

Meeting report

Identifying Gaps and Actors in European Travel Medicine: A Stakeholder Consultation Meeting 3-4 June 2025

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Content

Content	1
Executive Summary	2
Objective of the meeting	3
Abbreviations and acronyms.....	4
Attendees.....	5
Introduction and Presentations	6
Day 1 – Opening	6
Session 1: Landscape mapping	7
Session 2: Group discussions.....	10
Day 2 – Opening	12
Session 3: Other perspectives on surveillance and scientific advice	12
Session 4: Future perspectives on travel medicine – how to move forward?	13
Closing session.....	13
Agenda.....	14
Group photo of the participants.....	16

Executive Summary

At the ECDC's stakeholder meeting on travel medicine, held on 3-4 June 2025, participants from across Europe and international networks convened to identify shortcomings in the field and to define forward-looking avenues to address these shortcomings. The meeting marked an important first step in enhancing collaboration and clarifying the potential future role of the European Centre for Disease Prevention and Control (ECDC) in travel medicine.

The initial Landscape Mapping session provided valuable insights, highlighting opportunities to strengthen collaboration and consistency across EU/EEA Member States. A key finding was the need to strengthen the coordination of evidence-based advice across EU/EEA Member States, helping to minimise duplicated work and promote the alignment of advice. While the discussions primarily focused on identifying gaps and future needs, it is important to recognise that several elements are already in place across the travel medicine landscape. These include established international travel networks, relevant (disease) networks (including at ECDC) and the availability of standardized and regular reporting of surveillance data to e.g. ECDC. Participants noted the strong potential of ECDC's extensive surveillance data to more effectively support the development of practical, destination-specific advice for clinicians, the travel industry, and the travelling public.

The Group Discussions and Additional Perspectives on Surveillance and Scientific Advice sessions further explored the need for more integrated, interoperable surveillance systems that could better support rapid signal validation and align outputs with the operational needs of clinicians, public health authorities and travellers. Delegates emphasised the importance of translating surveillance data into timely, clear, and adaptable recommendations. Participants also highlighted the importance of systematically identifying priority populations – such as travellers visiting friends or relatives (VFR), seasonal workers, and religious pilgrims – to ensure that surveillance systems capture the full spectrum of travel-related risks. Most participants supported the need for a centralised reference body – potentially ECDC – to gather and assess evidence, especially for emerging diseases and new vaccines. While preserving national autonomy, a coordinated European framework could strengthen information validation and communication. Many stressed that such a body should focus on evidence assessment, leaving final recommendations to national authorities. Stronger links with community-level communication channels, both formal and informal, were seen as crucial for increasing the reach and impact of public health messaging. A proposed action is also to compile and share good practices from different countries to target specific traveller populations e.g. by using social media and to foster cross-country learning.

In the final session on Future Perspectives, participants focused on how to progress this agenda. There was broad support for ECDC to act as a central coordinating body, consolidating surveillance efforts, supporting outbreak signal validation, and facilitating the development of consensus-based guidance. ECDC's established strength in infectious disease surveillance was considered a natural foundation on which to build. The creation of a secure and trusted space for informal data exchange was repeatedly cited as a priority, enabling faster responses and earlier warnings while respecting national reporting protocols and privacy regulations.

The importance of broadening participation in future consultations was strongly underlined. Stronger engagement with the travel industry and organisations working with migrant communities was viewed as essential to delivering comprehensive risk assessments and targeted outreach. For future planning, participants suggested that ECDC could undertake a more comprehensive stakeholder mapping exercise, potentially using a questionnaire. This would help assess whether the current stakeholder base is sufficiently representative or if there is a need to expand and strengthen ECDC's networks.

In conclusion, there was clear support for ECDC to expand its role in travel medicine through a phased, pragmatic approach informed by prioritisation planning and stakeholder input. The outcomes of this meeting will contribute to the development of future ECDC work plans and should be discussed further at the ECDC Advisory Forum in September 2025.

Objective of the meeting

The objective of the meeting was to bring together key actors in travel medicine, both from within and outside the EU/EEA, to:

- Exchange knowledge on how travel medicine is organised,
- Identify existing gaps and challenges, particularly in relation to surveillance, early detection, and the provision of scientific travel advice, and
- Explore ways to enhance collaboration among stakeholders.

This meeting is a first step to defining ECDC's role in travel medicine and for enhancing collaboration with stakeholders.

Abbreviations and acronyms

COVID-19	Coronavirus disease
US CDC	United States Centres for Disease Control and Prevention
CDTR	ECDC Communicable Disease Threats Report
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
ECTM	European Committee on Travel Medicine
EEA	European Economic Area
EODY	Hellenic National Public Health Organisation
ESCAIDE	The European Scientific Conference on Applied Infectious Disease Epidemiology
ESCMID	European Society of Clinical Microbiology and Infectious Diseases
EU	European Union
GDPR	General Data Protection Regulation
HAS	French National Authority for Health
IATA	International Air Transport Association
iectm	International Expert Committee for Travel Medicine
IOR	Indian Ocean Region
ISTM	International Society of Travel Medicine
ITIT	Illness Tracking in Travellers
MERS	Middle East Respiratory Syndrome
MPXV	Monkeypox virus
NaTHNaC	National Travel Health Network and Centre (United Kingdom)
NFP	National Focal Point
NITAG	National Immunisation Technical Advisory Group
OCP	Operational Contact Point
Q&A	Question and Answer
SESPEV	Department for Public Health and Vaccine Evaluation (France)
SoHO	Substances of Human Origin
SHC	Superior Health Council (Belgium)
SUMMIT	SURveillance of Molecular epidemiology of Malaria In Travelers
TESSy	The European Surveillance System (to be replaced by EpiPulse Cases)
Swiss TPH	Swiss Tropical and Public Health Institute (Switzerland)
UKHSA	UK Health Security Agency
VFR	Visiting Friends and Relatives
WHO	World Health Organization
WTO	World Tourism Organization

