



# Hoge Gezondheidsraad Conseil Supérieur de la Santé Hoher Gesundheitsrat

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**SHC 9693 COVID-19 BOOSTER 12-17Y**

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# SHC 9693 COVID-19 BOOSTER 12-17 Y



## KEY POINTS ARGUMENTATION

Favorable international recommendations (to be updated 08/02/2022)

33%

All 30 EU/EEA countries are recommending primary vaccination against COVID-19 for 12-17-year-olds. Regarding the administration of a booster dose, most EU/EEA countries (19/30) are recommending booster doses to all adults 18 years and over and one country to priority groups including those aged 40 years and over. **Ten countries are recommending booster doses for adolescents below 18 years of age.** Two countries are recommending booster doses to all those 16 years of age and over (**Iceland and Ireland**) and eight countries to all those 12 years and over (**Austria, France, Germany, Hungary, Italy, Liechtenstein, Luxembourg and Romania**).



**In the US**, on 5 January 2022, the CDC endorsed the Advisory Committee on Immunization Practices' (ACIP) recommendations to also offer booster doses to those who are 12-15 years old, following the previous recommendation to offer them to those of 16 years and older.

**Israel** has recommended booster doses for everyone aged 16 years and older since late August. In November, this was extended to also include those aged 12 to 15 years.

**In the UK**, the National Health Service: "A booster dose of the coronavirus (COVID-19) vaccine is available for everyone aged 16 and over, and some children aged 12 to 15, who have had 2 doses of the vaccine at least 3 months ago.

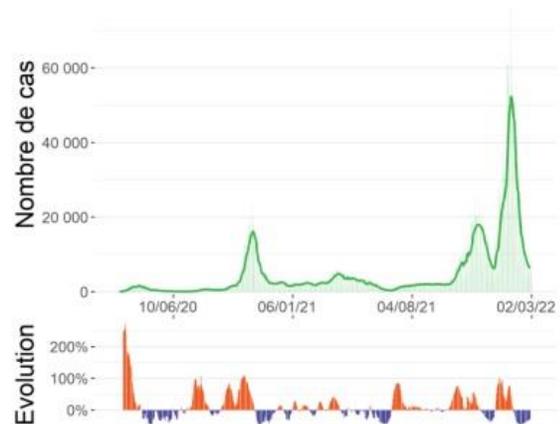
**Switzerland** also recommends booster doses to all adolescents 12-17 years of age 4 months after full vaccination (initial immunization) for everyone aged 12 or over.

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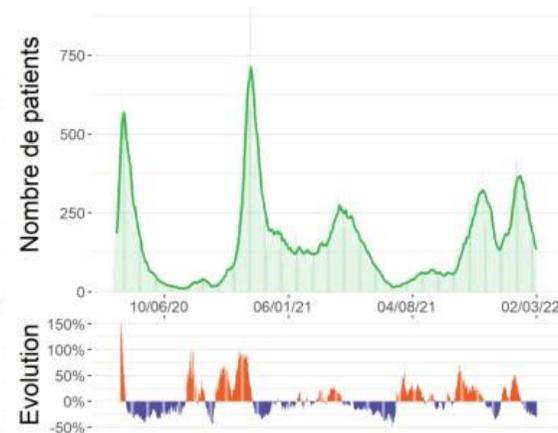
## KEY POINTS ARGUMENTATION Belgian epidemiological data

Evolution des nouveaux cas confirmés



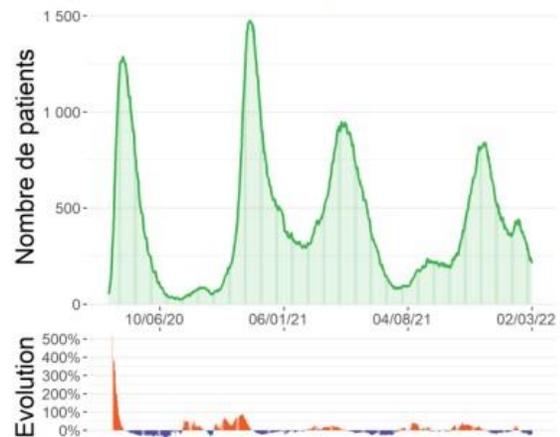
Source : Réseau des laboratoires cliniques et plateforme nationale

