



Decision in strategic inquiry OI/3/2020/TE on how the ECDC gathered and communicated information during the COVID-19 crisis

Decision

Case OI/3/2020/TE - **Opened on** 24/07/2020 - **Decision on** 05/02/2021 - **Institution concerned** European Centre for Disease Prevention and Control (No maladministration found) |

Background

The ECDC

1. The European Centre for Disease Prevention and Control (ECDC) was created in 2004, [1] following the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2002. [2] The SARS outbreak, which emerged in China and led to cases being detected in 33 countries, made decision makers around the world realise that, in an increasingly interconnected world, infectious diseases can spread incredibly rapidly.
2. In the European Union, such a threat was considered particularly pertinent: “ *where millions of people cross internal and external borders each day, tackling health threats requires a much closer co-operation between Member States, the European Commission, the World Health Organisation and affected countries around the world* ”. [3] The European Commission warned at the time that “[a] major outbreak such as an influenza pandemic could have catastrophic consequences ”. [4]
3. In response, a new independent EU agency, the ECDC, was created with the mission “ *to identify, assess and communicate current and emerging threats to human health from communicable diseases* ”, [5] to support preparedness planning and response, and to provide training and scientific advice to Member States and the Commission. It was given the role of:
 - searching for, collecting, collating, evaluating and disseminating relevant scientific and technical data;
 - providing scientific opinions and assistance;
 - providing timely information to the Commission, Member States, EU agencies and international organisations active in the field of public health;
 - providing scientific and technical expertise to the Member States, the Commission and other EU agencies for developing, reviewing and updating preparedness plans; and
 - fostering the development of sufficient capacity within the EU for the diagnosis, detection, identification and characterisation of infectious agents, which may threaten public health.



4. The EU law establishing the ECDC [6] (hereafter: 'the ECDC Regulation') is based on Article 168(5) of the Treaty on the Functioning of the EU (TFEU), according to which the EU should support, coordinate and supplement the actions of Member States in protecting human health. The Member States retain the primary responsibility for defining and delivering health services and medical care. The EU's role is to *complement* national policy.

5. When proposing the establishment of the ECDC, the Commission recognised the existence of epidemiological centres in the EU's Member States. These, it considered, must have a "*privileged place*" in a structure for closer cooperation at the EU level. In particular, national epidemiological centres should be essential partners in running surveillance networks, training actions and intervention teams:

" The existence of such resources in the Member States means that a large European Centre is not needed . Arrangements to give the Centre access to resources in national centres will be the key to keeping the Centre a relatively small, but effective, coordinating entity . The Centre will provide a structure enabling experts from different Member States to work together, for example, in WHO global outbreak investigation teams, and facilitating the subsequent sharing of results. The Centre would work with national public health institutes in equal partnership ". [7]

6. The ECDC was thus set up as a small agency with comparably limited resources, counting 286 employees and an annual budget of EUR 60.5 million in 2020. [8] In comparison, the German equivalent, the Robert Koch-Institut, has about five times as many staff, [9] while the US Centres for Disease Control and Prevention had, in 2020, an annual budget of USD 6839.9 million [10] and 10 639 employees. This included staff working in 60 countries worldwide, including in China, [11] with the aim to detect and control outbreaks at their source. [12]

7. In 2013, the ECDC was given additional tasks. [13] This increase in tasks was not accompanied by an increased budget for the ECDC.

8. Since its creation, the ECDC has been monitoring almost 60 infectious diseases, ranging from HIV/AIDS to rare zoonotic diseases. It has promoted vaccinations, helped enhance laboratory quality across Europe and trained public health epidemiologists from all over Europe. [14]

The ECDC during the COVID-19 crisis

9. The WHO has stated that it first learned of the new coronavirus SARS-CoV-2 on 31 December 2019, following a report of a cluster of cases of 'viral pneumonia' in Wuhan, China. [15] In January 2020, the ECDC began to monitor the novel coronavirus SARS-CoV-2 and the related disease (COVID-19), with the first case in the EU reported on 24 January. On 11 March 2020, the WHO declared COVID-19 a pandemic and, the following day, described Europe as the centre of the pandemic.



10. With millions of cases and hundreds of thousands of deaths in the EU/EEA and the UK, the immense dimensions of the COVID-19 pandemic do not compare to any other disease outbreak since the creation of the ECDC. [16] The COVID-19 pandemic has caused massive human suffering, pushing health systems and healthcare workers to their limits. The measures taken to contain the pandemic continue to have a major social and economic impact.

11. The COVID-19 pandemic has thrust the ECDC into the spotlight, testing its ability to live up to its mission. The ECDC's limits in dealing with a pandemic of the dimensions of COVID-19 have become evident. On 11 November 2020, the Commission recognised that:

"[...] at present the ECDC has a limited mandate/capacity to provide analysed data that support early evidence-based decision making and real-time situational awareness. In a context such as the COVID-19 pandemic, ECDC needs to be able to provide hands-on support to Member States, and the Agency's scientific recommendations for appropriate health measures need to address Member State-specific elements. The ECDC needs to become a real EU Health Agency that Member States can entrust to deal with crisis preparedness and response as appropriate". [17]

12. To transform the ECDC into "a real EU health agency", the Commission has proposed [18] to reinforce its capacities, in order "to support preparedness, surveillance, risk assessment, and early warning and response to face future cross-border health threats". [19]

13. An external assessment of the ECDC's COVID-19 response, commissioned by the ECDC, identified potential for improvement in its response to the pandemic [20] (hereafter, 'ECDC external assessment'). The external assessment includes recommendations covering multiple aspects of the ECDC's organisation and processes, and should serve to improve its operations and response to any large-scale public health event in the future.

The strategic inquiry

14. On 23 July 2020, the Ombudsman opened an own-initiative inquiry into how the ECDC (a) gathers and (b) communicates information during the COVID-19 pandemic, with a focus on the early stage of the crisis (January to April 2020).

15. The purpose of the inquiry was to provide an independent assessment of the ECDC's information-gathering capacity and how transparently the ECDC communicated that information to the public. The Ombudsman's findings are intended to feed into the ongoing discussion on strengthening the role of the ECDC in a possible future European health union.

16. On 23 July 2020, the Ombudsman asked [21] to inspect a certain number of documents held by the ECDC.

17. On 5 October 2020, the Ombudsman's inquiry team met [22] with ECDC representatives by videoconference to discuss various issues raised in the context of the inquiry.

18. On 11 November 2020, the Ombudsman asked to inspect additional documents and put [23] several follow-up questions to the ECDC. The ECDC provided the documents on 26 November and replied to the questions on 14 December.



