ECDC Meeting Report

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

Agenda

19 November 2020, Thursday, 13.00-14.30

13:00-13:05
Welcome by 5.1.2e
Response, ECDC
Chaired by 5.1.2e
ECDC

13:05-13:30 Session 1: How not to manage a pandemic? The view from England, Prof. 5.1.2e

13:30-13:55 Session 2: Development of protocol for After Action Review – focus on evidence based decision making – ECDC Contractors, FWC (Lot 2) - 5.1.2e 5.1.2e

13:55-14:10 Session 3: ECDC partnership with Africa CDC – a new impetus for health 5.1.2e .1.2e

14:10- 14:30 AOB
- ECDC Rapid Risk Assessment – SARS-CoV-2 mink related variants and risk for human health
- Updated contact tracing guidance
- Closed settings outbreak investigation protocol
- Next NFP webinar - 10 December, 2020

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Acronyms

AAR – After Action Review

IAR – In Action Review

JEE – Joint Evaluation Exercise

ECDC – European Centre for Disease Prevention and Control

EC – European Commission

EFSA – European Food Security Agency

EPIET – European Programme for Intervention Epidemiology Training

EU – European Union

EU-OSHA – European Agency for Safety and Health at Work

MERS – Middle-Eastern Respiratory Syndrome

MoH – Ministry of Health

NPI – Non-pharmaceutical intervention

NHS – National Health Service

PHE – Public Health England

PHSM – Public Health and Social Measures

PrEP – Pre-exposure prophylaxis

RRA – Rapid Risk Assessment

TESSy – The European Surveillance System

WHO – World Health Organization

EWRS – Emergency Warning and Response System

EBDM – Evidence based decision making

EBPH – Evidence based public health

SARS – Severe Acute Respiratory Syndrome

SAGE – Scientific Advisory Group on Emergencies

UK – United Kingdom

WP – Work package

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Session 1: How not to manage a pandemic? The view from England

Prof. Martin McKee – London School of Hygiene & Tropical Medicine, UK

Timeline of the development of the COVID-19 pandemic in the UK

January 31st: fist cases of COVID-19 confirmed in the UK

March 5th: First COVID-19 death confirmed

March 12th: Government advises anyone with symptoms to self-isolate for 7 days

March 20th: All schools closed

March 23rd: Lockdown begins in the UK

April 15th: All elective operating is postponed

April 22nd: UK hits peak of outbreak

May 11th: Government advises people to wear face masks when social distancing not possible

May 13th: Lockdown relaxed to allow outdoor exercise with 1 other person from another household

June 1st: Gatherings outdoors larger than 6 are prohibited, primary schools re-open

June 13th: "support bubbles" for those who live alone permitted

June 15th: Non-essential retailers and secondary schools re-open. Face mask compulsory in hospitals and in public transport

July 4th: Social distancing relaxed to less than 1 meter. Pubs, restaurants, hotels, and hairdressers opened. 2 households can meet indoors. Weddings with less than 30 guests permitted.

July 6th: People "shielding" allowed in gatherings larger than 6 and from support bubbles

By the beginning of the summer, many of the restrictions were removed, and the government promoted a cash incentive to go to hospitality venues, subsidizing their meals. This likely played a significant factor for the resurgence of the second wave.

Background: the UK government up to the pandemic

To understand what has happened in the UK, the development of the last few years needs to be taken in account, as well as the situation which the UK found itself in at the beginning of the pandemic. UK governments, since 2010, had pursued a policy of austerity. While spending on National Health Service (NHS) continued to increase, this was far slower than before, and followed with very large cuts to social welfare, local governments, education, and other sectors. There was also a large increase in insecure employment – many more people living in precarious situations.

In 2012, the government started a major reorganization of the National Health Service, which led to a fragmentation of the health system and an unclear line of accountability. Public health was moved to local governments, which were experiencing severe budget cuts. Under extreme financial pressures, local governments started to re-define core activities other than public health. Moreover, already since 2010 the government experienced severe cuts to civil service, with many activities contracted out to outsourced companies. This led to a lagging public servants' class, which could no longer service the governments and people's needs.

