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Ministry of Public Health, in Partnership with UNICEF Guyana COVID-19 VACCINATION Hesitancy Survey



**General Population; Adolescents, Healthcare Workers and Persons
over Sixty Years of Age.**

January, 2020.

Report

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Executive Summary

The Ministry of Health in partnership with UNICEF, as part of the national response to COVID-19, conducted a national survey to understand the population's perspective on the COVID-19 vaccine and to inform whether the acceptance of it will be hesitant when it becomes available.

Besides, this survey provides strong inferences that can inform the review and adjustment of implementation strategies for the national immunization program and can enable the development and adaptation of plans of action for new vaccines.

The Ministry of Health and its partners launched this survey to inform approaches and strategies to ensure uptake of the COVID-19 vaccine at the national, regional, and local levels when it is available.

Objectives of the survey

The survey will help to:

- Inform data-driven approaches to planning, implementing, and evaluating demand strategies.
- Enable the development and adaptation of a plan of action that considers the unique features and characteristics of the new vaccine.
- Guide strategic communications activities that promote COVID-19 vaccination and manage expectations.
- Facilitate the building of trust and managing misinformation towards acceptance and uptake of COVID-19 Vaccines.

Methodology and Data Collection

The survey is national in scope covering all 10 administrative regions. To achieve the objectives, this survey addressed key questions regarding the COVID-19 vaccines. The data collected will provide baseline values for three modules. (Module 1: Demography; Module 2: SAGE Vaccines Hesitancy and Module 3: COVID-19 Vaccine Hesitancy - Knowledge and Attitude.

The survey targets a general sample of the population along with sub-samples of key populations. The survey population consists of the general and key populations, residing in the 10 administrative regions. The key populations are persons \geq 60 years old; Health and social workers, and adolescents

Sample description

Overall, data was collected from 819 respondents. The general population sample comprised 638 respondents, the adolescent sample comprised 55 respondents, and the sixty years and above sample and the health care worker samples each comprised 50 respondents.

Key Findings

Vaccine Hesitancy

Overall, data was collected from 819 respondents. The general population sample comprised 638 respondents, the adolescent sample comprised 55 respondents, and the sixty years and above sample and the health care worker samples each comprised 50 respondents.

During the data cleaning process, 26 responses were removed from the general sample mainly due to inaccuracies in data capture.

Analysis of the data from the four samples indicates that there was a widespread belief that vaccines can protect from serious diseases. For instance, from the general sample, 86.8% of respondents stated that they believed that vaccines could protect them from serious diseases.

An exceedingly small percentage of respondents from the general sample, the sixty years and above, and the health workers samples reported that in the past they hesitated or refused to get a vaccination for themselves or child/children. Hesitation or refusal to take a vaccine was comparatively higher in the adolescent sample reaching 16.7%. Further analysis of the general sample shows 16.7% of respondents with 'no formal education' reporting that in the past they hesitated or refused to get a vaccination - either for themselves or their child/children.

Lack of relevant knowledge of the efficacy of vaccines, past experiences, perception of risk and lack of trust in vaccination programs, subjective fears, and belief were the main themes embedded in the open-ended responses as to why respondents in past hesitated or refused to get a vaccination - either for themselves or their child/children.

Overwhelmingly, the data show that there was a high positive characterization of vaccines. In the general sample, 87.4% of respondents characterized vaccines as either important, safe, or efficient. Among adolescents, 81.4% of respondents characterized vaccines as either important, safe, or efficient, and among respondents from the sixty years and above samples and health workers sample 76.0% 100.0%, respectively opined that vaccines were efficient, important, or safe.

COVID-19 Vaccine Hesitancy - Knowledge and Attitude

The survey does not provide evidence of widespread support for the COVID-19 vaccine. According to the data, 60.2% of the general sample either agreed or strongly agreed that it was important for everyone to get the COVID-19 vaccine once available. This can be interpreted as moderate support among the population for the COVID-19 vaccines. On the lower end of the spectrum, only 46.0% of respondents from the sixty years or older age group were of the view that everyone needs to get the COVID-19 vaccine once it is available.

Figures for the adolescents and health workers sample are below the general sample but still around the midway range (50.9% for adolescents and 56.0% for health workers). 68.0% of respondents from the general sample said that they would take the COVID-19 vaccine if it is introduced in the country. Percentages of respondents from the other samples expressing their willingness to take the COVID-19 vaccine was disturbingly lower than the statistics for the general family. Only 57.4% of health workers expressed willingness to take the COVID-19 vaccine, and only 45.8% of respondents sixty years or older demonstrated any willingness to take the COVID-19 vaccine. Among adolescents, 61.1% of respondents voiced their willingness to take the COVID-19 vaccine.

Only 29.3% of respondents from the general sample, 31.5% of adolescents, 22.0% of the sixty years and above sample, and 16.0% of health workers felt they had enough information on the COVID-19 vaccine.

A considerably large number of respondents indicated that they have concerns about the COVID-19 vaccine. The analysis reveals that as high as 77.3% of respondents from the general sample mentioned that they have concerns about the COVID-19 vaccine. When queried about their concerns, 95.3% of respondents said their concerns about the COVID-19 vaccines were with the perceived side effects or adverse effects of the vaccine. Among adolescents and health workers concerns about the vaccine were much higher at 88.9% for adolescents and 80.0% for health workers. The main concern was over the potential side effects of the vaccine.

Conclusions

Vaccine Hesitancy

The findings from all four samples indicate that there was a widespread belief that vaccines can protect from serious diseases.

Overwhelming the data show that there was a high positive characterization of vaccines.

Even though an exceedingly small percentage of reported hesitating or refusing vaccines; refusal and hesitation to take vaccines in the past was higher among the adolescents and sub-sample of individuals with no formal education.

The main barriers to vaccine uptake were knowledge of the efficacy of vaccines, past experiences, perception of risk, and lack of trust in vaccination programs, subjective fears, and beliefs.

COVID-19 Vaccine Hesitancy

The survey does not provide evidence of widespread support for the COVID-19 vaccine. This can be interpreted as moderate support among the population and special samples for the COVID-19 vaccines

Indication of the potential uptake for the COVID-19 vaccine was in the upper midway range and effort is needed to improve on this indicator.

A considerably large number of respondents indicated that they have concerns about the COVID-19 vaccine. The main barrier to the uptake of the COVID-19 Vaccine was not related to its efficacy but to the potential side-effects of the vaccine.

Recommendations – Intervention addressing vaccine hesitancy

- Promotion of accurate information on the COVID-19 vaccines along with the safety and benefits of the vaccine, in general, is necessary. Additional focus should include: the importance and efficacy of vaccines; messages should counteract and dispel erroneous previously held views on vaccines.
- A forum should be established where health care workers can provide information on COVID-19 and other vaccines. This recommendation will help to build trust.
- Sponsoring knowledge-building intervention which should seek to decrease individuals and parents' concerns about vaccination by giving them information about risks in different formats
- Individual-level interventions focusing on improving healthcare workers' confidence and communication skills.
- Multimedia – the creation of short videos showing individuals who contracted a vaccine-preventable disease along with an educational handout addressing common concerns about vaccination.
- Flyers and handouts, social media messages, and posts explaining how members of the public can find reliable and accurate information about vaccines on the internet.
- An intervention that aims to improve Doctors' and Nurses' confidence in communicating with vaccine-hesitant individuals and parents in three different steps: probing, acknowledging, and advising.

Module 1: Introduction and Demography

Introduction

The Ministry of Health (MoH) in partnership with UNICEF implemented a national COVID-19 Hesitancy survey. This survey is expected to contribute to the review and adjustment of the national immunization program to include the soon-to-be-available COVID-19 Vaccine. The Ministry of Health and its partners, as part of the national response to COVID-19, sought to understand the population's perspectives towards possible acceptance of the COVID-19 vaccine when it is available. This undertaking is expected to inform approaches and strategies to ensure uptake of the vaccine at the national, regional, and local levels.

The survey will also determine who the hesitant populations are and what are the enablers and barriers to vaccination uptake for these hesitant populations. It will also contribute to the development and adaptation of a plan of action that considers the unique features and characteristics of the new vaccine. The essential elements that should be included in the plan for the introduction of the new vaccine will be informed by this survey.

Objectives

The objectives of the survey are to help to:

- Inform data-driven approaches to planning, implementing, and evaluating demand strategies.
- Enable the development and adaptation of plans of action that considers the unique features and characteristics of the new vaccine.
- Guide strategic communications activities that promote COVID-19 vaccination and manage expectations.
- Facilitate the building of trust and managing misinformation towards acceptance and uptake of COVID-19 Vaccines.

Methodology and Data Collection

The survey is national in scope, covering all 10 administrative regions. To achieve the objectives, this survey addressed key questions regarding the COVID-19 vaccines. The data provide baseline values for three modules - (Module 1: Demography; Module 2: SAGE Vaccine Hesitancy and Module 3: COVID-19 Vaccine Hesitancy - Knowledge and Attitude.)

A sample of the general population was selected and supplemented by sub-samples of key populations. The general population consisted of persons residing in the 10 administrative regions while the key populations are: persons \geq 60 years old; Healthcare workers and adolescents.

The targeted sample size for the general population is 664 persons which were determined using a sampling table at the 99 % confidence level and 1 % margin of error. The selection of persons \geq 60 years old; Healthcare workers and adolescents were determined purposively.

Three approaches were adopted i.e. Telephone interviews in the coastal regions; client-initiated face-to-face interviews in the hinterland and a self-administered questionnaire on a Survey Monkey platform.

Sampling

A two-stage sampling process was utilized. For the general population, a simple random sampling process was used to select the households that were involved in the survey. For the key populations that were enumerated a cross-sectional stratified sampling was used. (persons from the national population and ≥ 50 persons for each key population over the 10 regions). The sample frame for the national population was the 2012 population and housing Census.

Table 1: Sample size relative to population

| Regions | Population | % of total Pop | # at 99% Conf. |
|---------------------------------|----------------|----------------|----------------|
| Barima-Waini | 27,643 | 4 | 25 |
| Pomeroon-Supenaam | 46,810 | 6 | 42 |
| Essequibo Islands-West Demerara | 107,785 | 14 | 96 |
| Demerara-Mahaica | 311,563 | 42 | 277 |
| Mahaica-Berbice | 49,820 | 7 | 44 |
| East Berbice-Corentyne | 109,652 | 15 | 97 |
| Cuyuni-Mazaruni | 18,375 | 2 | 16 |
| Potaro-Siparuni | 11,077 | 1 | 10 |
| Upper Takutu-Upper Essequibo | 24,238 | 3 | 22 |
| Upper Demerara-Berbice | 39,992 | 5 | 35 |
| | 746,955 | | 664 |

Table 2: Number of additional interviews targeted (

| Categories | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 | Region 7 | Region 8 | Region 9 | Region 10 | # Interviewed |
|-----------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|---------------|
| Persons ≥ 60 years old | 5 | 5 | 5 | 10 | 5 | 5 | 5 | 5 | 5 | 5 | 55 |
| Healthcare workers | 5 | 5 | 5 | 10 | 5 | 5 | 5 | 5 | 5 | 5 | 55 |
| Adolescents | 5 | 5 | 5 | 10 | 5 | 5 | 5 | 5 | 5 | 5 | 55 |
| Total | 15 | 15 | 15 | 30 | 15 | 15 | 15 | 15 | 15 | 15 | 165 |

Data collection

Data were collected using methods relevant to specific areas/regions and key population groups. The exercise sustained the disadvantage of excluding persons who the chosen method was not able to capture. For instance, persons without landline telephones in regions with general landline telephone access.

Data collection was carried out by CAPI (Computer Assisted Personal Interview) method using a mobile application developed on Open Data Kit (ODK) on a tablet which is a set of tools for open-source mobile data collection solutions. The ODK , was used for the development of the form of data collection, data collection on mobile devices, and sending the data to a server.