A. How the ECDC gathered information

The Ombudsman's assessment and findings

19. The Ombudsman assessed the ECDC's information-gathering capacity, under 'normal' circumstances and in the specific context of the COVID-19 crisis.

1. Timely access to Member State data

20. The ECDC works with Member States through disease surveillance networks in order to define suitable surveillance systems and methods. Therefore, the ECDC can influence data at source. The ECDC has informed the Ombudsman that, for most diseases, the quality and comparability of the data it receives is fit for purpose. That noted, the ECDC is dependent on data provided by national authorities. It has no powers to inspect or gather information at source.

21. The ECDC currently has three main mechanisms for obtaining data and information from the Member States:

- The European Surveillance System (TESSy) : TESSy [24] is a system to which Member States upload data on infectious diseases under European surveillance using standardised formats. It is the ECDC's main source of information.
- The Early Warning and Response System of the European Union (EWRS): The EWRS [25] is a web-based system to which Member States and the Commission must notify public health events meeting certain criteria [26] within 24 hours [27] .
- Surveys conducted by the ECDC : The ECDC may conduct surveys, on its own initiative or upon request from the Commission, asking Member States to provide information on specific issues that is not collected in TESSy.

22. In addition, the ECDC conducts 'epidemic intelligence screenings' by monitoring official websites from public health authorities worldwide on a daily basis. [28] This is a significant source of information for the ECDC.

23. The ECDC noted that cooperation with Member States, via their national authorities, is generally good and based on a relationship of trust.

24. However, the ECDC faced important challenges in accessing reliable, complete and comparable data from the above-mentioned sources in a timely manner, especially at the beginning of the COVID-19 crisis:

- There was a significant discrepancy, in terms of identifying the number of cases, between the data the ECDC received from Member States via TESSy and the data it collected through its epidemic intelligence screenings. Furthermore, the reporting on some key variables related to the cases (such as clinical symptoms, severity or preconditions) was incomplete. However, the ECDC explained that the main COVID-19 surveillance weakness was in the way Member States performed COVID-19 surveillance. [29] In fact, during the early stages of the COVID-19 pandemic, all Member States needed to repurpose their existing surveillance



systems, or build new population-based surveillance systems, following the ECDC's advice. The data the ECDC received from Member States via TESSy therefore did not always give a clear picture of the developing situation.

- Few Member States used the EWRS in January 2020 to share (updated) information on national measures taken in response to the Commission's COVID-19 alert notification. As the EWRS was not designed to receive large amounts of information, automatic extraction of information is difficult. Furthermore, the EWRS's incident management module, which was designed to collect information on response measures taken by countries, has proved not to be effective enough during the pandemic.

- The ECDC distinguished between surveys it carries out as part of its routine work, " *in peacetime* ", and those launched during the COVID-19 pandemic. During the COVID-19 pandemic, most of the ECDC's surveys were carried out following requests from the Commission and with short deadlines (days instead of weeks). There was a low level of response to many surveys from Member State authorities and, in many cases, the most affected countries did not respond to surveys.

Challenges in gathering timely, complete and comparable information

1. The European Surveillance System (TESSy)

In early January, COVID-19 was not yet one of the diseases listed in TESSy. In the meantime, Member States reported case-based data via the EWRS and to the WHO. When COVID-19 was added to TESSy on 27 January 2020, the ECDC started collecting case-based data from Member States directly.

The Ombudsman's inspection of ECDC documents revealed that the data the ECDC received via TESSy in the early stages of the pandemic was sometimes incomplete. By 13 March 2020, there were only 6 199 cases reported in TESSy, yet the ECDC's epidemic intelligence screening indicated a much higher number (28 358 cases). By 27 March, there were 79 194 cases reported in TESSy, whereas the ECDC had identified 265 500 cases through its epidemic intelligence screenings. Furthermore, the reporting on some key variables related to the cases (such as clinical symptoms, severity or preconditions) was incomplete. On 3 April, the ECDC had not received any weekly data in TESSy from four Member States. This included Member States particularly hit by the virus. The ECDC constantly reminded Member States of their reporting obligations in weekly calls between February and April 2020.

The ECDC emphasised, however, that the main COVID-19 surveillance weakness was in the way Member States performed COVID-19 surveillance. For example, few countries used population-based surveillance methods, in which a specific population (the whole population of a region or of a country) is monitored. The data the ECDC received from Member States via TESSy therefore did not always give a clear picture of the developing situation.

2. The Early Warning and Response System (EWRS)

On 9 January 2020, the Commission sent an alert, requesting Member States to notify COVID-19 related events to the EWRS. **Two Member States did not reply, 12 replied within**



48 hours, and 13 replied within two weeks. The content of the replies was generally brief and related to measures the Member States had taken. The Commission used the EWRS to share the ECDC's risk assessments and other official advice, such as from the WHO. France reported its first three cases via the EWRS on 24 January.

During the meeting with the Ombudsman's inquiry team, the ECDC explained that, in the early stage of the pandemic, there were some misunderstandings about how and where to report COVID-19 related information in the system. Overall, the ECDC noted that the scope of the EWRS is to quickly report and exchange information on emerging threats. It was not designed to receive large amounts of information. As a result, once cases started to emerge in the EU, information on case numbers was reported in TESSy (the dedicated system to which Member States submit data to the ECDC using standardised formats).

The ECDC further explained that the 'incident management module' in the EWRS, which was designed to collect information on response measures taken by countries, was not effective enough during the pandemic. For this reason, the ECDC started collecting information on response measures in a separate database, set up by the ECDC in cooperation with the Commission's Joint Research Centre.

3. Surveys conducted by the ECDC

During the meeting with the Ombudsman's inquiry team, the ECDC distinguished between surveys that it carries out as part of its routine work and those launched during the COVID-19 pandemic. It explained that routine surveys are usually planned two years in advance and are discussed in an *ad hoc* committee, which assesses their relevance and appropriateness. Member States are usually given several weeks to reply.

During the COVID-19 pandemic, most of the ECDC's surveys were carried out on request from the Commission and with short deadlines (days instead of weeks). The ECDC explained that it used surveys only when the requested data could not be collected through alternative means, such as TESSy, the EWRS or the epidemic intelligence screenings.

The ECDC informed the Ombudsman of 22 surveys related to COVID-19, which it sent to EU/EEA countries between January and 24 July 2020. The Ombudsman's inspection revealed **low response rates to most of the surveys** .

For example, the ECDC conducted one survey on laboratory capacities and capabilities in January and two in March. From 30 EU/EEA countries, 47 laboratories submitted data in response to the January survey. For the March surveys on laboratory shortages, the response rate was considerably lower: 15 and then 9 countries replying to the respective surveys. Other surveys in March and April - on issues like COVID-19 surveillance, testing and contact tracing - all saw low response rates (12-18 participants).

