ECDC Advisory Forum

Minutes of the Fifty-eighth meeting of the Advisory Forum

Stockholm, 24-25 September 2019

Contents

Opening and adoption of the programme

1. Andrea Ammon, ECDC Director, opened the meeting and welcomed the participants.
2. Mike Catchpole, ECDC Chief Scientist, welcomed Susan Van Den Hof, the new alternate for the Netherlands, Aigars Ceplitis, observer representing AIDS Action Europe, and Masoud Dara from WHO's Regional Office for Europe. This meeting was also significant in that it was the last for Jean-Claude Desenclos, AF Member for France, and the Chief Scientist thanked him personally for his extensive input over the years. Apologies had been received from Austria, Belgium, Estonia, Italy, Latvia, Malta, Romania, Slovakia, Turkey and the European Commission. Spain would only be represented on the second day of proceedings.
3. There were no conflicts of interest to declare and the draft programme was adopted with no changes.

Adoption of the draft minutes of the 57th meeting of the Advisory Forum (14-15 May 2019)

4. Comments from Frank van Loock, European Commission, on items 9, 20, 27 and 31 of the draft minutes had already been incorporated into the version circulated. There were no other comments and the draft minutes were adopted without further amendment.

IRIS prioritisation exercise: Roadmap for implementation of ECDC Strategy 2021–2027

5. Andrea Ammon, ECDC Director, gave a short introduction on the updated draft strategy 2021–2027.
6. In response to a question about how feedback from the Management Board and the external evaluation was being taken into account in the proposed draft strategy, Andrea Ammon stated that this could only be determined once the Management Board had approved each of those documents, but based on previous discussions and the current draft of the External Evaluation report she would not expect that fundamental changes to the Strategy would be required.
7. Andrea Ammon, ECDC Director, referring to a question about the possibility of an extension of ECDC's mandate, said that the external evaluation contained a recommendation to do an impact assessment on such an extension. With regard to the ambiguity between public health and infectious diseases in certain parts of the strategy, the text specified that public health implied infectious diseases, and that unless and until ECDC's mandate had been extended it should be understood that it was for infectious diseases only. With regard to resources for the Strategy, she explained that there were ongoing activities and projects which needed to be completed therefore it was only possible for ECDC to start earmarking and using resources once it embarked upon on new activities. She therefore hoped that the proportion of ECDC's resources that could be dedicated to new activities would increase over the years.
8. Barbara Albiger, Senior Expert, Scientific Quality, Office of the Chief Scientist, ECDC, introduced the principles of the IRIS prioritisation exercise,[1] following which feedback was received from the Advisory Forum membership that the process had been well prepared in advance.

Strategic objective 1.

Polling 1. Is the complete set of proposed actions under Action area 1.1 (Standards) appropriate and sufficient to achieve the strategic objective and goal 1?

Result: is supported with changes (2), is supported with minor changes (8), is fully supported (8).

Polling 2. Is the complete set of proposed actions under Action area 1.2 (Evidence) appropriate and sufficient to achieve the strategic objective and goal 1?

Result: is supported with changes (5), is supported with minor changes (6), is fully supported (7).

Polling 3. Is the complete set of proposed actions under Action area 1.3 (Methodology) appropriate and sufficient to achieve the strategic objective and goal 1?

Result: requires major changes (3), is supported with changes (4), is supported with minor changes (5), is fully supported (6).

Polling 4. Is the complete set of proposed actions under Action area 1.4 (Knowledge transfer) appropriate and sufficient to achieve the strategic objective and goal 1?

[1] IRIS prioritisation exercise —Principles and process (B Albiger)

Result: is not fit for purpose (1), is supported with changes (3), is supported with minor changes (9), is fully supported (5).

9. Mike Catchpole, ECDC Chief Scientist, asked for feedback, in particular reasons for the scores of 3 or less.
10. With regards to area 1.1 on Standards, the following points were noted:
    a. The fact that this is an area with many different actors needs to be emphasised
    b. It was suggested that it would be better to use the term 'best practices' rather than 'standards' for some of the proposed actions
    c. In the context of big data, Artificial Intelligence (AI) might be an alternative to standards in some areas, particularly as it would be important to look for other solutions rather than enforcing standards that it might be impossible for Member States to adhere to.
11. With regards to area 1.2 on Evidence, the following points were noted:
    a. There had been great improvement in the way ECDC had been dealing with evidence-based tasks and ways of working with evidence-based institutions. This was particularly important so as to avoid the duplication of work and to be able to work with countries according to their national needs and resources.
    b. The proposed 'one-stop-shop' for sharing of information needed to take into account that ECDC would be unlikely to have access to all evidence relevant to infectious disease public health practice and in addition there would likely be significant legal challenges, including with respect to GDPR, to sharing some forms of data or evidence.
12. With regards to area 1.3 on Methods, the following points were noted:
    a. A key issue was what was meant by 'developing' new tools and methodologies and whether this referred to new techniques developed from scratch or whether they should focus more on identifying, and where appropriate, combining best practice methods developed by others.
    b. Proposals regarding methodologies to be developed or shared should be more specific e.g. modelling was not mentioned specifically – particularly in order to assess the effectiveness of actions.
    c. New technologies adopted should not just be effective but also fit for use in the context of varying levels of technological literacy.
    d. Methodologies and tools did not necessarily have an impact on burden of disease and so ECDC should be more cautious in setting targets for impact, which should be based on evidence derived from epidemiological data, since this was what ECDC had access to.
13. With regards to area 1.4 on Knowledge Transfer, the following points were noted:
    a. This was considered to be one of the most important issues by several members, since without knowledge it was impossible to make recommendations or give advice to policy makers. Knowledge synthesis for policy-making purposes involved a great deal of work so it would be very useful for Member States.
    b. Other members advised some caution, noting that political and cultural context can be important to effective knowledge transfer, and as such working with or through national institutions would be important, and the reference to the use of social marketing was also questioned.
    c. The importance of implementation science in assessing what works, and how knowledge can best be translated into action, was emphasised.
    d. It was also noted that NGO were potentially important partners in this action, as channels for knowledge transfer.
14. Mike Catchpole, responded to the feedback provided, and noted the following points:
    a. Referring to the issue of standards, ECDC has a key role in advocacy, and can add useful input to the voice of public health. He accepted that AI might offer an alternative to standards in some areas, but there were areas, such as e-health, where there was a need for advocacy of standards in the context of public health.
    b. ECDC's coordinating and catalysing role in gathering and sharing evidence needed to be made clearer and its aspirations needed to be more specific with regard to the 'one-stop-shop' idea. This was about looking at all the activities and the data received and trying to make it easier to find it all in one place - creating a portal of entry to facilitate access. With regard to the legal issues involved in data sharing and GDPR, he pointed out that ECDC had been operating according to a set of principles similar to those relevant for GDPR for a number of years and had not found this to be a major barrier. However, the text would be modified to reflect this concern.

