HSE VACCINE APPROACH FOR VULNERABLE GROUPS in Ireland

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Version	Date	Changes from previous version
1	03/02/2021	
2	26/02/2021	- Feedback received on v1 from CCO Colm Henry (letter 4th February); Dr Philip Crowley; SIGG; PH Specialists; National Social Inclusion Office; HPSC, National Health Protection Pandemic Incident Control Team PICT chaired by Dr Lorraine Doherty, Dr. Austin O'Carroll; Dr. Angy Skuce; Pavee Point - Staff in Women's refuges allocated to Category 9 (Congregated settings) - Inclusion of separate section on Addiction settings - Inclusion of new challenges - Inclusion of new recommendations
3	03/03/2021	Progress re. Communications plan included.

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Executive Summary

Vulnerable groups including Travellers, Roma, those living in Direct Provision, Homeless Hostels, Women's Refuges and addiction settings have been significantly affected by the Covid-19 pandemic. Existing issues faced by these groups, including poverty, poor health outcomes and overcrowded accommodation have been further exacerbated during this crisis and have increased their vulnerability to contracting and becoming ill with the COVID-19. Similar to that of the outbreak management and response, the vaccination approach for vulnerable groups needs to be tailored and targeted to their specific complexities and needs.

Key Recommendations include:

- **Plans for rolling out Vaccine for vulnerable groups require a joined up approach within HSE and with stakeholders. An initial coordination meeting and working relationship with HSE Clinical Advisory Group and the COVID Vaccine HSE Roll out (HSE Operations) is required.**
- **The HSE should have a bespoke rollout process for each vulnerable group in place to ensure accessibility, suitability, optimal engagement and participation in the vaccination programme: Which group is going to be vaccinated; What vaccine will be used; Where they will access the vaccine; When will they receive it.**
- **HSE Social Inclusion to link in with clinicians across vulnerable group settings and utilise homeless GP clinics, HSE services, mobile teams (through service agreements or NGOs), isolation centres such as CRVP Hotel and also HSE pop up clinic at Traveller sites and HSE addiction clinics for vaccine administration to improve access.**
- **The State Claims Agency to consider providing indemnity for sites external to HSE/GP clinics.**
- **Prioritise single dose vaccines for vulnerable groups**
- **Consideration should be given to prioritize those over 45 years in certain vulnerable groups that experience premature ageing – specifically, people who use drugs, homeless and Travellers.**
- **Facilitate the vaccination of cohorts of vulnerable groups in congregated settings (e.g. by location such hostel, halting site), where a significant proportion of residents meet the criteria of category 5/6.**
- **Target vulnerable groups that are in danger of spreading the disease by the nature of the culture and behaviour. This includes settled Travellers who do not fall into category 9.**
- **A buffer stock of Covid-19 vaccines for outbreaks in vulnerable settings would enable a rapid timely response, at a time when a vulnerable group is engaged and accessible.**

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1. Introduction

There is an ongoing risk of COVID-19 outbreaks among vulnerable groups, including Travellers, Roma, those living in Direct Provision, Homeless Hostels, Women's Refuges and addiction settings. These groups, and the congregated settings in which they live, present unique challenges that require a tailored and targeted public health approach to maintain a reduced level of transmission and avoid further outbreaks.

Challenges, including difficulties in adhering to social distancing and infection prevention control measures, are often compounded by poor symptom recognition or disclosure and variable access to healthcare or a GP. Outbreaks in settings where vulnerable groups live are a risk for both residents and staff, and therefore present a risk to the community at large. Individuals within these groups have multiple vulnerabilities and one criteria, specifically age, is not sufficient in terms of identifying the most at risk. Health wise, many are older than their age and this needs to be reflected in vaccine prioritisation and sequencing.

