Expert Meeting
on Regional Integration and Infectious Diseases

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Opening Session
Mr Edmond Israel, The Asia-Europe Foundation’s (ASEF) Governor for Luxembourg, H.E. Ambassador Nguyen Quoc Khanh, Deputy Executive Director of the ASEF, Dr Bounpheng Philavong, Head of Health and Communicable Diseases Division of the ASEAN Secretariat and Mr John F. Ryan, Head of Health Threats Unit of Directorate-General for Health and Consumers of the European Commission, welcomed the participants and opened this first meeting of Asian and European experts on communicable diseases.

This event was part of a series of initiatives in the field of public health cooperation between Asia and Europe under the umbrella of the recently established ASEF Public Health Network - a five-year-long programme funded by the Government of Japan (2009–2013). This Network aims to serve as a bi-regional, multi-sectoral platform for enhanced collaboration on public health issues between Asia and Europe. It also seeks to strengthen capacity building and the competence of frontline players in the public health arena.

Structured as three thematic working groups, the Network facilitates a continuous working process among its members to achieve tangible outputs to support policy and decision-making. In 2010, several projects have been initiated and will be continued in the upcoming years:

- A series of three workshops to build up future scenario on multi sector pandemic preparedness and response (Cambodia / China / Belgium);
- An expert meeting on inter-regional cooperation on communicable diseases (Luxembourg);
- The 16th ASEF University on “Public Health & Vulnerable Groups: Access to Quality Health Care Services” (Poland).

Considering the increasing number of global threats that are not limited by borders, as seen during the SARS and Pandemic (H1N1) in 2009, this meeting gathered Asian and European experts from public health authorities, NGOs and regional organisations to strengthen multi-regional cooperation for better control of outbreaks of potential diseases.

The Expert Meeting aims to (i) assess the current situation, weaknesses, strengths and gaps of regional integration in combating infectious diseases; (ii) transfer experience and working methods between the two regions; and (iii) build up a long-term partnership between the EC and ASEAN on public health issues.
Session 1
Research Study
In order to identify the mechanisms and gaps in terms of regional and inter-regional cooperation in the field of infectious diseases in Asia and in Europe, ASEF commissioned a study to the London School of Hygiene and Tropical Medicine, intending to identify these points and possible synergies.

Abstract – Situational Analysis on Regional Mechanisms of Communicable Diseases Control

The preliminary conclusions were presented to the participants, giving an overview of the existing regional and cross-regional integration initiatives on the surveillance, detection and containment of emerging and re-emerging infection diseases. Reviewing the Southeast Asian and European regional initiatives to address communicable diseases, the report highlights the differences between the models of regional integration/cooperation in terms of the control of infectious diseases, in particular, the terms of legal framework, implementation of the measures and institutional framework. Despite these differences, however, the report identifies possibilities for synergy. From the preliminary conclusions, while the European Union (EU) seems to rely on a strong institutional organisation (enabling the development of sustainable projects and structures, i.e. the establishment of the European Centre for Diseases Prevention and Control), its Asian counterpart should be proud of Asia’s achievements in regional integration efforts, in particular, their rich experience in the field of communicable diseases.

Summary of discussion

Common challenges for Asia and Europe

Despite obvious differences between the two regions and organisations, participants flagged the issues of common interest:

- Currently, ASEAN does not have legal binding instruments that can enforce public health policies at a regional level;

- If both the European Commission and the ASEAN (Association of Southeast Asian Nations) can rely on formal, legally binding agreements, the implementation of the agreed regional initiatives in the field of public health and communicable diseases represent a serious challenge for
both organisations. This requires thorough monitoring of the implementation in order to ensure that decisions made at regional level are implemented at the national and local levels;

- The surveillance systems in the field of communicable diseases that can be operationalised in both regions were also of concern for both Europe and Asia;

- The two regions face important challenges in terms of communication, notably in terms of the necessity to ensure a better co-ordination of communication aspects;

- The necessity to mobilise beyond the health sector in terms of preparedness, response to outbreak and prevention (e.g. mobilisation of civil society and of the sectors and services indispensable to public health services and so on); and

- The existence of major health and wealth inequalities within the two regions.

Possible synergies for Asia and Europe

From the discussions, it was apparent that both Europe and Asia's efforts to develop regional initiatives and control infectious diseases could be complementary:

- Asia's experience in communicable diseases outbreaks;

- The EU's experience in institution building;

- These complementary characteristics can pave the way to synergies and exchanges between the two regions with an aim to benefit from lessons learnt and each other's experience.

