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Committee on Social Affairs, Health and Sustainable Development

Fighting vaccine-preventable diseases through quality services and anti-vaccine myth-busting

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Report¹

A. Draft resolution²

1. While the world's attention has shifted away from combating the Covid-19 pandemic to dealing with the consequences of Russia's war of aggression in Ukraine, serious outbreaks of preventable illnesses are on the rise, in Europe, and across the world.

2. Measles cases alone increased globally by 79% in the first 2 months of 2022, compared to the same period in 2021, with most cases occurring in unvaccinated or under-vaccinated individuals. Measles is a highly contagious viral disease. It remains an important cause of death among young children, despite the availability of a safe and effective vaccine. Other diseases that may attain epidemic proportions despite the availability of safe and effective vaccines include poliomyelitis, tuberculosis, diphtheria, and chickenpox. The Covid-19 pandemic continues to cause death, disability and chronic disease on a large scale. In Europe this is mainly due to insufficient vaccine uptake and the often premature relaxation of tried-and-tested public health measures.

3. Vaccination remains the safest and most effective method of protection against many infectious diseases. According to the World Health Organization (WHO), it prevents 2 to 3 million deaths a year. It is estimated that an improvement in the global coverage of vaccinations could save a further 1.5 million lives. The current resurgence of vaccine-preventable diseases is largely due to gaps in immunisation. According to WHO, suboptimal vaccine uptake is currently one of the most critical issues in public health.

4. The Parliamentary Assembly recalls its Resolution 2338 (2020) on "The impact of the Covid-19 pandemic on human rights and the rule of law", in which it stated that "[t]he positive obligations under the European Convention on Human Rights (ETS No. 5, the Convention) require States to take measures to protect the life and health of their populations" and the Convention on Human Rights and Biomedicine (ETS No 164, Oviedo Convention), which requires that member States "take measures to provide equitable access to health care of appropriate quality, taking into account health needs and available resources". Furthermore, the Assembly notes the Council of Europe Committee on Bioethics Statement on "Covid-19 and vaccines: ensuring equitable access to vaccination during the current and future pandemics" and the Committee's work on "Ensuring equitable access to vaccine, treatment and equipment in a context of scarcity", which provide valuable guidance and advice for Council of Europe member States. The Assembly is convinced that addressing suboptimal vaccination coverage is a matter of human rights protection and should be a priority for Council of Europe member States.

5. The Assembly stresses the importance of insuring quality standards in vaccination and welcomes the work of the European Directorate for the Quality of Medicines & HealthCare (EDQM) of the Council of Europe, which co-ordinates the independent batch release testing through the Official Control Authority Batch Release (OCABR) process, as part of an activity co-funded by the EU Commission and the EDQM. The EDQM functions in the framework of the International Convention on the Elaboration of a European Pharmacopoeia Convention (ETS No. 050), signed by the European Union and by 39 countries, including all EU member States, committed to achieving harmonisation of high quality standards for safe medicines throughout the European continent.

¹ Reference to Committee: Reference no. 4456 of 25 June 2019.

² Draft resolution adopted unanimously by the Committee on 18 May 2022.

6. To protect public health effectively, immunisation levels need to be increased and sustained as a matter of priority. Vaccinations largely prevent sickness and death associated with infectious diseases both for the individual vaccinated and for society as a whole, by means of developing what is called “herd immunity”. Vaccinations also bring wider health, social, political, and economic benefits, including poverty reduction and achieving greater gender equality, as well as savings in healthcare costs, lost wages, and lost productivity due to illness and death. Vaccinations allow people to live longer, healthier lives and reduce the long-term burden of disability. Expanding access to immunisation is crucial to achieving the UN Sustainable Development Goals (SDGs).

7. Strategies to comprehensively address inadequate immunisation coverage should address the root causes of this problem. Reasons for suboptimal vaccine uptake are context specific. They vary broadly and include social, economic, and cultural barriers, lack of access, availability, inadequate quality of services, and attitudes to vaccination. Covid-19 pandemic-related disruptions further increased inequities in access to vaccines. The displacement of millions of people due to conflicts and crises leads to disruptions in vaccination services. According to WHO and UNICEF, in 2020, 23 million children missed out on basic childhood vaccines through routine health services, the highest number since 2009 and 3.7 million more than in 2019. Emergency measures are required to address vaccination gaps resulting from the Covid-19 pandemic.

8. The Assembly is convinced that promoting peace, tackling poverty, and building robust and sustainable public health services people can trust are essential preconditions for improving vaccination coverage. As the Covid-19 pandemic demonstrated, such public health services need to be supported across the globe, as outbreaks of contagious diseases can spread quickly across countries and regions, with potential for further mutations of pathogens. The Assembly recognises that vaccines and vaccination are a global public good and inequity in access to vaccines anywhere in the world is a threat to us all.

9. Healthcare workers, pharmacists, and community outreach workers play a crucial role in successful vaccination and are the most trusted source of information on this subject, across countries and different groups. They need to be at the centre of vaccination strategies and must be involved in relevant decision-making processes.

10. The Assembly notes with concern that public debate on vaccines has become highly polarised and politicised in recent years. Unfounded concerns about Covid-19 vaccination, which had to be swiftly developed and was made mandatory in some cases, had a spill-over effect on other types of vaccination (and “anti-vaxxers” activism prior to the pandemic has created fertile ground for Covid-19 vaccine hesitancy). The Assembly’s Resolution 2361 (2021) on “Covid-19 vaccines: ethical, legal and practical considerations” and Resolution 2383 (2021) on “Covid passes or certificates: protection of fundamental rights and legal implications” provide useful guidance on the human rights compliant deployment of vaccines against Covid-19.

