British-Irish Parliamentary Assembly:

Committee B (European Affairs)

SHORT INTERIM REPORT ON VACCINE ROLL-OUTS

Introduction

1. In July 2021, the Committee launched a new inquiry on Vaccine roll-outs in BIPA's jurisdictions.[1] The inquiry is considering:[2]

1. Different approaches to vaccine roll out between jurisdictions.
2. Information and data sharing on vaccination programmes in both the European Union and Britain.
3. Differences in vaccine approval, production and procurement procedures in both the UK and Europe.
4. Levels of cooperation between Ireland and the UK in relation to healthcare, including Irish citizens' work in the NHS.
5. Participation in the Global Vaccine Programme, and whether there is a moral and practical responsibility for countries to help with vaccination against Covid-19 in poorer countries.
6. The use of vaccines/vaccine status in "re-opening" societies and economies
7. The roll out of vaccines in both the European Union and Britain over the coming 12 months.

2. We held our first evidence session on 23 September 2021. Due to ongoing Covid-19 restrictions, we and our witnesses met virtually. We heard from witnesses about the Covid-19 vaccine roll-outs in Ireland and in the Crown Dependencies (the Isle of Man, Guernsey and Jersey):

- Dr Lucy Jessop, Director of Public Health, National Immunisation Office, Health Service Executive (Ireland);
- Dr Nicola Brink, Director of Public Health; Alex Hawkins-Drew, Head of Public Health for Women's and Children's Services, Guernsey and Alderney
- Jacqui Dunn, Head of Health Protection, Public Health, Isle of Man Government
- Becky Sherrington, Head of Vaccination Programmes, Government of Jersey

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[1] The British-Irish Parliamentary Assembly brings together representatives of the governments of the UK, Ireland, Scotland, Wales, Northern Ireland and the Crown Dependencies.

[2] http://www.britishirish.org/

We also received written briefing from Ireland's Department of Health, and from the Chief Medical Officers offices of England, Wales, Scotland and Northern Ireland. We are grateful to those who have given evidence to our inquiry so far.

3. We were unable to publish this report as planned, in October 2021, as our Plenary meeting was cancelled due to the death of David Amess MP. Since October 2021, there have been substantial developments in the vaccination programme against Covid-19: in particular, the need for accelerated booster campaigns to respond to the emergence of the Omicron variant. We will produce a full report for this inquiry in due course, setting out our conclusions and recommendations on the lessons learned from rolling out the Covid-19 vaccines. This interim report sets out key points from our September 2021 evidence session, and identifies issues that we will explore further in future sessions. Data on vaccination coverage, infections and deaths in the report has been updated to reflect the position in the UK, Ireland and the Crown Dependencies as of February 2022.

Covid-19 and vaccination in Ireland and the Crown Dependencies

4. The table below shows infection and death rates for Covid-19 in the UK, Ireland and the Crown Dependencies, correct to February 2022:[3]

	Infections	Deaths
UK	18,348,029	159,605
Ireland	1,242,806	6,921
Guernsey	1,773	31
Jersey	9,682	78
Isle of Man	21,400	71

This means that Ireland has seen 258,000 infections and 1,200 deaths per million people in its population, while the UK has seen 280,300 infections and 2,300 deaths per million people. Data collection on Covid-19 deaths and infections is not standardised across countries, which means comparing data can be difficult. It will also take some time to fully understand and be able to compare the number of excess deaths due to Covid-19.

5. In the UK in February 2022, 91.3% of the population eligible for vaccination had received at least one dose of a vaccine, and 84.8% had received two. 65.7% had had a booster dose. In Ireland by February 2022, 94.8% of the population aged 18 and above are fully vaccinated with 2 doses and 83.2% of the population aged 5 and above (the eligible population) have had 2 doses. 71.4% of the population aged 18+ years have had a booster or additional dose of Covid-19 vaccine.[4] All three Crown Dependencies have made good progress in vaccinating their populations. As of February 2022:[5]

- The Isle of Man had a population eligible for vaccination (aged 18 years+) of 79,216. 87.3% have had their first dose, and 83.4% have had their second. 62.5% have had a third and/or booster dose.

