EAN MONTHLY NEWSFLASH

March Edition

Interview with ECDC's Director, Dr. Pamela Rendi-Wagner

Welcome to the new director of ECDC, Dr. Pamela Rendi-Wagner, and our congratulations to this important post. You started this job in June last year. Now that the first half year has passed, how have you experienced ECDC and were there any surprises to your expectations?

I joined ECDC last summer –The usually quiet summer period was actually a highly active and interesting start – at least from a public health and communicable disease perspective. Just as I had taken up office, transmission of the highly pathogenic avian influenza HPAI A(H5N1) was observed in dairy cattle in the United States with a few cases of human avian influenza reported among farm workers exposed to the cattle. ECDC was closely monitoring the situation, and we were very quick to issue communications on the topic and share our assessment that in the EU/EEA the risk was low for the general population. We also began implementing a comprehensive strategy to support the early detection and containment of potential human cases in the EU. This is a situation we continue to monitor closely while also ramping up our scientific work to ensure we can provide Member States with the information and tools they need to ensure Europe is prepared should we begin to

see human cases here.

Then we saw the emergence of mpox clade Ib in Central Africa. Given our experience with mpox clade II in Europe, it was essential that we act fast and do everything we could to gather more information, assess the risk to the EU/EEA and help with efforts on the ground in DRC. Immediately following the declaration of a Public Health Emergency of International Concern (PHEI) by the WHO and the detection of a first case in the EU, we issued a rapid risk assessment for EU/EEA countries and arranged for the EU Health Task Force to deploy ECDC staff to DRC in support of local efforts.

So these first months were a great start for me as the new director, since it enabled me to get to know the experts and the organisation in action.

What is your vision for ECDC and how will you be leading the organisation?
Next year we will be celebrating 20 years of ECDC. My vision is that after 20 years, European people should know, value and most importantly trust this leading public health agency.

Since taking up office, my priority has been to ensure that ECDC fulfils its purpose by providing useful, clear and timely science-based guidance to decision-makers at the Member State and European level. This means that ECDC acts with efficiency and agility and responds in a timely and proactive manner to health threats in line with the new mandate of our Agency and taking stock of the lessons we learnt from the COVID-19 pandemic.

My strategic outline as new director is 1. implementation of the new mandate, 2. prioritisation, and 3. more cooperation and better communication. In today's increasingly complex landscape where public health faces challenges from climate change, natural disasters, geopolitical conflicts, population displacement, growing health inequalities as well as misinformation and disinformation campaigns, there is a need for a more active and engaged European public health agency.

How do you see the ECDC Fellowship Programme developing in the future?
The ECDC fellowship programme plays an important part in forming the next generation of public health epidemiologists and microbiologists. Fellows make valuable contributions to European preparedness and response and strengthen our ability to make a positive impact. The fellowship is essential to our vision of a healthier – better prepared Europe.

Looking ahead, we will continue to focus on in-service, data-driven work that supports evidence-based decision making in public health institutes. It is essential that fellows have the opportunity to do real world work with a real-world impact. The EU Health Task Force means that fellows now have even more opportunities to support our response efforts to health emergencies across the globe.

Beyond this, we will see more cross-border exchanges between fellows and Member States so that we can build the strong international collaboration and networks that are needed to counter cross-border health threats and prepare for the next health emergency. We are also

committed to facilitating increased participation of Member States that are underrepresented in our fellowship programme.

We will also work to expand opportunities for high quality international assignments with our partners through the EU health task force.

Thinking of the EU Health Taskforce (EUHTF), how do you see the role of EAN members and current programme fellows in it?
EAN members and fellows can and do play an essential role within the EUHTF. In 2024, several ECDC Fellows and the first external experts were deployed on missions with the EUHTF. The largest of these was to support DRC authorities, WHO and Africa CDC in their response to the mpox epidemic.

EPIET fellows make up part of the EUHTS's expert pool during their two-year placement. I would really encourage EAN members to make sure they are also in the pool as it is a very exciting and impactful resource that allows experts to deploy to crises across the globe and get real, first-hand experience and play a positive role in global health.

How could a network of more than 900 alumni and active fellows all across Europa facilitate building trust into public health with the general public, organisations and member states?
The EPIET fellowship exposes participants to colleagues from across the EU – enabling them to share experiences and perspectives and build relationships that will endure. This is essential to establishing a more European perspective in public health through knowledge transfer and capacity building.

