L.C.A.I.
Long Covid Advocacy Ireland

Submission to the Independent COVID-19 Evaluation

February 26th, 2026

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About us

Long Covid Advocacy Ireland (LCAI) is an advocacy group comprised of Long Covid patients fighting for change in Ireland. Our vision is for Long Covid to be widely recognised in Ireland and for the HSE to provide multidisciplinary Long Covid clinics that are staffed appropriately, and to ensure that Long Covid services are available and accessible to patients in all counties of Ireland, for all age groups. Our mission is to advocate for services, treatments, research and supports as well as adequate preventions for Long Covid patients of all ages in the Republic of Ireland and to increase awareness and understanding of Long Covid amongst the wider community.

About this submission

This submission from Long COVID Advocacy Ireland (LCAI) is grounded in the understanding that the purpose of the Independent COVID-19 Evaluation is not only to review past decisions, but to enable Ireland to learn, improve, and strengthen its preparedness for future public health emergencies. As articulated by the Taoiseach when announcing the Evaluation, the process is intended to provide a comprehensive assessment of the COVID-19 response and an opportunity to identify lessons that will place the State in a stronger position should another pandemic or similar crisis occur. We welcome the opportunity to make a submission to the Evaluation. However, we are deeply disappointed that despite requests to successive Taoiseach's from LCAI, Long Covid was not explicitly included in the Terms of Reference and is not being examined in the comprehensive manner undertaken in other jurisdictions, most notably the United Kingdom. As a result, this public consultation process now represents the only avenue through which the lived experience of the hundreds of thousands of people affected by Long Covid in Ireland can be placed on the formal record of this Evaluation.

Accessibility

Please note that under Article 4.3 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), that public consultations should be accessible and allow submissions in accessible formats.

List of Acronyms

FADA	Follow-up After Disease Acquisition
FFP2	Filtering Face Piece 2
HPSC	Health Protection Surveillance Centre
HSA	Health and Safety Authority
HSE	Health Service Executive
IPC	Infection Prevention and Control
LCAI	Long Covid Advocacy Ireland
MERS	Middle East Respiratory Syndrome
NICE	National Institute for Health and Care Excellence
NPHET	National Public Health Emergency Team
PPE	Personal Protective Equipment
rt-PCR	Reverse Transcription Polymerase Chain Reaction
SARS	Severe Acute Respiratory Syndrome
SARS-CoV-1	Severe Acute Respiratory Syndrome Coronavirus 1
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SLWP	Special Leave with Pay
SME	Subject Matter Expert
WHO	World Health Organization

Introduction and Context

The purpose of the Independent COVID-19 Evaluation is not only to review past decisions, but to enable Ireland to learn, improve, and strengthen its preparedness for future public health emergencies. As articulated by the (then) Taoiseach when announcing the Evaluation, the process is intended to provide a comprehensive assessment of the COVID-19 response and an opportunity to identify lessons that will place the State in a stronger position should another pandemic or similar crisis occur.[1] Any meaningful evaluation of a pandemic response must consider the full spectrum of health outcomes arising from the outbreak.

An effective pandemic response should first and foremost focus on reducing impact to life and to health by reducing deaths, hospitalisations, and new or worsening chronic illness. It requires decision-making based on both known and unknown factors, with adequately staffed response teams who are the subject matter experts (SME) both on impacts and identified preventions. They provide expert and current advice and should be involved in regularly reviewing impacts, decisions, and policies with the leadership as new information emerges. An effective pandemic response communicates what factors are known unknown. It looks outward to other countries' impacts and lessons (especially where other countries experience impacts earlier e.g Italy and China) as well as inward monitoring. It should manage the impacts as they emerge within its own country and communicate the associated risks clearly and transparently with the public.

Increased incidence of chronic illness following infectious disease outbreaks is not unique to COVID-19. Indeed, long-term sequelae has been documented following the 1918 influenza "Spanish Flu" pandemic, 2003 SARS pandemic, 2009 H1N1 "Swine Flu" pandemic, and 2012 MERS epidemic, to name a few examples. Across the globe, millions of people infected with Sars-CoV-2 since the first wave in March 2020 have subsequently gone on to develop what is now known as Long Covid. Long Covid is defined by the WHO as the 'continuation or development of new symptoms 3 months after the initial Sars-CoV-2 infection, with these symptoms lasting for at least 2 months with no other explanation.'[2] There are more than 200+ documented symptoms of Long Covid, ranging from mild to debilitating, and lasting for months or years.

