ECDC Advisory Forum

Minutes of the Sixty-first meeting of the ECDC Advisory Forum

Stockholm, 11 May 2020

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Opening and adoption of the programme

1. Andrea Ammon, ECDC Director, opened the meeting (audio conference).

2. Mike Catchpole, Chief Scientist, welcomed Frank van Loock (European Commission) and Dorit Nitzan from WHO Regional Office for Europe. Apologies had been received from Aura Timen (EUPHA). There were no conflicts of interest declared and no additions to the existing programme which was adopted without change.

Adoption of the draft minutes of the 60th meeting of the Advisory Forum (18–19 February 2020)

3. There were no comments on the draft minutes and they were adopted. It was pointed out that the minutes of all extraordinary teleconferences held since February had been uploaded on AF Extranet where they were available for review.

Update on recent ECDC COVID-19 activities

4. Andrea Ammon, ECDC Director, gave a short update on activities related to COVID-19 since the last meeting.

5. Mike Catchpole, Chief Scientist, following up on comments he had received from some AF Members about being consulted before documents were presented to the Health Security Committee, noted that although the timescales were tight, from now on ECDC would attempt to seek the views of the AF. However, this would only be practical by means of a written procedure and at fairly short notice.

De-escalation of measures – monitoring impact and learning lessons

6. Mike Catchpole, Chief Scientist, noted that de-escalation was giving rise to many questions and it was important to learn from one another what approaches and measures were being taken. He therefore suggested a tour de table whereby each country would make a brief intervention to describe the measures being taken at present and those planned over the next couple of months.

7. Franz Allerberger, AF Alternate, Austria, said that in Austria schools and kindergardens would open next week (week 21) although there was still a great deal of uncertainty. The numbers attending would be cut by half to ensure physical distancing. Pupils would have to wear masks inside the school building. There would also be routine screening of nursing homes every six weeks (officially from July but every province in Austria had already started). With regard to surveillance, the screening of nursing homes had forced a change in national law to make it possible to screen the residents, but screening was not allowed in kindergardens or schools.

8. Alexandar Simunovic, AF Alternate, Croatia, said that some measures had already been lifted and the plan was to continue doing so. Many questions were currently being received from hotels and tourist destinations regarding de-escalation. The situation with schools was somewhat complicated, however measures for the use of public transportation were strictly prescribed.

9. Bruno Coignard, AF Alternate, France, said that de-escalation had begun that day (Monday 11 May 2020). People were not being forced to stay at home anymore and could now go outside and travel up to 100 km away from home. Schools will reopen progressively, starting with nursery schools and elementary schools. A document detailing the entire strategy would be sent by email. With regard to monitoring, the strategy was based on a territorial analysis of the epidemiological situation (incidence of confirmed cases, RT-PCR positivity rates), a strategic assessment of the healthcare capacity (especially in ICUs) and testing capacity (which the government had increased), and cluster detection, investigation and control. In recent weeks efforts had also been made to link up all the labs in France in order to obtain the results of lab tests more quickly and to centralise them (over 4 000 labs in France were connected to this system called SI-DEP). It was hoped that the indicators for confirmed cases would be much better within the next few days and also that there would be sufficient capacity to test all suspected cases.

10. Jan Kynčl, AF Member, Czech Republic, said that the de–escalation strategy consisted of several stages. The first would begin that day with school re-opening for students (voluntary attendance) at middle and high schools (limit of 15 persons in one classroom). Shops had also reopened as of today

(Monday 11 May 2020) although it was necessary to wear a face mask when entering. Face masks were still compulsory in all public spaces. The final lifting of measures was planned in two weeks when children aged 8–10 years would also be able to start school again. Class sizes would be reduced by half and there would be no school sports. The monitoring system being used in the Czech Republic focused on the ICU occupancy rate. This was being published on a daily basis. If all measures worked well within the next few weeks it was hoped that it would be possible to discuss masks only being obligatory for use on public transport or at public facilities.

