ECDC

Public Health Capacity and Communication Unit

Member State Consultation on ECDC Public Health Training 2016

10-11 May 2016, ECDC, Stockholm, Sweden

Executive Summary

Member State consultations with the National Focal Points for Public Health Training (NFP-PHT) are organised in accordance with ECDC's Founding Regulations. Since 2013, they have followed the structure agreed for the ECDC Coordinating Competent Bodies.

This year's consultation saw NFPTs participating from 22 Member States, along with representatives from WHO, the Association of Schools of Public Health in the European Region (ASPHER), Training Programs in Epidemiology and Public Health Interventions Network (TEPHINET) and the Chairs of the EUPHEM forum and EPIET training site forum.

During the consultation, the proposed priorities for public health training (2017–2019) were presented and discussed, based on the Public Health Training Strategy 2015.

The focus this year was on training needs assessment, conducted through the 2015 survey. The results were interpreted and advice was sought from countries on capacity indicators and the best tools for ECDC to develop to support countries when cascading the assessment, or collecting data in the future.

Three countries (Portugal, Spain and the Netherlands) presented the methodologies and findings of national surveys they had carried out on needs and capacity indicators. Representatives from the WHO Regional Office for Europe and from the International Health Regulations (IHR) team at WHO's Lyon Office shared updates with the NFPTs.

Participants debated the key themes for ECDC's focus in working groups and suggested tools that countries would need to carry out their own national training needs assessments. They also discussed how ECDC could better support the countries' own assessments. The 'wish list' included: ECDC developing and facilitating exchange of national training needs assessment experiences; defining what can be offered and providing a portfolio of ECDC training activities, and continuing to assess workforce capacity and training needs. In addition, ECDC should develop simple, practical tools focused on public health operations, including a form for rating training needs, retaining the link to IHR assessment. Finally, ECDC should aim to provide country-specific support.

The aim of ECDC's Continuous Professional Development Programme (CPDP) is not merely to train individuals but to meet institutional needs in Member States, meaning that it would be up to the NFPT in specific areas to define these needs and identify the most suitable individuals from an institutional perspective. The Senior Exchange Initiative and various other formats for short courses are key elements of such a programme, the objective of which is to strengthen capacity to control health threats under Decision 1082/2013.

ECDC signed a collaboration agreement with ASPHER in March 2016, formalising areas of the partnership, including networking and cascading of training. The NFPTs recommended that ECDC should continue this collaboration and focus on areas such as mapping the ASPHER network capacity to act as training providers in the countries.

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The merging of EPIET and EUPHEM into one single fellowship programme was discussed. There was strong support for the general idea, especially given the relevance of multi-disciplinary work, but specific issues were raised (i.e. the importance of protecting current branding linked to the respective networks).

In conclusion, the consultation once again offered an opportunity for the exchange of experience and the provision of extremely valuable advice to ECDC to help interpret and adapt its training strategy to the needs of the Member States.

1 Background

The European Centre for Disease Prevention and Control (ECDC) held its annual consultation on EU-level training strategies with its key counterparts from the Member States – the NFPTs – at its headquarters in Stockholm on 10-11 May 2016. This meeting is the main annual opportunity to coordinate strategic and technical issues in the PHT field for infectious disease prevention and control in the EU, and is used to review, update and provide guidance for the planning and shaping of ECDC's activities in this area.

2 Objectives of the consultation

At this year's meeting, the specific objectives were:

- For the NFPTs to update and give feedback regarding training and capacity-building needs in their countries to give ECDC a better understanding of their needs in coming years;
- For ECDC to update the NFPTs on the agency's progress in the PHT field since the 2015 meeting, as well as its programme for 2016 and priorities for 2017-2019;
- For ECDC to present the results of its Training Needs Assessment Survey (TRNA) 2015 and receive feedback on the methodology used and how it could be improved to obtain more data;
- For three countries (Portugal, Spain and the Netherlands) to present the methodologies and findings of national surveys they had carried out on needs and capacity indicators, and to receive feedback on them;
- To inform the delegates about the new framework for International Health Regulations (IHR), and how this will affect MS;
- To discuss and make recommendations on the merging of EPIET and EUPHEM into a single fellowship programme;
- For the NFPT Coordinating Committee to meet and update each other.

The meeting agenda is in Annex 1, and a list of the participants in Annex 2.

3 Presentations

Welcome and Introduction

Meeting participants were welcomed and introduced to the meeting's agenda and objectives. It was noted that the meeting was a formal opportunity for MS to inform ECDC about any PHT issues they were encountering in their countries, as well as for ECDC to open discussions with them about topics they were finding hard to move forward.

NFPT Coordinating Committee Update

The chair of the NFPT Coordinating Committee, gave an update of the NFPT Coordinating Committee's work. He reported that the committee had had four teleconferences since September 2015. As well as providing rapid advice to ECDC as needed and reviewing various technical reports, key discussions had involved ECDC's Training Needs Assessment Survey (TRNA) 2015, with members giving feedback on the questionnaire and

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sharing their experiences regarding targets for capacity and other relevant topics. The last two teleconferences had largely involved considering the agenda for the current meeting.

He noted that due to retirement there were two vacancies on the committee, and called on the NFPTs to volunteer to join and help guide ECDC in public health training matters.

Work Programme 2016 and Priorities of 2017-2019

The meeting participants received an update on the section's work programme for 2016 and its priorities for 2017-2019:

- The creation of a single Fellowship training programme and curriculum (see next presentation).
- Under the strategic objective of maintaining and strengthening the workforce, the different initiatives that target mid-career and senior professionals would now come under the umbrella of a Continuous Professional Development Programme (CPDP), as presented at consultation with NFPTs in 2015. The CPDP had now appointed a head, Sybille Rehmet, who previously worked at ECDC on preparedness, and will focus this year on the analysis and design of the programme.
- In 2016, ECDC will hold the Summer School and two courses, one on the control of multidrug-resistant organisms and one on the principles of public health surveillance and time series analysis.
- The E-learning project will continue a new year with the design of a Road Map, consistent with Fellowship and CPDP plans; in 2016 ECDC organised the course on writing abstracts that was piloted in 2015. A course on Outbreak Investigation is in the design phase; and, together with the Disease Programme (DP) Team, a course is under development for seasonal influenza immunisation campaigns targeting healthcare workers, with the objective of sensitizing them and increasing the uptake of the vaccine among this population.
- In the disease-specific areas, the core competencies for vaccine preventable diseases and immunization (VPD&) have been finalised after consultation with NFP-VPDs and having gone through several rounds of discussion in expert meetings. A technical report will be produced and used in a working group discussion on TRNA in the Annual Consultation of NFP-VPD in September.
- ECDC signed a collaboration agreement with the Association of Schools of Public Health in the European Region (ASPHER) in March. As well as possibilities for joint activities with ECDC, the exchange of faculty and training materials, the possibility of pilot collaborations with specific Schools of PH and the creation of a network of Schools of PH with a curriculum and interest in the field of communicable diseases are foreseen. (For more detail, see the presentation below with Louise Stjernberg.)
- The MediPIET Scientific Leadership of ECDC continues in 2016, and besides trainers having been identified among ECDC experts for some activities, and the involvement of fellows in missions, the network is busy with advocacy activities for its sustainability.
- In April, ECDC hosted the annual network meeting for the NFPs for Emerging and Vector-borne Diseases (EVD).
- On May 5, to support the WHO's 'Save Lives: Clean Your Hands' campaign, ECDC highlighted its training initiative and the MS training resources in the area of infection control and hospital hygiene by launching a web page devoted to the topic. ECDC is also developing an 'Infection Control Wiki', an e-learning tool for trainers, including chapters addressing core competencies on infection control and hospital hygiene.

