ECDC Advisory Forum

Minutes of the 34th meeting of the Advisory Forum

Stockholm, 14-15 May 2013

Contents

Item 1 - Opening and adoption of the agenda (and noting the Declarations of Interest, if any) *(Documents AF34/2 Rev.1; AF34/3 Rev.2)*

1. Johan Giesecke, Chief Scientist and Chair, welcomed the Members of the Advisory Forum (AF) to the Thirty-fourth meeting. A special welcome was extended to Outi Vaarala, an invited expert from THL, Finland. The Chair also welcomed Frank Van Loock and Cornelius Schmaltz from the European Commission and Danilo Lo Fo Wong from the World Health Organization, Europe. Apologies had been received from Austria, Bulgaria, Czech Republic, France, Greece, Iceland, Italy, Latvia, Liechtenstein, Malta, Montenegro, Poland, Serbia, The Former Yugoslav Republic of Macedonia, the European Patients' Forum and the Standing Committee of European Doctors.

2. The Chair reminded the participants of the new policy and procedures regarding the Annual and Specific Declarations of Interest and thanked all those members who had submitted their Annual Declarations. No verbal declarations of interest were made.

Item 2 – Adoption of the draft minutes of the 33rd meeting of the Advisory Forum held in Stockholm (20-21 February 2013) *(Document AF34/4)*

3. The draft minutes from the previous meeting in February had been previously circulated among AF members.

4. Additional comments were made in relation to Item 7b – Congenital Rubella Syndrome by Petri Ruutu, Member, Finland (para 89) and Darina O'Flanagan, Member, Ireland, who had not referred to the University of Ulster and asked for this reference to be deleted.

5. The minutes of the Thirty-third meeting were adopted with the above-noted changes.

Item 3 – Update from ECDC on the main activities since the last Advisory Forum meeting *(Document AF34/Info Note 1)*

6. Marc Sprenger, Director, ECDC, gave a brief presentation on the main activities since the last Advisory Forum meeting.[1] The written report included updates from the Disease Programmes.

7. Denis Coulombier, Head of Surveillance and Response Support (SRS) Unit, gave a brief update on staff changes within his Unit. As a result of the departure of two staff members in 2012, Josep Jansa has now taken over as Head of Section for Epidemic Intelligence and Response and Bruno Ciancio was Head of Section for Epidemiological Methods. A new EU Preparedness Group had also been formed to deal with the outcome of all response activities in order to improve response and preparedness in the future. Pier Luigi Lopalco has transferred from the Office of the Chief Scientist to become the acting Head of Section for Scientific Assessment since the last year.

8. Karl Ekdahl, Head of the Public Health Capacity and Communication (PHC) Unit, reported that Massimo Ciotti has become the new deputy Head of Unit and Caroline Aguado has become the Head of the new Information and Communication Technologies (ICT) Unit. A new Country Preparedness and Support Section have also been created within the Unit to complement the new EU Preparedness Section in SRS, and a new Communication Science Support Section to support communication efforts in the Member States.

9. Johan Giesecke, Chief Scientist and Chair, noted that the only change in his Unit had involved Pier Luigi Lopalco who has moved to SRS to act as Head of Section for Scientific Assessment. He has been replaced by Lucia Pastore who is now acting Head of the Vaccine-Preventable Diseases Programme.

[1] Item 3 - Update on ECDC activities

10. Marianne van der Sande, Member, Netherlands, sought an explanation regarding the Health Inequalities and Migrant Health Programme being labelled as a Disease Specific Programme in the Office of the Chief Scientist and inquired whether it was new. The Chair explained that it was not new and was included as the eighth Programme in the Disease Programmes Section, but acknowledged that is was not really a Disease Programme.

11. The Dutch Member of the AF was pleased that ECDC had pledged to reduce email traffic to the National Coordinators and the Focal Points. She asked that emails be addressed to the appropriate person so that they could be forwarded appropriately to avoid creating internal spam and to ensure that the correct person replied in-country.

12. Karl Ekdahl agreed that this was very important and explained that ECDC was currently examining how to fine tune the structure of the Competent Bodies internally in order to address emails more appropriately.

13. José Calheiros, Member, Portugal, noted that recent events associated with the launch of the tuberculosis report in Portugal had shown that this issue has to be dealt with urgently.

14. Andreas Gilsdorf, Alternate, Germany, inquired which Programme was dealing with the current corona virus outbreak and how the hierarchical structure at ECDC worked. The Chair responded that the corona virus falls under the Influenza Programme and explained that ECDC's structure consists of Units, Sections and Groups in descending order of hierarchy.

Item 5 – Scientific advice and risk assessments: update on assessments, reviews and guidance

Item 5a – Scientific Agencies Network

15. The Chair gave a short update on the EU Scientific Agencies Network. EU Agencies had formed a network of Directors and sub-networks for the Heads of Administration, Legal Officers and Heads of Communications, and these groups meet two to three times annually to discuss common issues. Since several of the Agencies deliver scientific advice, ECDC, as Agency Network Coordinator, had created a network of Chief Scientists or equivalent (around 10 out of 30 Agencies include individuals in such roles delivering scientific advice). The new Network is referred to as EU-ANSA and shall convene its first meeting in Stockholm at the end of May. Issues including the selection of experts, conflicts of interest and procedures for delivering scientific advice shall be discussed and the AF will receive a report back at the next meeting.

Item 5b – Progress on ECDC initiative to apply to the IMI call on vaccines

16. Maarit Kokki, Senior Advisor, Office of the Director, presented an update[2] on progress with ECDC's involvement in the Innovative Medicines Initiative (IMI) since last AF meeting, which was followed by a question and answer session.

17. Robert Hemmer, Member, Luxembourg, asked whether the Work Package 7 (WP 7) represented an overview to assess the feasibility of the other work packages and inquired what would happen if they proved not to be feasible. He also sought information on the timeline.

18. Maarit Kokki explained that the role of the WP 7 will be to review and make recommendations to the leaders of the other work packages, which they would then decide whether to implement (or not). The entire timeline envisaged is five years. Most of the work would be done in the first two or three years and the WP 7 initiative would occur towards the end of the project's lifetime.

19. Mike Catchpole, Member, UK, hoped that the WP 7 would influence the other work packages, particularly data sources and methods, and noted that it did not seem to propose any conflict of

[2] Item 5b - Progress on IMI call (M Kokki)

interest. He asked what the outputs of the project would be in terms of information disseminated to the public domain and whether there would be an opportunity for public-domain or peer-review output in relation to the results of the WP 7.

20. Maarit Kokki noted that 15 key outputs of the WP 7 had been identified, which should be delivered during the project before the final deliverables from the work packages. It was envisaged that all results would go to review panels, which enable all those wishing to comment to do so. A draft blueprint – the outcome of the entire project – will subsequently become public at the end for consultation. However, there were still many details to be considered and she welcomed review and input from the AF.