This first expert meeting focused mainly on the regional mechanisms put in place by the ASEAN and the EU. However, the Network will extend its future activities to South Asian countries to better reflect Asia and the geographic coverage of the Asia-Europe Meeting (ASEM) process.
Session 2
EU Vaccines Strategy
Abstract – European Commission’s Work on Childhood Immunisation

Vaccine coverage within the European Union’s Member States (EU MSs) is not homogeneous, and too many children are still at risk of developing severe complications from a lack of receiving vaccines for preventable diseases. Several factors contribute to this situation, e.g. the absence of or issues with operational immunisation programmes, or the lack of advocacy to healthcare professionals and public. In addition to this, religious considerations and critical media coverage play a significant role in the loss of trust in vaccines among some pockets of the population. The heterogeneity of immunisation schedules constitutes a major obstacle for 100,000 children aged from zero to fourteen years old, who migrate between Member States (MS) every year. Due to a lack of guidance, family doctors have to improvise on-site most of the time. To tackle such uncertain situations and avoid incidences of high disease in the EU, the European Commission took the initiative to, first of all, seek a firm political commitment from EU MSs to increase and maintain very high childhood vaccination coverage for top-priority diseases; and secondly, to provide evidence-based recommendations to address the main causes of insufficient vaccination coverage.

Abstract – Pandemic (H1N1) 2009 Influenza Vaccination in the EU

Despite the fact that vaccination is each Member State’s responsibility, there is definitely a need for better co-ordination in the EU in order to ensure adequate coverage and a similar level of preparedness in all countries. Three major bodies share the responsibility for pandemic vaccines: the European Commission (EC), the European Centre for Diseases Prevention and Control (ECDC) and the European Medicines Agency (EMA). With regard to the H1N1 pandemic, the MSs agreed on priority grouping in August 2009 due to the limited supply of vaccines at the early stage of the pandemic: the groups included people above six months of age with underlying chronic conditions, pregnant women and healthcare workers. In September 2009, the Commission published a working document on “Vaccination Strategies for the Pandemic (H1N1),” which summarised major objectives and guidelines.
However, MSs were free to develop different strategies according to their preference. In order to deal with exceptional circumstances, a special procedure, termed the “mock-up procedure,” was put in place to expedite the process of licensing and authorisation of vaccines, which typically took four months. Additionally, a joint procurement mechanism allowed MSs to share their expertise in evaluating the quality and efficacy of the new pandemic vaccines. From September 2009 to March 2010, several vaccines were approved through such procedures. To support better access to vaccines, the EU successfully supported joint procurement and experimented with a virtual stockpile (vaccines and antivirals), acting as broker between MSs. Considering the fact that only about 9% of the European population was eventually vaccinated, better risk and crisis communication strategies are required, taking into account new social communication technologies. The European Commission is currently assessing their pandemic vaccination strategy, and a Conference was held from 1–2 July 2010 by the Belgian Presidency to discuss the lessons learnt from the 2009 Pandemic. A revision of the EU Pandemic Preparedness Plan will be made accordingly.

Summary of discussion

The session was divided into two sections. The first introduced the European childhood immunisation programme and pointed out similar concerns with their counterparts from ASEAN. The second section focused more specifically on the EU’s pandemic vaccine strategy, underlining common efforts from both regions in promoting equitable access to vaccines.

First Section

A heterogeneous European landscape

The Meeting discussed the heterogeneity of Europe landscape and how this contributed to the strategies for increasing vaccines coverage. It was noted that in a comparison of vaccine coverage between East and West Europe, the former shows higher levels of coverage due to the past willingness of its inhabitants to accept vaccinations. More challenging situations on vaccination are faced by the latter due to criticisms from cultural and
philosophical perspectives regarding the need for vaccination. Misleading messages in the media or on the Internet have also caused people to be reluctant to be vaccinated, as recently seen during the H1N1 experience.

Since vaccination programmes are closely linked to education and healthcare systems, it seems exceedingly difficult to harmonise all of them at a regional level. Since 1995, the European Medicine Agency (EMA) has worked on improving harmonisation among EU Member States, but full harmonisation seems unrealistic. The EC has set up a scientific committee comprising representatives from the twenty-seven Member States, with equal votes for approving vaccines. Even if the approval process is unanimous, and the recommendation turns into an EC bidding decision to deliver the product licence, it does not mean that all Member States will have to use it. The national mechanisms of vaccine approval differ from one country to another. In addition to this, the existence of different implementation options reinforces the heterogeneity of vaccines' schedules.