c. Regarding social marketing, he was aware that policy makers used channels of communication that were more influential than peer-reviewed papers (e.g. social media) which was why ECDC was looking at building on its experience in this area to make information more accessible. He agreed that NGOs were important actors and should be included in the consultation process, and that ECDC could place more focus on learning from best practices and the theme of knowledge translation.

15. Andrea Ammon, ECDC Director, said that this action area went beyond simply improving accessibility to evidence and methods. It is not intended to approach policy-makers in countries directly; it was more about working with health authorities and institutions to make research more useful in the country. ECDC needs to boost its efforts in this area.

Strategic objective 2

Polling 5. Is the complete set of proposed actions under Action area 2.1 (Country focus) appropriate and sufficient to achieve the strategic objective and goal 2?

Result: requires major changes (1), is supported with changes (4), is supported with minor changes (7), is fully supported (6).

Polling 6. Is the complete set of proposed actions under Action area 2.2 (Prevention and control programmes) appropriate and sufficient to achieve the strategic objective and goal 2?

Result: is supported with changes (2), is supported with minor changes (7), is fully supported (9).

Polling 7. Is the complete set of proposed actions under Action area 2.3 (Training) appropriate and sufficient to achieve the strategic objective and goal 2?

Result: requires major changes (1), is supported with changes (5), is supported with minor changes (5), is fully supported (7).

Polling 8. Is the complete set of proposed actions under Action area 2.4 (Emergency preparedness) appropriate and sufficient to achieve the strategic objective and goal 2?

Result: requires major changes (1), is supported with changes (5), is supported with minor changes (5), is fully supported (7).

16. Mike Catchpole, ECDC Chief Scientist, asked for feedback on the polling.

17. With regards to area 2.1 on Country Focus, the following points were noted:

    a. Concern was expressed that Member States might not have the capacity to participate in the processes proposed. Moreover, those countries that were unable to do so would probably be the ones that needed the most help and support. It was also noted that the burden of implementation of some actions would fall on the Member States rather than ECDC, and therefore ECDC should monitor the situation and make allowances for the different types of health system in the Member States.

    b. It was noted that the actions currently focussed on vulnerabilities in the Member States, and that it would add further value if they also included the promotion and sharing of good practices between countries.

18. With regards to area 2.2 on Prevention and Control Programmes, no specific points were raised by the Advisory Forum.

19. With regards to area 2.3 on Training, the following points were noted:

    a. Divergent opinions were expressed on the relative balance that should be struck between, on the one hand, strengthening capacity in the traditional competencies of outbreak investigation, surveillance, etc., and on the other hand, "newer" competency areas such as bioinformatics, behavioural monitoring, social marketing, understanding of the political and social determinants of infectious disease, etc. It was suggested that one way of achieving a balance could be for ECDC to consider how training in some of the "newer" competency areas could be incorporated into existing 'tried and tested' modules and programmes

    b. It was noted that ECDC should continue to support training initiatives that avoided the net migration of the public health workforce out of countries with limited capacity

    c. It was suggested that training actions should be coordinated, and where appropriate integrated, with the 'knowledge transfer' actions (Action Area 1.4)

20. With regards to area 2.4 on Emergency Preparedness, the following points were noted:

    a. Several members expressed the opinion that ECDC should not be responsible for the organisation of the deployment of experts to crisis situations, noting that such deployments can be hazardous,

that there are large differences between the systems in countries, and in response settings and outbreak situations it was important to have that information in advance and understand the different systems in the countries, and that there were other actors who were better suited to this type of activity.

b. It was noted that joint activities undertaken with WHO, such as joint external evaluations, should be included as actions under this action area, and that it would be useful to also include the sharing of information from such activities.

c. It was suggested that it should be a clearer focus on assisting countries in improving their preparedness plans.

21. Karl Ekdahl, Head of Unit, Public Health Capacity and Communication, thanked the members for their comments. In response to the feedback from the Advisory Forum, he noted the following:

    a. He agreed that the wording of the Action Area 2.1 needed to be amended. ECDC did not wish to place a burden on the Member States but to become more efficient at supporting them. ECDC would discuss with national coordinators and competent bodies to see how it could improve in this area.

    b. He agreed that it was important to involve not only those countries with vulnerabilities but also others. This is currently already being done with the country visits which are peer reviewed and involve experts from various Member States. ECDC would also discuss how to use the competence and resources available in some countries to benefit others, and also how to use funding in order to aid those Member States with vulnerabilities to ease the burden. He noted that there was also a potential for adopting a more regional approach to benefit several countries in one area with similar issues.

    c. With regards to Action Area 2.3 he agreed that it was vital to retain classic epidemiological skills as a basis. The proposed actions would be reviewed with NFPs for training however he noted there was a consensus on the need for balance.