21. Anders Tegnell, Member, Sweden, suggested that a network should be created to bring together those actors/public health agencies involved in the project to try and understand it better.

22. Marianne van der Sande, Member, Netherlands, was in agreement and also wondered whether public health institutes would want to be involved with ECDC in the WP 7 or in the other work packages. She pointed out that most of the other work packages involved actors from the private sector and it would be good to have public health institutes more involved in the other work packages as well as supporting ECDC with the WP 7.

23. Maarit Kokki agreed and pointed out that a discussion had taken place among public health institutes who were full partners about increased public institute involvement (for example, as co-leaders of the work packages). One idea could be to have a regular session on IMI during AF meetings or in working group sessions to enable more in-depth discussion.

24. Kåre Mølbak, Member, Denmark, stated that public institutes should be involved in the governance and that there should also be more involvement from those parties who are not involved in the advanced consortium.

25. The Chair pointed out that ECDC's Management Board had not been of the opinion that ECDC should get involved and therefore it was important to tread carefully. For this reason, the proposed regular discussions during the working group sessions might be more conducive.

26. José Calheiros, Member, Portugal, said that there was little information available on the whole process and asked how the AF members could be better informed in the future.

27. Andreas Gilsdorf, Alternate, Germany, said that the AF working groups had very little time available and that the topic of IMI was complicated. He therefore suggested a specific working group to investigate the issue in more depth and advise ECDC and the AF.

Item 5c – Immunological findings associated with Pandemrix and narcolepsy

28. A presentation was given by Outi Vaarala, National Institute of Health and Welfare, Finland.[3]

29. Darina O'Flanagan, Member, Ireland, congratulated Professor Vaarala on her work. She pointed out that Ireland had a similar problem, with a study showing that 35% of the population had the allele. This raised an issue related to ethics since regulatory authorities did not support an active search for cases. Yet if children were misdiagnosed, they would end up being referred to psychiatrists for behavioural problems. The clinicians therefore needed to be made aware of the symptoms of narcolepsy. She asked whether there was a close link between H1N1 and sleep disturbance.

30. Outi Vaarala noted that her main message was that the H1N1 component in Pandemrix was crucial and the method of production might hold the key to the whole problem. There was a weak association between H1N1 and narcolepsy and it was likely that in developing Pandemrix, GSK had produced an antigen that triggered an immune response contributing to the development of narcolepsy. To find out whether this was true, she now needed to get hold of the appropriate reagents and samples for testing.

[3] Item 5c - Pandremix and Narcolepsy (O Vaarala) – Not available on the extranet due to confidentiality

31. José Calheiros, Member, Portugal, asked whether it might be possible to establish a 'bank' of sample vaccines (and patient serums) in the future to prevent a reoccurrence of the situation with Arepanrix.

32. Outi Vaarala responded that GSK was the only actor responsible for storing vaccine samples and they had not wanted to cooperate. The samples received from GSK were from a subsequent production batch. When asked about patient samples, Health Canada, who had provided the vaccine samples, said that they did not have any and referred to GSK.

33. Kuulo Kutsar, Member, Estonia, pointed out that the problem did not lie with Pandemrix or Arepanrix, but was more of a general immunological and pathogenic problem due to the influence of adjuvant in most inactivated vaccines. There were many people with autoimmune diseases who also needed to be immunised. He then recommended that the type of research undertaken in Finland be continued on a much broader scale, perhaps with support from ECDC.

34. The Chair noted that this was more the domain of the European Medicines Agency than ECDC, although ECDC could certainly assist where appropriate.

Item 5d – Results of the first ever ECDC public consultation of scientific guidance on norovirus

35. A presentation was given by Athanasia Kanellopoulou, Scientific Advice Process Coordinator, Office of the Chief Scientist, which was followed by a discussion.[4]

36. Mike Catchpole, Member, UK, having established that the scientific guidance had not been presented to the AF, referred to the AF mandate and the importance of seeking its views. In this instance, a decision had been made to proceed with public consultation without obtaining the views of the AF. He agreed with the concept of transparency and supported the initiative, but the views of the AF were vital and its guidance was likely to be compatible with the views of Member States.

37. The Chair queried whether the AF would prefer to see a guidance document of this type before or after public consultation.

38. Andreas Gilsdorf, Alternate, Germany, agreed with the views of the UK Member and was also concerned about the number of consultation mechanisms which had been created over time. He questioned whether it was more useful to consult the public, rather than the AF, and noted that there had not been many responses received (15). However, there could be useful lessons for the public health institutions to learn from the process.

39. Athanasia Kanellopoulou explained that the content was not the focus of the exercise. ECDC had chosen the guidance on norovirus since it was the best document available at the time. The public consultation process was meant to be a complementary tool rather than overlapping or replacing any other consultation processes. She asked how the AF wished to see the results and whether it wants to be more actively involved in the process.

40. Frank Van Loock, European Commission, shared the concerns of his colleagues and asked how respondents had been selected and whether there were any from outside the European Union.

41. It was clarified that ECDC had only received comments from within the European Union. However, if valid comments had been received from elsewhere, the Centre would have accepted those as long as they are in line with the provided guidelines for submitting comments. Athanasia Kanellopoulou explained that ECDC takes the final decision as to whether to accept a contributor's comments and is under no obligation to take all comments into account.

42. ECDC Director explained that the process had been initiated as ECDC had been criticised by pharmaceutical companies for not taking their comments on board. However, it was not possible to differentiate between pharmaceutical companies and others, and it was paramount to give all stakeholders the opportunity to comment.

[4] Item 5d - ECDC pilot public consultation (A Kanelloupoulou)

43. Mike Catchpole, Member, UK, agreed with this comment and concurred that the document should be sent to the AF after the public consultation process. However, if it was likely there would be contentious issues in the document, it could be sent to the AF beforehand.

44. Petri Ruutu, Member, Finland, suggested that it might be useful to have another discussion in the AF on the provision of scientific advice as it had been done some years before. There were lessons to be learned on how to streamline and make the process more efficient.

45. Darina O'Flanagan, Member, Ireland, noted that the Scientific Advisory Committee in her Institute reviewed such documents twice, once before they were published and again after they were finished. This could be useful advice for ECDC.

46. Athanasia Kanellopoulou explained that there was no bias in the drafting. The purpose of the public consultation procedure is to give everyone the opportunity to comment. However, it was noted that the draft document could have been published by ECDC, without the public consultation procedure. This procedure is already used successfully at the Commission and other EU Agencies, thus it was simply a question of applying existing procedures for promoting more transparency in the provision of the scientific and technical advice by our Agency.

