ECDC Advisory Forum

Minutes of the Sixtieth meeting of the ECDC Advisory Forum

Stockholm, 18-19 February 2020

Contents

Opening and adoption of the programme

1. Andrea Ammon, ECDC Director, welcomed all participants to the sixtieth Advisory Forum meeting and pointed out that the agenda had been rearranged to enable as much discussion as possible on the outbreak of COVID-19.

2. Mike Catchpole, Chief Scientist, ECDC, welcomed all participants including colleagues joining via teleconference from DG SANTE (Franck van Loock and Charles Price), from the World Health Organization's Regional Office for Europe (Nedret Emiroglu, Dorit Nitzan, Catherine Smallwood and Masoud Dara), from Greece, Iceland, Lithuania and Malta. Apologies had been received from Cyprus, Luxembourg and Portugal. There were no conflicts of interest declared.

3. Mika Salminen, AF Member, Finland, referring to the draft programme, proposed that more time should be found for a discussion of the situation relating to coronavirus and possibly some exchange of country experiences.

4. Mike Catchpole said that there would be time set aside for exchange of experiences, case definitions, community transmission, etc. during the risk assessment and response session, and during the Working Group sessions and plenary feedback. The draft programme was adopted with no further changes.

Adoption of the draft minutes of the 59th meeting of the Advisory Forum (11 December 2019)

5. No comments were received and the draft minutes were adopted.

Expert opinion on non-pharmaceutical counter measures against pandemic influenza

6. Angeliki Melidou, Expert, Influenza, ECDC, presented the revised version of the draft expert opinion which had taken into account comments received by the AF at its meeting in September 2019.

7. In the following discussion, it was noted that the document was useful as evidence-based information for use at national level, not just for the current emergency but also for revising national pandemic plans, however it would need further work before being released to the general public, mainly due to the evidence being offered to the public with the possibility that they will be misinterpreted. There were a number concerns and suggestions:

i) a number of comments were made that there should be clearer delineation of guidance for healthcare and community care settings, and that there should be clearer distinction made between medical and non-medical measures, and between measures that could be taken by individuals and those that are relevant to measures to be taken by authorities.

ii) A number of AF members suggested that separate guidance for the public should be produced, providing clear advice for actions they should take, with reference also to the role of NGOs

iii) the guidance regarding the cleaning of surfaces needed to be clarified to avoid it being interpreted as advocating restrictions on imports from countries with widespread community transmission

iv) it was noted that there needed to be a clear distinction between guidance related to the use of face-masks and guidance related to the use of respirators

v) consideration should be given to whether as well as referring to measures with regards to severity of disease, the document should also refer to the phases of a pandemic, which would change the action required and the measures taken.

vi) There was also a request for more information on risk calculations in the document

8. Mike Catchpole, Chief Scientist, ECDC noted the need to restructure the document and to rearrange evidence referring to situations outside of healthcare settings. He also understood that it was important to look at the interpretation of the facts. With regard to some of the comments on publishing a separate document for the public, he raised the issue of transparency as this might give the impression that something was being hidden. He also noted that a guidance to the public can only be made in a known pandemic scenario, such as COVID-19. Clear actions for the public cannot be assumed in a hypothetical scenario, when the severity-transmission pattern of the pandemic virus is unknown. He thanked the members for their feedback and asked for their understanding that due to lack of time it was not possible to respond to their individual comments.

Update on current epidemiological situation for COVID-19 and current ECDC risk assessment

9. Vicky Lefevre, Acting Head of Unit, Public Health Functions, ECDC, gave an update on the current situation and answered the questions below:

- How does ECDC collaborate with WHO?

ECDC's communications team liaised with all major stakeholders and working closely with WHO on case definitions, comments, testing and reporting protocols, etc. At one point ECDC had updated its case definition slightly ahead but WHO had followed suit a couple of days later. In general, collaboration was very good.

- Would it not be better to go beyond descriptive data and assess the bigger picture – i.e. showing incidence instead of just counting cases?

ECDC had looked at the first 40 cases in Europe and made an analysis of the data that would be shared with Member States that day for comment. To date, the cases reaching Europe had mainly been tourists from China and mostly elderly people. Autochthonous cases appeared to have been mild for the most part. ECDC had also just launched a cohort study on the repatriated EU citizens (450 people but possibly more) and requested information from the Member States which would make it possible to analyse a larger group.

- Was it ECDC's assumption on the basis of the information available that if there was transmission of COVID-19 at the present time in Europe it would only have a delayed (moderate) effect on healthcare systems since influenza was about to reach its peak for the season?

