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DIRECTORATE-GENERAL FOR HEALTH AND FOOD SAFETY

Public health
Health Security

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Health Security Committee

Audio meeting on the outbreak of COVID-19

Draft Summary Report

Chair: Stefan Schreck, European Commission, DG SANTE C3

Audio participants: AT, BE, BG, CZ, DE, DK, EL, ES, FI, FR, HU, IE, IT, LT, LV, MT, NL, PT, RO, SE, SK, IS, NO, CH, UK, AD, AL, RKS, UA, MD, DG SANTE, DG ECHO, DG MOVE, DG JUST, ECDC, WHO

Agenda points:

1. Update on the Delta variant – information point
2. ECDC Public health guidance – discussion point
3. New incidence indicators – discussion point
4. Information on the acceptance of certificates by third countries – information point
5. Preparation plans for the re-opening of schools – discussion point
6. AOB: Clinical trials – information point
7. AOB: Outbreak of SARS-CoV-2 in mink farm

Key Messages

1. Update on the Delta variant - information point

The ECDC gave an update on the variant situation in the EU/EEA. Sequencing activities are high in Western Europe compared to Eastern Europe. The **Delta** variant has now been dominant for a few weeks, the median for all cases sampled is **94.4 %.** The Alpha and Gamma variants are still present but Delta remains the variant of concern. ECDC reminded Member States to continue with the surveillance of variants, including for the purpose of detecting emerging variants. The ECDC is working with the WHO and other global partners to detect new variants and to understand the impact of the dominance of the Delta variant on the pandemic and on public health measures. There were no changes to the assessment of other variants of concern and no other variants have changed their classification in the last week.

DE asked the ECDC if they had any information on the **B.1.621** variant (first detected in Colombia). The ECDC confirmed that the B.1.621 variant was detected in early 2021 and the ECDC considered this as a variant of interest in the spring of 2021. There were some outbreaks, mainly in Belgium and it is currently present at low levels in the United Kingdom. The main driver for the spread of this variant is the epidemiological situation in South America. This variant is currently being discussed in the WHO group on variant evolution. There is limited laboratory and epidemiological evidence for further conclusions on this variant at the moment.

On this point, **ES** commented that the B.1.621 was first detected in Spain at the end of January 2021, with outbreaks linked to people coming from South America. The outbreaks were controlled but there have been more sporadic cases linked to migrating people. Currently there is an outbreak in one of the Canary Islands of cases linked to this variant, almost 50 % being linked to it. The variant is not of major concern in ES at the moment.

IT asked other MS on their measures for quarantining cases and close contacts of cases sequenced with the **Beta** variant. IT wanted to know what measures for isolation were in place and for how long contacts needed to be quarantined. In the case of **DE**, the same measures apply as with the Gamma variant, if a person has been in contact with a Gamma variant case, the quarantine is longer than for other variants. ES keeps the same quarantine for everyone because the sequencing data usually arrives after the contact has ended their isolation period.

2. ECDC Public Health Guidance – discussion point

In the context of public health management of COVID-19, **IE** requested the ECDC to provide a state of play on the need to update its guidance based on an assessment of contact tracing and close contact management guidance, especially with the surge of the Delta variant. The **ECDC** gave an overview on the different type of guidance it has been issuing and updating, especially on contact tracing. There will be an update on their surveillance guidance which will be published by the ECDC at the end of August. The ECDC asked Member States if there was a need to consider other topics for which they could issue guidance, or any areas where the ECDC could give support. On this, IE expressed interest in having guidance on contact tracing of individuals who have been vaccinated and any contacts with fully vaccinated people.

3. New incidence indicators – discussion point

In the context of the changing nature of the pandemic, there appears to be recent public discussions in Member States on their future approaches to **monitor the epidemiological situation** of COVID-19. With the increasing rate of vaccination, a 'pure' indicator on incidence may not be fully satisfactory for Member States' information needs. The **ECDC** presented on different aspects to take into consideration for changing the indicators to capture the pandemic. Compared to last year, the ECDC has started to use a set of combined indicators which correspond to what is recommended in the Council Recommendations 1475 and 912. The ECDC is trying to use the indicators to get a better description of the current epidemiological situation, especially by looking at **severity** and **incidence** in older populations. Discussions are ongoing to include other sets of indicators to get a more complete image of the situation, including the **notification rate**, the **test positivity rate**, the **rate of infection in older age groups**, the **ICU rates** and **mortality rates**. The ECDC will also introduce indicators such as vaccination coverage by country and by age group. Other considerations need to be taken into account to capture a Member States' epidemiological situation and mainly to decide on public health measures, especially the proportion and impact of variants of concern. The ECDC stressed that the type of interventions Member States introduce based on their epidemiological situation should depend on the behaviour and acceptance of measures, on the health care capacity and to take note of any changing epidemiological situation. Each Member State should also consider their guidance on which tests should be counted to allow for better comparability across the EU. The ECDC also commented that more testing corresponds to better changes for control and it should continue across Member States. At the same time, for surveillance and assessment purposes, it is important to define a population under surveillance and use as a numerator only cases that have been tested according to common criteria.

