

EAN News

Newsletter of the EPIET Alumni Network



September 2009

Editorial

Dear EAN Friends,

You had a nice summer? September has come and it's time to go back to school! To help you cope with this autumn feeling we have prepared yet another very rich edition of the EAN Newsletter.

ESCAIDE is coming soon and you will know more about the conference and what is planned. This is especially important for EAN since we will hold our general assembly and the elections for 4 new posts in the Board. Also, it's the best opportunity to meet Cohort 15 which has just started. So don't miss ESCAIDE!

The new cohort is currently in Lazareto. In the "European Perspective", Thomas Seyler tells us of vector borne diseases in Europe and among other interesting information he reminds us of the original use of this little island that everybody knows so well.

Also, we had the pleasure to interview Biagio Pedalino, a former Epiet Fellow working for Epicentre on his training and especially on life after Epiet. We hope that his experience can be of inspiration for the new cohort.

In the "Stories from the Field" we will read about the adventures of two members (Christian Winter and Hannah Lewis) in Laos between elephants, epidemiology, and motorbikes.

Finally, in our "Epi Tools" section we follow with the theme of communication and networking in public health already established in previous issues of the EAN Newsletter, introducing the Health Research Web (HRWeb) launched by the Council of Health Research for Development (COHRED).

As you can see there is not much about H1N1 in this issue because we are sure that you will hear what everybody is doing to contrast the epidemic (and the possible new wave) at ESCAIDE already. So, we hope that with the EAN Newsletter you will be able to take a relaxing break from the flu or, if you actually have the flu, well, stay in bed and look at all the nice pictures.

Enjoy your read!

From the EAN Board

Welcome Cohort 15!

The new cohort of fellows (EPIET, PAE and FETP) has just started. Here are their names and where they will be based. Good luck with this new adventure!

Name	Surname	Based in
Anoek	Backx	Cire-Sud, France
Anne-Sophie	Barret	HPSC, Ireland
Angie	Bone	InVS DMI, France
Grazia	Caleo	Epicentre, France
Valérie	Decreane	SMI, Sweden
Marie-Amélie	Degail	HPA CFI, UK
Dafina	Dobрева	DGS, Portugal
Sandra	Dudareva	RKI, Germany
Martina	Escher	Cire Antille-Guyane, France
Sophie	Gubbels	SSI, Denmark
Lucia	Hrivniakova	AGES, Austria
Andreas	Jacks	THL, Finland
Elisabeth	Kanitz	ISS, Italy
Maria	Kerammarou	CDSC/ NPHS, Wales, UK
Olivier	le Polain de Waroux	HPA, Ldn Reg, UK
Ricardo (Barreiros)	Mexia	FHI, Norway
Alma	Tostmann	HPA South West, UK
Jane	Whelan	RIVM, NL
Alper	Kilic	LGA BW, Germany
Camille	Escadafal	RKI, Germany
Jessica	Vanhomengen	Institute Pasteur, France
Cornelia	Adloch	RKI, Germany
Mathias	Altmann	RKI, Germany
Benedikt	Greutelaers	RKI, Germany
Elke	Mertens	LUA, Rhineland-Palatine, Germany
Matthias	Nachtnebel	RKI, Germany
Petra	Stöcker	RKI, Germany
Hendrik	Wilking	RKI, Germany
Beatrix	von Wissman	LGL, Bavaria, Germany
Janne	Møller-Stray	FHI, Norway
Yu-Lun	Liu	AGES, Austria

EAN Membership



With the arrival of Cohort 15 and other new members from FETP programs around Europe, we have now 243 members in the EAN! We remind you that all epidemiologists from European Training programs can automatically join the EAN by sending an email to eanboard@gmail.com. External applicants are also very welcome; these should be 10% of the internal EAN members. External applications need to be endorsed by 2 EAN members. External applications are approved every EAN during the annual EAN board meeting.

