ECDC Advisory Forum

AF23/Minutes

Minutes of the 23rd Meeting of the Advisory Forum
Stockholm 29-30 September 2010

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Opening and adoption of the agenda and noting the Declarations of Interest, if any *(Documents AF23/2 Rev.2; AF23/3 Rev.1)*

1. The Director greeted all participants and extended his best wishes for two productive days. He welcomed the Advisory Forum (AF) members and alternates to the AF's twenty-third meeting and asked the Forum whether Johan Giesecke, Chief Scientist and Head of the Scientific Advice Unit, could take over as chair of the meeting, while he would assume the role of privileged participant rather than that of chair. As no objections were voiced, this was taken as a vote of confidence for Johan Giesecke.

2. The Chair, Johan Giesecke, introduced the new Italian Member of the Advisory Forum, Silvia Declich and the Alternate from Norway, Hanne Nøkleby. The European Office of the WHO was represented by Guénaël Rodier. Observers included José Antonio Aranda da Silva (Pharmaceutical Group of the European Union), Ruth Gelletlie (European Public Health Association), and Anna Doboszyńska (European Federation of Allergy and Airways Diseases Patients' Associations).

3. Apologies were received from Bulgaria, Cyprus, Liechtenstein and Malta. Due to a strike of air traffic controllers in Belgium, the Commission's representative, Frank Van Loock, and the Member of Belgium, Herman Van Oyen, could not attend.

4. The Director pointed out that during a recent meeting at the European Parliament, participants had pointed out the relevance of declarations of interest and the strict rules that govern them. He subsequently asked that all AF members carefully fill in their declaration of interest forms, particularly when having ties to pharmaceutical companies. He also pointed out that potential conflicts of interest could arise unexpectedly, for instance, when last-minute additions to the agenda were made.

5. Kåre Mølbak, Member, Denmark, declared, in relation to agenda item 4 (Priorities for ECDC Work Programme 2011), that he is the leader of the EuroMOMO network, and his department is the hub of EUVACNET. He also noted that his Institute has a tender from ECDC for the seroepidemiology project (Item 5 - Surveillance issues: a) Proposals on ways in which to continue the following networks and possible integration in the Work Programme 2011: i. EUCAST Network; ii. EuroCJD Network; b) Seroepidemiology Project: Seroepidemiology as a public health tool to measure incidence of Salmonella and Campylobacter in humans). With further reference to the same item, Johan Carlson, Member, Sweden, declared that his Institute is involved with all these surveillance networks. Irina Lucenko, Alternate, Latvia, noted that she is the representative of Latvia in the EuroCJD project and Mike Catchpole, Member, United Kingdom, informed that his employer has close links to the current EuroCJD network coordinating unit. Darina O'Flanagan, Member, Ireland, noted that she is a member of the VENICE vaccine project (Item 6 - Epidemic Intelligence: update on recent threats in the EU). The Member from the United Kingdom, Mike Catchpole, informed, with reference to item 7 (Update on ECDC Microbiology Cooperation: Working with the National Microbiology Focal Points), that his employer has a contract with the EU to undertake a project on reference microbiology services at EU level. He also declared that he is the former chairman of the EPIET Steering Committee (including part of the period of evaluation) (Item 10 - Update on "External Evaluation of EPIET" and presentation of a new EPIET paradigm to address Member State needs). Under agenda item 10, Jean-Claude Desenclos, Member, France, informed that the INVS is funded by ECDC for participating in the EPIET training supervision. Kåre Mølbak, Member, Denmark, noted that his Institute hosts EPIET fellows. Gérard Krause, Member, Germany, informed that he is the

national head of FETP and a participant of RAGIDA (Item 11 - Results of the second expert consultation on the RAGIDA Project).

Adoption of the draft minutes of the 22nd meeting of the Advisory Forum held in Stockholm (5-6 May 2010) *(Document AF23/4)*

6. Paragraph 43 was modified to: The Member from Hungary stated that her country only had imported cases in the last ten years. Vaccination coverage for measles in Hungary is 99%, thanks to a mandatory vaccination system based on the right of the children to vaccination, anchored in the Hungarian constitution.

7. In reference to paragraph 48, the original text was replaced, upon the request of the Member from Belgium, with the following: "Another representative pointed out that Q fever was still a rare disease even if probably already endemic in some areas of Belgium considering the following: around 70% of the goat milk in Belgian milk tanks was tested positive for Coxiella. Belgium was actively screening the milk and so far identified 73 positive farms. Also, 75% of wool factory workers tested positive for Coxiella. The observations in Belgium cannot be traced back to the Netherlands; Coxiella is already endemic in Belgian life stock."

8. Paragraph 125 was corrected according to the amendment from the Belgian Member and reads now as follows: "The Alternate from Belgium informed that they have two saliva-based prevalence studies. The Alternate from Portugal informed that she has notification on Hepatitis C and only acute cases are notified, but most cases are chronic."

9. Paragraph 135 was amended accordingly: One area where the delegates expressed concern is the recent evidence and the efficacy of vaccine, especially with respect to the duration of immunity. It will be vital to have some information about the new evidence. It was advised to compare data from surveillance and ascertain if booster doses are needed.