Evolution des nouvelles admissions de cas COVID-19 confirmés en laboratoire à l'hôpital



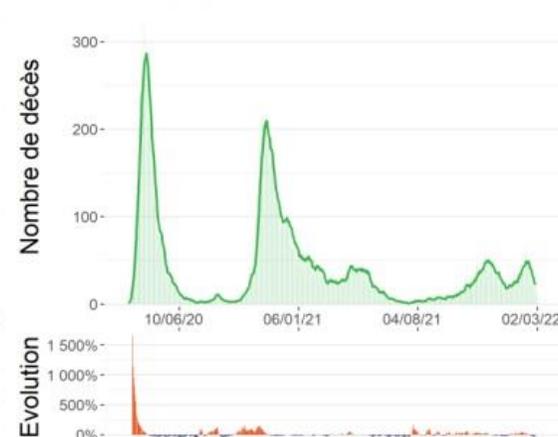
Source : Surveillance des hôpitaux (Sciensano)

Evolution du nombre de patients en USI



Source : Surveillance des hôpitaux (Sciensano)

Evolution du nombre de décès



Source : Surveillance mortalité COVID-19 (Sciensano)



## KEY POINTS ARGUMENTATION Belgian epidemiological data

Catégorie d'âge	Réduction relative du risque d'hospitalisation (non ajustée)		
	Entièrement vacciné (+14 jours) vs. non vacciné	Dose de rappel (+14 jours) vs. Non vacciné	Dose de rappel (+14 jours) vs. entièrement vacciné (+14 jours)
12-17	54 %	Non détectable	Non détectable
18-64	27 %	58 %	42 %
65+	Non détectable	64 %	69 %

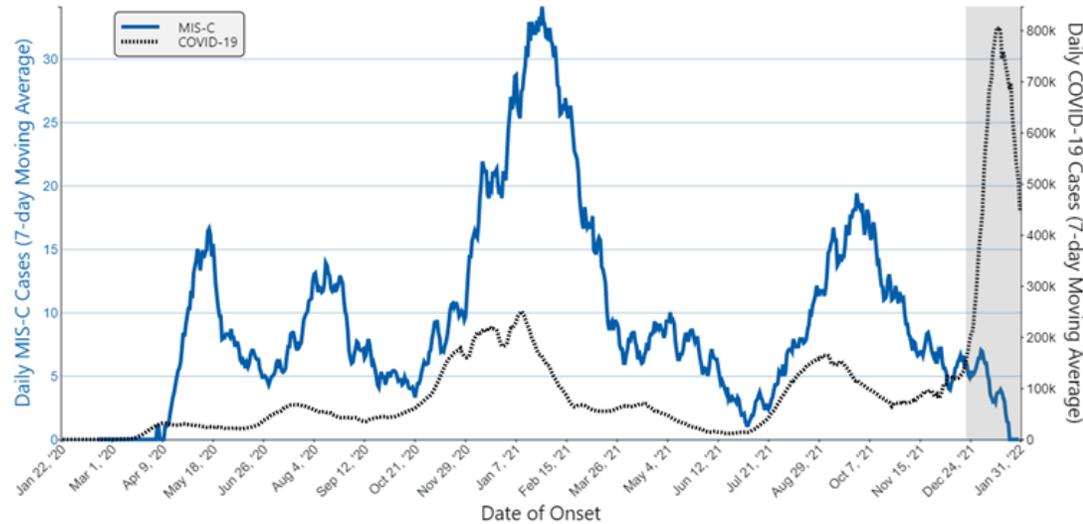
Catégorie d'âge	Réduction relative du risque d'admission en USI (non ajustée)		
	Entièrement vacciné (+14 jours) vs. non vacciné	Dose de rappel (+14 jours) vs. Non vacciné	Dose de rappel (+14 jours) vs. entièrement vacciné (+14 jours)
12-17	25 %	Non détectable	Non détectable
18-64	45 %	68 %	43 %
65+	8 %	74 %	71 %

