EUROPEAN COMMISSION
HEALTH AND DIGITAL EXECUTIVE AGENCY

EU4Health Unit

SPECIFIC CONTRACT

No SC 2021 P1 01

implementing framework contract No Chafea/2018/Health/03

1. The European Health and Digital executive Agency (hereinafter referred to as 'HaDEA', 'the contracting authority' or 'the Executive Agency'), under the powers delegated by the European Commission ('the Commission'), represented for the purposes of signing this contract by 5.1.2e or his/her duly authorised representative,

and

2. Stichting Nederlands Instituut voor Onderzoek van de Gezondheidszorg (**NIVEL**)
Private Law body
Statutory registration number: 41181331
Address: Otterstraat 118, NL - 3513CR UTRECHT, Netherlands
VAT registration number: NL 0070.77.191.B.01

appointed as the leader of the group by the members of the group that submitted the joint tender

and

3. Rijksinstituut voor Volksgezondheid en Milieu (**RIVM**)
Public body
Address: Antonie van Leeuwenhoeklaan 9, NL - 3721 MA Bilthoven, Netherlands
VAT registration number: NL821772302B01

and

4. infeurope S.A. (**infeurope**)
Private Law body
Statutory registration number: B20174
Address: 62 rue Charles Martel, LU - 2134 LUXEMBOURG, Luxembourg,
VAT registration number: LU15292018

and

5. Association of Medical Schools in Europe e.V (**AMSE e.V**)
Private Law body

Statutory registration number: VR 34019 B
Address: Alt-Moabit 96, DE -10559Berlin, Germany

and

6. Royal College of Surgeons in Ireland (**RCSI**)
Private Law body
Statutory registration number: CHY1277
Address: 123 St Stephen's Green, IE - Dublin 2, Ireland
VAT registration number: IE2199803V

and

7. LEGINDA GmbH (**LEGINDA**)
Private Law body
Statutory registration number: HRB17761
Address: Bleichstrasse 27, DE-66111 Saarbrücken, Germany
VAT registration number: D265030455

collectively 'the contractor', represented for the purposes of the signature of this framework contract by 5.1.2e 5.1.2e, 5.1.2e Stichting Nederlands Instituut voor Onderzoek van de Gezondheidszorg,

HAVE AGREED

ARTICLE 1 SUBJECT MATTER

1.1 This specific contract implements framework contract (FWC) No Chafea/2018/Health/03, signed by the parties on 14/06/2019.

1.2 In accordance with the provisions set out in the FWC and in this specific contract and their annexes, which form an integral part of it, the contractor must provide the services specified in Annex I – Technical Annex.

ARTICLE 2 ENTRY INTO FORCE AND DURATION

2.1 This specific contract enters into force on the date on which the last party signs it.

2.2 The provision of the services starts from the date of entry into force of this specific contract.

2.3 The provision of the services must not exceed **6 months**. The parties may extend the duration by written agreement before it elapses and before expiry of the FWC.

ARTICLE 3 PRICE

3.1 The price payable under this specific contract is 5.1.2b 5.1.2b

3.2 Reimbursement of expenses is not applicable to this specific contract.

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In Bruxelles, the contractor must include the following statement in the invoices: "Commande destinée à l'usage officiel de l'Union européenne. Exonération de la TVA Article 43 § 1 k 2ème tiret de la loi modifiée du 12.02.79. 'In the case of intra-Community purchases, the statement to be included in the invoices is: "For the official use of the European Union. VAT Exemption / European Union/ Article 151 of Council Directive 2006/112/EC.'

ARTICLE 4 COMMUNICATION DETAILS

For the purpose of this specific contract, communications must be sent to the following addresses:

Contracting authority:

European Health and Digital executive Agency (HaDEA)

EU4Health Unit
Place Charles Rogier 16,
1049 Brussels

E-mail: 5.1.2e @ec.europa.eu

Contractor (or leader in the case of a joint tender):

5.1.2e 5.1.2e

5.1.2e

Stichting Nederlands Instituut voor Onderzoek van de Gezondheidszorg

Otterstraat 118,

NL – 3513 CR, Utrecht, Netherlands

E-mail: 5.1.2e @nivel.nl

ARTICLE 5 PERFORMANCE GUARANTEE

Performance guarantee is not applicable to this specific contract.

ARTICLE 6 RETENTION MONEY GUARANTEE

Retention money guarantee is not applicable to this specific contract.

ARTICLE 7 PAYMENT ARRANGEMENTS

7.1 Pre-financing:

Pre-financing is not applicable to this specific contract.

7.2 Interim payment(s)

The contractor (or leader in the case of a joint tender) shall submit an invoice for one interim payment of 5.1.2b equal to 40 % of the total price referred to in Article 3.1 of the specific contract.

The interim payment shall be made in line with the provisions set in Article I.6.2 of the FWC.

7.3 Payment of the balance

The contractor (or leader in case of a joint tender) shall submit an invoice for payment of the balance.

The payment of the balance shall be made in line with the provisions set in Article I.6.3 of the FWC.

Annexes

Annex A – Description of the tasks

Annex V – Financial Annex

Signatures

For the contractor,

5.1.2e, 5.1.2e of Stichting Nederlands Instituut voor Onderzoek van de Gezondheidszorg

Signature:_____

Done at Utrecht

For the contracting authority,

5.1.2e

Signature:_____

Done at Brussels

In duplicate in English.

Qualified electronic signature by:
5.1.2e
Date: 2021-11-30 15:26:28 +01:00

EUROPEAN COMMISSION
HEALTH AND DIGITAL EXECUTIVE AGENCY

EU4Health Unit

Annex I

Technical Annex for Specific Contract No SC 2021 P1 01
based on framework Contract No /Chafea2018/Health/03

Title of action: Lessons Learnt from COVID 19 surveillance and other epidemics-

Study to support a real-time integrated surveillance system at EU level, assist and support Member States in the development of interoperable, reliable and modern national surveillance systems, driven by digital transformation

Contents

1. INTRODUCTION AND CONTEXT

A rapid response to cross-border health threats requires surveillance and monitoring mechanisms to ensure timely detection and identification of threats and for steering the public health response. Among an extensive set of lessons learned, the COVID-19 pandemic has shown the importance of efficient, timely and reliable surveillance systems. COVID-19 has demonstrated a lack of comparable data and understanding of the situation on which to base the required decision-making. Real-time surveillance[1], integrated with other information domains, is therefore an essential pillar to ensure a timely response to health emergencies. This needs to be based on the capacities and requirements at Union and national level.

