

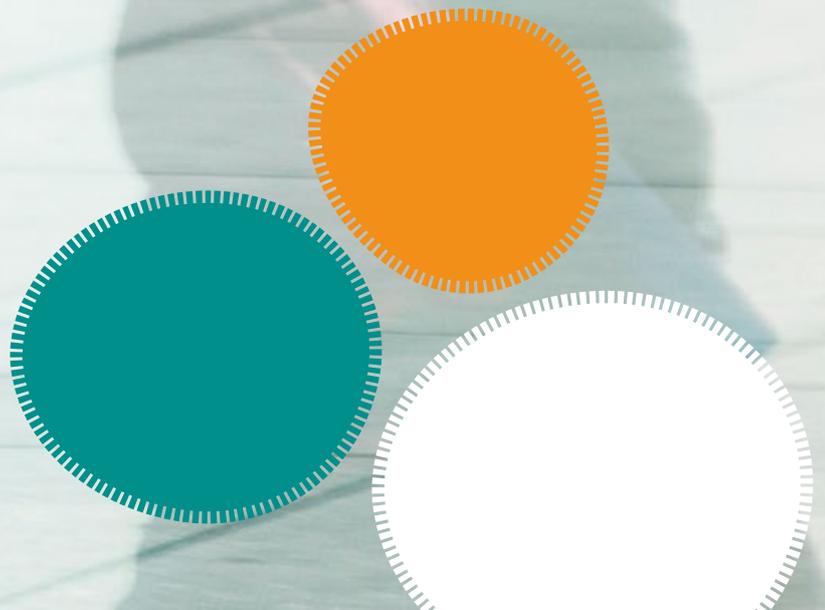
ESWI

... EUROPEAN SCIENTISTS FIGHTING INFLUENZA

THE FIRST EUROPEAN INFLUENZA SUMMIT

BRUSSELS, 26 MAY 2011

Organized by
the European Scientific Working group on Influenza (ESWI)



PROGRAMME

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FOREWORD

Professional awareness about the important burden of influenza on public health continues to grow in Europe, but there's still no consensus about the best way to monitor, treat and prevent the disease, the exact policy approach needed to promote the use of influenza antivirals and vaccines, or the most effective mixture of communication options for reaching the wider public. Getting a more focused dialogue on the challenges of combating influenza, whether seasonal or pandemic, laid at the heart of ESWI's first European Flu Summit.

On 26 May 2011, the First European Influenza Summit brought together more than 70 representatives of organizations of healthcare providers, senior citizens, at-risk patients and public health authorities. The aim of the meeting was to provide all influenza partners with an informal platform to exchange good practices and to initiate concrete actions to improve public health protection against influenza. 11 expert lecturers, including the co-chair of the US National Flu Vaccine Summit, addressed the audience to elaborate on 11 different aspects of the fight against influenza.

This magazine provides a report of the lectures and the discussions held at the Summit. The text can be copied and distributed freely. Additional questions to the Summit's faculty can be asked via ESWI's management (contact details see below).

The Second European Influenza Summit will be organized in May 2012.

About ESWI

The European Scientific Working group on Influenza (ESWI) is a partnership organization of stakeholders with a clear mission: to reduce the number of influenza victims in Europe.

Partnership organizations like ESWI are established to meet specific objectives and to undertake projects to address problems that neither partner could tackle adequately on its own. A successful long-term partnership is built on common grounds. In the case of ESWI, this common ground is a social concern to improve public health in Europe.

If you require further information please check the ESWI website at www.eswi.org or contact the ESWI manager, Mr David De Pooter, at david.depooter@eswi.org or +32 3 232 93 42.

EVM has provided an unrestricted grant to support the European Influenza Summit. An unrestricted grant implies that EVM financially supported the Summit, but has not been involved in the preparation of the Summit in any way.

REACHING OUT TO EUROPE'S INFLUENZA THE FIRST ANNUAL ESWI FLU SUMMIT

Aiming at a moving target

Held in Brussels, the one-day event on 26 May brought together public and private sector experts for a rich discussion of the issues in the sector, from country-specific vaccination strategies to dealing with a volatile press when health issues hit the news.

"It is very important that we all discuss and debate this subject to create a platform for flu stakeholders to exchange good practices and

initiate concrete actions in Europe." Dr. Ab Osterhaus, head of virology at Rotterdam's Erasmus Medical Centre and ESWI chair, told the summit in his

opening remarks. "We need to define a common policy ground in Europe on influenza, so we are reaching out to as many stakeholders as possible."

Partly inspired by the US National Influenza Vaccine Summit – which annually pulls together more than 100 public and private flu-related organizations under one roof – Osterhaus said the ESWI stakeholder platform is guided by four factors, namely that:

- European health care systems are among the best in the world
- influenza claims more lives than traffic accidents
- underlying disease and high age constitute a special risk
- influenza is a preventable disease

"We strongly believe that a focus on behavioural change and public health policy is indispensable for reaching the health protection objectives of the EU and the World Health Organisation [WHO]. The overall goal has to be the reduction of influenza's burden on society and the number of fatal cases in Europe," he said.

Stakeholder Profile: ESWI

The European Scientific Working group on Influenza brings together experts, advisors and partner organizations to address flu-related public health issues that none of the partners could adequately tackle on their own. Their objectives include public information campaigns, health surveillance techniques such as how to scale up preparations for a pandemic and support for the use of vaccines and antivirals.

ESWI works closely with a wide diversity of organizations, which includes:

- European Public Health Alliance
- World Health Organization
- European Respiratory Society
- World Organization of Family Doctors
- Pharmaceutical Group to the EU
- International Diabetes Federation-Europe
- Influenza vaccine and antiviral manufacturers
- European Lung Foundation
- US National Influenza Vaccine Summit
- European Medical Association

COMMUNITY:

Memory fades, influenza does not

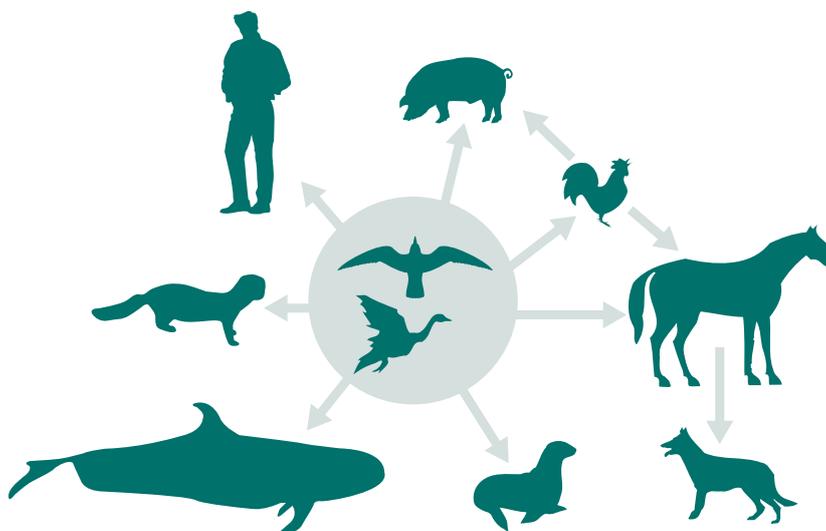
In his formal presentation Osterhaus reminded the ESWI audience that the world's receding collective memory of past epidemics means there is a constant risk that the public forgets how dangerous influenza can be. "How many people died from pandemic flu during the last century? Fifty to sixty million! And yet people still don't have the facts straight in their head," he observed.

