FRA EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

BULLETIN #7

CORONAVIRUS PANDEMIC IN THE EU – FUNDAMENTAL RIGHTS IMPLICATIONS: VACCINE ROLLOUT AND EQUALITY OF ACCESS IN THE EU

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Non-discrimination | Equality | EU Charter of Fundamental Rights

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Foreword

The global struggle to tackle the COVID-19 pandemic is beginning to bring results, despite setbacks in some countries. Vaccinations already started in some EU countries in December last year but are proceeding at different paces across the Union. In some countries, where vaccination rollouts and uptake are progressing well, people's hope is that life may soon be returning to a more normal rhythm. In other countries, people are disappointed when they experience delays or unequal access to vaccines.

FRA continues to collect information on the pandemic's impacts on fundamental rights and how EU institutions and Member States respond in a fundamental rights-compliant way. This seventh edition of our COVID-19 Bulletin examines how the next phase in tackling the pandemic by implementing an unprecedented vaccination effort is organised and implemented across the EU. Despite some problems and challenges, the vaccination effort is making encouraging progress. Yet it is worrying that those who question the validity of scientific advice remain unconvinced of the importance of vaccination. In this regard, EU institutions and Member States need to do more to restore public trust in science, while countering misinformation.

Although we may be winning the battle against COVID-19 infections, the impact of the pandemic on human health and fundamental rights is far from over. Overcoming the economic and social cost of this crisis will not be easy. We have already warned that the pandemic brings into sharp relief the importance of social rights that offer protection across many of the areas that most shape our daily lives.

The Charter of Fundamental Rights of the EU – the Union's own bill of rights – includes standards across education, employment and healthcare when Member States act within the scope of EU law. These give people in the EU the right to education, to fair and just working conditions, and to access preventive healthcare and medical treatment, among many others.

As the EU and its Member States roll out their ambitious recovery plan to reboot the economy, it is important to recall that the Charter should be fully respected in implementing the plan. In this regard, the EU's leaders meeting on 8 May 2021 in Porto recently relayed a hopeful message. They pledged to work towards a social Europe. Implementing the European Pillar of Social Rights as a fundamental element of the recovery from the pandemic, while ensuring equal opportunities for all, will make sure that no one is left behind, in line with the global Agenda 2030 for sustainable development.

Michael O'Flaherty

Director

Key findings

"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities."

Article 35 of the Charter

National vaccine deployment – planning and prioritisation

Vaccines are crucial to protect people's right to life and health. Deploying them is also essential for lifting restrictions on other fundamental rights that the EU Charter of Fundamental Rights enshrines, such as the freedom of movement, the right to engage in employment and the right to education.

Ensuring equitable access for all in the EU to an affordable (free) vaccine as early as possible is in line with the principle of non-discrimination in EU law. This is among the main objectives of the **EU strategy for COVID-19 vaccines**.

- In view of the shortage of vaccines, governments prioritise certain population groups to minimise death and severe illness, to reduce the pressure on national healthcare systems and the overall transmission of the virus. Prioritising vaccinations is based on medical expertise, but it is important to ensure equitable access to vaccination to avoid any discrimination in access to healthcare. In this regard, vaccine deployment should also take into account – besides age – the particular vulnerabilities of certain population groups, such as people with disabilities, people deprived of their liberty and unable to physically distance because of where they live (e.g. prisons or detention facilities for migrants), homeless people, asylum seekers and migrants in an irregular situation, and deprived communities, in particular Roma and Travellers. The **European Commission Communication on Preparedness for COVID-19 vaccination strategies and vaccine deployment** suggests Member States consider a number of groups that they could prioritise. Member States prioritised access to vaccines based on recommendations by international and EU health authorities. Relevant criteria included high risk of severe complications or death from COVID-19, high risk of being infected from exposure to the virus, and the probability of transmitting the virus. Accordingly, older people, especially those living in long-term care facilities, people with underlying medical conditions who are more likely to develop a severe form of the disease or die if they contract COVID-19, and frontline healthcare workers and staff of long-term care facilities had priority for vaccination across the EU.
- The criteria for defining the priority groups have not always taken into account the particular vulnerabilities of certain population groups, FRA evidence shows. Moreover, in some Member States there were allegations of queue jumping, which runs against the principle of vaccine equity.
- When prioritising vulnerable groups other than those above, Member States have not always followed guidance, particularly during the first phase of the vaccination rollout. Despite the focus on vaccinating older people, some older people faced practical challenges when trying to access vaccination, evidence indicates. This meant a number of older people were still unvaccinated by the end of April in some EU countries.
- National vaccination strategies did not prioritise diverse marginalised groups, such as Roma and Travellers, homeless people or those with drug dependencies.

— People deprived of their liberty face an increased risk of COVID-19 infection, given the crowded conditions in prisons and detention centres, and gaps in adherence to health protection measures. Nevertheless, only a third of EU Member States define detainees as a priority group in their national vaccination strategies, FRA evidence shows.

— Third-country nationals with insecure residence status, such as asylum seekers and migrants in an irregular situation, face difficulties in accessing vaccination when national health insurance schemes do not cover them. In several EU countries, however, the authorities waived formal requirements (e.g. having a social security number) that would prevent them from getting vaccinated.

Vaccination rollout – communication, (pre)registration and administration

Vaccine deployment has three components: communication, (pre)registration and administration. Certain safeguards are essential during each to ensure the protection of fundamental rights.

In its **statement of 22 January 2021 on equitable access to vaccination**, for example, the Committee on Bioethics of the Council of Europe underlines that realising the principle of equitable access to healthcare requires the provision of clear, accurate, understandable and reliable information, in a variety of formats, and adapted to the needs of different population groups. It also stresses that the actual access to vaccination services should be tailored to the needs of persons in vulnerable situations who have difficulty accessing health services.

An essential component of equitable vaccination rollout is non-discriminatory registration. These processes should be adapted to the difficulties certain population groups may face when registering for vaccinations, which should be easily accessible to everyone.

Member States use various channels to give information about their national and regional vaccination strategies, phases of vaccination and prioritisation of groups, ways to (pre)register and all other aspects of the vaccination process, as evidence collected by FRA shows. The channels include dedicated websites, call centres/hotlines for public inquiries and regular press conferences by authorities. They also use various communication materials, such as video and audio clips, posters, leaflets and digital campaigns on social media platforms.

— COVID-19 vaccination is free of charge in all Member States. However, there are sometimes limitations on eligibility tied to residence or legal status.

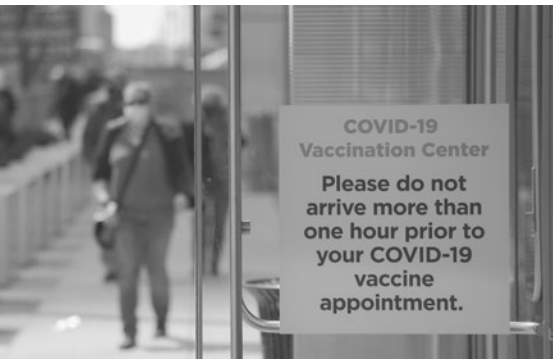
— Many countries have developed vaccination information campaigns, but rarely tailor them to diverse population groups in vulnerable situations, who are often hard to reach. For example, not all countries provide information in different languages for those who may not speak the national language well, such as ethnic, national or linguistic minorities, migrants, asylum seekers and refugees; campaigns specifically targeting Roma and Travellers are rare; and disability-inclusive and accessible information remains a challenge in some Member States.

— In general, to overcome the digital divide, all EU Member States established a variety of registration means catering for the specific needs of older people, people with disabilities and those with low digital skills or without access to digital technology, FRA evidence shows.

— Online platforms are the main way to register for vaccination across the EU. Additional ways, such as by telephone, through medical doctors, at pharmacies, at places of employment or directly at a vaccination centre, are also available. In some cases, local authorities and civil society organisations support older people, people with disabilities and other vulnerable people with their vaccination registrations.

— Many Member States established mobile vaccination services catering for the needs of certain population groups, such as older people, those with disabilities, people living in remote areas or homeless people. Some Member States also offer transport to vaccination centres.

Introduction



By 18 May 2021, COVID-19 had infected 32,257,738 people in the EU, and 713,077 people had died from it, according to the **European Centre for Disease Prevention and Control (ECDC)**.

The European Commission in its **Communication on a common path to safe and sustained re-opening,** of 17 March 2021, highlighted that swift and effective deployment of vaccines is "a key driver in bringing down the number of new cases". Vaccines will help in protecting people's rights to health and life, and in lifting restrictions to other fundamental rights.

One of the main objectives of the **EU strategy for COVID-19 vaccines** is to ensure equitable access to vaccination for everyone in the EU as early as possible in line with the EU Charter of Fundamental Rights, in particular Article 35 on the right to healthcare and Article 21 on non-discrimination. EU secondary law explicitly requires that access to healthcare be provided without any discrimination based on criteria including race and ethnic origin. In its Article 12, **the International Covenant on Economic, Social and Cultural Rights** provides for the right to the highest attainable standard of health, yet another legal underpinning to promote equitable access to vaccines.

Seventeen EU Member States have ratified the Council of Europe **Convention on Human Rights and Biomedicine (Oviedo Convention)**. Article 3 specifically provides that States, "taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality". Interpreting Article 3, the convention's monitoring committee published in January 2021 a **statement on COVID-19 and vaccines: ensuring equitable access to vaccination during the current and future pandemics**. It underlines that equitable access to vaccination requires "ensuring that everyone, without discrimination, is offered a fair opportunity to receive a safe and effective vaccine" (p. 1). It also notes that, "Faced with a scarcity of vaccines, there is a need to prioritise groups in relation to the provision of access to vaccination with the aim of minimising deaths and severe illness as well as reducing transmission". When doing so, it is necessary that, "within each group as defined by the prioritisation process, each person will be able to receive a vaccine". Given that some persons are more disadvantaged than others, this would require removing barriers to their vaccination and establishing practices that help reach out to them. The committee also highlighted the importance of strengthening transparency, information and communication as tools for building trust and ensuring equitable access to vaccination.

The European Commission identified priority groups for the initial phase of vaccine deployment, without ranking them, in its October 2020 **Communication on preparedness for COVID-19 vaccination strategies and vaccine deployment.** Moreover, the European Commission set targets for the rollout of vaccines across the EU in its **Communication on a united front to beat COVID-19** of January 2021.

In this context, Member States adopted and implemented national vaccination strategies. The ECDC (an EU agency) provides a regular **vaccine rollout overview (see also COVID-19 vaccine rollout overview and COVID-19 vaccine tracker)** across the EU, at the level of individual Member States.

"The virus is destroying many lives and much else of what is very dear to us. We should not let it destroy our core values and free societies".

Council of Europe Secretary General Marija Pejčinović Burić, COVID-19 Human rights are more important than ever in times of crisis (coe.int)

Equitable access to vaccines is crucial because the EU is adopting the **EU COVID-19 Certificate**. This certificate will be proof that a person has been vaccinated against COVID-19, received a recent negative test or recovered from COVID-19. The certificate aims to facilitate safe free movement inside the EU during the COVID-19 pandemic through the mutual recognition of national certificates.

This is the seventh FRA Bulletin on how the COVID-19 pandemic affects fundamental rights.

The first section outlines some of the main elements of national vaccine strategies and their planning, communication and deployment. It includes the need to prioritise groups in providing access to vaccination to minimise deaths and severe illness, and to reduce transmission. The second section describes the vaccination rollout. It examines communication strategies, registration channels and the administration of vaccinations. The Bulletin closes by summarising challenges and pertinent safeguards in relation to the introduction of COVID-19 certificates.

