EAN News

Newsletter of the EPIET Alumni Network

www.epietalum.net

April 2015

Editorial

Dear EAN Friends,

Finally - spring has arrived and with it our much awaited newsletter!

In this issue we start with a message from **Yvan Hutin** to the EAN members and a contribution from **Michael Edelstein** on the Measles elimination in Europe ("Why aren't we there yet?!").

In our Category "Stories from the field" we will hear from **Bernardo Guzmán Herrador, Jerker Johnsson** and **Marie-Amelie Degail** about EPIET, choices and carrier pathways within Europe and far beyond; and from **Viktor Dahl**, who went on an EPIET mission to Lebanon.

And there is more: **Florian Burkhart** is appealing to all of us with the EAN Grant-challenge and EAN-board member **Javiera Rebolledo** is reporting from a GOARN workshop in Guinea. We have information on the upcoming EAN-minimodule, the upcoming EAN social event - and a job opening in the editorial team **as Zuzana Klochanova** is sadly leaving the team.

Take a break from your busy day, grab a hot beverage, find a sunny spot and enjoy the read!

Yours,

The EAN Board

and Zuzana Klochanova/editorial Team

EPIET Alumni Network

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EPIET NEWS

by Yvan Hutin, Former Head of EPIET

I wanted to share with EAN members some news about my transfer in another unit of ECDC. In support of the delivery of part of the vision set out by Mike Catchpole for the role of the Office of the Chief Scientist at ECDC, the Heads of Unit for the Office of the Chief Scientist (OCS) and the Public Health Capacity and Communication (PHC) have agreed to my transfer from PHC to OCS. I have been asked by Mike Catchpole to provide leadership within OCS in developing a strategy for further strengthening scientific excellence within the Centre and for improving the utility of the Centre's scientific outputs for decision-makers.

My move will create a gap in the Public Health Training Section, which in the short term will be addressed by Arnold Bosman taking on the role as acting Head of EPIET. A medium/long term solution will be discussed with the training network in the context of ongoing discussions on the future training strategy.

I have enjoyed working with EPIET and EUPHEM very much in the last three years. These will be precious memories. I will miss working with the network, but I also welcome a move that will put less travel pressure on my family life and will help me re-focus on technical work. I trust that I will be in touch with fellows, graduates and supervisors and that my new job will also generate added value for the EPIET and EUPHEM fellowships.

Epi - on the spot

Measles elimination in Europe: why aren't we there yet?

by Michael Edelstein (EPIET Cohort 2012)

The story of measles epidemiology since the early 1980s is one of resounding success for the public health community. Even though the measles virus is one of the most contagious pathogens known to man, each case generating up to 18 secondary cases, and even though there is no specific treatment, widespread vaccination reduced the annual number of deaths worldwide from 2.6 million a year in 1980, to 145,000 in - a 94.5% reduction. Put differently, the measles vaccine has averted 15.6 million deaths between 2000 and 2013, making measles vaccination one of the most cost effective public health interventions of recent times.

In spite of this success, and in spite of the measles vaccine being part of all national routine immunization programmes, measles remains endemic in Europe and has seen a resurgence in the last five years. In 2014, The World Health Organization (WHO) reported over 22,000 cases in the EURO region, including several outbreaks with several thousand cases, mainly in the former Soviet Union, but also in the EU. This threatens the goal of measles elimination in Europe by the end of 2015. On 25 February 2015, the World Health Organisation Regional Office for Europe urgently called on policy makers, health care workers and parents to immediately step up vaccination against measles across age groups at risk.

The situation is particularly frustrating to the public health community as this burden of disease is entirely preventable. As Dr Zsuzsanna Jakab, WHO Regional Director for Europe, stated, "It is unacceptable that, after the last 50 years' efforts to make safe and effective vaccines available, measles continues to cost lives, money and time."

Why, in spite of a safe and effective vaccine, measles continues to circulate in Europe and further afield? The answer is simple: because a proportion of the population does not use the vaccine. The reasons underpinning vaccine hesitancy are complex and touch upon epidemiology, public health, sociology, anthropology and other disciplines. One simple, partial explanation is that, because measles is so infectious, the herd immunity threshold is high: up to 95%. This implies that, in an era where acquiring immunity through infection is rare, 95% of all individuals must be vaccinated to stop circulation. This compares with 80-85% for polio, 83-85% for rubella, and 75-85% for mumps. In the best of conditions, attaining such high immunization coverage is an operational challenge. In the specific case of measles, this has been hindered by the widely publicized claim in 1998, by Andrew Wakefield, a British GP, that the MMR vaccine was associated with developing autism. As a direct result, measles immunization coverage in the UK dropped from 92% in 1996 to 84% in 2002, and as low as 61% in 2003 in parts of London.

