An Roinn Sláinte
Department of Health
Office of the Chief Medical Officer

11th June 2021

Mr Stephen Donnelly TD
Minister for Health
Department of Health
Block 1, Miesian Plaza
50-58 Lower Baggot Street
Dublin 2

Dear Minister

As you will be aware, the Health (Amendment) Act 2021, which was signed into law on 7th March 2021, provides for a system of mandatory quarantine in designated facilities, having regard to a number of factors including the advice of the Chief Medical Officer and following consultation with the Minister for Foreign Affairs, to designate in writing any state where there is known to be sustained human transmission of COVID-19 or any variant of concern or from which there is a high risk of importation of infection or contamination with COVID-19 or any variant of concern by travel from that state.

As of 8th June 2021, the 51 states designated as Designated States under the provisions of Section 38E of the Health Act 1947 were:

> Afghanistan, Angola, Argentina, Bahrain, Bangladesh, Bolivia, Botswana, Brazil, Burundi, Canada, Cape Verde, Chile, Colombia, Democratic Republic of the Congo, Costa Rica, Ecuador, Egypt, Eswatini, Ethiopia, French Guiana, Guyana, India, Kenya, Lesotho, Malawi, Maldives, Mozambique, Namibia, Nepal, Oman, Pakistan, Panama, Paraguay, Peru, The Philippines, Qatar, Rwanda, Seychelles, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Tanzania, Trinidad and Tobago, Turkey, United Arab Emirates, Uruguay, Venezuela, Zambia and Zimbabwe

An Expert Advisory Group on Travel (EAGT) was established on 1st March 2021. Following a Government Decision on 9th April, membership of this group was augmented to include expertise on border security, hotel quarantine logistics, international travel law and foreign relations. This entails official representation from the Department of Justice, Department of Foreign Affairs, Department of Enterprise, Trade and Employment and the Department of Defence. This revised composition allows for consultation with a wider group of stakeholders at an earlier point in the process.

In keeping with the provisions of the Act, the technical advisory sub-group of the EAGT has established a methodological approach for risk assessments, and agreed by the EAGT, to inform the advice of the Chief Medical Officer in relation to the designation of territories as designated states, within the meaning of the Health Act 1947, where *there is known to be a sustained human transmission of COVID-19 or any variant of concern or from which there is a high risk of importation of infection or contamination with COVID-19 or any variant of concern by travel from that state*.

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These assessments, coupled with consideration of the broader issues relating to travel, take account of guidance and data from the World Health Organization (WHO), the European Centre for Disease Prevention and Control (ECDC), the Health Protection Surveillance Centre (HPSC) of the Health Service Executive, current international epidemiological data and most recent evidence relating to COVID-19 transmission from an extensive list of other specific sources.

Having considered the recommendations of the EAGT and the technical briefing as produced by the technical advisory sub-group, I am recommending that, being time-bound and considered interim in nature, travellers from both EU/EEA and non-EU countries should enter mandatory hotel quarantine based on the following prioritisation:

1. **Countries with known VOC**, based on individual country risk assessment using an agreed risk matrix, and alignment with the UK Red list, based on the common travel area, and likely onward contagion effect, and awareness of the processes and epidemiological intelligence underpinning such recommendations.
2. **Very high incidence** countries with a 14-day incidence ≥500 per 100,000, reflecting the ECDC high risk classification threshold.
3. **High incidence** countries with a 14-day incidence less than 500 per 100,000 and greater than 5 times the 14-day incidence rate of Ireland, reflecting the WHO recommendation to tailor restrictions based on epidemiological differences between country of origin and destination country.

Countries with known VOC

The EAGT's latest assessment considered data relating to the Beta (B.1.351), Gamma (P.1), and Delta (B.1.617.2) variants of concern. Based on individualised country-level analysis, and discussion of same, the EAGT has recommended the continued designation of **Canada**.

The EAGT also recommends the inclusion of **Uganda** based on a review and consideration of the most recent epidemiological data.

In considering its recommendations, the EAGT has highlighted challenges with data quality and availability, particularly with regards to limitations in or absence of genomic sequencing capacity and reporting in the majority of countries.

High or Very high Incidence

In addition to the direct data relating to VOCs, the EAGT recognises that high or very high incidence, is a risk in and of itself, given that viruses constantly change and that mutations may arise during the viral replication process. Recognising that a higher incidence rate represents an increased risk of a mutation arising, some of which, or combination of which, may provide the virus with a selective advantage, including increased transmissibility, the ability to evade the host immune response or the ability to impact on the potential effectiveness and benefits that it is hoped will be gained through our national vaccination programme for COVID-19.

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Very high incidence
Based on the application of this criterion, no countries are recommended for designation.

High incidence
Based on the revised multiplier, countries meeting this criterion are captured in the very high incidence category based on Ireland's current 14-day incidence, as such no countries are recommended for designation.

Revocation
Following individualised review of the data, no countries are recommended for revocation on the basis of very high/high incidence.