10. The draft minutes were then adopted.

11. One member requested to add a discussion on TESSy metadata and related specifications to the agenda.

12. The Member from the United Kingdom expressed his compliments in respect to the quality of the detailed minutes.

13. The Chair announced that during the break, member portraits and a group photo would be taken.

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

14. The Director relayed to the AF the statement he presented to the 'Fineberg Committee', so named after Professor Harvey Fineberg, President of the Institute of Medicine of the US National Academy of Sciences, and chair of the WHO's internal review committee of the management of the H1N1 pandemic.

15. Several AF members lauded the statement, pointing out its balanced take on the events surrounding the 2009 influenza A(H1N1) pandemic. While the statement focussed on positive aspects, such as information sharing among Member States, informing the public, and the rapid production of vaccines, it also acknowledged weaknesses in handling the pandemic. It was both 'critical and constructive', as one member said. Another member observed that ECDC's statement, unlike many others, was not self-congratulatory and

provided some real insights into the complexity of the problems raised by the pandemic. Dr Fineberg's committee is scheduled to deliver a final report to WHO in May 2011.

16. The Director's statement to the Fineberg Committee would be made available on the ECDC web portal, as requested by a member.

17. The ensuing discussion covered communication and assessment issues. For instance, some citizens found the term 'pandemic' confusing: it evoked images of a devastating and deadly pandemic when in fact everybody was surprised by the mildness of the H1N1 pandemic (despite its strong effect on children). The confusion was aggravated by a widespread perception that the response measures taken by public health authorities were out of proportion, undermining public confidence in the ensuing vaccination programme, and potentially harming other vaccination programmes by strengthening anti-vaccination movements.

18. In order to rectify this, two major issues needed to be addressed: a) better assessment via a 'basket of indicators' (e.g. virus behaviour, increased parameters on mortality and morbidity, better information from hospitals) to capture the severity of disease; and b) a better understanding of how risk perception works, particularly for the general public and healthcare workers.

19. One member added that although the investment in vaccines was the right thing to do, a cost-benefit analysis and an assessment of health gains in risk groups would have facilitated decision making. In the future, a decision model that allowed flexible decision-making would be ideal.

20. In Ireland, a system loosely based on the US hurricane classification system is used to assess and classify the severity of an influenza pandemic. The Member was therefore rather sympathetic to the suggestion that a grading system/classification tool should prove to be helpful; on the other hand, one should not raise unreasonable expectations.

21. The Director added as a caveat that although a comprehensive basket of parameters linked to a decision-making tool would be extremely helpful, the unpredictability of influenza would limit the usefulness of such a tool.

22. One member encouraged ECDC to step up its work on risk perception and communication: "How do we communicate risks and vaccination programmes? We need to speak with one voice."

23. One AF member questioned the necessity of pandemic phases, opting for increased flexibility when dealing with an essentially unpredictable disease. This flexibility was already reflected in the communications approach. Despite the existence of national and supranational pandemic preparedness plans, modern communication tools would allow us to deviate from rigid plans and adapt all steps to the changing situation.

24. On the topic of communicating with the public via social media/Web 2.0, a member cautioned that unless an organisation had plenty of resources to fully engage in social media activities, it should refrain from Web 2.0 activities. Any type of partial engagement would do more harm than good.

25. One member criticised the model and strategies proposed by Neil M Ferguson: the Ferguson model – a large-scale epidemic simulation – exaggerated the impact of the then-new influenza since it was probably influenced by an exaggerated picture of the situation in Mexico. Overall, Ferguson's modelling approach and the conclusions drawn from it were not helpful. He therefore recommended that European mathematical modellers should pool their resources and conduct risk assessments that are fine-tuned to "time and territory".

26. Another member pointed out that pandemic-planning staff was once taught that any pandemic would invariably be disastrous. While WHO and ECDC were stating that the pandemic was in full swing, the actual impact on public health appeared to be minimal, particularly when looking at the elderly who carried some residual resistance. If this had been taken into account, less vaccine had been bought, as the statement 'Two doses are needed!' was completely incorrect.

27. The Director supported the view that the term 'pandemic' was, for better or worse, closely connected to deadly large-scale outbreaks and potentially misleading. He also emphasised the role-model function of general practitioners and other healthcare professionals, who very often did not get vaccinated. Communication with the healthcare community is therefore essential, as this is where opinions on vaccination are shaped.

28. The Director asked the AF how they perceived ECDC's role: Do Member States seek advice, guidance, recommendations, or merely options? And how do ECDC and EMA differ in their approaches as advisers to the Member States; how can we distinguish their different roles and responsibilities?

29. One member characterised the role of ECDC during the pandemic as crucial. During the pandemic, ECDC's opinion was injected into every weekly meeting at her national public health institute and greatly appreciated by all meeting participants. Apart from these informational aspects, ECDC exerts a certain influence on national decisions, but the final word lies with the national authorities.

30. Strong recommendations would incur increasing challenges for the Member States, one member opined. She also said that the combination of EMA's more restricted view with its focus on individual medicines with ECDC's broader epidemiological and public-health view was beneficial. This view was supported by another member who expressed that recommendations from EMA and ECDC were jointly appreciated.

31. EMA's role was not perceived uncritically. As EMA requires a consensus decision taken by 27 national delegates who are influenced by their countries' interests, a potential conflict of interest arises – even without any industry affiliations.

32. One member added that general advice was not always helpful, since the situation in the Member States differed considerably. Therefore, a 'graduated advice path' might be more appropriate, as it took into account the situation in individual countries and addressed heterogeneity.

