



Joint Meeting for National Focal Points for Preparedness and Response & National Focal Points for Threat Detection, EWRS and IHR

Agenda

28 April 2022, Thursday, 13.00-14.30 CET

13:00-13:05	Welcome by ECDC chair
13:05-13:25	Session 1: Update from a DG ECHO multidisciplinary team deployed in Poland in support of displaced people from Ukraine - 5.1.2e and 5.1.2e 5.1.2e, ECDC
13:25-13:45	Session 2: Document on country experiences presented on HSC – 5.1.2e, ECDC
13:45-14:05	Session 3: Acute Hepatitis in children of unknown aetiology – 5.1.2e, ECDC
14:05-14:30	Discussion

Session 1: Update from a DG ECHO multidisciplinary team deployed in Poland in support of displaced people from Ukraine

5.1.2e and 5.1.2e, ECDC

A month ago ECDC sent two staff members to join the DG ECHO team. ECDC missions are part of DG ECHO mission (European Union Civil Protection Team – EUCPT) whose primary aim is to coordinate the delivery of goods as part of humanitarian aid. Over time the mission of the DG ECHO started shifting gradually from coordinating transportation to Ukraine to also supporting Poland in receiving displaced persons. ECDC has its own mandate in vaccines and protection, but in this specific case ECDC performed two types of tasks. On the one hand, these were tasks as being a part of the DG ECHO mission (activities like maintaining contacts with the Ministry of Health (MoH) and assistance with medical evacuation), but on the other hand, these also included ECDC-specific tasks focused on early warning, surveillance and immunisation.

We were based in the FRONTEX building in Warsaw. As part of the mission, we visited Reception Centres in Warsaw and the outskirts and also travelled from Warsaw to the border with Ukraine. This was a very moving experience – seeing people arriving to Poland and how welcoming the Polish population was. Also, everything was very well organized. We had the purpose to map the whole route of displaced persons from Ukraine through Poland. This allowed us also to see what capacity existed for epidemiologic and laboratory surveillance especially at the local level and to understand how responsive the surveillance system would be in case of an outbreak, the more so that at least in Poland, most of the displaced people are in the community (many Ukrainians were already living in Poland before the war, so people were hosted by relatives or placed in small accommodations). There are Reception Centres, but usually people do not stay a long time there and these are mostly women with young children resting before the long journey ahead.

We worked very closely with the (NIPH), but also with WHO, to try to document and also strengthen the surveillance of prevention of infectious diseases in a heterogeneity of settings. Next to this, it is not only infectious diseases - many of the people are also having chronic conditions and access to healthcare has to be ensured, as well as continuity of treatment. Increasing vaccination acceptance and uptake among the displaced persons has also been identified as a possible need for future work. Other issues discussed with the Polish authorities included continuity of care.

Observing the flow of displaced persons we noted that they would enter either by private means (cars, or on foot after being dropped at the border, or by train). Some would go directly to the community, others – to the train stations (there are 2 big stations in Poland), and embark for free on buses and trains to other destinations in Poland or the EU. If they would wish to stay – they could do that in the Reception centres for a while receiving advice and care, or if for a longer time – they would be offered a place in the Reception centres, and then distributed across the country. A substantive proportion of people would decide to go to other countries.

Three possible levels of enhanced surveillance for countries receiving displaced persons were defined:

Level 1: Screening and health assessment at Reception points at border crossing points, where local authorities and NGOs provide medicines for the coming days, and where an individual health assessment document would be issued to raise awareness for some specific conditions;

Level 2: Possible syndromic surveillance in larger Reception centres e.g. surveillance for specific restricted syndromes that may trigger action or intervention;

Level 3: Enhanced surveillance in the community (the people who had decided to stay in the community have access to healthcare and if there is a health condition it is reported to the national health authorities). There was also a discussion about additional surveillance like environmental poliovirus surveillance.

In a nutshell, this humanitarian emergency has unique features. We have seen an extremely large number of displaced persons over a short timeframe. The peak was in March, now some are already considering to move back. The second big challenge is that most of the displaced persons are in the community. On the one hand this is good, but it also entails challenges.