Measles elimination in Europe: why aren't we there yet?

In 2008, ECDC declared measles to be endemic again in the UK after 14 years. In spite of Wakefield's paper being retracted and the revocation of his medical license, measles vaccine coverage did not regain their 1996 levels until 2012. His claims impacted vaccination coverage as far afield as the USA , Australia and New Zealand.

More broadly, a WHO working group on vaccine hesitancy identified three issues underpinning vaccine hesitancy: the first one is confidence- not trusting the vaccine or the vaccine provider. The MMR/autism scare will have contributed to eroding confidence in the vaccine. In the USA, the "anti-vaxxer" movement rallies individuals from the whole political and socio economic spectrums against vaccination, either because they perceive vaccines to be unnatural and unholistic, or because they see vaccination as an anti-libertarian state intervention in their private lives. The rise of the anti-vaxxer movement in the USA coincides with a record number of measles cases in the USA in 2014 since measles elimination from the country in 2000, including several large outbreaks. While the libertarian movement is not as strong in Europe as it is in the USA, the wealthy, "worried well" groups who are hesitant about vaccinating exist in both. In addition in Europe, the Antroposophic and Dutch orthodox protestant communities refuse vaccination on ideological grounds, and although small in numbers, they have both experienced measles outbreaks in the recent past, contributing to the continuing circulation of the virus in Europe. The second issue leading to vaccine hesitancy is complacency: the vaccine is perceived to be unnecessary. This translates to members of the public and healthcare workers believing measles is a mild disease; members of the public perceiving their risk or the risk to their child to be low because others are vaccinated; and members of the public believing the vaccine is unnecessary because they live in communities isolated from the general public. Notably, large measles outbreaks have occurred in such communities, such as in the Amish community in Ohio in 2014 and the ultra-orthodox Jewish community in London in 2013 (although in this group the reasons for non-vaccination are multiple and include access as well as complacency).

The last issue hindering high vaccine coverage is convenience and access: while individuals may not be hesitant about vaccination there are practical barriers such as cost, access to services and long waiting hours that make going to the doctor for vaccination difficult.

These factors contribute to low-income families being more at risk of incomplete immunization compared with others. In Europe this extends to specific, hard-to-reach group such as the Roma community which has low immunization coverage, as a result of discrimination, lack of access to healthcare, poverty and poor education. In addition, in an era of economic austerity, ECDC cites increasing resource constraints on public health budgets as a potential factor of sub-optimal measles immunization coverage.

Suboptimal measles immunization coverage in Europe is a complex problem that can be explained by the existence of a range of undervaccinated groups, from poor, marginalized populations on one end to wealthy, misinformed "worried well" on the other , with religious and other ideological groups in the middle , who all contribute to lower vaccine coverage. In addition, under-resourced public health programmes and healthcare professionals who are unable to adequately promote vaccination add to the mix. In order to boost measles vaccine coverage in Europe, ECDC proposes a 5-pronged strategy: (i) Increase access for individuals and families to healthcare services, addressing hard-to-reach communities. (ii) Commit more financial and human resources for MMR immunisation programmes. (iii) Ensure healthcare workers have the required knowledge and skills to appropriately support vaccination take up as they have a critical role to play in parents' decision making (iiii) Enhance surveillance quality towards detection and investigation of all suspected cases (iiiii) Respond to outbreaks promptly and actively. To these, WHO has added the need to make high-quality evidence-based information available to the public on the benefits and risks associated with immunization against measles.

The number of measles cases has decreased by 96% in the European region over the past two decades. The remaining cases are the hardest to tackle. Only by closing the immunization gap will we address the last cases and reach the target of completely eliminating measles from Europe.

Stories from the field:

Where Are You Now? – Bernardo Guzmán Herrador, C16/2010

What was your first contact with infectious diseases and how did you end up doing EPIET?

I studied medicine in Spain and since the beginning I felt a special attraction towards microbiology, infectious diseases and epidemiology. Once I finished my degree I started a four-year residency in preventive medicine which includes a Master in Public Health and rotations at different levels of the public health system in Spain: hospital and district, provincial, regional and national level. Although the residency covers several areas of public health and health management, infectious disease epidemiology was always my favorite part.

I remember once, during a not too stressful night shift, I started googling for international epidemiology conferences and came across the ESCAIDE conference. That year (2008) it was going to be hosted in Berlin. The content looked really interesting to me (plus it was a good opportunity to meet with some old friends in Berlin) and I decided to attend the conference.

