NATIONAL COMMISSION FOR BIOETHICS & TECHNOETHICS

RECOMMENDATION*

On the compulsory vaccination of certain professional groups in the healthcare sector

Athens, 14 June 2021

NATIONAL COMMISION FOR BIOETHICS & TECHNOETHICS

* *this is not an official translation*

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I. Introduction

The National Commission for Bioethics and Technoethics (hereinafter "the Commission"), in its repeated meetings, addressed the issue of compulsory vaccination for medical doctors and nursing personnel, as well as all for those who staff health care facilities (both in the public and private sector) or care facilities for vulnerable groups (elderly, people with chronic diseases or people with disabilities), following a relevant question by the Prime Minister in the letter of the Minister of State of 7/5/2021 (No 110).

The issue of compulsory vaccination has already been raised by the National Bioethics Commission (NBC) in the past. In its 2015[1] Recommendation "Vaccination of Children", the NBC highlighted the significance of children vaccination for the prevention of infectious diseases and the protection of public health, noting that the safety of the recommended vaccines has been documented by scientific studies and data. However, the NBC noted that, as long as there is no serious issue of public health protection, the parental decision not to vaccinate a child cannot lead to the child's exclusion from social life. On the contrary, if there is a matter of urgent public health protection (e.g. if outbreaks of meningitis occur), restrictive measures to protect the unvaccinated children are necessary, even against the parents' will.

In a previous Opinion, titled "Infectious Contagious Diseases: Public Interest and Autonomy"of 2011[2], the NBC judged that vaccination of the population (including vulnerable groups) as an interventional preventive measure, should in principle be carried out on the basis of informed consent. It stressed, however, that in 'urgent situations' even compulsory vaccination cannot be precluded, particularly for those whose occupation make it more likely for them to carry an infection and transmit a disease; in such cases, a change in the duties of such employees should be considered.

In the present Recommendation, the Commission has specifically addressed the issue of compulsory vaccination for the personnel in healthcare facilities and vulnerable groups' care facilities during the current period of the COVID-19 pandemic. The issue of compulsory vaccination in healthcare or care facilities for vulnerable groups raises the basic dilemma of patient and vulnerable persons'

[1] Recommendation of the National Commission for Bioethics "Vaccinations of Children" Available at http://bioethics.gr/images/pdf/GNOMES/RECOMMENDATION_Immunization_In_Children_Final_GR.pdf.

[2] Recommendation of the National Commission for Bioethics "Infectious Contagious Diseases: Public Interest and Autonomy". Available at http://bioethics.gr/images/pdf/GNOMES/infectious-op-f.pdf.

protection versus the basic principle of self-determination (autonomy) of employees working in these facilities. In other words, the question that arises is whether it would be morally acceptable to take compulsory measures to vaccinate employees, given that the pandemic continues being a threat costing human lives, and since approved safe and effective vaccines are available.

To reflect upon the question, the Commission: 1) reviewed the international literature on the subject, 2) discussed in its plenary session with the presence of the COVID-19 Expert Committee the arguments that need to be taken into account, and 3) organized hearings with relevant institutions, associations and federations of health professionals and employees in care facilities for vulnerable groups.

The following were invited to the meeting of 2 June 2021 and attended the hearing: a) the Panhellenic Medical Association represented by Dr. Athanasios Exadaktylos, President, b) the Union of Nurses of Greece represented by Mr. Tzannis Polykandriotis, Secretary General, c) the Panhellenic Association of Care Units for the Elderly represented by Mr. Stylianos Prosalikas, President, d) the Panhellenic Association of Occupational Therapists represented by Mrs. Kyriaki Keramiotou, President, e) the Panhellenic Association of Physiotherapists represented by Mr. Petros Lymperidis, President, and g) the Panhellenic Association of Employees of Centres for Creative Leisure Activities of Children with Disabilities represented by Mr. Antonis Diamantis, member of the Board of Directors.

II.Reference data

1. The notion of compulsory vaccination

For a proper approach to the issue, it is necessary to clarify the concept of "obligation" and its different meanings. "Obligation" may refer to physical coercion of a person. It also includes imposing vaccination under the threat of sanctions for anyone who refuses (e.g. a fine or dismissal from work). Finally, this concept also includes the case of introducing vaccination as a necessary condition for the fulfillment of a public duty (e.g. the duty to complete nine years of education or the duty to military service). In all these cases, compulsory vaccination is morally and legally controversial, because the person is under some form of pressure, if not blackmail, to protect their rights or fulfil public duties.

