

3rd Life Course Immunisation Focus Group

MEETING REPORT (DRAFT)

Date: Friday 7th December 2018

Location: 10th Excellence in Pediatrics, Prague, Czech Republic

MEETING PURPOSE AND STRUCTURE	2
UPDATE ON THE EUROPEAN UNION	4
UPDATES FROM COUNTRIES	8
A. Four Lessons from Italy	8
B. Updates from Czech Republic	10
C. Updates from Lithuania	12
D. Comparison of Policies Between Norway and Poland	15
E. Updates from Serbia	20
REPORTS FROM INITIATIVES AND CAMPAIGNS	20
WORKING GROUPS RECOMMENDATIONS	24
A. Overcoming HCP Hesitancy	24
B. Economic Value of Life-course Immunisation	25
C. Antimicrobial Resistance and Vaccines Policy and practice	26
D. Mandatory Vaccination	27
E. Community Immunity	27
NEXT STEPS & ACTIONS IN 2019/20	28
Stakeholder Working Group Meeting on Varicella Vaccination	30
Stakeholder Working Group Meeting on Rotavirus Vaccination	30
Stakeholder Working Group Meeting on all-cause Meningitis Vaccinations	31
Stakeholder Working Group Meeting on Influenza Vaccinations	31
Stakeholder Working Group Meeting on Vaccinations for imported infections	31
LifeCourse Immunisation Policy Focus Group Meeting	32
CAMPAIGNS	33

MEETING PURPOSE AND STRUCTURE

EIP has been working for the past 7 years on overcoming barriers to vaccination uptake in childhood covering: HPV, influenza, meningitis, amongst others, at separate meetings across Europe, Middle East and Asia and have also included infectious disease sessions on the conference programmes and CME online courses on overcoming vaccine hesitancy.

For the past 3 years this approach has been broadened to take a LifeCourse approach linking with Adolescent Medicine and General Practitioners to include as many partner organisations as possible in the Focus Groups and planned actions to achieve its mission of overcoming the barriers to vaccination uptake (public and HCP uptake) across Europe.

The European Life Course Immunisation Initiative is tasked with uniting Healthcare Professionals to push for universal immunity at a policy level while overcoming vaccine hesitancy at the grassroots in healthcare systems (and amongst healthcare professionals themselves) across Europe.

- Mapping the latest opinions and barriers.
- Connecting vaccination key opinion leaders and frontline pediatric healthcare professionals, (who

administer vaccines on a daily basis) with associations and policymakers.

- As well as connecting associations and organisations advocating vaccination uptake across Europe to better collaborate and work with each other (the Together Network and Platform).

To help achieve and coordinate these goals, the **3rd Life Course Immunisation Meeting** took place in Prague, 7th December 2018, in parallel to the 10th Excellence in Pediatrics Conference, and in partnership with the WHO's Health Behaviour in School-aged Children (HBSC) and the Coalition for Life Course Immunisation (CLCI).

All types of vaccine preventable disease were in focus with the desire to overcome barriers across the board.

Professor Sir. Terence Stephenson, Professor of Paediatrics at University College London, Chair of the General Medical Council of United Kingdom, welcomed the participants to the 3rd Life Course Immunisation Focus Group and provided a brief overview of the agenda.

In summary, the overall purpose of the Focus Group was:

- to provide a comprehensive overview of current vaccines policies across Europe (Updates covering the European Commission and individual Countries);

- to examine changes made and positive steps taken on vaccination policies across Europe (and within European countries) during 2018;
- to outline vaccination priorities, reviewing surveillance data and current population coverage.

A second purpose of the Focus Group was to determine actions on vaccination across Europe that overcome barriers and increase uptake. In order to achieve these goals, several key speakers were invited to make a presentation which was proceed by an open discussion with speakers, experts and participants.

European Union related presentations included:

- **Update on Surveillance & Population Coverage Across Europe**
(Presenter: Anna Odone)
- **Update on policies and actions in the European Union 2018/19**
(Presenter: Dr Daphne Holt)

Countries related presentations included:

- **Four Lessons from Italy**
(Presenter: Carlo Signorelli)
- **Romania Vaccination Update – The Roma Population**
(Presenter: Marius Tudor)

- **Czech Republic Vaccination Update**
(Presenter: Roman Prymula)
- **Lithuania Vaccination Update**
(Presenter: Vytautas Usonis)
- **Serbia Vaccination Update**
(Presenter: Radovan Bogdanovic)
- **Comparison of Policies Between Norway and Poland**
(Presenter: Pawel Stefanoff)

After the presentations and debates, participants were divided into 5 working groups, covering :

1. **Strategies to overcome healthcare professional hesitancy in adopting new vaccines**
(Led by Terence Stephenson)
2. **Economic Value of Life-course Immunisation. What is known, what are the gaps, why is it important?**
(Led by David Sinclair)
3. **Antimicrobial Resistance and Vaccines Policy and Practice: What are the practical steps?**
(Led by Sam Nye)
4. **Mandatory Vaccination. A Solution or part of the problem?**
(Led by Daphne Holt)
5. **Herd Immunity: Strategies to increase the awareness of the importance of herd immunity**
(Led by George Syrogiannopoulos)

Each working group then outlined the Group's ideas and suggested future actions.

The following summarises the key points of each presentation and the key points debated during the open forum and in the working groups, before concluding on progress made in 2018 and actions, initiatives and campaigns needed in 2019/20.

UPDATE ON THE EUROPEAN UNION

Updates on Surveillance & Population Coverage Across Europe

Presenter: Professor Ana Odone
(Professor, Director School of Public Health - Uni San Raffaele in Milan, Italy)

A brief overview of what the EU currently does and arguably should be doing on immunization policy was delivered, namely providing the Focus Group with :

1. A contextual framework
2. EU surveillance of infectious diseases
3. EU role in technical support to Member States
4. EU role in policies
5. Immunization recommendations across MSs
6. Population coverage across MSs

Professor Odone started her presentation with a statement from Bruce Gellin (Director, National Vaccine Program U.S. Department of Health and Human

Services), "Talking about vaccines is different from talking about vaccination".

Following, Professor Odone presented the contextual framework of vaccination which contains important levels ranging from Surveillance – Research and development - Marketing authorization (Efficacy and Safe vaccines) – Recommendations – Organization of supply and immunization services – Vaccine Demand and Uptake by target populations.

These levels can be measured by Coverage Rates which in turn may inform about the Impact of Immunization Policies as well as about Planning and Implementation.

Professor Odone continued by focusing on how surveillance of infectious diseases is carried out at an EU level. The European Centre for Disease Prevention and Control (ECDC) collects, analyses and disseminates surveillance data on 56 communicable diseases (some are vaccine-preventable diseases) and related special health issues from Member States. Reporting is made in a standardised way to allow data comparability across EU.

The EU also provides technical support to Member States mainly through scientific advice, communication and training. As an example, Professor Odone presented the ECDC handbook on the design and implementation of immunisation information systems (available [here](#)).

In terms of the EU role in immunization policies, Professor Odone denoted that although vaccination policy is not a competence of the EU but of the national authorities, the European Commission assists EU countries in coordinating their policies and programmes by making recommendations. As an example, Professor Odone highlighted the recent Council Recommendation to strengthen the EU cooperation on vaccine - preventable diseases (April 2018). The EU also funds research and scientific initiatives and programmes. As an example Professor Odone presented the Joint Action on vaccination, co-funded by the Health Programme at €3.55 million.

Regarding Immunization recommendations across Member States, Professor Odone referred to the EDCD platform containing the most recent [recommendations](#), highlighting however, that there is heterogeneity of immunization offer and recommendations by member states. In regards to coverage, which data is not collected at EU level, Professor Odone explained that it is the World Health Organization who keeps track of the different vaccines, different recommendations and different programmes across countries.