Attendees¹

Affiliation	Name
GeoSentinel	Ralph HUIJS
European Committee on Travel Medicine	Olivia VEIT
EuroTravNet and WHO Collaborating Centre	Patricia SCHLAGENHAUF
National Travel Health Network and Centre (United Kingdom)	Dipti PATEL
ECDC Emerging and Vector-borne Disease Network (Belgium)	Tinne LERNOUT
ECDC Emerging and Vector-borne Disease Network (Denmark)	Lasse VESTERGAARD
Coordination Committee for NFPs for Preparedness and Response and NFP for Threat Detection (Portugal) ²	Paula VASCONCELOS
ECDC Threat Detection Network (Spain)	Gloria GONZALEZ DIAZ
ECDC Vaccine-Preventable Diseases Network (Denmark)	Peter ANDERSEN
ECDC Vaccine-Preventable Diseases Network (Greece)	Androula PAVLI
ECDC National Immunisation Technical Advisory Group (NITAG) Collaboration (France) ²	Pauline BARDIN
ECDC National Immunisation Technical Advisory Group (NITAG) Collaboration (France) ²	Frédérique d'HERBE
ECDC National Immunisation Technical Advisory Group (NITAG) Collaboration (France) ²	Andrea LASSERRE
European Union Reference Laboratory for vector-borne viral diseases	Chantal REUSKEN
University of Basel (Switzerland)	Cristoph HATZ
Emerging Infections Subcommittee of the European Society of Clinical Microbiology and Infectious Diseases (ESCMID)	Martin GROBUSCH
ECDC, Surveillance, Preparedness and Response (SPR unit)	Leonidas ALEXAKIS
ECDC, Surveillance, Preparedness and Response (SPR unit)	Margot EINODER-MORENO
ECDC, One Health related Diseases (OHD unit)	Céline GOSSNER
ECDC, One Health related Diseases (OHD unit)	Joana HAUSSIG
ECDC, One Health related Diseases (OHD unit)	Ole HEUER
ECDC, Scientific Evidence and Communication (SEC unit)	Piotr KRAMARZ
ECDC, Directly transmitted and Vaccine preventable Diseases (DVD unit)	Nathalie NICOLAY
ECDC, One Health related Diseases (OHD unit)	Ines REULET
ECDC, Surveillance, Preparedness and Response (SPR unit)	Gianfranco SPITERI
ECDC, One Health related Diseases (OHD unit)	Liese VAN GOMPEL

¹ Participants for the meeting were selected through a call for interest sent to three networks, the ECDC Emerging and Vector-borne Diseases Network, the ECDC Threat Detection Network and the ECDC Vaccine-Preventable Diseases Network, as well as the ECDC National Immunisation Technical Advisory Group (NITAG) Collaboration. Individuals who expressed interest were considered for participation, and two representatives from each network were selected to attend. In addition, organisations working on travel medicine in an international context were approached.

² Online attendance of one session

Introduction and Presentations

Day 1 – Opening

Céline Gossner, Head of the Section on Food-, Water-, Vector-borne and Zoonotic Diseases (FOVEZ) at ECDC, welcomed participants to the first ECDC stakeholder meeting on travel medicine and expressed appreciation for their attendance. She clarified that the meeting marked the beginning of a consultation process and highlighted that objectives of the meeting.

After a round of participants' introductions, ECDC chief scientist **Piotr Kramarz** provided an **overview of ECDC's new mandate**. He explained that, before the COVID-19 pandemic, the Centre's role in scientific advice had been limited to presenting options for Member States to consider, without issuing direct recommendations. It was then up to the countries to decide which course of action to take. With the revised mandate, ECDC gained the ability to offer stronger, though still non-binding, recommendations. This shift required the agency to consolidate and enhance its internal processes. He emphasised that all recommendations have to be grounded in robust, evidence-based public health approaches – an area in which ECDC has long been active.

Céline Gossner then delivered a comprehensive **overview of ECDC's work in the field of travel medicine**, highlighting its multi-unit and cross-cutting nature. She outlined the ECDC's network-based approach and highlighted various ECDC networks relevant to travel medicine, including those focused on emerging and vector-borne diseases, Legionnaires' disease, food- and waterborne diseases and epidemic intelligence. She outlined the ECDC's network-based approach, with National Focal Points (NFPs) and Operational Contact Points (OCPs) across the EU/EEA countries. NFPs usually serve as the first point of contact and are typically epidemiologists based in national institutes, while OCPs provide specialised expertise on diseases or work areas (e.g. epidemiology, microbiology, entomology). These networks are supported by the newly established European Union Reference Laboratories. She then detailed ECDC's indicator-based surveillance covering over 40 diseases, including dengue, malaria, and Zika virus disease. Data is collected from Member States according to set case definitions and reporting frequencies (daily, weekly, monthly, or annually). This surveillance includes detailed variables such as age, sex, place of infection, travel history, and clinical outcomes. Data is analysed and disseminated through surveillance reports, maps, and online platforms.