33. The needs of improved risk communication were mentioned by one member. It would be particularly helpful to have ECDC's opinion in regard to the critical stance shown by the Cochrane Reviews.

34. National emergency plans, as one member pointed out, provided a wealth of helpful information during the course of a normal pandemic. ECDC's role should therefore be to offer guidance outside routine planning and offer insights into the unthinkable or develop fringe scenarios (mild pandemic, severe pandemic) and work out the true burden of the pandemic. ECDC could think ahead of time and work on threshold values, indices, or a dispassionate cost analysis. For such activities, ECDC was a natural choice, as the Centre was not tied to national interests.

35. One AF member noted that most Member States would prefer to receive recommendations from EMA and ECDC, though no formal mechanisms existed in that respect.

36. In an attempt to round up the discussion, the Director cited the Dutch public health institute's (RIVM) practice of providing 'scientific advice' to the government: the government is then at liberty to follow the scientific advice or opt not to do so. A 'recommendation' in this context would carry the wrong connotation. RIVM cannot 'recommend' anything to the Dutch government, and neither can ECDC give recommendations to the Member States. The role of ECDC is to present a scientifically sound 'public health view'.

37. The Director proceeded by presenting a series of slides1 that highlighted the Centre's activities since the last AF meeting.

38. Further updates followed from the Scientific Advice Unit, the Preparedness and Response support Unit, the Surveillance Unit and the Communication and Country cooperation Unit. The text of all presentations is available in a digital format.[1]

Priorities for ECDC Work Programme 2011

39. The Chair presented the priorities for the work plan 2011,[2] complete with a breakdown of projects and their total proposed operational budget.

40. The Director pointed out that the overall budget was – through a prioritisation process – reduced by 20% to create a general contingency reserve, if unforeseen projects required supplementary funds. This would give ECDC increased financial flexibility.

Surveillance issues:

a) Proposals on ways in which to continue the following networks and possible integration in the Work Programme 2011

i. EUCAST Network *(Document AF23/5)*

41. Ole Heuer, Senior Expert, Surveillance Unit, ECDC, presented, for information and discussion, recommendations for the future relationship between ECDC and the European Committee on Antimicrobial Susceptibility Testing (EUCAST) as the current agreement between the two organisations expires in September 2011. Among the suggestions presented were that the continued activity of EUCAST be supported by ECDC with the current structure of the committee maintained (more details can be found in Ole Heuer's presentation slides[3]).

42. AF members raised issues regarding the extent of the implementation of the network by Member States, conflict of interest of researchers usually funded by pharmaceutical companies, and activities regarding antiviral and antifungal resistance.

43. In response to the questions, Ole Heuer explained that breakpoints are expected to be implemented all over Europe within two or three years. As for conflict of interest issues, the statute of the Committee states that all experts should express any conflict of interest, but does not specify if these declarations should be made public. Antifungal activities are on the agenda of EUCAST, but the work is not advanced, while antiviral activities are not implemented due to a lack of EUCAST members with expertise in this area.

[1] Item 3 - Update from ECDC.pdf
[2] Item 4 - Priorities of the WP2011 (J Giesecke).pdf
[3] Item 5a(i) - EUCAST network (O Heuer).pdf

44. The Director declared himself impressed by the excellent work done by EUCAST, which, in his opinion, deserves support, and paid tribute to the chairman of the Committee, Gunnar Kahlmeter.

ii. EuroCJD Network *(Document AF23/6)*[4]

45. Johanna Takkinen, Senior Expert, Surveillance Unit, ECDC, presented a proposal for the future surveillance of variant Creutzfeldt-Jakob's disease (vCJD) at EU level,[5] as the contract with the current dedicated surveillance network, EuroCJD, ends in May 2011. She provided a short overview of the current epidemiological situation of vCJD and its trends. The proposal includes the transfer of historical dataset to ECDC, continuation of diagnostic support, assessment of public health impact of new research findings, performance of applied epidemiological research and strengthening collaboration with veterinary field, among other points.

46. One member commented that it is necessary to maintain expertise in prion diseases in the Member States, but it is difficult to convince politicians to retain a budget for such activities. Johanna Takkinen agreed that without expertise in Member States, the network would not survive, and she reinforced that researchers need support.

47. Questions were asked regarding how to detect an emerging problem, information on the veterinary side of the disease, and current trends of vCJD. Johanna Takkinen said that it is hard to predict a second wave of the disease due to the long incubation period (average 13 years), but the incidence is decreasing. The incidence of bovine spongiform encephalopathy (BSE) in animals is also decreasing. In humans, 8–10 cases per year of vCJD reported in the UK would indicate the end of the epidemic, but 12 cases have been reported in 2009.

48. Andrea Ammon, Head of Surveillance, ECDC, asked the AF members whether it is worthwhile to keep the network, given the current epidemiological situation. One member was in favour of continuing with the network, albeit not enhancing it. Another recommended continuing and enhancing it, in preparation for a second wave of the epidemic.

b) Seroepidemiology Project: Seroepidemiology as a public health tool to measure incidence of Salmonella and Campylobacter in humans

49. Kåre Mølbak, AF Member, Denmark, gave a presentation on the Seroepidemiology Project.[6] He presented seroepidemiology as a tool to measure incidence of diseases (seroincidence), results from the MedVetNet study, ongoing activities supported by ECDC and perspectives for the project.

50. Participants expressed their surprise that sero-incidence estimates of infections were between 100 times to several 1000-times higher than the incidence of cases captured by routine surveillance. Most had expected the multiplying factor to be around 10 or 12.