EAN membership fees

The yearly membership fee is €20. New fellows are exempt from this for the first year of their fellowship. Starting from the second year of fellowship every member should pay the fee. We kindly ask you to contact Gianfranco (gfspiteri@gmail.com) and/or Chris (kitwilliams@doctors.org.uk), the EAN Treasurers, in case you want to get information on your membership payment. You should all have received a reminder about this: so please, make arrangements for overdue payments if you have not already done so. We also encourage you to pay for more than one year so to secure your membership for a longer period of time and avoid duplicating banking costs.

Please contact Gianfranco before the transfer & indicate your name and membership year as reference.

Name of Bank: HSBC Malta
Account Holder: Epiet Alumni Network
Account number: 85110443451
IBAN: MT41MMEB4485300000085110443451
BIC/Swift: MMEB MT MT
Sort code: 44853

We are also in the process of registering an EAN PayPal account to make it easier for our members to pay the fee, so watch this space!



EAN is again involved in the organization of the European Scientific Conference on Applied Infectious Disease Epidemiology (ESCAIDE).

This year's ESCAIDE will take place in Stockholm from **26-28 October 2009**, for the first time from Monday to Wednesday.

The conference venue will be the München Bryggeriet, which is located in central **Stockholm**. By now all those who submitted abstracts and latebreakers to ESCAIDE will have heard if they have been accepted or not. After the first round of accepted abstracts, EPIET clearly stood out with 39 out of 100 abstract slots occupied by fellows! This clearly shows the quality of EPIET training!

Please do not forget to register for the conference with www.escaide.eu.

Details of the programme

On ESCAIDE's homepage you will also have access to the programme, with a lot of new topics like Ageing and infectious diseases, GIS analysis, Genotyping for epidemiologists, and our newest bad guy H1N1!

General Assembly

The GA for EAN members with the annual voting of the vacant board positions will be held during the GA on Tuesday afternoon right after the programme, so please reserve some time for our yearly meeting and remember that only members who are up-to-date with their annual fees can vote.

EAN Board Elections

VOTE Four positions for EAN's board will become vacant this year. Barbara Schimmer, our current President, plans to step down and make the way free for the next "generation". The position of Secretary and Vice-Secretary were newly assigned last year, so they are not up for voting unless one of the newly elected members decides to run for one of the vacant positions. Other positions up for election this year are also the Vice-President, Treasurer, and Vice-Treasurer.

As explained in an email to all members, those eligible for voting are members who have their fees paid up to 2008/09 and who pay the current year 2009/10. You all know you can do this via online banking, to make everyone's life easier, don't you? Current fellows have no voting right.

Votes can also be delegated on a signed piece of paper (also via fax or PDF). A member can vote for up to 5 other members via delegated vote. So if you don't plan to attend ESCAIDE or the GA, please give your votes to a member who you know will be present.

This also means that if you are planning to run for one of the EAN board positions, you should make this known before the GA so that those members who delegate votes to others can also vote for you!

Tephinet

A big TEPHINET meeting was held in Lyon this year. Representatives for numerous FETP programmes worldwide were present, and also those planning to implement an FETP.

There were many fruitful discussions and exchanges and TEPHINET will be helping many programmes to get on their feet, but the most impressive realization was to be aware of EAN's role as a network and alumni association. To our knowledge, no other FETP programme has a formalized alumni network like EPIET and the European FETPs! EAN has been asked to aid TEPHINET and lead the way for other programmes to help them put up their own alumni network and talks are going even further, toward an international alumni network of field epidemiology programmes!

Members interested in this initiative please contact us! We will need a whole lot of hands here!



European Perspective

Mosquito-borne diseases in Europe

By *Thomas Seyler* (Epiet Cohort 12, French Institute of Pondicherry)



Mosquito brigades (DDT spraying) in Latina, Italy, 1948. Courtesy of Istituto Superiore di Sanità, Photo: Prof. Missiroli

In the times of our great-great grandparents, the authorities of the city of Mahon were imposing quarantine on suspected yellow fever patients in the Lazareto. The disease was feared in many European harbours and documented outbreaks such as the one affecting the city of Barcelona in 1870 were devastating (mortality rate of 550 per 100,000 inhabitants). The culprit was a black and white urban mosquito called *Aedes aegypti*. Further north, and as late as 1918, Malaria transmission was reported in the North Kent marshes, in the United Kingdom, where the mosquito *Anopheles atroparvus* was well-established. And if you were to make a sero-survey among Athenians today, you would find that some people born before August 1928 have dengue virus antibodies. In that year, approximately 650,000 inhabitants from the Greek capital contracted dengue fever and an estimated 1,000 died. As for yellow fever, the vector was a mosquito from the *Aedes* genus.

