To: (10)(2e) @ec.europa.eu'[(10)(2e) @ec.europa.eu]; (10)(2e) @ecdc.europa.eu' ((10)(2e) @ecdc.europa.eu)[(10)(2e) @ecdc.europa.eu]; (10)(2e) [(10)(2e) @folkhalsomyndigheten.se]; (10)(2e) [(10)(2e) @folkhalsomyndigheten.se]; (10)(2e) ((10)(2e) @folkhalsomyndigheten.se)[(10)(2e) @folkhalsomyndigheten.se]; (10)(2e) [(10)(2e) @helsedir.no]; (10)(2e) it[(10)(2e) @inmi.it]; (10)(2e) [(10)(2e) @inmi.it]; (10)(2e) [(10)(2e) @inmi.it]; (10)(2e) [(10)(2e) @batut.org.rs]; (10)(2e) [(10)(2e) @batut.org.rs]; (10)(2e) [(10)(2e) @isciii.es]; (10)(2e) (DGS/MAEI) ((10)(2e) @sante.gouv.fr)[(10)(2e) @sante.gouv.fr]; (10)(2e) [(10)(2e) @sante.gouv.fr]; (10)(2e) (10)(2e) ((10)(2e) @sante.gouv.fr)[(10)(2e) @sante.gouv.fr]; (10)(2e) @nijz.si[(10)(2e) @nijz.si]; (10)(2e) [(10)(2e) @nijz.si]; (10)(2e) ((10)(2e) @eody.gov.gr)[(10)(2e) @eody.gov.gr]; (10)(2e) ((10)(2e) @eody.gov.gr)[(10)(2e) @eody.gov.gr]; (10)(2e) [(10)(2e) @phe.gov.uk]; (10)(2e) [(10)(2e) @phe.gov.uk]; (10)(2e) [(10)(2e) @phe.gov.uk]; (10)(2e) [(10)(2e) @wales.nhs.uk]; (10)(2e) (Public Health Wales - No. 2 Capital Quarter) ((10)(2e) @wales.nhs.uk)[(10)(2e) @wales.nhs.uk]; (10)(2e) [(10)(2e) @wales.nhs.uk]; (10)(2e) @wales.nhs.uk[(10)(2e) @wales.nhs.uk]; (10)(2e) (10)(2e)[(10)(2e) @rivm.nl]; (10)(2e) [(10)(2e) @rivm.nl]; (10)(2e) (10)(2e)[(10)(2e) @rivm.nl]; (10)(2e) [(10)(2e) @rki.de]; (10)(2e) [(10)(2e) @rki.de]; (10)(2e) [(10)(2e) @rki.de]; (10)(2e) [(10)(2e) @rki.de]; (10)(2e) [(10)(2e) @rki.de]; (10)(2e) [(10)(2e) @rki.de]
Cc: (10)(2e) [(10)(2e)@thl.fi]
From: (10)(2e)
Sent: Fri 9/18/2020 11:09:37 AM
Subject: Feedback on WP6 task revisions before 25 SEPTEMBER 2020
Received: Fri 9/18/2020 11:09:38 AM

Dear WP6 partners

As you know one of the pillars of WP6 plans was simulation of disease X scenario. The present SARS-CoV-2 pandemic has brought this scenario into real life.
The consequence for WP6 is that the planned tasks relating to disease X are probably superfluous and we thus needed to make quite extensive changes to our workplan.
Based on internal discussions as well as presentations and discussion during the April online workshop, the last steering committee and the advisory forum, we made these changes.
Now we are in the process of getting the amendments accepted.
Important is to what extend the changes meet the previously expressed expectations and the present national needs. In addition it is important that plans developed are not duplication of other present activities etc.

Once we have agreement on the new task 6.2. we will submit the text to the SHARP coordinators, and the next steering committee for general acceptance so that we can continue our activities. At this moment we particularly value your input on these new plans which are detailed below.

After each of the subtasks we kindly ask you to give feedback on the proposal and whether it fits your expectations. Does the proposal address (a) national need(s) in the COVID-19 pandemic multisectoral collaboration in preparedness and response? If not~~should the task be deleted or~~ do you have any **adjustments or other** proposals for amendments? Are there any similar activities to which we should/could align?