As an example, he pointed to the myth which holds that avian flu must always go through poultry or pigs to reach humans. "We now know that it can directly infect humans. The Hong-Kong flu outbreak in 1997 was the first recognized case of the virus jumping from birds straight to humans. So they can spill over directly to humans, though not from human to human – yet," he said.

And while any news about a pandemic will dominate the headlines, it is too easy to overlook the dangers – and health statistics – linked to "ordinary" flu, he said. Because the genetic make-up of

a flu virus constantly 'drifts' or mutates, this requires annually updated vaccines since there is no persistent and broad immunity after infection or vaccination – despite some lingering public perceptions to the contrary.

Stepping up the flow of information about influenza to the public, the media and especially Europe's diverse public healthcare worker (HCW) community demands a more organised approach, said Osterhaus: "That's why this kind of summit is so important for interacting with stakeholders and managing the dialogue."



EU FLU VACCINE POLICY: AIMING HIGH

Influenza vaccination policies and public information campaigns vary greatly across the 27 EU nations – all the more so, as health care is a national responsibility. Steering them toward more coherence in their collective effort to reduce the burden of influenza on society falls primarily to the European Commission.

Raising Europe's vaccination rates and developing mutual-support mechanisms for the availability of vaccine stocks are two of the biggest policy challenges facing the EU in this area, as explained by the ESWI summit's second speaker, John Ryan head of the health threats unit at the European Commission's Directorate-General for Health and Consumer (DG SANCO).

Given that the Commission's goal for Europe is to achieve a 75-percent vaccination rate in the elderly and other at-risk groups such as health care workers by 2014-2015, Ryan said the EU has consistently advised the member states to adopt national and regional campaigns such as education and training to boost information exchanges on seasonal flu and thus lift their seasonal flu coverage rates.

The 2009 H1N1 avian influenza pandemic revealed a huge diversity of vaccination approaches, though he said some common observations could be drawn based on the Commission's review of events surrounding the pandemic as well as subsequent evaluations by WHO, the European Centre for Disease Control (ECDC), the European Medicines Agency (EMA) and national assessments. For example, one of the Commission's most important findings of the 2009 pandemic was the role that health care workers played in influencing the general public's attitude toward vaccination.

"Without HCWs' engagement and support, the effectiveness of communication to patients and the public will not be high, which means risk groups will be highly impacted," Ryan observed.

One big problem "was the disconnection

between the advice going to the general public and that going to HCWs about the seriousness of the pandemic. As a result, many HCWs did not take it seriously and so they did not recommend vaccination to their patients. We saw this in many member states," he said. "It boils down to dialogue, which is why it is so important to raise awareness among all stakeholders."

No hard power – but things are moving

As deadly as they are, pandemics are still rare. The more common killer is seasonal flu. Asked whether the Commission is giving any thought to a collective approach to combating seasonal flu, Ryan's answer was equivocal.

Noting that the Commission's "hard" or binding legislative power in the health sector is limited to a few areas, he said "unfortunately, seasonal flu does not fall in that category so we are restricted to soft measures such as [non-binding] recommendations. But we do issue reports on implementation of these recommendations, which can be embarrassing if a member states finds its name at the bottom of the list."

As far as Commission's 75-percent target vaccination rate for at-risk groups, only one country – The Netherlands – has reached that goal, for example.

Ryan admitted that the gap between the target and reality is large. But he also insisted that "the essential thing is to fix indicators and have a process for achieving them. We're already preparing for a joint procurement mechanism [see accompanying box] for vaccine procurement, and this could lead to other joint measures such as reinforced preparedness, which is currently done only on a voluntary basis."

The 2009 pandemic & vaccines: more EU solidarity needed

Many of the EU27 were in a difficult vaccine situation when the 2009 pandemic hit, according to Ryan. "This pitched one member state against another in the chase after vaccines, and some lost out when trying to vaccinate their citizens. As a result, we saw shortages in certain EU nations. This is unacceptable in an EU where solidarity and health security is a principle," he said.

To avoid such a situation the next time a pandemic hits, the EU's Council of Ministers asked the Commission to develop a voluntary mechanism for the joint procurement of vaccines and antivirals – a joint framework proposal which will be presented in December 2011 to national health ministers for their discussion and approval.

According to Ryan, such an approach would offer three advantages. It would:

- boost solidarity by guaranteeing a minimum level of equitable access to vaccines for priority risk groups
- group together the member states' purchasing power to produce better contractual terms regarding price, liability and delivery
- make the EU approach adaptable to existing national procurement practices

"The Commission is convinced that joint purchasing [of vaccines and/or antivirals] would boost our level of preparedness," observed Ryan.

HCW VACCINATION: ONE GERMAN HOSPITAL'S (QUALIFIED) VICTORY

Among Europe's largest hospitals, and the biggest in northern Germany, is the University Hospital Hamburg-Eppendorf (UKE). With 4,500 doctors, therapists, nurses and other medical personnel on its payroll, UKE handles 76,000 in-patients and a staggering 250,000 out-patients each year.

How UKE managed to chalk up an astonishing rate of HCW vaccination during the 2009 flu pandemic – only to see the momentum plunge once the pandemic wave was over – offers lessons learned for all, as Dr. Gabriele Andersen, UKE's chief occupational health doctor, told the ESWI summit.

In the years preceding the 2009 pandemic, UKE's HCW-vaccination rate was virtually no different from that prevailing across German HCWs as a whole: around 15-to-20 percent.

But with the prospects of pandemic onslaught, Andersen and team decided to take the bull by the horns and steer their organisation's HCWs to higher heights. The first thing they did was to create an in-house task force to coordinate the pro-vaccination campaign.

"A key objective was to give very clear

information to all our employees via multiple channels such as newsletters, posters, email, and so on and then to reinforce this with regular visits by vaccination information teams to all sectors of the hospital," she said. "We also set up an in-house hotline for questions from staff members and, most important, local vaccination points across hospital at places such as the intensive care unit, emergency rooms and the paediatric clinic. All this was done to make vaccination as easy as possible."