As an example, Professor Odone provided a reference to: Jorgensen, P., Mereckiene, J., Cotter, S., Johansen, K., Tsovala, S., & Brown, C. (2018) work covering: How close are countries of the WHO European Region to achieving the

goal of vaccinating 75% of key risk groups against influenza? Results from national surveys on seasonal influenza vaccination programmes, 2008/2009 to 2014/2015. [Vaccine. 36\(4\). 442-452.](#)

The paper concludes that: Despite policy recommendations, influenza vaccination uptake remains suboptimal. Low levels of vaccination is not only a missed opportunity for preventing influenza in vulnerable groups, but could negatively affect pandemic preparedness. Improved understanding of barriers to influenza vaccination is needed to increase uptake and reverse negative trends. Furthermore, implementation of vaccination coverage monitoring is critical for assessing performance and impact of the programmes.

Update on policies and actions in the European Union 2018/19

Presenter: Dr. Daphne Holt (Chair of the Coalition for Life-Course Immunisation - CLCI)

Dr. Holt started her presentation by sharing that her sources of information come from official documents, notes and slide decks from meetings where the Commission's perspective on vaccination was discussed by experts such as: Martin Seychell – Deputy Director General, DGSanté (Health and Food Safety), John-F Ryan – Director Public Health, Country Knowledge and Crisis Management DGSanté, Geneviève Chêne

- Directrice, Institut de santé publique, d'épidémiologie et de développement, Univ. Bordeaux, Coordinator of the Joint Action on Vaccination.

Dr Holt reiterated that the importance of life-course vaccination according to DGSanté, which is becoming more and more important, is that life-course vaccination maximises benefits of vaccination for individuals, public health and society. Life-course vaccination requires: political leadership, changing public perception of vaccination (it should be seen as the norm), engagement of healthcare professionals (they are at the frontline), integration of non-healthcare setting (e.g. workplace) and improved surveillance. Moreover, the promotion of life-course vaccination has to be evidence-based.

Past EU legislation on communicable diseases from 2000-2013 is available: Commission Decision 2000/96/EC (list of communicable diseases), Commission Decision 2002/253/EC (case definitions for communicable diseases), Regulation (EC) No 851/200417 (ECDC founding act, 2005), Decision No 1082/2013/EU on serious cross-border threats to health

Regarding the Commission's current work on vaccination, Dr Holt highlighted: the coordination of preparedness, assessment and outbreak management of vaccine - preventable diseases, Guidance on communication activities relating to vaccination programmes, the monitoring benefits and risks to derive and

disseminate evidence-based information on effectiveness and safety of vaccines / vaccination, organising a joint procurement for pandemic vaccines and other products (not forgetting that health is a member state competence is not a competence of the union itself)

The current EU policy initiatives on vaccination covers:

1. Proposal for a Council Recommendation and Commission Communication to strengthen the EU cooperation on vaccine-preventable diseases;
2. EU Joint Action on Vaccination, including life-course approach to vaccination in plans,
3. Taking into account research requirements for life-course vaccination.

The Council's recommendation on vaccination are:

1. Aimed at strengthening cooperation and coordination between EU countries, industry and other stakeholders to help:
 - Increase coverage,
 - Promote alignment of vaccination schedules across the EU,
 - Promote vaccine acceptance,
 - Support research and development,
 - Strengthen vaccine supply, procurement and stock

management, including in cases of emergency.

2. Envisaging establishing a European Vaccine Information Sharing System which will underpin:
 - Developing guidelines on a EU common vaccination schedule,
 - Options for developing a common EU vaccination card ensuring the continuity of immunisation when citizens move between member states;
 - A web-portal with information on the benefits and safety of vaccines.
3. Advocates creating a virtual data warehouse of vaccine needs and stocks which could enable Member States and the Commission to:
 - Identify available stocks of vaccines in cases of outbreaks or severe shortages; exchange surpluses.
4. Foresees a Coalition for Vaccination bringing together representatives of healthcare workers associations and relevant student associations to commit to increasing vaccination coverage in Europe.

The EU Joint Action on Vaccination was launched in September 2018 and aims to improve vaccination coverage, and thus health security, in Member States. It's co-funded by EU and Member States and coordinated by INSERM, France. There

are 20 partner countries (UK, Germany and Austria will join later). Main activities will include: public consultation to provide information and guide interventions /actions; coordinate cross-border measles vaccination campaigns and improve communication; annual competition of vaccination promotion in European schools; map and review electronic vaccination record systems that already exist and discuss how to best implement them.

A Stakeholder forum is envisaged to encourage participation from civil society. Regarding the new financial period 2021 – 2027, there is a new and improved European Social Fund plus (ESF+) with €101.2 billion to spend and ESF+: health strand - €413 million (under direct management) to help member states modernise their health systems. Moreover, ESF+: projects under shared management (€100 billion allocated) will also have funding opportunities for health

Horizon Europe programme health cluster; €7.7 billion - health through the life-course; environmental and social health determinants.

In addition, there is a new political environment based in the context of a change in the Commission starting in 2019 and the European Parliament elections. So this may represent an opportunity to fix new policy priorities in public health and for stakeholders to help set the new policy priorities in public health.

A member of the Focus Group interjected to update the Group that the Health Ministers of the EU adopted the Council Recommendation on strengthened cooperation against vaccine-preventable diseases focused on three main pillars: tackling vaccine hesitancy and improving vaccination coverage; sustainable vaccination policies in the EU; and EU coordination and contribution to global health.

UPDATES FROM COUNTRIES

A. Four Lessons from Italy

Presenter: Professor Carlo Signorelli (Professor of Hygiene and Public Health at the Universities of Parma and Vita-Salute San Raffaele, Milan, Italy)

Professor Signorelli provided a brief introduction of Italy's history of having championed several vaccination policies such as: smallpox, polio and acellular Pertussis vaccines, and being the first to introduce universal vaccination against hepatitis B virus in 1991 and against HPV in 2007.

However, Professor Signorelli set these in the context of recent events and shared information about four practice examples from Italy:

Suspension of mandatory vaccinations in Veneto region (2007)

In 2007 the Veneto Region in Italy (one of the regions in Italy with history of high vaccination coverage) suspended mandatory vaccinations and invested in educational and information campaigns to better counteract the spreading of anti-vaccination movements. As a result there was a greater coverage decrease in Veneto than in other Regions, showing that the nudge theory (a theory that states that people make wiser decision when their choices are presented better and their freedom of choice is kept) did not meet the goals. Professor Signorelli showed a graph illustrating that the suspension of mandatory vaccination decreased the coverage rates in Veneto from around 98% to 92%.

A strengthened political commitment (2014- to-date)

Since 2014, a strong political commitment started by the Ministry of Health in collaboration with the National Health Institute, the Italian Chief Medical Officer, the Italian Agency for Medicine (AIFA), Pharma companies and Scientific associations, has positively influenced scientists, journalists and judges about the usefulness of vaccination. The overall results of this commitment were considered positive since data shows that a new National Plan, new actions increased coverage rates. Moreover, there was a favourable increase of media coverage for vaccination compared to hesitancy. Nevertheless, in 2017 there was a decrease of favourable news on

vaccination probably due to a parliamentary debate on mandatory vaccination. Regarding coverage data, Professor Signorelli shared graphs illustrating that influenza coverage rates in the elderly and the national coverage rates for polio and measles increased since the 2014 political commitment. Another important fact is that the majority of the population agreeing that all vaccines should be mandatory or at least a small proportion all vaccines should be mandatory also increased since 2014.