47. ECDC Director recommended presenting a flow chart showing the clearance procedure for the scientific guidance at a future AF meeting, to give the AF Members a clearer overview.

Item 5e – Carbapenemase-producing Enterobacteriaceae in Europe – Results from the EuSCAPE (European Survey on Carbapenemase-Producing Enterobacteriaceae) project

48. Barbara Albiger, Scientific Officer, Antimicrobial Resistance and Healthcare-Associated Infections, Office of the Chief Scientist, gave a brief presentation on the item.[5]

49. Robert Hemmer, Member, Luxembourg, noted that there were no standardised methods used in CPE surveillance and queried whether ECDC had a role in establishing and promoting these.

50. Mike Catchpole, Member, UK, welcomed this initiative as an example of how ECDC could add value to European surveillance.

51. While agreeing with the Member of the United Kingdom, Kåre Mølbak, Member, Denmark, questioned some of the definitions applied, for instance, 'sporadic' outbreaks, which was a weak definition. Similarly, information on some aspects of spread (local or imported data) was lacking, yet overall, the initiative was satisfactory.

52. Barbara Albiger responded that standardisation was the aim of the protocol being developed and that EuSCAPE was trying to define a standardised method. With regards to the comment on definitions, she explained that the same definitions had been used in 2010 and 2012; and they had been retained in order to follow the same process. In response to the issue of local or imported data, some information had already been received, though it was incomplete since not all countries collected the same data. Hopefully this would improve after standardisation.

53. Sophie Quoilin, Alternate, Belgium, said that more bridges needed to be built between community-acquired surveillance and healthcare surveillance systems.

54. Marianne van der Sande suggested that this should be a joint exercise with microbiology to make it as useful as possible.

55. Barbara Albiger said that the team would consist of both epidemiologists and microbiologists who would be working together.

56. Danilo Lo Fo Wong, WHO Regional Office for Europe, offered his congratulations to ECDC for this initiative. It would be an interesting model to try and export to countries outside and to the east of Europe that did not have such surveillance systems, and he was looking forward to working with ECDC on this project.

[5] Item 5e - Results of the EuSCAPE project (B Albiger)

Item 5f – Documentary on extrapulmonary tuberculosis

57. Marieke van der Werf, Senior Expert Head of Tuberculosis Programme, Office of the Chief Scientist, presented a video documentary which was followed by a discussion.[6]

58. José Calheiros, Member, Portugal, said that the video was very relevant to the difficulty in diagnosing this type of disease, a problem which he had experienced first-hand in Portugal.

59. Robert Hemmer, Member, Luxembourg, inquired whether there was any data available on drug resistance and extrapulmonary tuberculosis (TB).

60. It was explained that this type of TB was often not confirmed by culture and hence there was little or no data available.

61. Frank van Loock, European Commission, sought an explanation on how this video would assist doctors treating first or second line TB patients and how added value could be obtained from it in relation to extrapulmonary TB.

62. Marieke van der Werf said that it would be difficult to measure the added value and that it would depend on how the video was distributed and to whom it was shown. One of the problems with the elimination of tuberculosis in the European Union is that doctors were not aware of the symptoms and signs of TB, which was why it is vital to raise awareness. TB should appear on the differential diagnostic list so this video was a means of putting it on the agenda for general practitioners.

63. José Calheiros, Member, Portugal, opined that if the video was well distributed and raised awareness on extrapulmonary TB, it would have an added value. Even doctors who were really concerned about extrapulmonary TB were not taught to be aware of the problem and sometimes diagnosed it as cancer of the larynx, for instance. ECDC's video would be very useful for raising awareness of the phenomenon across the EU.

64. Andreas Gilsdorf was not completely convinced of the utility of the video. He asked who the target audience was and how many people would see it. He was also uncertain whether extrapulmonary TB should be the main focus given the abundance of other issues concerning TB that needed attention. Instead of promoting extrapulmonary TB as a hot topic for specialists, it would be more useful to focus on the infectious aspect of TB or other more relevant issues.

65. Kåre Mølbak reasoned that for a doctor audience it was much too superficial, although it was important to get the patient's point of view. If the target audience was doctors, there should be more relevant details. He also conceded that there were other more relevant issues relating to TB, such as drug resistance, TB in children, spread of TB, to name but a few.

66. Petri Ruutu, Member, Finland, agreed with his Danish and German colleagues. He also felt that it had been difficult to extract information from the materials provided for TB Day in 2013 due to the focus on this issue.

67. Marc Sprenger pointed out that ECDC video clips broadcasted via Euronews in the past relating to other issues had reached an audience of up to six million people.

68. Marieke van der Werf explained that extrapulmonary TB had been the theme for TB Day Europe in 2013 as it is a very relevant issue for the EU in particular. She assured the AF Members that the focus for TB Day in 2014 would be on TB drug resistance.

Item 7 – Long-term Surveillance Strategy 2014–2020 *(Document AF34/5)*

69. Andrew Amato, Deputy Head, Surveillance and Response Support, thanked the AF Members for their input on the draft document and asked for any further comments.

[6] Item 5f - Documentary on extrapulmonary tuberculosis

70. Petri Ruutu welcomed ECDC's incorporation of the feedback given and had no further comments.

71. Mike Catchpole was also pleased to see the AF comments from the last meeting taken on board, but would also welcome some form of target for evaluation. He also asked about the definition of European surveillance and whether this implied collation and analysis at EU level or European country level surveillance taken and analysed in Stockholm. He emphasised that these were two different concepts.

72. Andreas Gilsdorf remarked that now might be the time to look at how resources could be allocated to meet the challenges ahead and mitigate the workload. Target 6 represents quite a heavy target – analysing whether European surveillance standards are being implemented. With reference to the target covering event-based surveillance, he wanted to know whether this referred to Member State-based or European-based surveillance. There were also a number of references to expanding the area covered by ECDC in the health security initiative and he advocated a cautious approach.

73. Darina O'Flanagan noted a reference to the 'dropping' of surveillance for rare diseases and expressed that this would not save a great deal in terms of costs.

74. Kåre Mølbak expressed his satisfaction with the document and he was pleased to see that the issue of reducing the double burden of reporting and collaboration between ECDC and other bodies had been tackled. Referring to the term 'syndromic surveillance,' he said that the current understanding of syndromic surveillance was one of situational awareness rather than early detection (e.g. events such as the Olympics).

75. Marianne van der Sande said that it was important not to lose the focus as surveillance did not represent early warning, outbreak investigations, or many of the other activities often erroneously linked to it.

76. Anders Tegnell, Member, Sweden, commenting on the scarcity of resources in the present economic climate, said that it was important to focus on what Member States had in common in terms of shared resources.