[3] Data for Ireland is from the Irish Health Protection Surveillance Centre and data for the UK is from Gov.uk. Data for the Crown Dependencies was shared by witnesses in February 2022.
[4] https://covid-19.geohive.ie/pages/vaccinations
[5] Data on vaccines administered is not directly comparable between jurisdictions due to differences in eligibility criteria: for example, the United Kingdom defines eligibility as people over the age of 16, while in Ireland adults and young people aged over 12 are eligible.

- Jersey's total population was 97,857. 87% of the resident population of Jersey aged 18 years and over has been administered a first dose, and 84% have been fully vaccinated.
- Guernsey's population was 65,780. 95% of the population aged 18 or over have had two doses of a vaccine, and a further 2% have had one dose only.

Approval, procurement and supply of vaccines

Box 1: Approval and implementation processes in the UK and Ireland

To gain approval for any vaccine, the vaccine developer must submit the results of all testing and trials to the relevant regulatory authority. The regulator carries out an evaluation of the vaccine's safety, effectiveness and quality, and concludes whether the scientific evidence is substantial enough to support approving the vaccine.

Ireland

As Ireland is part of the European Union, applications for vaccines are made centrally, to the European Medicines Agency (EMA). If the EMA concludes that the benefits of the vaccine outweigh its risks, it makes a recommendation to the European Commission to grant a conditional marketing authorisation. Conditional marketing authorisations are used in emergency situations in response to public health threats, as identified by the World Health Organisation. Once this is granted by the Commission, it is valid and legally binding in all EU member states. Ireland feeds into reviews and monitoring at European level via its Health Products Regulatory Authority. Ireland's prioritisation strategy was developed by the National Immunisation Advisory Committee and the Department of Health.

For Covid-19 vaccines, the EMA used an expedited procedure called a "rolling review". This means the EMA can review data from ongoing studies as it becomes available, rather than requiring developers to submit all data at the start of the evaluation. This can mean that a recommendation on a conditional marketing authorisation can be within a few weeks, followed by a fast-tracked decision in European Commission.

The United Kingdom

The UK amended legislation to allow for temporary UK-only authorisation of vaccines, before they receive EMA approval. Otherwise, the UK would also have been subject to the EU approval process up until the end of its transition period for leaving the EU (31 December 2020). Reg. 174 of the UK's Human Medicine Regulations (2012 and 2020) allows for the temporary/emergency authorisation of medical products, including vaccines.1 Evaluation of the evidence is carried out by the UK's Medicines and Healthcare products Regulatory Agency, with advice on prioritisation given by the Joint Committee on Vaccination and Immunisation (JCVI) and monitoring by Public Health England.

Differences in the approval processes

6. The Crown Dependencies used vaccines approved and procured by the UK Government, which then had to be designated by their own governments. This was helpful in getting vaccines to the population quickly. We discussed in evidence the role of Regulation 174 (see box, above), which had enabled the UK to approve Covid-19 vaccines more quickly than the EU bloc. For example, the BioNTech/Pfizer vaccine was approved for use in the UK from early December 2020, and the AstraZeneca vaccine from

the end of December. The EU did not approve its first vaccine (BioNTech/Pfizer) until 20 December, with the AstraZeneca and Moderna vaccines following in January. Dr Jessop, Director of Public Health for Ireland's Health Service Executive, noted the specific implications of differing approval processes and implementation timelines for people living in border communities, which we return to below.

