ECDC Advisory Forum

AF21/Minutes

Minutes of the 21st Meeting of the Advisory Forum
Stockholm, 17-18 February 2010

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Opening and welcome

1. The Chair, Johan Giesecke, ECDC Chief Scientist, opened the meeting and welcomed the Advisory Forum (AF) Members and Alternates to the AF's twenty-first meeting. He relayed apologies from the Acting Director, Karl Ekdahl, who was attending a meeting of EU Agency Directors in Brussels. He then introduced Commission representative Frank Van Loock, as well as WHO/EURO representatives Thomas Hofmann and Arun Nanda.

2. The Chair relayed apologies from the representatives of Denmark, Liechtenstein, Lithuania, Malta, the Slovak Republic and the European Patient Forum.

3. He then invited all interested AF Members to ECDC's Crisis Communication Workshop, scheduled to convene directly following the AF meeting on 19 February 2010.

Adoption of the draft agenda and noting the Declarations of Interest

(Documents AF21/2 Rev.1; AF21/3 Rev.1)

4. The draft agenda was slightly adjusted to accommodate the hectic schedules of some of the presenters, but otherwise adopted.

5. The Chair called for the submission of Declarations of Interest forms to the Secretariat in respect of the agenda items. In reference to agenda items 3 (Update on main activities since the last AF meeting) and 5 (Latest Influenza issues), Stefania Salmaso, Italy, declared that Network Venice is affiliated with Institution. Darina O'Flanagan, Ireland, also noted that she is a Member of the Venice Project (Project Leader, Seasonal Flu for vaccination coverage under item 5). Under item 4 (Epidemic Intelligence), Mike Catchpole, United Kingdom, noted that he is presenting a report on epidemiology of VTEC in England in the AF plenary session. In reference to item 6 (Priorities for Scientific Advice), he is an employee of HPA, which has a contract to undertake an evaluation of the pandemic vaccination response. Under item 8 (Surveillance), Herman Van Oyen, Belgium, remarked that he is involved with IPH via a grant. In reference to InVS (item 9 - EPIET update regarding external evaluation), Jean-Claude Desenclos, France, noted that a coordinator's post is funded by the EPIET-ECDC Programme. Under the same item, Mike Catchpole is the former Chairman of the EPIET Steering Committee. Franz Allerberger, Austria, declared that AGES is a host institution for the EPIET Training Programme and he is responsible in this respect. With regard to item 10 (Update from ECDC External Relations and Partnerships), Preben Aavitsland, Norway, declared that his Institute is the contract holder for the EpiNorth project.

Adoption of the draft minutes of the 20th Meeting of the Advisory Forum held in Stockholm (8–9 December 2009) *(Document AF21/4)*

6. In reference to paragraph 17, the Member from Slovenia, Irena Klavs, suggested the following modification: "The Member from Slovenia suggested that ECDC could benefit from information available from the WHO/Euro (study on health-related behaviour of young people) and Eurostat (Eurostat/EHIS: European Health Interview Survey)."

7. In reference to paragraph 35, Gérard Krause, Member, Germany, requested that "government employees" be replaced with "federal employees".

8. In reference to paragraph 44 of the previous draft minutes, the Member from Hungary, Ágnes Csohán, amended the text as follows: "In response to the query from the NGO representative, the Member from Hungary confirmed that only citizens that do not belong to a priority risk group in Hungary require prescriptions in order to purchase the influenza vaccine. As a matter of fact, 22% of the population was vaccinated free of charge in Hungary."

9. Following the aforementioned amendments, the draft minutes were adopted.

Update on main activities of ECDC since the last Advisory Forum meeting

a) Update from ECDC

10. The Chair updated the AF on ECDC's general activities since the last meeting. As both Karl Ekdahl and Maarit Kokki, Coordinator of the Cabinet, were on a mission, the Chair presented their slides.[1] Following Zsuzsanna Jakab's departure to WHO/Euro, Karl Ekdahl was appointed Acting Director of ECDC. Currently, ECDC's Management Board is planning to select a new Director during their 18th Meeting in Stockholm. Following the election, the incoming Director will be formally confirmed by the European Parliament, foreseen in April, prior to assuming his post in Stockholm.