22. Vicky Lefevre, Acting Head of Unit, Surveillance and Response Support, ECDC responded to the Advisory Forum feedback on Action Area 2.4, noting that any ECDC deployments would only be on request, and that ECDC had no intention of undertaking deployments on its own initiative. On the other hand, ECDC did have certain expertise which could be relevant in the field for those who requested it. Previous examples had been measles outbreaks in Member States, requests from GOARN and the cyclone in Mozambique, and ECDC was now being asked to assist with Ebola in DRC. Negotiations were ongoing with DG ECHO and DG SANTE to establish what ECDC's role should be, and to establish a clear mechanism based on a set of established priorities.

23. Andrea Ammon, ECDC Director, pointed out that in regards to the Advisory Forum's feedback on Action Area 2.3, ECDC's efforts focused on the public health workforce for infectious diseases, and that it was looking at how to balance and combine the need for old skills while dealing with new technologies and challenges and this would be a gradual development over a period of time. It was therefore important for ECDC to try and predict how training needs would change in the future and to think ahead.

24. Andrea Ammon, ECDC Director, in response to the Advisory Forum feedback on Action Area 2.4, said that the text would be clarified. The premise for ECDC had always been that it undertook international work in order to protect the EU and therefore its input was selective. Citing the example of the Ebola outbreak in Guinea during 2015, she pointed out that ECDC had been asked to deploy experts and that is how it would be in the future too. DG ECHO could take the full responsibility for a deployment, which was why the European Medical Corps was set up after 2015 and ECDC had insisted that public health was an element of this. ECDC did undertake joint evaluations with WHO and it was up to the country involved whether it wanted to share self-assessments with ECDC.

Strategic Objective 3

Polling 9. Is the complete set of proposed actions under Action area 3.1 (Identifying gaps) appropriate and sufficient to achieve the strategic objective and goal 3?

Result: requires major changes (2), is supported with changes (4), is supported with minor changes (8), is fully supported (4).

Polling 10. Is the complete set of proposed actions under Action area 3.2 (ENGAGE) appropriate and sufficient to achieve the strategic objective and goal 3?

Result: is supported with changes (6), is supported with minor changes (7), is fully supported (5).

Polling 11. Is the complete set of proposed actions under Action area 3.3 (Support transformation) appropriate and sufficient to achieve the strategic objective and goal 3?

Result: is supported with changes (6), is supported with minor changes (8), is fully supported (4).

25. With regards to area 3.1 on Identifying Gaps, the following points were noted:
    a. Several members expressed support for the actions, noting that this provided particular added value for Member States that lacked the capacity to undertake Foresight work.
    b. It was suggested that the impact of climate change should be considered within the Foresight work proposed by ECDC.
26. With regards to area 3.2 on Engaging (with EU Research and Innovation Initiatives), the following points were noted:
    a. It was noted that ECDC is a public health institute rather than a research institute, and that its activities should focus on problem identification, research call specification and research proposal evaluation, rather than on the production of high-level research *per se*.
    b. It was suggested that some more specific examples should be provided of topics on which ECDC would engage with research and innovation initiatives, and that ECDC should also consider engagement with global research and innovation initiatives, as well as those in the EU.
27. With regards to area 3.3 on Support Transformation, the following points were noted:
    a. The key to this area was how to take the benefits of new technological developments and implement them in order to achieve control of disease.
    b. It would be important to follow up on actual developments after the fact rather than just evaluating beforehand.
    c. The proposal would benefit from having a clearer delineation made between AI, data mining, image processing and e-health.
    d. Information on the importance of new methodologies did not just concern public health and infectious disease control but was also vital for food safety and this aspect seemed to be missing.
28. Andrea Ammon, ECDC Director, in response to the Advisory Forum feedback on Action Area 3.1, pointed out that support to countries was not just about identifying gaps but also about identifying best practices
29. Mike Catchpole noted that the proposal on Foresight was based on the previous feedback from AF54 (September 2018) that priority should be given to a focus on AMR and vaccine-preventable diseases, rather than emerging diseases and climate change (as had been the focus of the initial proposal from ECDC). Vicky Lefevre, Acting Head of Unit, Surveillance and Response Support, ECDC, also added that climate change had not been forgotten and was perceived as a major driver of change so it would definitely be included in Foresight activities, although not at the exclusion of AMR and vaccine-preventable disease Foresight work.
30. In response to the feedback from the Advisory Forum, Andrea Ammon, ECDC Director, responding to the comment on ECDC producing high-level research, said this was not what was being planned. For ECDC it was more about being able to give input in setting priorities for research within e.g. Horizon Europe and having an idea of what was coming.
31. Mike Catchpole, responding to the question on global initiatives and the role played by ECDC in this context, said that ECDC had been working with colleagues in the US CDC on whole genome sequencing and that work was ongoing in the TATFAR forum where the focus was on AMR. However, the main focus of initiatives needed to be on the EU.
32. In response to the Advisory Forum feedback, Vicky Lefevre clarified that ECDC wished to assess the potential of new technologies rather than developing them itself.

Strategic objective 4

Polling 12. Is the complete set of proposed actions under Action area 4.1 (Neighbourhood) appropriate and sufficient to achieve the strategic objective and goal 4?

Result: is not fit for purpose (1), is supported with changes (4), is supported with minor changes (9), is fully supported (4).

Polling 13. Is the complete set of proposed actions under Action area 4.2 (Global CDCs) appropriate and sufficient to achieve the strategic objective and goal 4?

Result: is supported with changes (5), is supported with minor changes (8), is fully supported (5).