ECDC's current assessment of the risk was that it was low for the next few (2-4) weeks, and this was based on the fact that influenza would reach its peak in next few weeks and that COVID-19 transmission would begin sometime afterwards.

- *How were asymptomatic cases being shown in the graph and how was ECDC differentiating between symptomatic and asymptomatic cases? Was ECDC doing any modelling with the data?*

ECDC was interested in carrying out a larger cohort study on symptomatic and asymptomatic COVID-19 cases and had been in contact with the other CDCs to obtain data available outside of China. Some further information had been made available in a new publication from China released on 17 February, with a situation update to 11 February. This had looked at 72 000 recorded cases of COVID-19, among those 44 000 were considered confirmed, of those 1.2% were asymptomatic and the case fatality rate was 2.3%. The CFR was highest (14%) in the over 80s age group and much lower in the other age groups. With regard to modelling, the AF members had received a scenarios paper based on modelling done by ECDC's modeller who was part of an EU and international modellers' network. Some of the information in the rapid risk assessment on COVID-19 (options for response) had also been based on the results of modelling, along with ECDC's advice on entry screening and contact tracing.

- How was data being collected in Europe, who was collecting it, how was it accessible, was WHO sharing it with ECDC?

Data was obtained through EWRS (fastest source) and TESSy. Data from TESSy was more reliable and structured but took longer to obtain. In all, 44 of the 45 cases in Europe had been reported in TESSy but TESSy contained 86 variables. ECDC was in discussions with WHO on simplifying the reporting form

but this was what was available at present. Data was also obtained from China and other non EU countries via WHO, from national ministries of health and via epidemic intelligence screening.

- What was the definition of a confirmed case?

A confirmed case was case confirmed by PCR and this was the case definition being used by ECDC.

Tour de table

10. **Slovakia**: one major problem had been the fears among the public. Testing at the national reference laboratory (NRL) had begun on 10 February 2020 and 44 samples had tested negative to date.

11**.** **Latvia**: 10-12 samples had been tested to date and all had been negative. Additional measures at the border involved a questionnaire for people arriving from China via non-Schengen areas.

12**.** **Finland**: the country had many flights to China – Finnair and three Chinese airlines. Since 5 February 2020 Finnair had stopped flying to mainland China, and two of the three Chinese airlines had also stopped. Finland had had one confirmed case in Lapland (popular with Asian tourists) and the patient, who was symptomatic, had been in isolation and had recovered fully. All other tourist contacts were traced and no further cases discovered. Case had been released and travelled back to China. Finland was using the ECDC case definition and had tested 30 cases so far. It was estimated that around 1 000 tourists from China had been in the country when they started investigating.

13. **Denmark** –there had been no cases in Denmark to date. Denmark was using the ECDC case definition but slightly modified – including fever as a symptom. So far 22 patients from mainland China had been tested and none were positive. A total of 18 people had been repatriated from Wuhan and tested and all had been negative and were in quarantine at home. Emergency legislation relating to epidemics had not been enacted as yet.

14. **France**: as of 17 February 2020 there had been 414 possible cases, with 95% excluded, eight cases awaiting laboratory results, 12 cases confirmed and one death among them. France was trying to bring its case definition in line with that of ECDC. There were two laboratories working on testing in France with NRL capacities. The first confirmed case had been on 23 January 2020, most cases were in Paris, but Bordeaux had had its first case and there was a cluster in the French Alps (index case from the UK) and another cluster for which France was collaborating with Spain on tracing activities. Responding to a question on how cases were counted in France, it was explained that France only reported the cases diagnosed using PCR in France.

15. **Belgium** had only had one positive case to date. Meanwhile, a decision had been taken that testing should only be carried out by hospital emergency units.

16. **Germany**: PCR protocols had been distributed to over 20 university hospitals and surveillance of the number of tests performed would be available within a week. To date over 1000 tests had been carried out in various laboratories. With regard to supplies of PPE, the market was empty and it was not easy to step up domestic production. Public health information and general hygiene campaigns were being run. Germany had 16 federal states and 370 local health authorities and the local health authorities had the power to decide on quarantine, measures at airports, etc. The cluster of COVID-19 cases in Munich had occurred as a result of a trainer from China visiting a large automobile parts supplier company between 19 and 23 January. The case was later diagnosed on her return to China on 26 January. All contacts had been followed up and over 20 local health authorities had been involved. All 124 people who had been in military quarantine in Germany following repatriation from China had now also been released.

17. **Croatia** was following advice from WHO, ECDC and DG Sante and had checked response, preparedness and cross-border communication procedures. An inventory study of hospital capability in the event of outbreak had also been carried out. Two tests had been carried out and general information was being provided for the public on the website of the national public health institute.

