EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

Mr Robby De Caluwé
President of the Committee
Special Committee to Examine the Belgian Approach on the COVID-19 Epidemic

Rue de Louvain n°48
1008 Brussels
Belgium

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Subject: ComCOVID-19: written questions

Dear Mr De Caluwé,

We have received your request with a set of questions from the Special Commission charged with examining Belgium's management of the COVID-19 epidemic.

We will reply to most of the questions. Some of them (parts of Q2, Q6, Q12, Q14, Q17, Q19, parts Q21, and Q22) do not fall under our mandate and we suggest that you contact Directorate-General for Health and Food Safety (DG SANTE) of the European Commission, Unit 01 – Strategy and Coordination at sante-consult-01@ec.europa.eu for their input.

We will be able to send you the replies by November 23rd.

Yours sincerely,

Andrea Ammon
Director

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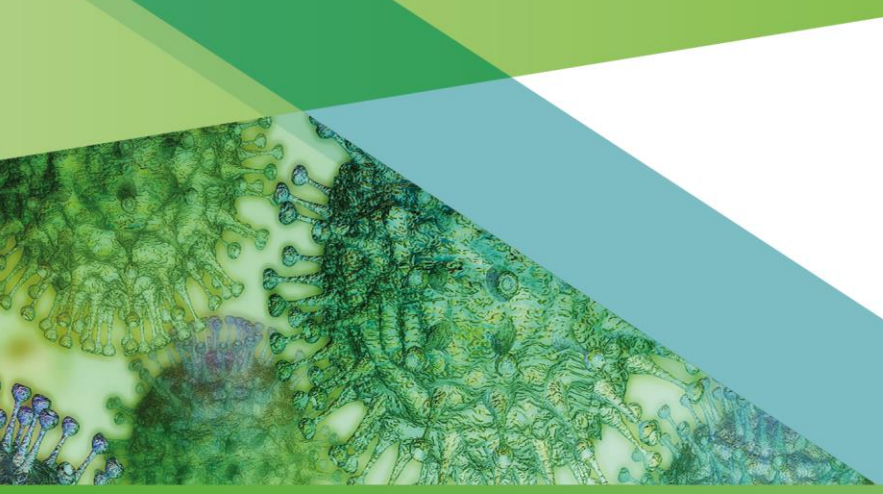

ECDC response to questions from the Special Committee COVID-19, Belgium

9 December 2020

1) **What is the difference between the objective, mission and task of the WHO and that of the ECDC? To what extent do they overlap, and to what extent are they complementary? What relations does the Centre have with the WHO? How is the flow of information organised?**

The primary role of the WHO is to direct and coordinate international health within the United Nations system. The WHO main areas of work are health systems; health through the life course; non-communicable and communicable diseases; preparedness, surveillance and response. In comparison, ECDC is an EU agency aimed at strengthening Europe's defences against communicable diseases. The main area for complementarity lies within the field of communicable diseases.

Over the years, ECDC has developed a very close collaboration with the WHO, particularly with the WHO Regional Office for Europe. Collaboration with the WHO Regional Office for Europe takes place within the framework of the ECDC-WHO/Europe Administrative Arrangement (2011). Subject-matter experts from ECDC and WHO communicate on a daily basis, however strategic discussions and alignment of activities are taking place during annual programmes' coordination meetings, as well as during high-level meetings between the Directors. ECDC works in synergy with the WHO and aligns its activities accordingly, including for example on the case definition and case reporting of communicable diseases.

Throughout the COVID-19 pandemic, ECDC has been working very closely with colleagues at the WHO headquarters and Regional Office for Europe. Apart from daily collaboration on a technical level, senior management of ECDC and WHO Regional Office for Europe are in close communication. Directors meet regularly to discuss recent developments and how to better support jointly the countries. The ultimate goal is to avoid duplication, improve synergies and complementarity. A concrete example of collaborative work was a joint WHO-ECDC

mission to Italy. When Italy saw a sharp increase in numbers of COVID-19 cases in late February/early March 2020, a joint WHO/ECDC team (with two experienced ECDC experts) was in Italy to support the national and regional authorities in their efforts to control the outbreak. This is a clear example of how synergy and complementarity between the two organisations can bring added value to our respective Member States.

2) **Were precautions taken at international level to deal with a pandemic?**
Yes, there have been coordination meetings with Member States, the European Commission, the WHO and other international partners to deal with the preparedness and response plans.

