ECDC Advisory Forum

AF22/Minutes

Minutes of the 22nd Meeting of the Advisory Forum
Stockholm, 5-6 May 2010

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Opening and introduction from the new Director of ECDC

1. The Chair, Chief Scientist Johan Giesecke, opened the meeting and welcomed the Advisory Forum (AF) members and alternates to the AF's twenty-second meeting. He also presented Dr Marc Sprenger, ECDC's new Director, who then proceeded to briefly introduce himself. The Director ended his presentation by acknowledging his predecessor's excellent work and renewed his determination to focus on scientific excellence, collaboration and partnerships, and organisational performance. Details can be found in the Director's presentation slides.[1]

2. The Director also took the opportunity to announce that the Chief Scientist has now been appointed as Chair for all future AF meetings.

3. One delegate expressed, in the name of the entire AF, a warm welcome to the new Director. In response to the Director's request to identify topics for ECDC's upcoming work plan, he said that it was too early to give specific recommendations at this stage, but that he supported all strengthening activities such as the surveillance networks and EPIET. He also preferred that ESCAIDE conferences be held in different EU locations. In addition, he proposed that EPIET networking should be expanded.

4. This was seconded by another delegate. She pointed out that ECDC has been a tremendous support to small countries and has also been responsible for much of the work in these countries. In smaller countries, threat assessment and response are usually carried out by the same person, which at times can incur a heavy workload. The assistance and support offered by ECDC should grow along with ECDC's demands and country specific needs.

5. The Director responded that while managing diversity is a difficult task, ECDC shall rise to the challenge. Part of this effort is a commitment to service orientation, one of the elements of ECDC's core value project, which is chaired by Andrea Ammon, Head of Surveillance Unit, ECDC.

6. One representative commended ECDC's "unique collection of intellectual talent" and the opportunity for innovation inherent in ECDC's responses to public health challenges: "ECDC is particularly helpful in its support of smaller countries, where it creates added value."

7. The Director added that he hoped that ECDC's future products would carry enough credibility so that the scientific guidance provided by ECDC would only have to be slightly modified at the country level in order to conform to the local/national situation, instead of duplicating efforts at the national health council levels.

8. In a related comment, one delegate explained that striking the right balance between conflicting demands has not always been easy. Frequently, health officials are caught between a) local politics, b) EU scientific advice, and c) public pressure, for instance, during the influenza pandemic. In situations like this, hard facts and evidence-based medicine are precisely what is needed in the Member States, he said.

9. One delegate seconded the Director's opinion on country cooperation by emphasising the importance of developing good relations with the EU's neighbouring countries. He also underlined that the Member States not only needed reports and surveillance at the EU level, but also better national surveillance, as action could only

[1] Item 1 - Presentation of new ECDC Director (M Sprenger).ppt

be taken at the national level. Thus any improvements of EU surveillance should also benefit the national level.

10. The Director added that prior to the release of ECDC's first Annual Epidemiological Report (AER), some Member States initially voiced concerns, but that the AER proved very helpful in the long run as it stimulated national surveillance.

Adoption of the agenda and noting the Declarations of Interest

(Documents AF22/2 Rev.2 and AF22/3 Rev.2)

11. The Chair relayed apologies from the representatives of Bulgaria, Denmark, Italy, Liechtenstein, and the European Patients' Forum.

12. The Chair called for the submission of Declarations of Interest forms to the Secretariat in respect of the agenda items. In reference to agenda item 4 (Update on main activities since the last Advisory Forum meeting), Preben Aavitsland, Member, Norway, declared that he is a member of the WHO Review Committee for IHR. Petri Ruutu, Member, Finland, informed that THL is a part of the VAESCO Project (agenda item 11, Update on ECDC involvement in public health aspects of vaccine safety/risk assessment). Under agenda item 7 (Update on measles elimination in Europe), Darina O'Flanagan, Member, Ireland, informed that she is a group leader in one of the VENICE Projects (childhood immunisation schedule). In reference to agenda item 8 (Q fever Risk Assessment), Jean-Claude Desenclos, Member, France, informed that he organised the meeting of experts in Paris from a logistics aspect only. Roel Coutinho, Member, Netherlands, noted that the Q fever assessment pertains to the situation in the Netherlands in which he is closely involved. He also declared that the 'Burden of Communicable Diseases in Europe' project is done partly in his department (agenda item 10, Update on the 'Burden of Communicable Diseases in Europe' project). Under item 9 (Priorities for Scientific Advice), Mike Catchpole, Member, United Kingdom, submitted a request that VTEC on Open forms should be included as a priority.

13. The Chair welcomed the following new members and alternates: Sophie Quoilin (Alternate), Belgium; Loreta Ašoklienė (Member), Lithuania; Rosa Cano-Portero (Alternate), Spain; Johan Carlson (Member), Sweden and Guénaël Rodier, WHO Regional Office for Europe.

14. The draft agenda was slightly adjusted to accommodate the scheduling constraints of some of the presenters, but otherwise adopted.

Adoption of the draft minutes of the 21st meeting of the Advisory Forum held in Stockholm, 17–18 February 2010 *(Document AF22/4 Rev.2)*

15. In reference to paragraph 39, the AF Member from France, Jean-Claude Desenclos, requested that "should share the final paper [...] before going public" be replaced with "would be useful to share the final paper [...] prior to publication".