ECDC also introduced the 'One Fellowship Programme', the proposed implementation of having EPIET and EUPHEM under one fellowship umbrella. Following an ECDC Director's Decision, EUPHEM and EPIET have started harmonising their procedures for the selection of the MS and EU tracks; this year both programmes have exactly the same procedure. Discussions are also ongoing how to align other processes in both paths, including site visits.

Plans for the coming few years were also outlined. In March 2014, revised financial regulations were issued for ECDC, as well as guidance from the European Commission, meaning that the agency's work plans will move towards a single programming document (SPD) rather than the previous model of a strategic multi-annual programme supplemented by annual work plans.

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The resources requested for budget and staff in the resulting SPD had been finalized, but other aspects of the draft could still be adjusted. On training, the following five targets should be achieved by the end of 2019:

1. A new CPDP operational in providing training for at least 300 MS experts per year. These experts will be working at the core functions for disease prevention and control, and the focus will be on antimicrobial resistance and healthcare-acquired infections. A country-driven catalogue of courses should be available and in use.
2. ECDC's Virtual Academy (EVA) should be fully operational. This would see distance learning courses freely available for all public health staff in the EU, and would offer a blended learning approach to all ECDC-coordinated training efforts.
3. The two fellowship programmes should have been harmonized into a single programme, and 40 junior specialists been trained in intervention epidemiology or public health microbiology per year.
4. Training participants should be participating in efforts led by NFPTs, with the training cascading down to sub-regional and local levels. (Identifying the right participants for this would be key, therefore NFPTs input would be crucial.)
5. Training should be based on solid needs assessments, regularly updated. ECDC should be providing preparedness support; training aims to support and increase capacity in MS.

This draft document had been presented to ECDC's Management Board in November 2015. A final version was due to be adopted in June, meaning there was still time to receive input from the participants.

One Fellowship Programme

ECDC presented the implementation of the "one fellowship programme". As well as updating the participants on the process to date, the main aim of their presentation was to elicit input from the NFPTs on a paper about the implementation of the programme due to be discussed by the ECDC's Advisory Forum in May, which would then be subject to a decision by ECDC's director in June.

Background

The EU's defences against infectious diseases depends on a continuously available competent workforce capacity at all levels. This requires high-quality graduate and post-graduate training within national universities and schools of public health, complemented with life-long professional development activities such as courses, conferences, peer review processes and on-the-job training.

Following the founding regulation establishing ECDC with a mandate to strengthen the EU's capacity for the prevention and control of infectious diseases, the agency's Public Health Training Section has periodically consulted the MS to review the strategy and listen to their expectations. Following their advice, ECDC developed training activities for senior and mid-career public health professionals through short courses that are currently consolidated in a 'training programme for professional development' in applied epidemiology, and the ECDC summer school. EPIET was integrated into ECDC in 2007, and EUPHEM was created in 2008.

In 2015, ECDC's Public Health Training Strategy called for creating a single training fellowship programme with two paths: EPIET for epidemiology and EUPHEM for public health microbiology. Each path would feature one EU track and one Member State track, and would have common programme objective and discipline-specific path objectives, a single training site forum, the same selection process (with discipline-specific criteria), one programme manual and a single name.

The main rationales for bringing EPIET and EUPHEM into a single programme were:

- Both programmes are well-established and have their own traditions, but have evolved in much the same direction, using the same 'learning by doing' approach;
- ECDC received feedback from its Management Board, the Joint Strategy Meeting and the ADM process that having two fellowship programmes was burdensome for countries;
- The two programmes already collaborate to a degree, for instance in joint site visits;
- Inter-disciplinary work is key to disease prevention and control, and close co-operation between epidemiologists and microbiologists is increasingly needed in surveillance and outbreaks;

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- A single fellowship programme with discipline-specific paths could be expanded to additional disciplines in future as needs and circumstances arise.

Between May and September 2016, the Advisory Forum and the NFPT Coordination Committee will review the placement criteria for the new programme. Rebranding it under a new name and aligning all the processes from EPIET and EUPHEM into one is due to take place between June and December 2017. The first cohort for the new programme is scheduled for 2017. Deciding what to call the new programme was a potential challenge, as both existing names are well-recognized brands in the public health field in the EU.

Regarding internal governance, under the single programme structure the Advisory Forum and the NFPTs would continue to have roles. The current heads of both programmes would become the head scientific coordinators and the overall programme leadership would be the new head of ECDC's PHT section.

Discussion

The meeting participants gave strong support to the general idea of merging the programmes, but many specific points were raised, the main ones being:

- Completion of fellowships deserved more than a diploma, point F in the proposal (fostering public health leaders) might be misinterpreted; while some alumni of the programmes have become leaders within the EU field, this should not be an objective of the fellowships – the purpose is to train experts in these fields. The desired profile for fellows may benefit from a further discussion. Experts are in greater demand than leaders.
- Regarding point D, there was a difference when considering the careers of EU-track and MS-track graduates of the programme, as the EU-track fellows do not always return to their MS to work.
- More clarity should be given on how the programme objectives and the discipline-specific learning objectives will be differentiated and evaluated. And analysis of what could be gained and lost from such a merger should be carried out.
- While easing of ECDC's administrative burden through harmonisation between the two programmes was a welcome development, there was concern over the need to keep clear distinction about the content of the training provided in the curricula, and to protect and keep the names of EPIET and EUPHEM name as well-established and recognised brands for the MS.
- A number of participants offered strong support for the concept of a single fellowship programme, noting that the main rationale for it was the concept of multidisciplinary work, and that collaboration between the two fields, which was already happening. A very good synergy between the two disciplines has been observed at a number of training sites and brought about positive results.
- Regarding point A, which listed infection and disease control and cross-border threats, suggestion was made for this point to be modified to specify threats of unknown origin as well as communicable diseases, according to ECDC mandate.
- The possibility of opening the programme to additional paths was welcome.
- More clarity was sought on how introducing the single fellowship programme would impact its collaboration with national programmes.