11. Tyra Grove Krause, AF Alternate, Denmark, said that following their lockdown from mid-March onwards they began to see a decrease in hospital cases by the end of March. In mid-April schools and kindergardens reopened with strict rules on physical distancing and hand hygiene. Denmark had continued to see a decrease in hospital cases and therefore hoped to enter the second phase of de-escalation by 18 May 2020 when the rest of the country's schools would be reopened along with bars, restaurants and shops. With regard to monitoring, there had been continuous monitoring of the public, and data had been collected on how the public interacted/travelled. They had also been looking at airway infections on the basis of syndromes. It was hoped that they would soon be able to do 40 000 tests per day (out of a population of five million). The reason for increasing testing was that they hoped to improve the detection of community transmission at an earlier stage. They had also begun doing cross-sectional epi studies to follow a cohort of people who would be tested continuously every second week with PCR and also some sero surveys. It was not mandatory to wear face masks in public but there was a possibility that this measure might have to be introduced where social distancing was not possible. At present, the social distancing requirement was 2 metres apart and this would probably be reduced to 1 metre in special circumstances.

12. Natalia Kerbo, AF Alternate, Estonia, said that they were using monitoring to try and detect community transmission and new cases. De-escalation measures had begun the previous week and these included the planning of treatment in hospitals and at healthcare centres. As of 11 May 2020, shopping malls and large shops would be opened and it was hoped that schools would reopen as of Monday 18 May 2020, but only for individual lessons and workshops. Schools would not reopen completely until 1 September 2020. Plans were also being made for sero surveillance to find out more about herd immunity within the population. All measures were being introduced very slowly, on a step-by-step basis.

13. Osamah Hamouda, AF Member, Germany, said that due to Germany's federal system the situation was slightly complex, but a gradual lifting of measures had begun on 4 May 2020. There was no uniform timescale within the country as each federal state was responsible for their own measures. Testing capacity and ICU capacity had been stepped up. The 400 local health authorities had been given support in the form of reinforcements (in total an additional 500 employees being funded by central government). If a threshold of 50 newly reported cases per 100 000 per week was exceeded in any week the state had to intervene and send additional support. At present, the number of localised outbreaks in hospitals, asylum centres, homes for the elderly and meat packing plants had increased. It was difficult to monitor the lifting of measures at national level because the situation was so diverse. They were trying to increase the number of variables for the cases reported in order to have a better overview of who these cases were. In general, shops and shopping malls were now reopening. Restaurants and cafes would also reopen soon but the timescale differed depending on the area. The situation for schools and kindergardens was also varied - in some areas schools were reopening for pupils doing exams as a priority, and some schools were opening for older students. In response to a question as to whether Germany's monitoring systems were sensitive enough to detect whether different approaches had a different impact, he said that there were some university projects trying to measure the effects in local areas but this was very difficult. Serological studies were being started in blood donors, and in the longer term, they were planning to carry out nationwide, serial, cross sectional studies.

14. Zsuzsanna Molnár, AF Member, Hungary, said that de-escalation had begun on Monday 4 May 2020 with the reopening of shops, museums, etc. The hardest hit region had been the city of Budapest and the neighbouring area of Pest. Schools remained closed but kindergardens would start to reopen soon depending on parental needs for a maximum of five children per group. With regard to healthcare and social care services, these were gradually opening up and screening in nursing homes had now been in place for one week at homes for the elderly. With regard to surveillance data collection, they were considering additional surveillance activities and were currently undertaking a large cross sectional representative survey involving 18 000 people which was being coordinated by the four medical schools

in Hungary. The survey was looking for active infection by PCR and also taking blood samples to be put aside for ELISA testing at a later stage.

15. Thorolfur Gudnason, AF Member, Iceland, said that the epidemic had reached its peak in Iceland in late March and there had currently been no cases for four days. So far 50% of the population had been tested; schools and day-care centres had not been closed. The only restrictions had been on mass gatherings of over 20 people, although this had now been increased to 50 people. It was hoped that it would be possible to increase it later to 200 and then to 2000 some time during the summer. There were only two patients in hospital at present and none on ventilators. The biggest challenge was how to open up borders. At present, there was a two-week quarantine period for visitors to Iceland and various measures were being considered in order to protect the public. He was therefore keen to see some the recommendations/guidelines soon to be published by ECDC on considerations for travel-related measures.