There I saw the word EPIET written everywhere and decided to ask several fellows about the programme and ….they convinced me (Paloma and Camelia, thanks a lot!). The idea of spending two years in a European country being trained specifically in field epidemiology really sounded like a perfect next step after finishing my residency. Two years later, in 2010, I applied to EPIET.

What is your best memory of your time as an EPIET fellow?

Hard to choose. From the professional point of view, it was the perfect choice. The Department of Infectious Disease Epidemiology at the Norwegian Institute of Public Health in Oslo has a long tradition of being a host site. That means that almost everybody knows why you are there, welcomes you, knows the expectations you have and sympathizes with the difficulties you might encounter. The fact that Norway is a small country (in terms of population) with a relatively centralized health system allows you to be actively involved in a lot of outbreak investigations and daily surveillance activities. In addition, you are also part of several international networks and projects, so you feel that you are involved in all possible levels, from local to international.

Personally, during the two years I met good friends for life and learned (and still improving every day) Norwegian to a decent level.

I became a sporty guy with new winter sport skills (the fact that it takes less than 20 minutes to go by metro from Oslo center to a huge forest where you find endless possibilities to cross country ski in the winter and bike in the summer still amazes me) and visited fantastic places (Northern Norway, fjords, Svalbard…). Last but not least, I have lost all logical reference ranges about what is “cold” and “warm” and, since Oslo is one of the most expensive cities in the world, wherever you travel feels cheap, which is an advantage ☺.

Do you have some funny stories to remember when you meet with your former EPIET /EUPHEM colleagues?

Lots of them, from the day number one in Menorca to the last day in our graduation ceremony in Edinburgh. Being completely humble and objective, I am convinced we had the best cohort ever. I have of course special memories from all the modules (Dublin, Bristol, Rome, Madrid, Paris, Stockholm….), and from the planned weekend trips prior to or after the modules (Ettore’s house in Toscana deserves to be mentioned explicitly) or visits I had in Oslo from several fellows during the two years. Due to personal and/or professional reasons I am still in touch with several of them. When we meet it is always fun to remember our adventures. Having friends and colleagues working on your same field in several European countries is one of the priceless outcomes of the fellowship.

Were your expectations of the fellowship fulfilled?

Absolutely. Being trained during two years in a different country is a luxury: It opens your mind, you learn how things can be done in different ways, and it helps you to better understand common international public health problems as well as to expand your network with other epidemiologists or microbiologists. Working so closely and being so exposed to many different profiles of professionals such as supervisors, office colleagues, fellows and coordinators during that time helps you to create and develop your own method, trying to adopt the best parts of all these professionals. In addition, as said before, getting to know Norway and the Norwegian society was certainly an added value. Without forgetting of course that EPIET has opened all the doors for the next chapter of the story.

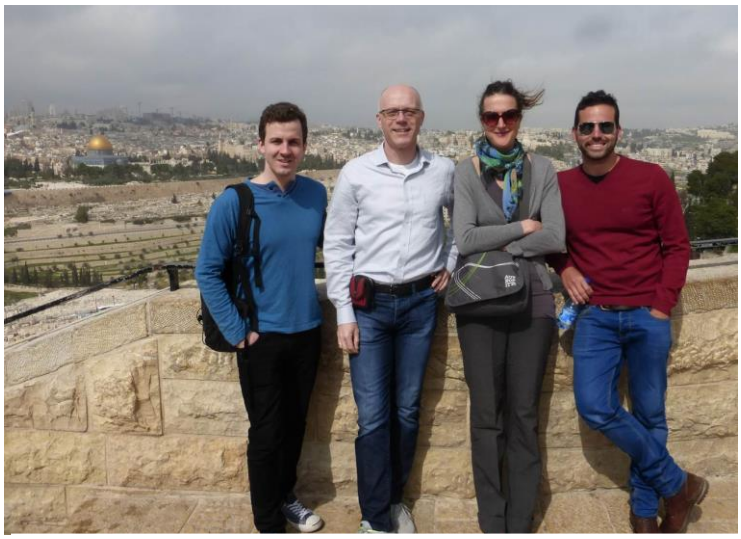
Where Are You Now? - Bernardo Guzman Herrador, C16/2010

And, finally: Where are you and what are you doing now?

