ECDC Advisory Forum

Minutes of the Eighty-first Meeting

Stockholm, 13-14 May 2025

Contents

Opening and adoption of the programme

1. Piotr Kramarz, Chief Scientist, ECDC, welcomed the participants to the 81st meeting of the Advisory Forum and apologised on behalf of ECDC's Director who could not be present because she was attending a meeting at the European Parliament. He welcomed Barbara Bekavac, newly appointed alternate for Croatia, Costas Constantinou, newly appointed alternate from Cyprus, Harold Noel, newly appointed alternate from France, Victor Aiyedun, newly appointed member for Ireland, José Luis Peñalvo García, newly appointed alternate for Spain, and Preben Aavitsland, recently reappointed member for Norway. He also welcomed Lauren MacDonald and Danilo Lo Fo Wong from the World Health Organization's Regional Office for Europe and Dirk Meusel, Laura Gillini and Marta Valenciano from the European Commission.

2. Apologies had been received from Bulgaria, Finland, Iceland, Latvia, Malta, and the Netherlands and Italy had still not nominated its new AF member. He also thanked the AF preparatory group for their help in creating the agenda for the meeting. He noted that the meeting would include a visit to the Emergency Operations Centre at ECDC to see how a typical daily Roundtable Meeting is conducted.

3. The draft programme was adopted with no further amendments and there were no verbal declarations of interest.

Adoption of the draft minutes from the 80th meeting of the Advisory Forum, 18-19 February 2025

4. The draft minutes had been circulated and the minor amendments requested by Finland and Czechia had been incorporated. There were no other comments and the draft minutes were adopted.

Update from the Chief Scientist

5. Piotr Kramarz, Chief Scientist, ECDC, said that the Agency was trying to make changes in the way the Advisory Forum was run, to make it more flexible, with e.g. to not always have working groups and to experiment more with the agenda. It was hoped that this would give more time for plenary sessions. He therefore asked the AF members to offer suggestions on improving ways of working. Piotr Kramarz mentioned that, since the previous AF meeting in February, ECDC had published public health advice on travel to Rome for the Jubilee 2025 online. The Centre had also published a point prevalence survey on healthcare-associated infections and produced a rapid outbreak assessment on a prolonged cross-border multi-serovar *Salmonella* outbreak linked to the consumption of sprouted seeds in March. For the World TB Day, the joint ECDC/WHO TB surveillance and monitoring report had been published, and an analysis of the data had revealed a 10% increase in childhood TB since the last report which is a very disturbing finding. European Immunization Week took place in April, with the main focus on measles. In connection with this, ECDC had published a set of operational tools to help public health authorities diagnose barriers to vaccination so that they could design strategies and interventions to improve vaccination acceptance and uptake. There had been a number of activities organised under the Polish presidency of the European Council, one particular example being an event bringing together experts and policy makers in the area of HIV/AIDS, hepatitis A, B, C and TB. With only five years to go to achieve the UN Sustainable Development Goal targets and a great deal of work still to be done to reach these targets, the participants carried out some very useful brainstorming in this area. He also pointed out that there was still one more day for the submission of abstracts for ESCAIDE which would take place in Poland during the period 19–21 November 2025, so he asked the AF members to inform their networks and encourage people to send in abstracts.

6. Antonis Lanaras, Head of Section, Governance and International Relations, ECDC, said that during the Polish presidency, ECDC's director had attended an informal meeting of the European Health Council in Warsaw in March and had made an intervention under the agenda item 'Health Promotion and Disease Prevention' in which she focused on vaccination and AMR. During the period since the last meeting, there had also been a number of visits to ECDC including the Director General of Africa CDC on 17 March. A meeting had also been arranged with the Director of the South Korea CDC, and she would be following up with a visit to ECDC that week before attending the World Health Assembly. During the period ECDC had continued its activities to support the candidate countries in bringing their acquis in line with EC legislation and memoranda of understanding had been signed with four countries

– Albania, Kosovo, Montenegro and Moldova. Ukraine, Serbia and North Macedonia had also agreed in principle on the text of the memorandum and Ukraine would sign it as soon as possible. A memorandum of understanding had also been signed with the International Association of National Public Health Institutes (IANPHI). Antonis Lanaras also updated the AF members on ECDC's postponed Joint Strategy Meeting which would now take place on 4 November in conjunction with ECDC's 20th anniversary. The agenda, topics and formal invitations would be sent to stakeholders shortly.

HIV standards of care

7. Teymur Noori, Expert HIV, Disease Programmes Unit, ECDC, gave a presentation and the floor was opened for discussion.

8. Magnus Gisslén, AF Member, Sweden, pointed out that for comorbidities there were different views across Europe on how to manage certain elements and he asked whether ECDC saw this as a challenge.

9. Harold Noel, AF Alternate, France asked whether it would be possible to link all the data that would be collected to existing surveillance systems since a great deal of information would be relevant for public health surveillance.

10. Ute Rexroth, AF Member, Germany, said that it was not always clear what a clinical mandate was and what a public health mandate was, and this could be a problem. She gave the example of treatment and care and also comorbidities in Germany which would come under the mandate of clinicians and there would not be any other body in the public health sector that could intervene. Consequently, she could foresee difficulties with implementation in Germany where medical treatment was independent.

11. Koen Blot, AF Member, Belgium, referring to the example of a measurable outcome for PreP and the wide variety in updates and use of PreP, asked how this could be translated into specific benchmarks and what the ideal or appropriate use of PreP would look like in order to have a measurable outcome. He liked the idea of self-audits but pointed out that they could be resource-intensive and wondered whether there were ways to reuse health data or perhaps combine PreP registers and reimbursement data (e.g. testing).

12. Teymur Noori, responding to comments by the AF Member for Sweden on comorbidities, said that this covered many different areas. It was helpful to involve the communities as they could identify the areas they wished to focus on. However, he pointed out that there were certain elements which went beyond ECDC's mandate (e.g. mental health). Responding to the comment by the AF Member for Germany on the difference between a clinical and a public health mandate, he agreed that certain areas were more clinically oriented. Since the introduction of the continuum of care concept in 2015, one of aims of ECDC's team had been to work closely with community and clinical bodies in the HIV field and not just look at the public health aspects in isolation.