Due to the congregated nature of their living circumstances, there is a high risk of exposure and transmission of these groups to Covid-19, and also a high risk of transmission from staff to service users, as evidenced in the high number of outbreaks in homeless hostels in January 2021. Prioritising these vulnerable groups is critical in order to mitigate the risk of outbreaks in institutional settings, ensure highest possible uptake and prevent exclusion of vulnerable people with undiagnosed clinical risk conditions.

2. Vulnerable group Prioritisation

The following groups, and the workers that support them, need to be considered high priority in the roll out of the Government's Covid-19 Vaccination Strategy and Implementation plan:

2.1 Travellers

The overall Traveller population in the country is estimated to be 30-35,000. Travellers remain the highest at-risk group in terms of outbreak identification and management among vulnerable groups. Each outbreak is complex and requires a significant amount of resources and engagement to manage. As of 21st February 2021, there are still several large scale outbreaks in a number of locations around the country clearly linked to the same events including funerals, and high level of non-compliance with the guidelines. The numbers in the 3rd wave, are already higher than 2nd wave (>2,000). We are seeing high rates of positivity in some outbreaks.

Travellers experience poorer health outcomes than that of the rest of society, and many suffer from underlying health conditions. They encounter extreme poverty; poor and overcrowded accommodation; high levels of unemployment; significant levels of discrimination and racism; and a lack of access to mainstream services. These issues have been further exacerbated during this crisis and have increased their vulnerability to contracting and becoming ill with the COVID-19 virus. Over half (56%) of Travellers live in overcrowded conditions, with many living in 'unauthorised sites' where basic facilities such as electricity and water are lacking. Large family units, coupled with crowded living conditions, nearly impossible for those testing positive with COVID-19 or those identified as a close contact, to follow the HSE's self-isolation guidelines[1].

According to the All-Ireland Traveller Health Study (AITHS), when standardised for age, the Traveller community mortality is 3.5 times higher than that of the general population. The Traveller male life

[1] Pavee Point Report: Approach and Recommendations for COVID-19 Vaccination Prioritisation & Roll Out for Travellers and Roma; 24th January 2021

expectancy is 61.7 years, and a Traveller female life expectancy is 70.1 years, a gap of over 15 years vs. the general population. The current Government Prioritisation (and NIAC) strategy does not reflect the lower life expectancy of Travellers, with only 3% of Travellers living to 65 years[2].

The Department of Health acknowledges this in its indicators for positive ageing which defines ***Traveller ageing as 40 years plus***. NUIG recent research on ageing and older Travellers and Homelessness consider **Travellers older than 50 years to be aged.** Travellers also do not tend to live in long term care facilities as they are usually cared for by extended family. Therefore, Travellers are mostly excluded from the current prioritisation list by proxy. There are also challenges in identifying Travellers within the community in absence of ethnic data being recorded and/or implemented on GP and other health data administrative systems. There is a risk that Travellers may not be able to access the vaccine without a targeted approach.

Table 1: COVID-19 outbreaks, outbreak cases and sporadic cases among Irish Travellers, reported on CIDR*; March 1st 2020 to midnight February 15th 2021

Irish Travellers	Outbreaks	Notified cases (both outbreak and sporadic)			
	Number of outbreaks	Number of cases	Number hospitalised	Number admitted to ICU	Number who died
Wave 1 (weeks 10-31 2020)	10	90	5	2	1
Wave 2 (weeks 32-47 2020)	74	1341	55	6	4
Wave 3 (week 48 2020-7* 2021)	115	1988	93	9	5
Total	199	3419	153	17	10

*CIDR -Computerised Infectious Disease Reporting system

2.2 Roma

There are approximately 5,000 Roma living in Ireland, with a high concentration in the East of the country (Dublin), extending to all parts of the country including Cork, Donegal, Midlands South East, recently Roscommon. Outbreak or case identification and management amongst Roma is challenging and complex: Roma are a largely an unknown community with precarious living conditions, and barriers to accessing essential services including health and issues such as trafficking etc. Inadequate and overcrowded accommodation is a major issue. There is no specific local authority response and they rely largely on the private rented sector in precarious living conditions often with a lack of sanitation facilities. There is a significant language barrier (most don't speak English) which is an impediment to access to medical care (GP), Covid testing and contact tracing. Many Roma people aren't literate, aren't digitally literate or don't have access to Internet.

