EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HEALTH AND FOOD SAFETY

Public health
Health Security

Luxembourg, 11 August 2021

Health Security Committee

Audio meeting on the outbreak of COVID-19

Draft Summary Report

Chair: [redacted], European Commission, DG SANTE C3

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

Agenda points:

1. **Overview of the spread of variants in Europe – information point**
2. **Heterologous vaccination and booster doses – information point**
3. **Correspondence of COVID-19 vaccines for the purpose of travel – information point**
4. **Application for EU adaptation grants – information point**
5. **Prolongation of the recovery period – information point**
6. **AOB – data on COVID-19 vaccination status of hospitalised patients – information point**

Key Messages

1. Overview of the spread of the variants in Europe

In light of the circulating variants, [redacted], from the University of Bern in Switzerland was invited to give a presentation on the ongoing research on the **spread of SARS-CoV-2 variants** during 2020 (*tinyurl.com/[redacted]-nature)* and an update on the spread of the **Delta variant** across the EU. [redacted] showed the spreading of the Alpha and Delta variants in Europe and emphasized the importance of non-pharmaceutical interventions. [redacted] gave an overview on the situation of the spread of variants last year and explained how her research is looking at the different viral changes of the variants, including their transmissibility and infection rates. The data showed that a more transmissible variant does not necessarily mean more cases. [redacted] emphasised that there is no single measure that applies to the virus and that it is important to take into account the epidemiological situation and behavioural aspects in each country. The Delta variant it seems to be more transmissible than its predecessor the Alpha variant, and it does not seem to share too many mutations with other variants of concern. There is more research needed as to the different mutations in the spike protein, for which [redacted] invited Member States to continue and enhance surveillance of the variants of concern, but also to support sequencing.

2. Heterologous vaccination and booster doses

There have been rapid developments in some Member States in their approach towards **heterologous vaccination** (mix and match) and **vaccine dose scheduling** (booster shots). The COM asked MS to

share their approach towards these two strategies in writing before the meeting. Of the reporting countries 13 EU/EEA MS are using some sort of heterologous vaccination, including: giving a second dose of an mRNA vaccine if the first dose was a vector vaccine; giving a second dose of a different vaccine if the first dose caused serious side effects. Other reasons for heterologous vaccination includes logistical reasons, distribution of vaccines, and the improved immune response as a result of the mix and match. 12 EU/EEA MS indicated they are not administering booster vaccination. Countries that are administering booster doses indicated they are doing so in cases such as: when there were complications with the vaccination schedule, for immunocompromised people, for older persons, and for people who completed their vaccination schedule with a vector vaccine.

DE provided more information on their current vaccination strategy by commenting that they accept the combination of the Vaxzevria and the mRNA vaccines but wanted to know about MSs' experiences on possible future requests for combinations e.g. SinoVac/Sinopharm and an mRNA vaccine combination. DE is also awaiting more information on heterologous vaccination from the European Medicines Agency.

HR asked about the available evidence that persons who have not zero converted to a second dose will zero convert to a third dose. On this point, the **ECDC** clarified what is meant by 'zero convert': it is defined as not being able to detect any response after vaccination, when a person's immune system does not prompt an immune response or one is unable to detect antibodies. The ECDC also replied to DE in that a meeting of the **NITAG** will be held on 20 August to discuss the available evidence from Israel, the United Kingdom, and the United States on booster doses. This will then be followed by an update and overview on the recommendations for booster doses and the ECDC is currently working on a technical document to approach booster vaccination relying on the available evidence for justifying it.

AD requested more information on whether in the case of booster doses, taking into account that they are an off label use, countries are requiring informed consent before vaccination.

The **COM** asked the HSC to continue sending their input on heterologous vaccination and on the booster doses survey.

3. Correspondence of COVID-19 vaccines for the purpose of travel

During the Health Security Meeting of 28 July, the topic of the **acceptance of vaccines for travel purpose**s was discussed. Since then, a list of the correspondence of vaccines administered in third countries, including vaccines corresponding to the EU marketing authorization and sublicensed vaccines was published on ReOpenEU. For this occasion, the HSC was sent a new survey to know whether incoming travellers that have received the full dose of one of the COVID-19 vaccines listed in the survey are to be considered as 'fully vaccinated' for the purpose of entering the country without having to undergo a COVID-19 test and/or to quarantine. The list of vaccines included vaccines currently under the **WHO EUL/PQ** evaluation process, vaccines not granted authorization but in rolling review, and vaccines without a granted authorizations. For the majority of vaccines, Member States have indicated they do not accept these vaccines and travellers must undergo a PCR and/or quarantine upon arrival.

HU made a general comment on the survey and explained that due to the complex legislation about travellers undergoing quarantine and/or a PCR test, the results of the survey are only an indication of the rules and exemptions in Hungary based on vaccination of the individual. HU clarified that the conclusions for these vaccines are not only based on the epidemiological and medical questions, but political and economic views have also been taken into account. Additionally, HU has made bilateral agreement with 20 countries on the acceptance of their vaccines.

