

## PARALLEL SESSION F

Saturday 18 November, 10:00–11:30

# Track F1: Workshop: Discussing the EUPHA statement on obesity in Europe

Chairpersons: Enni Mertanen<sup>1</sup>, Annette Matzke<sup>2</sup>

<sup>1</sup>President of the EUPHA section on Food and Nutrition, Utrecht, The Netherlands

<sup>2</sup>Swiss Society for Public Health, Switzerland

Organiser: EUPHA section on food and nutrition, EUPHA, Utrecht, The Netherlands

Contact details: d.zeegers@nivel.nl

This workshop of the EUPHA section on Food and Nutrition is intended to discuss the proposed EUPHA statement on obesity in Europe. This statement was set up using the EUPHA database by contacting the national associations and those expressing an interest in the area of food and nutrition. Based on a short questionnaire, the EUPHA statement was set up. The intention is to officially adopt the proposed statement at the EUPHA Governing Council in Montreux.

### A national programme to reduce/prevent obesity: the Swiss example

Christian Ryser

C Ryser

Suisse Balance, Switzerland

In this presentation, the Swiss national programme named Suisse Balance, initiated in 2002 by Health Promotion Switzerland and the Federal Office of Public Health, to reduce and prevent obesity is presented. Implemented measures in the form of examples of good practise will be illustrated and discussed.

### Presentation of the proposed EUPHA statement on obesity

Annette Matzke

E Mertanen, A Matzke, G Holmboe-Ottesen, D Zeegers Paget  
EUPHA, Utrecht, The Netherlands

In this last presentation before the discussion, the proposed EUPHA statement is presented. After the presentation of the methods and results, the draft statement will be up for discussion.

### Discussion

# Track F2: Workshop: Bringing together experiences with international outbreaks and learning from national policies

Chairpersons: Viviane van Casteren, Ralf Reintjes

Organiser: EUPHA Section on Infectious Diseases Control, Jelle Doosje, Netherlands Association for Community health services, Utrecht, The Netherlands

\*Contact details: jdoosje@ggd.nl

Close collaboration between countries is needed during international outbreaks. Some examples from the recent past have outlined the importance of early warning and of joined efforts with respect to outbreak investigation, outbreak management and outbreak evaluation. During the workshop, outbreaks with international implications will be discussed. The focus will be on integrating policies, from public health aspects of infection control (immunization, notification, contact tracing) to patient care (hospital procedures, antibiotic policies, disinfection). This workshop aims at a better understanding of the differences in policies between countries. Presentations will be given on: hospital and nursing homes outbreaks, an outbreak of a vaccine-preventable disease and of a sexually transmitted disease. In all presentation attention will be given to international aspects of early warning, contract tracing, treatment and evaluation. The presentations will be followed by a group discussion.

### Added value

Infectious diseases outbreaks reaching outside one country's border involve timely communication and sharing of best practices to control the outbreak. The workshop will present the experiences with international outbreaks from both, a patient care and a public health perspective.

### Outline workshop

- (i) Tjallie van der Kooi. *Clostridium difficile* PCR ribotype 027 in The Netherlands: a virulent strain reaches the European continent.

- (ii) Susan Hahné: Rubella outbreak in the Netherlands: new rubella genotype spread to Canada and led to congenital rubella infections.

- (iii) Aura Timen. The European response to the resurgence of an old (and forgotten?) sexually transmitted disease.

### Discussion

- (i) Beatrice Jans, Cross-border transmission of *Acinetobacter baumannii* to a Belgian nursing home in 2004.

### *Clostridium difficile* PCR ribotype 027 in The Netherlands: a virulent strain reaches the European continent

Tjallie van der Kooi

T van der Kooi<sup>1</sup>, DW Notermans, EJ Kuijper<sup>2</sup>, RJ van den Berg<sup>2</sup>, D Veenendaal<sup>3</sup>, E van Kregten<sup>4</sup>, S Debast<sup>5</sup>, CE Visser<sup>6</sup>, A Popma<sup>7</sup>, S van den Hof<sup>1</sup>

<sup>1</sup>Center for Infectious Disease Control, National Institute for Public Health and the Environment (RIVM), Bilthoven, The Netherlands

<sup>2</sup>Department of Microbiology, Leiden University Medical Center, Leiden, The Netherlands

<sup>3</sup>Regional Laboratory for Public Health Kennemerland, Haarlem, The Netherlands