Are risk assessments available?

Nineteen rapid risk assessments and three Threat Assessment Briefs in relation to the current COVID-19 pandemic are available on the ECDC website.

If so, were plans made for an international approach to that risk?

As this is a new virus with unknown characteristics, dynamic, transmission patterns and so on, there were not specific plans for this threat. Approaches have been adapted as knowledge about the virus became available.

Were there exercises/training courses (that you are aware of) to assess the scale of the problem, and what were the most important outcomes of those exercises/training courses?

In order to support Member States, ECDC translated scientific guidelines into micro-learnings (https://eva.ecdc.europa.eu/totara/catalog/index.php?catalog_cat_browse=16005&orderbykey=text&itemstyle=narrow) open to all on the ECDC learning management system called EVA (https://eva.ecdc.europa.eu/). Eight trainings were developed and others are being developed such as designing after action reviews and a training for managers of institutions with vulnerable populations.

3) **What is your assessment of the role played by the WHO in the earliest days, weeks and months of the crisis? Did the WHO raise the alarm late, as some people claim?**

ECDC cannot comment on the role of the WHO.

4) **One of the Centre's missions is to assist European countries to prepare properly for epidemics. What was the Centre's role in the context of the battle against the pandemic?**

To properly address the needs of the EU/EEA Member States and the European Commission, ECDC activated its Emergency Plan early in January. Through that plan the Centre has produced guidance and provided assistance in many different ways (e.g. responding to written requests, organising regular and ad-hoc video or telephone conferences). ECDC has also been producing daily epidemiological updates of the situation all over the world, and addressing the different requests received by the Commission and Member States. ECDC outputs related to COVID-19 can be viewed here: https://www.ecdc.europa.eu/en/covid-19-pandemic.

5) **In a crisis of this kind, the ECDC refers to it as a low, moderate or high risk. From what dates was it a low, moderate and high risk?**

Since 9 January, ECDC has produced 19 rapid risk assessments and three Threat Assessment Briefs in relation to the current COVID-19 pandemic. They are all made available on one dedicated webpage: https://www.ecdc.europa.eu/en/threats-andoutbreaks/reports-and-data/risk-assessments

The risk questions vary for each of the assessments and often concern different population groups, e.g. the general population versus vulnerable individuals. Therefore, there is not one risk level per assessment.

What are the consequences of these statuses?

While, according to its mandate, ECDC assesses the risk and outlines options for response, risk management is the responsibility of the Member States.

6) **What interaction was there between Belgium and the European Centre for Disease Prevention and Control (ECDC)?**

ECDC works with the Member States through the ECDC networks. For COVID-19, a special network was established for which the Member States nominated experts. Examples of interactions between ECDC and Member States are: Member States provide surveillance data to ECDC; ECDC asks Member States to respond to surveys; ECDC organises meetings for which Member State representatives are invited. The ECDC Advisory Forum has members from all Member States and there have been three regular meetings and 6 extraordinary meetings until now (beginning of December). A final (4th) regular AF meeting will take place on 15 December 2020.

ECDC Advisory Forum: https://www.ecdc.europa.eu/en/about-us/how-we-are-governed/advisory-forum

How did the Early Warning and Response System work (or not work)? And the Security Committee?

This question is best referred to the European Commission.

7) **On 15 July 2020, the European Commission published short-term recommendations for containing a second wave. These documents and recommendations contain proposals for the Member States for the period July-September. Few countries have applied these recommendations. What are the reasons for that?**

ECDC is not in a position to comment on reasons for Member States to apply or not apply recommendations.

8) **What critical analysis has there been of the handling of the crisis in Belgium (including epidemiological surveillance)?**

ECDC has not been asked by the Belgium authorities to perform a critical analysis of the handling of the crisis in Belgium and has therefore not performed such an analysis.

9) **How did the ECDC assess the consequences of different methodology for counting deaths in Belgium compared with other European countries?**

To address differences in surveillance strategies, testing rates, response measures, and sentinel surveillance systems, ECDC publishes country-specific details to help public health practitioners and decision makers understand the epidemiological situation within each country. Surveillance systems and methodologies vary between countries and ECDC recommends in all Risk Assessments to interpret the data with caution. You can find the country-specific details at this link:
https://www.ecdc.europa.eu/en/covid19/surveillance/weekly-surveillance-report (in particular in section 6).
Since the beginning of the COVID-19 pandemic, ECDC has published case definitions, testing protocols and monitoring protocols in an attempt to harmonise the approaches in the Member States, and to render surveillance data increasingly comparable. Since this is the responsibility of the Member State, ECDC cannot enforce the proposed approaches.