Speaking about the next steps, ECDC missions as part of EUCPT will continue. We also have an ECDC expert who joined the Refugee Health Extension office in Kraków. Work continues on topics identified during this first mission. ECDC supporting materials are already published on various topics and at some point there will be a more comprehensive summary of the activities.

LINKS:

ECDC Supporting materials

<https://www.ecdc.europa.eu/en/support-countries-neighbouring-ukraine>

Publications (to be downloaded from the link above):

Leaflet: Are you and your family protected from vaccine-preventable diseases?

Testing for tuberculosis infection and screening for tuberculosis disease among refugees arriving in European countries from Ukraine

Information to guide individual health assessment of refugees fleeing the war in Ukraine - Considerations for healthcare workers

Session 2: Document on country experiences presented on HSC - Transitioning beyond the acute phase of the COVID-19 pandemic. Approaches and tools used by a sample of EU countries in the transition and de-escalation phase – Interim report

5.1.2e

, ECDC

The EU/EEA countries are transitioning beyond the acute phase of the pandemic towards a more sustainable and integrated approach to COVID-19 response. In order to understand and explore what is happening on country level, ECDC carried out a series of dialogues with selected EU countries to discuss their approaches to transitioning, including their plans regarding specific key areas. The synthesis and sharing of the experiences and approaches by the selected EU countries are linked with tools developed by ECDC during the pandemic that can be used in support of this. A document was published a few days ago on the web site, summarising experience.

Regarding the methodology - 10 countries were selected by EC (HSC Secretariat) taking into consideration demography and other criteria to ensure representation throughout Europe. 8 positive replies were received, and 2 countries did not reply. The participating countries include: Croatia, Denmark, France, Italy, Malta, Portugal, Spain, and the Netherlands. 7 interviews were performed (Croatia, France, Italy, Malta, Portugal, Spain, The Netherlands), and 1 interview was performed in writing (Denmark).

Each country was interviewed for 45 to 60 minutes, on the basis of a questionnaire. The participants in the interviews included representatives from ECDC: Senior European Parliamentary Research Service (EPRS), Cal DP, Public Health England (PHE) Management plus a facilitator and a note taker. Representatives from the countries included: representative, Ministry of Health (MoH), Public Health institutes (1 to 6 for each country).

A list of **four questions** was used to drive the discussion:

Q 1: *What is the current objective of your national COVID-19 response?*

This was an introductory question to understand how the scene was set for a national response. It was aimed at understanding the aetiological agent characteristics; the approach to protecting vulnerable populations and protecting the healthcare system from collapsing; the ways to reaching optimal vaccination coverage. There was an emphasis on communication and how non-pharmaceutical interventions were implemented. In the transition period all countries reported they were moving to a more agile and flexible approach, still keeping some areas as a priority. They were all moving to a more sustained approach.

Q 2: Question 2 had two components:

2.1. *What are your country's current plans for the coming six to nine months with regard to COVID-19 response?*

With respect to the first part of the question there were a lot of commonalities: All countries reported they were de-escalating the measures, and that their re-introduction would depend on the situation. About surveillance all underlined the importance of improvement of the whole system of surveillance, the establishment of a sentinel surveillance system (except one country) and waste water surveillance (except two countries.). All countries had in their plans to protect the vulnerable populations and maintain the structures and procedures created during the previous waves of the pandemic. The actors involved in decision making were from policy and public health sector, stakeholders from the general population (three countries) and all the countries reported they expected a re-emergence of the virus in autumn/winter and the virus becoming endemic.

There were differences as well. One country reported it had no specific plan for the coming months, but was concerned about having a higher seasonal activity for other respiratory viruses for example influenza, due to the fact that people and especially children have been very protected during the pandemic, and they weren't in contact with any kind of virus. Another country stressed they have a very detailed plan, focusing on surveillance of people 65 years and above, who would be tested and requested to isolate. Protection of vulnerable population and vulnerable environments is also envisaged, wastewater surveillance, etc. The reports from other countries indicated that some had no specific plan and have been unable to establish a hospital-based surveillance; that the main objective would be to maintain open society and pursue a bottom-up approach, protect the health care system, do cancer screening or deal with long COVID.