Céline Gossner explained that ECDC has also access to travel data, such as that from the International Air Transport Association (IATA), to enable the estimation of infection rates among travellers returning from various destinations. This helps in assessing risks and developing risk estimation.

Leonidas Alexakis presented the ECDC activities related to event-based surveillance; ECDC collects unstructured data from both official and unofficial sources to monitor the epidemiological situation globally. Examples include monitoring cholera outbreaks and compiling country-specific updates to assess transmission patterns and risks. He further explained epidemic intelligence work under the Global Epidemic Intelligence and Health Security projects, which combine indicator-based and event-based surveillance, particularly for incidents outside the EU. Sources range from Ministries of Health and WHO to other credible unofficial channels. Outputs include detailed monthly maps for diseases such as MERS, dengue, and cholera, along with travel-related case data and associated risk assessments. Event-based surveillance can also detect imported cases, changes in transmission modes, or other unusual events, prompting targeted assessments.

A key output is the Communicable Disease Threat Report (CDTR), issued weekly in both restricted and public versions. Rapid risk assessments – sometimes produced within 24-48 hours – evaluate threats for EU citizens abroad, travellers, and the risk of importation/spread within Europe. An example was the assessment of Monkeypox virus (MPXV) clade I outbreaks in Africa. Risk assessments typically consider the likelihood of infection, potential impact, and overall risk, supported by clear methodologies.

In the area of substances of human origin, ECDC produces weekly seasonal surveillance maps showing West Nile virus circulation in humans and animals to guide blood donation deferrals and screening. Similar assessments are underway for dengue within Europe, with planned seasonal surveillance maps this summer.

Nathalie Nicolay highlighted ECDC's work on vaccination, focused mainly on routine immunisation across the life course.

Lastly, **Leonidas Alexakis** mentioned the ECDC's role in mass gathering preparedness, focusing on the assessment and mitigation of health risks before, during, and after large events. This work includes collaboration with WHO, particularly WHO Europe.

Session 1: Landscape mapping

Session 1, aimed at mapping the key stakeholders in the Travel Medicine domain within and outside the EU/EEA. The session was opened with a presentation by **Ralph Huits** of **GeoSentinel**, who outlined the mission of the network, i.e. to improve scientific understanding of the epidemiological risk factors and clinical outcomes of travel- and migration-related health threats.

At the heart of GeoSentinel are its member clinics, with over 60 clinics in 30 countries. These clinics contribute on a voluntary basis, often without dedicated funding. GeoSentinel fosters strong professional and personal relationships among its members and coordinates regular activities, including webinars, alerts, and an annual meeting.

Membership is based on criteria such as clinical expertise, traveller volume, and geographic relevance, with members required to submit at least 60 cases annually to the central surveillance database. In addition, affiliate members can share and receive alerts but are not part of the core data-contributing group. The network is primarily funded through a cooperative agreement between the US Centre for Disease Control and Prevention (CDC) and the International Society of Travel Medicine (ISTM).

Building on the wider discussion of travel health risk assessment, **Olivia Veit** introduced the **International Expert Committee for Travel Medicine (iECTM)** – a collaborative, independent platform where experts in public health and travel medicine from across Europe and beyond exchange evidence-based information to align recommendations across borders. The iECTM began in Switzerland, where regional disparities in malaria advice led to the creation of a forum. Over time, this initiative expanded – first to include Germany and Austria. Today, more than fifteen European countries participate, alongside ECDC and public health institutions from Canada, Australia, New Zealand and the US.

The iECTM is a platform to exchange scientific information, that fosters shared learning and helps harmonise guidance where possible. The iECTM is independent of industry influence, a point emphasised by **Olivia Veit**. Each participating country is ideally represented by two individuals – one expert in travel medicine and one in public health – who are directly involved in developing national and international guidance. The annual meetings are hosted in by the Tropical and Public Health Institute (Swiss TPH), Based, Switzerland.

A key success has been the harmonisation of malaria recommendations, previously inconsistent across countries. iECTM established a transparent, incidence-based classification, using WHO data to define malaria risk zones as high, moderate or low based on local case rates over the past three years. This risk mapping is now widely adopted and updated collaboratively at annual meetings. Yet significant data gaps remain:

- There is limited understanding of travellers' exact itineraries within endemic countries, for example, whether they stay in cities or venture to rural regions.
- Official data often fails to distinguish between tourists and returning migrants or VFR. Surveillance data might now capture all cases.

Olivia Veit presented one study that followed 1,000 travellers using geolocation data using the travellers' smartphones to a number of countries.

Beyond malaria, iECTM also addresses:

- Emerging infectious diseases, including dengue, chikungunya virus disease and Zika virus disease,
- Vaccination guidance, such as recent discussions around chikungunya virus disease and Japanese encephalitis vaccines,
- The needs of special risk groups – such as pregnant travellers, children, older adults and immunocompromised individuals.

A weekly news item highlight relevant outbreaks and changes in entry requirements is shared among members.

In closing, **Olivia Veit** outlined her vision for improving travel health data and practices across Europe. She emphasised the need for a standardised minimum dataset for malaria and other infections, one that clearly distinguishes tourist cases from those involving migrants and VFR, and that includes precise information on time and location of exposure. She also called for stronger, mandatory case reporting frameworks across all member states to address existing gaps in surveillance and data consistency. Finally, she proposed the creation of an independent, real-time communication platform to facilitate transparent and rapid information exchange among travel medicine professionals, free from commercial or political influence.