Given how quickly the pandemic and policy responses have unfolded, the Bulletin does not present an in-depth socio-legal analysis of measures and their impact, nor does it offer policy recommendations. Rather, it presents illustrative examples drawn from data that FRA's research network Franet has collected (see box). It is beyond the Bulletin's scope to analyse relevant international human rights law, since it applies only to the EU and its Member States.

Where the report mentions specific articles, they refer to the Charter of Fundamental Rights of the European Union. The Charter is a proxy for the many other human rights standards that apply at national level. These references do not imply that the Charter itself would be legally binding on the Member States in all these contexts.[1]

Bulletin #7 addresses several areas of life affected by the COVID-19 outbreak. They are all reflected in various articles of the Charter, but they are not all comprehensively covered by secondary EU law. For example, the Bulletin deals with core areas that measures in response to COVID-19 affect, such as education. These are mainly under Member States' jurisdiction. However, in combination, they might have implications in relevant fields of EU law such as non-discrimination.

Some examples of promising practices to address challenges with vaccine inequalities appear throughout the Bulletin. They have been selected from a pool of practices that Franet collected after FRA asked it to report on challenges and emerging inequalities in access to and uptake of vaccines and on promising practices that address these challenges. The practices that we detail show relevant actions taken across the EU at national, regional and local levels.

BULLETIN #7: COVERAGE AND TIMELINE

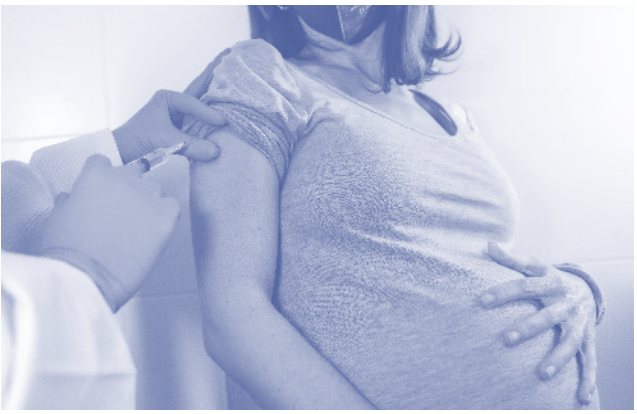
Bulletin #7 on COVID-19 outlines the situation in the 27 EU Member States from 1 March to 30 April 2021. It is structured differently from previous bulletins,* and focuses on equitable access to vaccines.

Franet collected data and information for this Bulletin across all 27 EU Member States, from sources that were publicly available at the time of data collection. The Bulletin presents the evidence with hyperlinks to the references embedded on the relevant text. For full references, please refer to the relevant country report. FRA's 2021 Fundamental Rights Report, published in June 2021, will address the impact of COVID-19 on fundamental rights across the EU in 2020.

* *Bulletins #1, #2, #3, #4, #5 and #6, published on 8 April, 28 May, 30 June, 30 July, 29 September and 30 November 2020.*

1

NATIONAL VACCINE DEPLOYMENT – PLANNING AND PRIORITISATION



"Swift and effective deployment of vaccines [...] will be a key driver in bringing down the number of new cases".

European Commission, Communication on a common path to safe and sustained re-opening

COVID-19 vaccinations are essential to combat the pandemic, the European Commission's **Communication on a common path to safe and sustained re-opening** underlines. COVID-19 vaccination presents an enormous challenge in view of limitations in vaccine supply and the logistical challenges of organising large-scale immunisation quickly. Member States have therefore put in place national vaccination strategies outlining the phases of vaccination and population groups to be prioritised for vaccination (see Table 1). These strategies draw on relevant recommendations from the World Health Organization, the European Medicines Agency and the ECDC, as well as the **European Commission Communication on preparedness for COVID-19 vaccination strategies and vaccine deployment**.

This section outlines which groups Member States have prioritised for early vaccination. It also explores how and to what extent vaccination strategies integrate vulnerable communities, including pregnant women, people with disabilities, people deprived of their liberty, homeless people, people with insecure legal residence status, Roma and Travellers, etc.

1.1 PRIORITY GROUPS FOR COVID-19 VACCINATION

Most Member States launched their national vaccination campaigns in December 2020 and administered the first doses at the same time. Some countries, such as Belgium, Croatia, Cyprus or Czechia, have not amended their national vaccination strategies. Others, such as Germany, the Netherlands, Slovakia, Slovenia or Spain, have updated them up to five times (see **Table 1**).

Vaccine supplies are limited, and the paramount overall goal is to prevent loss of human life. Member States therefore identified key priorities in shaping their vaccination strategies, including:

- reducing morbidity and mortality;
- preventing the overload of healthcare systems;
- ensuring the continuation of essential services.

Table 1: Overview of national vaccination strategies in the EU (including amendments up to 30 April 2021)

Austria	COVID-19 vaccines: prioritisation of the National Vaccine Council *(**COVID-19 Impfungen: Priorisierung des Nationalen Impfgremiums**)*, 14 December 2020. **Version 2.1, Stand: 26.12.2020**; **Version 3, Stand: 12.01.2021**; **Version 4.0, Stand: 31.03.2021**; **Version 4.1, Stand: 28.04.2021**. Amendments on 26 December 2020, 12 January 2021, 31 March 2021, 28 April 2021.
Belgium	Opinion for the operationalisation of the COVID-19 vaccination strategy for Belgium *(**Avis pour l'opérationnalisation de la Stratégie de vaccination COVID-19 pour la Belgique**)*, 3 December 2020
Bulgaria	National plan for vaccination against COVID-19 *(**Национален план за ваксиниране срещу COVID-19**)*, 7 December 2020 Revised national plan for vaccination against COVID-19 *(**Национален план за ваксиниране срещу COVID-19**)* Amendments on 3 February 2021, 19 February 2021, 22 February 2021
Croatia	National vaccination plan against COVID-19, (**Plan uvođenja, provođenja i praćenja cijepljenja protiv bolesti COVID-19 u Republici Hrvatskoj**) 23 December 2020
Cyprus	**National vaccination plan for COVID-19**, 15 December 2020
Czechia	Czech vaccination strategy for COVD-19' *(**Strategie očkování proti nemoci covid-19 v České republice**)*, 22 December 2020
Denmark	Guidelines for handling vaccination against COVID-19 *(**Retningslinje for håndtering af vaccination mod COVID-19**)*, 22 December 2020 (link is to version 3 of 5 February 2021, as version 1 of 22 December 2020 is no longer available). Vaccination calendar, version 10 *(**Vaccinationskalender, version 10**)*, 17 *March* 2021
Estonia	COVID-19 vaccination plan *(**COVID-19 vaktsineerimise plaan**)*, 19 January 2021 COVID-19 vaccination plan April–June 2021 *(**COVID-19 vaktsineerimise plaan aprill – juuni 2021**)*, 20 April 2021
Finland	Government Decree on voluntary COVID-19 vaccines (Decree No. 1105/2020) *(**Valtioneuvoston asetus vapaaehtoisista covid-19-rokotuksista/Statsrådets förordning om frivilliga covid-19-vaccinationer**)*, 23 December 2020 **Vaccination order for risk groups**, 5 February 2021 Amendment of 19 April 2021 (Decree No. 307/2021) *(**Valtioneuvoston asetus vapaaehtoisista covid-19-rokotuksista annetun valtioneuvoston asetuksen muuttamisesta ja väliaikaisesta muuttamisesta/Statsrådets förordning om ändring och temporär ändring av statsrådets förordning om frivilliga covid-19-vaccinationer**)* Amendment of 19 April 2021 (Decree No. 308/2021) *(**Valtioneuvoston asetus vapaaehtoisista covid-19-rokotuksista annetun valtioneuvoston asetuksen 2 §:n muuttamisesta/Statsrådets förordning om ändring av 2 § i statsrådets förordning om frivilliga covid-19-vaccinationer**)*
France	COVID-19 vaccination strategy *(**Covid-19: la stratégie de vaccination**)*, 3 December 2020, amended 15 April 2021 COVID-19 vaccination: what timetable? *(**Vaccination contre le Covid-19: quel calendrier?**)* Vaccines *(**Vaccins**)*
Germany	Ordinance on the entitlement to vaccination against the SARS-CoV-2 coronavirus *(**Verordnung zum Anspruch auf Schutzimpfung gegen das Coronavirus SARS-CoV-2**) (Coronavirus-Impfverordnung – CoronaImpfV)*), 18 December 2020 **Amendment of 8 February 2021**, **Amendment of 24 February 2021**, **Amendment of 10 March 2021**, **Amendment of 31 March 2021 (in operation)**, **Amendment of 29 April 2021 (in operation)**
Greece	National plan of vaccination coverage for COVID-19 (**Εθνικό σχέδιο εμβολιαστικής κάλυψης για COVID-19**), 18 November 2020 National vaccination operational plan against COVID-19 (**Εθνικό επιχειρησιακό σχέδιο εμβολιασμού κατά της COVID-19**), 23 December 2020Vaccination prioritisation against COVID-19 (**Προτεραιοποίηση εμβολιασμού κατά της Covid-19**), 18 February 2021
Hungary	Information to citizens based on the vaccine deployment plan *(**Lakossági tájékoztató az oltási terv alapján**)*, 31 December 2020
Ireland	**National COVID-19 vaccination strategy and first COVID-19 vaccine implementation plan** (see p. 9 of the Implementation Plan), 11 December 2020 **Provisional vaccine allocation groups**, 31 March 2021