An unexpected role player (2015-onwards) – Professor Roberto Burioni

Professor Signorelli gave the example of Dr Roberto Burioni, a Professor of microbiology at the Università Vita-Salute San Raffaele in Milan, who is trying to use social networks to oppose anti-vaxxers, with a rather aggressive tone, claiming that they are ignorant and that science is not a matter of democracy. According to the number of views, this approach had a positive impact on social media platforms, rebalancing scientific information against hesitancy and anti-vaccination.

Expansion of mandatory vaccinations (2017)

In 2017, there was a strong Italian policy to “stopgap” and raise vaccination uptake. Mandatory vaccinations rose from 4 to 10, certificates were asked at pre-school admission with fines (500€) for non-compliance, there was information strengthening and sanctions applied to

anti-vax medical doctors. Professor Signorelli showed the Group an example graph illustrating how the coverage rates for Polio and Measles in the region of Emilia Romana increased from 2017 up to now (2016 - 93% to 2018 - 96% and 2016 - 87% to 2018 -95% respectively).

After presenting the four examples from Italy, Professor Signorelli gave some insights on possible risks for a rebound due to the political context and the rise of populist ideas of anti-vaccination and discredited claims on dangerous risks of vaccines. As an example, Professor Signorelli cited a [The Guardian News article](#) divulging that the Italian health minister decided to discharge the entire board of Italy’s most important committee of technical-scientific experts, who advise the government on health policy.

In conclusion, Professor Signorelli stated that vaccine uptake and hesitancy policies and behaviours are highly influenced by countries and regions social, cultural and political contexts.

Discussion

Group discussion followed with a debate around a possible continuum between mandatory vaccination and totally voluntary vaccination (the nudge theory).

A Group member gave the example of the UK's strategy of making vaccination mandatory unless people clearly state that they do not want to get vaccinated and asked if this could also be implemented in

Italy. Professor Signorelli responded that in Italy, before 2017, there were four vaccines requirements for children enrolled in schools but these were never verified or checked. Since 2017, there was an improvement in such verification due to the mandatory law both in vaccines that are and are not mandatory.

The Focus Group commented on Professor Burioni's strategy outlined in the presentation and debated if the aggressive tone used by Professor Burioni is really helping or if he is "awaking the monster which is sleeping" in the sense that it might be risky to rely on someone that impulsive. Professor Signorelli responded that the "monster" was not sleeping since many anti-vaxxer were already reaching the media. In that sense Professor Burioni can be helpful because he reaches the media and disseminates scientific information.

The Group continued to share examples, including the case of France, which is a country with high rates of vaccine scepticism and with a new legislation on compulsory vaccination, and asked if political stability can help coverage rates and if changing the law every 3 years can be harmful. Professor Signorelli responded that changing legislation all the time is not always beneficial and that we as public health society should suggest governments to wait three years and evaluate the impact of new laws and only to change them if at all necessary.

The Group then pinpointed that 5% of not vaccinated population in Italy is a substantial number and asked if this percentage is related to conscientious objectors, in the sense that in the UK some parents have to show proof for a vaccination exemption (e.g. Religion exemption). Professor Signorelli stated that the 5% includes exemptions for medical reasons, migration (e.g. moved to other countries or regions) and errors in registration. According to data from the National Institute of Health the proportion of conscientious objectors is circa 0.7%.

B. Updates from Czech Republic

Presenter: Roman Prymula (Deputy Minister of Health, Professor of Preventive Medicine at School of Medicine, Charles University, Czech Republic)

Professor Prymula briefly presented the Czech Republic's Immunisation Programme by explaining that some vaccinations are mandatory (e.g. Hexa + MMR) while others are voluntary but recommended (e.g. Pneumo + HPV).

Overall, the immunization is covered by the health insurance fund. In terms of coverage rates of the recommended vaccines, Professor Prymula stated that these range from 70% to 80% for Pneumo and from 65% to 68% of HPV in girls.

Regarding Pertussis, Czech Republic had a steep rise in cases, possibly related with

the introduction of the acellular vaccine, reaching the highest point in 2014 and dropping until 2018. Adolescents were the most afflicted aged-group and therefore a booster shot was introduced at the age of 10-11 years old.

In summary, the history of the Immunization Program for Pertussis includes:

1. an Incidence until 1958 of 30,000-34,000 a year / 80 deaths a year;
2. In 1958 Vaccine was introduced;
3. Until 2006 Vaccination schedule for 3-5 month olds, a booster at 18-20 months and one at 5 years-old, and DTwP used (about 20% in Prague aP);
4. Since 2006 Vaccination schedule included 3-5 month olds, 1st booster 6 months later up to 18 months, 2nd booster at 5 years old, DTaP-IPV-Hib-HBV used; and
5. 3rd booster at 10-11th years old since 2009.

Professor Prymula commented that in terms of Influenzae B there is a high coverage rate and a large decrease in incidence disease following the introduction of routine vaccination. And in terms of Polio, there are no cases registered since 1960.

Mumps outbreaks have been registered in Czech Republic but there are almost no cases of Rubella. Regarding Measles

there were 3 outbreaks in the last few years (2014 and 2017).

Reported Cases of tuberculosis TB have been decreasing since 1958 in the Czech Republic and vaccination is not mandatory and is only recommended for vulnerable groups.

Regarding Tick-borne Encephalitis (TBE) vaccination is being considered for mass vaccination but it is not mandatory at present. The number of Varicella cases has also been decreasing since 2014.

Professor Prymula presented a chart with the Czech Republic Vaccination Calendar, highlighting the Mandatory and Recommended vaccinations in 2018. Professor Prymula also summarized the main changes in the Czech Immunization schedule in 2018 namely:

- Novel law 48/1997 30.6. 2017 for reimbursed services;
- HPV for boys aged 13 years (girls covered already since 2012);
- 2+1 schedule for Pneumococci – (3+1);
- New chronic diseases (IMD, IPD, Hib, flu);
- and new immunization for seniors 65+ PCV13; DTaP-Hib-HBV-IPV vaccination changes (2 doses since Week 9, 2 months apart;
- Booster between 11-13 month; Preterm newborns: 3+1;
- Booster DTaP-IPV at 5-6 years old;
- Booster DTaP-IPV at 14 years;

- MMR at 5-6 years old (second shot); and first shot fixed till 18th months).

To conclude, Professor Prymula shared his concern regarding the rise in vaccine hesitancy, mainly because this topic is increasingly and more successfully reaching mass media and also because it is very difficult to argue purely scientifically against anti-vaccination ideas. Moreover, Professor Prymula stated that there are steps being taken in Czech Republic towards the adoption of a law for vaccine-related injuries compensation due to mandatory vaccination.

Discussion

Following the conclusion of the briefing the Focus Group asked if countries in Central and Eastern Europe, such as Czech Republic, should be concerned about increases in incidence of tick-borne diseases due to climate change. Professor Prymula responded that this is a worrisome situation since climate change/warming is changing the distribution of ticks and there is a widespread presence of ticks in the Czech Republic.

The Group then asked if the shift made in measles vaccination from 5 to 6 years old is being effective in terms of higher coverage. Professor Prymula answered that this was introduced very recently and there is no data available yet.

The Group went on to question Professor Prymula about Meningococcal disease in

Czech Republic. Professor Prymula explained that in the last years there was a rise in MenC cases and because of this a 2+1 schedule for MenB is being considered for the youngest children and a one shot of MenC 1+.

C. Updates from Lithuania

Presenter: Professor Vytautas Usonis (Professor of Paediatrics at Vilnius University and currently Head of the Vilnius University Clinic of Paediatrics)

Professor Usonis started by presenting an historical and political background of Lithuania and by stating that the first National Programme on immunisation (NIP) was established in 1992 and is updated every 4 years.