Prof Karl Ekdahl, Head of Unit Public Health Capacity and Communication, responded to the points from the floor. He noted the strong support for the general idea and responded that regarding point on 'fostering leaders' clause as well as the idea of keeping the names EPIET and EUPHEM and placing them under a neutral umbrella name were valid points. On the differences in disciplinary specifics, he commented that the proposal was not to have the same curriculum and work, and that the learning objectives were not being discussed yet, but would be raised with the NFPs at a later date – the discussion was still on a broader scale for the Advisory Forum, but the learning objectives would be discussed with the NFPs after general principles had been agreed.

Regarding Point A, he said he was happy for it to be rephrased to reflect the mandate more precisely. On the manual, he explained that the intention was simply to place both programmes manuals in a single harmonised document that used consistent terms and structure throughout – the two manuals currently look very different when placed side by side, and not as if they might be part of the same overarching programme. Harmonizing would purely be regarding processes, such as candidate selection and site appraisal.

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ECDC noted that there was no reason for both programmes not to have the same administrative processes where possible but that the competencies taught in both will of course be different.

Participants suggested that ECDC already try to anticipate next external audit, and which indicators could be used to identify if the programme is achieving its stated objectives, in order to conduct monitoring and evaluating the new programme's objectives. ECDC took note of this advice as a good point.

On governance, there was a question whether the Training Site Forum's advice should not be channelled through the NFPTs to avoid the TSF's decisions being suggested at the Advisory Forum. A question was raised if the numbers of EPIET and EUPHEM fellow each year could be fixed, rather than flexible and changed every year. Prof Ekdahl replied that it was a good point regarding the TSF and would be considered.

Results of the ECDC Training Needs Assessment Survey 2015

ECDC presented the Training Needs Assessment (TRNA) 2015, its background, steps, methodology and results. Based on its Founding Regulation, other strategic documents and explicit recommendation from the Internal Audit Service (IAS) of the European Commission in May 2014 to determine that there were a sufficient number of specialists to train within the EU, ECDC carried out a comprehensive training needs assessment in MS in 2015, focussing on field epidemiology and microbiology.

ECDC first formulated an action plan, approved by the IAS, drawing on results from assessments of preparedness based on Decision 1082/2013. The idea was to use a systematic mechanism to gauge training needs and avoid placing too heavy a burden on the MS.

Having consulted the NFPTs in April 2015, ECDC explored a combination of methodologies and approaches. The agency carried out two literature reviews in parallel. The first was to identify effective needs assessment methods for public health capacity-building, and the second to identify established indicators to reflect workforce capacity which was challenging. Previous surveys, IHR assessments and pandemic preparedness assessment tools, country visits and workshops were all carefully considered.

The survey was launched online, and received a response rate of 65%. Twenty countries submitted responses via the EU survey tool, 20 provided access to the IHR monitoring questionnaire, and six countries provided partial answers via email. In many cases, the MS did not know the answers to some questions or did not answer them at all.

The MS experienced significant difficulties in quantifying and qualifying training needs for disease prevention and control. The main reasons for this were: difficulties in accessing the relevant data, and in some cases its existence at all; the diversity of public health systems; and the complexity of professional profiles in the public health workforce.

The results of the survey showed significant information gaps between countries on workforce capacity, and perhaps the biggest lesson from this is that the limited completeness shows these areas require a lot more analysis.

According to the IHR Core Capacities' monitoring (2014), only 35% of the MS had a national workforce development training plan or strategy.

ECDC had made some preliminary conclusions about these results, but sought the opinions of the meeting's delegates. One possible conclusion was that surveys on capacities and training needs could be useful and necessary to monitor trends, but should be part of a much broader multi-annual methodology, not just at EU level but also including consultations in the MS and even on the sub-national level and down to individual assessments.

ECDC sought advice from the NFPTs on the broad question of what they expected and wished for from the agency in terms of support for this type of exercise, particularly regarding workforce planning, the collection of data and assessment at national and sub-national levels. ECDC also asked how frequently the delegates felt surveys such as this should be (ECDC considered it was probably too heavy to carry out annually) and which combination of methods and prioritisation criteria they would favour to improve the results of such assessments in future. ECDC considers using desktop simulation exercises, regional workshops, analysis of lessons learned from real public health events (particularly the recent Ebola and Zika outbreaks), country visits, as well as greater alignment with other stakeholders such as the WHO, the European Commission and international stakeholders as other activities that could help improve the picture.

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Several comments were made from the floor in response. There was one question about access and analysis by ECDC of background data before the survey on specific areas in the MS (for example how many people work on VPD in a certain country)". ECDC explained that the data ECDC had were usually linked to the networks the agency is involved with, meaning NFPs and other contact points. ECDC could be said, therefore, to have mapped the capacity for people in MS with a very direct link with public health at the EU level, but it did not have these data at the MS level, which was one of the challenges.

One of the questions where ECDC would like to have the feedback from the NFPT was whether the training needs assessment data were too complex for the MS to obtain. Another question ECDC had posed was what kind of planning information the MS have about their workforces, which was greeted with near-silence. As it is very difficult for MS to obtain the relevant data, how can ECDC help them obtain it – or should the agency ask different questions?

One participant explained that it was very difficult to collect information of such capacities (i.e. how many people work on VPD) because field epidemiologists work on local and country level, and deal with many problems: from immunisation to outbreak investigation to surveillance. This makes giving figures on such categories very difficult.

After questions about the aim of the assessment, ECDC explained that the IAS had recommended the Agency to tailor its training efforts to the capacity gap in the EU, and to do this they had to go into detail to see which countries had which specific needs. The previous approach had been to offer everything to all MS. The ECDC's Founding Regulation establishes that the agency should ensure there were a 'sufficient number' of trained communicable disease specialists in the EU. IAS had argued that to meet this objective ECDC had to first know what was constituted a sufficient number. However, the idea is not simply to please the IAS, but find ways for ECDC to provide added value to the MS. In this case, the assessment survey revealed that workforce planning is not on the agenda in many MS, and data overviews are unfortunately lacking in many areas. This raised a crucial question: how can ECDC best be of service to help MS with this? This was even more important as the demographics in some MS meant that in a decade large parts of the public health workforce would no longer be available.

Furthermore, one issue was to make sure there were sufficient numbers of experts in the EU to perform all the tasks needed for public health, but that ECDC could never and should never replace the basic training for PH workforces in MS. ECDC had therefore identified its primary audience for training as all those working in one way or another on cross-border dimensions in infectious diseases in the EU, which roughly corresponded to all involved in the agency's competent body structure, including NFPs and operational contact points.