Italy	Elements of preparation of the vaccine strategy (***Elementi die preparazione e di implementazione della strategia vaccinale***), 2 January 2021 Interim recommendations on the target groups of the anti-COVID-19 vaccines (***Raccomandazioni ad interim sui gruppi target della vaccinazione anti-SARS-CoV-2/COVID-19***), 10 March 2021 National vaccine deployment plan (**Approvazione del Piano strategico nazionale dei vaccini per la prevenzione delle infezioni da SARS-CoV-2**), 12 March 2021
Latvia	Vaccination plan (**Vakcinācijas plāns**), 5 January 2021 Updated vaccination plan (**Informatīvais ziņojums "Par prioritāri vakcinējamām personu grupām**), 8 February 2021
Lithuania	Determining Priority Groups for Vaccination Against Covid-19 (the Coronavirus Infection) with Vaccines Purchased from the State Budget (***'Dėl skiepijimo valstybės biudžeto lėšomis įsigyjama COVID-19 ligos (koronaviruso infekcijos) vakcina prioritetinių asmenų grupių nustatymo'***), 23 December 2020 **Amendment of 5 January 2021**, **Amendment of 24 January 2021**, **Amendment of 28 January 2021**, **Amendment of 19 March 2021**, **Amendment of 24 March 2021**, **Amendment of 26 March 2021**
Luxembourg	Consolidated opinion on ethical aspects relating to the prioritisation of people to be vaccinated against COVID-19 (***Avis consolidé sur les aspects éthiques relatifs à la priorisation des personnes à vacciner contre la Covid-19***), 4 December 2020 Opinion of the Superior Council of Infectious Diseases: vaccination strategy against COVID-19 in Luxembourg – phases 2 and following 27 January 2021 (***Avis du Conseil supérieur des maladies infectieuses: Stratégie vaccinale contre la COVID 19 au Luxembourg – phases 2 et suivantes 27 janvier 2021***), 27 January 2021
Malta	National vaccine programme for COVID-19, Health Committee of the Parliament of Malta, transcript of the meeting (***Kumitat Permanenti Dwar Is-Saħħa (Rapport Uffiċjali u Rivedut)***), 15 December 2020 Statement by the Office of the Deputy Prime Minister and the Ministry of Health on the beginning of the vaccination campaign in Malta (***Stqarrija Mill-Uffiċċju Tad-Deputat Prim Ministru u Ministeru Għas-Saħħa L-Ema***), 22 December 2020 **COVID-19 vaccine frequently asked questions**, 6 May 2021
Netherlands	Vaccination strategy (***Vaccinatiestrategie***), 20 November 2020 **Amendment of 21 December 2020**, **Amendment 5 February 2021**, **Amendment 23 March 2021**, **Amendment 13 April 2021**, **Amendment 20 April 2021**
Poland	National vaccination programme against COVID-19 (***Narodowy program szczepień przeciw COVID-19***), 15 December 2020 **Amendment of 20 January 2021**, **Amendment of 4 February 2021**
Portugal	Vaccination plan against COVID-19 (***Plano de vacinação contra a Covid-19***), 3 December 2020 **Amendment of 28 January 2021, Amendment of 1 March 2021**, **Amendment of 10 March 2021**, **Amendment of 21 April 2021**
Romania	Strategy for vaccination against COVID-19 in Romania (***Strategie de vaccinare împotriva COVID-19 în România***), 27 November 2020 **Amendment of 20 January 2021**
Slovakia	National vaccination strategy (***Národná stratégia očkovania***), 16 *December* 2020 **Amendment of 19 January 2021**, **Amendment of 11 February 2021**, **Amendment of 26 February 2021**, **Amendment of 5 March 2021**, **Amendment of 27 April 2021**
Slovenia	National strategy on vaccination against COVID-19 (***Nacionalna strategija cepljenja proti COVID-19***), 3 *December* 2020 **Amendment of 1 March 2021**, **Amendment of 11 March 2021**, **Amendment of 24 March 2021**, **Amendment of 15 April 2021**, **Amendment of 23 April 2021**
Spain	COVID-19 vaccination strategy in Spain (***Estrategia de vacunación frente a COVID-19 en España***), Amendment of **18 December 2020**, Amendment of **21 January 2021**, Amendment of **9 February 2021**, Amendment of **26 February 2021**, Amendment of **30 March 2021**
Sweden	National plan for vaccination (***Nationell plan för vaccination mot Covid-19***), 31 August 2020 **Amendment 1 of 4 December 2020**, **Amendment 2 of 29 December 2020**, **Amendment 3 of 4 February 2021** Update Public Health Agency of 27 April 2021 (**Gravida med andra riskfaktorer kan få vaccin i fas 3**), Update Public Health Agency of 29 April 2021 (**Vaccination mot covid-19 för särskilda grupper från 16 års ålder**)

Source: FRA, 2021

They also used epidemiological or medical criteria. They prioritised groups at high risk of severe complications or death from COVID-19, and people who were highly susceptible to infection because their work, critical to maintaining essential services, exposed them to the virus. In practice, this translated into prioritising for vaccination:

- older people, especially those living in long-term care facilities;
- people with underlying medical conditions who are more likely to develop a severe form of the disease or die if they contract COVID-19;
- frontline health workers and staff of long-term care facilities.

Subsequent phases encompass the vaccination of progressively younger age groups, other key frontline workers, other people with underlying health conditions (ranked according to risk), and staff at schools and childcare facilities. Further background information on the national vaccination strategies is in the **Franet country reports**.

National vaccination strategies include flexibility clauses to allow for modifications during the rollout, according to evidence FRA has collected. This enabled countries to vaccinate additional population groups when supplies increased or to adapt their strategies when new data on vaccine safety and efficacy emerged.

There is also evidence of challenges in ensuring consistent implementation of the national strategies. For example, in Austria **civil society organisations** criticised the decentralised management of vaccination strategies, which allows federal states (*Länder*) to set different priority groups. They claimed that it leads to excluding some vulnerable groups, in particular people with disabilities. Coordination issues also arose in Italy, where some regional-level prioritisation decisions were not in line with the central government guidance. This prompted the Italian Commissioner for the COVID-19 Emergency to adopt an **ordinance** requiring all regions to adjust their regional plans to follow the national strategy.

1.1.1 Older people

As FRA Bulletin **#3** underlined, older people, particularly those living in long-term care facilities, are at particularly high risk of hospitalisation or death from COVID-19. Reflecting this, all Member States prioritised older people in their national vaccination strategies, and all specified older people living in long-term care facilities as the highest priority group (Table 2).

The definition of 'older persons' varied between Member States but was most frequently over 60 years of age. In the first phases of the rollout, the vaccination of people aged over 60 living in the community was prioritised, starting with the oldest age groups. Nevertheless, a number of older people, especially those aged over 80, remained unvaccinated at the end of April, evidence reported to FRA suggests. This was the case, for example, in **Czechia**, **Estonia**, **Romania** and **Slovakia**.

Table 2: Older people – priority ranking in national vaccination strategies

Category	Rank of priority	Listing in national vaccination strategies
Older people living in long-term care facilities	Highest	All Member States
Older people living independently with or without underlying medical conditions	High (second or third highest priority) Ranked in descending order starting with oldest age groups	All Member States

Source: FRA, 2021

INCENTIVES TO INCREASE VACCINE UPTAKE

The **Estonian** government is offering younger people the opportunity to get vaccinated when they help older people to get to vaccination locations in areas with lower vaccination coverage. For example, Ida-Virumaa's vaccination rates are lowest in the country. From 29 April, people aged 18 and over who accompany a person over 70 to get vaccinated there can be vaccinated as well. The younger person does not need to be related to the older person, but they both have to reside in the region.

Considering changes in the epidemiological situation, several Member States updated their strategies during the reporting period. A February update of the Dutch national strategy provided for **advanced vaccination of the age group 60–64 with the AstraZeneca vaccine** before older age groups, as the government prohibited the use of that vaccine for those over 65. The **January update** of the Portuguese vaccination plan added people aged 80 and over and living in the community to the first phase. This reflected evidence that the increase in infections due to the new coronavirus variant particularly affected this age group.

Despite the focus on vaccinating older persons, older people face challenges when trying to access vaccines (see also Section 2.3 on the administration of vaccines). For example, **French media** reported that many older people in rural areas found it difficult to reach COVID-19 vaccination centres. Similarly, **Dutch media** criticised the long distances some people have to travel to vaccination sites, which can pose problems for older people. **Portuguese** authorities reported difficulties in contacting older people by mobile phone. By the end of February, only 55 % of people aged over 80, or aged 50–79 with a high-risk disease, had responded to text messages inviting them for vaccination. Concerns emerged in **Romania** that opening vaccinations to large numbers of younger people who were classified as essential workers reduced the opportunities for older people and people with chronic diseases, who may face greater challenges in registering.

1.1.2 People with underlying health conditions

Specific medical conditions are linked to increased risk of severe illness or death from COVID-19. Member States identified those conditions as justification for giving people with those conditions priority in the national vaccination strategies. Member States ranked people by health risk for conditions such as cardiovascular, pulmonary or respiratory diseases, diabetes, obesity, certain neurological diseases, and conditions requiring chemotherapy, immunosuppression or transplantation. In Austria, Czechia, Latvia and Slovenia the national vaccination strategies also prioritised close contact persons, caregivers or support staff of people with the listed medical conditions.

Nevertheless, concerns emerged in some countries about the criteria for including people with underlying health conditions. For example, stakeholders in Poland called for people with additional underlying health conditions such as **diabetes**, **pulmonary hypertension** and **autism** to be included among priority groups. The **Slovakian** ombudsperson received several complaints that younger people with chronic diseases were not among the priority groups in the first phase of the vaccination rollout. In Slovenia, prioritising certain groups, in particular high-ranking officials and dignitaries, over people aged 60–69 years and chronic patients aged 18–64 prompted **media criticism**.

1.1.3 Key workers

As previous FRA bulletins reported, in particular **#6**, frontline healthcare workers with high exposure to COVID-19 have been the most infected professional group during the pandemic. For this reason and to maintain the proper functioning of the healthcare system, they received the highest priority in all Member States' vaccination programmes. Staff in long-term care facilities had the same ranking, to curb virus transmission to older people living in such settings.

These groups are typically followed by other health or social workers (ranked according to COVID-19 exposure or transmission risk), persons providing essential services, teachers, and staff at childcare facilities.

Table 3: Prioritisation of key workers for vaccination

Rank/phase	Priority group	Criteria for prioritisation
1	Frontline healthcare workers	Highest risk of COVID-19 infection and/or transmission
1	Staff of long-term care facilities	Close contact with highly vulnerable group and highest risk of COVID-19 transmission
2-3	Other healthcare workers and key workers in critical infrastructure (police, firefighters, army, energy and water supply, transport and distribution, pharmacy, post, etc.)	To provide essential services, often entailing close contact with potentially contagious people
3-4	Teachers, staff at childcare facilities	To allow reopening of schools and childcare facilities and to curb COVID-19 transmission

Source: FRA, 2021

Several Member States amended their vaccination strategies to give teachers and education staff higher priority, recognising the importance of safely reopening schools. For example, the Maltese government moved education staff up the priority list in **agreement with the Malta Union of teachers to end the teachers' strike** because of concerns over the safety and effectiveness of the COVID-19 mitigation strategies in place at schools. The Portuguese government added teachers as a priority group for vaccination in response to **concerns about the functioning of schools** amid the resumption of face-to-face teaching. Similarly, **the 24 February amendment of the German national vaccination strategy** included those working in childcare and primary education among those with high priority for vaccination. **Hungary started vaccinating teachers** on 1 April, before reopening kindergartens and elementary schools on 19 April.

Professional groups without priority for vaccination raised concerns about their exclusion in a number of Member States, for example the police in **Lithuania, customs officers** and flight **cabin crew** in Malta, and **university professors** and **judicial officers** in Portugal. They raised issues of unfair and unequal treatment, suggesting that other groups with similar tasks and working conditions were included in the priority lists.

Unions representing teachers and the police objected to changes to the Irish vaccination plan adopted on 30 March, which removed professional categories except frontline health workers. The **Irish government argued that an age-based system is fairer** and more scientifically sound – as age is the primary determinant of how likely COVID-19 is to cause death or severe illness – and also easier to implement.

1.2 VULNERABLE COMMUNITIES IN NATIONAL VACCINATION STRATEGIES

Global and EU-level guidance on vaccination strategies has highlighted the importance of including people in vulnerable situations in national vaccination strategies alongside older persons, people with underlying health conditions and key workers. For example, the **European Commission Communication on preparedness for COVID-19 vaccination strategies and vaccine deployment** also mentions communities unable to retain physical distance (e.g. those living in dormitories, prisons or refugee camps); workers unable to physically distance (e.g. those working in factories); and vulnerable socioeconomic groups (e.g. socially deprived communities). This reflects their higher risk of contracting and/or becoming seriously ill or dying from COVID-19.

This section looks at how national vaccination strategies integrated the following vulnerable groups:

- pregnant women;
- persons with disabilities;

- persons deprived of their liberty;
- homeless persons;
- persons without legal residence or with insecure legal status;
- Roma and Travellers.

Member States have not always taken up guidance in prioritising certain of these groups, the evidence suggests (see Table A2provided from Franet not working). In addition, other vulnerable groups, such as persons belonging to ethnic or national minorities, persons with drug addictions or dependencies, or persons with low literacy levels, were not specified as priority groups for vaccination in national vaccination programmes, FRA's evidence indicates.