Ironically, one of the factors that pushed

UKE's health workers to the vaccine station was personal discomfort, which arose for those who chose not to get a flu shot. "For unvaccinated HCWs, we made it obligatory to wear the N95 [face] mask to protect themselves and patients. It turned out this was a main way to get them to come get a vaccination: they did not like wearing the mask all day. This was not easily accepted but they had to do it because it came from our management board and thus could not be rejected."

Big-time results – but pandemic only

Andersen's well thought-out plan of attack delivered solid results. During the 2009/2010 pandemic flu season the rate of vaccination among UKE's health care workers shot up to an amazing 74 percent, thus catapulting the hospital far above the national average. But this victory did not last for long. By the time the 2010/2011 flu season rolled

around, the HCW self-vaccination rate plummeted to 27 percent.

What happened and why?

"We asked our HCWs why they rejected vaccination this year and the reasons were fairly predictable," observed Andersen.

Among the main reasons was the

misperception that immunity lingers from the previous year's pandemic flu vaccine. "Other reasons given were that vaccines provide insufficient protection or that they cause influenza. And there were also concerns about adverse reaction to vaccines and simply fear of the needle," she said.

Food for thought

Mandatory vaccination (as successfully implemented in the University Hospital Hamburg-Eppendorf) is a controversial strategy that pits healthcare worker autonomy against patient safety. The ethical argument that healthcare workers have a moral obligation to first protect themselves and then to protect their patients seems to gradually win ground. The discussion continues...

HCW Vaccination: Firm Guiding Hand Needed

Converting HCWs to the self-vaccination cause demands both awareness-raising and firm guidance from management, according to Andersen. The idea is to get the right mixture of positive incentives and negative disincentives, she said. To reverse her organisation's post-2009 pandemic slide in enthusiasm among HCWs to get a vaccination, Andersen said UKE's management is now mulling a new strategy based on a set of options that range across the following:

- better ways of distributing information to HCWs
- the use of only vaccinated staff in certain areas such as patients with immune deficiency
- declination forms whereby HCWs formally declare their rejection of vaccines
- obligatory flu vaccination
- a standing obligation that unvaccinated HCWs must wear a mask

Asked if UKE negotiated an accord with its hospital unions that all unvaccinated workers would have to wear a mask, Andersen said: "Yes, they agreed to strictly follow the orders of the hospital management. But, even so: if you can't get the consent of all players, you simply won't be successful."

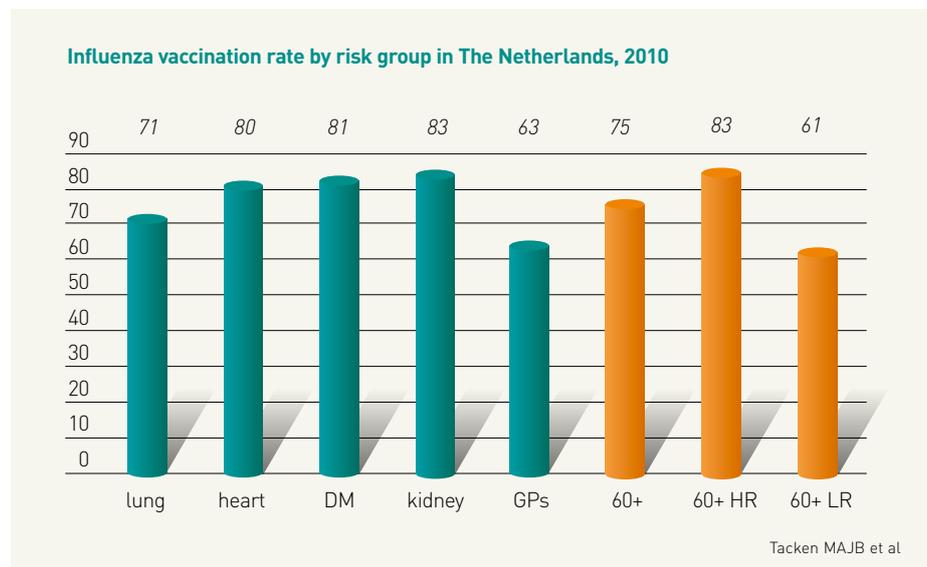
THE NETHERLANDS: VACCINATION FRONT-RUNNER

The Netherlands is among the few European countries that achieve a high rate of seasonal flu vaccination year after year. For example, WHO's recommended vaccination uptake target for the elderly (i.e., 65 years and older) in 2010 was 75 percent. The Dutch were not only the only nation in Europe that reached that goal but exceeded it with more than 80-percent of its elderly with accompanying risks getting vaccinated.

"We have a vaccination rate of around 60-to-70 percent for the population as a whole. And for the common childhood vaccinations like measles and rubella we have rates of almost 95%," speaker Ted van Essen, general practitioner and adviser to the Dutch Health Council, told his ESWI audience. "But we've been refining the strategy for a long time."

Indeed, the Netherlands began organising its stakeholder debate as early as the beginning of the 1990s with the creation of the Dutch Influenza Foundation (DIF) in 1992 – a broad coalition of public health authorities, professional medical associations, pharmacists, insurance companies, disease-specific patients groups and associations representing the elderly. With its funding shouldered 50-50 by industry and the Ministry of Health, DIF was the country's first public-private partnership in the health sector, and it used all modern media to drive home its central and positive message – "Work on your health!" – about the benefits of influenza vaccination.

"This was a 'push-and-pull' strategy to get patients in to see their doctor," said van Essen.



Although the DIF ceased in 1996, Dutch GPs picked up its ideas and have been running with them ever since to visible effect, given the country's high vaccination rate.

It don't come easy

The Netherlands' high influenza vaccine rates do not come casually: they're the result of years of stakeholder effort and "positive" aggressive campaigns to get Dutch patients in to see their doctor – initiatives which van Essen strongly supports. "You only have to look at the before-and-after results," he said.

Before 1991, the public got an annual letter from health authorities and some invitation cards from industry. There was no fee-for-service for the GP and the patient had to go to the pharmacy with a prescription."

From 1992 on with the creation of the Dutch Influenza Foundation and other initiatives things began to change, however. "Patient magazines carrying the vaccine message went from 23 in 1992 to 45 in 1996 and newspaper articles jumped from 34 to 271!" he said.

Obligatory HCW vaccination?

The Dutch vaccination success rate not only applies to at-risk groups and the population in general but also to its HCWs. In 2009, for example, pandemic vaccination rates among its GPs was 85 percent and that for HCW staff was 76 percent. Even for that year's seasonal flu vaccination, the rates were 63 and 60 percent, respectively.

