

EAN News

Newsletter of the EPIET Alumni Network



www.epietalum.net

December 2011

Dear EAN Friends,

As the time comes to look back at the year that has just passed and think about our New Year's resolutions, please welcome the December 2011 EAN Newsletter.

What did 2011 bring?

Well, for example a new way of looking at sprouts. For sure this previously pretty unremarkable ingredient, now jumps to the eyes of most of us no matter how well camouflaged it is. Not surprisingly, this edition of the newsletter is very much focused on the EHEC outbreak. But there are not only sprouts in the newsletter. We can read about a very retrospective (or shall we say teleretroscopic?) cohort study, about the international mission conducted for health preparedness for the African Cup of Nations, or about an interesting epi-tool to visualize clusters of infectious diseases in time. We also welcome the new cohort of EPIETs, EUPHEMs, and FETPs. In addition, the travel grants awardees share "their ESCAIDE 2011" with us.

What will 2012 bring?

As perfectly exemplified by the Epi-Cartoon, it's hard to guess (unless you trust the crystal ball, AKA statistical modelling), although we can be sure of some things. The EAN board will be the same as last year, for example. The EPIET programme might have to say goodbye to *la Líder Máxima* of EPIET (although for us this is just an "*Hasta Luego*" since Viviane is obviously still in the Network), but a new chief-coordinator is ready to take the responsibility of investing the future EPI-Knights. And most of all we can be sure that, once again, whatever public health threat is coming in 2012 the EAN members will work hard to control it, just like they did in 2011.

But first... some holidays.

Happy New Year, EAN!

The EAN Board

Lorenzo, Florian, Helen, Chris, Annick and Marc

From the EAN Board

EAN Membership

EAN is currently comprised of 280 members. All graduates and current fellows of European Field Epidemiology Training Programmes can join the EAN. External applications from colleagues working in public health epidemiology are also very welcome; they need to be endorsed by 2 EAN members. If you want to join, please send an email to eanboard@gmail.com to request the application form. Our statutes specify that external members may not exceed 10% of the regular members.

EAN membership fees

The annual membership fee is €20 and runs from January until December. Fellows in their first and second year of training are exempt from paying membership fees, according to the accepted statute's change at the 2011 General Assembly.

We kindly ask you to contact the EAN board (eanboard@gmail.com) in case you want to get information on your membership payment (put in the subject: **membership payment**).

For the time being we are using our bank account in Malta. Please indicate your name and membership year as reference in the bank transfer and also send an email to eanboard@gmail.com to inform us about your payment (sometimes names are not correctly transmitted with the transfer).

Name of Bank: HSBC Malta

Bank address: HSBC Bank Malta p.l.c., 233 Republic Street, Valletta VLT 1116, Malta

Account Holder: Epiet Alumni Network

Account number: 85110443451

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EAN Democracy

During the 2011 General Assembly in Stockholm, Lorenzo, Helen and Chris were re-elected as the President and Treasurers, respectively. We look forward to continue working in the new-'old'-board and try and finish some of the projects that we have started over the last two years.

EPIET and EUPHEM

We have the pleasure to welcome into the Network around 40 new fellows that enter in Cohort 17 for EPIET and FETP and Cohort 4 for EUPHEM.



EPIET

Ides Boone (BE), Landesgesundheitsamt Baden-Württemberg (LGA), Germany,
Marie Louise Borg (MT), Health Protection Agency South West (HPA-SW), UK
Carlos Carvalho (PT), Health Protection Agency/Health Protection Services (HPA-HPS), UK
Giovanna Ciaravino (IT), Instituto de Salud Carlos III (ISCIII), Spain
Frédérique Dorléans (FR), Statens Serum Institut (SSI), Denmark
Tanja Ducombe (LUX), Robert Koch-Institut, Germany
Nelly Fournet (FR), Rijksinstituut voor Volksgezondheid en Milieu (RIVM), The Netherlands
Paulius Gradeckas (LT), Országos Epidemiológiai Központ (OEK), Hungary
Pete Kinross (UK), European Centre for Disease Prevention and Control, Sweden
Teija Korhonen (FI), InVS - Centre for Disease Prevention and Control, France
Indra Linina (LV), Institute of Public Health, Belgium
Isabel Martínez Pino (ES), Epicentre, France
Carmen Montaña Remacha (ES), Istituto Sanitario Superiore (ISS), Italy
Aleksandra Polkowska (PL), Terveyden ja Hyvinvoinnin Laitos (THL), Finland
Justyna Rogalska (PL), Health Protection Surveillance Centre (HPSC), Ireland
Anneke Steens (NL), Folkehelseinstituttet (FHI), Norway
Ryszard Tomiałojć (LT), Narodowy Instytut Zdrowia Publicznego - Państwowy Zakład Higieny (PZH), Poland

Sabine Kasper (AT), Österreichische Agentur für Gesundheit (AGES), Austria
Cristina Giambi (IT), Istituto Superiore di Sanità (ISS), Italy
Denisa-Gorgiana Janta (RO), National Institute of Public Health, Romania
Andrea Kološová (SK), Regional Public Health Authority in Komárno, Slovak Republic
Rita Szabó (HU), Országos Epidemiológiai Központ (OEK), Hungary
Bolette Søborg (DK), Statens Serum Institut (SSI), Denmark
Danai Pervanidou (GR), KEELPNO, Greece

EUPHEM

Daniel Eibach (DE), Institut Pasteur (IP), France
Maria Dolores Fernandes Garcia (ES), Centro Nacional de Microbiología - Instituto Salud Carlos III (CNM-ISCIII), Spain
Andrea Sanchini (IT), Robert Koch Institute (RKI), Berlin, Germany
Lieke van Alphen (NL), Statens Serum Institut (SSI), Denmark

FETP Germany

Christophe Bayer, Robert Koch Institute (RKI), Berlin
Merle Böhmer, LGL Bavaria
Sebastian Haller, Robert Koch Institute (RKI), Berlin
Jane Hecht, Robert Koch Institute (RKI), Berlin
Melanie Schuster, LUA Rhineland Palatinate

FETP Norway

Horst Bentele, Norwegian Institute of Public Health, Oslo

FETP Austria

Shu-Wan Jian, Österreichische Agentur für Gesundheit (AGES)

FETP UK

Victoria Hall, HPA London & South East, Victoria
Gareth Hughes, HPA North East, Newcastle
Lucy McCann, HPA Chilton, Oxford
Caoimhe McKerr, HPA West Midlands
Lucy Thomas, HPA Colindale, Colindale

Interview

Nihao Yvan och välkommen till Stockholm!

