Report of the 5th Meeting of the ESSTI Steering Group

Held on 27-28 June 2006
At HPA Central Office, Holborn Gate, London

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Section One:
Orientation and information

1 Agenda

ESSTI Steering Group Meeting – Day 1: Tuesday 27th June 2006
HPA Central Office, Holborn Gate, London

Chair: Cathy Ison/ Kathy Lowndes			
Time	**Activity**	**Allocation**	**Speaker**
12.45	**Session 1: Welcome**	5 minutes	Cathy Ison
12.50	**Session 2: Review of previous meeting minutes**	10 minutes	Kathy Lowndes
13.00	**Session 3: Review of ESSTI 2001-2004**		
	Surveillance	30 minutes	Kathy Lowndes
	Microbiology	30 minutes	Iona Martin
	ESSTI_ALERT	30 minutes	Marita van de Laar
	Summary of ESSTI outputs	30 minutes	Cathy Ison
15.00	**Session 4: ESSTI 2006-2008: Objectives and deliverables**	30 minutes	Emma Savage
15.30	Break		
15.45	**Session 5: Discussion of ESSTI organisational issues**	1 hour 45 minutes	Chair: Cathy Ison/ Kathy Lowndes
	Budget		
	Constitution of steering group		
	Date of first collaborators meeting		
	ECDC case definitions		
	SOPs for ESSTI		
	WP9: Preparation for ECDC		Magid Herida
17.30	End of session		

19.00	Evening meal

ESSTI Steering Group Meeting - Wednesday 28th June 2006
HPA Central Office, Holborn Gate, London

Chair: Cathy Ison/ Kathy Lowndes			
Time	**Activity**	**Allocation**	**Speaker**
09.15	Tea/Coffee		
09.30	**Session 1: Discussion of individual work packages** WP5: ESSTI training project WP6: ESSTI outbreak typing WP7: ESSTI quality assurance and AMR monitoring	1 hour 45 minutes	Chair: Cathy Ison/ Kathy Lowndes Introduced by: Michelle Cole
11.15	Break		
11.30	**Session 2: Discussion of individual work packages** WP3: ESSTI surveillance project WP4: ESSTI_ALERT project WP2: ESSTI website project WP1: Project liaison and coordination	1 hour 45 minutes	Chair: Cathy Ison/ Kathy Lowndes Introduced by: Kathy Lowndes
13.15	Lunch		
14.00	**Session 3: Any other business**	1 hour	Chair: Cathy Ison/ Kathy Lowndes
15.00	End of Meeting		

2 Delegate list

Country	Name	Institution
Austria	Angelika Stary	Outpatients' Centre for Diagnosis of Infectious Venero-Dermatological Diseases, Vienna
Denmark	Steen Hoffmann	Statens Serum Institut, Copenhagen
France	Tony Nardone	Insitut de Veille Sanitaire, Paris
Italy	Barbara Suligoi	Istituto Superiore di Sanita, Rome
Netherlands	Marita van de Laar	National Institute of Public Health & the Environment (RIVM), Bilthoven
Observer	Magid Herida	ECDC, Stockholm
Observer	Stine Nilsen	WHO Europe, Copenhagen
UK (Scotland)	Hugh Young	Directorate of Medical Microbiology, Edinburgh
UK	Iona Martin	HPA Centre for Infections, London
UK	Catherine Lowndes	HPA Centre for Infections, London
UK	Noel Gill	HPA Centre for Infections, London
UK	Mike Catchpole	HPA Centre for Infections, London

ESSTI project staff	Cathy Ison	Project lead (Microbiology) HPA Centre for Infections, London
ESSTI project staff	Michelle Cole	Microbiologist HPA Centre for Infections, London
ESSTI project staff	Emma Savage	Scientific coordinator (epidemiology) HPA Centre for Infections, London
ESSTI project staff	Edmund Donovan	Administrator HPA Centre for Infections, London

3 Abbreviations used

AIDS	Acquired immunodeficiency syndrome
AMR	Antimicrobial resistance
ANC	Antenatal clinic
BSN	Basic Surveillance Network
CG	ESSTI Collaborative Group
CISID	Computerised Information System for Infectious Diseases
CT/Ct	*Chlamydia trachomatis*
DG SANCO	EC Health and Consumer Protection Directorate-General
DSN	Disease-specific network
DV	Dermatovenereology
EADV	European Academy of Dermatology and Venereology
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EFSA	European Food Standards Authority
EFTA	European Free Trade Association
EPI-X	Epidemic Information Exchange
ESSTI	European Surveillance of Sexually Transmitted Infections
ESSTI_ALERT	European surveillance system for monitoring unexpected and adverse STI transmission events
EU	European Union
EuroGASP	European Gonococcal Antimicrobial Susceptibility Programme
EuroHIV	European Centre for the Epidemiological Monitoring of AIDS
EWRS	Early Warning Response System
FPC	Family Planning Clinic
GASP	Gonoccocal Antimicrobial Susceptibility Programme
GC/Gc	*Neisseria gonorrhoeae*
GRASP	Gonoccocal Resistance to Antimicrobials Surveillance Programme

GUM	Genitourinary medicine
HIV	Human immodeficiency virus
HPA	Health Protection Agency, UK
HPV	Human papillomavirus
ISS	Istituto Superiore di Sanita, Rome, Italy
IUSTI	International Union against Sexually Transmitted Infections
ISSTDR	International Society for Sexually Transmitted Diseases Research
LGV	Lymphogranuloma venereum
MMWR	Morbidity and Mortality Weekly Report
MS	EU member states
MSM	Men who have sex with men
NAAT	Nucleic Acid Amplification Test
NG-MAST	*Neisseria gonorrhoeae* Multi Antigen Sequence Typing
PCR	Polymerase Chain Reaction
PID	Pelvic inflammatory disease
PN	Partner notification
QA	Quality assurance
RIVM	National Institute for Public Health and the Environment, the Netherlands
RSS	Really simple syndication
SG	ESSTI Steering Group
SMI	Swedish Institute for Infectious Disease Control
SOP	Standard operating procedure
STI	Sexually transmitted infection
TP/Tp	*Treponema pallidum*
WHO	World Health Organisation

Section Two: Discussions

1 Steering Group Meeting: Day 1

Tuesday 27th June 2006

Attendees:
Mike Catchpole (MC), Michelle Cole (MCl), Edmund Donovan (ED), Noel Gill (NG), Magid Herida (MH), Steen Hoffman (SH), Cathy Ison (CI), Kathy Lowndes (KL), Iona Martin (IM), Tony Nardone (TN), Stine Nilsen (SN), Emma Savage (ES), Angelika Stary (AS), Barbara Suligoi (BS), Marita van de Laar (ML), Hugh Young (HY)
Apologies: Gwenda Hughes
Chair: Cathy Ison/Kathy Lowndes

1.1 Session 1: Welcome and Introductions

Cathy Ison gave a brief welcome to the Steering Group members and introduced the new members of the ESSTI project team. All members of the Steering Group were then invited to introduce themselves.

1.2 Session 2: Review of previous Steering Group meeting minutes

Kathy Lowndes introduced the minutes from the previous Steering Group meeting. There were no amendments.

1.3 Session 3: Review of ESSTI 2001-2004

There were a series of presentations reviewing the achievements of ESSTI during the first phase of the network up to 2004. Presentations were given on Surveillance, Microbiology, ESSTI_ALERT and on the outputs of ESSTI.

See section 3, part 1 for Kathy Lowndes' presentation slides: *Review of ESSTI 2001-2004: Surveillance*.

See section 3, part 2 for Iona Martin's presentation slides: *Review of ESSTI 2001-2004: Microbiology*.

See section 3, part 3 for Marita van de Laar's presentation slides: *ESSTI Alerts: Current status of STI outbreaks in Europe.*

See section 3, part 4 for Cathy Ison's presentation slides: *ESSTI 2001-2004: Key Outcomes.*

1.4 Session 4: ESSTI 2006-2008

Emma Savage gave a presentation outlining the objectives and deliverables of the new phase of the network. Each of the nine work packages were described in turn and the outputs that ESSTI are expected to achieve were identified.

See section 3, part 5 for the presentation slides: *Overview of the ESSTI Proposal 2006-2008*.

1.5 Session 5: Discussion of ESSTI organisational issues

Budget

Cathy Ison first raised the issue of the budget. It was pointed out that the funding for each work package is clearly set out in the budget and cannot be altered. Clarification is needed from DG-SANCO whether it may be possible in future to move monies between work packages.

The European Commission needs a record of how much time each collaborator spends on ESSTI. Clarification is needed from the EC regarding whether time spent on ESSTI by each collaborator needed to be broken down by work package.

Key action points:

1. **Project team to establish what documentation the EC requires and to produce time sheets if necessary.**

Constitution of the Steering Group

Cathy Ison pointed out that ESSTI has now expanded to include the EU accession countries but that there is no representation from Eastern or Central Europe on the Steering Group. A discussion followed on how to select a new Steering Group member. SN said that WHO has an up to date list of surveillance focal points for each country and that Ulrich Laukamm-Josten could advise. There was a debate on whether it should be a person who was specified by the Ministry of Health for each country, as for the WHO-Euro focal point list. It was noted that in some cases, such people may not be the most active in the field of STI epidemiology or microbiology. However, ML suggested that it would be desirable to have the Ministry of Health formally involved. It was agreed that two new members from Central/Eastern Europe were required; one microbiologist and one epidemiologist from two different countries and that the members should be selected from the current list of collaborators.

Cathy Ison mentioned that Torsten Berglund from Sweden was absent from this Steering Group meeting and that he had recently got a new job but was keen to remain on the Steering Group. The new Swedish Surveillance collaborator is Anders Blaxhult. It was agreed that there should only be one person from Sweden on the Steering Group. In the first phase of the ESSTI project, SMI was a partner in the application hence there were two Swedish representatives on the Steering Group. However, SMI is not a partner on the second phase of the project. Also, Johan Giesecke, who was the named partner on the first phase of the project, is now at the ECDC.