The latest NIP was approved for the period of 2019-2023. The first immunisation calendar was inherited from the time of former Soviet Union, and since 1993 only vaccines of international standard are used in Lithuania. Therefore, in the children immunization calendar the 3rd dose of BCG is no longer included.

Regarding the Milestones of the development of NIP, Professor Usonis explained that since 1996 in addition to the vaccines provided by State other vaccines are available but not reimbursed, and that in 1998 the 2 dose of MMR vaccination was introduced and high MMR

coverage ensures sporadic low measles level in Lithuania.

Also in 1998 there was the introduction of Hep-B starting from newborns and in 2002 for teenagers that were not vaccinated earlier.

In terms of MMR coverage in 2002-2016, among children aged 2 years, Professor Usonis presented a graph showing that, although decreasing, coverage is still high. Regarding children aged 7 years old the coverage rate is a little lower but still acceptable.

Professor Usonis went on to provide the Group with a brief overview on vaccine preventable diseases in Lithuania, showing that for the case of Diphtheria, and following its outbreak in 1994-1995, a very effective vaccination campaign was implemented which resulted in a decrease in cases (the last case detected was in 2011 – a 55 year old with immunisation status unknown).

Regarding Tetanus, during 2005-2015 there were 20 cases detected (among them there were 7 deaths reported all over 60 years of age) and 2 cases in 2016 (A 74 and a 84 years old) resulting in 1 death.

Regarding Polio the last case reported was in 1972. Lithuania has been polio-free since 2001 and there is no OPV since 2007 with the exception of cases of children coming from Georgia, Russia or Ukraine.

In relation to *Haemophilus influenza*, Professor Usonis explained that Hib vaccination was introduced to Lithuania's NIP in 2004 and a total of 7 cases of *Haemophilus influenzae* spp cases were registered in 2016 and 14 in 2015 (all were hospitalised and there were no deaths reported).

Official data regarding Invasive pneumococcal diseases from 2016 stated that there were registered 56 cases (no death cases were registered). Professor Usonis cited his prospective study carried out in 2012-2013 to evaluate the circulation of SPn serotypes among young children in five cities of Lithuania before the introduction of universal vaccination with pneumococcal conjugate vaccine (PCV), in which it was found that the SPn colonisation rate was 40.8% (367/900), with a peak at two and three years old (48.8% and 45.4%, respectively). Of the 367 SPn isolates, the most common serotypes were 6B (15.8%, n = 58), 19F (13.9%, n = 51), 23F (13.9%, n = 51), 15 (10.1%, n = 37), 14 (9.5%, n = 35), 6A (9.3%, n = 34), 11 (4.6%, n = 17), 3 (3.0%, n = 11) and 18C (3.0%, n = 11); less frequent were 23 (non-23F) (2.7%, n = 10), 19A (2.2%, n = 8) and 9V (1.6%, n = 6).

Streptococcus pneumoniae nasopharyngeal colonisation in children aged under 6 years with acute respiratory tract infection in Lithuania, February 2012 to March 2013. Eurosurveillance, 20(13), 21079.).

Another important outcome from this study was that it provided important information for PCV vaccination. Therefore, PCV 10 was introduced to Lithuania's NIP since 2014.

Invasive meningococcal disease is highly prevalent in Lithuania and the highest incidence is found in the Vilnius county. MenB serogroup is the most prevalent, therefore since July 1st 2018 vaccination was introduced. The uptake of MenB vaccine has been increasing from 2014 to 2016.

Regarding Rotavirus there has been an increase of cases among all age groups with the higher incidences in children below 3 years old. Vaccination for Rotavirus has been included in the calendar.

To conclude, Professor Usonis highlighted that Lithuania is also focusing on vaccination throughout adult life and that the state covers: Rabies vaccination (postexposure), TD for every 10 years or after trauma, Influenza - >65 of age or risk groups and PCV for risk groups regardless of age, and vaccination after bone marrow transplantation.

Discussion

The Group then asked how the current uptake rates are with respect to adult vaccinations in Lithuania. Professor

Usonis responded that these are very low, even among target populations (e.g. the flu vaccine is about 10-15%) and that there is still a long way to go to reach good coverage rates. The Focus Group then commented on the high levels of pneumococcal disease in the data presented by Professor Usonis, and asked how can such data help make the case for increasing vaccination uptake. Professor Usonis responded that the study and its data have huge importance in demonstrating the burden of pneumococcal disease in Lithuania. These have implications for public health and for organizing universal vaccination.

The Focus Group then asked Professor Usonis for his view on how to best convince countries' health authorities to have MenB vaccine in the national calendar. Professor Usonis explained that countries should not be compared and strategies should be different. In the case of Lithuania what sparked the intention for MenB vaccination were 2 death cases in one day that had high coverage in the media, and subsequently many discussions were held in the parliament about cost-effectiveness (e.g. money vs. preventable death cases). Yet, in the end there is no recipe or a strategy that could fit all countries (e.g. different incidence rates).

D. Comparison of Policies Between Norway and Poland

Presenter: Dr. Pawel Stefanoff
(Epidemiologist, Norwegian Institute of Public Health)

Dr. Stefanoff summarised the objectives of his presentation were to: 1) To compare immunisation programmes in both Norway

and Poland and 2) To identify the best practices that could improve the Polish programme.

Dr. Stefanoff presented to the Group the contrasts between the countries **Immunisation programmes, in terms of structure**. Namely:

Norway	Poland
Immunization schedule approved by the MoH Norwegian Institute of Public Health (FHI) recommends changes based on systematic reviews and economic analyses	Immunisation schedule approved by the MoH Based on expert groups recommendations and available budget
FHI buys vaccines and distributes to immunization points	MoH buys vaccines and distributes to immunisation points through Public Health regional and local departments
Immunization nurses - Administer vaccines - Provide information to parents - Consult difficult cases with on call physicians - Register each vaccination in electronic register (SYSVAK)	General practitioners - Qualify and administer vaccinations - Inform patients about the adverse events - Register each vaccination on paper vaccination cards
Vaccinations are not mandatory	Vaccinations are mandatory Administrative procedure including fine (e.g. cutting school admission or social benefits).

Dr. Stefanoff shared that in Norway there is maximization of the number of antigens (12) and minimization of number of visits (7), which contrasts with Poland high

number of visits (11) and high number of monovalent vaccines (single antigen).

In terms of **Immunisation programme governance**, Dr. Stefanoff compared the two countries namely

Norway	Poland
FHI vaccination team - Composed of medical consultants - Ad hoc meetings to review recommendations - Ad hoc literature reviews subcontracted to specialized team - Plan to call a classic NITAG with 2 meetings / year - Development of adult immunisation programme	National Sanitary-Epidemiological Council has an annual meeting to recommend changes in immunisation programme - The Council deals with all PH problems - Not a classical NITAG
MoH approves the immunisation schedule and budget based on expert opinion - Transparency of decisions warranted by publishing all supporting documents on open website - Strict conflict of interest rules for FHI experts	Another expert group composed of clinical key opinion leaders provides advice to MoH on changes to the immunisation programme
	No transparent criteria for decision making - No separate budget line in the MoH budget - Reports from meetings of both advisory bodies not publicly available - No transparent conflict of interest rules

Dr. Stefanoff explained that the National Sanitary Epidemiological Council in Poland is a group which advises on all Public Health problems and not specifically focused on vaccinations. Furthermore, reports are not published not allowing a very transparent decision

making. And there is no specific budget which does not allow a very sustainable system.