7. We asked Dr Jessop whether the EU's slower approval process, relative to the UK's, had been a broader concern for Ireland. She emphasised that Ireland's vaccination programme had started only a short time after the UK's: Ireland started vaccinating using BioNTech/Pfizer on 29 December 2020, compared to 8 December in the UK. Dr Jessop felt that the difference of a few weeks between approval in the UK and approval in the EU for the vaccines was not unreasonable, and was important for building public trust in the approval process.

8. We note that the UK's expedited authorisation process has not always led to vaccines being authorised in the UK before the they are authorised in the EU. For example, the Janssen/J&J single dose vaccine was approved in by the EU in March 2021, while the UK did not authorise it until May 2021. This single dose vaccine could help to address second dose vaccine hesitancy for those who have side effects following a first dose, but does not appear to be widely used in the UK at present. The Committee will explore this further in future evidence sessions.

Procurement and allocation of vaccines

9. Ireland followed the EU's approval process for the Covid-19 vaccinations (see Box 1, above). Dr Jessop explained that following approval, Ireland's vaccination strategy was based on a need to purchase a range of vaccines in sufficient quantities to commence and roll-out an unprecedented national immunisation campaign. Being part of the EU procurement allowed Ireland to have an advanced purchase agreement for a variety of vaccines before they were approved. This allowed access to these vaccines as soon as they were approved, equitably across the EU based on population. Dr Jessop felt that the combined buying and approval power of the EU was essential in securing enough supplies of vaccines for Ireland. She explained that this advanced procurement process will continue to be essential for Ireland, and that the country has been well served by the EU's approach. It was also noted that in August 2021, Ireland had bought BioNTech/Pfizer vaccines from Romania.[6] Access to brokerage of this kind is a further substantial advantage for Ireland of being part of a wider bloc of States.

10. The vaccination allocations for the Crown Dependencies were calculated based on Jersey, Guernsey and the Isle of Man's populations. This is also the approach used to distribute vaccines between England, Wales, Scotland and Northern Ireland. All three Crown Dependencies told us that supply of vaccines had not been a substantial problem. We heard, however, that there might be a case for considering additional aspects of risk in deciding on future vaccine allocations. Becky Sherrington, Head of Vaccination Programmes for Jersey, told us that some of the risk associated with Covid-19 relates to Jersey's infrastructure: in particular, the island only has one hospital, and challenges around access mean there is associated risk of over-crowding. She suggested it would be helpful if such factors could be taken into account when assessing risk and allocating vaccines.

Prioritisation

11. The Crown Dependencies had largely followed the JCVI's advice on prioritising groups for vaccination. Alex Hawkins-Drew, Guernsey's Head of Public Health for Women's and Children's

[6] https://www.gov.ie/en/press-release/1ef9b-ireland-secures-almost-700000-additional-doses-of-pfizerbiontech-covid-19-vaccine-following-agreement-with-romania-and-the-eu/

Services, explained that Guernsey does not have the breadth of experience and resources that would allow it to diverge from JCVI's evidence-based recommendations, and so it made sense to follow JCVI's advice. We heard further that there was a good level of engagement between the UK-based organisations and those responsible for delivering the roll-out in the Crown Dependencies. Dr Brink, Guernsey's Director of Public Health, explained that there had been a lot of communication between Guernsey and UK bodies, including the Department for Health and Social Care, National Health Service and JCVI, and that they had found the UK organisations "very supportive".

12. Witnesses explained that where the Crown Dependencies had diverged from JCVI advice on prioritisation, they had done so due to address subtle differences between the islands and the UK. Jacqui Dunn, Head of Health Protection for the Isle of Man Government, gave the example of the need to get supplies to the island via air or sea, at a time when its borders were closed. To protect supply lines, the Isle of Man prioritised groups such as pilots and boat staff for vaccination. We also heard that in smaller communities, people often play multiple roles in their jobs. For example, Dr Brink told us that Guernsey's firefighters act as paramedics. We also heard that medivac pilots were immunised under the Health and Social Care worker criteria, reflecting their unique role in the Crown Dependencies. These circumstances necessitated some minor additions to vaccination prioritisation groups.