From the above cases of compulsory vaccination, however, it is necessary to distinguish those in which vaccination is established as a condition for exercising a right in specific occasions, such as, the provision of vaccination for visiting a country plagued by infectious diseases or for the employment in a health-related public or private profession (e.g. compulsory vaccination of cooks against hepatitis). For, in such cases, the person concerned retains the option not to be vaccinated, waiving the right to move or work temporarily; this is a choice between two rights, namely, between caring for their health and exercising the right to move or work, made by the subject of them.

Similar situations of choices between rights by their subjects are, in fact, present in every aspect of social life.

2. General conditions for the possibility of compulsory vaccination

Routine vaccinations (e.g. for known paediatric and other diseases) should be distinguished from vaccinations in emergency situations, such as a pandemic. Moreover, the compulsory vaccination of a population with the use of vaccines whose safety lacks evidence would clearly be a breach of the moral obligation to protect public health, even in pandemic emergencies. According to the World Health Organisation (WHO), in order to morally justify the mandatory nature of vaccination, at least for certain population groups, the safety of vaccines, their effectiveness and their availability must be confirmed, before equal access for all is ensured[3]. Such population groups are health care professionals (medical, nursing, laboratory personnel) and employees in care facilities for vulnerable persons (e.g. elderly or disabled persons) who are at high risk of SARS-CoV-2 infection or at increased risk of serious COVID-19 disease and even death.

Certainly, every new vaccine has potential side effects for those who are vaccinated. However, the critical element in decision making is the threshold of "risk" that is considered acceptable when using a new vaccine. In determining this threshold, we should take into account the frequency and severity of adverse reactions and the risk-benefit balance, not only for individual vaccinees but also in terms of public health. In the present case, the COVID-19 vaccines have been authorised for emergency use by the European Medicines Agency (EMA) and the US Food and Drug Administration (FDA) following a standard evaluation of safety and efficacy data[4][5][6]. Scientific studies on the safety and efficacy of these vaccines have shown that the risk for developing serious COVID-19 disease in unvaccinated individuals is greater than the potential side- effects of approved COVID-19 vaccines. This means that data in relevance indicates that potential benefits outweigh any adverse effects, both at an individual and a general population level.

In exploring the possibility of compulsory vaccination, it is also crucial to determine the criteria that need to be considered at a given time in order to implement compulsory vaccination. Such criteria include, for example, the infectiousness rate in the general population, the number of cases, the occupancy rate of ICU beds, the vaccination coverage rate in the general population, etc., for

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[3] World Health Organization. COVID-19 and mandatory vaccination: ethical considerations and caveats. policy brief 4/13/21.

[4] European Centre for Disease Prevention and Control. Questions and answers on COVID-19: Vaccines. Available at https://www.ecdc.europa.eu/en/covid-19/questions-answers/questions-and-answers- vaccines.

[5] Centers for Disease Control and Prevention. safety of COVID-19 vaccines. Available at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html.

[6] On 7 May and 1 June respectively, the pharmaceutical companies Pfizer and Moderna submitted applications to the FDA for final approval of the mRNA vaccines.

which the threshold for applying compulsory vaccination must also be defined. However, with regard to the ongoing COVID-19 pandemic, new variants and strains of the virus are constantly emerging, and some of which may not be adequately covered by existing vaccines. The duration of immunity from vaccines and the need for booster doses remain also still under consideration. These should be considered during the discussion before any threshold of compulsory vaccination is set.

3. Data from Greece

As for the general population, to date, more than 294 million people over the age of 18 in Europe[7] and almost 154 million in the United States of America have been vaccinated with at least one dose[8]. In Greece, by 13 June 2021, a total of 6,835,783 vaccinations had been carried out, of which 4,247,316 involve vaccinations with at least one dose in the general population. In fact, the availability of vaccines has increased greatly today (June 2021).

Specifically, for health personnel in both public and private health facilities, since the start of vaccinations against COVID-19 in our country, health personnel in health facilities have had immediate priority access to vaccines.