13. Piotr Kramarz, Chief Scientist, ECDC, pointed out that ECDC's revised mandate opened up possibilities in some of the areas mentioned by the AF Member for Germany.

14. Teymur Noori, responding to the question about the optimal uptake of PreP, said that there was no clear answer. WHO had a target of half a million people being in Europe on PreP by 2025 and at present there were around 300 000. The main challenge was giving access to more women, migrants, sex workers and people who injected drugs. With regard to the question on integration of monitoring and surveillance, he agreed that this could be useful to take into consideration for the future and explained that the first part of the report was about the overall situation and the second part went into more detail at the clinical audit level.

15. Jurgita Pakalniškienė, AF Member, Lithuania said that for Lithuania, a small country, standards, guidelines, etc. produced by ECDC were really useful. Legislation had been introduced on HIV testing and treatment and was constantly being used and updated and the standards being provided by ECDC would be very helpful. At present, PreP was not reimbursed by the state but hopefully ECDC's guidelines would help steer future work in this area.

16. Isabel de la Fuente Garcia, AF Member, Luxembourg asked whether the area of antenatal care was being covered and whether children were also being included in the different groups - e.g. vertical transmission, looking at why it was happening and where the gaps were and also migrants who were minors.

17. Teymur Noori confirmed that the antenatal element was currently under development. In the HIV area, migrants, together with MSM, were one of the key populations. Although there was no cross-cutting decision that all modules should include this component, he confirmed that they would be focusing on those who were most vulnerable.

18. Dimitrios Hatzigiorgiu, AF Alternate, Greece, said that a bulletin from the Ministry of Health in Greece would be issued imminently regulating the implementation of PreP, which meant that PreP would be fully funded and it would therefore be possible to update the map. He had a concern that GDPR legislation had had an impact on HIV surveillance. Following legislation in 2022, the national HIV registry had been transferred to the Ministry of Health in Greece so the public health organisation now only had access to anonymised data and this had had an impact on the active surveillance capacity.

19. Bernhard Benka, AF Member, Austria, noted that the document seemed to cater to many different groups and therefore there was a danger that no-one would read it because all the specialists relied on publications in their own fields. He therefore wondered whether the document should follow the same lines as that for TB standards since it had to cover such a vast field of infection control and prevention.

20. Costas Constantinou, AF Alternate, Cyprus noted that Cyprus was a small country and therefore it was not easy to develop its own standards. STI programmes were usually financed by the government so it was useful to have such guidelines in order to argue for financing (they had struggled for a number of years to obtain financing for PreP) and the case was similar for TB until the ECDC standards had been developed.

21. Harald Noel, AF Alternate, France, commented on the development of standards in other infectious disease areas, suggesting that when ECDC was carrying out such development, it should apply existing methodology first, with an exercise of prioritisation, mostly based on existing epidemiological data and public health programmes. He also suggested that ECDC should focus on the diseases where there was an insufficient body of recommendations and come up with a list that could be submitted to the AF for feedback and guidance.

22. Teymur Noori said that the topic of GDPR in connection with HIV surveillance had been a major issue for several countries. EDCDC was able to provide technical support on this issue so he suggested that those who were having problems should contact ECDC for support. He totally agreed that documents should be produced to be read and pointed out that, although the report itself was perhaps not so engaging, the auditing process was very important. In response to the comment by the AF Member for France about applying a specific methodology to an exercise of prioritisation, he said that this was very useful and could possibly be a task for future working group sessions at an AF meeting. A lot of the screening guidelines were based on expert opinions because the evidence base had been weak.

23. Marieke van der Werf, Head of Section STI, Blood-borne Viruses and TB, Directly-transmitted and Vaccine-preventable Diseases, ECDC, commenting on how the TB standards were used, said that for TB it had started with international standards of TB care and it was felt that it would be good to adjust the international standards to the European situation. After the first draft was produced, efforts were made to disseminate, the draft was then updated and later followed up with an audit to see how clinics were doing. An update had not been performed on the European standards of care since then and it could be that the WHO standards were more integrated and comprehensive enough for now. With everything that was produced in the TB section, efforts were made to see whether it required country support (webinars, training, workshops, etc) because it was not enough to just put it on ECDC's website.

24. Magnus Gisslén, AF Member, Sweden, said that from a public health perspective, it was important to prioritise surveillance in this area but when looking at aspects closer to the clinical areas and treatment, such as comorbidities, some might argue that these were more important and needed to be prioritised.

25. Teymur Noori agreed but pointed out that people were now living longer with HIV and therefore the comorbidity issue was critically important to them and something that they wanted to highlight.

26. Marieke van der Werf said that this was a joint activity with clinicians. ECDC had been responsible for the public health part and the clinicians had worked on the treatment issues, so it was seen as a joint action, covering both parts.

Development of an ECDC proposal for EU infection prevention and control guidelines in the context of EU actions to control antimicrobial resistance (AMR)

27. Diamantis Plachouras, Principal Expert, AMR and HAIs, Group Leader, HAIs, Disease Programmes Unit, ECDC, gave a short presentation and the floor was opened for discussion.

28. Jasna Karacic-Zanetti, Croatian Association for the Promotion of Patient Rights, agreed that the development of ECDC guidelines in this area was an important step towards the safeguarding of patient rights. She pointed out that a collaborative approach would be essential to harmonise standards, while respecting national public health systems, whilst emphasising that all efforts must be grounded in transparency and the responsibility shared across the EU.

29. Arinze Stanley Okoli, The Norwegian Research Centre congratulated the Agency on its noble attempt to develop guidelines. He wondered if the guidance would allow for adaptable implementation of the frameworks mentioned, which was essential, given the differences in laboratory capacity and surveillance systems. In addition, he wished to see mechanisms for compliance and measurement of effectiveness.

30. Kärt Sõber, AF Member, Estonia, said that as a small country, Estonia understood the benefit of such guidelines. In 2024, they had developed IPC guidelines and this year they were planning to develop guidelines on isolation requirements so it would be interesting to see ECDC guidelines for comparison purposes. They had also noticed, when developing guidelines, that there was a lack of evidence in some areas and that there was a need for more specific guidelines at the European level (e.g. for endoscopes) as at present, every hospital had its own set of guidelines.