A point was made about one of the figures in the results of the questionnaire (Figure 5), which had led to the conclusion that some 200 people required training. It was noted that three countries made up half the numbers on every bar, asking it if the intention was to look at these numbers according to the population of each MS and if a distinction was being made between expressed demand and expressed need. ECDC shared this reflection. Some MS wanted to train everyone, while others were more modest, and it was a problem that they were often simply not comparable. An alternative approach might be to start by looking at smaller MS and see how many individuals there were fulfilling these roles (NFPs and related EU positions and contacts). If the number of these was thought to be sufficient in some MS, this could provide an approximation of how many people were needed at a national level to cover the necessary functions. This calculation could then be carried through to analysis of medium and larger MS, after which the workforce demographic profiles and their training needs in each MS could be looked at in greater detail.

This suggestion was supported by some NFPTs as it was believed that ECDC has a good feel for what needs to be done in the MS, and so could probably estimate how many NFPS and similar contacts would be needed at a national level. One participant commented that NFPs would be very happy to collaborate on trying to assess this together, and offered her compliments to ECDC for undertaking the work, as assessing these gaps was crucial.

One participant suggested that in the future the agency try to identify groups of countries saying much the same things. If certain themes reoccurred, ECDC could then focus discussions on those and promote national or regional discussions on how ECDC could tackle the issues raised.

ECDC had considered looking at reoccurring themes and this idea would be included in the working group discussions later.

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Dr Anna Cichowska, Programme Manager Public Health Services at WHO Regional Office for Europe, informed the meeting participant of an upcoming Human resources for Public Health Workshop that will be held in October 2016 in Bosnia-Herzegovina for the countries of the south-eastern Europe Health Network (SEEHN). The workshop focusses on aligning country's human resources for public health with their needs in light of their burden of disease and associated health policy. The workshop will explore country studies of successful implementation of public health initiatives and the associated implications for public health workforce (meaning those working in health promotion, protection and disease prevention) In advance of the workshop participants will prepare these country studies which will be shared and discussed with the other participants. Countries will then be encouraged to make a country-level plan to create a future public health success story and identify what human resources for public health will be needed. Dr Cichowska volunteered to share some of the lessons learned from the workshop afterwards.

TRNA: Proposal on Indicators of Capacity

ECDC presented the rationales and methodology for a literature review indicators of country capacity in the TRNA, the objective of which was to identify indicators, quantitative or qualitative, to estimate the 'sufficient number of trained specialists' mentioned in ECDC's Founding Regulation. Two research questions were used to carry out the review:

1. What indicators and/or targets have been established or used to estimate sufficient numbers of trained specialists?
2. Which additional or alternative quantitative indicators can be used to ascertain the sufficient number and/or capacity of trained specialists?

This encompassed a base of 440 articles, which was eventually narrowed to 20 for the conclusions of the review. The key findings of the review were that as well as enumerating public health workforces in the MS, it was also essential to take stock of the size of the competent workforce, to anticipate and plan workforce development, and to steer related policies (including recruitment and retention). There was a lack of uniformity across all spheres, and it was becoming even harder to benchmark and classify. Job tasks and functions were not uniform.

Additional indicators of capacity they found through the literature review could be the presence of advanced level training programmes and research institutions in the MS, the number of graduates and knowledge areas; the number of publications that could help indicate the level of epidemiological research activity in an MS; the membership of individuals in national societies or associations in the European Epidemiology Federation; and the existence of multidisciplinary response teams.

For a follow-up, in 2016 the team started looking into a new indicator: countries' capacities to publish outbreak investigations in peer-reviewed journals. At the moment they are seeing if this has been done in any other areas of public health and specifying the languages, dates and types of studies that should be included. The project is still at quite an early stage, and she welcomed input from the NFPs on their countries' capacity in this area.

One participant advised to map where EPIET and EUPHEM graduates were in their careers. ECDC explained that this is already done annually, using PubMed, LinkedIn and other methods, but it is of limited use as it simply informs where they are. ECDC is interested to discover if any countries have different indicators or targets for this. When carrying out country needs assessments outside the EU, ECDC sometimes found such indicators were very well defined at the ministry level, e.g. one epidemiologist per 30,000 people. They had noticed in the survey that there was a wide variance on this in EU countries, either because there was no information available on it, or because the data was not accessible by the NFPTs.

TRNA: Logic Model (Country Preparedness)

ECDC gave a presentation on the use of a logic model in setting up core competences and training in preparedness, outlining the importance of differentiating between a capability to respond and a capacity to respond, the former being more about knowledge and skills within a public health system and the latter requiring concrete resources to draw on such as infrastructure and prearranged policies and plans.

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The key outputs for this area of ECDC's activities in 2016 were the development of evidence-based advice on effective response arrangements for public health emergency preparedness (PHEP); the development of a list of core competencies for PHEP, including workshops with NFPs on planning for and evaluating operational national PHEP plans, and regional courses on PHEP and simulation exercises; the creation of a PHEP toolkit that would feature planning guidance, evaluation tools, training curricula and advice on the management of highly infectious patients; and a repository of good practice.

The rationale for developing a logic model for PHEPs was explained as a way to achieve some of these aims. Starting from a logic model developed by the Rand Corporation and Harvard University, they had reviewed European incidents such as the recent Ebola outbreaks and tried to translate the American logic model into a European context. The main reason for using a logic model is that public healthy emergencies are rare, making them hard to analyse. By first identifying the capabilities that would be needed to face a PHE effectively one can create a model that acts as a framework for preparedness and training in MS. Once these needs are identified, ECDC will organize a system of partnership in which they will invest resources, MS will invest resources, with all collaborating on a work plan for several years, creating best practice workshops and other activities. The proposal would be presented to ECDC's Management Board in June.

There was a question about how ECDC's proposal actions would be different from what was done last year in the TRNA survey. Those training public health specialists could be the same people involved in PHEP. It was clarified that there wouldn't be a new survey for this. The 2015 TRNA would be fully taken into account but policies can change days after surveys are completed. The idea was to meet face to face more and find simple mechanisms of gauging this.

ECDC's country support taskforce could make life a lot easier from a training perspective, and that sharing experiences and best practice workshops would also be crucial.

WHO IHR Core Capacities and Joint External Evaluation Tool

Pierre Nabeth (WHO Lyon) gave a presentation of the new monitoring and evaluation framework for the International Health Regulations (IHR2005), which should be implemented by participating countries by June 2016.

He outlined the background to the new framework. The Ebola crisis of 2013/14 highlighted a weakness in the dependence on the IHR's self-assessment tool, which tended to overestimate countries' capacity to face public health emergencies. In November 2014, the IHR Review Committee therefore recommended a move away from exclusive self-evaluation to an approach that combined self-evaluation, peer review and voluntary external evaluations with domestic and independent experts. A formal consultative process was launched, the result of which is the WHO's proposed new framework.