The ECDC confirmed that, during the pandemic, the level of Member State response to surveys was lower than usual. It noted that, in many cases, the most affected countries were the ones with lower response rates. The ECDC considered that this was understandable in



the context of the crisis and that it was probably due to the higher workload experienced by these Member States. In these cases, the ECDC tried to follow up with the individual Member States or to fill the information gaps via epidemic intelligence screenings, if possible.

2. International cooperation

25. The ECDC Regulation requires the ECDC to work in close cooperation with organisations operating in the field of data collection from non-EU countries, the WHO, and other international organisations. [30] Unlike the US CDC, the ECDC has no staff outside its jurisdiction (that is, outside the EU). It is therefore dependent on the timely cooperation of its international partners.

26. Questions have been raised as to whether China demonstrated sufficient transparency towards other countries and the WHO about its experience with the virus in the early days of the pandemic. In particular, while the Chinese Centre for Disease Prevention and Control (Chinese CDC) was reporting only a handful of cases in mid-January 2020, prominent health experts were making public concerns regarding wide-scale human-to-human transmission by 18 January, [31] with evidence (and prescient advice) by 25 January [32]. Arguably, this should have called into question the data being made available by the Chinese CDC. The Ombudsman also understands that, by 27 January 2020, the ECDC was still missing important data, in particular a more detailed epidemiological description of cases, and did not know why such data was not yet available from the WHO and China. In the meantime, the ECDC was relying on information it was able to gather through media reports.

27. The Ombudsman confirmed that the ECDC signed an 'administrative agreement' with the WHO Regional Office for Europe in 2011 and memoranda of understanding with both the Chinese CDC and the US CDC in 2007. The memoranda are identical and indicate the joint interest in enhanced cooperation. They set broad areas of cooperation to which the memoranda will apply as well as matters and events in which mutual consultations will be conducted.

28. In the exchange with the Ombudsman's inquiry team, the ECDC commented on the excellent level of cooperation with the WHO, its main international partner. Throughout the pandemic, collaboration with the WHO and, in particular, the Regional Office for Europe became even more intense, adapting to the rapidly changing situation, which required ECDC experts to work closely with the WHO and align activities. Apart from daily collaboration on a technical level, senior management of the ECDC and the WHO Regional Office for Europe were in close communication. Directors met regularly to discuss recent developments and how to better support countries together.

29. The ECDC considers its collaboration with other Centres for Disease Control (CDCs), both at multilateral and bilateral level, equally important. In June 2019, on the initiative of the ECDC, an international forum (the Network of major CDCs) was established, in order to exchange information and expertise to respond effectively to threats posed to public health. The ECDC considers that the network, currently chaired by the ECDC, has proven useful



during the COVID-19 pandemic. The ECDC was in contact with both its American and Chinese counterparts from the beginning of the outbreak in Wuhan in January 2020 as well as with new international partners such as South Korea and Singapore.

30. Regarding the Chinese CDC, the ECDC made clear that it is not in a position to assess whether the Chinese CDC shared *all* the information it had or whether it did so in a timely manner. However, the ECDC stated that it has no reason to question its cooperation with the Chinese CDC. In particular, it noted that it received information from the Chinese CDC that added value to the information detected by the ECDC through epidemic intelligence. The ECDC also suggested that any issues in relation to information sharing might have been due to the structure of the Chinese health system. [33] Therefore, if the Chinese CDC did not communicate certain information, or did not communicate information earlier, this could have been because the Chinese CDC itself did not have the information at that point in time.

31. The ECDC also noted that, where there was a lack of information, it tried to follow up with specific questions to the Chinese CDC. The ECDC confirmed that it had contacted the Chinese CDC already on 10 January 2020, asking several questions aimed at understanding the mode of transmission, in order to assess the risk for Europe and determine what advice to give to the Commission and to the EU Member States. In the first months of the pandemic, the ECDC was in regular contact with the Chinese CDC, which provided updates on scientific developments such as case definition and national epidemiological data, once available to them. However, epidemiological information such as the number of infected healthcare workers and case fatality rates were forthcoming only after intense media reporting.

32. The ECDC further explained that additional information was shared in the meetings between the European Commission and the Chinese National Health Commission (Ministry of Health) that the ECDC also attended.

33. The Ombudsman is not in a position to take a view on whether the extent, the quality and the timing of the cooperation between the ECDC and its international partners (including the Chinese CDC) was, at each point in time during the crisis, adequate. [34] However, the Ombudsman is convinced of the benefits of increasing transparency about relations between the ECDC and its international partners so that others, in particular scientific experts, can assess the timeliness, quality and completeness of the information exchanged. [35]

3. ECDC's evaluation of laboratory capacity

34. Having access to adequate laboratory capacity is necessary in order to obtain the data required to carry out robust modelling and forecasting. Therefore, knowledge of the laboratory capacity of Member States is important. The surveys on COVID-19 laboratory preparedness, conducted by the ECDC at the beginning of the pandemic and only a few weeks apart, led to very different results regarding the preparedness of EU Member States.

35. The first survey [36] was launched in the last week of January and asked questions about



laboratory preparedness, including weekly testing capacities and challenges, such as a lack of equipment. A summary of the survey results was published on 13 February 2020 and indicated " *that European specialised laboratories are prepared for the current situation, and suggest[d] that a more sensitive case definition than currently in use would not create an immediate bottleneck* ". [37] Based on this survey, the ECDC informed EU health ministers during the Council meeting of 13 February 2020 that: " *by mid-February, that is now, all countries have the capability of testing for this virus [...] the overall capacity from this survey to deal with diagnostic of cases is around 8 000 per week. So we have substantial capacity in Europe to actually identify cases* ". [38]

36. On 25 January 2020, following the confirmation of the first three cases in the EU, the ECDC gave a positive assessment of the EU's capacity to deal with the virus, concluding that "*[a]t this stage, it is likely that there will be more imported cases in Europe. Even if there are still many things unknown about 2019-nCoV, European countries have the necessary capacities to prevent and control an outbreak as soon as cases are detected.*" [39]

37. The two subsequent surveys conducted by the ECDC only a few weeks later in early March and mid-March 2020 indicated that there were significant laboratory shortages in most participating countries. An EU-wide capacity of 8 000 tests per week proved far too little. [40]

38. The ECDC explained to the Ombudsman that the epidemiological situation changed in those few weeks. It stated that "*the assessment [of January and mid-February] referred to a specific time where prevention of importation and limiting the further spread of the virus once imported were the main goals of the containment strategy. What [the] ECDC and Member States could not predict was that, at that time, the virus was already circulating in the community in several countries. To detect this, Member States would have needed huge laboratory capacity to test everyone with COVID-19 compatible symptoms. This was not feasible for any country in the world and in light of this, the WHO gave recommendations on who should be prioritised for testing. Unfortunately, there is no way that the diagnostic capacity for a new virus can be scaled up to this level in such a short time frame. The assessment did not refer only to laboratory capacity, but to the epidemiological workforce needed to perform contact tracing. Modelling or forecasting was not performed at that time, simply because there was no data to model and no clear epidemiological parameters to use. Therefore this had no role in the assessment.*"

39. The Ombudsman is not a scientific body and does not have the expertise to review the scientific assessment made by the ECDC. In particular, it is not for the Ombudsman to take a view on whether the assessment of the stage of the pandemic (containment versus mitigation) was accurate at any given moment in time.