Before the meeting, the HSC was asked to report on their latest state of play on the discussion of possible future use of indicators and on the combination of indicators to measure the epidemiological situation. The majority of Member States reported that **discussions are ongoing** on the possible changes to indicators. The majority of Member States indicated that they still rely on the indicator of incidence as the primary indicator to describe their epidemiological situation. The COMM urged Member States and the ECDC to consider a set of indicators more focused on disease severity for capturing the

epidemiological situation and stressed the importance of strengthening surveillance of new variants and vaccine breakthrough cases.

NL gave a presentation on their work in re-assessing the indicators used to measure the incidence rate, especially in considering a broader set of indicators. Some examples include: evaluating test positivity, the need to include increased immunisation either through infection or vaccination, evolving testing strategies, different variants with different risk levels and the different responses to the new variants of concern. NL argued that the goal should be to ensure an effective response to the health crisis and have a coordinated approach for analysing the risk assessment within Europe.

EL raised one issue related to the incidence indicators, especially by focusing on the summer and holiday season where come countries experience geographic localities with higher population densities. EL asked for what other MS are doing in terms of increasing their testing capacities for the summer and especially how to measure the incidence in places with high amounts of tourists. EL expressed concern over the fact that case numbers are still largely the benchmark for identifying the epidemiological situation for each MS and there needs to be more effort into looking at different indicators including ICU rates, death rates, and vaccination and testing rates. Discussions are ongoing in EL to include indicators between vaccinated and unvaccinated individuals in order to better make comparisons, predictions, and modelling for indicators to also help the vaccination campaign.

ES added that the surveillance of the COVID-19 evolution should be one of the disease indicators. Vaccination is a key indicator in ES but it explains the evolution and it will not help to follow up on the disease. ES agreed that there is a need to modify the approach at EU level for capturing the evolution of the pandemic, but test and incidence rates might not be of interest as there are different testing rates across the EU.

In **DE** it was decided to use more indicators, but this is the responsibility of all federal states. On 17 August, for example, one Federal State decided on a new ordinance which involves looking at multiple indicators on a four week basis in order to determine the measures needed to contain the spread of the virus.

FR continues to monitor indicators and provides weekly summaries. For FR the incidence rate is still relevant, and the analysis of it needs to be taken into the context and incidence remains a tool for the epidemiological situation.

DG JUST asked the ECDC whether their map displaying the incidence rate for each Member State should help MS to implement travel restrictions. The **ECDC** explained that the main goal of the surveillance is to inform the vaccination programs, to help Member States develop their public health interventions and inform modelling to understand and prepare public health systems. The map is also used to monitor variants of concern and the vaccine efficacy.

4. Information on the acceptance of certificates by third countries – information point

The **COMM** received a request from DE on the **acceptance of EU vaccination certificates** by third countries for the purpose of travel. The COMM is working with interested third countries that want to be linked to the EU Digital COVID Certificate (EUDCC). As a first step, CH was connected to the EUDCC. CH now has a formal commitment to the EU that it will accept certificates from all EU MS. The COMM is systematically asking third countries to commit to accepting certificates by the EU MS. Two additional equivalence decisions have been adopted with the Vatican and San Marino and the Commission has finalised the equivalence decisions for Turkey, North Macedonia and Ukraine. The adoption of these three new Decisions is scheduled for 19 August and Publication on 20 August. Other applications have been received from third countries including: Faroe Islands, Israel, the United Kingdom, Singapore, Morocco, Panama, Moldova, Armenia, and six East African countries.

DE asked the COMM for an overview of the countries in writing. DE also wanted to know how to give DE citizens coming from abroad and being vaccinated with licensed vaccines but not EU accepted vaccines (i.e. sublicensed vaccines) a EUDCC. The **COMM** clarified that DE may issue a EUDCC

based on proof that the national has received vaccination with any of the corresponding vaccines in a third country. The COMM also clarified questions on the technical issues by saying that the sublicensed vaccines are not yet coded in the system and they are working to finalise the list. The COMM added that this will be further discussed in the eHealth Network, especially on the updated guidelines to reflect coding of third country vaccines.

NO wanted to know what the COMM was doing in terms of equivalence of vaccines, especially in the context that many EU/EEA MS are administering heterologous vaccine schedules and some third countries do not recognise such a schedule as being fully vaccinated. The COMM clarified that the equivalence decision follows the same approach as with the EU MS and the **EUDCC** indicates the latest vaccination dose received. The COMM has also sent a questionnaire to third countries on the acceptance of EU tests and recovery certificates.

PT raised the issue of people previously infected with COVID-19 entering a third country where their recovery certificate and one vaccine dose might not be enough to get exempted from quarantine. The COMM replied that some MS do not recognise one dose of vaccine for recovered patients for waiving travel restrictions; however, this may be added to the list of questions sent to third countries (that should be analysed by MS in the context of equivalence decisions), knowing that the main criteria are related to technical interoperability. DG JUST added that in the frame of the equivalence decision the implementation act needs to be done according to the Regulation.