18. **Hungary** had not had any cases so far. ECDC's case definition was being used. All seven of those repatriated from China who had been in quarantine had now been released.

19. **Netherlands** - no confirmed cases, laboratory test surveillance, information being provided to the public, little PPE available. A group of GPs were being asked to provide sentinel samples on a weekly basis and these were being tested. Testing was otherwise being carried out on the basis on symptoms (no swabbing of people without symptoms). Those who had returned from China had been placed in quarantine and released.

20. **Sweden** had had one case to date (self-isolated and recovered.) So far 150 tests had been carried out by eight laboratories and the indication for testing was that there had to be symptoms.

21. **Czech Republic**: five people repatriated from China, all tested twice and released on 17 February 2020. The national reference laboratory for influenza was performing all testing and to date 80 tests had been carried out. Leaflets had been prepared containing recommendations from ECDC and WHO, slightly modified for national requirements. European guidance was required for airborne infections generally (intensive care, artificial respiration machines, etc.) which would cover both COVID and other diseases.

22. **Ireland:** no cases to date, tested 80 people, still in preparedness phase. Government had declared a national health emergency and purchased supplies. Ireland's pandemic plan had been under revision but the outbreak had emphasised the need to complete this as a priority.

23. **Slovenia**: no cases to date, some students repatriated from China, all tested negative. Doctors decided the criteria for testing. There were six Slovenians on the cruise ship in Yokohama and they were all in good health.

24. **Spain:** 60 people had been tested to date, two positive cases, both recovered and discharged. All contacts had been followed up. A total of 19 people had been repatriated to Spain to date, all had tested negative and all were in good health. As much information as possible was being made available on the Ministry of Health webpage.

25. **Austria** had set up a telephone hotline which reflected the extent of concern among the population. Austrian Airlines had stopped all flights to China, but some Chinese airlines were still flying. The number of cases was being announced on a daily basis on the Ministry of Health website. So far 170 tests had been performed and there were no positive cases. Local health authorities were responsible for taking their own decisions and implementing measures at local level. Asked about ECDC's views on environmental infection risk.

26. **Romania**: one positive case among the cruise ship passengers had been hospitalised in Japan with a mild infection. There were 14 Romanians among the crew of the ship and no information was available on their status. Romania was not testing asymptomatic people. Two repatriated Romanians who had arrived from Germany had been quarantined. A government decree had been passed establishing the possibility for the Ministry of Health to declare a health emergency if necessary.

27. **Estonia**: no cases to date, using ECDC case definition and providing information in the form of FAQs on the national health institute website, particularly for doctors. Six samples tested, all negative. A number of people had returned from Hong Kong and the French Alps and been tested – negative for coronavirus but some tested positive for influenza A.

28. **Italy**: all flights from China had been stopped at the end of January. A state of emergency had been declared. All contacts of Italy's three positive cases have been quarantined and all 56 people repatriated from China had also been quarantined. Information had been being provided on social media (Facebook) to try and prevent fake news, etc. Italy was using the ECDC case definition.

29. **Norway:** so far no cases but two false positive samples from a regional laboratory. Due to media interest there were three media teams working in shifts.

COVID-19 Risk assessment and response

What are the AF's views on the current and likely future risk for the EU/EEA and what are the key uncertainties that impact on that assessment?

What are the AF's views on priorities for response and the likely timescales required for full implementation of those options?

31. Mike Catchpole, Chief Scientist, ECDC opened the session with a short presentation before the floor was opened for questions and comments from the AF Members.

32. Anders Tegnell, AF Member, Sweden was not concerned about importation but more about the establishment of continuous transmission and how to measure once it was established.

33. Frode Forland, AF Observer, Norway thought it would be useful to have more data on the number of people in need of hospitalisation and how long they might need to stay, as these rates might be lower than those seen in China. More information on the risk factors for severe disease would also be useful.

34. Herman van Oyen, AF Member, Belgium, wanted more information on the length of time for which measures would need to be implemented (i.e. how long could the outbreak be contained using the measures currently in place and a time profile for the risk of importation and the progression of the disease).

35. Osamah Hamouda, AF Member, Germany wondered whether common ground could be found for the definition of community transmission, how to manage contacts with mild symptoms and how soon to release cases from hospital so as not to overload the healthcare system. He wondered whether it made any sense to test those without symptoms and also what it meant if a person tested negative (test sensitivity issues).

36. Fernando Simón Soria, AF Member, Spain, was concerned about the risk of importation and how to deal with secondary clusters, given that contact tracing was currently a greater burden on the public health system than actual healthcare.

37. Mika Salminen, AF Member, Finland was interested in the disease profile, how it affected different populations, how it spread, what was the attack rate and what would happen when China lifted restrictions.