<sup>4</sup>Department of Microbiology, Meander Hospital, Amersfoort, The Netherlands

<sup>5</sup>Department of Microbiology, Sint Jansdal Hospital, Harderwijk, The Netherlands

<sup>6</sup>Department of Microbiology, Academic Medical Center, Amsterdam, The Netherlands

<sup>7</sup>Department of Hospital Hygiene and Infection Prevention, Slotervaart Hospital, Amsterdam, The Netherlands

In 2004 higher morbidity and mortality, associated with *Clostridium difficile* associated diarrhoea (CDAD) were described in North America. This was related to a hypotoxin-producing

strain, PCR ribotype 027, toxinotype III. In June 2005 an outbreak in an English hospital was linked to this ribotype too. Up to April 2006 75 English and, since late 2005, eight Belgian hospitals have been affected.

In summer 2005 ribotype 027 was first detected in The Netherlands. In response, the Dutch Centre for Infectious Disease Control, collaborating with various experts, has formulated guidelines for infection control and treatment. The Leiden University Medical Centre serves as reference centre for typing of *C.difficile*. Laboratories are encouraged to have samples typed in case of an outbreak of CDAD or clinically suspect cases. Surveillance was set up: inquiries are made after antibiotic use, testing strategies, control measures and incidences.

Measures taken in 027-affected hospitals include: treatment with vancomycin instead of metronidazol, thorough cleaning and disinfection, isolation of all patients with diarrhoea until tested negative and restriction of certain antibiotics. Epidemic spread of 027 has been detected in 10 hospitals and 1 nursing home. Six more hospitals had isolated cases only. In at least two cases transmission between hospitals has taken place. During 027-associated CDAD epidemics, the monthly CDAD incidence varied widely between hospitals, from 50 to 137 per 10 000 admissions. Pre-epidemicly this varied from 3 to 38.

By February 2006 the incidence had decreased in the majority of Dutch institutions. However, the outbreaks proved difficult to control: most hospitals have new cases for a long time. Also, at a low pace, new hospitals are detecting 027. The emergence of 027 resulted in the collaboration of the European Study Group for *C.difficile* (ESGCD) with the European Centre for Disease Control (ECDC) and the National Institutes of Health.

### Rubella outbreak in the Netherlands: new rubella genotype spread to Canada and led to congenital rubella infections

Susan Hahné

S Hahné, J Macey, Y van der Veen<sup>1</sup>, R Van Binnendijk<sup>1</sup>, G Tipples<sup>2</sup>, S Dolman<sup>3</sup>, H Ruijs<sup>1,4</sup>, A Timen<sup>1</sup>, AM Van Loon<sup>5</sup>, H De Melker<sup>1</sup>

<sup>1</sup>Centre for Infectious Disease Control, Rijksinstituut voor Volksgezondheid en Milieu (RIVM), The Netherlands

<sup>2</sup>Public Health Agency of Canada (PHAC), Canada

<sup>3</sup>Ontario Ministry of Health and Long-Term Care (OMHLTC), Canada

<sup>4</sup>Municipal Health Authority (GGD) Rivierland, The Netherlands

<sup>5</sup>Department of Virology, University Medical Centre (UMC) Utrecht, The Netherlands

#### Background

In the Netherlands and Canada, the coverage for one dose of measles, mumps, and rubella vaccine (MMR) exceeds 95%, concealing a socially, religiously, and geographically clustered community with low vaccine coverage. Between September 2004–2005 and February–June 2005, respectively, rubella outbreaks occurred in this community in the Netherlands and Canada. We describe these outbreaks and their control to identify opportunities for prevention of congenital rubella infection (CRI).

#### Methods

In the Netherlands and Canada laboratory-confirmed rubella is notifiable. Case finding in the Netherlands included laboratory tests on saliva and dried blood spots; in Canada it was conducted through contact tracing and outbreak investigation. Vaccine efficacy (VE) was estimated with the screening method (The Netherlands) and cohort method (Canada). Outbreak control was compared between the two countries.

#### Results

A total of 698 rubella cases were reported (The Netherlands: 387; Canada: 311). The median age was 13 years in the Netherlands and 10 years in Canada ( $P < 0.01$ ). 39 cases were in pregnant women (The Netherlands: 29; Canada: 10). In cases for whom viral genotyping was done (The Netherlands: 2; Canada: 3), the sequences proved identical and were genetically closest to genotype 1 g. Most cases were in unvaccinated individuals

(The Netherlands: 98%; Canada: 99%) and belonged to the Netherlands reformed community (The Netherlands: 95%; Canada: 99%). The VE was 97% in the Netherlands (95% CI 92–99%) and 99% in Canada (95% CI. 89–100%). Outbreak control differed between the two countries. Thus far, 14 CRI cases have been reported in the Netherlands (Canada: not yet available).