**The impact of migration on vaccination coverage**

In most of the EU countries, childhood vaccination is free of charge and covers both legal and illegal migrants. Migration is therefore not a financial issue in Europe but more a question of immunisation status for these children and the difficulty to reach them.

On the contrary, the issue is of great public health concern in Asia, considering the importance of migration movements in the region and the limited financial capacities of most of the governments. Access to basic healthcare services for migrants is truly a challenge, and can pose diverse health security problems to governments.

**Effectiveness of vaccination coverage**

The effectiveness of vaccine coverage is a multi-dimensional question, which involves both delivery and quality issues that can differ greatly in individual countries.

In the European Union, the Public Health sector is the prerogative of the state. So far, the EC recommendations are considered the most appropriate
tool to strengthen political commitment and enforce vaccination strategies at regional level. Logistics are also highly controlled and usually ensured by childcare NGOs, public authorities or hospitals. Regarding the cold chain, large European providers are usually in charge of procurement and selected via calls for tender. There is no concern about the quality of the vaccines. However, the problem is much more complicated in developing countries, where a combination of factors interacts. The level of vaccine coverage is not necessarily low because of a lack of political commitment, but can be due to poor infrastructure, faulty cooling systems and limited financial capacities. The effectiveness of delivery and the quality of vaccines can be both questioned, especially in countries with a tropical climate.

In Europe, one should also be careful in interpreting global key figures that often hide very poor immunisation standards in some pockets of a population, as in the case of the Netherlands.

Several European networks and the ECDC have begun collecting and assessing data on vaccines’ effectiveness. Usually, a national regulatory body includes a follow-up of the vaccines on the market as a condition for a licence. Such monitoring is not limited to childhood vaccines, but includes other diseases as well, such as hepatitis and pandemics. It can then be used to monitor the effectiveness of the vaccination coverage.

ASEAN experience

While the European Commission plays a key role in the EU, in Asia, there is no regional cooperation on immunisation, which is mainly implemented at a national level. ASEAN countries follow the rules of the WHO-SEARO (World Health Organisation-Southeast Asia Regional Office) or the WHO-WPRO (Western Pacific Regional Office). The mechanisms of sharing, surveillance and reporting are all handled by the WHO, which constitutes the reference in the region. In addition to this, diversity in terms of geography, political situation and socio-economic levels are so important that immunisation varies from one country to another. As part of the blueprint of actions for 2010–2014 that address the Millennium Development Goals, the ASEAN is currently in the process of programming, and will most likely include
immunisation as well. In this context, the experience of the EC can be of interest to the ASEAN countries.

**Second section**

**Vaccine production and pharmaceutical industry: towards better access to vaccines**

In Europe, there is definitely a concentration of vaccine production, which is led mainly by multinational companies such as GSK or Novartis. Prior to the pandemic, several EU MSs already signed contracts of procurement, which mentioned that a contract becomes active when WHO declares stage six. Manufacturers used their considerable leverage to avoid bearing liability for the effects of the vaccines, as part of the procurement contract. Considering such a model unacceptable, Poland decided not to procure vaccines, and did not organise any national campaign. In this way, such situations helped EU MSs to realise that they would do better to negotiate at a regional level.

It is vital to develop strong local capacities to reduce the degree of dependence on vaccine prices. However, this is a long process, which takes about five years. Currently, global production capacity is concentrated in Europe, and there is a clear tendency to extend existing production facilities rather than build new local capacities. Some participants raised the relevance of having national vaccine manufacturers, which responds more clearly to the needs of the population, for example, in Hungary and India.

Quite the opposite of the United States, the EU considers pandemic vaccines different from seasonal vaccines. Pandemics attack a population that was not previously exposed to the virus or any type of vaccine. Therefore, it contains chemical substance to increase immune response (with different boosting principles).

This year, the ASEAN began to explore possible collaboration with the pharmaceutical industry in order to promote better access to anti-viral and pandemic vaccines. The issue of fairness in access to vaccines is one shared by the two regions.

**Communication challenges**

When the Influenza A (H1N1) outbreak occurred in Mexico, the EU MSs
held a daily conference at a regional level, organised by the Health and Consumer Directorate-General (DG SANCO). Although communication channels have worked very well at a governmental level, it has been a complete failure in terms of general communication to the public. Healthcare workers should be more actively involved in communication strategy. Building trust takes time, which is not easily manageable during a pandemic outbreak. Special attention to communication networks needs to be explored.

