## National Public Health Emergency Team – COVID-19
### Meeting Note – Standing meeting

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Thursday 4th March 2021, (Meeting 79) at 10:00am</th>
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<tr>
<td>Location</td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td>Chair</td>
<td>Dr Ronan Glynn, Deputy Chief Medical Officer, DOH</td>
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### Members via videoconference
1. Dr Kevin Kelleher, Assistant National Director, Public Health, HSE
2. Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)
3. Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group (EAG) Chair
4. Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA
5. Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital
6. Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE
7. Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH
8. Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor
9. Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital
10. Ms Rachel Kenna, Chief Nursing Officer, DOH
11. Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH
12. Dr Lorraine Doherty, National Clinical Director Health Protection, HSE
13. Dr Colette Bonner, Deputy Chief Medical Officer, DOH
14. Ms Yvonne O’Neill, National Director, Community Operations, HSE
15. Mr Phelim Quinn, Chief Executive Officer, HIQA
16. Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI
17. Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH
18. Dr Darina O’Flanagan, Special Advisor to the NPHET
19. Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH
20. Dr Breda Smyth, Public Health Specialist, HSE
21. Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH
22. Ms Deirdre Watters, Communications Unit, DOH
23. Dr Colm Henry, Chief Clinical Officer, HSE
24. Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)
25. Mr Liam Woods, National Director, Acute Operations, HSE
26. Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway
27. Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications
28. Prof Mary Horgan, President, RCPI
29. Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)
30. Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;
31. Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH
32. Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital
33. Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)

### ‘In Attendance’
1. Ms Laura Casey, NPHET Policy Unit, DOH
2. Dr Trish Markham, HSE (Alternate for Tom McGuinness)
3. Mr Gerry O’Brien, Acting Director, Health Protection Division
4. Mr Ronan O’Kelly, Health Analytics Division, DOH
5. Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
6. Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH
7. Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH
8. Ms Sheona Gilsenan, Senior Health Data Analyst R&D & Health Analytics Division, DOH

### Secretariat
1. Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH

### Apologies
1. Dr John Cuddihy, Interim Director, HSE (HPSC)

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1 References to the HSE in NPHET minutes relates to the staff of the HSE present at NPHET meetings and not the HSE Board which is the HSE in law unless otherwise stated.
1. Welcome and Introductions
   a) Conflict of Interest
   Verbal pause and none declared.
   
   b) Apologies
   Apologies were received from Dr John Cuddihy.
   
   c) Minutes of previous meetings
   The minutes of the 4th and 11th February had been circulated to the NPHET in advance of the meeting. These were agreed subject to minor amendments and formally adopted by the NPHET.
   
   d) Matters Arising
   There were no matters arising at the meeting.

2. Epidemiological Assessment
   a) Evaluation of Epidemiological data: (incorporating National Data Update, Modelling Report, and International Update)
   The DOH, the HPSC, and the IEMAG provided an overview of the latest epidemiological data regarding confirmed cases, including the current information on hospitalisation, critical care, mortality, sampling, testing, and contact tracing. The data presented were as follows:
   
   The DOH, the HPSC, and the IEMAG provided an overview of the latest epidemiological data regarding confirmed cases, including the current information on hospitalisation, critical care, mortality, sampling, testing, and contact tracing. The data presented were as follows:
   