According to the General Secretariat of Primary Health Care of the Ministry of Health and taking into consideration the vaccination prioritization data, managed by the General Secretariat of Public Administration Information Systems of the Ministry of Digital Governance (last updated on 17.05.2021) and the available vaccination data (last updated on 04.05.2021):

- The vaccination rate of health personnel (medical, nursing, laboratory staff) in public and private health care facilities in our country is 70%.
- The vaccination rate of administrative and support staff in public and private sector health facilities is 54%.
- The vaccination rate for health, administrative and support staff and those working in care facilities for vulnerable groups (elderly, chronically ill or disabled people) is 54%.

In other words, there are lower vaccination rates among administrative and support personnel in healthcare facilities and personnel in care facilities for vulnerable groups.

The recent development of compulsory vaccination of those serving in the Special Disaster Response Units (DRUs) following an order issued by the Fire Service Headquarters is of particular interest. According to the rationale of the Order, the personnel of the DRUs participate in the European Civil Protection Mechanism and therefore must at all times be ready to intervene - at the request of the European

[7] European Centre for Disease Prevention and Control. Data on COVID-19 vaccination in the EU/EEA. Available at https://www.ecdc.europa.eu/en/publications-data/data-covid-19-vaccination-eu-eea.

[8] Centers for Disease Control and Prevention. COVID Data Tracker. COVID-19 Vaccinations in the United States. Available at https://covid.cdc.gov/covid-data-tracker/#vaccinations.

Union - in rescue operations around the world; given this, the personnel must be vaccinated against both coronavirus and other infectious diseases to be able to perform their duties.

4. The case of Italy

Italy is the only European country so far to have adopted compulsory vaccination for healthcare personnel. Under an emergency decree of 1 April 2021, health professionals who refuse to be vaccinated have the option of being transferred to another position with a reduced risk of disease transmission or suspended without pay for up to one year. The decree was supported by the Order of Doctors, Surgeons and Orthodontists (FNOMCeO). It is estimated that only 1 in 10,000 health professionals still refuse to be vaccinated, while workers in healthcare facilities or nursing homes with lower qualifications also show greater reluctance to be vaccinated[9].

5. The UK Human Rights and Equality Commission

In its conclusion to the government, the above-mentioned independent commission concluded that the implementation of a measure making vaccination against COVID-19 compulsory for workers in elderly care facilities is a reasonable and justified measure, because the state "rightly gives priority to the right to life of both the residents in the facilities and the staff". The same committee is expected to announce its decision on the mandatory requirement for health care workers[10].

III. Ethical considerations

1. The principles of autonomy, utility and non-maleficence ("benefit and do-not-harm")

From an ethical point of view, the issue of compulsory vaccination is related to the relationship between the principle of personal autonomy and the protection of public health as a collective good. The protection of public health in this sense corresponds to a moral duty of social solidarity, of which everyone is a subject. Particularly in the case of medical doctors and nurses in permanent contact with patients, the principle of non-harm and the duty of care for patients dictated by

[9] Paterlini M. Covid-19: Italy makes vaccination mandatory for healthcare workers. BMJ 2021;. 373:n905

[10] The text of the decision has not been published but specific references to its contents have been made in the British press and other media. https://www.theguardian.com/society/2021/jun/02/uk- rights-watchdog-endorses-compulsory-covid- jabs-for-care-home-staff.

their status must also be considered.

In contrast to the medical paternalism of the past, in modern medical ethics, the principle of personal autonomy has become a key concept. According to this principle, everyone is entitled to have direct control over their own health, freely deciding on medical procedures that concern them.

Individual autonomy in the field of health does not normally affect third parties, so there is no question of restricting it. In exceptional circumstances, however, this can occur when there is an imminent risk to public health and the exercise of this autonomy by an individual conflicts with the rights of others. In such circumstances, it is morally legitimate to impose restrictions. However, the question on the extent of such restrictions remains open, when they mean forced interventions in the body (as, for example, with compulsory vaccinations), considering respect of human dignity.

In the case of physicians and nurses, the principle of non-maleficence (established in relevant codes of conduct)[11] justifies more severe restrictions on individual autonomy, especially because these professionals have voluntarily committed themselves to avoiding any conduct that could cause harm to their patients during exercising their practice. This conduct should not be understood in a narrow sense - as a harmful medical act carried out on the patient - but includes situations which may in general cause a risk of harm to the patient, such as if the doctor or nurse are themselves carriers of a communicable disease and comes in contact with the patient.