EAN: Nihao Yvan. Congratulations, you will soon become the EPIET chief coordinator. You are not yet part of the EPIET family but you've been following its evolution for a while. Can you tell us a bit more about your connections to EPIET?

Yvan: I first learned about EPIET in 1995. That year, I had just finished a residency in clinical medicine in Paris and I wanted to start a new life in epidemiology

in public health. Alain Moren hired me to work with Epicentre, but on the first day that I arrived to start work, he welcomed me to say goodbye (That was a bit of a shock!). He was off to start this new European Programme called EPIET. Philippe Malfait, my Epicentre office colleague, soon became a fellow of the first cohort. At that time, I thought: “Wow, if all the fellows know as much epidemiology when they start, what can they learn after?” But Philippe was an outlier I guess. Philippe, Richard Pebody and I ended up working together again on a Monkeypox investigation in the Democratic Republic of Congo in 1997 as a joint EIS / EPIET team. It’s actually surprising that we are here to tell the story given the kind of airplanes we flew. Later, in 2001, when I was working at WHO headquarters in Geneva, I maintained contact with EPIET and asked the coordinators if we could not send fellows to the field to pilot test our new WHO injection safety assessment tool. Julia Fitzner and Jean Francois Aguilera went together in Burkina and did a great job (and published it!). I was always happy to have this kind of pilot-testing done by fellows rather than by old-guard professional consultants. If you are willing to invest a bit more supervision time, you get more ideas and more creativity! Later on, when I joined the India FETP as resident advisor for WHO, I collaborated with EPIET on the “laboratory for epidemiology module” developed by WHO Lyon office. I got to work again with Julia Fitzner (who had by then become a WHO colleague) and I got to know Marta Valenciano and Arnold Bosman. The link continued as in 2007, EPIET asked the India FETP team to come and share a ‘training of the trainers’ module on scientific writing with the EPIET coordination team. We had a great week in Madrid and ended up developing a model that was adapted to EPIET. Of course, in the meantime, during the various TEPHINET meetings, I got to see many EPIET fellows and their presentations that always struck me as being high quality (and wondered whether the interest for ABBA had anything to do with the location of ECDC).



Yvan, giving his first field interview in Chinese, Hunan, China.

EAN: It is surely linked to ECDC location. You gave us the opportunity to see your dancing skills on ABBA and many other EPIET classics during the EPIET award ceremony last month. I am confident about your integration in the EPIET family!

Back to your professional experiences; you were an EIS at the CDC Atlanta and later worked as an adviser for the Indian FETP.

What has been your best experience as a trainee in Atlanta?

Yvan: As an EIS officer, I was posted in the hepatitis branch, at the US CDC headquarters. It’s hard to individualize a single best experience, but the team was extraordinary: Hard working, fun, progressive and dedicated. I happened to be the only EIS officer and there were about 7 EIS graduates as supervisors. Every draft had to be reviewed numerous times by mentors who each had a different special ‘interest’ (some of them even admitting they had obsessive compulsive traits about hunting double space while correcting field reports). I learned a lot and it was an atmosphere that really nurtured high-quality, professional, peer-to-peer interactions with the objective of generating good science for public health.

EAN: What has been your best experience as a trainer/adviser in India?

The five years in India were full of activities that all offered many opportunities to discover the country, its people, its culture and its science. The stories that would come back from the field in terms of outbreaks or other programme experiences all had something to tell about India. Hence, it’s hard to single out something special. However, what we called the ‘mini-contact sessions’ during which we reviewed fieldwork reports led to fantastic moments. In one of those, after a long day of reviewing projects in a small room of a hospital of the suburbs of Calcutta, the scholars gathered (without me) in front of the metro station to chat for two hours. The next day, they told me that they had realized that they could help each other a lot through peer review without the intervention of an outside ‘expert’. It was a bliss moment.

EAN: I can imagine that reaching a stage where fellows make it to “supervise” each other autonomously must be extremely satisfying. It must also be reassuring when leaving a programme. After working for 5 years at the Indian FETP, you went to China, where you have been up to now. What is your current job?

Yvan: I work at the WHO China office, where I started as hepatitis officer. My main task was to finish the special China project of the Global Alliance on Vaccine and Immunization (GAVI), with a special focus on its final evaluation. I tried to facilitate a transition towards a ‘second generation’ hepatitis programme looking beyond hepatitis universal B

immunization to include things like surveillance, and progressively, screening for treatment. However, in the last few months, I have been also in charge of the EPI team that takes care of all immunization related activities. In that capacity, we work with the Ministry of Health of China and its technical agency, China CDC, on policies and plans for EPI.

EAN: Does this 2 year- experience in China change your way of approaching a FETP?

Yvan: During the two years in China, I kept close contacts with the Chinese FETP and worked with them on four hepatitis-related projects. As always the case with FETP officers, at the expense of a bit of technical input, I got high quality products and lots of creativity. China did not change the way I look at FETP, but it provided me with an opportunity to go back to public health service after the Indian experience. That somehow helped me be more comfortable with a new, longer commitment in the field of training now. FETP is about learning through service. That means that field epidemiology is and should always be at the service of public health. Public health actions taken as a final result of an epidemiological investigation are there to show whether you reached your goal. A career that goes back and forth between public health service and training makes it easier to understand this aspect of our work. It takes you from one end of the stick to the other.

EAN: You are quite familiar with three FETPs (EIS, India and China). Have they developed any kind of alumni network such as EAN?

Yvan: China does not have an alumni association. In that field, they could benefit from interactions with EAN! India does have one. I am not sure how active it is beyond an email newsletter. The public good that an alumni association can generate is not immediately apparent. It also requires a core of individuals ready to invest more to pave the way with good vision and leadership.