   • A total of 4,351 cases have been notified in the 7 days to 3rd March, which is a 15% decrease on the previous 7 days to 24th February in which there were 5,116 cases.
   • As of 3rd March, the 7- and 14-day incidence rates per 100,000 population have decreased to 91 and 199, respectively; these compare with rates of 108 and 231 on 24th February.
   • Nationally, the 7-day incidence as a proportion of 14-day incidence is 46%, demonstrating that there have been fewer cases in the last 7 days, 25th February to 3rd March, compared with the preceding 7 days, 18th to 24th February.
   • The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10th January to 591 on 3rd March. The 5-day average has decreased by 16% since the last NPHET meeting on 25th February (700).
   • Incidence is decreasing across most age groups except those aged 0-4. The decrease in incidence is relatively evenly spread across age groups with the lowest incidence seen in those aged 65-74 years. In the last 14 days, 18th February to 3rd March, 10% of cases notified were aged over 65.
   • Of cases notified in the past 14 days, 18th February to 3rd March, 69% have occurred in people under 45 years of age; the median age for cases notified in the same period is 33 years. Among those aged under 45, the highest incidence is in those aged 19-24 years.
   • The number of close contacts captured during the week ending 28th February was 9,322, a 15% decrease from the previous week (10,969).
   • The average number of close contacts per adult confirmed case remains stable at 2.6 contacts per case.
   • Of the 6,692 close contacts created between 15th to 21st February where test 1 results were available, 1,668 (24.9%) were positive. A high positivity rate of 32.6% was seen in household contacts.
   • Of the 1,999 close contacts created between 8th to 14th February where test 2 results were available, 187 (9.4%) were positive. A high positivity rate of 13.9% was seen in household contacts.
   • While 14-day incidence rates remain high across the country, 17 counties have a 7-day incidence as a percentage of the 14-day rate less than 50%, indicating fewer cases notified in the last 7 days, 25th February to 3rd March, compared with the previous 7 days, 18th to 24th of February.
   • Of the 9,497 cases reported in the last 14 days, 18th February to 3rd March, 5.0% (478) were healthcare workers.
• The best estimate of the reproduction number (R) is 0.6 – 0.9. The rate of decline of the disease is continuing at -2% to -4%, this rate of decline has been stable for two weeks.
• A range of mobility and compliance data suggest that mobility is increasing, although levels remain low overall.
• There were 107,896 tests undertaken in the last week. The 7-day average test positivity rate has decreased to 4.2% on 3rd March on from 5.0% on 23rd February.
• Excluding acute, serial and mass testing in response to outbreaks, the community test positivity rate has decreased over the last week to 2nd March; the rate remains high at 13% over the 7 days to 2nd March, which compares to 15% on 23rd February.
• According to contact management programme data, 17 counties have community positivity rates (excluding acute, serial and mass testing in response to outbreaks) greater than 10%.
• There were 461 confirmed COVID-19 cases in hospital this morning, compared with 593 on 25th February; this is a 22% decrease since the last NPHET meeting. There have been 26 newly confirmed cases in hospital in the 24 hours preceding this morning.
• There are currently 110 confirmed cases in critical care, compared with 136 on 24th February. There have been 3 admissions in the previous 24 hours.
• To date, there have been 715 deaths notified with a date of death in February. This compares with 1,314 and 196 deaths notified (to date) with a date of death in January and December, respectively. Of the 715 deaths in February, 95 have thus far been associated with hospital outbreaks and 273 have been associated with nursing home outbreaks. To date in March, there have been 8 deaths.
• In total, 15 cases of B.1.351 (variant first reported in South Africa) have been confirmed by whole genome sequencing. Of these, 3 cases of the variant B.1.351 have been identified in the last week.
• 3 confirmed cases of P.1 (variant first reported from Brazil) have been identified in Ireland to date.
• One case of the B.1.525 variant (variant under investigation) has been reported in Ireland.
• As of 3rd March, the 14-day incidence per 100,000 population in Northern Ireland was 177; this is 11% less than the 14-day rate in the Republic of Ireland (199 per 100,000 population). The latest 7-day incidence per 100,000 population in Northern Ireland is 76, which is 16% less than the 7-day incidence rate in the Republic of Ireland (91 per 100,000 population).

It should be noted that in week 8, (21st to 27th February 2021), a significant number of outbreaks (99), were reported that related to cases notified before February. The majority of these related to private household outbreaks.