31. Koen Blot, AF Member, Belgium said that he also welcomed the initiative and would like to review the draft proposal. He pointed out that long-term care facilities were an important stakeholder (already in ECDC's list) and that they needed to be consulted vis-a-vis the practicalities of implementation.

32. Harold Noel, AF Alternate, France said that this was an interesting initiative. He suggested that the issue of lack of guidelines could perhaps be presented to the Commission with a view to obtaining funding and/or to make upcoming guidelines more evidence-based.

33. Jan Kynčl, AF Member, Czechia said that he was happy to see the development of these guidelines, particularly since AMR was any area which did not receive much focus compared with foodborne pathogens. He suggested that it was good to have a broad spectrum of stakeholders involved, especially since the guidance was to be submitted for public consultation.

34. Ute Rexroth, AF Member, Germany said that such guidelines might be even more important for long-term care facilities than for hospitals since more guidelines were already available for hospitals. She suggested that the European Society of Clinical Microbiology and Infectious Diseases (ESCMID) could be involved. She said that she would forward the proposal to the NFP for healthcare-associated infections as she felt it was important to circulate it in that network for discussions at the technical level.

35. Isabel De La Fuente Garcia, AF Member, Luxembourg said that the initiative was highly appreciated as in Luxembourg they had been trying to produce some guidelines for around five years. The main challenge had not been how to implement but where to find the resources. By presenting the initiative to the AF, she hoped it would be possible to obtain feedback both from the countries and from the field.

36. José Luis Peñalvo Garciá, AF Alternate, Spain said that in Spain there was an IPC plan which had been in operation since 2014 and that it would be interesting to compare the ECDC guidelines with their own.

37. Dimitrios Hatzigeorgiu, AF Alternate, Greece said that ECDC's guidelines would be welcomed but that, at the same time, Greece was developing its own guidelines that would be ready in the next three months, and therefore complementarity would be very important. Although ECDC's guidelines could serve as a reference point, the national guidelines would take precedent.

38. Bolette Søborg, AF Alternate, Denmark suggested that it was important for the EU Joint Action on Antimicrobial Resistance and Healthcare-Associated Infections (EU JAMRAI) project to be involved.

39. Diamantis Plachouras acknowledging the issue of national guidelines and how they could be affected by EU guidelines, said that national competences had been taken into account during development and that this issue was also being discussed with the Commission. The guidelines were in no way mandatory, but instead should simply serve to support the countries and possibly serve as a means for obtaining the necessary resources. Although the guidelines could not go into specific areas or cover the prevention of specific pathogens, they would definitely benefit from receiving AF feedback. He agreed that long-term care facilities were an important stakeholder and pointed out that it would therefore be necessary to find a representative group at European level, if one existed. He confirmed that one of the experts leading one of the work packages was representing EU JAMRAI and that ECDC was also an observer for EU JAMRAI and had a lot of interaction with the project. With regard to the question on research funding, there was a separate section on research funding which highlighted areas with knowledge gaps and the need for further evidence. It was hoped that this could provide information for the Commission on future research activities.

Carbapenem-resistant Enterobacterales – translation of genomic surveillance results into action

40. Anke Kohlenberg, Expert AMR and HAIs, Disease Programmes Unit, ECDC, gave a short presentation and the floor was opened for discussion.

41. Jan Kynčl, AF Member, Czechia said that coordination and management needed to be at the national level and there should be support for genomics at national level. Although EU-level work directives needed to be implemented nationally, each country also had to show its level of active preparedness and this needed to be prioritised by stakeholders and politicians. Surveys were sent to experts but it was also important to involve politicians more as they were able to move issues forward to a more productive phase. Additional support could then be provided in the form of external quality assessments for genomics.

42. Kärt Sõber, AF Member, Estonia said that in order to carry out surveillance it was necessary to have data and for this it was a question of whether whole genome sequencing was being performed and whether there was sustained financing for it. She stressed that the management of CRE outbreaks was strengthened through training. However, in Estonia's hospitals the belief was that the IPC unit should deal with such outbreaks and, if there were not enough experts available, it was difficult to go into hospitals and identify shortcomings. In Estonia, hospitals sometimes struggled with CRE outbreaks on their own and methodological support/guidance could be very useful for them. She stressed that it was important to understand the gaps which were preventing recommendations from being implemented.

43. Preben Aavitsland, AF Member, Norway said that many of them understood the obstacles set out in the slides and that it was important to remember that European-level surveillance and response had to build on good national systems. He believed that ECDC could provide guidance and recommendations for public health institutes on the structuring of platforms for data surveillance and data sharing at European level. Public health institutes also needed guidance on legal issues associated with the linkage of sensitive data to genomic sequence data and how to address the relevant obstacles related to this legal framework (e.g. data sharing, data protection and GDPR). In the event of inter-hospital CRE outbreaks, the national surveillance institute needed to be able to work together with the national reference laboratory and the relevant hospitals. The problem arose if the national reference laboratory was not a part of the national surveillance institute or national surveillance system.

44. Arinze Stanley Okoli, The Norwegian Research Centre asked what the future research endeavours would be in this area, what the frontiers in research were and which bioinformatic tools were currently being used. He asked about the interpretation of genomic data being integrated into hospital clinical management and noted that AI and machine learning were already increasingly being integrated into the analysis of this kind of data.

45. Piotr Kramarz, Chief Scientist, ECDC, referring to the comments by the AF Member for Czechia, said that experts were ECDC's first line of communication, however it is also necessary to place items on the political agenda to make a difference. The results of the rapid risk assessment would be communicated to the Heath Security Committee which could then issue a recommendation, and this

was one way for ECDC to put this on the agenda. Another option would be to communicate with the competent bodies.