Coastal Regions 3, 4, 5, 6 & 10

- *Participants were engaged electronically*
- **Telephone interviews** - Households were randomly selected from the directories of landline and the Kobo toolbox was used
<https://ee.humanitarianresponse.info/x/NhKq9jW6>
- **Survey Monkey** was shared by email/WhatsApp to all the email addresses/numbers provided by MoPH and UNICEF. This was used especially to collect data from the key populations.

Hinterland regions, i.e. 1, 2, 7, 8 and 9

Participants were engaged face-to-face

Face-to-face survey participants were selected through a two-stage sampling process. The centres/sites/communities were **purposively** selected while a **simple random sample** was used within the centres/sites/communities to select participants. Every 3rd person, with replacement, to be part of the survey.

- **Client initiated visits (Face-to-face) Hinterland Regions:** Respondents visiting Social, Health care and Community workers, every 3rd person as asked to participate in the survey, with replacement. The responses were also recorded in Kobo toolbox and submitted in real-time to a central repository.
- **Survey Monkey:** A link with the survey was circulated by email and WhatsApp

Research Ethics and informed consent

To ensure that the key ethical principles for the conduct of evaluation involving human subjects are followed, each potential respondent was given full information about the study including the purpose and potential benefits, their rights, and how the information collected will be used. They were also informed that all data will be kept confidential, being only accessible by members of the study team. Verbal consent was collected from all those who agreed to participate. All participants were informed of their right to discontinue their participation at any point and approaches for ensuring confidentiality were described. The responders' names were not required.

Adolescents were required to seek the consent of their parent or guardian after the parent or guardian would have read the survey or would have had the survey read to them. If adolescents selected 'NO' to either of the following questions the survey disappeared from their device.

- Has your parent or guardian to read the survey (or you read it to them)?
- Have you received consent from your parent/guardian?

Quality control

Data checking and validation for completeness and consistency were carried out daily from downloads from KoBo Toolbox, based on the uploaded entries to KoBo collect from the tablets. Data that were deemed inconsistent were highlighted and shared with the relevant supervisors and teams for rectification and cleaning. However, quality control was ensured daily, with corrections to be carried out on a real-time basis within the first 48 hours of data collection.

Data Management and analysis

All quantitative data were analyzed using Excel and Statistical Package for the Social Sciences (SPSS). Based on the raw data, available for download from KoBo Toolbox, a master database was developed, and data cleaning was carried out. A quantitative data framework was set up in Excel for all validated data. A series of frequencies count, percentages, ratios, measures of central tendencies, and variations were employed in the analysis of the data.

Sample Description

Overall, data was collected from 819 respondents. The general population sample comprised 638 respondents, the adolescent sample comprised 55 respondents, and the sixty years and above sample and the health care worker samples each comprised 50 respondents. During the data cleaning process, 26 responses were removed from the general sample mainly due to inaccuracies in data capture.

Typically, female participation in the survey was greater than male participation. Females comprised 69.3% of the general sample, 56.4% of the adolescent sample, 64.0% of the sixty years and above sample, and 84.0% of the health worker's sample.

Table 3: Sample distribution by gender

| | General Sample | | Adolescents | | 60 years and above | | Health workers | |
|--------------|----------------|--------------|-------------|--------------|--------------------|--------------|----------------|--------------|
| | Frequency | Percent | Frequency | Percent | Frequency | Percent | Frequency | Percent |
| Female | 442 | 69.3 | 31 | 56.4 | 32 | 64.0 | 42 | 84.0 |
| Male | 196 | 30.7 | 24 | 43.6 | 18 | 36.0 | 8 | 16.0 |
| Total | 638 | 100.0 | 55 | 100.0 | 50 | 100.0 | 50 | 100.0 |

The mean age group in the general sample is 43.8 years and the modal age category is the 40-49 years age group. The mean age of the adolescent sample is 16.09 years. The median and modal age are 17 years. The mean age for girls is 16.10 (95% C.I. for the mean: lower bound 15.30 and upper bound 16.89). The median age for girls is 16.00 and the modal age is 17. The mean age for boys is 16.08 (95% C.I. for the mean: lower bound 14.87 and upper bound 17.30). The median age for boys is 17.0 years and the modal age is 18 years. There was no significant difference in the mean age of girls and boys in the sample. Despite the numerical dominance in the sample girls had a lower median (see box plot below) and modal ages.

Figure 1: Sample distribution by age category

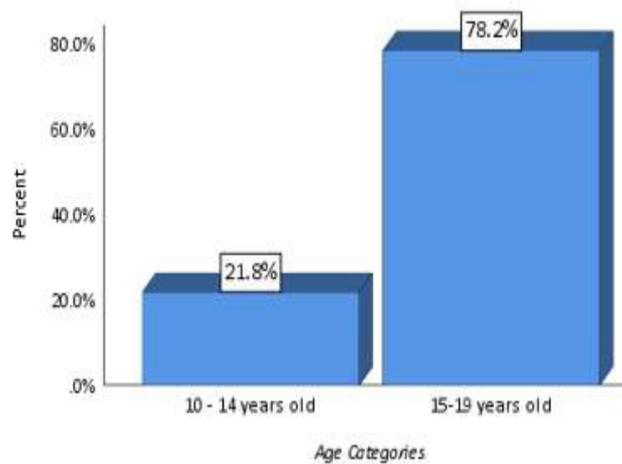
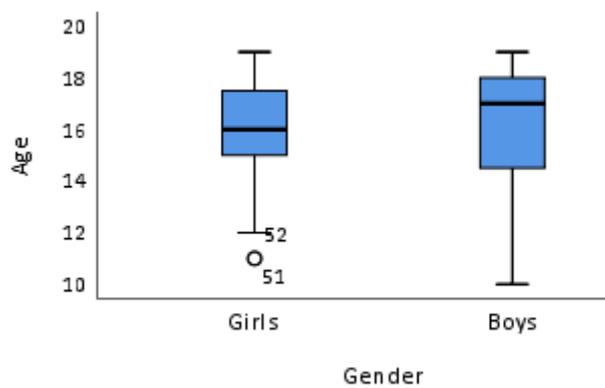


Figure 2: Box Plot gender and age of respondents



The mean age of the sixty years and over sample is 69.3 years and the mean age of the health care workers sample is 34.2 years.

Regional disaggregation of the general sample reveals that Region 4 comprised 40.9% of all respondents. Region 3 and Region 6 comprised 14.4% and 14.6% of the sample, respectively. Regions 2, 5, and 10 comprised 6.6%, 6.6%, and 5.4% of the sample, respectively. Regions 1, 7, 8, and 9 comprised 2.8%, 2.7%, 1.6%, and 4.6% of the sample, respectively.

For the adolescents' sample, Region 4 was the most represented region comprising 20.0% of the adolescent sample. Similarly, in the sixty years and above sample, Region 4 respondents were 24.0% of this sample, and Region 4 respondents comprised 40.0% of the health care workers' sample. The health care worker sample did not have any respondent from Regions 6 and 8.

Table 4: Sample distribution by Region

| Region | General Sample | | Adolescents | | 60 years and above | | Health workers | |
|--------------|----------------|--------------|-------------|--------------|--------------------|--------------|----------------|--------------|
| | Frequency | Percent | Frequency | Percent | Frequency | Percent | Frequency | Percent |
| Region 1 | 18 | 2.8 | 6 | 10.9 | 1 | 2.0 | 2 | 4.0 |
| Region 2 | 42 | 6.6 | 7 | 12.7 | 3 | 6.0 | 3 | 6.0 |
| Region 3 | 91 | 14.4 | 3 | 5.5 | 4 | 8.0 | 13 | 26.0 |
| Region 4 | 259 | 40.9 | 11 | 20.0 | 12 | 24.0 | 20 | 40.0 |
| Region 5 | 42 | 6.6 | 5 | 9.1 | 4 | 8.0 | 2 | 4.0 |
| Region 6 | 92 | 14.5 | 4 | 7.3 | 6 | 12.0 | 0 | 0.0 |
| Region 7 | 17 | 2.7 | 5 | 9.1 | 5 | 10.0 | 3 | 6.0 |
| Region 8 | 10 | 1.6 | 5 | 9.1 | 5 | 10.0 | 0 | 0.0 |
| Region 9 | 29 | 4.6 | 3 | 5.5 | 5 | 10.0 | 2 | 4.0 |
| Region 10 | 34 | 5.4 | 6 | 10.9 | 5 | 10.0 | 5 | 10.0 |
| Total | 634 | 100.0 | 55 | 100.0 | 50 | 100.0 | 50 | 100.0 |

Figure 3: Number of respondents by region in the adolescent sample



The most frequently occurring education level reported by sample respondents in the general and adolescent sample is 'secondary complete'. In the general sample, 43.0% of respondents from the general sample and 43.6% from the adolescent sample communicated that they completed secondary education. For the sixty years and above sample, 'primary complete' (32.0%) is the most frequently occurring educational achievement. The health workers sample reported 84.0% of the sample completing higher education.

Table 5: Sample distribution by Education Level

| Education Level | General Sample | | Adolescents | | 60 years and above | | Health workers | |
|----------------------|----------------|---------|-------------|---------|--------------------|---------|----------------|---------|
| | Frequency | Percent | Frequency | Percent | Frequency | Percent | Frequency | Percent |
| Higher | 131 | 20.6 | 3 | 5.5 | 9 | 18.0 | 42.0 | 84.0 |
| No formal schooling | 6 | 0.9 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Primary complete | 73 | 11.5 | 3 | 5.5 | 16 | 32.0 | 0 | 0.0 |
| Primary incomplete | 27 | 4.3 | 3 | 5.5 | 3 | 6.0 | 0 | 0.0 |
| Secondary complete | 273 | 43.0 | 24 | 43.6 | 15 | 30.0 | 8 | 16.0 |
| Secondary incomplete | 125 | 19.7 | 22 | 40.0 | 7 | 14.0 | 0 | 0.0 |
| Total | 635 | 100.0 | 55 | 100.0 | 50 | 100.0 | 50.0 | 100.0 |

For the general sample, the most frequently occurring marital status is married (42.7%). This was the same for the sixty years and above sample (40.0%) and the health workers sample (52.0%). Ninety-six-point four percent of the adolescent sample were single.

Table 6: Sample distribution by Marital Status:

| Marital Status | General Sample | | Adolescents | | 60 years and above | | Health workers | |
|-----------------|----------------|---------|-------------|---------|--------------------|---------|----------------|---------|
| | Frequency | Percent | Frequency | Percent | Frequency | Percent | Frequency | Percent |
| Divorce | 24 | 3.8 | 0 | 0.0 | 3 | 6.0 | 2 | 4.0 |
| Living together | 76 | 12.0 | 1 | 1.8 | 3 | 6.0 | 4 | 8.0 |
| Married | 271 | 42.7 | 1 | 1.8 | 20 | 40.0 | 26 | 52.0 |
| Separated | 22 | 3.5 | 0 | 0.0 | 2 | 4.0 | 1 | 2.0 |
| Single | 194 | 30.6 | 53 | 96.4 | 5 | 10.0 | 17 | 34.0 |
| Widow/Widower | 48 | 7.6 | 0 | 0.0 | 17 | 34.0 | 0 | 0.0 |
| Total | 635 | 100.0 | 55 | 100.0 | 50 | 100.0 | 50 | 100.0 |

Module 2: Vaccine Hesitancy

Vaccines are among the most effective prevention tools against infectious diseases. However, it is evident from social media that there is a burgeoning distrust in the vaccine as an effective public health measure against infectious disease. Public health experts use the term vaccine hesitancy to describes the situation where individuals delay acceptance or refuse vaccines despite the availability of vaccine services. The European Centre for Disease Prevention and Control defines vaccine hesitancy in this manner:

Vaccine hesitancy is defined as a behavior, influenced by several factors including issues of confidence (level of trust in vaccine or provider), complacency (do not perceive a need for a vaccine, do not value the vaccine), and convenience (access). (ECDC 2015, 1).