I decided two EPIET years were not enough to achieve a level of excellence in cross country skiing, so…..I am still at the Department of Infectious Disease Epidemiology at the Norwegian Institute of Public Health in Oslo. Already almost five years: two as EPIET and almost three post-EPIET (time flies…). Although it is the same corridor and almost the same colleagues, my responsibilities have been changing throughout the time. Not a single day is boring here and each season has brought new and interesting challenges and projects. I work at the food-, waterborne, zoonosis and travel medicine group. Our routines and projects are varied: surveillance, advice to the population, training, teaching, international research (I am mainly involved projects related to waterborne diseases and the effects of climate). I am an active part of the outbreak group, being involved in several epidemic intelligence and preparedness activities and outbreak response and investigations in Norway. I am also responsible for the maintenance of the national web-based event based surveillance system. We are also quite active in supporting responses to international public health crises (which brought me to collaborate with GOARN following the armed conflict in Zamboanga, Philippines at the end of 2013). The most recent challenge has been our active role in a project with the International Health Department at the institute in which we cooperate with specific countries to strengthen their public health systems by the facilitating the implementation of International Health Regulations core capacities. This is a long term project that already brought me to Moldova and Palestine in the last few months.

The fact that you never know how the day is going to end and the mix of acute crises and long term projects is what makes this job quite fun (and a bit stressful sometimes). So, yes: so far so good. This has just started.

Six generations of former/current EPIETs working in Norway (and this is just a sample): Bernardo together with Emily MacDonald, Hilde Kløvstad, Katrine Borgen, Line Vold and Margot Einöder



Field visit, February 2015: Jerusalem, together with colleagues from the Norwegian Institute of Public Health: Eirik Vikum, Bjorn Iversen, and Karin Nygård (who is also a former EPIET fellow).

Save the date:

Where Are You Now? - Marie-Amélie Degail, C15/2009

My first contact with the EPIET programme was in Lazaretto during the 3 weeks Introductory course of Cohort 14, as an external participant. I was then working at the French institute of Public Health in the International Department, among the Epidemic Intelligence team. I decided to apply the following year, in the midst of the H1N1 flu pandemic and was happily and successfully selected by the Health Protection Agency (HAP), Colindale in London. Mingling in London wasn't that easy, but the good thing was that many EPIET fellows (former and current) were around, helping me to adjust to the new environment.

I had the immense chance of working with brilliant epidemiologists at the HPA.
During the programme, EPIET offered me the opportunity of participating to a retrospective mortality survey with Epicentre-MSF in Haiti. This opportunity was a turning point for me, enabling me to start working with MSF.

By the end of EPIET, I was happy to have renewed my skills in Intervention Epidemiology, created an interesting professional network and felt more confident in working as a field epidemiologist.

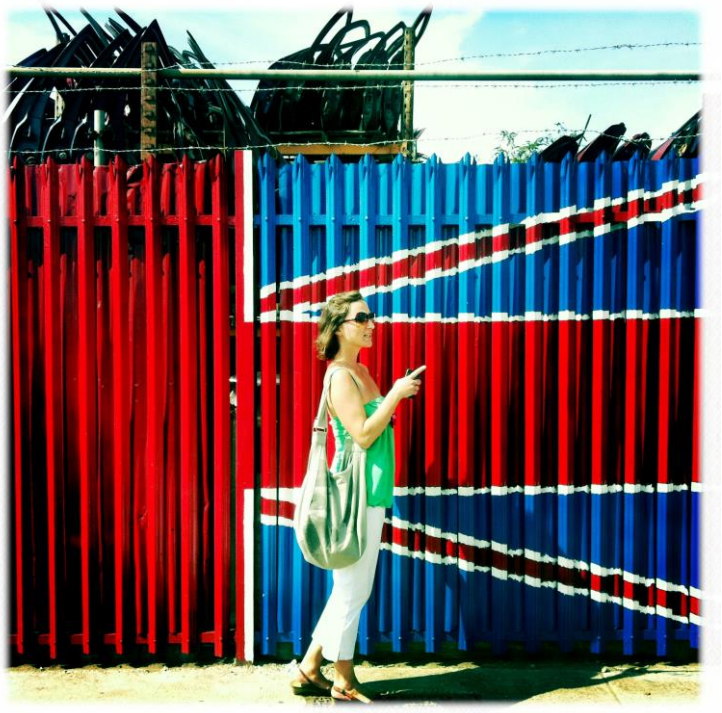
Right after EPIET, I decided to start as a consultant epidemiologist before looking for a «stable» job in Europe. I flew to South Kivu in the Democratic Republic of Congo (DRC) where I had first started working in 2005 as a junior epidemiologist, in the very same mission, in order to train the person in charge of project monitoring to the basics of epidemiological surveillance. When I came back, I worked for Epicentre and then the World Health Organization (WHO), all opportunities arising thanks to the network I had managed to build during my 2 years of EPIET, and thanks to good friends trusting me.