In 2016 the UK voted to leave the European Union (Brexit). The process took up much of the government's time since then, which left little space for dealing with other issues, including the pandemic. While there was a major simulation exercise on a possible flu pandemic plan (2016), the findings were not implemented. The newly established government in 2019 seemed unprepared to deal with such an enormous crisis.

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Epidemiological and policy evolutions

The initial lockdown was delayed compared to other countries. A large horse racing event took place before the lock down which has now been recognized to have been a possible super-spreader event.

A second wave, as of 16 November 2020, has taken place, with a rapid resurgence in confirmed cases as well as a rise in the death rates. Similar to the rest of Europe, the outbreak spread initially to younger people.

The following characteristics of the pandemic of the UK can be observed:
- during the initial phase the spreading happened to all parts of the country, unlike some other countries in Europe;
- the pandemic is closely associated with deprivation, with greatest rates in the poorest areas, highlighting the existing inequalities and greatest impact in ethnic minority populations;
- second wave has been concentrated at first in North West, where lockdown was lifted prematurely;
- in autumn, the spread began in younger people and moved progressively to older groups.

In the initial response, there was a clear understanding and recognition that the NHS was severely under-resourced to deal with this crisis. The adopted slogan was "Stay home, Protect the NHS, Save lives". The approach taken has been to use the planning done for pandemic influenza.

A few problems could be recognized from the start:

Scientific advice – the government was informed by the Scientific Advisory Group on Emergencies (SAGE). The membership in the group varies depending on the threat. Initially, there was a lack of transparency on who was part of the group and what advice has been given. In response, an independent SAGE was created by concerned researchers, meeting in public sessions, addressing questions and publishing arguments for its recommendations. The government responded by publishing (most) names of SAGE members and releasing minutes of its meetings. In fact, both groups have almost always reached the same conclusions. The independent SAGE has, however, been able to investigate a wider set of questions/issues due to its independence and to engage with the public and press. Its weekly briefings are watched by several thousand people.

Testing and tracing – the existing public sector capacity for contact tracing was ignored, and most contact tracing was outsourced to firms with no experience, which resulted in inconsistencies and poor management of these activities. Most contact tracing was performed remotely, by reaching targeted persons by phone.

The independent SAGE proposed a comprehensive strategy: *Find, Test, Trace, Isolate, Support* system, but the government was struggling to cope with severe gaps in all areas, e.g.:

- *Find*: few attempts were made to find cases in high-risk settings. The health and social care workers have been eventually included but other groups such as taxi drivers were excluded;
- *Test*: because contact tracing was centralized, people with symptoms were directed to testing centres hundreds of kilometres away; moreover, often there was a lack of sufficient number of tests sets. The mobile testing, supported by the army worked well but was handed over to a security company (G4S) when problems arose.
- *Tracing*: very few contacts identified.
- *Isolation*: less than 20% of those who should isolate complied with the rule.
- *Support*: little support was provided to those who had to isolate.

Procurement - the procurement, in a time of transition created by Brexit, was problematic. The government used provisions for emergency situations as regards to the tendering system for PPE, tests kits, and medicines, signing big contracts that were not advertised. The process has been seen to lack transparency.

Stake holders' collaboration – there was a poor link between local governments, NHS, and other stakeholders. Operationally, technical problems were encountered when keeping count of cases.

The economic impact

While the government initiated a number of programs to try to manage and contain the economic impact (e.g. Job Retention Scheme; Job Retention Bonus; Kick start Scheme; and the Coronavirus Business Interruption Loans Scheme) the UK entered this crisis with a large share of people in the informal economy, who were mostly left out from support packages. The pandemic revealed big gaps in the welfare state.

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What went well?