2.2. *What discussions are ongoing with regard to de-escalation and which actors are part of these?*

It surfaced that a large number of actors were involved in the discussion about de-escalation (political and public health decision-makers, stakeholders from the general population). Some countries stressed the importance of following a bottom-up top approach, listening to the citizens and maintaining an open society, with the goal of guiding individual citizens' responsibility and fighting pandemic fatigue. Plans for transition include triggers for de-escalation and re-escalation, vaccination programmes, recovery and reinforcement of healthcare systems and revival of programmes that have been neglected in the Covid-19 emergency.

3.1. Does your country's plan include any of the following components: testing strategy, control measures, communication strategy and research readiness?

As regards the testing strategy, some countries reported they did not intend to change them, while others were currently revising them. The countries revising their testing guidance put a focus on certain target groups, including vulnerable groups and those in contact with vulnerable settings, and are less focused on testing asymptomatic/mild cases and their contacts. As a result, there are now lower overall testing volumes, but also high numbers of self-tests and rapid antigen detection tests. This raises difficulties in interpreting positivity rates.

With respect to control measures, all countries will continue to remove NPIs (if the trend is not changed), while keeping common measures: improved ventilation; hand and respiratory hygiene; recommendations to stay at home when sick. Mask use and physical distancing recommendations were found to differ significantly across countries and settings. Measures are typically kept in place in public indoor spaces and institutions, as well as public transport.

The communication strategy was found to be important, so as to enable continued preparedness. Key aspects noted were: active engagement with the population and relevant stakeholders for compliance with NPIs and for de-escalation / re-escalation of measures; constant transparency on the implementation of NPIs; transitioning from daily to weekly updates in technical reports or press conferences, to reduce the volume of information communicated to the general public.

Research readiness was identified as a priority but challenges surrounding funding and coordination remain. The research gaps extend to vaccine effectiveness, duration of immunity, burden of post-acute COVID-19.

Q 3.2. In relation to these components, do you have any already established triggers for de-escalation? For re-escalation?

Three countries reported having established triggers/tiers for de-escalation, re-escalation or for the removal of all measures; two countries have proposed triggers or plans for triggers, but political decisions are pending or are currently being negotiated; three countries have no formally established triggers, but mention that measures are guided by hospitalisations, intensive-care unit (ICU) admissions or/and incidence and test positivity rates. The five-tier system for de-escalation / re-escalation of the Danish government was presented.

Q 4. Have you performed any in-action review (IAR) or are you planning any after-action review (AAR), especially with regard to travel measures and non-pharmaceutical interventions, or a national review?

While the consulted countries reported a number of efforts to review their national pandemic response to date and identify and implement lessons learned, many of them had not yet conducted formal evaluations. All highlighted the importance to focus on learning and implementing lessons from the COVID-19 pandemic, for example through the use of AARs, already in this early post-acute phase. Gaps remain in the evaluation of NPIs, which would include the need to assess their effectiveness, impact, cost effectiveness and social acceptability.

LINK:

Transitioning beyond the acute phase of the COVID-19 pandemic. Approaches and tools used by a sample of EU countries in the transition and de-escalation phase – interim report

<https://www.ecdc.europa.eu/en/publications-data/transitioning-beyond-acute-phase-covid-19-pandemic-interim-report>

Session 3: Acute Hepatitis in children of unknown aetiology

5.1.2e, ECDC

Back in April ECDC was notified through IHR about cases in Scotland of severe acute hepatitis. In all these, children were previously healthy and viral hepatitis types A, B, C and E was excluded. The cases were identified since the middle of January and the children were under 10 years old. Further notification came from the UK. On 12 April there were 61 cases reported in England, Wales and Northern Ireland, where most of the children were under five years old. Many cases were jaundiced with preceding gastrointestinal symptoms, and the majority of children were hospitalised. A few of the cases progressed to acute liver failure, and some required transplantation.