16. In reference to paragraph 41, the AF Member from Ireland, Darina O'Flanagan, requested that "plan to use H1N1 vaccination centres for MMR" be replaced with "hope to use H1N1 vaccination centres for MMR."

17. Following the above amendments, the draft minutes were adopted.

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

a) Update from ECDC

18. Karl Ekdahl, Head of the Health Communication Unit, ECDC, updated the AF on ECDC's general activities since the last meeting. His overview included the draft Seat Agreement with Sweden, plans for a new building, and the Director's Annual Report 2009. Details can be found in his section of the presentation on recent ECDC activities.[2]

19. Maarit Kokki, Coordinator, Office of the Director, ECDC, reported on some key issues that kept the Office of the Director busy since the last meeting of the AF. Activities included preparations for the 18th Management Board meeting, the briefings for the new Director, and the coordination of two country visits. Details are available in her respective section of the presentation slides.[3]

20. Updates from the other Units followed: Denis Coulombier (Head of Preparedness and Response Unit), Piotr Kramarz (Deputy Head of Scientific Advice Unit), Andrea Ammon (Head of Surveillance Unit), Ines Steffens (Head of the Scientific Communications Section and Managing Editor of Eurosurveillance, Health Communication Unit) presented their updates as PowerPoint slides.[3]

21. In response to Piotr Kramarz's presentation, an AF delegate pointed out that the evaluation of the pandemic was important and that he was rather displeased about the low immunisation uptake rates. He also recommended seroprevalence studies. Piotr Kramarz responded that efforts are underway to pool together expertise from several seroprevalence studies performed in the Member States. The next EISN (European Influenza Surveillance Network) meeting would address this topic.

b) Update from the European Commission

22. Matti Rajala, Commission Liaison Officer on Secondment and representative of the European Commission, briefed the AF on administrative changes at the Directorate-General for Health & Consumers (Mrs Testori-Coggi was appointed as the new Director General; the Commission's pharmaceutical unit has now started in DG SANCO). He also reported on an evaluation report on pandemic response, the review of the "Community pandemic influenza preparedness plan" (a proposal for a Council Recommendation), and several pandemic influenza preparedness activities. Details on the Commission's activities can be found in Matti Rajala's presentation.[3]

c) Update from the WHO Regional Office for Europe

23. Guénaël Rodier, Director, Division of Communicable Diseases, Health Security and Environment, highlighted the major developments at the WHO Regional Office for Europe. Led by the Regional Director, Zsuzsanna Jakab, the management team now includes Arun Nanda and Lucianne Licari. He outlined the vision of the new Regional Director, including "six main priorities" and areas where WHO/Euro and ECDC share similar activities. He also provided an activity update.[4]

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[2] Item 4a - Update from ECDC.ppt
[3] Item 4b - Update from the European Commission (M Rajala).ppt
[4] Item 4c - Update from the WHO Regional Office for Europe (G Rodier).ppt

24. In response to Guénaël Rodier's presentation, one delegate predicted that in times of economic crisis, rising unemployment and income loss, it would become increasingly difficult to adequately deal with public health problems since the financial means are lacking.

Epidemic Intelligence: Update on recent threats in the EU

a) Update on emerging threats

25. Denis Coulombier, Head of Preparedness and Response Unit, ECDC, provided a brief update on monitored threats. He reported that 18 threats were monitored, five threat assessments were completed, and the A(H1N1) threat was now closed. Further details are available in his presentation.[5]

b) Poliomyelitis in Tajikistan

26. Guénaël Rodier reported on poliomyelitis in Tajikistan and the Tajik health authorities' efforts to curb the outbreak. As of 4 May 2010, 216 cases had been reported. Further details are available in his PowerPoint presentation.[6]

27. In response to a question, he affirmed that all cases except two involved children.

28. One representative sought clarification on the procedures and criteria of announcing the "eradication of polio". Guénaël Rodier replied that an outbreak such as the one in Tajikistan would not automatically imply that the certification of the WHO European Region as polio-free would have to be revoked.

29. Further questions referred to the type of polio vaccine recommended by WHO (oral polio vaccine [OPV 1]), the coverage in Dushanbe (98%), and whether there were difficulties in accessing OPV (such problems were only reported from Australia, where some local facilities had to resort to IPV).

30. One delegate mentioned that the current outbreak provided an opportunity to create awareness for poliomyelitis in her country.

c) Infection with Enterobacteriaceae that produce *Klebsiella pneumoniae* carbapenemases (KPC): recent experience from France and implications for Europe

31. The Member from France briefed the AF on the recent experience from his country with Enterobacteriaceae that produce *Klebsiella pneumoniae* carbapenemases (KPC).[7] He ended with a plea for more research, complete transparency and guidelines targeting patients that were transferred from high-risk countries. At the EU level, a European risk assessment (ECDC) would be helpful. Also, KPC should be included in epidemic intelligence routine activities. Finally, national and international (European) guidelines should be developed.