- Research: the UK has world leading research teams. The Oxford developed vaccine was one of the first to enter Phase III trials. There were also major initiatives to evaluate drugs.
- National Health Service: The phenomenal effort by staff, despite systematic problems has to be recognised. There has been very rapid (almost overnight) conversion of hospital facilities and new staffing models. There has been rapid learning from experiences.
- Local public health teams: proactive approach for setting up their own tracing systems, despite major barriers.

In summary, the first wave (January - June 2020) could have served as lessons for second wave and as something that other countries could learn from.

Questions

What would be the three major issues to change for the future to improve, and how would you advise to move forward?

We may need to have a political structure to respond more effectively at regional, national, and European level. We faced particular problems at decision-making level in many countries and at European level. Countries that have difficulties to respond effectively were those that were hit worst in the global financial crisis. What that tells us is that the social safety nets are incredibly important and there should be a large emphasis in trying to address the problems of precarious employment and welfare systems. There are issues around the macro economy as well. The One health approach needs to be adopted more, in order to prevent and handle more efficiently pandemic situations and crisis like the one of the minks in Denmark. Health in All policies should be taken more into account, including strengthening public health capacities.

To what extend do you think the civil protection mechanisms, very well developed in the UK, were able to contribute to the management of the pandemic?

The failure to engage local public health departments was dreadful because there is a lot of expertise there (even though these structures were hit by misguided reorganization in 2012, enacted by the Health and Social Care Act). One of the areas where contact tracing already existed was for sexual health clinics, but these were also fragmented with the reorganisation of public health that happened few years ago. The lessons were not implemented from previous planning exercises, as the Government was, since 2016, too diverted on planning for the exit of the UK from the EU.

The UK has one of the highest scores in Europe for the Joint External Evaluation of its IHR Core Capacities. What does this say about the usefulness of the JEE framework for assessing health emergency response capacity?

There were a number of indexes with high score for UK like JEE and the Global Health Security Index. However, there were problems when implementing in practice the planned assumptions. Important issues to consider is the political dimension, which became a critical factor for the work of public health experts. For example, when Rudolf Virchow went to investigate the typhus epidemic in Upper Silesia, he identified the political determinants of health. A paper looking at the five countries in the world with the highest number of infections had something in common - their populist policies pursued by the governments, highlighting failures of governance and political processes. Assessment indexes were looking at the certain things without capturing the political aspect, which is key for the current pandemic.

What changes in decision-making need to happen at EU level?

The president of the European Commission, Ursula von der Leyen, has called for a united healthcare for Europe. We have argued for exactly the same during a debate at the European Health Forum Gastein. Member states need to recognize that we all have to work together for a better health.

What elements of the health systems response would you expect to institutionalize in the long term?

It is important that we stop outsourcing everything and build up governments. The UK was looked up for its civil servants work and strengths, which unfortunately faltered, and now the UK has to build it back.

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How do we avoid statistics on ethnic minorities that lead to stereotyping and discrimination?

I recognize the historical origins of these problems but we need to have open discussions about the issues. What we need to have is very rigorous anti-discrimination legislation in Europe. The UK is not unique with ethnic disparities in Europe, they are probably not so visible in the rest of Europe. We have started to overcome some issues, for example with Roma in Central Europe. Public Health is about making the invisible visible. There is a whole group in society that are essentially invisible in our data, and that means we don't understand their needs.

Session 2: Development of a protocol for an After Action Review – with a focus on evidence-based decision making – ECDC Contractors, FWC (Lot 2)

5.1.2e , University of Amsterdam, the Netherlands

Evidence based decision making (EBDM)

During this pandemic political leaders and decision makers have actively sought the advice of public health experts. Most governments have said their pandemic response decisions on school closures, lockdowns, wearing fabric masks, etc. are based on science. While science and evidence definitely have been factors in the decision making during this pandemic, exactly how has the use of scientific evidence worked? And to what extent does it correspond to best practice developed in the countries and the EU level (ECDC)?

The approach to national Intra Action Reviews (WHO) is to ask broad strategic questions - What worked well? What needs to be further improved? How should the response be adjusted going forward?, etc. However, a much more targeted approach may have a benefit to focus on specific issues – for example reviewing details of how scientific evidence has been used during the pandemic for implementing a specific response measure.