Specifically, the newly proposed task 6.2 for WP6 now reads:

Task 6.2: Learning from COVID-19
Lead: RIVM/EMC; participants: all SHARP partners

Understanding multisectoral collaboration during the COVID-19 pandemic, based on sectors, tools, instruments and core elements identified. Prepare a lessons learned document for future disease X.
The aim of the task is to (better) understand the mechanisms underlying the multisectoral collaboration. Focus will be on the decision making process and the interaction between policy and stakeholders.

6.2.1: The decision making process: the example of COVID-19 and testing strategies
All EU Member States have access to the same scientific information and the advices of international organizations such as the WHO and ECDC. However, there are large differences between MS regarding test strategies used during the first have **wave?** of the COVID-19 pandemic. There are (large) differences in volume of testing and criteria for testing, and these may also change over time. What causes these differences and changes? In this task we will investigate this by studying the three (3) countries with the highest number of tests conducted and three (3) countries

with the lowest number of tests conducted and investigate what factors cause these differences. As a source of information we will approach relevant decision makers, including at least one policy maker, a national IHR expert and a (national) expert from the laboratory side per country. Based on the outcomes of these inventories further stakeholders/sectors will be approached for subsequent interviews. We will study what factors contributed to the final decision(s) on test strategies and study the role of the different stakeholder, particularly the public health (IHR) and the laboratory side.
The outcome of this task will be an evaluation and analysis of these factors. Together with the protocol developed for this task the results will be shared with JA member states. The protocol may be used by individual member states and/ or may be adapted (with help of WP6) to address other non-medical measures (see optional task 6.2.3) .

Question to WP6 partners: during the last advisory forum andinterest was expressed in insight into different test strategies, the decision making process to come to these strategies for criteria and volume for testing as part of the national COVID-19 control strategies. The presented plan is meant to come to a better understanding of factors underlying these strategies in order to support further national and/or international test strategies.

We would very much value to get input on:

- **Your views on the present relevance of this subtask, in particular in relation to potential preparedness of controlling a potential second wave.**
- **The timeliness of this action**
- **Does this subtask fulfil a particular need for your country? If so could you specify?**
- **To your knowledge are there any other similar actions ongoing to which this subtask should align? Of which make this subtask superfluous? And to whom should we get into contact with in that case?**

6.2.2. Understanding the interaction between policy and stakeholders

One important sector identified in the COVID-19 pandemic is the general public. The general public is the sector that has to understand, accept and comply to these measures. The literature review identified the citizens as separate sector, however it is unclear what their role is, can or should be. Therefore, in this task we will focus on the general public as sector. Do they know who are the decision makers in their country during the COVID-19 crisis? Do they know who is responsible for what and where decision makers get their knowledge? And what should be the role of the general public? Does understanding, acceptance and expectation change over time?
These questions will be addressed by conducting several group interviews with Dutch Citizens. The first set of (pilot) interviews will be conducted during the (upsurge) of the first wave of the COVID-19 pandemic. Results from these interviews will be used to develop a protocol with improved methodology (including substantiated sample size) to perform a new set of interviews in summer. This protocol will be made available to all JA partners who will be encouraged to perform a similar exercise using this protocol in summer 2020. The outcome of this task will be the evaluation of the group interviews from the different member states participating in the JA.

Question to WP6 partners: we previously discussed the pilot during the last steering committee and advisory forum and interest was expressed in insight into the role of the general public as separate sector and particularly how to improve engagement and compliance of the general public for the control strategies. At this moment the pilot study is finalized and the protocol is improved. The intent is to present the results and the translated protocol for national use in the SHARP partner countries.