In this context, the provision of vaccination as a necessary prerequisite for these professions could be justified on ethical grounds, particularly because the choice of this profession is free and by definition implies a commitment to the patient. In that sense, it is not a 'compulsion', under the meaning mentioned above.

Specifically, vaccination has been shown to significantly reduce the likelihood of hospitalization or serious disease. Therefore, in addition to the fact that the protection of vulnerable people is an ethical priority to everyone in times of a pandemic, healthcare personnel in particular have a moral obligation not to harm and to provide care to patients and also to scientists/employees who, for medical reasons, cannot be vaccinated.

In the case of non-vaccination of health unit staff, the risk of harm is direct, due to possible transmission of the virus by asymptomatic staff, but also indirect due to the inability of the sick personnel to provide their services, burdening their colleagues with additional load of patient care. Healthcare employees are at increased risk of contracting the disease due to their daily contact with sick people. Protecting the health of these employees in pandemic situations is therefore crucial for the adequate staffing of health structures. This ensures the best possible functioning of the health system, which is already under pressure in times of a pandemic.

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[11] Gur-Arie R, Jamrozick E, Kingori P. No Jab, No Job? Ethical Issues in Mandatory COVID-19 Vaccination of Healthcare Personnel. BMJ Global Health 2021; 6. Available at https://gh.bmj.com/content/6/2/e004877.

Furthermore, considering that approved vaccines have been shown to reduce - to a certain extent - the transmissibility of COVID-19[12][13], the vaccination of healthcare personnel is morally important under this light as well, as it ensures continuity in the provision of health and medical care services. Indeed, studies have shown that even a single dose of some COVID-19 vaccines reduces transmission in the close environment by 38%-49%[14] or that viral load is reduced in vaccinated individuals after the first dose, suggesting that it may lead to lower transmission[15]. More recent studies held in real-world conditions on healthcare personnel have shown that mRNA-based vaccines reduce symptomatic and asymptomatic infections by 85-90% in fully vaccinated individuals and by 70-80% in single-dose vaccinated individuals[16][17].

In addition, the priority vaccination of health professionals of all categories, especially in public facilities, sets an example for the general population and strengthens public confidence in the National Health System. The hearings of interested organizations (see above) revealed that the positive influence (direct or indirect) of health professionals on the population is enhanced in relationships involving closer daily contact between professionals and interested groups.

Similar justification pertains to vaccination as a necessary condition for other professionals in health or care institutions (e.g. nursing homes), even though the principle of non-maleficence may not be explicitly stated in codes of conduct of related professions. For, again, the element of free involvement of these professionals in an environment where vulnerable persons are residing, bears particular significance regarding the responsibility of the former for the safety of the latter.

2. The principle of proportionality

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[12]The Robert Koch Institute. effectiveness and safety (as of 12.5.2021). Available at https://www.rki.de/SharedDocs/FAQ/COVID-Impfen/gesamt.html#FAQId15851642.

[13] Centers for Disease Control and Prevention. Interim Public Health Recommendations for Fully Vaccinated People. Available at https://www.cdc.gov/coronavirus/2019- ncov/vaccines/fully-vaccinated-guidance.html.

[14] Centers for Disease Control and Prevention. Interim Public Health Recommendations for Fully Vaccinated People. Available at https://www.cdc.gov/coronavirus/2019- ncov/vaccines/fully-vaccinated-guidance.html.

[15]Levine-Tiefenbrun M, Yelin I, Katz R, Herzel E, et al. Initial report of decreased SARS-CoV-2 viral load after inoculation with the BNT162b2 vaccine.Nat Med 2021; 27: 790-792.

[16]Thompson MG, Burgess JL, Naleway AL, et al. Interim Estimates of Vaccine Effectiveness of BNT162b2 and mRNA-1273 COVID-19 Vaccines in Preventing SARS-CoV-2 Infection Among Health Care Personnel, First Responders, and Other Essential and Frontline Workers - Eight U.S. Locations, December 2020-March 2021. MMWR 2021; 70: 495-500. Available at https://www.cdc.gov/mmwr/volumes/70/wr/mm7013e3.htm.

[17] Hall VJH, Foulkes S, Saei A, et al. COVID-19 vaccine coverage in health-care workers in England and effectiveness of BNT162b2 mRNA vaccine against infection (SIREN): a prospective, multicentre, cohort study.Lancet 2021; 397: 1725-35. Available at https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00790-X/fulltext.