In terms of **Immunisation coverage monitoring**, Dr Stefanoff highlighted the following differences:

Norway	Poland
SYSVAK: vaccination registry - Vaccination nurses register each vaccine given - The registry is linked with the population register - Numerator: vaccine dose administered - Denominator: actual Norway residents	Administrative method - Based on vaccination cards stored in vaccination points - Annual paper report filled by each vaccination point - Numerator: vaccinated children in each birth cohort - Denominator: number of vaccination cards
Permits monitoring of vaccination coverage in real time - by birth cohort - by risk group - detect early signals of decreased coverage	The system quality depends on the documentation
	No possibility to monitor vaccination in high risk groups

Norway's electronic registry system allows for on-time monitoring (which can be stratified by age, group etc) but in contrast in Poland the paper card system does not work well because people move around

and frequently lose their cards. Regarding **adverse events** following immunisation (AEFI), Dr Stefanoff presented the following differences:

Norway	Poland
Healthcare workers report diagnosed AEFI - Paper forms sent to FHI - Passive surveillance	Physicians (GPs and hospitals) diagnose AEFI - Paper forms sent to PZH - Passive surveillance

FHI consultants qualify according to WHO criteria	FHI consultants qualify according to: • WHO criteria • Polish AEFI definitions
AEFI summary statistics published annually	AEFI summary statistics published annually
Separate system: Everyone can report AEFI using an online form • Signals verified but not published in annual reports	Separate system: Everyone can report AEFI to the Office for Registration of Medicinal Products • Signals verified but not published in annual reports

Dr Stefanoff also presented a useful summary of differences between countries regarding **Communication on vaccine safety**, namely:

Norway	Poland
Nurses are the main source of information • Approx. 1000 vaccination points	Physicians are the main source of information
FHI consultants • Update guidelines on each vaccine and useful news • Answer all questions from healthcare personnel • Have on-call duties every day • Prepare social campaigns to address concrete issues	The State Sanitary Inspection • Manages the vaccine distribution • Regularly visits the vaccination points • Provide information for vaccinators
Norwegian Medicines Agency • Prepares information for healthcare workers • Controls the safety of registered vaccines	The National Institute of Public Health • Runs a website for parents and healthcare workers (with no specific budget) • Advises the central agencies
	Many websites of vaccine producers
	No national strategy

It's worth noting that in Norway, nurses are the main source of information while in Poland physicians are the main source of information – which makes it more difficult to an ease communication and access. Dr Stefanoff commented how coverage rates, which used to be high, are decreasing in Poland. For instance MMR vaccine uptake in 3 years old children has been declining in Poland (95% in first dose) besides being mandatory and increasing in Norway.

Regarding Measles (cases 2007-2016), both countries are near elimination phase but in Norway the decrease in the number of cases is more evident and in Poland where there has been a slight increase in the last years. In terms of Mumps (cases 2007-2016) there are almost no cases in Norway, bar an outbreak in 2015, and in Poland there is also a downward trend. There are no reports of Rubella cases in Norway, but in Poland there are still some cases and there was a compensatory outbreak in 2013 among unvaccinated young males (which were historically not vaccinated, only girls were vaccinated). The rate of adverse event following immunization (AEFI) is higher in Norway than in Poland but decreasing, while in Poland it is still increasing.

To conclude the briefing to the Group, Dr Stefanoff referred that to improve immunization, Poland should:

1. Modernize immunization schedule (more antigens less visits),
2. Improve the transparency of decision taking,
3. Implement immunisation registry in order to more precisely monitor coverage,
4. Implement better targeted communication campaigns,
5. Develop a communication strategy involving several institutions
6. Increase the role of nurses in the vaccination programme (they have more time and are more approachable than medical doctors),

Following the conclusion of the briefing, the Working Group commented that vaccine hesitancy seems to be on the rise in Poland and asked how that can also influenced the data that was presented, as well as the influence of the political context and the trust levels in Polish politicians. Dr Stefanoff responded stating that there was a survey conducted 10 years ago that showed that in Poland people do not trust governmental institutions (which is the opposite of Norway). The reasons for this might be linked with a cultural background but also due to the Polish political background of an authoritarian system until the 1990's that did not provide information or

education related to vaccination and did not invest in communication.

E. Updates from Serbia

Presenter: Professor Radovan Bogdanovic (Institute of Mother and Child Healthcare of Serbia)

Professor Bogdanovic briefed the Group that Serbia has had a very good reputation in terms of vaccination policy and results until the last 3-4 years. But since then the coverage rates have dropped due to two main reasons:

1. Short supply of vaccines
2. Anti-vaccines movement growth (noting that hesitancy is especially high for MMR vaccinations).

In addition, and within this context measles outbreaks peaked in the first months of 2018, with 5,500 cases recorded, among those aged 13-14 years old, around 30% were hospitalised due to pneumonia or other complications.

New cases of measles are still occurring and the authorities response has been somewhat delayed. Nevertheless, coverage rates are improving in some regions reaching the target level, yet in other regions it is still below 90%, demonstrating a disjointed pictures with huge variations in coverage across regions.

In conclusion, Professor Bogdanovic commented that stronger concerted effort against the anti-vaccines movement is needed and this should also tackle anti-vaccine doctors and paediatricians that are still hesitant.

The Focus Group asked Professor Bogdanovic what could be done to help the hesitant paediatricians. *Professor Bogdanovic* explained that each year paediatricians have continued training where they explore the topic of vaccination and there are efforts to try to influence the general public through press and media to stress the importance of vaccination to overcome current hesitancy among healthcare professionals in Serbia.

REPORTS FROM INITIATIVES AND CAMPAIGNS

Update from the Coalition for Life Course Immunisation (CLCI)

Presenter: Malcolm Taylor

Mr Malcolm Taylor gave a brief update on the Coalition for Life Course Immunisation. The CLCI is network of experts and associations from civil society including Public Health NGOs, patients groups, academics, health professionals from across Europe, aiming to prevent infectious disease over the Life-course through wide-scale immunisation.

In order to achieve that CLCI aims to Help Government & Regulators to recognize the benefits of: preventing infectious disease, combating Antimicrobial Resistance (AMR), the good qualities of Herd effect and the benefits to individual, society and economy. By encouraging reporting, comparison and sharing best practice, increasing uptake, overcoming hesitancy, and by cooperating with other stakeholders such as health-care professionals and patient groups.

Recent activities CLCI have been involved with, include:

- Dec 2017 2nd EIP Life-Course Immunisation Focus Group, Vienna, 9th EIP
- June-2018 Policy Forum on Antimicrobial Resistance and Vaccines, European Parliament Brussels
- Oct 2018 EHFG Co-hosting session on Life-course approach to immunisation with Health Policy Partnership
- Dec 2018 3rd EIP Life-Course Immunisation Focus Group, Prague, 10th EIP

In addition, CLCI have participated in:

- Apr 2018 Participated in Active Citizenship Network Meeting: European Patients' Rights Day
- Apr 2018 Participated in Euractiv meeting: 'Empowering citizens to protect their health'

- Jun 2018 Participated in Futures Workshop: '*Immunisation in a digital world*' organised by International Longevity Centre – UK

CLCI Plans for 2019 include:

- Trying to find interested persons among the patients groups, parents or older persons groups, provide them with sound knowledge and encourage them to "spread the good news".
- Increasing Peer learning that is often more efficient than top-down information and the formation of working parties

The Winner of the Vaccines Today Champions Competition

Awarded by Gary Finnegan and Speaker: Mihai Craiu

Mr Gary Finnegan explained the concept of the Vaccines Champions Communication Challenge 2018 hosted by Vaccines Today. The contest was open to healthcare workers, scientists, students and others residents of the European Union that actively contribute to raising awareness and the positive promotion of vaccination through social media channels.