11. It is important to acknowledge that trust in governments in general and in public health systems specifically are important factors when people make decisions about vaccination. In this context, the Assembly notes with alarm that the European Region has a higher-than-average percentage of negative opinions on vaccine importance, safety, and effectiveness. In fact, 7 of 10 countries with the worst opinion on vaccine safety belong to our region. Furthermore, vaccine hesitancy seems to be more present among younger generations. Older generations tend to have more confidence in vaccines, as they have witnessed the consequences of outbreaks of contagious diseases and the way in which they have been combatted through vaccination.

12. The Assembly calls on Council of Europe member States to take urgent action, and to acknowledge public responsibility for lowering barriers to vaccine uptake, in full respect of the principles of human rights, democracy and the rule of law. The Assembly welcomes the Tailoring Immunisation Programmes (TIP) approach developed by the WHO Regional Office for Europe, as a useful model that can be emulated in different national and subnational contexts. This approach, grounded in scientific evidence and country experience, aims to identify populations with suboptimal vaccination uptake, as well as systematically identify barriers to and drivers of vaccination in those population groups; and to design context-specific interventions to address barriers and leverage drivers of vaccination – with the aim of increasing vaccination uptake. The rapid response approach designed to ascertain the qualitative contexts of population perception on vaccination uptake developed within the context of the Covid-19 pandemic allows for rapid up-to-date and relevant data collection and decision making.

13. The Parliamentary Assembly of the Council of Europe calls on Council of Europe member States to give high priority to the prevention of the resurgence of contagious diseases. The Assembly recommends that

member States develop comprehensive, forward-looking, pro-active and human-rights compliant vaccination strategies, by ensuring that:

- 13.1. with respect to access, availability, and quality of services:
 - 13.1.1. investment in building robust, and sustainable immunisation systems and national immunisation schedules that is adequate, and considers the lessons learned from past epidemics and pandemics and emerging challenges;
 - 13.1.2. quality vaccination services are available and accessible to all people within the state's jurisdiction; and that this includes provision of adequate vaccine supplies, free vaccination for all, and better follow up from the health care system; when supply is inadequate, the principle of equitable access to vaccines should be ensured;
 - 13.1.3. the rights of individuals are respected, the risk of harm is minimised, positive outcomes for persons concerned are ensured; effective systems for monitoring potential adverse effects of vaccines and independent compensation programmes are in place;
 - 13.1.4. mandatory vaccination is only considered as a last resort, when this is necessary in order to fulfil a legitimate aim, is provided for by law, and is proportionate; its introduction is subject to public debate, parliamentary scrutiny and judicial oversight; and less constraining measures are given preference when feasible;
 - 13.1.5. the principle of the best interests of the child is respected in all matters concerning children and vaccination; relevant legislation is reviewed to allow children to be vaccinated in their best interest in situations where one or both parents are against such vaccination, including by ensuring that the right of the children to be heard on matters concerning their own health is duly taken into account, in accordance with their age and maturity;
 - 13.1.6. the work of development agencies is supported, with a view to extending the benefits of vaccination to people in countries that experience shortages; vaccination is promoted as an international public good and the sharing of know-how is facilitated, including by lifting restrictions arising from patents and intellectual property rights when appropriate;
- 13.2. with respect to public attitudes to vaccination:
 - 13.2.1. barriers to and drivers of vaccination are analysed on a regular basis, and the needs of specific groups of population are duly researched and understood; targeted evidence-based interventions are designed and implemented; subnational entities and local communities are engaged in developing and implementing tailored strategies to support vaccine uptake; co-operation with non-governmental organisations and/or other local efforts is supported to reach out to marginalised groups and overcome social and cultural barriers to vaccine uptake;
 - 13.2.2. reliable and transparent information on vaccination, including contraindications, is available and accessible, and is up-to-date;
 - 13.2.3. misinformation is addressed through relevant policies, regulations and other measures, including through good use of information and communication technologies; digital behaviour is monitored, researched and considered in public policy-making and communication strategies on vaccination;
 - 13.2.4. open and transparent dialogue and communication on the safety and quality control of vaccines, and benefits of vaccination are supported; resilience and health literacy are improved, in co-operation with the education sector and media, including social media platforms; user-friendly awareness materials are developed for various target audiences; such materials address barriers and drivers related to a particular group; the language used is accessible and appropriate;
 - 13.2.5. anti-vaccination attitudes are tackled through systematic, targeted counter-narratives, that are context-specific, based on science, address doubts and concerns raised, and highlight individual and collective responsibility for one's own health, one's children's health, as well as other people's health, including that of vulnerable groups who cannot get vaccinated for health reasons but who benefit from "herd" immunity, when a sufficient proportion of the population is vaccinated;
 - 13.2.6. media codes of ethics are strengthened with emphasis on social responsibility for countering disinformation on vaccination, and for enabling maximum visibility for quality information on vaccination from trustworthy sources; internet intermediaries are encouraged to support anti-

vaccine myth-busting and to raise awareness of potential risks of false information for public health protection;

- 13.2.7. all health-care workers benefit from embedded training on vaccine safety, characteristics, and technical components, and are equipped with communication tools and materials for promoting vaccine awareness; dedicated staff and space for communication on vaccination is envisaged, to allow for flexibility and ease of access to relevant information;
- 13.2.8. healthcare workers have sufficient time to spend with parents and other patients, to discuss with them any concerns that they might have with respect to vaccination; this implies that their working conditions, including working time, workload, and remuneration, are adequate;
- 13.2.9. politicisation of vaccine policies is avoided, and non-partisan continuity in public health policies is promoted, based on the advice and guidance from WHO, other relevant international and national scientific bodies, public health authorities and institutes;
- 13.2.10. the World / European Immunization Week celebrated in the last week of April is supported, to highlight the collective action needed and to promote the use of vaccines to protect people of all ages against disease;
- 13.2.11. full use is made of WHO toolkits and the resources developed by the European Centre for Disease Prevention and Control.