16. Lorraine Doherty, AF Member, Ireland, said that Ireland had seen a decrease in the number of cases and hospitalisations but was still challenged by over 400 outbreaks in nursing homes/residential facilities. There had also been 10 outbreaks at meat processing plants. Testing had been scaled-up and the aim was to perform 100 000 tests per week by the end of May. Contact tracing was also being scaled up quite significantly, with a plan to test all contacts. A strict approach was being taken to de-escalation, with the country due to reopen in five phases, three weeks apart. The first phase would start on 18 May 2020. Schools and colleges would not be opened, only to allow teachers to do lesson plans, and shops would not be opened either. The Department of Health in Ireland had published a road map on its website and she would share this with ECDC. Infections in healthcare facilities, healthcare workers, nursing homes and ICUs were being closely monitored along with excess mortality rates. Ireland was taking quite a conservative approach compared to other countries, and each phase of the de-escalation would be monitored to assess whether further restrictions could be lifted.

17. Isabel De La Fuente Garcia, AF Member, Luxembourg, said that schools had begun to open on 4 May 2020, with older children returning first, and the rest by the end of May. Numbers in classes were reduced. Shops had also reopened. Masks were mandatory whenever social distancing was not possible – i.e. on public transport, in schools, at supermarkets, etc. Surveillance was being increased, with mass testing of civilians being organised, along with testing at nursing homes, in schools and at hospitals. Epi studies were underway (samples would be taken from the whole population via PCR over the next two months). The results of the first screening had been made available two days ago and only 2% of the population in this representative sample had been seropositive.

18. Frode Forland, AF Member, Norway, said that after going into lockdown on 12 March, Norway had seen the epidemic curve beginning to bend by the end of the month. During the last three weeks the country had been gradually reopening, first with kindergardens and then schools for younger children, followed by all primary and secondary children. Shops and restaurants had not been closed, but had had to implement measures for physical distancing. The infection prevalence in the country had been 1–2% which was quite low. An intensive testing strategy was now being activated and it was hoped that any outbreaks would be local rather than national. An app had been launched that people could use to 'self-record' and around 25% of the population had downloaded it so far, although ideally around 50% would need to do so. The plan had been to open schools on a rotational basis a month at a time but that was not approved by the Ministry. The strategy for the future was to test intensively. Norway was performing PCR testing and seeing good results, which were helping with capacity. It was also hoped that it would be possible to do self-sampling at a later date.

19. Silvia Declich, AF Member, Italy, said that de-escalation had begun on 3 May 2020 and it was planned for shops to reopen on 18 May and restaurants, bars and hairdressers on 2 June 2020. Schools would not reopen until September and exams would be done remotely (or individually). A government decree had been passed on 26 April 2020 requesting the Ministry of Health to prepare a monitoring document issued on 30 April 2020. This set out indicators for monitoring capacity, diagnosis, the stability of transmission, and the maintenance of the healthcare services. The idea was that this monitoring would be done on a weekly basis nationally and region by region. The first monitoring report had been too early after de-escalation to see any significant changes. At national level there had been a study of excess mortality and the clinical records of patients who had died of COVID-19 were being analysed on an ongoing basis. A national study of serology was due to start soon with around 100 000 participants.

20. Małgorzata Sadkowska-Todys, AF Member, Poland, said that de-escalation had begun although for the time being the number of people allowed to gather in groups was still limited. In June, final

exams would be held in schools (primary and high schools). However, counter measures would be introduced – physical distancing measures - and face masks would be mandatory. Hotels and shops were allowed to open although not many of them were doing so, as yet. The week before there had been an increased number of cases in Silesia, therefore testing had been enhanced among miners as an occupational group. A sero-epidemiological survey was also being planned.