Decision 1082/2013/EU[2] laid down the principles of European epidemiological surveillance. There are 57 communicable diseases and 2 special health issues that are under mandatory epidemiological surveillance at the EU level. The list of diseases under EU surveillance and their case definitions are established by Implementing Decision (EU) 2018/945[3].

In line with the **European Health Data Space (EHDS)**[4], the 2020 EU Strategy for Data[5] define the importance to promote better exchange and access to different types of health data, both to support healthcare delivery (primary use of data) and to deliver cutting edge health research and policy development (secondary use of data). Data usage and merging with other health data for integrated surveillance will fall under the secondary use of data.

Following the General Data Protection Regulation (GDPR) article 4(25) **Data concerning health or health data** is defined as personal data related to physical and mental health of a natural person, including the provision of health care services, which reveal information about his or her health status. Health data is listed as "special category of data", protected under art.9 GDPR (sensitive data), requiring strict legal basis and higher level of protection.

In practice, however health data are often understood as any personal data generated within health care systems and some may also include data concerning health, which are collected by citizens and patients through wearable devices, apps and self – reported information (i.e. health related data created, recorded or gathered by or from patients or other caregivers, to help to address a health concern, including health and treatment history, biometric data, symptoms, lifestyles choices)[6].

The COVID-19 has demonstrated the importance of the secondary data for the development of policy in response to crisis situations. The European level surveillance would have enabled quicker responses[7], if common surveillance objectives had been agreed across countries together with common criteria for testing and reporting and common definitions for a case, for a severe case, for a disease outcome (death, recovered,

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[1] Real-time surveillance: enhanced surveillance with epidemiological monitoring in real-time, such as the data on the daily number of new reported COVID-19 cases and deaths by EU/EEA country, https://www.ecdc.europa.eu/en/publications-data/data-daily-new-cases-covid-19-eueea-country

[2] Decision 1082/2013/EU on serious cross-border threats to health, article 6 defines the EU epidemiological surveillance. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32013D1082&from=EN

[3] Commission Implementing Decision (EU) 2018/945 of 22 June 2018 on the communicable diseases and related special health issues to be covered by epidemiological surveillance as well as relevant case definitions, C/2018/3868, OJ L 170, 6.7.2018

4European health Data Space(EHDS): https://ec.europa.eu/health/ehealth/dataspace_en

[5] European Commission. European Data Strategy. available at: https://ec.europa.eu/info/strategy/priorities-2019-2024/europe-fit-digital-age/european-data-strategy_en

[6] Hansen J. et al, (2021), Assessment of the EU Member States' rules on health data in the light of GDPR, Study for European Commission.

[7] Study supporting the Impact Assessment of policy options for an EU initiative on a European Health Data space, Inception report, July 2021.

recovered with sequalae). Furthermore there was a lack of resources for comprehensive data collections (both in terms of cases and in terms of information collected on cases). ECDC did not have the mandate to standardise surveillance, nor the financial resources to support rapid surveillance developments in Member States.

Although pandemic surveillance objectives evolve with the phases of a pandemic and there are defined by international (WHO) guidelines[8,9], the availability of comprehensive digital health information from different sources that can be used for public health (secondary use) would represent a strong basis for integrated, real time surveillance, which would contribute to the achievement of various objectives.

Another important evidence brought up by the COVID-19 pandemic were the challenges[10] related to large amounts of unstructured data, storage of data in silos, use of different terminologies by different actors in the health care systems.

The European surveillance systems under the European Centre for Disease Prevention and Control (ECDC)

The EU networks for epidemiological surveillance are operated and coordinated by the European Centre for Disease Prevention and Control (ECDC), including support to national reference laboratories.

The ECDC surveillance portal for infectious diseases (EpiPulse)[11] will be the main instrument for information gathering on communicable diseases in Europe. EpiPulse was launched in June 2021 as the online entry-point for EU/EEA surveillance activities. It brings together the data and events reporting, analysis and visualisation of surveillance outputs, and interpretation and risk assessment of findings. It integrates the functionality of indicator- based surveillance (TESSy)[12], molecular typing[13], Epidemic Intelligence Information system (EPIS)[14] and ECDC threat tracking tool[15].

The European routine surveillance systems

ECDC collects, validates, analyses and disseminates routine surveillance data on notifiable infectious diseases from 30 European Union/European Economic Area (EU/EEA) Member States. Depending on surveillance objectives, data collections are yearly, monthly, weekly, or immediate. In addition, ECDC carry out special surveillance systems that aims at collecting high quality data for priority diseases in order to inform robust public health action. This is the case for active surveillance carried out for invasive bacterial infections (SpidNet[16] and Pertinent[17]) to inform vaccine updates and vaccination programmes, for monitoring influenza vaccine effectiveness (I-MOVE[18]) to inform vaccine composition

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[8] WHO guidance for surveillance during an influenza pandemic: 2017 update. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

[9] Maintaining surveillance of influenza and monitoring SARS-CoV-2 – adapting Global Influenza surveillance and Response System (GISRS) and sentinel systems during the COVID-19 pandemic: Interim guidance. Geneva: World Health Organization; 2020 (WHO/2019-nCoV/Adapting GISRS/2020.1), https://apps.who.int/iris/bitstream/handle/10665/336689/WHO-2019-nCoV-Adapting_GISRS-2020.1-eng.pdf

[10] IACOB, N., & SIMONELLI, F. (2020). Towards a European Health Data Ecosystem. European Journal of Risk Regulation, 11(4), 884-893. doi:10.1017/err.2020.88

[11] EpiPulse - the European surveillance portal for infectious diseases, https://www.ecdc.europa.eu/en/publications-data/epipulse-european-surveillance-portal-infectious-diseases.

[12] European Surveillance System (TESSy): https://www.ecdc.europa.eu/en/publications-data/european-surveillance-system-tessy

[13] Molecular and genomic typing: https://www.ecdc.europa.eu/en/molecular-and-genomic-typing

[14] Epidemic intelligence Information System (EPIS): https://www.ecdc.europa.eu/en/publications-data/epidemic-intelligence-information-system-epis

[15] Epidemic intelligence tools and information resources, https://www.ecdc.europa.eu/en/threats-and-outbreaks/epidemic-intelligence.

[16] SpIDnet project: Invasive pneumococcal disease in European Union and European Economic Area, , https://sites.google.com/a/epiconcept.fr/ipd-surveillance/home-2

[17] Pertinent project: Pertussis in Infants European Network.

[18] I-MOVE (Influenza – Monitoring Vaccine Effectiveness in Europe, https://www.imoveflu.org/

and alternative prevention and control measures in case of suboptimal effectiveness, and for assessing the prevalence of healthcare associated infections (point prevalence surveys).