11. The Chair, reporting for Maarit Kokki, relayed that the Cabinet is currently in the process of reorganising its country-related work, while at the same time continuing the development of its Management Information System (MIS).[2]

12. Piotr Kramarz, Deputy Head of the Scientific Advice Unit (SAU), gave a brief update of his unit's activities which included, among many other events, the Eurovaccine conference in Stockholm on 11 December 2009. Further details can be found in a series of PowerPoint slides.[3]

13. Updates from the other Heads of Units followed. Andrea Ammon (Surveillance), Denis Coulombier (Preparedness and Response), Ines Steffens (Head of the Scientific Communications Section and Managing Editor of *Eurosurveillance*), and Anni Hellman (Administration) presented their updates as PowerPoint slides.[4]

b) Update from the European Commission

14. Frank Van Loock, the representative of the European Commission, introduced himself and then proceeded to brief the AF on a variety of issues currently of importance to the Directorate-General for Health and Consumers, including seasonal influenza, the schedule for the community pandemic influenza preparedness plan, climate change and antimicrobial resistance. Details are available in his presentation.[5]

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[1] Item 3a- Update from ECDC.ppt
[2] *Ibid.*
[3] *Ibid.*
[4] *Ibid.*
[5] Item 3b - Update from EC (F Van Loock).ppt

c) Update from the WHO Regional Office for Europe

15. Preceding Thomas Hofmann's presentation, Arun Nanda took the opportunity to convey greetings from former ECDC Director Zsuzsanna Jakab to the AF.

16. Thomas Hofmann presented a comprehensive overview of activities conducted by WHO/Euro's Unit for Communicable Diseases.[6]

Discussion

17. In response to Thomas Hofmann's presentation, an AF delegate pointed out that WHO maps still lag twenty years behind the political realities. He added that the timeline given by WHO for the eradication of measles/rubella was not very realistic.

18. Arun Nanda pointed out that the measles map showed incidence which was higher in the western European countries and therefore the colouring ended up giving an erroneous impression that the Central European Countries were not part of the same (EU) grouping. As to the eradication goals, he pointed out that such goals are often intended to be inspirational.

19. One representative pointed out the key role that Acute Flaccid Paralysis (AFP) surveillance had played in the eradication of polio. Without a similarly powerful tool for measles, eradication would be very difficult.

20. Another delegate doubted whether the current division of labour between ECDC, DG SANCO, and WHO in the areas of risk assessment, risk management and generic response was productive. She cautioned that the actual response would suffer from "gaps and overlaps" in the activities carried out by these three organisations. During the pandemic, some of these gaps had become apparent, particularly in the area of data exchange. "How do we produce results together?", she asked.

Epidemic Intelligence: Update on recent threats in the EU

a) The Q fever outbreak in the Netherlands

21. Marianne van der Sande, Netherlands, reported on the Dutch Health Authorities' efforts to curb outbreaks of Q fever, a zoonosis caused by the obligate intracellular bacterium *Coxiella burnetii*. In 2007, Q fever emerged as an important human and veterinary public health challenge with large epidemics in the southern part of the Netherlands. Further details are available in her PowerPoint presentation.[7]

b) An outbreak of hepatitis A in France linked to consumption of dried tomato produced in Turkey

22. Jean-Claude Desenclos, Member, France, reported on a Hepatitis A outbreak in France caused by a rare, probably imported genotype found in dried tomatoes.

