EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HEALTH AND FOOD SAFETY

Public health
**Health Security**

Luxembourg, 26 January 2022

**Health Security Committee**

**Audio meeting on the outbreak of COVID-19**

**Summary Report**

**Chair**: Head of Unit, European Commission, DG SANTE C3

**Audio participants:** AT, BE, BG, CZ, CY, DE, DK, EE, ES, FI, FR, HU, HR, IE, IT, LT, LU, LV, MT, NL, PL, PT, RO, SE, SI, SK, NO, IS, LI, DG SANTE, DG MOVE, DG ECHO, DG JUST, DG ENER, DG HR, HERA, COUNCIL, ECDC, EMA

**Agenda points:**
***EU/EEA only***
1. HSC recommendation on quarantine and isolation – discussion point
2. Outcomes of the joint HSC-eHN technical SG meeting and further steps regarding the revisions of the EU DCC – information/discussion point
3. Council Recommendation – Presentation by DG JUST
4. AOB: Observatory on the Supply of Medical Radioisotopes – presentation by DG ENER

**Key messages:**

**1. HSC recommendation on quarantine and isolation**

The Commission is in the process of updating the HSC document on recommendations on the duration of quarantine and isolation. The document was shared with the HSC and a few countries sent comments in writing. More comments were received orally during the meeting. The Commission will compile all comments with the ones already received, and will circulate a new version for the approval from the HSC.

**2. Outcomes of the joint HSC-eHN technical SG meeting and further steps regarding the revisions of the EU Digital COVID Certificate – information/discussion point**

The EU Digital COVID Certificate Regulation, which entered into force on 1 July 2021, applies until 30 June 2022. Therefore, the Commission is preparing a legislative proposal to extend its validity. Apart from this extension, the proposal will also address specific issues that have arisen in the context of the application of the EU Digital COVID Certificate. To support the preparation of this proposal, the Commission circulated a second survey to the HSC, aiming to seek their views on the following topics: (1) Issuance of EU DCC

vaccination certificates for individuals participating in clinical trials; (2) The validity period of the EU DCC recovery certificate; (3) The validity period of EU DCC vaccination certificates (primary series) for under 18 year olds; (4) Use of antibody tests for issuing the EU DCC recovery certificate; and (5) Acceptance of EU DCC vaccination certificates from non-EU authorised vaccines. Based on the outcomes of the two EU DCC surveys, as well as the discussions that took place during the HSC meetings, an internal document will be prepared by the Commission on the conclusions and main points raised. This document will be circulated to the HSC for review and agreement, and will feed into the ongoing Commission processes in the context of the EU DCC Revision.

**HU** stressed the need to accept WHO COVID-19 listed vaccines, not just EMA-approved vaccines in the EU. This remains particularly a problem for HU, as a large part of the Hungarian population received the Sinopharm (produced in China) or the Sputnik (produced in Russia) vaccine. The **Commission** is aware of the problems encountered by HU. Therefore, a specific question related to this issue was added in the questionnaire. Discussions are ongoing within the Commission on the possible extension of the EU Digital COVID certificate. Once published and adopted by the Commission, the proposal will be further discussed in the European Council and in the Parliament.

**ES** supports the proposal of HU. ES emphasized that vaccine acceptance should not be based on a marketing strategy but on the quality of the vaccine. Regarding the validity of recovery certificates, this should be based on the probability of reinfection, which is generally low. However, in recent months, more reinfections have been recorded. Nonetheless, it is too early to change the validity of these certificates, as not enough data is available. The **Commission** replied that it had several conversations with the ECDC on this subject, during which the ECDC also informed the Commission that at this stage, there is not enough evidence/data available to modify the recommendation.

### 3. Council Recommendation – Presentation by DG JUST

On 25 January, the Council adopted the Council Recommendation 2022/107 (previously known as 2020/1475) on the coordinated approach to facilitate safe, free movement. The new recommendation focuses on a more **persons-based-approached**, moving away from a country-based-approach for the purpose of travel. Individuals with a valid **EU Digital COVID Certificate** should, in principle, not be subject to additional restrictions, regardless of their place of departure in the EU. The validity of vaccination certificates was specified in the Delegated Act adopted on 21 December 2021. The **EU traffic light map** has also been adapted. The map is now mainly for information purposes but also serves to coordinate measures for areas with particularly high level of virus circulation. The emergency brake procedure has been simplified and can be triggered by either Member States taking additional measures, or by the Commission based on ECDC surveillance. The new Council Recommendation will enter into force on 1 February 2022, aligned with the delegated act on validity of vaccination certificates.