38. Kåre Mølbæk, AF Member, Denmark suggested that it was important to identify high-resource countries capable of measuring transmission as assessment should be based on detection capability and not transmission. It was important to know when and where to look for the virus and China was possibly not even the issue anymore.

39. Aura Timen, EUPHA, completely agreed with the AF Member for Denmark and suggested trying to find an indicator that could combine the ability of a system to assess cases and to cope with cases at the same time. Some of the issues discussed were for a shorter timeframe and some for a longer timeframe and she therefore suggested prioritising what was important now for the next few weeks.

40. Jaap van Dissel, AF Member, Netherlands, highlighted the risk of moving to the next phase too early or too late. The Netherlands could foresee problems with hospital bed capacity and the main concern was to take measures to temporise or spread out the outbreak.

41. Silvia Declich, AF Member, Italy wondered about the possibility for asymptomatic cases to transmit the disease and whether they should be quarantined.

42. Bruno Coignard, AF Alternate, France was concerned about the possibility of importation from Africa, the frequency of transmission among children (in relation to school closure measures to be taken during the next phase.) There were also issues relating to faecal transmission, super spreaders and almost no information available about the seasonality of the disease.

43. Osamah Hamouda, AF Member, Germany said that it was becoming obvious that the whole concept of containment did not work and was not helpful since diseases did not respect borders. Therefore instead of discussing risks it was necessary to discuss recommendations and what advice to give. All other issues were irrelevant at present.

44. Kåre Mølbæk, AF Member, Denmark said that it would be useful to have serological studies as a way of measuring the attack rate.

45. Jurijs Perevoščikovs, AF Member, Latvia, wondered whether local transmission in one European country would be designated as being the same as local transmission in all EU countries.

46. Mika Salminen, AF Member, Finland agreed that containment measures would eventually become futile and that it might be better to see what happened over the next two weeks. If transmission continued apace then it would be necessary to take mitigation measures. He suggested having a teleconference in around two weeks or one month to update.

47. Osamah Hamouda, AF Member, Germany said that it was likely that there would be many undetected cases and if China could not eliminate the virus from its population it would eventually reach Europe. It would not be possible to implement the measures put in place in Hubei anywhere else in the world. They were proving effective at present but did not represent a long-term solution.

48. Herman van Oyen, AF Member, Belgium, was of the opinion that it was more important to have an understanding of the proportion of people infected with mild symptoms, the level of severity and the duration.

49. Kåre Mølbæk, AF Member, Denmark, referring to possible scenarios, noted that this was a beta coronavirus and there were no examples to date of such a virus having sustained human transmission without an environmental or zoonotic component.

50. Mike Catchpole, summarising the discussions, said that they had been very helpful. While still in containment mode one of the main questions was how to detect cases, who to test, where the virus was likely to come from and what were proportionate measures for preventing transmission.

COVID-19: Options for response under different future scenarios

51. Mike Catchpole, Chief Scientist, ECDC, introduced the paper on options for response under different future scenarios, making the point that global progression of the outbreak would be irrespective of the efforts being made to contain it in the EU. He also pointed out that the proposed scenarios were to help thinking in Member States.

52. Anders Tegnell, AF Member, Sweden said that for Scenarios 2 and 3 the measures were probably quite similar and that the last scenario was very contextual and depended on the resources available so he suggested leaving it out.

53. Kevin Kelleher, AF Member, Ireland – disagreed with the AF Member from Sweden since the transmission from containment to mitigation represented a massive step in terms of healthcare.

54. Kåre Mølbæk, AF Member, Denmark said that the proposed scenarios would be really useful to present at home in Denmark. He suggested adding another scenario whereby initially there was an apparent containment and then the virus might rebound in the autumn (i.e. second wave in a pandemic).

55. Mike Catchpole, Chief Scientist, ECDC suggested that any detailed feedback could be provided as written comments so that it could be added to the document before the next meeting.

56. Bruno Coignard, AF Alternate, France said that his institute had done a similar exercise in France and ended up with the same four scenarios as ECDC. The fourth scenario, involving widespread transmission and causing a significant important impact on the healthcare system, was found to be the most likely.

57. Jan Kynčl, AF Member, Czech Republic said that his main worry was that this scenario only related to European countries and did not take into account the tropical climate or seasonality (flu in Europe) at the present time.

58. Mike Catchpole, Chief Scientist, ECDC, introduced the working group topic on country support and priorities for ECDC with respect to the COVID-19 emergency situation.

Day Two

Country support – what are the AF's views on the priorities for ECDC in providing support to EU/EEA Member States in respect of the COVID-19 emergency situation?