Most countries would be more than pleased with those levels but van Essen thinks big – and controversially. "I think we should just make vaccination mandatory for HCWs," he said.

That sparked no little debate from his ESWI summit listeners, with some participants arguing against the idea out of concern that HCWs might confide to a patient that they were forced to get a vaccination, thus sending the wrong message.

Van Essen conceded that point, but said "it's a question of public education. Ethically, you could also argue the issue from the other direction: that HCWs have a moral obligation to first protect themselves and then to protect their patients. After all, the hepatitis B vaccine is mandatory for surgeons or else they are excluded from treating a patient. So there is a precedent for such an approach and I think we should build on that."

Vaccination Dutch-style

A number of success factors account for the Netherlands' impressive vaccination rates. According to van Essen, these include:

- one professional held accountable: the GP with a patient list system
- a national electronic medical records system that allows physicians and HCWs to identify names and addresses of all at-risk patients, (i.e., 30% of the population)
- free vaccinations for patients at-risk
- a guaranteed fee for GPs who administer the vaccine
- centralised government purchasing of vaccines
- easy paperwork for the GP and convenient vaccinations hours – including evenings in certain cases – for patients
- a simple campaign based on a postcard invitation-with-flyer from the GP
- systematic feedback to evaluate effort and results.

"I've tried to find the one reason why this whole system works so well, but that's not the answer," he said. "It's really the balance and combination of all these factors – the 'shotgun' approach – that explains its effectiveness."

COMING OUT... FROM THE HOSPITAL BASEMENT

Traditionally, hospitals' in-house pharmacists were largely unseen for the important role they play in delivering the right medicine to the patient and the right pharmacological advice to medical staff. But pharmacists increasingly play a pro-active role in hospitals by intervening, often at bedside, as the flu patient's specialised pharmaceutical care manager, as Arnold Vulto, professor of Hospital Pharmacy & Practical Therapeutics at Erasmus University Medical Center, told the ESWI summit.

The conventional image of the hospital pharmacist as "dispensing medicine from a little window" in the hospital basement is long outdated, said Vulto. Indeed, his profession is one of many that contributes to today's increasingly complex stakeholder dialogue on vaccination policy and how to implement it.

"We have 30 staff working in our hospital who are all focused on specialised pharmacological care," said Vulto. Noting that post-graduate specialisation is now indispensable in the pharmacological sector, he said hospital pharmacists have turned into "specialists dealing with high-risk influenza patients who have to be innovative and quick in their

decisions, as that often means the difference between life or death."

Observing that his profession "came out of the closet" in the 1960s, Vulto said hospital pharmacists are now far more service-oriented. "Today it's 'care orientation': specialised pharmacological care based on personalised medicine and bedside pharmacy techniques."

Vulto is a member of the 21,000-strong European Association of Hospital Pharmacists and chief editor of its in-house publication, the European Journal of Hospital Pharmacy.

Food for thought

Studies have shown that influenza vaccination of healthcare workers reduces employee illness and absenteeism. In nursing home settings, vaccination of healthcare workers decreases the impact of influenza on the residents. And yet, vaccination rates among European healthcare workers are generally low.



The European Association of Hospital Pharmacists

EAHP is the federation of national associations of hospital pharmacists, uniting more than 21,000 hospital pharmacists in 31 countries.

The European Journal of Hospital Pharmacy is the official EAHP journal.
www.eahp.eu

While hospital pharmacists are today regarded as independent information source on pharmaceuticals in the hospital, Vulto said their ability to provide independent advice on influenza cases depends heavily on rapid access to up-to-date and reliable information sources, which was not always the case as the 2009 pandemic unfolded.

Digging for the data – fast

Pharmacological information about the 2009 pandemic was uneven and somewhat confusing, according to Vulto. Although the Europe Medicines Agency, WHO and various national institutes eventually provided enough pandemic vaccine information to enable him and other pharmacists to properly advise their hospital staff, Vulto said it was an uphill battle to dispel misplaced public fears about the vaccine.

“Some countries provided information faster to pharmacists than others. Germany put out weekly updates during the pandemic, which were very useful. But the transparency of information in other countries could have been much better,” he said.

“This was our first experience with large-scale pandemic vaccine production and it raised a lot of questions within our community. No one really knew what type of antigen or adjuvant was best, for example, or whether we should have recommended booster shots for at-risk groups,” he said.

“Eventually, however, we found good data about types of antigen and antigen sparing strategies, information about booster guidelines and updates about vaccine production limitations. In the end we did get the guidance we needed on these issues,” observed Vulto.

Pharmacists: advocating vaccination in the hospital

“If our sector wants to address the vaccination challenge, then we need to move away from promoting the ‘balanced view’ and go for a more pro-active stance,” Vulto told the ESWI summit. “But this means that the public needs a consistent vaccine message that is repeated over and over again, following a long term communications strategy.” According to Vulto, such a strategy should be based on a set of simple, but positive messages about the benefits of vaccination, namely that:

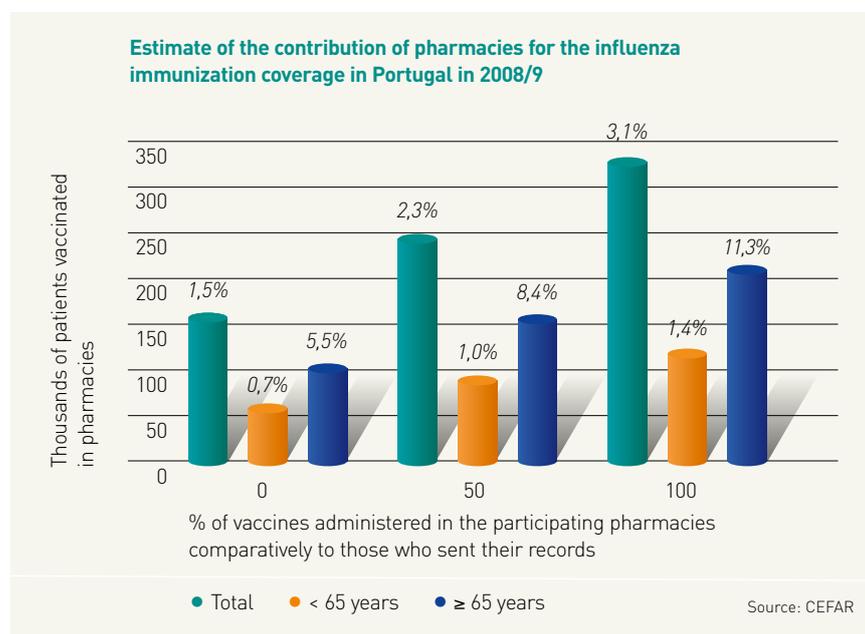
- it stimulates one’s own immune system to protect himself, thus mimicking natural immunity
- the responsible citizen gets vaccinated to prevent the virus from spreading to family, friends and colleagues
- the call-of-duty is even stronger for health care staff to protect vulnerable hospitalised patients

Vulto said the level of mis-information about vaccines that circulates among HCWs can be very persistent, despite the facts. “I’ve heard everything from fears that the vaccine is dangerous to a refusal to be ‘manipulated.’ It is astonishing to learn sometimes how little hospital staff know about vaccinations,” he said. “But it also shows that they need an independent information source, which hospital pharmacists can – and should – play as informed facilitators.”

