach, which connects multiple IT systems and provides an overview linking appointment scheduling with distribution and delivery, and even electronic immunisation registries at the vaccination centres. Others focused on the capacity of the vaccine centre to vaccinate and calculated a supply based on this.

Some Member States stated that it was the medical professionals at the local level who would identify those in the population qualified to be in the priority group and arrange the vaccination invitation. They would then order vaccine doses appropriate to the number in that group that could be utilised within the strict usage guidance of the specific vaccine.

Many Member States referred to the importance of an equitable distribution of vaccine across the country such that no region received more vaccine doses than any other per capita.

Vaccination settings

The settings for the initial roll-out of the vaccine were identified as LTCFs, hospitals, primary care facilities and community pharmacies. Several Member States indicated they would also use mass vaccination centres when the vaccine became more widely available, and plans were in place or being developed for establishing these settings.

Recording vaccination

Many Member States have well-established electronic systems for the recording of vaccinations. These are sometimes linked to electronic health records or are a stand-alone electronic registry of immunisation. Healthcare workers involved in vaccination are therefore already very familiar with these systems. Others have developed or are in the final phases of developing bespoke or new electronic vaccine registries. One Member State mentioned a web-based data portal that allowed access in real time to data for rapid reporting. Another mentioned that since they had developed a completely new vaccine registry, they would continue to duplicate by using a paper-based system in parallel as back-up.

Follow-up

At the time of vaccination, Member States reported that recipients would be provided with information on the vaccine before being administered. This would include common minor side effects and also how to report any more serious adverse reactions potentially related to the vaccination. In many Member States, vaccine recipients will be

asked to wait a period of time (15 minutes was common) under medical supervision in the vaccination centre following vaccination to capture any immediate adverse reactions.

The process for reporting adverse reactions is through electronic systems, in many cases using the same system used for recording the vaccination. Some Member States reported the intention of using a separate portal, linking the vaccination database to an adverse drug reporting system. Some of these electronic systems are still in development.

It is clear from the responses that Member States are taking pharmacovigilance very seriously. There is a recognition that these vaccines are new to the market and that post-marketing surveillance of the efficacy, safety and the duration of protection ensures that the positive risk-benefit profile established at the time of approval can be continuously reviewed as the vaccine becomes widely used. Hence, vaccination recommendations can be adapted where needed to reflect the new findings.

Routine pharmacovigilance based on established real-time monitoring of possible side effects or vaccination-related complications used for all vaccines will be supplemented by additional studies and activities in Member States. There was mention of the planned use of post-authorisation safety studies, in one example using a smartphone app. In addition, some Member States plan to conduct close active surveillance of the vaccinated population by proactively contacting individuals following vaccination.

Information sessions on post-vaccination processes are being organised with patient associations, healthcare professional associations and the media. Instructions specific to reporting undesirable adverse events will be disseminated through media outlets, posters at vaccination centres, and included in any communication sent after vaccination.

Member States were keen to point out that all personal information would be subject to the application of strict data protection requirements.

Minimising waste

In addition to the measures taken to allocate vaccine doses accurately to vaccination centres based on anticipated throughput as described earlier, Member States were asked what other measures they have in place to minimise waste. Reserve lists were identified as one solution, either based on the priority group or on frontline workers that could attend at short notice.

3. Risk communication

Risk communication is considered a vital component of any mass vaccination campaign. Member States were therefore asked to consider what plans they have for ongoing media engagement, managing negative reports in the media, monitoring social media and any intentions to use specific individuals to promote the vaccination campaign.

Media engagement

All Member States reported that they had plans in development or in place to launch a media campaign in support of the vaccination to build and sustain trust. Many described a multi-channel campaign that includes television, radio messages and social media. The preferred option was to use trusted individuals such as scientists and senior health professionals to inform citizens regarding the safety and efficacy of the vaccine. Regular Q&A sessions on broadcast media with experts, and a website regularly updated with current information, were also planned. Some also described the use of influencers to convey important messages through informal channels and stakeholder engagement such as professional associations, religious institutions, business groups and community representatives to encourage engagement. One Member State specifically mentioned the availability of a call centre to offer advice and support.

Negative reports in the media

Member States described having several strategies in place to monitor the media to take reports seriously and address them but also challenge any misinformation. Member States will investigate any reports in the media and if found to have any validity, stated very clearly that they will be open and transparent when it comes to genuine side effects of vaccines and will report the same in an appropriate fashion. All Member States reported having systems in place to address safety concerns as they arise. To deal with misinformation, one Member States suggested that key opinion leaders will be engaged to provide factual information, while another suggested the use of an online fact-checker connected to the government website to provide information on the vaccination campaign.

Social media monitoring

Many but not all Member States stated that they would monitor social media to be aware of and prepare to counter rumors and respond to misinformation. One Member State said they were actively liaising with social media companies to enable early identification of potential misinformation and disinformation so that appropriate action could be taken quickly. Others suggested that they would not challenge misinformation or disinformation

directly on social media platforms but would counter them by disseminating factual information through the same channels.