These relationships mean that during a crisis, fellows and alumni already know colleagues from across the EU/EEA and crucially – have a similar outlook and shared standards. As a result, they can work together quickly and effectively – something that is essential to rebuilding trust at all levels.

EPIET fellows have a variety of training opportunities during and after their fellowship. These are focussed on building the skills needed to deliver. This is crucial to building trust with the public and designing evidence-based public health interventions. If people feel safe, they will be much more likely to trust the guidance and recommendations they receive from health authorities. Delivering better outcomes is key.

In September, the new cohort of 2024 took up their posts for two years of training by service at public health institutes in Europe - often in a new country. Do you have any tips or words for the new fellows?
Seize every opportunity that the fellowship offers. Stepping up for more responsibility at your training site, getting that holistic view and engaging with different perspectives means you will be better prepared and ultimately – be more successful in protecting the public we all serve.

Embrace every aspect of the training with an open mind. Try to really dig into the details of surveillance, outbreak investigations, data analysis and generating the evidence base for

decision making. You might be surprised by which areas you find most interesting.

Is there anything you would like to say to the EAN?
I would like to thank the EPIET Alumni Network and its board members for their contributions. The success of the EAN is testament to the commitment of its members and board – who dedicate their own time to this important project and facilitate training modules.

An active professional network has always been a key objective of the fellowship programme. Members play a vital role in fostering international cooperation and information exchange by building relationships and breaking down barriers. Thank you for all you do to promote a truly European perspective when it comes to public health.

Bridging sex and gender data gaps in outbreak response

Every day, and especially around International Women's Day, it's important to recognize that health emergencies affect people differently, with gender playing an important role in shaping those outcomes.

We spoke with Marie-Amélie Degail, an EPIET alumna from Cohort 15 (2009-2011) and now a Senior Epidemiologist at the World Health Organization, where she is the lead for Integrated Outbreak Analytics. Marie-Amélie recently co-authored a scoping review that highlights the persistent gap in collecting, analyzing, and using sex-disaggregated and gendered data during disease outbreaks, particularly in low- and middle-income countries (LMICs). We asked her about the key findings, why these gaps exist, and how better data can drive gender equity in health, particularly during outbreaks. Many thanks as well to McKinzie Gales and Emelie Yonally Philips, the joined first authors of the publication, who collaborated on this interview too.

Your scoping review highlights major gaps in how sex- and gender-disaggregated data is collected and used during outbreaks. What are the most important gaps the authors identified?
Although sex data may be available it is rarely used beyond age pyramids, and differences by sex are rarely investigated. Similarly gendered data are not always collected during outbreaks which contributes to large evidence gaps that may hamper our ability to adequately respond to outbreaks. In addition, although epidemiologists have repeatedly

outlined the need to collect, analyze and interpret data on pregnancy status during outbreaks, it continues to be poorly captured with the recurring excuse of pregnancies being often unknown and/ or unreported in many societies before the second trimester. Similar gaps exist in the evidence made available on disease preventative measures or susceptibility in pregnant women.

Despite international standards and guidelines encouraging gender-inclusive approaches, these gaps persist. Why do you think that is?

This paper has not "invented" the data gap. All of the authors of this paper were not only inspired by the SAGER guidelines but also by Caroline Criado Perez's book "Invisible Women". The gender gap not only impacts public health but all the domains of human life, industry, and economy. We are yet to find a way to make societies value equally everyone's life and well-being. In emergencies this trend is further exacerbated by the need to prioritize rapid actions, so it becomes even less likely that we gather comprehensive data. However, since we know that sex and gender shape disease vulnerability, transmission, and outcomes, not prioritizing this data in outbreaks is detrimental to response efforts and communities.

What are the biggest challenges in collecting sex-disaggregated and gendered data during outbreaks and public health emergencies, and especially in LMICs?

This is a really great question, and one of the knowledge gaps we identified and hope to explore further. What are the barriers to collecting, analyzing and using these data? We do know that sex data is often collected during outbreaks in LMICS. However, only a few publications reported sex-disaggregated outcomes and even fewer discussed reported differences.