14. The Assembly expresses its support for the work of the European Commission and European Parliament on promoting a joint European approach on vaccination and encourages stronger co-operation with European countries which are not members of the European Union, in particular with the support of Council of Europe structures, such as the European Directorate for the Quality of Medicines & HealthCare (EDQM) and the Steering Committee for Human Rights in the fields of Biomedicine and Health (CDBIO).

15. The Assembly welcomes WHO's strategy and vision for the European Immunisation Agenda 2030, which aims to extend the benefits of vaccines to everyone, everywhere, and undertakes to support its implementation through parliamentary co-operation.

B. Explanatory memorandum by Ms Carmen Leyte, rapporteur

1. Introduction

1. On 20 May 2019, the Committee on Social Affairs, Health and Sustainable Development tabled a motion for a resolution on “Vaccine hesitancy: a major public health issue”.³ Across the world, immunisation rates are declining due, to a great extent, to misinformation spread by anti-vaccination movements. To address this concern, the motion stressed the importance of Council of Europe member States working closely together in combating vaccine hesitancy through awareness-raising and educational measures aimed at the general public. The motion was referred to the Social Affairs Committee for report, and Mr Igor Kagramanyan was appointed rapporteur on 13 September 2019. Following Mr Kagramanyan’s resignation from the Assembly, due to his appointment as First Deputy Minister of Health of the Russian Federation, Mr Vladimir Kruglyi was appointed as a rapporteur on 22 September 2020. Mr Kruglyi ceased to be a member of the Assembly, as a result of the expulsion of the Russian Federation from the Council of Europe, and I was subsequently appointed rapporteur on 17 March 2022.

2. On 9 February 2021, the Sub-Committee on Public Health and Sustainable Development held a hearing on “Overcoming vaccine hesitancy: strategies for parliaments and parliamentarians” with the following experts: Ms Lisa Menning, Team Lead (acting), Demand and Behavioural Sciences, Department of Immunization, Vaccines and Biologicals, World Health Organization (WHO), Ms Dolores Utrilla, Associate Professor of Public Law at the University of Castilla-La Mancha, Spain / Assistant Editor at EU Law Live, Mr Neil Datta, Secretary of the European Parliamentary Forum for Sexual & Reproductive Rights (EPF), Ms Janne Bigaard, Kræftens Bekæmpelse (Danish Cancer Society), Mr Robert Kanwaji, World Vision programme coordinator for Ebola Vaccine Deployment, Acceptance and Compliance (EBODAC) and CSO Representative to the COVAX Demand working group, and Ms Laurence Lwoff, Head of the Bioethics Unit of the Council of Europe.

3. In the context of preparing this report, Mr Kruglyi conducted a fact-finding visit to WHO Headquarters in Geneva, Switzerland on 20 July 2021. There, he met with experts Ms Lisa Menning, Mr Tim Nguyen and Ms Aleksandra Kuzmanovic, to discuss ways to ensure higher vaccine uptake and overcome vaccine hesitancy. During his fact-finding visit to Geneva, Mr Kruglyi and a representative from the Secretariat also had the pleasure of meeting with Mr Gaudenz Silberschmidt, Director on Health and Multilateral Partnerships, to discuss future collaboration between WHO and PACE. On 6 May 2022, I conducted an online fact-finding visit with the WHO Europe Office during which I had a meeting with experts Mr Siddhartha Datta, Ms Siff Malou Nielsen and Mr Brett Craig to learn more about the Tailoring Immunization Programme. I very much appreciated the input from the technical experts, which I have incorporated into this draft report. I am very grateful for the assistance that WHO has given us so far, and I am convinced that the visit to Geneva and our work on this report is only the first step in this broader collaboration between our two organisations.

4. The Secretariat distributed a survey on vaccine hesitancy through the European Centre for Parliamentary Research and Documentation (ECPRD) network in the summer of 2020, receiving 37 replies all in all by the end of November 2020, from the parliaments of member States: Albania, Andorra, Austria, Belgium, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Latvia, Lithuania, the Republic of Moldova, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, San Marino, Slovenia, the Slovak Republic, Spain, Sweden, Switzerland, Turkey, and Great Britain. I am grateful for their collaboration on this important topic.

5. The topic of vaccination has drawn considerable attention due to the Covid-19 pandemic, proving that our global health security requires improvements. Given recent developments and following discussions with WHO, I suggest changing the title of the report to “Fighting vaccine-preventable diseases through quality services and anti-vaccine myth-busting”. Suboptimal vaccine coverage is a complex issue and cannot be explained only by looking at vaccine hesitancy. Confidence in vaccines and their uptake is influenced by a range of factors, including easiness and convenience of getting vaccinated and other social, economic, and cultural factors. I hope that the present report will be a useful step in addressing inadequate vaccine uptake and ensuring higher immunisation rates in Europe and in the world.