1.2.1 Pregnant women

Pregnant women and persons in close contact with a pregnant woman feature as priority groups for vaccination in five EU Member States, evidence collected by FRA suggests. In all cases, amendments to the national vaccination strategies added them, for example in **France** (from April), **Hungary** (from March) and **Slovenia** (from April). **Sweden** included pregnant women with risk factors as a new priority group in April.

The **Austrian vaccination plan** initially included only persons in close contact with a pregnant woman as a priority group, but was amended **in March** to include women receiving fertility treatment and women planning on having a child soon, and **in April** to incorporate women in the second and third trimesters of pregnancy. **Germany's national vaccination plan** includes persons in close contact with a pregnant woman in the second priority group for vaccination, but not pregnant women themselves.

1.2.2 Persons with disabilities

FRA Bulletin **#2** underlined the high risk from a COVID-19 infection for people with disabilities, particularly those living in institutional settings. Most national vaccination programmes take the vulnerability of people with disabilities into account and include them among priority groups for COVID-19 vaccination, albeit in different forms.

- Many Member States – including Austria, Belgium, Cyprus, Czechia, Denmark, France, Hungary, Lithuania, Luxembourg, Malta, the Netherlands and Portugal – included people with disabilities living in long-term care facilities among the highest priority groups for vaccination.
- Some national vaccination programmes, for example in Bulgaria, Croatia, Italy, Lithuania, Latvia, Romania and Sweden, list 'persons with disabilities' as a separate priority group.
- Germany, Finland, France, Ireland, Netherlands, Portugal, Sweden and Slovenia specifically mention Down syndrome as a condition for prioritisation.
- Some EU countries include close contact persons, family members, caregivers or guardians of people with disabilities as priority groups, for example in Croatia, Denmark, Finland, Italy, Lithuania, Romania and Spain.
- Several Member States, for example Austria, Cyprus and Czechia, merge risk criteria related to disability under the category 'underlying health conditions'.
- Only Germany and Ireland specifically refer to persons with intellectual disabilities as a priority group.
- People with disabilities who attend school are a priority group in Greece and Spain.

Civil society organisations in several Member States played a crucial role in advocating the inclusion of persons with disabilities and their support workers among priority groups. Disability rights organisations in **Finland** demanded that personal assistants and family carers of persons with disabilities be vaccinated at the same time as the persons they support, emphasising that support to persons with disabilities is as important as the assistance health and social care personnel provide for persons in institutional and/or home care. Civil society organisations in **Germany** advocated the inclusion of deaf-blind, blind and severely visually impaired persons in the priority list.

Table 4 presents the relevant national provisions.

Table 4: Integration of vulnerable communities as priority groups for vaccination in the national vaccination strategies (where indicated, the number in brackets signifies the rank of the priority group in the national vaccination strategies, including amendments up to 30 April 2021)

Member State	Persons with disabilities	Persons experiencing homelessness	Persons deprived of their liberty	Persons without legal residence or with insecure legal status	Other (vulnerable) groups classified as priority groups and added to the national vaccination strategy (including amendments)
Austria	✓ Integrated into 'residents of long-term care' (1) + 'persons (regardless of age) with underlying health conditions and high risk' (2)	✓ In homeless shelters only (3) and staff in shelters; Integrated into 'residents in shared accommodation or tight/precarious living or working conditions'	✓ Persons in prisons (3) and staff members; integrated into 'residents in shared accommodation or tight/ precarious living or working conditions'	✓ In asylum quarters; integrated into 'residents in shared accommodation or tight/ precarious living or working conditions' (3)	Close contacts of older people (1) Contact persons of pregnant women (3) Pregnant women in second or third trimester of pregnancy (3); women before fertility treatment (5) + women planning on having a child (6)
Belgium	✓ As residents of care facilities	×	×	×	Essential workers (police)
Bulgaria	✓ Users of social services (2)	×	×	×	Election officials (3) Vulnerable groups of the population at high epidemiological risk of infection related to their conditions and way of life (5)
Croatia	✓	×	✓	✓	Guardians of persons with disabilities dependent on guardian
Cyprus	✓ in institutionalised setting or with health condition; with tetraplegia	×	✓ In prisons (6)	✓ In centres for refugees and migrants (6)	×
Czechia	✓ In care facilities (top priority groups) Some forms of disabilities (psychotic disorders, autism, intellectual disabilities or dementia) integrated into 'lower-priority chronic patients'	×	×	×	×
Denmark	✓ In nursing homes (1) and residential care (not those living at home, who were included in different groups)	×	×	×	Close relatives of patients with conditions or diseases or close relatives who are indispensable as caregivers (6)
Estonia	×	×	×	×	Caregivers or relatives of the risk groups (at the discretion of the family doctor)
Finland	✓ Specific reference to people with Down syndrome (3)	×	×	×	Caregivers living in the same household as a prioritised person (2–3) Election officials/voting commissions (1) (elections in June)
France	✓ In institutionalised settings (1); trisomy-21 (2)	×	×	×	Pregnant women from the second trimester of pregnancy (2)
Germany	✓ Trisomy-21 and specific mental disabilities	✓ In shelters and other accommodation for the homeless (2)	✓ Detainees are integrated into 'precarious living conditions (3)'	✓ Joint accommodation for refugees/asylum seekers/persons who are subject to deportation (2)	One contact person of members of specifically listed prioritised groups and pregnant women (2) Persons accommodated in women's shelters, introduced as a group (2)
Greece	✓ Attending schools	×	✓ Integrated into 'people in overcrowded facilities'	×	People aged 18–59 living in overcrowded facilities; people in close contact with animals that may carry mutated strains of SARS-CoV-2
Hungary	✓ In institutional settings (2)	✓ As recipients of social services (2)	×	×	Pregnant and nursing women
Ireland	✓ Aged 65+ with intellectual disability (4); aged 18–64 with trisomy-21	×	×	×	'Aged 18–64 living/working in crowded accommodation where self-isolation and social distancing is difficult to maintain' (9)

Member State	Persons with disabilities	Persons experiencing homelessness	Persons deprived of their liberty	Persons without legal residence or with insecure legal status	Other (vulnerable) groups classified as priority groups and added to the national vaccination strategy (including amendments)
Italy	✓ Severe disabilities (1); parents/ guardians of children with severe disabilities younger than 16 (1)	×	✓ Detainees	×	Caregivers of people with severe disabilities (1) Staff in 'detention system'
Latvia	✓ (3)	✓ If living in shelters (6)	✓ Detainees (6)	×	Persons living with children with certain diseases Persons caring for seriously ill persons at home
Lithuania	✓ in social care institutions + persons with disabilities and their family members	×	×	×	×
Luxembourg	✓ In 'approved accommodation facilities' (1)	✓ Integrated into 'living in precarious situation' (6b)	×	×	Persons living in retirement and care facilities (1) Persons living in precarious situations (6a)
Malta	✓ People with mental health problems in long-term care facilities (1)	×	×	×	×
Netherlands	✓ People with disabilities living in institutions (2) People with Down syndrome (2)	×	×	×	Riot police; staff at Dutch embassies and consulates and their family members; and athletes participating in the next Olympic Games
Poland	×	×	×	×	Residents of social care centres and other places of in-patient stay
Portugal	✓ Those in institutions (1) Down syndrome (1)	✓ Homeless people (regardless of age) (2)	✓ Particularly vulnerable inmates, e.g. hospitalised inmates not subject to criminal penalties (in prison health facilities – psychiatric and mental health clinics) (1)	×	×
Romania	✓ Persons with disabilities and the members of their households (2a)	✓ Persons experiencing homelessness (not limited to people in shelters) (2a)	✓ Persons deprived of their liberty (3a)	✓ All categories of migrants (3a)	×
Slovakia	x	×	×	×	×
Slovenia	✓ Persons with trisomy-21 (1)	×	×	×	Residents in other social welfare institutions (1) Diplomats and staff of presidency (2) Pregnant women (7)
Spain	× Not listed as a priority group as such but people with disabilities who are dependent (institutionalised or not) and need intensive support can be prioritised (4)	×	×	×	Caregivers of dependent people living in institutions or not (4)
Sweden	✓ Persons with disabilities, including trisomy-21 (2–3)	×	×	×	Persons living in long-term care facilities or receiving home care (1.1) Adults in the same (1.3) household as someone of group (1.1) or (2.2) 'Persons aged 18–59 with conditions that make it difficult to follow recommendations on infection control measures, which also expressly includes persons living in socially vulnerable situations' (3.3) Pregnant women with risk factors (3) 'Specific groups from 16+' (3)

Source: FRA, 2021

1.2.3 Persons deprived of their liberty

Previous FRA bulletins (see **#2**, **#3**, **#4**) underlined the increased risk of COVID-19 infection for persons deprived of their liberty, given the crowded conditions in prisons and detention centres, and gaps in adherence to health protection measures.

Only a third of EU Member States – Austria, Croatia, Cyprus, Germany, Greece, Italy, Latvia, Portugal and Romania – define detainees as a priority group in their national vaccination strategies, according to evidence collected by FRA. **Detainees in Portugal started to receive COVID-19 vaccinations on 20 January,** and particularly vulnerable **inmates at prison health facilities were also vaccinated**.

Luxembourg **acknowledged the vulnerability of persons in detention** but did not define them as a priority group. Similarly, the Spanish **national vaccination strategy** recommended the vaccination of detainees, without specifying them as a priority group.

In Germany, **civil society organisations** called for higher priority for persons in prisons and prison-like institutions, as did the **Superior Council of Infectious Diseases** in Luxembourg and the **Polish Commissioner for Human Rights**.

1.2.4 Homeless persons

As highlighted in previous bulletins (**#1**, **#2**, **#3**, **#6**), persons experiencing homelessness are at increased risk of COVID-19 infection, given their precarious living conditions and the fact that many suffer from underlying medical conditions. Their risk is exacerbated by poor access to healthcare or public health information, personal protection equipment and COVID-19 testing. Section 2.3.4 provides more information on the vaccination of homeless people.

Several EU Member States took the vulnerability of homeless people into account when drafting their national vaccination strategies. Austria, Germany and Hungary ranked homeless people in shelters as a high-priority group from the first versions of their national vaccination strategies. Portugal and Romania added homeless people (not limited to people in shelters) as a high-priority group in amendments to their national vaccination strategies.

In contrast, Slovakia referred to homeless people as a priority group in its **initial vaccination plan** but removed the reference in the **first amendment of the plan** without explanation. Similarly, the first draft of the third update of the Swedish national vaccination plan referred to people experiencing homelessness, but **this reference was later removed**.

The Irish National Immunisation Advisory Committee identifies members of the Roma and Traveller communities and homeless people as the only specific groups with significantly increased risk from being infected, who therefore should be prioritised for vaccination. Although the official vaccination strategy does not specifically mention them, Ireland makes provision to vaccinate these groups earlier than others in their age cohorts. **A specific programme to vaccinate homeless people in Dublin began** at the end of April, for example.

Civil society in several countries underlined the importance of including homeless people in vaccination strategies. The non-governmental organisation (NGO) **Médecins Sans Frontières** in France drew attention to the unequal access of homeless people to vaccination, as they are **not included** among priority groups.

1.2.5 Persons without legal residence or with insecure status

Previous FRA bulletins (**#1** and **#6**) illustrated that migrants, asylum seekers and refugees might face a higher risk of COVID-19 infection because of precarious living conditions and limited access to health services. In its report *Migrant Inclusion in COVID-19 Vaccination Campaigns*, the International Organization

for Migration argued that irregular and undocumented migrants and forcibly displaced people face challenges in accessing vaccines. Evidence that FRA collected for this Bulletin confirms these findings for many Member States (see also **Section 2.1.2**).