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[6] Item 3c - WHO Update (T Hoffman).ppt
[7] Item 4a - Q fever Outbreak in the Netherlands (M van der Sande).ppt

c) Epidemiology of VTEC in England with emphasis on the role of open farms as risk factor

23. Mike Catchpole, Member, United Kingdom, presented a series of slides[8] on the 'Epidemiology of E. coli O157, England/UK'. According to the presented data, children below the age of five years have more than five times the risk of acquiring laboratory-confirmed VTEC O157 infection when compared with adults aged 20-29 years. This might not come as a surprise since a number of infections could be traced back to visits to open farms ('petting farms' or 'petting zoos' for small children) and having contact with livestock.

24. Following his presentation, Darina O'Flanagan, Member, Ireland, noted that her country had also reported a high rate of exposure to VTEC, frequently in connection with private wells in rural areas after periods of flooding.

d) *Salmonella* Goldcoast: Update to an ongoing investigation

25. Annick Lenglet, Expert, Preparedness and Response Unit, updated the AF on an ongoing investigation on *Salmonella* Goldcoast.[9] The current outbreak was identified in October 2009 following an urgent inquiry from Hungary regarding an unusual increase in human cases. Thus far, six other EU Member States have reported cases with similar PFGE profiles. To date, no particular food product could be implicated. Further microbiological investigations have been encouraged for human isolates at the EU level, and links have been established with animal health laboratories to carry out similar investigations on animal and food isolates.

e) Measles outbreak in Bulgaria, joint mission by ECDC and WHO/EURO (7–12 February 2010)

26. Angel Kunchev, Member, Bulgaria, reported on an outbreak of measles in his country that mostly affected the Roma community, a group that not only faces difficult socio-economic conditions but also has low vaccination coverage. Most measles cases are identified among the Roma community living in the north eastern part of the country. Details are available in his PowerPoint presentation.[10]

27. One delegate suggested that the Bulgarian Health Authorities should consider persuading Roma village elders that vaccination is the best way to protect their children. This has proven to be a successful strategy in Poland.

Latest Influenza (seasonal and pandemic) issues

a) ECDC approach to planned evaluations of the Influenza A(H1N1) pandemic

28. In his presentation[11], Pasi Penttinen, Senior Expert, Preparedness and Response Unit, pointed out that at this stage, ECDC is aware of five ongoing international

[8] Item 4c - Epidemiology of VTEC in England (M Catchpole).ppt
[9] Item 4d - *Salmonella* Goldcoast (A Lenglet).ppt
[10] Item 4e - Measles outbreak in Bulgaria (A Kunchev).ppt
[11] Item 5a - Planned evaluations of the Influenza.ppt

evaluation processes on the Influenza A(H1N1) pandemic and a number of other multinational or specialist evaluations underway. In all, there were around fifteen processes involving EU countries. He mentioned that ECDC had a list of these available on request but that it had also performed its own internal evaluation of the early period (led by an external expert) in the summer of 2009.

29. In response to the above-noted presentation, one delegate opined that the focus of all evaluations should be on surveillance and sharing of information and analyses. For example, during the pandemic, it was difficult to obtain reliable data on ICU admissions. "Even now it is still difficult to get a good overview." This view was seconded by another delegate who emphasised that a focus on best practices and everyday work was better than a generic evaluation. One Member even recommended that evaluations should focus primarily on surveillance.

30. One representative explained that pandemics typically last for two years, and that a final outcome for the current Influenza A(H1N1) pandemic has not yet been realised. He added that, despite the achievements of the evaluations, their results will only be temporary.

31. Another delegate expressed concern over the way in which the results of such an evaluation are communicated, especially now that the public discussion is highly focused on the profits of the vaccine producers and the media are rife with rumours of a "falsified pandemic".

32. Another representative stated the importance of "restricting this evaluation on ECDC's main functions and that any evaluation of ECDC's role should be done externally in order to guarantee objectivity and credibility."

33. Pasi Penttinen alleviated fears that ECDC would launch yet another time-consuming evaluation. Instead, the Centre would provide tools, support the EU and WHO processes, but not start its own pan-European evaluation. Or, as Pasi Penttinen put it, "We want to minimise your workload!"