### 4. AOB: Observatory on the Supply of Medical Radioisotopes – DG ENER

**DG ENER** informed the HSC about the High Flux Reactor outage. The operator of the High Flux Reactor in Petten, Netherlands, did not resume operations as planned on 20 January 2022, due to the detection of a water leak in the reactor beam tube cooling system. The High Flux Reactor outage can impact the supply of molybdenum-99 and lutetium-177 (used for certain medical treatments) in the coming week/s. **Medical institutions should contact their radioisotope suppliers to determine the specific impact on their orders**. The Commission will further inform the HSC once additional information is available. The Commission will share a document with the HSC for distribution to their national medical institutions.

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***EU/EEA countries and observers* - the meeting brought over 100 participants together**

**Agenda points:**

1. Omicron epidemiological update and the 19th update of the ECDC Rapid Risk Assessment: "Assessment of the further emergence and potential impact of the SARS-CoV-2 Omicron variant of concern in the EU/EEA"– presentation by ECDC
2. The managing of COVID-19 cases in school settings – presentation by MS - discussion point
3. AOB: Swine-origin reassortant influenza A/H1pdm09N1av-like virus disease – presentation by DK

**Key messages:**

1. **Omicron epidemiological update and the 19th update of the ECDC Rapid Risk Assessment: "Assessment of the further emergence and potential impact of the SARS-CoV-2 Omicron variant of concern in the EU/EEA"– presentation by ECDC**

ECDC provided an overview on the most recent epidemiological situation. At the end of week two (16 January), the overall epidemiological situation in the EU/EEA was characterised by a high overall case notification rate which has increased rapidly in the past three weeks and an elevated but stable death rate. While the rapid spread of the Omicron variant continues, both Delta and Omicron are co-circulating, with reported cases due to Omicron that are younger than those due to Delta. Vaccination coverage in the eligible population is 80.9% and data still shows that vaccination results in the prevention of severe disease and death. Vaccination coverage in the total EU/EEA population is 69.4%, which at the moment is insufficient to stop transmission. There are still large gaps in the uptake of a full vaccination course across all EU Member States, with coverage ranging from 28.2% to 82.7%

On 26 January, ECDC published the 19th update of the Rapid Risk Assessment on COVID-19. The Risk Assessment has gone through the Advisory Forum consultation, with a lively debate among Member States. Although the risk of severe disease appears to be lower, the large number of cases could lead to an increase in hospitalisations and further burden the healthcare systems. Due to the very high circulation of Omicron in most EU/EEA countries, the probability of infection for the EU/EEA population in the coming weeks is considered to be very high. Very large numbers of mild cases cause societal disruption due to staff absences in all sectors, including shortage of healthcare workers. Additionally, measures to counter disease spread, e.g. quarantine of contact persons, add to the societal disruption. DK reported an increasing trend of BA.2 in recent weeks, approximately 50/50 proportion between BA.1 and BA.2. Data shows that this Omicron sub-lineage might be increasing in proportions in some other countries too.

ECDC recommends focusing on completing primary vaccination and administering booster doses, as well as maintaining non-pharmaceutical interventions. ECDC also recommends adapting the strategy from one focused on managing transmission of SARS-CoV-2 to one that aims to manage the outcomes of COVID-19, by balancing an acceptable level of COVID-19 hospitalisation and mortality, against an acceptable level of non-pharmaceutical interventions, given their societal impact. In order to successfully transit into what may be a post-acute phase of the pandemic, is to ensure access to COVID-19 vaccination and to protect vulnerable groups.

## 2. The managing of COVID-19 cases in school settings – presentation by MS - discussion point

The Commission noticed two different selective exchanges in the Early Warning and Response System related to: 1) the management of contacts and 2) on the use of masks in school settings. LU, SK, NL and IT presented their current guidelines and different scenarios in school setting related to quarantine, testing, contact tracing, and the use of face masks. Other Member States communicated their current measures in writing. The Commission will compile all information and will share this in single document with the HSC.