In examining vaccine hesitancy respondents were first asked whether they felt that vaccines can protect them from serious diseases. Analysis of the data from the four samples indicates that there was a widespread belief that vaccines can protect from serious diseases. From the general sample, 86.8% of respondents stated that they believed that vaccines could protect them from serious diseases. Among adolescents sampled, 89.1% were of the view that vaccines can protect them from serious diseases and 88.0% of respondents from the sixty years and above sample and 94.0% of health workers were of the view that vaccines can protect them from serious diseases.

Table 7: Perception of whether vaccines can protect you from serious disease

Do you believe that vaccines can protect you from serious diseases?

| Response | General sample | Adolescent sample | Sixty years and above sample | Health workers sample |
|--------------|----------------|-------------------|------------------------------|-----------------------|
| | % | % | % | % |
| Yes | 86.8 | 89.1 | 88.0 | 94.0 |
| No | 13.2 | 10.9 | 12.0 | 6.0 |
| Total | 100.0 | 100 | 100.0 | 100.0 |

Figure 4: Respondents perception of whether vaccines can protect them from serious diseases

In the general sample, the chart below shows that there is only a small difference among males and females with regards to their perspectives on whether vaccines can protect them from diseases. The data make clear 87.4% of males and 86.6% of females were of the view that vaccines can protect them from serious diseases. Regional comparisons reveal that in general belief that vaccines can protect someone from diseases was high. However, of

concern was Region 10 where only 67.6% of respondents were of the view that vaccines can protect someone from serious diseases.

Figure 5: Comparison between Male and Female Respondents on the perception of whether vaccines can protect them from serious diseases

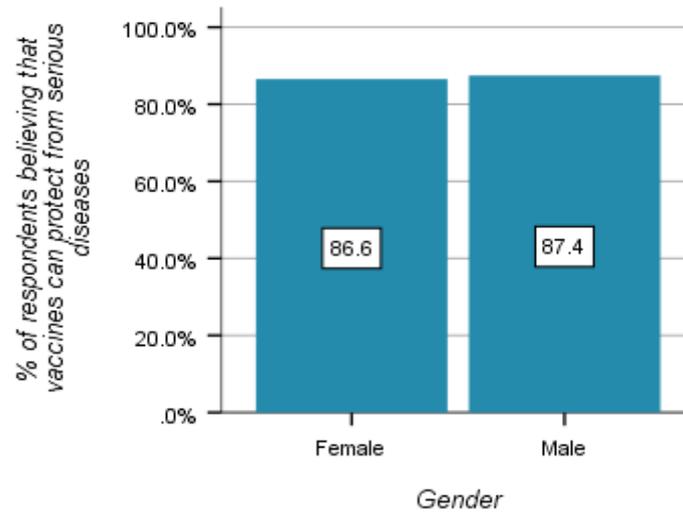
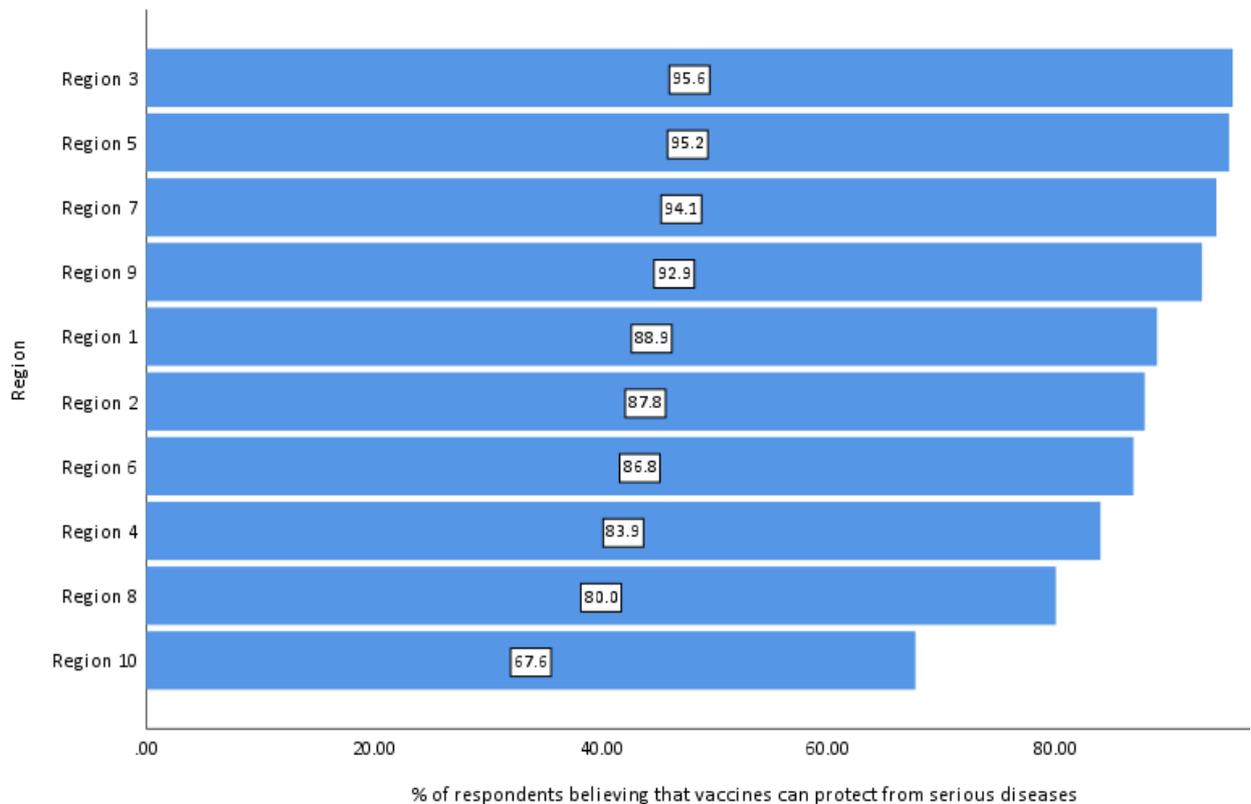


Figure 6: Regional Comparisons of Respondents' views on whether vaccines can protect them from diseases



An exceedingly small percentage of respondents from the general sample, the sixty years and above, and the health workers samples reported that in the past they hesitated or

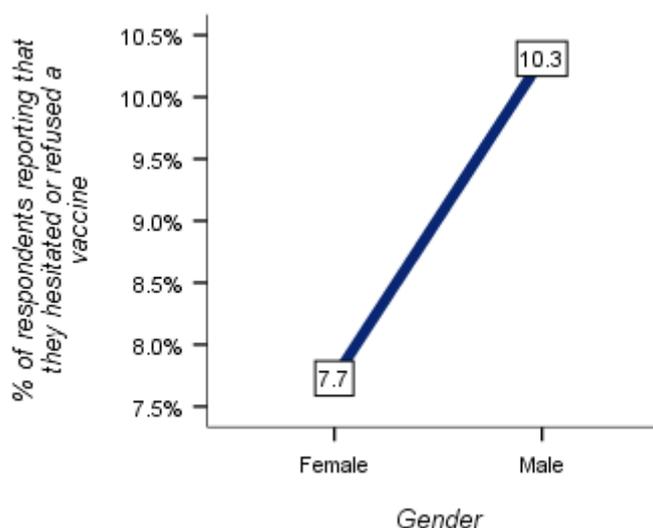
refused to get a vaccination for themselves or child/children. Hesitation or refusal to take a vaccine was comparatively higher in the adolescent sample reaching 16.7%.

In the general sample, gender comparisons point to more males (males 10.3% and females 7.7%) reporting that in the past they hesitated or refused to get a vaccination - either for themselves or their child/children.

Table 8: Have you ever hesitated or refused to get a vaccination

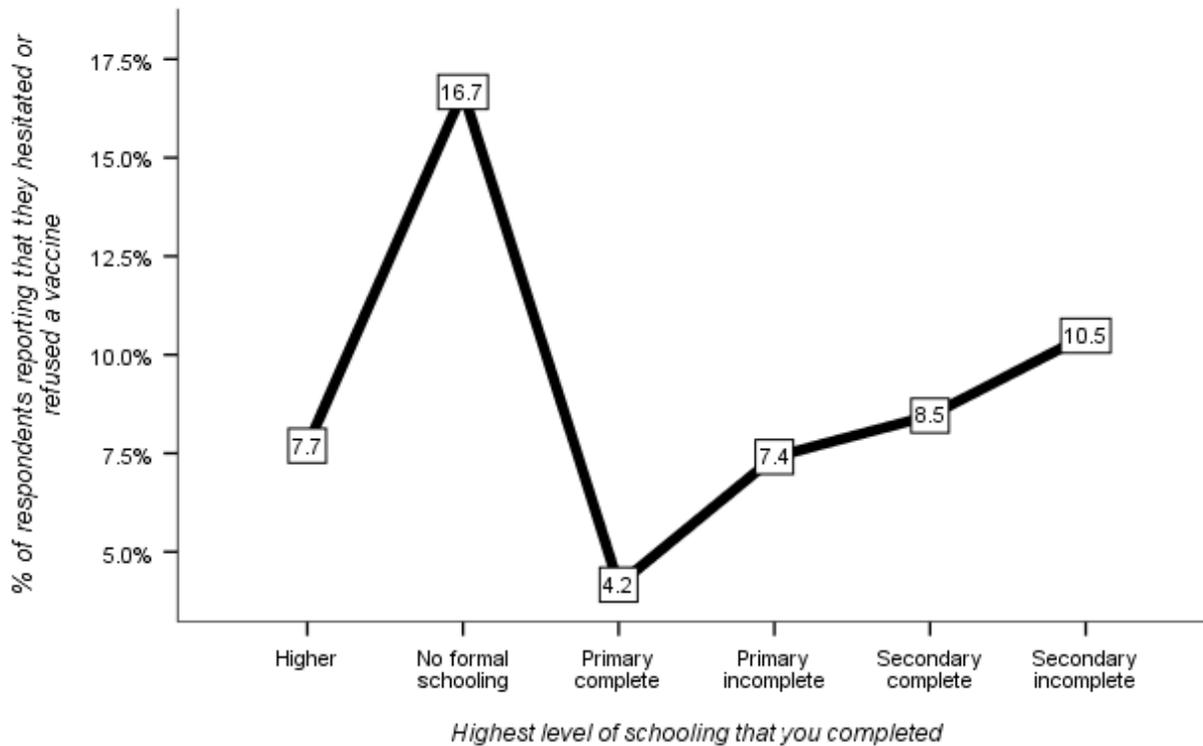
| <i>Have you ever hesitated or refused to get a vaccination - either for yourself or your child if you have one?</i> | | | | |
|---|----------------|-------------------|------------------------------|-----------------------|
| Response | General sample | Adolescent sample | Sixty years and above sample | Health workers sample |
| | % | % | % | % |
| No | 91.5 | 83.3 | 94.0 | 94.0 |
| Yes | 8.5 | 16.7 | 6.0 | 6.0 |
| Total | 100.0 | 100 | 100.0 | 100.0 |

Figure 7: Gender comparisons of respondents who in the past hesitated or refused to get a vaccination - either for themselves or their child/children



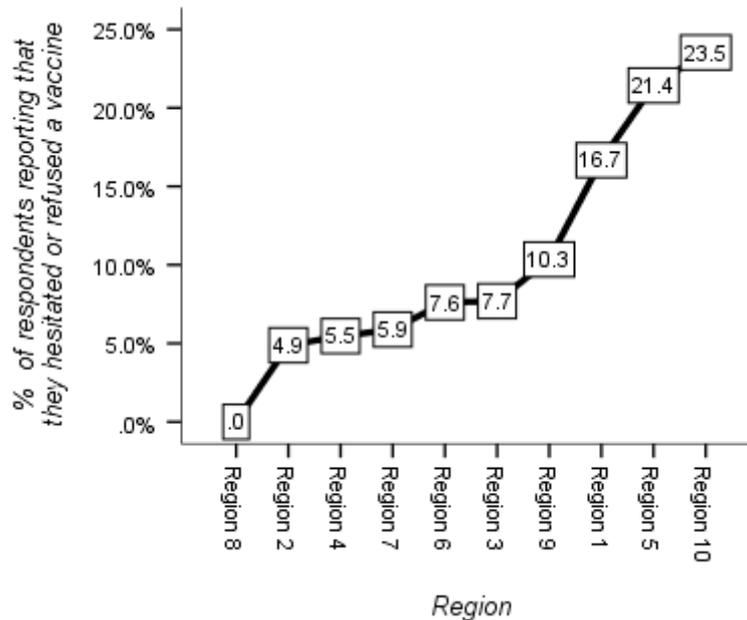
Another important finding relates to education level, where analysis of the general sample shows that 16.7% of respondents with 'no formal education' reporting that in the past they hesitated or refused to get a vaccination - either for themselves or their child/children. This proportion is almost twice the prevalence of this phenomenon in the sample.