During the H1N1 outbreak, media impact and awareness was unsuccessful, mainly due to the moderate nature of the pandemic. Additionally, people were unsure about the vaccines’ safety. When vaccines were licensed for vulnerable groups, clinics were concerned about their effects on children and pregnant women.

Manufacturers are definitely not in a favourable position to contribute to the global communication effort; in fact, this could have an adverse effect.

**Lessons Learnt & Perspectives**

According to the ECDC, the pandemic will continue to circulate as a seasonal virus in the years to come. People who are vaccinated will enjoy better protection. Currently, major international and regional organisations are still in the midst of evaluating their campaigning and strategy. The outcomes of these assessments will be of great use in strengthening existing preparedness plans.
Session 3
Health Cooperation in Asia
Abstract – ASEAN Regional Cooperation in Communicable Diseases and Pandemic Preparedness and Response

Established in 1967 and including ten Member States in Southeast Asia, the ASEAN plays a significant role in overall regional co-ordination. Due to the region’s unique geographic, economic, social and cultural conditions, the need for a regional organisation to lead initiatives and manage progress is continuously growing. In terms of health cooperation, the ASEAN has developed a number of regular meetings and working groups as well as programmes within the framework of cooperation in communicable diseases, and pandemic preparedness and response funded by international donors. Most have seen tangible outcomes, strengthening capacity building and setting up standards and frameworks. In spite of the ASEAN’s achievements, however, the biggest challenge remains in the sustainable management of existing and future programmes. This is mostly due to limited funding and human resources. In addition, there are huge economic disparities among ASEAN Member States, and thus, the ASEAN has a high dependence on contributions from international organisations and development agencies.

Abstract – Insight of a Member State of an ASEAN Technical Working Group on Pandemic Preparedness and Response: Indonesia’s Lessons Learnt

Like other ASEAN countries, Indonesia was also affected by the influenza pandemic (H1N1) in 2009, but its impact was amplified by its geographic condition of having multiple access points to the country’s border. Indonesia ascertained that trans-boundary transmission required multi-sector and regional responsibility to respond to the pandemic. The government set up a framework consisting of six pillars, covering issues from social distancing to post-pandemic response, which were managed by different command and control centres at national, provincial and district levels. Risk communication is considered a cross-cutting activity. In line with its “Whole-of-Society” approach, Indonesia developed a National Multi-Sector Pandemic Preparedness and Response Plan (NIP2RP) in 2008. Consisting of three main phases: “Planning, Preparation, and Response,” the National Plan outlined a series of tasks such as raising awareness, cross-border and multi-
sector pandemic flu response simulations, national campaigns using the mass media, investment in logistics and hospital management and active involvement in regional cooperation.

Abstract – Recent Experience of Pandemic A (H1N1) 2009 in Japan and its Collaboration with Asia

In Japan, since the 1970s, several pre-existing systems had been established for influenza virus surveillance, such as the sentinel surveillance for influenza-like illness (ILI). When facing the Influenza A (H1N1) pandemic, Japan organised case-based surveillance for three months (28 April–23 July 2009), based on lab-confirmed cases and daily reports. Depending on symptom types and severity, and infection routes, suspected and confirmed cases were defined. Shortly after the first domestic case of Influenza A/H1N1 case was confirmed in May 2009, outbreaks among several schools were reported. After this, the government announced an extensive school closure – 650,000 children/students in over 4,200 schools were quarantined in their homes. Statistics proved that the extensive school closure was effective, with a lower number of ILI cases. The number of infected patients in Japan had been estimated as 15% of the population, but had a very low mortality rate (0.15 out of 100,000 population). In terms of international cooperation, the H1N1 pandemic demonstrated the importance of increased technical transference and information sharing among countries to better control the spread of diseases. The development of new methods of virus detection is also required, especially in the WHO Collaborating Centre on Influenza.

Abstract – Cross-border Cooperation in Animal and Human Health in Asia 2007–2013

The European Commission has been providing support to Asia in terms of animal and human health since the early nineties, through a number of projects and programmes. During the highly pathogenic avian influenza (H5N1) crisis, the Commission put forward the importance of cross-regional cooperation to effectively prepare for and respond to high-impact health risks, in particular, pandemics. The Commission’s Strategy Paper for Regional EU-Asia Cooperation (2007–2013) identifies cross-border cooperation in
animal and human health as a specific and important topic. For the past four years (2007–2010), 48 million Euros worth of regional funds have been invested in health-based cross-border cooperation in Asia (and in addition to this, important financial contributions have been made to research), combining animal and human health cooperation for the first time, in addition to the environment. In particular, the Highly Pathogenic Emerging and Re-emerging diseases (HPED) programme, which began in January 2010, is designed to strengthen the institutional capacities of ASEAN, SAARC (South Asia Association for Regional Cooperation) and their Secretariats to control HPED and to improve epidemic and pandemic preparedness in the region in a sustainable manner. For the next three years (2011–2013), the major focus will be putting the “One Health” approach into practice; this approach addresses major health risks that originate from the interactions between animals, humans and their diverse environments. The Commission is determined to move this approach forward in tandem with its major international partners.