Many mentioned that the key driver in all interactions with the media was to maintain public trust.

Vaccine campaign promotion

Member States were asked if they had any plans to promote the vaccination campaign through the use of celebrities or key figures. Some suggested they would use ordinary citizens rather than celebrities as the first people to be vaccinated and highlighted in the press. Others suggested they would use recognised community leaders or well known and respected older people to highlight the vaccine roll-out. They also suggested they would use public health doctors, GPs and community pharmacists to promote vaccine take-up rather than celebrities.

4. Lessons learned from previous roll-out (both their own and those of other countries)[1]

In the second round of the stress test, conducted approximately one month after the first, additional questions were asked regarding what had been learned in the initial roll-out, what mechanisms were in place to learn from other countries outside of the EU as they roll out their vaccination campaign and how they would accommodate the availability of multiple vaccines in their processes. As only a small number of countries completed the second stress test, the results are limited.

Member States reported that they had learned lessons from the first roll-out and had adjusted their processes to take these into account, demonstrating the agility of the vaccine roll-out process.

In terms of the learning from the international experience, to ensure up-to-date sharing of information Member States have regular bilateral calls, information exchanges and follow international initiatives (ECDC, WHO, the Commission). One Member State pointed to the importance of learning from the experience of countries where the vaccination programme has already started, particularly regarding safety issues. It was noted that one way of addressing reluctance to be vaccinated is pointing to successful vaccination campaigns ongoing in other countries.

The situation whereby multiple vaccines become available was a further consideration. One Member State stated that for each vaccine they would have different standard operating procedures, specific training and a different supply chain structure to ensure that each vaccine was delivered and used in the correct way.

Feedback from participants on the stress test

Countries were asked to fill in a short evaluation of the stress test, including potential issues with performing the test and any issues that might have been identified during the test.

- The six countries that responded to the evaluation agreed or strongly agreed that the stress test was useful, worked well and that the aim for the test was fulfilled;
- The stress test was useful as it created an opportunity to discuss the topic, review plans and coordinate a response across sectors and organisations;
- One country mentioned that this exercise would have been useful at an earlier stage when planning commenced;
- In the second round of the stress test, one Member State commented that they didn't identify any lessons or issues when conducting the stress test but this was because they had started the deployment so had already adapted their plans to the situation at the time.

Follow-up

The scenario-driven stress test was the major part of the exercise. In addition, a webinar with all the participating Member States was held in mid-January. Over 30 participants joined the webinar, which provided an opportunity to present the results of the stress test and for countries to share their experiences, key gaps and good practice both in the stress test and in the early weeks of vaccine roll-out.

Contributing ECDC experts (in alphabetical order)

Kim Brolin, Tarik Derrough, Lucia Pastore Celentano, Paul Riley

[1] Only applicable to countries participating in the second stress test round

Annex A.

Stress test scenario (Round 2)

Limited availability of a single vaccine

It is 12 January 2021.

On 21 December 2020, Vaccine A received conditional marketing authorisation for use in the EU by the European Commission based on the European Medicines Agency recommendation. This was earlier than expected.

Your first shipment arrived in the days between Christmas and New Year enabling you to start vaccination at a convenient date according to your preference. The initial allocation was small but you are expected to receive a second shipment this week sufficient to cover 1% of the population with two doses based on population size according to Eurostat data for 2020. It is therefore unlikely there will be sufficient vaccine for all prioritised groups in this round of delivery.

Vaccine is packaged and labelled in your country language. It is presented as a multidose vial and your country will have to procure syringes and needles for safe administration. Unpreserved sodium chloride 9 mg/mL (0.9%) solution for injection is the only diluent that should be used. This diluent is not provided in the vaccine carton.

When it arrives in your country from the manufacturers, Vaccine A is frozen and is packaged into 2 millilitre glass vials — each holding five doses, although some countries are managing to get six doses out of each vial. Vials are packed into trays. One tray holds 195 vials. Up to five trays fit into a box. Each insulated box also contains 25kg of dry ice to guarantee the vaccine stays frozen during transit to the destination country. Beyond that, countries are expected to ensure the maintenance of the cold chain according to the product specification.

Vaccine A has very rigorous cold chain requirements that none of the other vaccines currently in use in your country for other diseases have. The product specification states that this vaccine must be kept at -70°C ±10°C. Each vial of the vaccine holds five doses when diluted. Once thawed, the undiluted vial can be kept in a refrigerator for only five days. A diluted vial can be kept for only six hours before it must be discarded.

The expectation from senior government officials is that as the vaccine arrives it will be distributed and administered to the relevant target group(s) as soon as possible. The media is reporting on the vaccinations campaigns progress every day in the news, creating considerable anticipation in the population as they await their turn.