Figure 8: Comparisons of respondents who in the past hesitated or refused to get a vaccination - either for themselves or their child/children by educational achievements



Regional comparisons point to Region 5 and Region 10 as regions with somewhat disturbing proportions of respondents mentioning that in the past they hesitated or refused to get a vaccination - either for themselves or their child/children. The data show that the prevalence of this phenomenon is roughly two and a half times the sample proportion.

Figure 9: Regional comparisons of respondents who in the past hesitated or refused to get a vaccination - either for themselves or their child/children



Lack of relevant knowledge of the efficacy of vaccines, past experiences, perception of risk and lack of trust in vaccination programs, subjective fears, and belief were the main themes embedded in the open-ended responses as to why respondents in past hesitated or refused to get a vaccination - either for themselves or their child/children. One of the respondents remarks that he/she refused to take the vaccine because of “inadequate information about the vaccine.” Another says that they “fear of taking vaccines, the pain and side effects” were the reasons why he/she refused vaccines. “I wasn’t sure about the vaccine and if it was really good” retorts one respondent.

Another claimed that “I heard rumours of the vaccine, so I didn't want it, I was unsure of the side effects.” One respondent narrates:

“Only once did I refuse, and it was because I saw someone get sick after taking it. Cannot remember the name of the vaccine.”

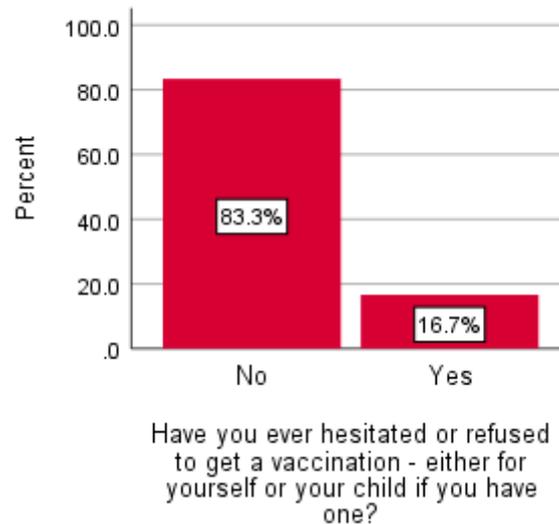
Interestingly, another respondent explains.

“[the] HPV, it was given for school-age children. Because I wasn't knowledgeable on the vaccine, I refuse for my child to take it.”

Despite the data revealing that adolescents demonstrated marginally higher confidence in vaccines being able to protect people from diseases when compared to the general sample, their data reflect a higher proportion of respondents hesitating or refusing to get the vaccination. The adolescents' sample data indicate that 16.7% of adolescents said they have hesitated or refused to get a vaccine either for themselves or a child within their care. Open-ended responses point to the following reasons for vaccine hesitancy among adolescents.

- i. The belief that vaccination is unsafe and may harm the individual and/or family in some way.
- ii. The belief that vaccines have serious side effects and that it is better to use natural/organic substances to help strengthen their immune system instead.
- iii. The belief that some vaccines are unnecessary. E.g. babies taking HBV vaccine at birth
- iv. “Belief that that God can heal them. And man can’t.”

Figure 10: Respondents who hesitated or refused to take vaccines for themselves or child/children



Overwhelming the data show that there was a high positive characterization of vaccines. In the general sample, 87.4% of respondents characterized vaccines as either important, safe, or efficient. Among adolescents, 81.4% of respondents characterized vaccines as either important, safe, or efficient, and among respondents from the sixty years and above samples and health workers sample 76.0% of respondents and 100.0% of health workers opined that that vaccine were efficient, important, or safe. It should also be noted that there was a worrying level of ambivalence concerning the characterisation of vaccines among the sixty years and above sample (20.0%).

Table 9: Respondents perception of the characteristics of vaccines

| Which of the following characteristics do you think apply to vaccines in general? | | | | |
|---|----------------|-------------------|------------------------------|-----------------------|
| Response | General sample | Adolescent sample | Sixty years and above sample | Health workers sample |
| | % | % | % | % |
| Efficient | 7.9 | 22.2 | 6.0 | 50 |
| Important | 49.5 | 33.3 | 40.0 | 36 |
| Inefficient | 0.5 | 1.9 | 0 | 0 |
| Neither good or bad | 11.2 | 14.8 | 20.0 | 0 |
| Safe | 30.0 | 25.9 | 30.0 | 14 |
| Unimportant | 0.2 | 0.0 | 2.0 | 0 |
| Unsafe | 0.8 | 1.9 | 2.0 | 0 |
| Total | 100.0 | 100.0 | 100.0 | 100 |

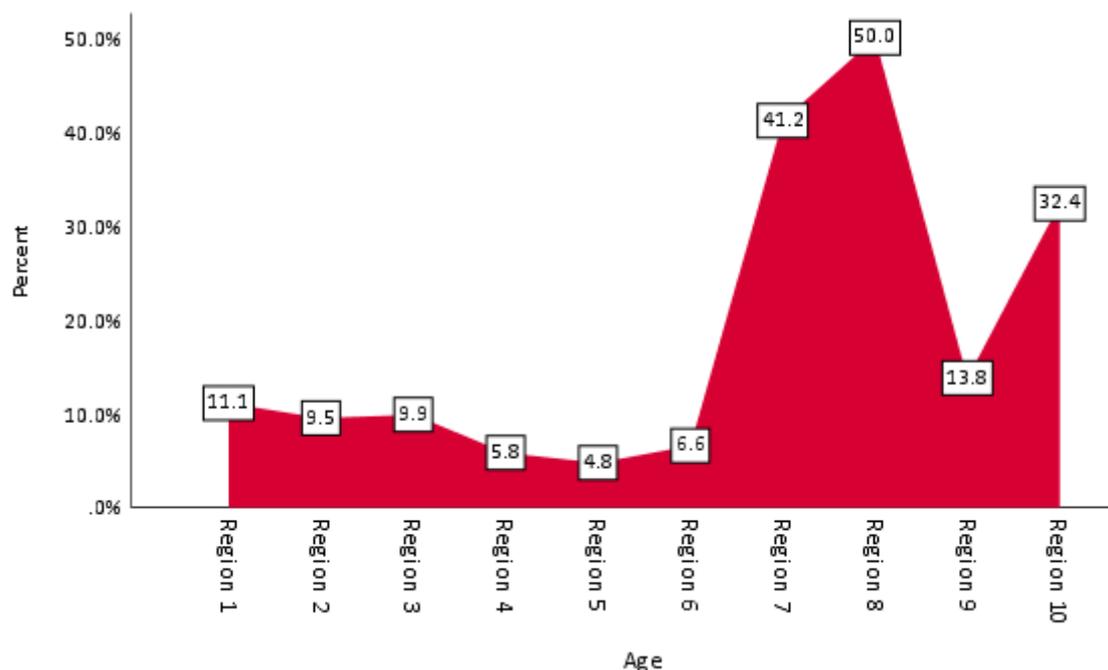
The survey found only a small proportion of respondents reporting that they know someone who does not take vaccines because of cultural and religious reasons except the health worker sample where 26.5% of respondents said they knew someone does not take a vaccine because of religious or cultural reasons. As is observed from the data only 10.2% of respondents claim that they know someone who does not take vaccines because of cultural or religious reasons.

Table 10: Do you know anyone who does not take a vaccine because of religious or cultural reasons?

| Do you know anyone who does not take a vaccine because of religious or cultural | | | | |
|---|----------------|-------------------|------------------------------|-----------------------|
| Response | General sample | Adolescent sample | Sixty years and above sample | Health workers sample |
| | % | % | % | % |
| No | 91.5 | 90.7 | 94.0 | 73.5 |
| Yes | 8.5 | 9.3 | 6.0 | 26.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |

Relative to the sample proportion (8.5%), the regional comparison of the general sample reveals troubling statistics regarding the proportion of respondents who knew someone who does not take vaccines because of religious reasons. It is observed from the data that 41.2% of respondents from Region 7, 50.0% of respondents in Region 8, and 32.4% of respondents from Regions 10 stated that they know someone who does not take vaccines because of cultural or religious reasons. Some of the issues identified through open-ended interrogation include: "Culture of bush medicine", "Preference for the use the herb", and "[individuals] don't take any foreign substance into their body including blood."

Figure 11: Regional Comparisons of proportions of respondents reporting that they know someone who does not take vaccines because of religious reasons



It is further observed from the data that a very sizeable proportion of respondents felt that people who refuse vaccines for cultural and religious reasons are risking their health and the health of their families by not taking the vaccine. Overall, 79.7% of respondents from the general sample, 80.8% of adolescents, 55.3% of respondents from the sixty years and above sample, and 84.4% of the respondents from the health workers sample felt that people who refuse vaccines for cultural and religious reasons are risking their health and the health of their families by not taking the vaccine.

Table 11: Respondents perception on whether a person who does not take vaccines risk their health and their families

| <i>Do you think they are risking their health or the health of their family by not taking the</i> | | | | |
|---|----------------|-------------------|------------------------------|-----------------------|
| Response | General sample | Adolescent sample | Sixty years and above sample | Health workers sample |
| | % | % | % | % |
| No | 20.3 | 19.2 | 44.7 | 15.6 |
| Yes | 79.7 | 80.8 | 55.3 | 84.4 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 |

Module 3: COVID-19 Vaccine Hesitancy - Knowledge and Attitude

Survey data show widespread awareness of the COVID-19 vaccine with 97.6% of respondents from the general sample relating that they heard of the COVID-19 vaccine. Across all the samples respondents were aware of the COVID-19 vaccine. Eighty-four point nine percent (84.9%) of adolescents, 98.0% of respondents sixty years or older, and 94.0% of health workers.

Table 12: Have you heard of the COVID-19 Vaccine

| General sample | Adolescents | Sixty years or older | Health workers |
|----------------|-------------|----------------------|----------------|
| 97.6% | 84.9% | 98.0% | 94.0% |

Health workers generally saw themselves as part of the high-risk group for COVID-19. As is gleaned from the data, 74.0% of health workers considered themselves as part of the high-risk group to COVID-19. Further, 65.3% of respondents sixty years or older felt they were part of the high-risk group to COVID-19. Adolescents were least likely among the four groups to see themselves as being part of the high-risk group.