46. Anke Kohlenberg was aware that whole genome sequencing was not yet fully established in all countries, but pointed out there was training ongoing, and the European Union Reference Laboratory for Public Health on Antimicrobial Resistance in Bacteria was now operational. However, she was aware of the need for capacity and resources to be available. She also recognised the need for more guidance. ECDC had now established a whole genome sequencing platform but the data being used for European surveillance was only as good as the national data provided. She also noted the need to look into data sharing and the associated legislation. With regard to training, there was an initiative called the GenEpi-BioTrain (Training in genomic epidemiology and public health bioinformatics) involving public health professionals, bioinformaticians and microbiologists, however it was important to train as many people as possible and for them to train others in order to achieve a sustainable staffing level. With regard to the comment on external quality assessments for genomics, she pointed out that this would actually now be provided on an annual basis to national reference labs by the EU Reference Laboratory for Public Health on Antimicrobial Resistance in Bacteria. She agreed that there was a need to identify gaps but also pointed out that these would differ from country to country. With regard to research, what was needed for public health surveillance was more applied research on how to translate and visualise the results. There were a number of tools available and when data from national reference laboratories was going out into the public domain (e.g. publications) this could be useful because it was used by researchers as a basis for developing tools for better data analysis.

47. Jurgita Pakalniškienė, AF Member, Lithuania said that they had had an issue with CRE outbreaks in hospitals and had received a great deal of support from ECDC, for which they were very grateful. Training was very important and a number of courses had been organised for infection control specialists in hospitals, however, it would be helpful to have more. It would also be useful to know how to use laboratory results and have recommendations for a patient transfer to another hospital.

48. Bolette Søborg, AF Alternate, Denmark suggested that an inventory of best practices would be helpful and, looking at the Council recommendation on AMR, it was almost mandatory. She pointed out that hospitals should not be expected to have to deal with this kind of outbreaks on their own.

49. Koen Blot, AF Member, Belgium said that the situation was complicated because of the systemic issues with coordination between public health institutes, hospitals and laboratories, communication and timely data flows, financial issues, new types of data with genomic information, and interpretation of bioinformatics. However, budgets were limited so it was not possible to do sequencing for all pathogens and not even just for AMR. There were also other pathogens that were becoming more relevant. He suggested that geo mapping of genomic information might potentially be relevant. This could be at the country, region, province, city, laboratory or hospital level, although the timing and data receipt would have to be fast to be actionable. However, to do this there would be a need for a set of guidelines or a proposal/harmonised plan in terms of what should be developed at hospital/national reference laboratory level in order to coordinate the collection of data for action. One suggestion might be to compile some form of inventory and then increase awareness of this across the different public health sectors as a first step in trying to coordinate the complexity of the situation.

50. Harold Noel, AF Alternate, France agreed that all considerations needed to be seen in the context of limited resources. In France they were lucky to have experienced a boom in access to genomic data, however it was still necessary to define the optimal approach to sequencing or genotyping during an outbreak, especially since in France, most of the sequencing was done by the national reference laboratories and there were problems with delays. It would therefore be very helpful if ECDC could take the lead on defining a recommendation or an optimal approach to sequencing during outbreaks at European level. He also pointed out that, since genomic sequencing was costly, the question of data sharing should also incorporate guarantees for the laboratories/microbiologists purchasing the sequences as they would need to be able to make use of the sequences produced in order to get a return on investment.

51. Danilo Lo Fo Wong, WHO started by acknowledging WHO's close collaboration with ECDC on this issue, particularly through EARS-Net. WHO was working in this area with both EU and non-EU countries and in recent years it had been able to support professionals in non-EU countries so that they could join training workshops. However, since some of these projects had now come to an end, he wondered

how they could continue to move forward and collaborate, building on synergies but at the same time ensuring that there was no duplication of work.

52. Anke Kohlenberg, Expert AMR and HAIs, Disease Programmes Unit, ECDC said that the suggestion for an inventory of best practices and standards at European level was very useful. She also acknowledged that there was a need for training at public health institute level. With regard to the point about geo mapping, she noted that certain tools were already being used (MicroReact) as a starting point.

53. Daniel Palm, Head of Section, Microbiology and Bioinformatics, SPR, thanked the AF members for contributing to the project with data. With regard to the issue of resources, there had been many discussions on this in the AF, starting with the molecular surveillance roadmap in 2010 and the development of a strategy. This would now all be translated into the surveillance standards. ECDC had also been working with HERA and had facilitated channelling over EUR 100 million into infrastructure in the countries. However, ECDC had also understood that it was not just the infrastructure that was needed, but also the expertise in using it. A project had been launched (GenEpi-Bio Train) that offered training to bioinformaticians, microbiologists and epidemiologists, through work on case studies, outbreaks and how to translate data into actionable information. Demand for this training had been so high that the module on AMR was now being relaunched and the ECDC team had asked the NFPs for Microbiology to nominate the appropriate individuals from the national institutes for training.

54. Dimitrios Hatzigeorgiou, AF Alternate, Greece, referring to the question as to how the results of genomic CRE surveillance should be translated, said in Greece they supported the use of genomic surveillance to detect super spreader events and to guide targeted IPC actions, especially in the event of inter-hospital transfers to facilities with a lower CRE burden. He also wished to advocate for the linking of WGS to clinical outcomes, such as length of stay or mortality, for serious strains in order to prioritise interventions.

55. Ute Rexroth, AF Member, Germany said that what was seen here was not limited to AMR. Genomic surveillance resulted in more signals and these were more widespread, however it was not always clear what should be done with this information. ECDC's role was very helpful in detecting such signals and providing timely information and she suggested that, when such signals were detected, there could be some type of bi-weekly forum for epidemic intelligence exchange to discuss them at greater length and obtain a better awareness of the situation.

56. Anke Kohlenberg thanked all the AF participants for their input and valuable advice.

Facilitating vaccination acceptance and uptake: a life course approach

57. John Kinsman, Acting Group Leader, Prevention and Behaviour Change, Disease Programmes Unit, ECDC, gave a presentation and the floor was opened for discussion.

58. Koen Blot, AF Member, Belgium was pleased to see this topic presented at the AF and suggested that the same approach could also be applied to STIs and invasive mosquito species to name but a few. In Belgium there had been a measles outbreak in 2024 and when he and his team met with the sub-national level public health authorities, they related anecdotal experiences and were trying to understand what was going on when what they really needed was a clear diagnosis of the situation and to look at vaccination acceptance, and the need to be aware of it and to have tools to help. However, he was aware that there were also budgetary implications. He said it would be interesting to see how this type of approach could be organised in federal states. He suggested that a webinar might be one solution (given the language barriers at sub-national level).