77. Mike Catchpole pointed out that sophisticated techniques such as analytical modelling and GIS had been named in the document. He was uncertain whether it would ever be possible to apply these at European level; however, point prevalence was very relevant and useful. The primary purpose of European surveillance was cross-border threat detection. He also noted that a reference to Legionnaires was conspicuous by its absence.

78. Andrew Amato, explaining the reference to ECDC's mandate, stated that this had been driven by the EWRS changes that would come in the next few years. There would be two reviews of ECDC's mandate during the seven-year period covered by the plan which was why it was possible that the mandate might change during that period. He thanked all the AF Members for their comments and feedback.

Item 6 – Epidemic intelligence: update on recent threats in the EU

79. Anthony Mounts, WHO Headquarters, Geneva, and Jean-Claude Desenclos, AF Member, France, participated in the session via teleconference.

Item 6a – Update on H7N9 outbreak in China

80. Angus Nicoll, Head of Disease Programme Influenza, Office of the Chief Scientist, gave a short presentation on the status of the outbreak.[7]

[7] Item 6b - Update ECDC (A Nicoll)

Item 6b – Appearance of novel coronaviruses originating from the Middle East in patients at European hospitals – an update

81. Anthony Mounts, WHO Geneva, gave a short epidemiological update on the global situation in relation to the novel coronavirus[8] and Jean-Claude Desenclos, Member, France, gave an update on the coronavirus infection in France.[9] This was followed by a discussion.

82. Mike Catchpole sought clarification on the current clinical status of the two French patients. He also inquired about references to Saudi Arabia in the presentation made by his French colleague, as the patient in question had come from the United Arab Emirates.

83. Anders Tegnell asked whether there was currently any evidence of human-to-human transmission within the community.

84. Darina O'Flanagan inquired about the severity of the symptoms (diarrhoea and fever) in the first of the two cases in France since these symptoms had apparently necessitated hospital admission.

85. Andreas Gilsdorf pointed out that many patients seemed to be immunocompromised and asked if any information was available on the actual number of cases.

86. Frank van Loock asked what, if anything, WHO had been able to do about obtaining accurate information from Saudi Arabia more quickly.

87. Angus Nicoll, ECDC, asked whether WHO believed that the countries involved in the Arabian peninsula had the capacity to investigate or obtain this information. The outbreak had been going on for seven months and information was still missing, which would have been obtained much more quickly in Europe.

88. Denis Coulombier, Head of Surveillance and Response Unit, ECDC, asked whether there was further information on exposure, following rumours that Case 1 in France had visited a large camel market in Saudi Arabia.

89. In responding to the question on human-to-human transmission, Anthony Mounts said that there was no direct evidence, however, two of the most recent cases had not been connected to the outbreak in the health facility and had had no animal exposure. The virus had now demonstrated an ability to transmit from human-to-human although currently the only evidence was from families and healthcare facilities. With regard to immunocompromised patients, the information received by WHO was that the main cluster occurred in association with a dialysis unit, which meant immunocompromised patients. In some cases there were co-morbidities, such as heavy smoking. The majority of the cases in the cluster possessed an immunocompromising feature. With regard to the issue of obtaining information from Saudi Arabia, Keiji Fukuda, Assistant Director-General of WHO, had visited the country for a week to encourage the government to be more transparent with their data. However, it had been established that there were capacity problems and the Ministry was stretched by the amount of work required and had limited capacity for data collection. The Ministry had invited external experts for advise, albeit was not currently willing to extend that invitation to others who could assist with the outbreak investigation, which was very frustrating.

90. In responding to the question about the reference to Saudi Arabia for the cases in France, Jean-Claude Desenclos indicated that that he had used the term 'Saudi Arabia' improperly and that he meant 'Arabic peninsula' instead and confirmed that the patient was from the United Arab Emirates. Regarding the clinical status of the two cases, they were currently both in a critical condition. In answer to the question on symptoms, when Case 2 was hospitalised Case 1 had no symptoms of Case 1 so it was difficult to say what kind of transmission had occurred, although it was probably respiratory. Both patients were immunocompromised, one with a kidney graft and the other on corticosteroids. In answer to the question on exposure, in the United Arab Emirates, the patient had been in contact with camels and birds (falcons) but had not visited any caves. He confirmed that the diarrhoea was severe enough for the patient to be hospitalised.

91. Denis Coulombier proposed a discussion on the impact that the latest information should have on the guidance being developed in Europe (advice to travellers to the Arabian peninsula,

[8] Item 6b - Update from WHO (A Mounts)
[9] Item 6b - Update from France (J-C Desenclos)

immunocompromised patients, medical evacuations to the EU). There had been some panic in Saudi Arabia which could trigger more medical evacuations to the EU. He wondered whether it would be possible to identify where these evacuations could be expected in the EU and what specific preparation measures could be taken.

92. Kåre Mølbak, Member, Denmark, said that, based on the experience from France, there was a need to be aware of a broader clinical spectrum of this disease. He believed that the case finding strategy should be expanded in light of the information now available and wondered whether more recent genetic/typing information was available on corona which might be useful.

93. Darina O'Flanagan agreed that the definition should be expanded to include diarrhoea in the symptoms.

94. Andreas Gilsdorf agreed with Ireland and he also concurred that travel advice should include information for immunocompromised travellers travelling to the areas in question. There were indications now available which could make the travel advice more explicit. With regard to evacuation, he pointed out that there had been two cases of corona coming into Germany and a letter had now been sent to all evacuation agencies to remind them of the IHR to report potential case of infectious diseases. It was hoped that this would make agencies more aware, should there be any future evacuations involving respiratory problems.

95. Frank van Loock, European Commission, said that in principle, private evacuation must be signalled to control towers at airports so the authorities would be bound by IATA to report. DG MOVE could encourage authorities to act upon this information or report it collectively. He suggested that ECDC might be able to provide some specific medical advice in relation to evacuations to improve coordination in this area.

96. Niki Paphitou, Member, Cyprus, noted that Cyprus had specific concerns, given the current economic crisis in the country. There had been discussion of a sudden influx of refugees from Syria due to the conflict and this could possibly introduce the virus to Europe. She wondered whether any information should be made available on guidance in terms of how to handle this situation.

97. Anders Tegnell remarked that the situation regarding medical evacuations was very difficult because it was changing all the time. Consequently, there was limited value in trying to map such evacuations or send out questionnaires. Travel advice was also a difficult and sensitive issue so it was important to reach a consensus prior to issuing such advice at EU level.

98. Marc Sprenger suggested that the approaching World Health Assembly might offer a forum for ministers from European countries to discuss this issue at a political level.

99. Denis Coulombier, Head of Surveillance and Response Unit, thanked all the participants for their comments and contributions to the discussion.

Result of the Working Group Session

Working Group A – What are the public health aspects of detection/eradication of Helicobacter pylori infection to prevent gastric cancer? Is there a role for ECDC?