The UK, who started vaccination with Vaccine A just over a month ago has already reported a few adverse reactions and adjusted their precautions of use to take this into account reinforcing the importance of vigilance as vaccine programmes are rolled out. The UK has recently also altered its strategy to administer second doses a maximum of three months apart rather than the recommended three weeks. This is in response to the limited availability of the vaccine and a belief that the more people vaccinated quickly with the first dose the better. The USA, who also started their vaccination campaign with another vaccine, Vaccine B, nearly a month ago, is considering administering a half dose of this vaccine to maximise coverage with their limited stocks.

The good news is that Vaccine B, a vaccine based on similar technology to Vaccine A but with a less rigorous but still important cold chain requirement, has also been approved in the past few days. Small quantities of this will also become available in the next days and weeks in Europe.

Ministers are asking for a daily report on uptake and any issues so they can brief the media.

Annex B.

Response template (Round 2)

Limited availability of a single vaccine

N.B. The bullet points below are to guide your response. Feel free to elaborate beyond these, as appropriate to your specific setting.

1. Pre-deployment

Given the scenario, describe in as much detail as possible the pre-deployment steps. Include information on:

- The governance structure overseeing vaccine deployment;
- Plans for training of staff and what the training will include;
- A description of the distribution network and the steps in place to ensure the cold chain both during distribution and when stored at the national, regional and local level sites;
- The process for identifying and getting eligible individuals to the right vaccination site at the right time.

Response: Click or tap here to enter text.

2. Distribution

Given the scenario, describe in as much detail as possible the plans for distributing the vaccine from the arrival point at the country border into the arms of your prioritised target group. Include information on:

- The process being used to accurately allocate vaccine to the various sites and any additional steps to maximise uptake and minimise waste. Describe any foreseen bottlenecks and include any mitigation strategies if unexpected problems arise.
- The settings being used for vaccination including security, staffing and infection prevention and control (IPC) measures for public and staff.
- The process for recording vaccination, any documentation and data protection mechanisms you will use and any documentation you will provide to people being vaccinated.
- The process for follow up after vaccination both at the individual (e.g. adverse event monitoring) and population level (e.g. monitoring uptake, safety, etc.).
- Contingency plans to not waste vaccine vials in case immediately prioritised groups do not show up for vaccination to the extent expected.

If any of these systems are not yet in place, please indicate the timescale for how quickly they can be put in place (days, weeks, months).

Response: Click or tap here to enter text.

3. Risk communication

A. The vaccine is eagerly anticipated by the general population, so it is important that as the vaccine programme progresses it is continuously promoted in the media in a positive way. What plans for ongoing media engagement do you have? Provide an example of a press release and lines to take for media engagement.

Response: Click or tap here to enter text.

B. It is inevitable that reports will emerge in social media and quickly be reported in the mainstream press of any perceived side effects or deaths associated with vaccination whether they are valid or not. What is your plan to manage these reports and respond to them in a timely manner?

Response: Click or tap here to enter text.

C. Social media is likely to be very active once the vaccine programme starts. There will be positive and negative information circulating. What plans do you have to monitor, investigate and challenge social media stories that may be inaccurate, incorrect and could potentially damage the vaccination campaign?

Response: Click or tap here to enter text.

D. Individuals popular in mass media may offer themselves to be vaccinated as part of the vaccination campaign. What plans do you have to promote the vaccination campaign?

Response: Click or tap here to enter text.

4. Other

A. If you have already received and distributed an initial allocation of vaccine which you received between Christmas and New Year are there any lessons that you learned during that process and have you made any changes subsequently in your planning for the vaccination campaign?

Response: Click or tap here to enter text.

B. Some countries outside the EU started their vaccination campaigns earlier and so there is an opportunity to learn from their experience. The media will also be using differences in strategy to criticise your country if other countries are perceived as more successful. What plans do you have in place to review and adapt your vaccination strategy if required?

Response: Click or tap here to enter text.

C. Having two different vaccines available complicates the supply chain as they have different cold chain requirements. They are also packaged in different quantities and have slightly different recommended dose intervals (21 days for vaccine A and 28 days for vaccine B). How will you adapt your plans as these two and in the future more vaccines with different requirements become available?

Response: Click or tap here to enter text.

Additional information

Country: Click or tap here to enter text.

Contributors (name and function): Click or tap here to enter text.

Please indicate on your response if you do not wish ECDC to share your written response without consulting you first: Click or tap here to enter text.

Annex C.

Evaluation form

Please use the tick boxes below to comment on the way the exercise was organised and whether it achieved its aim. This will help us to develop further activities.

Country: ..... Name (optional) .....

Exercise Content	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The exercise was well organised	☐	☐	☐	☐
2. The scenario generated useful discussion	☐	☐	☐	☐
3. The stress test generated important issues and lessons identified	☐	☐	☐	☐
4. The aim of the stress test was achieved	☐	☐	☐	☐

The aim of the stress test was: To assist EU/EEA countries in assessing their preparedness for the deployment of vaccines, identifying gaps and follow up actions

In relation to the stress test, what would you consider worked well in your country?

In relation to the stress test, what would you consider were the main issues and gaps that you identified? Did you learn anything from the initial roll-out of vaccine received during the Christmas period?