51. One question from the plenary addressed the detection of asymptomatic cases, which was answered by referring to a clearly defined population that was known to have been exposed to a dose of infection. Kåre Mølbak also pointed out that the antibody decay curve was the backbone of the presented model, with decay potentially different in different areas.

[4] Herman Van Oyen, Member, Belgium, could not attend AF23, but had noted that "[i]t was foreseen to integrate all DSN in ECDC. If this is no longer the case, some additional information to reasons why such an exception?"
[5] Item 5a(ii) - EuroCJD network (J Takkinen).pdf
[6] Item 5b - Seroepidemiology as a public health tool (K Moelbak).pdf

He also speculated that persons who grew up in a rural environment could be more resilient, as opposed to people from urban areas. Part of his work, he continued, involved assessing antibody response in asymptomatic people who took part in screening studies during which blood samples were taken.

Epidemic Intelligence: update on recent threats in the EU

52. The afternoon continued with a session entitled 'Epidemic intelligence: update on recent threats in the EU', which was chaired by Denis Coulombier, Head of Preparedness and Response support Unit, ECDC.

a) Polio situation in the European region

i. Situation of poliomyelitis in the European region

53. In a series of detailed slides, Guénaël Rodier, Director, Communicable Diseases, Health Security and Environment, WHO Regional Office for Europe, briefed the AF on an outbreak of wild poliovirus in Central Asian countries and Russia, covering the time span between January and mid-September 2010.

54. After providing an overview of the current epidemiological situation, he informed that central Asian countries should have access to Russian laboratories, which he considered "a natural choice". He also expressed his surprise that Uzbekistan had not yet reported any polio cases, despite cross-border traffic. Meanwhile, supplementary vaccination activities in the area were now well on the way.

ii. Impact on preparedness in the EU

55. Pierluigi Lopalco, Head of Section VPD, Scientific Advice Unit, ECDC, reported on poliomyelitis in the EU region and the consequences of the current outbreak for Europe.[7]

iii. Discussion

56. The Alternate from Portugal was surprised to see that her country, despite high vaccination coverage, was classified as a 'polio risk country', according to an Interagency Coordinating Committee (ICC) assessment. Guénaël Rodier advised to contact David Salisbury (Director – Immunisation, Department of Health, United Kingdom) to ascertain the exact reasons.

57. Further questions probed into the endemicity of polio in Tajikistan, and the criteria for declaring the country polio-free in 2002. In his response, Guénaël Rodier said that previous cases had originated in India, and Tajikistan neither had nor reported any polio cases for two years before being listed as polio-free.

b) Emergence of vector borne diseases in the EU

i. Local transmission of dengue fever in France

58. Jean-Claude Desenclos' (Member, France) presentation 'Distribution of *Ae. Albopictus* in Europe, July 2010'[8] informed the AF about the surveillance of dengue and chikungunya fever in France and several aspects of two limited outbreaks of autochthonous transmission of dengue (two cases) and chikungunya (two cases).

[7] Item 6a(ii) - Impact on preparedness in the EU (PL Lopalco).pdf
[8] Item 6b(i) - Local transmission of dengue fever in France (J-C Desenclos).pdf

59. Questions from the AF concerned the vector and its survival during winter (*Ae. albopictus* eggs survive the winter but there is no adult activity after November). In reply to a question about blood donations, Jean-Claude Desenclos pointed out that persons from affected areas were not allowed to donate blood.

60. According to Jean-Claude Desenclos, the number of imported dengue cases rose, but it is unclear if this was due to more dengue cases in endemic countries. Better diagnostics have also played a role.

61. Jean-Claude Desenclos hesitated to cite climate change as a factor for the spread of the mosquito, instead, he said that a 'specific variation in the climate might cause a high vector density.' Another factor he identified was travelling and transportation.

ii. Outbreak of West Nile in Greece[9]

62. Sotirios Tsiodras, Alternate, Greece, presented an outline of the events of the epidemic in Greece including the timeline of the epidemic, the epidemic curve, the geographical distribution and the incidence of severe cases. The outline of the response of Public Health authorities in Greece was presented, emphasising actions pertaining to: a) awareness about the disease and communication with clinicians and the public; b) the establishment of an ad hoc surveillance system; c) the work of a local crisis management field team that coordinated the inter-sectoral response, local health promotion actions and mosquito control; d) immediate blood safety measures; e) collaboration with veterinarian Public Health authorities and Entomologists for strengthening the surveillance networks; and f) collaboration and communication with the ECDC, the European Commission and international experts. The Alternate from Greece also expressed his appreciation for ECDC's team visit to his country and the performance of the risk assessment regarding this outbreak. He also acknowledged the entomological expertise provided by the colleagues from the University of Bologna following the request from the Greek Public Health authorities, which was helpful in the response to the pandemic.

63. Referring back to a 1996 outbreak in Romania, the Romanian AF Member emphasised the importance of tracking flight patterns of those migratory birds that are involved in West Nile virus transmission. In Romania, half of the southern districts report cases, as do the northern parts of Transylvania and Moldova, which could be related to the movements of migratory birds. Public health experts are currently trying to isolate the virus to determine whether West Nile virus lineage 1 or 2 affects the areas mentioned above.