ECDC also carries out global event-based surveillance of potential public health threats to the EU/EEA and its progressively moving towards automated screening and assessment of media and social media with tools supported by artificial intelligence.

The national competent authorities in charge of infectious disease surveillance nominate disease and public health function experts with cross-cutting surveillance, threat detection and microbiology expertise to dedicated EU/EEA networks coordinated by ECDC.

The general objectives of EU/EEA surveillance are to:

1. Detect and monitor any multinational infectious disease outbreaks with respect to source, time, population and place in order to provide a rationale for public health action;
2. Monitor trends in infectious diseases over time and across Member States to assess the present situation, respond to rises above warning thresholds and facilitate appropriate evidence-based action;
3. Contribute to the evaluation and monitoring of prevention and control programmes targeted at infectious disease surveillance in order to provide the evidence for recommendations to strengthen and improve these programmes at the national and European level;
4. Identify population groups at risk and in need of targeted prevention measures;
5. Contribute to the assessment of the burden of infectious diseases on the population using such data as disease prevalence, complications, hospitalisation and mortality;
6. Generate hypotheses on (new) sources, modes of transmission and groups most at risk and identify needs for research and pilot projects.

Data comparability across Member States is further enhanced by common reporting protocols, external quality assessment of laboratory performance and regular exchange of best practice within the EU/EEA networks. However differences exist between Member States surveillance systems, particularly in terms of performance attributes. Such differences have been heightened by the huge data requirements during the COVID-19 pandemic, resulting in further incomparability of data.

The ECDC's strategy for the surveillance of COVID-19 was published in April 2020, early in the pandemic. The main pillars of the ECDC surveillance strategy continue to emphasise population-based surveillance and integration of data from the various healthcare levels. However, due to the ability of SARS-CoV-2 to rapidly mutate to evade the pressure of Non pharmaceutical interventions (NPI) and of natural and acquired immunity, we will face an ongoing pandemic risk in the coming years. In order to give the necessary time for vaccine development and deployment, it is necessary to have highly performing surveillance systems in place to rapidly control and/or delay the global spread of a variant SARS-CoV-2 for which there would be limited protection in the population.

Therefore, some of the COVID-19 surveillance objectives have become more relevant with time, i.e. virus genetic and phenotypic characterization to detect variant viruses and to inform vaccination programmes and vaccine development. Furthermore, future COVID-19 surveillance systems should be characterised by high sensitivity in order to rapidly detect areas of transmission and trigger sequencing of cases in order to control or delay the emergence and spread of variants that may evade the protective effect of previous vaccination or infection, thus holding a pandemic potential. Such systems could not be

easily integrated in existing primary-care-based surveillance systems (e.g. those in place for the surveillance of influenza) because of their insufficient sensitivity.

Therefore, it is likely that future surveillance systems will have to rely on a combination of healthcare and self-reporting (crowdsourcing surveillance) data, using modern technologies such as mobile apps (symptoms checkers and similar) integrated within the healthcare systems. However, any such system will be difficult to implement and will not necessarily ensure the required sensitivity. As observed at the beginning of the pandemic in China and in Europe, the early detection of community transmission was based on the observation of cases of severe respiratory infections.

Thus, one essential pillar of future COVID-19 surveillance will be hospital-based surveillance of Severe Acute Respiratory Infections (SARI). At the moment, not all countries are able to carry out this type of surveillance and ECDC is investing resources and budget into supporting EU/EEA countries establishing such surveillance systems. These systems, albeit based on a syndromic case definition, require laboratory confirmation, thus also provide a pool of samples for sequencing and contributing to the early detection of variant viruses. Furthermore, given the high quality of data which includes information on vaccination status, SARI surveillance can be used for monitoring vaccine effectiveness.

On 10 June 2021, ECDC organised a strategic surveillance workshop with members of their Advisory Forum, some national competent bodies and the European Commission to identify the best ways to strengthen EU and national surveillance, capturing the lessons learnt from the COVID-19 response. The consultation was based on the types of surveillance systems, focusing on population-based surveillance, and surveillance through linkage with health databases, enhancing surveillance systems through epidemiological studies and community involvement through syndromic surveillance or non-health surveillance systems.

The Health Union Proposal[19] that will establish the new Health Security Framework is under negotiation and will change the ECDC mandate and the surveillance systems operation. The EU surveillance systems are expected to have an enhanced role[20]:

"Digitalisation of surveillance systems at EU and national levels based on the lessons learned from the COVID-19 pandemic" is a priority. The digitalisation of the surveillance systems is expected to contribute to the European Health Data Space Initiative[21].

- in the development of digitalised EU level surveillance systems for communicable diseases and related health threats, in close collaboration with the EU Member States as well as the development and maintenance of digital applications and platforms to support disease prevention and control and e.g. outbreak response activities such as contact tracing;

"ECDC will invest further resources and efforts to develop surveillance systems based on the secondary use of health data collected from electronic health records, laboratory information management systems, and other relevant existing electronic health databases"

The Health Emergency preparedness and Response Authority (HERA) was announced on 16 Sept 2021[22]. With regard to epidemic surveillance it will extend support programmes

[19] Health Union Proposal available at: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52020PC0726&from=EN
[20] ECDC single programming priorities for 2023-2025 , under review by the ECDC Advisory forum
[21] European Health Data Space (EHDS), available at: https://ec.europa.eu/health/ehealth/dataspace_en
[22] https://ec.europa.eu/commission/presscorner/detail/en/qanda_21_4733

set up under HERA Incubator to strengthen the detection and identification of variants in the EU. It will also support actions to boost global surveillance.

The European real-time enhanced surveillance systems

The COVID-19 pandemic has highlighted the need for rapid and reliable information on a variety of indicators to steer the pandemic response. Some of such indicators have been defined by ECDC in its *Monitoring and evaluation framework for COVID-19 response activities in the EU/EEA*[23], published in June 2020. Several of such indicators have been difficult to rapidly retrieve in the Member States, thus hindering the timeliness and effectiveness of the public health response.

Several diseases carry an epidemic and/or pandemic potential, albeit pandemics have been relatively rare events (there have been five pandemics in the past 100 years, (H1N1 Spanish flu) - 1918/19, (H2N2)1957, (H3N2) 1968, H1N1 -2009, and (COVID-19) 2019. For a pathogen to cause a pandemic it has to be: 1) pathogenic for humans, 2) easily transmissible from person-to-person, and 3) antigenically unique (i.e. pre-existing immunity in the population is low). To detect the emergence of such pathogens requires intense surveillance, not only among humans, but also among animals and in the environment. Once a pandemic starts, the timeliness of data becomes of paramount importance for containing and or mitigating its impact. Having a catalogue of data sources, available in digital format, and having piloted their combined use to derive key indicators in real time would be one of the challenges to prepare for the next pandemic. In the EU/EEA, but also elsewhere in the world, current surveillance systems lack the required sensitivity, timeliness and richness of information, to fulfil the pandemic requirements.