³ [Doc. 14890](#).

2. The history of vaccines and how they work

6. Vaccination is a routine medical intervention. To date, it remains the safest and most effective method of protection against many infectious diseases. According to WHO, it prevents 2 to 3 million deaths a year.⁴ It is estimated that an improvement in the global coverage of vaccinations could save a further 1.5 million lives.⁵

7. The history of vaccines begins with the long history of infectious diseases in humans. Evidence exists that inoculation against smallpox was practiced in India and China over 2000 years ago. The first modern concept of vaccination as we know it, was developed by Edward Jenner in 1796, as he successfully used material from cowpox pustules to create protection against smallpox. Jenner's innovation made the practice widespread, and his method underwent medical and technological changes over the next two hundred years.⁶ The author of the modern scientific approach to vaccination is Louis Pasteur, who invented a way to prevent infectious diseases by introducing weakened pathogens into the body. This method served as a breakthrough in medicine and gave rise to a new era of immunisation, which made it possible to stop deadly epidemics around the globe.

8. By 1900, the world had developed two human virus vaccines, one against smallpox and another against rabies, and three bacterial vaccines against typhoid, cholera, and plague. During the 20th century, other vaccines were developed against what were once commonly fatal infections, including pertussis, diphtheria, tetanus, polio, measles, and rubella, as well as other communicable diseases. With the availability of more vaccines, high-income countries began recommending routine vaccination for children.

9. Between 2000 and 2015, the measles vaccine alone prevented an estimated 20.3 million deaths, according to a joint report by UNICEF, WHO, Gavi, the Vaccine Alliance and Centers for Disease and Control and Prevention.⁷ It is further estimated that vaccines against 10 major diseases have saved over 37 million lives in nearly a hundred low- and middle-income countries (LMICs) since 2000. The study, which was published in *The Lancet*, estimates that the numbers could double by 2030. Thus, there is no doubt that immunisation is a crucial global health investment.

10. Vaccines work by preparing a person's immune system, the body's natural defences, to recognise and defend itself against a specific disease. Vaccines often contain weakened or inactive parts of a particular microorganism or toxin (antigen) that trigger an immune response within the body. Newer vaccines contain the blueprint for producing antigens, instead of the antigen itself.⁸ The vaccine will prompt the immune system to respond as much as it would on its first reaction to an actual pathogen. Vaccination is therefore a safe and clever way of preventing us from getting sick in the first place, rather than treating the disease after it occurs.

11. When a sufficient number of people have been vaccinated, this creates what is called "herd immunity".⁹ This implies that vaccines not only protect the person who is vaccinated, but also other people who cannot be vaccinated because of age, health conditions (e.g., immune deficiencies or allergies) or other factors. The people who have been vaccinated act as a "buffer" between infected persons and those who are vulnerable. Each individual vaccination is therefore beneficial for society as a whole. The percentage of people who need to be vaccinated to achieve herd immunity varies with each disease and depends on the contagiousness of the virus. Thus, to achieve herd immunity against influenza 75% of the population must be vaccinated against the disease, for measles this figure reaches 95% of the population.

12. Suboptimal rates of vaccine coverage are a threat to public health, as society becomes more vulnerable, both with respect to new diseases (for example, it appears that countries without universal policies of BCG vaccination might be more severely affected by Covid-19 compared to countries with universal and long-standing BCG policies^{10 11}) and to diseases that have previously been under control but may resurge because of reduced immunisation. In 2018, our continent saw a dramatic resurgence of measles, with the total number of cases being the highest in the decade, due to declining immunisation rates.¹²

⁴ <https://www.who.int/topics/immunization/en/>.

⁵ <https://www.unicefusa.org/stories/how-save-15-million-lives-year-vaccinate-worlds-children/31793>.

⁶ https://www.historyofvaccines.org/timeline#EVT_100871.

⁷ https://weshare.unicef.org/C.aspx?VP3=SearchResult&LBID=2AMZKT1T6IR&IT=Thumb_FixedHeight_M_Details_NoTo oITip#/SearchResult&LBID=2AMZKT1T6IR&IT=Thumb_FixedHeight_M_Details_NoTo oITip&VBID=2AMZVNWY55VV.

⁸ <https://www.who.int/news-room/feature-stories/detail/how-do-vaccines-work>.

⁹ <https://www.gavi.org/vaccineswork/what-herd-immunity>.

¹⁰ <https://www.medrxiv.org/content/10.1101/2020.03.24.20042937v1>.

¹¹ https://www.lemonde.fr/sciences/article/2020/05/23/covid-19-le-bcg-un-futur-allie-contre-les-formes-severes_6040558_1650684.html.

¹² <https://news.un.org/en/story/2019/08/1045151>.

3. Vaccine hesitancy

13. According to WHO, vaccine hesitancy refers to the delay in acceptance or refusal of vaccination, despite the availability of vaccination services. Hesitancy is often context-specific and affected by how people think and feel about vaccines, vaccine-preventable diseases, safety issues, other programme concerns, social influences, and anti-vaccination activism. In some settings, hesitancy is assumed to be the cause of poor uptake, but closer study often reveals the greater importance of factors such as accessibility, availability, and quality of services.¹³ While scientists and medical doctors have spent the better part of the 20th century developing reliable ways of combating diseases through vaccination, and relevant services have been made more easily accessible, the number of people getting vaccinated is currently in decline.