21. Loreta Aškolienė, AF Member, Lithuania, said that surveillance was continuing, along with intensive contract tracing. So far over 180 000 tests had been carried out (representing more than 7% of the population) and de-escalation measures had begun. Shopping malls were now open, along with restaurants and cafes (for outside service only). Kindergardens would be opened from week 21. At the moment, the situation was uncertain regarding schools and the protocol was still under development. The wearing of masks was obligatory at present but from next week it would only be mandatory inside and not outside. There was also a discussion about increasing the size of permissible gatherings to 30 people.

22. Carlos Matias Dias, AF Member, Portugal, said that Portugal had experienced maximum incidence at the end of March and the effective reproduction number was now fluctuating at around 1 in most regions. Since last Monday 4 May 2020, lockdown measures had been being eased as part of a three-phase plan but the general rule was still to stay at home. Teleworking measures would also continue but there would be a progressive opening up of outside services every two weeks (mainly public services, shops, restaurants, etc.) while keeping human density as low as possible. Schools will be reopened in phases and the first phase would be schools for students entering university next year so that they could prepare for national exams. With regard to monitoring, surveillance systems, statistical modelling and data from Google mobility were being used. Population behaviour was also being studied by academia. A serosurvey was being carried out at present (May) and another was planned in three months.

23. Irena Klavs, AF Member, Slovenia said that Slovenia had a very low level of active COVID 19 infection. In the previous week, the daily average of cases had been three, which corresponded to 1.5 per million population. An estimate of active COVID-19 infection among the population had been published the previous week based on a sample of 1367 people who had been tested over 10 days in April. The response was 46% and only one participant had had an active COVID-19 infection. This corresponded to a point prevalence of under 1 per thousand people. The survey was also a seroprevalence survey and the estimated prevalence was 3.1% (CI 2-4%) which would be used as a baseline for future prevalence estimates. In response, the government was now lifting measures and the borders that had been closed between regions were now open. Masks were still required in public places, there were disinfectants on buses, etc. but non COVID healthcare was being scaled up. Next Monday, 18 May 2020, elementary schools would reopen for younger children along with kindergardens. On 25 May 2020, classes would recommence for older students at elementary schools and secondary schools. With regard to data collection/monitoring, a network of 14 acute-care hospitals across Slovenia had been established which facilitated the reliable monitoring of the weekly number of cases admitted to hospitals and ICUs in the country. In addition, data would be collected on the weekly number of discharges and hospital deaths in order to monitor the capacity of the healthcare system. Another survey was planned in six months, and it was hoped that it could be expanded to ER surveillance. Residents and staff at nursing home facilities were also being tested regularly.

24. Birgitta Lesko, AF Alternate, Sweden, said that Sweden would be continuing with the measures currently in place and no major changes were planned. Sweden had not implemented a lockdown, just certain restrictions and recommendations. Schools had been open, with exception of colleges and universities. Shopping malls had also remained open, but with very few customers. They had been following epidemiological data on a daily basis and also data on ICU admittance. There had been a slow but constant reduction in numbers over recent weeks which was promising. The number of tests had been increased in May, not just for hospital admissions but also generally. There had been a number of positive tests detected in healthcare personnel. The aim was to test 100 000 people each week. There had been a significant reduction in travel across Sweden (by 21%), as much as in neighbouring countries which had had lock-down restrictions. With regard to PCR testing, this was 13% positive (29 000 individuals tested the previous week); the majority of cases had been patients admitted to hospital. Data was now also being collected on upper respiratory infections.

25. Florin Popovici, AF Member, Romania, said that the emergency status would be cancelled at the end of the current week and de-escalation measures would then begin. Museums, libraries, parks and

recreational areas would reopen but schools would only be opened for those students who had to take exams. Schools would not reopen generally until September. Hotels would also be able to reopen from the end of the week but not restaurants or cafes, as yet. There were still around 30 000 people in quarantine. It was hoped that plans would be in place for a national seroprevalence study by the end of the week and this would take place in July. Next week he would be having discussions with the Ministry of Health about influenza vaccination for the general population.