TN suggested that the steering group needs to have fresh perspectives and that a rotational membership should be considered. This was not popular as continuity was thought to be very important. The budget is fixed and does not allow for additional members. It was decided that due to the number of

countries in the network, the Steering Group could never reflect every country's perspective, but all major decisions proposed by the Steering Group should first be ratified by the collaborative group.

Key action points:

1. **Steering Group to look at list of collaborators and choose 2 people by end of July 2006. WHO to be consulted - *done*.**

2. **Torsten Berglund to be contacted to verify who is responsible for STI surveillance in Sweden and then that person to be invited to sit on the Steering Group. – *done.***

3. **Torsten Berglund and Johan Giesecke to be informed of Steering Group decision regarding Swedish representation- *done*.**

4. **Tony Nardone to send EuroHIV Steering Group terms of reference – *done.***

5. **Terms of reference for the Steering Group to be written. Cathy Ison to circulate suggestions by the end of July. These will also form part of the SOPs which need to be finalised by September. – *done.***

<u>Collaborative Group Meeting</u>

ESSTI is required to hold 3 annual meetings, one per annum. It was decided to hold the first one this year if possible. Potential locations were discussed. It was suggested that holding the meeting in conjunction with another international meeting such as EADV in Rhodes or in the future with IUSTI (e.g. Dubrovnik 2007) would be prudent. Budget restrictions require the meeting to be held somewhere which can be reached by budget airlines (e.g. London, Amsterdam). It was thought that Eastern/Central Europe should hold one of the annual meetings. AS said that Vienna could possibly host this year's collaborative group meeting in early December or late November.

Key action points:

1. **Find out dates of all upcoming relevant conferences during next 2-3 years. – *done.***

2. **Angelika Stary to enquire about Vienna hosting the 2006 Collaborative Group meeting. – *done.***

3. **Tony Nardone to check the dates of the EuroHIV meeting to avoid a clash. – *done.***

<u>ECDC case definitions</u>

The case definitions that have been written by the ECDC for the reporting of notifiable diseases which include the STIs syphilis, gonorrhoea and Chlamydia (including LGV) were discussed. CI apologised for the short notice in bringing them to the Steering Group's attention. MH said that ECDC

needed feedback by 29th June 2006 when a meeting would take place at ECDC to finalise the case definitions. TN pointed out that all national institutes have already been consulted in the process. NG thought that even after ECDC have finalised the document, there would be a long process of legal ratification before the case definitions became "law" in the EU and that there might be an opportunity at a later stage to make changes (although this was uncertain). AS said that IUSTI was unaware of these case definitions. The Steering Group agreed to look at the case definitions and to inform ECDC of any major corrections that needed to be made although it was made clear that this was not the definitive view of ESSTI due to the very short timescale.

[Day 2: After the formal end of the meeting a small group met with Magid Herida who would be attending the meeting at ECDC on the 29th June. MH made detailed notes regarding the changes to the case definitions that the Steering Group thought were necessary and agreed to pass these on to Andrea Ammon at the meeting.]

Key action points:

1. **Cathy Ison to send an email to Andrea Ammon regarding the changes to the case definitions and to relay the concerns of the Steering Group that given the delay to the start of phase 2 of ESSTI, it had not been possible to do a full consultation with our members within the time limits - *done*.**

2. **Cathy Ison to mention that IUSTI had not been informed or consulted on the case definitions. – *done.***

3. **Case definitions to be sent to all the network collaborators. –*done.***

<u>Standard Operating Procedures</u>

Emma Savage introduced the SOPs and informed the Steering Group that the SOPs had to be finalised by September although given the delays to the start of the project it is possible that we could ask for more time. The ECDC case definitions have to be used for any data on diseases included in the list of reportable diseases (in ESSTI's case; Chlamydia, gonorrhoea and syphilis) that are reported by the member states to ESSTI. NG pointed out that many of the SOPs would be generic and could be agreed by all the other DSNs.

The discussion of the SOPs focused on number 5: "Ways in which data are made comparable and compatible". KL said that STI data are not directly comparable from different countries due to the high levels of heterogeneity in surveillance and that ESSTI should perhaps aim for the lowest common denominator for its data collection (i.e. aggregate yearly reporting). TN pointed out that EuroHIV also generally collects aggregate data for HIV although AIDS case reporting is case-based. However, there is more standardisation of definitions and lab diagnoses for HIV than for other STIs. There followed a discussion on whether the lowest common denominator for reporting should be used. MC suggested that as STI surveillance in Europe is very heterogeneous that the SOPs for ESSTI should be more descriptive than prescriptive. It was suggested that perhaps ESSTI could describe different

levels and categories of surveillance according to the current surveillance systems in operation in each country and thus their ability to report data (e.g. aggregate versus case-based data, timeliness, amount of data reported etc). ESSTI could help define best practice for surveillance of STIs and this may in turn encourage member states to make improvements to their surveillance systems. Countries could move up levels during the project if their surveillance system changed.

As an aside, SN said that WHO also collects data in the CISID database but there is no validation or expert interpretation. WHO is happy to collaborate with ESSTI as laid out in the grant. WHO Euro stated that it would be happy to share the CISID database with ESSTI and to collaborate with ESSTI to enable expert validation and interpretation of the data. SH said that the age group classes that WHO use are not useful for STIs as they do not reflect particular high risk groups.

SOP 7: "Proposed public health action, infection control procedures, and laboratory procedures" was discussed. MC suggested that ECDC should work with ESSTI when developing recommendations because part of the ESSTI proposal is to establish guidelines for dealing with STI outbreaks. CI said that an assessment of laboratory diagnoses is needed as this determines the quality of the surveillance data. It was thought impossible to harmonise all the EU labs in terms of diagnostic tests used and their performance but that maybe something could be done to assist quality assurance of labs. NG commented on whether quality assurance for the other STIs, apart from gonorrhoea, is part of ESSTI. Funding is an issue though. The antimicrobial resistance study in ESSTI could act as a model for lab techniques and quality assurance.

Key action points:

1. **Project team to look at ESSTI files and data from questionnaires and to propose categories of levels of surveillance for the SOPs.**

2. **Project team to draft and circulate SOPs for comment so that they can be finalised by September.**

3. **Agreed later that Cathy Ison would ask DG-SANCO for an extension to the deadline for the SOPs.**

<u>Work Package 9: Preparation for ECDC</u>
Magid Herida gave a short presentation on the role and objectives of ECDC.

See section 3, part 6 for Magid Herida's presentation slides: *ECDC: Coordinated surveillance at the European level.*

It was pointed out that when the ESSTI proposal was written ECDC was not yet functional and so WHO Euro are the official ESSTI collaborators for the establishment of an ESSTI database. The situation has now changed and ECDC is also currently building a database although it was not yet known what variables are to be collected. It was suggested that the database ESSTI

is required to build should now be done in collaboration with ECDC especially as it is understood that ECDC would eventually take over the running of any ESSTI database after the evaluation of the network at the end of 2008. MC suggested that the databases could be managed in London but any database should match the technical specifications of any ECDC database.

WHO Europe should also be involved as they already have a database up and running and according to the grant, ESSTI and WHO Euro are collaborators. The question of why we need three different databases (i.e. CISID, ECDC and ESSTI) was raised, as collaborators get fed up submitting their data numerous times. ML stated that all three organisations must work together and that EU regulation states that ECDC must maintain the database for surveillance. The issue of data ownership will also need to be clarified.

2 Steering Group Meeting: Day 2

Wednesday 28th June 2006

Attendees:
Mike Catchpole (MC), Michelle Cole (MCl), Edmund Donovan (ED), Noel Gill (NG), Magid Herida (MH), Steen Hoffman (SH), Cathy Ison (CI), Kathy Lowndes (KL), Tony Nardone (TN), Stine Nilsen (SN), Emma Savage (ES), Angelika Stary (AS), Barbara Suligoi (BS), Marita van de Laar (ML), Hugh Young (HY)
Apologies: Gwenda Hughes, Iona Martin
Apologies for afternoon session: Noel Gill, Angelika Stary, Tony Nardone
Chair: Cathy Ison/Kathy Lowndes

2.1 Session 1: Discussion of individual work packages

Michelle Cole introduced work package 5 (ESSTI training project), work package 6 (ESSTI outbreak typing) and work package 7 (ESSTI quality assurance and AMR monitoring).

See section 3, part 7 for Michelle Cole's presentation slides: *Work packages 5, 6 and 7*

Work Package 5: ESSTI training project
It was agreed that the microbiology training should take place at HPA Centre for Infections, Colindale as it was not feasible to move strains and equipment around Europe. HPA Centre for Infections already has a purpose-built training laboratory. There is funding for 10 people to participate in two courses (20 in total) and therefore it will be necessary for potential participants to apply for places. It was thought that the trainees need to be competent in English and have basic microbiology skills but the selection process still needs to be addressed.

NG suggested that the participants should be working closely with the senior laboratory person who is responsible for the other microbiology work packages, as this could help improve the quality of the microbiological components of ESSTI. ML proposed that some basic epidemiology should also be included on the training course. It was suggested that the two courses could both be held early in 2007 so that participants acquired expertise that could be useful for microbiology work packages.

Key action points:
1. **Steering Group to prepare application forms in time for the Collaborative Group meeting. The Collaborative Group will discuss and propose participants.**

2. **Applications to be received by end of January 2007 for proposed courses in April/May 2007.**

3. **Ivana Bozicevic to be contacted regarding collaboration with the WHO funded training programme on the 2nd Generation HIV/AIDS Surveillance on STI surveillance -*done*.**

Work package 6: ESSTI outbreak typing

ESSTI is funded to perform molecular typing for outbreaks of gonorrhoea and syphilis. The question of what the typing should aim to achieve and how should it link to ESSTI_ALERT was raised. The Steering Group discussed whether typing should be performed retrospectively or in real-time. It was acknowledged that from an epidemiological perspective, real-time typing can be problematic, in that matching typing and patient data can be difficult in a timely manner. HY said that in Scotland typing is being used in real-time and has been found to be useful.

