EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HEALTH AND FOOD SAFETY

Public health
Health Security

Luxembourg, 09 February 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, CZ, CY, DE, DK, EE, EL, ES, FI, FR, HU, HR, IE, IT, LT, LV, MT, NL, PL, PT, RO, SE, SI, SK, NO, IS, LI, DG SANTE, DG MOVE, DG ECHO, DG JUST, DG HR, HERA, SG, COUNCIL, ECDC

EU/EEA only

Agenda points:

1. Update on the epidemiological situation in the EU/EEA – presentation by ECDC
2. Joint Action to Strengthen Health preparedness and response to Biological and Chemical terror attacks (TERROR) – information point from the Norwegian joint action coordinator
3. Transmission of SARS-CoV-2 Omicron VOC sub variants BA.1 and BA.2: Evidence from Danish households – presentation by Denmark
4. Paper on response to new emerging VOC "Discussion points for initial lessons learnt from the EU/EEA response to the Omicron Variant of Concern" - presentation by ECDC - discussion point
5. Issuing recovery certificates based on rapid antigen tests – presentation of ad hoc survey results and discussion in view of a forthcoming delegated act
6. Validity period of vaccination certificates for children and youth <18 years of age – up-date on Member States' view
7. EU4Health Work Programme 2022 – information point by DG SANTE, HERA and ECDC

Key messages:

1. <u>Update on the epidemiological situation in the EU/EEA – presentation by ECDC</u>

The overall epidemiological situation in the EU/EEA was characterised by a very high overall case notification rate that has increased rapidly in the past six weeks and an elevated but stable death rate. As of 28 January, the epidemiological situation in the EU is of very high concern. The Omicron variant of concern is now dominant in most countries. Vaccination coverage in the total population is 70.1%, which remains insufficient to stop transmission. There is still considerable variation in full primary vaccination coverage across Member States in the targeted population, which ranges from 28.8% to 83.5%.

The **Commission** asked ECDC which countries have exceeded the peak of the Omicron wave. **ECDC** responded that so far, based on the combined indicator index used by ECDC, five countries (ES, FI, SE, SK, NO) have moved to a lower category. ECDC recommended having a look at the weekly country overview. At EU level, ECDC expects notification rates to continue increasing until weeks 5 or 6.

2. Joint Action to Strengthen Health preparedness and response to Biological and Chemical terror attacks (TERROR) – information point

Joint actions are funding instruments, designed and financed by Member State authorities and the Commission to address specific priorities under the EU Health Programme. Joint Actions have an EU added value – they are expected to contribute to solving problems at the European level, and to have a greater impact than single national activities. The need for this particular Joint Action to Strengthen Health preparedness and response to Biological and Chemical terror attacks (TERROR) has been discussed in previous HSC meetings and was prompted by cases of terrorist attacks in Europe.

The Joint Action TERROR – launched in 2021 - is coordinated by Norway with 31 participants from 17 EU/EEA countries and Serbia, receiving 5 million € EU co-funding. The objectives of the Joint Action include addressing **gaps in health preparedness** and addressing the urgent need to strengthen **cross-sectoral work with security, civil protection and health sectors**. The Joint Action cooperates with several EC Directorates General, including DG HOME, DG ECHO and HERA. To reach its objectives, further networks, partners and engagement from countries are needed. The Commission will send a survey to the HSC members to identify relevant stakeholders in their countries for engagement with this Joint Action.

ES is one of the coordinating countries involved in the Joint Action work packages. The Joint Action TERROR builds on many discussions that began before the start of the pandemic. Many activities have attempted to increase cross-sector cooperation regarding the intentional use of biological and chemical terrors in different scenarios. ES encourages countries to increase their interest in this Joint Action.

FI welcomed the presentation. FI asked whether the rescEU actions and the call for chemical, biological, and nuclear threats are related to the Joint Action TERROR.

The **Commission** replied that DG ECHO also cooperates with the Joint Action. The TERROR Joint Action was planned and conceived before COVID-19. As part of the response to the pandemic, RescEU came into place, mandates changed and soon there will be a completely new cross-border framework for health threats. With the involvement of DG ECHO and HERA, it can be ensured that the Joint Action will take into account all new developments.

3. Transmission of SARS-CoV-2 Omicron VOC sub variants BA.1 and BA.2: Evidence from Danish households – presentation by Denmark

Denmark carried out a study on the transmission of the Omicron sub variants BA.1 and BA.2 with different scenarios, immunity status and households. The study shows that vaccines work, and boosters work better against the new Omicron variant. Unvaccinated individuals seemed more susceptible and more infectious, while individuals who received a booster are less susceptible and less infectious, compared to fully vaccinated individuals (primary course). According to the study, the omicron sub-lineage BA.2 is inherently substantially more transmissible than the BA.1 sub-lineage. It also possesses immune-evasive

properties that further reduce the protective effects of vaccination against infection, but do not increase transmissibility from vaccinated individuals with breakthrough infections.

ES asked for more information about the study population, including the socioeconomic status, the number of people in the households, and the different ages in the households, given that these can influence the outcomes of the study.