Table 13: Percentage of respondents who view themselves as part of the high-risk group for COVID-19

| General sample | Adolescents | Sixty years or older | Health workers |
|----------------|-------------|----------------------|----------------|
| 59.7% | 51.9% | 65.3% | 74.0% |

For respondents who did not consider themselves at risks, their rationale can be classified in seven (7) thematic areas: (i) perception that they have a strong immune system, (ii) adoption of healthy lifestyle practices and use of natural remedies, (iii) young and therefore not at risk, (iv) following COVID-19 prevention guidelines, (v) limiting social interaction, (vi) Absence of underlying medical conditions, and (vii) trust in God

Below we capture some statements

| Themes | Selected Statement made by Respondents |
|---|---|
| Thinking they have a strong immune system | My immune system is strong Not sickly Has a good resistance and can fight the bacteria |
| Adoption of healthy lifestyle practices and use of natural remedies | Eat healthily Taking bush medications Because I am building my immune system and I am not suffering from any health conditions. Using herbs Use a lot of herbs and eat healthily |

| | |
|--|---|
| | |
| Age | Because of her age (not over 60) Am younger Only persons with other medical issues and above 60 are considered high-risk I am young |
| Adopting COVID-19 prevention guidelines | Following the COVID-19 19 guidelines Because I adhere to the guidelines. Taking precaution |
| Limiting social interaction | Because I don't live near a lot of people BECAUSE I STAY AWAY FROM PEOPLE At home all the time I do not go out unless it is important. I'm mostly at the farm with no other person. Always at home and if she goes, she wears her mask. Unsure who might be infected (asymptomatic), don't usually be out where there are large groups of people. |
| Absence of underlying medical conditions | I do not suffer from any underlying illness It only seriously affects persons with other medical issues No NCDS, YOUNG AGE |
| Religious- trust in God. | Trusting God for protection Have good health and strength and the Lord. Trusting God |

Can a person who is not sick or who does not show symptoms spread the coronavirus? The survey assesses respondents' views on this question and found that 71.0% of respondents from the general sample said 'yes' pre-symptomatic and asymptomatic people could spread the disease. This statistic was significantly lower among adolescents with 57.4% saying they can spread the coronavirus.

Table 14: A person who is not sick or who does not show symptoms cannot spread the coronavirus

| General sample | Adolescents | Sixty years or older | Health workers |
|----------------|-------------|----------------------|----------------|
| 71.0% | 57.4% | 70.0% | 65.3% |

A sizeable majority of the respondents sampled were of the view that vaccines can strengthen the immune system. According to the data from the general sample 71.6% of respondents from the general were of the view that vaccines can strengthen the immune system. Among adolescents, 88.9% were of the view that vaccines can strengthen the immune system. Belief that vaccines can strengthen the immune system was lowest among persons sixty years or older (52.0%) and highest among health care workers (93.9%).

On the other hand, 23.2% of respondents from the general sample said they did not know if the vaccine can strengthen the immune system. This statistic is indicative of the need for more information on the way vaccines work. Supporting evidence reflecting that there is a need for more information to members of the public on how vaccines work is uncovered in the survey where it is found that only 34.3% of respondents from the general sample, 29.6% of adolescents, and 38.0% of respondents sixty years and older saying that they did not get enough information on vaccines in general and on their safety. Even among health care workers the challenge persists with only 60.0% saying that get enough information on vaccine and their safety.

Figure 12: Do you think vaccines strengthen the immune system?

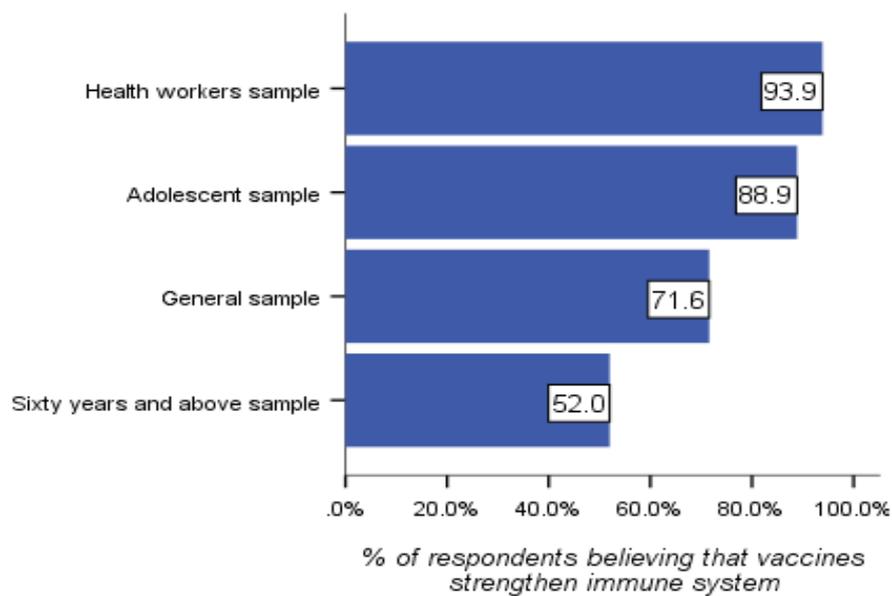
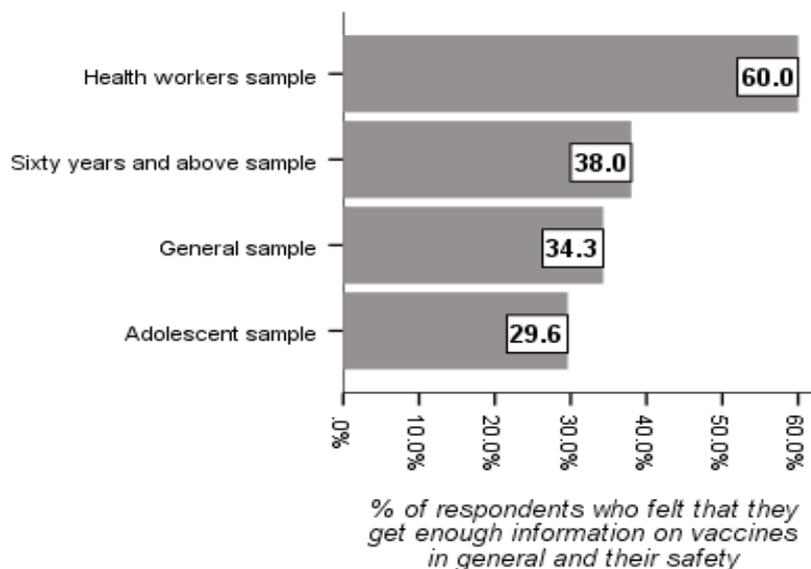


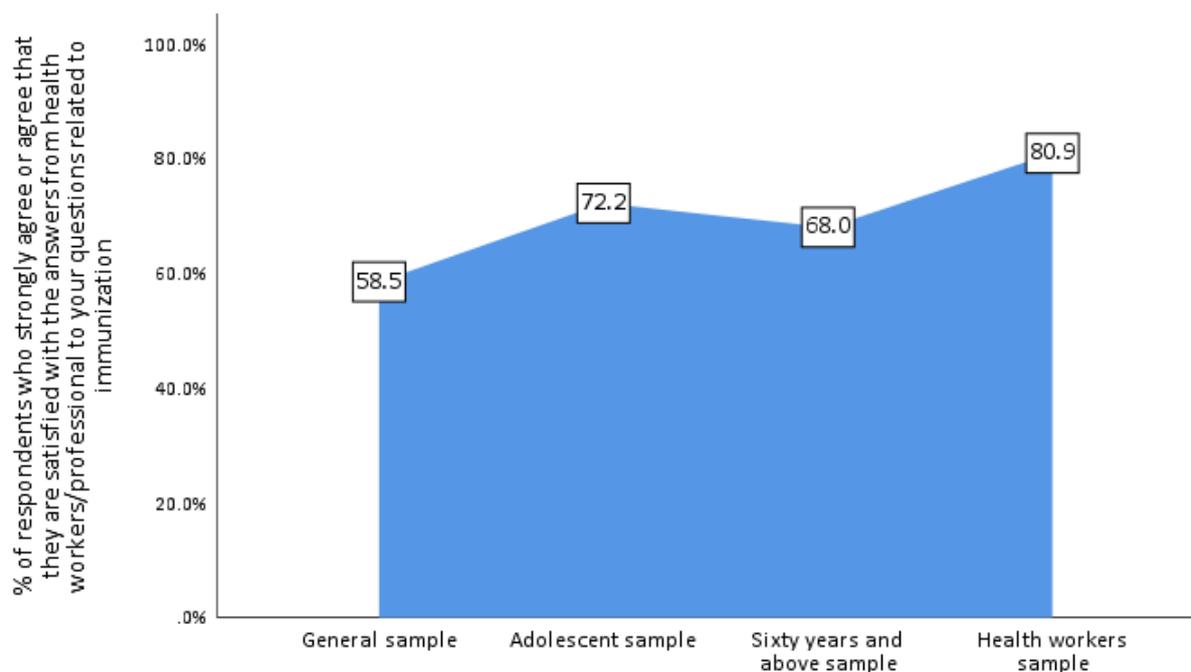
Figure 13: Do you feel you get enough information on vaccines in general and their safety



Respondents' perception that they did not have enough information on vaccines in general and on their safety may be linked to respondents believing that there are better ways to prevent diseases than vaccines. Statistical test unearthed an association between respondents' perception of the adequacy of information they have on vaccines and their safety and their perception of whether they are better ways to prevent diseases than vaccines ($\chi^2(1) = 13.974, p = 0.001$). Further, the data show that 52.3% of respondents who felt they lacked information on vaccines and their safety believed that there are better ways to prevent diseases other than vaccines, while on the other hand only 37.2% of respondents who said 'yes' they are getting enough information on vaccines felt there were better ways than vaccines to prevent diseases.

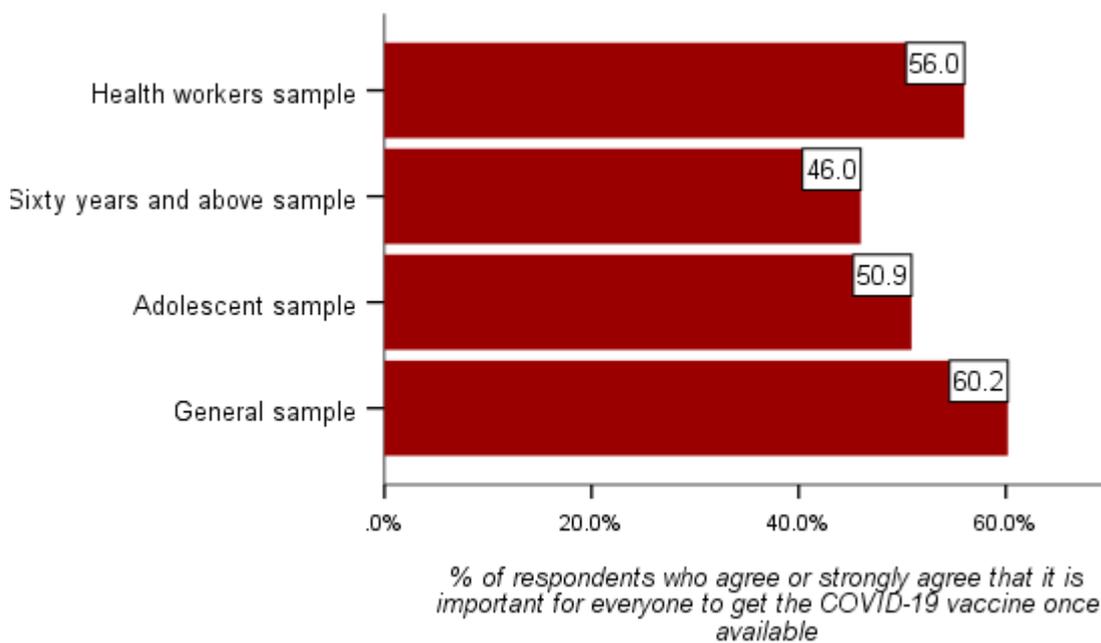
A moderately large proportion of respondents reported that they were satisfied with the health professional/health worker's answers to my questions related to immunization. The analysis reveals that 58.5% of respondents from the general sample were satisfied with health professional/health worker's answers to their questions related to immunization. This statistic suggests that there is a need for standardized information on immunization to be made available both for health workers and the public. Among the other groups sampled this situation is not as demanding with 72.2% of adolescents, 68.0% of respondents sixty years and older, and 80.9% of health care workers indicating that were satisfied with the answers from health workers/professional to their questions related to immunization