The imposition of vaccination as a necessary condition of employment is in any case subject to the principle of proportionality, based on the moral importance of protecting public health. Applying the principle in this context means assessing the necessity of the measure, first in relation to the vaccination coverage rate of the general population and reaching immunity at local level, and then in relation to the coverage rate of the specific population targeted by the measure.

Thus, when the first percentage is already close to the threshold of the "immunity wall" with the practice of voluntary vaccination, there is no need to provide for compulsory vaccination, perhaps not even for measures to encourage vaccination or discourage its avoidance. If this has not been achieved, then, depending on the actual situation, priority should be given to the provision of measures for encouraging vaccination and, if this does not work, to the targeted provision of vaccination as a working prerequisite for a specific population of professionals.

The figures for (a) the threshold of the 'immunity wall', (b) the desired rate of vaccination coverage in relation to the epidemiological data at the level of the general population and (c) the influence on the specific targeted population should be established on purely epidemiological criteria. The verification of these criteria must be transparent and accessible to anybody.

IV. The legal dimension

Vaccination as a medical act of prevention is, in principle, subject to the common provisions of medical law. According to these, a necessary condition for the performance of medical acts is the informed consent of the person concerned (Art. 5 et seq., Oviedo Convention, Art. 11, 12 Code on Medical Ethics). This condition is indirectly established in Article 5 para. 5 of the Constitution (individual right to Health), and explicitly by Article 3 para. 2 of the EU Charter of Fundamental Rights. In addition to binding law, it is also mentioned in all modern international non-binding legal texts and codes of conduct.

Forcing a person to undergo vaccination (with any of the three concepts of compulsion mentioned above) would be contrary to the above legislation and could be considered a violation of the human dignity principle (Art.2(1) Const., EU Charter) and the right to bodily integrity (ECHR), as it represents an intrusive medical act[18].

[18] Recent case law of the Hellenic Council of the State (2387/2020) and the ECtHR (Vavřička vs Chech Republic) accepted the compulsory nature of vaccination for the enrolment of children in non-compulsory education (kindergartens, nursery schools), explicitly distinguishing these cases from compulsory education (primary school, secondary school). Other ECtHR judgments (Solomakhin v. Ukraine, Boffa et al. v. San Marino, Jehovah's Witnesses of Moscau v. Russia) analyze in detail the issues of vaccination, although not vaccination of health employees. These decisions highlight that the restriction under Article 8 (protection of privacy) is justified if it serves a legitimate aim and is a necessity in a democratic society, i.e. if the restriction is due to an identified pressing social need and whether it is proportionate to the objective pursued education.

It is true that, according to the Oviedo Convention, public health is recognized explicitly as a general reason for rights restrictions (Article 26)[19]. However, in its explanatory report, the Convention does not mention, among other examples, the case of compulsory vaccination[20]. At least for EU law, the reason for limiting the right to informed consent would hardly be acceptable in view of its explicit enshrinement in the Charter.

Recent specific legislation in our country has confirmed the voluntary nature of vaccinations, however, it provides for the exceptional and under strict conditions compulsory vaccination by ministerial decision, in order to address a risk to public health[21]. An interpretation of this exception, in line with the Constitution and the international or EU texts mentioned above, would definitely exclude the three already mentioned cases of 'forced' vaccination. It does, however, include the other cases where vaccination is required as a necessary condition, where the person concerned retains freedom of choice. In this light, the requirement to vaccinate those employed in health or care facilities for vulnerable groups may rely on the exception provided for in Law no. 4675/2020. Specifically, vaccination against COVID-19 may be established by special decision of the Minister of Health as a necessary condition for the recruitment of doctors, other scientific, technical or administrative personnel in the above institutions, as a necessary condition for the occupation of those already working in services involving contact with the public, and in case of refusal, their transfer to a non-public contact service or (as far as the public sector is concerned) the adoption of measures based on labor relations legislation.

That measure may remain in force at least as long as the pandemic lasts.

Recommendation

The "escalating initiative" of the State

Despite the above moral and legal justification, vaccination represents a strong intrusive act on the body of the person, which cannot be disregarded. Moreover, the imposition of compulsory vaccination carries the risk of reducing trust in public health bodies or even of provoking reactions that would fuel the anti-vaccination

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[19]Contrary to the ECHR which has provisions for restrictions on the grounds of public health only on the freedom of movement (Art. 5).