Austria, Croatia, Cyprus and Germany included persons without legal residence or with insecure status, particularly when living in shared accommodation, as a priority group in national vaccination strategies from the start. Romania added migrants living in centres and all other categories of migrants as a priority group in its January update of the national strategy. In contrast, Slovakia removed refugees from the priority list in the first revision of the national vaccination plan. Sweden included undocumented persons in the first draft of the third amendment to the national vaccination plan, but **this reference was eventually removed**. Free vaccination is expressly open to asylum seekers in Austria,[2] **Latvia** and **Sweden.**

Migrants living in 'hotspots' on the Greek islands (see Bulletin **#1)** do not have priority for vaccination. **Civil society organisations called** for the immediate vaccination of migrants and refugees living in reception facilities and camps. The **Greek Minister for Migration Policy stated** that Greece planned to start vaccinating residents and staff in refugee camps in May, as epidemiological data did not show particular spread in the camps.

Vaccinations are available for everyone irrespective of health insurance status in **Bulgaria**, **Croatia**, **Estonia**, **France**, **Germany**, **Greece**, **Luxembourg** and **Portugal**. Other countries have tied eligibility to health insurance. In **Czechia,** for example, EU citizens covered by public health insurance in another EU country are also eligible for vaccination, if they have the relevant form. In contrast, vaccines are available to third-country nationals only if they are registered in the public health insurance system. Since third-country nationals without a residence permit are usually not registered in this system, they may not have access to the vaccine. Similar rules apply in **Lithuania, Malta** and **Slovakia**.

Belgium,[3] **Denmark, Lithuania and Slovenia** limit eligibility to permanent and temporary residents. The **Finnish** Ministry of Social Affairs and Health recommended providing COVID-19 vaccines to persons who do not have legal residence or public health care cover, except tourists. However, municipalities can decide whether or not to follow this recommendation, and as of May 2021 only the city of **Rovaniemi** did so.

1.2.6 Roma and Travellers

FRA's bulletins, in particular **#5**, show that Roma face an increased risk of contracting COVID-19 due to overcrowded housing conditions and health threats resulting from poor access to water, food, electricity, sanitation and medicine.

However, national vaccination strategies did not include Roma and Travellers, as persons belonging to ethnic or national minorities, as a priority group, evidence collected for this Bulletin indicates. The **Slovak national vaccination plan** initially included people from marginalised Roma communities as a priority group, but subsequent revisions of the plan removed this reference. **The Minister for Health indicated that** public authorities plan to focus on vaccinating vulnerable groups, such as marginalised Roma communities and homeless people, once the Johnson & Johnson vaccine is available, as it is more easily storable than other vaccines.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2

VACCINATION ROLLOUT: COMMUNICATION, (PRE)REGISTRATION AND ADMINISTRATION

"Communication materials should be tailored to the needs of the target audience. As far as practicable, they should be produced in a variety of formats, suitable for persons with different levels of education and communication needs (e.g. texts in braille, easy to read or pictorial leaflets), translated in all the relevant languages at local and regional level and distributed in locations that the target groups attend [...]. These materials should contain clear, accurate, and up-to-date information on the vaccines and on how to access vaccination services."

Council of Europe, Committee on Bioethics, 'COVID-19 and vaccines: Ensuring equitable access to vaccination during the current and future pandemics', 22 January 2021.

2.1 INFORMATION AND COMMUNICATION

Effective communication in implementing COVID-19 vaccination strategies and deployment plans is the key to minimising perceptions of lack of equity in access to vaccination, increasing the level of vaccine acceptance, reducing immunisation anxiety, and raising awareness of benefits, side-effects and risks.[4] Moreover, "transparency, information, and communication are essential [...] to building trust, enabling the process of informed consent and ensuring that every person for whom the vaccine is indicated is provided with a fair opportunity to access vaccination."[5]

The **Committee on Bioethics of the Council of Europe underlines** that realising the principle of equitable access to healthcare requires the provision of clear, accurate, understandable and reliable information, in a variety of formats and adapted to the needs of different population groups.

2.1.1 Information campaigns for the general population

Most Member States developed and implemented dedicated information campaigns on vaccines in March and April, evidence collected by FRA shows. In some, such as **Portugal** and **Spain,** the national vaccination strategies announced in December 2020 included communication plans. **Greece** and **the Netherlands** also commenced public information campaigns in December 2020. Other EU countries developed campaigns in the course of the vaccination rollout: in **Austria**, **Estonia** and **Romania** national campaigns started in March; in **Czechia** and **Spain** in April.

Member States use a range of different channels and means to inform people of their national vaccination strategies. They all developed dedicated websites providing information on all aspects of the vaccination process. Most countries have established call centres/hotlines for answering public inquires. Moreover, they provide information through different channels, from regular press conferences and communication materials (e.g. video and audio clips, posters and leaflets) to digital campaigns on social media.

CONCERNS ABOUT VACCINE HESITANCY AND UNEQUAL UPTAKE

Eurofound's report on **'Living, working and COVID-19'**, published in April 2021, finds mental health and trust declining across the EU as the pandemic enters another year. The report is based on a dedicated online survey. The third round of this survey includes new questions about people's own experience of the disease, attitudes about the vaccines and the vaccination programmes, trust in science and pharmaceutical companies, and use of and trust in social media. According to the survey, 64 % of respondents living in the EU Member States would like to be vaccinated against COVID-19, while, on the contrary, 27 % would not like to take the vaccine. The main cause of vaccine hesitancy is lack of trust in the safety of the vaccine. Moreover, findings reveal a correlation between low levels of trust in institutions and vaccine hesitancy across the EU. This points to an essential component of effective vaccine uptake: having a clear and transparent communication strategy that helps to build trust in the safety of the vaccines and in the success of the national vaccination campaign.

Survey data across the EU suggest that certain population groups are more reluctant to get the vaccine. In some cases, this could also reflect the impact of persisting patterns of social exclusion and marginalisation.

In a survey conducted in early February 2021 in **Estonia,** 69 % of Estonians stated that they would definitely or most likely plan to be vaccinated themselves, compared with 47 % of non-Estonians. A **public opinion poll** conducted in January 2021 in Latvia showed that only 50 % of residents wanted to get vaccinated as soon as possible, and 37 % would refuse to be vaccinated. By April, however, the proportion of those willing to get vaccinated had **increased** significantly, to 68 % of Latvians and 61 % of non-Latvian residents.

The **Swedish** Public Health Agency presented data that show lower vaccination coverage among persons in the same priority group depending on country of birth, which often coincides with socioeconomic inequalities such as lower income and education, as well as worse working and living conditions. As of 21 April 2021, the vaccination coverage (dose 1) of persons aged 65–79 born in Sweden was 41%, compared with 19 % for persons born in the Middle East, 17 % for persons born in North Africa and 16 % for persons born in the remainder of Africa. In the **Netherlands**, doubts about the vaccines may play a role in low uptake of vaccines in socioeconomically disadvantaged areas.

Reports of possible, but very rare, serious side-effects reduced public trust in AstraZeneca's COVID-19 vaccine. This presented a particular challenge for vaccination rollout in many countries. In **Croatia**, every third person invited for an AstraZeneca vaccine declined the vaccine. **The Latvian Minister for Health** reported that two thirds of people scheduled to be vaccinated during the Easter holidays refused to take the AstraZeneca vaccine. In Spain, **media reported** a large reduction in the percentage of people who considered the vaccine 'safe' (from 59 % to 38 %) and a significant increase in the percentage who considered it 'unsafe' (from 25 % to 52 %) in March.

The Finnish Parliamentary Ombudsman received complaints concerning the absence of vaccine choice for 65- to 69-year-olds, who were allocated the AstraZeneca vaccine. Several complainants alleged that it amounted to discrimination based on age and/or violated the patient's right to self-determination guaranteed in Finnish law.

These concerns prompted some countries to act to increase trust in the AstraZeneca vaccine. For example, in late March, Lithuania **changed its vaccination priority list to include the country's top officials** and members of parliament, who were vaccinated in public in an effort to **promote trust in the AstraZeneca vaccine and COVID-19 vaccination overall**.

"Vaccination strategies are only lawful if proportionate. [...] The Covid-19 pandemic has proved once again the importance of engagement and communication. States need to build trust and provide clear, transparent and reliable information".

Rik Daems, President of the Parliamentary Assembly of the Council of Europe, Saint Petersburg International Legal Forum on 'Vaccination by Law', 19 May 2021

PROMISING PRACTICE - LEAVING NO ONE BEHIND: JOINED-UP EFFORTS WITHIN AND BEYOND PUBLIC AUTHORITIES

The Swedish Association of Local Authorities and Regions **works closely** with the local disability and substance dependency services, the Migration Agency, the Prison and Probation Service and the Agency for Support for Faith Communities to reach those who may otherwise not receive accessible information or are at risk of being left out of the vaccination rollout. It also ensures close cooperation and engagement with the Swedish Church, the Red Cross, and several CSOs and immigrant organisations. These partnerships help to overcome barriers in accessing persons and groups that are otherwise hard to reach, such as homeless people, asylum seekers, sex workers, persons with a mother tongue other than Swedish, and persons who may have little faith in public authorities and health services.

The authorities disseminate information through their established contacts, complemented by features on local radio stations, translated vaccination information material in stairwells, laundry rooms and grocery stores, and films and lectures featuring key individuals from the target groups. They also advertise in the national press, in local media, on websites and on social media.

Some EU countries also established channels for interactive information or took measures to tackle online disinformation. For example, **the Regional Section of the Centre of the Portuguese Medical Association** developed a social media campaign to increase the public's level of trust in COVID-19 vaccines, which replied to concerns about COVID-19 vaccines. To address insecurity and misinformation associated with COVID-19 vaccines, a group of Portuguese scientists from the Champalimaud Foundation held **online conversations with the public** in April. **The Finnish Institute for Health and Welfare** arranged webcasts for the public to ask about COVID-19 vaccines, vaccinations and the order of priority in vaccinations. In Italy, the **Ministry of Health** and the **Higher Institute of Health** developed specific sections on their websites, providing information on the most common fake news about COVID-19 vaccines. This measure aims to tackle widespread concerns about side-effects of the vaccines by providing the public with evidence-based and scientifically sound information.

In April, several Member States developed communication material targeting specific professional groups. For example, the **Slovenian information platform** includes posters and leaflets aimed at healthcare workers, nursing home staff and teachers, while the **Latvian** national information hub includes materials for family doctors. A **digital package of promotional and information materials** for the long-term care sector is available in Germany. Moreover, the German Federal Ministry of Health offers **virtual and interactive information events** for doctors, pharmacists and nursing staff, who play a significant role in providing citizens with information about vaccinations.

Other Member States developed outreach campaigns targeting priority groups. In Slovakia, the **'Vaccinate your grandma and grandpa'** campaign encourages people to register their grandparents for vaccination.

In the administration phase, provision of information involves, among other things, informing the person receiving the vaccine about the benefits as well as the risks and possible side-effects of the vaccine. Some countries set the provision of information before vaccination as mandatory or highly recommend and it must be objective and tailored to the individual's ability to understand it (**Bulgaria**, **Estonia**, **France**, Germany,[6] **Slovenia**, Sweden[7]).

2.1.2 Tailored outreach to individuals in vulnerable situations

FRA's bulletins have consistently highlighted the pandemic's disproportionate impact on persons and groups in vulnerable situations. Equitable access to vaccination also requires efforts to ensure that clear, transparent and reliable information reaches people whom communication campaigns for the general public may miss.