Dr. Mihai Craiu (paediatrician, National Institute for Mother and Child Health Bucharest, Romania) won the competition and made a presentation about his activities on joining the online vaccine

conversation to help parents understand the need for immunisation.

Dr. Craiu started by explaining he has a facebook page called “Virtual Hospital for Children” and also by giving an overview of the immunization situation in Romania. According to WHO-UNICEF estimates NIC in Romania is below herd-immunity threshold, and according to the National Institute of Romania 59 people died during the measles epidemic (out of 15 519 cases up to 1st December 2018),

The decrease of immunisation coverage in Romania has many determinants ranging from hesitancy, anti-vaxx champions, doctors and authorities. The main sources of hesitancy includes: bad science, fake news (e.g. Andrew Wakefield and autism) and anti-vaxx champions (tv stars, religious leaders and also doctors etc). Overall, doctors and paediatricians feel they have weak tools to combat this strong movement.

Faced with this situation Dr Craiu started to go to NGOs organised meetings and not only to medical congress where he could only cover the GPs and not the public, and also started to be “on-line” where patients are usually looking for information.

Social Media Education on health-related issues became a reality after realizing that people get frustrated from the patient-doctor dialogues and usually go online and that doctors can get real-issues that reflect patients’ fears and perceptions

if they watch what people write online. Dr Craiu stated that online-communication empowers patients because they do not feel fearful to ask questions.

In conclusion, Dr Craiu explained that Social Media can be the new Agora because patients feel empowered by the democracy of online communication and are not afraid to ask questions that seem unapproachable in GP’s office. Social Media can, and should, be used for improving basic health literacy.

The Vaccines Survey and Together Platform (EIP)

Presenters: George Syrogiannopoulos and Russell Hale

Professor George Syrogiannopoulos (Professor and Chairman of Paediatrics at the University of Thessaly) provided an overview of the EIP’s European Life Course Vaccination Initiative strategy. Professor Syrogiannopoulos started by explaining that frontline pediatricians are the healthcare professionals who play a crucial role in the successful implementation of vaccination programs since they educate parents, advocate and administer vaccinations in their everyday practice.

Also they know what works and what doesn’t in their everyday practice when addressing parents’ concerns. They have valuable insights that could shape more efficient policies to improve vaccination

rates. In that sense, frontline pediatricians should have a more active role in the design of policies that increase vaccination coverage.

Professor Syrogiannopoulos stated the Initiative's Primary Targets, are to:

1. **Align** efforts and strategies of organisations targeting to **increase vaccination coverage rates** across Europe.
2. **Facilitate** collaboration, best practices / ideas exchanging and educational materials sharing between organisations promoting vaccination benefits in Europe.
3. **Overcome** vaccines **hesitancy** by mobilising and equipping the medical community to discuss and address concerns on vaccinations and advocate **vaccination benefits to their patients**.

In terms of strategic approach for this initiative is the conviction that there is a direct relationship between the Healthcare Professionals **vaccine uptake and their willingness to advocate** vaccines to their patients.

By establishing whether the **Healthcare Professionals vaccination uptake** would lead to strong advocacy for vaccinations could open up numerous interventions to form **strategies** aiming to increase vaccination uptake among our colleagues, driving behavioural change and

subsequently mobilising the medical community to advocate vaccinations to their patients.

Another target is to address fragmented information available for vaccination promotional activities across Europe. There is the need to establish what is happening, when, how much, and how efficient current actions are. Gathering this data will enable to focus on where the problem is and tackle information gaps country-by-country, region-by-region

Training Frontline Healthcare Professionals to address patients concerns in relation to vaccinations is also a concern. The initiative aims to offer, in collaboration with partners, the educational resources needed for the frontline paediatricians to be trained on how to address patients' concerns, overcome hesitancy and drive behavioural change.

Mr Russell Hale (General Manager at EIP) continued the presentation by summarising the 4 Pillars/Components of the Vaccines Initiative:

1. **Survey and Mapping:** which consists in targeting to identify opinions, trends, and concerns on vaccinations targeting 5,000 Healthcare Professionals across Europe in 2019.
2. **Together Platform:** An online platform for organisations promoting vaccinations across Europe to present

and share their activities, campaigns and materials - “a network of networks”.

3. **Educational Resources:** Free resources on the latest data on disease prevalence and vaccines safety - equipping HCPs to overcome hesitancy in their everyday practice.
4. **Policy Meetings:** Bringing organisations promoting vaccinations together, to align efforts, examine policies, decide strategies and plan targeted activities

To conclude, Mr Hale explained that throughout 2019/2020 there will be many additional Campaigns and potential Working Groups established through the Together Network targeting specific conditions/vaccines (**Influenza, Meningitis B, Varicella, Boosters** etc.) addressing issues related to hesitancy and educational gaps. EIP's (45,000+) member database provides the base and ability to focus on specific regions/countries where problems are identified to adjust strategies and communication messages as needed.

WORKING GROUPS RECOMMENDATIONS

Focus Group Participants then divided into 5 Parallel Working Groups each tasked to debate, produce and report on possible way to overcome barriers on the following topics:

1. **Overcoming HCP Hesitancy**
2. **Economic value of vaccinating across the life course**
3. **Antimicrobial Resistance and Vaccines**
4. **Mandatory Vaccination**
5. **Herd Immunity**

A summary of the initial findings and recommendations of each Working Group are detailed below:

A. Overcoming HCP Hesitancy

(Led by Terence Stephenson)

The Working Group discussed strategies to overcome healthcare professional hesitancy in adopting new vaccines. Participants prioritised the following recommendations:

1. **Data and Privacy Protection:**
Doctors are often reluctant to communicate with patients being cautious due to the increased sensitivity on data and privacy

protection. A clear guidance is required, to provide clarifications to healthcare professionals and instruct them how they could communicate on vaccinations to their patients.

2. **Time and availability:** It has identified that limited time available for each consultation is one of most important reasons why healthcare professionals avoid to discuss vaccinations and answer questions from their patients. That applies both to consultations offered through a hospital facility or a private practice. Clear guidance from the facilities management could partially address the problem in hospitals. Actions to increase healthcare professionals commitment to vaccinations could prioritise vaccination coverage in private practices.
3. **Social Media:** Anti-vaccination sentiment is mainly spread through social media. Healthcare professionals are reluctant to engage in public discussions through social media and often do not feel comfortable in using the social networks and platforms. Young healthcare professionals being more comfortable in using and communicating through social networks if informed and engage might step up to counteract misinformation and misconceptions.
4. **Word of Mouth:** People often trust recommendations from friends and colleagues. Communication with

patients through social networks should be done as informal chatting in a way that people would feel comfortable and empowered.

Anti-vaccination sentiment could be addressed through the word-of-mouth of our trustworthy friend who is a healthcare professional and can offer a credible advice.

5. **Countries cultural differences and attitudes towards vaccinations:** It is evident that certain countries which do not have mandatory vaccinations still have high rates of vaccination uptake. Further investigation is required what drives the population attitudes in these countries and whether these attitudes are related to the healthcare professionals commitment.
6. **Changing opinions:** Doctors who are able to communicate in a good manner, face-to-face in a very empathetic way and considering the patient as someone with their own knowledge usually help patients overcoming hesitancy. The power of the HCP is changing opinions is crucial but HCPs should be trained to learn how to drive behavioural change.