After the coffee break, the Landscape Mapping session continued with **Patricia Schlagenhauf** describing **EuroTravNet** and the **WHO Collaborating Centre for Travellers' Health**. EuroTravNet was established in the early 2000s as part of an EU-

funded initiative specifically to map travel medicine practices and monitor travel-associated illnesses across Europe. It operates under a broader global mandate as part of the GeoSentinel network, with sites throughout Europe. EuroTravNet facilitates informal, regular online communication among member sites, enabling rapid sharing of outbreak information and discussion of new vaccines and cases.

EuroTravNet's activities include inputting data on travel-related infections at its sites, hosting monthly 30-minute discussion forums, early detection of trends and outbreaks relevant to Europe – considering vectors and climate – exchanging information on new travel medicine interventions and vaccines (e.g., Qdenga), and providing digital travel medicine advice via ITIT. The network generates case and clinical data on infections, including travel itineraries, purpose, demographics, migration status, rare events, antimicrobial resistance, and adverse reactions to anti-malarial medications and vaccines. Challenges include ethics clearance, data protection, lack of denominators for analysis, and funding annual meetings. Opportunities lie in closer collaboration with ECDC for rapid alerts, coordinating access to unlicensed medicines, identifying arboviral risk areas, and monitoring migration-related infectious diseases.

The **WHO Collaborating Centre (WHO-CC) for Travellers' Health**, based at the University of Zurich, has a global mandate to support WHO in surveillance, digital approaches to travel medicine, and information products. It produces guidance documents to reflect member state needs, interacts on policy issues, and participates in WHO policy advisory committees. The Centre also interacts with other WHO Collaborating Centres and WHO departments and addresses challenges such as evaluating the effectiveness of entry screening and disinfection methods to reduce disease spread via travel.

Shifting focus from international networks to **country perspectives**, **Tinne Lernout** from **Sciensano** outlined the structure and activities of travel medicine in **Belgium**. Belgian travel clinics operate within a legal framework where the Federal Public Health Service delegates certain tasks, such as vaccinations and health consultations, to authorised centres, mostly based in hospital settings. Clinics must meet specific criteria, including having a specialist in internal medicine with infectious diseases expertise, maintaining up-to-date knowledge through annual symposiums, and collaborating with hospital emergency services. Belgium currently has a limited number of such centres, with, for example, one in Brussels handling around 13,000 consultations annually.

The **Belgian Study Group on Travel Medicine**, established in 1995, comprises representatives from university hospitals and health institutes. It provides epidemiological data, exchanges best practices, and develops guidance on vaccinations and treatments. The group meets regularly and organises biannual seminars and consensus meetings to update travel guidelines, which are published online for wider access. **Tinne Lernout** concluded that some harmonisation between countries would be beneficial.

Moving on to the next national perspective, **Lasse Vestergaard** from the **Statens Serum Institut** (SSI), who attended the ECDC meeting alongside his colleague **Peter Andersen**, outlined **Denmark's** approach to travel medicine and the development of national guidelines. SSI has the authority to issue official travel health recommendations, which are largely based on the WHO travel book – a practice that has been followed for around 20 to 30 years. These guidelines are updated annually, although recently the country-specific information has not been revised as regularly. A small expert committee, appointed by relevant medical societies, reviews and discusses the guidelines. The guidelines provide general advice rather than individual patient consultations. Practitioners and travel clinics across Denmark broadly apply these recommendations, which include a categorisation of travel risk into four groups depending on destination and traveller type (e.g., short business trip versus long-term backpacking). Vaccination and malaria risk advice are included. Information is published on a dedicated website accessible to travellers and clinics. Large private clinic networks and pharmacy vaccination clinics also align their advice closely with SSI recommendations, helping to maintain consistency nationwide.

SSI also monitors emerging health risks and the approval of new vaccines and adjusts recommendations accordingly. For example, recent changes were made to the dengue vaccine guidance in response to WHO updates, and SSI issued warnings about increasing risks of severe malaria linked to travel to certain countries.

However, SSI also faces challenges: there is no dedicated national funding for travel medicine work, which has hampered service continuity – especially during COVID-19, when some individual travel advice services had to be suspended. At the European level, Denmark welcomes efforts to harmonise travel health recommendations, emphasising the need for transparency, objectivity, and independence to avoid conflicts of interest in travel medicine guidance.

Representing the **Hellenic National Public Health Organisation (EODY)**, **Androula Pavli** outlined the current state and challenges of travel medicine in **Greece**. She emphasised the increasing importance of travel medicine due to globalisation and rising travel to exotic destinations, alongside a significant influx of migrants and travellers, including medical tourists, business visitors, and students. Despite growing demand, Greece's travel medicine services have not developed proportionally. Studies revealed inadequate pre-travel preparation among Greek travellers, particularly regarding vaccinations (such as hepatitis) and malaria prophylaxis. Less than half of travellers to African destinations were found to be properly advised.

Greece's system is fragmented and segmented. Regional Public Health Departments (57 across the country) provide pre-travel consultations and are legally designated yellow fever vaccination centres but cannot prescribe or administer all necessary travel vaccines or malaria prophylaxis. They are staffed by public health officers rather than travel medicine specialists. Other providers include primary care practitioners, infectious disease clinics, private clinics, and military health services, though many lack specific travel medicine training.

EODY offers some guidelines and workshops, but travel vaccine recommendations are not fully integrated into the national vaccination programme. Coordination between providers is often lacking, leading to gaps in service and advice.