There is a high level of mistrust and fear with regards to authorities. Those who test positive do not want to disclose close contacts, and, if identified, there is a reluctance for close contacts to be tested. Many do not agree with Covid as an infectious disease hazard. If someone is symptomatic and tests positive they and their family/housemates lock down/go to ground.

There is a high incidence of severe illness/case fatality rate anecdotally and from hospital reports especially in the first phase. Some outbreaks in the Roma have been significant, including 70 linked confirmed cases in South in November, and 30+ cases in North West in September. The figures above are like to be a significant under-representation of actual cases. Some cases are absorbed into hospital

[2] https://www.gov.ie/en/publication/39038-provisional-vaccine-allocation-groups/

records and not all Roma cases are being captured in the ethnic identifier in Call 1. A high case fatality and morbidity rate were recorded by Beaumont and Connolly hospitals in the first wave, with high death rates amongst this group.

Table 2: COVID-19 outbreaks, outbreak cases and sporadic cases among Roma, reported on CIDR*; August 22nd 2020 to midnight February 15th 2021

Roma	Outbreaks	Notified cases (both outbreak and sporadic)			
	Number of outbreaks	Number of cases	Number hospitalised	Number admitted to ICU	Number who died
Wave 2+3	9**	468	29	3	5

*CIDR -Computerised Infectious Disease Reporting system
**149 confirmed cases were linked to the 9 Roma outbreaks notified between August 22nd 2020 and February 15th 2021

2.3 Homeless Settings

In December 2020, there were approximately 8,200 living in Homeless Settings in Ireland, including 4,447 single adults and 970 families (DOH: 2020). Over 70% of the homeless population live in the Dublin area. In the Dublin region there are approximately 2,500 staff working in either Dublin Regional Homeless Executive (DRHE) or HSE funded accommodation facilities and there are currently 282 medically vulnerable homeless individuals being supported in shielding facilities as part of the winter plan

Since March 2020, a total of 220 persons living in Dublin Regional Homeless Executive (DRHE) accommodation were diagnosed Covid Positive, and over 1,335 Covid suspect or close contact service users have been accommodated in DRHE/HSE Covid Isolation Facilities. At any one time, up to 65 DRHE Covid positive service users are being supported in DRHE/HSE Covid Isolation facilities. Since Dec 1st there has been a significant increase in the number of staff working in homeless facilities testing positive, with over 50 staff currently being supported. The level of transmission amongst staff is a risk to homeless service users.

The median age of **homeless medical inpatients** is 20 years younger than that of housed patients. For Homeless people 45 years plus is considered as **aged** by clinicians especially in Inclusion Health and Homeless GPs[3]. The average age of death for homeless women is 38 years and for homeless men is 42 years. **Homeless patients also demonstrate a premature onset of multi-morbidity**, associated with increased use of unscheduled healthcare, and harshness of the homeless existence. Homelessness represents a state of extreme socio-economic deprivation, and is associated with increased prevalence of behaviours associated with morbidity (smoking, alcohol and drug use) but also with increased psychological stress.

Staff in hostels are effectively social care workers, but they are not formally classified as such, as they are usually employed by the voluntary sector. Staff who are providing social care and support in homelessness settings should be considered eligible for prioritisation alongside health and social care staff.