Healthcare setting outbreaks:
• There were 21 new clusters notified in hospitals in week 8 of 2021. A number of these represent historical outbreaks.
• As of today, there are 111 open clusters associated within 42 hospitals; there have been 221 deaths and 1,823 confirmed cases linked to these outbreaks. Of these confirmed cases, 41% are related to healthcare workers.
• There were 6 clusters notified in nursing homes/community hospitals in week 8, this compares with 12 outbreaks in these settings in week 7.
• There are currently 136 open clusters associated with nursing homes; there have been 629 deaths and 5,064 confirmed cases linked to these outbreaks. Of these cases, 40% of confirmed cases are related to healthcare workers.
• There are 23 open outbreaks in community hospitals and long stay units; there have been 38 deaths and 572 confirmed cases linked to these outbreaks with 51% of these cases recorded as healthcare workers.
• There were 19 new outbreaks in residential institutions in Week 8.
• There are currently 141 open clusters associated with residential institutions; there have been 19 linked deaths and 1,063 linked confirmed cases to these outbreaks.
• Within these residential institutions, there were 11 outbreaks notified in centres for disabilities in week 8; there were 92 open outbreaks in centres for disabilities at the end of week 8.
Outbreaks associated with educational settings and childcare facilities:
- There were 79 new outbreaks notified during week 8 in settings associated with education and childcare facilities.
- There were 15 outbreaks newly notified in childcare facilities in week 8 with 49 new linked cases. There were 77 open outbreaks in these settings at the end of week 8.
- There were 61 outbreaks newly notified outbreaks associated with third level institutions/students in week 7 with 73 open outbreaks associated with these settings. The majority of these outbreaks were notified in the West region and represent clusters under investigation over recent weeks (54).
- There were 3 outbreaks associated with school children and or school staff in week 8 with 33 open outbreaks. One of the newly notified outbreaks in week 8 represents a late notification from December 2020.
- The Chair of the IEMAG outlined provisional findings on the pattern of cases observed in cases under the age of 18 years:
  - The patterns across each of the waves suggest that children of secondary school age tend to mirror trends in the adult population, while children of primary school age are at highest risk of contracting COVID-19 from someone in their household.
  - In January/February 2021, COVID-19 cases in children are likely to have been under ascertained, following the decision to stop testing close contacts of confirmed cases of COVID-19 due to excessive demands on the testing system.
  - An apparent increase in cases in children is likely to have coincided with the resumption of testing of close contacts. These trends highlight the need for caution when interpreting increases/decreases in cases among certain age-groups.

Vulnerable groups, Travelling Community, Direct Provision & Prison Outbreaks:
- There were 30 new outbreaks reported in vulnerable populations in week 8.
- There remains a high number of Irish Traveller outbreaks with 23 new outbreaks and 74 linked cases in week 8 compared with 22 new outbreaks in week 7; there were 142 open outbreaks in the Irish Traveller community at the end of week 8. This represents an 18% increase on the number of open outbreaks on the previous week.
- There were 2 outbreaks reported in the Roma Community during week 8.
- There have been 4 new outbreaks in direct provision centres in week 8. At the end of week 8 there were 25 open outbreaks in direct provision centres.

Workplace outbreaks
- There were 37 workplace outbreaks reported in week 8 across a variety of settings, which is 12% higher than the number of outbreaks identified in week 7 (33). There were 10 in commercial settings, 7 related to food production settings, 5 in manufacturing settings, and 2 related to the construction industry. In addition, 8 outbreaks related to Defence, Justice, and other Emergency services.
- There were 223 open outbreaks in workplaces up to the end of week 8.

In summary, the epidemiological situation in Ireland is improving but remains very finely balanced. While we are seeing continued, slower, yet constant progress against all indicators of disease, incidence remains high. Community test positivity remains high but appears to be reducing.

Health and social care services continue to experience significant pressure from the current wave of infection. The number of confirmed cases in hospital and ICU is still high but continues to reduce. The number of cases in long-term residential care settings has decreased rapidly over recent weeks, more so than would be expected given the level of disease in the wider community. Deaths associated with outbreaks in these settings also appear to be decreasing, with these trends supporting the emerging evidence of the protective effect of vaccination.