**LU** reported a lot of cases among the school age population. The higher incidence rate is mainly driven due to the Omicron variant. LU noticed a strong decoupling from high case rates in the population while hospitals/ ICU/ deaths remain low. Currently, LU has a voluntary antigen testing scheme for pupils in place. Quarantine and isolation measures are also in place, facemasks are mandatory in primary and secondary schools, the vaccination rate for pupils aged 15 to 19 years old is above 80%. A 3G EU Digital COVID Certificate is in place for teachers.

**NO** is focusing on keeping schools open, with different levels of measures depend on the situation, and also include regular testing. At this point, NO believes it is necessary to discuss the value of all measures in schools, since the infection in children is very mild or asymptomatic, while the measures themselves have consequences for children. NO questions if it is really useful to focus on the measures in schools given the current situation where transmission in the society, as well as among vaccinated, is quite high. **LU** experiences the same problems as NO, most cases are very mild or asymptomatic among this age group. However, politically, it is very difficult to reverse these measures, as the general level of incidence should not get too high to jeopardise the system. LU believes it is important to keep the measures in place for the time being, but agrees with NO that there is a need to continue discussing lifting these measures. Both **NO** and **LU** agreed that by maintaining regular testing in schools and not in the general population, this automatically draws attention to the high prevalence in schools as many asymptomatic cases are detected, whereas this is not the case for the rest of society.

**HR** asked which type of test (nasal or saliva) are being used in the schools. **LU** is using nasopharyngeal swabs.

**IE** recently eased COVID-19 restrictions but maintained current precautions in schools. The reason for this is that parents with children aged 5 to 11 years old have the opportunity to have their children vaccinated. IE might discontinue these efforts after February, as the rationale for doing this will be reduced.

The **Commission** asked how contact-tracing is carried out by LU. **LU** explained that they have an online declaration procedure in place. In addition, LU does not oblige vaccinated individuals to quarantine, which also reduces the contact-tracing activities.

**SK** presented its current guidance for schools. SK has implemented a three-phase system (green/orange/red) to monitor the epidemic situation in schools. Measures for prevention of spread are in place (e.g. facemasks, hand hygiene, physical distancing, etc.), children have the option of using voluntary self-tests at home (recommended twice a week), unvaccinated staff are required to be tested every 7 days, vaccinated/recovered staff only when showing symptoms, schools are required to report the COVID-19 situation every Monday, and a campaign to vaccinate school staff and college students is in place.

In the **NL**, teachers and students must quarantine after contact with a detected case of COVID-19, regardless of their vaccination status. Exemptions are in place for people who have recovered from a COVID-19 infection within the last eight weeks, people who have received a booster dose, everyone under 18, and people 18 years and older working at daycares, primary and secondary education. The NL advises to wear medical facemasks in schools, however, this is not a requirement. Students and teachers are advised to test themselves frequently, preferably twice a week. In the event of a major outbreak in a school, the local health authorities advise on the health measures to be taken.

**IT** provided an epidemiological overview and presented the COVID-19 school measures currently in force. School measures depend on the vaccination status of the exposed individuals and the number of identified cases. On December 16, IT started vaccinating children aged 5-11 years old. The percentage of outbreaks in schools has remained consistently low, schools do not represent the top three transmission contexts in Italy.

**HR** asked if close contacts who have recently recovered are exempt from quarantine. **IT** mentioned that recovered and vaccinated students follow the same rules. If someone has recovered from COVID-19 within the past four months, they do not need to be quarantined.

Some Member States have communicated their current rules for schools in writing. The Commission will compile all the data and share the document with the HSC.

### 3. <u>AOB: Swine-origin reassortant influenza A/H1pdm09N1av-like virus disease – presentation by DK</u>

Denmark reported a severe human case of Swine-origin reassortant influenza A/H1pdm09N1av-like virus disease in Early Warning and Response System. The case occurred in late November 2021. Extensive clinical and laboratory examinations were carried out. The only single diagnostic finding was an airway swap sample, which showed positive for influenza A at the local microbiology laboratory. All of the genes, except the NA and NS genes, were derived from influenza A virus subtype H1N1pdm09 virus of swine origin. The case is considered sporadic, thus with no known person-to-person onward transmission or evidence of local community transmission detected. Further analysis of the zoonotic potential of the virus is ongoing, as well as the collection of additional clinical details. Coordination meetings have been held between national human and veterinarian health authorities.