Again, my consultancy with WHO was a turning point. I was responsible for conducting 11 polio vaccination coverage surveys (using the LQAS methodology) in Katanga, DRC. Not only did I conduct these surveys but I got to meet the man who would become my husband. Therefore, after a couple of months I was employed by Epicentre and then MSF with a more durable contract in DRC first on the Ebola outbreak that occurred in Isiro (Province Orientale), then on a risk assessment of measles outbreak in Katanga and the preparation of the cholera vaccination in Kalemie and finally, again, on the measles surveillance for the whole of DRC.

These experiences in field epidemiology and the time spent overall in DRC led to my application to a project manager position in Lebanon; with my team we implemented a community-based surveillance system in 75 Syrian Informal Settlements enabling us to get unique health information on these populations who had basically access to nothing. This work was presented at ESCAIDE by Mohammad Haidar in November 2014. The project manager position gave me the opportunity of training young epidemiologists to field epidemiology. I particularly enjoyed that aspect of my work, especially since Mohammad Haidar has since then started working with MSF.

While working in Guinea on the Ebola Outbreak in January-March 2015, I was happy to meet up with EPIET/EUPHEM alumni from my cohort and others. It somehow felt at home with these epidemiologists having a similar background and a common story within the EPIET/EUPHEM family. I also got to meet with former EIS fellows, and the fact that we also shared a common experience facilitated with engaging with them.

I now live in New York with my husband who works for MSF NY. I am waiting for my work permit, but have already met with friends of EPIET alumni who could help me find a job, and above all who could become my friends too.
Overall, not only is EPIET a professional experience I would recommend to every hard working and motivated young epidemiologist, but it is a human experience where I made (hopefully) long-lasting friendships.



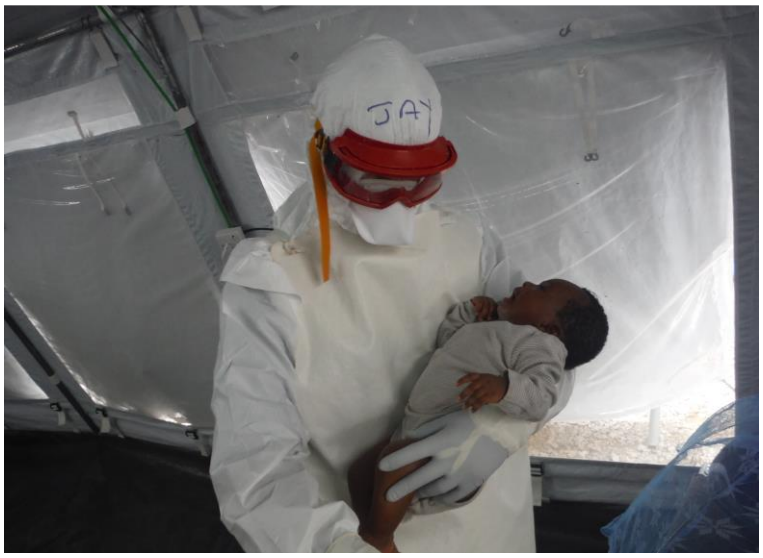
Where Are You Now? – Jerker Jonsson, C9/2003

After finishing my internship as a newly hatched doctor in 1996, I worked with MSF in a refugee camp in Kenya on the border of Somalia. That was my first real contact with infectious diseases of any magnitude. I was, among other things, responsible for the TB-program in three camps in the area. We also had some small outbreaks of cholera during my stay there. Another big problem was malnutrition among the children. Children who were included in the therapeutic feeding program for a few months kept coming back a month or two after being discharged. The problem was that the World Food Program (WFP) packages were not large enough and there were very few possibilities for the refugees to get hold of extra food in any way. This was in the middle of nowhere in a desert-like landscape where few things could grow. The local WFP did not respond when we urged them to increase the food rations. So we did a quick cluster survey on the amount of malnutrition in the under five year olds that showed a sharp increase during the latest year coinciding with the reduction in food rations. This was then presented to the head office of the WFP who rapidly increased the food rations. That was an eye-opener for me regarding how efficient epidemiology could be used.

After that experience I was choosing between paediatrics and infectious diseases and ended up specializing in the latter. During my specialization we once had a one week course on epidemiology and among the lecturers there was a vet from Spain who was doing his EPIET in Sweden. I decided already then that I would apply to EPIET once I had finished my specialization. But already in the last year before becoming a specialist in infectious diseases I started focusing more and more on tuberculosis. My general idea was always to go to and work in a low-income country again. When I applied in 2003 I was lucky enough to get my first choice which was Madrid. I spoke a little Spanish before but also thought of this as a great opportunity to learn a new language.