Ethnic or national minorities, migrants, asylum seekers and refugees

The availability of information on vaccination in various languages varies widely across the EU, FRA evidence shows. For instance, Bulgaria, Croatia, Portugal, and Romania provide information about the vaccines and vaccination procedures only in their national languages. That creates an additional obstacle to residents who do not speak them.[8] The Romanian National Audio-Visual Council **asked the government at least to include subtitles in the languages of the national minorities**.

Some countries, including Cyprus, Czechia and Greece, provide information in English in addition to the national language. Others have translations in national official or minority languages or in languages of recognised minority groups, such as Belgium, Estonia, Finland, Latvia, Lithuania, Poland, Slovakia and Slovenia.[9] The Latvian **Ministry of Health** proposed amendments to national legislation to allow the use of other languages for health information purposes.

About a third of EU Member States provide information in a number of languages to reach various immigrant groups. In Austria translations are available in six languages, in Denmark in nine, in the Netherlands in 10, in France in 23 and in Ireland in 36.[10] Several countries made additional efforts to reach out to all sections of society. For example, a countrywide free hotline in **Germany** provides information in Arabic, English, Russian and Turkish; and the hotline in **Luxembourg** is available in 17 languages in addition to French, German and Luxembourgish. The COVID-19 telephone line in **Sweden** is available in 12 languages, and all regions established a dedicated telephone line in several languages for vaccination-related questions.[11]

In other Member States, including Cyprus, Italy, Latvia, Malta, Portugal and Romania, private bodies, civil society or international organisations provide translations. The **Romanian private media outlet Libertatea translated basic information** into the four most common languages of non-EU immigrants in Romania. The Latvian NGO I Want to Help Refugees **translated basic information** about vaccination into Arabic, Dari, Tigrinya and Turkish. In Italy, the online service **JumaMap – Refugees Map Services** provides information on COVID-19-related measures and local registration options in over 10 languages to migrants, asylum seekers and humanitarian protection status holders.

The UN Refugee Agency **set up a website for refugees and asylum seekers** in Malta, offering information on COVID-19 and the vaccine rollout. Information is available in Arabic, Bengali, English, French, Somali and Tigrinya and is disseminated on WhatsApp and through NGOs and migrant community organisations. **The UN Refugee Agency also cooperates with the Cyprus Refugee Council** in providing information in various languages. **The UN Refugee Agency also cooperates with the Cyprus Refugee Council** in providing information in various languages. The **High Commissioner for Migration in Portugal** sent an email to immigrant associations in English and Portuguese to disseminate information on how to register for the vaccination.

Roma and Travellers

Previous FRA bulletins, in particular **Bulletin #5,** highlighted the need for targeted efforts to ensure that relevant information reaches Roma and Travellers, particularly those living in marginalised settings. However, evidence collected for this Bulletin shows limited outreach efforts to improve vaccination uptake by Roma and Travellers.

Irish authorities developed an **information video and poster**, including video interviews with Traveller Primary Healthcare Workers, who are Travellers themselves. A **Roma COVID-19 helpline** is also available in English, Romanes and Romanian. The **Slovak** Office of the Government Plenipotentiary for Roma Communities launched an informational campaign called 'Join us, get your vaccine!' It included a series of **videos** in both Romani and Slovak to increase Roma communities' interest in vaccination. Community workers also communicate information on vaccination and assist people with online registration.

EU-WIDE INFORMATION ON COVID-19 VACCINATION STRATEGIES AND DEPLOYMENT PLANS

Since the outbreak of the pandemic, EU institutions have sought to provide comprehensive information on topics including restrictive measures, recovery plans, and vaccine availability, safety and deployment. The **ECDC** works closely with EU/EEA countries and the European Commission to monitor the rollout of COVID-19 vaccines, support preparedness activities and provide **an overview of vaccination deployment strategies and plans**.

The **European Commission** has a dedicated web page, **'Safe COVID-19 vaccines for Europeans',** with information about the EU vaccine strategy, vaccination in figures, safety reports and securing doses of future vaccines, as well as expert responses to people's concerns about the vaccines.

PROMISING PRACTICE - SUPPORT FROM NON-GOVERNMENTAL ORGANISATIONS

Civil society and voluntary organisations supported groups that might face barriers in registration in a number of countries. Hungarian civil society organisations **established registration hotspots** helping people to register an email account and get access to computers with internet access to enable vaccine registration. Voluntary organisations in Poland **provided similar support**.

Disabled persons' organisations were instrumental in developing information in accessible formats. The Spanish network of organisations of people with intellectual disabilities, Plena Inclusion, regularly updates an **easy-read version of the national COVID-19 vaccination strategy**. Belgian NGOs, such as Inclusion ASBL, organised information sessions on vaccination for persons with disabilities and their family members. The Bulgarian Association for Persons with Intellectual Disabilities translated **easy-read information about vaccines,** which Inclusion Europe and the European Association of Service Providers for Persons with Disabilities had developed, into Bulgarian. In Malta, the Commission for the Rights of Persons with Disability provides **information on its website in easy-read**.

For more information, see Belgium, Inclusion ASBL, 'Coffee and chat: the vaccine against COVID-19' (*'Café papote: le vaccin contre la covid-19'*) and 'COVID-19: online info session about the vaccination' (*'Covid-19: info session en ligne sur la vaccination'*).

People with disabilities

Lack of disability-inclusive and accessible information concerning COVID-19 remains a challenge.[12] There is partial compliance across the EU with international web accessibility standards for information related to vaccines, FRA evidence for March and April suggests. Information in easy-read format is available in just over a third of the EU Member States, provided by either public institutions or civil society organisations.

The main Swedish COVID-19 information portal largely complies with national legislation on the accessibility of digital public services.[13] That in **Denmark** partly complies with the harmonised standard EN 301 549 on web accessibility. The **Latvian national information website** has adjustable fonts and contrast for persons with visual impairment.

Some countries created specific web pages for people with disabilities on the vaccination plan and rollout. In Ireland, **accessible information about each of the major vaccines** is available in large print, easy-read and audio formats. A vaccination information sheet in **easy-read in both Dutch and Frisian** and **another six languages** is available in the Netherlands. The **Swedish Agency for Participation** collects links to information about the vaccination in accessible formats on its website, while the website of the French **Secretary of State responsible for people with disabilities** compiles information in easy-read.

Most EU countries ensured sign language interpretation during regular press conferences providing information on vaccination strategies. Some EU Member States made additional efforts to provide accessible information for people with hearing impairments. The **website of the Finnish Institute for Health and Welfare** provides information, instructions and materials in sign language and other accessible formats. In France, videos in easy-read and sign language are broadcast online, including on **YouTube**. Similarly, in Ireland a series of **videos with Irish Sign Language** explain vaccine safety and side-effects. In **Sweden**, it is possible to listen to the main information web pages through a built-in function, and some information is available in plain language Swedish and sign language.

Clear gaps in the provision of accessible information emerged in some Member States. The Estonian Chamber of Disabled People reports that information related to COVID-19 vaccination was mostly ensured in sign language, but subtitles are lacking for vaccination information on TV and online, while no easy-read information about COVID-19 vaccines is available.[14] In Slovenia, according to the National Institute of Public Health there are no materials in easy-read, braille or Slovenian Sign Language.[15] The **Consultative Commission on Human Rights in Luxembourg** highlighted the need to include easy language and languages understandable to asylum seekers in communication efforts.

2.2 (PRE)REGISTRATION CHANNELS FOR VACCINATION

In March–April, all EU Member States made efforts to ensure the availability of registration options catering for older people, those with disabilities and those with low digital skills, FRA evidence shows. These include websites and mobile apps alongside more traditional means such as registration by phone, contacting a doctor or pharmacy, through employers or directly at vaccination centres.

More than half of EU Member States established central registration channels. Others – including Austria, Finland, Germany, Italy, Lithuania, Spain and Sweden – take a decentralised approach, with subnational entities including *Länder,* provinces, autonomous communities or local authorities organising and administering vaccinations.[16] In some cases, there is a unified point of entry to the various registration portals and sources of information. For example, the Red Cross developed a **centralised information website** in cooperation with the Austrian Federal Government. It links to the registration portals of the nine federal provinces. Links to the 21 regional portals are also available on the **main information channel in Sweden**. Six of the 16 German federal states now partially or fully use a standardised online module operated by the **National Association of Statutory Health Insurance Physicians**. In Italy, six regions had joined the central **online registration platform** in cooperation with the Postal Service by April 2021.

"Registration for vaccination should be designed and implemented in a non-discriminatory way, avoiding discrimination including any based on disabilities, age, economic or social capacities."

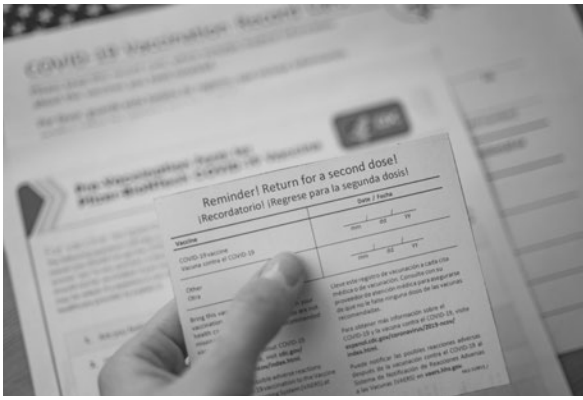
European Law Institute, ELI Principles for the COVID-19 Crisis: 2021 Supplement, Principle 17, p. 5.

2.2.1 Online registration

Online registration platforms exist in almost all EU Member States. In some countries, preregistration is open for all (Austria, Latvia, Romania). In others, it is for those falling into a priority group currently being vaccinated (Italy, Sweden).[17] Individuals are contacted by various means (text message, email, letter) when it is their turn according to the national vaccination plan. In other cases (Belgium, Cyprus, Denmark, Luxembourg, Spain), individuals are first contacted by letter, email, text or other ways. The notifications provide them with registration credentials and prompt them to register in the system.

Mobile apps are also used in some cases, for example by the **Stockholm** region in Sweden and **Emilia-Romagna** in Italy. In **Slovenia,** some vaccination centres provide for mobile app registration, and the National Institute of Public Health in collaboration with the Ministry of Health announced that a mobile **app for vaccination registration will be released in May**.

The use of online platforms for vaccine registration and appointments has contributed considerably to the effective overall rollout of the national vaccination strategies. However, concerns remain about risks of unequal access to these platforms. For example, disability organisations in **Austria** pointed out that online vaccine registration systems do not provide barrier-free access for people with disabilities, especially for those with visual impairments. Complaints were also raised in **Denmark** concerning older people's difficulties in using the online system. In **France**, the COVID-19 Control and Liaison Committee noted that the 'digital divide' accentuates inequalities in access to vaccines, and called for solutions for people without telephone or internet access. Similar concerns were raised in **Hungary**.



Technical problems with online vaccine registration platforms were identified in a number of countries, such as **Croatia** and **Poland**. In **the Netherlands**, the Outbreak Management Team voiced concerns that the national COVID-19 vaccination information and monitoring system is incomplete, as it does not have all figures relating to the vaccines administered.

2.2.2 Offline registration

Vaccine registration offline, for instance by dedicated hotlines, is possible in almost all Member States. In addition, EU countries have established a variety of different ways to register, some applying a mix of approaches depending on the priority group.