10) **Why was it decided to give modest recommendations (e.g. concerning face masks) so that the Member States were left to decide for themselves? Is that advisable during a global crisis?**

ECDC develops guidance by assessing the scientific evidence. Options for response are provided depending on the available evidence. Risk management is not in the ECDC mandate and is the responsibility of the Member States.

11) **In an initial phase, the epidemic was limited to Wuhan in the Chinese province of Hubei. What was the ECDC's advice to Member States for people travelling from that region (testing, quarantine, etc.)?**

In the ECDC Rapid Risk Assessments published on 17 January 2020, 22 January 2020, 26 January 2020, and 31 January 2020 the risk for travellers is assessed and options for response are provided.

12) **How often did the Health Security Committee meet in the period up to the end of March 2020? What were the conclusions of those meetings?**

This question is best referred to the European Commission.

13) **At the end of January, the WHO declared the epidemic to be a Public Health Emergency of International Concern (PHEIC). Were adequate precautions taken in the course of February to prevent this crisis in Europe? Was too much attention not paid to a potential outbreak in Africa?**

ECDC took immediate action on the situation in coordination with the European Commission and EU/EEA Member States much in advance of WHO declaring COVID-19 a PHEIC.

Preparedness, readiness and contingency plans in EU/EEA Member States have to be revisited to ensure actions are taken in due time.

The coordination between ECDC and Africa CDC was well established since the very beginning of the pandemic, including participating in the weekly conference calls of the Africa Task force for Novel Coronavirus (AfCOR) weekly and therefore proper attention was paid to the situation in the continent.

14) **There was a meeting of the Health Security Committee on 31 January 2020. The minutes state that not one Member State reported a shortage of personal protective equipment. Only 4 countries stated there was "the potential need for PPE in case of an expanding situation in the EU." Which countries were they? Did the EU take steps to obtain more personal protective equipment?**

This question is best referred to the European Commission.

15) **At a meeting on 13 February 2020, it was stated that there was sufficient laboratory capacity in Europe. Based on which statistics was that conclusion reached? Was each country expected to decide for itself whether testing capacity was adequate, or was a minimum level set by the ECDC?**

In order to specifically answer to what was stated in a meeting on February 13 it would be helpful to know what meeting this refers to and the minutes for an exact description of the topic discussed. However, a general reply to what was known about the laboratory capacity at this stage of the pandemic is:
In the early phase of the pandemic ECDC did a capacity assessment of Member States on their ability to detect the novel coronavirus in their laboratories, following the methods published after the initial characterisation of the virus was made mid-January 2020. The assessment of the readiness of EU/EEA laboratories for molecular detection of 2019-nCoV demonstrated a fast implementation of molecular diagnostics by the European specialised laboratory networks with a good geographical coverage for testing. Overall, 38 laboratories with capacity at a minimum of 8,275 tests per week as reported.[1] At country level, 24 of 30 EU/EEA countries had already implemented molecular tests for 2019-nCoV while the laboratories in the remaining six countries had arranged to ship clinical specimens of suspected cases to a specialised laboratory abroad, while planning to implement assays between 30 January and 17 February 2020. Overall conclusion from the assessment was that, while molecular testing for 2019-nCoV was quickly implemented in EU/EEA countries there was still room for improvement especially in the aspect of clinical validation of specificity and sensitivity.

[1] Chantal B.E.M. Reusken, Eeva K. Broberg, Bart Haagmans , Adam Meijer , Victor M. Corman, Anna Papa, Remi Charrel, Christian Drosten, Marion Koopmans, Katrin Leitmeyer, on behalf of EVD-LabNet and ERLI-Net. Laboratory readiness and response for novel coronavirus (2019-nCoV) in expert laboratories in 30 EU/EEA countries, January 2020. Eurosurveillance Volume 25, Issue 6, 13/Feb/2020

https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.6.2000082

16) **The 'case definition' in Belgium was based initially on ECDC advice. In February and early March, this case definition was very limited. It had to involve clear symptoms, and there needed to be a link to an infected region (China and some regions of Northern Italy). Why was it so restrictive? Did this not lead to a much larger outbreak in Europe?**

ECDC, following also the advice from the Health Security Committee and the ECDC Advisory Forum, aligned the COVID-19 case definition for the EU/EEA countries with the global case definition established by WHO. When ECDC proposed to expand the case definition to China and other countries in East Asia, Member States were concerned about the limited resources available for testing at that point in the crisis. Nonetheless, ECDC expanded its case definition. At the same time, the geographical restrictions for testing referred only to mild presentations. As from 2 March 2020, individuals with severe symptoms were recommended to be tested regardless of an epidemiological link to the affected areas.