The new framework for IHR monitoring is a combined approach consisting of four components:

- annual reporting using a revised self-assessment tool;
- after action reviews;
- simulation exercises;
- and joint external evaluations.

Dr Nabeth went through each component in detail. The reporting to the WHA is aimed at assessing the sustainability of core capacities in participating countries according to a grading scale. The tool to do this has been developed in alignment with pre-existing tools such as the Joint External Evaluation Tool and used documentable evidence. It is self-administered on an annual basis.

The after action review is a post-mortem evaluation after a public health event. Countries are expected to have the capability to carry these out for significant disease outbreaks and public health events.

Simulation exercises were still in the process of being developed. The aim of these is to act as a qualitative component by identifying the functionality of core capacities, and to become part of MS's continuous national preparedness process. They will use as their basis existing exercises, with a central workbook and database to be developed.

The aim of the joint external evaluation component is to assess countries' capacity to prevent, detect and rapidly respond to public health threats. Participation in this component will be voluntary for countries, and

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will have a multi-sectoral approach both in the host countries and the teams of external experts. The reports will be released publicly and are to be carried out every 3-5 years, using the Joint External Evaluation Tool.

For each of the 19 technical areas of IHR2005 capacity, indicators have been defined for the Joint External Evaluation to inform an action plan, divided into 'Prevent', 'Detect', Respond and 'Other IHR-related hazards and Points of Entry' (the latter including chemical events and radiation emergencies).

Dr Nabeth showed several examples from the interfaces and mapping tools to be used, and then took questions from the floor. One question was who would bear the cost of external evaluations. Dr Nabeth replied that the process was initiated by the Global Health Security Agenda (GHSA), which WHO was a part of, and that the GHSA would bear much of the cost – he pointed out that the global situation in public health at the moment meant a lot of money was available to strengthen capacities, but the real question was targeting the funds properly.

In response to a question on the relationship between the JEE Tool and the GHSA, Dr Nabeth commented that the tool had been developed because self-assessment had been shown to be unreliable – it was crucial the countries' real capacities be assessed.

ECDC that after action reports were not something MS carried out systematically after public health events, and asked whether MS would appreciate if ECDC collaborated with the WHO to offer advice on this. In addition, he wondered if this question could be addressed either by one of the fellowship training programmes or the CPD programmes.

One participant commented that it was important to have the IHR, but that it would be advisable to combine indicators on the situation within the EU to the questionnaires. It was clarified that it was a global tool, and formal consultations were held in each region about it.

Selection of EU Track Fellows EPIET and EUPHEM

ECDC presented an overview of the 2016 cohort selection process for EPIET and EUPHEM. Changes were done in response to the IAS recommendation in 2014 to simplify the selection process for EU Track Fellows. ECDC decided to remove the step whereby Member States reviewed and ranked EU-track candidates. The main rationale for this was that MS responded in widely different ways to this step, with some interviewing each candidate and some not in touch with them. Nevertheless, in over 90% of cases, the MS ranking concurred with that of ECDC's own panel. Removing this step made the process five weeks shorter, giving more breathing space for the complex Framework Partnership Agreements and Specific Grant Agreements.

As of 2016, there is instead a single ECDC's Director Decision, and the same process for EPIET and EUPHEM, including the rotation of MS to host the EU Track Fellows.

The expression of interest for the selection process in 2016 saw nine MS asking for places in the available 14 EPIET EU-track seats, and 10 MS asking for the available 11 EUPHEM EU-track seats. As a result, ECDC decided to allocate nine EPIET EU-track seats to nine MS and 7 EUPHEM EU-track seats to 7 MS. The idea behind this was to maximise the number of MS participating in the programmes.

This led to a detailed discussion on this issue from the floor. Questions included: why there were only nine MS who applied and if ECDC had explored this. ECDC replied that the reason for the low number had not yet been explored, and that this meeting was the first real opportunity to do so.

There were comments in relation to the email received by the coordination committee, perceived as not entirely clear. The rules on such rotations are expected to be decided very early before the selection process took place and before every MS declared what they wanted.

There were some ideas about why so few MS applied for an EU-track fellowship: the administrative and financial burdens that come along with it; and also, having already a number of alumni working at a national level. The MS-track might be more widely seen as less resource-demanding.

One participant suggested having a mechanism that would involve the country in the process but that would be lighter; ensuring that the MS is not left out of the process completely.

Karl Ekdahl responded that this was an opportunity to ask two questions of the meeting's participants: Would you want to be included in the selection of EU track fellows from your country? And if the same situation arises in the next call for expression of interest that one of the paths could not be filled through rotation, would they favour more than one slot going to a single MS or not?

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There was some discussion on this issue, including further options being suggested, with the general consensus that all MS would like to be involved in some way but that there was not enough information available to answer precisely how. It was suggested ECDC send a proposal to NFPs after the meeting, and Prof Ekdahl agreed on this and said in the meantime ECDC would look into legal aspects of the matter.

Countries' experience: national needs assessments and capacity indicators

Representatives of three MS presented their experiences with carrying out national training needs assessment surveys.

The first to present was Silvia Herrera-León of Spain, on behalf of Maria Victoria Martínez de Aragón. They had a low response rate, but the data was nevertheless valuable. They conducted two online surveys, which were addressed to all national and regional authorities of the epidemiology and surveillance public health services (National Surveillance Network), and all epidemiologists working within the corresponding national and regional services (at central, intermediate and local levels). They were all asked to disseminate the link to the surveys through the national, regional and local services.

The main information that was collected was:

- The number of epidemiologists working in each regional and national institution (central, intermediate and local levels);
- Demographic data, education, years of experience, income, interest and limitations for training.

A list of main functions and activities of applied epidemiology were provided, and respondents were asked if the activity was performed, if so the frequency and capacity of it. If a need for training was identified, they were asked what they considered the best method: face-to-face, online, a temporary stay at a specialized site, supervised field work and other options.

Dr Herrera-León then presented the results in detail. Some significant challenges included gaps in data such the total number of epidemiologists in each region. The surveys were also sent to people in responsible positions in the public health field, but there was a distribution of the surveys within the regions. They were hoping for more luck with the launch of a second survey, building on the data they had gathered from this one, including gaps in applied epidemiology capacities they had identified. They were also discussing the possibility of including public health microbiology.

Jeannette de Boer of the Netherlands then presented her country's public health needs assessment survey. A literature review revealed that there was no data on the precise size of the Dutch public health workforce. They adapted the term 'Essential Public Health Operations' created by the WHO for their national situation. They selected organisations that provide public health services, and within these organisations sent an online survey looking to assess the educational qualifications and the hours spent on EPHO's by individual workers. The questionnaire was developed on the basis of a review of literature on workforce enumeration, interviews with public health experts and consultation with other researchers. The online questionnaire was designed to be filled in very easily and quickly.