Figure 14: Are you satisfied with the answers from health workers/professional to your questions related to immunization



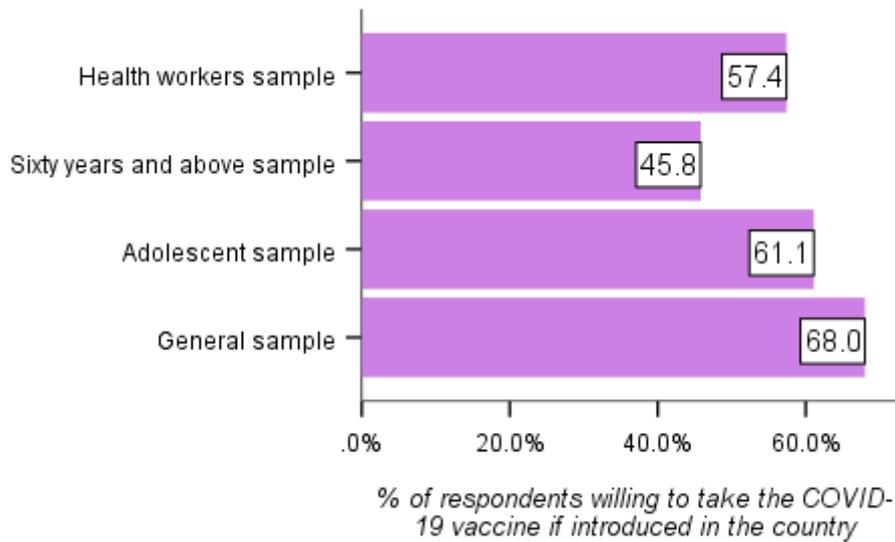
The survey does not provide evidence of widespread support for the COVID-19 vaccine. According to the data, 60.2% of the general sample either agreed or strongly agreed that it was important for everyone to get the COVID-19 vaccine once available. This can be interpreted as moderate support among the population for the COVID-19 vaccines. On the lower end of the spectrum, only 46.0% of respondents from the sixty years or older age group were of the view that everyone needs to get the COVID-19 vaccine once it is available. Figures for the adolescents and health workers sample are below the general sample but still around the midway range (50.9% for adolescents and 56.0% for health workers).

Figure 15: *is important for everyone to get the COVID-19 vaccine once available. Do you ...?*



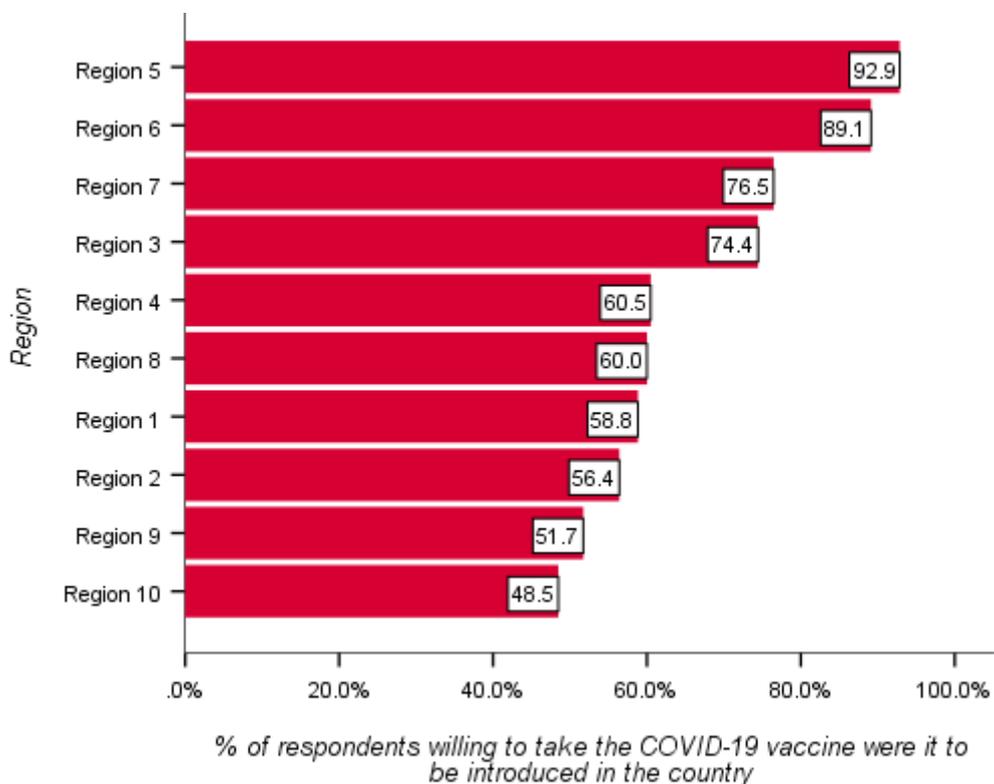
Probably the most important finding of the survey is that 68.0% of respondents from the general sample said that they would take the COVID-19 vaccine if it is introduced in the country. Percentages of respondents from the other samples expressing their willingness to take the COVID-19 vaccine was disturbingly lower than the statistics for the general family. Only 57.4% of health workers expressed willingness to take the COVID-19 vaccine, and only 45.8% of respondents sixty years or older demonstrated any willingness to take the COVID-19 vaccine. Among adolescents, 61.1% of respondents voiced their willingness to take the COVID-19 vaccine.

Figure 16: If a COVID-19 vaccine were to be introduced in the country, would you take the vaccine?



It is observed from the general sample that there were high potential acceptance rates for the COVID-19 vaccine in Regions 5, 6, 7, and 3. In Region 5, 92.9% of the sample uttered their willingness to take the COVID-19 vaccine. Potential acceptance of the COVID-19 vaccine was lowest in Region 10.

Figure 17: Regional comparisons on respondents' willingness to take the COVID-19 vaccines - General sample



Among the adolescent and sixty years or older samples, potential acceptance rates differed from the general sample. Among adolescents, potential acceptance of the COVID-19 vaccine was exceptionally high at a perfect 100% in Region 9 and relatively high in Region 7 at 80.0%. For the sixty years or older sample, Region 3 had the highest potential acceptance of COVID-19 vaccine rate (100.0%) and Region 10 had the lowest (20.0%).

Figure 18: Regional comparisons on respondents' willingness to take the COVID-19 vaccines - Adolescents sample

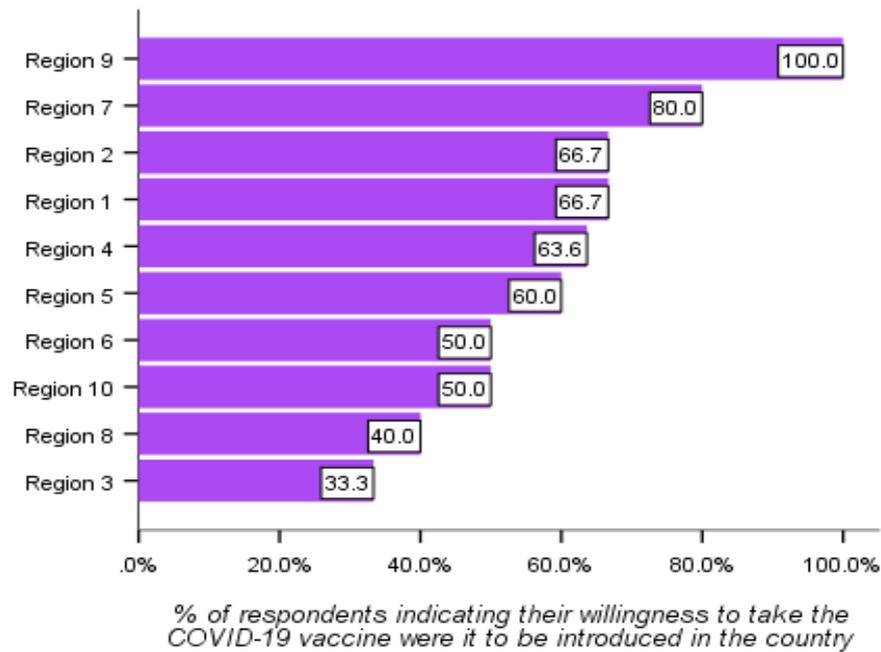
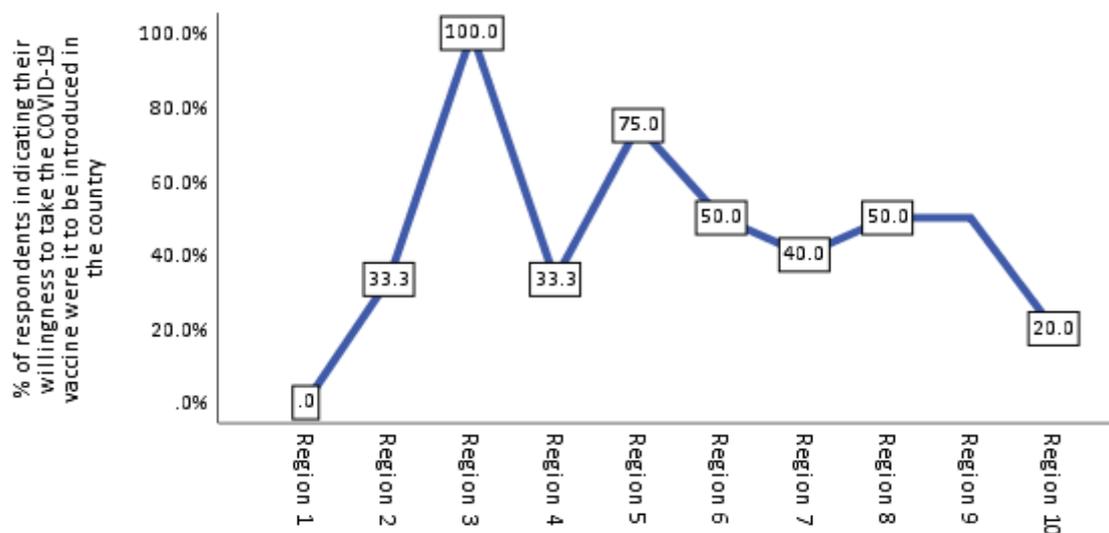
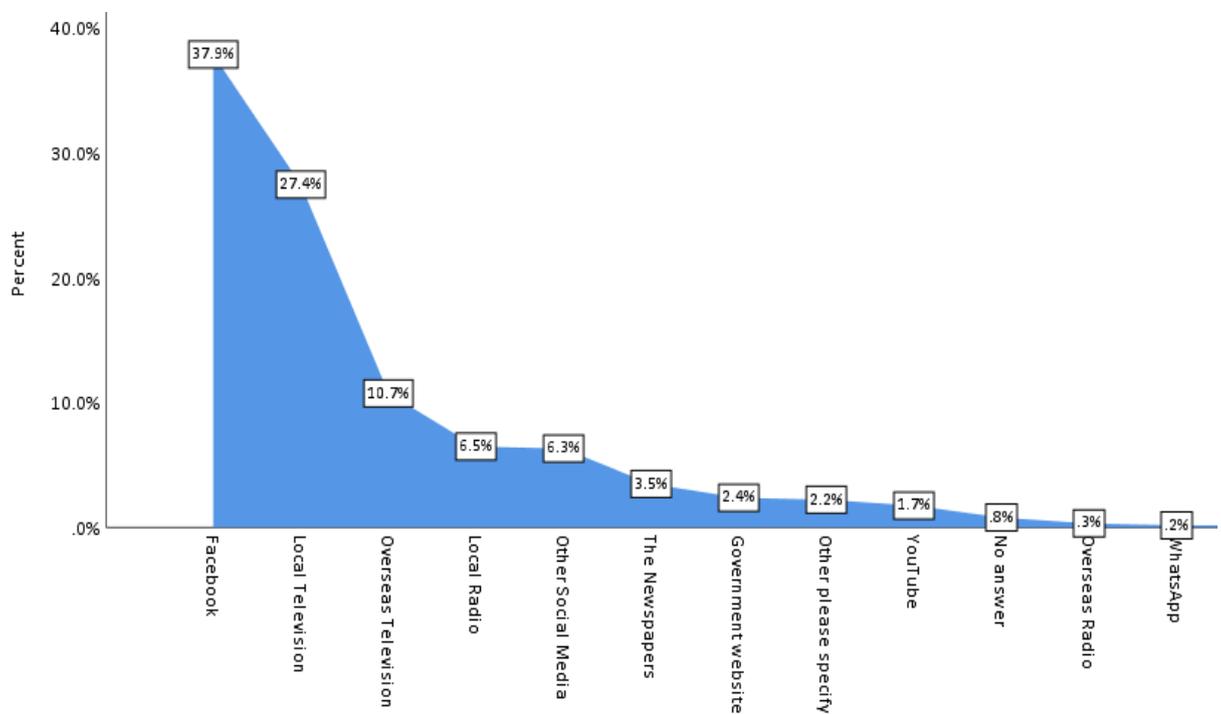