CI stated that molecular typing can be very useful for identifying clusters but does not have sufficient discrimination to give any direction to the transmission chain. ML said that some people may want to use it to aid partner notification and it will not be possible to do this because of the lack of discrimination within a cluster. There are also serious ethical issues regarding feeding back information to patients.

NG suggested that the variability in each outbreak could be measured but raised the question of the sample to be tested. If it was a large outbreak, would it be possible to take samples from different clinics in the city of the outbreak? HY also suggested that the level of culture available in different countries needs to be assessed in that some countries may be using non-cultural detection. It was also suggested that a survey of background heterogeneity of gonococcal strains could be useful and that gonococcal isolates collected in 2004 may be a suitable source.

ESSTI is funded to test 100 samples per year and the Steering Group and Collaborative Group need to decide which strains should be tested and how this links to the surveillance work packages. The microbiology working group needs to prepare guidelines for the referral of samples for typing for presentation at the Collaborative Group meeting in November 2006.

Key action points:

1. **Consider typing of gonococcal strains collected during the sentinel study in 2004 to give information on background heterogeneity.**

2. **Prepare guidelines for referral of isolates/samples for typing during an outbreak.**

Work package 7: Quality assurance and AMR monitoring

Recommended methodology for susceptibility testing has been requested. CI suggested methodology could be put onto website but there is too much variation across Europe to attempt a universal recommended methodology.

MC said that understanding the implications of this variability on the surveillance data is vital and more input from collaborators is needed.

Reference labs should ideally use a more uniform methodology. Cathy Ison reported that concordance between countries that participated in the first quality assessment exercise was thought to be good, considering all countries used a different methodology. However, the reviewers of the ESSTI publication in the Journal of Antimicrobial Chemotherapy claim that concordance must be >90% to be classed as 'high' and therefore it has been changed in publication. There appears to be no evidence base for this.

NG suggested that ESSTI should encourage an External Quality Assurance scheme in primary diagnostic labs as well as reference labs. CI was concerned that this would be a huge undertaking at this time, but it could be something to look at if time and budget allows. BS said that it is essential that cut off for sensitivity must be homogenised across Europe because of effects on epidemiology to allow comparability of data.

The choice of strains to be used in the next exchange panel needs to be discussed by the microbiology working group and should be ready to be presented at the next Collaborative Group meeting in November 2006. The strains will be prepared centrally and distributed to all centres, to minimise variability.

ESSTI is funded to perform three annual sentinel studies as part of the formation of the Euro-GASP (European Gonococcal Antimicrobial Susceptibility Programme). A strategy for the optimum timing and number of isolates needs to be discussed at the Collaborative Group meeting. The collection period could begin in June 2007 to coincide with UK GRASP. NG suggested that the sampling strategy should aim to record the peak within any one year, such as the holiday peak season. CI reported that seasonal variation has not been demonstrated by her laboratory. The microbiology working group needs to decide on the protocol for the sentinel studies.

CI reported that sample size is always going to be a problem because some countries cannot provide many strains since the number which is referred is very low. HY suggested that a basic questionnaire is needed to establish sample size. This raises the issue of the effect of the sample size on determining changes in resistance levels. NG suggested some demographic data should be collected such as travel history among MSM.

Key action points:

1. **Laboratory questionnaires to be sent to new network members.**

2. **Microbiology working group needs to decide on the protocol for the sentinel studies.**

2.2 Session 2: Discussion of individual work packages

Kathy Lowndes led the discussion on work package 3 (ESSTI surveillance project) and work package 4 (ESSTI_ALERT STI early warning system project). A series of smaller working groups were proposed to address specific questions and finer details. The working groups would then report back to the steering group and provide draft proposals to the Collaborative Group for approval.

Work Package 3: ESSTI surveillance project

It was agreed that a smaller working group would work on the recommended SOPs that are required for this work package (i.e. the collection of routine surveillance STI data). This group should include members from both ECDC and WHO. MC said that the purposes and objectives of collecting surveillance data should be clearly defined prior to the commencement of the surveillance project (i.e. burden of disease, informing clinical practice, defining vulnerable populations and the comparability of data across Europe).

The working group would also discuss other areas of surveillance in which ESSTI could play a role even if it is not a defined deliverable in the project (such as prevalence monitoring systems for Chlamydia and HPV). However, it was noted that there may be other groups working on these areas such as the EpiGenChlamyida group. An assessment of surveillance methodologies for HPV and genital warts in the context of implementation of a vaccination programme was also suggested.

A working group on Syphilis/LGV was suggested and agreed to. This group would concentrate on completing work on syphilis and LGV that was started during the first phase of ESSTI.

Work Package 4: ESSTI_ALERT

Kathy Lowndes raised some of the problems that were faced during the first phase of ESSTI_ALERT such as the levels of reporting, definition of an event of interest, timeliness of reporting in different countries, etc. The question of who should report from each country was discussed. It was felt that the national surveillance lead should remain as the reporter, although problems with this system were acknowledged as it is often clinicians at a local level that are aware of outbreaks. ML said that in the Netherlands all ESSTI_ALERT outputs were disseminated to all local partners to facilitate collaboration and this could be done in all countries. MC suggested that the website could have an RSS (Really Simple Syndication) feed to provide prompt information on outbreaks.

It was agreed that an evaluation of the public health impact of ESSTI_ALERT should be undertaken and that the target audience needed to be defined. ESSTI_ALERT is due to restart in January 2007 after consultations at the collaborative group meeting.

Key action points:

1. **A questionnaire assessing the impact of ESSTI_ALERT to be designed by the working group.**

Work Package 2: ESSTI website project

The website is an important part of this phase of ESSTI. Editors are needed for input on the content of the website. It was pointed out that the website needs updating urgently. This will be done as soon as the appropriate software is acquired by the project team in London. Suggestions for the website included links to other microbiology and surveillance sites (e.g. NG-MAST), a password protected area as members are due to submit data via the website, and a forum for discussion.

Work Package 1: Project Liaison and Coordination

Working Groups to be set up with members primarily from the Steering Group. Communication amongst the working group is to be predominantly by phone or email as no travel is budgeted for this purpose. The working groups will then report to the Steering Group and Collaborative Group. Working groups to initially be established in the following areas; Microbiology, Surveillance/IT database, ESSTI_ALERT, Website and Training. In the event of any future outbreaks working groups will be set up if necessary.

Key action points:

1. **Project team to draft outlines for the working groups and to circulate these to the Steering Group for approval and comment – *done.***

2. **Marita van de Laar and Magid Herida to discuss who will be the ECDC representative on ESSTI.**

2.3 Session 3: Any Other Business

Cathy Ison informed the Steering Group that ESSTI was holding a symposium at the EADV conference in Rhodes in October 2006. This will be the first ESSTI seminar day. There is no money in the budget for travel to seminar days however.

Key action points:

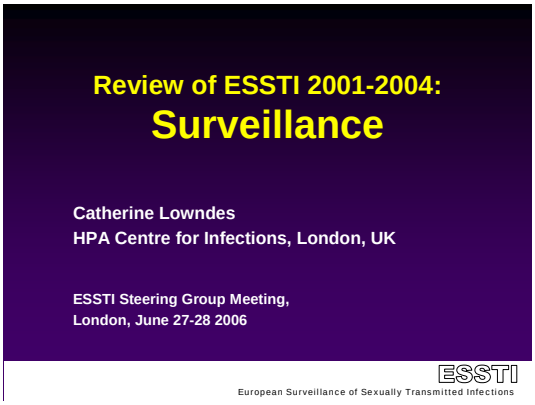
1. **DG-SANCO to be invited to all future meetings and to be informed of the current delay in starting ESSTI.**

Section Three:
Presentation Slides

1 Review of ESSTI 2001-2004: Surveillance

Day 1, session 3: Review of ESSTI 2001-2004
Kathy Lowndes' presentation slides

Slide 1



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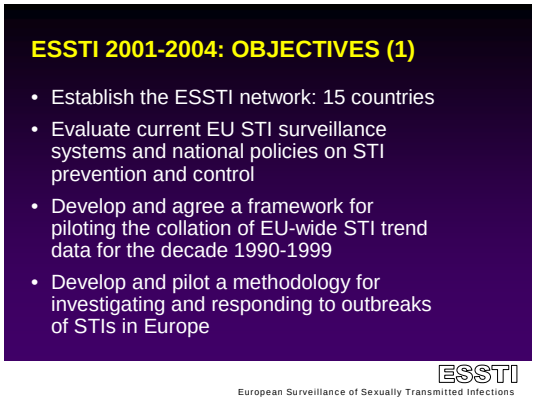
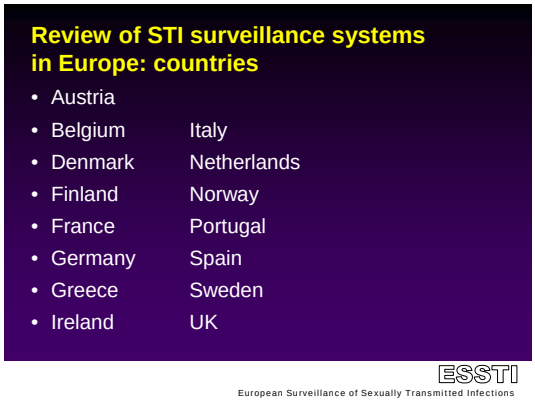


Slide 3

Slide 4

Slide 5

Slide 6



Slide 7

Survey results: STI care

- STI services provided at a wide variety of sites:
  - public and private
  - % STIs seen
- Specialised confidential STI or DV services in most large towns / cities, free / largely free at point of care
- In general STI/DV clinics see higher proportions of syphilis and Gc than chlamydia and viral STIs (high-risk populations)

ESSTI
European Surveillance of Sexually Transmitted Infections

Slide 8

STI care (cont.)