Challenges to EBDM

In December of 2018 ECDC conducted an expert workshop on the use of evidence in decision-making during public health emergencies. The workshop report noted that existing literature is limited and suggested that crisis management decisions are not always evidence-based, which can result in public criticism and scrutiny. Conversely, crisis management decisions might be taken not based on scientific evidence (e.g. due to lack of time or enough evidence). We have seen such dynamic clearly with COVID-19. The ECDC report lays out 3 common challenges to evidence-based decision-making during disease outbreaks:

1. obstacles or barriers (e.g. uncertainty concerning risks, insufficient medication, mistrust in government);
2. variability in how decision makers and stakeholders interpret and apply evidence;
3. competing demands on time, limiting the ability to consider and act upon the available evidence.

What is evidence?

In 2003, WHO's Regional Office for Europe adopted an initial broad definition of evidence as *"findings from research and other knowledge that may serve as a useful basis for decision-making in public health and healthcare".* The types of evidence in the context of public health emergencies include peer-reviewed scientific research articles, but could also be surveys, surveillance data, guidelines and assessments. Decision makers may prefer local data (e.g. epidemiological, historical, and qualitative information) as a form of evidence. Evidence is context-dependent and is often broader than the knowledge produced through focused 'scientific method'.

The approach for a focused AAR protocol

The project will propose an AAR that is focused on evidence-based decision making. The project is *Not* about the relationship between politicians and health experts, but the approach is based on a case study methodology for evidence-based technical public health decisions; and focus on how evidence is processed and interpreted as basis for decisions and recommendations within health agencies, and assessment of continuous gathering of evidence after the decision is being made.

ECDC approach to AAR is applied to a case study. Other than the focus on evidence-based decision making, the content of the case to be explored is not pre-determined, but depends on the national context, priorities, and choices. This approach will try to focus on the technical decision-making by the public health experts

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involved, leaving aside the political aspect. The analytical framework used is the evidence-based public health (EBPH) approach, outlined by Satterfield et al in 2009. The decision making is in the middle and influenced by several other factors.

Figure 1. Evidence-based public health (EBPH) analytical framework

Source: Satterfield et al. (2009).

Best available research evidence

In principle decisions would likely be influenced by the best available evidence about benefits, harms, and costs of alternative interventions. During the pandemic (particularly at the initial stage) the evidence-base was of weak, with no past data that could easily be translated to the current context. At the same time, there was significant pressure to act rapidly.

When focusing on decisions regarding COVID-19 school closures, for example, the decision trees/matrices have been probably utilized to assess the level of community spread, the number of infections inside schools, etc. In the course of pandemic, what has been learned is that primary schools are not playing key role in the spread of the infection. The evidence based for decision making might include also other types of evidence, such as **socio-economic repercussions that need to be taken into account** - for example, the lowered productivity of parents if kids stay home, loss of education, limited social interaction for children, etc.

Resources, including practitioner expertise

As shown in Figure 1 the resources required and available, incl. human (team) and organisational ones play an important role in influencing decision making process. For the school closures example, that would mean who has experience with school closures, what evidence is needed, how well scientific evidence is translated to inform school practitioners?

Population characteristics, needs, values, and preferences

Another point to consider is characteristics, needs, values, and preferences of those who will be affected by the intervention. This is could be assessed by looking at key stake holders participating in technical decision-making (regarding school closure), influences of media for a certain outcome, local context, etc. COVID-19 pandemic made it evident that it is very important to get the population buy-in for the different proposed policies (e.g. social distancing) in order high compliance to be obtained. It seems very difficult to enforce policies, if the population at large is not on-board.

Environment and organizational variables

As a whole, environment and organizational context also has an influence on decision-making. In the context of school closures to assess these variables, there would be a need to evaluate if:

- there is sufficient institutional capacity at the school and its district to respond;
- there is sufficient detection and response capacity in the region;
- the schools have sufficient capacity to operate safely;
- there is a good collaboration in decision making between the education and health sectors.