4. Application for EU adaptation grants

DG ECHO was invited to present the call for proposal for the **2021 Adaptation grants**. The COM reminded the HSC Members that the objective of the action is to upgrade or repair emergency

response teams and/or capacities to a state of readiness and availability that makes them deployable as part of the **European Civil Protection Pool (EUCPP)** and the **European Medical Corps**, under the **EU Civil Protection Mechanism (UCMP**).

DG ECHO first gave an overview of the different capacities available for replying to any type of emergency, including national capacities, the European Civil Protection Pool and rescEU. The European Civil Protection Pool is composed of more than 100 different capacities that belong to Member States and are put together in a common pot to be deployed upon requests of assistance by Member States, third countries or international organizations. Of these, 16 are health and medical capacities, nine of which have already been certified and 7 which are in the process of being certified. The purpose of rescEU is to be of last resort when national and the European Civil Protection Pool capacities are not sufficient in order to address emergencies.

The Adaptation grants are provided through the EU budget of civil protection and the aim is to ensure that capacities available in the EU UCMP are valid and ready for deployment. The Adaptation grants do not co-finance the development of new capacities, they only upgrade or repair existing ones. The call for proposals includes two topics: first, upgrading or repairing of multipurpose EUCPP response capacities to respond to COVID-19 related emergencies and second, the upgrading of all other capacities (non-health/medical related capacities). The applications are open to any public or private legal entity established in one of the EU eligible countries and that the country participates in the UCMP. DG ECHO invited HSC MS to have a look at their website or to send an email to their functional mailbox. The deadline for submission of applications is **24 September.**

ES asked whether the MS civil protection partners and emergency teams had been informed on the applications. DG ECHO confirmed that the information had been shared with the national civil protection authorities.

5. Prolongation of the recovery period

HR requested before the meeting information on why the limitations of evidence for the duration of protection are considered a valid justification for limiting the duration of recovery to 180 days in the **EU Digital COVID Certificate** (EUDCC), while the same limitations are not used to limit the duration of certificates of vaccination. HR clarified that it would make sense to extend the validity of the certificate of recovery for more than six months. The ECDC explained that the validity of vaccination certificates are set at national level and currently vary between 90 to 365 days, for those countries that have set limits. The ECDC added that the purpose of the EUDCC is to facilitate safe and free movement during the COVID-19 pandemic, and the certificate entered into force on 1 July in all EU Member States and is valid for a period of 12 months. The Certificate indicates whether a person has been vaccinated, has a negative COVID-19 PCR test or has a certificate of recovery (in the last six months (180 days)). ECDC explained that the limits of validity for any of the conditions depends on emerging evidence in so far as the evidence proves the level of protection; the validity of certificates will also depend on waning immunity and the need of boosters. Specifically on the recovery certificate, studies have shown that people retain immune memory of approximately six months after infection, and this depends on the severity and age of the patient. ECDC further clarified that there is not enough information on the correlation between symptoms, the disease severity, and age and protection against reinfection. Little data is available on the protection of the vaccines against the new variants.

While the Regulation empowers the Commission to change the duration of validity for recovery certificate based on guidance from the HSC/ECDC considering emerging evidence, ECDC stressed that more evidence would be needed to justify an extension beyond six months.

DE wanted to know if it was possible to extend the regulation to include more days, beyond the 180 days. The COMM will get back on this topic after internal discussions.

HR wanted to know why only **PCR** tests are accepted as proof of recovery and if the rapid antigen tests **(RAT)** or anti-genic tests could be accepted in certain circumstances. The ECDC replied that

while PCR tests are included in the EU DCC regulation, also the RAT could be considered. The COM mentioned that anti-genic tests (e.g ELISA) are not included in the definition of tests in the EU DCC regulation and can therefore not be considered in this frame. However, there are ongoing discussions in the technical working group about these tests as well.

AOB points

AOB – data on COVID-19 vaccination status of hospitalised patients

The **COM** asked Member States on whether they have been collecting data on the vaccination status of **hospitalised patients** with COVID-19. The ECDC commented that only six MS report the COVID-19 cases indicating the vaccination status (including date of vaccination) which is key to understand the level of protection at the time of infection. However, if countries report vaccination status, for the majority of cases it is 'unknown'. The ECDC asked MS to submit this data so they can carry out an analysis on the effectiveness of vaccines to prevent hospitalisations.

ES asked if there was a template to indicate the status of hospitalised patients, to which the **ECDC** confirmed that all the variables are saved. **ES** and **IE** also asked for caution when presenting this data as it could lead to misunderstandings, especially as it is not capturing other less severe cases and because the higher the vaccine coverage the higher the proportion of cases who are vaccinated even with very high vaccine effectiveness and this may not be easy to explain. **IE** commented that due to their current cyber-attack they are in the process of gathering this data and will share more complete data on their hospitalised cases soon.