32. During the discussion, it was asked whether ECDC should take a more active approach towards KPC. One delegate said that his country experienced over 70 cases in 2009, predominantly imported through contacts with India and Pakistan (NDM-1 was

[5] Item 5a - Epidemic intelligence Update on recent threats (D Coulombier).ppt
[6] Item 5b - Poliomyelitis in Tajikistan (G Rodier).ppt
[7] Item 5c - Spread and control of KPC and other resistant bacteria in Europe (J-C Desenclos).ppt

strongly linked to India and Pakistan). Since KPC infection is not easily detected, protocols for detection were essential, as was stringent infection control.

33. The Member from France was asked whether the French KPC cases had been reported under the IHR/EWRS. He replied that this had not been the case as the link to Greece was not proven. EPIS was suggested as a suitable information platform for KPC, but one delegate strongly disapproved as this would increase the flood of EPIS messages even more.

34. The Alternate from Greece noted that KPC pathogens were obviously on the rise, but maintained that for information purposes, KPC cases would fall under the umbrella of AMR issues. In Greece, a national strategic plan had been initiated to address a certain clone (ST2), which circulated in Greece, but also in several other countries, including the U.S.A. He was also in favour of starting a risk assessment process that included intervention measures.

d) Rift Valley fever infection in a German tourist returning from South Africa

35. Gérard Krause, Member, Germany, presented a series of slides on the case of a 50-year-old woman who was, upon returning from South Africa, diagnosed with Rift Valley fever.[8] The disease was probably transmitted through mosquito bites. After careful consideration, the Member's institute did not go beyond reminding travellers of general preventive measures. At the public health level, some questions remain: where is the threshold of posting information via EWRS and IHR? Could an information overflow cast doubts on public health warnings by blowing things out of proportion? This topic was suggested by Denis Coulombier to be proposed for a Working Group discussion in the next AF meeting.

36. A delegate reminded the AF that, based on estimates, 14 000 to 20 000 UK residents would travel to South Africa for the 2010 soccer world championship, an increase of at least 40% compared with normal travel patterns.

e) The volcanic eruption of the Eyjafjallajökull and its effect on health

37. In his presentation,[9] Haraldur Briem, Member, Iceland, reported on the types of volcanic ash particles released by the eruption of Eyjafjallajökull and assessed their effects on human health. The recommendations of the Icelandic health authorities can also be found in the presentation.

f) Update on EU investigation: *Salmonella* Goldcoast outbreak

38. Annick Lenglet, Expert, Food and Waterborne Diseases and Zoonoses Disease Programme, Preparedness and Response Unit, ECDC, updated the AF on an ongoing investigation on *Salmonella* Goldcoast. A reference laboratory (Ida Luzzi's lab at the Dipartimento di Sanità Alimentare ed Animale, Instituto Superiore di Sanità, Rome, Italy) recently genotyped a series of isolates (employing PFGE with two enzymes) in order to compare human isolates of *S*. Goldcoast. Details on which isolates were redone are available in Annick Lenglet's PowerPoint presentation.[10] As a result, two clusters

[8] Item 5d - Rift Valley Fever infection (G Krause).ppt
[9] Item 5e - Volcanic eruption in Eyjafjallajokull and its effect on health (H Briem).ppt
[10] Item 5f - *Salmonella* Goldcoast progress on the investigation (A Lenglet).ppt

could be identified. The majority of isolates in cluster A emanates from humans and pork meat from Hungary and Italy, while the majority of isolates in cluster B had a reported travel history to Spain.

Update on measles and rubella elimination in Europe

39. Pier Luigi Lopalco, Head of Section, Vaccine Preventable Diseases, Scientific Advice Unit, ECDC, started his presentation with a series of maps that show that measles outbreaks are a recurring phenomenon, and that eradication (operative goal: 1 case per million) is a difficult task. One of the problems seems to be low vaccination coverage, and very young children are affected the most. Further details are available in his presentation.[11]

40. In response to the above-noted presentation, one delegate emphasised the importance of communication and asked, "How are we supposed to deal with irrational views and behaviour? What is our strategy when addressing the anti-vaccine movement?" He then stated that a communication strategy is needed and that ECDC could bring together people who have first-hand experience of successful strategies in their countries.

41. Another delegate opined that in order to achieve the goal of eradication, the ministries of health need to be motivated. Only through their commitment, sufficient funding would become available.

42. One delegate suggested that the health authorities should consider persuading the elders of insufficiently vaccinated communities that vaccination was the best way to protect their children. This has proven to be a successful strategy in Poland.

43. 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 children's right to vaccination, anchored in the Hungarian constitution.

Feedback on the initial experiences with the epidemic intelligence information system for the Food- and Waterborne Diseases and Zoonoses Network (*Document AF22/5*)

44. Annick Lenglet, Preparedness and Response Unit, reported on EPIS for FWD network users and the information shared so far, for example on norovirus, Hepatitis A and Listeria. Further details are outlined in her presentation slides.[12]

45. In response to the above presentation, several delegates opined that EPIS was a useful tool, but there was a real danger that network users would become inundated with messages. Combined with a lack of discipline and e-etiquette ("People don't stick to the thread!"), this diminished the system's usefulness. Denis Coulombier, Head of Preparedness and Response Unit, remarked that future updates would reduce the number of messages.