One widespread option – in around a third of Member States – is to register for vaccination through medical doctors. In some countries, an appointment through a general practitioner is the main means of registration. Slovenia has no central system for registration, and requires people wishing to get a vaccine to **register with their personal doctor**. People in **Bulgaria**, in addition to the online **vaccination registration platform,** can register in person with their personal doctor, or at a temporary vaccination centres at different medical establishments and the regional health inspectorates.

Another possibility is arranging vaccination through employers. This method targets particular professional groups. Employers organise vaccinations for people who live or work in a health or care facility, or inform them that registration for the group is open, for instance. All health and care workers in **the Netherlands** receive a letter from their employer inviting them for vaccination. For some categories of health and care workers, the vaccination is administered at their workplace, for example in **Germany**, **Estonia**, **France**, **Latvia** and **Lithuania**.

Other possibilities include registering at a pharmacy or a citizen service centre, or through a third party (**Greece)**, at cash machines in post offices (**Italy**) or in person directly at vaccination centres (**Bulgaria** and **Poland**).

2.2.3 Challenges concerning vaccine registration

Despite the range of registration options in place and the support that public and non-governmental bodies give people to register, FRA evidence shows that challenges remain. For example, the Finnish Association of the Deaf claimed that the call-back service used by some municipalities is not accessible to persons with a hearing impairment. To address this, on 31 March, **the association announced** that its regional workers would assist persons with a hearing impairment to book vaccination appointments. The **National Authority for the Rights of Persons with Disabilities, Children and Adoptions** also raised accessibility concerns. The **Romanian National Authority for the Rights of Persons with Disabilities, Children and Adoptions** also raised accessibility concerns.

The Slovakian ombudsperson pointed out the risk that some population groups cannot register, especially those without internet access or the skills to use an online reservation system. Arguing that telephone registration does not take sufficient account of the situation of all population groups, the **ombudsperson asked the Minister for Health** to consider ways for all disadvantaged groups to access vaccination.

PROMISING PRACTICE - REGISTRATION CHANNELS FOR SPECIFIC TARGET GROUPS

In Ireland, **family doctors contact** people aged over 70 and those at very high risk. Those without a family doctor are asked to call the COVID-19 Helpline. Persons aged 58–69 are **invited to register for their vaccination online** or to use the COVID-19 helpline. People with hearing impairments also have the option to text to register for their vaccine, or to use the Irish Remote Interpreting Service.

In Finland, many municipalities sent letters, phone calls or text messages to older persons (aged 70+) and those belonging to a risk group to inform them of the vaccination schedule or to set up a vaccination appointment. Malta and Portugal apply a similar staggered approach, moving progressively from more traditional to fully digital means of registration as vaccination continues.

For more information, see national Franet reports.

LOCAL EFFORTS TO OVERCOME POTENTIAL BARRIERS FOR OLDER PEOPLE

Some **municipalities and districts in Germany offer tailored support** services for older people. These include support in registering for vaccination, availability of (accessible) transport to a vaccination venue, and personal assistance during the process.

2.3 ADMINISTRATION OF VACCINATIONS

Once registration is completed, people need to access vaccination centres. This presents a significant logistical challenge, particularly for those in rural areas without extensive health infrastructure, or for particular groups such as homeless people or those with reduced mobility. This section looks at how Member States organise the administration of vaccines to ensure that everyone receives their vaccine.

COVID-19 vaccination is free of charge in all EU Member States. However, limitations on eligibility tied to residence or legal status can result in unequal access to vaccines (see **Section 1.2.5**).

2.3.1 Vaccine locations

All Member States administer vaccines in healthcare facilities or in dedicated vaccination centres set up in convention centres, sports arenas or schools. For example, in **France**, to speed up the vaccination process, mega-vaccination centres were set up with capacity to deliver around 1,000 to 2,000 vaccinations daily, while the **Slovak** government allowed the establishment of vaccination centres in non-medical premises. **Latvia** opened larger centres in the biggest cities, and **Slovenia** provides vaccinations in community health centres in smaller communities. Some Member States, including **Poland and Romania,** also put in place temporary vaccination points, such as mobile vaccination options or drive-throughs.

In several Member States, family doctors or general practitioners can also vaccinate, either their own patients or people registered through a centralised system (**Malta**). The **Austrian** vaccination deployment plan allows resident doctors to vaccinate in federal provinces.

Other Member States designated different vaccination locations for specific target groups, for example depending on age, profession or disability (**Finland**, **France**, **Ireland**, **Luxembourg**, **Netherlands**, **Sweden**).[18] In some cases, hospitals vaccinate their staff, an in-house doctor or a nurse can vaccinate residents of nursing homes or other institutions, and older persons living at home can receive vaccinations from family doctors or in a pharmacy (**France**). In **Estonia**, designated healthcare providers carry out vaccinations at the workplaces of frontline workers and providers of vital services.

"Where vaccination free of charge cannot be achieved, measures should be taken to ensure that any possible fee for the vaccine or its administration does not represent a barrier for access to vaccination for any person or group."

"Vaccines should be offered at a place and time that is accessible for target groups, which may require novel or flexible delivery strategies. These may include mobile clinics in rural areas or establishment of vaccination clinics in non-traditional settings. Partnering with local non-governmental organisations or faith-based agencies can assist in reaching marginalised groups."

Council of Europe, Committee on Bioethics (2021), 'COVID-19 and vaccines: Ensuring equitable access to vaccination during the current and future pandemics', 22 January 2021.

2.3.2 Vaccination for people without legal residence or with insecure status

People without legal residence and those with insecure status, such as immigrants in an irregular situation, could face several practical hurdles to accessing COVID-19 vaccines. Member States have taken measures to address this. For example, **Cyprus** is planning a special online registration procedure for those not registered in the national health system, which requires prior approval by the Ministry of Health. However, , those concerned – usually EU citizens and third-country nationals – complained about the lengthy procedure and lack of choice of the vaccine they receive, unlike the rest of the population.[19]

Fear of expulsion may stop immigrants in an irregular situation from contacting public authorities to get vaccinated. Organisations in Germany **called** for the suspension of all obligations to notify migration authorities about undocumented migrants during the pandemic period.

2.3.3 Vaccination of people with reduced mobility or living in remote areas

Several Member States deployed mobile vaccination facilities to reach those with reduced mobility, those living in remote areas or other specified population groups. For example, **Belgium used mobile teams** for those who cannot reach a vaccination centre for health reasons. In **Bulgaria** and **Slovakia** (Banská Bystrica region) mobile teams vaccinate persons living in remote and hard-to-reach locations. Mobile teams travel to vaccinate the oldest age groups living in villages in **Sweden**, those older than 80 or in need of care in **Denmark**, and people in need in **Lithuania** and **Poland**. The Seine-Saint-Denis Departmental Council in **France** set up a vaccine awareness bus, on which people over the age of 75 can get vaccinated.

Other EU countries used mobile facilities to reach residents in long-term care facilities. For instance, Austrian federal provinces (**Vienna**, **Styria**, **Salzburg**) used mobile vaccination teams to visit old people's and care homes, as did **Slovenia**, where doctors also vaccinate persons with reduced mobility on home visits. **Maltese authorities** set up such teams for older people living in care homes or who are not able to leave their home. In Romania, by the end of April 2021, mobile units were used exclusively for the residential care facilities.[20]

Cyprus deploys mobile units to vaccinate bedridden persons and persons deprived of their liberty, for example in central prisons. In **Hungary**, vaccination buses, which were initially used to vaccinate soldiers, are used to vaccinate general population groups as of 15 March.

2.3.4 Vaccination services for homeless people

Several Member States made efforts to vaccinate homeless people, who may struggle to access mainstream health services. In the city of **Ruse**, the Bulgarian Red Cross and the regional health inspectorate set up the country's first temporary vaccination centre for homeless persons in April. **Ireland** put in place a specific vaccination programme for high-risk people who are homeless or living in hostels. The Dublin Regional Homeless Executive consulted with NGOs and the Health Service Executive and will work with the Dublin Fire Brigade to transport people to a vaccination centre.

Several German cities, including **Berlin**, **Frankfurt** and **Hanover**, sent mobile teams to administer vaccinations in facilities for homeless people without appointments.

ENSURING ACCESS TO VACCINES FOR PEOPLE WITHOUT A SOCIAL SECURITY NUMBER

To facilitate access to vaccination, the **Greek authorities** allow people without a social security number to obtain a temporary number without going through the regular procedure. This is particularly important for undocumented migrants. Anyone can request a temporary social security number for the vaccination, and is then issued with a vaccination certificate.

The **Portuguese** government created a website for migrants not registered with the national health service, including undocumented migrants. It facilitates access to vaccination. By 21 April, the dedicated platform had received **more than 4,000 applications.** Local health units will contact applicants, in accordance with the priorities and criteria that the national vaccination plan defines, to assess their eligibility and schedule the procedure.

Civil society organisations, for example the Belgian NGO **Doctors of the World,** noted that it may be challenging for homeless people to present themselves twice at vaccination centres for double-dose vaccines. Reflecting these concerns, **Portugal recommended vaccinating homeless people with single-dose vaccines,** and the Belgian municipality of **Mons** announced its intention to use single-dose vaccines for homeless people.

2.3.5 Challenges in the administration of vaccines

Favouritism and queue jumping undermine public trust in the vaccination procedures. Several EU countries reported them, including examples involving family members and celebrities. For example, **Austrian media** cited examples of doctors vaccinating their immediate families, although they were not part of the target group in the vaccination plan. Similar incidents involving family members were reported in **Croatia**. **Slovenian** media reported that the health inspectorate had carried out 143 checks by late March, and established that 21 providers had vaccinated individuals not belonging to prioritised groups, mostly **relatives and acquaintances of employees**.

Other issues concerned the allocation of 'leftover' vaccines, for those scheduled to be vaccinated who did not appear, which would otherwise be destroyed. Cases emerged in **Estonia** of younger people not belonging to any risk group being vaccinated, and in **Malta reports appeared about abuse of** reserve lists of people invited for a vaccine at short notice. **Irish** media reported that leftover vaccines in hospitals went to family members of senior staff, and that a **private hospital offered vaccines to senior staff** of health insurance companies with which it had a commercial relationship.

A group of 200 celebrities were vaccinated at Warsaw Medical University in **Poland** at a time when the only group entitled to vaccination was healthcare workers. The Ministry of Health fined the university PLN 350,000 (about € 78,000).

Other concerns relate to the practice in Bulgaria and Romania of vaccinating anyone who wishes, undermining the prioritisation of particularly vulnerable groups. The Romanian municipality of Deva announced in April that it had **opened the first drive-through vaccination centre,** where people can get their vaccine without prior registration. Similar **drive-through centres later opened in other large cities**. During Orthodox Easter at the end of April, the municipality of Constanta, a tourist destination on the Black Sea, announced that **tourists could be vaccinated without prior registration**.

In **Bulgaria**, '**green corridors**' allowed all adult citizens who did not fall within the priority groups to receive a vaccine. This represented a major change to the national vaccine deployment plan. Four civil society organisations, led by the Bulgarian Helsinki Committee, **described** this practice as unfair, discriminatory and detrimental to the most vulnerable groups in the population. General practitioners also **complained** that random vaccination through the green corridors left doctors with insufficient vaccine doses for their registered patients.

PROMISING PRACTICE - TRANSPORT SERVICES TO ENABLE ACCESS TO VACCINATION CENTRES

Many Member States provided transport options to enable people to reach vaccination centres. **Belgium offers** free public transport tickets to those travelling to and from their vaccination appointments. Municipalities in **Luxembourg** provide free shuttle buses to the vaccination centres for people over the age of 65. Vaccination centres in Lithuania offer transport services for those who are not able to reach them alone.[31] **Sweden** offers specific transport for persons who are unable to get to the vaccination sites; people can order such support by phone in parts of **Estonia** with lower vaccination coverage.