Long Covid is not a marginal issue, but indeed one of the most significant and enduring health consequences of the pandemic. It also remains an ongoing public health challenge. The Health Service Executive's (HSE) FADA study on Long Covid estimates that 16% of the adult population (more than 650,000 adults) has, or has had, Long Covid.[3] The impact of an infection in children isn't mild, Long COVID is common, affecting up to 10% to 20% of children with a history of COVID-19. This is so significant that Long COVID appears to have overtaken Asthma in America as the predominant childhood illness.[4] For hundreds of thousands of people across Ireland, it has resulted in long-term disability, loss of employment, financial hardship, and social

[1] https://www.oireachtas.ie/en/debates/question/2023-07-11/102/
[2] https://www.who.int/europe/news-room/fact-sheets/item/post-covid-19-condition
[3] https://about.hse.ie/news/hse-publishes-findings-of-survey-examining-the-long-term-impact-of-acute-covid-19-disease/
[4] https://jamanetwork.com/journals/jamapediatrics/fullarticle/2834486

isolation. Yet patients have frequently encountered barriers to recognition, diagnosis, treatment, and social supports. The absence of coordinated, multidisciplinary services within the HSE, combined with inconsistent clinical pathways and limited public awareness, has compounded the impact of the condition and contributed to avoidable suffering. The consequences of Long Covid also extend beyond individual patients, placing sustained pressure on families, communities, health services, and the wider economy.

Long Covid must be understood as a core part of the pandemic and its legacy, and as such the Independent COVID-19 Evaluation must not only examine emergency decision-making relating to the acute impact of the virus, but also the State's response to the ongoing health impact and needs that have followed. Recognising and learning from these experiences is critical to improving current supports for those affected and strengthening Ireland's preparedness for future public health crises.

This submission therefore examines key decisions, policies, and public communications made during the period from January 2020 to January 2022 - the emergency phase of the pandemic - and considers their short- and long-term impacts. By tracing how early assumptions, service models, risk communication, and policy priorities evolved (or failed to evolve) over time, the submission aims to identify where opportunities were missed, where harms may have occurred, and what lessons can be learned.

Section 1 - Long-term Health Impact

Part 1 - Long Covid should have been a known risk

When a novel pathogen emerges, public health decision-making must operate under uncertainty; however, such decision making should be informed by prior outbreaks and evidence.

Historical experience from previous epidemics and pandemics should have made it clear from the outset that post-viral sequelae were a plausible and likely consequence of widespread SARS-CoV-2 infection. Long-term health effects following viral illness are well documented across multiple pathogens, including 1918 influenza pandemic, HIV/AIDS epidemic, 2015/2016 ebola outbreak, 2003 SARS pandemic, 2009 H1N1 "Swine Flu" pandemic, and 2012 MERS epidemic, to name a few examples. Specifically looking at similar coronaviruses, following the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak, a substantial proportion of patients experienced persistent symptoms months to years after acute infection, including fatigue, reduced exercise tolerance, sleep disturbance, and neurocognitive difficulties. Studies of survivors demonstrated ongoing functional impairment and reduced quality of life even several years later, with some individuals unable to return to previous employment. Similarly, after Middle East Respiratory Syndrome (MERS), long-term pulmonary dysfunction, chronic fatigue, and psychological sequelae were reported. Taken together, chronic illness following acute infection is not unusual nor unexpected in infectious disease epidemiology.

This existing body of evidence was available well before 2020 and should have informed pandemic risk assessment and planning. Early clinical reports in 2020 also described patients experiencing prolonged recovery trajectories, including ongoing fatigue and breathlessness after hospital discharge.[5,6] By mid-2020, patient-led research groups internationally were documenting persistent multi-system symptoms following even 'mild' infections,[7,8] indicating that long-term sequelae were not limited to severe acute disease. The emergence of Long Covid was therefore not an unforeseeable phenomenon but rather consistent with prior scientific knowledge regarding post-viral illness. A precautionary pandemic response should have anticipated the possibility of new-onset chronic illness at population scale and incorporated this risk into decision-making, surveillance, healthcare planning, and public communication from an early stage.

The relevance of this history for the Independent Evaluation in Ireland is twofold. First, it raises questions about whether sufficient attention was given to the potential long-term burden of infection when assessing risks and benefits of policy choices that influenced transmission levels. Second, it highlights the importance of embedding post-viral illness expertise into pandemic preparedness frameworks. International public health authorities, including the WHO, now recognise Long Covid as a significant component of the pandemic's health impact. Learning from earlier epidemics, where long-term sequelae were documented but often under-recognised, is essential to ensure that future responses more fully account for chronic health consequences alongside acute outcomes.

Part 2 - Response to Long Covid

Despite the growing recognition during 2020 that some individuals experienced prolonged illness following acute SARS-CoV-2 infection, the policy and health system response to Long Covid was slow, fragmented, and insufficiently aligned with emerging scientific evidence. Patient reports of persistent symptoms emerged internationally in spring 2020, with clinicians publishing early case series by mid-2020 in both hospitalised and non-hospitalised patient populations.[9,10] By 2021, the scale of the issue was increasingly recognised, including the development of NICE Guidelines in the UK[11] and a clinical case definition by the World Health Organization in October 2021.[12] This evolving international evidence indicated early on that Long Covid represented a potentially significant long-term health burden requiring coordinated health system planning.