VACCINATION TAKE-OFF: PORTUGAL'S PHARMA BLAZE NEW PATH

By stroke of luck Portugal launched a new national flu vaccine campaign just before the 2009 pandemic struck. A key part of the initiative was a new law to allow the country's pharmacies to administer flu shots.

The country's National Association of Pharmacies (ANP) was heavily involved in the effort, designing the intervention model and persuading its sector and the public to embrace it. How far this may go is uncertain, but the results to date have been encouraging, according to Suzete Costa, pharmacist and researcher who addressed the ESWI summit on ANP's behalf.



"I was directly involved in this campaign and it took a lot of preparatory work to bring the public and our pharmacy sector on board," said Costa.

The reform allowed pharmacies to expand their scope of activity into new areas, including immunisation. In addition to the vaccination intervention model it defined, ANP provided a training programme to prepare pharmacies for the new campaign and other support measures.

"This was a short-term but massive training programme for pharmacists all across the country," said Costa, adding that ANP provided a list of nurses for interested pharmacies: "Basically, we offered our constituents a choice between hiring a nurse or having training themselves."

Taking place over a 12-week period in advance of the 2008/09 flu season, the programme saw nearly half of Portugal's 1914 pharmacists complete the vaccination training course.

As a result, the number of flu vaccines administered in Portuguese pharmacies during the 2008/09 season rose to as much as one-fifth of the national total, with pharmacists themselves – as opposed to on-site nurses – carrying out the great majority of immunisation service on their premises.

CISTS

Prescription-vs-dispensation

Costa has strong, if not controversial, views about the pro-active role that pharmacists should play in her country's battle to prevent influenza.

"We think qualified community pharmacists in Europe should be able to administer flu shots to high-risk patient groups such as the aged – without a prescription. This could be done via a protocol with national health authorities... something similar to what occurs in the United States," she told her ESWI audience.

She holds the view that, at the very minimum, pharmacies and pharmacists should be included in flu pandemic strategies, particularly when a rapid response that must be administered close to the population is required. "This would serve to promote preventive measures and offer access to essential medicines and services," observed Costa.

For the 2009 pandemic however Lisbon ruled that the pandemic vaccines would be handled via national health centers, allowing seasonal flu to be administered as an option at pharmacies.

How much farther ANP can carry out its intervention goals remains to be seen. "There is a split between those who prescribe and those who dispense in our country, even if most medicine comes from pharmacies, whether reimbursed or not," she said.

Costa acknowledged, however, that the sector's liberalisation may have its limits. "In our country there are certain vaccines – for pregnant women, for example – that must be done at national health care centers, so that is not part of our ANF plan," she said.

Portugal's intervention model for its pharmacists

ANF based its intervention model on the US experience with its own pharmacists. Models were developed for vaccine delivery, emergency procedures and the creation of immunisation records to help Portugal's pharmacists provide the new service. All pharmacies were invited to participate, with ANF placing special emphasis on targeting older adults – those 65 years and above – who had an influenza vaccine prescription.

The wider intervention model's objectives were to:

- raise public awareness of the new pharmacy-based service
- inform target populations about the benefits of immunisation
- track the percentage of vaccines administered in pharmacies and how pharmacies contributed to the national influenza immunisation rate

The results were encouraging, according to Costa.

Approximately 60 percent of Portugal's 2670 pharmacies participated in ANF's intervention programme – and of these, nearly half sent in immunisation data to ANF. Even more striking, 91 percent of all the immunisations carried out in the drug stores were performed by the pharmacists themselves, with each pharmacy treating an average of 206 patients.

The positive trend has continued since then, with the number of participating pharmacies rising from 1,588 in 2008/09 to 1,622 in 2009/10. Meanwhile, the number of pharmacies that sent in data jumped a spectacular 33 percent from 733 to 1,033.

VACCINATION IN THE UK: STRONG INDUSTRY-HCW INTERACTION

The UK is a strong supporter of public-private partnerships and the pharmaceutical sector is no exception.

Representing seven vaccine manufacturers, the UK Vaccine Industry Group (UVIG) is the sector's policy voice and it liaises closely with government health authorities, GPs and other HCWs and the Association of the British Pharmaceutical Industry to raise public awareness of the benefits of vaccination, Richard Stubbins, UVIG chairman, told the summit.

"We keep a regular dialogue with all four UK health departments regarding vaccines, production volumes and future planning possible changes to government recommendations," said Stubbins.

Indeed, UVIG's companies are tightly plugged into the UK's annual cycle of activity, starting in February with WHO's flu virus guidelines and ending with the last deliveries of vaccines in December each year. The group also works with "clusters" of GPs, who collectively negotiate and buy their vaccines stocks directly from the manufacturers – still a rare approach across Europe.

On the uptake

The UK's approach to vaccination has delivered good results so far, particularly to at-risk groups. "For the last five years the uptake rate for the UK's over-65 group has hovered at average of 70 percent each year – and sometimes up to 75 percent," said Stubbins. "We've also seen the vaccination uptake among HCWs shift from 16 percent in 2008 to 34 percent in 2010/11."

According to Stubbins the UK still needs to improve its rate of uptake for the overall population, however. Noting that one of the problems was the lack of a national media campaign in 2010, he said

"this definitely had an impact on uptake. We think this should be reinstated. Other tasks require checking the programme's overall cost effectiveness and reviewing intervention options such as lowering the UK's current 65-year age limit for free vaccines to the elderly."

He also thinks there should be tighter collaboration among all vaccination stakeholders and a greater willingness on industry's part stand up and address issues in public. "We need to maintain public confidence in our sector so we need to address these issues in an organised and consistent manner," he said.

Stakeholder Questions to UVIG

Q: Your HCW vaccination uptake rate in 2008 rose steadily from 16 to 35 percent for 2010/11. How did this happen?

Stubbins: Part of the rise was due to the pandemic, and part to the strong emphasis given by the NHS [the UK's National Health Service] to make sure that HCWs were immunised.

Q: Is it common practice that vaccination information leaflets are circulated in the UK with a vaccine manufacturer's name on it?