B. Economic Value of Life-course Immunisation

(Led by David Sinclair)

The second Working Group discussed the economic value of vaccinating across the life course: The Participants prioritised the following recommendations:

- 1. Making Economic Value a Central part of the Decision Criteria:**
National Immunization Technical Advisory Groups (NITAGs) are often focused on the economic aspects to decide on immunisation policies. For some countries the economic dimension is the only factor they consider. There are countries where effectiveness and social impact are considered as equally important. Decision makers should be advised to consider all factors when making decisions on immunisation policies.
- 2. Proving the Effectiveness of vaccination through the life course:**
The Group discussed if we currently have enough evidence and are in a position to conduct the right modelling to demonstrate the cost-effectiveness of lifecourse immunisation or if this is the first necessary step in proving the effectiveness to decision makers.
- 3. Cost-effectiveness:** There is a broad consensus that vaccination through the life course is cost-effective with only slight variations condition/disease related. Governments should be advised to materialise their stated focus on prevention by investing properly on vaccinations policies.

C. Antimicrobial Resistance and Vaccines Policy and practice

(Led by Sam Nye)

Participants of the Working Group discussed the practical steps to combat Antimicrobial Resistance through improved vaccination coverage across the life-course. Participants prioritized the following recommendations:

- 1. A bottom up approach to promoting lifecourse Vaccinations as a Way of Combating Antimicrobial Resistance.** Successfully engaging with the public and targeting targeting patient groups to explaining them how taking the vaccine could benefit society as a whole through combating Antimicrobial Resistance
- 2. The importance of engaging with stakeholders from other sectors.** Other sectors also have significant contribution on antimicrobial resistance. The healthcare community should engage with all stakeholders and especially from the agriculture sector to get priorities aligned and collaborate in reducing antimicrobial resistance.
- 3. Proving the Case that Vaccinations can Help Tackle the Rise of Antimicrobial Resistance Across Europe.** Making sure these evaluations are carried out and that this evidence is used to inform the

debate and form new policies at the country level.

D. Mandatory Vaccination

(Led by Daphne Holt)

Participants of the fourth working-group were asked to debate if Mandatory Vaccination is a Solution or part of the problem? Set in the context of several European countries having made childhood vaccinations mandatory. Is this the right way to go for adult vaccinations or for healthcare professionals? Participants prioritized the following recommendations:

- 1. Mandatory vaccination of Adults.**
The consensus was that policymakers should only consider mandatory vaccination in the event of a specific public health threat, and then via a focused intervention.
- 2. Mandatory vaccination of Healthcare Professionals:**
Healthcare Professionals are often frequently in contact with the most immunocompromised in society. The Group debated if HCPs should have mandatory vaccination and for what diseases, if in regular contact with seriously ill patients, with the broad consensus that this would be a sensible move.

- 3. An automatically opted-in system for HCPs:** The broad consensus was that best policy to be followed is an automatically opted-in system for the healthcare professionals in the sense that a healthcare professional should have his vaccinations unless he says that doesn't want to be vaccinated. This policy would also help decision makers identify concerns and educational gaps among the medical community that they could address.

E. Community Immunity

(Led by George Syrogiannopoulos)

Participants of the final Working Group were asked to recommend Strategies to increase the awareness of the importance of herd immunity. Participants prioritized the following recommendations:

- 1. Long term change:** Herd Immunity process requires a long time until produces positive results. Communication of the long term benefits could have similarities with the communication followed in other areas such as climate change, litter recycling, or 5 a day vegetables - we can take ideas from other areas.
- 2. Start early:** It takes a long time to create change so it is important to start building on the importance of herd immunity from the early years of a healthcare professional. The

responsibility and the role of the healthcare professional in achieving herd immunity should be part of the education in medical schools.

3. **Altruism is a good appeal?** People always care for their families and friends. Appeals related to the fact that when vaccinated you protect your child or grandparents creates an important emotional link that could increase vaccination uptake.
4. **Technology solutions.** Using digital games and simulations will help to demonstrate what happens when you are vaccinated and when you are not. These could be shown in public spaces, public transport, or classrooms. Using virtual reality goggles to see in 3D the effects of being sick could also stress on the fact of the importance to get vaccinated.

CONCLUSIONS

Professor Stephenson concluded the 3rd life course immunisation focus group by thanking the participants and the co-chairs and by sharing a personal concern regarding the Health Care Professionals working in his Hospital who do not uptake the flu vaccine even when it is free of charge – average rate of uptake is around 50%. Professor Stephenson shared that one solution to tackle this year has been having a drop-in place with a responsible person available with the vaccines with no

need to make an appointment. Another issue of concern that Professor Stephenson shared is that we should empathise with HCPs who are at the front, since more doctors are feeling pressed by the number of people they have to see, they do not have time to tackle these difficult issues of vaccine hesitancy, and the most simple thing to do is conflict avoidance.

NEXT STEPS & ACTIONS IN 2019/20

The European Life Course Vaccination Initiative in 2019/20

To build on the broad consensus that collaboration and joint actions in tackling vaccine hesitancy and increasing vaccination rates is vital, the **European Life Course Vaccination Initiative in 2019/20** has been tasked with bringing together all stakeholders to discuss in depth, build a consensus on the steps ahead, and produce a roadmap of actions to increase vaccination coverage in Europe with targets to:

1. **Collect and present evidence needed** for the decision makers to revise and update their current policies and recommendations
2. **Align efforts and strategies of organisations** targeting to increase

vaccination coverage rates across Europe

- 3. Mobilise and equip the medical community** to engage, address concerns on vaccinations, and advocate vaccination benefits to patients.

The Need to Inform Decision Makers, Counter Misinformation and Collaborate

From Discussion at the 3rd Life Course immunisation Focus Group in Prague, it's clear that decision makers are often not informed, or arguably do not always act on the scientific evidence, the recommendations and guidelines, and the outcomes and experiences from successful implementations. In addition, the public often remains confused and misinformed without the tools to filter information spread through social media, the medical community is often not able to step-up and building vaccines confidence and efforts made by organisations are fragmented, not aligned and often overlapping.

Stakeholders Working Groups Meetings

To counter this, EIP and partners will host **5 Stakeholder Working Groups**

Meetings in 2019 targeting to help countries improve their immunisation strategies, and revise and update their policies and recommendations. Researchers and experts, key opinion leaders, medical associations, public health experts and officials, government organisations and regulatory authorities from EU Member States will be invited to actively participate in the open discussions, share their experiences and ideas and contribute to the meetings' goals.

The following **Working Groups** are proposed in 2019:

- 1. The path Towards Universal Varicella Vaccinations** (July 2019)
- 2. Rotavirus Vaccination. What Should Change?** (July 2019)
- 3. Is it Time to Protect all Against all Types of Influenza Viruses?** (Sep 2019)
- 4. Can we Control All-Cause Meningococcal Disease?** (Sep 2019)
- 5. How to Address Challenges from Immigration, Climate Change and Frequent Travelling?** (Oct 2019)

The Stakeholder Working Group Meetings are targeting to agree a consensus on vaccinations where significant discrepancies on policies are identified. With Vaccine policy, decision processes

and outcomes varying widely across Europe, despite the official guidelines, countries have often adopted heterogeneous vaccination strategies resulting to different coverage rates among the populations in Europe. The decision-making remains country-specific reflecting varying epidemiology as well as country-specific differences in healthcare systems, level of evidence, vaccine acceptability and financing. The Stakeholders Working Group Meeting are targeting to help countries improve their immunisation strategies using evidence based, transparent and sustainable processes.