40. That noted, the different statements of the ECDC, in January/February and March, may have led to confusion on the part of the public, since the statements were not presented in a manner which explained that developing context (see also below paragraphs 74 to 81 on 'the ECDC's role in communicating information to the general public').

41. It remains the case that when the approach changed from 'containment' to 'mitigation'



(due to evidence of increasing community transmission), there was inadequate laboratory capacity at Member State level to deal with this scenario. One of the consequences of not having sufficient laboratory capacity to obtain data was its impact on the ECDC's modelling and forecasting.

4. ECDC's modelling and forecasting

42. The Ombudsman understands that modelling and forecasting requires timely, reliable and complete data. Consequently, any lack of such data, as identified in the preceding sections, directly affects the ECDC's modelling and forecasting capacity.

43. Beyond that, the Ombudsman notes that the ECDC external assessment identified weaknesses in its in-house modelling and forecasting capabilities, and that there is a clear potential to strengthen the latter. [41] The ECDC external assessment concluded that building stronger modelling and forecasting capabilities should enable " *a forward-looking view on development of the number of cases and...ensure stakeholders have the possibility to prepare for different scenarios ahead of time* ". [42]

Conclusion: Information gathering

44. The ECDC supports national epidemiological centres, the Commission and other EU agencies. It has no power to gather data or information at source, either within the EU or abroad. The ECDC relies instead on the resources and timely cooperation of Member State authorities, centres for disease control in non-EU countries and international partners. An external evaluation of the ECDC published shortly before the COVID-19 crisis, in September 2019, already mentioned this dependency as a 'threat' to the ECDC's effectiveness. [43]

45. Access to timely and complete data is a precondition for the ECDC to conduct its rapid risk assessments [44] effectively, including epidemic modelling and forecasting. [45] However, Member State authorities and international partners did not always provide the ECDC with such data in a timely or complete manner. This situation is particularly worrying given that the ECDC was created to strengthen EU capacity to react to public health emergencies.

46. In particular, the Ombudsman notes a power asymmetry between the ECDC and the Member States. Contrary to what the Commission envisaged when proposing the ECDC, it is not in " *equal partnership* " with national health institutes. It depends on Member State authorities to provide it with timely and complete data. Although the ECDC Regulation expressly requires Member States to report to the ECDC relevant data in a timely manner, [46] this obligation is difficult to enforce in practice, including in situations where some Member States may lack adequate information-gathering or reporting capacities.

47. The ECDC external assessment confirmed that the ECDC should receive data in a more harmonised and timely manner from Member States. [47]



48. In its comments to the Ombudsman, the ECDC noted that there is a need to strengthen its mandate, in order to enable it to impose certain surveillance methods and standards. At the same time, competent Member State authorities should be given sufficient financial resources in order to bring all national surveillance systems up to the same level of quality.

49. Having learned from these weaknesses in the early stages of the COVID-19 pandemic, the Commission now intends to better equip the ECDC to deal with crisis situations. To this end, the Commission has proposed several amendments to the ECDC Regulation, including:

- The creation of a high-performing epidemiological surveillance network at EU level, [48] using artificial intelligence, harmonised datasets and digital tools for accurate modelling, risk assessment and response. National reporting of timely, complete and comparable data to the ECDC, including health systems indicators, is an integral element in this wider system of surveillance. To support Member States in improving their national surveillance systems, the Commission proposes making financing available under the upcoming EU4Health programme [49] .

- That the ECDC should be responsible for updating the EWRS to enable the use of artificial intelligence technologies and interoperable data-gathering digital tools. [50]

- That the ECDC, in close collaboration with Member States and the Commission, should bolster its modelling, anticipation and forecasting capacity. [51] The Commission proposes that this should include the role to monitor and evaluate preparedness [52] .

50. The Commission's proposals aim to provide financial support and other incentives for Member States to enhance their information-gathering and reporting capacities, by enhancing the surveillance networks themselves, and by increasing the in-house capacities of the ECDC. This would be a welcome development. Having said that, it is clear that the ECDC will remain dependent on national data and information, in line with the EU's current limited competence in the area of public health. The Ombudsman trusts that the EU's co-legislators will reflect on the findings of this inquiry in the context of the wider debate on creating a new European health union.

B. How the ECDC communicated information

The Ombudsman's assessment and findings

51. The Ombudsman evaluated the transparency of the ECDC's scientific assessment work, including the data underlying it, and how the ECDC communicates information to the public.

1. Transparency of the ECDC's scientific assessment

52. The Ombudsman's role is not to evaluate the scientific assessment of the ECDC at any given moment in time. It is also not within the Ombudsman's mandate to hold accountable the EU's Member States or the ECDC's international partners for their (lack of) cooperation with the ECDC. However, the Ombudsman considers it essential that the ECDC conducts its scientific assessment work in as transparent a manner as possible, and that it discloses the data underlying its assessments (including a potential lack thereof). Doing so enables the



public, in particular experts at national, European and international level, to understand and scrutinise the ECDC's conclusions, and to hold accountable all actors involved. [53]

1.1 Transparency of how the ECDC's scientific assessment evolves

53. In the exchange with the Ombudsman's inquiry team, the ECDC explained that all its rapid risk assessments are published on its website. By following and comparing them, it is possible to trace if and where its advice changed. The data on which the ECDC's rapid risk assessments are based is normally publicly available either in the risk assessment itself or elsewhere on the ECDC's website, in a format that allows for further processing.

54. The ECDC further explained that it bases its advice on the evaluation of up-to-date scientific evidence available at the time it issues its risk assessments. As the evidence can change, the advice needs to be adapted to reflect this.

55. The Ombudsman asked the ECDC to illustrate this point by using the example of its advice on the use of face masks. In essence, the ECDC updated its advice on face masks several times and, each time, included a reference to the new scientific evidence that had become available.