64. Spain reported a second WNV infection and at the same time expressed concern that only very few pesticides are approved. Pesticide guidelines do not allow the authorities to take proper steps to control the vector. A fellow AF member replied that he found US advice helpful, which suggested that adulticides should be sprayed onto trees, shrubs and other upland vegetation, while larvicides should be used in 'enclosed' waters, i.e., dumpsters, old tires, birdbaths, etc. Details are available at: http://www.maine.gov/dep/blwq/topic/westnile/municipal.htm and http://www.maine.gov/agriculture/pesticides/public/index.htm#mosquito

iii. Impact on preparedness in the EU

65. Hervé Zeller, Senior Expert, Scientific Advice Unit, ECDC, followed up on the two presentations and presented on dengue and West Nile fever and the impact on preparedness.[10]

[9] Item 6b(ii) - Outbreak of West Nile in Greece (S Tsiodras).pdf
[10] Item 6b(iii) - Impact on preparedness in the EU (H Zeller).pdf

He emphasised that public health measures, intersectoral and international collaboration are essential to adapt to this new situation: enhanced lab capacities were needed and an EU Regulation for blood donations from areas affected by West Nile virus. Also needed were risk assessments and risk maps.

c) Narcolepsy associated with pandemic influenza vaccine

i. Narcolepsy following pandemic vaccine

66. Petri Ruutu, Member, Finland reported about a putative link between GlaxoSmithKline's Pandemrix pandemic H1N1 vaccine and six cases of narcolepsy in Finland, which eventually caused the Finnish National Institute for Health and Welfare to recommend that Pandemrix vaccinations be discontinued.

ii. Plan for an EU study

67. Petri Ruutu's presentation was followed by Piotr Karmarz's (Deputy Head of Unit, Scientific Advice) short presentation[11] entitled, 'Narcolepsy: plan for an EU study' which eventually caused the Finnish National Institute for Health and Welfare to recommend stopping active campaigning with Pandemrix vaccine.

iii. Discussion

68. Participants wondered about the long delay between the onset of symptoms and diagnosis, and how this would influence the study. As narcolepsy develops slowly, some people might have experienced early symptoms before the actual influenza shot. Other AF members cautioned that the sample size calculation was important and mentioned a possible selection bias, due to the fact that there was a lot of publicity around this phenomenon both in Finland and Sweden, which might have influenced reporting of cases and also cause a recall bias (cases wherein the events were recalled much better than the controls). The Polish Member assuaged these fears by stating that bias would not be an issue in a properly conducted case-control study. Piotr Kramarz clarified that, to ECDC's knowledge, most cases in Finland and Sweden have actually been reported before media attention started; thus the impact should be minimal. Also, subjects from several other countries, where there was no media reaction, will be included in the study, which should reduce the impact of any such residual bias in the pooled analysis. In any case, the concern will be discussed with the project team as to how to best address it.

69. The fact that the VAESCO project had been in place since 2008 was seen as a fortunate coincidence. VAESCO could now be utilised to assess a possible association between pandemic vaccines, pandemic influenza, other factors on the one hand with GBS, and narcolepsy on the other.

[11] Item 6c(ii) - Narcolepsy_Plan for an EU study (P Kramarz).pdf

Update on ECDC Microbiology Cooperation: Working with the National Microbiology Focal Points *(Document AF23/7)*[12]

a) General background

70. Amanda Ozin-Hofsäss, Senior Expert Bacteriology, Scientific Advice Unit, ECDC, gave a presentation on ECDC's activities in the field of microbiology.[13] A milestone in ECDC's laboratory strategy was the publication of a technical document entitled 'Core functions of microbiology reference laboratories for communicable diseases', which was endorsed by all Member States. This document is regarded as the basis for all further work in this field.

71. Amanda Ozin-Hofsäss also mentioned that ECDC was involved in a total of 27 projects with a microbiology/laboratory network component. In response to a comment that recommended a strategic focus and thus fewer projects, she acknowledged this general statement and added that it seems like many projects, but it is probably because they are presented in a single table and not as part of the Disease Specific Programmes (DSP). The AF was aware of this and has endorsed most these projects, the majority of which (16) could be described as DSP network projects. The other projects deal with scientific advice for capacity building of reference laboratories, biosafety, mapping laboratory capacity and laboratory quality issues.

b) Reference laboratories

72. Irina Codita, National Microbiology Focal Point, gave a brief overview of the situation of microbiological laboratories in Romania.[14] She described the situation of the national reference laboratories, their legal foundation, the accreditation process, and the number and location of laboratories, their choice of equipment, and their participation in international activities. When addressing problems of the Romanian system, she cited her country's difficulties in establishing of BSL-3 facilities with World Bank funding.

73. In closing, she mentioned that ECDC's technical document, 'Core functions of microbiology reference laboratories for communicable diseases', was adopted as a guidance document in Romania.

c) Microbiology training

74. Marion Koopmans, National Microbiology Focal Point, Netherlands, reported on the work of the National Microbiology Focal Points (NMFPs), a group of experts that had been meeting twice a year since 2007.[15] The NMFPs main achievement was the production of the 'Core functions' document. She emphasised that public health microbiology is not synonymous with clinical microbiology; it is a field of science in its own right. She elaborated on her work with the European Public Health Microbiology Training Programme (EUPHEM), launched in 2008 with its first two graduates in 2010.