2. OBJECTIVES AND SCOPE

The objective of this request for service is to gather the experiences from implementing surveillance at national and European level during the response to the COVID-19 crisis and earlier public health emergencies and to define the parameters for the creation of integrated digital surveillance systems, collecting data real-time and using artificial intelligence, where appropriate.

The information gathered should be used to assess the performance of the surveillance systems for COVID-19 and other public health epidemics with the aim of identifying best practices at national level that could be applied for the design of a strategy to establish an integrated, digitalised routine surveillance and enhanced surveillance with the use of real-time epidemiological monitoring, primarily aimed at public health emergencies, such as epidemics and pandemics.

Based on national experiences shared during the above-mentioned meeting about lessons learnt from the COVID-19 response, we know that COVID-19 has prompted a digital revolution in many surveillance systems. The national priorities on surveillance are to foster integration, digitalisation and establishment of real-time surveillance through the following actions:

1. To define common surveillance standards, indicators and ensure interoperability between different systems to allow linkage with other data sources.
2. To assess what are the legal requirements for the secondary use of health-related data.

[23] Monitoring and evaluation framework for COVID-19 response activities in the EU/EEA: https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-framework-monitor-responses.pdf

This is a basic condition to allow linkage with other health-related data (primary health care, hospitals, emergency and ICU services), such as studies on risk factors for transmission in health care settings, and non-health sector data, occupational risk, life style data, etc.

3. To establish a mechanism for data linkage, which ensures compliance with the data protection regulation and facilitates transfer and data comparability within and between the EU MS and EEA countries.
4. To set up a mechanism for rapid data transfer within each country and at EU level, as timely reporting is essential in case of crisis.

   To address this challenge, some countries have established mechanisms to link surveillance systems with other health registers, such as those of primary health care, general practitioner health records, vaccine registers, hospital databases, laboratory registers, population registers, veterinary surveillance databases, etc.

   This linkage allows the performance of vaccine effectiveness or sero-epidemiological studies, which may be used to complement routine surveillance data.

Literature/scoping review:

The study to be contracted out will start with a **scoping review** on the scientific evidence including existing experiences, benefits, gaps and needs with regard to the use of integrated, digitalised and real-time surveillance systems in the EU MS and EEA countries.

The analysis should take into account different types of surveillance systems, the type of data available in digital formats that can be exchanged to build an integrated, real-time surveillance, using health systems indicators (e.g. number of cases, deaths, by age, gender, SES, geographical distribution, health care services, hospital beds availability, specialized treatment and intensive care capacity, number of health workers trained staff, laboratory facilities and reports, emergency services data, pharmaceuticals use, stock, rupture and forecast, etc.), health status, risk behaviour, co-morbidities, vaccination status, and duly anonymised electronic health records.

Besides the availability of data in digital form, there are few main issues that should be considered for the analysis that limit re-use of health data for secondary uses in the EU,

The existence of legal barriers for data sharing, due to divergent rules, processes, standards and infrastructures for health data re-use across EU Member states, following the OECD report[24], but as well within the countries. This includes as well the variation in the interpretation and implementation of GDPR across the MSs[25].

A key technical barrier is the limited interoperability between healthcare data sources which hampers electronic communication between data from different actors within the care system and exchange of information within an integrated system[26]. The assessment of the interoperability of the Electronic Health Record (EHR) systems in the EU[27],

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[24] Aarestrup, F.M., Albeyatti, A., Armitage, W.J., Auffray, C., Augello, L., Balling, R., Benhabiles, N., Bertolini, G., Bjaalie, J.G., Black, M. and Blomberg, N., 2020. Towards a European health research and innovation cloud (HRIC). Genome medicine, 12(1), pp.1-14.

[25] Study on the use of real-world data (RWD) for research, clinical care, regulatory decision-making, health technology assessment, and policy-making, summary available at https://www.ppmi.lt/en/news/study-on-the-use-of-real-world-data-rwd-for-research-clinical-care-regulatory-decision-making-health-technology-assessment-and-policy-making-460.html

[26] The New European Interoperability Framework, ISA.

[27] Thiel, R. et al., (2019) Final report- eHealth, Interoperability of Health Data and Artificial Intelligence for Health and Care in the EU, Lot 1 - Interoperability of Electronic Health Records in the EU SMART 2019/0056, *European Commission DG COM*. Available from: DG Sante.

indicates that despite having established health record systems, cross-sectoral interoperable EHRs are not present in most countries.

First consultation of the experts groups based on the literature/scoping review:

The draft literature review report will serve to identify key issues that require further in-depth knowledge and will inform the initial consultation of the two expert groups (the national competent bodies for surveillance of communicable diseases managed by ECDC and the members of the Health Security Committee (HSC), EWRS working group members), during the structured webinars and an online survey questionnaire.

The tenderer is expected to organise two webinars to present the main finding of the background document, draft recommendations and moderate the discussion to reach a consensus on the draft background paper, including on the recommendations for the establishment of integrated surveillance at national and EU level.

Background paper pooling the findings to inform the JA

The scientific literature/scoping review, the webinars and survey reports main findings will be used for the preparation of a **background paper** presenting current national experiences on the feasibility, cost and public health impact of integrating different digital data sources for surveillance purposes during the response to the COVID pandemic and other crisis situations.

The background paper should also list the difficulties encountered in data exchange and the solutions found to address surveillance system insufficiencies in gathering all the information required to ensure continuous, real-time monitoring of the situation at national and regional level.

This background paper will be used to identify the requirements or parameters for developing a future integrated, electronic data-based, real-time surveillance system in Europe that uses artificial intelligence, where appropriate.

Final consultation of the expert groups:

The final draft background document will be presented during the webinars for the subsequent consultation and approval by the two expert groups.

As a final deliverable, the final background paper describing best practices based on national experiences will help to define the **parameters and requirements for the establishment of routine integrated surveillance at national level**, and will inform the design and implementation of the integrated surveillance Joint Action. The background paper should have a specific section on **enhanced real time surveillance** for public health emergencies response.

3. DESCRIPTION OF WORK PACKAGE

The subsequent workpackage and task numbers correspond to those in the Framework contract Chafea/2018/Health/03.