Many homeless people who are not sleeping rough are living in hostels where there is a high risk of outbreaks amongst residents and staff. Many people who sleep rough are currently being supported off the street in emergency accommodation as part of the restrictions in place. Targeting of this group for vaccination whilst they are in accommodation is critical. In Dublin, rates of infection have been kept below 2.67% of the overall DRHE homeless population, with intensive effort and interagency

[3] http://ie.depaulcharity.org/wp-content/uploads/sites/2/2020/06/Depaul-Premature-Ageing-Report-Feb-2018_0.pdf

collaboration. However, the potential for an outbreak remains. Considering the premature aging and high comorbidity such an outbreak could have devastating effects.

Table 3: COVID-19 outbreaks, outbreak cases and sporadic cases in Homeless settings, reported on CIDR* + By DRHE; March 2020 to February 15th 2021

	Outbreaks	Notified cases (outbreaks only)			
	Number of outbreaks	Number of cases	Number hospitalised	Number admitted to ICU	Number who died
Homeless (CIDR)	19	69	6	3	2
Dublin Region Homeless Executive data (To be reconciled & updated on CIDR)		220			

*CIDR -Computerised Infectious Disease Reporting system

2.4 Addiction Settings

There are 47 residential units (detoxification units, stabilisation units and rehabilitation units) for people with drug and alcohol problems that are funded by the HSE, which have approximately 800 beds. There are 11,449 people in receipt of OST at the end on January 2021, with some cross over into homeless services. Approximately 2/3 attend HSE services and 1/3 attend primary care physicians in the community.

The cohort have a vulnerability due to weakened immune system (viral illness such as HIV or Chronic Hepatitis C, liver cirrhosis plus direct effect of heroin on system) and poor health overall. EMCDDA data would indicate that the Irish population of heroin users is ageing and that due to health morbidities associated with injecting drug use, an opioid user age 40 should be considered at the same risk as an individual 20 years older. In this group of older opioid users, the physical ageing process may be accelerated by the cumulative effects of poly-drug use, overdose and infections over many years. Older people with opioid problems have higher rates of degenerative disorders, circulatory and respiratory problems, pneumonia, breathlessness, diabetes, hepatitis and liver cirrhosis than their peers and younger people who use drugs. They may also be more susceptible to infection, overdose and suicide.

2.5 Women's Refuges

There are 143 women's refuge units currently available in 20 facilities with a minimum of 140 women being supported at any one time. The average length of stay can vary with women who have children with them in the refuge, likely to stay for a prolonged period (3 months). Service users include individuals affected by domestic violence, substance abuse, alcoholism. The profile of workers include social care staff; substance misuse teams, social inclusion supports. There has been an increase in service demand during Covid (Up 19% in refuge use; up 40% in outreach services). So far there have been few outbreaks in these facilities – single cases require high levels of support however.

2.6 Direct Provision

There are 70 Direct Provision Centres (DPC), Emergency Accommodation and Reception Centres (EROC), with approximately 7,000 residents and 500 staff. A third of residents are single males, a third are families and there are also two EROC centres for programme refugees with approximately 300 residents. A quarter of all residents in DPC's, and emergency accommodation centres, are school-attending children. Many adults in DPC work also in congregated settings including Residential Care

Facilities, as home helps, food industry and other low paid jobs and pose a risk from cross infection across facilities. Of the 7,000 residents approximately 70 could be considered medically vulnerable in light of Covid-19. Approximately 30 residents in Direct Provision are over the age of 70 years.

The overall management, conditions, relationship with residents, knowledge and implementation of Covid-19 guidelines, and approach vary considerably from centre to centre. There are a number of unique characteristics of DPCs:

