EUROPEAN COMMISSION
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 C ADV01

Audio participants: : AT, BE, CZ, DE, DK, EL, FI, FR, HR, HU, IE, IT, LT, LU, MT, NL, PL, PT, RO, SE, SI, SK, NO, CH, UK, SM, AD, AL, XK, DG SANTE, DG MOVE, DG JUST, DG HOME, COUNCIL, ECDC, WHO, PHIRI

Key Messages

1. **Surveys launched among EU countries regarding Council Recommendation 2020/912 and Council Recommendation (EU) 2020/1475 – information by DG JUST and DG HOME**

Directorate-General JUST and HOME presented two questionnaires to Member States circulated in the context of the Council's Integrated Political Crisis Response (IPCR) group. The questionnaires seek to have Member States' views on key aspects of Council Recommendation 2020/1475 (travel within the EU) and 2020/912 (travel to the EU). Replies by Member States are due by the week of 13 September, and the results will be presented during the next IPCR meeting on 20 September and during the HSC meeting on 22 September, 2021. The Commission thanked Member States in advance for their replies and encouraged HSC members to liaise with their counterparts in the IPCR for the replies to the questionnaires.

2. **Increasing uptake of COVID-19 vaccination**

On 31 August, European Member States reached its target of vaccinating 70 percent of its adult population. Yet, the daily increases in vaccination coverage are slowing down, with very small daily increases across Europe. On top of this, the vaccination coverage of specific professional groups, such as health care workers, differ in coverage across EU Member States. Therefore, several Member States are discussing measures on how to increase the uptake of COVID-19 vaccination. Measures range from vaccination incentives and campaigns, up to mandatory vaccination policies, which are imposed by some employers. Among them are not only hospitals, which require staff to be vaccinated if in contact with patients, but also large multi-national companies, which impose require that their staff is vaccinated at the workplace. To address these developments, and to generate exchange and discussion among Member States, there was a more extensive point on vaccination uptake during this HSC meeting with four interventions, which presented various aspects on vaccination hesitancy, how to increase vaccination coverage, and on mandatory vaccination policies among certain professional groups.

a. **The Population Health Information Research Infrastructure (PHIRI) for COVID-19**

PHIRI for COVID-19 is a European mechanism that aims at facilitating and supporting data-driven population health research and exchanges of best practices to support decision-making (the project is funded under the HORIZON2020). PHIRI analyses the **direct and indirect impacts** of COVID-19 on the population's health. PHIRI for COIVD-19 provides a health information portal to link different data sources and to use Pan-European data; it also provides for the exchange between countries on COIVD-19 **best practices and expertise**; and it promotes **interoperability** and tackles health information inequalities.

The PHIRI **Rapid Exchange Forum** established a sustainable infrastructure to support and facilitate rapid exchange between competent authorities for pandemic response and their advisors, researchers in the field and stakeholders (EU networks, ECDC, JRC, WHO) to manage the COVID-19 pandemic. The Forum facilitates:

- rapid responses to research and policy questions that are raised in countries
- to promptly disseminate internationally agreed guidelines, standards and reports
- to exchange (best) practices among countries regarding COVID-19
- to provide expertise to policy considering the shifting landscape of evidence

The PHIRI Rapid Exchange Forum also gathered information on **mandatory vaccination**. COVID-19 vaccination is mandatory for healthcare professionals in six EU/EEA MS (AT (in some provinces for (new) hospital staff) FR, HU, EL, IT, UK), for teachers in AT (in some provinces for (new) teachers) and IT, and is currently under discussion in HU. In EL, the vaccine is also mandatory for soldiers.

Rapid Exchange Forum meetings are held every Monday morning at 10:00h and HSC members are welcome to attend these meetings. Countries contribute to the topics addressed during these Forum meetings.

b. COVID-19 and mandatory vaccination: Ethical considerations and caveats – presentation by WHO

The World Health organization (WHO) published in April 2021 a policy brief on *COVID-19 and mandatory vaccination: **Ethical considerations and caveats**.* During the presentation, the WHO explained what "**mandatory vaccination**" entails. "Mandatory vaccination" is normally not entirely compulsory, i.e. force of threat criminal sanction are not used in cases of non-compliance. Still "mandatory vaccination" policies limit individual choice by making vaccination a condition of, for example, attending school or working in particular industries or settings, like health care. WHO does not presently support the direction of mandates for COVID-19 vaccination, having argued that it is better to work on information campaigns and making vaccines accessible.

Ethical considerations and caveats regarding mandatory COVID-19 vaccination mentioned by WHO:

- **Necessity and proportionality** - Mandatory vaccination should be considered only if it is necessary and proportionate to the achievement of an important public health goal identified by a legitimate public health authority. A mandatory policy would not be ethically justified if such a public health goal can be achieved with less coercive or intrusive policy interventions. Individual liberties should not be challenged for longer than necessary, so policy-makers should frequently re-evaluate the mandate to ensure it remains necessary and proportionate to achieve public health goals.
- **Sufficient evidence of vaccine safety** – Sufficient data is necessary to demonstrate the vaccine being mandated is safe in the population the vaccine is to be made mandatory. Policy-makers should

consider specifically whether vaccines authorized for emergency or conditional use meet an evidentiary threshold for safety sufficient for a mandate.