EAN: It could indeed be a great opportunity for EAN to share our experience with the Chinese FETP and help them out with setting up a similar network. Are you part of the EIS alumni network? Can you tell us more about it?

Yvan: Yes I am. The EIS alumni network functions a lot informally as the sense of identity has always been very strong. Hence, formal interactions and process are less essential. However, they could benefit from a more structured approach and maybe learn from younger, more dynamic bodies such as EAN!

EAN: What is, according to you, the benefit for alumni to be part of such a network?

Yvan: Beside the short-term benefits of an alumni network (e.g., job announcements), there are real opportunities to explore. The alumni association is an

important stakeholder for the programme. The limited understanding that I have of EAN and EPIET so far suggests that this is a strong point of EAN. I find it exciting and will be happy to work with EAN to further develop that.

EAN: And we will be to work with you.

Yvan, after two years spending two hours in Chinese lesson every day, you now speak fluent Chinese. You explained me a lot of interesting combinations of character but... How do you say and what does "Epidemiology" mean in Chinese?

Yvan: Chinese is a language that makes you humble as the more you learn, the more you realize there is way more you will never know. But I can say 'epidemiology' at least. It's 流行病学, 'Liuxingbingxue'. "Liu", the first character, is about fluidity (there are three drops of water on the left side and three rivers at the bottom). "Xing", the second character, has a very broad meaning that sort of reflects the idea of proceeding forward. 'Liuxing' together means 'popular' as in 'it's a popular song'. 'Bing', the third character, means sickness (The sort of 'cape' with spikes at the top is a radical that refers to diseases). 'Xue', the last one, means 'study' (A child under a roof). Altogether, epidemiology is basically the study of the diseases that move in the population. Most scientific terms in Chinese are made of simple conceptual characters. 'Denominator' for instance, is the 'mother of the fraction'.

EAN: In our previous newsletter, we gave the floor to your predecessor Viviane. You have experienced the goodbyes to a programme. What would be your wishes for her?

Yvan: I am really sad to see Viviane go as I would have loved to work with her more as a friend and as a colleague. It's great to know she won't be far. In terms of wishes, first, I wish her to enjoy Berlin as much as she plans to. I understand it's a fabulous place, with special opportunities in terms of alternative living and low carbon footprint wear (I have unfortunately never been there). Second, I wish her to fully enjoy the dive back into a more mainstream approach to public health so that maybe, the desire of coming again to capacity building comes back in a deeper way later. Once you have it in you it does not go away.

ESCAIDE 2011

Travel Grant Recipients

As each year, EAN supported travel grants for ESCAIDE to seven applicants (five with an oral presentation and two with poster presentations). Some of the recipients have drafted their experiences at ESCAIDE for us in our newsletter.

Odette Nicolae, National Institute of Public Health, Romania

I am a Romanian senior medical epidemiologist. It was a great opportunity and the single way for me to attend ESCAIDE 2011, under the support of an EAN travel grant and I thank you for it. I prepared (together with another two colleagues of mine) and gave an oral presentation regarding the SARI Surveillance, which I am deeply involved in, with information from the first post-pandemic season in Romania. I felt very well there, “on stage”, even if I was a little nervous before, but I was a little disappointed after, due to the few questions received. The subject is beautiful and gives way to multiple questions.

I enjoyed a lot the plenary sessions, especially the final, “special” one (“EHEC/HUS 2011”). It is very much to learn from the experience of our colleagues in Germany. The other brilliant plenary session was, in my opinion, the “D” one (“Enhancing health and health equality through vaccination programmes”). The presentation of Dr. Daniel Levy-Bruhl was a good lesson to remember about the economic evaluation in the decision making process. The parallel sessions were also very interesting and it was frustrating to not to be able to participate in all of them. But, as epidemiologists, we have to learn to prioritize.

I also had the opportunity to see and hear that Mrs. Marina Yannakoudakis, an European Parliamentary, seems to appreciate the epidemiologists more than some professionals whose work is closest to ours...

The icing on the cake, beyond the scientific aspects of the conference, was the EPIET/EUPHEM award ceremony and ESCAIDE gala dinner. I was deeply impressed by the honor and appreciation given to two important names of the EPIET program (Dr. Alain Moren, the Father of EPIET and Dr. Viviane Bremer who will leave soon the EPIET team).

Congratulations to the organizers of ESCAIDE 2011!

Delia Hergheea, Romania

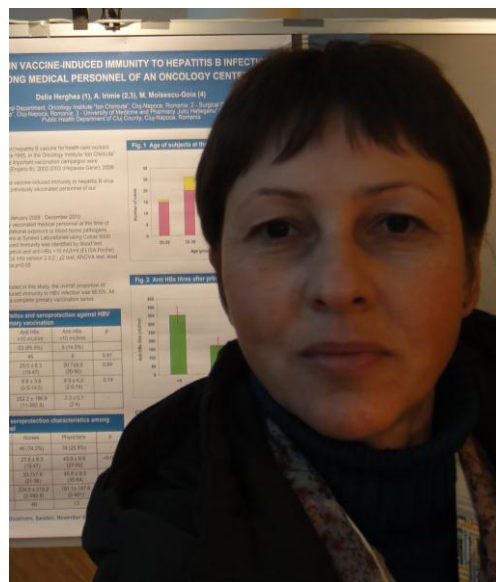
The common element of the presentations offered in the 2011 ESCAIDE conference was the international surveillance, communication and rapid alert system development, and the realization of a better link between surveillance and infection control. I was particularly interested in the availability of Romanian surveillance data at the European level.

Because of sentimental reasons I have to remind the plenary session “Parasitic infections of increasing relevance for Europe”, when it was launched the invitation for the European Multicolloquium of Parasitology “Parasites in a changing world”, which is going to take place next year in Cluj-Napoca, Romania.

As hospital epidemiologist, the nosocomial infections drew my attention in the first place. The antibioresistance session insisted on the danger represented by multiple mechanisms of antibiotic resistance, which limit the therapeutic arsenal of these infections. The plenary session “The Hospital as an infectious disease amplifier” specified that the dissemination of multidrug resistant bacteria could generate critical aspects in the context of emphatic population mobility and patient hospitalization in other country than the native one. This is why the nosocomial infections generated by multi-resistant bacteria represent another domain where global surveillance becomes a priority.