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In the protocol to be developed for this project, we propose to use a case study approach with mixed-methods. This includes attention to the process of selection of participants who sit at the table to conduct an after-action review, as they are critical for the final outcome. The protocol should also review ethical principles of research (beneficence, non-maleficence, justice, and autonomy), and emphasize the importance of transparency.

In Summary, the protocol for an AAR is to focus on:

- EBDM during COVID-19;
- technical public health decision making;
- providing a tool for countries to conduct EBDM AAR independently;
- a case study methodology, with leaving the choice of the case/ topic for review is open for those conducting the AAR;
- the use of EBDM analytical framework;

When developing the protocol, the ECDC's experience with After Action Reviews and the ECDC IAR materials will be taken into consideration, as well as when feasible and relevant the WHO published guidance on IAR and AAR.

Questions

Could there be an AAR protocol focused on long-term care facilities?

The idea of this protocol would be to look at the decision-making context and what kind of evidence has been used to make certain decisions. Access to long-term care facilities can be used as a case/example (in the Netherlands, for example, the access to these facilities was blocked for a while). It surely possible to apply this protocol to a decision for a specific setting and situation.

Examples of AAR (non-covid-19 related) conducted in the countries mentioned during the meeting:

- *Italy had an experience with AAR with ECDC on West Nile Virus outbreak.*
- *Netherlands had an AAR on the accidental laboratory release of poliovirus.*

ECDC encouraged colleagues (NFPs) to send suggestions regarding topics of AAR – already conducted, or planned, or of interest, based on which ECDC can draw upon when developing the protocol, and further on conducting AAR together.

ECDC partnership with Africa CDC – a new impetus for health security in Africa

5.1.2e 5.1.2e , ECDC

Africa CDC is a technical agency of the African Union, established because of a shared perception that the national public health has an impact on the regional security and economic functioning of the continent. Similarly to its sister organisations, Africa CDC works to facilitate access to critical information and establish emergency operation centres when necessary. Unlike the ECDC, whose supranational nature is opted-in by already existing public health organizations of member states, Africa CDC works through five Regional Collaborating Centres, placed around the continent. Different regional collaborating centres are in different stages of development.

Moreover, many international public and private organizations are present in the continent and actively involved with the work pursued by the Africa CDC.

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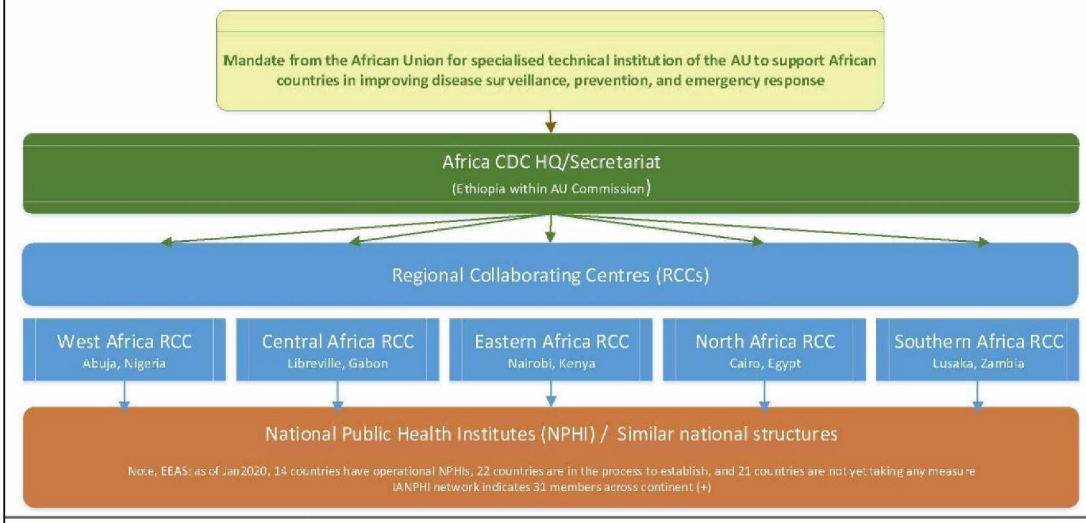