#### Conclusions

In 2004, a newly identified genotype 1 g rubella virus caused a large outbreak in a religious community with low MMR coverage in the Netherlands and spread to a linked community in Canada. CRI continues to be reported only from within this community. The estimated VE was high. Outbreak control differed between the two countries; its effectiveness is difficult to assess due to differences in determinants such as demography and pre-existing immunity. Ultimately, CRI prevention depends on achieving high MMR coverage in all communities.

### The European response to the resurgence of an old (and forgotten?) sexually transmitted disease

Aura Timen

A Timen<sup>1,2</sup>, M Hulscher<sup>3</sup>, D Vos<sup>1,2</sup>, MJW van de Laar<sup>1</sup>, JE van Steenberghe<sup>1</sup>, K Fenton<sup>4</sup>, R Gro<sup>3</sup>, JWM van der Meer<sup>3</sup>

<sup>1</sup>Centre for Infectious Disease Control, Rijksinstituut voor Volksgezondheid en Milieu (RIVM), The Netherlands

<sup>2</sup>Dutch Association of Public Health Services (GGD Nederland), The Netherlands

<sup>3</sup>Radboud University Medical Centre, Nijmegen, The Netherlands

<sup>4</sup>National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention (CDC), Atlanta, USA

#### Background

The past decades the process of guidelines development benefited from the use of evidence based approaches and from criteria for good clinical guidelines. We applied the knowledge from clinical guidelines to investigate the quality of the outbreak management process and recommendations during the recent LGV outbreak in Europe. LGV, a sexually transmitted infection (STI) caused by *Chlamydia trachomatis* serovars L1-3 emerged in predominantly HIV positive men who have sex with men (MSM). LGV poses a threat to public health because the clinical manifestation could easily be missed with the potential of international spread. In recent years, large sexual networks of MSM with numerous anonymous partners from different countries have contributed to the spread of HIV, resistant gonorrhoea and early syphilis.

#### Methods

A cross sectional survey with a structured questionnaire was carried out between October 2005 and March 2006 among the surveillance leads and reference microbiologists of countries participating in the European Surveillance for STI network (ESSTI includes 22 EU countries, Iceland, Norway, Turkey) and Switzerland. The questionnaire was designed on the framework derived from the literature and an international validated instrument for appraisal of guidelines: AGREE. When available, also the country's LGV guideline(s) were analysed.

#### Results

Completed questionnaires were received from 18 countries (18%). Of them, 11 countries set up a national alert and response system including provisional control guidelines (9/11) and dissemination of information to health professionals (100%). Evidence was systematically collected by searches of literature (10/18) and electronic data bases (9/18). Informal consensus procedures are mostly used to formulate recommendations (9/18) on the basis of experience based analysis of evidence (8/18). Control measures were put in place in order to identify new cases (8/17), promote awareness among the risk group (9/17) and STI clinics (9/17). Differences were seen with respect to case-definitions, laboratory methods and antibiotic therapy. Currently, LGV cases were reported by 10 countries in Europe.

## Conclusions

Contrary to regular guidelines, outbreak management recommendations involve value judgements by professionals with no or only scarce time for re-evaluation of the decision. Principles of evidence based medicine were not consistently used to extract and analyse evidence for best practice during the LGV outbreak, leading to differences in outbreak management between (or within a) countries. Strong points were the timely alert and response systems put in place by 11 countries, the collaboration between public health and clinicians and the involvement of the risk group in disseminating alerts and advocating awareness. More international collaboration is needed to improve the response to international outbreaks and threats.

