National Immunisation Advisory Committee
An Coiste Comhairleach Náisiúnta um Imdhíonadh

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Immunisation Advisory Committee

Minutes of Meeting	
Full NIAC meeting **Date:** 23 March 2026	**Time:** 3-5pm **Venue:** Hybrid (Board Room, HIQA Office, Smithfield and Online via MS Teams)

Attendance	Apologies
Chair Edina Moylett **Deputy Chair** Corinna Sadlier	
Committee Members (and Alternates) Alan Baird, Brian Cleary, Karn Cliffe, Cillian De Gascun, Ashwin Delmonte Sen, Daniel Hare, Sujil Jacob, Patrick Kelly, Cliona Murphy, Lois O'Connor, Astrid Weidenhammer	Aoife Fallon, Michelle Flood, Bridget Freyne, Juliette Lucey, Cathal O'Broin, Ruth O'Riordan, Scott Walkin, Mary Ward
In Attendance DOH: Ellen Crushell HPRA: Ronan Donelan HPSC: Lisa Domegan HSE: Áine McNamara NIO: Lucy Jessop Medical Secretary: Ellen Walsh Trainee review group: Jennifer Cox Observers: Patricia Harrington Others: N/A	 Bearach Reynolds Finnuala Lonsdale Michael Carton Chantal Migone
Secretariat Clinical Lead: Sarah Geoghegan Special Advisors: Ellen Cosgrave, Fiona Cullinane, Karen McCarthy, Helena Murray Clinical Pharmacist: Margaret Donnelly Senior Analysts: Valerie Power, Gillian Walsh Programme Manager: Melissa Jones Programme Coordinator: Trish Clarke	

	Agreed Minutes	Action No.
1	**Introductions** ▪ Welcome to Margaret Donnelly, NIAC Clinical Pharmacist.	
2	**Minutes of previous meetings** 1) Completion of declaration of interest form. (Ongoing) 2) Draft and issue update human papillomavirus HPV recommendations regarding people in the sex industry. (Ongoing) 3) NIAC workplan 2026 to be shared with the Department of Health (DOH). (Complete) 4) Chairs are sought for influenza and pneumococcal working groups from members of the committee. (Ongoing – Influenza chair sought, pneumococcal chair confirmed) 5) Draft and issue updated version of Chapter 22 (Tuberculosis) on Bacillus Calmette-Guérin (BCG) vaccination. (Complete)	
3	**Statement of Interests** ▪ No further statements were declared at the meeting.	
4	**Review of pertussis vaccine booster interval in healthcare workers** Note: In these minutes the abbreviation aP refers to all acellular pertussis vaccines, high and low dose. ▪ For healthcare workers (HCWs) in direct contact with pregnant women and/or unimmunised infants. ▪ The current NIAC guidelines from Chapter 15 were reviewed. *Background:* ▪ Based on evidence to suggest protection from acellular pertussis vaccine wanes in less than 10 years, UKHSA guidance now recommends a five-year pertussis booster interval for HCWs working in high-risk healthcare settings. ▪ A query was submitted to NIAC on reducing the booster interval for HCWs from 10 years to five years in keeping the UKHSA, along with a request from the Guideline Development Group updating Guidance for Public Health Management of Pertussis regarding the booster dose interval asking NIAC to review their guidance.	

	Agreed Minutes	Action No.
	Question: For HCWs in direct contact with pregnant women and/or unimmunised infants, at what interval should booster doses of pertussis vaccine be considered? ▪ The epidemiology of pertussis was reviewed. It remains endemic worldwide despite high vaccine coverage. Five to six year epidemic cycles are still seen in Ireland. ▪ Unimmunised infants are at the highest risk of adverse outcomes. There has been a rise in incidence since 2023. There have been five infant deaths since 2012. ▪ Whole cell vaccines (wP) were replaced with acellular vaccines (aP) in 1996 and may provide differential priming effects when considering booster doses later as immunity from acellular vaccine appears to be less durable. ▪ Incidence rates of healthcare-associated pertussis cases in Ireland were reviewed, however, for a high proportion of cases the likely setting of exposure was noted to be unknown. *Benefits and harms* ▪ The primary aim of HCW pertussis vaccination is for the protection of young infants who are at risk of severe disease when unimmunised. The vaccine is considered safe with individual protection against severe infection established. ▪ Existing evidence on the duration of acellular pertussis vaccine protection was reviewed. Whole cell Pertussis (wP) vaccines appear to provide longer lasting protection. International evidence indicates that protection from acellular Pertussis (aP) vaccines wanes from about two to four years and returns close to baseline by five years, despite preserved immune memory. Pertussis infection may still occur in aP vaccinated, but may have milder or asymptomatic disease. It is unclear to what extent aP vaccination prevents transmission of pertussis infection in healthcare settings. There is no mucosal immunity with aP vaccines. ▪ Vaccine effectiveness studies were reviewed. A systematic review was presented showing that aP vaccine effectiveness wanes across age groups	