DK presented the information that ES requested. It mentioned that more households with BA.1 were involved in the study; but the other characteristics were extremely comparable.

IE asked if DK has any evidence regarding individuals infected with BA.1 and the chances of getting re-infected with BA.2. **DK** clarified this specific question was not studied within the scope of the study.

4. <u>Paper on response to new emerging VOC "Discussion points for initial lessons learnt from the EU/EEA response to the Omicron Variant of Concern" - presentation by ECDC - discussion point</u>

Following the discussion on 2 February on "transitioning beyond the acute phase of the COVID-19 pandemic", which reflected the risks, as well as necessary steps to take for transitioning to a longer term disease management of COVID-19, the ECDC prepared a second discussion paper on "initial lessons learnt from the EU response to the OMICRON variant of concern". This second paper should be the starting point for debate among Member States, to consider the appropriate response to take in the case that a new variant of concern is detected.

The aim of the ECDC is to identify and discuss initial lessons learnt from the first days of the emergence of the Omicron variant of concern and give member States the opportunity to reflect, share experiences and identify areas of good practice and areas for further strengthening. ECDC identified three categories to facilitate for a joint discussion among Member States: 1) detection and characterisation of new variants; 2) coordination of response measures; and 3) communication. ECDC also suggested best practices for in- and after-action reviews, including: 1) holding a workshop dedicated to lessons learnt from EU/EEA responses to the Omicron Variant of Concern; 2) involvement of partners and stakeholders, also outside the health sector; 3) jointly identifying lessons-learnt from the response to the Omicron wave and agree on actions to strengthen preparedness for the potential emergence of a new variants of concern. Member States welcomed the paper of the ECDC, but mentioned they needed more time to prepare for such a discussion. Member States will provide answers in writing.

IE thanked ECDC for starting the discussion. IE will come back with comments in writing.

AT welcomed the ECDC document and noted there were several points missing in the document, including human resources and preparedness. **ECDC** responded that it omitted questions about general lessons learnt related to COVID-19, and focused only on the response to the Omicron variant of concern.

SE welcomed the discussion regarding lessons learnt from the response to Omicron and thanked the ECDC for developing the paper. SE emphasised the importance of focusing on the new phase the pandemic is entering, which needs to assess carefully the proportionality and risk-benefit balance of measures. SE perceives the suggested dedicated workshop as a good way forward.

DE thanked the ECDC for the document and underlined the importance of being better prepared for a possible next wave.

The **Commission** will collect the comments from HSC representatives in writing.

5. Issuing recovery certificates based on rapid antigen tests (RAT) – presentation of ad hoc survey results and discussion in view of a forthcoming delegated act

The Commission initiated preparatory work for a delegated act that would allow for the issuance of RAT-based recovery certificates. The Commission sent out an invitation to the EU/EEA representations, asking them to nominate experts to represent national authorities in an EU Expert Group meeting on the EU Digital COVID Certificate. On 10 February, the expert group will meet to have a first discussion on the possible delegated act. In preparation for this meeting, the Commission circulated a short survey to the HSC addressing specific questions linked to the possible delegated act, including the duration of issuance, possible additional data fields needed, scope, and the validity period of recovery certificates based on RAT.

DE has not reached the Omicron peak yet and is expecting to reach it in the next couple of weeks. Given the current situation, DE's available laboratory PCR-test capacities are limited. It remains unclear if there will be enough PCR-tests in the coming weeks. DE will continue to make use of the PCR-tests as much as possible, but welcomes the possibility to use RAT-tests if they run out of PCR-tests. A change in the regulation might also be useful for possible future waves. DE agreed that the use of the RAT-tests should be based on the HSC RAT common list.

ES mentioned that, to simplify the issue, it might be helpful to look at the certificates from an acceptance perspective rather than from an issuing perspective.

FI supports issuing recovery certificates based on RAT-test. In FI, RATs are widely used in the northern part of the country due to long distances and logistical challenges related to PCR-testing. If accepted, FI would like to be able to issue such recovery certificate to citizens who have tested positive with a RAT test in the past six months for those who still wish to receive such certificate.

IE mentioned the need to emphasise that in the case of acceptance, the recovery certificates can only be based on **professionally** taken RAT-tests. IE disagreed with ES, and suggests keeping the perspective on issuing such recovery certificate.

The **Commission** responded that RAT-tests are already used to issue a EU Digital COVID Certificate based on COVID-19 tests, but only those on the RAT-tests HSC common list. Therefore, it would make sense to allow such test also for the recovery EU Digital COVID Certificates.

AT asked whether it would become mandatory for AT to accept RAT-based recovery certificates for entry into their country of if it would be voluntary to issue or accept such certificates at national level.

DG JUST mentioned that a meeting with the specific expert group will take place on 10 February. Article 3 of the regulation states that only trained medical professionals or trained testing professionals can perform the tests. If recovery certificates based on the RAT test are accepted, Member States will also

have to accept these recovery certificates issued by other Member States. DG JUST emphasized that the main issue is the lack of PCR-tests. In order not to deprive citizens of their rights to exercise the right to free movement if not enough PCR-tests are available, Member States will have the possibility to issue a recovery certificate based on RAT-tests. It would be possible to specify that when a country has enough PCR-tests, recovery certificates should not be issued based on RAT-tests.