14. Today, suboptimal vaccine coverage is one of the most critical issues in public health. This is illustrated by the resurgence of diseases preventable by vaccination, as well as our dependency on high immunisation rates for Covid-19 for seeing the end of the pandemic. In 2019, the WHO ranked vaccine hesitancy as one of the top ten threats to global health.

15. The first opponents of vaccines appeared at the same time as the vaccines themselves - more than 200 years ago. In general, the arguments of supporters and opponents of vaccination were the same as they are now: the first group pointed to a significant decrease in the incidence of diseases, the second ones — to possible side effects, and were opposed to the state intervening in their private sphere.

16. In 1998, *The Lancet* published a study on autism by a British former physician named Andrew Wakefield in which he falsely claimed to link the measles, mumps, and rubella (MMR) vaccine to autism and colitis in children. The study was later thoroughly debunked and resulted in *The Lancet* formally retracting it in 2010. A few months later, Wakefield was stripped of his medical licence. The General Medical Council, the public body to maintain the official register of medical practitioners in the United Kingdom, wrote that “the children that Wakefield studied were carefully selected and some of Wakefield’s research was funded by lawyers acting for parents who were involved in lawsuits against vaccine manufacturers”. Additionally, there were reports that Wakefield had a further conflict of interest in the form of a patent for a single measles vaccine.

17. Today, we know that there is no link between vaccines and autism or autistic disorders, something which has been demonstrated in numerous studies conducted across the world in large populations. Although Wakefield’s study was found to be seriously flawed and fraudulent, its publication has unfortunately led to dropping immunisation rates in some countries, and subsequent outbreaks of the three diseases the MMR vaccine effectively and safely protects against. The most commonly refused vaccines in our member States are the MMR vaccine (in Azerbaijan, Cyprus, Poland, San Marino, the Slovak Republic, and Turkey), HPV (Denmark, Estonia, Iceland, Ireland and Latvia), rotavirus (Estonia and Finland), or other influenza vaccines, according to answers received through the ECPRD questionnaire.

18. The answers received through the questionnaire further reveal that most of the people who refuse vaccines, be it for themselves or for their children, fall in the 25 to 40 age group. In other countries, such as Finland, Latvia or the Slovak Republic non-vaccinated people are usually young children whose parents are vaccine-sceptics. A study on the global state of vaccine confidence revealed that the European Region has a higher-than-average percentage of negative opinions on vaccine importance, safety, and effectiveness.¹⁴ In fact, 7 of 10 countries with the worst opinion on vaccine safety belong to our region. Furthermore, vaccine hesitancy seems to be more present among younger generations. Older generations tend to have more confidence in vaccines, as they have witnessed the consequences of outbreaks of contagious diseases and the way in which they have been combatted through vaccination.

19. The same study points out that problems linked to religious compatibility are not as present in Europe as in some other regions. Europeans seem to be more concerned about the safety of vaccines than about the risks of contracting infectious diseases. It remains to be seen how these attitudes will be affected in the long-term by the current Covid-19 pandemic.

20. In general, Western and Northern European countries tend to express less concern about vaccine safety than Southern and Eastern European countries, with France and Italy having the highest percentage of vaccine scepticism. Trust towards health authorities appears to be essential for higher vaccination rates.¹⁵ Prior negative developments in the health sector can therefore contribute to vaccine hesitancy.¹⁶

¹³ <https://apps.who.int/iris/bitstream/handle/10665/341623/WER9622-eng-fre.pdf?sequence=1&isAllowed=y> page 216.

¹⁴ Larson H J et al. *The State of Vaccine Confidence 2016: Global Insights Through a 67-Country Survey*.

¹⁵ F. Petrelli et al. *Vaccine hesitancy, a public health problem*.

¹⁶ *Ibid.*

4. The social and economic benefits of vaccination

21. Expanding access to immunisation is crucial to achieving the UN Sustainable Development Goals (SDGs). Vaccination reduces healthcare costs and loss of productivity for the patient and the person caring for him or her. Not only do vaccinations prevent sickness and death associated with infectious diseases, they also contribute to broader gains in social and economic development; by preventing illness, for example, immunisation may improve a child's cognitive skills, physical strength, and performance at school, thus leading to increased productivity in the long term. Moreover, by improving financial security and reducing risk, preventing illness through vaccination may lead to increased investment and improved political and economic stability.¹⁷

22. People from lower socio-economic backgrounds have been found to be disproportionately affected by vaccine-preventable diseases, and vaccination has the potential to reduce this inequity. Equitable vaccine uptake is needed to ensure that underserved and marginalised communities benefit from vaccination services in the same way as the rest of the population.

23. Health equity involves everyone being able to achieve their full health potential, regardless of social position or other socially determined circumstances. Policies which ensure high and equitable vaccine uptake generate wider health, social, political, and economic benefits. Moreover, immunisation can improve coverage of other health interventions, as well as reducing poverty.

24. A study conducted by Johns Hopkins University in 2016¹⁸ found that for every dollar invested in vaccination in the world's 94 lowest-income countries, US\$ 16 was expected to be saved in healthcare costs, lost wages, and lost productivity due to illness and death. Moreover, when including broader benefits, such as the value that people place on living healthier, longer lives and the long-term burden of disability, the net return increases to US\$ 44 per dollar invested, bringing the overall economic benefit for the 2011–2020 period to more than US\$ 1.5 trillion.