Polling 14. Is the complete set of proposed actions under Action area 4.3 (Coordination) appropriate and sufficient to achieve the strategic objective and goal 4?

Result: requires major changes (1), is supported with changes (2), is supported with minor changes (9), is fully supported (6).

33. Mike Catchpole, ECDC Chief Scientist, introduced Antonis Lanaras, ECDC's newly appointed head of section for European and International Cooperation, who had coordinated production of the proposal on Strategic Objective 4.

34. With regards to area 4.1 on Neighbourhood Countries, the following point was noted:

    a. African countries should be included in this action.

35. With regards to area 4.2 on Global CDCs, the following points were noted:

    a. Jean-Claude Desenclos, AF Member, France, said that, as Secretary General of IANPHI, he understood the importance of this action area very well and he urged further cooperation. By way of example, he pointed out that ECDC's Director had attended IANPHI meetings in the past and it was very useful to have this type of interaction. Support for this collaboration, as well as collaboration with other Global actors, was also expressed by other Advisory Forum members.

    b. Bilateral cooperation between public health institutes should also be stimulated by ECDC and other CDCs, since all public health work was undertaken in a 'global village', which was why it was so important to find ways of working together.

    c. It was asked why Russia was not included in this action.

36. With regards to area 4.3 on Coordination, the following points were noted:

    a. Paul Cosford, AF Member, UK, said that if the UK were to leave the EU, it would be mutually beneficial to both ECDC and the UK to continue to have a strong relationship, as reflected in this action area.

    b. It was asked how and whether ECDC would work with the private sector in the context of this area of action.

    c. There should be a clearer link to activities with EFSA at EU level to take account of food chain safety.

37. Antonis Lanaras, Head of Section, European and International Cooperation, responded that the northern African countries along the Mediterranean (Algeria, Egypt, Libya, Morocco and Tunisia) were included in this proposed area of action as they are included in the European Neighbourhood Policy

38. In response to the Advisory Forum feedback, Andrea Ammon, ECDC Director, said that during a meeting with all the CDCs with whom ECDC had collaboration agreements, it had been agreed that there should not be duplication of the work that IANPHI had done. ECDC was more interested in making its bilateral collaboration more multilateral. With regard to Russia, she explained that the current situation between the EU and Russia did not allow formal relationships. There were selected interactions at a technical level but not at the formal level. However, ECDC did surveillance for some diseases for the whole of Europe together with WHO and this included Russia. When talking about other actors, ECDC used the term 'international partners' in the text and would collaborate with such organisations or groups, including partners that it had not collaborated with in the past but with whom it might benefit from having a working relationship with in the future.

39. In response to the feedback from the Advisory Forum, Antonis Lanaras, referring to cooperation with the private sector, said that although the possibilities were limited, any initiatives that could be of added value for EU health security would be taken into account and explored. With regard to EFSA, there was a general reference in the text to EU agencies and it was hoped to further strengthen activities with other EU agencies in the area of health – specifically EMA, ECHA, EFSA and EMCDDA.

40. Andrea Ammon, ECDC Director, referring to the inclusion of the private sector, said that there had been many debates on this issue in the AF, and the advice was always to be very careful. ECDC was looking at not working with single companies but rather working with European associations rather than with individual companies. However, it was currently working on a policy which would refine and which confirmed its position as an independent institution.

41. Mike Catchpole thanked the participants for reviewing all the proposals and ECDC colleagues for organising and drafting them. All comments from the AF would be taken into consideration in order to build all the goals and activity areas into the Strategy.

Conclusions and Actions

The Advisory Forum concluded that the documentation on the draft Strategic Objectives and proposed actions had been well prepared, and the results of polling indicated that there was support, most frequently in full or with minor changes, for the proposed actions in all actions areas. ECDC will update the Strategy 2021-2027 in the light of the feedback received from the Advisory Forum.

Priorities for the first three years of the new Strategy

42. The Advisory Forum was asked to indicate, by polling, which actions within each Action Area they would propose should be given priority for inclusion during the first three years of the Roadmap for implementation of the Strategy.

43. Following polling, the actions proposed for ECDC focus in the first three years were as follows:

Action area 1.1 - Review and update or develop, and adopt, disseminate and promote adoption of standards.

Action area 1.2 - Increase the engagement of Member States and other partners in its priority setting, analytical, and knowledge creation work to ensure that ECDC outputs are relevant for them.

Action area 1.3 - In collaboration with partners, develop and promote the use of methodologies to increase the impact of public health actions in the field of communicable disease prevention and control.

Action area 1.4 - Provide communication of and access to evidence.

Action area 2.1 - Develop a mechanism to facilitate the identification of vulnerabilities and gaps in the Member States; develop a mechanism to invite the Member States, via the CCBs, to submit their requests for support via the ECDC ordinary SPD and work planning process.

Action area 2.2. - Develop and periodically update scientific advice on communicable disease preventive measures; monitor and evaluate effectiveness and impact of communicable disease preventive measures through surveillance and epidemiological studies; monitor emerging pathogens and their determinants and reservoirs (e.g. through the monitoring of disease vectors).

Action area 2.3 - ECDC Fellowship Programme.

Action area 2.4 - Performing rapid risk assessments: Rapid risk/outbreak assessments aim at supporting the countries and the European Commission in their preparedness and response to a public health threat; supporting the Commission in monitoring and evaluating gaps in preparedness and Decision 1082/2013/EU implementation.

Action area 3.1 - Foresight programme - undertake evidence reviews, foresight studies and consultations with its partners in the EU/EEA countries, other EU Agencies and global centres to identify important gaps in knowledge or uncertainties that need to be addressed in order to better inform prevention and control of current and likely future infectious disease threats; assess drivers of AMR and VPD and their likely impact on infectious disease threats over a 3- to 8-year horizon, to guide public health interventions and EU preparedness for major AMR and VPD threats.