Living in Madrid was great and I thoroughly enjoyed it in many ways. I'm still married to someone I brought back to Sweden from Spain. Other than that it is hard to pick something that was particularly interesting since I got to be involved in many different things that were all interesting. I also had an international mission in East Timor where we did a cluster survey of immunization coverage in children under five for the WHO. It was also great to get to go around Europe for all the joint courses we had and to compare our different host countries.

When back in Sweden I started working as a County medical officer in Stockholm (but also worked one day a week in the hospital at the TB outpatient policlinic). I was headhunted for the position six months before finishing the EPIET due to the combination of epidemiology and infectious diseases I suppose. After three years I wanted to see more patients than just one day a week and this coincided with an offer at the Public Health Agency of Sweden to take over the national surveillance of TB. So optimistically I started off doing the surveillance one day a week and seeing TB-patients four days a week. Gradually the workload at the agency grew and now I'm there three days a week and spend two days a week at the hospital. It is a very good mix and each of the two jobs make the other more interesting. But it is very difficult to find time for any missions, even short missions, when you have two jobs. Though I did manage to go on a mission to Sierra Leone in November last year. None of my employers could refuse time off for an Ebola-mission. So I left for Kenema in Sierra Leone to work for the International Red Cross at an Ebola treatment centre



I worked as a clinician and did not do any epidemiology other than counting confirmed cases and deaths. The mission was short, too short, and even if it was hard at times it was a very rewarding and in many ways very positive experience. I think I was mentally fairly well prepared that I would find it most difficult with children being sick and not having any caretaker staying with them when they were dying. And this was really the most difficult thing. But I hadn't thought at all about the ones who actually survived, which in our setting was a bit more than 50 %, and how good it felt to get to tell someone that they were due for a "happy shower" and could leave.

Where Are You Now? - Jerker Jonsson, C9/2003

There was a very good team spirit among both the national and the international staff and I felt lucky that I could be a part of this team that did something really good. Hopefully I will be able to get more time off in the future, for other missions (but not wishing for any more Ebola, anywhere). I wouldn't mind going back to Sierra Leone for some other kind of mission. It's a green and beautiful country with very friendly and welcoming people. If you ever get the chance to visit, go for it.

GOARN operational workshop on Ebola response

by EAN board member Javiera Rebolledo (C16/2010)

As partner of GORAN, EAN was invited to participate in a two days GOARN operational workshop in Guinea. The workshop took place on the 21st and 22nd March in Conakry and I participated on behalf of the EAN board and as an epidemiologist deployed by GOARN in Guinea. The aim of the workshop was to facilitate informal exchange and discussions in order to find solutions to operational and technical difficulties encountered by persons deployed.

Main topics discussed on the first day were: Organizational aspects of deployments (before), logistics, transportation, communication, security, coordination, central/prefecture-communication with international and national partners, etc… On the second day, topics were more focused on the Ebola response and the main lessons learned, the remaining challenges and the possible solutions in terms of active surveillance, alert, rapid response, epidemiological investigations, contact follow-up, data management, information flow, etc… I believe that it was very important that EAN participated in this meeting as we were the only attending partner being a 'network' rather than an agency, NGO or a Public health Institution. Despite the fact that EAN is a 'network' partner, a considerable amount of EAN members have been deployed in the affected countries since the beginning of the epidemic, however it was also good being there as someone currently being on the field, as I was deployed in Dubreka at that moment, and I could contribute and feedback with a real and practical point of view.

Although the exact number of EAN members having been deployed for the Ebola response and preparedness in West Africa is unknown, we estimate that about 40 - 50 EAN members were deployed since the beginning of the epidemic. However, since we have no records on deployed members, this number remains an estimation. Furthermore, many of the EAN members deployed were also deployed through other or their own Institutions/organizations/NGOs rather than as EAN members solely.

The involvement of EAN members in the response and preparedness of the Ebola epidemic will therefore require further retrospective analysis to better understand the contribution of the EAN network in this epidemic and the value/importance of EAN as a GOARN partner

EPIET mission to Lebanon: Viktor Dahl, C2013

What was your mission about and why did you want to get involved in this particular mission?