Figure 19: Regional comparisons on respondents' willingness to take the COVID-19 vaccines – Sixty years or older sample



It is gleaned from the general sample data that Facebook and local television were the most important sources of information on COVID-19 for respondents. For adolescents, Facebook and overseas television were their main sources of information on COVID-19, for the sixty years and above sample local and overseas television were the main sources of information on COVID19, and for health worker government website and overseas television were the main sources of information on COVID-19. This finding points to the important role these media can play in sharing accurate information on the COVID-19 vaccine and counteracting misinformation.

Figure 20: What is the most common information source you turn to, for information on COVID-19? – General sample



The most common information source respondents turn to, for information on COVID-19

Figure 21: What is the most common information source you turn to, for information on COVID-19? – Adolescent sample

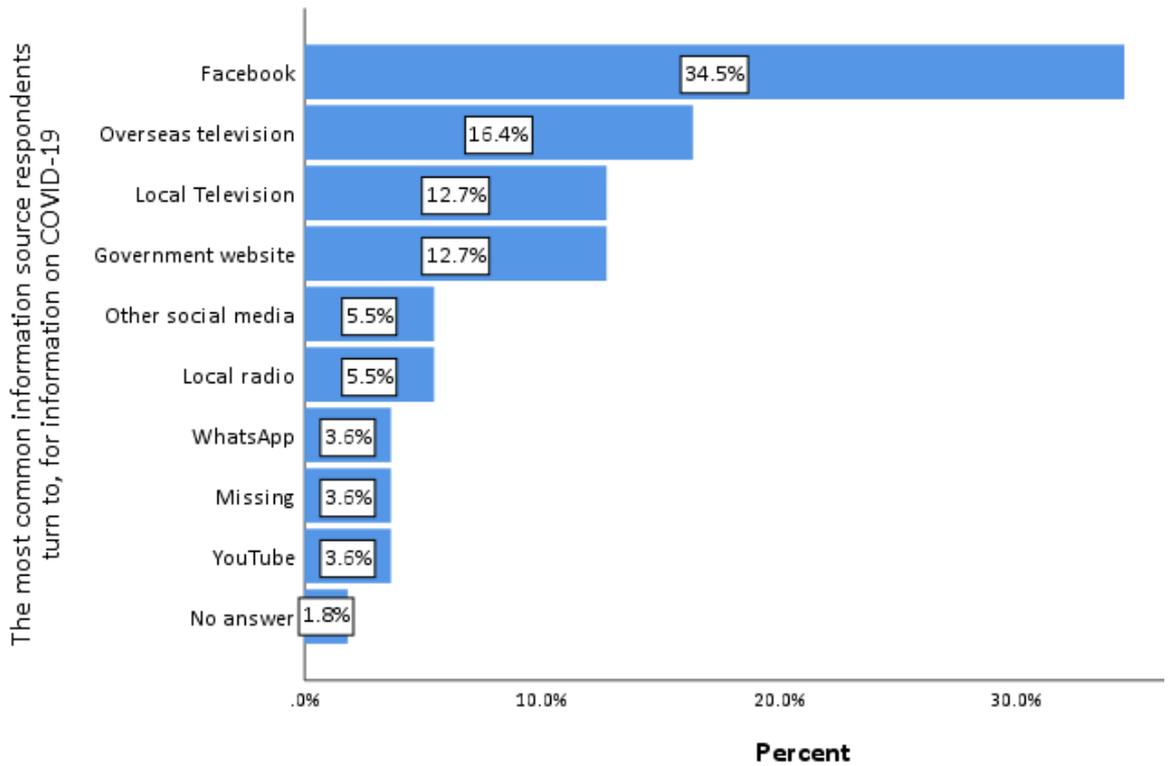


Figure 22: What is the most common information source you turn to, for information on COVID-19? – Sixty years or older sample

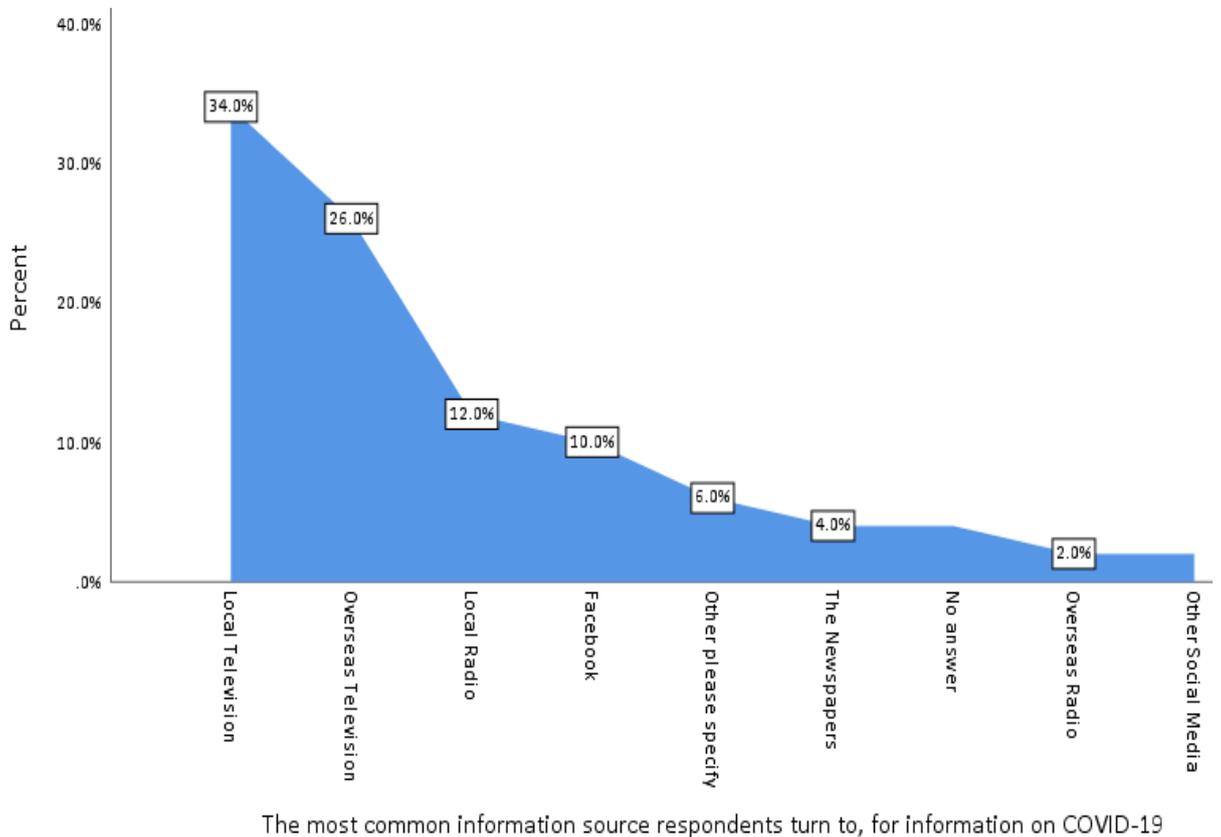
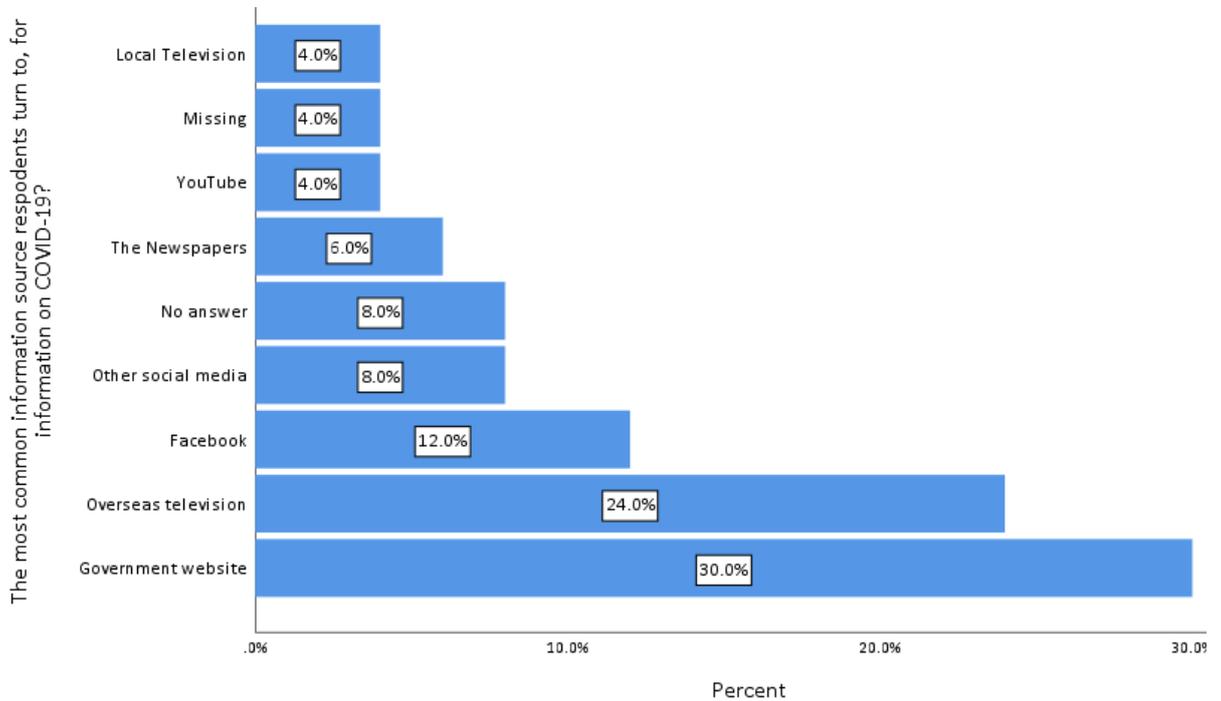


Figure 23: What is the most common information source you turn to, for information on COVID-19? – Health workers’ sample



Further, respondents expressed difficulties determining the veracity of COVID-19 vaccine-related information. Only 40.5% of respondents either agree or strongly agree that it is difficult deciding which information on the Coronavirus vaccine was real, false or rumour. For adolescents, the situation was worst with 66.7% of respondents claiming that it is difficult deciding which information on the Coronavirus vaccine was real, false or rumour

Table 15: Percentage of respondents claiming that have a hard time figuring out what information they receive about the COVID-19 vaccine is real, fake or just rumours

| General sample | Adolescents | Sixty years or older | Health workers |
|----------------|-------------|----------------------|----------------|
| 40.5% | 66.7% | 54.0% | 56.0% |

Not surprisingly, only 29.3% of respondents from the general sample, 31.5% of adolescents, 22.0% of the sixty years and above sample, and 16.0% of health workers felt they had enough information on the COVID-19 vaccine. Immediately, these findings necessitate more information being made available to the public on vaccines in general and on their safety. Further, the findings also reinforce the need for standardized information on the COVID-19 vaccine.

