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:** 25 May 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, Ashwin Delmonte Sen, Aoife Fallon, Bridget Freyne, Daniel Hare, Sujil Jacob, Patrick Kelly, Cliona Murphy, Lois O'Connor, Ruth O'Riordan, Astrid Weidenhammer	Cillian De Gascun, Michelle Flood, Juliette Lucey, Cathal O'Broin, Scott Walkin, Mary Ward
In Attendance DOH: Bearach Reynolds HPRA: Ronan Donelan HPSC: N/A HSE: Áine McNamara NIO: Lucy Jessop Medical Secretary: Ellen Walsh Trainee review group: N/A Observers: Patricia Harrington Others: Mary Corcoran, Robert Cunney	Ellen Crushell Michael Carton, Lisa Domegan Chantal Migone
Secretariat Clinical Lead: Sarah Geoghegan Special Advisors: Ellen Cosgrave, Fiona Cullinane, Karen McCarthy, Helena Murray, Bryony Treston Clinical Pharmacist: Margaret Donnelly Senior Analysts: Valerie Power, Gillian Walsh Programme Manager: Melissa Jones Programme Coordinator: Trish Clarke	

	Agreed Minutes	Action No.
1	**Introductions** ▪ Goodbye and thanks to Dr Helena Murray (NIAC Special Advisor), Dr Ellen Cosgrave (NIAC Special Advisor), Dr Bearach Reynolds (DCMO alternate), and Dr Finnuala Lonsdale (HPRA alternate).	
2	**Review of March 2026 Full Committee meeting action items** 1) Updated recommendation and wording to be drafted on pertussis vaccination in healthcare workers (HCWs). (ongoing) 2) Updated wording on Hepatitis B vaccination in HCWs vaccinated in childhood to be drafted and circulated. (Ongoing)	
3	**Statement of Interests** ▪ Conflicts of interest to be published in line with transparency obligations of HIQA. ▪ None declared.	
4	**Coadministration of MenACWY vaccines** **Background:** ▪ Three conjugate MenACWY vaccines are now available for use in Europe. MenQuadfi has been recently procured by the National Immunisation Office (NIO) for the adolescent programme. ▪ A request was made by the NIO to NIAC to review if MenQuadfi can be considered equivalent to Nimenrix and Menveo with regard to concomitant administration due to some updates in the summary of product characteristics (SmPC) regarding co-administration of MenQuadfi with HPV and Tdap-IPV vaccines. ▪ Of note, Tdap-IPV is not used as part of the Irish vaccine programme. **Question:** Is MenQuadfi equivalent to Nimenrix and Menveo with regard to concomitant administration with Tdap/HPV vaccines to adolescents as part of the routine schools' immunisation programme? ▪ The SmPCs along with the original data informing the SmPCs were reviewed. The new section on co-administration notes reduced geometric mean titres (GMTs) and seroresponses for Serogroup A, W, Polio types 1 & 3, Diphtheria,	

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	HPV types 6 and 58 when Tdap-IPV and HPV are co-administered with MenQuadfi. It notes the clinical implications are unclear. ▪ The Met50 trial was reviewed. Tdap co-administration with MenQuadfi resulted in lower GMCs for 3 of 4 pertussis antigens, though clinical relevance is not known. The EMA recommended this be noted in the product information. ▪ MEQ00071 study was reviewed. MenQuadfi was non-inferior to a single dose of Nimenrix. Co-administration with Tdap-IPV and HPV showed lower GMTs for serogroups A and W, and reduced seroresponses to serogroup A. Prior MenC vaccination had no impact. Anti-HPV type-6, type-58, polio type 1 and 3, and pertussis toxoid antibodies were lower when concomitantly administered with MenQuadfi. ▪ The European Medicines Agency (EMA) noted the strong immune responses to meningococcal serogroups, but that seroresponse rates were generally higher than when given alone. It was therefore more favourable to give sequential administration, and that this should be noted in the product information. ▪ International recommendations were noted including co-administration recommendations from Australia, Canada, United Kingdom and France. ▪ It was noted that Serogroup A does not circulate in Ireland. Serogroup W and Y have small numbers of infections. Two options were considered by the working group: 1. Unchanged current wording stating that any of the three Men ACWY vaccines can be administered at the same time as HPV and Tdap vaccines. 2. Unchanged for the adolescent programme, but include some caveated language in the chapter which highlights potential for decreased antigen responses with co-administration.	

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	▪ It was noted by the working group that the clinical significance of reduced titre induction is unknown. There are potentially large practical implications for administration of the adolescent programme if current recommendations for co-administration were changed to sequential administration. NIAC also makes an overarching recommendation that non-live vaccines may be co-administered. ▪ The working group proposal is that recommendation for co-administration of Men ACWY vaccines with other non-live vaccines in the adolescent programme should remain unchanged. Minor changes will be required to the wording in the chapter to incorporate the availability of MenQuadfi. This was agreed by the committee. ▪ It was also noted that NIAC tends to make recommendations on the basis of vaccine type rather than a specific vaccine brand or product. ▪ It was discussed with representation from the NIO and it was advised that a significant amount of additional work would be required to carry out an additional visit as part of the adolescent programme (if sequential administration was recommended instead of co-administration). ▪ More broadly, NIAC's role in reviewing new vaccine products for which a recommendation already exists was discussed. Where the product is the same (same vaccine type) with no clinical implications, this would not need to be reviewed by NIAC.	1
5	**Invasive pneumococcal disease (IPD) due to serotype 4** ▪ Epidemiology of pneumococcal infections in Ireland was reviewed in advance of upcoming changes to the pneumococcal vaccine programme later this year. ▪ The introduction of vaccination had an impact on IPD notifications. A rise in replacement serotypes was seen. It was noted that there has been an increase in serotype 4 particularly following vaccine introduction. ▪ There have been no recent failures in vaccine-eligible children notably. ▪ Isolates were sequenced to understand the epidemiology of serotype 4 given that it can be associated with community outbreaks. ▪ Four clusters were identified. There was a rapid temporal shift in clade from clade ST205 to ST801 following vaccine introduction. A total of 34% of cases	