[11] Item 7 - Update on measles and rubella elimination in Europe (P L Lopalco).ppt
[12] Item 6 - Feedback on initial experiences with EPIS for FWD and Zoonoses network (A Lenglet).ppt

Q fever risk assessment

46. Frode Forland, Seconded National Expert, Scientific Advice Unit, ECDC, reported on a literature review resulting in an evidence table which in turn led to a risk assessment on Q fever. The review was conducted by a team of ECDC scientists supported by ECDC's librarian. As a guiding principle, the team looked for the best available evidence based on the principles of evidence-based medicine. Frode Forland explained how ECDC answered questions on Q fever related to blood, chronic cases, pregnancy, and surveillance that had been forwarded by the Commission. This work was coordinated with EFSA. Additional information can be found in Frode Forland's presentation.[13]

47. One delegate remarked that the risk assessment illustrated the lack of knowledge on Q fever.

48. Another representative pointed out that Q fever was still a rare disease even if probably already endemic in some areas of Belgium considering that 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 livestock.

49. The Director commended the study and recommended that EFSA and ECDC should present their Q fever reports jointly.

50. In closing, Frode Forland pointed out that 3000 cases in the Netherlands alone represented a substantial number. He added that ECDC would look into the question of pasteurised milk and its potential infectiousness.

Update on the 'Burden of Communicable Diseases in Europe' project (*Document AF22/6*)

51. Piotr Kramarz, Deputy Head of Scientific Advice Unit, ECDC, briefed the AF on the 'Burden of Communicable Diseases in Europe' (BCoDE) project. One of the project's main goals was to provide data for planning and prioritising. He also addressed the various methodological decisions that were made by the project consortium. According to the presented timeline, the study results will be disseminated in 2013.[14]

52. There was an overall positive reaction from the Advisory Forum to the BCoDE Project, with high expectations regarding the results.

53. One representative remarked that the study would most likely touch upon sensitive issues, for example, when making between-country comparisons. This should be taken into account pre-emptively. As the BCoDE study would have to draw on mixture of data of varying quality, estimates and approximations may differ from the official statistics – another point to address proactively.

54. The Commission representative voiced concerns that the quality of the study could become negatively influenced by bringing in advocacy issues. He recommended that BCoDE should avoid any temptations to mix advocacy with science.

[13] Item 8 - Q fever risk assessment (F Forland).ppt
[14] Item 10 - Burden of Communicable Diseases in Europe (P Kramarz).ppt

55. Piotr Kramarz acknowledged these concerns and assured the AF that the consortium had taken measures to avoid these pitfalls.

56. In response to Piotr Kramarz's question whether BCoDE should account for the whole spectrum of diseases, also those with negligible burden, several AF Members advised not to exclude some of these conditions but to consider the investment in their control, for instance, through vaccination as a possible reason for the burden being low.

57. In response to Piotr Kramarz's question whether BCoDE should include some diseases currently not listed in Decision 2119/98, for example, infection with the Human Papillomavirus and related cervical cancer or Helicobacter pylori and following gastric cancer, several AF Members supported this approach. One AF Member suggested BCoDE should specify if all consequences of *H. pylori* infection per se will be included or solely gastric cancer. One AF Member queried what level of evidence of causality will be used to decide if a condition is a consequence of communicable disease.

Update on ECDC involvement in public health aspects of vaccine safety/risk assessment *(Document AF22/7)*

58. Piotr Kramarz, ECDC, updated the AF on ECDC activities in vaccine safety monitoring in Europe.[15]

59. Several AF Members strongly supported the idea of the European Vaccine Safety Data Linkage System (E-VSD). They acknowledged the fact that sample sizes and resources of a single EU Member States may not be sufficient to provide reliable estimates of risk of rare adverse events following immunisation and were looking forward to support at the EU level.

60. In response to several questions raised by Piotr Kramarz at the end of his presentation (for instance, the possible "development of a European Vaccine Safety Datalink [E-VSD], which may need funding at a minimum of € 1.5 million"), one delegate referred to the disproportionate expense of expanding safety monitoring and questioned whether the costs would be justified by some marginal benefits. Piotr Kramarz noted that in serious vaccine safety crises, continuity of vaccination programmes is at stake with serious consequences, for instance, decreasing vaccine coverage and possible resurgence of diseases.

61. Another question raised was how (negative) results should be communicated: some adverse effects of vaccination were undeniable, and yet the majority of people benefitted greatly from vaccination. This issue will have to be addressed.

62. One delegate said that some Member States had excellent computerised vaccination registers that would greatly aid when assessing vaccine safety. Another delegate added that including multiple countries would allow for taking into account the wide range of vaccination products available in Europe.

63. One AF Member remarked that qualitative databases often exist in countries with small populations. Other AF Members responded that such databases still cover large populations regardless of the size of the country's population.

[15] Item 11 - ECDC involvement PH aspects vaccine safety risk assessment (P Kramarz).ppt

64. Following a remark regarding the importance of quality assurance in participating databases, Piotr Kramarz commented that many of the databases in the network have a solid track record of quality checks, including publications, but indeed one of the objectives of the project would be data quality improvement where needed.