[12] Herman Van Oyen, Member, Belgium, who could not attend AF23, remarked that the role of the NFP should be clarified. The additional attribution of a role in surveillance may hamper the nomination of the most appropriate person.
[13] Item 7a - General Background NMFP (A Ozin-Hofsäss).pdf
[14] Item 7b - Reference laboratories (I Codita).pdf
[15] Item 7c - Microbiology training (M Koopmans).pdf

75. The Director took the opportunity to express his personal satisfaction that ECDC had refrained from establishing its own laboratory capacity and instead supported the Member States by strengthening their laboratory systems.

76. He asked the AF what the essential components of a national laboratory network were, particularly when taking into consideration the cutbacks in the public health sector. ECDC would like to provide assistance in national assessment processes.

77. Members discussed the ECDC general laboratory strategy (MB11/11 paper) as presented. One member acknowledged that facilitation of collaborations of EU high containment laboratories and networking of national reference laboratories were essential and of added value; however, the key objectives in the overall strategy on how to achieve specific goals is at this point not concrete enough. Training was another essential issue, he continued, as was the integration of public health microbiology with public health epidemiology (as could be seen by examining the current situation of WNV and AMR).

78. Amanda Ozin-Hofsäss was asked whether the directory of laboratories she had mentioned earlier was accessible via the ECDC web portal. She responded that in 2011 the ECDC Knowledge Management team will be further developing this start-up directory to make it accessible via a future "microbiology" extranet for AF, MB, NMFPs and other agreed ECDC partner groups. Similarly, recent survey results of public health microbiology systems, structures, gaps, and needs (conducted with the NMFPs in 2008 and analysed in 2009-2010) would be shared in an ECDC Technical Report publication expected in December 2010. This publication will be comprised of aggregated data from the responding countries.

79. The AF then split into three working groups.

Results of the Working Group Sessions

a) Working Group A: Collaboration with national microbiology laboratories and research institutes in the EU

80. Chaired and reported by the Member from Germany, the group discussed criteria for what national microbiology reference laboratories should cover. They acknowledged the document from ECDC[16] as a satisfactory and useful source for this purpose and had only a number of minor suggestions to improve clarity.

81. With regards to current work of the European Commission (DG SANCO), exploring options for a concept and the infrastructure of reference laboratories/laboratory system to serve the EU (called EURLOP project) and the need to have feedback from the National Microbiology Focal Points (NMFPs). Further use of surveys to Member State contact points with too many, and too detailed questions were considered difficult to follow and time-consuming. Conflicts of interests were also mentioned including duplication of previous work of ECDC.

82. The importance of supporting microbiology laboratory reference centres was recognised, especially for smaller countries, which need it the most.

83. As for the EC suggestion of mapping of reference laboratory capacity in the EU in the above mentioned EURLOP project, the AF working group found that it is not necessary to

[16] ECDC Technical Report. Core Functions of microbiology reference laboratories for communicable diseases. Stockholm; June 2010.
http://www.ecdc.europa.eu/en/publications/Publications/Forms/ECDC_DispForm.aspx?ID=538

have such detailed knowledge of such national level services, and specifically internal financial issues. As a conclusion, the group declared that ECDC should technically and strategically support DG SANCO to improve on design of the study's approach and provide independent scientific advice on these issues, as part of the ECDC microbiology work programme, even if the project is funded by the EC. Also, it was pointed out that ECDC would be a good coordinator and technical implementer for any future supranational system, even though many of the current ECDC staff are not microbiologists by training.

84. Among the various comments and questions from the floor, one member argued that the AF should encourage Member States to include ECDC in this process of discussing options for supranational microbiology reference laboratory capacity in the EU in the future and that funding should not be a battle between ECDC and the EC.

85. As for lab surveys, they were considered important by one member, though time-consuming. Another member suggested that ECDC should first determine what it expects from the laboratories and then ask Member States what they need to deliver such expectations.

86. One member of the AF expressed concern that European funding for laboratories might go where the best capacity is already established.

87. Another member commented that ECDC needs to define a strategy for national microbiology reference laboratories, since the Agency seems to be the most suitable in Europe for doing so. It was also argued that there is a need for precision in terminology, for example, 'laboratory capacity' and 'surveillance' should be better defined.

88. The Chair considered relevant the process ECDC has just undertaken and presented at this AF meeting regarding a "mid-term review" of ECDC microbiology activities and laboratory collaborations to clarify where ECDC stands today and what Member States can expect from ECDC for the next steps.

89. One member listed what he expects from ECDC: continued coordination, provision of scientific advice and guidance and education, collection of information, less meetings and more efficiency.

90. The Director wrapped up the discussion with a few questions: What should Member States have in terms of microbiology reference laboratory capacity? What is needed? Who can provide what is needed? How can all of this be organised when Member States face budget cuts? These questions are particularly relevant in the context of meeting the expected 2012 implementation plans for the International Health Regulations (IHR 2005).

b) Working Group B: Main challenges for the EU in communicable diseases over the next decade: How should ECDC address them?

91. Tsiodras Sotirios, Alternate, Greece, chaired the working group and Marion van der Sande, Alternate, the Netherlands, reported back to the AF.[17] The group identified a few challenges: incorporating new science; emphasising the role for partnership in public health; (un)foreseeable challenges; financial constraints; improving communication of uncertainties; and overlapping of actions/players. An example was given in the field of healthcare-associated infections.