Reporting from Working Groups

59. Kåre Mølbæk, AF Member, Denmark gave a report for Working Group A.

60. Mika Salminen, AF Member, Finland, pointed out that Finland was running the SHARP joint action and if there were any countries that needed support with the sending of samples for testing there was some financing available to help.

61. Kevin Kelleher, AF Member, Ireland, stressed the importance of flu respiratory screening this year, pointing out that if certain countries needed extra funding DG SANTE should make this available.

62. Herman van Oyen, AF Member, Belgium strongly agreed with this point.

63. Anders Tegnell, AF Member, Sweden gave a report for Working Group B.

64. Aura Timen, EUPHA, added that the group had felt that there was a need for a place to discuss technical issues, which they had been doing to date in the EWRS committee. She therefore asked if ECDC could help with the setting up a forum for this somewhere.

65. Bruno Coignard, AF Alternate, France, said that it was necessary to increase the bottom-up rather than top-down exchanges and appealed to all to contact their NFPs and urge them to use their influence to help make this happen.

66. Frode Forland, AF Observer, Norway, gave a report for Working Group C.

67. Osamah Hamouda, AF Member, Germany reemphasised the importance of ECDC's guidance when talking to politicians as they could not ignore this. He stressed how important it was to be very clear in messages as scientific evidence was sometimes difficult for politicians to understand and there should be no possibility for them to misinterpret.

68. Mike Catchpole, Chief Scientist, ECDC pointed out that as COVID-19 was an emerging infection, the evidence base was limited as yet, and ECDC would probably need to seek advice from its AF members more frequently.

69. Mike Catchpole noted that there was general support for ECDC collectively having a discussion by audioconference. The common theme was how and when to move from containment to mitigation, a wish for clarity in terms of assessment of evidence. The need to coordinate studies (particularly with WHO), a discussion of costs versus impact concluded that it would be very difficult to produce a cost benefit analysis which was valid across the whole of the EU so coming up with a single EU cost would not be in line with the discussions we had had in this forum before.

70. Andrea Ammon, ECDC Director, said that exchange of information and ideas was also valuable for ECDC. It was important to agree on how to deal with certain countries' announcements regarding ongoing community transmission in terms of travel advice, testing, etc. She pointed out that, as with most epidemics over the last 25 years, communication was critical and the biggest challenge would be the shift in phases in terms of risk communication. It was possible to prepare for this now, even though some countries might have to shift phases more quickly than others, or not at all. ECDC could provide options and guidance but it was up to the Member States whether they followed this. She agreed that frequent meetings of the AF would be useful and there were also exchanges in many other technical groups, such as between the flu contact points (NFPs), etc. She suggested that it might be useful in each Member State to have a coordinating function bringing all the various strands together.

71. Mika Salminen, AF Member, Finland agreed that national coordinators needed to be informed but the AF was the body that should be advising on scientific policy issues. Any technical decisions having a major impact on public health needed to be discussed at the AF first.

72. Kevin Kelleher, AF Member, Ireland asked if there was a clear definition of what was meant by community transmission.

73. Anders Tegnell, AF Member, Sweden said that the consensus in Working Group B had been that ECDC was the forum to have contact with in the first instance since in many countries the structures had been changed to reflect the crisis and special groups set up, the AF was the best first point of call for questions at present.

74. Fernando Simón Soria, AF Member, Spain, referring to the definition of community transmission, pointed out the importance of not having conflicts in communication between ECDC, the countries and/or the Commission. With regard to the options for response comments, he pointed out the importance of being able to adapt technical documents for this particular situation.

75. Osamah Hamouda, AF Member, Germany said that defining community transmission and sustained community transmission was important but it was more important to realise the consequences of identifying community transmission or sustained community transmission in a particular area. In essence, this was the same as defining risk groups/areas. It was also necessary to distinguish between people infected with the virus (asymptomatic) and people infected in hospitals.

76. Aura Timen, EUPHA, suggested talking about areas with community transmission but including a definition that the country used or approved itself. She also wished to echo what had been said by the AF Member for Sweden, that most countries were operating in crisis mode and therefore the usual focal points were not necessarily leading since special structures had been activated.

77. Kåre Mølbæk, AF Member, Denmark pointed out that if there was evidence of sustained community transmission in Singapore or Japan then it would be the same for Europe and therefore it was necessary to be proactive by preparing for this.

78. Herman van Oyen, AF Member, Belgium, agreed with most of the comments and was also of the opinion that it was necessary to be more proactive in anticipation of developments. He pointed out that ECDC's advice was actually often adopted by Member States, so it needed to be very clear. He reiterated that it was necessary to go beyond counting cases and to frame the information in terms of population size, number of positive tests, negative tests, etc. to make clear the clinical situation. Proactive action at EU level could be extended to existing tools – e.g. EURO MOMO.