- Residents represent a diverse, vulnerable, sometimes traumatised population with multicultural demands. Prior negative experiences with homeland/international authorities can hinder communication efforts and trust between residents and various figures of authority. The International Protection Accommodation Services (IPAS) are a key partner in the management of a case or outbreak or vaccination campaign. Language barriers are also an issue and can propagate this fear and mistrust. This can in turn lead to reluctance to engage with public health advice.
- Residents living in DPCs live in a congregated setting and share communal facilities such as kitchens, laundry facilities etc. There are often multiple occupants to a room, including non-family members living in the same room. This poses major challenges when cases are identified in terms of prevention of transmission and isolation of known cases.
- Residents commonly work in minimum wage employment in sectors which are themselves high risk environment and there is a high risk of cross transmission. Industries involved include healthcare, food production (particularly meat factories), retail and construction. Many residents share transport to and from work.
- Direct Provision centres are dynamic environments whereby new residents are regularly transferred between different centres. There is a continuous stream of new arrivals seeking asylum into the country, who after undergoing an isolation period of 14 days, move into the National Reception Centre Balseskin. This centre has had three significant Covid-19 outbreaks, which in turn have caused major issues in the ability to provide reception services to new arrivals. There is also a need to move those out of Balseskin Reception centre to Direct Provision centres around the country in order to maintain capacity.

There has been a high number of outbreaks in Direct Provision, particularly in Wave 1 and Wave 3. The congregated nature of these settings means that controlling ongoing transmission within a centre is extremely challenging and difficult, and poses a risk to residents. As residents are often not ill, their compliance to government measures is a challenge and many continue to work in risky settings against public health advice.

Table 4: COVID-19 outbreaks, outbreak cases and sporadic cases in Direct Provision, reported on CIDR; March 1st 2020 to midnight February 15th 2021

Direct Provision	Outbreaks	Notified cases (outbreaks only)			
	Number of outbreaks	Number of cases	Number hospitalised	Number admitted to ICU	Number who died
CIDR Data	64	618	19	0	0

3. Recommendation for applying Priority List

We recommend that the HSE apply the Government prioritisation groups in a pragmatic way which accommodates groups who do not fit into mainstream society: those who are socially excluded as well as medically at risk. Many of the people in social inclusion groups are not chronologically old but are

prematurely aged or have chronic disease risks. The Prioritisation list below is adapted to show where the various groups fit into the Government list.

Prioritisation	Social Inclusion Group	No. Individuals (Approx.)	Rationale
1- People aged 65 years and older who are residents of long-term care facilities (likely to include all staff and residents on site)	Homeless hostels that cater for long term elderly residents including those run by NGOs, religious communities etc.	<500	De facto Nursing Homes
2 – Frontline Health Workers	Traveller Health Unit Staff + Traveller Primary Healthcare project worker	300	At very high or high risk of exposure and/or transmission
	Healthcare staff supporting Covid-19 isolation facilities	200 – 300	
	Roma Health staff including CRVP Isolation Hotel		
	Health and social care staff supporting Homeless or addiction settings		
	Refugee and Direct provision (EROC) Healthcare workers		
3. People aged 70 and older	Older Travellers, Roma, IPAS and Homeless	<1000	By protecting those at greatest risk of poor outcomes from the disease
4 - People aged 16-69 with a medical condition that puts them at <u>very high risk</u> of severe disease and death*		Estimation <300	By protecting those at greatest risk of poor outcomes from the disease the principle of minimising harm is upheld**.**
5 - People aged 16-64 who have an underlying condition that puts them at <u>high risk</u> of severe disease and death*	Single homeless especially with dual diagnosis HIV BBV, Alcohol and drug addiction Chronic hepatitis C	Estimation >2,000	By protecting those at greatest risk of poor outcomes from the disease the principle of minimising harm is upheld**.**
	Direct Provision Residents with comorbid conditions incl. HIV	< 200	
	Travellers with Co Morbid conditions, especially in Outbreak settings	Estimated <10,000	
	Roma with Co Morbid conditions	Estimated < 500	
9 - People aged 18-64 living or working in crowded settings	Members of the Travelling Community living in halting sites and some LA sites	15,000	Disadvantaged sociodemographic groups more likely to experience higher burden of infection.
	Hostel/Addiction/Homeless hub staff members	3,000	
	Residents Homeless sites	4,000	
	Addiction service users	10,000	
	IPAS-DP Centre Staff	500	
	Residents in IPAS facilities	6,500	