EODY's role includes developing national guidelines (based on WHO, ECDC, US CDC advice), providing general public guidance (not individual advice), surveillance of travel-related diseases, and coordinating responses to public health events. Greece does not have a dedicated expert committee for travel vaccines, and many newer vaccines available in Europe are not accessible in Greece.

Androula Pavli concluded by stressing the critical need for an integrated travel medicine network in Greece, increased investment in training and research, and strengthened collaboration with European and international agencies.

Dipti Patel from the **UK National Travel Health Network and Centre (NaTHNaC)** concluded the morning session with an overview of travel health services and guidance in the **United Kingdom**. She highlighted travel patterns, noting that Europe remains the most popular destination for UK travellers, with Spain leading. Beyond Europe, significant numbers of travellers visit countries like India, Pakistan, and Nigeria, many of whom are VFR travellers. Travel health guidance in the UK is provided nationally through the UK Health Security Agency (UKHSA). NaTHNaC, commissioned by UKHSA, offers travel health advice for England, Wales, and Northern Ireland; Scotland operates slightly differently but often uses NaTHNaC's information.

The delivery of travel medicine services mainly occurs in community settings, particularly through travel clinics and increasingly through pharmacies – a trend accelerated by the COVID-19 pandemic. Regulation is complex, involving different bodies such as the Care Quality Commission (CQC) for Healthcare Services and the General Pharmaceutical Council for pharmacists. This complicates oversight of travel medicine services. Education and training in travel medicine are provided by various bodies including royal colleges and travel medicine societies, though there are no uniform standards for employment or training requirements.

NaTHNaC maintains a comprehensive website, [TravelHealthPro](#), serving as the primary public-facing resource for travel health advice. It offers up-to-date recommendations, country-specific health information, vaccination protocols, and outbreak alerts. These recommendations are based on validated data from WHO, ECDC, and UK expert panels, with reviews occurring regularly depending on disease risk.

Yellow fever vaccination is tightly regulated in the UK, with designated centres (around 1,700 in the UK) required to meet standards and staff trained through an online course and evaluation. Surveillance of travel-related infections is robust, with enhanced monitoring for diseases such as malaria, dengue, and others. In 2024, there were approximately 940 reported cases of dengue, with enhanced surveillance enabling detailed follow-up.

Dipti highlighted some challenges:

- Limited detailed data on traveller activities and destinations within countries
- Gaps in data collection, especially for returning travellers
- Inconsistent service delivery across numerous yellow fever centres
- Difficulties engaging the travel industry, which often resists communicating risks to customers
- Communication challenges reaching all traveller groups effectively

The country perspective presentations resumed in the afternoon with **Paula Vasconcelos from Portugal's Directorate-General of Health**, who joined online (for this presentation exclusively) to offer an overview of Portugal's travel medicine landscape¹. Paula explained that formal travel medicine services in Portugal began in the 1990s under the WHO's International Health Regulations, initially focusing on yellow fever vaccinations across five regional centres. These centres, integrated into primary healthcare, have since expanded and evolved into [international vaccination centres](#), many affiliated with hospitals specialising in infectious diseases.

A key point was that travel medicine in Portugal is not a recognised medical specialty but is governed by a certification of competence overseen by the Portuguese Order of Physicians. To be certified, medical doctors must complete extensive training in global health, epidemiology, vaccination, and cross-border diseases, including supervised consultations.

While most services are delivered through public health structures, private healthcare groups, such as the [Portuguese Society of Travel Medicine](#), academic institutions also play a role: an example cited was the [Institute of Hygiene and Tropical Medicine at the University of Lisbon](#), which provides extensive travel consultations and updates its advice based on international sources.

The presentation emphasised the increasing importance of travel medicine due to rising international mobility. **Paula Vasconcelos** highlighted the need for better integration between public and private sectors, more systematic data sharing, and the potential for travel medicine to become a formal medical specialty. She advocated for greater multidisciplinary collaboration, including academic and public health networks, to strengthen future readiness and response, particularly in light of lessons from COVID-19.

Gloria González Díaz from **Spain's Ministry of Health** concluded Session 1 with a presentation on how travel medicine is structured in Spain. She began by outlining the legal framework, noting that foreign health is a responsibility of the national government. It is regulated by a Royal Decree which mandates the surveillance and control of health risks related to international passenger traffic, including vaccination and the issuance of health certificates.

Travel medicine is delivered through 118 vaccination centres. Of these, 29 are state-managed and dedicated solely to travel medicine, while 89 are delegated centres, managed by regional or local authorities and usually embedded within hospital preventive services. Despite their smaller number, state-run centres handle a higher volume of travellers due to their exclusive focus. These centres provide pre-travel health advice, administer vaccinations, recommend malaria prophylaxis and other preventative measures, and distribute educational materials.

Gloria González Díaz highlighted the key differences between state and delegated centres: delegated centres may charge for consultations, offer a broader range of vaccines, and are not exclusively dedicated to travel medicine. The [General Subdirectorate of Foreign Health](#), where she works, oversees the functional coordination of all centres. It issues international health alerts, technical guidelines, and vaccination protocols. It also develops national vaccination recommendations in consultation with Spanish scientific societies and coordinates consensus documents that are distributed to the vaccination centres.

She identified several challenges, including:

- Lack of interoperability between electronic medical record systems, preventing access to patient histories
- Limited visibility of post-travel illness data
- Difficulty accessing real-time international outbreak information.
- Gaps in knowledge of travel medicine systems across Europe

She concluded by recommending the creation of a European working group under ECDC to harmonise vaccine recommendations and share best practices.