100. Mike Catchpole, Member, UK, reported on the conclusions of Working Group A.[10]

101. The Group concluded that there is a case to cover all the questions, however, more information is needed in order to advise – more clear assessment of the size if the issues, studies on cost-effectiveness, relative and attributable risk of *H pylori* for gastric cancer, whether a vaccine is likely to be available or not and where does it fit in the national priorities. It is believed that ECDC should be doing more, an example of *Clostridium difficile* was brought up.

102. Anders Tegnell, Member, Sweden, queried whether the Working Group (WG) thought of examples of health interventions.

[10] Working Group A

103. Darina O'Flanagan inquired whether the WG believes eradication is a realistic possibility. It was explained that eradication in this context means treatment.

104. José Calheiros emphasised that the association of helicobacter with gastric cancer is present, and that even if the numbers of the infection are low, cancer affects many more. He agreed that ECDC has a role to play and that this is an opportunity for the Centre to tackle an emerging threat.

105. The Chair agreed that it is not the infection but the ensuing cancer that ECDC should be concerned about.

Working Group B – Challenges and opportunities for science based health communication in disease prevention strategies

106. Ruth Gelletlie, Member, European Public Health Association, reported back on the conclusions of WG B.[11]

107. The group had a lively discussion and concluded that even though the importance that people attribute to communication is high, the concept has many different interpretations. The WG looked at documents with varied definitions. The need to have a clear definition should be the first priority in order to allow an adequate formulation of the problem. Cultural differences and national context should also be taken into account, as in some countries the government is seen as a trusted source, while in others they are not. Academics are the best source for knowledge on health communication; however, the professionals working on it are the ones with a better understanding of how to put it into practice. The WG concedes that ECDC should not develop separate networks. Health communication should be integrated in the Organisation, with staff working as part of a team led by the scientific team, supporting the delivery of the messages. Member States wish to receive facts and evidence-based information. Lines To Take (LTTs) were suggested as tools which organisations such as WHO and ECDC should share with their stakeholders. The group believes that ECDC should develop ready-made communication materials, which could be adapted and adopted. This kind of support would be much appreciated in order to address health care workers attitudes and behaviours, since problems such vaccination opposition and AMR are becoming huge issues in some countries. ECDC can act as a knowledge broker, helping countries with fewer resources, by providing courses in risk communication. These courses should have clear learning objectives and be delivered in the countries, tailored to the country's objectives.

108. The WG concluded that ECDC should improve its own communication. The fact that countries receive many emails, surveys and questionnaires seems to indicate that ECDC has too many communication channels and should model its own communications behaviour.

109. Anders Tegnell questioned how health communication measures with other priorities and questioned whether this is an area where ECDC needs to be spending their resources.

110. Mike Catchpole felt that ECDC's Risk Assessments provide good LTT with a set of recommendations. He recalled his experience as head of National TB Service, when his team put a lot of effort on evaluation of communication materials. There is not a lot of literature in this area. If evaluation is evidence-based, it could be an area for ECDC to explore.

111. Ruth Gelletlie noted that in consideration of the fact that this is her last AF meeting, she has seen a big change in terms of putting social sciences in the centre of the arena in the way we tackle infectious diseases. She mentioned that there is still a lot to learn from non-infectious diseases and all public health, but there is definitely a need for new tools in the areas of HIV and measles, where there is already sound scientific knowledge. She urged ECDC not to under-prioritise health communication but instead to re-evaluate its importance.

112. Kåre Mølbak, Member, Denmark, stated that organisations should have a clear knowledge of what to communicate, otherwise they should not do it at all. ECDC's Risk Assessments have a clear supporting role, whereas behaviour change seems to be out of ECDC's core fields. He warned against a naive approach that assumes that change of knowledge will also change behaviour, which is not always the case. People's behaviours depend on, among others, facts such as the local community

[11] Working Group B

and peer pressure. He disagreed with the term "social marketing", which he feels it is a top-down approach.

113. Ágnes Csohán, Member, Hungary, pointed out that Europe is multilingual. ECDC's scientific and professional communication is excellent as it is. If the Organisation should want to define health communication and start changing behaviour, it would have to make efforts to prepare communication materials in different languages, with involvement of the local communities, which appears to be a big task.

114. While acknowledging the altruistic intentions of the work, Marianne van der Sande cautioned that ECDC needs to understand where it can make the most impact and best support the Member States. Some existing initiatives are not the way to go.

115. Karl Ekdahl, Head of Public Health Capacity and Communication Unit, ECDC, thanked the AF for the valuable discussion. He pointed out that countries' needs and expectations on ECDC vary a lot, depending on the amount of resources available. He agreed that a top-down approach will not work and that ECDC does not want to handle health communication in that manner. ECDC is working closely with the Disease Programmes, in identifying specific problems where the Centre can make a difference. For instance, those affecting Roma populations, by having dialogue at a grass-roots level, with countries and Roma organisations, and by providing a platform for sharing good experiences. Vaccine opponents are not working locally but globally on social media; thus ECDC needs to address them by using the same tools. The templates mentioned by the WG are already being produced and widely used by the countries. An example of EAAD communication materials was highlighted: countries tailor the messages but use the concept. He emphasised that ECDC's efforts should be driven by the countries' requests.

116. The Director of ECDC noted that in times of staff reductions, it is important to select topics carefully. ECDC can contribute to solve problems, as in the example of the Roma vaccination. The Centre is also looking at unconventional models for vaccination and ECDC would like to share that information with the AF in the future, for evaluation testing. EAAD has been a good experience in health communication. ECDC hopes to contribute in the knowledge of risk communication and in the understanding of what is the best way to communicate about risks and perceived risks. The Centre should improve communication, starting with the knowledge that communication needs to be improved.

Working Group C – How do we ensure the excellence of Scientific Advice?

117. Kåre Mølbak, Member, Denmark, presented the conclusions of Working Group C.[12]

118. The aim of the WG was to help ECDC in streamlining its terminology and processes. The Group agreed that the types of publications on ECDC's website are based on concepts that are not very clear, which ECDC needs to move away from. The review of scientific advice outputs is also to have a consistent branding, clarity and transparency. ECDC is proposing a structure that distinguishes between View, Summary of Evidence and Guidance. The Centre needs to develop a structure that is coherent with general terminology. Risk Assessments should be included in the proposed framework.

119. After initial discussion, the group proposed to organise scientific advice outputs under three categories: 1) view (or scientific assessment), 2) summary of evidence; and 3) guidance. The WG emphasised the purpose of scientific advice, which is to help risk managers, policy makers and others in decision making. Suggested changes to ECDC proposal:

- Scientific assessment: a scientific view/comment based on a non-systematic literature review and/or from an expert opinion. It may occur in parallel with the Risk Assessment, if it is considering a scientific question that it is not related to a threat, or in the case of a group of experts that meet and provide expert opinion that could help risk managers to take a decision.