Quite quickly an alert was made through the media, internet and ECDC as the situation progressed and new cases were reported. As of 26 April 2022 a total of 55 cases were reported to ECDC from twelve EU/EEA countries (Austria, Belgium, Denmark, France, Germany, Ireland, Italy, Netherlands, Norway, Poland, Spain, Romania) but there came also reports from the USA (12 cases), Israel (12 cases) and Gaza (1 case). To date the cases reported from the UK are already 111. The age of cases is from 11 months to 16 years. In terms of statistics of the EU/EEA cases, ten tested positive for adenovirus and three for SARS-CoV-2 and five of the EU/EEA cases required a liver transplant.

Following an ECDC inquiry to the countries if this was normal, three countries (Denmark, Netherlands and Ireland) reported cases exceeded what was expected. It was only in the Netherlands that Adenovirus activity was found.

The presenter focused on the findings from the UK as they had the heaviest burden of cases, and started investigations ahead of everybody else. A report was published by the UK HSA on internet a few days ago, where one can check the findings and hypotheses. In a summary the epidemiological findings are that these were previously healthy children. The most common cases included jaundice, vomiting, diarrhoea and nausea. 30% had fever, and 20% had respiratory symptoms. All had very high transaminase levels, 65% were 3-5 years of age, (median 3 yrs), 80-90 % were white British, 54% female. The trawling questionnaires did not identify any common factors among the cases – exposure to food, travel, etc.

In terms of microbiology, the UK reported that all cases tested negative for hepatitis A-E; 75% tested positive for adenovirus. 11 of them were typed and all were type F41. Adenovirus was detected more commonly in blood/serum samples, than in stool or respiratory samples. It was noted that quite low level of Adenovirus was found in blood samples, which made it challenging to do homogeneous sequencing. 16% were positive for SARS-CoV-2 and three cases (of the 81) were coinfecting. Several other pathogens in smaller numbers were detected. Exceedances were also checked. England and Scotland had seen exceedances in adenovirus, enterovirus, human metapneumovirus, rhinovirus and norovirus in under 10-year-olds group. Adenovirus was found to have a particularly marked exceedance.

A rather complicated toxicology analysis was performed to see if there were any signals for a possible toxicological cause. Such was not identified. Hospital admission for the 1-4 year group was also monitored and it was found that there were specialist paediatric liver care admissions, super urgent liver transplants and emergency admissions for liver-related disease.

The current hypothesis is that a cofactor affecting young children having an adenovirus infection, (mild in normal circumstances), triggers a more severe infection or immune-mediated liver damage. However, other aetiologies are still under consideration and have not yet been excluded. The disease pathogenesis and routes of transmission are still unknown.

Obviously, the priority to date is to determine the underlying aetiological factor. The UK investigations still give no answers. It is imperative to work together in order to prevent any further cases. It would be important to collect and collate of data; do case finding, testing and reporting and maintain communications with the communities and healthcare workers.

For the promotion of control measures, the UK case definition was adapted in cooperation with WHO, though not so much. It is recognized that case definitions are challenging and evolve over time, but the intention is to keep case definitions broad at this point of time.

In terms of case finding and investigation ECDC recommends to enhance awareness among clinicians through clinical networks. Work is under already way with the European Association for the Study of Liver and the European Society of Clinical Microbiology and Infectious Diseases. The need is also recognized of wider case finding around a probable case and searching for outbreaks of adenoviruses or other viruses in communities (through review of laboratory data, local syndromic surveillance data, sampling, etc.). Questionnaires have been circulated and a trawling questionnaire is available on EpiPulse.

Initially a lot of data were collected from different sources and we are still receiving information, screening and monitoring it. It is necessary to be more systematic and ECDC is working together with the WHO to develop a surveillance system to encourage countries to report comprehensive information. A lot of information is available in EU countries, but denominated data are still missing (how many are tested, how many are negative or positive, etc.). We call on EU member countries to report cases to ECDC in TESSy and keep the information up to date.