3.1. Work Package 2: Tasks related to coordination and scientific support to the expert group

3.1.1. Task 2.2 -Preparation of a scientific background document

The tenderer shall produce a scoping review of the scientific evidence on integrated, digitalised and real-time surveillance, data linkage with relevant other health registers, for supporting health emergency response. This scoping review will then inform the background document for discussion with the expert groups in dedicated meetings organised as webinars.

As part of the literature review, the tenderer is asked to map best and good practices by screening the scientific and grey literature in all EU languages for any experiences with implementing integrated, digitalised and real-time surveillance systems at national or EU level, to support the response to COVID-19 or any other epidemics in the past 10 years.

As an example of good practice, Croatia recently adopted an Act on health data and information (NN 14/2019) defining a harmonised legal framework on health data management, as well as promoting a comprehensive and more efficient use of technologies fostering eHealth, similar legislation on the secondary data use was as well adopted last year by Finland.

Another good practice example is the mortality monitoring, the EURO-MOMO[28] data, combines the weekly mortality data from civil registry with the microbiological data base, for the disease specific indicator (COVID-19 or Influenza)[29]. The EUROMOMO model was created to monitor mortality data, such as influenza activity and extreme weather conditions, it was later adapted to address other health threats.

Another example for near real-time surveillance at EU/EEA level is the surveillance of travel-associated Legionnaires' disease. Cases are reported to ECDC and the network as soon as they occur, triggering immediate notification and public health follow-up of clusters linked to any specific accommodation site.

Relevant examples that should be searched includes the use of electronic health records linked with immunisation information systems and pathogens sequence databases, which would enable the overall assessment and monitoring of disease trends, risk factors, vaccine effectiveness, genetic correlates of severity and of effectiveness of pharmaceutical and non-pharmaceutical measures, while also generating sound parameters to be included in forecasting models.

Other possible example of good practice to be sought will be data linkage with veterinary surveillance system in relation to detection of zoonotic diseases with public health interest.

For the good practice mapping, the tenderer is expected to consult and adapt the best practice criteria[30] proposed by Steering group for health promotion and disease prevention (SGPP) and, possibly, other international health security best practice definitions, if available.

Based on an agreed good practice definition, the tenderer will identify and assess the transferability potential of the best practices to other diseases and health events under surveillance and the conditions required to replicate these practices in other countries

Prioritisation of the diseases and events for integrated surveillance analysis

There are 57 diseases and 2 health issues under EU surveillance, and in order to control the scope of this project, it is important to prioritise those diseases and health issues whose prevention and control would benefit the most from integrated digital and real-time surveillance.

Initially, for the scoping review, it is proposed to consider all diseases and health issues under routine epidemiological and laboratory surveillance.

Subsequently, however, the tenderer is invited to focus on a group of diseases under surveillance that could be prioritised for integrated, digital surveillance, based on their severe public health impact and the availability of effective prevention and control measures. In this context,

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[28] EuroMOMO (European monitoring of excess mortality for public health action) project, initially funded by the EU Health Programme in 2007, https://www.euromomo.eu/how-it-works/flumomo/

[29] Nielsen Jens, Rod Naja Hulvej, [redacted] S, Lange Theis. Estimates of mortality attributable to COVID-19: a statistical model for monitoring COVID-19 and seasonal influenza, Denmark, spring 2020. Euro Surveill. 2021;26(8):pii=2001646. https://doi.org/10.2807/1560-7917.ES.2021.26.8.2001646

[30] Criteria to select best practices in health promotion and disease prevention and management in Europe available at:https://ec.europa.eu/health/sites/default/files/major_chronic_diseases/docs/sgpp_bestpracticescriteria_en.pdf

identification of minimum required data and prioritisation of zoonotic diseases of interest will be covered. Real-time surveillance should be limited to highly epidemic/pandemic-prone diseases.

Tasks of the tenderer include:

A comprehensive scientific literature review of lessons learnt in EU/EEA countries and at the EU level from responding to COVID-19 and other past epidemics regarding integrated digitalised and real-time surveillance, data linkage with other health registers and relevant other sectors, in support of health emergency response. The literature review will cover as well the identified good practices of linking surveillance systems with other health databases and registers in the EU, EEA and other countries with relevant experience, such as US, Canada, Australia, etc. All the relevant findings should be merged in **a summary report of the lessons learnt from COVID-19 response with a focus on surveillance systems integration and data linkage**, main surveillance types and diseases covered, opportunities and concerns for future surveillance system integration per area, and the transferability and replicability by diseases surveillance system and group of countries; and

- A set of topics recommended for discussion both among public health authorities and between these and other sectors (with a view to increase the effectiveness of integrated digitalised surveillance, including the linkage with other health registers and relevant other sectors, in support of routine surveillance. In addition, a particular focus should be given to the use real-time surveillance in support to health emergency response. These topics will inform the production of the **questionnaire for the subsequent survey among surveillance experts** and will be the basis for the organisation of the moderated webinars.

The duration of task 2.2 will be 4 months depending on the urgency and the complexity of the health topic.

- Deliverable 1 (D1 – 01)– Literature review protocol including the proposed method, literature search methods, analysis and structure of the review report
- Deliverable 1 (D1 – 02) – Literature review, a summary report and set of topics recommended for in-depth analysis and discussion with the experts groups.

3.1.2. Task 2.7 - Organise and moderate scientific webinars

Under this task the tenderer is requested **to organise and animate two webinars based on the draft literature review report**. The first webinar will be organised for the national competent bodies for surveillance, microbiology, and including experts from digital public health field, expert groups managed by ECDC and the second webinar will be organised for the Health Security and the EWRS working group, managed by the EC - Health Security unit (SANTE C3).

As part of the preparation of the webinars, the tenderer is expected to identify what are the key topics for in-depth analysis by the expert groups. The list of topics (not exhaustive) could address the following questions: what are parameters and conditions for the setting up of the integrated, digitalised surveillance for all diseases under surveillance and what are the requirements, conditions and threats, difficulties for setting up of the integrated, digitalised surveillance at national level. The in-depth analysis and moderated consultation should cover all diseases under routine surveillance, and in particular focus on the surveillance of diseases with epidemic potential.

This includes:

- Preparing the agenda of the webinars

- Propose relevant experts in the field to participate in the two webinars, who could present the best practices, which were identified when preparing the literature review.

This will be facilitated by the EC, who will point to speakers from EC, ECDC and the expert committees' experts.

- Organising the contributions from experts (e.g. collecting their PPTs)

- Moderating it (2 hours) and

- Organising follow-up survey for the evaluation of the webinar, e.g. via EU survey.