Session 2: Group discussions

Spain's presentation was followed by a lively group-wide discussion. The group discussion revealed several critical **gaps and systemic challenges** in the organisation and delivery of travel medicine across Europe. A recurring theme was the **lack of harmonised guidance for travel advice** among EU Member States and the absence of EU-wide **coordination**.

Most participants expressed a clear **need for a centralised reference body issuing baseline advice** – potentially ECDC – to gather and assess evidence, particularly for emerging diseases and newly approved vaccines. While national autonomy remains essential, a coordinated European framework would improve information validation and overall communication. Importantly, many participants emphasised that they do not necessarily want the reference body to issue final recommendations; rather, they value a mechanism that supports evidence assessment while leaving the responsibility for final recommendations with national authorities. The absence of such a framework was identified as a core gap.

Another important gap lies in the **availability of real-time data and surveillance infrastructure**. While reporting for diseases such as malaria, dengue, and chikungunya generally follows established procedures, there was interest in **dynamic, user-friendly dashboards** that could map outbreaks and provide practitioners with rapid, geographically precise information.

The discussion also clarified that much of the relevant data – such as disease incidence in specific countries or travel-related cases – is already **available in fragmented form**. The challenge is not only in data collection but in its **structuring, contextualization, and accessibility**. Clinicians and public health officials need interfaces that allow for country-specific queries (e.g., "What's the malaria risk in Thailand?"), rather than having to piece together information from disease-by-disease sources. This highlights the need for a **functional integration layer** that translates raw surveillance data into **actionable travel health guidance**.

Unlike the originally planned breakout format, after the coffee break the group discussion continued in a single plenary session, chaired by **ECDC's Nathalie Nicolay and Gianfranco Spiteri**, and focused on three thematic areas: **Stakeholder Mapping, Surveillance, and Scientific Advice**. The first topic explored through leading questions was stakeholder mapping.

The group was asked what **stakeholders** that play a role in travel medicine should be involved in follow-up discussions. **Peter Andersen** highlighted the need to include the **WHO**, which has historically played a central role in providing travel-related data. **Olivia Veit** pointed out that Germany and France, as key EU Member States, were absent from the current table, despite their

institutional weight and relevance to vaccine development and health preparedness. Responding to this, **Céline Gossner** clarified how participants to the meeting were selected, meaning that a call for interest was sent to three networks³, and individuals who expressed interest were then considered for participation. From those who responded, two representatives from each network were selected to attend, which explains why two participants from the same country could be included if they came from different networks. She also noted that some countries had no participants because no one from the networks there expressed interest. Similarly, while other countries showed strong interest, they could not prioritise participation to this meeting. She emphasised, however, that no country is being excluded and that follow-up discussions with all countries will take place afterwards. Céline also mentioned that WHO was invited to the meeting but has not been able to attend.

Ralph Huits suggested including the **International Society of Travel Medicine (ISTM)**, given its global reach and critical role in connecting travel health professionals. **Chantal Reusken** proposed involving **high-risk Member States**, particularly those with former colonial ties, as these countries tend to maintain frequent travel flows to endemic areas, reflecting historic and familial connections. **Patricia Schlagenhauf** drew attention to the **travel industry**, especially **tour operators**, as essential actors in pre-travel health communication and risk management. **Martin Grobusch** added the **World Tourism Organization**, which could provide critical insights on tourism trends and mobility patterns. **Tinne Lernout** recommended the inclusion of **migration organisations**, emphasising that migrants constitute a distinct population with specific health risks, behaviours, and access issues – factors often overlooked in mainstream travel health planning.

Although the second question, how stakeholders interact with each other, was not discussed in detail, it was briefly noted that interaction between actors such as the travel industry and public health organisations remains fragmented.

Following the discussion on stakeholder mapping, the group turned to the theme of **Surveillance**, suggesting that travel medicine data is available relevant to most diseases. Participants acknowledged that while surveillance mechanisms exist across various domains, infectious diseases, migration, and tourism statistics, they are often fragmented and not always tailored to the specific needs of travel health.

In response to the question of what could be improved in the early detection of infectious diseases among travellers, **Patricia Schlagenhauf** emphasised the importance of better diagnostics, noting that more rapid, accurate tools could significantly enhance front-line detection efforts. However, improvements in diagnostics alone would not be sufficient. Participants stressed the need for interoperable systems, shared data standards, and stronger cross-border data integration. A more systematic identification of priority populations, such as VFR travellers, seasonal workers, and religious pilgrims, was also raised as essential to ensuring surveillance reflects the full spectrum of travel-related risk.

The discussion then moved to the question of how ECDC outputs, such as surveillance reports, communicable disease threat reports, and risk assessments, are used to inform travel advice, and how these tools could be improved. **Gianfranco Spiteri** noted the value of the Communicable disease threat reports (CDTR), while **Martin Grobusch** highlighted the potential of surveillance data to support predictive modelling and scenario planning for emerging risks. **Dipti Patel** underlined the importance of communication materials in relevant languages and advised that public health messages be developed in partnership with community groups to improve accessibility and cultural relevance. In the same vein, **Céline Gossner** noted that the new ECDC mandate now includes communicating directly with citizens, not only professionals – a shift that supports a more public-facing approach.