Harder to reach groups and vaccine hesitancy

13. We were interested in understanding what steps governments have taken to ensure groups and people that are "harder to reach", or who may be hesitant to be vaccinated, are able to access good quality information on the vaccine, and the vaccination itself. We were encouraged to hear about a range of initiatives. The UK, Ireland and the Crown Dependencies have also taken steps to widen the pool of people who can give vaccines: for example, by training and authorising midwives to vaccinate pregnant women. Alex Hawkins-Drew told us that Guernsey has designed a range of bespoke outreach programmes, for groups including disabled adults, disabled children and pregnant women. She explained that their approach has focused on building relationships with people and communities that and tailoring information to their specific needs. For example, Guernsey has run bespoke programmes for pregnant people, with midwives offering vaccinations (and trained as vaccinators), as well as information about vaccinations, at pre-natal appointments. Dr Jessop told us that Ireland has similar programmes in place to try to reach harder to reach or hesitant groups: for example, working in prisons, with the Irish Roma and Traveller communities, and with industries such as meat packing that have had high Covid-19 rates.

14. We were also interested in the role that allowing people a choice over which vaccination they have can play in reducing vaccine hesitancy. Becky Sherrington told us that there was a "certain degree" of hesitancy related to vaccine in Jersey, while Alex Hawkins-Drew told us that in Guernsey, some people had expressed a preference for an mRNA vaccine (rather than AstraZeneca). Jersey and Guernsey, like the Isle of Man, did not allow people to choose which vaccine they had for their first dose, which was important in terms of maintaining confidence and managing supplies. Dr Jessop told us that in Ireland, concerns about the AstraZeneca vaccine mainly related to the second dose. Choice was not allowed for the majority of the programme, much more recently, to ensure as many people as possible are fully vaccinated, Ireland is allowing people who have had a first dose of AstraZeneca to opt for an mRNA vaccine for their second dose. Public Health England's position remains that vaccines should

only be mixed in "extremely rare occasions", such as when the vaccine given for the first dose is unavailable for the second.[7]

Vaccination programmes in the border counties

15. We asked Dr Jessop specifically about vaccination and Covid-19 rates in the border counties. Border counties have some of the lowest uptake of vaccinations in Ireland, as well as higher rates of Covid-19 disease. Dr Jessop explained that the question of why vaccination rates are lower in border counties is complex. Cross-border workers, who were vaccinated in Northern Ireland (where vaccinations started earlier) may account for some of the variation: we return to this issue below. The high rates of Covid-19 suggest that there are other factors at play, however. Dr Jessop suggested that vaccine hesitancy is part of the explanation, and that the border communities will be a focus of upcoming campaign and outreach work around the vaccine.

16. We heard that there had initially been some difficulty in identifying cross-border workers who had been vaccinated in Northern Ireland. Dr Jessop explained that the problem was not a lack of co-operation with Northern Ireland: rather, the data that would have been needed to identify those who had been vaccinated (such as address data) was not available at the time. We would urge that future protocols for data collection on the two vaccination programmes are developed with the specific circumstances of border communities in mind. Dr Jessop told us in February 2022 that further targeted work on improving access to information and vaccine services in the border counties has improved uptake. The lower uptake observed originally was, therefore, concluded to be a reflection of the actual vaccine, and not of people being vaccinated in Northern Ireland in large numbers.