We also found that sex and gender are often used interchangeably even though they are quite distinct and have very different impacts on outbreaks. This may suggest that one barrier is that the differences between sex and gender data are not yet well understood and gender indicators are not yet integrated into data collection and analysis plans. Challenges are also going to be context specific as there may be sensitivities to the types of sex and gender data you can easily collect.

How do these data gaps affect people during an outbreak, and especially women, men, and gender-diverse groups? Can you share an example where having better gendered data might have improved the response?

We have plenty of examples!

In some cases, the issue is that we simply don't have the data. For instance, when reviewing studies on Hepatitis E, we found that reported sex disparities varied by country—some showed higher prevalence and severe outcomes in men, while others showed the opposite. We do know that biological differences in immune responses make males more susceptible. We also know that behavioral risk factors play a role in shaping exposure and vulnerability. However, the studies we reviewed didn't include data on these behavioral factors, which means we lack critical insights into how gender norms, roles, and relations might be driving these disparities. Without that understanding, how can we effectively respond and address transmission? And when it comes to gender-diverse groups in LMICs, we found no

data at all – so we don't even know what the disparities are.

In other cases, the data exists but isn't being considered in analyses or used to inform responses. A clear example is the 2015 Zika outbreak. We knew sexual transmission was occurring. We also knew that in some of the hardest-hit areas, rates of unintended pregnancies were extremely high (almost 50% in some regions), many women faced barriers to contraception, and gender inequality was widespread. Despite this, public health messaging focused on advising women to prevent Zika and delay pregnancy—effectively placing a double burden of responsibility on them while ignoring the structural barriers they faced.

We also have examples where the response itself is driving gender inequality. We saw the increase in GBV and teen pregnancies in response to COVID lockdown measures. We also have evidence that in some contexts increased WASH messaging places the burden of additional water collection on women and girls and can in fact place them at increased risk of experiencing sexual violence if they have to travel to get water.

And more….

During a dengue outbreak in Asia, it was reported that more men were affected. However, it was later understood that in those communities women tended to go to traditional healers hence evading the public health system, Therefore they did not benefit from the support provided to cases that were reported in the official system.

Another study showed that the physiological changes of pregnancy may mask the extent of infection in pregnant women which may make it difficult for clinicians to diagnose dengue in these patients.

During the Ebola virus disease outbreak in Eastern DRC, access to care for women was reduced by risk of gender-based violence on women and destruction of health care facilities.

Can you tell us more about how Integrated Outbreak Analytics (IOA) is working to improve how data informs outbreak responses, and specifically how it's tackling the gender data gap? Are you seeing any progress yet?

IOA recognizes that it is impossible to fully understand outbreak dynamics without systematically collecting and analyzing sex-disaggregated and gender-sensitive data. By working closely with ministries of health and partners, IOA strengthens the quality and scope of outbreak data to uncover how different groups are affected—both by the disease itself and by response interventions.

A clear example of this work can be seen in the 2018 Ebola outbreak in Eastern DRC. Initial epidemiological data showed that more women than men were affected by Ebola, but vaccination data was not disaggregated by sex, and there was no information on those ineligible for the vaccine due to pregnancy or breastfeeding. An IOA approach was used to understand the underlying risks affecting women and found critical gaps in surveillance and psychosocial follow-up for pregnant and breastfeeding women exposed to Ebola. The

absence of documentation meant these high-risk individuals were overlooked in response efforts.

These findings led to immediate changes in data collection and response efforts. Pregnant and breastfeeding women were documented in surveillance and vaccination data to ensure their risks were recognized and breastfeeding frontline workers were provided with support kits if they chose to stop breastfeeding to receive the vaccine. In June 2019, global policy changed to allow pregnant and breastfeeding women access to the Ebola vaccine trial—an important step in reducing preventable transmission.

Breaking barriers for women: the role of behavioural and structural factors in HIV prevention

In recognition of International Women's Day, the ECDC Lighthouse Community of Practice (CoP) hosted a webinar on "Breaking barriers for women: the role of behavioural and structural factors in HIV prevention". We spoke with John Kinsman, an expert in behavioural change at ECDC and leader of the CoP in Social and Behavioural Sciences for the Prevention of Communicable Diseases. He was also a key contributor to the recent fellowship module on behavioural and social sciences.

The webinar focused on the behavioural and structural factors that shape women's risk of HIV acquisition. What were the key takeaways you hope participants gained from the webinar and discussion? What do you see as the most urgent challenges that still need to be addressed?