Apart from this, I watched attentively the presentation of Dr. Marie-Pierre Allié the president of Médecins Sans Frontières France, who underlined the role of multidisciplinary teams which acted in complex emergencies in different parts of the world. The key element insisted upon was the importance of identifying intervention modalities, in order to assure a long-term collaboration of all the factors involved in the management of this situation.

In the end, I want to say it was an honor to receive the EAN Travel Grant for the second time, and I am grateful to the members of the EAN evaluation team. I consider that ESCAIDE conference represents a reference event for epidemiology specialists, due to the varied and actual subjects, and to the high level of presentations. Perhaps a future ESCAIDE conference held in Romania would increase the number of Romanian epidemiologists in this kind of scientific manifestations.



Dr Delia Hergheea in front of her poster at ESCAIDE 2011

Dr S. Gupta, India

Last year it was a wonderful opportunity provided by TEPHINET 6TH Global Scientific Conference held in Cape Town-South South Africa to present orally my

thesis topic for MAE_FETP, "Factors responsible to precipitate outbreaks of measles in district Kangra, Himachal Pradesh, India, 2007. Certainly, that was a good experience in itself to interact with medical scientists across the globe but I was all alone. But this time, in ESCAIDE 2011, my long deserving medico wife also accompanied me. And undoubtedly, this occasion so provided to us couple by EAN board by providing travel grant was a great opportunity to present the four posters in any international conference. I was shaky when I was supposed to come alone with four posters in the conference but later on, with finally joining of my wife gave me tremendous boost to carry the conference with cool head upon the shoulders.

The topic of most interest was infectious epidemiology in the three days sessions. We enriched our knowledge about applied infectious disease epidemiology and epidemiological methods used to approach public health issues. A large number of oral and poster presentations regarding to different topics impressed us enormously. One of the finest posters presented was *A mixed outbreak of rubeola-rubella in District Kangra of Northern India* which carried two laboratory confirmed viruses in mixed outbreak setting and was appreciated by many of eminent personalities in the event and they also suggested to calculate the cost benefit ratio in policy framing stages to the planners. On the basis of the analytical studies done on measles and rubella in Himachal Pradesh and various scientific papers presentations in the national and international fora and journals and subsequent recommendations, Govt of India has proposed to introduce to MR vaccination at the age of 16-24 months in the well performing states like Himachal Pradesh. The project (www.femwiki.com) was our very useful epidemiological tool from ESCAIDE channel that we discovered. Excellent conference in all the departments of epidemiology, microbiology and allied sciences indeed.

Dr Mohammed Abdulaziz, Nigerian Field Epidemiology and Laboratory Training Program

As a 2nd year resident of the Nigerian Field Epidemiology and Laboratory training Program, attending ESCAIDE 2011 in the wonderful city of Stockholm is a great and unique experience for me. The EAN travel grant made this possible because the cost of travel and accommodation would have been beyond my reach. The experience started with the pre-conference training on evidence based public health in Water front congress center. The training was educative and my personal opinion is that the instructors did a very good job. The conference was well organized and the topics for the plenary sessions were well suited for the audience. I was particularly impressed by the presentation of Dr Marie-Pierre Allie of Médecins Sans Frontières titled, "Control of infectious diseases in complex emergency situations", because she brought out coordination and

communication challenges often faced by field epidemiologist working in such situations in Africa. My ESCAIDE conference experience climax with my presentation in the parallel session and I was happy to share the Nigerian experience with measles case-based surveillance system with the audience. The ESCAIDE 2011 experience was both academically and socially fulfilling for me and my gratitude goes to the EAN board for their support.

Andreia Jorge Silva, Portugal

My participation in ESCAIDE 2011 it was only possible by EAN travel grant, were I present a poster about Surveillance System for an academic week in Portalegre. This was the result of an investigation as a FETP (Field Epidemiology Training Program) in Portugal. I am teacher in Health Superior School of Portalegre and I developed this project as main investigator in a great team of colleagues who are also teachers in this wonderful school who support his collaborators projects and who involves volunteer students in it. This possibility was really an opportunity to participate in ESCAIDE 2011, who is a great event, gathering people from several countries allowing charring experiences from all over the world. And for me came it only came true do to the encouragement given by EAN.

The program was much challenged, the plenary sessions were very much interesting, some because were about new themes and the others about regular themes but still emergent and with new approaches. It was amazing the number of oral communications; many times I had difficult to choose the parallel session to participate. About the poster presentations it was very pleasant to read about the experiences and the results regarding different investigations or similar investigations but from different countries. It was also great the possibility to discuss informally with the author.

The topics about mass gathering, migrants, outbreak investigations and vaccine coverage were, for my personally interests, the ones of the most interesting. However, all presentations there I have opportunity to participate were very nice presentations. I think ESCAIDE is a magnificent event for the quality in all presentations, for the innovations in methodology, for presenting recent data, new approaches for the same themes and because provide discussions between the participants who allows charring ideas.

This event also provides the feeling that we are not alone in a specific topic project; we can share doubts and successes. One other thing that is great is the possibility to have the abstracts book in the beginning of the conference, to fellow during the conference sessions, take some notes and some questions.

Finally, personal it's a great social environment who allows informal learning and the creation of network

to the following investigations. The place was absolutely wonderful, the conditions of congress center was very much facilitators for gathering. Of course, a special thanks to EAN team for the travel grant who allows this magnificent experience, get in the ESCAIDE spirit.



Dr Chaibou (left) and Dr Abdulaziz (right) and with another participant during ESCAIDE 2011.

Dr Maman Sani Chaibou, Republic of Niger

Je suis Médecin Nigérien hospitalier travaillant dans le cadre de l'introduction du vaccin antiméningocoque A MenAfriVac en tant que membre du comité de pharmacovigilance (point focal clinique) la conférence de l'ESCAIDE m'a permis de présenter les travaux de la surveillance des AEFI et ce grâce au soutien de l'EAN. J'ai été impressionné combien l'Europe se préoccupe des pathologies tropicales en particulier les maladies à potentiel épidémique. J'ai vu des présentations de qualités et des travaux de recherche très intéressants. Ma participation est une première je suis entrain de sensibiliser mes collègues de l'opportunité que leur offre cette conférence pour présenter les travaux de leurs recherches.