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[5] https://www.businessinsider.com/coronavirus-recovery-damage-lung-function-gasping-air-hong-kong-doctors-2020-3

[6] https://www.nytimes.com/2020/04/13/opinion/coronavirus-recovery.html

[7] https://wellcomeopenresearch.org/articles/5-224

[8] https://www.proquest.com/openview/77e19227a111e6bfa7f2f75b691e3b91/1?pq-origsite=gscholar&cbl=2043523

[9] https://onlinelibrary.wiley.com/doi/10.1002/jmv.26368

[10] https://link.springer.com/article/10.1186/s12913-020-06001-y

[11] https://www.nice.org.uk/guidance/ng188/chapter/5-Management

[12] https://www.who.int/publications/i/item/WHO-2019-nCoV-Post_COVID-19_condition-Clinical_case_definition-2021.1

In Ireland, the principal structural response during this period was the publication of the Interim Model of Care for Long Covid by the Health Service Executive in September 2021. While the establishment of specialist clinics represented an important and welcome acknowledgement of patient need, the model was explicitly interim and implementation was limited in both capacity and geographic coverage. Significant regional inequities in access emerged, referral pathways were often unclear or restrictive, and multidisciplinary integration across specialties such as cardiology, neurology, immunology, and respiratory medicine remained underdeveloped despite growing evidence that Long Covid was a multi-system condition. Importantly, the interim model was not subsequently updated in 2022, despite rapid advances in scientific understanding. In fact, the interim model of care still, to this date, has not been updated to reflect the tens of thousands more studies that have been published on Long Covid and substantial developments in clinical and scientific understanding over the last six years. While the HSE Long Covid Working Group was tasked in 2025 with revising the model, the pace and approach to this work does not reflect the urgency warranted by the scale of unmet need or the ongoing impact of Long Covid on patients' lives.

From the beginning of the pandemic, Long Covid patients have persistently struggled for recognition and validation of their symptoms within clinical and social systems. Many individuals report difficulty obtaining diagnosis, clinical acknowledgement, workplace accommodations, or access to social protection supports. This struggle has been present from 2020 and continues to this day. This reflects a broader historical pattern seen in post-infectious illnesses, where emerging chronic conditions often face dismissal until scientific consensus is clear. However, by 2021 there was already substantial peer-reviewed evidence demonstrating physiological abnormalities in subsets of Long Covid patients, including cardiopulmonary impairment, autonomic dysfunction, and neurocognitive deficits.[13,14,15,16,17] A precautionary, patient-centred response during this period would therefore have prioritised clinical education, early surveillance systems, disability pathways, public awareness campaigns and research investment.

Long Covid during was not and is not solely a clinical issue but also a foreseeable population health and socio-economic issue. Potential implications for workforce participation, disability prevalence, and long-term health service demand were already identifiable by 2021 based on international evidence. Yet Long Covid was not consistently integrated into broader pandemic policy considerations, including cost-benefit assessments of mitigation measures or planning for long-term health system capacity. This separation between acute pandemic management and long-term morbidity planning represents a critical area for examination within the Evaluation.

Overall, while Ireland did take steps to recognise Long Covid between 2020 and 2022, including the Interim Model of Care and establishment of coordination structure, these actions did not fully match the scale, urgency, or complexity of the emerging evidence. Examining the reasons for:

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[13] https://thorax.bmj.com/content/76/4/396.abstract
[14] https://www.sciencedirect.com/science/article/pii/S1470211824033918
[15] https://www.mdpi.com/2076-3425/11/2/235
[16] https://www.mdpi.com/2077-0383/10/24/5913
[17]

- delayed service development and limited implementation,
- The gaps in the provision of post viral awareness, detection and symptom management training within the medical community to help the many patients whose symptoms were, and often still are, psychologised and told “it’s in your head” from medical professionals who were not made aware.
- The omission of post viral impact in the pandemic response teams management and recording of risk, despite surplus historical and scientific research.
- The lack of broader infection impact communication to make the public aware of the post viral health consequences of infection, so the population was equipped with the knowledge to manage and reduce risk and impact for themselves and others.

will be essential both to improving current support for the hundreds of thousands affected by Long Covid in Ireland and to ensure that future public health emergency responses incorporate long-term morbidity planning from the outset.