- Timeline: 3 months to execute this task

- Deliverable 2 (D2– 01)– Draft webinar plan, including the promotion plan, draft agenda, proposed speakers, plan for the moderation (questions to be addressed) and evaluation plan
- Deliverable 2 (D2– 02) - Webinar – expert groups consultation (competent authorities on surveillance, EPIS and microbiology)
- Deliverable 2 (D2– 03) - Webinar – expert groups consultation on HSC on EWRS
- Deliverable 2 (D2– 04) –final webinar report, including orientations on the way forward on setting up the EU routine integrated surveillance and in particular, real-time enhanced surveillance, for supporting health emergencies response

3.1.3. Task 2.5 - Survey among the expert group members

Based on the literature review (D1 – 02), the tenderer is expected to propose a draft set of questions to the contracting authority. The survey will be carried out in parallel with the webinars organisation to yield the largest involvement of the two expert groups.

The tenderer is requested to prepare a survey questionnaire based on the questions retained by the contracting authority. The final questions (up to 10) will be approved by the EC (DG SANTE) with the aim to provide an insight or overview of different opinions within the expert group. The questionnaire will be using closed and open questions, and be launched as an online survey, using the EU survey tool[31], among the members of the two expert groups mentioned under "Objectives and Scope".

The tenderer will inform the expert group members about the survey (give them at least 15 working days to respond), send up to 3 reminders (plus one phone call per expert) and analyse the results. The maximum response period should not exceed 4 weeks.

Timeline, execution of the task: 3 months for the survey and its analysis.

- Deliverable 3 (D3– 01)– Draft questionnaire for the online survey
- Deliverable 3 (D3 – 02) – Draft survey report on routine integrated surveillance and real-time enhanced surveillance, in support of health emergency response
- Deliverable 3 (D3 – 03) – Survey report on routine integrated surveillance and real-time enhanced surveillance, in support of health emergency response

3.1.4. Task 2.1 - Preparation of a discussion paper through an expert group process

a) Coordinating the experts' contributions to a discussion paper: The consultation of the Health Security Committee members, working group for EWRS[32] and the national surveillance competent authorities[33] managed by the ECDC will be invited to review the background discussion paper.

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[31] EUSurvey - Welcome (europa.eu)
[32] Health Security Committee (HSC) | Public Health (europa.eu)
[33] ECDC competent authorities: https://www.ecdc.europa.eu/en/about-us/governance/competent-bodies

b) Sound (re)drafting of the discussion paper taking all contributions from the experts into account. The final draft discussion paper on routine integrated digitalised surveillance and real-time enhanced surveillance for health emergency response should include an options map for setting up EU integrated routine surveillance, including the real – time enhanced surveillance, in support of health emergency response.

c) Creation of a specific Health Policy Portal group, animating and moderating the time-bound expert group electronically through the HPP Portal, in preparation of the requested discussion paper.

Timeline: The duration of task 2.1 will be 6 months for a simple paper (up to 3 draft versions)

- Deliverable 4 (D4– 01)– Draft discussion paper on routine integrated surveillance and real-time surveillance, in support of health emergency response
- Deliverable 4 (D4 – 02) - Final draft paper on routine integrated surveillance and real-time surveillance, in support of health emergency response
- Deliverable 4 (D4 – 03) – Final paper on routine integrated surveillance, including a map with the options for setting up EU integrated surveillance and real-time enhanced surveillance for health emergency response

4. REPORTING

The contractor shall report every *month* to the Commission on the evolution of project's activities and compliance to the agreed quality requirements.

5. MEETINGS

Meetings shall be chaired by the Commission and prepared by the contractor. Different type of meeting can be held as presented below:

- a kick-off meeting;
- monthly progress report meetings or end-of-phase meetings, for presentation of the deliverables by the contractor (duration of 1 or 2 hours);
- technical meeting to be organised on ad-hoc basis whenever needed (duration of 1 hour);
- a final report/closing meeting (maximum duration half day
- *Other as needed*

The meetings will usually take place mostly as virtual meeting or on the Commission's premises in Luxembourg. The use of videoconference facilities will be considered. A meeting with use of videoconference shall be charged the same way as an on-site presentation at the Commission's premises, without any travelling costs being charged by the contractor. The contractor will organise these meetings and ensure operational contacts with the attendants.

The contractor shall communicate the documentation for the meetings at *least e.g. a week* before the meeting date (agenda, progress reports, presentation to the Member States, etc.).

The preparation of the minutes of each meeting shall be the responsibility of the contractor. Minutes shall be made available to the Commission for approval within *5 working days* following the meeting.

6. CLOSING

This phase is launched when 100% of project deliverables have been submitted by the tenderer to the Commission for final approval.

7. MONITOR AND CONTROL

It transcends all project phases and ensures that project activities are implemented according to project plans and quality standards, deviations from project targets are identified and preventive/corrective measures are taken to tackle potential issues.

8. DELIVERABLES

The deliverables, including reporting requirements and delivery deadlines will be described in the relevant order for services/task description under the specific contract.

The contract duration is 6 months.

Summary of the deliverables table

Task	WP 2- Objective/s of section	Deliverable		Delivery month from signature of the tenderer
		Code	Title	
0	Project management	D0 -01	Inception report having as annexes:	
			Quality Management Plan	1
			Project Handbook	1
			Project Work plan	1
		D0 -02	Project Progress Reports	1+ monthly updates
		D0 -03	Interim report	3
		D0 -04	Final Report	7
2.2	Preparation of a scientific background document	D1 - 01	Literature review protocol including the proposed search methods, analysis and structure of the review report	1
		D1 - 02	Literature review, including the summary and set of topics recommended for in depth analysis and discussion with the experts groups	4
2.7	Organize and Moderate scientific webinars	D2– 01	Draft webinar plan	3
		D2– 02	Webinar – expert groups consultation (competent authorities on surveillance, EPIS and microbiology)	4
		D2– 03	Webinar – expert groups consultation on HSC on EWRS	4
		D2– 04	Final webinar report	6
2.5	Survey among the expert group members	D3– 01	Draft questionnaire for the online survey	3
		D3 – 02	Draft survey report on routine integrated surveillance and real-time surveillance, in support of health emergency response	5

		D3 – 03	Survey report on routine integrated digitalised and real-time surveillance, in support of health emergency response	6
2.1	Preparation of a discussion paper	D4– 01	Draft discussion paper on routine integrated surveillance for health and real-time surveillance, in support of health emergency response	4
		D4 – 02	Final draft paper on integrated surveillance	5
		D4 – 03	Final paper on routine integrated surveillance, including an options map for setting up EU integrated surveillance and real-time enhanced surveillance for health emergency response	6

The following deliverables are required:

- **Deliverable a**: **Inception report**

The Inception Report shall include a detailed and fully updated work plan, the methodology and the minutes from the kick-off meeting. The report has to be delivered following the kick-off meeting after a maximum of 2 weeks.