Je remercie sincèrement tous les membres de l'EAN pour leur sacrifice, leur générosité et leur détermination.

EAN Prizes at ESCAIDE 2011

The winners of the 2011 EAN Prize were:

Best poster:

- Alison Waldram: The changing profile of Salmonella serovars in England & Wales

Best presentation (3 ex aequo)

- Emily MacDonald: Outbreak of Yersinia enterocolitica O:9 infections associated with bagged salad mix in Norway, February to April 2011
- Hanna Nohynek: Abrupt increase in incidence of narcolepsy in children and adolescents, not in adults after pandemic vaccination in Finland in 2010
- Lelia Thornton: Bloodborne virus exposure in healthcare settings in Ireland: review of lookback exercises 1997-2011

Congratulations!

A sincere thank-you also goes to the members of the Prize Committee, who judged the oral and poster presentations.

Stories from the Field

A voice from the past: an epidemiologist above suspicion.

By Saverio Caini, EPIET Cohort 16

Last November, at ESCAIDE, I presented a poster entitled "Smallpox in the Medici family: a historical cohort study. Florence, Italy, 1519-1737". A few days after my return to Budapest, my mentor for this project, a professor of history of medicine at the University of Florence, sent me several letters written by Cosimo III de' Medici, penultimate Grand Duke of Tuscany of Medici family. One of these letters, addressed to Rinaldo d'Este, Duke of Modena and Reggio Emilia, bears the date of July 19th, 1710, i.e. only a few days after Cosimo's daughter, Anna Maria Luisa, had recovered from smallpox. Very curiously, in this letter he lists most of the results we obtained, after three centuries, through modern epidemiological methods and statistical analyses. I therefore decided to translate it and report a few excerpts.

Florence, July 19th, 1710

Dear Rinaldo (...), Anna has completely recovered from smallpox; actually, you could hardly see a scar on her face. In any case, little would have changed. She's forty-three years old by now, married from twenty-five, no offspring. (...) Of my children, only she was missing. Ferdinando and Gian Gastone were struck down by smallpox before entering their twenties, while training themselves in the art of war. Finally, she has been reached as well. Never mind. My family has been taught the hard lesson: you can't escape smallpox. (...) The doctors in our court have always been unable to preserve us from sickness and to heal anything: but at least, they had the good idea

of keeping records. I couldn't remember anyone of my family, who didn't suffer from smallpox. And in fact, all but one suffered from it, and some have even died: like three sisters of Cosimo II, my grandfather. (...) The miasma, the doctors say, the mal'aria (...), and they remind me of 1626, when my father was struck together with three brothers and one uncle of his. But the air, it penetrates everywhere; if it's bad, it should poison everyone. So, why do males get sick young and females old? Why do men survive and women die? No, this scientific method they speak about, it's nonsense. Let doctors say what they want, I would rather believe my own eyes. (...) Only God can see and judge people's sins, only His hand can reach everyone and separate the wheat from the chaff. We preserve our daughters from impurity during their childhood, while males are allowed to lead a dissolute life since their youngest days: this explains everything, to me. (...) Where will this haughty science lead us? Can anyone really believe that this novelty from the North, this purulent substance taken from sick cows, will preserve our descendants from their fate? That's nonsense. (...) I have no illusions. Surrounded as it is by doctors, my family is dying out. My children have no offspring, and the Grand Duchy will soon become prey to foreign powers. Who will sit on my throne, when the last of my descendants will close his eyes? I can't see that far. (...) Let my successors on the throne of Tuscany know what awaits them: smallpox will continue to ravage their lives, until the end of the time (...).

Thus, Cosimo III was already aware of our main results, three centuries before us: high attack rate, median age at infection lower for males, higher case-fatality ratio for women, some case clustering. All easily explicable, once you know viruses and you have spent three weeks in Menorca: but amazing for a man of XVIII century. His predictions were not successful, however. The last Grand Duke of Medici family would die in 1757, but most of his successors will be spared from smallpox, thanks to the nonsensical novelty coming from England. He would probably have benefited from an EPIET vaccinology module!

“Illuminating the past can enlighten the future”
(J.Stuart)

Suggested readings

Jenner E, An inquiry into causes and effects of the variolae vaccine, 1798

Potocki J, The manuscript found in Saragossa, 1805

Eco U, The name of the rose, 1980



Health Preparedness for African Cup of Nations 2012 - WHO mission to Equatorial Guinea and Gabon

By Ellen Heinsbroek, EPIET Cohort 16/3

The 2012 African Cup of Nations (AFCON) will be held in Equatorial Guinea and Gabon from 21st January to 12th February 2012. During these three weeks, sixteen qualified countries will compete to become the new African football champion. It is going to be a large event, with approximately half a million tickets on sale, and a stadium capacity of up to 45,000 spectators per game.

In October 2011, I took part in a two-week WHO mission to Equatorial Guinea and Gabon to support public health planning for this mass gathering event. The objectives of this mission were to review health measures implemented for AFCON 2012, to identify critical areas in the current status of planning, and to provide additional advice and make targeted recommendations. The aim of the mission was to improve public health planning for this event, but also to add to the bigger picture of 'health legacy': to use the planning for such a mass gathering event for a lasting positive impact on the health system of the host country. 'Public Health' was interpreted during this mission in the widest sense possible; not only did we discuss infectious disease risks and surveillance, but we also covered wider issues such as 'command and control' -the chain of responsibility and reporting during the event-, and emergency preparedness, including disaster management at the stadiums.

I joined a mission team composed of a consultant from WHO headquarters, two consultants from WHO Inter-country support team of Central Africa and the Health Operations Manager of the 2010 FIFA World Cup. For two weeks we worked together from early morning to late at night to prepare meetings, site visits and workshops. It was great to work together in such a diverse team, with different experiences and backgrounds!