34. Andrea Ammon, Head of ECDC's Surveillance Unit, agreed that surveillance data were not always very reliable. She acknowledged that the numbers in ECDC's weekly overview were not always comparable and that there was a particular weakness at the severe end of the spectrum, people in hospitals and deaths, but that this was also true for many other diseases surveyed. She also stated that all evaluations should be finalised by June; otherwise there would be insufficient time to make any changes for the 2010/2011 influenza season.

35. The lack of certain scientific-technical evaluations was criticised by one of the AF delegates. For example, more information on antiviral effectiveness would be very helpful. Also, did countries that used oseltamivir extensively report a lower death rate? Similarly, how did vaccination coverage affect the pandemic?

b) ECDC Review and Risk Assessment: The more likely scenarios for Influenza in 2010 and the 2010/2011 influenza Season and implications for Work Priorities *(Document AF21-5 Rev.1)*

36. Angus Nicoll, Influenza Coordinator, Scientific Advice Unit, presented the recorded human pandemic influenzas from 1885 to 2009; emphasising how the new pandemic virus (in this case 2009 H1N1) 'elbowed out' other influenza A viruses.[12] He pointed out that influenza has reached its post-peak period in Europe. He stated that "one should not assume that the new seasonal influenza would be the same as the old one, in terms of risk group, age groups and clinical form of severe cases". He proceeded to present ECDC's work regarding the "ECDC Forward Look Risk Assessment" thanking the many members of the AF and their delegates who assisted in the work. This included the paper's background, methodologies, limitations and conclusions.

37. The Member from Iceland said that there are more data available on the year 1959 relating to the 1957 pandemic; to which the Influenza Coordinator replied that there are probably multiple sources of historical data on prior pandemics in national languages, and he encouraged Member States to make them available to ECDC.

38. The delegates from Belgium, Greece and Italy reacted to the mortality data reported to ECDC, questioning their accuracy.

39. The Member from France raised the issue of dissemination and communication of the results of ECDC reviews and ECDC sponsored studies. It would be useful to share early the final paper on ECDC Review and Risk Assessment with the MB and AF Members first, prior to publication. For the I-Move vaccine efficacy study of the H1N1 2009 pandemic vaccine, he stated that sharing of that crucial information with EU Member States prior to publication in a scientific journal was necessary since these studies were done primarily to help decision making. In response, Angus Nicoll pointed out that the ECDC Forward Look had been undertaken with AF members, but agreed that communication between Member States could be improved. He pointed out that with the I-MOVE project (vaccine effectiveness), ECDC's findings would be communicated to the Members first and subsequently to the stakeholders.

40. The Member from Italy inquired whether there would be further recommendations regarding the use of vaccines against influenza this year. Angus Nicoll replied that the main benefits of vaccination would appear next winter (2010/2011), and cautioned that guidance and evaluation should not focus solely on the use of vaccines.

c) Country experiences on vaccination: Presentations from Ireland, the Netherlands and Romania

i) Presentation from Ireland

41. Darina O'Flanagan, Member, Ireland, presented confirmed laboratory and hospital cases, including vaccines distributed of which more than 800,000 citizens have been vaccinated to date. Also included in her report were demographics by age, risk and

[12] Document AF21-5 Rev.1, ECDC Review and Risk Assessment: The more likely scenarios for Influenza in 2010 and the 2010/2011 Influenza Season and implications for Work Priorities (A Nicoll). See also ECDC Review and Risk Assessment (A Nicoll).ppt

health worker groups, noting the alarming low number of nurses who received vaccination. She mentioned that they used Celvapan and Pandemrix vaccines and they hope to use H1N1 vaccination centres for MMR. Details are found in Darina O'Flanagan's presentation.[13]

ii) Presentation from the Netherlands

42. During her presentation,[14] Marianne van der Sande, Alternate, Netherlands, remarked that due to the national regular vaccination programme in place, and with the logistic support of the Ministry of Defence, around five million received vaccinations, which is close to 80% of the eligible population, and to an estimated 30% of the total population. She reported that initially only the identified seasonal high-risk groups were eligible, and that later healthy children and pregnant women were added as well. Healthy children were vaccinated with Pandemrix, most other risk groups with Focetria.