Summary of discussion

Since the outbreaks of SARS and highly pathogenic avian influenza, Southeast Asia has responded impressively and worked closely at a regional level, putting in place several institutional mechanisms and co-ordination arrangements, as well as key regional initiatives in both the animal and human health sectors. The ASEAN is also the only regional organisation which has been able to set up and manage a regional stockpile. Close relationships have been developed with their neighbouring countries, as well as with the European Commission.

Challenges in involving the private sector

In line with the “Whole-of-Society” approach, public-private partnership is essential in improving pandemic preparedness plans. However, for several reasons, implementation is usually much more complicated in reality. The economic and financial crises put additional pressure on the private sector, which led them to focus on business priorities rather than preparing continuity plans for severe pandemics.
Indonesia’s case illustrates the possible integration of the business sector with national strategy. As a part of the Indonesian National Committee, private companies are directly involved in the process of consultation and provide training to government officials. Unfortunately, disparities are still a huge challenge in local communities.

At a regional level, the ASEAN has no official agreement with the private sector, but invites them to ASEAN events and programmes as observers on an ad-hoc basis. In 2008, the ASEAN Technical Working Group on Pandemic Preparedness and Response initiated the development of multi-sector indicators to monitor pandemic preparedness and response plan formulation in non-health sectors. Eight essential sectors that must continue to function during a pandemic in order to maintain basic functions of society and mitigate the impact of a pandemic were identified: health, food, water and sanitation, energy, public security and order, finance, telecommunications and transportation.

How can the organisation of cooperation and implementation be improved in order to make collaboration sustainable?

While international donors are showing a strong commitment to supporting comprehensive programmes and empowering Asian institutions, it raises the issue of limited human resources from the recipients’ organisations and countries. Receiving multi-donor funding, ASEAN and SAARC secretariats have to deal with an increasing number of responsibilities, including monitoring, implementation and reporting.

In addition to this, more support for continuing the existing projects and programmes should be considered instead of implementing new programmes. When ambitious regional programmes are put in practice at local levels, state agencies are often not equipped to implement the programmes due to a lack of capacity and resources. It is also true that, especially for big projects, the involvement of too many different players, such as international organisations, civil society organisations and multi-level agencies, makes implementation extremely challenging.
Social distancing measures: the case of Japan

With a population of 130 million, Japan had a lower mortality rate than other highly industrialised countries, such as the US, Australia and the UK. This was due to the implementation of an effective method, school-closure, and the development of a flexible strategy of case-based surveillance. Suspension of classes and school closures have been used in past pandemics (as in the USA) and during seasonal influenza outbreaks in some countries and areas (as in Japan and Hong Kong [China]). The effectiveness of this intervention may depend on many factors such as the epidemiological features of the disease (e.g. the incidence rates in school-age children), the level of transmission, a rural or urban setting, when the measure is started and stopped and whether it is applied in conjunction with another intervention. Past experience and various studies indicate that the suspension of classes may play a role in decreasing the number of cases and deaths, delaying the outbreak peak and slowing down the spread of the disease. In many countries, school closures are acceptable and feasible. For example, extended families may be able to look after the children while their parents continue working. In Europe, where family structures are different, it can create significant societal disruptions.

In addition to this, an effective influenza virus surveillance and detection is necessary. Thanks to swift confirmation utilising existing systems, many medical practitioners in Japan were able to give antivirals to patients within twenty-four hours of infection.

The international cooperation between the National Institute of Infectious Diseases of Japan (NIID) and neighbouring Asian countries is seen as a priority in reinforcing regional health security. The ASEAN Plus Three Laboratory Collaboration is an illustration of this willingness, among other examples. Cognisant of the importance of technical transference and information sharing among countries in order to control the spread of disease, Japan also participates in a laboratory-based network in the Asia-Pacific rim. Through this network, partner countries and WHO WPRO aim to standardise the protocol for the detection of pathogens and genotyping, quality control and validation of protocols, construction of databases and
exchanges of information and researchers. A NIID representative closed his presentation by stressing that the rapid development of new virus detection methods is vital, especially in the WHO Collaborating Centres on influenza, and that the characterisation of virus genomes will display the evolutonal steps of viruses and may shed light on the effectiveness of countermeasures to influenza isolation.