	Agreed Minutes	Action No.
	with substantial waning in vaccine effectiveness over time, waning to 42% at four years post-vaccination in the 11-20 year old cohorts. Other systematic reviews show similar findings. ▪ A systematic review of 11 studies which evaluated antibody persistence over time indicated that antibody levels fall rapidly in the first one to two years post-vaccination. Primary studies show similar findings. ▪ Overall, the serological evidence suggests that although a decennial booster restores antibody responses, confirming immune memory, circulating antibody levels before boosting are low. For example, findings from one study of a group of Australian HCWs indicated persisting immune memory up to 12 years despite low levels of circulating antibodies pre repeat booster. ▪ The ability of aP vaccines such as Tdap to prevent asymptomatic transmission is uncertain. Evidence of asymptomatic transmission within households and non human primate models is available. A WHO position paper in 2015 notes that there is no published evidence to document a protective effect of aP vaccination of HCWs with regard to transmission of pertussis to neonates and/or infants. Vaccination of HCWs is considered only partially effective in preventing nosocomial spread of infection. *Values and preferences and acceptability* ▪ No national data are available on uptake of pertussis boosters among HCWs in Ireland, and challenges in the uptake of influenza vaccine among HCWs are noted. *Resource use and feasibility* ▪ Nosocomial outbreaks are costly. Booster campaigns during epidemic peaks may be an alternative use of resources with prespecified criteria as to when these campaigns would be triggered. *International recommendations* ▪ It was noted that international recommendations for pertussis vaccine for HCWs diverge, with some countries recommending five year intervals, others	

	Agreed Minutes	Action No.
	recommending 10 year intervals and others recommending a single dose of Tdap vaccine in adulthood. ▪ In the UK pertussis vaccine is recommended at five-year intervals for HCWs who have regular contact with pregnant women and young infants. UKHSA has outlined priority groups for occupational vaccination. The considerations were summarised and presented. Three options for discussion were presented including: 1. No change to recommendations: Boosters every 10 years may be considered. 2. Hybrid option: Boosters every 10 years may be considered. During pertussis outbreaks or epidemic peaks, a booster may be considered for those who had not received a pertussis-containing vaccine in the previous five years. 3. Move to a five year interval for repeat doses: Boosters every five years may be considered. The proposals were discussed among the committee. ▪ It was highlighted that due to issues with data availability, the current uptake rates of pertussis booster vaccine among HCWs are unknown. ▪ A discussion was held around the possibility of offering pertussis vaccine along with seasonal winter vaccines, however, due to logistical and operational concerns others were in favour of separate campaigns, with the suggestion to offer pertussis vaccine boosters in the spring/summer. ▪ The point was made that a change should be made to the current recommendation given that the evidence shows waning of protection before 10 years. A recommendation to change the interval from a 10-year to a five-year interval was agreed by consensus. ▪ Targeted vaccination campaigns for relevant HCWs may be the most appropriate strategy. Stronger language around recommending a five year booster dose is favoured by the committee over the current wording, stating a vaccine "should be considered." Healthcare students would also be included in recommendations issued.	1