92. One member commented that the main problem is filling the gaps between ECDC and Member State's work, such as in wild life microbiology in the EU. Another expressed that

[17] Working Group B.pdf

Member States are pleased to receive risk assessments from ECDC in areas where they lack expertise (such as emerging and rare diseases, and antimicrobial resistance), but not so much for more common and vaccine-preventable diseases. In his opinion, ECDC should first assess what capacity there is in Member States and apply the findings as criteria for defining priorities.

c) Working Group C: ECDC's role in epidemiological function capacity building

93. Mike Catchpole, Member, United Kingdom, reported the group's discussion to the AF.[18] Three points were highlighted: workforce development in Member States, including recruiting and retaining skilled staff and continuing education; science/methodology, including guidelines, protocols and models of best practice; and infrastructure, including support for sub-regional cooperation and software tools.

94. During the discussion, it was repeated that ECDC needs to identify where the gaps are. WHO questionnaires, according to one member, do not necessary help in this sense and can be counter-productive. Country visits could be more helpful in identifying issues.

95. One member commented that many countries have difficulties training epidemiologists and there is a shortage of highly skilled people. He suggested the creation of a European school of epidemiology, which could be attractive to people in the Member States who endeavour to have a career in this field.

ECDC's Work with the EU Member States

96. The Chair presented, for information only, ideas in regards to ECDC's work with national Competent Bodies (CB).[19] He stated that the present structure of ECDC CB has become rather complex and suggested a few improvements to the system, including the reduction of the number of CB per Member State to one only and a cascading system for nominating national experts/focal points.

97. AF members generally welcomed the idea of restructuring and asked detailed questions about the nomination process of experts/focal points and whether some CB would be excluded from this system. Johan Giesecke explained that answers for those questions remain open, as many aspects still need to be thought through.

98. One member suggested that the names of focal points be made public, to which Andrea Ammon replied that this information would be available via the extranet, albeit not public due to data protection issues. Member States would thus be responsible for keeping it up-to-date. One member stated that he did not see any data protection issues in respect to such information being made public.

[18] Working Group C.pdf
[19] Item 8 - ECDC's work with EU Member States (J Giesecke).pdf

ECDC's Role in Stock Holding of Rarely Used Therapeutic or Prophylactic Immunoglobulins *(Document AF23/8)*[20]

99. Several Member States have raised the issue whether there might be a role for ECDC in holding a (real or virtual) stock of rarely used immunoglobulins and antitoxins. The AF Member from the UK presented the item for discussion. He gave an overview of an anthrax outbreak situation in the UK, when immunoglobulins had to be sourced from the U.S.A. He suggested that ECDC could be a 'one-stop shop' for products of this sort, which are rarely used, by either holding a catalogue with information about where to find the products or by holding information about which countries have a stockpile of specific products.

100. For the first time, electronic voting was used in the AF meeting. Members voted on the matter. The questions and the results were the following:

- Is there a need for Commission's coordination with respect to stock holding of rarely used therapeutic or prophylactic immunoglobulins?
  - Yes: 92.31%
  - No: 7.69%
- Is there a role for ECDC in holding a (real or virtual) stock of rarely used immunoglobulins and antitoxins?
  - Yes: 66.67%
  - No: 33.33%
- If yes, should there be a refrigerator at ECDC?
  - Yes: 42.31%
  - No: 57.69%

101. During the discussion, the AF Member from Sweden stated that his country has some experience in stockpiling such products and regarded the activity as a large undertaking, prone to logistical problems and political obstacles. As distances are large in Europe, he suggested a sub-regional cooperation in the fashion of the existing Nordic countries' cooperation.

102. Most members perceived an added value for ECDC in coordinating such cooperation. The creation of a catalogue with information about which country holds which products, with contact names and telephone numbers, was suggested. The representative from WHO welcomed the idea of having a source in the EU for therapeutic and diagnostic rare products.

[20] Herman Van Oyen, Member, Belgium, who could not attend AF23, noted that "the problem also exists in his country. However, the role of ECDC should in the first place bring this to the attention of DG Sanco. It is the responsibility of DG Sanco to organise the discussion as this issue should firstly be treated at the political level. The outcome can serve to define the role of ECDC."

Update on "External Evaluation of EPIET" and presentation of a new EPIET paradigm to address Member State needs *(Document AF23/9)*[21]

103. Arnold Bosman, Head of Training Section, Preparedness and Response support Unit, ECDC, presented the European Programme for Intervention Epidemiology Training (EPIET) external evaluation report and a list of actions that ECDC is taking to implement these recommendations.[22] He also spoke about a new paradigm for a training programme, including two different tracks for EPIET: an EU track (training abroad) and a MS track (training in own country).

104. Several members thanked and congratulated ECDC for the training programme and applauded the suggested increasingly flexible approach. The MS track was considered a satisfactory solution for the brain-drain problem faced by some Member States. There were comments about the need to reinforce national training programmes, career paths in Member States for trained professionals and continuing education.

105. In response to questions from the floor, Arnold Bosman explained that the risk of reducing quality by expanding the number of trainees in modules has been looked at, and that some modules will allow an increase to large numbers of fellows provided that teaching is done in small working groups of eight to ten people. Other modules have a different pedagogical design, and will have a maximum limit to the total number of fellows. These operational details will be discussed with the EPIET training site forum, as the appointed (by ECDC Director) group of expert advisors for the programme.