ECDC suggests that countries do epidemiology awareness work: establish if cases reported are above what would normally be expected based on review of emergency department and hospital admissions for liver disease, including transplant records; review data from syndromic surveillance systems, available information on adenovirus circulation in the community, etc.

With respect to testing recommendations are: early collection of multiple specimen types and testing with different diagnostic methods; exclude hepatitis A-E; prioritise adenovirus testing, prefer whole blood to plasma; refer to national laboratories and do toxicology and screening for other diseases as well. Recommendations in terms of typing include: store specimens for further testing and typing later; type adenovirus and SARS-CoV-2 positive samples; conduct whole genome sequencing on positive adenovirus samples, and share this not only with ECDC but also other international bases. One of the hypothesis is this is adenovirus that is some kind of a new variant and this can only be uncovered if looking at the genome sequencing.

A lot has been done already on the level of actions like sharing of information with EU/EEA countries; use of EpiPulse platform to share updates on situation and investigation tools (case definitions, testing algorithms, trawling questionnaire); communications with various networks, the European Hepatitis Surveillance Network and professional societies (EASL, ESCMID, ESPID). ESPID did a survey among its members and the results will be shared. It highlights cases in countries we did not realise were affected. Emerging information is being collected through all sources (EpiPulse, the Early Warning and Response System of the European Union (EWRS), media), etc. and collaboration with WHO and US CDC continues. The collaboration with WHO Europe is really good and there are daily meetings now.

ECDC is finalizing the Rapid Risk Assessment and it will be published on 28 April 2022. There is a lot of uncertainty, the aetiological pathogen is still not determined and it is very difficult to assess risk, but the potential impact is very high. What is worrisome is that there is a capacity aspect of the paediatric and pathology units and there is a limit.

Regular outputs will continue (e.g. weekly Communicable Disease Threats Report and news items). Roll out of reporting national data on cases by EU/EEA countries and other countries in the WHO EURO region is happening through the European Surveillance System (TESSy) at ECDC. Support is provided to countries around case finding, surveillance, testing and epidemiological studies. There is also on-going monitoring of the situation through the ECDC Epidemic Intelligence activities, as well as continuous communication with EU/EEA countries, national and international public health authorities, and clinical societies.

DISCUSSION

ProMED communicated cases in Canada and Japan as well. Nearly 200 cases of a mysterious outbreak of severe hepatitis in children have now been reported worldwide. One of the hypotheses is related to possible Aflatoxin exposure. Aflatoxin was/is being tested in the UKHSA cases but no results as of now. Reports from the UK say this is not excluded, but no signals have been identified so far.

What was the rationale behind changing the UK case definition – it was mentioned unknown aetiology led to remove confirmed case, what about age and time inclusion up to October? Is it foreseen to reduce testing parameters in reporting protocols and which of them should be prioritized? It was mentioned Typing Adenovirus + WGS are recommended, is it only if this fits the case definition? Can the mentioned ESCMID survey results available /published be shared?

We are reticent to push a confirmed case if an aetiological factor is missing. This is sensible, before we get the agent. We shifted back to October, as there were cases from the end of last year. The case definition is broad and this is why we got back to October. The protocol is indeed broad. The countries do screening, this is intense and overwhelming, but for the time being we are looking at the adenovirus. The door should be kept open. We are working with the UK, WHO and countries until we get further information. ESCMID survey results will be shared if possible.

With regards to adenovirus WGS - the priority is to conduct WGS on Adenovirus positive cases and share this with international platforms e.g. ECDC/Genebank.

LINKS:

Latest technical report on acute hepatitis

<https://www.gov.uk/government/publications/acute-hepatitis-technical-briefing>

ProMED communicated cases in Canada and Japan

<https://promedmail.org/>

ECDC Typing

5.1.2e @ecdc.europa.eu

ANNOUNCEMENT:

Epitweetr online workshop is planned for users and experts in the field, 14-16 June 2022, 14.00-18.00 CEST. Those interested may contact 5.1.2e@ecdc.europa.eu