[20] Although it was mentioned by some in the relevant discussions (see minutes).

[21] This is the law no. 4675/2020 (Art. 4(3)), which stipulates that: "In cases when there is present risk of spreading a communicable disease, which may have serious public health implications, compulsory vaccination to prevent the spread of the disease may be imposed by decision of the Minister of Health, following an opinion of the NCDC. That Decision shall specify the population group for which vaccination with a specified vaccine becomes mandatory, the designated area of coverage, if any, for the vaccination of the population with a specified vaccine, the nature of obligation, the period of validity of the compulsory vaccination, which must always be decided as an exceptional and temporary measure to protect public health for a specific group of the population, the regulation of the vaccination procedure and any other relevant details".

climate. This option should therefore be the last resort, only in the case that milder alternatives that could equally serve the intended purpose have been exhausted.

The Commission notes that the following recommendation only applies to specific professional groups of employees in public and private healthcare institutions and to personnel in care facilities for vulnerable groups. The Commission's proposal is a "staged initiative" approach on the part of the State, with three stages:

a) Targeted information and awareness campaigns for voluntary vaccination

The information provided must be targeted and tailored to each professional group (medical doctors, nurses, laboratory personnel, care personnel, etc.) and must be based on scientific evidence that is constantly updated.

For successful information, a prior understanding of the reasons why some health professionals or care workers have concerns or show resistance to COVID-19 vaccination is essential. According to the information gathered from the hearings with the representatives of the interested organizations, the type of reservations towards vaccination varies considerably among healthcare employees.

Therefore, for information and general persuasion efforts to be effective, an understanding of fears and general perceptions must be established. By analogy with targeted information and awareness- raising campaigns aimed at the general population, campaigns in specific professional groups in health care facilities and care facilities for vulnerable people should be linked mainly to

i) the systematic promotion of confidence in vaccines and their effectiveness, with the help of experts, scientific data and public institutions. To this end, it is especially proposed to design online courses on the necessity and benefits of vaccination, and to make attending these courses a requirement for health and administrative personnel in hospitals and care and treatment units for vulnerable groups.

ii) highlighting the benefits of vaccination for individual and collective social well-being, with an emphasis on positive role models and clear messages, using positive language and evidence-based emphasis on the risks of non-vaccination, using available sources of fact-checking[22] and combating fake news and misinformation of all kinds[23]. This is important as victims of misinformation show a reduced intention to vaccinate[24]. There are studies demonstrating a negative correlation between adoption of COVID-19 conspiracy theories and taking relevant health protection measures, but also a positive correlation between COVID-19 conspiracy

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[22] See e.g. https://covid19.gov.gr/mythoi-covid19/.

[23] Fighting misinformation. European Commission. Available at https://ec.europa.eu/info/live-work-travel-eu/coronavirus-response/fighting-disinformation_el#---3 '

[24] Foreign disinformation' social media campaigns linked to falling vaccination rates. BMJ newsroom 22/10/20. Available at https://www.bmj.com/company/newsroom/foreign-disinformation-social- media-campaigns-linked- to-falling-vaccination-rates/ and Exposure to misinformation could make people refuse a COVID-19 vaccine. Imperial College London News 5/2/21. Available at https:// www.imperial.ac.uk/news/214393/exposure-misinformation-could-make-people-refuse/.

theories and online social media as their source[25].

Recent studies from the USA report an additional and useful differentiation of groups not attending for vaccination. In addition to those who are reluctant (or ideologically opposed to vaccination) there are those who have not even entered the process of deciding whether or not to vaccinate. For those in this category of vaccine apathy, which seems to be found across all socio-economic strata, and thus potentially also in groups of health professionals, the design of vaccination messages requires different planning[26].

The Commission stresses that, given the different perceptions of vaccination among health employees and the phenomenon of vaccine apathy, specific targeted information and awareness-raising initiatives (to increase vaccination) need to be undertaken not only by the State, but also by the management of health care facilities, professional and scientific organizations involved in this field, as well as religious institutions.

b. Encouragement/discouragement measures

In the context of encouraging or facilitating measures, further targeted actions could be designed by the State in cooperation with the management of health facilities purposing in promoting voluntary vaccination, such as, for example, facilitating vaccination appointments, flexibility in working hours on vaccination days, priority when choosing the dates of paid leave of absence, etc.).