iii) Presentation from Romania

43. In his presentation,[15] Florin Popovici, Member, Romania, noted that a locally-produced vaccine called Cantgrip is used in his country, which was not tested for below age 16 and had no specific indication or counter-indication for pregnant women; 1.4 million vaccines were made available. There were reports of an epidemic in schools. He presented the vaccination timeframe and target groups; however, he noted that among those risk groups vaccinated, 83 per cent remains unknown.

44. Following the presentation from Romania, the Chair thanked the three presenters. The Member from Poland inquired about the total vaccination coverage of the population in Ireland. The response was 20 per cent. In response, Angus Nicoll pointed out that presentation of the coverage should be done by the risk and target groups chosen by the countries rather than at the population level. He also mentioned that there would be a special VENICE survey undertaken on pandemic coverage in the spring serving both EU and WHO data needs.

45. The Alternate from Greece commented on the low number of nurses getting vaccinated in his and other countries; and to give more focus on educational campaigns. This was seconded by the NGO representative that there should be "deeper investigation on why physicians have negative reactions to the vaccines". He added that there is prevalent ignorance about the decision-making process in acquiring drugs or vaccines; that public health authorities should coordinate better with the European Medicines Agency (EMA).

46. The Member from Spain inquired about the coverage between urban and rural areas, and also populations where medical doctors with vaccines against those who did not acquire the vaccines.

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[13] Item 5c - Country Experiences – Ireland (D O'Flanagan).ppt
[14] Item 5c - Country Experiences – Netherlands (M van der Sande).ppt
[15] Item 5c - Country Experiences – Romania (F Popovici).ppt

d) Reporting of Influenza to ECDC and WHO/Europe

47. In her report, Andrea Ammon informed that "there is now single reporting on influenza through the joint web entry page already in use for HIV and TB" and that "WHO is currently manually updating it; however, an automated transfer from TESSy to Euroflu will be ready soon." She reported that further discussions are needed for the joint surveillance on influenza and extended a warm appreciation to all 'flu' reporters in the Member States and the session participants.

Priorities for Scientific Advice *(Document AF21-6 Rev.1)*

48. Piotr Kramarz, Deputy Head of the Scientific Advice Unit, ECDC, presented the status, timeline and process of setting priorities for scientific advice.[16] Currently, the initial list of proposed priorities identified by ECDC Experts has been sent to AF Members and the ECDC Competent Bodies for Scientific Advice with a request to propose additional topics. Piotr Kramarz explained the "three-point scoring process", the factors to consider in prioritising and the lessons learned from similar, previous exercises. He then presented the initial list of priorities.

49. Johan Giesecke then urged the AF Members to participate and submit new proposed topics.

50. The Member from Ireland requested clarification regarding the way the meningococcal vaccine topic was formulated in the presentation. Piotr clarified the issues.

51. The Member from Luxembourg inquired why pneumococcal vaccine was not included on the initial priority topic list. Piotr Kramarz responded that an expert panel has already been set up and is working on pneumococcal vaccine guidance.

52. The meeting then adjourned and following a brief coffee break, the AF delegates convened in their respective Working Groups.

53. During the beginning of the second day of the meeting, Karl Ekdahl, Acting Director, gave a brief update about the EU Agencies' dialogue with European Commission President José Manuel Barroso. An inter-agency meeting will be organised and there were debates about the European Agencies' mandate, whether it should have a global mandate or not in the light of the global economic crisis. He explained the temporary arrangements within ECDC and gave an update about the recruitment of the new ECDC Director.