Section 2 - Public Health Communication

Communication on Transmission

When a novel pathogen emerges, public health decision-making must operate under uncertainty; however, such decision making should be informed by available scientific evidence and prior incidence experience and lessons, including from related pathogens. In the case of SARS-CoV-2, there was already relevant knowledge from the 2003 SARS outbreak demonstrating that airborne transmission could occur, including well-documented superspreading events associated with aerosol dispersion in indoor environments.[18] Despite this, during the 2019-nCoV Expert Advisory Group on February 5th, 2020, the group made the decision to change initial Health Protection Surveillance Centre (HPSC) Infection Prevention and Control (IPC) recommendations from aerosol/airborne precautions in acute hospital settings, and contact and droplet precautions in primary care, to droplet and contact precautions in both settings.[19] This decision to downgrade IPC precautions no doubt led to preventable infections and the subsequent development of Long Covid for some. Importantly, early experimental evidence specific to SARS-CoV-2 itself was available very early in the pandemic. A letter published on 17 March 2020 in the New England Journal of Medicine reported that SARS-CoV-2 remained viable and infectious in aerosols for at least three hours under experimental conditions, with stability characteristics similar to SARS-CoV-1.[20] The authors concluded that aerosol transmission of SARS-CoV-2 was plausible. Taken together, prior

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[18] https://openurl.ebsco.com/EPDB%3Agcd%3A11%3A25362971/detailv2?sid=ebsco%3Aplink%3Ascholar&id=ebsco%3Agcd%3A16258463&crl=c&link_origin=scholar.google.com

[19] https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/submissions/2020/2020-06-30_correspondence-cillian-de-gascun-consultant-virologist-and-laboratory-director-ucd-national-virus-reference-laboratory-scc19r-r-0339-0340-0341_en.pdf

[20] https://www.nejm.org/doi/full/10.1056/NEJMc2004973

knowledge from SARS-CoV-1 and early laboratory evidence regarding SARS-CoV-2 suggested from an early stage that inhalation transmission was credible and potentially important.

Despite this early evidence, official public health communication in Ireland throughout 2020 and emphasised droplet transmission and surface hygiene as the primary routes of spread. While this aligned with initial international guidance, it did not reflect the precautionary implications of emerging aerosol evidence. Even in 2021, when the airborne nature was clearly recognised as the predominant transmission route by the scientific and public health community, HSE guidance downplayed this risk. Indeed, in a Parliamentary Question Deputy Róisín Shortall, in July 2021, asked the Minister for Health the reason the statement that there is currently no strong evidence to suggest that SARS-CoV-2 is spread through airborne transmission remains on the HSE website.[21] This significant gap in communication on knowledge of viral transmission resulted in more people being infected.

In March 2020, guidance published by the Health Service Executive (HSE) stated that COVID-19 "is spread in sneeze or cough droplets," with prevention advice focusing on handwashing, respiratory etiquette, cleaning surfaces, and maintaining a two-metre distance. This framing was repeated consistently across Government communications during the first wave. Public messaging from national leadership reflected the same understanding: on 12 March 2020, then Taoiseach Leo Varadkar addressed the nation and emphasised measures such as handwashing, covering coughs, and physical distancing to prevent spread, without reference to airborne or inhalation risk. The emphasis on droplets and surfaces aligned with contemporaneous international guidance but did not reflect the precautionary implications of emerging aerosol evidence.

Despite the scientific consensus that has emerged since 2021 that SARS-CoV-2 is transmitted predominantly through inhalation of virus-containing aerosols in indoor air, this understanding has not been clearly or consistently communicated to the public in Ireland. Public-facing information from the HSE continues to place substantial emphasis on hand hygiene, surface cleaning, and short-range droplet precautions, with comparatively limited focus on ventilation, air filtration, or the importance of high-quality respiratory protection in shared indoor environments - particularly under the heading "How to protect yourself and others."[22] Individuals cannot make informed risk assessments if they are not provided with accurate information about how infection occurs. It also limits the adoption of effective mitigation measures in workplaces, schools, healthcare settings, and homes. For those who have developed Long Covid, and for those seeking to avoid it, the continued under-communication of airborne risk represents not only a scientific gap but a public health failure. A key lesson for future pandemic preparedness is that transmission routes must be communicated transparently and updated rapidly as evidence evolves, even when this requires revising earlier guidance.

Similarly, early narratives suggesting that children were largely unaffected by COVID-19, or were not significant drivers of transmission, influenced both policy decisions and public perception. While children were less likely to experience severe acute illness compared with

[21] https://www.oireachtas.ie/en/debates/question/2021-07-27/3301/
[22] https://www2.hse.ie/conditions/covid19/preventing-the-spread/how-coronavirus-spread/

older adults, evidence emerged during 2020 and 2021 that children could transmit SARS-CoV-2[23,24] and could also experience post-infectious complications, including Long Covid and other sequelae.[25] The persistence of messaging that minimised risk to children contributed to reduced urgency around mitigation measures in educational settings and delayed recognition of paediatric Long Covid. Children were not - and still are not - included within the Long Covid Interim Model of Care. Examining how these narratives developed, how evidence was interpreted, and how communication evolved is important for understanding the full impact of pandemic decision-making on children and young people.