- **Deliverable b**: **Interim progress report**

The Interim Reports will describe the work carried out and the results obtained during the period (M3), the duration of which is specified in the specific contract and state in particular:

- the effects, if any, of the results obtained on the overall work covered by the contract;
- the work programme planned for the following period.

- **Deliverable c: Final implementation report**

This report shall briefly describe the work carried out (when and by whom the activities were carried out), methods applied, problems encountered, solutions found and limitations.

The Final Implementation report shall consist of:

1. A report (electronic version) in English, consisting of the following sections:

- Executive summary
  - an abstract (not exceed 200 words) in English and French.
  - a summary (maximum 6 pages) in English and French.
- Introduction (describing the topic of the report, stating the objective of the study);
- Background and context
- Methodology (motivating its adoption);
- Activities carried out (providing sufficient level of details on timing and actors involved

- Problems encountered and solutions found
- Recommendations

2. Comprehensive list of data generated, at the maximum available level of detail. If the contract acquires data/equipment from third party data providers or other sources, the contract must be in the position to submit the raw data to the Commission. All pre-existing rights shall be fully and irrevocably acquired by the Union.

3. The electronic version of the above mentioned report, data set and relevant material.

4. If requested in the Specific contract, to add as annex the different Activity reports.

The document shall be produced in a master version for further publication. Specific identifiers must be incorporated on the cover page provided by the Contracting Authority; the final report shall be produced in a master version for further publication. The contractor might be requested to encrypt possibly sensitive data before the publication.

The following disclaimer (both in English and French as mentioned below):

"This report was produced under the EU for Health Programme 2021-2027 under a service contract with the Health and Digital Executive Agency (HaDEA) acting under the mandate from the European Commission. The information and views set out in this [report/study/article/publication…] are those of the author(s) and do not necessarily reflect the official opinion of the Commission/ Executive Agency. The Commission/Executive Agency do not guarantee the accuracy of the data included in this study. Neither the Commission /Executive Agency nor any person acting on the Commission's / Executive Agency's behalf may be held responsible for the use which may be made of the information contained therein."

«Les informations et points de vue exposés dans le présent (ou la présente) [rapport/étude/article/publication, etc.] n'engagent que leur auteur (ou leurs auteurs) et ne sauraient être assimilés à une position officielle de la Commission/Agence Exécutive. La Commission/ Agence Exécutive ne garantisse pas l'exactitude des données figurant dans la présente étude. Ni la Commission/ Agence Exécutive ni aucune personne agissant au nom de la Commission/ Agence Exécutive n'est responsable de l'usage qui pourrait être fait des informations contenues dans le présent texte.»

- **Deliverable d: "Activity report"** shall be required related to the concrete tasks to be carried out within Work Package 2. Activity report will be on:

  i. Final version of the discussion paper

  ii. Final Scientific background document

  iii. Report on the peer review carried out (selection of the experts, methodology applied, comments received…) and revised final document

  iv. Report on the survey among the expert groups, including the survey questionnaire, raw results data, and the data analysis

v. Report on the webinar, summarizing the presentations, main discussion points and agreed outcomes of the webinar including the results of all follow-up actions.

- All copyrights shall belong to the European Union (see Article I.10.1 and II.13 of the Framework Contract).

- For further details on the content, structure and graphic requirements of the deliverables, please see section 3.

- Each deliverable must be written in English and presented in a clear and easily understandable language. The reports shall be well structured, based on best available evidence/laboratory measurements, online experiments and robust data and indicators, to be collected through a thorough analysis of available scientific literature, past/current EU funded projects and other sources. All the literature used in the report must be presented with a grading system accepted by the scientific community (for example, please see methodology from Cochrane). Quantitative data must be presented using graphs and maps, with tables in annexes. Furthermore, the document shall be produced in a master version for further publication.

Apart from that each Activity report shall include

- an abstract of no more than 200 words and a publishable executive summary of maximum 6 pages, both in English and French;

- specific identifiers which must be incorporated on the cover page provided by the Contracting Authority;

- the following disclaimer (both in English and French as mentioned below):

"This report was produced under the EU for Health Programme 2021-2027 under a service contract with the Health and Digital Executive Agency (HaDEA) acting under the mandate from the European Commission. The information and views set out in this [report/publication…] are those of the author(s) and do not necessarily reflect the official opinion of the Commission/ Executive Agency. The Commission/Executive Agency do not guarantee the accuracy of the data included in this study. Neither the Commission /Executive Agency nor any person acting on the Commission's / Executive Agency's behalf may be held responsible for the use which may be made of the information contained therein."

«Les informations et points de vue exposés dans le présent (ou la présente) [rapport/publication, etc.] n'engagent que leur auteur (ou leurs auteurs) et ne sauraient être assimilés à une position officielle de la Commission/Agence Exécutive. La Commission/ Agence Exécutive ne garantisse pas l'exactitude des données figurant dans la présente étude. Ni la Commission/ Agence Exécutive ni aucune personne agissant au nom de la Commission/ Agence Exécutive n'est responsable de l'usage qui pourrait être fait des informations contenues dans le présent texte.»

9. 11. REQUIREMENTS FOR PUBLICATION ON INTERNET

The Commission/ Executive Agency is committed to making online information as accessible as possible to the largest possible number of users including those with visual, auditory, cognitive or physical disabilities, and those not having the latest technologies. The Commission supports the Web Content Accessibility Guidelines 2.0 of the W3C.

For full details on the Commission policy on accessibility for information providers, see: http://ec.europa.eu/ipg/standards/accessibility/index_en.htm

For the publishable versions of the study, abstract and executive summary, the contractor must respect the W3C guidelines for accessible pdf documents as provided at: http://www.w3.org/WAI/ .

9.1. 11.1 Structure

All reports should have numbered paragraphs and pages and a clear identification, containing:

- the contract number (not the call number),
- the acronym,
- the version (draft, revision or final) and
- the date.

The reports and the deliverables shall be in English, unless otherwise indicated in the specific contract.

9.2. 11.2 Graphic requirements

The contractor must deliver the study and all publishable deliverables in full compliance with the corporate visual identity of the European Commission, by applying the graphic rules set out in the European Commission's Visual Identity Manual, including its logo. The graphic rules, the Manual and further information are available at:

http://ec.europa.eu/dgs/communication/services/visual_identity/index_en.htm

Depending on the particular service requested, reports and similar document will need to be provided either in a standard WORD template or in professional graphic design. Each request for services will specify which document has to be provided in which format.