- **Primary care**; FPC; ANC; youth/student clinics (**Ct**)
- Specialist settings: gynaecology, dermatology, ID clinics
- Role of private sector
- > Diffuse and heterogeneous care structures for STIs: challenge for surveillance systems

ESSTI
European Surveillance of Sexually Transmitted Infections

Slide 9

Partner notification / contact tracing

- Considerable heterogeneity: practices; % contacts reached
- Mainly voluntary
- Patient or mixture of patient / provider referral
- Less frequent for viral than bacterial STIs
- In general PN carried out more frequently in STI clinics than in other STI care settings
- Etiological / epidemiological treatment of contacts
- Patient-expedited delivered therapy: Ct

ESSTI
European Surveillance of Sexually Transmitted Infections

Slide 10

Universal STI case reporting (1)

- Mainstay of EU surveillance systems for Gc & syphilis
- Mandatory for syphilis and Gc in 11/15 countries
  - Mandatory from STI clinics only in UK
  - No mandatory reporting in France or Netherlands
  - Mandatory for syphilis only in Germany
- Chlamydia: clinical reporting mandatory only in Sweden and Ireland (and from UK STI clinics)

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Universal case reporting (2)

- Mandatory clinical reporting of viral STIs only in UK and Ireland; similarly for clinical STI syndromes (PID, etc)
- Bacterial STIs: laboratory confirmation required:
  - For syphilis in 9/13 countries where syphilis notifiable (not in Austria, Ireland, Belgium, Spain)
  - For Gc in 7/12 countries
- Aggregate reporting: Spain, UK, Austria
- Variations in amount and quality of data reported

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Factors affecting performance of universal case reporting systems (1)

- **Coverage**:
  - varies from very low (<10%) to close to 100%
- **Sensitivity**:
  - Laboratory diagnostic methods used
  - Partner notification practices
  - Screening programmes and practices
- **Specificity**:
  - Case definitions for reporting (lab. confirmation)

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Factors affecting performance of universal case reporting systems (2)

- **Representativeness**:
  - diffuse nature of STI care sites; public / private
  - UK: STI clinics only
  - bias towards reporting from STI clinics in Austria, Ireland, Greece and Denmark
  - Italy: geographical differences in coverage (North vs South)

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Laboratory reporting (mandatory / voluntary)

- 8/15 countries: universal laboratory reporting
- Portugal, Spain, Ireland: introduction planned
- Belgium, France, Netherlands, Spain: voluntary sentinel (sample-based) laboratory reporting systems
- Norway, Finland, Germany (syph), Greece (Gc): linkage laboratory and case reports
- Denmark, Norway, Sweden: denominator data (no. of tests performed); Greece for Gc

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Sentinel (sample-based) surveillance systems (1)

- Low coverage of universal systems in some countries
- Diffuse nature of STI care sites
- Need for clinical, demographic and behavioural data to understand epidemiology of STIs
- 8/15 countries: voluntary sentinel case reporting systems (recently introduced in Germany, Netherlands, Portugal)
- Spain: system to be introduced

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Sentinel surveillance systems (2)

- Reporting sites:
  - Public STI clinics only (Italy, France, Portugal, Austria, Netherlands)
  - Range of sites where STIs are managed (Germany, Finland, Belgium)
- More and better-quality data
- In general, more STIs (and syndromes) included
- Useful for
  - following comparative trends in STI incidence
  - understanding factors driving STI transmission
  - detection of changes in STI incidence in specific risk groups

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Enhanced surveillance systems

- Syphilis outbreaks in at least 10/14 countries in last 5 years
- UK, France, Ireland, Germany: enhanced surveillance systems: detailed data collection forms from clinicians and patients
- Aim: understand factors driving outbreaks, implement appropriate primary and secondary prevention measures

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Common priorities for improvements to surveillance systems

- Increase coverage and timeliness of mandatory universal case reporting systems
- Introduction / expansion laboratory reporting systems
- Introduction of disaggregate reporting
- Improvement in amount and quality of data reported
- Implementation of sentinel and enhanced surveillance systems

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Feasibility of sharing comparable surveillance data across Europe?

- Heterogeneity!
- But, common modalities and common priorities for improvements
- Estimation / comparison of STI incidence: universal reporting:
  - Improve coverage and timeliness where necessary
  - Laboratory reporting cf. clinical reporting?

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Sharing comparable data across Europe?

Sharing epidemiological data on STIs >>> understanding of factors driving STI transmission:

- Countries with good universal reporting systems
- Countries which lack good universal systems: sentinel systems
- Need to reflect diversity of sites where STIs are managed: surveillance in primary care is a particular challenge

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Challenges for STI surveillance systems

- Chlamydia and viral STIs:
  - Frequently asymptomatic
  - Increasing importance of viral STIs; HPV vaccine
  - Wide population distribution, frequent management in primary care settings
  - Case reporting inadequate
  - Need for prevalence monitoring to understand epidemiology

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Challenges for STI surveillance systems (cont.)

- Changing STI epidemiology:
  - Need for flexible systems, e.g. to detect and respond appropriately to localised STI outbreaks (syphilis, LGV)
  - To detect and respond to changing patterns of Gc AMR

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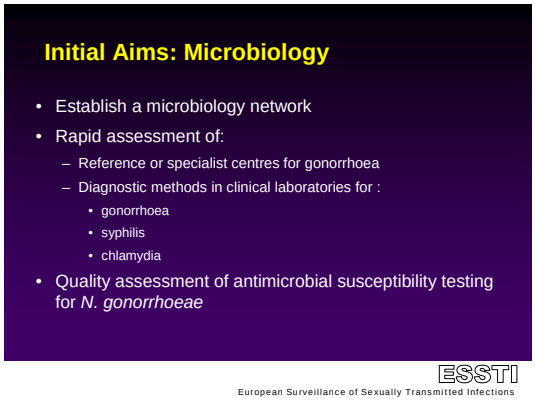
2 Review of ESSTI 2001-2004: Microbiology

Day 1, session 3: Review of ESSTI 2001-2004
Iona Martin's presentation slides

Slide 1

Slide 2



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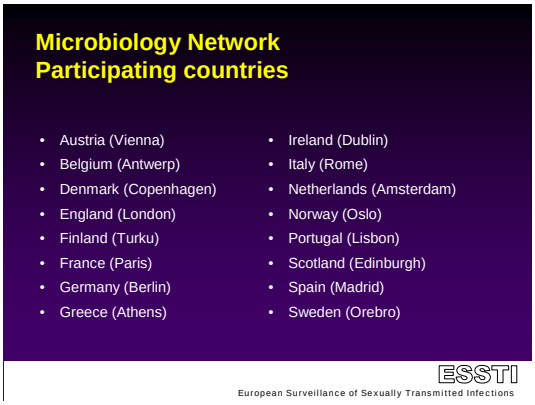

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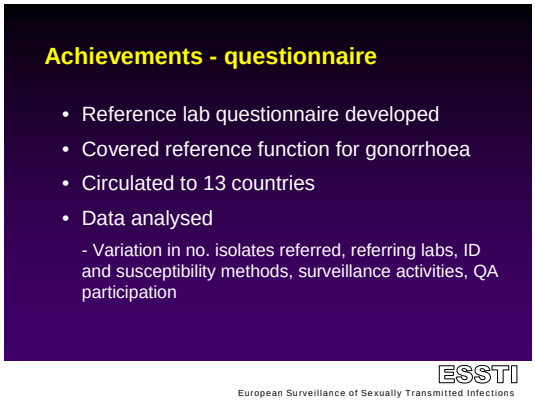

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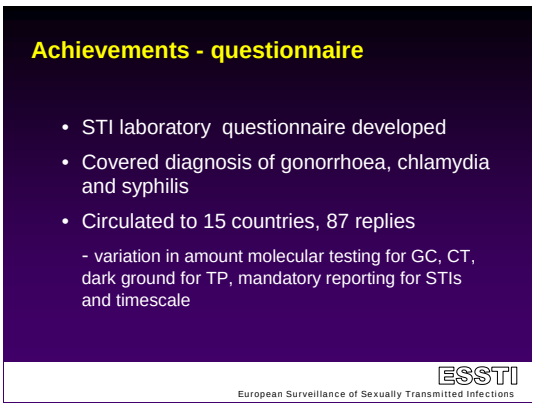

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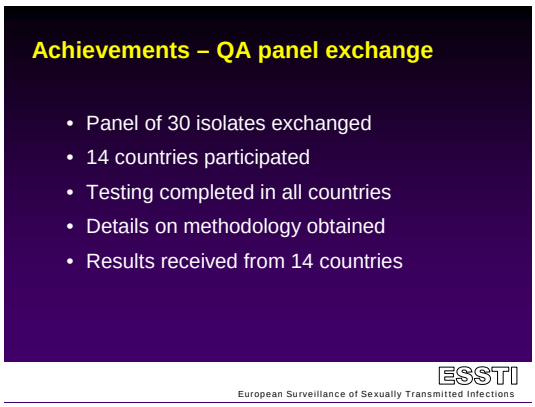

Slide 7

Results by category concordance

Antimicrobials tested (minimum)

- Penicillin
- Ciprofloxacin
- Tetracycline
- 3rd gen. cephalosporin

- Penicillin – 87.8%
- Ciprofloxacin – 80.1%
- Tetracycline – 72.5%
- Ceftriaxone – 93.8%

No 2 countries used exactly the same methodology for testing

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QA results

- Discordance occurred close to category cut off values
- Isolates fully sensitive or resistant high concordance by category
- Concordant triplicate testing of isolates was high for all antimicrobials by laboratory