Lessons from the HPV vaccination campaign

17. Dr Jessop explained that Ireland's approach to the Covid-19 vaccination programme had been informed by its experience delivering the HPV vaccination programme from 2010. The vaccine protects against the HPV virus, and was initially offered to girls aged 12 and 13 in schools (it is now also offered to boys). 82% of people eligible had the vaccine in its first year, and uptake peaked at 87% in 2014/15. In 2016/17, however, uptake dropped to just 51% amid concerns about safety. The Irish health services found that campaigns that had worked well previously were not raising the vaccination rate, and decided to take a different approach. This included working more closely with a wider range of stakeholders, redesigning communications, using peer-led and advocate-led campaigns, and ensuring that healthcare professional such as GPs and pharmacists are well equipped to offer information and answer questions on vaccines.[8] In 2017/18 the HPV vaccine uptake rate went up to 65.4%, and in 2019/2020 it reached 76.2%. The lessons learned from the HPV vaccination programme have been important in developing Ireland's approach to Covid-19 vaccinations. We believe that they are also likely to be relevant to other countries in overcoming vaccine hesitancy as the Covid-19 vaccination programmes progress and become embedded.

Compulsory vaccinations

18. Some countries have introduced vaccination requirements for people in certain job roles. On 11 November 2021, new Regulations came into force in the UK requiring all adult care staff to be fully vaccinated, or face redeployment or losing their jobs. In light of this development, we were interested to know whether Ireland or the Crown Dependencies had considered similar measures. Dr Jessop told us that Ireland had focused on educating and communicating with people to encourage them to have

[7] https://www.bmj.com/content/372/bmj.n12

[8] Ireland's approach to overcoming HPV vaccine hesitancy is set out in Annex 1.

the vaccine, rather than mandating vaccination. She acknowledged that there were some calls for compulsory vaccinations in some sectors, but said that unlike in the UK, as far as she was aware, this was not an option that Ireland was exploring at present. This was also the current approach of the Crown Dependencies.

The Covax programme and booster campaigns

19. The Covax programme aims to ensure that people in all countries have timely, fair and equitable access to Covid-19 vaccinations.[9] It is run by organisations including the World Health Organisation. We asked our witnesses about their countries' participation in the programme. We were interested in hearing about the balance between ensuring that enough vaccinations are available domestically (including for third "booster" doses) and ensuring that countries across the world can access vaccines. Witnesses from the Crown Dependencies told us that as their vaccines come via the UK, it is unlikely that they have enough surplus to donate. The UK itself participates in Covax. Dr Jessop explained that Ireland is aware of the need for fair and equitable access and is participating in the programme, but the numbers of vaccines being donated are a matter for the Government and can only come directly from the manufacturer if they are to be donated to Covax (rather than from vaccine already delivered to individual countries).

Since we took evidence in September 2021, the Crown Dependencies, Ireland and the UK have all launched booster dose campaigns in response to the Omicron variant. Data on booster uptake is above. The UK began offering boosters to anyone whose second jab was at least six months ago in September 2021, and launched an accelerated programme in December 2021. As of Feb 2022, the Covid-19 vaccine programme in Ireland expanded with all aged 16 years and above eligible for a booster dose of vaccine and all aged 5 years and over eligible for a primary course of vaccine.

Conclusion

20. The evidence that we have heard so far raises a number of issues. We intend to explore these in greater depth, including with witnesses representing the United Kingdom and its devolved nations, as the vaccination programmes develop. They include:

- **The ongoing impact of different authorisation processes: for example, as new vaccines are developed and existing ones require renewed authorisation.**
- **The implications of differing vaccination programmes for people living in border communities, and how lower rates of Covid-19 vaccination in border counties can be addressed.**
- **Wider strategies to overcome vaccination hesitancy, and to ensure clarity over measures such as masks and social distancing as the vaccination programmes progress.**
- **The Covax programme including how countries are negotiating the balance between donating vaccines and carrying out domestic vaccination programmes in response to changes in Covid-19.**
- **How Covid-19 epidemiological data is collected within countries, and how data collection could be improved to enhance understanding of the pandemic.**

[9] COVAX (who.int)

Annex I: HPV Vaccine - summary of response to decrease in vaccine confidence in Ireland

Background:

HPV vaccine was introduced in Ireland in 2010 for girls aged 12 to 13 years to protect against the most common causes of cervical cancer. The vaccine was well received and uptake of the vaccine was around 82% in that first year. In the following years uptake of the vaccine continued to rise and peaked at 87% during 2014/2015. At this time Ireland had one of the highest uptake rates of HPV vaccine in the world.