The Acting Chair thanked the presenters for their inputs and invited observations from the NPHET Members:
• The HPSC confirmed mitigation measures were being taken at third level institutions, where significant outbreaks were being observed.
• Several Members of the NPHET commented with concern on the significant numbers of outbreaks occurring in certain vulnerable groups such as the Traveller Community. Public health measures targeted at these groups must continue to be kept under review, including the possible role that vaccination might play in protecting this vulnerable population.
• The NPHET Members raised queries regarding average length of stay of patients with SARS-CoV-2 in hospital, and also raised concerns regarding certain issues in classification of patients in hospital as either ‘COVID-19’ or ‘post-COVID-19’ patients. To ensure consistency, the HSE dictates that after 14-days in hospital receiving treatment for COVID-19, a patient is reclassified as ‘Post COVID-19’.
• The need for standardisation of reporting and classification of cases and deaths in hospital was raised. Work is ongoing through HSE Acute Operations to ensure standardisation of practice across all sites.
• The Chair of the IEMAG confirmed that data related to length of stay in hospital/critical care and admission probability by age have been reviewed and indicate no significant differences across the disease waves since the outset of the pandemic.

International Travel & Variants of Concern:
• The Acting Chair outlined to the NPHET that an Expert group on international travel had been established, chaired by NPHET Member Dr Darina O’Flanagan, to examine international travel and VOCs on an ongoing basis. The establishment of the group is timely in the context of planning for the implementation of mandatory quarantining facilities in Ireland for travellers from ‘Category 2’ (high-risk) countries. Classification of countries as either ‘Category 1’ or ‘Category 2’ will continue to be kept under review.
• It was noted that some NPHET Members continue to favour broader international travel restrictions beyond the plan for country categorisation.
• The HPSC continues to follow-up probable cases of new variants in clusters of new outbreaks. Of note, ongoing complex contact tracing of some clusters of probable variants of concern have not yet found a link to international travel.
• The NVRL presented data from 1,055 whole-genome sequences that have been received since the last update:
  o Sequencing reveals that the B.1.1.7 variant is the most prevalent lineage of SARS-CoV-2 in Ireland.
  o Lineages B.1.177 and B.1.258, which were introduced in Ireland over the Summer of 2020, have diverged and are decreasing in frequency but remain present across different Community Health Organisation (CHO) areas.
  o The presence of all three variants suggests low diversity of new lineages of SARS-CoV-2 in Ireland, however, there is significant divergence within these lineages, which the NVRL will continue to monitor for the development of new mutations.
• The NVRL is working with the HPSC to agree the optimal timing, frequency, and format for the reporting of variants of concern and SARS-CoV-2 surveillance data. When these questions have been answered, the HPSC surveillance report will be shared with the NPHET.
• The NPHET Members commended the NVRL and the HPSC for their work, noting that evidence from other jurisdictions suggests that variants of SARS-CoV-2 compete with one another, highlighting the need for robust monitoring and sequencing for novel variants.

3. Review of Existing Policy
   a) Report on Ventilation

The paper detailed conclusions and recommendations made by the Expert Group on ventilation and related measures to reduce airborne transmission of COVID-19. In particular, the paper concluded:
• Ventilation is an important factor in reducing the risk of long-range airborne transmission of SARS-CoV-2, particularly in enclosed spaces.
• Simple strategies to ensure adequate ventilation can help to reduce the spread of COVID-19 in many settings. Moreover, these strategies can also reduce the risk of superspreading events where many people become infected at the same time.
• Ventilation is one part of a layered strategy to reduce transmission and should be used in conjunction with other mitigations.

The CSA acknowledged the wide network of consultation behind the report, particularly noting work carried out in conjunction with colleagues from the HPSC.

The NPHET agreed that a deeper analysis of the overall role of ventilation within the established suite of public health measures and the operational consequences of same would be beneficial. While acknowledging the breadth of expertise represented on the Expert Group on the role of Ventilation, the NPHET agreed that further engagement was required, both within the health system and cross-sectorally, to enable the development of a more integrated evidence base on ventilation.

The Acting Chair thanked the CSA for presenting the Expert Group’s paper and the Members for their contributions and noted that the paper would be communicated with the HSE and the AMRIC for consideration as part of their ongoing review of guidance development.

4. HIQA Expert Advisory Group
a) Updated recommendation on mask wearing in children

The HIQA presented the paper “Advice to the National Public Health Emergency Team: Reduction of the minimum age for the application of mask wearing requirements and recommendations – 3rd March 2021”, for discussion.

The purpose of the HIQA report was to provide advice to the NPHET on the policy question: “Should the minimum age for the application of mask wearing requirements and recommendations be reduced?”