The **COMM** also raised the issue of booster vaccines and how to code booster vaccines in the **EUDCC**. Solutions to this will be proposed during to the eHealth Network as several Member States are preparing to administer booster doses. On heterologous vaccination, including EU authorised/non EU authorised vaccines, one could continue with the current approach of accepting the heterologous vaccination for waiving travel restrictions as long as this is the vaccination policy of the Member State of origin and showing the last vaccine. EMA and ECDC have some information on effectiveness of heterologous vaccines, but not enough on the combination of EU authorised and non EU authorised vaccines. EC also underlined that the current regulation only allows EUDCC to include information for last vaccine, and not a full path and that any change (e.g. to show all the vaccines on the same QR code) would require a delegated act (not possible before end September – October, in best case scenario) and it is not clear how to deal with already issued certificates. Moreover, one should define rules for interpreting heterologous vaccination (which may be very complex in the absence of strong evidence); the absence of such rules could lead to arbitrary decisions of border guards/those checking the certificates. No reactions of MS were made.

5. Preparation plans for the re-opening of schools – discussion point

Given that the **school season** is approaching, the COMM asked MS on their plans for re-opening of schools. **IT** has in place rules and measures for re-opening schools including obligatory face masks, physical distance measures, measures for the entrance/exit of schools/universities to avoid large gatherings, alternation of class schedules, sanitation and cleaning protocols. All workers and university students must present a EUDCC to access facilities. Discussion in IT is ongoing to provide free testing at schools in specific situation, and local authorities may apply waivers for mask wearing in which all students have completed vaccination schedule or have a recovery certificate.

In **EL** 75% of all teachers have been vaccinated, for the remaining percent of teachers that are unvaccinated, testing twice a weeks will be mandatory, with the second test being paid by the teachers. The use of face masks is obligatory for all ages and discussions are ongoing for the scheduling of classes.

AD[1] presented their plans for re-opening of schools, including screening facilities in place at the entry of schools to carry out massive tests, weekly screenings using RAT offered to non-immunized students, mask use for anyone over the age of six. Vaccination of adolescents 12-15 will begin in September. School activities will be performed in 'bubble groups' of students belonging to the same classroom.

[1] Andorra.

The **ECDC** commented that they updated their guidance on the re-opening of schools on 8 July and are ready to support MS in re-opening their schools. Their latest guidance includes updated evidence for measures, transmission patterns, new and emerging data on the Delta variant. The aim of MS should be to re-open schools but with the appropriate measures in place such as using masks, distancing, cohorting classes and groups, and regular testing. The ECDC will update the guidance if needed.

DE asked MS on how they plan on dealing with positive cases and what the measures are for quarantining of positive cases and contacts. IT commented that at the moment they apply quarantine to all the class if there is a positive case. **AD** isolates just the close contacts. In cases where student do not where masks, for example classes of students six and younger, the entire class is isolated. In cases of three or more cases the whole class is isolated.

DE commented that the experience of last year where children were unable to attend their schools and day-care centres for months at a time has shown the devastating effects of school closures on the cognitive, but also on the social and emotional development of children and adolescents. On the other hand, science has made it clear that, thanks to the vaccination program, protection options now exist for a large part of the population. So far, it has not been shown that the delta variant does lead to more severe courses of disease in children and adolescents, although it is more contagious overall. The federal government is funding further ongoing studies to demonstrate the effectiveness of infection control measures in educational and care facilities. In particular, these should realistically assess the development of the health situation, including the psychological stress on children and adolescents caused by the contact restrictions.

AOB points

AOB – Clinical Trials

Back in July, the **COMM** sent a request to the HSC for input concerning the issue of COVID-19 vaccination certificates for **clinical trial participants**, to ensure that those persons are not disadvantaged due to their participation in clinical studies and to avoid a potential negative effect on present and future studies. However, now that the EU Digital COVID Certificate has been launched, more concrete questions are starting to arise. The COMM sent a survey to the HSC asking about the acceptance of vaccines and support for clinical trials. In 5 MS, a person participating in a clinical trial cannot receive a vaccine certificate. In five Member States the vaccination certificate would be issued to participants who have received a vaccine, not a placebo. Four Member States reported they would waive travel restrictions for holders of such vaccination certificates only if the certificates are issued for authorized vaccines (after the trial and after the authorisation procedure).

The **UK** commented on the usefulness of these replies and highlighted that the policy in the UK is that any clinical trial participants would be exempt from quarantine as long as there is proof that the individual participated in a clinical trial in an EU MS. The UK would therefore be interested in receiving further information from EU MS on the certification of clinical trial participants.

AOB: Outbreak of SARS-CoV-2 in a mink farm in Spain – information point

ES reported that there is a new outbreak in a **mink farm** in the Province of A Coruña in the Autonomous Region of Galicia. The case is currently under investigation and there are national protocols for controlling the mink farms and a procedure for sequencing. There is currently no sequencing information on the outbreak for this mink farm. ES will communicate the information once the sequencing data is available.