[12] Working Group C

- Systematic review: Systematic review of the scientific literature with regard to a specific question or a set of questions. It is a summary of evidence of the scientific literature, based on specific questions and specific criteria. Also possible to include grey literature and expert opinion. This is identified as a very important task of ECDC.
- Guidance: based upon a systematic review of scientific evidence and on a scientific experts panel appraising the evidence and providing a list of options with regards to the potential benefits, costs and harms of measures, areas and level of uncertainty and recommendations for future research.

120. The Chair and Chief Scientist added that the term "Expert Assessment" was also discussed within his Unit.

121. Mike Catchpole, Member, UK, expressed his agreement with the overall approach and supported this framework. His preference would be "scientific assessment" rather than "expert assessment".

122. Frank Van Loock, European Commission, queried whether the term "profiling" was ever discussed amongst the WG. The word is related to food-related risk assessment and provides a quick analysis and feedback when the risk is high.

123. Kåre Mølbak, Member, Denmark, clarified that the "profiling" was not discussed. There are many words but it is the belief of the WG that this terminology improves consistency.

124. Ruth Gelletlie, Member, European Public Health Association, expressed her satisfaction with the last slide in the presentation as it clearly depicts the difference between assessments. She asked whether the framework includes the health behaviour area, as discussed before.

125. It was clarified that the WG only looked at a slice of science outputs related to scientific advice, not to all categories.

126. The Chair concluded that "Guidance" and "Guidelines" are sometimes difficult to differentiate by non-English speakers. He recalled that ECDC included the category "recommendations" some years ago, but after some discussion, it was stricken off the list.

Item 8 – Evaluation of the rapid risk assessment outputs and procedures *(Document AF34/6)*

127. Josep Jansa, Head of Section, Epidemic Intelligence and Response, Surveillance and Response Support Unit, ECDC, provided a short presentation.[13]

128. In October 2011, the Centre submitted an offer for a consultancy on this subject, in order to improve the quality of ECDC's outputs related to RRA and to ensure their timely production in a well-coordinated and efficient manner, taking into account ECDC's overall activities regarding risk assessments. Two deliverables were agreed: a survey to Member States, European Commission, EU agencies and WHO to review the usefulness and added-value of the current RRA. The other deliverable was a workshop to discuss results and optimise procedures. A clarification of the key topics (triggers, related outputs, roles, responsibilities, tools, etc.) previously identified as unclear, was achieved at the end of the workshop. On the production of the RRA, it has been concluded that if nothing is found to modify the risk of the threat, there is no need to change the RRA and ECDC should update the epidemiological information instead. There is a need to improve the knowledge and training to applying procedures and SOPs, of which some may need adjustments. An action to be taken is to develop SOPs for the production of Round Table outputs, a systematic approach that has already been approved by the ECDC Senior Management Team. For the productions of RRA, the Internal Response Team needs to be empowered.

129. Andreas Gilsdorf, Alternate, Germany, noted that he recognises the work being done over weekends and evenings in order to produce RRAs. Most RRAs have been very helpful for the MS. It is a challenge to assure that everyone is working on the same page while also ensuring a standardised approach to high quality outputs. He supports this approach and believes all Units should follow the

[13] Item 8 - Rapid Risk Assessment (J Jansa)

same format. It is not agreed in ECDC, however, if the RRAs fit the Scientific Assessment category but he is convinced that it does: the Response team should not take their RRA as a different type of Scientific Advice.

130. Kåre Mølbak, Member, Denmark, raised the issue of data that is published in a RA and/or on paper or peer reviewed journal such as *Eurosurveillance*. When these papers are published, there might be on-going work and some discrepancies may occur in numbers. He believes that all data should be available for the team that conducts the assessment.

131. Josep Jansa, ECDC, thanked the AF for their valuable input. It was agreed that ECDC needs to balance the on-going scientific work and needs to deliver information in time.

Item 9 – EPIET & EUPHEM Fellowship programmes: principles and programme objectives for the short-, mid- and long term *(Document AF34/7)*

132. Arnold Bosman, Head of Section, Public Health Training, Public Health Capacity and Communication Unit, ECDC, gave a presentation on the EPIET and EUPHEM fellowship programmes.[14]

133. The AF was informed that one EUPHEM Programme Evaluation was finalised in February 2013, and the report should be available for discussion shortly. There has also been one EPIET Broad Stakeholder Consultation and following this, a change to contracts and rotation of EU-track fellows has been initiated. During the previous AF meeting, there was a WG on EPIET aimed to discuss the rationale behind the decision of rotation of fellows in EU-tracks. There are several layers of capacity building within the EPIET: the receiving organisation learns, the fellow performs public health tasks, as well as additional layers to be built after graduation. The issue is how to ensure equity. The concept, "distributive justice", is based on equity, equality and being needs-based. From a training perspective, this is difficult to establish. It was questioned whether ECDC's mission is based on needs? Equal rotation seems the best alternative, ensuring that everyone gets an opportunity.

134. The Centre has introduced EU-track fellows in which Member States can "buy" EU-track fellows so as to avoid vacant spaces.

135. A clarification was made with regards to the decision making process and it was stated that the AF is involved regarding the volume of fellows to train and criteria for the selection of Member States.

136. Twelve countries are hosting EUPHEM and the remaining nine will be prioritised next year. According to the current rotation proposal, the countries eligible for next year are: Slovakia, Belgium, Czech Republic France, Hungary, Romania, Slovenia, Sweden and United Kingdom. Member States should put forward expressions of interest in case they are available to host. It was highlighted that ECDC was positively surprised to learn that most countries were interested to host EUPHEM. Overall, a bright future is envisioned for the training, despite challenging times ahead, and it is hoped that it can be further discussed how to ensure an even distribution of the training(s).

137. Marianne van der Sande, Member, Netherlands, expressed some concerns with regards to separate tracks being the way forward. EPIET should be a strong united programme with a diverse curriculum, including microbiology but also social science, health economics, etc. It was unclear how many EUPHEM trainees end up in public health in Europe. It is unfortunate to see vacant places in excellent EPIET training sites and the Netherlands was disappointed by the decision to reduce the number of EPIETs.

138. Irena Klavs, Member, Slovenia, congratulated ECDC for its Public Health Training function as it is considered to be an activity that mostly contributes to the establishment of a public health workforce. Coming from a Member State with fewer resources, the modules and the rotation scheme is much appreciated. It was suggested to consider that all training sites that can afford a salary could have a Member State EPIET fellow every second year. If EU has 28 countries, ECDC would have to ensure 14 fellows for each cohort.