Scientific assessment concerning face masks

The ECDC's assessment on the use of face masks in the community fundamentally changed over the course of two weeks in March and April. On 25 March, it stated that "[t] here is no evidence on the usefulness of face masks worn by persons who are not ill to prevent infection from COVID19, therefore this is not advisable" [54]. On 8 April, it stated that "[t] he use of face masks in public may serve as a means of source control to reduce the spread of the infection in the community by minimising the excretion of respiratory droplets from infected individuals who have not yet developed symptoms or who remain asymptomatic" [55].

The ECDC's technical report on 'Using of face masks in the community', published on 8 April, also referred to the extensive use of face masks in the public in Asian countries during the 2003 SARS epidemic, and noted that this has been linked to a slightly lower risk of SARS among persons without known contact with SARS patients. The technical report also outlined the potential disadvantages related to the widespread use of face masks by the general population. One major concern was the severe shortages of face masks in healthcare, where the evidence for their effectiveness is much stronger.

The ECDC explained that, following the publication of the report in April, more evidence has become available supporting the effectiveness of the use of masks in the community. While this evidence was not yet conclusive, it increased the confidence in the potential benefits of face masks, and led the ECDC to further strengthen its recommendation on their use in the community. [56]



56. The Ombudsman recognises the ECDC's efforts to ensure that it is possible to follow how its scientific assessment evolves. She considers, however, that it would be helpful to indicate in the risk assessment itself when the ECDC changes its advice based on new scientific evidence becoming available. This would provide more clarity than expecting people to compare current and previous risk assessments.

1.2 Transparency of the information underlying the ECDC's scientific assessment

57. The Ombudsman assessed the transparency of the data underlying the ECDC's scientific assessment based on three examples: (1) the publication of COVID-19 related survey results, (2) openness about the completeness of TESSy data, and (3) the transparency of the contacts the ECDC had with international partners, most notably the Chinese CDC.

1. Publication of COVID-19 related survey results

58. The inspection of twelve COVID-19 related surveys showed that the ECDC did not publish the results of all the surveys it conducted.

59. While the results of four of the COVID-19 related surveys up until the end of April 2020 were made public in full, other survey results were not published or published in summary form only (for an overview see Annex I).

60. The ECDC explained to the Ombudsman that, in general, when it conducts surveys, it will indicate to respondents (1) the purpose of the survey and (2) whether and how the results will be published. If the ECDC intends to publish the results as a technical report, the Member States are informed of this, are given more time to respond and the opportunity to comment on the draft report. In addition, the report goes through a detailed internal clearance workflow.

61. The Ombudsman considers that the ECDC could have, in principle, decided to publish all survey results.

62. If a Member State had objected to publication, such a request should have been analysed under the applicable confidentiality rules. [57]

63. In light of the above, the Ombudsman suggests that the ECDC develop a policy on the publication of survey results. In doing so, the Ombudsman trusts that the ECDC will take into account the public interest in transparency. The Ombudsman notes that, following the launch of her inquiry, the ECDC published the results of its most recent survey on laboratory practices and needs of Member States on 18 January 2021. [58] She welcomes this step.

2. Openness about the completeness of data in TESSy



64. The Ombudsman found that the data on SARS-CoV-2 case numbers that the ECDC received from Member States in TESSy was often incomplete and that the ECDC relied, in such situations, on its 'epidemic intelligence screenings'. [59] The Ombudsman reiterates that she considers it of utmost importance that the ECDC is transparent about lacking or incomplete data underlying its scientific assessment work.

65. In its exchange with the Ombudsman's inquiry team, the ECDC pointed out that it is possible to see on its website the often significant difference between the data reported by the Member States in TESSy and the data collected through the ECDC's epidemic intelligence screenings. The Ombudsman confirmed that the ECDC publishes information about the completeness of TESSy data reported per Member State in weekly surveillance reports on COVID-19 (for more details see Annex I).

66. The Ombudsman welcomes the ECDC's efforts to provide transparency through its website about the completeness of data in TESSy. She understands, however, that this information is available only for the most recent week (with no historical record). This means that it is not possible to see an overview of what data Member States reported in TESSy in any other week. The Ombudsman therefore encourages the ECDC to create an archive on its website, which contains all the weekly overviews of data reported by Member States to TESSy in relation to COVID-19 since the beginning of the pandemic. This would allow the public to consult and, through comparison, better interpret that data.

67. The Ombudsman notes that, until July 2020, the ECDC included in its rapid risk assessments on COVID-19 a general statement that "[t] *here is still limited epidemiological and clinical information on COVID-19*". [60] Since October 2020, the ECDC has made clear that its assessment is dependent on national surveillance data. [61]

68. The Ombudsman considers it crucial that information on the completeness and quality of data is included in the rapid risk assessment itself, as this is essential for interpreting the ECDC's information and advice. To this end, it is welcome that the ECDC has begun to state in its risk assessments that it relies on data provided by Member State authorities. She suggests that the ECDC also include in its rapid risk assessments a reference to where on its website more detailed information on the completeness and quality of data in TESSy is available.

3. Transparency of the ECDC's contacts with international partners

69. The ECDC Regulation requires the ECDC to work in close cooperation with organisations operating in the field of data collection from non-EU countries, the WHO, and other international organisations. [62]

70. As noted above, [63] questions have been raised about whether China made available all information about the virus to other countries and the WHO.

71. The Ombudsman asked the ECDC whether it tried, in view of these concerns, to obtain



further information from the Chinese CDC in January. The ECDC confirmed that it had done so, and provided the Ombudsman with an overview of its exchanges with the Chinese CDC (see also paragraph 31 above). The Ombudsman notes that these exchanges are not public.

72. Providing greater transparency about the exchanges between the ECDC and the Chinese CDC, as well as other international partners, would allow the public to scrutinise this relationship and whether the information exchanged was adequate. The Ombudsman is aware that exchanges with the Chinese CDC might fall under the confidentiality clause in the memorandum of understanding signed in 2007. That said, there is a public interest in providing as much transparency as possible about such exchanges.

73. The Ombudsman encourages the ECDC to examine whether and, if so, to what extent and when information about exchanges between the ECDC and international partners, including the Chinese CDC, could be made public.

2. The ECDC's role in communicating information to the general public

74. The Ombudsman notes that the ECDC's mandate requires it to communicate about current and emerging health risks. The ECDC Regulation states that it shall "*ensure that the public and any interested parties are rapidly given objective, reliable and easily accessible information with regard to the results of its work. In order to achieve these objectives, the Centre shall make available information for the general public, including through a dedicated website [...]*". [64]

75. Prior to the COVID-19 pandemic, the focus of the ECDC's communication strategy was on informing experts in Member States and internationally. During the meeting with the Ombudsman's inquiry team, the ECDC confirmed that it considers its stakeholders to be the national authorities in the Member States. The ECDC stated that it is not under public scrutiny as much as some other EU agencies [65] when it comes to transparency issues.