59. Rebecca Moore, AF Member, European Institute of Women's Health, said that her institute was working on a Horizon project funded by the Commission on HPV screening and vaccination among females in prison and she wondered whether this approach could be tailored to such specific groups.

60. Bolette Søborg, AF Alternate, Denmark, said that it was good that ECDC had finally got into this area. In Denmark they had been working on it ever since they had had a national crisis with the human papillomavirus (HPV) vaccine (and WHO was also now using tools in this area). It was a fundamental issue which needed to be tackled in all European countries and it was crucial to raise awareness, perhaps by organising a conference or webinar.

61. Jurgita Pakalniškienė, AF Member, Lithuania, asked whether the Agency was planning to translate the tool and if so, when. She also asked whether it would be an online tool or in paper format. In Lithuania they were planning two qualitative studies, based on the tool presented, so it would be useful to know whether they could use ECDC's translation or would have to arrange this themselves. Vaccine coverage was an issue that was high on the agenda of the country's new government and measures had already been planned and were being implemented.

62. Ute Rexroth, AF Member, Germany said that at the national level in Germany they had a team for vaccination communication and acceptance at the public health institute and they worked on qualitative studies on vaccination acceptance. This meant that there was a lot of knowledge at national level, but perhaps not so much at the regional/local level and there was a need for a more scientific approach to change this. She felt that it should be easy to customise and/or adapt the context to local circumstances and settings (measles, HPV, etc.) and it would therefore be great if it were possible to have a German translation to distribute to local networks.

63. John Kinsman agreed with the point on the potential for expanding to cover STIs, mosquitoes and other areas but wondered how it could be done. As yet, ECDC did not have proof of concept in the countries and therefore he asked the AF members to provide feedback if they implemented the tool. ECDC had a community of practice (ECDC Lighthouse) and was currently in the process of dissemination. With regard to the translation, the funds had been made available at ECDC, but he was unsure how long it would take to obtain the translations. The idea of tailoring the approach to different populations was, of course, possible, it was just a question of small adaptations to make it relevant. Responding to the question as to whether the programmes had been evaluated, he said that some had been, and some had not. There was no standard for evaluating this type of intervention and his team was looking at how to do this in the future. They were in the process of putting something together for ESCAIDE, but they also needed to reach other audiences, so he urged the AF to disseminate in their countries, right down to the local level if possible. With regard to customisation, he explained that the documents would be Microsoft Word documents that could be adapted at will.

64. Preben Aavitsland, AF Member, Norway said that he welcomed this tool and in Norway they were already using the model for surveys on vaccine acceptance. It made it easier to measure and understand the challenges, and also to compare with other countries.

65. José Luis Peñalvo Garciá, AF Alternate, Spain thanked ECDC for bringing this type of research into the spotlight as it was very important. In Spain they had experienced vaccine hesitancy during the COVID-19 pandemic and as a result they had created a new unit for this type of research in behavioural studies, to try and frame the epidemiological situation in Spain. He would pass the information on to the new unit and also try to distribute the toolkit to the various regions of Spain to see if they had any questions or feedback.

66. John Kinsman liked the idea of sharing and comparing data between countries and confirmed that his team was planning to collect data from countries systematically on specific topics. As a final plea, he asked the AF members to let him know if they were using the toolkit and to provide feedback on any challenges, data being collected, where ECDC support would be useful, etc. This information could be collected in a repository which might be useful for other countries to look at.

67. Rebecca Moore said that it was really important that the whole model was based on talking to the users, and user experience which she really appreciated.

European Health Data Space: Considerations for public health surveillance and research

68. Luis Alves de Sousa, Expert, General Surveillance and eHealth, Public Health Functions Unit, ECDC, gave a presentation.

69. Kärt Sõber, AF Member, Estonia said that she was not familiar with the technical issues and asked whether she was correct in understanding that the European Health Data Space set out requirements in terms of electronic health data exchange and what should be in national legislation and what was expected from the healthcare providers and their IT and Electronic Health Records (EHR) systems. She asked whether there were any requirements for them to fulfil and also about opting out from secondary use in the event of a case of infectious disease, except where there was a direct risk to public health.

She wondered if these criteria were defined somewhere. In Estonia, the Ministry of Social Affairs was the national contact point for this Regulation so she assumed that this was the body to contact to determine the actual impact of the Regulation at national level.

70. Koen Blot, AF Member, Belgium pointed out that not many AF members were actively involved in the European Health Data Space (EHDS) and therefore it might be useful to review the topic again in the future, but focussing on specific aspects. He asked whether there an incentivisation for the software providers or whether this was left to the Member States. With regard to fee collection, distribution to data holders and reimbursement of costs, he wondered how these costs would be calculated. Would it be the national authority that would be responsible for coordinating and, in a multi-country situation, who would coordinate.

71. Luis Alves de Sousa, referring to the digital infrastructure for primary use in the EHDS, said that Group 1 and Group 2 priority categories of electronic health data were separated because a digital infrastructure (i.e. eHealth Digital Service Infrastructure) already existed for exchanging information for categories in Group 1 (e.g. patient summary or electronic prescriptions in various countries). The difference was that at present they were voluntary but would become mandatory for the six priority categories. There was one element of the Regulation that would force all Member States to ensure that their health data space systems were compliant and certified to a minimum at state level. With regard to the right to opt out by natural persons, he explained that it was very important to differentiate between its applicability under primary and secondary use. For the former, it delimits the use and exchange of EHR data, while for the latter, it can affect the usability and representativeness of data. The application of the EHDS framework of secondary use of data will depend on whether a disease is under statutory surveillance or not. With regard to the question of fees, this would be defined by the Commission in the Implementing Acts at a later date.

72. José Luis Peñalvo Garciá, AF Alternate, Spain, referring to secondary data use of health records, asked whether ECDC was trying to standardise the process by which the data was analysed. He also asked about the opt-out and whether he had understood correctly that, when trying to obtain data for research, the patient was not asked. If this was the case, how would the patient know if/when to opt out if they were not asked.

73. Ute Rexroth, AF Member, Germany, referring to standardisation, said that there were some aspects that would have synergies – e.g. notification – but that there were different pathways. There would be a great deal of work for the authority responsible and she was relieved that ECDC, rather than the Member States, would be responsible for the surveillance data. She asked for clarification of ECDC's role.