The HIQA noted that, in the context of limited research evidence, this advice is informed by the expert opinion of the HIQA COVID-19 Expert Advisory Group (EAG). In addition to a number of presentations on issues relating to the above policy question, a representative of the National Parents Council also addressed the EAG, highlighting comments, queries, and concerns on behalf of parents nationwide.

Arising from the findings of this discussion, the HIQA provided the following advice to the NPHET:

• To date, with respect to SARS-CoV-2, the burden of disease and the extent of transmission between children or onwards to households by children, has been low. Success in minimising the transmission of SARS-CoV-2 within the school environment has been due to the implementation and adherence to layered mitigation measures by school communities, and the use of robust Public Health Risk Assessment by Public Health teams to guide the prevention and management of outbreaks.
• It is unknown whether variants of concern, which are associated with increased transmissibility, will alter the present context of successful mitigation of the spread of SARS-CoV-2 within school settings.
• The current guidance with respect to mask use in children does not preclude children from wearing masks. Parents and children may choose that a child wear a mask on the basis of their individual assessment of the benefits and harms.
• Overall, the totality of the evidence base points towards a reduction in SARS-CoV-2 transmission associated with mask use. However, the evidence base with respect to children is limited. Mask use effectiveness appears to be reduced in younger age groups. Furthermore, the ability of young children to comply with face mask use has been noted to be poor.
• There is concern regarding the potential harms associated with face mask use, for example, anxiety or negative impacts on communication, particularly for younger children.
Given consideration of the evidence and the concerns raised, no consensus was reached to support a change at the present time in the minimum age for requirements and recommendations with respect to mask use in the community.

Consensus was achieved on the following points:

- The importance of schools remaining open; on-site schooling is viewed as essential to meet the educational, social, and emotional development and well-being needs of children.
- The need to clearly communicate to school communities that while the classroom represents a controlled, low-risk environment for the transmission of SARS-CoV-2, there may be greater potential for transmission associated with other aspects of the school-going experience, for example, transport or break times.
- The need to maintain high levels of adherence to the current layered public health measures by all those involved across the whole school-going experience. These include the avoidance of attendance by pupils with symptoms without consulting their GP, physical distancing both within schools, on schools’ grounds and travelling to and from schools, hand hygiene, cough etiquette, and increased ventilation.

Given the emerging evidence regarding the importance of variants of concern to community-level transmission, this advice should be kept under review and should be informed by national and international surveillance data and relevant evidence from the literature. It should be clearly communicated to the public that evolving evidence regarding transmission may result in changes to the current recommendations.

The Acting Chair thanked the HIQA for its advice and invited the NPHET Members to discuss same. Key points in the discussion were as follows:

- Members agreed that there is insufficient evidence at this time to warrant changing the guidelines. However, this could change in light of any new evidence that becomes available.
- There was a concern that recommending facemask use may further marginalise certain cohorts of children, that are already at risk of stigmatisation, who may not be able to participate in mask wearing.
- The HIQA advised that the potential negative effects of stigmatisation, resulting from current or possible future guidance, had been discussed and were considered when developing the recommendations made in the paper.
- It was brought to the attention of the NPHET that in updated guidance, the UK has not recommended the mandatory wearing of facemasks in primary school children.
- The HIQA commended the input from the representative of the National Parents Council, which provided important insight into the concerns of parents. The HIQA found that, although mandatory mask wearing did not have widespread support amongst parents, the issue is very polarising. The primary concern among parents remains that children return to school as soon as possible.

The NPHET confirmed that the advice on this matter will be kept under review and should continue to be informed by national and international surveillance data and relevant evidence from the literature. The NPHET further advised that it should be clearly communicated to the public that evolving evidence regarding transmission may result in changes to the current recommendations on face mask use in the community.