Olivia Veit encouraged the increased use of social media to target specific traveller populations, and recommended visibility in travel settings such as airports and even on planes. However, **Patricia Schlagenhauf** cautioned that airports and the travel industry do not always engage fully due to concerns about the perception of risk affecting business and therefore proposed leveraging alternative outreach channels such as schools and football clubs, referencing a case involving a famous footballer from West Africa. **Céline Gossner** further suggested that good practices from different countries should be identified and shared to learn from each other work.

Overall, participants agreed that there is a need for both technical improvement (e.g., diagnostics, predictive data, integration) and strategic outreach (e.g., audience targeting, messaging platforms, multi-sectoral cooperation). The integration of public health intelligence, behavioural insights, and community engagement was seen as central to guiding both travel advice and broader public health interventions.

The group addressed the topic of **Scientific Advice**, exploring how scientific evidence can better inform policy and practice in travel medicine across Europe and globally.

One of the key concerns raised was the lack of detailed data on travellers, as opposed to populations in disease-endemic areas. **Christoph Hatz** highlighted that while there is good information on local disease patterns, the same must be often extrapolated for travellers, whose exposure, mobility, and behaviour may differ from local populations. This gap makes it difficult to provide accurate and precise advice for both outbound and inbound travellers.

³ I.e. ECDC Emerging and Vector-borne Disease Network, ECDC Threat Detection Network, and ECDC Vaccine-Preventable Diseases Network

Martin Grobusch underlined the need to strengthen diagnostic capabilities, particularly through strategic partnerships with endemic countries and regions. Enhancing on-the-ground testing infrastructure could lead to earlier case identification and more effective response coordination. Echoing this, **Lasse Vestergaard** stressed the importance of investing in testing and laboratory systems in endemic areas, noting that front-line surveillance is only as strong as its diagnostic backbone.

The discussion also turned to the timeliness and transparency of data sharing. **Chantal Reusken** emphasised the necessity of establishing robust data-sharing agreements between institutions and countries to ensure real-time access to critical information. **Ralph Huits** agreed, adding that such sharing must be timely to be actionable. **Patricia Schlagenhauf** pointed to the importance of ensuring that surveillance data are published quickly enough to influence public awareness and decision-making. However, as **Céline Gossner** noted, while the capacity to generate data exists, there are often constraints on the ability to disseminate findings across all platforms and stakeholders – a gap that must be addressed through greater coordination and resource allocation.

Day 2 – Opening

Leonidas Alexakis, ECDC opened Day 2 of the meeting with a brief recap of Day 1, which included presentations from supranational organisations involved in travel medicine, as well as contributions from countries explaining their approaches. He anticipated that the focus of Day 2 would be on identifying any outstanding gaps and ensuring all relevant issues are addressed. He expressed gratitude for the strong participation hitherto and hoped for similarly productive discussions and outcomes during the day. He then welcomed everyone and referred to the agenda.

Session 3: Other perspectives on surveillance and scientific advice

Chair **Liese Van Gompel**, ECDC, opened the session, introducing three presentations, starting with **Pauline Bardin** from France's Haute Autorité de Santé (HAS), **National Immunisation Technical Advisory Group** (NITAG). **Pauline Bardin** outlined NITAG's role as an independent public health advisory body responsible for issuing vaccine recommendations based on scientific evidence, expert consensus, and public consultation. She detailed the complex evaluation process for vaccine recommendations, including requests, assessments, expert consultations, and final validation by the Technical Vaccination Committee. NITAG operates several procedures depending on urgency, from nine months to just weeks.

Pauline Bardin then focused on the chikungunya vaccination strategy in response to the outbreak in Réunion and Mayotte. An urgent request was received in December 2024 to define which populations should be prioritised for vaccination, considering limited vaccine availability. The vaccine, authorised in June 2024, is a live attenuated vaccine shown to be highly immunogenic and generally well tolerated, although some serious adverse events and miscarriages were reported. NITAG recommended prioritising vaccination for adults aged 65 and over with comorbidities, and younger adults with comorbidities, while advising against vaccination in pregnant women due to insufficient safety data.

In the ensuing discussion, questions addressed concerns about vaccine safety in older adults, the miscarriage cases, comparison with US CDC recommendations, and the lack of real-world data on outbreak control. She emphasised that recommendations would be updated as more data emerge, and that vaccination campaigns' acceptability differed between Réunion and Mayotte.

The **ITIT project**, presented by **Patricia Schlagenhauf**, details a digital approach to traveller infection surveillance via a smartphone application. The app gathers real-time, geolocated health data from users before, during, and after travel. By encouraging symptom reporting on a daily basis, as well as post-travel questionnaires, it aims to supplement traditional surveillance methods which often miss mild or asymptomatic cases. Features include symptom surveys, health diaries, travel-linked data, and access to disease outbreak information. To date, data has been collected from nearly 2,000 users in 95 countries, with 42% reporting symptoms such as gastrointestinal or respiratory issues. Severity ratings and environmental data – including local pollution – are also tracked.

Ethical protocols such as e-consent and data protection measures are incorporated. The app is available in eleven languages, and there are plans to expand the user base and add functions like outbreak alerts and usage reminders. The presentation also notes challenges, including user retention and adapting to country-specific requirements, with ongoing efforts to improve its design and integration.

Martin Grobusch presented **ESCMID's Emerging Infections Subcommittee**, a group formed to provide rapid, expert commentary on new infectious threats across Europe. The subcommittee issues timely statements on outbreaks, collaborates with a wide expert network, and delivers weekly updates and educational initiatives. Its goal is to complement existing institutions by supporting members with up-to-date, practical information for outbreak recognition and response.