Communication of Decision-Making

LCAI are also concerned about the clarity and consistency of early risk-based decision-making during the initial phase of the pandemic response, and the extent to which decisions were shaped by domestic risk assessment versus external political developments, such as those in the United Kingdom. From a public health perspective, pandemic response measures should be grounded in a clearly articulated objective - namely reducing overall impact on life and health through minimising transmission, hospitalisations, deaths, and long-term health impacts. However, some early decisions do not appear to have taken such a precautionary risk-reduction approach. For example, travel-related restrictions and guidance introduced in March 2020 limited movement for individuals returning from regions deemed high-risk, such as Italy. Yet this approach did not extend to individuals returning from the Cheltenham Festival, despite the large number of attendees travelling from Ireland to a mass gathering event that subsequently turned out to be a super spreader event. Public statements by then Minister for Health Simon Harris indicated that the National Public Health Emergency Team (NPHET) had considered Cheltenham specifically when developing advice. However, the rationale underpinning this risk differentiation was not clearly communicated to the public.

Understanding the framework used to assess and balance risks in these early decisions is important for the Evaluation. Specifically, there must be an examination of the epidemiological assumptions, modelling inputs, or precautionary principles that informed decisions; how uncertainty was incorporated into risk management; and the degree to which Irish policy choices were influenced by decisions in neighbouring jurisdictions such as the UK. Future pandemic responses should have greater transparency regarding how risks are evaluated, prioritised, and communicated, in order to build public trust.

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[23] https://gvn.org/sars-cov-2-transmission-to-from-and-among-children-what-is-new/#:~:text=Is%20there%20some%20reason%20to,was%20%3E1(15)

[24] https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247(22)00124-0/fulltext

[25] https://www.frontiersin.org/journals/pediatrics/articles/10.3389/fped.2021.656768/full

Communication on Health Risks

A further gap in the pandemic response concerns public communication of risk - particularly once evidence of Long Covid became clear. While acute risks such as hospitalisation and death were frequently communicated in public messaging, the risk of long-term morbidity such as Long Covid was less consistently or prominently conveyed. In February 2021, the WHO reported that an estimated 1 in 10 persons who were infected would develop Long Covid.[26] However, public communication in Ireland did not consistently incorporate Long Covid risk as a central component of infection risks during key policy phases, including periods of reopening and the relaxation of population-level mitigation measures. As a result, the vast majority of the general public were not, and are still not, fully informed about the potential long-term health consequences associated with infection when making personal risk decisions.

With the lifting of the vast majority of mitigations in 2022, risk management shifted progressively onto individuals. However, the risk of long-term health consequences following infection were not adequately communicated. Public messaging from Government, the HSE, and the office of the Chief Medical Officer, continued to focus heavily on handwashing, personal responsibility, and protecting “the elderly and vulnerable.” This framing did not reflect emerging evidence that COVID-19 carries risks across all age groups, nor that the health impacts of infection may be cumulative, with repeated infections increasing the likelihood of adverse outcomes, including Long Covid.[27] As a result, many individuals were left to make personal decisions about exposure without being provided with clear, evidence-based information about potential long-term risks to themselves or to others.

Communications of Vaccine Strategies and Effectiveness

Ireland’s COVID-19 vaccination programme unquestionably reduced severe disease, hospitalisation, and death. However, aspects of the policy framing, prioritisation decisions, and public communication during warrant examination, particularly in relation to how vaccination was positioned within the broader pandemic control strategy and how risks were communicated to the public and frontline workers.

From late 2020 onward, vaccination became increasingly framed as the primary pathway out of the pandemic, with comparatively less emphasis placed on the continued importance of layered mitigation measures such as ventilation, masking, and transmission reduction. Public messaging at times contributed to the perception that vaccination alone would provide comprehensive protection, including against infection and onward transmission. For example, in August 2021, then HSE CEO Paul Reid stated publicly that 88% of adults were

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26 https://www.who.int/europe/news/item/24-02-2021-new-policy-brief-calls-on-decision-makers-to-support-patients-as-1-in-10-report-symptoms-of-long-covid

27 https://www.scientificamerican.com/article/do-repeat-covid-infections-increase-the-risk-of-severe-disease-or-long-covid/

“fully protected” following vaccination uptake. While vaccines do provide strong protection against severe outcomes, the use of language such as “fully protected” risked reinforcing a misunderstanding among the public that vaccines were capable of preventing infection entirely at a time when emerging evidence was already demonstrating breakthrough infections and waning protection against transmission, particularly with the emergence of new variants.