Communication management and vaccine campaigns

In the light of the H1N1 situation in 2009, it was clear that communication had a direct impact on the success of the vaccine campaigns. Multiple sources of information and confusing messages negatively affected a campaign’s overall success. The fear of the side effects of vaccines and weak trust in vaccines’ efficiency led to an obvious reluctance to be vaccinated among the population. Moreover, the high cost of the vaccines further increased public resistance to the vaccine.

In Indonesia, in order to overcome the communication barriers due to the country’s unique conditions such as a vast number of islands – some of which are very remotely located – and multiple ethnic groups, the government received assistance from UNICEF and SIDA (Swedish International Development Cooperation Agency) in terms of designing strategies and outreach. They discovered that there are different languages and terminologies not only between local communities, but also between different sectors (e.g. the agriculture and poultry sectors). Therefore, it was suggested that mapping the fragmented communication should precede the harmonisation of communication.

The “One Health” and “Whole-of-Society” approaches

Both Asia and Europe re-affirmed that the “One Health” approach reflects the necessity of tackling health issues beyond the health sector. Further concerted efforts should contribute to better organisation of cooperation and implementation to make multi-lateral, multi-level and multi-sector collaboration feasible and sustainable.

The EU has set up a new animal health strategy, which includes public health, research and sustainable development, preventative measures such as vaccination, disease surveillance and emergency preparedness, and
reliance on cross-sector support and cooperation. In terms of research, joint infectious diseases programmes have been initiated and key areas which needed cooperation were identified, such as vector-borne diseases, novel integrated surveillance methods, vaccine development and neglected zoonosis. Lastly, the HPED regional programme in Asia is also one of the EU’s initiatives in the “One Health” approach.

In close collaboration with the WHO, ASEAN is playing a leading role in regional arrangements involving animal and human health sectors, in particular, in terms of how to respond to outbreaks of infectious diseases at a regional level. Having made an early pledge to integrate the “One Health” approach in its regional mechanisms, ASEAN is already committed to going beyond animal health, towards the human health and environmental sectors. ASEAN is also taking into consideration the influence of other sectors such as education, infrastructure, trade and tourism. As a part of the efforts to effectively consolidate fragmented work within the divisions at the ASEAN Secretariat, the organisation plans to integrate them into a single framework as part of the ASEAN Plus Three Emerging Infectious Diseases Programme over the next five years.
Session 4
Regional Communication Strategy
Abstract – Communication and Integration Strategy: The ASEAN+3 EID Programme

The ASEAN+3 (ASEAN Plus China, Japan and Republic of Korea) Emerging Infectious Diseases (EID) Programme has 5 Communication Strategies. Under Strategy 1: Co-ordination, Harmonisation and Collaboration, focal bodies which are responsible for implementation of strategy and development of protocol were appointed and provided with a mandate by ASEAN+3. Regional risk communication strategy was developed in March 2008, based on a needs assessment and training needs survey. A Risk Communication Resource Center for ASEAN for research and training programme was also established for Strategy 2: Risk Communication. Various programmes such as “The Sharing of Experiences of Best Practices (Thailand),” “Knowledge, Attitude and Practice (KAP) survey (Lao PDR),” “Advocacy Strategy on Rabies Prevention and Control (Vietnam)” and “Development of Information, Education and Communication (IEC) Materials on Dengue Diseases (Vietnam)” have been implemented for Strategy 3: Strengthening Communication Capacity. For Strategy 4: Real-Time Communication and Information Sharing, protocol was developed and an ASEAN+3 EID website that serves as platform for news on surveillance and information exchange was reconstructed. Meeting with the Secretariat of the Pacific Community (SPC) for sharing common areas of interest is one of the examples of Strategy 5: Regional Networking and Partnerships.