Priorities for Scientific Advice

65. Piotr Kramarz, ECDC, gave an overview about the priority setting process. An initial priority list has been prepared by the Scientific Advice Unit with the input from ECDC Disease Specific Programmes. The Competent Bodies, the Advisory Forum and EVAG have suggested several additional topics in 2010, and as a result, a master list has been created. Some flexibility in the list is always advisable to be able to include additional topics arising from new needs during the year.

66. The scoring process details were described. Scoring takes place within well defined categories. Every member of the AF has three points to be allocated within each category. The allocation of points is fully flexible. Not all the points have to be used and all three can be assigned to one topic. A high response rate is needed, and this year's response rate of 80% (24/30 members) is highly appreciated.

67. It is sometimes difficult to categorise the topics, for instance, among the food- and waterborne diseases, some topics are similar to VPD or AMR topics. This issue will be rigorously addressed in next year's prioritisation exercise.

68. In the general scientific advice category, the highest scores were appointed to topics related to "evidence-based" approach, from which the highest score was given to evidence-based health communication contributing to the improvement of vaccine intake.

69. Piotr Kramarz informed that Paulo Moreira and the recently created Knowledge and Resource Centre (KRC) in the Health Communication Unit are already working on this issue together with VPD colleagues. The table of priorities is available in the presenter's slides.[16]

70. The scores will be used for the development of the ECDC Work Programme 2011. Factors deciding upon inclusion into ECDC Work Programme are: issues common to several Member States; magnitude of the threat; need for coordination at the EU level; gaps in current public health knowledge; lack of guidance; application of upcoming technologies; and potential to accelerate development of new technology (European added value).

71. Piotr Kramarz ended his presentation by thanking the AF for their overall support and advice and for aiding ECDC in proposing new topics and providing the scores.

72. A question was raised whether ECDC would be able to implement all this, considering the priorities of the staff members. It was proposed to see which projects have been set and the actual budget and staff allocation by the end of the year.

73. Piotr Kramarz responded that in 2009, the proportion of the three highest scoring topics in each category included into the Work Programme 2010 was presented to the AF (it was 80%). The most important reason for not including the items has been the lack of resources or other urgent topics suggested by the European Commission.

[16] Item 9 - Priorities for Scientific Advice (P Kramarz).ppt

74. The AF members asked if they would be able to receive feedback on topics included in the Work Programme. This information should also be posted onto the ECDC website.

75. Another AF member was concerned that there might be highly political and urgent inquiries stemming from the European Commission, which would be prioritised ahead of important topics, and hence strongly supported the idea of regular monitoring and feedback from ECDC.

76. One AF delegate noted that there is a need for ECDC to work on public health evidence, that there is too much focus on medical evidence, and that these two are slightly different by nature.

77. A comment was made that there is a particular role for ECDC in supporting the Member States that do not have enough resources for enhancing their evidence based methods for scientific evidence provision.

Reports from Working Groups A, B, C

a) Working Group A - Surveillance Data: Point Prevalence Survey (PPS) of Healthcare-Associated Infections and Antibiotic use in Acute Care Hospitals

78. Sotrios Tsiodras, Alternate, Greece, gave a presentation of the results.[17]

79. Objectives of the survey have been to estimate the total burden (prevalence) of Healthcare-Associated Infections (HAI) and antimicrobial use in acute care hospitals in the EU; to describe patients, invasive procedures, infections (sites, micro-organisms including limited AMR markers) and antimicrobials prescribed (compounds, indications) by type of patients, specialties or healthcare facilities and by EU country, adjusted or stratified; as well as to disseminate results at local, regional, national and EU level.

80. The first issue was the timing and participation of the Member States in the EU-wide PPS during 2011-2012. The Working Group proposed to focus on the full survey during 2011-2012, with a degree of flexibility. A one-month scenario per year would be preferable. The starting point would be October 2011. The pilot experience will be looked at as an example to ascertain the feasibility. All countries will be encouraged to participate and financial constraints will be considered.

81. The second issue discussed was how to use the PPS results at the national and international level. It would be helpful for the countries to estimate the burden in a standard EU way. Targets should be identified for quality improvement. A question for the future is how to integrate the issue of HAI in global patient safety strategies at the national and EU level.

82. The third issue identified was the representative sampling in hospitals. The quality of detection differs across hospitals. There might be potential selection bias of hospitals with certain characteristics, for instance, the ones refusing may be not participating in networks. The importance of training was brought up.

[17] Working Group A - PPS of HAI and Antibiotic use in Acute Care Hospitals.ppt

83. The fourth issue was the workload for national HAI/AB use surveillance teams and country support: software, helpdesk, training material (CfT PPS pilot support).

84. The fifth issue was the approval of National Ethical/Privacy Commissions. National centres should deal with this issue by consulting legal services within the country, following EU directives. ECDC may help with a proposal on the procedure on how to ensure the anonymity of the data and standard informed consent for patients.

85. The sixth issue was the periodicity of repeated EU PPS. It should be repeated at least every four to five years, all together, same year and month.

86. An additional issue was raised about the compatibility with national ongoing programmes.

87. Johan Giesecke, Chair, ECDC, opened the floor for any other comments from the group.

88. The AF delegates appreciated the lively and interesting session. The project is considered to be an ambitious one and a major achievement from ECDC. The survey has been conducted in the EU using the same methodology. Almost all countries can participate in the first wave.