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Overall QA results

- Disc testing showed greatest result variability
- Etest showed greatest agreement
- Need for greater standardisation for more comparable results in Europe
- Quality control strains with more current susceptibilities required

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Outcomes of initial aims

- Identified the 'reference' GC centres
- Snapshot of laboratory diagnosis of bacterial STIs in Europe
- Established a network of laboratories involved in susceptibility testing for GC
- Comparison of detection of resistant GC across Europe using existing methodology

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EURO-GASP sentinel surveillance, 2004

- Bayer funded project
- 12 ESSTI labs participated
- Consecutive GC isolates over 5 months (max 100) collected
- 1055 isolates
- Tested in London and Copenhagen, same susceptibility methodology

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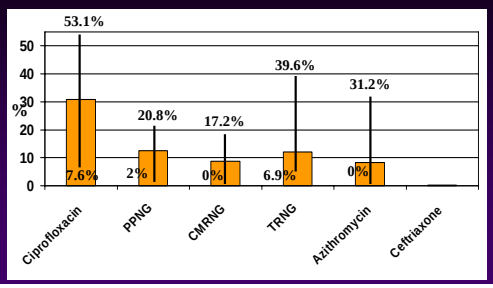
Overall incidence of resistant *N. gonorrhoeae*



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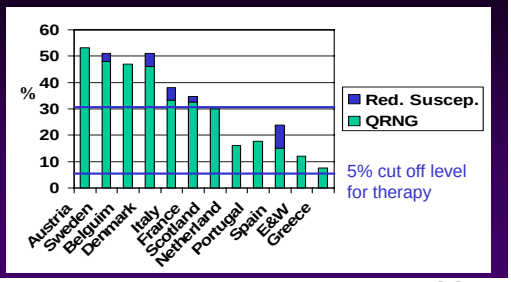
Combined Ciprofloxacin Resistance and Reduced Susceptibility



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- 1st European gonococcal susceptibility data available
- High levels of ciprofloxacin and azithromycin resistance
- Implications for choice of therapy in each country and individuals having sex abroad
- Formation of EURO-GASP

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Publications and presentations

- QA and questionnaire data on laboratory diagnosis and susceptibility testing
- EURO-GASP surveillance data

  - JAC back-to-back papers due out in next few weeks

- Presentations at ISSTDR, HPA conference

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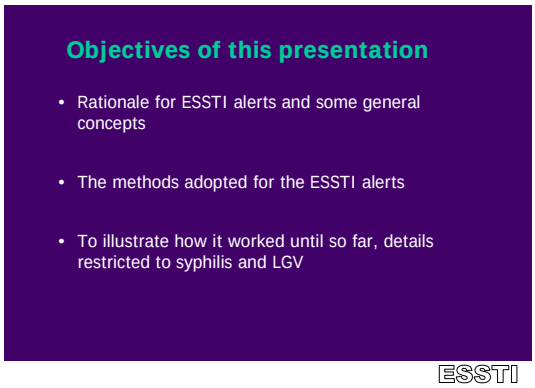
3 ESSTI Alerts: Current status of STI Outbreaks in Europe

Day 1, session 3: Review of ESSTI 2001-2004
Marita van de Laar's presentation slides

Slide 1

Slide 2



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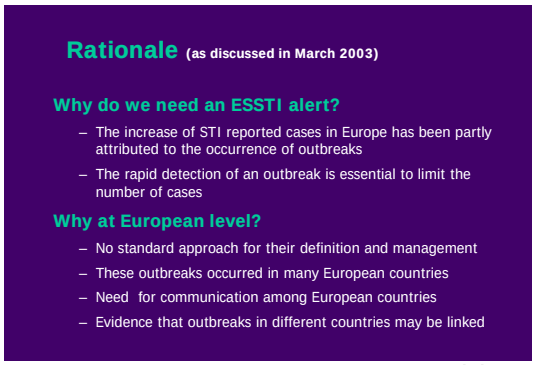

Slide 4

Slide 5

Slide 6

Slide 7

Country Response 2003

Country	April-May	June	July- August	September
Belgium		Zero reporting	Zero reporting	Zero reporting
Denmark	Zero reporting			Zero reporting
Greece		Zero reporting	Zero reporting	Zero reporting
Netherlands		Zero reporting		
Scotland			Zero reporting	
Spain			Zero reporting	
France			Event	
Germany	Event		Event	
Portugal	Event	Zero reporting		Event
Sweden	Event	Event	Event	

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Events reported up to Sept. '03

Event reported	Country	No. event
Congenital syphilis	Portugal, Germany	3
Syphilis (MSM)	Sweden, Germany	2
Syphilis (Heterosexuals)	Sweden	1
Gonorrhoea cluster	Sweden	1
Congenital Gonorrhoea	Sweden	1
Congenital Chlamydia	Sweden	1
Hepatitis A outbreak	Germany	1
Gonorrhoea resistance increase	France	1
Total		11

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Key questions (Oct '03)

- How to improve the system?
  - Kind of data collected
  - Method of data collection
- Is the monthly assessment too frequent?
- How to improve the feed back?
- What's the best way to use these data?
- What's going in term of outbreak detection?

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Response - (March 04)

	I Quarter (June-Sept '03)	II Quarter (Oct-Dec '03)	III Quarter (Jan-Mar '04)
No. Countries missing	7	6	2
No. Countries null reporting	5	7	6
No. Countries reporting	4	3	8
Total	16	16	16
% Response	**56**	**63**	**63**

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Events reported (March 2004)

Event of interest	Country reporting	No. of events
Syphilis (MSM)	Sweden (3), Denmark (3)	6
Syphilis (Heterosexual)	Sweden (2), Ireland (1)	3
Congenital Syphilis	Germany (2), Portugal (2)	4
Congenital Chlamydia	Sweden (2), Scotland (1)	3
Congenital HIV	Germany (2), Denmark (1)	3
HIV	Germany (1), Denmark (2)	3
Gonorrhoea	Denmark (3)	3
Congenital Gonorrhoea	Scotland (1)	1
Resistant Gonorrhoea	Scotland (1), Sweden (1)	2
Shigellosis	Germany (1)	1
LGV	Netherlands (1), Belgium (1), France (1)	3
Total		32

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Syphilis events reported

Country	Event	# Cases observed	# Cases expected	Time period
Denmark	Syphilis (MSM)	41	12	Jan - Mar'04
Sweden	Syphilis (MSM)	42	Not Known	Jan – March '04
Sweden	Syphilis (Het.)	2	1	March '04
Sweden	Syphilis (Het.)	2	1	Feb '04
Ireland	Syphilis (Het.)	10	0	June-Sept 03
Germany	Congenital Syphilis	2	Not Known	Dec '03 – Jan '04
Germany	Congenital Syphilis	2	Not Known	Feb-Mar '04
Portugal	Congenital Syphilis	1	Not Known	Jan '04
Portugal	Congenital Syphilis	3	Not Known	Feb-Mar '04
Total		105	-	

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Conclusions (2004)

- The system is improving
  - Countries participation
  - Type of events reported
  - Quality of data gathered
- Potential for further improvement
  - Technical problems
- Aspects to clarify
  - Date of notification and period of observation
  - Case definition

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Discussion

- Need for analytical study
  Development of:
  - Standard questionnaires
  - Standard protocols for CC and Cohort studies on STI outbreaks
  - Proposal: Creation of a Working Group
- Control measures
  - Missing in many reports
  - Available data legitimate a "standard" approach
  - Proposal: evaluation of the control measures implemented

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Examples of STI Outbreaks in EU

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Outbreaks Syphilis: Time

- First reported in 1997 in Bristol, UK
- Length of the outbreaks:
  - Only 2 lasted for less than 6 months
  - For 9 outbreaks, length range is 17- 28 months
- No seasonal pattern

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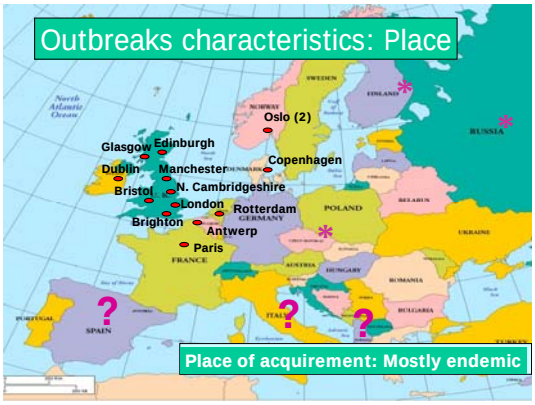

Slide 18

Outbreaks syphilis: Person

- **Magnitude of the outbreaks:**
  - 13-763 cases involved
  - N. of cases routinely reported: 1 – less than 40/year
- **Age:** range 19-80 years
- **Sexual orientation:**
  - 13/14 involved homosexuals or bisexuals
  - Range of involvement of MSM: 63% (Belgium) - 100% (Norway)
- **Clinical features:**
  - 6 congenital cases (2 Denmark, 4 UK)
  - 8/13 reported cases of early latent syphilis
  - 11/12 reported HIV+ persons involved (from 2 to 59 cases)

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Standardised Q:
Risk behaviour and control measures

- Unprotected sex, especially oral sex and especially among homosexuals (9)
- High partner exchange in the last three months (6)
- Attendance of relevant networks (e.g. gay saunas) (4)
- Drug use in connection with sexual activities (2)

Control measures taken:

- Health promotion
- Case finding

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Syphilis MSM (examples)

	Sweden	Denmark
Time	Dec '03-Mar'-04	Jan - Mar '04
Place	>2/3 clustered in Stockholm 11 cases infected abroad (1 Denmark)	30 clustered in Copenhagen Link with EU
Person	42 cases No mention on HIV status	41 cases 34 Danish (83%) 40 Men (98%) 33 MSM (80%) 13 HIV pos. (32%, 2MSM)
Action taken	Health Promotion Case finding & treatment Further studies (active surveillance)	Health Promotion Case finding & treatment Further studies (analytical study)