I arrived in Malabo, Equatorial Guinea on Saturday 1st October. Equatorial Guinea is the most fascinating and the strangest country I have ever been to. It is a small country, both in size and population (approx. 700,000 inhabitants). It is the only country in Africa where Spanish is the official language. Petrol was discovered in Equatorial Guinea about 15 years ago, and since then the country's economy has flourished, although I'm not sure how much the country's population has benefitted from this. The country's wealth is reflected in interesting features: for example, for the June 2011 African Union Summit, held near Malabo, a completely new 'city' -Sipopo- was established, consisting of a fancy conference centre, a shiny new hospital, an artificial beach, an 18 hole golf course and 52 identical villas with swimming pool: one for every African leader attending the summit.

It is very difficult to present a good picture of Equatorial Guinea after a visit of just one week, but it certainly had a different atmosphere than any country I have been to before. I found it surprisingly quiet on the streets: brand new roads, but not many cars. The majority of people we met on the streets were Chinese construction workers. After a turbulent history of oppression and dictatorship, the city still has a 'controlled' feeling to it: we were not allowed to take pictures in Malabo and according to our mission leader the Equatorial Guinean officials knew exactly where we went and what we did during every hour of this mission. I never found out whether this was true, but would not have been surprised at all.

On Monday 3rd October we met with the Ministry of Health and COCAN (organizing committee of the AFCON). In this introductory meeting it quickly became clear that not much public health planning for the AFCON had taken place yet. Some members of the COCAN even met each other for the very first time! This was going to be an interesting week...

The next day we conducted site visits to the COCAN main office, stadium, airport, hospitals and laboratories on the island. We concluded from the visits that the structures in place at the stadium, hospitals and laboratories were adequate, but that specific planning for the event had not yet taken place. It was further recommended to strengthen port health at the airport and to set up a National (Health) Operations Centre in the COCAN main office or the Ministry of Health during the period of the AFCON.



The mission team meets with the WHO country office representative and the Gabonese Minister of Health

On Wednesday 5th and Thursday 6th October, we held a two-day interactive workshop with 32 participants of the Ministry of Health, the COCAN and the WHO country office. It was a pleasure to work with the workshop participants. Not much planning had been done yet for the AFCON at all, but the participants were interested to hear our recommendations and actively participated in the workshop. We provided guidance on a variety of different topics: Who reports to whom in case of an outbreak? Where should ambulances be positioned near the stadiums? Which topics should be covered in health promotion? The list of recommendations is too long to cover in this report: there is a lot of work to be done in the next months. The workshop received a fair bit of media attention: the next day I heard us on the radio and even saw us on TV!

On Sunday 9th October we travelled to Libreville, Gabon. Libreville is a typical African city: large, crowded, and full of traffic jams. I enjoyed being back in a more lively city again! The mission in Gabon followed the same structure as in Equatorial Guinea. During the mission it appeared that some planning for the AFCON had already taken place, and that representatives of the COCAN had even visited South Africa for advice. Still, there were many topics that hadn't been covered in the planning, and we left the workshop participants with many recommendations and guidance for the way forward.

I'm very aware that not all our recommendations can and will be acted on with merely three months left between the mission and the event. Still I hope that each participant will bring back one or two ideas from the workshop to his or her sub working group. Some of the key recommendations have already been followed up in Equatorial Guinea: two colleagues from WHO went back to the country in November to provide further assistance in improving International Health; to train health workers at airports and border crossings, and to improve the work of the IHR national focal point. It is hopefully the start of building a health legacy, with the health systems of

both countries gaining some lasting improvements from this event and mission.



On the Equatorial Guinea news!

The mission was short and intense, taking place in two fascinating countries. I really enjoyed working together with the mission team, the WHO country offices, and the Ministry of Health and COCAN of both countries and would like to thank everyone involved in the mission for this fantastic experience!

Some impressions from the first three days of the HUS/EHEC outbreak in Germany

By Mona Askar PAE/EPIET (cohort 16)

A loud alarm fills the room followed by a nurse and a doctor suddenly appearing in the room fully dressed in green gowns, masks, gloves and hats. Within seconds they change tubes and infusions, give i.v. drugs and disappear as fast as they entered. I am observing the scene that seems so familiar and far away at the same time - it has been quite a while since I used to do that work.

My work has changed- in my hand there is no longer a syringe but a 38 page questionnaire and a pen...

It is Friday 19th May, I will never forget this date - it will be in nearly every report, every paper, every presentation and every interview my colleagues, the RKI president, or the German minister of health are going to face in the coming weeks and months... I am on an outbreak investigation in Hamburg. The first outbreak I ever investigated outside my office at RKI and it will turn out to be much bigger, much more comprehensive, challenging and interesting than I ever expected.

Looking backwards it seems just a weird coincidence that my co-fellows and I were just listening to a presentation on *E. coli* at the national reference center in Wernigerode in the frame of our lab module- when I was called by Katharina Alpers and asked if I would like to join my colleagues Christina Frank and Dirk Werber in an outbreak investigation of diarrhoea-associated hemolytic uremic syndrome

(HUS) in children in Hamburg. So, I directly returned to Berlin.

I meet my colleagues in the early Friday morning on the train to Hamburg. They update me with all information we got until then: The day before the RKI was informed by a local public health department about a cluster of HUS in 3 children in a hospital in Hamburg. On the same day an invitation to assist in the outbreak investigation followed. Dirk and Christina are well experienced with EHEC/HUS and only 2 years ago they had already investigated another HUS/EHEC outbreak in Hamburg.

Upon arrival we have our first meeting with representatives of Hamburg's regional and local health authorities. It soon becomes clear that the situation is much more serious and tense than expected. The number of HUS cases had increased over night; the local health authorities were informed about approximately 12-16 cases in and around Hamburg - and during our meeting the number will increase continuously. What is even more alarming to us: not only children are affected by HUS but also adults.

Some further meetings are following. Contacts to hospitals have to be established and a first briefing of the press relations officer is following. Until now only the local media had taken up this subject.

It is already afternoon when we start interviewing children and their parents with bloody diarrhoea or HUS due to an EHEC infection at Hamburg's university hospital. We will manage to interview around 6 patients on this first day - and we will learn a lot about them, how they ended in this room full of medical equipment and noisy alarms and beeps, when and what kind of symptoms they developed, with whom they were playing, what birthday parties they visited, what they had for dinner a week ago...