During the 2009 Influenza (H1N1) pandemic, the website worked as a platform for communication and information sharing among ASEAN Member States. Via the pandemic experience, cross-cutting principles for communication and information sharing were re-identified, including sustainability, transparency, consistency, trust and political commitment. In terms of sustainability, several programmes, such as the ASEAN+3 EID website, which will be managed by Indonesia, the Risk Communication Resource Centre for ASEAN, managed by Malaysia, the documentation of best practices, led by Thailand and the annual ASEAN Dengue Day, which was approved by ASEAN Health Ministers, are recognised.
Abstract – Indonesia’s Experience and Specific Needs, Success Story and Lessons Learnt

Initiated in 2000 and officially launched in 2003, the utilisation of the ASEAN+3 website was assessed in 2007. It displayed several types of barriers to information sharing related to political commitment (sensitive information), co-ordination and partnerships (data processing and harmonisation) and national capacity (reporting systems and national communication infrastructure). Based on this assessment, a new website was developed in 2008 (www.aseanplus3-eid.info). Following its protocol, the ASEAN+3 agreed to focus on key areas which included co-ordination, harmonisation and collaboration, risk communication, strengthening communication capacity, real-time communication and information sharing and lastly, regional networking and partnerships. Indonesia, who hosted the website of the ASEAN+3 EID programme, will take over the management of the website from June 2010 onwards.

Abstract – Crisis Communication, Health Security Committee Communicators’ Network

Set up in March 2009, the EU Health Security Committee Communicators’ (HSC) Network comprises press officers and spokespersons from national health authorities, EU agencies and UN agencies. This network focuses on crisis communication in response to health threats. The network provides a forum where crisis communication-related issues and practices can be exchanged, discussed and used for coordination purposes. All parties retain their ability to communicate independently. As part of the lessons learnt, it appears important to explore social/new media more effectively and understand the impact of messages and citizens’ needs. Media and stakeholders also need to be involved in the communication process to be effective. In the future, the EC should provide more guidelines, toolkits, training and workshops on specific issues in order to support the EU MSs’ activities.
Summary of discussion

The EU and ASEAN communication networks are quite different in many aspects. However, communication is a global issue and both regions share common concerns. Each crisis is unique and requires an ad-hoc response. The H1N1 pandemic showed just how challenging and difficult the exercise can be, and how planning systems in place were not flexible enough to adjust to the situation. Despite the vast differences between Asia and Europe, there is definitely value in learning from the experience of others.

Gaps at national and local levels

Communication coverage can be easily confined to a central level, due to poor local capacities in terms of both human resources and technologies. Internet access is not uniformly spread across all countries and districts.

Website management and maintenance

Five people currently take care of the ASEAN website management, while the EC relies on a much larger team composed of in-house staff as well as external consultants; for example, twenty people work on a daily basis to circumvent hacking.

Apart from a clear difference in financial resources, the need for commitment from all Member States in website maintenance to ensure accurate data update is clear. It is obvious that only one country or limited personnel cannot handle such a large task.

ASEAN does not impose any specific format or language for uploading data. The quality and validity of the information provided is completely reliant on the Member States’ scrutiny. It definitely raises the question of measuring the benefit of reducing extra work for its MSs against the difficulty of using and analysing heterogeneous data. It should be seen as an investment with real potential for returns. The ASEAN has set up a risk communication centre to develop MSs capacities for any public health threats. It could also be used as a resource centre.
Challenges in involving journalists

There is currently debate on how to involve journalists closely in regional communication processes. The EC drafted a work plan to involve journalists’ networks, but there is no clear strategy yet. Japan has already initiated a programme of talks with journalists, mainly from the medical and science sectors. However, the spectrum of journalists needed is much wider during a crisis and poses a challenge. Even if the ASEAN easily identifies relevant journalists at a national level for a press briefing, it will be difficult to know who the final writer will be in a crisis situation, and other factors are involved, such as the editor’s decision on whether to sensationalise the news or not.

Role of the research community in communication at-risk

The research community should be also considered an important stakeholder in the communication process. Decision-making is mostly based on judgement rather than evidence during a crisis period. Researchers need to be involved to improve information collection and analysis. They can also contribute to the development of tools for evaluating and assessing messages.
Session 5
Research & Development
Abstract – ASEAN Initiative for Healthy Tourism and Travel

The impetus for research partnership has arisen from the ASEAN's concerns with regard to the re-emergence of communicable diseases such as malaria, tuberculosis, HIV, AIDS and avian influenza. The recent H1N1 pandemic has reinforced the need for this project, emphasising the need for effective surveillance and risk management and highlighting the tourism industry's vulnerability to health issues. The aim of the research was to develop a theoretical framework for healthy tourism and to provide policy guidance for national initiatives. The project responds to a recognised need for mechanisms and indicators within tourism planning, development and operations to support and ensure the health, safety and wellbeing of the local community, their environment and visitors. Funded by AusAID (Australian Agency for International Development) and managed by the ASEAN Secretariat, this three-year programme involved ten ASEAN Member States: Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam. Based on an ethical approach to tourism planning, the project seeks to promote a process of collaboration between major tourism stakeholders in each location, including tourism and health authorities, local tourism and service providers, host communities and visitors. Such an approach to tourism is aimed at addressing the health and safety needs of visitors to tourist destinations in each of the ASEAN nations while providing continuous benefits for host populations. It supports the principles of Sustainable Tourism in “Agenda 21 for the Travel and Tourism Industry,” specifically addressing how tourism can contribute to healthy living.