54. On the same day, copies of the ECDC Weekly Influenza Surveillance Overview (WISO) were distributed in order to supplement his Angus Nicoll's previous presentation on influenza.

[16] Item 6 - Priorities for Scientific Advice (P Kramarz).ppt

Reports from Working Groups A, B, C

a) Working Group A: Current Quality Assurance Measures of Member States

55. On behalf of the group, the Member from Finland, Petri Ruutu, presented the project entitled "Development of a quality tool for monitoring and evaluating of data quality in surveillance systems." He outlined the objectives and timeline of the project and sought guidance from AF delegates. He suggested that the project be a working group topic.[17]

56. Johan Giesecke, ECDC Chief Scientist, commented that in terms of laboratory quality, a national microbiology focal person plans to visit ECDC in the near future. The issue of data quality could be addressed during that meeting.

b) Working Group B: Organisation of the Evaluation of the Influenza A(H1N1) Pandemic

57. The Member from Belgium, Herman Van Oyen, presented the boundaries of the evaluation, namely, the mission of ECDC: surveillance, risk assessment and communication. He also presented items within the "public health process", surveillance and scientific process.[18]

58. The Member from Italy informed that "the Member States did not approve the evaluation in Barcelona due to the workload involved." She added that the term 'evaluation' has been changed to 'lessons learned.'

c) Working Group C: Social Determinants of Infectious Disease: A Priority for the Spanish Presidency – What Role Should ECDC Play?

59. The Alternate from Greece, Sotirios Tsiodras, announced that ECDC has "conducted a review which demonstrates that in every EU Member State, socioeconomic factors result in the inequitable distribution of communicable diseases." He then proceeded to present ECDC's comments on the topic. Among the results of the group's discussion were "not all risks are the same" and that a "better understanding of the determinants and diseases of the working group is needed." The group's conclusion regarding ECDC's role is "assist in identifying and addressing social determinants of infectious diseases in collaboration with the Member States, the EU and WHO."[19]

60. Following the above-noted presentation, the Member from the United Kingdom commented that his country is documenting social determinants vis-à-vis burden of disease.

61. The Alternate from Sweden queried what ECDC would do about social determinants.

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[17] Report from Working Group A.ppt
[18] Report from Working Group B.ppt
[19] Report from Working Group C.ppt

ECDC Annual Epidemiological Report *(Document AF21-7 Rev.1)*

62. Johan Gieseke, ECDC Chief Scientist, informed that he is seeking views from the Advisory Forum to alter the format of the annual report. He proposed that the annual report be split into three separate publications, which would cover: a) surveillance data from the year n-2; b) threats handled in 2009; c) a review article based on a special public health issue submitted to *Eurosurveillance*. More details can be found in document AF21/7.

63. Following the Chief Scientist's presentation, the AF Members from Finland, Germany and the United Kingdom agreed to the new format of the annual report.

64. The Member from Ireland suggested acquiring a separate ISBN for the publications.

65. The Member from Norway proposed that the publications could be supplements to *Eurosurveillance*. In response, Ines Steffens, Head of the Scientific Communications Section and Managing Editor of *Eurosurveillance*, cautioned about possible branding problems that could occur. In addition, she stated that *Eurosurveillance* remains editorially independent of ECDC, and as such, does not exclusively publish ECDC authored papers.

Surveillance issues

a) European Point Prevalence Survey (PPS) of Healthcare-Associated Infections (HAI) and Antibiotic use in Acute Care Hospitals

66. Carl Suetens, Senior Expert, Head of Section for ARHAI, Surveillance Unit, informed the AF delegates that the pilot protocol will be distributed following the meeting. He proceeded with a presentation where he highlighted a "harmonised method in HAI prevalence survey in Europe". Then he presented the timeline, objectives and issues involved in the transmission of the PPS for HAI. Details are found in his presentation.[20]

67. Following Carl Suetens' presentation, the AF Member from France regretted that this agenda item, which he considered a very important one, was merely presented for information, and expressed disappointment over the lack of supporting documentation for the Advisory Forum.