	Agreed Minutes	Action No.
	▪ It was agreed that wording around management of adult contacts of pertussis will also need to be updated if wording on HCWs is updated to maintain continuity: - Tdap may be considered for adult contacts who have not had a pertussis vaccine in the previous five years. Adult contacts, including HCWs, who have not had a pertussis-containing vaccine within the previous five years should be given Tdap.	
5	**Hepatitis B vaccination in healthcare workers** *Question for consideration:* What is the optimal approach to serological testing and further vaccination in those vaccinated in childhood given the introduction of childhood vaccination schedule in 2008? *Background:* ▪ Hep B vaccination was introduced to the Primary Childhood Immunisation Schedule (PCIS) in 2008. ▪ Serological testing post vaccination is not routinely recommended for those vaccinated in the PCIS. ▪ Multiple requests to NIAC have been made by the NIO and Occupational Medicine for guidance for those now entering into work in healthcare. ▪ Current NIAC recommendations were reviewed. ▪ The National Health Protection Office (NHPO) guidance document was published in November 2025. ▪ There is a slight difference in wording between the UK Advisory Panel for Healthcare Workers Living with Bloodborne Viruses (UKAP) and NHPO but both recommend a "challenge dose" with a single dose of Hep B vaccination to establish the presence of immune memory. ▪ International practices were reviewed. Most countries with childhood vaccination recommend giving a challenge (fourth) dose and measuring the serological response following this dose.	

	Agreed Minutes	Action No.
	A draft recommendation was proposed: ▪ Anti-HBs level should be checked in immunocompetent healthcare workers. ▪ If <10mIU/mL, give one dose of hepatitis B vaccine (fourth dose). ▪ Recheck anti-HBs one to two months after this fourth dose. (Timeframe of one to two months will need to be standardised across all sections in the chapter). ▪ If anti-HBs <10mIU/mL, check HBsAg and anti-HBc. ▪ If HBsAg and anti-HBc negative, complete hepatitis B vaccine course (count fourth dose as first dose of this vaccine course). ▪ Recheck anti-HBs level one to two months after the last vaccine dose. ▪ If anti-HBs remains <10mIU/mL, the person is considered susceptible to hepatitis B infection. A proposal to remove the wording in Chapter 9 about "reliable history" was made. Documented proof of vaccination should be available to occupational health to aid decision making, particularly around exposure prone procedure certification. A draft of an update of the chapter will be circulated to the committee for final comments. Updates to recommendations for other risk groups in whom hepatitis B vaccine is currently recommended are currently under review and will be brought to the committee for discussion.	2
6	**Epidemiology updates** *MenB outbreak in the UK* ▪ Total number of cases 29; 20 confirmed, 9 probable. ▪ All belong to ST-41/44 complex which has been in circulation in UK for five years. This strain has also been seen in Ireland. Bexsero should be effective against this strain. An extensive vaccination and chemoprophylaxis campaign is underway in the UK.	

	Agreed Minutes	Action No.
	▪ Annual notifications in Ireland were reviewed. There has been a significant decline in MenB cases in Ireland from 1999 to date. Last year 37 cases were notified, and nine this year to date. ▪ The case fatality rate (CFR) has been approximately 10-11% in Ireland in recent years. Most cases occur in the 0-4 year old age group but do also occur in older groups. ▪ Vaccination uptake rates in children are approximately 87%, which have declined slightly. ▪ A review of the optimal use of meningococcal B vaccines in adolescents and young adults is currently on the NIAC workplan. Work is due to recommence on this in Q3/Q4 2026, with recommendations anticipated in Q1/Q2 2027. ▪ The outbreak in the UK is of significant concern however it does not further increase the risk of meningococcal outbreaks among adolescents or young adults in Ireland. It is well established that there is an increased risk of invasive meningococcal disease in adolescents and young adults, which is why NIAC closely monitors the epidemiology of IMD in this population and (prior to the UK outbreak) has prioritised re-examining the use of Men B vaccines in adolescents and young adults in its work plan for 2026. ▪ The NIAC representative from the Department of Health indicated that where feasible they would like NIAC to review Men B recommendations in adolescents and young adults sooner than the planned timeline. It was highlighted that within the current resources available to NIAC, this would require the ongoing work on enhanced influenza vaccines or pneumococcal vaccines to be paused. The timelines for both reviews were agreed based on operational deadlines and thus delaying either could impact these vaccination programmes. It was also highlighted that the learnings from the Men B outbreak in the UK will take time to be fully understood and reported, and there is thus benefit to retaining the current timelines. It was further discussed that the planned Men B vaccine review is very important and involves complex considerations, there would be potential risks associated with rushing or reducing the scope or depth of the review. It was agreed that for now there would not be a change to the agreed timelines, but that NIAC will continue to monitor the situation.	