[14] Item 9 - EPIET and EUPHEM fellowship programmes (A Bosman)

139. Andreas Gilsdorf, Alternate, Germany, noted that he was expecting more discussion on options and would have preferred that the EUPHEM Evaluation had been shared before ECDC enlarges the programme. It was asked how ECDC can fill the empty seats? Germany has six national training sites; if the country gets 1 EPIET fellows, the other sites are not used in the training cycle. Empty sites cannot easily filled by the EPIET Associated Programmes, as there is a fixed budget for them as well. Like in the MS-track the population has to be taken into consideration when defining the training needs of each country. EPIET sites are an additional value increasing capacity and it is believed that this is not considered sufficiently in the proposed approach.

140. Darina O'Flanagan, Member, Ireland, considered that the lively discussion shows how important EPIET training is for all Member States. She agreed with Slovenia that training is important in order to build capacity in smaller countries. As these countries are more dependent on external training, the inclusion of the MS-track has Ireland's full support. As for EUPHEM, with combined training, the Irish member did not agree. "A Separate EUPHEM track is good, and that is why we see increasing numbers year after year. The decreasing number of jobs is evident and thus if EUPHEM MS-track is used, these people will secure jobs in their countries."

141. Mike Catchpole, Member, United Kingdom, felt that the MS-track is a key to equity and a good solution in addressing that issue. He would support added investment and/or removing investment from the EU-track. It was questioned whether placing fellows actually provides capacity. It is believed that this decision is a fundamental mental shift and he felt disappointed that the change has not been discussed in the AF. An additional comment was made on a language issue: if French and German languages are available to a wider public, this can cause moves between the countries that speak the same language. Opportunities will be lost for the sake of equity.

142. Anders Tegnell, Member, Sweden, believes that EPIET fellows make a big impact and the MS-track is a part of that. He was surprised to see relations between EPIET and EUPHEM and requested for ECDC not to take it as a long-term commitment that countries want more EUPHEMs than EPIET. He expressed concerns about the market for microbiologists. An issue of different level training sites was raised. It was suggested that ECDC should invest more in countries where there are good training conditions and sites. Should ECDC aim at having high quality of training or equal distribution of training? Both pros and cons should be assessed.

143. Frank van Loock, European Commission, noted that cutting training is one of the worst options. ECDC's core functions are risk assessments, scientific advice and EPIET. If a cut is made on the EU-track, the Centre would lose one of the main foundations of this organisation. There are supervisor's networks and trainees' networks, people are training in the country and staying in the country. Additional tracks should not be to the detriment of the EU-track. Quantity will be an issue and when cross-border health becomes a threat, we could argue for a EUPHEM and public health workforce development.

144. Arnold Bosman thanked the AF for their comments and feedback. The perspective of smaller countries is well understood. As for larger countries, he felt that EUPHEM should not be discussed as a programme before the evaluation report is discussed in the AF. There is a challenge in scaling up, for instance, in autonomous regions, to say that there can only be one person every two years is unrealistic, but what could be a sustainable level? More discussions on this are needed in the future, perhaps with a smaller group from the AF. ECDC needs this input. The issue of there being more quality in some sites than others also involves discussing in which direction ECDC wants to go. The idea that training should only be done in high-quality sites is too narrow. ECDC is not a training institution; its mandate is to increase capacity building across the EU. Decisions need to be made in order for ECDC to start making a road map.

145. The ECDC Director concluded that the discussion around the table is not about austerity or decreasing the budget, it is a matter of different views.

146. The Chair proposed to put together a Working Group on this matter and noted that all expressions of interest to participate in this WG could be directed to Arnold Bosman after the meeting.

Item 11 – Update on the second External Evaluation of ECDC

147. The AF was informed of the latest developments relating to the second independent external evaluation of ECDC. By the end of 2012, a contractor was selected to carry out this project; however, the Management Board Steering Committee on this matter was disappointed at the initial results and thus the contract was ended. ECDC revised and improved the tender in order to avoid similar situations with the future tenderer. In April 2013, ECDC was about to launch a new tender when DG SANCO proposed using their framework contract, which includes the provision of public health evaluation and clearly states it could be used by agencies such as EFSA, ECDC and EMA. The use of the framework facilitates procedures, since all administrative process is removed. The framework contract was adjusted to ECDC rules and debated by the Management Board Steering Committee. The latter were in favour to use the framework with a caveat that ECDC will be privy to the four companies that are selected. The Centre will launch the same call for tender, allocate time to the companies so they can prepare their bids and will subsequently evaluate their offers. One of these processes does not preclude the other.

Item 12 – Update on the implementation of ECDC Independence policy

148. Ben Duncan, Senior Advisor to the Director and Compliance Officer, Director's Office, provided an update on ECDC's independence policy.[15] He thanked the AF members for submitting their Declarations of Interest and Declarations of Commitment. A current status of Annual Declarations of Interests (ADoI) received from ECDC staff, AF, MB and external experts was provided. The ADoI are submitted voluntarily, and it was emphasised that it is important also for the alternate members to submit their declarations. It was suggested to create a Working Group in order to discuss whether the way ECDC's independence policy is implemented is reasonable and proportionate, namely, whether the AF agrees if it is reasonable to exclude members of Disease Networks, if there are ways in which we could decrease the burden on our Member State partners, and how to ensure ECDC's approach is consistent and coherent with that of key partners (Member States national public health institutes, Commission, WHO, etc.).

Item 10 – Update from the European Commission

Item 10a – Interim report on the state of implementation of the Council Recommendation on Seasonal Influenza Immunisation 2009 in the Member States and at EU level

149. Frank Van Loock, European Commission, provided a short update on the interim report on the state of implementation of the Council Recommendation on Seasonal Influenza Immunisation 2009 in the Member States and at EU level. Due in June 2013, the updated report is being prepared in close collaboration with ECDC, including the use of data from ECDC. The Commission aims to provide the recommendation for adoption during one of the Council's meetings in September. Contacts are in place with the coming presidency, mostly the Health Security Flu Section.

Item 10c – Public Health Programme 2014-2020

150. In the Public Health Programme 2014-2020, different activities have been lined up. The Commission is awaiting decisions on the Strategic Work plan and the European Parliament's feedback.

[15] Item 12 - Update on independence policy (B Duncan)

Item 10b – Serious cross border threats to health

151. On cross border health threats, the third trial of meetings between the European Parliament, Council and the Commission has reached a commitment and it is hoped to have a first reading of the agreement in the coming months. Events such as coronavirus and H7N9 may lead to final adjustments and a vote on the document still has to be carried out. The proposal strengthens preparedness for public health crisis and provides a legal basis for vaccine production. The Commission will be able to trigger vaccine production in coordination with WHO. The role of ECDC, as a consequence of the new legal proposal, will not change. However, the risk preparedness activity is strengthened, so it is likely that ECDC's tasks in this area will be reinforced. ECDC is tasked to operate the EWRS. In the new EU-28 setting, environmental and chemical information will also be shared. ECDC will not be asked to produce risk assessments on this. The Commission took the opportunity to extend a special thank you to the Irish EU Presidency for steering the discussions.