Stubbins: The leaflet is sent out by the doctor, but it does contain the company's name because they paid for it.

Q: Wouldn't it be better to remove their name from them?

Stubbins: Despite the success of the UK's influenza campaign, there is still a need to boost confidence in vaccines. There is skepticism toward government and, it is true, also industry. But we think our sector is upholding its part by providing posters, cards and signs that are bright

and impactful in order to emphasize the risks and the need for vaccination.

Q: Do you see any fundamental changes needed to the UK's programme?

Stubbins: An age-based strategy would be much easier to implement than a risk-based one. That said, it would still have to offer protection for all at-risk groups and include financial incentives for GPs and the participation of industry.



Fact file: The UK's flu vaccine programme

The UK's national programme for vaccination is based on:

- priority for 65 years and over
- priority of at-risk groups that include chronic illness, healthcare workers and pregnant women
- procurement linked to direct purchases by GPs from manufacturers
- reimbursement by government to GPs for the cost of vaccines
- financial incentives for GPs to procure vaccines and administer them to all those eligible

Why has this been successful?

Such an approach sets clear and consistent targets nationally and "is reinforced by immunisation coordinators working at the local level, recommendations from the government's Chief Medical Officer (CMO) and by the procurement incentives for doctors," observed Stubbins.

RAISING FRENCH AWARENESS ABOUT INFLUENZA

Of the millions who suffer from influenza each year in France – between two and eight million people annually – the effects of the disease hit the country's elderly the hardest. How to work with the government and scientific community to abate these and other flu victims is among the main policy goals of France's industry-supported Group d'expertise et d'information sur la Grippe (GEIG), Bruno Lina, chairman of GEIG's scientific advisory board, told the summit.

Vaccinometre: Real-time monitoring of vaccine uptake in > 65

GEIG
Groupe d'Expertise et d'Information sur la Grippe

VACCINOMETRE

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Combien d'entre vous sont vaccinés contre la grippe saisonnière?

Dès la fin octobre, retrouvez chaque semaine le vaccinomètre de la grippe saisonnière, pour mesurer la couverture vaccinale des plus de 65 ans !

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Similar to the UK's vaccination campaign approach, France's scientific and industry stakeholders work closely with each other and with the national Ministry of Health to reach out to the general public. While all segments of the population are targeted, particular effort has gone toward persuading France's over-65 citizens to protect themselves against seasonal influenza.

"The over-65 crowd may equal only 5-to-10 percent of influenza victims each year in France, but they represent 90 percent of all deaths related to the disease," said Lina, adding that one of GEIG's key functions is to carry out real-time surveillance of vaccine uptake across this at-risk group in France.

"GEIG has been shaking up ideas since the beginning by continually launching its own initiatives," Lina told his audience. For example, it began following of vaccine uptake trends in 1990, following by pandemic planning as early as 1993. By 2008 it was doing real-time surveillance of vaccine uptake and, for the 2011-2012 flu season, it will organise exhibits in hospitals on the benefits of vaccination.

"We do this to track the trend vaccination uptake during a campaign so that resources can be redirected if the uptake is inferior to expectations. This also has the added advantage of providing data to policymakers about the trend," he said.

GEIG: how does it work?

GEIG was founded in 1986 to promote knowledge about influenza and its vaccination, and is financed by five commercial laboratories involved in the distribution of vaccines across France. The five are: Sanofi Pasteur MSD, GSK, Pierre Fabre, Abbot Products SAS and Novartis Vaccines.

With its industrial support balanced by the independent expertise of GEIG's Scientific Advisory Board, the organisation has been directly involved in France's national influenza vaccination campaigns for the past 25 years.

The organisation devotes much of its effort to awareness-raising about the facts surrounding vaccination. It works closely with French health authorities during vaccination campaigns and with the scientific community via annual influenza conferences, GEIG's website and scientific journals.

It also liaises with the press – across all media channels – to provide regular updates on the evolution of flu viruses, descriptions of its epidemiology and trends in vaccine uptake. "We organise so many regular briefings with the press on all of these subjects that you could even argue that we are doing the duty of the Ministry of Health!" said Lina. "That's how well known we are to the French press."

WHO & FLU: HELPING EUROPE MONITOR ITSELF

Sentinel surveillance is the collection and analysis of data by institutions chosen for their geographic location and their ability to accurately diagnose and report high quality data. This is key to the WHO's goal of collecting virological information on patients with symptoms of severe acute respiratory infection (SARI), often a first sign of an influenza outbreak, Dr. Caroline Brown, head of the respiratory pathogens programme at WHO's Europe office in Copenhagen, explained to the ESWI summit.

Noting that SARI is characterized as developing over seven days and requiring overnight hospitalization, whose symptoms include a history of fever of at least 38°C coupled with coughing and shortness of breath or difficulty in breathing, Brown said good surveillance "means we need the age stratification for the virology, and the outcome data for SARI patients: how many died, how many were hospitalised and how many went into intensive care? And the data has to be comparable across regions, between seasons and going back in time."

WHO's surveillance of SARI in Europe started in 2001 with about 14 nations and is now widely carried out in cooperation with the EU's European Centre for Disease Prevention and Control (ECDC).

"Today it is done by about 50 European countries, using the platform called EuroFlu, which allows each to obtain influenza surveillance and burden data about SARI," observed Brown.

Sentinel flu surveillance

Brown said SARI surveillance encompasses four broad goals: monitoring the virus types and subtypes and their antigenic and genetic characteristics of locally circulating flu strains for annual vaccine strain selection; providing representative viruses for vaccine strain production; monitoring locally circulating viruses for their sensitivity to antivirals; and finally tracking clinical data from outpatients to determine the timing and intensity of the next influenza season.

According to Brown the countries of Western Europe have a good track record of monitoring SARI and seasonal influenza vaccine use. But Europe's southern and eastern states "are still strengthening their community surveillance and introducing sentinel systems for the surveillance of SARI," she said, adding that the greater challenge and need for sentinel surveillance lies mainly to the east of Europe – in the Balkans and Central Asia.

As a result, WHO's "EuroFlu" system was extended in 2009 across the Euro-Asian continent to embrace the following countries (with Russia split into seven districts):

- Albania
- Armenia
- Georgia
- Kazakhstan
- Kyrgyzstan
- Malta
- Romania

- Republic of Moldova
- Russian Federation
- Serbia
- Ukraine

The surveillance system shows that "Kyrgyzstan has the lowest influenza vaccine uptake of all," she said.

Stakeholder Questions to WHO

Q: The Commission gets a weekly report to see if there is any influenza event that needs to be shared with the member states. How is this done at your end?

Brown: We coordinate our surveillance data with the ECDC; it's as straightforward as that.