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Outbreak of LGV: early reports

Early reports in the Netherlands

- December 2003: cluster of LGV cases among MSM in Rotterdam
- First case was diagnosed in April 2003 with classical buboes: *Chlamydia trachomatis* serovar L2
- More cases were identified: only severe proctitis; no urogenital infections
- Date of onset of clinical signs as early as August 2002

Recognition was hampered

- Long-time existing ano-rectal signs, complaints & symptoms
- Regarded as:
  - Crohn disease
  - Rectal carcinoma
  - . . . . .
- LGV not considered in the aetiology

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Outbreak of LGV: investigation and alert

Risk profile first cluster

- Caucasian, MSM, 29-47 yr, predominantly HIV +, STI, Hepatitis C
- Sexual active in leather scene & sex parties,
- Reports of unprotected anal intercourse, oral contact, fisting, use sex toys, 'heavy' sex
- Sauna's, leather bars, sex party, through internet
- Contacts reported in various cities in Europe and the US.

rivm

From: H Gotz *et al.*
Eurosurveillance Weekly 2004

Slide 23

Outbreak of LGV: investigation and alert

Alert to increase awareness

- National alert STI and HIV clinics, gastro-enterologists, gay scene
- International alert through the EU alerting system
- ESSTI alert with details on first cluster
- EPI-X in US and Canada; MMWR paper (Oct '04)

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- ESSTI facilitated rapid information exchange and dissemination of results
- ESSTI: end of first contract coincided with LGV
- ESSTI Meeting on LGV in April 2005

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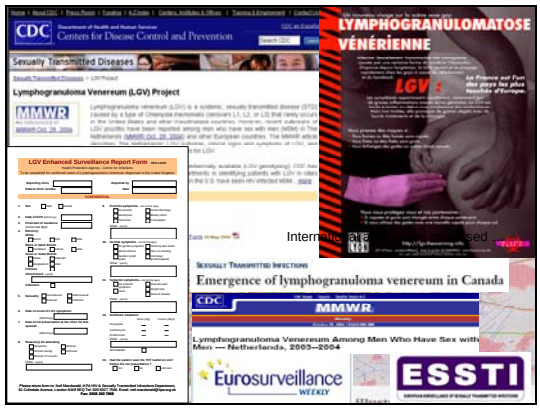
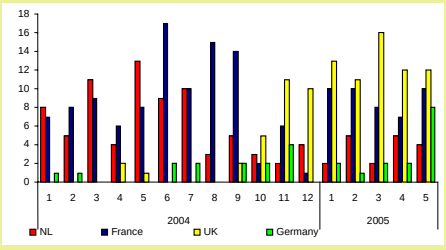


Slide 25

Epidemic curve LGV in Europe



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International Outbreak of LGV

Rotterdam: 13 PROCTITIS LGV in MSM
NL: 2004: 77 2005: 18

Antwerp: 8 PROCTITIS LGV MSM: all
Linked to Rotterdam

Stockholm: 3 INGUINAL LGV in MSM
Retrospective evaluation of 200 specimens MSM

Barcelona: 2 PROCTITIS LGV in MSM
Linked to Amsterdam

France: 169 LGV in MSM
2002/2003: retrospective 21
2004: 103

United Kingdom: 113 LGV in MSM 64 in 2005
Retrospective: 5

Germany: 33 LGV / 5 INGUIN and 21 PROCTITIS MSM: 63%

Italy: Turin: 1 INGUINAL LGV MSM

Geneva: 1 LGV in HIV negative MSM

rivm **Abstracts MP-139 Belgium; MP-141 UK; MP-142 France** ESSTI

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Characteristics LGV in 2004/05

	UK	FR	NL	Germany
Confirmed cases / routine Enhanced surveillance reports	113 63/95	124 9	83/95 26/95	Convenience sample 33
Anorectal Inguinal Symptoms at consultation	60/63 10/63 57/63	all - all	75/83 5/83 69/83	21/33 5/33 ?
MSM Known HIV+ Concurrent STI	all 51/63 22/62	all 8/14 9/14	80/83 54/83 52/83	21/33 22/33 ?
Acquisition - endemic Unprotected anal intercourse	47/56 42/61		12/16 10/16	
Group sex / party No new sex partners < ½ year No sex partners lifetime			10/16 10 [1-30] 178 [6-500]	

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Characteristics LGV 2004/05

	UK	FR	NL	Germany
Confirmed cases / routine Enhanced surveillance reports	113 63/95	124 9	83/95 26/95	Convenience sample 33
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Acquisition - endemic Unprotected anal intercourse	47/56 42/61		12/16 10/16	
Identified Genotypes	L2, L2b, 3 different strains	L2b	L2b	L2, 2 different strains

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Opportunities for international collaboration

- Alert for clinical recognition
- Active case surveillance
- Analytical epidemiology
- Microbiological investigation
- Focused research studies

Meeting ESSTI to facilitate information exchange and communication

- State of the art of the epidemic
- Microbiological and clinical issues
- Recommendations to improve LGV control and prevention

ESSTI recommendations (April 2005)

Clinical recognition still needs to be improved

Active case surveillance
- International internet-based case reporting
- Uniform questionnaire on LGV (basic dataset)
- Europe-wide accepted case definition

Microbiological investigation
- International comparison of strains
- Improvement of diagnostics (real-time PCR)

Analytical epidemiology
- Multi-centre study on epidemiology
- Mulit-center study on clinical features and predictors

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Evidence	ESSTI requirements
Variability in what is reported, by whom and timeliness of reporting	It should be flexible and simple It should be clear what is required and what we want to include
High concentration of cases in spatial term and mainly involving big cities (capitals)	It should process data coming from specific areas
Slight increase followed by dramatic increase in the number of cases during the outbreaks	1. It should be sensitive to small increase in the number of cases 2. It should be able to handle with rare organisms
Mostly endemic cases, but evidence of links among outbreaks	It should be able to detect rapidly outbreak within each country but also across Europe
Specific high risk group mainly involved (MSM and HIV+ positives)	In setting the threshold we should take into account: –The number of epi-linked cases –The number of people with specific risk behaviours

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ESSTI alert discussion
It should be continuous
It should be systematic
It should be able to handle with rare events
It should be able to detect outbreak across Europe
How to proceed?
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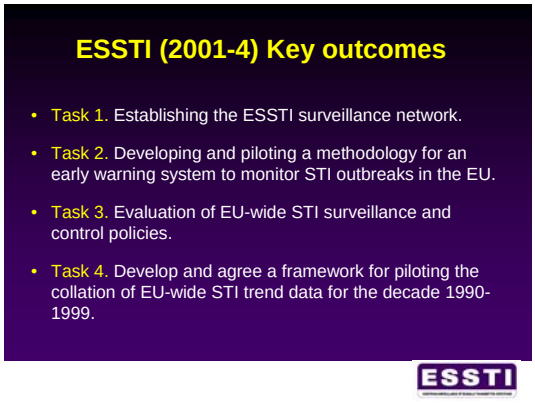
4 ESSTI 2001-2004: Key Outcomes

Day 1, session 3: Review of ESSTI 2001-2004
Cathy Ison's presentation slides

Slide 1

Slide 2



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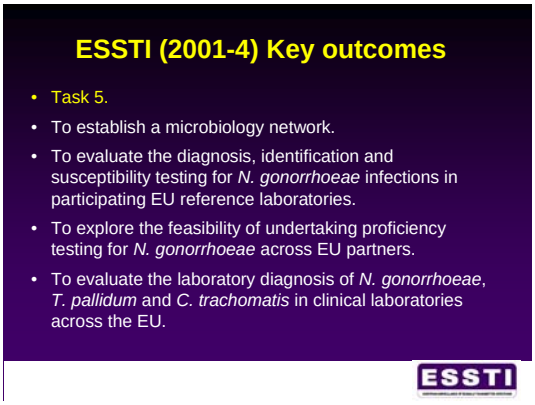

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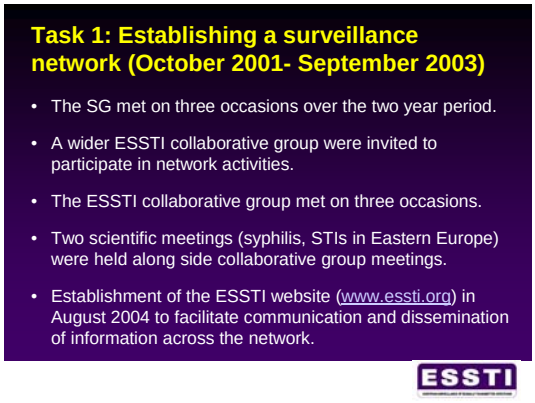

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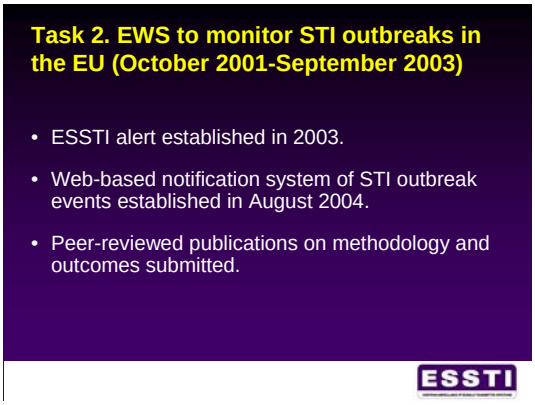

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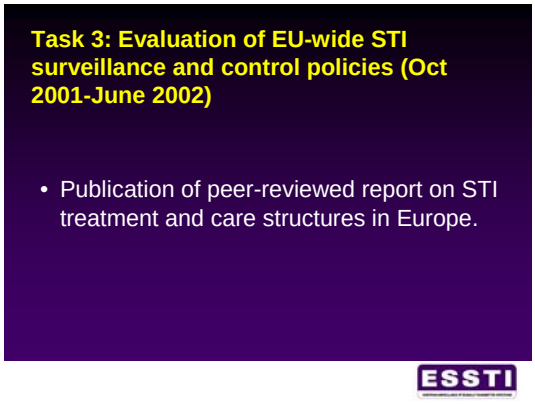


Slide 7

Task 4: Develop and agree a framework for piloting the collation of EU- wide trend data for the decade 1990-1999 (April 2002- September 2003)

- Publication of report on the epidemiology of STIs in Europe 1990-1999.