152. Fernando Simón, Member, Spain, commented that he was extremely pleased to see the document. He thanked the Commission, the EU and the Irish Presidency for being able to see this long and complicated discussion come to an end.

153. Andreas Gilsdorf, Alternate, Germany, noted that the document includes most of the comments and many of the changes seem quite reasonable. It was proposed to have a discussion on the document during the next AF meeting, as the perception of ECDC's tasks varies for different players. If EWRS's scope is widened, would this imply that ECDC widens its scope? It was questioned how to deal with the vast preparedness area that is included in the document.

154. The Commission's representative reassured that the fact that EWRS is sharing other types of information (chemicals and environment) will have very little impact on ECDC's role. It just means operating EWRS on the wider scale but data will be shared back to the Commission.

155. The Chair suggested discussing the document at the next AF meeting in September.

Item 10d – Update from Directorate F - Health, Directorate-General for Research and Innovation

156. Cornelius Schmaltz, European Commission, provided the AF with an update on the research on infectious diseases.[16] The Directorate-General for Research and Innovation is working with emerging infectious diseases (including influenza) in a total of 29 projects. Five new projects are under negotiation, including the negotiation for a "universal" influenza vaccine. A new project PREPARE Platform for European Preparedness Against (Re-) emerging Epidemics and Global Research Collaboration for Infectious Disease Preparedness was mentioned. The presentation also focused on the 12 actions of the 2011 EU Action Plan on AMR, and the Innovative Medicines Initiative, the largest public-private partnership aiming to improve the drug development process, that supports collaborative research projects on safety and efficacy, knowledge management and education and training.

157. Fernando Simón, Member, Spain, requested to have the presentation, due the large number of information it contains. The AF was assured that all presentations would be uploaded onto the AF Extranet shortly after the meeting.

158. The Chair questioned whether there will not be a FP8. It was clarified by the representative of the Commission that this term has been replaced with "Horizon 2020".

159. Andreas Gilsdorf, Alternate, Germany, noted that such projects require a large action from ECDC, thus it is needed to be aware that it will involve additional work, input and activities.

160. Frank Van Loock, European Commission, clarified that ECDC has to be able to receive some reimbursement for all the projects that it provides input for and proposed to come back to this issue in the future.

[16] Item 10d - Update from Commission (C Schmaltz)

Item 6 – Epidemic intelligence: update on recent threats in the EU *[continuation from Day 1]*

161. The Director of ECDC took the opportunity to address the AF members to thank them for their valuable input on the coronavirus during the Day 1 of the meeting. He proposed to use the input received from the Forum in order to produce an AF statement. It was pointed out that this is unprecedented in the AF, however, it is felt that is it important to register that the AF asks ECDC to carry out activities. Denis Coulombier projected the draft document for the AF.

162. Mike Catchpole, Member, UK, supported the document but suggested a small change with regards to countries outside the EU.

163. Fernando Simón, Member, Spain, suggested highlighting the concern that the AF is unaware what the authorities of other countries are doing about the virus.

164. Kåre Mølbak, Member, Denmark, proposed to include that countries with most cases should share biological specimens.

165. Andreas Gilsdorf, Alternate, Germany, recognised that the document includes valid points. He believes that this it is the right mandate for the AF to advice ECDC, but not Member States. A minor change in the document was suggested.

166. Darina O'Flanagan, Member, Ireland, believed that the tone of the document might be worth revising. However, she agreed that a number of elements are needed which do not have an answer at this point, i.e. more information is required.

167. Marianne van der Sande, Member, Netherlands, agreed that real-time information is needed.

168. Angus Nicoll, Head of Disease Programme Influenza, Office of the Chief Scientist, provided some of the latest information he had received during the previous evening. He believes it is not a question of not revealing the information but in fact Saudi Arabia is not taking the actions we would like them to take. However, the country officials need to be assisted in order to come out of that shell, we need to assist them and not criticise. It is a very delicate issue and they do not like to be reminded that they are struggling and not really investigating as they should, since they don't have the tradition of investigating healthcare associated infections. Regarding the transfer of biological specimens, there is a major mistrust and it is advised against including this in the document.

169. Danilo Lo Fo Wong, WHO/Europe, agreed that the message of sharing the information timely needs to be stressed. That is also foreseen to happen in the IHR.

170. Florin Popovici, Member, Romania, queried whether the statement speaks for the AF as a whole or only for the members that are present.

171. The Director of ECDC clarified that the statement emanates from the entire AF. The document is being revised and upon finalisation it will be sent to the Commission.

172. Darina O'Flanagan, Member, Ireland, noted that the statement should also compliment Saudi authorities on what they are doing well, such as inviting international experts, and not be completely negative in the message.

173. Andreas Gilsdorf, Alternate, Germany, queried whether the statement will be a part of the RRA or sent as separate document at the same time as RRA. It was advised against the latter option. The Director of ECDC confirmed that it will be a separate document.

Item4 – Update regarding the EU presidencies

Item 4a – Update from Ireland

174. Darina O'Flanagan, Member, Ireland, provided a short update on the Irish EU Presidency. The AF was informed that Ireland is currently concentrating on the upcoming World Health Assembly. The information about cross-border threats document has been received. Substantial efforts from WHO on tobacco control have been recognised.

Item 4b – Update from Lithuania

175. Loreta Ašoklienė, Member, Lithuania, updated the AF on the upcoming first Lithuanian EU Presidency, starting 1 July 2013.[17] Efforts will be made in order to advance EU legislation on pharmaceutical medical devices, public health, eHealth. High priority will be on tobacco control. Lithuania has a very ambitious objective to reach an agreement in the Council. It is acknowledged that it is a very complicated and sensitive file, and thus it is foreseen as a difficult task. Some of the key events were mentioned, such as the Information Council of Health Ministers (8-9 July 2013).

176. Danilo Lo Fo Wong, WHO/Europe, thanked Ireland for encouraging Member States to finalise AMR Action Plan and challenged Lithuanian EU Presidency to work on another AMR Action Plan.

Item 13 – Any other business

177. The Chair, Johan Giesecke, thanked all the participants for their valuable input. A special thank you was extended to Petri Ruutu from Finland, Gérard Krause from Germany and Ruth Gelletlie from the European Public Health Association on behalf of all the AF members for all their work and devotion as this was their last AF meeting.

178. As there was no other business, the meeting was concluded. The next AF meeting will take place on 25-26 September 2013 in ECDC, Stockholm.

[17] Item 4b - Update from Lithuania (L Asokliene)