



## ECDC: EU CENTRE FOR DISEASE PREVENTION AND CONTROL No. 6, 2006

In July 2003, the European Commission presented a proposal for the establishment of a European Centre for Disease Prevention and Control (ECDC), EPI-NEWS 11/04. The proposal was rooted, among others, in the shared conviction of European politicians following the SARS outbreak that outbreaks of infectious diseases required concerted action at the EU level. In 2003, the Prime Ministers of the EU member states decided that the Centre would have its seat in Sweden. During 2004, the European Parliament and Council laid the legislative groundwork for the Centre and by May 2005, it was officially inaugurated in Stockholm.

### Establishment

Zsuzanna Jakab, former senior civil servant at Hungary's Ministry of Health, was appointed Director of the ECDC in December 2004. Next, an executive expert group was recruited: Head of the Scientific Advice Unit, Johan Giesecke, Professor and former State Epidemiologist for Sweden; Head of the Surveillance and Communication Unit, Andrea Ammon, former State Epidemiologist for Germany, and Head of the Preparedness and Response Unit, Denis Columbier, former Head of the Department of Public Health Information Systems at the National Public Health Surveillance Centre in France. Jef Maes from the European Environment Agency was appointed Head of Administration and Management Support, and, finally, Karl Ekdahl, former Deputy State Epidemiologist for Sweden, was appointed Strategic Advisor to the Director of the ECDC.

By the end of 2005, the Centre totalled 29 employees and during 2006 the staff is expected to reach 50 employees. This staff is supplemented by a number of nationally funded experts employed with the ECDC. The ECDC's preliminary budget totals  $\square$  17.2M. Approximately 15% of the budget is earmarked for construction and infrastructure, while staff salaries total  $\square$  7.7M. The remaining funds will cover projects, networks, scientific meetings, etc.

### Strategy

Currently, data on infectious diseases is retrieved via a series of networks seated in various EU member countries. During 2006, the neces-

sary preparations will be made for the ECDC to assume responsibility for the surveillance data retrieval by 2007.

This process will include a transition period in which the about 20 European surveillance networks of the EU will be integrated with the ECDC's joint surveillance centre. Furthermore, as from 2007 the ECDC will manage the European Programme for Intervention Epidemiology Training, EPIET, and the ECDC is now also part of the EU's Early Warning and Response System (EWRS), which facilitates information exchange between national health authorities on prevalences and outbreaks of infectious diseases, etc. The coming years will see investment in the Centre's infrastructure, including the establishment of a centre for preparedness coordination. ECDC quality assurance is safeguarded by a consultancy team composed of senior officials from the institutes of public health within the EU member states. Moreover, the ECDC has set up a panel of scientific advisors to assist this team and, according to requirements, the centre will establish further scientific panels to elucidate particular issues.

### Activities

The ECDC justified its *raison d'être* as early as 2005, when the avian influenza virus A H5N1 was closing in on Europe's borders. In this period, the Centre cooperated with health authorities across Europe to undertake risk assessment of the avian influenza threat to public health in Europe, and to develop EU guidelines for the protection of individuals following possible exposure to infected poultry.

January 2006 saw the notification of human cases of avian influenza in Turkey, and a few days later epidemiologists from the ECDC participated in an international WHO-lead team of investigators. Avian influenza surveillance and preparedness will continue to enjoy high priority in 2006, as will pandemic influenza preparedness. During 2005, representatives from the ECDC, the Commission and the WHO visited six countries to assess their pandemic emergency plans. Similar visits will take place in another six countries during the first six months of 2006. Preliminary results from the visits are

expected to be presented at a joint EU/WHO meeting in May 2006. For further information on the ECDC, please visit [www.ecdc.eu.int](http://www.ecdc.eu.int). (B. Duncan, ECDC)

### AVIAN INFLUENZA: UPDATE

Iraq has reported the first cases of infection with the avian influenza virus A H5N1 in humans: Infection of a 15-year-old girl who died on 17 January has been confirmed by a WHO laboratory. The girl had been in contact with diseased poultry. Her 39-year-old uncle, who nursed her during the illness, developed symptoms on 24 January and died on 27 January. His and another case are currently under investigation. All cases lived in Northern Iraq, close to the Turkish border. Furthermore, the death of a 13-year-old boy from Omaha in Southern Iraq is being investigated. An international team of experts is assisting the Iraqi health authorities' investigations.

In Turkey, human infection is thought to be under control. The most recent case was a patient admitted on 13 January 2006, and nearly all Turkish cases have been related to contact with diseased or dead birds. All evidence indicates that no sustained human-to-human transmission has occurred, and WHO estimates that the virus does not spread from birds to humans more easily than observed earlier. New cases of human infection may occur while the avian influenza A H5N1 is in circulation among poultry in Turkey. However, the number of patients is expected to be rather limited as experience from the previous two years' Asian outbreaks indicates that intervention procedures considerably reduce the risk of human infection. Since the first human cases were diagnosed in Vietnam in December 2003, another 165 cases have been reported, including 88 fatalities, in 7 countries: Cambodia, China, Indonesia, Thailand, Vietnam, Iraqi and Turkey. There are currently no avian influenza related restrictions on travel to countries affected by the disease.