This communication framing has had catastrophic downstream consequences. It contributed to the widespread “vax and relax” perception, that many understood to mean that other protective measures were no longer necessary once being fully vaccinated. In turn, this influenced individual risk assessment, workplace safety expectations, and policy decisions regarding the removal of mitigations. For individuals at higher risk, - including those with underlying conditions and those unable to receive vaccines - the shift toward vaccination as the dominant protective strategy created additional uncertainty and reduced access to public spaces due to the removal of other mitigations.

There are also concerns regarding the prioritisation and operational aspects of the rollout, particularly for frontline healthcare workers during the early phases when vaccine supply was limited. Reports indicated that some healthcare workers with ongoing high-risk exposure did not receive vaccination as early as expected, while in certain instances surplus doses were administered to non-priority individuals, including relatives of staff. Subsequent guidance from the HSE required vaccination centres to maintain standby lists of healthcare workers to prevent wastage. For frontline workers facing daily occupational exposure - including those who subsequently developed Long Covid - delays or inconsistencies in access to vaccination had both immediate and long-term implications for their health and ability to work.

Finally, as evidence evolved showing that vaccination alone could not eliminate transmission or prevent Long Covid, communication did not adjust with the sufficient clarity or speed needed to reflect this nuance. While vaccines remain a critical tool, an effective pandemic strategy requires accurate communication about both the strengths and limitations of interventions. Over-reliance on a single intervention, or public messaging that overstates its protective scope, can undermine public trust and take-up of future vaccination (due to many break-through infections) when expectations are not met.

For the purposes of the Evaluation, we would therefore urge examination of:

- How vaccination was positioned within the overall pandemic control strategy relative to other mitigation measures
- The evidence base informing public communication regarding protection against infection and transmission
- Prioritisation decisions affecting frontline workers and high-risk groups

- How communication evolved as evidence on breakthrough infections and Long Covid emerged
- The longer-term impact of vaccine-centric messaging on public behaviour, risk perception, and trust

Understanding these factors is essential not only for assessing the COVID-19 response but also for informing future vaccination strategies.

Section 3 - Decision-Making around Prevention Strategies

Missed opportunities for layered mitigations

Despite a number of recognised public health measures that would reduce the spread of the virus, including masking, air ventilation and filtration, testing and contact tracing there appeared to be a progressive narrowing of focus toward vaccination as the primary long-term prevention strategy. While vaccination has been a critical and life-saving intervention, an “all eggs in the vaccine basket” approach did not fully reflect the reality that vaccines alone could not eliminate transmission, prevent all infections, or entirely remove the risk of Long Covid, particularly in the context of emerging variants. In this context, layered prevention strategies including clean indoor air, FFP2 respirators, and widespread testing were increasingly recognised as essential components of pandemic control. The Evaluation should examine why these tools were not more systematically implemented in Ireland.

One example where clarity on decision-making is when the Irish government, having entered the 2020 holiday season with the lowest incidence of COVID-19 in Europe following a November lockdown, allowed for such an easing of restrictions in early December, permitting inter-county travel and household mixing. This decision around the need for a “meaningful Christmas” heightened risk and the impact was clear to see when, then Minister for Health Stephen Donnelly announced that a new variant first identified in the UK was present at a “significant level”. It accounted for **two-thirds of all new COVID-19 cases** in Ireland. During December 2020, there were no mandatory pre-departure testing or strict quarantine requirements for arrivals from the UK or the EU. It felt like a re-run of Cheltenham under the previous Minister, with no lessons learned. Travel from Great Britain to Ireland was significant, with approximately **135,900 passengers** arriving by air that month. Research indicates that roughly **45% of flights** with infectious cases arriving in Ireland in December 2020 originated in Great Britain. Public health experts concluded that this international travel, combined with increased social mixing, likely seeded the Alpha variant and contributed to Ireland experiencing the **highest spike in cases in the world** by January 2021, seeding our third wave. One of the many consequences of this was schools remaining closed, despite initial plans for them to re-open due to the low-levels before Christmas.

There was also an ongoing narrative that children were at low risk and were not major contributors to transmission. These assumptions influenced risk tolerance at a population level

despite scientific evidence that children could transmit infection and could go on to develop Long Covid.

The scientific consensus that COVID-19 is predominantly airborne has significant implications for prevention policy. Recognition of airborne transmission has prompted calls internationally for changes in engineering standards in healthcare and educational environments, alongside consistent use of high-quality respirators in high-risk settings. Evidence demonstrates that such measures are effective: healthcare studies have shown that universal masking policies and improved respiratory protection reduce hospital-acquired infections, protect vulnerable patients, and reduce staff shortages.[28] Prevention measures therefore provide both health and economic benefits, including reduced disruption to healthcare services and improved workforce resilience.