Q: Do national systems in Europe overlap with EuroFlu and the ECDC?

Brown: EU countries report to the ECDC, which automatically transfers the data to EuroFlu and then to WHO's own FLUID ["Flu Informed Decisions"] system. This is antigenic information we're talking about – influenza A & B and other characterisations that go to EuroFlu via ECDC.

Q: Is there any redundancy between those systems?

Brown: Technically yes. But politically it's difficult to get all the countries to report.

Q: What is the more urgent SARI surveillance task in your view?

Brown: We think country-level collaboration is the priority to improve data quality via legal and technical aspects, with a stress on sustainable components. Work is also needed to gather denominator data [population statistics] for their hospital impact and preliminary "burden" estimates.

Q: Are you happy with the results so far?

Brown: Well, these systems [across south-eastern Europe and Central Asia] are still young and we all are still learning the best practices. But so far, the SARI clinical data are consistent with virological trends in the participating countries.

GETTING RESULTS, US-STYLE

Arguably, the US government has pushed policy innovation and market mechanisms farther than any other nation in the effort to push up vaccination rates across its 300 million-plus population. Is this the way ahead for European countries or does it work best in the free-for-all market conditions of America?

While some aspects of the US approach may be too daring for some, there's no discounting the country's vigorous stakeholder dialogue on vaccination or its willingness to experiment, as Litjen Tan, co-chair of the US National Influenza Vaccine Summit and director for medicine and public health at the American Medical Association (AMA), told his ESWI listeners.

A key pillar to the US government's (USG) flu vaccination strategy was the government's decision in 2010 to finally recommend universal flu vaccination for all people above the age of six months. This was twinned with a standing target vaccination goal of 90 percent and intervention beginning as soon as seasonal influenza vaccines are available – and continuing throughout the season.

What was the rationale for moving away from the USG's previous set of tailored risk-based recommendations?

"The vaccination guidelines had simply grown too complex to be practical," said Tan. "In 2007 we had 12 specific vaccination target groups, and it was just too much to ask GPs to remember all this. With a universal recommendation, there is no ambiguity about the issue. Also, it was more difficult for patients to self-identify based on risk conditions, while the coverage level across all the

target groups was, in general, low."

But even a more straightforward, easy-to-understand guideline doesn't guarantee that vaccination rates will automatically rise, said Tan. "No matter how we endeavour to educate the public or give away free vaccines or try to make the whole process fun and convenient – some organisations even throw pizza-plus-vaccination parties – the rate still only goes up to about 75 percent in the US. We simply hit this stagnation point." For example, the US vaccination rate achieved under the new universal recommendation for the 2010/11 flu season rose only slightly compared to the 2009/10 season: from 41 percent of all people over six months of age to 42 percent. Moreover, the results for many sub-categories of the population were not much better, with vaccination for the over-18 crowd bumping up only one percentage point, from 40 to 41. The response of the over-65 population was encouraging, however, with vaccination rising from 70 percent in 2009/10 to as

much as 75 percent the following year.

As for vaccination of health care workers and how to set the conditions for this to happen, Tan's position was unambiguous.

"We need a new model such as mandatory vaccination for HCWs," he said. "You can easily get 90 percent coverage if it's a condition of employment. Not surprisingly, in hospitals where that is the case, we're seeing 99 percent of their HCWs getting vaccinated."

Pushing the envelope

Pointing to what he called a failure of the US public's 'health belief model', Tan said the government is working with a broad range of stakeholders to push the vaccination "envelope" in all directions. For example, US pharmacies now aggressively market their vaccines stocks "which has added the side benefit of driving patients to their GPs to get a prescription," said Tan.

General merchandise stores are also getting into the act, with more than a quarter of the above-65 crowd in the US getting their vaccines at large discount pharmacies or even at superstores such as WalMart.

“Why are the stores doing this? Because of demand: many patients find it inconvenient to go to their doctor’s office. This is a very interesting trend that we are beginning to see in the US,” he observed.

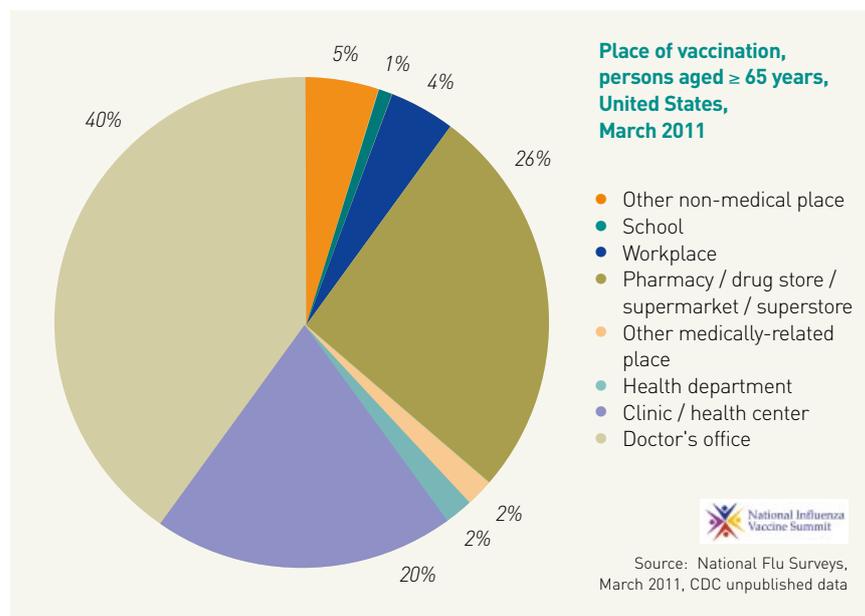
Stakeholder Questions to Tan

Q: What about monitoring if you do vaccination in supermarkets?

Tan: Admittedly the situation in the United States is a bit different. At-risk patients – about 40 percent of them – get their vaccination from their GPs. The other 60 percent does this via pharmacies, retail stores and other access points.

Q: Who pays for the vaccine?

Tan: Our payment system is very complicated. The US government pays if the patient has no insurance or if he is over 65 via our Medicare system for the elderly. For all others between:



private insurance foots the bill. This poses some cost challenges since, for instance, supermarket vaccinations are based on a cash-out-of-pocket price of around \$25. This is done via a standing order of the GP – not via a prescription.

Q: What is your main challenge for this coming year?

Tan: Maintaining the gains we’ve already achieved. The overall vaccination coverage among adults with risk conditions is about 35 percent and in that regard we haven’t done as well as

Europe. Boosting vaccination coverage among HCWs in long-term health care centres is another key goal for us.

Q: What were the more noticeable effects of the US government’s universal vaccination recommendation?