- **Sufficient evidence of vaccine efficacy and effectiveness** – Data on efficacy and effectiveness should be available to show the vaccine is efficacious in the population for whom vaccination is to be mandated and the vaccine is an effective means of achieving an important public health goal.
- **Sufficient supply** – In order for a mandate to be considered, supply of the authorized vaccine should be sufficient and reliable, with reasonable, free access for those for whom it is to be made mandatory - this is currently not a huge problem in Europe.
- **Public trust** – Policy-makers have to carefully consider the effect that mandating vaccination could have on public confidence and trust - it might affect both vaccine uptake and adherence to other important public health measures.
- **Ethical processes of decision-making** – Good governance – Legitimate public health authorities that are contemplating mandatory vaccination policies should use transparent and deliberative procedures. Mechanisms should be in place to monitor evidence constantly and to revise such decisions periodically.

Mandatory COVID-19 vaccination in context:

- **General public**: Vaccination mandates for general adult populations are rare. A mandate for vaccination of the public is considered necessary and proportionate to achieve intended public health goals. Policy-makers should still consider whether a mandate for the public would threaten public trust or exacerbate inequity for the most vulnerable or marginalized.
- **Schools**: Given the current lack of data on the safety and efficacy of COIVD-19 vaccines for children, COIVD-19 vaccines have not yet been authorized for children under 12 years of age. Mandates for routine paediatric vaccines are distinct from vaccines authorized for emergency use in many respects.
- **Health workers** – Mandatory vaccination most often discussed in the context of health and social care. Whether a mandate for health workers is necessary and proportionate will depend on the local context and should be investigated empirically before a mandate is considered for this population.

MT asked how the situation would change when the COVID-19 vaccines receive full rather than emergency vaccine approval. The **WHO** indicated that this is more of a legal change than an ethical one, as more than five billion doses of vaccine have already been administered worldwide, demonstrating significant evidence for the safety and efficacy of the vaccines. However, in many countries, legal mandates will depend on the full approval of the COVID-19 vaccines.

c. Behavioural aspects of COVID-19 vaccine hesitancy in the EU – presentation by ECDC

The **ECDC** has looked into **behavioral aspects** of the COVID-19 hesitancy in EU MS, focusing on the 3Cs (complacency, confidence, convenience) and their impact on vaccine decision-making. ECDC identified trends in vaccine hesitancy among different population groups (healthcare professionals, parents and adolescents, social vulnerable populations, the general population) and pointed out their drivers/barriers and needs to overcome hesitancy. Next steps should include: the development of context-specific strategies to foster and maintain **trust**; the creation of tools for **development** and **evaluation** of these strategies; **training** for healthcare professionals, civil society leaders, and professionals on the strategies; open-source database to provide **easy access to evidence** for Member States and local health authorities; and communities of practice to **facilitate continual learning** across Member States and local health authorities.

The **COUNCIL** asked if the ECDC has performed any subgroup analysis for different groups of healthcare workers (e.g. doctors, physio, nurses, care personnel, etc.). **ECDC** responded that they did analyse different groups of healthcare workers, mainly doctors, GPs, nurses.

MT asked if social media listening is used by ECDC to inform policies addressing vaccine hesitancy. Social media listening is not used by ECDC.

d. Experience of Member States with mandatory vaccination

IT and **FR** shared their **experiences** on mandatory vaccination policies for specific population groups.

Since 1 April 2021, COVID-19 vaccination has been mandatory in **Italy** for healthcare professionals working in public and private healthcare facilities, medical practices, pharmacies and parapharmacies. Starting from September 2021, the EU Digital COVID Certificate is mandatory in the education setting for all school staff as well as for university students, as well as to access national and local transport, both public and private. Possible extension of mandatory vaccination and the EU Digital COVID Certificate in Italy will be further discussed.

In **France**, COVID-19 vaccines are mandatory for several population groups, including healthcare professionals, medical transport and firefighters. In France, mandatory vaccination is considered as effective as it has increased the vaccination rate among these population groups.

3. Update on the work of the Technical Working Group on COVID-19 diagnostic tests (SANTE C3)

The HSC was informed about the work of the Technical Working Group on the revised definition and criteria to evaluate rapid antigen tests representing the consensus reached. New definition/criteria will apply to all new proposals submitted after 12 July 2021. A date should be agreed as of when the new definition/criteria will apply to those rapid antigen tests already included on the list. This gives manufacturers time to provide additional evaluation data, if necessary (most likely **May or September 2022**). The overall goal is to only include rapid antigen tests in the EU common list that have been evaluated based on prospective field studies. However, retrospective clinical (in vitro) studies provide helpful complementary information – if based on reliable and well-defined panels. Moreover, considering the context of the pandemic, there is a need for evaluations with shorter timeline to be executed Only rapid antigen tests based on nasopharyngeal/ oropharyngeal/nasal swabs should be included (i.e. no tests based on saliva samples). The next Technical Working Group meeting will be held on **14 September 2021**.

4. Acceptance of recovery certificates (MT)

On the topic of the EU Digital COVID Certificate, which is now widely used to promote free movement within the EU/EEA, it was clear from the start that Member States would have the freedom to decide on the conditions of acceptance of each type of certificate (namely testing, vaccination and recovery from SARS-CoV-2 infection). Malta has recently announced that it would not be accepting recovery certificates for entry into the country. Malta presented its position, where Malta’s policy objective is to maintain caseload low at all times to protect hospital and healthcare services and avoid the need for a full lockdown. Malta has never accepted recovery certificates, even before the announced introduction of the EU Digital COVID Certificate. Malta only accepts fully vaccinated persons, 14 days after the second vaccination, to enter the country without additional testing and/or quarantine.

5. AOB – Notification of new COVID-19 outbreaks in Long Term Care Facilities through EpiPulse

ECDC provided a short update on how to report on COVID-19 outbreaks in Long Term Care Facilities through the new features of the EpiPULSE platform.