Figure 2. Africa CDC structural organization

EU for Health Security in Africa: ECDC 4 Africa CDC

The overall aim of the initiative is to build a long-lasting partnership between two technical agencies by sharing practices and developing capacities and capabilities in preparedness, surveillance, and response to health threats posed by communicable diseases. This partnership project has also a component on capacity building supporting Africa CDC in the implementation of their strategy in this field. The funding authority is the European Commission: DG DEVCO, using the financial Instrument of the European Development Fund. The project duration is 48 months (2021 – 2024) and the allocated budget of the action is:

- 9 million EUR ECDC/DG DEVCO Contribution Agreement – signed in October 2020
- 1 million EUR Africa CDC/DG DEVCO direct grant for project staff in Africa

This project is different from previous ECDC externally funded projects, as it is the first time for the agency to support the EU's development cooperation policy, signalling an ambition of the EU to deepen the future cooperation between Europe and Africa in the area of health. However, the mechanisms was set up before the COVID-19 pandemic and therefore did not have in the objectives to be an ECDC mechanism to support Africa CDC in the response to COVID-19.

Work packages:

WP1 – Preparedness, outbreak response, coordinated and functioning EOCs - Expected result: Increased capacities of the Africa CDC and its RCCs to support national CDCs, laboratories and health workforce in preparedness, outbreak response and coordinated emergency operations.

WP2 – Harmonised surveillance system, data management, and epidemic intelligence - Expected result: A pilot model, with lessons learned documented, for harmonised surveillance of communicable diseases and early warning, harnessing existing regional integrated surveillance and laboratory networks.

WP3 – Public health workforce development and capacity building - Expected result: The establishment of a sustainable African-based public health workforce development programme in epidemiology is promoted by the Africa CDC.

WP4 – Horizontal activities and management of the Action - Expected result: Support the implementation of the technical WPs 1 to 3. It will ensure the effective and efficient implementation of all management, coordination, communication, and reporting tasks.

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During the first year **an inception diagnostic and gap analysis** is to be performed, in order to support better planning of targeted and tailored activities to attain the overall objectives. This includes:

- desk research, understanding of ongoing activities, partners, donors, tools, materials, and analysis of needs;
- Identification and engagement of key stakeholders and establishment of links with technical networks;
- fact-finding and needs identification missions.

There are a number of challenges, including:

- **Legal framework for continental health security in Africa** involving Africa CDC HQ, RCCs, and NPHI in African Union member States;
- Differences and similarities in given **mandate of the European and African technical agencies** for disease prevention and control (risk assessment vs- risk management mandates);
- **Engagement of national public health institutes/national CDCs and relying on disease surveillance networks** (e.g. epidemiologists, microbiologists, veterinary sectors in all MS);
- **Donor coordination and magnitude of partners**, including division of labour between Africa CDC and WHO (AFRO and EMRO);
- **Administrative capacity and available human resources** at Africa CDC and its Regional Coordinating Centres.

Looking forward

ECDC needs to learn and understand how it can promote and use the expertise available in national authorities of EU member states in order to enhance this project. Moreover, the NFP network can be an important and rich resource of information, and ECDC would be eager to hear the contributions of this network in the inception phase.

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Meeting agenda point: Any other business/ Additional information

ECDC Rapid Risk Assessment – SARS-CoV-2 mink related variants and risk for human health

5.1.2e **, ECDC**

ECDC has recently published a rapid risk assessment of the SARS-CoV-2 mink related variant.