I went to Lebanon during two weeks in December 2014 to work with the WHO office in Beirut to develop a strategy to control hepatitis A in Lebanon. After the start of the Syrian civil war in 2011 more than a million refugees from Syria have arrived in Lebanon. This has coincided with a steep increase in the number of reported cases of hepatitis A in Lebanon. The ministry of health had asked the WHO for their opinion on how to best handle this situation. Should the work with water and sanitation be intensified or was vaccination campaigns a better option? Could a potential vaccination campaign be targeted to a certain area or certain risk groups? I wanted to go because the Syrian civil war is one of the major humanitarian disasters of our time and I thought that this could be a way that I could contribute to the response. The shorter duration of the mission also made it possible to combine with my family situation with two young children.

What did you do? What were your tasks when you arrived? What did you do in the end?

I was given data from the national surveillance system to analyze and made descriptive epidemiology and time-series analysis. I also met with experts from the Lebanese Ministry of Health, from the Lebanese associations for infectious diseases and pediatrics, UNICEF and UNHCR to learn more about the background. In addition to that I made visits to the Syrian refugee camps and the primary health care centers that the refugees used primarily in order to better understand their situation.

In what kind of team did you work?

I had a driver and a junior staff member from the WHO office to help me with interpretation when needed. Otherwise I mainly worked alone.

How was the support in the field?

The WHO office had prepared a schedule with meetings and field trips before I arrived. The staff of the WHO office in Lebanon was very helpful and we had daily discussions on the progress of my investigation. I also had great support from the EPIET-program and daily e-mail contact when needed.

Who took over your work after you left?

On the last day of my mission I presented the findings of my mission for the minister of public health. I also wrote a report for the WHO office.

What about security issues in general?

I always felt safe. Beirut felt safe even though there was some military and militia presence. There had been recent IS activity and kidnapping of Lebanese soldiers in certain areas with Syrian refugee camps close to the Syrian border. But when I made visits to the Syrian refugee camps I only went to the areas that were considered safe by the UN. At those time I was accompanied by a driver and an interpreter and had radio contact with the UN security office in Beirut.

What did you gain from the mission?

I got valuable experience in descriptive epidemiology by analyzing the national surveillance data. It was interesting to work at the WHO office and learn more the daily life in a WHO country office. I also learned a lot by visiting refugee camps and talk to Syrian refugees and learn more about their situation and also by seeing how other UN organizations such as UNHCR operates.

ESCAIDE travelgrant 2015: EAN Grant challenge

by Florian Burkhart (EPIET Cohort 12/2006)

Most of you probably remember the one topic raising from the grave each and every EAN general assembly: how can we reach a sustainable travel grant support for ESCAIDE? The suggestions ranged from PharmaCorp donations to transferring Miles&More. One big problem always remained (as with all other EAN activities): who 's going to organize and maintain the effort? Before I answer that question, I would like to stress the importance of EAN travel grants: it is a great act of collegial kindness to support excellent researchers and promising newcomers from all over the world whose only failure is to have limited funds available for travel. ESCAIDE can be very expensive (especially in Stockholm) as I learned when I once had to foot the bill out of my own pocket. Apart from being kind to others, the contributions from the awardees of the last three years were extraordinary interesting: anthrax in Georgia, mobile phone disease notifications in rural India by unofficial health care providers. Last, it's an EAN thing independent of ECDC. From field epidemiologists for field epidemiologists.

So how to organize a sustainable travel grant effort? In 2014, cohort 11 (2005) got together and chipped in enough money to pay the 800 €* needed for one grant. Cohort 11 adopted one travel grant and that deserves our respect.

By simple extrapolation, I would like to challenge any other cohort (starting with my own C12/2006) to donate enough €€ for one grant. The rules are simple:

- Donate any amount of money to the EAN account below, labelled "*EAN travel grant 2015 cohort <year>*"
- There are no conditions or strings attached to the donation, except the ones below
- The money must be used by EAN only for the purpose of financing travel grants
- EAN board may decide to aggregate the donations or even postpone the grants. It would be a shame if, say, 3+ grants are donated in 2015 and none in 2016.
- EAN travel grant selection criteria are used
- Donations are kept anonymous by EAN treasurers

It would be wonderful for a cohort to "adopt" a grant and maybe even support/network/go for a beer with the winner during ESCAIDE.

What do you think?

Vote with your wallet!

* Travel grants given by EAN include < 800 € grant to non-EU applicants and a 600 € grant to EU-applicants.

Appi Eppi

MAPS.ME

MAPS.ME (http://maps.me/en/home) is a comprehensive Offline Map and Navigation App.

It's free of charge and available on all major mobile platforms.