These measures are recommended as proportional, justified and necessary in *preventing, limiting, minimising or slowing the spread of COVID-19 in the state* with particular regard to the following:

- the critical timepoint and increasing risk to the vaccination program in Ireland and to the control of the COVID-19 epidemic in Ireland from the importation of new variants of SARS-CoV-2, including from some EU countries with outbreaks involving new variants
- the inability of many countries both within and outside the EU to adequately monitor the emergence of new variants through systematic genomic sequencing and the difficulty therefore to obtain reliable information on the circulation of new variants in many countries
- the unknown and presumably inadequate compliance rate with the system of home quarantine as currently deployed in Ireland, and need for strengthening of existing measures including the passenger locator form and day five PCR testing post-arrival
- the uncertainty relating to the ability of some new variants, and evidence supporting an ability of the B.1.617.2 variant, to out-compete the predominant strain (B.1.1.7) currently circulating in Ireland
- the ongoing identification of new cases of novel variants in the community in Ireland, and the very significant public health resources that are being deployed to prevent further transmission
- the nature and potential impact of COVID-19 on individuals, society and the State, and current restrictions as they apply to the population.

I also wish to advise that the EAGT-TAS has developed a risk-matrix based approach to informing the risk assessments, which is currently being run in parallel, and subject to validation and agreement at the EAGT it is proposed that this will underpin recommendations made on the basis of VOCs. Fuller details are included in the technical briefing accompanying this letter.

Based on and having considered and assessed these recommendations from the EAGT, it is my advice that the following country be designated under the provisions of Section 38E (1) of the Health Act 1947 and Health (Amendment) Act 2021 as a designated State within the meaning of the Act:
Uganda.

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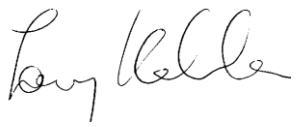
Based on, and having considered and assessed the recommendations from the EAGT, it my advice that of countries previously designated, and in accordance with Section 38E(4) of the Health Act 1947, no countries are recommended for revocation.

The EAGT and the technical advisory sub-group will continue to review the epidemiological situation, on an ongoing basis, and update its recommendations on a weekly basis and I will advise you accordingly.

Yours sincerely



Dr Tony Holohan
Chief Medical Officer

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Annex A. Restriction of travel from non-EU/EEA and EU/EEA countries with prioritisation of Mandatory Hotel Quarantine as follows:

1. VoCs		2. Very high incidence	3. High incidence[1]
Afghanistan	Mozambique		
Angola	Namibia		
Argentina	Nepal		
Bahrain	Oman		
Bangladesh	Pakistan		
Bolivia	Panama		
Botswana	Paraguay		
Brazil	Peru		
Burundi	Philippines		
Canada	Qatar		
Cape Verde	Republic of South Africa		
Chile	Rwanda		
Colombia	Seychelles		
Costa Rica	Somalia		
Democratic Republic of the Congo	Sri Lanka		
Ecuador	Sudan		
Egypt	Suriname		
Eswatini	Tanzania		
Ethiopia	Trinidad and Tobago		
French Guiana	Turkey		
Guyana	Uganda		
India	United Arab Emirates		
Kenya	Uruguay		
Lesotho	Venezuela		
Malawi	Zambia		
Maldives	Zimbabwe		

[1] Based on 14-day incidence of 578.5 per 100,000 (being 5 times the 14-day incidence of 115.7 per 100,000 in Ireland for week 22, extracted from ECDC on 10 June 2021)

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Annex B: States designated on the basis of variants - Summary of Risk Assessment

Canada

Canada was first designated by the Minister for Health on 15 April due to concerns relating to the B.1.351 and P.1 variants. Data from 1 June to 8 June reported the proportion of these variants nationally at 21.6% (17% P.1, 3.5% B.1.617 and 1.1% B.1.351), compared to 15.2% (10.5% P.1, 3.2% B.1.617, and 1.5% B.1.351) in week 21 and 11.7% (9.4% P.1, 1.3% B.1.351 and 1.0% B.1.617) in week 20.[1] Individual provincial data from 2 June to 8 June was analysed with British Columbia reporting 1.9%, 43.8%, and 46.5% of the B.1.351, P.1 and B.1.617 variants respectively, Ontario reporting 94.3%, 48.2% and 0% of B.1.351, P.1 and B.1.617 variants respectively, Quebec reporting 0.3% and 5.6% of P.1 and B.1.617 variants respectively, Alberta reporting 4.0%, and 31.3% of P.1 and B.1.617 variants, and Manitoba reporting 3.8%, 1.5%, and 13.5% of B.1.351, P.1 and B.1.617 variants. All other provinces and territories provided <5% of positive sequences for each variant.