	Agreed Minutes	Action No.
	Respiratory virus update ▪ COVID-19 activity has been low to moderate to date this year. BA.3.2 emerging to dominate in recent weeks. ECDC risk assessment reports no evidence of increased severity and is unlikely to have any significant epidemiological impact. ▪ Influenza activity was early and intense with activity declining in recent weeks. There have been 5,735 hospitalisations during this season to date, increased from previous year, noting an earlier season onset. Median age of hospitalised flu cases is 61 years (interquartile range: 9-79). A total of 64% were unvaccinated. The highest age-specific incidence is in those aged 80 years and older. ▪ ICU admissions peaked between weeks 49-51 in 2025; with a lower peak than last season. A total of 257 deaths due to influenza were notified. Two deaths occurred in teenagers. Of those who died, 180 individuals were aged 80 years or older. ▪ The respiratory syncytial virus (RSV) season began later in 2025. A review of the impact of the Nirsevimab programme for 2025/2026 is underway. ▪ There have been 2,427 RSV hospitalisations to date with a median age of three years. There have been 78 RSV intensive care unit (ICU) admissions, compared with 83 during 2024/2025 season. A total of 31 deaths due to RSV occurred in those aged 65 years and older. ▪ There are currently low levels of transmission. *Pathfinder update* ▪ There is a cumulative uptake of 52% for catch-up campaign. ▪ There is an 88% cumulative uptake in maternity hospitals and CHI. *Mpox* ▪ There has been one case of Clade 1a in Ireland in 2025. ▪ There have been six cases of Clade 1b, including in one child since August 2025.	

	Agreed Minutes	Action No.
	▪ There have been 14 Clade II cases in Ireland in 2026; with six cases in vaccinated individuals. ▪ As of March 2026, there have been 78 confirmed cases of Clade II in Ireland, of which 37 were previously vaccinated (27 were fully vaccinated). ▪ Vaccinated cases were less likely to be hospitalised and the number of symptoms reported was less than in the unvaccinated. ▪ Breakthrough cases arose 1-34 months following initial vaccination (data not complete). There are no significant updates on avian influenza since the last NIAC meeting.	
7	**Administration and Governance** ▪ NIAC annual report 2025 was presented to the HIQA board.	
8	**Correspondence** **Incoming** 1) 2026.02.12 – National Health Protection Office email to NIAC re. Expression of Interest for Guideline Development Group for updated bacterial meningitis guidelines. 2) 2026.02.27 – Pfizer email to NIAC re. RSV post marketing surveillance report. 3) 2026.03.02 – GSK email to NIAC re. Updated Arexvy SPC and real-world evidence presented at ReSViNET 2026. 4) 2026.03.06 – GSK email to NIAC re. Energix B SPC update. 5) 2026.03.06 – GSK email to NIAC re. Rotarix SPC and PIL update. 6) 2026.03.10 – GSK email to NIAC re. HZ incidence in immunocompromised patients. **Outgoing** 1) 2026.02.12 – NIAC email to Department of Health re. 2026 workplan. 2) 2026.02.23 – NIAC letter and appendix to Minister for Health re. Selective BCG programme.	
9	**Chapter updates** ▪ There was an update on language included for BCG vaccination of children travelling to countries where TB is endemic.	

	Agreed Minutes	Action No.
	▪ It was noted that there was a potential gap in the recommendations published in the 2023 update, at the time of publishing the most recent BCG vaccination update: ○ There was no recommendation for BCG vaccine for unvaccinated children aged less than five years travelling to high TB incidence settings. ▪ The updated wording was presented as published in the Chapter 22 February 2026 update.	
10	**AOB** ▪ SAGE meeting planned for 5-8 October 2026.	

Action Number	Actions Arising	Responsibility	Due By
1	Updated recommendation and wording to be drafted on pertussis vaccination in HCWs	Secretariat	Q3 2026
2	Updated wording on Hepatitis B vaccination in HCWs vaccinated in childhood to be drafted and circulated	Secretariat	Q3 2026

Signed:



Dr Edina Moylett
NIAC Chair

25/05/2026