## Cross-border transmission of *Acinetobacter baumannii* to a Belgian nursing home in 2004

Beatrice Jans

B Jans<sup>1</sup>, C Suetens<sup>1</sup>, B Coignard<sup>2</sup>, Y Glupczynski<sup>3</sup>, Y De Gheldre<sup>3</sup>

<sup>1</sup>Epidemiology unit, Scientific Institute of Public Health, Brussels, Belgium

<sup>2</sup>Institut de Veille Sanitaire, France

<sup>3</sup>Reference Laboratory, University Hospital of Mont-Godinne (UCL), Microbiology Department, Yvoir, Belgium

## Background

Between July 2003 and May 2004, a major outbreak of *Acinetobacter baumannii* producing VEB-1 type, Extended Spectrum  $\beta$ -Lactamases (ESBL) occurred in France. Alerted by the French 'Institut de Veille Sanitaire' (InVS), the Unit of Epidemiology of the Institute of Public Health (IPH) and the reference laboratory of UCL Mont-Godinne set up a surveillance system in Belgian hospitals and laboratories. By the end of

March 2004 the two first cases of infection with the resistant *A.baumannii* strain, similar to the French type were detected in two hospitals in Tournai and confirmed by the reference laboratory. The cases, both elderly persons, came from the same Belgo-French border nursing home (NH).

## Methods

In April 2004, the Unit of Epidemiology, the reference laboratory and the Sanitary Inspection of the French Community undertook an epidemiological and microbiological investigation in the involved NH. For each participating resident and nursing staff member, screening swabs were taken and a questionnaire was filled in.

## Results

In this private NH with 75 low-care NH-beds, 57% of the residents and 47% of the nursing staff participated in the study. Besides the two initial cases, a third resident (asymptomatic carrier) was identified. Within the participating residents, 65% had a French nationality. This migration phenomenon is highly specific for the Franco-Belgian border NH population. Two of the three *A.baumannii* cases were French citizens, previously admitted in French health care facilities. The third case occurred probably by cross-contamination in the NH. In Belgian border NH, French residents often visit French hospitals for diagnostic/therapeutic reasons, have their private French general practitioner and receive the visit of French relatives.

## Conclusions

Patient movements between French and Belgian hospitals are scarce. However, they are frequent between northern French hospitals and Belgian NH and are potential transmission paths for micro-organisms who may explain cross-border spread of epidemic strains.

# Track F3: Workshop: Contextual and compositional determinants of inequalities

**Chairpersons:** Alastair H Leyland, Paolo Villari, Giuseppe La Torre  
**Organiser:** EUPHA section on Public Health Epidemiology, Alastair H Leyland. MRC Social and Public Health Sciences Unit, University of Glasgow, Glasgow, UK

\*Contact details: a.leyland@msoc.mrc.gla.ac.uk

Although acknowledged that people's health is patterned both by individual socioeconomic circumstances and by those of the area of residence, the issue as to whether it is specific features of the social and physical environment that impact on health (as opposed to population health differences reflecting different concentrations of socioeconomic deprivation) remains contentious. A full understanding of social inequalities requires an understanding of the mechanisms underlying the social patterning of behaviours, health, and mortality and of the extent to which this pattern reflects contextual and compositional differences. Reducing inequalities will require intervention, and successful interventions must distinguish between contextual and compositional mechanisms. This workshop will explore the issues underlying contextual and compositional determinants of inequalities through three papers. Specifically, it will cover the nature of environmental influences on health or health behaviour, ways in which the environmental effect may vary depending on individual socioeconomic circumstances, the relationship between environmental exposure to a physical hazard and area and individual socioeconomic deprivation, and the difficulties in (and consequences of) choosing between models of social aetiology and geographical clustering. All papers consider the implications for targeting interventions—at an

individual or community level—and will lead to an open discussion of these issues.

## Socioeconomic variation in health-related behaviours: the role of environmental characteristics

Frank J van Lenthe

FJ van Lenthe, CBM Kamphuis, K Giskes, M Huisman, J Brug, JP Mackenbach

Department of Public Health, University Medical Center Rotterdam, The Netherlands

The obesity epidemic demands evidence-based interventions in populations with the highest prevalence. It is generally believed that our 'obesogenic' environment contributes to the epidemic, with an unfavourable distribution of environmental characteristics resulting in higher prevalence of poor diet and physical inactivity in lower socioeconomic groups. Evidence, however, is still scarce. We therefore investigate the contribution of environmental characteristics to socioeconomic inequalities in poor diet and physical inactivity in the Netherlands. Data are taken from the most recent major wave of data collection in the GLOBE study. Participants in all socioeconomic groups indicated a benefit from social support, but people from low socioeconomic backgrounds perceived more barriers to healthy behaviour. Environmental factors partly explain socioeconomic inequalities for aspects of physical inactivity. Changing unfavourable environmental characteristics may substantially