But that is all ancient history. The latter half of the 19th century saw the last reported autochthonous outbreak of yellow fever in Europe while no dengue transmission has been documented on the old continent after the Greek episode of 1928 (*Aedes aegypti* is no longer found in Europe). The extensive use of DDT (black and white pictures at the Italian Institute of Health showing the 'mosquito brigades' are a reminder of the scale of the operations), the draining of marshes and changing lifestyles meant that malaria was eliminated from Europe in 1975.

Today, the burden of mosquito-borne diseases in Europe (excluding overseas territories) is almost entirely due to imported cases. Increased international mobility and specifically air-passenger flows between the EU and tropical regions where the

diseases are endemic have led to an increased number of people developing the symptoms in Europe upon, or shortly after, arrival. In 2006, EU member states (excluding France and Denmark) notified 4,187 imported confirmed malaria cases to ECDC. The European Network on Imported Infectious Disease Surveillance (TropNetEurop), which covers around 10% of patients in Europe with imported diseases, reported between 100 and 200 imported clinical dengue cases annually since 2002. The majority of cases occurred among European tourists, while immigrants and refugees accounted for a small share of all imported cases (less than 10%).

The main message here is that the burden of vector-borne diseases in Europe is relatively low compared to other infectious diseases and remains largely a travel medicine issue. Prevention measures therefore rely on a sustained effort to inform travellers on the available strategies to avoid infection while visiting endemic or epidemic regions. Prompt and effective treatment of imported cases depends on a timely diagnosis, so raising awareness among health professionals in Europe is equally important. It is also in the interest of the EU to enhance international cooperation in the field of surveillance and control of vector-borne diseases in endemic regions.

This being said, some recent events have raised concerns about the possible resurgence of autochthonously transmitted mosquito-borne diseases in the EU. These events have already been described in Eurosurveillance. Here is a brief overview.

In September 2008, the regional microbiological laboratory of Bologna reported the first autochthonous human case of West Nile virus infection in Italy. West Nile virus is transmitted through the bite of an infected *Culex* mosquito. Autochthonous human cases had already been reported in other EU member states, most notably in Romania (1996 outbreak, 500 clinical cases), Hungary (sporadic cases, 14 in 2008) and France (latest human case in 2003). While the situation is nowhere near the US experience where the disease emerged in 1999 and is now endemic in all states, it does indicate that environmental and entomological conditions leading to the transmission cycle do exist in some parts of the EU.

In summer 2007, one year after the re-emergence of Chikungunya fever in the Indian Ocean and South Asia, the regional health authorities of the Emilia-Romagna region (Italy) reported the first autochthonous Chikungunya outbreak in a temperate climate, with 217 laboratory-confirmed cases. The vector, *Aedes albopictus*, is established in several EU member states.

In August 2006, an autochthonous case of *Plasmodium vivax* malaria was diagnosed in Corsica (France). Similar cases of local transmission (without counting the so-called airport malaria) were documented in Spain (2001), Greece (1998) and Italy (1997), and ESCAIDE participants this year will hear about another case from France. Some mosquitoes of the *Anopheles* genus - vectors of Malaria in Europe before 1975 - are still to be found throughout the continent.

The presence of known vectors within the EU is no novelty - nor is it necessarily worrying in itself. It is no novelty in the cases of *Anopheles* and *Culex*, and the recent re-introduction in the 1990s of the *Aedes* genus (with *Aedes albopictus*) has been linked to increased international trade volumes (rather than global warming). It is not worrying in itself: the presence of a vector in a given region does not imply transmission of the disease, as it depends on a host of environmental and social factors (introduction of the parasite/virus; development of the parasite/virus in the mosquito; contact with humans). What the recent events described above show is that these conditions are met in some parts of southern and eastern Europe in the summer. Imported cases (or migrating birds in the case of West Nile virus) have been in contact with the vector; the temperatures were high enough and the vector lived long enough for the infectious agent to develop in its salivary glands; there were enough infectious mosquitoes and susceptible humans around for an infective bite resulting in a human infection.