Session 4: Future perspectives on travel medicine – how to move forward?

Closing session

Meeting convener, **Céline Gossner, ECDC**, expressed her gratitude that the meeting was able to take place. She outlined the next steps, noting that a meeting report will be prepared and shared. This report will inform internal discussions aimed at defining ECDC's priorities and determining what is realistically feasible. The timing of the meeting aligns well with ECDC's ongoing work on the 2026 work plan. Céline mentioned that the findings would also be discussed at a strategic level during the Advisory Forum in September. She suggested providing a progress update in about six months to maintain continuity and engagement. She concluded by thanking all participants, ECDC's IT and admin support colleagues, and expressing hope for continued collaboration in the future.

Agenda

Day 1 – Tuesday 3 June 2025	
08:30 – 09:00	Registration
09:00 – 09:35	Opening
	- Welcome, overview scope and objectives of the meeting (Céline Gossner, ECDC, 5 min) - Overview of ECDC's new mandate (Piotr Kramarz, ECDC, 15 min) - ECDC's activities in travel medicine (Céline Gossner, ECDC, 15 min)
09:35 – 10:30	Session 1: Landscape mapping <u>Chair: Céline Gossner</u>
	International travel medicine networks: - Geosentinel (Ralph Huits, 15 min) - European Committee on Travel Medicine (Olivia Veit, 15 min) - EuroTravNet and WHO Collaborating Centre for Travellers' Health (Patricia Schlagenhauf, 20 min) - Discussion (5 min)
10:30 – 11:00	Coffee break
11:00 – 12:20	Session 1: Landscape mapping – continuation <u>Chair: Céline Gossner</u>
	Country perspective: - Belgium (Tinne Lernout, Sciensano, 15 min) - Denmark (Lasse Vestergaard and Peter Andersen, Statens Serum Institut, 15 min) - Greece (Androula Pavli, Hellenic National Public Health Organisation, 15 min) - The United Kingdom (Dipti Patel, National Travel Health Network and Centre, 15 min) - Discussion (20 min)
12:20 – 12:30	Group photo
12:30 – 13:30	Lunch break
13:30 – 14:15	Session 1: Landscape mapping – continuation <u>Chair: Céline Gossner</u>
	Country perspective: - Portugal (Paula Vasconcelos, Directorate-General of Health, 15 min) - Spain (Gloria Gonzales Diaz, Ministry of Health, 15 min) - Discussion (15 min)
14:15 – 15:15	Session 2: Plenary discussion <u>Chairs: Nathalie Nicolay and Gianfranco Spiteri</u>
	<u>Leading questions for the discussion:</u> Stakeholder mapping: - Were any key stakeholders omitted in the presented overview (first session)? - How do the stakeholders interact with each other? Surveillance - From a surveillance perspective, what are the most urgent needs in the travel medicine domain in your country/in Europe/globally? - What can be improved in the early detection of infectious diseases among travellers? How can this be done?

	3. Do you use ECDC outputs (surveillance reports, communicable disease threats report, risk assessments) or data when developing and providing travel advice? How could these outputs or data be improved to make them more useful for travel advice purposes? Scientific advice 1. From a scientific advice perspective, what are the most urgent needs in the travel medicine domain in your country/in Europe/globally? 2. What are the key components of effective travel advice for infectious diseases? 3. How do you develop scientific advice/travel recommendations? 4. How do you determine the target audience for travel advice and what methods do you use to reach them? 5. Do you have any established collaborations with other countries or institutions to develop travel advice and recommendations?
15:15 – 15:45	Coffee break
15:45 – 17:00	Session 2: Plenary discussion <u>Chairs:</u> Nathalie Nicolay and Gianfranco Spiteri
	Continuation
17:00 – 17:30	Break
17:30 – 22:00	Bus to social activity and dinner Stockholm city centre

Day 2 – Wednesday 4 June 2025	
09:00 – 09:15	Opening day 2
	Wrap-up day 1 (Leonidas Alexakis, ECDC, 15 min)
09:15 – 10:30	Session 3: Other perspectives on surveillance and scientific advice <u>Chair:</u> Liese Van Gompel
	Vaccination strategy in the context of the chikungunya outbreak in Réunion and Mayotte (Pauline Bardin, Frédérique d'Herbe, Andrea Lasserre, Haute Autorité de Santé, France, 20 min) • New digital approaches to infection surveillance of travellers - the ITIT project (Patricia Schlagenhauf, 20 min) • Role of the Emerging Infections Subcommittee of the European Society of Clinical Microbiology and Infectious Diseases (Martin Grobusch, 20 min) • Discussion (15 min)
10:30 – 11:00	Coffee break
11:00 – 12:15	Session 4: Future perspectives on travel medicine – how to move forward? <u>Chairs:</u> Piotr Kramarz and Ole Heuer
	Roundtable discussion on the future perspectives of travel medicine within and outside the EU/EEA, and strategies to enhance collaboration among key stakeholders (75 min). <u>Leading questions:</u> 1. What are the current barriers to collaboration among travel medicine departments/institutions and stakeholders? 2. How can we foster better collaboration both within and outside the EU/EEA?
12:15 – 12:30	Closing session <u>Chair:</u> Céline Gossner
	• Summary of key findings and action points • Next steps and follow-up actions • Closing remarks
12:30	Take-away lunch

Group photo of the participants