74. Preben Aavitsland, AF Member, Norway, answering the four questions posed, said that in Norway they believed that the European Electronic Health Record exchange would help with the sharing process by increasing interoperability. They also thought that it would improve surveillance and support public health research. However, looking at the timetable, 2028 seemed very ambitious given the legal and technical complexity of the project.

75. Luis Alves de Sousa said that for the eligible data types under secondary use which came from EHR data, this would tend to be standardised because of technical requirements imposed by the EHDS framework for primary use, however, for other eligible data types for secondary use, standardised semantics were not clearly defined in the legislation. With regard to consent, if the patient participated under the terms of the European Health Data Space secondary use, there was always a choice to activate opt out. He also confirmed that there would be a substantial amount of work involved to implement the European Health Data Space Regulation at national level.

Feedback from the Emerging and Vector-Borne Diseases network meeting

76. Olivier Briet, Expert, Medical Entomology, Disease Programmes Unit, ECDC, gave a short presentation.

77. Harold Noel, AF Alternate, France pointed out that on ECDC's website there was a repository of dengue distribution across Europe that had not been mentioned which was very useful. He noted that ECDC used to fund the EuroTravNet and asked about the current status of this network.

78. Arinze Stanley Okoli, The Norwegian Research Centre asked whether the increasing number of outbreaks of arbovirus and/or mosquito-transmitted flaviviruses were they due to climate change or whether there were other reasons.

79. Olivier Briet, replying to the comment on the repository of dengue distribution, said that ECDC was planning to move to weekly reporting of autochthonous cases of dengue, chikungunya, Zika and Crimean Congo Haemorrhagic Fever. He was not sure about the status of the EuroTravNet but ECDC did participate in the European Travel Medicine Conference which was held on an annual basis. With regard to the question about the reason for increasing numbers of outbreaks, he confirmed that this was mainly due to climate change, but also because the mosquito *Aedes albopictus* had been introduced into Europe and was spreading over the last 20 years by filling a niche, moving from southern Europe towards the north. In Europe there was also a lot more virus importation now than in the past. As yet, there had not been any sustained outbreaks and although there had been outbreaks of chikungunya (arbovirus) in Italy, as yet the virus is not overwintering. There had been a large outbreak worldwide, particularly in Brazil in 2024, which was why Europe had seen many importations. With Japanese encephalitis, pigs are important hosts, and this is what had happened in Australia –the virus probably arrived from Papua New Guinea via migrating birds and was transmitted via local mosquitoes to pig farms and in these farms the virus can multiply quickly. With regard to travel medicine, he confirmed that ECDC would soon be having a meeting with representatives from the Member States to try and determine what the needs were and to discuss added value. There were a number of organisations active in the area of travel medicine in Europe and ECDC needed to define its role more clearly in order to collaborate more effectively with these organisations.

80. Piotr Kramarz, Chief Scientist, ECDC, thanked the AF participants for their input during Day 1 and reminded them that dinner would be served on the rooftop terrace.

Day 2

Update from the European Commission

81. Dirk Meusel, DG SANTE, European Commission, gave an update on the Commission's activities related to ECDC's mandate on several areas that had seen activity since the previous AF meeting.

The Union Prevention and Preparedness plan for health crises

82. This activity corresponds to Article 5 of Regulation (EU) 2022/2371. The objective is to create a living document that complements national plans and outlines the coordination between the Commission, relevant EU agencies and other organisations in the event of a major crisis with a public health dimension. He presented the structure of the plan, including an annex that would have flowcharts outlining who would deal with threat detection, assessment, and so on. The plan aligns with other wider initiatives, such as the Preparedness Union Strategy of March 2025 and ProtectEU of April 2025. A call for evidence is ongoing, and the aim is to publish the plan in Q4 of 2025 and to then in 2026 test and improve it.

Surveillance activities

83. Surveillance activities are covered by Articles 13 and 14 of the cross-border health threats regulation. There is a package of three legislative acts currently being drafted, which refer to the surveillance network, the lists of diseases to be mandatorily reported, and the EpiPulse platform. He gave an overview of the timeline for the adoption of the full surveillance package, which is envisioned for July to October 2025. He also discussed direct grants to Member States to improve their surveillance systems and scale up their capacity-building in line with ECDC's guidance and in line with lessons learned from the COVID-19 pandemic. In April 2025, a two-day Inception Conference had taken plan in Luxembourg with the 23 countries that had been given grants presenting their projects to each other and possible common work areas in the future. There is also the possibility of developing Train the Trainers programme at the EU level and then having training programmes in the Member States on capacity-building, and he noted that this could be something that the AF might feel is needed for national surveillance systems.

EU Reference Laboratories implementation

84. Corresponding to Article 15 in the regulation, the implementation of the EU References Laboratories is closely linked to the ECDC disease networks. They are being nominated and adapted in a decision and their task is to work on reference diagnostics, references material resources, collaboration and research, support to outbreak response and training. He gave an overview of the plans for these laboratories. Discussions are ongoing regarding the possibility of a reference laboratory for biotoxins, and he noted that the AF's feedback would be more than welcome. There are no existing EU networks on this currently, and it is outside ECDC's current scope and mandate.

Preparedness trainings

85. Corresponding to Article 11 in the regulations, the Commission supports preparedness training for health professionals. He gave an overview of the training sessions for 2025, which include topics such as infodemic management and training on designing, adapting and implementing simulation exercises.

The EU Health Task Force

86. The EU Health Task Force took a major step on 2 April, with the adoption of an Implementing Act setting out the procedure concerning the mobilisation of the enhanced emergency capacity of the Task Force.

87. Concerning the Public Health Emergency Preparedness Assessments (PHEPA), to date, 11 missions have been carried out, and there was a workshop in Luxembourg in May that gave an overview of the process, a summary of the main findings from these and some updates on the future cycle of the process.

88. Dirk Meusel also presented two other activities of interest. The first was the European High Performance Computing Joint Undertaking, which has created AI factories. He said this could be interesting for Member States for forecasting or modelling exercises to run AI models in high performing computing environments, and if there is interest from ECDC for the Member States this could be pursued. Finally, he mentioned TEHDAS 2, raising awareness on the Second Joint Action Toward the European Health Data Space.