Slide 8

Task 5:To evaluate the diagnosis, identification and susceptibility testing for *N. gonorrhoeae* infections in participating EU reference laboratories.

- Questionnaire circulated to 14 EU participants and Norway.
- Presentations at international conferences.
- Accepted for publication, Journal of Antimicrobial Chemotherapy 2006.

Slide 9

Task 5:To explore the feasibility of undertaking proficiency testing for *N. gonorrhoeae* across EU partners.

- Exchange of panel of GC isolates tested by existing methodology.
- Presentations at international conferences.
- Accepted for publication, Journal of Antimicrobial Chemotherapy 2006.

Slide 10

Task 5: To evaluate the laboratory diagnosis of *N. gonorrhoeae*, *T. pallidum* and *C. trachomatis* in clinical laboratories across the EU.

- Questionnaire circulated to clinical laboratories in 14 EU participants and Norway.
- Presentations at international conferences.
- Publication in preparation.

Slide 11

Sentinel study for AmR in GC.

- Funded by Bayer.
- High levels of antimicrobial resistance.
- Presentations at international conferences.
- Accepted for publication, Journal of Antimicrobial Chemotherapy 2006.

Slide 12

ESSTI co-ordinating centre 2001-4

- Kevin Fenton (Project & Surveillance Lead)
- Catherine Ison (Microbiology Lead)
- Kathy Lowndes (ESSTI co-ordinator)
- Gilly Arthur (ESSTI co-ordinator)
- Iona Martin (ESSTI microbiologist)
- Jodi Blackham (ESSTI administrator)
- Isabella Von Holstein (ESSTI administrator)

5 Overview of the ESSTI proposal 2006-2008

Day 1, session 4: ESSTI 2006-2008: Objectives and deliverables
Emma Savage's presentation slides

Slide 1

Overview of the ESSTI proposal 2006-2008

Dr Emma Savage

ESSTI coordinator

Slide 2

Overall Aim

- The ESSTI (European Surveillance of Sexually Transmitted Infections) Ne
- twork aims to develop and coordinate epidemiological and laboratory surveillance of STIs in the European region in order to better inform STI prevention, care and control.

Slide 3

Specific objectives of ESSTI

- S1: Maintain and develop the ESSTI network with EU member states; EFTA-EEA; Turkey
- S2: Collate, analyse and report surveillance data on the major acute STIs from participating countries
- S3: Extend ESSTI_ALERT, the European early warning system for unexpected and adverse STI transmission events (e.g. outbreaks)
- S4: Implement a European Gonococcal Antimicrobial Susceptibility Surveillance Project (Euro_GASP) including a quality assurance system, recommended methods, training programmes and molecular typing for outbreaks
- S5: Deliver training programmes on STI surveillance and STI lab diagnostic methods to network participants
- S6: Develop and use the ESSTI website to disseminate information to European policymakers; professionals; and public.

Slide 4

Slide 5

The To Do List……

Slide 6

WP1: Project liaison and coordination

Activities	Deliverables
• 3 collaborative group meetings	• Publication of meeting reports (website, email, post)
• 3 steering group meetings	• Delivery of technical, administrative and financial reports to EC
• 6 surveillance site visits	
• 6 laboratory site visits	

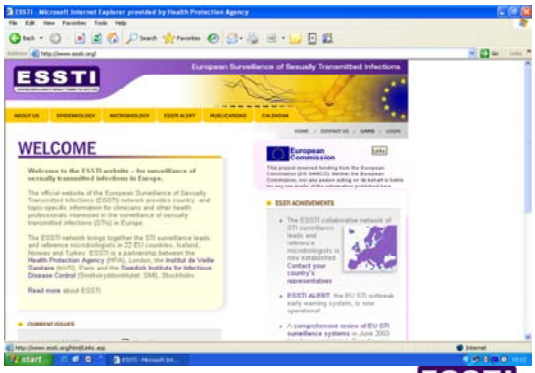
Slide 7

WP2: ESSTI Website Project

Activities
- Updating monthly the ESSTI website
  - www.essti.org

Deliverables
- Public Website
  - News/Publications
  - ESSTI publications and reports
  - Guidelines on STI diagnosis and treatment
  - Links to websites
  - Information on ESSTI training programmes
- Password-protected website
  - ESSTI_ALERT interface
- Integrated "sexual health" page for EuroHIV and ESSTI

Slide 8



Slide 9

WP3: ESSTI surveillance project

Activities
- Collection, collation, verification and analysis of STI surveillance data
  - gonorrhoea, syphilis, chlamydia, genital herpes and genital warts

Deliverables
- Annual summary tables of STI surveillance data
- 3 peer reviewed publications
- Creation of database of STI surveillance data with web access

Slide 10

WP4: ESSTI_ALERT STI Early Warning System

Activities
- Monthly active notification scheme of new incidents

Deliverables
- Monthly, quarterly and annual summary reports on notifications
- 3 peer-reviewed publications
- EU Guidelines on the management of acute STI outbreaks

Slide 11

WP5: ESSTI Training Project

Activities
- 2 1-week lab diagnostic training courses (2006,2008)
- 1 1-week STI surveillance training course (2006/7)
- 3 1-day expert seminars

Deliverables
- Training materials on website

Slide 12

WP6: ESSTI Outbreak Typing

Activities
- Molecular typing of outbreak strains

Deliverables
- Guidelines for submitting *N. gonorrhoeae* specimens for molecular typing
- Annual report on ESSTI outbreak typing
- Peer reviewed publication

Slide 13

WP7: ESSTI Quality Assurance and AMR Monitoring

Activities

- Selection of Panel of Control Strains
- Annual exchange of 10 strains
- Euro_GASP

Deliverables

- Publication of European Methodology for testing control strains panel
- Publication of expected categories of resistance
- Publication of panel exchange results
- Publication of summary results of panel exchange
- Publication of summary results of Euro_GASP prevalence results

Slide 14

WP8: Dissemination of results

Deliverables

- Production of STI fact sheets
- Annual reports
- Monthly updating of news section of ESSTI website
- Presentation of ESSTI results at scientific conferences

Slide 15

WP9: Preparation for ECDC

Preparation of Standard Operating Procedures (SOPs) by September 2006

1. Coordinating structure and decision-making process
2. Project management, administration and supervision
3. Case definitions, nature and type of data to be collected

Slide 16

SOPs cont.

4. Data management and protection, including data access and confidentiality
5. Ways in which data are made comparable and compatible
6. Data dissemination and reporting
7. Proposed public health action, infection control procedures and laboratory procedures.
8. Network participants

Slide 17

How is ESSTI going to accomplish these objectives?

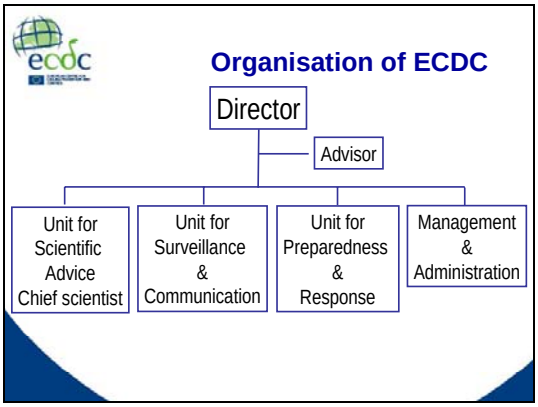
Over to you….

6 ECDC: Coordinated Surveillance at the European Level

Day 1, session 5: Discussion of ESSTI organisational issues
Magid Herida's presentation slides

Slide 1

Slide 2



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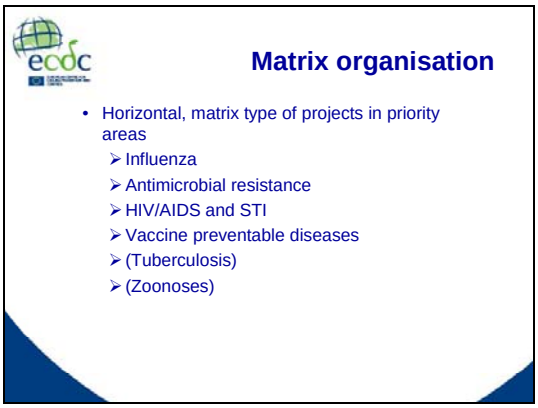

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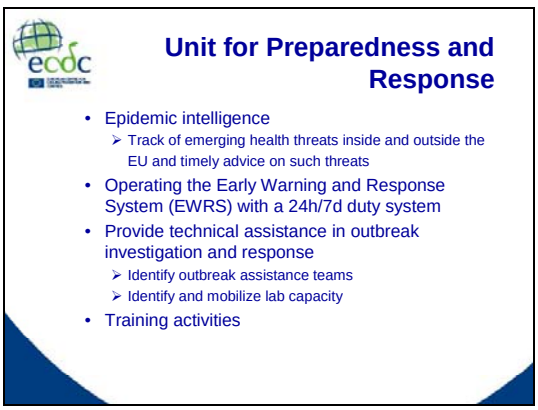