79. Mika Salminen, AF Member, Finland also hoped to be going home with a clear message on how to handle the situation. In Finland, websites in the affected areas had linked to public health institute testing guidance and travel advice through the Ministry of Foreign Affairs

80. Mike Catchpole, Chief Scientist, ECDC went through ECDC's proposals concerning community transmission definitions and categorisation of areas once again. The issues in relation to definition were 1) what was meant by community transmission 2) what was meant by an affected area 3) what this meant in terms of what countries should be doing (investigation/management of individuals coming from affected areas). The floor was then opened for discussion.

81. Kåre Mølbæk, AF Member, Denmark noted that the definitions were very dependent on a country's capacity to detect cases. Therefore low income countries would be unlikely to be classified as countries of ongoing community transmission as they would not be testing and detecting adequately. He therefore suggested using the term 'areas of uncertainty. Obviously, the definitions were more of an issue for foreign ministries in relation to the imposition of travel bans.

82. Mike Catchpole pointed out that some countries were 'self-declaring' as being areas of community transmission and that ECDC should recognise this fact.

83. Kevin Kelleher, AF Member, Ireland pointed out that there were many people involved in the process of decision-making with regard to testing and therefore it was necessary for messages to be clear.

84. Anders Tegnell, AF Member, Sweden, said that figures needed to be translated into risk and the risk needed to be assessed before any decisions could be taken. It was necessary to use resources

appropriately and right now, other than testing for those who had visited central China, this meant discussing on a case-by-case basis.

85. Andrea Ammon, ECDC Director, pointed out that the number of tests reported by Member States during the tour de table the day before were still quite low and therefore she did not understand why AF members believed that the definitions would add such a burden to their testing.

86. Aura Timen, EUPHA, recommended waiting to see how the situation developed.

87. Silvia Declich, AF Member, Italy noted that the more data available the more the classifications would change and this would happen very quickly, with a significant impact. Trying to differentiate areas for surveillance/testing purposes would just create more confusion. She suggested adhering to the line taken by WHO with regard to affected areas.

88. Herman Van Oyen, AF Member, Belgium, said that it was necessary to look at the feasibility of such definitions. The information would change rapidly and therefore it would not be relevant. Instead he suggested remaining vigilant would be a better approach.

89. Mika Salminen, AF Member, Finland, said that there should be less categories as there were enormous challenges in making fine distinctions between cases. In practice, adding Japan or other countries to the list this would lead to lots of people asking for tests, most of whom would be negative, but the burden on healthcare systems would be enormous.

90. Mike Catchpole asked what criteria the AF Member for Finland would apply in his country for advising physicians/clinicians when to test.

91. Mika Salminen replied that he would probably apply the criteria of severe respiratory symptoms. At present, cases presenting with a cough, fever, or sniffles and coming from China would be tested. However, extending this to include Japan, Singapore and Vietnam would not be sustainable.

92. Andrea Ammon wondered what would happen if China lifted its ban on travel.

93. Mika Salminen replied that he did not believe that would change much initially. However, adding other countries with the same very low threshold would be problematic.

94. Fernando Simón Soria, AF Member, Spain said that his personal position would be to just test those from Hubei or possibly extending this to mainland China. In his opinion, it was irrelevant whether there was community transmission, the time factor and incidence was much more important. In Spain, over 600 tests had been carried out so far but it was not just a matter of the number of tests. Each person had to be isolated, hospital workers were afraid of being infected and those tested were being stigmatised. He also believed that aligning with WHO's position was the best approach. The affected areas with community transmission could be changed as the situation progressed but he was of the opinion that some of those currently listed by ECDC as high were actually intermediate.

95. Bruno Coignard, AF Alternate, France suggested that when comparing Hubei with the rest of the population of China at present the ratio was 1-40 and therefore it was best to focus on Hubei for now. Although the criteria presented were clear the incidence was lacking. The issue was not testing, but categorisation and listings by foreign ministries. It was impossible for EU Member States to quarantine all people coming from China, Singapore and Japan. He also agreed that it was necessary to have a stable classification.

96. Mike Catchpole observed that the discussion indicated that ECDC attempts to identify localised community transmission were not widely considered to be helpful and that incidence would be a better indicator.

97. Kåre Mølbæk, AF Member, Denmark said that the wording of the definition was not so important, more the actual category, to ensure that the situation remained manageable. For example, with a case of severe pneumonia it would be natural to look for the virus. He was still in favour of splitting China into Hubei province and the rest of mainland China which would also be helpful for travel advice. If the incidence information could also be added this would provide a workable solution.