25. Several international organisations have been set up and other efforts have been made to ensure equitable allocation of vaccines and to protect the world against infectious diseases. These include the creation of Gavi, the Vaccine Alliance in 2000, the Coalition for Epidemic Preparedness in 2017, as well as the development of several action plans, resolutions, and immunisation agendas. The global co-operation of these agencies together with WHO and UNICEF was essential to provide a fast and equitable solution to vaccine development and allocation when the Covid-19 pandemic hit the world.

26. WHO's Immunization Agenda aims to address the challenges related to vaccines over the next decade. The strategy for the 2030 Immunization Agenda is to extend the benefits of vaccines to everyone, everywhere. It is underpinned by four core principles: it puts people in the centre, it is led by countries, it is implemented through partnerships, and it is driven by data. The Covid-19 pandemic has laid bare the fact that our global health security is only as strong as our weakest link, and thus it is in the interest of us all to ensure a high and equitable level of immunisation across the globe.

5. Ensuring higher immunisation rates

5.1. *The right to health and ethical and legal considerations on mandatory vaccinations*

37. The right to health is a fundamental part of our human rights and of our understanding of human dignity. Article 12 of the International Covenant on Economic, Social and Cultural Rights recognises that everyone has the right to enjoy the highest attainable standard of physical and mental health (12.1). Moreover, States have a responsibility to take necessary steps to achieve the full realisation of this right by the prevention, treatment and control of epidemic, endemic, occupational and other diseases (12.2c). The right to health is also enshrined in Article 11 of the European Social Charter. It thus follows that states have a responsibility to ensure public health and high immunisation coverage.

28. There are difficult ethical and legal issues that need to be considered when dealing with the issue of vaccine hesitancy and suboptimal vaccine coverage. There are a range of initial steps that can be taken to fully understand the exact reasons for low confidence and uptake, and to then design and evaluate corresponding strategies. Interventions may include better-tailored communications, community engagement

¹⁷ <https://www.gavi.org/vaccineswork/value-vaccination>.

¹⁸ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1086>.

activities, and service quality enhancement to more adequately meet the needs of specific populations. Member States must ensure that measures are democratic and human-rights compliant.

29. In certain circumstances, with the persistent failure of non-coercive strategies, there may be a need for more drastic measures to address a sudden decrease in vaccination or other situations where public health is dependent on an urgent improvement in vaccination coverage. Following the resurgence of vaccine-preventable diseases and the decrease in immunisation coverage across Europe, some member States have imposed stricter measures such as mandatory vaccination programs to tackle the problem. With Covid-19 specifically, some have also made it mandatory to be vaccinated against the infectious disease or be in possession of a sanitary pass to access certain spaces.

30. Such measures have revived the debate around immunisation coverage and fundamental rights. The legal implications of such measures are complex, and often it will be the case that certain rights and freedoms must be considered and balanced against each other. Articles 8 and 9 of the European Convention on Human Rights enshrine the right to respect for private and family life and respect for freedom of thought, conscience, and religion respectively. Parents who refuse vaccination for their children or other individuals who refuse vaccination often argue that mandatory vaccination is a breach of their rights and freedoms as outlined in these two articles.

31. These are, however, not absolute rights and can be limited where it is prescribed by law, to pursue a legitimate aim which is necessary in a democratic society. Among the reasons for interference with these rights are the protection of health, whether it is individual health or public health, and the protection of the rights and freedoms of others. In the case of parents refusing vaccination of their children, the right to health and the protection of rights and freedoms must be recognised both for the child who remains unvaccinated because of his or her parents' refusal, as well as others in the community who will encounter the unvaccinated child. As the refusal of vaccination can have profound consequences and may put lives at risk, the exercise of the rights provided for in articles 8 and 9 of the Convention may be legitimately restricted.

32. In April 2021, the Grand Chamber of the European Court of Human Rights (the Court) delivered a much-anticipated judgement in *Vavříčka and Others v the Czech Republic* on mandatory childhood vaccination, in which parents who failed to comply, without good reason, with the legal duty to vaccinate their children against nine diseases, were fined and their children were not accepted in nursery schools. The Court clarified that, ultimately, the issue to be determined was not whether a different, less prescriptive policy might have been adopted, as had been done in some other European States. Rather, it confirmed that States enjoy a wide margin of appreciation when it comes to determining vaccine policies, which in the court's opinion the Czech authorities had not exceeded. It thus concluded that the measures could be regarded as "necessary in a democratic society".

33. Despite the Court's judgement, when considering the necessity of mandatory vaccination programs, I urge member States to rather investigate the fact that the countries that enjoy the highest levels of immunisation coverage do not operate with mandatory vaccination. It seems that the legitimate aim sought by mandatory vaccination programs, namely for States to reach higher levels of immunisation coverage, and thus to protect the public health, can in fact be accomplished by less-constraining measures.

34. In cases concerning mandatory vaccination for children, the best interests of the child must be a primary consideration, as confirmed also by the Court, and must be used as a legal principle of interpretation of other rights and freedoms. One must also evaluate the child's own right to health and to the impact of any sanctions and exclusions that the child may endure because of his or her parents' choice of refusing vaccination. In doing so, one must take into account the health risks that a child may be exposed to if he or she remains unvaccinated, and moreover that a child may be put in a vulnerable situation following sanctions such as exclusion from schools, kindergartens and other public spaces. Member States should review their legislation to allow children to be vaccinated in their best interest in situations where one or both parents are against such vaccination, including by ensuring that the right of children to be heard on all matters concerning their own health is duly taken into account, in accordance with their age and maturity.