68. Carl Suetens explained that this issue is proposed as a topic for a working group in the next AF meeting.

69. Andrea Ammon, Head of Unit, Surveillance, acknowledged the point made by the Member from France. She added that the idea is to "present this topic initially to the plenary and then to discuss it further in detail in a working group."

70. The Member from Norway inquired if AF Members should appoint a new contact point for HAI, or will they use the same contact point for HAI surveillance. Referring to

[20] Item 8a - European PPS of HAI (C Suetens).ppt

the presentation, he pointed out that one of the challenges posed for Member States is to modify their national PPS protocol to fit the new protocol.

71. The Alternate from Austria advised that it is prudent to separate AMR contact points from the HAI contact points.

72. The Member from Poland inquired about the "representativeness of data".

73. In response to the Member from Poland, Carl Suetens informed that the full PPS survey in 2011 will be based on a representative sample of hospitals. The exact sampling design will be discussed with statisticians from different Member States. In response to queries raised about the HAI contact points, Carl Suetens replied that HAI surveillance contact points are already nominated by the Competent Bodies for surveillance, namely, general HAI surveillance contact points and specific contact points (for surgical site infection and ICU-acquired infection surveillance). He added that it is not mandatory for AF Members to nominate an additional contact point for the PPS.

b) Update on the Activities of the Project of European Surveillance of Healthcare-Associated Infections in Long-term Care Facilities *(Document AF21-8 Rev.1)*

74. Carl Suetens provided a recap on the objectives and methods of the HALT project.[21] He also highlighted some preliminary results and that it is the first international survey conducted on healthcare-associated infections in long-term care facilities. He concluded the session by presenting future plans and points for discussion.

75. Following the above-noted presentation, the Member from Belgium sought the definition of a nursing home.

76. The Members from France and Norway remarked that the protocol is too lengthy and that a shorter version is needed.

77. The Member from France expressed his apprehension regarding its acceptability. He also raised the issue about representativeness (representative sample of long-term care facilities) which, unlike the hospital PPS (previous item), is probably not to be pursued in a first stage for HALT. He suggested that "an integrated module, that is, how to develop basic principles in establishing representative samples" might be needed. He added "the timeline (May) is too short for implementation of the full HALT PPS", and requested "increased flexibility." He also suggested that the contact points should not be multiplied and that it should go via the Competent Bodies for surveillance.

78. This suggestion was seconded by the Alternates from the Netherlands and Sweden.

79. In response, the Acting Director stated that ECDC is currently discussing how to simplify the contact point schemes in order to avoid coordination problems.

[21] Item 8b - European Surveillance of HAI in LTCF (C Suetens).ppt

80. Regarding the definition of nursing homes, Carl Suetens replied that "ESAC has already collected qualitative data on this issue" and accordingly, HALT has defined four categories of nursing homes as explained in the background paper.

81. In terms of the sampling issue, Carl Suetens agreed that drawing representative samples (or rather "convenience samples") of long-term care facilities is not feasible at this stage. He also acknowledged the request to propose a shorter version of the protocol and to be more flexible in the timing of the survey in May, but said that the latter is conditional upon the terms of the contract.

82. Andrea Ammon added that a limited extension of the contract may be possible in order to allow more flexibility for the implementation of the HALT PPS in May.

83. The Head of Unit, Surveillance, also conveyed that for HAI nominated by the Competent Bodies, an "overarching general HAI surveillance contact point is in place."