For more information, please visit [www.ssi.dk](http://www.ssi.dk). (S. Glismann, Department of Epidemiology)

## Individually notifiable diseases

Number of notifications received in the Department of Epidemiology, SSI (2006 figures are preliminary)

Table 1	Week 5 2006	Cum. 2006 <sup>1)</sup>	Cum. 2005 <sup>1)</sup>
AIDS	0	6	11
Creutzfeldt-Jakob	0	3	0
Food-borne diseases	4	42	33
of these, infected abroad	0	8	7
Gonorrhoea	5	44	106
Hepatitis A	1	2	13
of these, infected abroad	0	0	2
Hepatitis B (acute)	1	3	8
Hepatitis B (chronic)	8	20	14
Hepatitis C (acute)	0	0	1
Hepatitis C (chronic)	3	21	27
HIV	2	16	33
Legionella pneumonia	2	12	10
of these, infected abroad	0	1	2
Leptospirosis	0	3	3
Meningococcal disease	0	3	13
of these, group B	0	2	10
of these, group C	0	0	2
of these, unsp. + other	0	1	1
Mumps	0	4	0
Neuroborreliosis	1	8	10
Ornithosis	0	3	2
Pertussis (children < 2 years)	1	10	35
Purulent meningitis			
Haemophilus influenzae	0	0	0
Listeria monocytogenes	0	0	0
Streptococcus pneumoniae	0	1	20
Other aethiology	0	0	0
Unknown aethiology	0	1	1
Under registration	5	21	-
Shigellosis	1	11	11
of these, infected abroad	1	9	10
Syphilis	3	11	13
Tetanus	0	0	2
Tuberculosis	7	35	35
Typhoid/paratyphoid fever	2	5	3
of these, infected abroad	2	5	3
VTEC/HUS	1	10	15
of these, infected abroad	1	3	8

## Selected laboratory diagnosed infections

Number of specimens, isolates, and/or notifications received at Statens Serum Institut

Table 2	Week 5 2006	Cum. 2006 <sup>2)</sup>	Cum. 2005 <sup>2)</sup>
Bordetella pertussis (all ages)	5	31	102
Gonococci	7	37	43
of these, females	1	7	4
of these, males	6	30	39
Listeria monocytogenes	0	4	3
Mycoplasma pneumoniae			
Resp. specimens 3)	20	105	361
Serum specimens 4)	17	72	189
Streptococci 5)			
Group A streptococci	1	11	16
Group B streptococci	3	11	2
Group C streptococci	1	5	3
Group G streptococci	0	14	17
S. pneumoniae	12	165	147

Table 3	Week 3 2006	Cum. 2006 <sup>2)</sup>	Cum. 2005 <sup>2)</sup>
Pathogenic int. bacteria 6)			
Campylobacter	31	101	166
S. Enteritidis	2	8	17
S. Typhimurium	5	26	28
Other zoon. salmonella	6	30	23
Yersinia enterocolitica	4	11	19
Verocytotoxin-prod. E.coli	1	6	9
Enteropathogenic E. coli	3	14	14
Enterotoxigenic E. coli	4	12	9

Table 1, notes
In 2006, none of the following cases have been reported: Anthrax, botulism, cholera, diphtheria, haemorrhagic fever, leprosy, measles, plague, polio, rabies, rubella, typhus exanthematicus
1) Cumulative no. 2006 and corresponding period 2005

Tables 2 & 3, notes
2) Cumulative no. 2006 and corresponding period 2005
3) Respiratory specimens with positive PCR
4) Serum specimens with pos. complement fixation test
5) Isolated in blood or spinal fluid
6) See also www.germ.dk

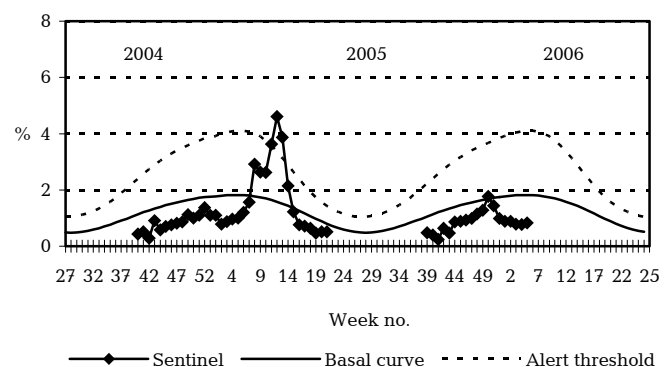
## Patients with laboratory diagnosed chlamydia by gender and county, 3rd quarter 2005

County	2005			2004
	M	F	Total	Total
Cph. & Frb. Municip.	460	689	1,152 *)	1,040
Copenhagen	277	436	717 *)	548
Frederiksborg	111	208	319	314
Roskilde	77	137	214	252
West Zealand	109	203	312	278
Storstrøm	85	173	258	208
Bornholm	16	20	36	18
Funen	201	371	572	426
South Jutland	89	192	281	244
Ribe	105	191	296	208
Vejle	141	267	409 *)	372
Ringkøbing	87	175	262	219
Aarhus	297	542	839	786
Viborg	92	136	228	233
North Jutland	208	430	638	556
Whole country	2,355	4,170	6,533	5,702

\*) Gender unknown in a few cases

## Sentinel surveillance of the influenza activity

Weekly percentage of consultations, 2004/2005/2006



Sentinel: Influenza consultations (as percentage of total consultations)

Basal curve: Expected frequency of consultations under non-epidemic conditions

Alert threshold: Possible incipient epidemic