106. Denis Coulombier, Head of Preparedness and Response support Unit, ECDC, added that ECDC needs a commitment from Member States to provide facilities to help organising courses. As for short modules, he emphasised the need for different training content for middle-level professionals in the Member States. A model for managerial skills is available for Member States but not yet open to EPIET fellows.

Results of the second expert consultation on the RAGIDA Project
(Document AF23/10)

107. Katrin Leitmeyer, Senior Expert, Preparedness and support to Response Unit, ECDC, reported on the progress of the Risk Assessment Guidance for Infectious Diseases Transmitted on Aircrafts (RAGIDA) Project,[23] for discussion and comments. The second part of the project is being completed.

108. There was a brief discussion about the necessity of developing guidance on measles and rubella, diseases that are vaccine preventable, but, due to a lack of time, the Chair requested that AF members submit their comments in writing directly to Katrin Leitmeyer.

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[21] Herman Van Oyen, Member, Belgium, who could not attend AF23, remarked as follows: "The question is if the increase in budget should only be given to the EPIET fellow and if in the long run there is no risk for an imbalance towards on the job-trained persons. There should be a better interaction with the formal academic training, including PhD level. There should also be a reflection on the involvement of ECDC in the continuous training of (senior) officials already working in MS in the framework of lifelong learning, but also because there is a substantial heterogeneity in capacity within Europe. With respect to breakdown of the MS track fellows, the criteria of population size may be the most easy one, but it is probably not the most efficient (see the concept of the "Matheus effect" in sociology). Other criteria in terms of the need for more highly trained people may also be considered."

[22] Item 10 - Update on External evaluation of EPIET (A Bosman).pdf

[23] Item 11 - Results of the second expert consult on RAGIDA (K Leitmeyer).pdf

Update on antimicrobial resistance (AMR) and healthcare-associated infections (HAI) activities

109. Dominique Monnet, Senior Expert and Programme coordinator, and Anna-Pelagia Magiorakos, Expert (both from AMR/HAI, Scientific Advice Unit, ECDC) reported updates on five activities from their programme: a) EARS-Net, HAI-Net and European point prevalence survey on HAI and antimicrobial use; b) Rapid threat assessment on New Delhi metallo-betalactamase (NDM-1) carbapenemase-producing *Enterobacteriaceae* from the Indian subcontinent; c) Risk assessment on the spread of carbapenemase-producing *Enterobacteriaceae* through patient transfer between healthcare facilities, with special emphasis on cross-border transfer; d) Multidrug-resistant (MDR), extensively drug-resistant (XDR) and pan-drug resistant (PDR) bacteria in healthcare settings – Expert proposal for a standardised international terminology; and e) Trans Atlantic Task Force on Antimicrobial Resistance (TATFAR). More details in their presentation slides.[24]

ECDC Communication and Country cooperation Unit (CCU) Activities

110. Sarah Earnshaw, Expert in Public Communication, Communication and Country cooperation Unit, ECDC, provided an update on the activities and preparations for the European Antibiotic Awareness Day 2010.[25] She described the materials that will be available to Member States for use in national campaigns on 18 November. 36 Participants have confirmed their participation.

Update regarding the Spanish EU Presidency

111. The Alternate from Spain, Rosa Cano-Portero, delivered a presentation about the more than 40 health-related events and activities undertaken by the Spanish government in the first half of 2010, when the country held the Presidency of the EU.[26] Highlights were: a directive and action plan on organ donation and transplantation, a directive on the application of patient's rights in cross-border healthcare and a conference on patient safety, plus a multitude of meetings, conferences and workshops.

Report back on Advisory Forum teleconferences

112. Johan Giesecke, Chief Scientist and the Chair of the AF, announced that this item will be postponed to a forthcoming Advisory Forum meeting.

Confirmation and approval of 2011 Advisory Forum Meeting Dates

(Document AF23/11)

113. The Chair confirmed the dates for the 2011 AF meetings: 16-17 February (AF25), 5-6 May (AF26), 28-29 September (AF27), and 7-8 December (AF28).

Any other business

114. As requested by the Director, the AF members were presented several questions via the new electronic voting system. The questions and the results were the following:

[24] Item 12 - Update on ARHAI activities (A-P Magiorakos, D Monnet).pdf
[25] Item 13 - EAAD (S Earnshaw).pdf
[26] Item 14 - Update regarding the Spanish EU Presidency (R Cano-Portero).pdf

- Should ECDC have a prominent role in organising capacity building of public health laboratories in the EU?
  - Yes: 85.71%
  - No: 14.29%
- Should ECDC take the lead in setting up reference laboratories in the EU?
  - Yes: 69.57%
  - No: 30.43%
- How do you see the interaction between ECDC staff and the AF during this meeting?
  - Adequate: 62.50%
  - ECDC staff should be more active: 12.50%
  - AF should be more active: 25%
- ECDC played a role in the assessment of pandemic preparedness for the Member States. ECDC should play a similar role in assessing whether the Member States fully implemented the IHR in 2012?
  - Yes: 85.71%
  - No: 14.29%
- I expect that, given the developments in my country, the National Public Health Institute has adequate resources in 2011 to fulfil its mission.
  - Yes: 28.57%
  - No: 71.43%
- One of the requirements in the IHR is that my country is able to diagnose or detect a public health threat. In my view, my country is able and ready to meet the requirements of the IHR.
  - Able: 52.38%
  - Not able: 14.29%
  - Unsure: 33.33%

115. The Chair thanked everyone for a fruitful meeting and wished them a safe journey back home.