89. One delegate was concerned about the comparability between the Member States. Another delegate expressed some concern about this comment. It would be easier to make the comparison between countries, but the ongoing health surveys comparison between the years may compromise the process? Thus the major objective should not be the comparison between countries.

90. There was an opinion from the floor with regards to the comparison that adaptation would the best way, without compromising the national programmes.

91. It should be feasible to have two approaches to adopt the protocol. The overall aim is to be flexible, not to force countries to be forced to partake.

92. Another AF member recalled the need to maintain flexibility, which was expressed during the previous AF. Aggregated denominator data will be used in general for adaptation in national protocols. The first exercise at the national level would be to adapt the protocols and then in parallel replace the date in the protocol. Some hospitals have two protocols, some have one national protocol.

93. In reaction to a statement about the comparison of Member States not being objective, one country questioned the necessity of the common protocol altogether.

94. The response from ECDC was that the politicians favour comparisons and there is a slight risk that these comparisons will be done anyway. Member States can use the PPS to define which module of surveillance they would implement afterwards: one of ICU infections, one of surgical side effects.

95. One delegate was hesitant about the comparison. The reason for seeing the differences is to determine if the countries can do something about it, otherwise there is no rationale.

96. Another delegate highlighted the importance of hospitals having a system for comparison in place; standard indicators will illustrate improvement. He recalled the experience of nosocomial infections in the U.S.A., in which it is vital to know that the hospital has entered in the system.

97. Some members opined that it would be interesting to examine the most important risk factors in countries via the PPS survey, rather than to overemphasise comparisons between the countries.

b) Working Group B - WHO Review Committee: Informal Think Tank for Input on Review Process and Working Methodology

98. Preben Aavitsland, Member, Norway, presented the results from Working Group B, the WHO review of the 2009 Pandemic and the 2005 International Health Regulations (IHR).[18]

99. The WHO Director General has appointed a Review Committee of 29 members from the IHR Roster and others who are all independent experts, not representing their home country or institution. There are four members from the WHO/Euro region: Pat Troop (UK), Preben Aavitsland (Norway), Silvia Bino (Albania) and Viktor Fedorov (Russia). The Chair of the Committee is a former dean of the Harvard School of Public Health.

100. The objectives of the Review Committee had been decided by the Executive Board: to review the scope, appropriateness, effectiveness, and responsiveness of global actions, as well as the role of the WHO Secretariat in supporting pandemic preparedness, alert and response in relation to the pandemic. To identify and review the major lessons learnt from the global response to the current pandemic and to recommend actions to be taken by Member States and the Director-General to strengthen preparedness and response to potential future influenza pandemics and other public health emergencies.

101. Review of the IHR functions had been already scheduled. In January 2010, the Executive Board decided to combine these two reviews and the final report will be submitted to the World Health Assembly in May 2011.

102. The Member from Norway remarked that the Committee needs to know how well WHO analysed and provided feedback on data on mortality and risk groups. A major concern was that scientific advice might have been compromised by politics. How were the advisory committees appointed? The best experts? Or political appointments? How the key decisions were made, for instance, the number of doses recommended? Were vaccine donations worthwhile? He noted that rumours should be taken seriously and investigations thoroughly conducted.

103. The meeting of the Review Committee is open to the public and the media. The report will be published. There was some confusion regarding the dual role of the review, both pandemic and IHR.

104. Following a question from the floor, the Member from Norway responded that the Review Committee will review the entire IHR functions: how well the intelligence systems worked; how well the ship sanitations worked and; how well the international collaboration worked.

[18] Working Group B - WHO Review Committee.ppt

c) Working Group C - How to Measure the Impact of Scientific Advice

105. Franz Allerberger, Alternate, Austria, presented input from Working Group C on how to measure the impact of scientific advice.[19] The Working Group was chaired by Andrzej Zielinski, Member, Poland. The issue is that one of the indicators of the ECDC Multi-annual Work Programme deals with measuring the impact of scientific advice produced by the Centre. The Working Group was asked to discuss ideas about optimal ways to measure the impact. An important issue was to advise on a "cost-effective" way of collecting this information without generating substantial data collection/analysis burden.

106. The overall impression was that ECDC provides satisfactory and helpful advice and that it is delivered in a timely manner. ECDC's "stamp" on scientific advice has proved to be highly useful. ECDC's advice is often translated and posted locally on respective websites, and it has been particularly appreciated by smaller countries, which by nature have limited resources.

107. The questions raised in the Working Group included how to measure the impact and whom to ask. Whether it would be the Ministry of Health, CMO, District Health Officer, etc. The Working Group concluded that a questionnaire should be produced listing up to six examples of scientific advice recently produced by ECDC and having several questions about impact (see below). All questions should be addressed on different levels.

108. Possible questions would address the following elements: being aware of advice produced; translation into local advice; developing recommendations based on advice; decisions taken based on advice; actions actually taken; and public health outcome, which is the most challenging.

109. The Working Group also conceded that it is worthwhile to learn from negative examples, namely, what was not used and why.