As sequences are frequently reported in bulk by provinces on different days this can give rise to variation in the distribution across provinces week-to-week. As of 10 June, 1,461 cases of B.1.617 have been reported, an increase from 968 in week 20, 380 in week 19 and 8 cases in week 18.[2] The 14-day incidence in Canada has decreased from 140.4 in week 20 to 86.4 in week 21,[3] with overall 7-day test positivity of 2.7%.[4] As of 7 June, 7.9% of the population are reported as being fully vaccinated, with 62.3% having received one vaccination dose.[5]

Indicator	Green	Amber	Red
VOC			
VOC proportion overall			**21.6%**
B.1.351 proportion	1.1%		
B.1.617 proportion	3.5%		
P1 proportion			17.0%
Meets indicator standard for reporting VOC i.e. (WGS of 10% samples or >500 per week)	**Yes**	**NA**	**No**
Most recent representative data			
Variant trajectory/trends	**Decreasing prevalence**	**Stable prevalence**	**Increasing prevalence**
EPIDEMIOLOGICAL SITUATION			
Incidence rate (7 day) per 100,000	**32**		
Incidence in last 7 days (% change)	-29%		
Incidence rate (14 day) per 100,000	**86**		
Test positivity rate in last 7 days, per 100,000	**2.7%**		
Testing rate in last 7 days per 1,000	189		
VACCINATION			
Fully vaccinated (total population)			**7.9%**
First dose (total population)	62.3%		
TRAVEL			
Travellers arriving in Ireland in 14-day period	**56**		

[1] https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html?stat=num&measure=total_last7&map=pt#a2
[2] https://www.ctvnews.ca/health/coronavirus/tracking-variants-of-the-novel-coronavirus-in-canada-1.5296141
[3] https://www.ecdc.europa.eu/en/publications-data/data-national-14-day-notification-rate-covid-19
[4] https://health-infobase.canada.ca/covid-19/vaccination-coverage/
[5] https://ourworldindata.org/covid-vaccinations

Uganda

Data relating to COVID-19 in Uganda is limited, particularly with respect to variants of concern, owing to low and inconsistent sequencing. Uganda has reported cases of B.1.351, B.1.525 and B.1.617,[6] being the first country on the African continent to confirm the presence of the latter. Additionally, the variant, A.23.1, was first identified in samples in Northern Uganda from December 2020, and although of uncertain significance, has mutations that are similar to the B lineage VOCs.[7] No sequences have been submitted to GISAID since 26 April, of the 30 genomes reported on Nextstrain between March 2020 and April 2021, more recent samples are primarily the B.1.525 (71%) and B.1.617 (28%) variants, however caution should be applied in interpreting this data, given the limited number of samples.[8]

Although testing is limited, and largely confined to Kampala (which accounts for 60-80% of tests but c.10% of the population[9]), Uganda has reported a significant increase in recent weeks with a +115% change in the 14-day incidence from 9.4 in week 21 to 20.1 in week 22, and a +370% in absolute cases in the two-week period to 10 June. However, the demographic profile of Uganda includes a large rural population, and incidence rates based on total population, including low levels of testing, may underestimate the actual incidence and may significantly underestimate the incidence in the greater Kampala region. Both the WHO and IPCR reviews have noted the deteriorating epidemiological situation[10] with the IPCR reporting that "The COVID-19 situation in Uganda is now the worst it has been since the outbreak of the pandemic, with the number of recorded cases is increasing rapidly. The positivity rate has also significantly increased" from 10% to 16.3% in week 21 to 22 respectively.[11] Contact tracing is not currently in place. President Museveni recently announced new restrictions with effect from 7 June and to apply for a 42-day period, noting that fatality and critical illness levels now exceeded those seen in the country's first wave, with concerns voiced in relation to potential hospital capacity and oxygen supply issues. [12]

Indicator	Green	Amber	Red
VOC			
VOC proportion overall			
B.1.351 proportion		Reported	
B.1.617 proportion		Reported	
P1 proportion		Not reported	
Other variants of note		A.23.1 and B.1.525	
Meets indicator standard for reporting VOC i.e. (WGS of 10% samples or >500 per week)	**Yes**	**NA**	**No**
Variant trajectory/trends		**Unknown prevalence**	
EPIDEMIOLOGICAL SITUATION			
Incidence rate (7 day) per 100,000	**16**		
Incidence in last 7 days (% change)			+171%
Incidence rate (14 day) per 100,000	**20**		
Test positivity rate in last 7 days, per 100,000			16.3%
Testing rate in last 7 days per 1,000			46.1
VACCINATION			
Fully vaccinated (total population)			**0.01%**
First dose (total population)			1.2%
TRAVEL			
Travellers arriving in Ireland in 14-day period	**8**		

[6] https://africacdc.org/download/outbreak-brief-72-coronavirus-disease-2019-covid-19-pandemic/
[7] https://www.medrxiv.org/content/10.1101/2021.02.08.21251393v1
[8] https://nextstrain.org/ncov/global?f_country=Uganda
[9] https://thedocs.worldbank.org/en/doc/595971521054661269-0010022018/original/GreatKampalaMetropolitanAreaQuickFacts.pdf
[10] https://apps.who.int/iris/bitstream/handle/10665/341673/OEW23-310506062021.pdf
[11] Ugandan Ministry of Health as reported to IPCR 25 May to 7 June https://ipcr.consilium.europa.eu
[12] https://www.cidrap.umn.edu/news-perspective/2021/06/uganda-enters-2nd-covid-19-lockdown-surges-noted-elsewhere