We had two great speakers at our webinar to commemorate International Women's Day, Magdalena Ankiersztejn-Bartczak and Harriet Langanke, and a lively conversation developed in response to their excellent presentations. Through all this, the following key learnings emerged:

- **Gender-responsive prevention.** Efforts must be made to ensure that all women have full access to combination prevention, including biomedical, behavioural, and structural interventions that are tailored to their needs.
- **Education and community engagement.** Awareness raising among women, healthcare professionals, and policymakers is essential in breaking down barriers to HIV prevention.
- **Targeted interventions for migrant and mobile populations.** Healthcare services must address the unique challenges faced by displaced populations to prevent treatment disruptions and improve access.
- **Challenging stigma and gender norms.** Inclusive policy changes and advocacy efforts are needed to dismantle stigma and discrimination that hinder HIV prevention efforts.
- **Collaborative efforts across sectors.** Healthcare providers, policymakers, and community organisations must work together to scale up HIV prevention programs effectively.

The most urgent challenges concern the multiple barriers that women face in accessing HIV prevention services, due to gender-based violence, economic and emotional dependence on men, the need for negotiation with male partners (e.g., for use of condoms), social stigma, and lack of knowledge. There is also the fact that HIV education often focuses on men who have sex with men (MSM), leaving many women unaware of available HIV prevention options. Even when women are aware of prevention methods, many don't know where or how to access them. Barriers such as cost, legal and social insurance status (e.g., undocumented migrants), and healthcare discrimination further complicate access. Unlike MSM, women often lack strong networks for sexual health information and support, resulting in less community mobilisation around women's HIV prevention needs.

The webinar is part of a broader ECDC webinar series on Social and Behavioural Sciences for the Prevention of Infectious Diseases. What other topics have been covered in the series, and where can these be accessed?
The Lighthouse has now held six webinars, each attracting between around 200 and 500 people. The webinars are open to people who are already in the Lighthouse Community of Practice as well as people who have not (yet?) registered. We are always keen to have people participate in a webinar and then join the Lighthouse community so that they can then access the other materials and the learning and networking possibilities that it offers.

The six webinars have covered the following topics. The webinar series and summaries of each webinar can be accessed **here**.

- Webinar 1: Health literacy in the prevention of infectious diseases
- Webinar 2: Social and Behavioural Science in Action: Shaping Public Health Strategies for Infectious Disease Prevention.
- Webinar 3: Building and maintaining trust in policies, programmes and communication for infectious disease prevention
- Webinar 4: Behavioural Science in Action: Understanding Vaccine Acceptance and Uptake
- Webinar 5: Behavioural Science in Action: Using Behavioural Science to Counteract Antibiotic Resistance
- Webinar 6: Breaking barriers for women: the role of behavioural and structural factors in HIV prevention

explain who the CoP is designed for? Specifically, how can networks like these support more effective and gender sensitive infection disease prevention strategies?

The ECDC Lighthouse is an online Community of Practice that aims to help protect against infectious diseases in the EU/EEA through the application of social and behavioural sciences. It was launched in November 2024, with membership open to professionals involved in the prevention of infectious diseases in the EU/EEA, including those working in public health agencies (national or regional), universities and research institutions, as well as professional, civil society and community-based organisations. The ECDC Lighthouse builds on one of the key lessons from the COVID-19 pandemic: that social and behavioural issues need to be taken fully into account if prevention efforts against infectious diseases are to be optimally effective.

The main goals of the ECDC Lighthouse are:

- Strengthening the capacity of actors involved in public health in EU/EEA countries to use social and behavioural science for infectious disease prevention;
- Facilitating mutual learning and exchange of good practices between practitioners working on infectious disease prevention;
- Uniting people and fostering collective and multi-disciplinary efforts to integrate social and behavioural science methods and approaches into prevention activities.

Much work within the social and behavioural sciences focuses on factors that can either inhibit or facilitate adherence to public health measures. We know that gender can play an enormous role in this, and as such, gender is an intrinsic and important consideration when we are thinking about or developing prevention strategies and programmes.

Members of EAN will be very welcome to join the Lighthouse! When you register, please don't forget to fill in your country so that we can validate your membership to this platform that serves the EU/EEA. Welcome!

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 line. Please indicate your name and membership year as reference in the bank transfer and also 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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