EE is in favour of moving this delegated act rather quickly in order to have the possibility to issue recovery certificates based on RAT-tests. When it comes to the validity period of the certificates, EE experts have different opinions. As long as there is no scientific evidence available, it might be better to keep the current validity period for the moment.

The **Commission** will collect any further comments in writing.

6. Validity period of vaccination certificates for children and youth <18 years of age – up-date on Member States' view

As part of the preparatory work for the adoption of a delegated act linked to the EU Digital COVID Certificate, the Commission is assessing whether the validity period of vaccination certificates for children and youth (<18 year olds) should be changed. This topic will also be discussed at the EU expert group meeting on the Digital COVID Certificate on 10 February. During the HSC meeting, the Commission asked for Member States' view regarding the possibility for a different validity of vaccination certificates for children/youth under 18 years of age from the 270 days validity established in the delegated act that entered into force on 1 Feb 2022. Some countries welcomed the discussion and explained the national policies regarding booster doses offered for adolescents. The approaches taken by member States differ, however, a few countries voiced support for not setting a validity period for children's/youths' vaccination certificates.

DE has implemented a national booster vaccination recommendation for children aged 12 to 18, but not for children under 12.

The **Commission** is aware that DE and LU have implemented national recommendations for booster vaccination for children, and is aware that BE and NL do not plan to give booster doses to children under 18 at this stage.

FI supports such a delegated act. In FI, boosters are recommended only to adolescents over 12 years of age with severe immunocompromising illnesses.

In **EE**, booster dose recommendations for children under 18 have been discussed. Also with regard to holiday plans: parents want to know whether their children's certificates would still be valid. The Estonian government has decided to extend vaccination certificates for children under 18. EE is in favour for a common agreement on this subject, in order to avoid travel disruptions.

IE supports having no validity period for children that have completed a primary course of vaccination.

SE does not recommend a booster dose for children below 16 years. SE does not recommend vaccination for children between 5 and 11 years old, but this might change.

In **LT**, booster doses are available for persons over 18 years of age; they are not given to children. LT currently determines that children are issued a vaccination certificate for unlimited time after the primary vaccination scheme. It would be important to have an EMA position on booster doses for children. The **Commission** mentioned that an EMA recommendation is expected at the end of February or early March.

In **FR**, children between 12 and 18 years old are eligible for a booster dose. A booster dose is not mandatory and therefore does not influence the validity of the vaccination certificate.

CY supports a different rule regarding the validity of vaccination certificates for under 18. CY currently only administers booster doses to young adults over 18.

The **NL** will soon discuss a different validity period of vaccination certificates for people under 18. Therefore, the NL welcome a survey on this topic.

BE has no validity period for vaccination certificates for minors under 18 years old. BE is awaiting a recommendation from the EMA. Booster doses are permitted for children under 18 with parental consent, e.g. for travel purposes.

SE stopped use of the EU Digital COVID Certificate at the border. SE does not administer booster doses to children and adolescents at this stage.

DG JUST clarified that for the time being, the EU Digital COVID Certificate mainly concerns minors between 12 and 18 years old. Children under 12 years should be exempt for such certificate according to the current recommendations.

NO does not recommend a booster for minors under 18 years of age. NO does not recommend a full primary vaccination for children under 16 years of age without individual increased risk of severe disease. Due to the different vaccine strategies for children in Member States, and to avoid restrictions in movement for children and adolescents without a clear public health rationale, NO would be in favour for a common approach regarding an age limit of 16 or 18 years for the use of EU Digital COVID Certificate. NO would be in favour of making an exception regarding the validity period for vaccination certificates for children and adolescents under 18 years of age.

7. EU4Health Work Programme 2022 – info point SANTE, HERA and ECDC

The Annual Work Programme 2022 implementing the EU4Health Programme has been published. Colleagues from SANTE, HERA and ECDC introduced the actions on crisis preparedness to the HSC. These are:

- Direct grants to Member States' authorities in relation to the implementation of antimicrobial resistance measures (joint action);
- A call for proposals for projects to support Member States and other relevant actors to implement relevant results of innovative public health research in relation to vaccination against COVID-19;
- A direct grant agreement with WHO to support its work in protecting people in the Union and its neighbourhood from serious cross border health threats;
- Direct grants to Member States' authorities to enhance whole genome sequencing and/or reverse transcription polymerase chain reaction (RT-PCR) national infrastructures and capacities to respond to the COVID-19 pandemic and future health threats; and

- A call for proposals to support structured dialogue at national or regional level on public procurement in the health sector.

In addition, several calls for tender will be launched, concerning an ever-warm facilities (EU FAB) for vaccines and therapeutics production; procurement of vaccines against infectious disease threats such as pandemic influenza; IT development for early warning, modelling, simulation, and forecasting and market research and mapping of innovative diagnostic testing solutions.