Should vector-borne disease be a public health priority in the EU? No, but vigilance is required. And vigilance, as always, implies surveillance. Human surveillance can be improved by raising and maintaining awareness among GPs and consultants on signs and symptoms, and by strengthening laboratory capacity at regional level. Entomological surveillance can make a difference by developing harmonised indicators to refine and compare local risk estimates (see maps produced by ECDC¹ and the work of the EDEN project²) and by identifying the most efficient and acceptable vector control strategies. Last but not least, effectively training the next generation of entomologists will be crucial in order to tackle future challenges (including the ones brought by other vectors such as ticks and sandflies).

The prevention and control of mosquito-borne diseases is also a field in which we Europeans can learn a great deal from foreign professionals whose countries have incessantly had to combat these diseases as a major health problem.

¹http://ecdc.europa.eu/en/publications/Publications/0905_TER_Development_of_Aedes_Alboipictus_Risk_Maps.pdf

² <http://www.eden-fp6project.net/>

Interview

EAN interviews Biagio Pedalino (Epiet Cohort 7, Epicentre) on Epiet, post-Epiet, and life in general.



As EAN members we know that, no matter if we work at local level or internationally, infectious disease epidemiology is a global discipline. The efforts of Epicentre (the epidemiological satellite of Médecins Sans Frontières) in tackling infectious diseases emergencies all over the world demonstrate perfectly this philosophy.

We asked 9 questions to Biagio Pedalino, Head of the Intervention Epidemiology & Training department of Epicentre in Paris. Biagio graduated in Medicine in 1993 and specialized in Public Health and Epidemiology in 1998 in Palermo, Sicily. After working at both local (public health unit) and national level ISS (Istituto Superiore di Sanita', Rome), he was part of EPIET Cohort 7 based 1 year at HPA (Health Protection Agency) in Belfast and 1 year at HPSC (Health Protection Surveillance Centre) in Dublin, Island of Ireland between 2001 and 2003. After EPIET Biagio worked as an independent consultant for a couple of years and had an experience in a pharmaceutical industry for 18 months. Since April 2007 Biagio is based at Epicentre.

EAN: What was your first contact with infectious diseases?

Biagio: I was eight when my younger brother had measles... and despite the close contact I didn't get the disease. Then I thought... hmmm why someone gets the disease and someone else doesn't...???

EAN: What is your best memory of your time as an EPIET fellow in both Belfast and Dublin?

Biagio: Two episodes, not epi related though, but still. When I first arrived in Belfast I wanted to take advantage of the language classes and asked Brian for the "permission" to attend an English class. Brian looked at me and said: "I don't see the need of going to an English class... we understand you!!!". Of course my problem was the Belfast accent to which however I got used after a couple of pints in a bar with friends. The second episode was in Dublin: Darina was worried about the area I was living in, and talking to Stefania on the phone (I am sure about more important matters) said "I am worried about the area where Biagio is living" to which Stefania replied "I wouldn't be worried about that, he survived Palermo for 10 years, I am sure he'll be fine anywhere!"

EAN: How did the EPIET fellowship prepare you for your job at Epicentre?

Biagio: I joined Epicentre a couple of years after the EPIET fellowship, after some experience as consultant field epidemiologist for different organizations, and a brief experience in the pharmaceutical industry. In the end, no matter the logo and hat we may have and wear, the EPIET programme prepares fellows to face any possible intervention epidemiology jobs, locally, nationally or internationally. It provides you with a global vision on public health and epidemiology; it enables you to see things in a structured way, to share the same understanding with other people, to acknowledge the value of being a good team member and to dare taking responsibility as a team leader.

EAN: What do you like the most of your current position?