We would very much value to get input on:

- **Your views on the present relevance of this subtask, in particular in relation to potential preparedness of controlling a potential second wave.**
- **The timeliness of this action and the proposed reporting of results + protocol.**
- **Does this subtask fulfil a particular need for your country? If so could you specify?**
- **To your knowledge are there any other similar actions ongoing to which this subtask should align? Of which make this subtask superfluous? And to whom should we get into contact with in that case?**

6.2.3 optional - The decision making process : COVID-19 and non-medical measures

All EU Member States have access to the same scientific information and the advices of international organizations such as the WHO and ECDC. However, there are large differences between MS regarding the non-medical measures implemented. What causes these differences and what can we learn from it? How were the decisions made and who

was involved in this decision making
For this task we will adapt the protocol developed for the evaluation of test-strategies (task 6.2.1), which we can either employ again in 3 countries with extensive non-medical measures and 3 countries with limited non-medical measures (full lockdown vs. more liberate approach) and/or provide the protocol to the individual member states to be used to understand the impact of own national strategies. To be determined at later stage (depending on capacities and COVID-19 dynamics). The outcomes may be collected by WP6 and analyzed as in task 6.2.1 . alternatively the outcomes with those from 6.2.1 might serve as basis for best practices evaluation as requested by WP4 in task4.2.1.

Question to WP6 partners: this subtask was particularly requested during the last advisory forum, and additional action to the proposed subtask 6.2.1. As a result the subtask as written above is proposed, however, the WP6 leads fear this subtask is presently too broad as proposed to lead to any meaningful outcome and to be executed timely within the COVID-19 pandemic and within the timeframe of SHARP. We thus would ask to WP6 partners to express whether there is still an interest in this subtask. If so, to detail one specific non-medical measure that you consider most important.

We would very much value to get input on:

- **Whether there is still an interest in this subtask**
- **If so- please specify which particular non-medical measure is important to address in your view**
- **The feasibility of conducting this action within the present COVID-19 pandemic an within the remaining timeframe of SHARP.**
- **To your knowledge are there any other similar actions ongoing to which this subtask should align? Of which make this subtask superfluous? And to whom should we get into contact with in that case?**

6.2.4 Survey among all countries to inventory lessons learned during COVID-19 and remaining possible needs for further development of and critical questions for a disease X scenario

Based on the results of tasks 6.2.1 and 6.2.2 (and 6.2.3) and evaluation of the elements in the decision making process and interaction with relevant sectors as proxies for the understanding mechanisms of collaboration in COVID-19, a survey will be carried out to make a final inventory of the lessons learned during the COVID pandemic, and remaining needs for development of (country specific) recommendations regarding multisectoral collaboration, e.g. in case of identified important core- elements that were not/less relevant during the COVID-19 pandemic (e.g. chemical sector elements).

The outcome of this inventory is a decision on the need and feasibility of a (targeted/ lean) new disease X scenario simulation, as part of e-learnings and/or table top exercises (see task 6.3)

Question to WP6 partners: during the workshop in April we discussed whether there was still interest in another (lean version) disease X scenario. The COVID-19 pandemic has shifted focus in this JA very much towards this situation, but there are still potential (unknown) risks, also of non-biological nature, that we need to be prepared for. For instance the chemical partners expressed continued interest in simulating such scenario. We thus propose to make a final inventory of the lessons learned during the COVID pandemic including a need and feasibility analysis of a new (targeted/lean) disease X scenario simulation. We thus would ask to WP6 partners to express whether there is still an interest in this subtask. If so, to detail one specific non-medical measure that you consider most important.

We would very much value to get input on:

- **Whether there is still an interest in this subtask**
- **If so do you have any particular scenario (biological, chemical, environmental, nuclear) in mind ?**
- **The feasibility of participating in this subtask within the present COVID-19 pandemic and within the remaining timeframe of SHARP.**
- **The need for a separate disease X simulation or could it be part of the planned table tops and e-learnings?**
- **The feasibility of participating in non-COVID-19 e-learnings and table top exercises within the present COVID-19 pandemic and within the remaining timeframe of SHARP.**
- **To your knowledge are there any other similar actions ongoing to which this subtask should align? Of which make this subtask superfluous? And to whom should we get into contact with in that case?**

Could you please send your answers to the questions above before FRIDAY SEPTEMBER 25, 2020 AOB, so we can use your input to adapt the plans of task 6.2. to better accommodate the SHARP partners countries your country's needs, to prevent duplication of actions and/or conduct of unnecessary or superfluous activities and to enhance feasibility of actions.

Thank you very much!! We need your input to assure WP6 activities remain valid within this new situation.

On behalf of the WP6 leads,

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