EAN MONTHLY NEWSFLASH

October Edition

Get prepared for ESCAIDE !

The annual **European Scientific Conference for Applied Infectious Disease Epidemiology (ESCAIDE)** is running in Stockholm, Sweden, both in-person and online from the **20th to 22nd November this year**. The EAN board is involved in the organisation of several events both prior to and during ESCAIDE.

Here is a little reminder of the main attractions of this year:

- **MOOD Mini module: Monday 18th (pm) and Tuesday 19th (am) November** at the Public Health Agency of Sweden, Stockholm (Folkhälsomyndigheten). **Registration are closed !**
- **Dinner and drinks: Tuesday 19th November,** starting at 7pm CET at Vapiano Vasagatan (close to centra station).
- **EAN General Assembly: Wednesday 20th November,** from 12.45 to 13.45 CET in the Auditorium 3 (FOGELSTRÖM). Voting for new board members will be opened after the GA, if you are interested in becoming a board member please **contact us**.
- **BarCamp: Thursday 21st November,** from 18.30 to 20.00 CET at Level 7. You can already share your questions with us at eanboard@gmail.com
- **Career compass: Friday 22nd November** from 12.45 to 13.24 at the Auditorium 2 (RIDDARSALEN). Check out the profile of our amazing panel members **here**!
- **Best oral presentation: Friday 22nd November. We are still looking for judges !!** Please give your availability in this quick survey **here** and indicate for which fireside sessions you would be willing to score the presentations!
- **Photo contest: Friday 22nd November.** Send your photo(s) to EAN email (**eanboard@gmail.com**) with the **consent form** until **15 November.**

Of course we will have our information stand during the whole time.. Come and say hello !

We hope you are as excited as we are for ESCAIDE this year. We look forward to seeing you in Stockholm!

Spotlight on mpox with Sam Boland

Dr. Samuel Boland (PhD, Truman Scholar, Marshall Scholar, Chatham House Leadership Academy Associate) is a researcher and public health professional specialising in public health emergency preparedness and response. He has worked for and across the academia, policy, INGO, and UN sectors (and is currently primarily affiliated with the World Health Organisation Regional Office for Africa). He is currently the incident manager for the current mpox outbreak.

How did you find yourself in the shoes of incident manager for the response to the mpox outbreak in the WHO African Region?

Since 2011, I've been working across sub-Saharan Africa on a range of health and humanitarian crises, from maternal health in South Sudan to Ebola in Sierra Leone and the DRC, and now, mpox. Throughout my career, I've focused on what I call the "three Ps": policy, procedure, and politics. Policy is about the governance that guides our work—what needs to be documented and how we develop effective regulations. Procedure is about bringing that policy to life; it's one thing to have a strategic objective or a plan, but it's another to know, step by step, how to implement it. You really need field work for that, especially in places where procedures aren't fully in place and you need to build them ground-up, like in much of rural sub-Saharan Africa. Politics involves engaging and convincing the right people to ensure progress without unnecessary roadblocks or red tape or ego getting in the way.

Academia has been a crucial part of this journey. I completed a PhD in Public Health and Policy from LSHTM, but even before that, I was already responding to Ebola outbreaks in West Africa. My academic pursuits and fieldwork have always complemented each other. In fact, I often paused my PhD to respond to emerging crises, gaining invaluable hands-on experience. I also sought out different perspectives and approaches, such as studying health governance on a fellowship at Chatham House in the UK.

More than anything, I believe it's about putting yourself out there. Timing plays a role, but, relatedly, being present is key. It's not about trying to make a name for yourself—the work will do that for you. It's also important to step back from your main focus, engage with others, and draw connections between the various pieces of the public health puzzle. By doing so, you don't just learn from the depth of experience your colleagues bring; you also start to see how everything fits together. Try to think of epi not about analysis of laboratory outputs—think about surveillance, it as the foundation and thread that pulls together risk communication, vaccination, logistics, and so forth. Understanding the broader system of public health and emergency response is essential.

haven't seen in a decade, and the fact that we got on well back then means we still work well together now. Building and maintaining these relationships is crucial to a well-functioning team.

We are now months after mpox was declared as a Public Health Emergency of International Concern (PHEIC) for a second time. What are the main challenges you are facing in the management of this event?

This is always a great question, and it's one that doesn't have a straightforward answer. In fact, if you asked me again in half an hour, I might give a different response. Instead of pinpointing specific challenges, I think it's more useful to categorize the kinds of obstacles we face—something true for any public health emergency response.

One key category is tricky epidemiology. This is certainly the case for mpox. There's a lot of stigma associated with the disease, which means many people don't come forward for testing. On top of that, in many parts of Africa, access to essential infrastructure for laboratory testing and healthcare services (and many other critical things) is severely limited. Take the DRC, for example—less than half of the cases there are tested for mpox, largely due to these systemic issues. Another significant challenge is the broader context of public health in Africa, particularly in places like the DRC where many of the hardest-hit areas are also affected by ongoing conflict and displacement. These overlapping crises create additional layers of complexity that make managing a health emergency even more difficult.