Their main conclusions were as follows:

- The EPHOs could be used for describing the core tasks in public health in the Netherlands. They planned to carry the exercise out for infectious disease control in 2017.
- EPHOs can be translated to specific working fields within public health, and this was a good, solid method of measuring the capacity and the training needs in public health.
- The results give a good image of the workforce and their level of education and the training needs.

Paulo Noguiera then presented the results from Portugal. The approach there was somewhat different, as a new government had ordered a shake-up of the entire public health system in the country, leading to a task force being created to consider every aspect of the system. This task force had been running for four months, and Dr Noguiera used some of the time to conduct his own survey of the task force. Among other findings in a complex and dynamic political environment, the task force had suggested that a minimum of three trained individuals per region were needed in Portugal, plus one trained individual at local level (in Portugal's categorization, 1/200000 inhabitants).

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Dr Nogueira reflected that other methodologies for measuring Portugal's workforce needs had been used, including the Global Health Security Agenda Pilot Assessment of Portugal final report of June 2015 and the JEE tool.

Some comments from the floor included the point that the term 'epidemiologist' is not used in many MS, adding to the challenge of comparing such surveys in meaningful ways. The difficulties in measuring the size of the public health workforce were also exacerbated by precisely defining what is meant by public health, which does not only involve communicable diseases. In many MS, there is some overlapping.

Dr de Boer commented that this was a rationale for using the EPHOs created by the WHO, which did not involve the titles used by public health workers, but the functions.

The meeting's participants then split into three working groups, each with one facilitator and one rapporteur. The objective of the working group session was to:

- Collect feedback on countries' experience with the Training Needs Assessment and their insight into interpretation of the results (Part I);
- Share countries' experience and receive their advice on tools for needs assessment (both methods and content) on the national level (Part II);
- Discuss proposal for "sufficient number of trained specialists" as presented in plenary (Part III).

The questions posed were:

Part I

1. Are there any key themes in the results of the TRNA that ECDC should work on?
2. Would it make sense to 'cluster' Member States, based on their individually expressed training needs?

Part II

3. Which tools do countries need to carry out their own national training needs assessments? How could ECDC better support countries' own assessments?

Part III

4. Is the proposal for a standard of "sufficient number of trained specialists" applicable in your country?
5. What other indicators would you suggest?

Feedback from the Working Groups

Rapporteurs from the three working groups fed back to the plenary on what they had discussed.

Working Group 1 reported the following points via its rapporteur (Delphine Antoine):

The group felt some clarification of the concepts under discussion was needed. For example, was this about identifying needs, or wishes? They also suggested that the wording make it clear that this was about identifying essential *functions* to be done in each country.

Reasons of not answering the questionnaires included that they had not been sent to the most appropriate person in the MS; lack of time; lack of available data; the questions were not adapted to national contexts; and there were no agreed standards in the country on what was needed. Questionnaires were also answered in different ways. In some MS, discussions were held within the national institutes, in others not. Some MS clearly identified the education path for epidemiology, while others gave the same functions for public health workers from different backgrounds.

1. Are there any key themes in the results of the TRNA that ECDC should work on?

The group felt that financial constraints on personnel and language issues in training were worth taking into account more, and also pointed out that microbiology was not covered by the questionnaire. One suggestion was to develop a focus group on some key functions.

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2. Would it make sense to 'cluster' Member States, based on their individually expressed training needs?

The group felt this needs would not yet be practical, as there were too many organisational and conceptual differences between MS public health systems.

3. Which tools do countries need to carry out their own national training needs assessments? How could ECDC better support countries' own assessments?

The group suggested the following 'wish list':

- Develop and facilitate exchanges on TRNA national experiences, not only within the ECDC meetings, but also between countries;
- ECDC to define what can be offered and provide a portfolio of training activities and minimum requirements (for example, only in English, only on-site, and so on);
- ECDC work plan with core activities in all countries and an estimate on human resources needed and then training needs;
- Link to IHR assessment;
- Form with scoring on training needs;
- Simplify and be more operational;
- One area as a pilot working with disease programmes;
- Develop country-specific support.

4. Is the proposal for a standard of "sufficient number of trained specialists" applicable in your country?

The group pointed out that 'sufficient number' had not been defined. The ideas was also not necessarily related to training needs, and the group pointed out the difference mentioned in an earlier presentation between capacity and capability.

5. What other indicators would you suggest?

Some indicators the group suggested were: outbreak and field investigations; the outcomes of Fellowship training; the number of PH staff trained through Fellowship programmes and through CPD; and information on capacity.

The idea was to take IHR competencies into consideration.

Working Group 2 reported the following points via its rapporteur (Paulo Nogueira):

1. Are there any key themes in the results of the TRNA that ECDC should work on?

The group thought that the term 'public health professional' should be clarified to make the questionnaire more easily understood, and that qualitative methods should be used. Each MS has a different public health structure, making it difficult to harmonise questionnaires.

2. Would it make sense to 'cluster' Member States, based on their individually expressed training needs?

It was felt this might make sense for the Nordic countries but otherwise the group was against the idea. They suggested ECDC instead clustered by the most important subjects and topics. The group felt that ECDC should offer training to prepare experts where needed in all MS regardless of where the country was or how it could be clustered.

3. Which tools do countries need to carry out their own national training needs assessments? How could ECDC better support countries' own assessments?

The group could not define precisely which tools countries needed, but agreed that they should be as simple and practical as possible and should focus on public health operations.

4. Is the proposal for a standard of "sufficient number of trained specialists" applicable in your country?

The group was unsure who would be in a position in MS to answer this question. They referred to the difficulty previously mentioned in the meeting in differentiating between capability and capacity, as well as the problem

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in defining precisely what was meant by a 'trained specialist'. They felt that all specialists in public health should be included in this calculation, and not just epidemiologists.

The group agreed that having a minimum number was most significant at a local rather than national level, especially when considering the way public health emergencies usually played out. They felt that a minimum of three to five trained specialists per MS was essential.

5. What other indicators would you suggest?

The group suggested looking at the number of infectious diseases specialists. One comment on the format of the questionnaires was that qualifiers should be used more in the wording.

Working Group 3 reported back through their rapporteur (Kathrine Borgen).

1. Are there any key themes in the results of the TRNA that ECDC should work on?

The group supported the idea of ECDC harmonizing the TRNA with what is done by the WHO and through the IHR assessments. They also suggested it might be a good idea to use the same three levels as IHR ie central, intermediate and periphery.