76. The Ombudsman notes that the ECDC's narrow definition of who its stakeholders are is reflected in its communication strategy. [66] In particular, the ECDC does not consider the general public "*as a primary audience*", but aims at supporting national authorities in their public outreach efforts. The ECDC's communications strategy defines its target audience as health professionals, policy makers, health communicators and the media. [67]

77. Despite the media being identified as part of its target audience, the ECDC seems to engage in relatively limited direct and proactive outreach to the press. This shortcoming had already been identified in an evaluation of the ECDC's media work that was finalised in September 2019. As a consequence, press coverage of the ECDC and its work during the COVID-19 crisis was comparatively low, a fact raised in the ECDC external assessment. [68]

78. In terms of digital communication, the ECDC publishes news articles on its website and communicates its work on social media channels (principally Twitter, Facebook and



LinkedIn). While the Ombudsman appreciates that the ECDC has made an effort to try to reach the public through social media channels, it is clear from the ECDC's communication strategy that the wider public is not a target audience and that, as such, digital content may not always be developed for this audience and/or with a view to boosting engagement.

79. The Ombudsman further notes that the ECDC's website is available in English only, as are its rapid risk assessments and leaflets, as well as most of the infographics, videos and posters related to COVID-19. [69] Making public information material in English only substantially limits its potential reach and reinforces the ECDC's dependence on national authorities to reach the public.

80. The Ombudsman considers the COVID-19 crisis as an opportunity for the ECDC to rethink its role in communicating health threats to the public and, in particular, to take a broader view on who its stakeholders are. In revising its communication strategy, the ECDC should consider identifying the wider public as a target audience, and adapting its strategy, communication content and outreach activities accordingly.

81. While the ECDC so far has had limited financial and human resources at its disposal, the Ombudsman trusts that the current proposals to strengthen the ECDC also take these communication needs into account. This includes resources both for greater public outreach and for making the ECDC's public information material available in more official EU languages. [70] The Ombudsman will make a suggestion to that effect.

Conclusion: Transparency as key tool

82. Transparency of the ECDC's work is crucial. It enables the public and experts to understand the ECDC's responsibilities and to scrutinise its scientific assessment work and outputs. However, it would also raise public awareness of the limitations the ECDC faces by the nature of its mandate and powers.

83. The Ombudsman has emphasised [71] that the EU and its administration must maintain their high standards of transparency, not despite the COVID-19 crisis, but precisely because of the crisis and the need to reinforce trust in public authorities.

84. The Ombudsman acknowledges the efforts made by ECDC during the COVID-19 crisis to conduct its scientific assessment in a transparent manner. In light of the findings in this inquiry, the Ombudsman considers, however, that there is room for the ECDC to improve how it communicates information to the public. [72] She therefore makes suggestions for improvement below.

Suggestions for improvement

The Ombudsman makes the following suggestions for improvement to the ECDC:

1. The ECDC should indicate consistently in its risk assessments when it changes its advice based on new scientific evidence becoming available, in order to enhance transparency of how its scientific assessment evolves.



2. The ECDC should, on the basis of a publication policy, seek to publish the results of surveys, ensuring the highest standards of transparency and taking into account the public's legitimate interest in these results, in particular during a public health emergency.

3. The ECDC should create an archive on its website, which contains all weekly overviews on whether the data in TESSy is complete, facilitating scrutiny of that data. In order to provide greater clarity, the ECDC should include in its risk assessments a reference to where on its website this information is available.

4. The ECDC should examine whether and, if so, to what extent and when exchanges it has with international partners could be made public, in order to allow greater public scrutiny of whether the information in these exchanges is timely, complete and of the necessary quality.

5. The ECDC should revise its communication strategy, with a view to designating a wider target audience (the general public) for its communication work, promoting more proactive media relations, and enhancing its use of digital communications channels by developing tailor-made content.

6. The ECDC should update its language policy, with a view to making available public information material in official EU languages other than English. To this end, the ECDC should take into account the Ombudsman's practical recommendations on the use of official EU languages when communicating with the public.

Emily O'Reilly European Ombudsman

Strasbourg, 05/02/2021

Annex I - Publication of COVID-19 related survey results

The results of four of the COVID-19 related surveys that the ECDC had conducted by the end of April 2020 were made public in full:

- The survey on COVID-19 laboratory preparedness conducted during the last week of January 2020 (published on 13 February via the online platform Eurosurveillance [73]);
- The regular COVID-19 surveillance surveys first launched on 20 March 2020 (published as of June 2020 on the ECDC website via the 'weekly surveillance report on COVID-19');
- The regular surveys on COVID-19 testing strategies and testing numbers per week first launched on 9 April 2020 (published as of June 2020 on the ECDC website via the 'weekly surveillance report on COVID-19');
- The results of a short questionnaire on country capacities (COVID-19 contact tracing



resources) conducted between 14 and 17 April 2020 (published on 5 May 2020 via the ECDC website as part of a technical report on 'Contact tracing for COVID-19' [74]);

The Ombudsman notes that the results of the two 'regular surveys' were first made public two months after their initial launch.

The ECDC also published a brief summary of the survey on laboratory shortages, launched on 3 March, in its updated rapid risk assessment of 12 March 2020. Another survey on laboratory needs and practices, launched on 15 March, and a survey on COVID-19 sero-epidemiological investigations in the EU/EEA region, conducted in April 2020, were not published.

Annex II - Publication of information on TESSy data completeness

The ECDC has published 'weekly surveillance reports on COVID-19' since 21 May 2020. These reports provide an overview of COVID-19 epidemiology in the EU/EEA and the UK, using the available data compiled from multiple sources. [75] The reports contain a section on 'TESSy data quality', which includes data on TESSy data completeness (where the data reported in TESSy is compared with what the ECDC identified via its epidemic intelligence). In relation to those cases reported in TESSy, the reports contain a chart on variable completeness (that is, whether Member States reported case-based data, such as age, gender, symptoms, hospitalised etc.). [76] In addition, the ECDC publishes weekly COVID-19 country overviews, which also indicate TESSy data completeness by country. [77]

[1] Regulation 851/2004 establishing a European centre for disease prevention and control (hereafter: 'ECDC Regulation');

<https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32004R0851&from=EN>

[2] SARS is a viral respiratory disease caused by a SARS-associated coronavirus. For further information:

https://www.who.int/health-topics/severe-acute-respiratory-syndrome#tab=tab_1

[3] Proposal for a Regulation of the European Parliament and the Council establishing a European Centre [for Disease Prevention and Control], Brussels, 16.9.2003, COM(2003) 441 final/2, p. 2, available here:

<https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52003PC0441&qid=1606226852010&from=EN>
(hereafter: 'Commission proposal setting up the ECDC')

[4] Commission proposal setting up the ECDC, p. 2.