Action: The NPHET adopts the recommendations set out within the HIQA’s paper, “Reduction of the minimum age for the application of mask wearing requirements and recommendations: 3rd March”, noting no change to the current guidelines.
5. Future Policy
   a) Vaccination

   i. **HPRA Vaccine Safety Update**

   The HPRA provided a report, for noting, on the national reporting experience for COVID-19 vaccines. The report will be published on the HPRA website on 4th March. Key points were as follows:

   - Up to 25th February, a total of 3,484 reports of suspected side effects were notified to the HPRA.
   - The most commonly reported suspected side effects notified to the HPRA are in line with those typically associated with vaccination, including the types of side effects described in COVID-19 vaccine product information.
   - National reporting experience to date continues to support the favourable assessment that the benefits of COVID-19 vaccines outweigh the risks.
   - The European Medicines Agency (EMA) Safety Committee is currently reviewing the worldwide safety data for mRNA (Comirnaty® and COVID-19 Vaccine Moderna® vaccines), and the information is in line with the known benefit-risk profile. The EMA will publish safety update reports describing the assessment for both vaccines on its website.

   The HPRA informed the NPHET that the EMA’s human medicines committee (CHMP) has commenced a rolling review of the Sputnik V (Gam-COVID-Vac) COVID-19 vaccine. The HPRA further noted that the Johnson & Johnson Janssen Vaccine is due for CHMP decision on 11th March.

   It was requested that the HPRA include assessment of evidence from the UK on the short-term side-effects of the Astra-Zeneca vaccine in order to address concerns raised by healthcare workers.

6. Communication Update

   The DOH and the HSE presented “Communications Update: 4th March 2021” to the NPHET, for noting.

   **Quantitative Tracker**

   The nationally representative sample of 2,200 people conducted on behalf of the DOH on 1st March reveals:

   - The level of worry at 6.3/10, has fallen back to October levels, as public concern about health system overload falls back. However, the level of worry over prolonged restrictions has risen to a peak, at 3.6. It is now at the same level as worry over the health of family and friends, and the economy, which remains high.
   - 47% of the population do not want further restrictions, while 40% do. A third of the population now think that Ireland is too slow in “returning to normal,” the highest level yet.
   - People are disengaging from COVID-19 related news.

   **Social Activity Measure**

   The Social Activity Measure (ESRI/Department of the Taoiseach) gives insight into how people are coping with the prolonged period of restrictions:

   - While people are finding it tough going, the large majority (79%) believe that preventing the spread of Covid-19 is more important than the burden of restrictions.
   - The data also show systematic misperceptions about socially activity. Presently, half the adult population does not meet up with anyone outside their household over a 48-hour period, with less than one quarter meeting up with three or more. Yet these more socially active people believe that they are meeting fewer people than average.

   **Quantitative Tracker – vaccine module**

   - 56% of the population know someone in their immediate social circle who has had COVID-19.
   - 89% (72% definite, 17% probable) say they will get the COVID vaccine when it is offered to them.
   - 35% say they have concerns around the vaccine - 25% are worried about side effects of the vaccine,
20% worried about the long-term effects on health.

- GPs are the most trusted source of information on the vaccine for 76% of the population, followed by the HSE (55%) and the DOH (51%).

**Qualitative Tracker**

Feedback from the qualitative tracker, for the week commencing 15th February, reveals:

- Citizens remain despondent with the toll of restrictions, yet there is light emerging given the vaccine news. Managing vaccine communication – so it is not seen as an OFF/ON switch – is an important part of managing the country’s expectations.
- Young Adults exist in a social media space governed by controversy and entertainment. COVID-19 communication must enter this realm to be relevant to this cohort.
- At the heart of communication: a simple explanation of the both virus and vaccine, myth-busting information regarding why vaccine worries are unfounded, and a simple path of benefits for young adults to see why the vaccine is relevant to them.
- Communication with vulnerable groups must be tailored; progress is best made collaboratively in this space, by engaging with community leaders.

The Acting Chair thanked the DOH and the HSE for their update and noted that the #Antiviral campaign video, targeted at young adults, will be shown to the NPHET Members once released. The campaign serves as an example of the excellent work carried out by the HSE and the DOH in messaging for this cohort.

**7. Meeting Close**

*a) Agreed actions*

The key actions arising from the meeting were examined by the NPHET, clarified, and agreed.

*b) AOB*

No matters were raised under this item.

*c) Date of next meeting*

The next meeting of the NPHET will take place Thursday 11th March 2021, at 10:00am via video conferencing.