26. Tanya Melillo, AF Alternate, Malta, said that non-essential shops had reopened on 4 May, including shopping malls, it had been recommended that all employees and clients wore masks. Masks were also required when using public transport. They were waiting for two weeks to see if these measures would affect the R value (below 1) before lifting any other measures. Schools would not be opening until the beginning of the next scholastic year in September. Screening of asymptomatic people among the general public was being increased and essential services, such as police, armed forces, civil protection, healthcare workers and carers in homes, were also being targeted for testing. Once they had been tested, swabbing would be offered to staff working in large companies (on average 800-1 000 could be swabbed per day). The elderly and vulnerable people were still in lock down. In shops the recommendation for physical distancing was one client per 10 square metres. So far restaurants, bars, beauty services, hairdressers, tattooists, spas, etc. had not reopened and all sport and entertainment activities were still prohibited.

27. Mike Catchpole, Chief Scientist, ECDC thanked the members for their reports. It appeared that many countries were planning a deliberate gap between each phase. The most obvious variation was with regard to the re-opening of schools, with a number of different approaches being tested. He emphasised the importance of sharing information from the results of monitoring to obtain early insight into anything possibly associated with a rebound.

28. Frode Forland, AF Member, Norway, noted the importance of doing some systematic research after the pandemic and hoped that ECDC would take this proposal forward.

29. Mike Catchpole responded that this would depend on the collection of broadly consistent and compatible data. ECDC would investigate what was feasible but it would depend on colleagues in the Member States being able to collect the appropriate information to generate compatible data.

30. Osamah Hamouda, AF Member, Germany, said that perceptions among the general public were quite different, depending on media, communication, etc. One of the crucial topics at present, with the approaching summer season and people being outside more, was whether there was any evidence on transmission in the open air. He wondered whether it would be possible to determine a position on the risk of being out in the open (noting that he had seen people walking dogs in the woods wearing masks and riding bikes wearing masks).

31. Mike Catchpole said that ECDC could look at the evidence available but he was not sure how useful it would be.

32. Franck van Loock, European Commission, noted that there were a number of Member States facing outbreaks in meat processing plants and since this was a unique environment, there might be some lessons learned on how to control outbreaks in such an environment. He suggested that those Member States that had advice could share this with colleagues in the Commission so that some general recommendations could be made.

Winter season/pneumococcal vaccination programmes

33. Mike Catchpole, Chief Scientist, ECDC, asked the members to share information on their plans for the second half of 2020 in relation to influenza surveillance and pneumococcal vaccination programmes in the light of the COVID-19 pandemic.

34. Lorraine Doherty, AF Member, Ireland, said that they were planning to immunise all children aged 2–12 years against influenza this winter. They were also revamping influenza preparedness plans, particularly for nursing homes and healthcare workers. In response to a question on which vaccines they were planning to use, she replied that they would be offering live attenuated vaccine, but not for older children as they had been unable to obtain sufficient stocks.

35. Tyra Grove Krause, AF Alternate, Denmark, said that they hoped to increase coverage of the influenza vaccination programme and therefore they had bought more vaccines than in previous years, both for influenza and pneumococcal. They would also try to send out reminders to all those aged 65

years and over. For the first time, pneumococcal would be offered free of charge to all risk groups in Denmark.

36. Charles Price, European Commission, noted that only around 42% of the risk group 65 years and above were immunised against influenza last year and wondered if ECDC could do additional work to calculate the potential additional lives that could be saved by increasing the number of vaccinations for this age group. He suggested that it might also be worth looking at other age groups.

37. Mike Catchpole asked for comments from ECDC colleagues regarding surveillance of influenza and pneumococcal vaccination.

38. Bruno Ciancio, Head of Section, Surveillance, ECDC, said that at ECDC discussions were ongoing about surveillance plans in consultation with WHO Europe and the surveillance network and they were working on a number of parallel streams – primary care surveillance, syndromic surveillance of viral respiratory infections, and plans to work on a more hospital-based SARI system. ECDC had requested a reallocation of some of its budget to cover this new work, which they hoped to have approved by the Management Board. If approval was given they would probably try to engage with a number of Member States that would be willing to participate. SARI surveillance would look at severe infections over time, including pharmaceutical interventions. ECDC was also in touch with EURO MOMO and had plans for special surveillance – particularly in long-term care facilities. A guidance would be published in the next few days on this subject, providing information to Member States on how to step up surveillance in this area and it was hoped that it would then be possible to monitor the situation in these particular settings more closely. With regard to the idea of doing some systematic research after the pandemic, as suggested by the AF Member for Norway, he agreed that this was very important. In the latest ninth update of ECDC's rapid risk assessment on COVID-19 (page 23) there were a number of proposals regarding the monitoring of impact when lifting of measures. ECDC was also maintaining a database of all measures introduced or removed in Member States which we would be used for comparative analysis later. This work would feed into mathematical modelling which could also provide some insights into how the various measures affected the epidemiology. However, the first stage would be to collect sound epidemiological data for assessment purposes.