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	(n=44) were identified as potential hospital clusters (within two weeks of the isolation date). ▪ All of the Irish cases were genomically quite similar. Clusters with 0 SNP differences were reviewed and likely reflect clusters of infections. ▪ A total of 24% of serotype 5 cases occurred in people experiencing homelessness. ▪ The Irish genomics data was compared to that from the UK. Serotype 4 has been linked with shipyard outbreaks internationally. Epidemiological data from other countries was reviewed along with risk factors. Some factors included those experiencing homelessness and use of illicit drugs. ▪ There was a link with homelessness in Ireland, though the study is limited by use of addresses only. Homelessness, as well as crowded living and drug use may need to be considered as risk factors for infection and vaccine prioritisation. Given the age profile, it is unlikely these patients were vaccinated against pneumococcal disease. Of note, the PCV21 does not include serotype 4.	
6	**Epidemiology updates** **Invasive Meningococcal disease (IMD)** ▪ Cases from 1999-2026 were reviewed. ▪ A total of 18 IMD cases were notified in 2026 to date. ▪ One MenC case was reported here for the first time since 2021. This person was born overseas in a location without routine MenC vaccination. ▪ There was a comparable number of MenB cases in this epidemiological year compared with the previous epidemiological year.	

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7	**NIAC Advocacy** Advocacy is listed in the terms of reference for NIAC and while it undertakes an advocacy role, this has yet to be formalised and operationalised. ▪ The aim was to define NIAC's advocacy remit and strengthen its impact through the development of NIAC's first Strategic Advocacy Plan. ▪ A scoping review was conducted including a grey literature search, peer-reviewed literature search, along with a series of five co-design workshops. ▪ The definition of vaccine advocacy was reviewed. A reviewed definition included "The promotion of the best scientific knowledge, moral attitudes and public health practices with regard to vaccination." Examples of National Immunisation Technical Advisory Group (NITAG) advocacy activities were identified and reviewed, though literature was found to be relatively sparse. Three priority goals and accompanying actions were identified, and stakeholder mapping was performed for each: **1: Improving transparency in NIAC processes.** It is planned to develop an evidence to recommendation (EtR) process document to help increase public understanding of NIAC's work. **2: Advocating for data and evidence needed to support NIAC's work.** There is a plan to draft a position paper on NIAC's data and evidence needs. **3: Enhancing guideline reach and uptake.** The final aim is to conduct a guideline user survey.	2, 3, 4
7	**Administration and Governance** ▪ NIAC 2025 Annual Report. This report has been presented to the HIQA Board. Members are encouraged to review. ▪ Expertise on NIAC (Immunology, others). It was noted that where required for reviews, immunology expertise will be co-opted.	
8	**Chapter updates** Chapter 3 – Immunisation of the Immunocompromised	

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	▪ There is a current recommendation for vaccination to be deferred for three months after receiving IVIG. This is contrast to a recommendation made in Chapter 2. It is proposed that Chapter 3 be updated to align with Chapter 2 including: 1. Live vaccines to be given 8 months post intravenous immunoglobulin. 2. Minimal interval between HSCT and COVID-19 and influenza vaccines during periods of increased transmission to be reduced to 3 months in line with other international groups' recommendations. 3. The footnote on DTaP/IPV on the table in Chapter 3 no longer relevant given than DTaP/IPV is not available in Ireland. This will be updated to state that DTaP/IPV should be given at 6, 8 and 10 months post-transplant for those aged 16 years and older. A major revision is planned for Chapter 3. It is noted that is the second most frequently downloaded chapter and generates frequent clinical queries.	5
9	**Correspondence** **Incoming** 1) 2026.04.30 – Request for NIAC member to join National Anaphylaxis Education Steering Group 2) 2026.05.05 – ACT for Meningitis email to NIAC Chair re. MenB vaccination 3) 2026.05.05 – Pfizer email to NIAC re. PCV13 update 4) 2026.05.14 – DOH email to NIAC re. Clesrovimab timeline. **Outgoing** 1) 2026.04.30 – NIAC email to Chief Medical Officer re. Meningococcal Carriage Study 2) 2026.05.06 – NIAC email to Pfizer re. PCV13 update 3) 2026.05.08 – NIAC nomination to National Anaphylaxis Education Steering Group.	
10	**AOB** Nil	

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Action Number	Actions Arising	Responsibility	Due By
1	Minor updates to the Meningococcal chapter to incorporate the availability of MenQuadfi in the wording.	Secretariat	Q3 2026
2	Develop an EtR process document to help increase public understanding of NIAC guideline development process.	Secretariat	Q4 2026
3	Draft a position paper on NIAC's data and evidence needs.	Secretariat	Q4 2026
4	Conduct a guideline user survey.	Secretariat	Q3 2026
5	Updates to Chapter 3 as outlined.	Secretariat	Q3 2026

Signed:



Dr Edina Moylett
NIAC Chair

20/07/2026