17) **When the crisis erupted in early March, some Member States (France and Germany) decided to reserve personal protective equipment for themselves. What was the European Commission's reaction to that decision? How can that be avoided in future?**
Was there a lack of solidarity?
This question is best referred to the European Commission.

18) **How did ECDC advice on the wearing of face masks evolve? Who needed to be provided with those masks (medical personnel and/or the general public)? What type of masks needed to be provided, and how many? How did that change over time?**

ECDC provided advice on face masks for healthcare workers in healthcare settings in the 'Infection prevention and control for the care of patients with 2019-nCoV in healthcare settings' published on 2 February 2020. This guidance has been updated five times with the latest update published on 6 October. The recommendation on face masks has been consistent in these documents. Respirators (FFP2/3) have been recommended in all these documents for the care of COVID-19 patients. In the second update, published on 31 March, medical face masks were recommended in cases there was a shortage of respirators. In the same update, ECDC recommended considering the use of surgical 'medical' face masks by all healthcare workers for personal protection and source control.

In addition, ECDC produced The checklist for hospitals preparing for the reception and care of COVID-19 patients to support the public health preparedness planning for hospitals.

Use of masks in the community was addressed by ECDC in a technical report with the title 'Using face masks in the community' published on 8 April. The recommendation was that 'The use of face masks in the community could be considered, especially when visiting busy, closed spaces, such as grocery stores, shopping centres, or when using public transport, etc.' and that ' The use of non-medical face masks made of various textiles could be considered'. The issue was further addressed in the 'Guidelines for the implementation of non-pharmaceutical interventions against COVID-19' published on 24 September. The recommendation was that 'implementation of the use of face masks in the community

when physical distancing cannot be guaranteed should be strongly considered, both indoors (e.g. supermarkets, shops and public transport) and in crowded outdoor settings in areas with community transmission of COVID-19. In addition, use of face masks should be strongly recommended for groups at risk of developing severe complications if infected (e.g. individuals in older age groups or having underlying conditions) and in people whose occupations involve extensive face-to-face contact with the public in areas where there is ongoing transmission'. The use of non-medical ('community') face masks was considered an acceptable option that may successfully address the issue of availability and cost.

ECDC provided in February guidance on needs assessment for personal protective equipment including respiratory protection to support preparedness planning in healthcare settings.

19) **Europe did not create any framework for the Member States for issuing positive or negative travel advisories. How is that possible? Is there no mandate for setting up crisis coordination? Are there no bodies for this purpose in existence?**

This question is best referred to the European Commission.

20) **After the first lockdown, European borders were re-opened, and it was possible to travel within the EU. Why did the ECDC not arrange classification into different zones (red, orange, etc.), rather than leaving this to be done by the Member States themselves?**

There is no scientific evidence for categorising countries in different zones for the purpose of informing border measures at the stage of significant transmission of COVID-19. A decision to do so is a political decision and therefore not in the mandate of ECDC.

21) **The approach in Europe was at Member State level. ECDC updates the statistics of the various countries, and harmonises them. How do the figures for Belgium relate to those in our neighbouring countries and other EU Member States?**

Figures for Belgium and other Member States are available on COVID-19 country overviews.

Has ECDC already carried out an evaluation of which measures seemed to be effective in the approach to the pandemic?

ECDC reviewed the literature on evaluation of non-pharmaceutical interventions applied during the COVID-19 pandemic in the 'Guidelines for the implementation of non-pharmaceutical interventions against COVID-19'.

Will there be a report comparing how the EU Member States reacted, how fast they reacted and what the effect is on the statistics and on the policy implemented in those Member States (in comparison with the others)?

This question is best referred to the European Commission.

22) **Do some of the powers of the Member States for health care need to be transferred to the European level (e.g. pandemic management)?**

This question is best referred to the European Commission.