What happened next?

During 2016 HPV rates in Ireland declined significantly following negative coverage about the vaccine safety on both mainstream and social media. The uptake rate for HPV vaccine fell to 51% during 2016/2017, down 36% points in just 24 months.

Following the decline in HPV vaccine uptake the HSE responded with a campaign based on programmes that had been successful for similar projects before. The campaign highlighted evidence and facts delivered by experts and was supported by strong and sustained public and media relations work and a limited public information campaign using video and social media.

The outcome

Facts and evidence seemed to have little or no impact on the fear that been created around the vaccine's safety. There was lots of kick back and negativity to promoted posts and the health service was being overwhelmed by a huge volume of comments. Significantly, the campaign was not making any real difference to uptake rates of the HPV vaccine.

The response

The Irish health services re-grouped, provided more resources and listened to parents and to our vaccination teams who were carrying out the immunisations in school and to colleagues. We heard that:

- Parents want to protect their children; and the majority didn't know who to trust
- They were navigating the noise (arguments and counter arguments) with significant frustration
- They wanted to be given the facts so that they could make an informed decision
- They felt fear and doubt caused by social/news stories
- They sense when they're being manipulated
- They trusted experts but felt rushed into consenting to get their child vaccinated
- Many saw our careful evidence-based language as confirming risk
- They trusted other parents who they felt know the real stories

So what was needed?

Any information needed to be:

- Informative - use of memorable stats or facts, show me why
- Empathetic - acknowledgment of how difficult this decision is for a parent
- Reflective of reality – be able to relate to them on a personal level – informed, not guilt
- Confident - addressing rumours head-on
- Real people - telling real stories. Getting information from 'people like me'
- Empower- parents were encouraged to get the facts from credible sources so they could make an informed decision themselves around vaccination.
- Connect – sharing of stories from different angles, experts, parents, children, people with cancer
- Call to action – encourage parents to stop and think, get the facts and make an informed decision

Actions and initiatives, all of which had parents at the centre included:

Extensive stakeholder engagement and empowerment. This included working closely with the Irish Cancer Society who built an alliance of over 40 organisations who committed to supporting the HPV vaccine.

The use of radio advertising to reach a mass audience

Updating, re-wording and redesigning information materials and leaflets

Providing more time for parents to consent to vaccination

Tireless media relations

A major media launch

Peer led video social media campaign

Supporting the vaccination teams who deliver the immunisation programme

Providing information to healthcare professionals like GPs and Pharmacists who may be asked for advice about vaccination even though they were not the professionals who delivered the vaccination programme

Provided information on the HPV dedicated website www.hpv.ie and updated the site regularly to respond to parents, students and professionals frequently asked questions including a page dedicated to share scientific information about vaccine safety and efficiency

Enlisting the support of a patient advocate – the truly unique Laura Brennan. Laura was a young woman with cervical cancer who approached the Irish health services in 2017 to offer support in promotion the HPV vaccine. She worked tirelessly to promote the vaccine right up to her untimely death aged 26, in March 2019. Laura's unprecedented work as a patient advocate for the HPV vaccine influenced parents throughout Ireland and further afield through her later work on behalf of the World Health Organization.

During 2017/2018 the HPV vaccine uptake rate went from 56.3% to 65.4%. In 2018/19 it rose to 73.7% and in 2019/2020 it reached 76.2%. Uptake is not yet available for 2020/2021.

In Ireland the HPV vaccine is now offered to all children aged 12 to 13. Further information can be found here: https://www.hse.ie/eng/about/who/communications/digital/blog/how-we-used-social-media-to-increasehpv-vaccination-rates.htm