Tan: Well, it surely had something to do with the rise in child vaccination from 29 percent for 2008/09 to around 50 percent in 2010/11. Also, the vaccination rates for pregnant women rose dramatically from 6-19 percent to 49 percent in 2010/11. These results were delightful for us.

Fact File: The annual US influenza summit

The US National Influenza Vaccine Summit (NIVS) started with 30 people 11 years ago and now has 160 participants and many organizations, said Litjen Tan, NIVS’ co-chair.

The membership of NIVS includes a huge diversity of stakeholders: from vaccine manufacturers and distributors, federal agencies and professional medical entities to hospitals to employers, consumers and advocacy groups – 130 in all. “This allows a full 360-degree view of all the moving parts in the US associated with flu immunisation,” he said. Aside from its educational activities, NIVS also organises regular communications between its stakeholders via meetings, email updates and weekly conference calls. “This kind of face-to-face meeting, with all partners present, provides a safe venue to raise issues and to discuss potential solutions honestly,” he said.

MEDIA, MEDICINE & THE PUBLIC: A LOVE-HATE AFFAIR

How should influenza scientists and industry deal with the media during a major public health incident when even the most objective medical facts can be ignored or distorted by journalists looking to exaggerate a story beyond its legitimate news value? Can the flu research community ameliorate this situation – or is it condemned to live with the vagaries of the press?

The 2009 pandemic was one example of how ill-informed news reporting can stoke a health panic – or create a backlash against authoritative medical voices, according to Hanns-Joachim Neubert, president of the European Union of Science Journalists' Associations.

"While in general the public do not trust the media, paradoxically it overwhelmingly relies on the media as its main source for information – and the pandemic was driven by the media," Neubert told the ESWI summit.

He said it was imperative that the medical world understand – even if it doesn't accept – the role that hype plays in the media. "Journalists have to use exaggeration just to satisfy their editors and their organisation's bean-counters [accountants and financial officers] so that a story will sell," said Neubert.

Three obstacles stand in the way of good scientific and medical reporting, according to Neubert:

- the commercial nature of journalism
- the low broadcast prime-time priority assigned by editors to scientific topics
- the internal 'pecking order' of media organisations

The biggest obstacle is an editor's ranking of news topics for coverage. "Health topics may be of utmost interest to the public, but at the same time its interest in general science comes only after sports, entertainment and politics in that order. Unfortunately, science is simply not prime-time fodder," observed Neubert. "Also, it is hard for a journalist to report on uncertainties: you can't convince people that pandemic flu is a major threat when most have not experienced it."

Another major factor that runs against good scientific reporting in the press is the 'pecking order' or internal hierarchy of media organizations.

"Once a health-related topic such as influenza pandemic rises to a certain economic or political level, it is taken away from the specialised journalists who know the subject," he said. "It

then gets handed over to the press organisation's 'star' reporter and this is where the mistakes begin: these are journalists who don't first check their stories with the other reporters who know the subject."

Finally, Neubert said there were limits to how much information the individual can process in an era of information overload.

Though he insisted that medical reporting by mass media has improved in the last 20 years, he questioned whether this has led to more medical literacy across the population in general. "While the level of the public's uptake of medical information is still an open question, one thing is certain: science is progressing faster than the media can report on it and faster than people can understand it," he said.

Self-interest: media have to come clean, too

Neubert was critical of Europe's pharmaceutical industry for using what he called "non-transparent" communications techniques such as advertorials.

"These look like real articles, but which carry no industry name above them. The public cannot see the difference between serious portals and 'factual' ones used by some companies for very aggressive but non-transparent marketing," declared Neubert. "Serious science journalists have learned to be very suspicious about them."

Several members of the audience took issue with that point of view. One industry official countered: "I take exception to what you say about industry. Vaccine manufacturers were very careful during the pandemic to steer clear of any comments about public policy or how to manage the pandemic. We focused on manufacturing the vaccines and antivirals, and that was that: industry came out clean on this."

Whereas scientists are trained to list potential conflicts of interest, Neubert admitted that for journalists "a story has to be sold to someone. For public-owned channels, this is not an issue. But

for the pay-TV, it's true you have to hype things to get them picked up." Ultimately, he said the best science reporting flows from authoritative sources whom the reporter feels he can trust. "I have about 50 contacts who I trust but it requires time to build this up. You cannot do it with a single press conference. Medical scientists need to do the same thing: build those relationships with the press based on trust. Then you can sell your message," he said.

Damage Control: Tips for Dealing with the Press

According to German science editor Hanns-Joachim Neubert, the best way for the influenza research community to avoid getting burned by the press is to stick to some basic guidelines. These call on stakeholders to:

- be precise and open about their research results – and the latter's funding 'background' information: who paid for it?
- pre-identify the media that you want to target
- pay close attention to the way the journalist summarises your answers to his questions
- accept that journalists need to be critical but that they can be your partner, too – if the trust is there.

SUMMIT CONCLUSIONS



In 2003, the World Health Organization (WHO) launched its vaccination recommendations for seasonal influenza, urging every Member State to annually immunize at least 75% of its senior citizens against influenza by 2010. In 2011, most of the European countries do not even come close to the WHO recommended vaccination rates, despite European health care systems being amongst the best in the world. In fact, influenza still claims more lives than traffic accidents, especially among the risk groups, which include the elderly and patients with chronic disease like asthma, COPD, diabetes, heart disease...

While EU countries are lagging behind Northern American countries such as Canada, the influenza partners at the European Influenza Summit (including international public health authorities like WHO and the EU Directorate-General for Health and Consumers) agreed that only by ensuring collaboration between all parties involved in the field of influenza, Europe will be able to lower the impact of the disease on public health. Illustrating the need of joining forces in a decisive partnership, WHO and EU representatives emphasized the importance of exploring ways to involve additional healthcare groups in the fight against influenza.

ESWI had anticipated this call by bringing together health professionals like hospital pharmacists, general practitioners, community pharmacists and hospital managers as well as organizations of the elderly, diabetes patients, respiratory disease patients and heart patients in a unique and fruitful meeting on 26 May 2011. And while the European Scientific Working group on Influenza had already been working with public health officials and policy makers on previous occasions (such as the ESWI Influenza Workshops for Public Health Officials and the ESWI Influenza Conferences), it more recently also has been establishing close working relationships and structural ties with most of the above stakeholder organizations. Hence, ESWI has now become a true network of collaborating partners, covering the broad field of influenza.

In the post-summit period, ESWI will continue to expand its network of influenza stakeholders and to intensify its communication and awareness raising efforts with them. The European Influenza Summit will be the annual pinnacle of this partnership collaboration.

On behalf of ESWI's Board of Directors,

Prof Ab Osterhaus
ESWI chair



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