In **France**, people who cannot travel alone, in particular people with disabilities, can use an ambulance or a taxi to go to the nearest vaccination centre, with the cost fully covered in advance by health insurance. Several **Portuguese** municipalities provide free taxi services to transport people to vaccination centres.

"We need to put in place the EU COVID-19 Certificate to re-establish people's confidence in Schengen while we continue to fight against the pandemic. Member states must coordinate their response in a safe manner and ensure the free movement of citizens within the EU. Vaccines and tests must be accessible and free for all citizens. Member states should not introduce further restrictions once the certificate is in force."

Juan Fernando López Aguilar,
Chair of the European Parliament Committee on Civil Liberties, Justice and Home Affairs

COVID-19 CERTIFICATES

Before the end of March, most Member States announced strategies for COVID-19 certificates, in either paper or digital form. By mid-April, these national initiatives were at different stages of discussion and/or implementation in several Member States. Proposals for national certificates varied considerably in content (e.g. certifying full or partial vaccination; including information only about vaccination or also about negative COVID-19 tests and recovery from the disease), time limitations and the rights they would eventually bestow on holders. The issues discussed ranged from whether acquiring such a certificate would be free of charge to whether it would be mandatory for crossing borders or accessing restaurants, hotels, hairdressers, or sporting and cultural events. These discussions also raised concerns about how to ensure that introducing COVID-19 certificates does not result in discriminatory practices, especially against persons who do not want to or cannot be vaccinated, and those who could not afford to travel or to access certain services if costly negative tests were a precondition.

Given this, the European Commission proposed an EU certificate that would harmonise national solutions (regarding their interoperability, security and verifiability) to facilitate free movement and bring more legal certainty for citizens who exercise their right to freedom of movement. The Commission proposal for a **Digital Green Certificate** (now renamed EU COVID-19 certificate) sets out uniform conditions for issuing, verifying and accepting certificates of (1) COVID-19 vaccination, (2) tests and (3) recovery from infection, to ensure interoperability between the different solutions that the Member States are developing. On 20 May, **the European Parliament and the Council reached a provisional political agreement** on the Regulation governing the EU Digital COVID Certificate, which the EU legislator will still have to adopt formally. This means the certificate is supposed to be ready by the end of June, as planned. The regulation would enter into force on 1 July and **be in place for 12 months**, with a phasing-in period of six weeks to issue certificates in those Member States that need additional time.[21]

The EU COVID-19 certificate[22] will be free of charge, easily obtainable in digital or paper format and also available to persons vaccinated before the EU Digital COVID Certificate Regulation entered into force. It will contain a digitally signed QR code to ensure security and authenticity. Member States may also use the certificate for national purposes if national law provides for it. The Commission will build a gateway to ensure all certificates can be verified across the EU, and support Member States with technical implementation. Member States remain responsible for deciding which public health restrictions can be waived for travellers but will have to apply them without discrimination to all travellers who hold an EU COVID-19 certificate. Member States must refrain from imposing additional travel restrictions on the holders of an EU digital COVID certificate unless they are necessary and proportionate to safeguard public health. The Commission will also make € 100 million available to support Member States in providing affordable tests.

The EU COVID-19 certificate will facilitate safe free movement. During the deliberations on introducing it, European and national bodies have raised a number of concerns about potentially negative fundamental rights impacts that warrant consideration. In April, at the request of the European Parliament, FRA also contributed to the reflections on adopting EU legislation on the certificate.

To prevent negative fundamental rights implications, international, EU and Member State bodies highlighted the need to implement key safeguards based on four core principles.

1. **Necessity and proportionality.**

— Purpose limitation: the use of EU COVID-19 certificates should be limited to the current COVID-19 pandemic and to the purpose of facilitating the free movement of persons within the current situation.[23] The free movement of persons who, based on sound scientific evidence, do not pose a significant risk to public health in relation to transmission of COVID-19 should not be restricted, as such restrictions would not be necessary to achieve the objective pursued.[24]

— National schemes should be made interoperable with the EU certificate, and Member States should not impose additional unilateral travel restrictions contrary to the purpose of the EU certificate.[25]

— Time limitation and regular assessment: the certification framework should be regularly assessed and adjusted, based on technical and scientific progress.[26]

2. **Non-discrimination and equality.**

— The principle of non-discrimination requires that everybody should have equitable and free access to vaccines, testing and a proof of recovery.

— The risk of discrimination between vaccinated/immunised persons and those who have not been vaccinated, when they exercise individual freedoms or access certain services,[27] should be mitigated. Negative tests should also allow people to exercise the same rights and freedoms as vaccination certificate holders.

— Testing should be universal, accessible, timely and free of charge, to ensure that everyone enjoys their rights, can participate in various areas of life and can access services without discrimination.

3. **Data protection.**

— Vaccination certificates contain sensitive health-related data. The obligation to disclose such sensitive personal data, and the possible use of the data, raise concerns about privacy.[28] Processing such data requires a particularly high level of protection.[29]

— Personal data obtained from the certificates cannot be stored in destination Member States and there will be no central database at EU level. The list of entities that will process and receive data should be public so that citizens can exercise their data protection rights under the General Data Protection Regulation.[30]

4. **Effective and independent oversight.**

— Existing independent national human rights bodies, such as national human rights institutions or equality bodies, should be consulted to ensure that countries' implementations of the EU COVID-19 certificate comply with human rights.

— The Commission should regularly monitor the fundamental rights impact of the EU COVID-19 certificate.

Endnotes

1 Note that, according to Article 51 of the Charter and the related case law, the Charter applies only when the Member States are acting within the scope of EU law. On the interpretation of Article 51 by the Court of Justice of the European Union, see FRA (2018), **Applying the Charter of Fundamental Rights of the European Union in law and policymaking at national level – Guidance**.

2 Austria, Federal Chancellery, **web page of frequently asked questions about the COVID-19 vaccination**; Federal Ministry of Social Affairs, Health, Care and Consumer Protection, COVID-19 vaccinations: prioritisation of the National Vaccination Council (2021), (**COVID-19-Impfungen: Priorisierung des Nationalen Impfgremiums),** Version 4.0, 31 March 2021.

3 See national Franet report for more information.

4 Efficient communication is one of the key tools in ensuring high vaccine uptake according to the ECDC. See **Overview of the implementation of COVID-19 vaccination strategies and deployment plans in the EU/EEA**, 6 May 2021, p. 25.

5 Council of Europe, Committee on Bioethics (2021), '**COVID-19 and vaccines: Ensuring equitable access to vaccination during the current and future pandemics'**, 22 January 2021.

6 Germany, Section 1 (4) sentence 1 of the Federal Ministry of Health's vaccination ordinance. See national Franet reports for more information.

7 See national Franet reports for more information.

8 See national Franet reports for more information.

9 See national Franet reports for more information.

10 See national Franet reports for more information.

11 Sweden, Swedish Association of Local Authorities and Regions (Sveriges Kommuner och Regioner) (2021), **'Regionernas planering avseende vaccinering mot Covid-19, delrapport 5'**, 26 April 2021. Information regarding language versions provided in interview with a healthcare expert at the Swedish Association of Local Authorities and Regions, 5 May 2021.

12 European Disability Forum (2021), **European Human Rights Report – Impact of COVID-19 on persons with disabilities**, 8 April 2021; see in particular pp. 83–85.

13 This means that the site is mainly at level AA in the WCAG 2.1 standard. See the website's **accessibility statement**.

14 Estonian Chamber of Disabled People (Eesti Puuetega Inimeste Koda) (2021), response to information request, 8 April 2021.

15 Information provided by the National Institute of Public Health (Nacionalni inštitut za javno zdravje) (2021) upon request (email), 4 May 2021.

16 See national Franet reports for more information.

17 See national Franet reports for more information.

18 See national Franet reports for more information.

19 Pitta, A. (2021), '**We're second-class citizens, say non-Gesy members'**, Cyprus Mail, 25 April 2021.

20 See national Franet reports for more information.

21 Previously, on 21 April, Member States' representatives in the eHealth Network adopted technical specification guidelines. That is a voluntary network connecting national authorities responsible for eHealth. In addition, the network developed a common design template.

22 See also **the Proposal for Digital Green Certificates for third-country nationals legally staying or residing in Member States**.

23 European Data Protection Board and European Data Protection Supervisor (2021), 'EDPB-EDPS **Joint Opinion 04/2021** on the Proposal for a Regulation of the European Parliament and of the Council on a framework for the issuance, verification and acceptance of interoperable certificates on vaccination, testing and recovery to facilitate free movement during the COVID-19 pandemic (Digital Green Certificate)', 31 March 2021.

24 Amendments adopted by the European Parliament on 29 April 2021, **P9_TA(2021)0145**, recital (7).

25 Amendments adopted by the European Parliament on 29 April 2021, **P9_TA(2021)0145.**

26 The European Parliament proposed that it should be in place for 12 months and no longer. However, at this stage, it is still unclear whether or not vaccines prevent transmission of COVID-19; see Amendments adopted by the European Parliament on 29 April 2021, **P9_TA(2021)0145**; WHO (2021), '**Interim position paper: considerations regarding proof of COVID-19 vaccination for international travellers**' (5 February 2021); **Council of Europe information document** 'Protection of human rights and the "vaccine pass"', 31 March 2021.

27 See Amendments adopted by the European Parliament on 29 April 2021, **P9_TA(2021)0145**. See also Committee on Bioethics (DH-BIO) (2021), **'Statement on human rights considerations relevant to "vaccine pass" and similar documents', p.3**: "the principle of equitable access to healthcare laid down in Article 3 of the Oviedo Convention [requires that] particular attention must be paid to individuals in vulnerable situations and to the exacerbation of inequalities within such groups due to the public health crisis, including in their access to vaccination".

28 Committee on Bioethics (DH-BIO) (2021), **'Statement on human rights considerations relevant to "vaccine pass" and similar documents'**. See also **Recommendation CM/Rec(2019)2 of the Committee of Ministers to member States on the protection of health-related data.**

29 Any processing of such data must meet, in particular, the criteria of necessity and proportionality, with regard both to the type of data processed and exchanged and to the length of time they are kept, as well as the criteria of lawfulness, purpose, security and other criteria laid down in Convention 108+. See Council of Europe Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data ('Convention 108') and its amending Protocol ('Convention 108+') (**Details of Treaty No.223**).

30 Amendments adopted by the European Parliament on 29 April 2021, **P9_TA(2021)0145.** See also **Recommendation CM/Rec(2019)2 of the Committee of Ministers to member States on the protection of health-related data.**

31 According to information provided to Franet contractor by the Kaunas city municipality hotline.

FRA EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS

PROMOTING AND PROTECTING YOUR FUNDAMENTAL RIGHTS ACROSS THE EU

This Coronavirus Bulletin focuses on equitable access to vaccines. It outlines the situation in the 27 EU Member States from 1 March to 30 April 2021. The bulletin looks at two main areas: planning and prioritisation in deploying Covid-19 vaccinations and their rollout in the countries. It covers information and communication campaigns, as well as (pre)registration channels for and the administration of vaccinations.

The bulletin highlights how deploying vaccines is essential for lifting restrictions on fundamental rights that the EU Charter of Fundamental Rights enshrines, such as the freedom of movement, the right to engage in employment and the right to education. Ensuring equitable access for all in the EU to an affordable (free) vaccine as early as possible is in line with the principle of non-discrimination in EU law.

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