110. The fact of seeking ECDC advice as a measure of impact itself was also brought up. Ask the "requesters" about the impact (three to six months later). Be careful not to over burden the Member States with advice (need for careful consideration for the topics of advice). Review the impact assessment framework of the European Commission to discover lessons learnt.

111. The Chair, Chief Scientist Johan Giesecke, remarked on the utility of the feedback from Working Group C, and sought reflections from the AF members.

112. One delegate remarked on the importance of targeting the Ministries of Health when conducting a survey. Those who are responsible for public health policies should be targeted. Sometimes the objectives of MOSA versus CMO are not the same.

113. One AF member recalled the excellent presentation on Q fever from the previous meeting day. He added that publication and citation would also be a measure of impact.

[19] Working Group C - How to measure the impact of scientific advice.ppt

Surveillance issue: Development and implementation of enhanced Hepatitis B and C surveillance in Europe *(Document AF22/8)*

114. Marita van de Laar, Senior Expert HIV/STI/BBV, Surveillance Unit, ECDC, informed that there has been a call for more reliable data for Hepatitis B and Hepatitis C in Europe. The European Parliament is concerned and there is also a request from the respective patient organisations. EuroHepNet has collected some data on HAV and HBV but this project finished in 2005, and the data are incomplete. There was a need to obtain detailed information on surveillance systems and prevention programmes regarding Hepatitis B and C and a survey in Member States was carried out. Further details are available in her presentation.[20]

115. ECDC has almost finalised the report, which will be sent to the Member States for validation and approval in May and will subsequently be published in the summer.

116. The report also contains country profiles on surveillance and prevention and has looked at similarities and differences. While a number of similarities were found, structure and data sources vary across countries. Sometimes the data collection structure does not match the objectives for surveillance. The set of variables remains the biggest challenge. Age and gender are variables that are most commonly collected. Risk factors are not well covered, and hence there is room for improvement. Different case definitions were used across Member States but the Senior Expert cautioned that the new case definition was already implemented by a number of countries. Another interesting challenge is the distinction between stages of infection. Only a few countries report acute Hepatitis C, although there are no serological markers to distinguish between acute and chronic Hepatitis C; acute stages are most likely defined based on medical history.

117. The ECDC Senior Expert proposed to discuss the next steps and get the opinions from the AF members on the implementation of the components for the enhanced surveillance of Hepatitis B and C in the EU.

118. Marita van de Laar informed about the establishment of a Hepatitis B and C Surveillance Network and the call for a Coordination Group, which will lead to a protocol for Hepatitis surveillance at EU level including a set of variables. A list of topics that need to be addressed was presented: objectives for surveillance, reporting of acute and chronic cases and end stage disease, underreporting versus asymptomatic infection and the impact of prevention programmes on the interpretation of the surveillance data. Furthermore, the methodology (standardised) for data collection on prevalence surveys needs to be further discussed and clarified.

119. A representative of the AF commented positively on establishing a network and asked whether labs would also be included. He queried whether it would be possible to include sequencing data. It is clear that the success of the treatment depends on genotypes.

120. One delegate advised to revisit how the Hepatitis data are collected. Clearly the patient organisations and the European Parliament want to know the rate of incidence of Hepatitis, since the data collected represents the marker and there is no acute marker for Hepatitis C. Many resources may need to be used in order to do so. The delegate

[20] Item 12 - Enhanced Hep B and C surveillance in Europe (M van de Laar).ppt

questioned whether any country would have the experience of calculating the rate of incidence.

121. Another delegate mentioned that much work has been invested in Hepatitis C, that there is a Hepatitis C register and database which tracks people, since they know their type of exposure. Given the large amount of data of nosocomial and blood-borne infections, the delegate suggested investigating it further.

122. One of the AF members suggested studying the nosocomial transmission and the role of healthcare workers, given the significant mode of transmission in many countries. Hepatitis C will remain a widespread problem for future decades. A suggestion was also made to differentiate between Hepatitis B and Hepatitis C problems since the former issue will be resolved in the near future, unlike the latter.

123. The Member from Poland stated that "the burden of disease is such that we cannot resign. We have to harness mathematical modelling to make the estimation." He also noted that his country is currently conducting a large study on prevalence with Swiss financing, where they have to use dry blood tests. He requested that ECDC incorporate such tests into their studies.

124. One delegate opined that collecting data might be a waste of time since "it is not a matter of surveillance - it is a matter of survey." A few studies have been conducted on intravenous drug users in the U.S.A. There are many associated issues such as social determinants. For nosocomial infection, it can be detected that there are outbreaks and those can be controlled by acting. Concerning intravenous drug users, it is difficult to measure incidence among them.

125. 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.

126. Marita van de Laar thanked the AF delegates for their feedback and assured that ECDC will take into account the lessons learnt with HIV and STD (Chlamydia). For these diseases, it is vital not only have case-based reporting, but also prevalence studies. There are many prevalence studies in Europe, but it is very difficult to compare them. The idea was to develop a method to collect more comparable data. Unlike some speakers, ECDC is challenged on working on Hepatitis C as there are issues to address. There are clusters and generations developed by nosocomial transmission. In the case-based reporting, the nosocomial route is usually reported. There is not much prevalence data published in Europe. It is important to have a common approach when considering prevalence data. The Senior Expert advised that genotyping is not feasible at present but that this would need to be addressed with respect to EU capability and capacity building (explore the possibility of reference centres, or sentinel type surveys). Genotyping will be very useful in addressing nosocomial transmission. Patient organisations are highly active since they suffer and do not have access to treatment everywhere.