	Staff in women's refuges	100	
	Residents Women's refuges	200	
	Members of the Roma Community	4,000	
	Undocumented Migrants	> 10,000	
TOTAL		**Estimated 68,400**	

* See Paper 'National Immunisation Advisory Committee Interim Recommendations Priority groups for COVID-19 vaccines, February2021'

4. Key Challenges to vaccine roll out

There are a number of common, and significant, challenges to the rollout of the vaccination amongst these vulnerable groups, which need to be considered. These include:

- Low levels of trust with authorities
- Vaccination hesitancy and mis-information from online or home sources
- Low perception of risk associated with Covid-19
- Low confidence in the vaccine/health system
- Undocumented: Concerns re. sharing of data among government departments
- Lack of endorsement from trusted providers and community leaders.
- Lack of primary care access: No GP; medical card; PPSN etc.
- Low levels of literacy or language barriers
- Not reached by mainstream information campaign
- Hesitancy amongst staff supporting vulnerable groups
- Complex process to administer vaccines

Vaccination hesitancy is a significant issue for the national COVID-19 vaccine rollout, and recent international evidence suggests this is much more prevalent amongst minority ethnic groups, including Travellers and Roma. The UK Scientific Advisory Group for Emergencies (SAGE) have indicated that people from minority ethnic backgrounds were less likely to take the coronavirus vaccine and this was highest in Black groups, (72% unlikely/very unlikely to get vaccinated); Asian groups (42% unlikely/very unlikely). Other White ethnic groups, including Eastern European communities, also had higher levels of COVID-19 vaccine hesitancy compared with White UK/White Irish ethnicity. In Ireland, research has indicated that those of non-Irish ethnicity are more likely to be vaccine resistant[4].

Many of the vulnerable groups do not access mainstream news media outlets and often use social media for access to information. There are already reports of fears and concerns about the COVID-19 vaccination including how quickly it was developed, manufactured and approved. There is a lack of trust in health services, particularly amongst the Roma community who have a recent lived experience of medical testing/experimentation and sterilisation in their countries of origin. **Culturally appropriate and accessible information** is critical to counter misleading messages and misinformation from sources such as home society and religious leaders.

These measures will help to ensure questions are answered and fears allayed over a prolonged period of time. Hesitancy is not necessarily only related to misinformation. Staff working in some congregated settings appear to be just as hesitant as the general public in this vaccination roll-out. Therefore, there is a need to target this group and address some of their concerns.

[4]Article: Psychological characteristics associated with COVID-19 vaccine hesitancy and resistance in Ireland and the United Kingdom; Jamie Murphy et al; Nature Communications

Access to the vaccine will be challenging for those who do not have a GP, or a PPSN number. Vulnerable groups (and in particular those who live in congregated settings, or undocumented migrants) require a model for vaccine administration that will encourage and facilitate participation, and ensure ease and **equity of access**. The process of administering vaccines to some vulnerable groups will be complex, and the approach needs to be carefully considered. GP surgeries and stand-alone vaccination centres/points that require travel to/from may not be suitable for ensuring engagement and participation in the vaccination programme. Alternative appropriate methods for administering the vaccine need to be considered, (i.e. mobile vaccination team/use of addiction clinics/stand-alone vaccine sites etc.). This requires agreement from HSE Clinical Advisory Group, State Claims Agency and the COVID Vaccine HSE Roll out (HSE Operations)

The **administration and uptake of a second dose** of the vaccine will be challenging. This will particularly be the case for hard to reach communities such as Roma, undocumented, homeless (who move hostels), and those already displaying hesitancy. Alternative methods for administrating the vaccine (mentioned above) may partly alleviate this. **However, prioritising the single dose vaccine for vulnerable groups would support efficiency and coverage in complex environments.**

Individuals within each of the vulnerable groups fall within several of the priority categories for the vaccine, but primarily in category 4/5 (People aged 16-69 with a medical condition that puts them at very high/high risk of severe disease and death) and category 9 (People aged 18-64 living or working in crowded settings). **Distinguishing between individuals living in one setting** could make the overall vaccine process for some vulnerable groups inefficient and difficult to implement in practice. It may also lead to non-compliance and discontent. This will particularly be the case for individuals in homeless and addiction settings, and Travellers, who display a higher prevalence of co-morbidities.