# SHC 9693 COVID-19 BOOSTER 12-17 Y



## KEY POINTS ARGUMENTATION MIS-C data USA

Daily MIS-C Cases and COVID-19 Cases Reported to CDC (7-Day Moving Average)



- The median age of patients with **MIS-C was 9 years**. Half of children with MIS-C were between the ages of 5 and 13 years.

- 59% of the reported patients with race/ethnicity information available occurred in children who are Hispanic/Latino (1,746 patients) or Black, Non-Hispanic (2,050 patients).

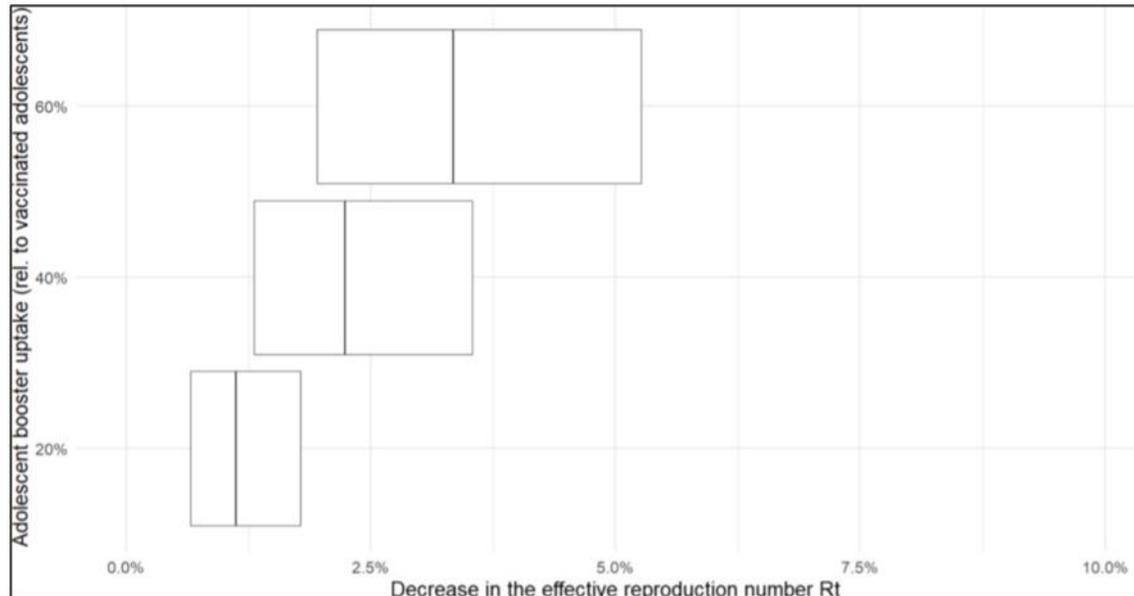
- 98% of patients had a positive test result for SARS CoV-2, the virus that causes COVID-19. The remaining 2% of patients had contact with someone with COVID-19.

- 60% of reported patients were male.



## KEY POINTS ARGUMENTATION EU and Belgian mathematical models

**Figure 3.** The expected impact of providing booster doses to adolescents on the SARS-CoV-2 transmission at population level, quantified by the relative decrease of the effective reproduction number  $R_t$ , for a high, medium, and low uptake of booster doses in the group of adolescents



The vertical bars correspond to the respective median estimate, and the boxes cover the 95% Confidence Interval (CI).