Action area 3.2 - Systematic analysis of knowledge gaps for policy decisions that require appropriate research in order to address them, and establishment of effective mechanisms for communicating these to research commissioning bodies.

Action area 3.3 - explore with its partners the most relevant role for ECDC in the area of innovation and technological advances.

Action area 4.1 – develop and implement a comprehensive programme to support the EU pre-accession countries to be ready for future full membership of the ECDC and ENP partner countries to improve health security.

Action area 4.2 - increased collaboration with major CDCs.

Action area 4.3 - continue providing technical support and scientific advice to the EU Member States on serious cross-border threats to health and strengthen collaboration with key partners, both at the EU and global level.

Conclusions and Actions

ECDC will take into account the Advisory Forum's views on priorities for the first three years in developing its Roadmap for implementation.

EPHESUS – Evaluation of EU/EEA surveillance of sexually transmitted infections

44. Gianfranco Spiteri, Expert, Surveillance, Surveillance and Response Support Unit, ECDC, gave a short presentation[2] and the floor was opened for comments.

45. There was support from AF members for the overall EPHESUS recommendation to maintain the current surveillance network for sexually transmitted infections (STIs) and endorsement of the evaluation results presented in the Evaluation report. Key points that were raised during the discussion included:

    a. There are particular challenges in the surveillance of STIs, and that for smaller countries with limited resources it is difficult to meet current surveillance requests, and that as such any recommendations to extend existing surveillance activity would probably be infeasible for those countries

    b. ECDC was asked if it could provide an idea of how many full-time employees would be needed at national level to get the surveillance of STIs done

    c. Concerns were expressed regarding the representativeness of the STI data submitted to ECDC, and how surveillance systems would help in understanding the different risk groups and differential problems in risk groups which could then be helpful in terms of control

    d. It was suggested that ECDC should consider how point-of-care testing interfered with the surveillance and reporting (in particular chlamydia and HIV) and how these tests should be reflected in ECDC's surveillance, and whether a sentinel-based approach might lack sensitivity for detecting emerging problems

    e. *Mycoplasma genitalium* is a matter of concern for Denmark's SSI and as such Tyra Grove Krause, AF Alternate, Denmark, asked whether ECDC was planning to look into this

    f. ECDC was asked what the evaluation had shown with regards to responding to the recommendations of the last evaluation of these systems, and also whether there was a plan to change the overall surveillance system in the future and move away from the fragmented networks that were originally brought into ECDC

    g. Masoud Dara, WHO European Office for Europe, complimented ECDC on the work in this area. WHO was also interested in gathering information on surveillance in the area of STIs but so far the data were very scarce and had come mainly from a survey launched by WHO's headquarters in Geneva. He therefore hoped that it would be possible to cooperate with colleagues from ECDC and also to extend the data collection to non-EU countries

46. Mike Catchpole, Chief Scientist, ECDC, referring to the question on defining standard resources in the Member States, said that collectively ECDC had struggled with this, and in one specific disease area it would be even more difficult. Under the EPIET programme efforts had been made to look more broadly at staffing levels but otherwise it was problematic as it would involve attempting to balance resources across all ECDC's activities.

47. Gianfranco Spiteri responded to the Advisory Forum feedback, noting the following:

    a. Referring to the capacity of Member States to undertake comprehensive surveillance, said that different approaches had been tried because it had not been possible to obtain a comprehensive picture through normal surveillance. He also pointed out that ECDC tried to limit the amount of data collected to keep the burden to a minimum.

    b. With regard to increasing representativeness, for some countries, data were very complete but for others less so. For example, STIs among MSM were increasing; diagnosis of STIs among HIV-infected persons was stabilising, while among those who were HIV-negative there was more of an increase, so certain trends could be identified but not detailed analysis. Efforts were being made to assess representativeness particularly for the Euro-GASP programme, by comparing

[2] EPHESUS evaluation: Surveillance of sexually transmitted infections in the EU/EEA (G Spiteri)

Euro-GASP data to ECDC epidemiological surveillance data. There are significant differences among countries in the level of completeness on sexual behaviour information reported and these are planned to be addressed in future ECDC activities.

c. With regard to point-of-care tests, these could only be integrated into national surveillance systems if used within national healthcare settings.

d. With regards to the detection of emerging threats, for certain topics, such as gonorrhoea and AMR, ECDC relied heavily on countries reporting unusual AMR patterns, such as the example of the travel-associated cases of extensively drug-resistant *Neisseria gonorrhoeae* in 2018 for which ECDC had produced a risk assessment.

e. With regard to the previous evaluation, he noted that there were some areas that ECDC had not managed to address, such as chlamydia and focussing more on prevalence studies. However, discussions were ongoing with countries as to the best approach or perhaps the idea of a European prevalence survey, although this would take some time and significant resources.

f. With regard to *Mycoplasma genitalium*, Member States had said previously that it was not an issue and that ECDC should therefore not focus on it. However, a network meeting was planned for 2020 and this was area topic that would be reviewed again then in the context of increasing antimicrobial resistance in this pathogen and increased availability of commercial diagnostic tests.

48. With regards to the question about looking at the current approach to surveillance as a whole, Mike Catchpole confirmed that they would be looking at the overall results of the EPHESUS programme to discuss overarching issues and cross programme cooperation, however he would be cautious about moving away from a disease-specific network approach due to the specialist knowledge available.

49. Andrea Ammon, ECDC Director, said that the final EPHESUS evaluations would be done during 2020 and in 2021 a new proposal would be made, based on the results of all the evaluations.