127. The Chair concluded that the next step is to establish a Hepatitis Surveillance Network (contact points have been nominated at the occasion of the survey and the validation of the report) and Coordination Group (through an open call in the Network based on common terms of reference [this was done following the AF22 meeting]); the Coordination Group will meet on 7-8 September 2010.

128. Andrea Ammon, Head of Surveillance Unit, ECDC, also noted the absence of viable options, and that progress is needed on Hepatitis matters. She encouraged the AF

to examine which experts have been nominated in their countries and suggested that this issue can be discussed further again with the AF.

Disease Programme Activities: Antimicrobial resistance and healthcare-associated infections: ECDC strategy for developing guidance on prevention and control of HAI and on antimicrobial stewardship (in support of Council Recommendation of 9 June 2009 on patient safety including prevention and control of HAI [2009/C 151/01])

129. Marc Struelens, Senior Expert, Scientific Advice Unit, ECDC, presented the DSP activities. The Centre is aiming to strengthen national strategies, to produce scientific guidance with international experts on evidence-based measures and best practices for effective HAI prevention and antimicrobial stewardship. Coordination is encouraged, where needed, notably to manage the risks associated with cross-border spread of multi-drug resistant bacterial pathogens.

130. Two consultation meetings have been held this year to identify priority topics for ECDC guidance; the first range of issues pertains to the organisational components of hospital infection programmes. The second range of issues is related to prevention of surgical site infection, including perioperative prophylaxis. Recent data reported from many countries suggest opportunity for improvement in this area, by showing that up to 50% of surgical patients may receive prophylaxis for more than 24 hours after surgery, a practice which is not based on good evidence. Additional priority topics include standard precautions and isolation precautions, prevention of ventilator associated and hospital-acquired pneumonia, catheter-related bloodstream infection and catheter-related urinary tract infection.

131. The current plan of ECDC is to contribute to this scientific guidance with international experts on evidence-based measures and best practice for effective HAI prevention and antimicrobial stewardship. During the next three years, the development of guidance on antimicrobial prophylaxis for surgery will start. Further details are available in Marc Struelens' presentation.[21]

132. Following a query from a delegate, Marc Struelens responded that ECDC has not considered the need to address this important topic since WHO has already launched the development of guidance documents on prevention of catheter related infection based on well accepted evidence. To avoid duplication, ECDC will collaborate with WHO.

Recently produced ECDC document "ECDC Guidance: Public health management of sporadic cases of invasive meningococcal disease and their contacts" *(Document AF22/9)*

133. Helena de Carvalho Gomes, Expert Vaccine Preventable Diseases/Evidence-based Medicine, Scientific Advice Unit, ECDC, presented the recently produced evidence-based guidance document on management of sporadic IMD cases and their contacts.[22] The paper is planned to be published soon. The project was outsourced to an external

[21] Item 13 - Development of guidance for prevention and control of HAI and antimicrobial stewardship (M Struelens).ppt
[22] Item 14 - Public health management of meningococcal disease (H de Carvalho Gomes).ppt

expert group. Areas addressed were limited to five deemed to be the most relevant. For each area, a specific research question was asked and a systematic evidence search was performed. The expert posed two questions to the Forum, namely, are there relevant areas that ECDC have missed and that should be covered in the guidance document? Are there areas that would need an update because relevant evidence has been missed or new relevant evidence has become available in the last one and a half years?

134. The Chair opened the floor for comments and suggestions from AF.

135. One area where the delegates expressed concern is the recent evidence and the efficacy of vaccine, especially with respect to 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.

136. One delegate raised the issue that this project was not disseminated to the AF members for comments. In response to that, Johan Giesecke clarified that sometimes ECDC brings matters forward for discussion during AF plenary sessions, and sometimes seeks written advice via email. He informed that ECDC will disseminate the respective document to the AF for review and written feedback shortly following the meeting.

Other matters and closure

137. The Alternate from Belgium presented an update regarding her country's Presidency of the European Union.[23]

Future AF Working Group (Teleconference)

138. Johan Giesecke remarked that AF members have expressed their wish for ECDC to continue with the teleconferences. The First Advisory Forum Teleconference Meeting for the Working Group on Pandemic Mortality will take place on 18 May 2010. A working group forum and meeting documentation will be integrated into the ECDC AF Collaborative Workspace.

List of meetings organised by ECDC in 2010

139. Philippe Harant, Planning and Monitoring Manager, Office of the Director, ECDC, gave a short introduction regarding the 2010 meetings[24] and apologised for the late notice caused by some delays in the system.

Any other business

140. The Member from Poland suggested that all ECDC staff and AF delegates attending the meeting wear their name badges during the AF meetings.

141. The Chair thanked everyone and wished them a good summer and a safe journey back home.

[23] Item 15a - Update regarding Belgium Presidency of the EU (S Quoilin).ppt
[24] Item 15c – List of meetings organised by ECDC in 2010 (P Harant)