Biagio: Being in charge of both intervention epidemiology and training, I am very lucky to have the opportunity to combine and directly translate intervention epidemiology into training courses. In addition, I am always impressed by the speed into which results of an epi intervention may change or modify operations in the field, a field policy on vaccination for instance, and the impact of our job. Sometime, especially in developed countries, epidemiologists and public health personnel have to wait for years and may never see the impact of their actions, over here, I can tell you... if something goes well, you immediately see it, and if something goes wrong... you'd see it even sooner...

EAN: What do you like the least?

Biagio: The coffee in our coffee machine...

EAN: In light of your professional experience, looking back, is there anything you would rather had gone differently during your EPIET training?

Biagio: When I went through the EPIET programme the cohort was quite small and exchange of info, knowledge and experience within the cohort, with coordinators, other facilitators, or participants in the EPIET activities was relatively easy. What I would recommend today is to keep this exchange alive despite the challenge of being in a bigger cohort. I am sure that the current coordinators do their best to ensure that. As a fellow, I would certainly promote that even more to be sure that the network (surely well established within the same cohort) is also established with the co-current cohort.

EAN: You obviously are doing the job of your dreams, but if you would not be an epidemiologist, what would have been your second dream job?

Biagio: Having my own cocktail bar/restaurant on a beach somewhere warm at least 6 months a year...Still not excluded though... and of course you would be all invited for the opening...and to conduct a couple of studies on mojito and frozen margarita consumption...

EAN: Surely, when you applied to EPIET, the interviewing panel asked you the dreaded question: *where do you see yourself in 10 years time?* How did you answer?

Stories from the Field

With Love from Laos: The Land of a Million Elephants and the White Parasol

By *Hannah Lewis (Epiet Cohort 12, WHO Laos)* and *Christian Winter (PAE Cohort 12, WHO Laos)*.



H1N1 Training

After finishing EPIET (Hannah) and PAE (Christian), we both wanted to apply our newly learnt epidemiological skills in the field so were very excited when we found out about the opportunity to work in Lao PDR. This South-East Asian country is slightly bigger than the UK, has a population of 5.6 million and is ranked 133 out of 179 countries in the Human Development Index.

When I (Hannah) arrived in Lao PDR in November 2008 it was my first time in the country and my first position with the World Health Organization. Thanks to an informal dinner briefing and many e-mail exchanges with my predecessor, Annick Lenglet (EPIET cohort 10) and support from Amy Cawthorne (EPIET cohort 9) in the regional office, the transition was relatively smooth. However, they hadn't prepared me for how long and hot the rainy season would be, that intestines come in all shapes and sizes in Lao dishes (offal is my one pet hates!) and that Beer Lao has almost a complete monopoly on alcohol sales and advertising! Culturally it was a bit of a shock but I soon learnt that in spite of being a poor and small landlocked country with a turbulent political history that Lao people are extremely open and friendly and the country is beautiful with many parts left unexplored.

I (Christian) joined the Communicable Disease Surveillance and Response (CSR) team at the WHO Lao Country Office when pandemic H1N1 2009 hit the world. Being members of the CSR team, both our jobs involve capacity building in the country - supporting our national counterparts to develop the public health system (surveillance and response, clinical management, infection control, zoonoses and communication). As this was the first time either of us had worked on surveillance and response issues in a developing country, there was a very steep learning curve. Core epidemiology skills are key as the

Biagio: Fortunately, the hosting site panel did not ask that question (when I applied the selection process was different). The national panel, probably knowing me, asked a more reasonable question “what do you want to do after the EPIET programme”, to which I replied “I will obviously come back to Italy, if any job is available”, that objective has obviously been revised since.

EAN: It has now been more than 8 years since that day. You have less than 2 years to go. Still heading there or have your plans changed?

Biagio: Well, again, my original plan when I started EPIET was to go back to Italy after the training and apply my newly acquired skills over there. However, after the programme, I thought... “the contribution to our own country may be given differently and not necessarily directly, and maybe sometimes we need to look at the forest and cannot focus on the trees only”... and here I am... will I go back eventually? Who knows?

surveillance system is in its infancy and basic principles such as data checking and validation and even data analysis are not standard practise, especially once outside the national epidemiology institute. Our CSR team is currently large with seven international and a similar number of national staff and there is a fantastic team spirit.