**ECDC:** Mathematical modelling suggests that the administration of a booster dose against COVID-19 to adolescents aged 12-17 years results **in a small reduction (1-3%)** of the effective reproduction number ( $R(t)$ ) in the whole population, varying according to the level of uptake of booster doses among adolescents

**SIMID.be:** According to this modelling, additional boosters would have a positive effect in reducing the burden of disease in the population and a faster relief of care and school populations. However, **the simulations do not predict that, with the current variant, the boosters of teenagers make a difference to a possible new disruption of the healthcare system**



## CONCLUSIONS AND RECOMMENDATIONS

- 1) EMA-approved vaccines are **safe and effective** and **have saved, are saving and will save lives**.
- 2) The mass vaccination campaign against COVID-19 in Belgium **was an absolute necessity**. It is/was based on the best available scientific evidence and the consensus of multidisciplinary experts. It is/was very effective, **it saved many lives and to a large extent limited serious forms and hospitalizations in Belgium**.
- 3) In the current epidemiologic context of COVID-19 in Belgium and the Variant of concern (VOC) Omicron, the Council recommends in the course of 2022 **a gradual transition from a mass vaccination campaign to an increasingly targeted and individualized one for at risk people**. In case of a deterioration of the global or Belgian epidemiological situation or in case of the appearance of new VOCs more critical than Omicron, Belgium must **also be ready to quickly relaunch a mass vaccination campaign**.
- 4) **Optimal protection of people at risk of severe disease remains the first priority**. It has been shown that a booster dose is required to maintain this optimal protection. Vaccine effectiveness (VE) against severe outcomes (hospitalizations, admissions to intensive care units (ICU) or death) continues to be very high in the context of Omicron. **Risk communication activities to people at risk, emphasizing the importance of being fully vaccinated (including recommended additional or booster doses), remain of great importance.**



## CONCLUSIONS AND RECOMMENDATIONS

5) The protection offered by vaccination against infection and onwards transmission is **lower for the Omicron than for the Delta SARS-CoV-2-variant and decreases more rapidly with time.**

6) Concerning the booster dose for 12- to 17-year-olds, the **SHC recommends the systematic administration** of a booster dose for:

- **All children and adolescents who are immunocompromised patients** (SHC 9691, February 2022);

- **All children and adolescents with level 1, 2 and 3 priority comorbidities** (SHC 9618, February 2021 and SHC 9641, April 2021).

- **All children and adolescents living under the same roof as people who remain at risk of severe disease despite full vaccination** (e.g. frail grandparents, immunocompromised brother or sister, etc.). The aim of this vaccination is to indirectly help protect those risk groups (SHC 9618, February 2021). However, the SHC again indicates that the duration of protection in the context of Omicron is lower and decreases more rapidly with time and that cocoon vaccination complements but does not replace non-pharmaceutical interventions (NPIs) for those at risk of severe disease.

The use of the **Pfizer-BioNTech mRNA booster dose (30 µg) is recommended** in adolescents to further minimize the rare risk of myocarditis and/or pericarditis following vaccination in this age group.



## CONCLUSIONS AND RECOMMENDATIONS

7) **Since EMA approval, all children and adolescents who wish to receive this booster, for whatever reason, can have access to it.** A primary vaccination schedule against COVID-19 can be completed by a booster immunization, in order to trigger immune memory and broader immune response, as observed in the 18-plus population. But, there is uncertainty about the magnitude of the impact of this booster on this age group in the current (postomicron wave) context.

Based on this, the SHC recommends that a booster dose for healthy vaccinated adolescents 12 to 17 years of age **would be given in Belgium when appropriate**. Taking into account the current spread of COVID-19, the severity of the disease in younger persons, and the known risk of side effects (particularly the very rare complications of myocarditis), **the SHC is not in favor of the systematic administration of a booster dose** for healthy vaccinated adolescents 12 to 17 years of age **at this very moment**.

8) Finally, the SHC again recommends the Belgian Authorities to strongly advocate for **standardization of the rules relating to Digital COVID Certificates (at least EU level)**. As a minimum, the requirements should at least take into account the availability of EMA-approved vaccines for the different age groups. In general, access to areas of public life should not be restricted for children and adolescents depending on their vaccination status.



**THANK YOU!**

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