At the same time, the mandatory use of double masks and personal protective equipment, or the replacement of self-tests by rapid tests (with frequent use of the latter) could be adopted as measures to discourage vaccine avoidance.

c. Provision for compulsory vaccination

As a last resort, this provision should have a specific time frame and should only be implemented if the previous measures do not result in a significant increase in the vaccination rate. The precise implementation of such a measure must be defined on the basis of labour or public law and must take into account any consequences to the allocation of duties and the staffing structures in the event of non-compliance, in order to avoid the malfunction of these facilities or the burden on other employees by assigning them extra duties usually done by the unvaccinated personnel.

If compulsory vaccination is decided, it is recommended that the timing of this measure be carefully planned (based on the current epidemiological situation). In

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[25]Health-protective behaviour, social media usage and conspiracy belief during the COVID-19 public health emergency. Cambridge University Press 9/6/20. Available at https://www.cambridge.org/core/journals/psychological-medicine/article/healthprotective-behaviour-social-media-usage-and-conspiracy-belief-during-the-covid19-public-health-emergency/A0DC2C5E27936FF4D5246BD3AE8C9163.

[26] Wood S, Schulman K. When Vaccine Apathy, Not Hesitancy, Drives Vaccine Disinterest.JAMA June 02, 2021. Available at https://jamanetwork.com/journals/jama/fullarticle/2780792.

this case, vaccination should be carried out with the available formulation that has been shown to cause the fewest possible and least serious adverse reactions. The application of the measure shall be scheduled as to the order in which the personnel is being vaccinated. For example, employees in intensive care units should be given priority over others. In individual cases of staff members for whom vaccination is contraindicated on health grounds, provision should be made for exemption from compulsory vaccination.

In conclusion, it is necessary to give priority to options aimed at convincing the interested persons on the importance of vaccination through targeted information and awareness campaigns - at national, regional, or local level - in order to encourage voluntary vaccination[27].

This strategy of gradual initiative on the part of the State has as an obvious precondition the provision of adequate means and services to prevent the spread of risk in the specific workplaces (working schedules that allow keeping the necessary distance, supply of personal protective equipment, etc.). This helps to increase trust of the interested persons by encouraging them to opt for voluntary vaccination. It is worth recalling the recommendation of the HNBC on individual responsibility[28], according to which the State should encourage individual responsibility by taking concrete measures to demonstrate its interest in protecting public health.

The priority of such choices is justified not only morally - so as not to compromise the principle of autonomy - but also practically, so to avoid reactions of generalized questioning of vaccination and discrediting of the State's initiatives, even at the level of the general population. This latter scenario should not be underestimated, given the great interest that is *de facto* being expressed about the quality of the COVID-19 vaccines and the associated publicity of either the effectiveness (e.g. in terms of coverage of mutations) or the incidence of side effects, where these are identified. It should be stressed that, in general, the imposition of mandatory measures in the field of public health is likely to undermine the necessary climate of public confidence in health authorities, which should not be ignored in decision-making.

Finally, the Commission stresses that, over time, the reluctance to vaccinate against COVID-19, both for specific professional groups and for the general population tends to decrease, as indicated by the daily data of the vaccination process in Greece. This fact should be taken seriously into account in the implementation of the options stated above.

The above recommendations rely on an evidence-based analysis of the individual

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[27] Bradfield OM, Giubilini A. Spoonful of honey or a gallon of vinegar? A conditional COVID-19 vaccination policy for front-line healthcare workers, J Med Ethics 2021. Available at https://jme.bmj.com/content/early/2021/04/28/medethics-2020-107175. About the incentives. For some examples that have been used, see https://theconversation.com/free-beer-doughnuts-and-a-1-million-lottery-how-vaccine-incentives-and-other-behavioral-tools-are-helping-the-us-reach-herd-immunity-160591.

[28] National Bioethics Commission, Recommendation "The bioethical dimension of individual responsibility in the response to COVID-19 (coronavirus)" 2020. Available at http://www.bioethics.gr/images/pdf/GNOMES/Recommendation_coronavirus_FINAL_GR.pdf.

rights and social responsibility obligations that citizens in general and all employees in the sensitive healthcare sector in particular, have to demonstrate towards patients and society as a whole. Individual rights and social responsibility obligations are not mutually exclusive; on the contrary, their synthesis is a key foundation for social progress and prosperity.