5. Approach to overcome the barriers

Advance preparation before Vaccine roll out is the key. Listening and engaging with these vulnerable groups are critical to building confidence in the Covid-19 Vaccination programme. This will take time, resources and flexibility in accessibility, approach and rollout. A targeted and collaborative approach with state agencies, Local HSE Social inclusion staff, Local Public Health Departments, Section 39 organisations and community organisations supporting and engaging with these groups.

Recommendations:

- **Plans for rolling out Vaccine for vulnerable groups require a joined up approach within HSE and with stakeholders. An initial coordination meeting and working relationship with HSE Clinical Advisory Group and the COVID Vaccine HSE Roll out (HSE Operations) is required.**
- **The HSE should have a bespoke rollout process for each vulnerable group in place to ensure accessibility, suitability, optimal engagement and participation in the vaccination programme.**
    - **Which group is going to be vaccinated**
    - **What vaccine will be used**
    - **Where they will access the vaccine**
    - **When will they receive it.**
- **HSE Social Inclusion to link in with clinicians across vulnerable group settings and utilise homeless GP clinics, HSE services, mobile teams (through service agreements or NGOs), isolation centres such as CRVP Hotel and also HSE pop up clinic at Traveller sites and HSE addiction clinics for vaccine administration to improve access.**
- **The State Claims Agency to consider providing indemnity for sites external to HSE/GP clinics.**
- **Prioritise single dose vaccines for vulnerable groups**

- **Consideration should be given to prioritize those over 45 years in certain vulnerable groups that experience premature ageing – specifically, people who use drugs, homeless and Travellers.**
- **Facilitate the vaccination of cohorts of vulnerable groups in congregated settings (e.g. by location such hostel, halting site), where a significant proportion of residents meet the criteria of category 5/6.**
- **Target vulnerable groups that are in danger of spreading the disease by the nature of the culture and behaviour. This includes settled Travellers who do not fall into category 9.**
- **A buffer stock of Covid-19 vaccines for outbreaks in vulnerable settings would enable a rapid timely response, at a time when a vulnerable group is engaged and accessible.**
- Ethnicity to be included in the data capture in order to monitor progress; and adapt and scale up the programme if/when necessary. Access to data regarding uptake of the vaccine to enable a targeted 'mop up' exercise.
- Vaccine offers and endorsements from trusted sources to increase awareness and understanding and to address different religious and cultural concern.
- A communication plan for each group, which has complimentary yet diversified tools and of information, tailored to the unique challenges, concerns and languages of each group is in progress. The approach to accessing target groups to deliver information needs further consideration (i.e. through outreach etc.).
- A hands-on approach is needed, with trusted sources or 'champions' within each of the vulnerable groups, to listen and alleviating the concerns of individuals and encourage participation is key. Champions can be identified within each group (Traveller Community Health Workers; Roma support workers; Health staff and agency staff supporting homeless hostels; Direct provision residents that are healthcare workers).
- Where possible a consistent approach to each group, during each stage should be applied (i.e. rollout of vaccine in DP centres under Category 9, should occur nationally at the same time)
- It may be important also to have process in place to support the 2nd dose for people who got 1st dose and may be absent or have moved away

Finally, this overall social inclusion approach would require considerable coordination and support from HSE Covid Vaccine Leads, Senior Management & National Immunisation Office, State Claims Agency, Local Social inclusion, Public Health and Community Health; and a formal engagement/service agreement with national and local NGO's to support.