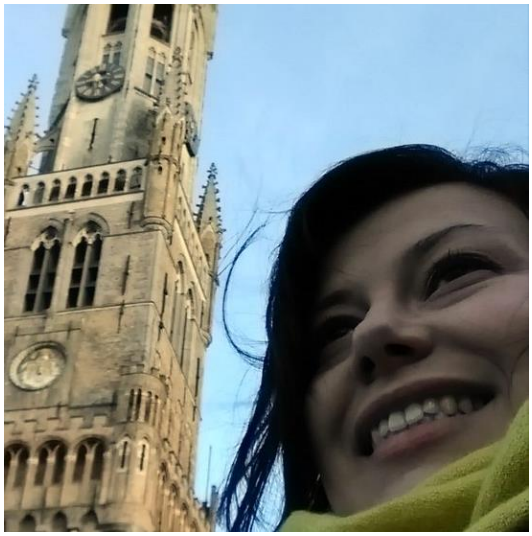
EAN member **Aileen Kitching**: "I was introduced to it by a mapper when I was on a GOARN mission, the whole team were using it in the field. You don't need internet access to use it, it works off GPS positioning, which makes it really useful in the field. I use it a lot & really like it. Thought it might be useful for others also."

From the editorial team:

A goodbye ....

by Zuzana Klochanova (EPIET Cohort 2013)

My name is Zuzana Klochanova, second year EPIET-EU fellow, and last year I worked together with Suzan Trienkens and our great EAN board on delivering you the EAN newsletter.



I started this voluntary activity like "when a blind chicken finds a corn", just after chatting with old friends at ESCAIDE. But already after a while it turned into amazing experience! It was a great pleasure being part of the editorial team: I have learnt a lot, but have also gotten to know the EAN family so much better.

It is very sad to say goodbye to the editorial team, but every end is beginning of something new, and so there is an amazing opportunity right for **YOU** maybe!!!!!

WANTED:

The editorial team is searching for a new member responsible for: *Design & Layout*

The requirements are:

- Open-minded person willing to be a volunteer
- Flexibility, creativity, and sense for art

Please, don't hesitate, and contact us at eanboard@gmail.com

From your EAN Board

EAN module: OUTBREAK ANTHROPOLOGY

In light of the ongoing Ebola outbreak in West Africa, EAN is putting on a workshop in London from 18-19 May to explore the contribution that anthropology can make to epidemiologists' traditional approaches to infectious disease control, particularly with respect to outbreaks. The objectives of the workshop are: to give participants a comprehensive knowledge of the main methods and tools used to generate and analyse anthropological data; to demystify the process of qualitative research and break down barriers between epidemiologists/microbiologists and their qualitative research colleagues; to explore opportunities for increased collaboration between field epidemiologists/microbiologists and anthropologists in order to improve outbreak response measures; and to prepare field responders heading to Ebola/other outbreak areas for what they might encounter and how best to approach their fieldwork to reflect local socio-cultural contexts. Participation in the workshop is free for active members of the EAN, with around 35 members expected to attend. We thank the UK Infectious Disease Research Network (www.idrn.org) for hosting the event, and the University of Glasgow, UK, for providing funding. You can find more information about the workshop at the following link: http://epietalumni.net/event/outbreak-anthropology-for-epidemiologists/

Looking forward to seeing you in London!!

The EAN-module is sponserd by:

From your EAN Board

EAN social event

Happen to be in London on the 18th of April?
Join us for drinks & dinner:

Ground floor of Bird of Smithfield

from 8pm on 18 April 2015

This area is by the (still operational) meat market (Smithfield Market) located in central London and our Mdm President Naomi Boxhal has booked a space for us. Get in touch: http://epietalumni.net/event/ean-dd-for-londoners/ – or just show up!

From the treasurers:

DON'T FORGET to pay the annual membership fee which is €20 (GBP 18) or €200 (GBP 180) for the life membership. The easiest way to pay is via Paypal on our website (http://epietalumni.net/)

Fellows in their first and second year of training are exempt from paying membership fees, according to the accepted statutes change at the 2012 General Assembly.

The details for how to transfer fees by online banking are on this page; if you require any further information on membership payment, we kindly ask you to contact the EAN board (eanboard@gmail.com), putting "membership payment" in the subject line.

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).

Thank you for your support!

EAN Bank details

EURO ACCOUNT (€20)

Bank: HSBC UK
Address: 18 London Street, Norwich, NR2 1LG, UK
Account holder: Epiet Alumni Network
Account Number: 71822755
Sort code: 40-05-15
IBAN: GB11MIDL40051571822755

GBP ACCOUNT (£18)

Bank: HSBC UK
Address: 18 London Street, Norwich, NR2 1LG, UK
Account holder: Epiet Alumni Network
Account Number: 43922782
Sort code: 40-35-09