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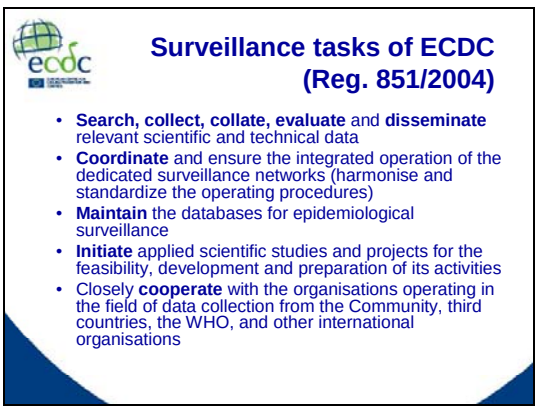

Slide 7

Added value of coordinated approach by ECDC

- Coverage of all diseases
- Coordinated approach to surveillance: SOPs, database, outputs
- Sustainability of funding
- Synergistic effects
  - Overarching issues affecting more than one disease
  - Integrated work on "New" modes of transmission
  - Economically more efficient
  - Agenda setting according to European priorities
- Work towards better comparability of all surveillance data
- EU training

Slide 8

The starting basis

- List of notifiable diseases (44, AMR, nosocomial infections)
- 17 networks:
  - Cover 20 diseases (+3 not on the list),
  - Basic coverage for all (?)
  - Surveillance objectives vary
- 25 (27) EU-Member States (MS), 3 EEA/EFTA countries:
  - More or less of the list covered
  - Different systems where data come from

Slide 9

Requirements

- Objectives
- Case definitions
- Variables
- IT concept: database, data exchange, data access, data dissemination
- Analytical approaches

Slide 10

Collaboration

- Member States:
  - Proposal from working groups of nominated experts
  - Discussion in Advisory Forum
  - Wider consultation if required
  - To achieve consensus and joint effort
- Surveillance networks:
  - Epidemiological and laboratory expertise
- Other networks:
  - Research projects funded by EU Commission
  - Laboratory networks, e.g. PulseNet Europe
  - According to future surveillance objectives
- WHO:
  - Alignment of reporting
- EFSA:
  - Task Force for zoonoses report

Slide 11

Mission statement Surveillance and Communication

To strengthen the European surveillance in order to reinforce detection, prevention and control of infectious diseases in Europe

Slide 12

Components of the envisioned surveillance system

- Routine surveillance:
  - Basic information for all diseases to be covered => ECDC
  - Gradually refined and enlarged according to objectives agreed upon with MS
- Enhanced surveillance:
  - Priority diseases with more detailed information
  - ECDC or MS (decision on case by case basis)
- Feasibility projects/studies:
  - New diseases or methods
  - Only in some countries before involving all MS

Slide 13

Evaluation of networks

- Basis for decision on
  - What should be carried on, omitted, added?
  - Where should this be done?
- External evaluation
- Standard protocol
  - Usefulness
  - Technical performance
  - Fulfilment of grant objectives
- Assessment of compatibility with future surveillance objectives

Slide 14

THANK YOU!

7 Work Packages 5, 6 and 7

Day 2, Session 1: Discussion of individual work packages
Michelle Cole's presentation slides

Slide 1

WP 5. ESSTI TRAINING PROJECT

An essential element of ESSTI is the provision of training and skills transfer including:

LABORATORY TRAINING:

Two, one-week training courses on STI laboratory methods will be held at the HPA, England. It will include a mixture of seminars and practical sessions. 10 participants per course will be given tuition in the methodology, quality control and quality assurance of antimicrobial susceptibility testing for *N. gonorrhoeae.*

Deliverable 5.1: Training materials to be made available on the ESSTI website (ongoing).

Slide 2

WP 5. ESSTI TRAINING PROJECT

When?

A5 states for two 1-week laboratory diagnostic training courses [alternate years] to be held in 2006 and 2008.

Collaborators meeting end of 2006, so it is suggested to hold the training courses in spring 2007 and spring or autumn 2008.

Where?

HPA-Colindale has a functional teaching laboratory on site, along with a lecture theatre and seminar rooms.

Slide 3

WP 5. ESSTI TRAINING PROJECT

Who?

It is suggested that the course is aimed at a fairly basic level, to those who would benefit the most from a week of laboratory training. The delegates should be employed in a diagnostic laboratory that performs STI diagnoses, be competent in microbiological techniques and have a good understanding of English. Full notes and references should be included for the delegates to take back to their colleagues to share their learning experiences.

20 places available over the two years, so we need to think who can participate:

- Individuals could be nominated by collaborators
- Develop an application form which should include minimum criteria for applicants

Slide 4

WP 5. ESSTI TRAINING PROJECT

What should the course include?

The emphasis will be on in the methodology, quality control and quality assurance of antimicrobial susceptibility testing for *N. gonorrhoeae.* However, as a full week is assigned to this task there is scope to expand the content to other bacterial STIs and to quality procedures.

A suggested course outline may include;

Lectures

Past, present and future of ESSTI

Diagnosis of bacterial STIs (gonorrhoea, chlamydia & syphilis)

Quality assurance & standard operating procedures

Slide 5

WP 5. ESSTI TRAINING PROJECT

Laboratory techniques

Isolation and identification of GC

Antimicrobial susceptibility testing of GC

Non-viable GC culture PCR

Syphilis serology

Demonstration of Chlamydia NAATs

Other activities

Visit to a GUM clinic and hospital diagnostic laboratory

Other notes: To assess the level of the course can be achieved by developing a short questionnaire to evaluate experience and visits to other laboratories (WP1 = 6 laboratory visits (2 per annum)).

Slide 6

WP 5. ESSTI TRAINING PROJECT

Decisions required from today's steering group meeting:

- How to assess who should attend the training course
- Any other ideas on what the course should include

Slide 7

WP6 - ESSTI OUTBREAK TYPING

S4: To implement a European Gonococcal Antimicrobial Susceptibility Surveillance Project (Euro-GASP), including a quality assurance system, recommended methods, training programmes and **molecular typing for outbreaks**.

Slide 8

WP6 - ESSTI OUTBREAK TYPING

Deliverables:

- D6.1: Guidelines for submitting *N. gonorrhoeae* (and any other organisms) specimens for molecular typing will be published by end 2006. (Website)
- D6.2: Annual report on ESSTI outbreak typing activities to be included in the ESSTI Annual Report document (Report; Website)
- D6.3: Peer-reviewed publication on molecular typing methods for *N. gonorrhoeae* [At least one over three-year period]

Slide 9

WP6 - ESSTI OUTBREAK TYPING

Currently the HPA has the current molecular typing methods in place;

- Syphilis – Arp / Tpr typing
- Gonorrhoea – NG-MAST (Por / TbpB typing)
- LGV – L1, L2 and L3 serotyping
- It is anticipated that routine chlamydia typing will be available by the end of 2006

Slide 10

WP6 - ESSTI OUTBREAK TYPING

Decisions required from today's steering group meeting:

- What do we want to achieve from the typing?
  - Retrospective analysis of possible clusters/outbreaks
  - Link to ESSTI_ALERT for the real-time detection of clusters/transmission chains
- Which organisms shall we type?
- What demographical data we will need?
- Are there any ethical considerations?

Discuss - D6.1: Guidelines for submitting *N. gonorrhoeae* (and any other organisms) specimens for molecular typing

Slide 11

WP7 - ESSTI QUALITY ASSURANCE AND AMR MONITORING

AN ANNUAL EXCHANGE OF 10 STRAINS of unknown susceptibility will be provided to all laboratories in triplicate. These will be tested by each laboratory, using their own methodology, and the results returned centrally for analysis. This will allow individual centres to identify reproducibility problems, and comparison between labs.

Deliverable 7.3:Publication of results of panel exchange on the password-protected part of the ESSTI website [annual] 2006-8

Deliverable 7.4:Publication of summary results of the panel exchange on the public domain of the ESSTI website [annual], 2006-8

Slide 12

WP7 - ESSTI QUALITY ASSURANCE AND AMR MONITORING

Decisions required from today's steering group meeting:

- Send out the original panel exchange to the new accession countries?
- Do we want actual MICs obtained, or just categories ie. resistant / susceptible?
- Should we suggest a methodology?

Slide 13

WP7 - ESSTI QUALITY ASSURANCE AND AMR MONITORING

A PANEL OF CONTROL STRAINS will be available to all European reference and specialist centres in the first instance. The panel will be chosen from strains that have previously been tested in all of the labs to achieve a consensus result. This will ensure a common reference point to which individual labs can control their own methodology.

Deliverable 7.1: Publication of recommended European Methodology for testing the panel of control strains on the ESSTI website by end 2006

Deliverable 7.2: Publication of expected categories of resistance for the panel of control strains on the ESSTI website by end 2006

Slide 14

WP7 - ESSTI QUALITY ASSURANCE AND AMR MONITORING

To discuss at today's steering group meeting:

- Which strains - those with clear susceptibilty / resistance, and / or those with MICs close to the breakpoints?
- Choose strains from QA exchange panel?
- The recommended methodology

Slide 15

WP7 - ESSTI QUALITY ASSURANCE AND AMR MONITORING

Euro-GASP. A representative sample of strains will be collected from each country and sent to one of three centres in London, Vienna, or Copenhagen. Each centre will test strains from up to 10 countries. These studies will be used to give estimates of prevalence of resistance.

Deliverable 7.5: Publication of summary results of the Euro-GASP prevalence results on the ESSTI website

Slide 16

WP7 - ESSTI QUALITY ASSURANCE AND AMR MONITORING

Decision required from today's steering group meeting:

- When – start June 2007 to coincide with UK GRASP?

To discuss:

- Sample size
- Demographics linked to strains
- Ethical considerations
- Collect strains as done previously?

Slide 17

Other work

Two questionnaires

- Laboratory methods and procedures for reference or specialist laboratories
- Laboratory diagnostic practices for STI diagnostic laboratories

Send to new accession countries?

Re-work and re-send to all other countries?