Then, of course, there's the politics. Politics can be tough, not because politics are inherently bad—it's a natural part of the process—but because it can sometimes feel like it gets in the way of getting the actual work done. It's important to feel that frustration but not let it become defeat. Politics doesn't obstruct the work; it's fundamentally part of it. So, rather than fighting against it, it's critical to work with it.

Ultimately, I'd say the biggest challenge facing the mpox outbreak does come back to politics, though maybe that's not quite the right word. It's about focus, attention, and funding. The PHEIC declaration has been essential in raising these, but there's still a real frustration knowing that the funding available in Africa to address this issue is, frankly, minimal compared to what's spent elsewhere. For instance, the global request for the mpox response is, generously, a few hundred million dollars at most. Meanwhile, a single large American hospital can have an annual operating budget exceeding 10 billion dollars. That means the emergency response budget for the entire continent of Africa is less than one Western hospital's budget by more than a factor of ten.

These stark realities matter as we strive to build infrastructure, increase testing, and ensure people receive the care they need. The underlying issue isn't solely these other challenges—it's that these difficulties stem from choices. They are choices made by political leaders, especially in wealthier nations, who don't give public health in Africa the time, attention, or funding it needs to address the equity problem. And without addressing that issue, we can't properly support the people who need it most, and problems like mpox will keep coming back.

outside of Africa. What lies ahead of us in the African region and in the rest of the world?

I expect that we'll see a rise in mpox cases across Africa, driven by two main factors: improvements in surveillance sensitivity and the spread of outbreaks as cases move from one hotspot to another. However, over the coming months, I anticipate this increase will plateau and then begin to decline. This shift will result from a combination of efforts, including vaccination, awareness campaigns, and effective risk communication and community engagement. It's really the interplay of these factors that will allow us to hit that plateau, after which we should see cases decrease as quickly as they initially spiked. That said, I do believe we'll continue to see cases for quite some time.

Of course, this is expected for endemic mpox, but even for non-endemic clades, like clade Ib, we'll likely encounter sporadic cases for a while. It's important to remember that identifying cases should be seen as both a signal of an underlying epidemiological issue and as evidence of a functioning surveillance system. Finding a case should be treated seriously, but the fact that it was detected at all indicates that the system is working. In most parts of the world, these cases will be quickly contained, thanks to robust health systems, effective infection control, and the ability to easily reach and vaccinate people. However, this is more challenging in places like rural DRC, where access to healthcare and infrastructure is limited as above.

The priority must be to keep improving our response—day by day, week by week, month after month, and year after year if we have to. Our focus should be on strengthening the capacity of health systems to detect, respond to, and contain outbreaks. We are getting there, and we will get there, and at the end of the day, I want to really express my sincerest thanks to the huge number of hard working people, the under-sung heroes, who do this work every day to save lives.

A new version of the Declaration of Helsinki is out !

The new version of the Declaration of Helsinki (2024) has been adopted by the World Medical Association (WMA) in Helsinki. The previous version dates back to 2013!

The **Declaration of Helsinki (DoH)** is the WMA best-known policy statement. The DoH was first adopted at the 1964 WMA General Assembly in Helsinki. Its purpose was to guide physicians engaged in clinical research and to define responsibilities of researchers in order to protect research « subjects ».

This year, **key revisions were made to reflect the current ethical landscape and digital transformation in medical research**.

The 2024 update indeed transitions from focusing on human "subjects" to human "participants", highlighting the need for a more respectful and participant-centered

The new version also introduces the **notion of eConsent** and provides updated guidelines on the future use of data and samples especially in a context where large amount of data are digitally available and « research waste » a very real possibility. These revisions also insist on the need to **bridge data biases towards more inclusive and precise data collection and data interpretation**.

Several other changes were integrated in the 2024 version and we invite the EAN network to **read the full new text here.**

Be part of the community : ways to stay involved and connected!

Do what you love to do!

You'd like to get active on a project for our community? An experience you'd like to share or a topic you'd like to educate on? Please reach out to us at eanboard@gmail.com if you'd like to discuss your idea and want our support. We are available to help you bringing your ideas come to life.

Support us with mini-assignments

Our community lives from all of us and the capacities of the board alone are limited. Every now and then, we may reach out to ask for your help on specific tasks or activities to get the best out of it for all of us.

Activate your membership

Many benefits are lined up for active members of the network (GOARN requests of assistance, bulletins, discounts on mini-modules, access to specific ressources on our website...).

Membership runs from Nov. 1 until Oct 31 of the following year - but you can activate your membership at anytime! **The annual membership fee is now €30 / £28. There is a 10-year membership available at €250 / £230.**

Fellows in their first and second year of training are exempt from paying membership fees. We have added a new payment option for credit cards to make membership renewal a bit easier. To use this option, please go to our website and follow the instructions there.

The details for how to transfer fees by online banking are also on the **EAN webpage**; 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

send an email to **eanboard@gmail.com** with a copy of the receipt/invoice to inform us about your payment (sometimes names are not correctly transmitted with the transfer). Thank you for your support!

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Update your membership