Table 16: Do you feel you get enough information on COVID-19 vaccines and their safety?

| General sample | Adolescents | Sixty years or older | Health workers |
|----------------|-------------|----------------------|----------------|
| 29.3% | 31.5% | 22.0% | 16.0% |

A considerably large number of respondents indicated that they have concerns about the COVID-19 vaccine. The analysis reveals that as high as 77.3% of respondents from the general sample mentioned that they have concerns about the COVID-19 vaccine. When queried about their concerns, 95.3% of respondents said their concerns about the COVID-19 vaccines were with the perceived side effects or adverse effects of the vaccine. Among adolescents and health workers concerns about the vaccine were much higher at 88.9% for adolescents and 80.0% for health workers. The main concerns were over the potential side effects of the vaccine

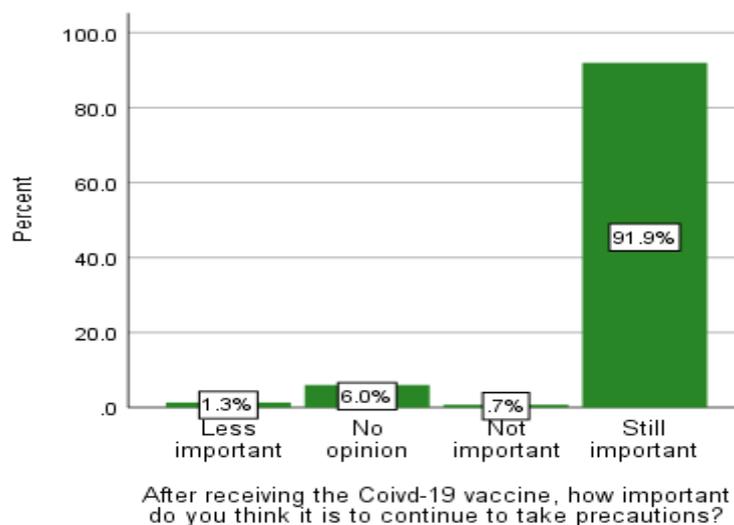
Table 17: Percentage of respondents with concerns about the COVID-19 vaccine

| General sample | Adolescents | Sixty years or older | Health workers |
|----------------|-------------|----------------------|----------------|
| 77.3% | 88.9% | 60.0% | 80.0% |

Finally, 92.1% of the general sample, 83.3% of adolescents, 90.0% of the sixty years and older group, and 93.9% of health workers all felt that even after receiving COVID-19 vaccines, it is still important 92.1% to continue to take precaution.

Finally, an extremely large number of respondents said that even after receiving the COVID-19 vaccine they will continue to take the necessary COVID-19 prevention precautions. 91.9% claimed it is still important to take the COVID-19 precaution even after vaccination.

Figure 24: After receiving the Covid-19 vaccine, how important do you think it is to continue to take precautions?





Conclusions and Recommendations – Intervention addressing vaccine hesitancy

| Findings | Conclusions | Recommendations |
|---|---|---|
| Vaccine Hesitancy | | |
| <p>From the general sample, 86.8% of respondents stated that they believed that vaccines could protect them from serious diseases.</p> <p>In the general sample, 87.4% of respondents characterized vaccines as either important, safe, or efficient. Among adolescents, 81.4% of respondents characterized vaccines as either important, safe, or efficient, and among respondents from the sixty years and above samples and health workers sample 76.0% of respondents and 100.0% of health workers opined that vaccines were efficient, important, or safe.</p> | <p>The findings from all four samples indicate that there was a widespread belief that vaccines can protect from serious diseases.</p> <p>Overwhelming the data show that there was a high positive characterization of vaccines.</p> | <p>Interventions can build on these intersubjective norms (a belief that vaccines can protect from serious diseases and positive characterization of vaccines as important, efficient, and safe) in shaping interventions addressing vaccine hesitancy.</p> |
| <p>Hesitation or refusal to take a vaccine was comparatively higher in the adolescent sample reaching 16.7%. Further, analysis of the general sample show that 16.7% of</p> | <p>Even though an exceedingly small percentage of reported hesitating or refusing vaccines; refusal and hesitation to take vaccines in the past was higher among the</p> | <p>Education and information packages should be appropriate to these groups</p> |

| | | |
|---|---|---|
| respondents with 'no formal education' reporting that in the past they hesitated or refused to get a vaccination - either for themselves or their child/children. | adolescents and sub-sample of individuals with no formal education. | |
| Lack of relevant knowledge of the efficacy of vaccines, past experiences, perception of risk and lack of trust in vaccination programs, subjective fears, and belief were the main themes embedded in the open-ended responses as to why respondents in past hesitated or refused to get a vaccination - either for themselves or their child/children. | The main barriers to vaccine uptake were knowledge of the efficacy of vaccines, past experiences, perception of risk, and lack of trust in vaccination programs, subjective fears, and beliefs. | Promotion of accurate information on the COVID-19 vaccines along with the safety and benefits of vaccines, in general, is necessary. Additional focus should include: the importance and efficacy of vaccines; messages should counteract and dispel erroneous previously held views on vaccines. |
| COVID-19 Vaccine Hesitancy - Knowledge and Attitude | | |
| 60.2% of the general sample either agreed or strongly agreed that it was important for everyone to get the COVID-19 vaccine once available. On the lower end of the spectrum, only 46.0% of respondents from the sixty years or older age group were of the view that it is important for everyone to get the COVID-19 vaccine once it is available. Figures for the adolescents and health workers sample are below the general sample but still | The survey does not provide evidence of widespread support for the COVID-19 vaccine. This can be interpreted as moderate support among the population and special samples for the COVID-19 vaccines | Sponsoring knowledge building intervention which should seek to decrease individuals and parents' concerns about vaccination by giving them information about risks in different formats |

| | | |
|--|---|---|
| <p>around the midway range (50.9% for adolescents and 56.0% for health workers).</p> | | |
| <p>68.0% of respondents from the general sample said that they would take the COVID-19 vaccine if it is introduced in the country. Percentages of respondents from the other samples expressing their willingness to take the COVID-19 vaccine was disturbingly lower than the statistics for the general family. Only 57.4% of health workers expressed willingness to take the COVID-19 vaccine, and only 45.8% of respondents sixty years or older demonstrated any willingness to take the COVID-19 vaccine. Among adolescents, 61.1% of respondents voiced their willingness to take the COVID-19 vaccine.</p> <p>Only 29.3% of respondents from the general sample, 31.5% of adolescents, 22.0% of the sixty years and above sample, and 16.0% of health workers felt they had enough information on the COVID-19 vaccine.</p> | <p>Indication of the potential uptake for the COVID-19 vaccine was in the upper midway range and effort is needed to improve on this indicator.</p> | <ul style="list-style-type: none"> • A forum should be established where health care workers can provide information on COVID-19 and other vaccines. This recommendation will help to build trust. • Individual-level interventions focusing on improving healthcare workers' confidence and communication skills. • Multimedia – creation of short videos showing individuals who contracted a vaccine-preventable disease along with an educational handout addressing common concerns about vaccination • Flyers and handouts, social media messages, and posts explaining how members of the public can find reliable and accurate information about vaccines on the internet. • An intervention that aims to improve Doctors, and Nurses' confidence in communicating with vaccine-hesitant individuals and parents in three different steps: probing, acknowledging, and advising. |
| <p>The analysis reveals that as high as 77.3% of respondents from the general sample</p> | <p>A considerably large number of respondents indicated that they have concerns about the COVID-19 vaccine. The main barrier to the</p> | |

| | | |
|--|--|--|
| <p>mentioned that they have concerns about the COVID-19 vaccine.</p> <p>When queried about their concerns, 95.3% of respondents said their concerns about the COVID-19 vaccines were with the perceived side effects or adverse effects of the vaccine.</p> <p>Among adolescents and health workers concerns about the vaccine were much higher at 88.9% for adolescents and 80.0% for health workers. The main concerns were over the potential side effects of the vaccine</p> | <p>uptake of the COVID-19 Vaccine was not related to its efficacy but about the potential side-effects of the vaccine.</p> | |
|--|--|--|



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Appendix A: Survey Team

| Survey Team | | Function |
|---------------------|--|--|
| MoH and UNICEF team | Minister of Public Health Hon. Dr. Frank Anthony | Oversight team |
| | UNICEF Representative Mr. Nicolas Pron | |
| | UNICEF Deputy Representative Mr. Irfan Akhtar | |
| | Dr. Ertenisa Hamilton | Survey Managers |
| | Dr. Oneka Scott | |
| | Mr. Michael Gillis | |
| | Dr. Clement Henry | Sampling, Data Analysis, and report writing team |
| | Mr. Michael Gillis | |
| | Mr. Ato Heyliger | Sampling support |
| | Dr. Patrick Matala | Technical Support |
| | Ms. Jewel Crosse | Communication for Development support |
| | Mr. Kelvin Daly | Information Technology support |
| | Ms. Melissa Joseph-Wade | Logistics support |
| | | |
| | Dr. Lauren Bancroft | Supervisor |
| | Medex Wilton Benn | Supervisor |
| | Ms. Nickishaw Khan | Supervisor |
| | Dr. Delroy Pyle | Supervisor |
| | Dr. Samantha Kennedy | Supervisor |
| | Ms. Debra Pollard | Supervisor |
| | Mr. Ato Heyliger | Supervisor |
| | Ms. Shandel Archer | Supervisor |
| | Ms. Sheneca Castello | Supervisor |
| Ms. Alicia Singh | Supervisor | |
| | | |
| Leonie Braithwaite | Interviewer | |
| Mr. Sylvester Nanan | Interviewer | |

| | |
|---------------------------|-------------|
| Ms. Noelene Siland | Interviewer |
| Mr. Kevin Johnson | Interviewer |
| Ms. Amanda Scott | Interviewer |
| Ms. Shemika Smartt | Interviewer |
| Ms. Collet Baird | Interviewer |
| Mr. Michael O'Donoghue | Interviewer |
| Ms. Nichelle Cadogan | Interviewer |
| Mr. Adrion Sukhdeo | Interviewer |
| Ms. Sharon Hope | Interviewer |
| Ms. Hannah Smith | Interviewer |
| Ms. Auvrel Lyte | Interviewer |
| Ms. Alicia McLeod | Interviewer |
| Ms. Nicolette Thomas | Interviewer |
| Ms. Candacy Gonputh | Interviewer |
| Medex Anasha Venture | Interviewer |
| Ms. Natasha Layne | Interviewer |
| Mr. Neala Misir | Interviewer |
| Ms. Leauta Hubbard | Interviewer |
| Ms. Dawn Pearson | Interviewer |
| Ms. Dhanwanttie Ramdeholl | Interviewer |
| Ms. Basantie Lallbachan | Interviewer |
| Ms. Patricia Ramnauth | Interviewer |
| Mr. Lenski Henry | Interviewer |
| Mr. Balraj Sanase | Interviewer |
| Ms. Leandre Stellingburg | Interviewer |
| Ms. Vanessa Wong | Interviewer |