98. Mike Catchpole noted that it had been suggested to identify a high risk country as one with widespread community transmission (China probably being the only one so far) and for anyone returning from such a country testing of any respiratory tract infection could be warranted. Medium-to-low risk countries could be those with sporadic community spread outside of known clusters, where

an appropriate response could be to continue testing only severe cases. Finally there could be a category for countries with a low capacity for diagnosis.

99. Kevin Kelleher, AF Member, Ireland agreed with this proposal.

100. Anders Tegnell, AF Member, Sweden agreed with the AF Member for Finland that it was not always necessary to only follow the most scientifically sound approach if this was not feasible.

101. Jurijs Perevoščikovs, AF Member, Latvia did not agree that the incidence rate was a good indicator. For example, it was impossible to know the definition used in Vietnam or how many tests had been performed. It was important to decide on the message that they wished to send to clinicians regarding protection of people from potential exposure. He suggested using another case definition for severe acute respiratory infection for those having travelling to other countries.

102. Osamah Hamouda, AF Member, Germany said that it was necessary to look at incidence, although they would probably not have a good idea of true incidence until some time in the future. As a second choice it was possible to look at the number of reported cases as a proxy for incidence. However, this needed to be kept in proportion as 75 000 people out of a population of 1.4 billion was not many. He agreed with the concept of having widespread community transmission as a step in the right direction. In Germany they had only included Hubei and then added four neighbouring cities with quarantine measures. It was important to bear in mind the consequences of the definition and the implications for travel restrictions.

103. Karl Ekdahl, Head of Unit, Disease Programmes, ECDC, said that China CDC had informed ECDC that they were running out of test kits and only Hubei had introduced the clinical case definition. It was therefore important to be cautious when drawing conclusions on what was happening in areas outside of Hubei province.

104. Bruno Coignard, AF Alternate, France asked whether this meant that they would keep the same definition and also whether the definition would be aligned with WHO's in the near future. He pointed out that he had informed his Ministry that he would obtain information to help take a decision as a result of this meeting.

105. Herman Van Oyen, AF Member, Belgium said that people in his institute at home would want information on the conclusion of these discussions. He preferred not to single out certain countries but instead to focus on the severity of disease and include that in the differential of diagnosis. There was not enough evidence available yet to take public health action on deciding whether to quarantine people arriving from certain countries.

106. Mike Catchpole suggested that they would work on the suggestion of identifying a high risk country as one with widespread community transmission (China probably being the only one so far) and medium-to-low risk countries could be those with sporadic community spread outside of known clusters, and a category for countries with a low capacity for diagnosis, and draft a proposal for circulation later that day or the next day. He suggested that sore throat should be removed from the list of symptoms and fever added.

107. Aura Timen, EUPHA, was in agreement about getting rid of sore throat, but in the Netherlands they had 'fever and…', not 'fever or…'.

108. Fernando Simón Soria, AF Member, Spain agreed with getting rid of sore throat and adding fever but not 'fever and…' since many had not had fever onset until a few days after showing symptoms.

109. Mika Salminen, AF Member, Finland agreed that it should be 'or' with any of those symptoms

110. Kevin Kelleher, AF Member, Ireland suggested that the phrase 'requiring hospitalisation' should be removed.

111. Jurijs Perevoščikovs, AF Member, Latvia did not understand why sore throat should be removed because it was a sign of respiratory infection. He asked whether Latvia should make additional proposals for the definition in writing and had some further questions about testing of suspected cases within families.

112. Mike Catchpole said that it had become evident from clusters in France and Germany that the virus transmitted very well. He suggested sending in the questions in writing and ECDC would advise.

113. Bruno Coignard, AF Alternate, France, referring to the third criteria for exposure, said that he disagreed with it since, if it was applied in France, every patient with an influenza-like illness in hospitals across the country would be included. He also wondered what should be done with asymptomatic patients with a positive test – should they be treated as confirmed cases even if they did not match the criteria?

114. Andrea Ammon, Director, ECDC suggested adding '14 days before the onset' in order to limit the period.

115. Fernando Simón Soria, AF Member, Spain noted that in the next few weeks the problem would be solved because influenza was now decreasing, however he agreed with the proposal.

116. Anders Tegnell, AF Member, Sweden said that he had sent in written comments on this issue before the meeting.

117. Mike Catchpole suggested the phrase 'When in close contact with a confirmed or probable case of COVID-19 and not having been wearing protective equipment'. He then asked for feedback on the fourth question – Would Member States be willing to report weekly aggregate numbers of cases and contacts in home quarantine, hospital and numbers discharged from hospital through EWRS?