It's all about communication! (Christina and Dirk)

Later I will realize that those first stories will be the ones that I will never forget. I still remember every name of the little patients we interviewed that day; I can recall what the parents told us about their eating habits - yes, and who reported to have eaten sprouts.



Hamburg's university hospital

Personally, the exploratory patient interviews on the very first days remained the hardest of the whole outbreak: parents answering questions while sitting next to their ill child who just returned from the operating theatre with about two third of the bowel removed - and suddenly they mention their second child on the ICU in a HUS-associated coma. In this moment I am hit by the whole catastrophe of this disease and outbreak.



Analysing and discussing the findings of the exploratory patient interviews (Dirk and Christina)

Late in the evening and back in the hotel we analyze our first results, discuss a first hypothesis. After some hours of sleep we continue to interview patients. This time we focus on adult patients lying in different hospitals in Hamburg. The exploratory patient interviews are extensive and time consuming. It takes about one hour per patient- excluding the preparation with scrubs before entering a patient's room according to the isolation guidelines. The interviews are exhausting - especially for the patients. Many are suffering severe pain - sometimes we have to interrupt an interview.

The hospitals are overwhelmed by the massively increasing amount of new HUS cases and the number of patients entering the emergency room with bloody diarrhea. While normally 2-3 patients with bloody diarrhea are seen per week, now about 60 patients are coming - per day! The hospitals are preparing

themselves for more cases: patients who came for routine procedures or elective surgery are sent home or to other hospitals. A triage system is put in place - specific wards are used to separate all patients with bloody diarrhea from the rest of the emergency room patients. Patients are coming daily for lab screening until indications for kidney impairment makes their hospitalization necessary - or hopefully not. We are invited for meetings of the hospitals disaster management. We are asked everywhere for our assessment of this situation. What to our opinion is the probable source?

The source of this outbreak is probably food-borne. Food items that were the vehicle in previous EHEC outbreaks like raw milk, meat, and sprouts seem to be unsuspecting in this setting, since they are only reported by a minor proportion of the interviewed cases. What all interviewed first cases have in common is a peculiar healthy way of living. They eat a lot of fresh vegetables or salad mostly organic. Most of the patients are vegetarians or seldom eat meat. The patients are young or middle-aged and have all been previously healthy. What is also striking is the high socioeconomic level of the patients. Some cases are of special interest to us. For instance a father and daughter that felt ill at the same time. There were only two occasions that they had eaten together: 10 and 3 days prior to the onset of symptoms. Based on the known incubation period for EHEC, only the second joint dinner seems relevant. Later during this outbreak we will learn that the outbreak strain EHEC O104:H4 is characterized by a prolonged incubation period...

At this point, we are unable to suspect a particular food item, but interviews hint towards raw vegetables as the cause of the outbreak.

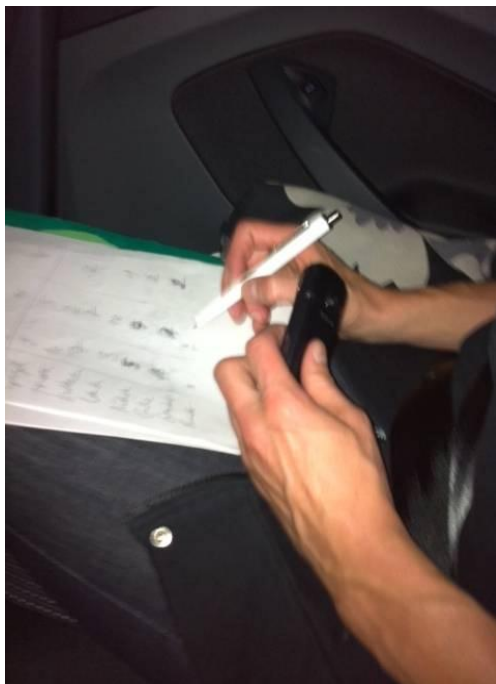


Dirk and me (in front of a food retailer often mentioned in case interviews)

In order to test the hypothesis we plan a first case-control study. We want to include cases (defined as

adult HUS patients hospitalized in 3 hospitals in Hamburg) and controls that were to be matched on age-group, sex and ZIP code to account for the socioeconomic status of the case individuals. We then decide to use hospital controls defined as persons that were hospitalized within the last 2 weeks. Persons with diarrhoea or HUS should be excluded. We manage to develop a questionnaire by Saturday night. On Sunday early morning we call our contact persons in the hospital. We need the permission of all hospitals included in the study and a list of all patients that are hospitalized or visited the emergency room to identify our controls. We struggle with some data policy issues. In the end, it will take until Sunday afternoon until everything is arranged. By luck another colleague of us (Helen Bernard) is spending the weekend in Hamburg - she joins us on Sunday and we are very thankful for her support. Meanwhile, the situation requires a lot of coordination and communication work - press releases have to be arranged and discussed with the heads of our department and the RKI. The task requires the full attention and work of at least one of our team.

For this first case-control study we manage to interview 14 cases and 16 controls. Since we failed to recruit enough controls (middle-aged females are not often hospitalized except for pregnancy) we also include some controls that were hospitalized on the gynecology and obstetrics ward without living in the same area as the matched case. While driving back to Berlin, we already conduct a preliminary analysis of our case-control study - not by calculating OR's in STATA but simply by counting by hand and using the calculators of our mobile phones...



Practical epidemiology from Helen's hands: first analysis of the case-control study in the car while driving home using the mobile phone torch

Our analysis reveals that the consumption of raw tomatoes and cucumbers is associated with disease. For me it is impressive that the results of this first rough-and-ready case-control study (never published since it failed our methodological requirements for the identification of controls) revealed nearly the same results as the next "proper" case-control study that is going to take place only 2 days later.

It is already after midnight when we arrive in Berlin. Only few hours later the RKI emergency operations center will be activated. The outbreak will involve most of the Department for Infectious Disease Epidemiology for the following weeks and months. Daily national and international teleconferences and meetings will follow. A lot of studies, interviews, presentations and reports are going to be prepared.



On the way to Hamburg-some members of the interview-team: case-control study conducted on 24th of May (Matthias, Petra, Janina, Stine, Karen, Merle, me, Thorsten, Udo, Julia).