There were also repeated public discussions during 2021 and 2022 regarding ventilation and air filtration as preventive measures, which created expectations that structural improvements to indoor air safety would follow. In December 2021, then Minister for Education Norma Foley announced funding of approximately €27 million for ventilation supports in schools, and in July 2022 Minister Donnelly indicated that ventilation and filtration measures were under consideration more broadly. However, these discussions did not translate into widespread deployment of high-efficiency filtration in schools, healthcare settings, and public buildings. Still, in 2026, the majority of these spaces do not have clean air, despite Ireland's Health and Safety Authority (HSA) publishing a very welcome new code of practice for indoor air quality in 2023. While this code of practice is fantastic legislation, the awareness and legislation hinders the success and meaningful impact.

This raises a central question for the Evaluation: at critical decision points, were economic considerations prioritised over the protection of life and long-term health. While economic stability is important, pandemic decision-making should be grounded first and foremost in the preservation of life and prevention of avoidable harm. Reopening strategies often emphasised rapid commercial recovery, yet there was insufficient conditionality requiring businesses to implement robust airborne mitigation measures such as upgraded ventilation and high-efficiency filtration. Many workplaces and hospitality settings reopened without demonstrable improvements to indoor air safety. The absence of systemic action on clean indoor air in Ireland represents a missed opportunity to reduce transmission and therefore reduce Long Covid incidence and the ongoing repeated re-infection and increases in illness to date.

A further significant decision point occurred in February 2022, when the Government in Ireland lifted mask mandates on public transport and in healthcare settings. This marked a clear shift in framing, from a collective "protect the vulnerable" approach to what many now describe as an "only the vulnerable" model of risk management. For people who are immunocompromised, clinically vulnerable, or living with Long Covid, the removal of universal masking in essential environments such as hospitals and public transport effectively required them to assume

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28 https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/abs/impact-of-universal-masking-in-reducing-the-risk-of-nosocomial-respiratory-viruses-among-people-with-cancer/A940A27B9800694368FA7280D9C6EB9C

disproportionate personal risk in order to attend medical appointments, access treatment, or participate in daily life. In high-risk clinical settings in particular, where sick and infectious individuals are concentrated, the withdrawal of universal source control reduced protections at the very point where they were most needed. This decision warrants examination in terms of the risk assessment underpinning it, the consideration given to cumulative and repeat infection risks, and the equality implications for those already most impacted by the pandemic.

Given that Long Covid now affects millions globally and has no definitive treatment, prevention remains the most effective strategy for reducing long-term harm. Evidence supporting prevention tools such as FFP2 masks and clean air was clear since 2020, yet Ireland did not appear to adopt a comprehensive layered mitigation approach incorporating clean indoor air, respirators, strategic testing, and exposure reduction. The Evaluation should therefore examine what prevention options were considered in the pandemic response, what risk–benefit analyses were conducted, and why certain structural airborne mitigations were not implemented. Key lessons for future pandemics include the importance of acting early, using multiple prevention layers rather than relying on a single intervention, and recognising that preventing infection is central not only to reducing deaths but also to preventing chronic illness and long-term disability.

For the purposes of the Evaluation, we would therefore urge examination of:

- Why were airborne precautions sidelined despite historical evidence as well as studies from US, China, Europe in 2020 & 2021 showing respiratory particles stay airborne from minutes to hours
- Why were ventilation & filtration solutions shelved
- Why was a letter from 200 aerosol scientists warning the WHO of indoor airborne transmission[29] not considered, especially considering that shortly after the letter was published in July 2020, the WHO acknowledged the "emerging evidence" of airborne spread in specific, crowded, and poorly ventilated indoor settings.
- Why were decisions impacting children seemingly made without questioning the “mild” or limited transmission narrative
- Why was no research requested by the government within hospital/care homes or school settings on transmission
- Why was a layered precautionary approach sidestepped
- Why vaccinations and hand washing was - and continues to be - the main prevention focus
- Why immunocompromised and clinically high-risk individuals were made to bear disproportionate risk in essential spaces following lifting of mask mandates in essential services, and whether equality, disability, and human rights considerations were adequately assessed in that policy shift.

[29] https://academic.oup.com/cid/article/71/9/2311/5867798

Section 4 - Additional Comments

This section outlines further points and observations that LCAI wishes to highlight, but which we were unable to explore in depth elsewhere in this submission, as many of our members are unwell themselves. The lived experience of people affected by Long Covid encompasses a wide range of health, social, and systemic challenges, many of which continue to evolve. These comments are intended to ensure that key issues are formally recorded for the Evaluation, even if there was insufficient space to provide full analysis or evidence for each point.