A mink variant represents a SARS-CoV-2 strain with a mutation in the spike protein, which occurred during mink-to-mink transmission, and that spilled over to humans. The first human-to-mink transmission was recorded in April 2020 in the Netherlands, with subsequent reports from Denmark, Italy, Spain, Sweden and the United States. As of the publication of the RRA, since evidence is building up rapidly, only the Netherlands and Denmark have shown SARS-CoV-2 mink variants circulating in human populations. The mink variants identified in Denmark and in the Netherlands do not appear closely related and are part of different genetic clades, pointing to a lack of direct link between the mink farms. Community transmission of mink variants was identified in Denmark, while there was only limited transmission in the Netherlands.

The Danish alert was sent on 4 November 2020, detailing 214 human COVID-19 cases infected with a mink related variant. Since June 2020, more than 200 mink-farms were also declared infected. Most human cases and farms happened in the North Jutland Region. All variants identified in humans and mink are part of five genomic clusters. The "Cluster 5" variant, reported in 12 human cases in August and September 2020 in North Jutland, was of particular concern because of four simultaneous genetic changes, three substitutions and one deletion, in the spike protein.. Such a variant showed lower susceptibility to neutralizing antibodies, rising concerns on the potential implications on re-infection, diagnostic, treatment, and vaccine effectiveness of candidate vaccines. Denmark put in place a robust response to decrease circulation of all mink variants in humans and mink.

ECDC looked at the evidence available and assessed the risk for human health posed by any mink variant. As usual with risks assessments, we looked at probability and impact of the infection, determining:

Probability of infection:
- **low** for the general population,
- **moderate** for populations in areas with high concentration of mink farms
- **moderate** for individuals with occupational exposure

Impact of infection (as in previous RRAs)**:**
- **low** for non-medically vulnerable individuals
- **very high** for medically vulnerable individuals

Based on this, the risk was assessed as in the table below:

Risk	Non-medically vulnerable	Medically vulnerable
General population	**LOW**	**MODERATE**
Leaving in areas with mink farms	**LOW**	**MODERATE-to-HIGH**
Occupational exposure	**MODERATE**	**VERY HIGH**

The specific risk posed by the "Cluster 5 variant" was too early to assess, close monitoring is needed.

Together with the European Food Safety Authority (EFSA) and with the European Agency for Safety and Health at Work (OSHA), ECDC developed several options for response, divided in four groups.

1. Human testing, sequencing and characterisation of antigenic properties and virus infectivity
2. Infection prevention and control measures for mink farm workers and visitors
3. Animal testing and prevention of spread from animals
4. One Health preparedness and response strategies

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Updated contact tracing guidance

5.1.2e, ECDC

The new updated guidelines by ECDC can be found online now, where several new topics are discussed, including:

- Updates to the definition of contacts
- Revised recommendations around the testing and quarantining of contacts
- Options for enhanced contact tracing, including 'backward' or 'retrospective' contact tracing
- Specific recommendations for key settings, including long-term care facilities and prisons (found in Annex 1)
- Suggestions for the prioritization of resources
- Recommendations for contact tracing using mobile applications
- Indicators for monitoring and evaluation, and options for the analysis of contact tracing data

Two contact tracing initiatives have also been introduced:

1. Collaboration with Member States volunteering to explore data availability and options for collecting data across countries, specifically focused on analysis of data regarding settings of transmission.

2. Collaboration with EPIET fellows on using data to calculate contact tracing indicators and attack rates among contacts, with the aim of standardizing and support data analysis and sharing expertise.

A reminder: ECDC continues to support the use of Go.Data as a generic contact tracing tool, and has made it now available in all EU/EEA languages.

Closed settings outbreak investigation protocol

5.1.2e, ECDC

ECDC is making available for Member States a protocol for closed-settings outbreaks investigations. By "closed-setting" it is intended any setting with a population in close contact and (relatively) secluded from the general population (e.g. outbreak taking places in food processing plants, prisons, military barracks, refugee camps, religious places). The draft protocol was developed by WHO. Should NFPs need it, it can be adapted and made available upon discussion with WHO. We welcome member states to contact ECDC for any support. Moreover, if any similar investigation has been done at national level, we welcome forwarding any protocol or outbreak questionnaire developed for such an investigation.

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