39. Mike Catchpole suggested that if Member States were thinking about vaccines, it was important to announce their plans soon so that stocks could be made available. In response to the question from the Commission regarding modelling the potential marginal benefit in terms of hospital admission/ICU bed usage by increasing vaccine coverage in the over 65 age group, he confirmed that ECDC could certainly look into this.

Longer term needs with respect to COVID-19

40. Mike Catchpole, Chief Scientist, ECDC gave a short presentation to introduce the last item.

41. Frode Forland, AF Member, Norway said that the indicators given in ECDC's last rapid risk assessment were helpful and he recommended these. He could also share a map over all published studies that they had been compiling with WHO. If ECDC was able to play a role as a coordinating body for studies in the future this would be crucial.

42. Franz Allerberger, AF Alternate, Austria, responding to the comments by the AF Member for Germany on wearing masks for outdoor activities, said that it would be helpful for ECDC to state what was *not* required, such as wearing masks for outdoor activities. By way of example he cited the fact that in Austria, the authorities were considering the mandatory wearing of masks on beaches.

43. Lorraine Doherty, AF Member, Ireland, agreed that the sooner work started on the coordination of studies and methodologies and priority groups for future COVID-19 vaccines, the better. Another area which needed investigating was the ongoing testing strategy as it would be useful to compare and contrast with other countries. One final area that would be very useful would be some guidance on vulnerable groups and how to support them.

44. Charles Price, European Commission, said that it would be helpful to consolidate some of the gaps already pointed out by ECDC and perhaps look at priority proposals for future funding of EU research.

45. Mike Catchpole confirmed that ECDC would share on the AF forum its rapid risk assessments and other guidance documents before publication via written procedure.

46. Andrea Ammon, ECDC Director, noted that one of the documents ECDC was currently working on was a revised forecast which had involved extensive discussions with Member State modelling teams. It was becoming evident that there was still a lot to do and a great deal more to learn. It was therefore important to find a way to make the learning systematic so that it could be used in the future. She thanked the members for their useful feedback and suggestions.

Annex: List of participants

Member State	Representative	Status
Austria	Franz Allerberger	Alternate
Croatia	Aleksandar Simunovic	Alternate
Czech Republic	Jan Kynčl	Member
Denmark	Tyra Grove Krause	Alternate
Estonia	Natalia Kerbo	Alternate
France	Bruno Coignard	Alternate
Germany	Osamah Hamouda	Member
Hungary	Zsuzsanna Molnár	Member
	Ágnes Hajdu	Alternate
Ireland	Lorraine Doherty	Member
Italy	Silvia Declich	Alternate
Lithuania	Loreta Ašoklienė	Member
	Nerija Kuprevičienė	Alternate
Luxembourg	Isabel De La Fuente Garcia	Member
Malta	Tanya Melillo	Alternate
Netherlands	Susan van den Hof	Alternate
Poland	Małgorzata Sadkowska-Todys	Member
Portugal	Carlos Matias Dias	Member
Romania	Florin Popovici	Member
Slovenia	Irena Klavs	Member
Sweden	Birgitta Lesko	Alternate

Observers		
Iceland	Thorolfur Gudnason	Member
Norway	Frode Forland	Member
Non-Governmental Organisations (NGOs)		
EIWH	Rebecca Moore	Member
European Commission		
DG SANTE	Frank van Loock	
DG SANTE	Charles Price	
WHO		
WHO Regional Office for Europe	Dorit Nitzan	