EPIET: Update regarding external evaluation

84. Arnold Bosman, Head of Section for Training, Preparedness and Response Unit, presented the key areas subjected to external evaluation, the number of courses carried out and the next steps of the evaluation. He mentioned that the final report will be available in summer 2010. In this presentation, he highlighted the change in the funding structure; that the budget was transferred from "salary" to "operations". He anticipates complaints in delayed allowances due to this change, and the inflexibility of the new funding structure. He said there is a need for "additional course topics." He stressed the strong need to continue providing short courses, and noted that the "collaboration with national training programme has been excellent". Details can be found in his presentation.[22]

85. Following the EPIET update, the Member from Belgium inquired whether "the evaluation will cover job retention/survival of fellows that received training?" He also noted that it is "wiser to focus on the topics already provided and more experienced participants."

86. The Member from Germany declared a conflict of interest. He praised the outcome of EPIET trainings, saying "it has made huge contributions" and "provides networking opportunities for ECDC within Europe." He appealed to AF Members to "maintain and enhance the training" since EPIET still has a long way to go compared to the US. Among some of the solutions proposed were improved coordination and support to national partners.

87. The AF Member from Slovenia suggested that "salaries for associated EPIET fellows should be provided by the host countries (institutions), while ECDC pays for the modules." She also agreed that EPIET is "a beneficial investment."

88. The Member from Finland commented that sometimes the "notice for application time is too short."

[22] Item 9 - EPIET Update (A Bosman).ppt

89. With respect to the inquiry pertaining to job security, the Head of Section for Training replied that 90 per cent of trainees maintained their jobs in the public health sector; the rest went to the private sector and academia. He added that the short warning time is now mitigated by implementing web-based registration and the new routing selection.

Update from ECDC External Relations and Partnerships

90. Alena Petrakova, Senior Expert/Team Leader, Country Relations and Coordination, Director's Cabinet, presented the ECDC roadmap for EU Candidate and Potential Candidate Countries on the road to EU Membership.

91. The Senior Expert/Team Leader explained that ECDC is exploring the following areas of cooperation: a) Surveillance of Communicable Diseases; b) Preparedness and Response; and c) Capacity Building. In addition, she presented the aim of the ECDC Steering Group, which is to facilitate and monitor the development of cooperation with Candidate Countries (CC) and Potential Candidate Countries (PCC), and contribute to their integration with the EU, within the mandate of ECDC. She also informed about the following objectives of the Steering Group:

- Mapping ECDC contacts with CC and PCC up to present;
- Developing and monitoring the implementation of the "ECDC Roadmap for developing and implementing cooperation with the EU Candidate and Potential Candidate Countries in 2010-2013"; and
- Contributing to ECDC meetings with partner countries.

92. Further details can be found in Alena Petrakova's presentation.[23]

Presentation of ECDC AF Collaborative Workspace

93. Catherine Ginisty, Senior Web Editor, Health Communication Unit, presented the different functionalities of the ECDC AF Collaborative Workspace. She informed that Governance shall issue a communication to AF Members with respect to their login names and passwords prior to the next Advisory Forum meeting.[24]

Other matters

a) Update regarding the Spanish EU Presidency

94. In his presentation, the Member from Spain, Pedro Arias Bohigas, informed the plenary that the focus of the Spanish Presidency is on monitoring health-related issues. He highlighted the European Year for Combating Poverty and Social Exclusion; the EC Solidarity in Health and its social dimensions; the need to "pay more attention to

[23] Item 10 - Update Country Relations and Coordination (A Petrakova).ppt
[24] Item 11 - ECDC AF Collaborative Workspace (C Ginisty).ppt

surveillance data"; and how the financial crisis impacts health inequality. More details are found in his presentation.[25]

b) Update on the AF teleconferences

95. Johan Giesecke affirmed that the AF teleconference sessions will continue, albeit this will depend on the nature and necessity of the given issue.

Closing

96. Karl Ekdahl, Acting Director, ECDC, thanked the participants for their enriching discussions during the plenary sessions and working groups. He also took the opportunity to encourage them to attend the Crisis Communication Workshop directly following the meeting.

[25] Item 12a - Update Spanish presidency (P Arias Bohigas).ppt