Being in a supportive role can be tough sometimes - it would often be much easier to do things ourselves than explain the need and then the principles behind, for example, an epidemic curve. Also, it is sometimes hard to relinquish control over a work project and not to feel responsible for the outcome but at the end of the day we are just assisting. However, the work can also be amazingly rewarding.

We were lucky enough to start at WHO just as the first cohort of Lao Field Epidemiology Training (FET) started. Eight central and provincial doctors with very little epidemiological training are being put through a one year FET course comprising lectures (by national staff and WHO) and field work. Lecturing the FETs on different topics such as basic epidemiology, and accompanying them on outbreak investigations has been fun and inspiring. We've also learnt a lot about epidemiology in a developing country from them and are constantly surprised by how quickly they are picking up new concepts and applying them. We are very happy that an 'EPIET'-like spirit is present as we see them assist each other and provincial colleagues and having fun when socialising together. We'd like to thank EPIET for letting us use some training material - the co-ordinators would be very impressed with their EPIET-style presentations!

Naturally, like most epidemiologists world over we are now consumed with pandemic H1N1 2009. I (Hannah) have been supporting national epidemiologists with enhanced surveillance. I have assisted in initiating ILI clinical surveillance nationwide for the first time, integrating different types of influenza data and determining criteria for sample collection so that the national laboratory does not become overwhelmed. I (Christian) have been responsible for clinical management and infection control of pandemic H1N1 in the country since the beginning of the pandemic. The health care system is set-up in a hierarchical way, with six central hospitals, 16 provincial hospitals, 127 district hospitals and 750 health centres. In spite of having short-comings, this system facilitated the organization of nation-wide H1N1 training using the train-the-trainer method. I supported this training by developing training agendas, up-to-date guidelines, presentations and case scenarios. Using interactive case scenarios for group work and discussions was a very effective and a new learning method for most Lao clinicians. I learnt a lot myself during these trainings, like how to spontaneously give a speech in front of hundreds of participants! I was very glad that translation into Lao was required, giving me time to think what to say next...

Alongside these activities, our work has become very applied - providing option papers for the MoH- from definitions for community wide transmission and criteria for Tamiflu use to whether various public

health measures such as community mask use and school closure are effective in the Lao context. As most, if not all, H1N1 epidemiological information has come from countries more developed than Laos we await to see how the pandemic will pan out here. With many ethnic minority groups, particularly in remote hard to reach areas and a basic health care system, the months ahead are likely to be challenging especially with the upcoming South East Asia (SEA) Games.

Meanwhile, dengue is also a neglected but very present threat in Laos and we have been working to improve surveillance, control, and clinical management in the country. We have also had trips to the field for both workshops (pandemic planning, clinical management) and outbreak investigations. The outbreak investigations are often to remote provinces where conditions are basic and very little information can be gleaned before arriving at the scene. As laboratory testing is so limited and when available, takes time, good descriptive epidemiology is important in trying to determine the source of the outbreak and informing on control measures.

Of course, life in Laos isn't just about work! We socialise a lot with our work colleagues and "expats" from all over the world. There is little nightlife in Vientiane as the culture is very family-orientated. We socialise mostly though sports and dinner, but also escape once in a while to Bangkok or Kuala Lumpur to enjoy the offers of a city-life, including cinemas, shops and escalators (there is only one in Vientiane!). We also both love exploring Laos and have been on weekend trips, mostly on our motorbike - exploring waterfalls and caves, climbing and hiking.



During an outbreak investigation: norovirus on cruise ships?

EPI Tools

Health research as a development tool: introducing *HRWeb*

By *Lorenzo Pezzoli* (Cohort 12, EAN Board) and *David Abreu* (COHRED)



<http://www.healthresearchweb.org/>

There is a difference between health research that is done to deliver technical solutions for those who can afford them or health research as a central element of alleviating human suffering, improving health and health equity, and contributing to a country's development.