50. Mike Catchpole concluded that the AF had no major disagreements with the findings in the report, that broadly speaking the current surveillance systems met the objectives, although there were some longstanding issues and weaknesses. He noted that there had been a number of initiatives over the years to try and overcome specific difficulties with collection of data on risk patterns this, however they had met with limited success. Therefore, ECDC still had to work on this, as it was important to look at requirements before committing resources, and this would be a topic for discussion at the network meeting in 2020, the conclusions of which would be fed into a proposal for the Strategy in 2021.

Conclusions and Actions

The Advisory Forum endorsed the findings in the report, that the current surveillance systems broadly meet their objectives, although there were some longstanding issues and weaknesses, including specific difficulties with the collection of data on risk factors. ECDC will discuss these issues at the STI network meeting in 2020, the conclusions of which will be fed into a proposal for a new strategic approach to surveillance.

Expert opinion on non-pharmaceutical countermeasures against pandemic influenza

51. Angeliki Melidou, Expert Influenza, Surveillance and Response Support Unit, ECDC, introduced the paper and the floor was opened for comments.[3]

52. There was a wide-ranging discussion on the paper, with several members noting that guidance on this topic was useful and important, but with the following key points also being made:

a. Concern was expressed that there was no weighting or grading system for the various studies and more details were required in this area in order to make clearer the evidence base behind the conclusions. In particular, there was a concern that some of the measures discussed in the document, which could have enormous consequences, were only supported by indirect evidence, but the simple fact of their inclusion in the document would probably lead to requests for action from politicians in the event of a pandemic. As such it would be important to make a clear distinction between the aspects for which there was clear evidence and those for which there

[3] Non pharmaceutical countermeasures against pandemic influenza (A Melidou)

was only indirect evidence. It was also suggested that there could be clear statements about measures for which the evidence was that they did not have a beneficial effect.

b. A number of points were felt to be unclear and unrealistic. For example, some of the language was unclear with regards to the travel restrictions and border closures, and the specific procedures for medical care in hospitals and clinics were missing (special waiting rooms/isolation rooms) and these were important because they could have an impact for policymakers.

c. A concern was expressed that some of the countermeasures proposed were in conflict with individual rights, and that some options would require the implementation of new laws.

d. ECDC was asked whether it recommended use of the document for pandemic planning in Member States, and it was noted that it would also be very helpful if ECDC could provide some support to individual countries in this area – e.g. how to stock up with protective equipment.

e. It was suggested that the next step could be a simpler guide for public health authorities, taking into account factors such as the severity of clinical illness, the population attack rate and age distribution in order to facilitate decision-making on aspects such as school closures. It was also suggested that there should be more about the specific groups that were more susceptible to certain viruses and how to identify these groups at an early stage. Such a guide would also be useful more generally since similar considerations also applied for other respiratory illnesses.

f. It was proposed that the document should be linked to some awareness activities relating to pandemics. It was also suggested that an Infographic showing the purpose and effectiveness of various actions at each stage of the process would be very useful

g. Masoud Dara, WHO Regional Office for Europe thanked ECDC for excellent collaboration in this area. There would be new information coming as WHO was currently developing a grading mechanism, but the quality of evidence would be medium to low due to the low number of publications available. He added that despite the lack of quality evidence, there was a certain amount of common sense involved when deciding on the steps to take at national level, depending on the situation and, in the final instance, it would of course be up to the Member States to decide in their own context what to do.

53. Angeliki Melidou responded to a number of the points raised, and also asked for comments or feedback in writing on the specific options for action proposed. With regards to the questions about the grading of the evidence of effectiveness, she pointed out that the document was not a systematic literature review, but she understood that this would be useful for the countries and would look into the possibility of addressing this. She also pointed out that WHO was planning to publish guidance in 2019 and their draft conclusions were in line with that of ECDC. With regard to travel restrictions/border closures, she said that general reviews had suggested that these could be effective when done early and completely. However, ECDC did not recommend this and it was not an option for action.

54. Pasi Penttinen, Head of Programme, Influenza and other Respiratory Viruses, ECDC, responding to the comment on specific risk groups, said that this was an interesting suggestion, and ECDC would look into how this could be incorporated. He also noted that it had been difficult to know how best to present the evidence when writing the document, given the lack of robust studies on many of the measures that are currently used or considered in many countries. He noted that ECDC was also involved in a pandemic preparedness process which was being led by the Global Health Security initiative. A workshop was being planned based on ECDC and WHO documents which would take place in Rome in November for G7+ countries. This would look at measures and how the timing of measures was applied in different countries. It would also discuss public communications during a pandemic. Several countries would be participating so he anticipated that some of the outcomes would be useful and relevant to the ECDC Expert Opinion.

55. Mike Catchpole, Chief Scientist, ECDC, agreed that a document of this type should never hide the truth; however, in the first instance, ECDC needed to reflect on further changes to the text. With regard to the social and legal impact, although it was vital to respect personal rights and freedoms, this would have to be dealt with in more detail at the national level in individual countries. He supported the idea of an Infographic but the first step would have to be to decide how to present the evidence which was patchy at best.

56. Andrea Ammon, ECDC Director, responding to the question about stockpiling, noted that this was seen as an element of risk management and the primary discussion needed to be between risk managers.

57. In addition to comments about the content of the document itself, there were a number of comments regarding the composition of the Expert Panel convened for its production, with some concerns expressed regarding whether all panel members had expertise in the area of influenza, rather than in more generic aspects of pandemic planning. It was also noted that after the 2009 pandemic in Germany, significant efforts were made to update pandemic planning, involving both the pharmaceutical and non-pharmaceutical aspects, and therefore ECDC should ensure that the document benefits from input from

the knowledge and experience of those experts who were involved at national level in the countries at that time.