[5] Article 3 and Recital 7 of the ECDC Regulation. Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses that result from the infection, presence and growth of pathogenic (capable of causing disease) biological agents in an individual human or other animal host.

[6] Regulation (EC) No 851/2004 establishing a European Centre for disease prevention and



control: <https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=celex%3A32004R0851> .

[7] Commission proposal setting up the ECDC, p. 6 (emphasis added).

[8] ECDC annual budget 2020:

<https://www.ecdc.europa.eu/sites/default/files/documents/ECDC-annual-budget-2020.pdf>

[9] The Robert-Koch Institut has 1400 employees. Further information is available here:

https://www.rki.de/DE/Content/Institut/OrgEinheiten/Ueberblick.pdf?__blob=publicationFile

[10] <https://www.cdc.gov/budget/documents/fy2021/FY-2021-CDC-Budget-Detail.pdf>

[11] The US CDC China currently consists of three US Assignees and 11 Locally Employed.

Further information is available here: <https://www.cdc.gov/globalhealth/countries/china/>

[12] <https://www.cdc.gov/globalhealth/what/default.htm>

[13] With the adoption of Decision No 1082/2013/EU on serious cross-border threats to

health: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32013D1082>

(hereafter: 'Decision on serious cross-border threats to health')

[14] For further information, see the highlights of the ECDC's annual report for 2019:

<https://www.ecdc.europa.eu/sites/default/files/documents/director-report-2019-short-version.pdf>

[15]

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail>

[16] COVID-19 is the first pandemic since the 2009 influenza pandemic A(H1N1). The 2009

pandemic A(H1N1) influenza virus emerged in North America and infected about 125,550

people in Europe.

[17] European Commission, Communication, 'Building a European Health Union: Reinforcing

the EU's resilience for cross-border health threats', COM(2020) 724 final, 11 November 2020,

p. 4, available here:

https://ec.europa.eu/info/sites/info/files/communication-european-health-union-resilience_en.pdf

[18] Commission Proposal for a Regulation of the European Parliament and of the Council

amending Regulation (EC) No 851/2004 establishing a European Centre for disease

prevention and control, COM(2020) 726 final, 11 November 2020, available here:

<https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52020PC0726> (hereafter:

'Commission proposal strengthening the ECDC')

[19] In particular, the Commission considers that the ECDC should have reinforced capacity

to:

· " *develop prevention and response plans against future epidemics and stronger capacities for*



integrated rapid epidemic and outbreak response”;

· “ *monitor and assess health systems capacity for diagnosis, prevention and treatment of specific communicable diseases as well as patient safety* ”; and

· provide “ *nonbinding recommendations for risk management* ” to reinforce the control of epidemics and outbreaks

[20] ECDC, Strategic and performance analysis of ECDC response to the COVID-19 pandemic, 11 January 2021, available here:

<https://www.ecdc.europa.eu/en/publications-data/strategic-and-performance-analysis-ecdc-response-co>
(hereafter: ‘ECDC external assessment’)

[21] The letter opening the inquiry is available here:

<https://www.ombudsman.europa.eu/en/correspondence/en/130708>

[22] The report on the meeting of the European Ombudsman's inquiry team with the European Centre for Disease Prevention and Control is available here:

<https://www.ombudsman.europa.eu/en/report/en/134847>

[23] The request for a written reply is available here:

<https://www.ombudsman.europa.eu/en/correspondence/en/134848>

[24] More information on TESSy is available here:

<https://www.ecdc.europa.eu/en/publications-data/european-surveillance-system-tessy>

[25] More information about the EWRS is available here:

<https://www.ecdc.europa.eu/en/publications-data/early-warning-and-response-system-european-union->

[26] Article 9(1) of the Decision on serious cross-border threats to health says:

“ National competent authorities or the Commission shall notify an alert in the EWRS where the emergence or development of a serious cross-border threat to health fulfils the following criteria:

(a) it is unusual or unexpected for the given place and time, or it causes or may cause significant morbidity or mortality in humans, or it grows rapidly or may grow rapidly in scale, or it exceeds or may exceed national response capacity; and

(b) it affects or may affect more than one Member State; and

(c) it requires or may require a coordinated response at Union level .”

[27] Article 2(1) of Commission Implementing Decision (EU) 2017/253 laying down procedures for the notification of alerts as part of the early warning and response system established in relation to serious cross-border threats to health and for the information exchange, consultation and coordination of responses to such threats:



https://eur-lex.europa.eu/eli/dec_impl/2017/253/oj

[28] The ECDC explains on its website that it screens " *up to 500 sources every day to collect COVID-19 figures from 196 countries. This includes websites of ministries of health (43% of the total number of sources), websites of public health institutes (9%), websites from other national authorities (ministries of social services and welfare, governments, prime minister cabinets, cabinets of ministries, websites on health statistics and official response teams) (6%), WHO websites and WHO situation reports (2%), and official dashboards and interactive maps from national and international institutions (10%). In addition, ECDC screens social media accounts maintained by national authorities, for example Twitter, Facebook, YouTube or Telegram accounts run by ministries of health (28%) and other official sources (e.g. official media outlets) (2%)* ". Further information is available here:

<https://www.ecdc.europa.eu/en/covid-19/data-collection>

[29] For example, few countries used population-based surveillance methods, in which a specific population (the whole population of a region or of a country) is monitored.

[30] Article 11(2), third indent, of the ECDC Regulation.

[31]

<https://www.imperial.ac.uk/mrc-global-infectious-disease-analysis/covid-19/report-1-case-estimates-of-c>

[32]

<https://www.imperial.ac.uk/mrc-global-infectious-disease-analysis/covid-19/report-3-transmissibility-of-c>

[33] The ECDC noted that the Chinese CDC is a technical agency and that, in China, the outbreak response is led by the National Health Commission in collaboration with the local provincial administration and health institutions.

[34] The Ombudsman notes that the WHO has sent a mission to Wuhan to examine the events surrounding the first weeks of what was to become the Covid-19 pandemic, see:

<https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-m>

[35] See paras. 69-73.

[36] Entitled 'EVD-LabNet 2019 n-CoV laboratory preparedness survey'.