Update from ECDC's project on Evidence-Based Public Health methods

89. Helena de Carvalho Gomes, Head of Section Scientific Process and Methods, Scientific Methods and Standards Unit, ECDC, gave an update on ECDC's project on evidence-based public health methods. She started with an overview of evidence in public health, then moved on to the public health evidence ecosystem. She gave a short update on innovation on what the agency has done and is doing, including its role across the evidence cycle and the Evidence-Based Public Health initiative, which includes methods guidance, innovation and capacity-building, and a project to strengthen the impact of its scientific reports and other outputs.

90. José Luis Peñalvo García, AF Alternate, Spain, thanked ECDC for the very relevant and needed work. He said that his institution was working on automating systematic literature review using AI tools, and he was happy to share information on that if others were interested. Regarding the evidence synthesis framework, he asked whether ECDC had any plans to offer capacity training on theoretical modelling for public health evaluation, for example, to assess the impact of public health strategies in the EU. He felt this is really needed, that public health experts be trained in something a little more theoretical so they can forecast the potential effects of public health strategies into the future. Also under current discussion in his institution was the creation of causal inference laboratories, so that they learn how to deal with the amount of data relating to public health coming into their systems, so trying to align with other efforts and harmonising data and making data available, and they need capacity for that.

91. Ute Rexroth, AF Member, Germany, thanked Dr Gomes for her interesting presentation, which she said covered a very relevant topic from the Member States' point of view. She said that this fitted in with the previous day's presentations and discussions, which made it clear that ECDC is really broadening its scope and methods and branching out into additional areas, such as travel medicine treatments and using social science methods more. She said that this approach came with a risk of leading to a loss of scientific excellence. ECDC used to be very specialised, highly competent, and now,

especially with treatment aspects and so on, the question is how to keep that. The agency's recommendations need to be fast but also updated: such a huge number of outputs for so many target audiences on so many topics present a huge challenge to have sound scientific expert and updated analysis on the latest evidence. She appreciated the idea of recommendations being practicable and contextualised but noted that in order to achieve this ECDC would need insight into the local level, and in different settings, e.g. hospitals, schools, and long-term care facilities, and would also need to get their messages across to all their target audiences in a timely way. She wondered if this might all be too much for the agency to take on.

92. Harold Noel, AF Member, France, asked what precautions ECDC is taking regarding the use of AI tools to synthesise evidence, particularly in terms of confidentiality. On the broadening of ECDC's scope of activities, he noted that this might also entail added legal scrutiny and asked if ECDC was preparing for facing such challenges. He agreed with Ute Rexroth that a broader scope of activities could be overly challenging for the agency to take on, and wondered if ECDC had considered prioritising, and if so how. He also asked what ECDC is doing in terms of public health advocacy, especially regarding the European Parliament, and what the agency's overall strategy is towards this important decision-making body.

93. Bolette Søborg, AF Member, Denmark, asked if ECDC had considered how to evaluate within its structure what is feasible and what has proven successful and useful for its intended target groups. She wondered if there was an evaluation tool on the way and whether the agency would have this in its toolkit to look at specific topics in specific areas depending on how timely it needs to be.

94. In response to these comments, Helena de Carvalho Gomes said that if anyone in the AF was looking into the use of AI and machine learning, it would be good to liaise on their efforts so there would not be duplication of work. She added that Large Language Models need human oversight. Regarding capacity needs for modelling, she said that ECDC had invested in analysis capacity and modelling capacity since the COVID-19 pandemic. There are now three biostatisticians and six mathematical modellers working at the agency, but this still a modest size. As an entry-point, the agency invites Member States to participate in modelling hubs, but that the agency is not in a position to offer enormous resources to Member States, but that further collaboration would be welcome. She said one idea that had previously been raised at the AF would be whether they would recommend that ECDC set up operational contact points for modelling and analytical work. She said it might make sense to have a dedicated network for this.

95. She said that ECDC has guidelines for the use of AI tools, which are based on the European Commission's guidelines. The agency is experimenting with these AI tools to understand how they work and what they can offer, for example in coding, but it is also being cautious and is aware of the limitations. This means that ECDC is looking into partnering – for example, the ECDC Crowd project is working closely with Cochrane – and looking at customising tools rather than using commercially available third-party services. The agency also has an AI working group that brings colleagues together, looking into such areas as how AI might be used for epidemic intelligence, for evidence synthesis and so on. She invited any institutions with groups looking at AI to get in contact and perhaps set up a community to collaborate.

96. She also noted that the agency is modestly sized but with a very broad mandate and significant expectations. This meant that a lot of activities had to be done in collaboration. She said that the idea was not for ECDC to produce more outputs, but instead to create packages of outputs that focus on the intended impact and draw on experts from various fields. This will take time to implement as it requires changing the way the agency works.

97. Regarding the challenges around producing timely recommendations and assessments, she said that the agency wants to continue to take a structured and transparent approach so that both policymakers and the public understand how ECDC comes to its conclusions. The Centre cannot always wait until there is very high-quality evidence, but it still needs to follow appropriate steps. The goal is to be as evidence-based as possible, and to also be clear that decisions can still deviate from the Centre's conclusions, as there will be other factors, such as political considerations, that will be brought to bear on any public health actions.

98. Piotr Kramarz commented that the AI landscape is increasingly complicated and difficult to keep track of, and that ECDC's AI working group was a useful way for colleagues to evaluate and control the available tools. ECDC staff are not permitted to enter any confidential information into AI tools and quality controls are also in place. Regarding ECDC broadening the scope of its activities, such as travel

medicine, he said that the agency had to react to the needs of Member States but is very careful and evaluates how it can add value to what is already available from other organisations. In the area of treatment, the agency does not have a huge amount of expertise internally, but the mandate says it can support learned societies that can develop treatment guidelines with some public health and epidemiological information that can inform the decisions and provide priorities but not necessarily develop them itself. With social sciences, there is a very small team, so the agency will not be able to work at a sub-national level but it can help Member States use the appropriate methods. Last year, the Centre set up a community of practice that involves hundreds of people from Member States in this area, but the agency's capacity is nevertheless limited. Prioritisation is very important, he said, and that once the agency had developed its framework for scientific prioritisation, they would ask the AF for feedback on it. Regarding advocacy, he said that ECDC quite often responds to questions from the European Parliament, and it is also invited to some meetings in the EP where it provides more detailed information on its activities and opinions. He said that the agency's Director had been in the Parliament meeting with the SANT Committee the day before.