58. Pasi Penttinen said that earlier in 2019 ECDC had had a series of workshops with pandemic planners from the Member States who had reviewed the document in question and provided feedback. Consequently, he could be sure that the document was in line with the expectations of the national planners.

59. Mike Catchpole concluded that the document had been broadly well received by the AF although the evidence was still patchy, even 10 years after the pandemic. The document clearly addressed a need but it would be necessary for ECDC to incorporate the many comments, have further discussions in house and look at how to deal with the quality of evidence before moving to public consultation. He thanked the AF for its useful feedback.

Conclusions and Actions

The Advisory Forum welcomed the development of guidance on this topic, which members considered addressed an important need for authoritative evidence. However, a number of concerns were expressed, particularly with regards to how the evidence, which is weak or inconclusive for several of the measures, has been evaluated. ECDC will review and revise the guidance in the light of the Advisory Forum's feedback, and will bring it back to the Advisory Forum following wider consultation.

Day 2 - Feedback from AF Working Groups

Working Group A – TB disease programme evaluation

60. Thorulfur Gudnason, AF Observer, Iceland presented the report for Group A.[4]

Working Group B – TB disease programme evaluation

61. Carlos Matias Dias, AF Member, Portugal presented the report for Group B [5]. The floor was opened for discussion and views on any additional points that should be taken into consideration in the evaluation. The following points were noted:

    a. Several members commented on the diversity of the scale of the burden of TB across Europe, with suggestions that ECDC should focus on helping countries or regions that needed to develop further in certain areas rather than trying to over-burden itself or other Member States by trying to treat all equally

    b. There were several opinions expressed on the issue of monitoring determinants, including: it could be useful to differentiate at the individual level (e.g. income, education or family status) rather than the group level, which was the classic approach; there are so many factors involved that consideration could be given to different types of social determinants being monitored for specific areas of Europe; instead of discussing determinants it would be better to discuss what the programme should achieve in each case – i.e. define more measurable goals

    c. There should be a better division of labour between ECDC and WHO with specific tasks for ECDC to focus on

    d. Country visits to high-burden countries should be maintained

62. Marieke van der Werf, Head of Disease Programme, Tuberculosis, ECDC, responded to the feedback, noting that ECDC is aware of the differences between countries, and has just finished a project to provide training and workshops to five of the WHO-designated high-priority countries. With regard to country visits, if there were long gaps between visits, this was because the Member States had not requested them. On the issue of social determinants for TB and other diseases, ECDC had run a project with the Working Group for the Surveillance Network which resulted in a technical report and their conclusion had been that ECDC should not start collecting a whole range of information because it was very country-specific. The only addition suggested to ECDC was to collect information on the duration since migration to the EU. With regard to country support, capacity building and preparedness, it had been suggested that ECDC should deprioritise this, but the Disease Network Coordination Committee was of the opinion that ECDC needed to do more work in this area (e.g. best practices, advising Member States, etc.)

[4] ECDC Advisory Forum Working Group: Tuberculosis Disease Programme Evaluation (T Gudnason)
[5] Tuberculosis Disease Programme Evaluation - Feedback Working Group B (C Matias Dias)

Therefore, the messages were mixed which was why she looked forward to seeing the results of the evaluation.

63. Jaap van Dissel, AF Member, Netherlands, said that the Netherlands had recently had a country visit and received good advice on how to organise work on TB so country visits could be very useful when revising the local TB programme.

Conclusions and Actions

ECDC will take into account the feedback provided by the Advisory Forum in formulating its plans for responding to the conclusions of the Evaluation Report on the Influenza and Respiratory Tuberculosis Disease Programme.

Working Group C – criteria for ECDC initiating work on emerging threats

64. Tyra Grove Krause, AF Alternate, Denmark reported feedback from the group.[6]

65. Following the feedback from Group C, Mike Catchpole, Chief Scientist, ECDC noted that the group appeared to see a role for such a tool but that certain aspects could be simplified and others added, pending some road-testing and a wider consultation process. Further opinions from the wider Advisory Forum were then provided, including:

    a. Experience with other similar tools had shown that the weighting of criteria has a fundamental impact on the overall assessment result

    b. Such tools are useful for assisting decision-making, and can stimulate more informed discussion, but they cannot be used as the sole basis of decisions

    c. The tool should be kept as simple as possible, with a reduction in the current number of proposed criteria

    d. It was felt that while the tool was being developed to assist ECDC and the Advisory Forum in assessing the need to undertake action on emerging threats, it would also be useful to make it available to Member States

66. In response to the points raised in discussion, Mike Catchpole noted that the tool would support decision making by providing a framework. It would be a resource to help provide a greater degree of consistency and transparency which in turn could help with decision making.

67. Piotr Kramarz, Deputy Chief Scientist, ECDC, said that the tool was originally conceived as an internal tool for decision making, and work had begun with a broad set of criteria modelled mostly on the RKI framework, however this will be simplified. Following the advice from the Working Group, the idea of the threshold to start working on an issue will be dropped. Overall, Piotr thanked the participants for their useful feedback.

68. Andrea Ammon, ECDC Director, said that it was important to have a tool not just for new topics but also for existing topics. One possibility that had been mooted in the past was variant Creutzfeldt-Jakob disease (vCJD) but for other diseases on the list, it would be good to have more sound argumentation for the next review. She pointed out that having diseases on the list required constant resources.

69. Mike Catchpole asked that the members of Working Group C agree to provide further comments on a revised version of the tool, and noted that if anyone else was interested they should please get in touch.

Conclusions and Actions

ECDC will revise the proposed framework for assessing emerging threats and consult further with the Advisory Forum working group, before bringing the topic back for further review by the full Advisory Forum.