COHRED is an International NGO based in Geneva supporting countries to optimise their health research potential to improve health and reduce health inequities. COHRED prioritises the poorest countries, regions and populations, linking health research with science, technology and innovation, with the vision that everybody, independently from the country they live in, should achieve optimal health.

Over the last decade, health research has become progressively more relevant in both international and national development. In many low income countries, the overwhelming proportion of research funding (>90%) comes from many different external sources. This multi-faced budget is often the only resource available to stimulate the national research and innovation sectors. Therefore, it is not surprising that many national research managers are increasingly interested in having access to systematically collected information on international health research involving their own countries. Yet such information is hard to come by.

COHRED has been working intensively with countries, institutions, researchers, media, donors and sponsors over the past years, listening to the needs of different health research stakeholder groups. The information needs of these groups are extensive and varying on the one hand, but similar on the other: basic research management information to enable them to improve their impact, synergy, collaboration, and focus.

It surely happened to many of us when drafting a study protocol, to search for information about ongoing projects and their results in the country of interest. Who is doing what in which country? What is the main research need in this country? What has been done so far? Have the results been published? Who to contact if I need funding for my project? With whom should I collaborate to optimize the research? And so on... In most of the cases this information is already floating in the Internet Ocean, but it takes many sleepless nights to "surf" it all, with the risk of missing some key aspect anyway.

With the risk of sounding like a movie trailer: Imagine a World where all these important questions could be answered with just a couple of clicks! With this in mind COHRED has designed the Health Research Web (<http://www.healthresearchweb.org/>) or *HRWeb*, as a global forum to share all relevant information on health research by country.

The main features of *HRWeb* are:

- Researchers, health donors, or sponsors will have access to detailed and searchable information on current research projects in each country; institutional and personnel profiles; information on grants or calls for proposals; capacity building activities; networking opportunities and ethical review processes;
- Governments will have direct access to statistical information: for example, the percentage of research done on certain topics, external funding sources and levels to research and training activities;
- Media will have access to contact details of key players in the national health research systems, health research abstracts and data on disease-focused programmes or financial flows to be able to improve their reporting;
- Civil society organisations engaged with health research - from conducting it, to supporting it, to communicating it - will know who to contact to monitor progress and assess responsiveness of governments and international researchers to the problems of the poor;

How does this work? On the main page, an interactive map permits you to select the country of interest. For each country different sections allow you to get to the information you need: Governance and Policies, National Priorities for Health Research, Key Institutions or Networks, Ethics Review, Research Financing and Partnerships, Projects and Publications, and other Information Resources.

All this information is downloadable already aggregated or in user defined graphs and in excel spreadsheets for the users to conduct their own analysis and also conduct cross-country comparisons, analyses of national health priorities - to see which research interventions are most effective in each country.

The aim of *HRWeb* is very simple: it intends to be an open service broadly based on interactive global cooperation for better knowledge. The strength of

this project does not only rely on the important information that users can download and use, but on the innovative concept that the website is meant to grow with the input of its users. Information can be shared and updated by each user.

If the aim of is simple, the technology behind it, which was derived from a platform piloted by the Ministry of Health in Brazil, is of the most advanced kind. Logically, the user profiles (governments, research institutions or single users) have different levels of access, but each user can use the website to upload information in a *wiki-way*.

The key feature of *HRWeb* is really that it is an attempt to break away from the traditional mode of data collection: “by a few on the many”. Instead, using advances in technology and global data sharing, *HRWeb* is meant to evolve around user-driven knowledge. The focus is on the users, with COHRED’s main roles as platform development and editorial quality.

As deeper and broader information on countries’ health research systems will be progressively added, *HRWeb* will become a platform for access and sharing of information between all active in health research. As usual in public health, efficient communication is the key! The project will at first focus on low and middle income countries with the aim to expand globally once information on all interested countries will be added.

HRWeb can only work optimally if the users get actively involved. It needs to rely on the contributions of each partner, keeping in mind that there really should not be a distinction between *Developed and Developing World* when it comes to public health, but everybody should contribute, if not with equal resources, always with maximum level of effort.