5.2. Promoting non-partisan continuity in vaccination policies and accelerating efforts to fight misinformation and false information on vaccines through evidence-based and transparent communication

35. Vaccines have historically been highly regulated by governments, recommended by governments and sometimes even required and mandated by governments. Thus, guidance and information from trusted sources are fundamental to ensure high immunisation rates. I therefore note with concern that public debate on vaccines has become highly polarised and politicised in recent years. During the pandemic some member

States have communicated important information on vaccines almost exclusively through government officials. Given that health care workers are some of the most trusted sources in regard to vaccination, such an approach could risk reducing important public health decisions which are meant to save millions of lives to a question of politics. Member States should thus actively include and follow advice from public health experts and health authorities, such as national health institutions and WHO, in decision-making processes and communication to the public, as well as promoting non-partisan continuity in public health policies.

36. The spread of intentionally false and misleading information, in particular online, poses a serious threat to public health. We have learned from the hearings held with experts that antivaccination groups tend to be better at reaching the undecided on social media platforms, than the public authorities are. Facebook, Twitter, and Google play an important role in the dissemination of fake news, in particular because they connect ad placement to traffic.¹⁹ The current organisation of the ad tech industry, through the use of intermediaries, encourages the spreading of false information, as businesses behind the advertisements rarely know where their ads end up and thus indirectly fund intentionally misleading and false information.

37. At the national level, governments should review the legislation to place due diligence obligations on businesses within their jurisdiction so that they do not contribute to and profit from the spread of intentionally misleading and false information on vaccines, which endangers public health. However, co-ordination at the international level is also needed in order to hold platforms accountable. The international community should thus come together and look at policies and regulations to address this issue. This must, however, be based on full respect for human rights and freedom of speech. As those who intend to spread false and misleading information about vaccines will find alternative ways of doing so, it is equally important to build resilience and improve health literacy, including by working with the education sector, and to ensure access to reliable and trustworthy information to today and tomorrow's generations.

38. In this regard, it is also worth mentioning the WHO experience, as it works with social media platforms on targeted campaigns to change perceptions and to improve knowledge. They conduct daily monitoring of media and social media outlets to see what health-related conversations are on-going. This allows them to better address particular issues. Based on topics that are trending, WHO then steps in with advice to prevent misinformation from spreading, for example by producing "myth busters". There is a recognised need to invest in a strong digital presence of trusted sources and voices from each country. At the national level, I think that our member States have a lot to learn from this approach, and we need to invest in more research on digital behaviour.

5.3 Barriers to vaccine uptake and practical measures to increase confidence in vaccines

39. To better understand how to combat vaccine hesitancy, as well as to ensure higher and more equitable vaccine uptake, it is essential that we examine different reasons why some people are hesitant towards vaccinating themselves and their children. Better knowledge of who these people are will help us understand in what way we should address their concerns and thus what the most efficient ways of reaching out to these people are. The Tailoring Immunization Programmes (TIP) of WHO Europe offers a model for population segmentation, diagnosis of underlying causes of under-vaccination in hesitant subgroups, as well as tailoring of interventions to address the underlying factors.²⁰

40. The logic of the TIP approach is to first identify susceptible or lower coverage population groups. The second step is to determine barriers and drivers to vaccination. Importantly, the process closely involves recipients of vaccination and their community representatives as partners in the process, to contribute important insights, but also harness their participation. In the third step, this insight is then used to design evidence-based interventions for high and equitable vaccine uptake. By promoting high and equitable vaccine uptake, TIP processes contribute to the achievement of no less than 14 out of the 17 UN Sustainable Development Goals.²¹

41. WHO does not yet have data on the effect of the Covid-19 pandemic on attitudes to vaccination. Some few preliminary insights may indicate that there has been a decrease in uptake of routine immunisation. However, during my fact-finding meeting with the WHO Europe Office, it was noted that this may not necessarily indicate an increase in hesitancy, as many healthcare services were disrupted due to the pandemic. This issue will have to be further explored by conducting insights studies. Based on data on Covid-19 vaccination so far, there are different barriers among different population groups (e.g., older adults and

¹⁹ Suliman, M: [How to Disrupt Fake News Markets](#).

²⁰ <http://www.euro.who.int/en/health-topics/disease-prevention/vaccines-and-immunization/activities/tailoring-immunization-programmes-tip>.

²¹ <https://apps.who.int/iris/bitstream/handle/10665/329448/9789289054492-eng.pdf>.

those with underlying conditions, pregnant women, rural residents, etc.). When planning activities and measures to increase confidence and uptake in vaccines, member States should use the insights in the second step of the TIP approach to ensure they are tailored specifically for the population groups in question.

42. Apart from hesitancy, there may also be practical issues influencing uptake, such as easiness and convenience of getting vaccinated. This may include supply, ease of access and cost of vaccines. It is important to differentiate between these drivers so that strategies can be targeted to the different problems or barriers, and therefore contribute to closing gaps and increasing vaccine uptake. Hesitancy could become a tempting explanation for low uptake when authorities seek to deflect attention from health system problems. Focusing only on hesitancy may also mistakenly place responsibility on populations to be “less hesitant”, rather than on programmes and systems in our member States to become more accessible and trustworthy. Some of the countries with low immunisation coverage, such as Romania, lack vaccine supplies.²²

43. We should strive to create an enabling environment by reducing barriers and making it easy, quick and, ideally, free to get vaccinated. This recognises that sometimes reluctance or resistance may actually be a response to the burdens or inconvenience of getting vaccinated or poor experiences at the point of vaccination. As underlined by my colleague Ms Jennifer De Temmerman, in her report on Covid-19 vaccines²³, engagement with non-governmental organisations, trusted persons within communities and other local efforts in developing and implementing tailored strategies to support vaccine uptake is of utmost importance.