Looking back to these work intensive months, I learned a lot - not only about epidemiology, communication and miscommunication (especially with the media), but how to control one's own panic after having eaten cucumber, tomatoes, and lettuce from the hotel's breakfast buffet and feeling a bit of an upcoming belly ache However, most of all I learned from my colleagues. I am deeply impressed how enthusiastic and cooperative the team was working together. Within minutes whole teams were set up to leave for interviewing cases in the north of Germany or entering and analyzing data - no matter if it was on week-ends, public holidays or if they had to leave their children with their grand parents for a whole week. Despite the high workload and sometimes frustrating moments, I found the teamwork impressively focused, fruitful and not to forget - fun. Thank you for that!

What's happening in this picture?

By Merle Böhmer (PAE, cohort 17), Udo Buchholz (EIS) and Hendrik Wilking (PAE, cohort 15)



There are two men and one lady having dinner at a restaurant. They seem a little nervous despite the friendly environment radiating German “Gemütlichkeit”. Notice the wooden furniture, the red-checked tablecloth, 19th century farming devices and the inevitable aphorism on the wall. Please note the three diners ordered fried egg and potatoes, an omelette and a warm soup with plain bread. Without any vegetables or salad? Cheerless and unhealthy you might think. No, it was a survival strategy!

This dinner took place at restaurant K on June 07th 2011 after a long day of work starting at 06:00 in the morning on the highway from Berlin to Lübeck and a lengthy quizzing of the chef of the kitchen. It was the third week of the ongoing STEC-outbreak in Germany and there was still uncertainty about the specific vehicle. In the course of the outbreak this restaurant was recognized as one of the hotspots. The owner and especially the chef were inconsolable when they heard how many guests had become ill after visiting the restaurant. Worldwide publicity had focused on the restaurant as if it was responsible. For them it was a matter of duty to help us out in this outbreak investigation. In the evening they invited us for dinner and it was an honour for us to accept, although we felt nervous about the fact of not knowing in which chair at the 2x2 table we would be placed. At any rate we really can say we tested our own hypothesis!

The first 7 days in the STEC O104 outbreak investigation in France.

By Chesco Nogareda, EPIET Cohort 16

Saturday 25th June. I was with Biagio at the airport in Bristol right after the Rapid Assessment module. We were waiting for the check-in to Paris when I received a phone call from Jet de Valk, my supervisor at InVS in France: “Chesco, there is an outbreak of STEC O104 in Bordeaux. Up to date there are 8 cases of HUS and bloody diarrhoea. This strain is the same found in the German outbreak. Most of the cases attended an open day event at children community centre. We need to start immediately an investigation!”

Upon arrival I started to draft a protocol gathering all the information available. It was very important to carry out the outbreak investigation as soon as possible.

In the evening, the main objectives and methods were established after discussing with my supervisor by phone.

Sunday 26th June. We meet at InVS. We could reach by phone the organisers of the open day event and compile more details about the activities and food items consumed during the event. A cold buffet composed of raw vegetables containing sprouts was served for attendants.

Monday 27th June: A complete questionnaire was created to interview all participants, including organisers and food handlers. At the same time, we received the list of all participants with their telephone numbers. We were ready to start the interviews, but wait, in this list there were more than 200 participants, that's a lot of people!!

Tuesday 28th June: We asked support to other departments at the InVS to carry out the interviews by phone. Many people agreed to participate. In the afternoon, we met with all of them to explain the outbreak and the questionnaire.

Wednesday 29th June: We started the interviews.

Thursday 30th June: We continue with the interviews.

Friday 1st July: We finished interviews.

Almost all participants accepted to be interviewed. All of them were aware of this fatal strain. A total of 169 participants including 24 cases were identified.

Saturday 2nd July: First a rough analysis. I send an e mail to my supervisor to let her know the first preliminary results: “It seems that those who consumed fenugreek sprouts were more like to become ill than those who did not”.

Sunday 3rd July: Rest at home.

Epi-Tool

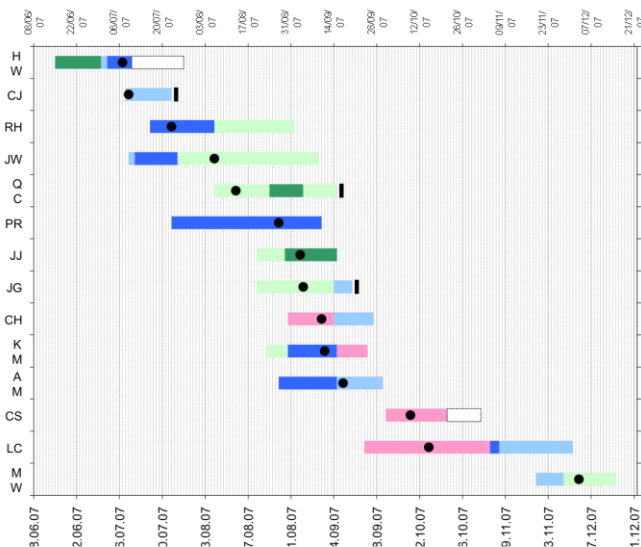
Timeline for Infection Clusters

Contributed by Christopher Williams

The HPA East of England Regional Epidemiology Unit has created "Timeline for Infection Clusters (TICL)". It is a Microsoft® Office Excel-based tool which allows the visual representation of movements of patients associated with clustering of infections (see screenshot). The TICL allows for a maximum of 20 named locations (such as wards) which are represented in the timeline using pre-defined colours. For each patient, data entry consists of the date of positive specimen and up to ten dated movements. From this information a timeline is generated which shows colour-coded location movements for all patients. Sorting options are available to order patients within the timeline according to admission date, specimen date, first location and by patient identifier. In addition, movements within any one specified location can be grouped at the top of the timeline according to the date of movement into the location. Timelines can be exported as a graphics file for use in reports and presentations.

The software was authored by Gareth Hughes & Mark Reacher, Health Protection Agency, East of England REU and is available from

<http://www.hpa.org.uk/webc/HPAwebFile/HPAwebC/1259152177862>



Sample screenshot of TICL

(text has been taken from the instructions of the software)

Epi-Cartoon



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