- **March 2020 - Withdrawal of testing waiting lists:** A significant early failure was the decision to remove all individuals from COVID-19 testing waiting lists overnight in March 2020, regardless of symptom severity, requiring patients to return to their GPs to be re-referred. This resulted in delays of several weeks for many people, compounded by the need to send tests to laboratories in Germany due to limited domestic capacity. As a consequence, many individuals were delayed access to testing, increasing the likelihood of false negatives or inconclusive results and creating long-term implications for diagnosis and later recognition of Long Covid.

- **Restrictive testing criteria:** Early testing policy required individuals to exhibit at least three specific symptoms in order to qualify for COVID-19 testing: high temperature, new-onset cough, and difficulty breathing. Other symptoms, such as loss of taste or smell, gastrointestinal upset, and fatigue, were not recognised despite being documented symptoms as early as 2019.[30] This left many symptomatic individuals untested and delayed diagnosis, isolation, and appropriate care.

- **Exclusion from Special Leave with Pay (SLWP):** Many frontline workers in essential services outside healthcare contracted COVID-19 at work and subsequently developed Long Covid. They were denied access to SLWP because Long Covid was not formally recognised in 2020, and once attempts were made to return to work, payments ceased. This lack of support forced many to lose their careers or incomes, as reasonable accommodations were not provided, compounding the long-term impact of their illness.

- **Ending of Special Leave with Pay (SLWP) for healthcare workers:** The recent termination of the SLWP scheme for healthcare workers with Long Covid represents one of the most serious failures of Ireland's pandemic response. Frontline staff contracted COVID-19 while caring for patients in the early waves, often without adequate PPE and before vaccines were available, and many developed severe Long Covid, leaving them unfit to work. While the SLWP scheme had acknowledged this occupational exposure and provided financial protection, its withdrawal now places the approximately 120 healthcare workers on the scheme at risk of reduced pay, loss of pensions, and even homelessness. This decision sends a devastating message that those who sacrificed their health for the public good have been abandoned.

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30 https://article.scholarena.com/The-Epidemiology-Diagnosis-and-Treatment-of-Coronavirus-Disease-2019-COVID-19-A-Review.pdf

- **Exclusion from research participation:** Many people with Long Covid in Ireland were initially unable to participate in COVID-19 research or have their experiences formally recognised unless they had a positive rt-PCR test or had been admitted to hospital. This effectively excluded a large proportion of patients, including those who could not access testing or chose not to seek hospital care due to fear of isolation or dying alone, leaving their experiences unrecorded and underrepresented in the evidence base.

- **Lack of up-to-date clinical knowledge and symptom recognition:** Patients who were not admitted but attended hospital COVID assessment suites reported that they were, in many cases, more familiar with emerging research from Wuhan and Italy than the clinicians assessing them. Individuals presenting with gastrointestinal, inflammatory, or neurological symptoms were often told that PCR tests were limited and that, in the absence of classic respiratory symptoms, they should return home and self-isolate. Many of these patients never recovered and have been living with Long Covid since 2020, raising concerns about early symptom recognition, testing access, and missed opportunities for appropriate follow-up and documentation.

- **External pressures and international comparisons**: During the pandemic, political narratives frequently emphasised “league table” comparisons with other European countries, which risked marginalising the lived experiences of individuals and families affected by infection, severe illness, or Long Covid. Clear, inclusive, and compassionate communication is essential to maintain public cohesion and focus during health crises.

- **Business lobbying and mitigation measures:** Pandemic decision-making was influenced by pressures from industries directly affected by restrictions, such as hospitality and airlines. It is worth examining whether discussions with these sectors considered strategies to reduce viral transmission through ventilation and filtration, and if not, why such preventive measures were not systematically implemented.

Conclusion

LCAI urges the Independent COVID-19 Evaluation to recognise Long Covid as a central and ongoing consequence of the pandemic, rather than a marginal or secondary issue. The evidence presented in this submission demonstrates that the State’s response - from early risk communication to prevention, vaccination rollout, and service provision - often failed to account for the long-term health impacts of the virus. Decisions were frequently made without transparent risk frameworks and with delayed or inconsistent adoption of scientific evidence.

The lived experience of Long Covid patients highlights gaps in service provision, recognition, and accountability, including with the still outdated Interim Model of Care and the ending of Special Leave with Pay. Addressing these issues is not only a matter of justice for those affected but is critical for strengthening Ireland’s preparedness for future public health crises.

We also wish to draw the Evaluation’s attention to LCAI’s presentation to the Oireachtas Committee on Health in 2024, which provides further context and first-hand testimony from

people living with Long Covid. We hope this submission, alongside that presentation, contributes constructively to the Evaluation's goal of learning lessons and improving Ireland's public health response, particularly for those most affected by Long Covid. **We would welcome the opportunity to meet with the Independent COVID-19 Evaluation Team to discuss our submission and provide further evidence.**

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