118. Kevin Kelleher, AF Member, Ireland said that he did not have a problem with this although it might be problematic, given the current volume of information in EWRS.

119. Osamah Hamouda, AF Member, Germany said that he was willing, but did not know if it was possible as they would have to collect the data from local health authorities.

120. Bruno Coignard, AF Alternate, France said that he too was willing, but was not sure if he would be able to do it. He suggested that TESSy might be a better channel because there were currently so many messages in EWRS.

121. Herman Van Oyen, AF Member, Belgium agreed that it would be better to use TESSy, asking for data on positive cases with no symptoms at EU level and then adding some information on the clinical situation.

122. Mike Catchpole thanked the members for their helpful feedback. He would talk with the ECDC team, address all of the points and revert later that day or the next. He had noted in particular the request for ECDC to provide clearer options for policy-making colleagues.

Status of Third Joint Strategy Meeting

123. Mike Catchpole, Chief Scientist, ECDC, suggested that he would send around an update on the status of the third joint strategy meeting.

Chief Scientist's report on the work of the AF in 2019

124. Mike Catchpole, Chief Scientist, ECDC, asked if there were any comments on the Chief Scientist's report on the work of the AF in 2019.

125. Herman van Oyen, AF Member, Belgium had discussed this with his colleague and pointed out that there was a need to distinguish between what had been decided by the AF and what had actually been implemented. He would ask his colleague to provide her comments in writing

126. Mike Catchpole, referring to the possibility of arranging to meet again in the next 6-8 weeks, suggested that ECDC should look at resources available. However, he understood that AF members would be willing to participate in ad hoc audioconferences on specific issues in relation to COVID-19, whereby ECDC could aim to put together a package of outputs for consultation in each case.

127. Bruno Coignard, AF Alternate, France agreed with this idea however he pointed out that it would be necessary to liaise with the appropriate person in each case, so although the 'entry point' could be the AF, it would depend on the questions asked as to which expert would have to be consulted in each case. He therefore asked if it would be possible for an AF Member to be replaced by a different expert if necessary.

128. Mike Catchpole confirmed that this would not be possible. Such an expert could be invited to attend the meeting/audioconference as an observer/guest but could not replace a member of the AF.

129. Andrea Ammon, ECDC Director, thanked the AF members for their helpful feedback during discussions. She also pointed out that this was the 60th meeting which meant that the AF had now provided good advice and constructive proposals for ECDC on a total of sixty occasions and she thanked the members for their dedication and support.

130. Mike Catchpole noted that in principle the next scheduled AF meeting would be on 11 May, and was to be held back to back with the third joint strategy meeting.[1] He wished everyone a safe journey home.

[1] Following the meeting, it has been decided to postpone the Third Joint Strategy Meeting due to the coronavirus outbreak.

Annex: List of participants

Member State	Representative	Status
Austria	Franz Allerberger	Alternate
Belgium	Herman van Oyen	Member
Croatia	Aleksandar Šimunović	Alternate
Czech Republic	Jan Kynčl	Member
Denmark	Kåre Mølbak	Member
Estonia	Natalia Kerbo	Alternate
Finland	Mika Salminen	Member
France	Bruno Coignard	Alternate
Germany	Osamah Hamouda	Member
Greece *(via audio-conference)*	Sotirios Tsiodras	Member
Hungary	Zsuzsanna Molnár	Member
Ireland	Kevin Kelleher	Member
Italy	Silvia Declich	Member
Latvia	Jurijs Perevoščikovs	Member
Lithuania *(via audio-coneference)*	Nerija Kupreviciene	Alternate
Malta *(via audio-conference)*	Tanya Melillo	Alternate
Netherlands	Jaap van Dissel	Member
Romania	Florin Popovici	Member
Slovakia	Henrieta Hudečková	Alternate
Slovenia	Marta Grgič-Vitek	Alternate
Spain	Fernando Simón Soria	Member
Sweden	Anders Tegnell	Member
Sweden	Birgitta Lesko	Alternate

Observers		
Norway	Frode Forland	Member
Iceland *(via audio-conference)*	Thorolfur Gudnason	Member
	Guðrún Sigmundsdóttir	Alternate
Non-Governmental Organisations (NGOs)		
European Public Health Association (EUPHA)	Aura Timen	Member
AIDS Action Europe	Aigars Ceplitis	Alternate
European Commission (via audio-conference)		
DG Sante	Frank Van Loock	
DG Sante	Charles Price	
WHO (via audio-conference)		
	Nedret Emiroglu	
	Dorit Nitzan	
	Catherine Smallwood	
	Masoud Dara	