The group felt the survey had not succeeded in capturing the information needed to identify training needs in MS, and that there was a need to reach both deeper and broader. Deeper in the sense of reaching the regional or intermediate levels, and broader in the sense of not focussing only on epidemiology as a profession but as discussed in previous sessions to also focus on functions. In relation to this, the group discussed the possibility of using the WHO's EPHOs definitions as used by the Netherlands for their survey and seeing if they could be adapted to use them as indicators of functions that would be necessary in public health for communicable diseases. Another suggestion was to use simulation exercises across the layers of PH systems but also across the MS. The group also felt that carrying out after action reports was crucial, and harvesting the information from them to use as a proxy to locate the gaps, asking how each country or layer dealt with the crises presented in the exercises. This could provide more easily accessible information, which would also have the benefit of stemming from action rather than filling in a questionnaire, and which could then be used to interpret training needs.

2. Would it make sense to 'cluster' Member States, based on their individually expressed training needs?

The group felt this could be a benefit if done both geographically but also perhaps based on the PH systems they have, and topic-independent. They felt it was a little unclear whether it was the training itself that would be clustering or the training needs assessment. The group thought that a benefit of geographical clustering is the networking component to it – people getting to know each other and who is responsible in different fields in nearby MS could prove to be very important in cross-border events.

3. Which tools do countries need to carry out their own national training needs assessments? How could ECDC better support countries' own assessments?

The group discussed stakeholder mapping in this context, and suggested MS might be able to benefit from the methodology ECDC was using for this to carry it out in their own countries. Communicating with a huge number of stakeholders, the group pointed out, is often a key challenge in public health.

Another idea was to facilitate the mobility of experts, and exchange of experts between MS in topic/specific fields but also in training and assessment – it was noted that IHR has self-assessment but also external assessment.

The group also recommended ECDC continue to support collaboration with ASPHER, and perhaps map that network's capacity in the countries.

4. Is the proposal for a standard of "sufficient number of trained specialists" applicable in your country?

The group didn't discuss this in detail, but Dr Borgen said that in listening to the feedback from the previous two groups she had thought that when looking at the need for trained experts in infectious diseases one should probably consider two separate issues: what had to be carried out on a day-to-day basis to run the surveillance systems and have enough capacity to know what is taking place in their country; and what had to be done to scale up in the event of a public health emergency. She felt these were two very different capacities, and should be taken into account when trying to evaluate the number of trained specialists needed.

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Sybille Rehmet of ECDC commented on this that simulation exercises were enormously useful as they showed clear gaps are in systems, but agreed that they were good at emulating the situation in crisis mode, but not for the day to day running of a PH system and this should definitely be kept in mind.

5. What other indicators would you suggest?

No additional indicators were reported by this working group.

Arnold Bosman thanked the rapporteurs, and noted that there was a lot overlap between the groups' thoughts, which would give ECDC's future considerations more focus.

ECDC Updates

Continuous Professional Development Programme

The ECDC's Continuous Professional Development Programme (CPDP) presentation focused on how it had progressed since being presented to the consultation in 2015. It is still in the analysis and design stage, but was now taking more shape – comment and guidance from the NFPTs was sought.

He explained that the programme was not intended to reinvent the wheel and would try to avoid duplicating training that already exists in the EU, instead hoping to complement and fill gaps where needed.

The CPDP was first proposed to ECDC's Advisory Forum in 2015, and endorsed by its Management Board in June the same year. A head of the programme was recruited, with Sybille Rehmet appointed on May 1 to work within the PHT section. The design of the programme is due to be completed in 2016, with development running into 2017. The hope is for the programme to be operational by the end of 2017, but this may be too optimistic considering its current status. It would be open to all MS, for NFPTs to prioritise candidates, and ECDC's Management Board would decide on the work plan.

The goal of CPDP is to contribute to life-long-learning in a 'blended' format (ie online and face to face) for EU public health professionals who:

- work in preparedness, prevention, detection, assessment and control of communicable diseases;
- are in ECDC's primary target audience (competent bodies, the European Commission, EU agencies);
- are available and committed to cascading training to regional/local levels;
- are mid-career and senior professionals.

A key goal of the concept is that of cascading, which had been defined as the process of transferring the knowledge and skills gained from ECDC's educational activities 'down the chain' from national to local levels to strengthen and align existing practices and foster evidence-based practice.

Part of the design was also to define what skills and competencies were relevant. There is not yet a curriculum, but the plan is for it to be based on a risk analysis framework, meaning the total of event detection process each MS needs to have; the threat assessment processes; the ability to manage threats; risk communication; crisis evaluation and preparedness. This would probably need some rethinking he said, considering the strong advice from the working groups earlier to try to align with either the WHO's EPHO definitions or the IHR framework.

They had identified several areas of competencies that would need to be monitored:

- Senior professionals working with cross-border health threats;
- All ECDC Disease Programmes and Public Health Functions;
- The supervisors of the EPIET and EUPET fellows, who are also in need of lifelong learning and CPD;
- The skills required for cascading training.

Regarding the scope of the programme, foreseen training components included ECDC activities that were already running, such as the Summer School, e-learning courses; the senior exchange initiative and external courses. They also wanted to expand learning through teaching. Regional courses were also being considered.

One area ECDC has been considering for CPDP is the mapping of capacity and training needs, for instance mapping the demographics of all ECDC's NFPs and Operational Contact Points.

Meeting participants welcome progress in the programme, but several delegates emphasised the importance that it remain as flexible as possible, as a rigid programme would probably not suit all MS. The possibility of introducing spontaneous topics when needed was suggested, such as had been done in Germany for local health officers asking for training in special protection measures as a result of the Ebola and Zika outbreaks.

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ECDC commented that needs like this could sometimes arise and that in country support activities especially a more ad hoc mechanism could be applied. A key point was the emphasis on lifelong learning, so CPDP should have more flexibility than a two-year programme.

Prof Ekdahl remarked that ECDC was not aiming to train individuals per se but to meet institutional needs in the MS, meaning it would be up to the NFPs in the specific areas to define the needs in their country and which individuals would be most fitting for this from an institutional perspective. He added that a concept paper was being finalized and was hoped to be sent to the Advisory Forum in September and that ECDC would discuss this with the NFPs as their advice would be crucial.

Virtual Academy

The ECDC's Virtual Academy (EVA) is already used for follow up on the progress of the fellows, for providing courses in blended format and for one e-learning course on Abstract writing.

This online learning platform will provide in the future access to training on various disease prevention and control topics in order to strengthen the capacity of MS. To provide online courses, ECDC signed two Framework contracts for development of such courses. ECDC is also planning to partner with a network of organisations to share resources. Trainers will be selected from in house ECDC experts, expert networks such as EPIET, EUPHEM, MediPIET and ECDC's Disease-Specific Networks, as well as from ECDC's National Focal Points for Training and partner organisations such as ASPHER and TEPHINET.