44. Further to this, it is of utmost importance that our member States build strong health systems and offer universal health care for their populations. Through the analysis of the ECPRD questionnaire, for example, it became apparent that the fact that vaccines are not covered by state healthcare in all member States is a concrete barrier to ensuring higher vaccine uptake. Moreover, it is not sufficient to look at only demand and supply of vaccines. Going through all the different technical components of immunisation programmes, including planning, training on safety and management, is indispensable in this regard. Member States should make full use of the technical assistance of WHO both through the TIP programme and various online tools. Member States may also look at the practical recommendations and strategies proposed by the former Council of Europe Committee on Bioethics (DH-BIO) (now the Steering Committee for Human Rights in the fields of Biomedicine and Health (CDBIO)) on equity in access to vaccines²⁴ and health literacy.²⁵

45. Insufficient awareness of the need for vaccination and doubts about the safety of immunisation (for instance fear of the occurrence of adverse events in the post-vaccination period) are among the reasons for refusal of carrying out routine immunisation. Open and transparent dialogue and communication about uncertainties and risks, including around the safety and benefits of vaccination, are important for building confidence in vaccines and thus increasing motivation and ensuring higher vaccine uptake. In this regard, it is important for member States to have in place independent vaccine injury compensation programmes, to ensure compensation for undue damage resulting from vaccination, in line with Article 24 of the Oviedo Convention.

46. Acknowledging that not everyone has the same level of scientific literacy, we need to put more efforts into making correct information available to everyone, including by translating technical language in a way that can be understood by the public and which is culturally appropriate. Moreover, important public health information should be made available also in non-official languages, so as to ensure that those who are not proficient enough in the national language(s) have access to the same information. WHO has developed several online trainings for healthcare workers and others in order to more effectively communicate on the risks and benefits of vaccination, building trust and having important conversations with patients and caregivers.

47. When it comes to child vaccination, healthcare workers should be able to spend more time with parents, both before and after the birth of the child, to discuss with them any concerns that they may have regarding vaccination. This will allow parents to be better informed about the risks of not vaccinating their children. Such support is likely to improve parents’ trust in public health authorities and to improve vaccination rates. Other effective measures include using mass media to inform parents about the need for immunoprophylaxis, as well as investing more in educational measures for the younger generation (future

²² European Commission: [Mandatory vaccination: an individual choice or a matter of public health?](#) ESPN Flash Report 2017/47.

²³ <https://pace.coe.int/en/files/28925>.

²⁴ Committee on Bioethics (DH-BIO), [Covid-19 and vaccines: Ensuring equitable access to vaccination during the current and future pandemics](#).

²⁵ Committee on Bioethics (DH-BIO), [Advancing health literacy for equitable access to healthcare: towards a guide to health literacy policy, strategy and service design](#).

parents) by integrating knowledge on the benefits and necessity of vaccination in education, including primary school, to build social acceptance and foundational knowledge.

48. Special attention should be paid to the training of doctors of all specialties on immunoprophylaxis in medical universities. It seems appropriate to introduce an independent discipline “Immunoprophylaxis” into the curricula of students studying in all medical specialties. Within the framework of conferences and congresses on epidemiology, it is necessary to organise schools on immunoprophylaxis.

6. Concluding remarks

49. The resurgence of vaccine-preventable diseases in the European region is alarming. To date, vaccination remains the safest and most effective method of protection against infectious diseases, preventing millions of deaths each year. Moreover, vaccinations contribute to broader gains in social and economic development and expanding access to immunisation is crucial to achieving the UN Sustainable Development Goals.

50. In order to ensure higher immunisation rates, member States should first and foremost use awareness-raising activities, educational measures and enhancements to service quality that are democratic and human rights compliant.

51. Suboptimal vaccine coverage is a complex issue and cannot be explained only by looking at vaccine hesitancy. Confidence in vaccines and their uptake is influenced by a range of factors, including easiness and convenience of getting vaccinated and other social, economic, and cultural factors. We should strive to create an enabling environment by reducing barriers and making it easy, quick and, ideally, free to get vaccinated. Building stronger health systems and ensuring that vaccines are covered by state healthcare are important factors in increasing equitable access to vaccines for all population groups.

52. Sufficient time and resources must be invested in order to acquire better knowledge of who is hesitant towards vaccinating themselves and their children, and their concerns must be listened to in order to develop and implement tailored strategies for specific population groups. In this regard, engagement with non-governmental organisations, trusted persons within communities and other local organisations is of utmost importance.

53. Transparent communication on the risks and benefits of vaccination, training of healthcare workers, and strengthening health literacy are all indispensable measures that member States must prioritise. Healthcare workers should be able to spend more time with parents, both before and after the birth of the child, to discuss with them any concerns that they may have regarding vaccination. The spread of intentionally misleading and false information, in particular online, poses a serious threat to public health. At national levels member States should invest in more research on digital behaviour and accelerate their efforts in dissemination of information on social media platforms. At the international level, states should come together to look at policies and regulations that would hold platforms and other actors profiting from the spread of dangerous misinformation accountable.