[6] ECDC decision making tool for addressing infectious disease threats – AF Working Group C (T Grove Krause)

Update on the main activities since the last Advisory Forum meeting

70. Andrea Ammon, ECDC Director, presented details of ECDC's reorganisation.[7] Following the presentation she requested specific feedback on the placement of *Eurosurveillance* under the Chief Scientist from the point of view of editorial independence. In response to the question regarding *Eurosurveillance*, there were no opinions expressed that it would be inappropriate to place *Eurosurveillance* under the Chief Scientist, and a number of opinions that this was the most suitable placement within the new organisational structure. The importance of maintaining robust and explicit arrangements to ensure editorial independence was noted. There was also support expressed for the shift towards knowledge sharing and the focus on disease programmes. Questions were raised regarding how the changes would impact on connections with Competent Bodies and the Disease Networks, and on where influenza would be placed within the disease programmes.

71. Andrea Ammon, ECDC Director said that any further feedback on the placement of *Eurosurveillance* would be welcome. She explained that the driver for the restructuring was that ever since moving to a matrix organisation in 2011, the annual planning process and negotiations had been painful for everyone and required too much focus. When she began as ECDC Director in 2017, she had commissioned a review of ECDC's performance as an organisation which concluded that outputs, although effective and widely appreciated, were too costly in terms of resources. This was followed by simulation exercises for ECDC processes, which resulted in the new model being adopted. With regard to the disease programme and the two sections, it was very apparent that there were overarching concepts that applied to more than one of the diseases and which could be addressed under the umbrella of vaccination coverage. There was no correct or incorrect of grouping diseases and many different models were used in the Member States so a decision had been taken to adopt this model and she hoped that if adjustments were necessary they could be made later, as needed. The Director also explained that the ECDC staff working with contact points in the countries had been moved to the appropriate new entity in the structure. Any changes would be discussed with the networks to ensure that they supported the work at the appropriate level.

72. Mike Catchpole, ECDC Chief Scientist, confirmed that the majority of influenza activity would come under vaccine-preventable diseases.

Update on the planning of the Third Joint Strategy Meeting (JSM)

73. Mike Catchpole, ECDC Chief Scientist, gave a short update on progress in planning the JSM.[8]

74. Andrea Ammon, ECDC Director, said that invitations had not yet been sent out but that it was hoped that the new EU Health Commissioner and the new director of WHO's Regional Office for Europe would be able to attend.

Dates for Advisory Forum meetings in 2020 and 2021

75. Maarit Kokki, Head of Executive Office, ECDC presented the dates for AF meetings in 2020 and 2021.[9] She pointed out that the AF meeting in May 2020 on Monday 11 May would be a one-day meeting before the 2-day JSM, which would begin on 12 May.

76. In response to a question on whether in the interests of climate change ECDC was planning on reducing the number of meetings, Maarit Kokki said that ECDC's regulations stated that the AF should meet four times per year, however one of these meetings had already been changed to an audio meeting.

77. The participants agreed on the dates for AF meetings in 2020.

Update from WHO's Regional Office for Europe

78. Masoud Dara, WHO Regional Office for Europe, gave a brief update.[10]

79. Aigars Ceplitis, Observer, AIDS Action Europe, asked for clarification of what was meant by an optimised treatment regimen and, in relation to WHO country visits, whether these were administered by the Ministry of Health in the relevant country. He asked because HIV infection rates had not fallen in the Baltic States despite treatment now being available irrespective of CD4 counts, and he also had concerns

[7] Update on ECDC activities (A Ammon)
[8] ECDC Third Joint Strategy Meeting – Update September 2019 (M Catchpole)
[9] ECDC Advisory Forum meeting dates for 2020 and 2021 (M Kokki)
[10] WHO/Europe updates on Communicable Diseases (M Dara)

regarding coverage of medication costs. This and other issues would merit discussion during a WHO country visit to Latvia.

80. Masoud Dara explained that the optimised treatment regimen looked at the national guidelines in countries and decided what was effective before WHO made specific recommendations. In relation to country visits and access, he was in agreement with the Observer from AIDS Action Europe. All countries said that they were treating all HIV patients, irrespective of CD4 count, however the extent to which this was being done varied considerably. Country visit requests were sent to ECDC and WHO by the Ministry of Health. WHO also involved other organisations and mechanisms and engaged national experts/focal points in the process. However, he pointed out that it was not a question of 'inspecting' countries, it was more important that they were involved and engaged in the process.

Close of the meeting

81. Mike Catchpole, ECDC Chief Scientist, said that the next AF meeting would take the form of an audio conference on 11 December 2019. He thanked all the AF Members for their contributions and wished them a safe journey home.

Annex: List of Participants

Member State	Representative	Status
Croatia	Aleksandar Šimunović	Alternate
Cyprus	Linos Hadjihannas	Member
Czech Republic	Jan Kynčl	Member
Denmark	Tyra Grove Krause	Alternate
Finland	Mika Salminen	Member
France	Jean-Claude Desenclos	Member
Germany	Osamah Hamouda	Member
Hungary	Zsuzsanna Molnár	Member
Ireland	Kevin Kelleher	Member
Lithuania	Loreta Ašoklienė	Member
Luxembourg	Isabel De La Fuente Garcia	Member
Netherlands	Jaap van Dissel	Member
	Susan van den Hof	Alternate
Portugal	Carlos Matias Dias	Member
Slovenia	Marta Grgič-Vitek	Alternate
Spain	Fernando Simón Soria	Member
Sweden	Anders Tegnell	Member
	Birgitta Lesko	Alternate
United Kingdom	Paul Cosford	Member
Observers		
Iceland	Thorolfur Gudnason	Member
Norway	Frode Forland	Member
Non-Governmental Organisations (NGOs)		
European Institute of Women's Health	Rebecca Moore	Member
AIDS Action Europe	Aigars Ceplitis	Alternate
WHO		
	Masoud Dara	