Senior Exchange Initiative

Senior Exchange Initiative was piloted in 2014. In 2015 a Call for expression of interest was addressed to National Focal Points for Training. Based on the expressions of interest 12 candidates had been selected to participate in 2016 edition. Five topics had been identified as the most popular choices for exchange visits, but once candidates and host sites started to prepare the visits, these choices became more diverse. The programme had encountered several logistical challenges. Arranging the practicalities of site visits had sometimes proven more complicated and lengthy than foreseen. Nevertheless, 12 site visits were planned: majority for May, one in June and one in August. The initiative will be carefully evaluated. National Focal Points for Training will get access as observers to the dedicated in EVA space for this activity. Next call for expression of interest will be initiated most probably in January 2017.

ECDC-ASPHER Collaboration

Louise Stjernberg, Vice Chancellor of the Red Cross University College in Stockholm and liaison between ECDC and ASPHER gave a presentation with Carmen Varela Santos on this very fruitful partnership. ECDC signed a collaboration agreement with ASPHER in March, formalizing areas of partnership, including networking and cascading of training. Founded in 1966, ASPHER promotes activities that foster the exchange of information and best practices amongst its members in an effort to achieve high standards of public health education and training across Europe. It has over 110 institutional members in 43 European countries, and more than 5,000 academics are employed in its member institutions. It is a non-profit, independent, and non-governmental organization.

Both ECDC and ASPHER had designated liaison persons who will meet every year to identify joint and/or synergetic activities for the upcoming one-to-three years, which would submitted for approval to ASPHER and ECDC. The liaison persons will continuously monitor the joint activities and keep senior management of both organizations informed. For joint activities, each organisation will bear its own costs. The intellectual property of products resulting from the collaboration will be agreed upon in advance for each specific activity.

Through this collaboration, ECDC and ASPHER aim to establish a network of Schools of Public Health that deliver training in the area of communicable disease prevention and control. The purpose of such network is to provide an academic partnership to ECDC and its NFPTs in order to support national workforce development operations and strategies. General areas of shared interest include continuous professional development, competency development, network strengthening, public health training strategies, training needs assessments, workforce development, accreditation, training methodologies and delivery formats. Specific activities foreseen included capacity-building events for CPD, joint studies and projects, joint authorship of articles and joint workshops.

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A Working Group had been created with the following members: Robert Otok (ASPHER), Jeannette de Boer (NSOPH), Miguel Angel Royo (ENS), Julien Goodman (APHEA), Louise Stjernberg (ASPHER liaison) and Carmen Varela Santos (ECDC liaison). Their tasks included drafting the goals of the Network of PH Schools that deliver training in communicable disease prevention and control, objectives in the pilot phase and criteria for membership.

In a comment from the floor, about the distribution of the 43 members across Europe. Louise Stjernbeg said there was a good distribution, and showed a map of the members from ASPHER's website.

Final remarks and closure

Arnold Bosman gave a brief summary of the main points of the consultation, highlighting the importance of having had a discussion in working groups on training needs assessment; and the inspiring and encouraging feedback on the continuous professional development programme, with the clear message that dialogue needed to continue with NFPTs throughout the design stage, and that the Coordinating Committee would play an essential role in that.

He said there had been four volunteers to join the Committee:

Jeannette De Boer

Delphine Antoine

Katharina Alpers

Silvia Herrera-León

He proposed that if the NFPTs approved of appointing these four joining the committee they declare this through a round of applause. This was duly given, and these four were accepted into the Committee.

Dr Bosman thanked the training section for preparing the meeting, in particular Barbora Kinross for managing its organisation; Karl Ekdahl for his support and approach in aligning preparedness, training and communication; the NFPs for their dedication and investment of time away from their national commitments; the Coordination Committee for their work in the previous year; and ECDC's Senior Management Team for its support. He ended with a tribute to Carmen Valera Santos for her energy, expertise and commitment, and wished her the best of luck in carrying on the work of the PHT section.

Karl Ekdahl closed the consultation by thanking Arnold Bosman on behalf of ECDC for the immense impact he had made in the field of public health training, and his inspiring vision and enthusiasm for the work. He shared the confidence on a seamless handover of the section.

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Annex 1. Meeting agenda

Tuesday, 10 May 2016

8:30-9:00 Registration of participants

9:00-9:10 Welcome and introduction (Karl Ekdahl and Arnold Bosman)

9:10-9:20 Coordinating Committee NFPT Updates (Paulo Nogueira)

9:20-9:30 Work Programme 2016 and Priorities of 2017-2019 (Carmen Varela Santos and Aftab Jasir)

9:30-10:30 One Fellowship Programme (Karl Ekdahl and Arnold Bosman)

10:30-11:00 Coffee break

11:00-11:45 Results of the ECDC Training Needs Assessment Survey 2015, Proposal on Indicators of Capacity, Logic Model (Country Preparedness) (Carmen Varela Santos, Barbora Kinross and Irina Ljungqvist)

11:45-12:30 WHO IHR Core Capacities and Joint External Evaluation Tool (Pierre Nabeth, WHO Lyon)

12:30-13:30 Lunch

13:30-14:00 Selection of EU Track Fellows EPIET and EUPHEM (Arnold Bosman)

14:00-15:00 Countries' experience: national needs assessments and capacity indicators, representatives of Member States

15:00-15:30 Coffee break

15:00-15:30 Submission of Reimbursement applications

15:30-17:00 Working Group Topics:
- Interpretation of TRNA results
- Tools for needs assessment cascade

17:00-17:15 Wrap up of Day 1 (Arnold Bosman)

Wednesday, 11 May 2016

9:00-10:00 Feedback from Working Groups (rapporteurs from WGs)

10:00-10:30 Coffee break

10:30-12:30 ECDC Updates:
- Continuous Professional Development Programme
- Senior Exchange Programme
- ECDC-ASPHER collaboration
- Other topics

12:30-13:00 Final remarks, closure (Arnold Bosman)

13:00-14:00 Lunch
(Working lunch of Coordination Committee in ECDC Auditorium)

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Annex 2. List of participants

National Focal Points for Training in the Member States and representatives from other organizations

Louise Stjernberg	ASPHER
Robert Muchl	Austria
Javiera Rebolledo	Belgium
Anna Kurchatova	Bulgaria
Monica Sala	Chair of EUPHEM Forum
Pavla Krizova	Czech Republic
Tyra Grove Krause	Denmark
Natalia Kerbo	Estonia
Outi Lyytikainen	Finland
Delphine Antoine	France
Elke Mertens	Germany
Marta Majorosne Dr Melles	Hungary
Margaret Fitzgerald	Ireland
Paolo D'Ancona	Italy
Jeannette De Boer	The Netherlands
Katrine Borgen	Norway
Paulo Nogueira	Portugal
Jeremy Duns	Rapporteur
Florin Popovici	Romania
Irena Klavs	Slovenia
Silvia Herrera-León	Spain
Fehminaz Temel	TEPHINET
Helen Maguire	United Kingdom
Pierre Nabeth	WHO Lyon

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Ida Czumbel
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Marion Muehlen
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