99. Helena de Carvalho Gomes added that another form of advocacy ECDC is undertaking is trying to communicate public health knowledge gaps and needs to the EU public health research funding mechanism in a more structured way. That was an easier task when all the thinking was around COVID-19, but now public health is not the leasing voice in all cases. Nevertheless, this is an area where evidence synthesis and having a more systematic approach can help.

100. Piotr Kramarz also noted that the agency has been audited about its actions during the pandemic, providing explanations and timelines of what it did and when, so it is not unused to a high level of scrutiny.

Why and how should a public health agency work with influencers?

101. Piotr Kramarz introduced the next presentation, noting that in the crowded online field, where disinformation and misinformation are rife, the Centre needs to find innovative ways to compete with its evidence- and fact-based messages.

102. Barbara Albiger, Acting Head of Section Communication, and Mikolaj Handzlik, Communication Officer, Scientific Methods and Standards Unit, ECDC, gave a presentation on ECDC's collaboration of social media influencers (also called content creators) and the motives behind this. Partnering with influencers helps reach and engage audiences that public health agencies might not reach, and a well-selected group of influencers can communicate health messages in a relatable way, making complex topics more accessible to the public in a way that public health agencies cannot. Using their own words, and social media platforms, they help to simplify complex topics and increase awareness of public health initiatives in their own country's language. The latter is important as ECDC mainly communicates in English. ECDC uses them to amplify key messages ensuring trusted information is spread more widely.

103. Barbara Albiger showed how ECDC is adapting to a changing information ecosystem by presenting the latest Eurobarometer's update regarding EU citizens' knowledge and attitude to science and technology, showing that the main sources of information for EU citizens are television (61%), social media (31%), newspapers 19%), radio and podcasts (17%) and website (10%). The barriers to engage with science and technology include a lack of time. Many people do not have time to read the agency's long technical reports and need to be able to extract the relevant information in a more accessible and readable way.

104. While ECDC's website attracted 8.7 million visitors in 2024, it had 29 million impressions across social media platforms, with 697 000 followers. She gave an overview of the agency's social media accounts, and then gave the floor to Mikolaj Handzlik, Communication Officer, ECDC, who presented in more depth on the agency's influencer marketing campaigns.

105. He explained why the Centre works with content creators: they can significantly expand the reach of public health messages to audiences ECDC does not easily reach, in all EU languages. They also provide credibility and trust, as people tend to gravitate to people a little more like them – they are less distant than an institution. Their content is also often highly creative, and they can sometimes act without having to deal with the red tape or other barriers that an EU institution can face. Influencer campaigns, if utilised well, can also be very cost-effective in comparison to regular media-buying. He

explained what ECDC's principles are for this activity, as well as the logistics of it. The agency ran five campaigns lasty year, with themes including the promotion of vaccination, fighting stigma in relation to HIV/AIDS and other STIs, and antimicrobial resistance. So far in 2025 it has run two campaigns: one on STIs and one for European Immunization Week.

106. He presented some future plans in this area, including a visit to ESCAIDE by invited podcasters, as well as training the agency's scientific experts in this area to make them more visible on social media as ambassadors for the Centre's public health messages.

107. Barbara Albiger added that ECDC has been sharing its experiences with other institutions and will have a technical meeting for National Focal Points for Communication in September to share experiences and network further between Member states

108. Piotr Kramarz said this could be expanded and looked at in detail in the next AF on communications work more generally. He said any AF members interested in becoming ECDC ambassadors were welcome to contact the Communications team for support.

Information on the new Advisory Forum collaboration platform (ECON)

109. Anca Moruzov, Principal Expert Information Management, Scientific Methods and Standards Unit, ECDC, gave some information on the ECON platform, a new online workspace for Advisory Forum members. She went into the platform to demonstrate its navigation and functions and said that if participants had any additional requirements they should feel free to reach out to her or other ECDC colleagues.

110. Piotr Kramarz thanked all participants for their discussions, feedback and advice, and closed the meeting.

Annex: List of participants

Member State	Representative	Status	Participation Mode
Austria	Bernhard Benka	Member	In person
Belgium	Koen Blot	Member	In person
Croatia	Barbara Bekavac	Alternate	In person
Cyprus	Costas Constantinou	Alternate	In person
Czech Republic	Jan Kynčl	Member	In person
Denmark	Bolette Søborg	Alternate	In person
Estonia	Kärt Sõber	Member	In person
France	Harold Noel	Alternate	In person
Germany	Ute Rexroth	Member	In person
Greece	Dimitrios Hatzigeorgiou	Alternate	In person
Hungary	Zsuzsanna Molnár	Member	In person
Lithuania	Jurgita Pakalniškienė	Member	In person
Luxembourg	Isabel De La Fuente Garcia	Member	In person
Poland	Małgorzata Sadkowska-Todys	Member	WebEx
Portugal	Ana Paula Rodrigues	Member	In person
Romania	Aurora Stănescu	Alternate	WebEx
Slovakia	Helena Hudecová	Member	In person
Slovenia	Marta Grgič-Vitek	Alternate	In person
Spain	José Luis Peñalvo García	Alternate	In person
Sweden	Magnus Gisslén	Member	In person
Observers			
Norway	Preben Aavitsland	Member	In person

European Commission Non-Governmental Organisations (NGOs)			
Croatian association for the promotion of patient rights	Jasna Karacic-Zanetti	Member	In person
The Norwegian Research Centre	Arinze Stanley Okoli	Member	In person
The European Public Health Association	Ricardo Mexia	Member	WebEx
European Institute of Women's Health	Rebecca Moore	Alternate	In person
European Commission			
DG SANTÉ	Dirk Meusel		WebEx
DG SANTÉ	Laura Gillini		WebEx
DG SANTÉ	Marta Valenciano		WebEx
WHO Europe			
Lauren MacDonald			WebEx
Danilo Lo Fo Wong			WebEx