[37] <https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.6.2000082>

[38] The recording of the Council meeting is available here:

https://video.consilium.europa.eu/event/en/23906?start_time=0

[39] ECDC, 'Novel coronavirus: three cases reported in France', news story, 25 January 2020, available here:

<https://www.ecdc.europa.eu/en/news-events/novel-coronavirus-three-cases-reported-france>



[40] Germany alone conducted more than 1 million tests per week during the 'second wave' of COVID-19 infections and more than 23 million tests in total since the beginning of the pandemic. Further information is available here:
https://www.rki.de/DE/Content/Infekt/EpidBull/Archiv/2020/Ausgaben/45_20.pdf?__blob=publicationFile

[41] ECDC external assessment, pp. 5 and 62.

[42] ECDC external assessment, p. 43.

[43] European Centre for Disease Prevention and Control, Third independent external evaluation of the ECDC in accordance with the ECDC Regulation, September 2019, Final Report, pp. 43 and 141, available here:
<https://www.ecdc.europa.eu/sites/default/files/documents/third-independent-external-evaluation-of-ECDC.pdf>
. The evaluation found that " *a factor negatively influencing the tools' [TESSy's] effectiveness relates to discrepancies in the reporting levels and the quality of reporting between Member States* " .

[44] Rapid risk assessments provide a timely summary and assessment of a public health threat for EU/EEA countries related to a specific event. They aim at supporting countries and the Commission in their preparedness and response to a public health threat and include potential options for response. ECDC may issue updated risk assessments as outbreaks or public health events develop,

[45] As the Commission noted in its proposal setting up the ECDC, "[i]n controlling a disease outbreak, time is of the essence. Every day lost in identifying the threat, deciding on control measures and implementing them can result in the outbreak spreading further. These lost days can mean the difference between a small outbreak and a serious epidemic. If the disease or pathogen involved is particularly lethal, then delay may cost lives " .

[46] Article 4 of the ECDC Founding Regulation.

[47] ECDC external assessment, p. 62.

[48] Article 5(2) of the Commission proposal strengthening the ECDC.

[49] EU4Health is a programme under the forthcoming EU financing period (2021-27) that will have a particular focus on boosting EU's preparedness for major cross-border health threats and strengthening health systems:
https://ec.europa.eu/health/funding/eu4health_en .

[50] Recital 15 and Article 8(3) of the Commission proposal strengthening the ECDC.

[51] Article 5b(1)(j) of the Commission proposal strengthening the ECDC.

[52] Article 5b(1)(b) of the Commission proposal strengthening the ECDC.



[53] For further information on the usefulness of transparency in this context, see the UK Institute for Government, "Science advice in a crisis", 18 December 2020, available here: <https://www.instituteforgovernment.org.uk/publications/science-advice-crisis>

[54] ECDC, Rapid risk assessment: Coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA and the UK – seventh update, 25 March 2020, available here:

<https://www.ecdc.europa.eu/en/publications-data/rapid-risk-assessment-coronavirus-disease-2019-covid-19>

[55] ECDC, Rapid risk assessment: Coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA and the UK – eighth update, 8 April 2020, available here:

<https://www.ecdc.europa.eu/en/publications-data/rapid-risk-assessment-coronavirus-disease-2019-covid-19>

[56] As reflected in the ECDC's 11th update of the rapid risk assessment on COVID-19, 10 August 2020, p.18, available at:

<https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-rapid-risk-assessment-20200810.pdf>

[57] Article 21 of the ECDC Regulation.

[58] ECDC, Technical Report, "ECDC rapid assessment of laboratory practices and needs related to COVID-19", 18 January 2021, available here:

<https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-rapid-assessment-laboratory-practices>

[59] See above para. 24.

[60] See, for example, ECDC, Rapid Risk Assessment, Resurgence of reported cases of COVID-19 in the EU/EEA, the UK and EU candidate and potential candidate countries, 2 July 2020, p. 7, available at:

<https://www.ecdc.europa.eu/sites/default/files/documents/RRA-Resurgence-of-reported-cases-of-COVID-19>

[61] See, for example, ECDC, Rapid Risk Assessment, Risk of COVID-19 transmission related to the end-of-year festive season, 4 December 2020, p. 10, available here:

[https://www.ecdc.europa.eu/sites/default/files/documents/Risk-assessment-COVID-19-transmission-rela](https://www.ecdc.europa.eu/sites/default/files/documents/Risk-assessment-COVID-19-transmission-related-to-the-end-of-year-festive-season)

. It says: "*The epidemiological data used in this assessment are dependent on the availability from Member States through surveillance reporting or publicly available websites. The data not only reflect the epidemiological situation but are also dependent on local testing strategies and local surveillance systems.*"

[62] Article 11(2), third indent, of the ECDC Regulation.

[63] Para 26.

[64] Article 12(1) of the ECDC Regulation.

[65] Most notably the European Food Safety Authority, the European Medicines Agency or



the European Chemicals Agency.

[66]

<https://www.ecdc.europa.eu/sites/default/files/documents/CommunicationStrategyMB38-2016-2020.pdf>

[67] Ibid. p. 3/4.

[68] ECDC external assessment, p. 21.

[69] There are three exceptions, a poster on effective hand washing (

<https://www.ecdc.europa.eu/en/publications-data/poster-effective-hand-washing>), and two infographics on COVID-19 (

<https://www.ecdc.europa.eu/en/publications-data/infographic-covid-19>) and face masks in the community (

<https://www.ecdc.europa.eu/en/publications-data/infographic-using-face-masks-community>). These are available in 26 languages.

[70] See the European Ombudsman's practical recommendations for the EU administration on 'The use of official EU languages when communicating with the public', available here:

<https://www.ombudsman.europa.eu/de/correspondence/en/129519> .

[71] On 20 April 2020, the Ombudsman wrote to the Presidents of the European Commission and the European Council to make some proposals for how to maintain high transparency standards during the COVID-19 emergency. The letters are available here:

<https://www.ombudsman.europa.eu/en/case/en/56900>

[72] This potential is also recognised in the ECDC external assessment (p. 63), which argues the ECDC should become a *"transparent organisation, that makes its information and priorities easily accessible"*.

[73] Eurosurveillance is an open-access platform, directed at the European public health community, to exchange relevant findings on communicable disease surveillance, prevention and control.

[74]

<https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-Contract-tracing-scale-up.pdf>

[75]

<https://www.ecdc.europa.eu/en/news-events/ecdc-launches-new-weekly-covid-19-surveillance-report>

[76] ECDC, COVID-19 surveillance report, Week 49, 2020, available here:

https://covid19-surveillance-report.ecdc.europa.eu/#4_TESSy_data_quality

[77] ECDC, COVID-19 country overview, Week 49,2020, available here:

<https://www.ecdc.europa.eu/en/covid-19/country-overviews>