Each multi- stakeholder one-day meeting is dedicated to one of the vaccinations where significant discrepancies are identified across Europe. Each meeting targets to examine the latest available scientific data related to the disease and the available vaccines, review the current vaccination policies and coverage across all European countries, build a consensus among all stakeholders on the steps ahead and produce a roadmap of actions and a position paper that will help decision makers to revise and update their policies and recommendations. Further detail on each Working group are included, below:

Stakeholder Working Group Meeting on Varicella Vaccination

MEETING 1: The path towards Universal Varicella Vaccinations in Europe

- **Recommendations** - existing recommendations, policies spectrum, current vaccination coverage
- **Policies** - funding, high-risk groups, Co-payment models
- **Evidence** - Latest date, coverage rates achieve. impact on disease prevalence, hospitalisation and complications
- **Barriers** - Low public health priority/burden, cost effectiveness, Safety related to MMRV-associated febrile seizures
- **Actions** - Road map, Align efforts, Actions toolkit per country

Stakeholder Working Group Meeting on Rotavirus Vaccination

MEETING 2: Rotavirus Vaccination in Europe. What should change?

- **Recommendations** - existing recommendations, policies spectrum, current vaccination coverage
- **Policies** - funding, high-risk groups, Co-payment models
- **Evidence** - Latest date, coverage rates achieve, impact on

hospitalisations, rotavirus-positive samples, and emergency departments

- **Barriers** - Low public health priority/burden, cost effectiveness and funding, Safety and lack of commitment among healthcare professionals
- **Actions** - Road map, Align efforts, Actions toolkit per country

Stakeholder Working Group Meeting on all-cause Meningitis Vaccinations

MEETING 3: Can we control all-cause meningococcal disease in Europe?

- **Recommendations** - existing recommendations against all serogroups of Neisseria, policies spectrum, current vaccination coverage
- **Policies** - funding, high-risk groups, Co-payment models
- **Evidence** - Lessons learned from meningococcal serogroup C conjugate (MCC) vaccines, MenB vaccination programs, epidemiology of incidents
- **Barriers** - Lack of awareness, cost effectiveness and funding, safety concerns and support from HCPs
- **Actions** - Road map, Align efforts, Actions toolkit per country

Stakeholder Working Group Meeting on Influenza Vaccinations

MEETING 4: Is it time for Europe to protect all against all types of influenza viruses?

- **Recommendations** - existing recommendations for Influenza Vaccination (all ages including children)
- **Policies** - Policies spectrum, current status of coverage, Quadrivalent vs. trivalent vaccines, high-risk groups, vaccination of healthy children
- **Evidence** - latest data influenza B to the seasonal influenza burden, vaccination of healthy children, Coverage rates
- **Barriers** - Low awareness on influenza types, Cost effectiveness of quadrivalent vaccines, Lack of commitment among HCPs
- **Actions** - Road map, Align efforts, Actions toolkit per country

Stakeholder Working Group Meeting on Vaccinations for imported infections

MEETING 5: How to address challenges from Immigration,

climate change and frequent travelling?

- **Recommendations** - Newly-arrived migrants in the EU/EEA, Travellers; Dengue Fever, Tick-borne encephalitis (TBE). Climate Change
- **Policies** - National Policies for vaccination of Immigrant Populations and Travellers
Vaccination. Preparedness of health systems
- **Evidence** - Measles cases in Europe in relation to immigration, Dengue Fever Cases, Tick-borne encephalitis (TBE) & Climate Change
- **Barriers** - Low awareness, Cost effectiveness of migrants immunisation programs, Education gaps
- **Actions** - Road map towards an immunisation policy addressing the immigration crisis, Align efforts, Actions toolkit per country

N.B - agendas and final focus of each Working Group may change through stakeholder consultations in Q1-Q2 2019

LifeCourse Immunisation Policy Focus Group Meeting

The 4th LifeCourse Immunisation Policy Focus Group - Copenhagen, 6 Dec 2019

In addition to the 2019 Working Groups, EIP will once again host The 4th

LifeCourse Immunisation Policy Focus Group Meeting in Copenhagen, Denmark on Friday 6th December 2019, focusing on policies to address the multiple, simultaneous challenges that complicate achieving and maintaining high vaccine uptake across Europe. The meeting is held in collaboration with the WHO Collaborating Centre for International Child & Adolescent Health Policy and 20 other government and non-government organisations and medical associations involved in Vaccinations across Europe and tasked to:

- **Improve Vaccines Confidence** and combat the anti-vaccination movement through social media
- **Increase Healthcare Professionals Vaccines uptake** to increase willingness to advocate vaccinations and drive behavioural change
- **Utilise** Young Healthcare Professionals skills in using social media to counteract anti-vaccination movement
- **Address lack of awareness and equip HCPs with the skills** to address vaccines related concerns
- **Overcome barriers related to Socioeconomic and family backgrounds**, religious and ethnic groups

The approach concerns the fact that although national immunisation strategies have traditionally focussed on infants and children, experts increasingly urge policy makers on the need to protect the wider

population against infectious diseases by moving towards a life-course immunisation approach. In addition, the Meeting is focusing on multiple, simultaneous challenges that complicate achieving and maintaining high vaccine uptake. An increasingly vocal anti-vaccination movement among the population, underserved populations and minority ethnic and religious groups, lack of commitment of the HCPs to personally vaccinate themselves and advocate vaccinations to patients.

CAMPAIGNS

A Need to Counter Anti-Vaccination Rhetoric on Social Media & Increase Vaccination Uptake Among Adolescents

As highlighted during discussion at the 3rd Focus Group, Adolescents are a very challenging group to change behaviours of and thus increase vaccination rates, as they rarely visit HCPs, and often fall between the responsibility of the pediatricians and adult practitioners. EIP is suggesting a **campaign that aims to utilise all available communication channels to reach adolescents and their parents and promote adolescent vaccinations**. Schools, Universities and Cities (controlling Education and Sports Facilities) will work together with the medical community to increase vaccination uptake among adolescents.

In addition, Anti-vaccination rhetoric utilises social media to foster online spaces that strengthen and popularise anti-vaccination discourses. Social media is often acting as a "breeding ground" for false and harmful information about the safety of vaccines and fuelling parents' fears of side-effects. **Young healthcare professionals, using social media at a personal level are best place to step up and counteract moving the balance towards credible evidence based information in relation to vaccination benefits and this will also be an EIP cause/focus in 2019/20.**

A Summary of Core Activities of the Initiative Continued from Phase I

Activities in 2019/20 are build on the achievements and plans to date, most notably:

1. **The Healthcare Professionals' Online Vaccine Survey** - tasked with collecting insights from healthcare professionals from all European countries, that will guide us on how to help the healthcare professionals increase vaccines confidence among their patients, and will shape our educational programs to provide the practical skills needed. The survey is structured in 4 chapters: Vaccine Hesitancy, Herd/Community Immunity, Adoption of New Vaccines,

Interventions - **Preliminary Results will be announced July 2019.**

2. **The Together Platform** - An online platform for organisations promoting vaccinations across Europe to present and share their activities, campaigns and materials. Acts as an archive of all vaccination promoting campaigns categorised by disease and country, to serve as a source of content and ideas. Monitor promotion activities on vaccinations each year in each European country to identify gaps and mobilise organisations to become more active and engaged. **Launch Date April 2019**

3. **Online Sessions on Building Vaccines Confidence** - free-to-view online sessions, launched in May 2019, designed to offer to healthcare professionals the necessary knowledge and skills on:

- **Vaccines/Disease risk evaluation** by analysing diseases prevalence and possible implications in comparison to vaccines effectiveness and safety data
- **Community Immunity** by analysing the mechanics, the vaccinations that are contributing, the impact of vaccination policies and diseases prevalence
- **Official Guidelines** by analysing the data that are supporting these recommendations and how to communicate these guidelines to patients

- **The techniques to drive behavioural change** to patients and how to successfully manage common misconceptions, myths and concerns.