



1<sup>st</sup> November 2021

Mr Stephen Donnelly TD  
Minister for Health  
Department of Health  
Block 1, Miesian Plaza  
50-58 Lower Baggot Street  
Dublin 2

*Via email to Private Secretary to the Minister for Health*

Dear Minister

I have today received recommendations from NIAC regarding booster doses of COVID-19 vaccines for healthcare workers (see enclosed). It is my understanding that a comprehensive account of the evidence underpinning the recommendation will follow later this week.

In coming to these recommendations, NIAC has considered the evidence in relation to duration of protective immunity following COVID-19 vaccination of healthcare workers (HCWs), as well as epidemiological data pertaining to HCWs in respect of breakthrough infections, hospitalisations and ICU admissions and deaths. In the advice received today, **NIAC has recommended a booster dose of an mRNA vaccine (full dose Comirnaty®, half-dose Spikevax®) for healthcare workers regardless of whether the primary course was of an mRNA or an adenoviral vector vaccine. The booster dose should be given six months (with a minimum interval of five months) following completion of the primary vaccination schedule.** Further, if a HCW has had a breakthrough infection following their primary vaccination course, the booster dose should be delayed for at least six months after the COVID-19 infection was diagnosed. In cases where an mRNA vaccine is contraindicated, consideration may be given to administration of a booster dose of another authorised COVID-19 vaccine based on an individual risk-benefit assessment.

As you will be aware, the European Medicines Agency (EMA) human medicines committee has concluded that a booster dose of the COVID19 vaccines Comirnaty® and Spikevax® may be considered in people aged 18 years and above. In the case of Spikevax®, the booster dose authorised consists of half a dose used for the primary vaccination schedule. Multiple studies have shown that a heterologous (mix-and-match) strategy appears safe and effective in providing a significant immune boost and may be most beneficial in those who initially received a non-mRNA vaccine e.g. HCWs who may have received an adeno-viral vector vaccine as part of their primary vaccination schedule. Nonetheless, it should be noted that the EMA decision relates to homologous boosting only.



As noted by NIAC, although there has been some loss of vaccine effectiveness in preventing infection, the currently authorised vaccines are still highly effective in preventing illness severe enough to warrant hospitalisation, ICU admission or death. In coming to these recommendations, NIAC point out that the evidence supports that vaccine efficacy and effectiveness against symptomatic disease for HCWs is similar to that for the general population. Moreover, breakthrough infections in HCWs are largely acquired in the community with less than 2% of infections acquired in healthcare settings. This underpins the importance of the NIAC recommendation that public health and social measures such as good respiratory hygiene, social distancing and good ventilation continue to be observed. As NIAC notes, booster doses are but one element of a multifaceted approach to containing outbreaks of infection. In that regard, NIAC has strongly encouraged all HCWs to complete a primary COVID-19 vaccination course as well as a seasonal influenza vaccine as part of these recommendations. As previously stated by NIAC, booster doses of COVID-19 mRNA vaccines can be given at the same time or at any interval before or after seasonal influenza vaccine.

Thus, while HCWs themselves are not at increased risk of serious disease, NIAC has provided a dual rationale which underpins the recommendation to provide a booster dose to HCWs; by decreasing the incidence of infection in HCWs this will decrease the likelihood of onward transmission to clinically vulnerable patients under their care, who themselves are at higher risk of serious disease should they contract SARS-CoV-2. In that context NIAC has recommended that frontline healthcare workers in direct patient contact should be prioritised for the administration of a booster dose. In addition, by lowering the incidence of breakthrough infections in HCWs this should assist in supporting continuity of healthcare services. Available evidence suggests that neutralising antibodies are important for protection against infection, decline over time, and a booster dose increasing neutralising antibody titres.

I note the NIAC recommendations are in line with the aim of the vaccination programme to ensure equitable access to a safe and effective vaccine with the goal of limiting mortality and morbidity from COVID-19, protecting healthcare capacity, and enabling social and economic activity. Further, they take cognisance of the principle of minimising harm, one of the guiding principles of the vaccine allocation framework, in that they seek to protect those with a significantly elevated risk of death or severe disease and also offer the potential indirect benefit of ensuring continued healthcare provision encompassing both COVID and non-COVID care.

I am endorsing the NIAC recommendations as set out above, which will be updated as required, based on any further NIAC advice.

Yours sincerely

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Dr Tony Holohan  
Chief Medical Officer