Standard WORD template

A simple Word template will be provided to the contractor after contract signature. The contractor must fill in the cover page in accordance with the instructions provided in the template. The use of templates for studies is exclusive to European Commission's/HaDEA' s contractors. No template will be provided to tenderers while preparing their tenders.

Professional graphic design

The contractor must apply the rules set out in Visual Identity Manual for the graphic design of both the cover page and the internal pages of the study. The professional font (EC Square Sans Pro) to be used for the study will be made available to the contractor free of charge upon acceptance of the terms and conditions of its use after contract signature. The use of templates for studies is exclusive to European Commission's/HaDEA' s contractors. No template will be provided to tenderers while preparing their tenders.

9.3. 11.3 Data protection

Submission of a tender implies acceptance of all the data protection terms specified in the present specifications, the call documents and in particular in the attached model FWC (Annex VI) including its special conditions.

All the offers received by the HaDEA will be treated confidentially. Processing of personal data is subject to the provisions of Section II.9 of the model FWC. More information about data protection at HaDEA in procurement procedures can be found on the following website: https://hadea.ec.europa.eu/dpn-public-procurement_en

Within the duration of the FWC, the contractor shall ensure handling and storage of all pertinent data of the contract implementation and deliver them to HaDEA in the form and the frequency requested. The data will be stored by the contractors and may be consulted by HaDEA and the Commission.

Annex V Financial offer

Chafea/2018/health/03

Concerning a Single Framework Contractfor the provision of support services for managing expert grups

SC 2021 P1 01

Name of Tenderer: NIVEL

A. UNIT PRICE PER TASK			Financial Offer in € (1) *Excluding VAT Unit prices*	PRICE	QUANTITY	TOTAL
WP1 Organising an expert group or stakeholders meeting in Luxembourg or Brussels or online						
Task 1.1	**Administrative tasks**					
	Sub task 1.1.1	**Administrative Preparation of a physical meeting:**				
		meeting with 30 to 60 participants	*Unit price per meeting*	13200		
		meeting with 15 to 30 participatns	*Unit price per meeting*	8800		
		meeting with 10 to 15 participants	*Unit price per meeting*	7700		
	Sub task 1.1.2	**Administrative Preparation of an online meeting:**				
		meeting with 30 to 120 participants	*Unit price per meeting*	6600		
		meeting with 15 to 30 participatns	*Unit price per meeting*	4400		
		meeting with 10 to 15 participants	*Unit price per meeting*	3650		
	Sub task 1.1.3	**Administrative tasks after the meeting**	*Unit price per meeting*	2750		
Task 1.2	**Logistics:**					
	Sub task 1.2.1	Catering: coffee: (including coffee, tea, fruits, small biscuits (2 per person), water	*Unit price per participant and per day of meeting*	20		
	Sub task 1.2.2	Catering: healthy lunch	*Unit price per participant and per day of meeting*	53		
	Sub task 1.2.3	Provision of the meeting room				
		meeting room for 30-60 participants	*Unit price per day of meeting*	5500		
		meeting room for 15- 30 participants	*Unit price per day of meeting*	3300		
		meeting room for10-15 participants	*Unit price per day of meeting*	2200		
	Sub task 1.2.4	Organizing and paying a social dinner for the invitees	*Unit price per participant*	79		
	Sub task 1.2.5	Organizing and paying Travel ticket per invitee				
		participant coming from an EU MS	*Unit price per invitee*	594		
		participant coming from an EEA/neigbourhood country	*Unit price per invitee*	704		
	Sub task 1.2.6	Organizing and paying hotel per invitee	*Unit price per invitee for 1 night*	238		
	Sub task 1.2.7	Transportation from the airport to the hotel/venue per invitee and viceversa	*Unit price per invitee*	264		
Task 1.3	**Communication and dissemination services**					
	Subtask 1.3.1	Public announcement of an expert meeting	*Unit price*	792		
	Subtask 1.3.2	Flash report	*Unit price*	792		
	Subtask 1.3.3	Meeting minutes	*Unit price*	3168		
	Subtask 1.3.4	Press information package	*Unit price*	3168		
WP2 Coordination and scientific support to the Expert group						
Task 2.1	Preparation of a discussion paper througth an expert group process					
	Sub task 2.1.1	6 months process including 3 draft versions	*Unit price*	56100	1	56100
	Sub task 2.1.2	12 months process including 5 draft versions	*Unit price*	79200		
	Sub task 2.1.3	18 months process including 7 draft versions	Unit price	93500		
Task 2.2	Providing scientific background analysis					
	Sub task 3.2.1	1 month	*Unit price*	27500	1	27500
	Sub task 3.2.2	3 months	*Unit price*	60500	1	60500
	Sub task 5.2.3	6 months	*Unit price*	95700		
Task 2.3	Organisation of a peer review and preparation of the final document		*Unit price*	11000		
Task 2.4	Stakeholder analysis					
	Sub task 2.4.1	1 month	*Unit price*	19800		
	Sub task 2.4.2	3 months	*Unit price*	38500		
	Sub task 2.4.3	6 months	*Unit price*	63800		
Task 2.5	Survey + analysis of the outcomes among the expert group members		Unit price	18900	1	18900
Task 2.6	Public online survey		*Unit price*	37500		
Task 2.7	Organise and moderate a webinar on a specific health topic. Including the report		*Unit price*	13500	2	27000
Task 2.8	Identify the experts		*Unit price per expert*	1980	2	3960
WP 3 General support services to the expert group						
Task 3.1	Translation of documents from any EU language into another EU language		*Unit price per page*	77		
Task 3.2	Graphical preparation of documents		*Unit price per page*	121		
Task 3.3	Photos for graphical document preparation		*Unit price per photo*	264		
Task 3.4	Managing and animating in a continuous way online expert/stakeholders groups on the Health Policy Portal		*Unit price per year*	13200		

B. UNIT PRICE FOR TRAVEL COSTS AND THE SUBSISTENCE ALLOWANCES (LINKED TO A MEETING IN LUXEMBOURG/BRUSSELS WITH CHAFEA/COMMISSION)	Financial Offer in € (1) *Excluding VAT Unit prices*	QUANTITY		TOTAL
Meeting in Luxembourg for 1 person for 1 day	*Unit price per person*	800	4	3200
Meeting in Brussels for 1 person for 1 day	*Unit price per person*	400		

TOTAL COSTS (A+B)		197160