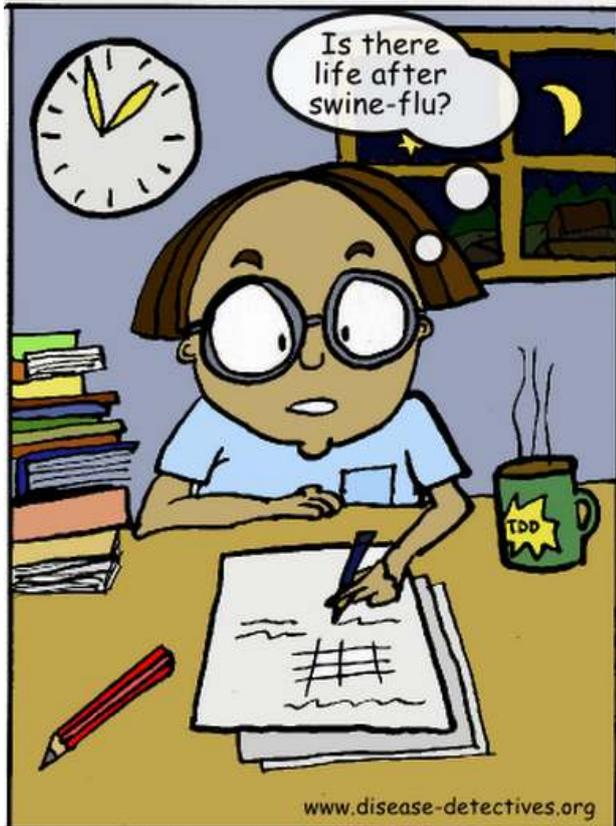
Born in the EU, but with members working all over the World on *Global Public Health*, the Epiet Alumni Network (EAN) is strategically placed not only to benefit from *HRWeb*, but especially to encourage this initiative. So we invite all EAN Members and their host institutions to register and get involved!

HRWeb went *live* on 31 August 2009 and will be officially presented at the Global Forum for Health Research in Havana, Cuba (Nov. 16-19). At present *HRWeb* is in *beta version*, in this phase many of the utilities of are still being built and the project will still expand for the next months. During the Beta testing, the adaptability of *HRWeb* is the key feature. COHRED encourage users to define or identify new functionalities that will make *HRWeb* even better suited towards health, equity and development for all. The *HRWeb* programming team encourages all of you to send ideas and make changes. Even programming support is very welcome from those of you who are especially technically-savvy.



For information and support, please contact the *HRWeb*team: David Abreu, Claudia Nieto, Sylvia de Haan, Carel IJsselmuiden and Bruno Coelho. For further information contact: abreu@cohred.org.

EPI Cartoon



This edition's Epi Cartoon is kindly provided by Esther Kissling and Florian Burckhardt from their www.disease-detectives.org initiative.

Upcoming Conferences and Courses

- [5-8 May 2010, 28th Annual Meeting of the European Society for Paediatric Infectious Diseases \(ESPID\). Nice, France,](#)
- [1-4 February 2010, 2nd International Conference on Drug Discovery and Therapy \(2nd ICDDT 2010\), Dubai, UAE.](#)
- [10-11 December 2009, 5th National Workshop of Veterinary Epidemiology, Torino, Italy](#)
- [7-11 December 2009, Concepts of Epidemiology: crash course, Edinburgh, UK](#)
- [16-20 November 2009, Global Forum for Health Research: Innovating for the health of all. Havana, Cuba](#)
- [26-28 October 2009, 3rd European Scientific Conference on Applied Infectious Disease Epidemiology \(ESCAIDE\), Stockholm, Sweden](#)
- [8 - 11 October 2009, 10th Congress of the International Federation of Infection Control \(IFIC\), Vilnius, Lithuania](#)
- [23-26 September 2009, BALTIC CONGRESS ON INFECTIOUS DISEASES, St Petersburg, Russia](#)
- [23-25 September 2009, eHealth 2009: 2nd International ICST Conference on electronic healthcare for the 21st century, Istanbul, Turkey](#)

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