Abstract - The Gender Dimension in the Prevention and Management of Avian Flu and Dengue in Selected Countries in Southeast Asia

In 2008, the ASEAN Plus Three Programme embarked on a multi-phase initiative aimed at enhancing policies for the development of gender-specific prevention and control strategies dealing with avian flu and dengue in Cambodia, Indonesia and Vietnam. The programme was divided into three phases: a) generation of information on the gender impact of dengue and
avian flu in Cambodia, Indonesia and Vietnam; b) dissemination of research results to these countries; and c) development of a set of recommendations on how to integrate gender issues into dengue and avian flu programmes. The research represented the first phase of the programme. It intended to: a) understand the gender differentials in risk exposure, knowledge of and attitude toward avian flu and dengue; b) determine the difference in the perceptions of men and women of the causation, manifestations and management of these diseases; c) elicit sources of information and management related to the two illnesses by the gender of respondents; d) delineate the illness experience of family members by gender; e) assess the gender difference in terms of healthcare seeking behaviour; f) find out the social impact of illness on male and female family members; and g) provide recommendations for gender-sensitive dengue and avian flu policies and programmes. These objectives were addressed through a survey of males and females in communities with outbreaks of the two diseases between 2006 and 2008. The project implementers were staff from the Ministry of Health of each of the three countries. The study showed that gender differentials exist in exposure to and knowledge of transmission, prevention, information sources, content and utilisation of health care facilities for the management of infectious diseases. Furthermore, it was noted that women are primarily given the burden of care for sick family members. Hence, gender is seen as a key entry point in understanding the risks associated with particular infectious diseases. The research concluded that gender concerns must be identified and incorporated into community-based preventive, promotive and management programmes. Two other challenges were addressed: a better comprehension of gender-based causal dimensions of infectious diseases and the incorporation of gender in policies and programmes involving infectious diseases.

Abstract – EU-funded Research on Human Infectious Viral Diseases

The presentation began with a summary of the current situation of research in Europe. While research represents the competence of MS States, various resources are fragmented and duplicated, and MSs’ investment on research is still unsatisfactory, with only about 2% of GDP spent on research. Moreover,
researchers have insufficient status in many aspects and face barriers to their mobility. Therefore, the role of the European Commission in research is, among others, to pressure policy makers to increase research spending to 3% of the GDP. As a funding agency, the EC also supports research done by multi-national, multi-disciplinary teams in pre-defined research areas in order to integrate limited resources. The FP7 (the Seventh Framework Programme for research and technological development) – the European Union’s instrument for funding research from 2007–2013 – has identified nine thematic priorities for its collaborative research, and health was ranked the second highest priority after information and communication technologies. Within the health arena, major activities are based on cross-cutting issues such as international cooperation, Small Medium Enterprises (SMEs), child health, ageing populations and gender-related issues. The Innovative Medicines Initiatives (IMI), supporting pre-competitive pharmaceutical research and development between multiple stakeholders, is the outcome as well as the reinforcing body of these major activities. The main objective of the IMI is to accelerate the development process of medicine in terms of enhancing medicine’s safety and effectiveness for patients. The FP7 also looks at infectious diseases such as anti-microbial resistance, poverty-related diseases (PRD), emerging infectious diseases (EID) and neglected infectious diseases. The EU has invested over 100 million Euros on influenza research since 2000. In addition to forty-nine research projects, four or five new projects are slated to begin in 2010 – a total of fifty-three to fifty-four EU-funded influenza projects – making the EU the leader of the largest integrated effort in the world. Moreover, the EU’s influenza research aims to form an ideal balance between animal and human health projects, in line with its “One Health” approach. One notable aspect of the EU’s international cooperation in research is that the EC designs the topics and identifies the strategic areas, but asks the participating countries or research groups to take the lead in conducting the research itself. Influenza-related FP7 projects will launch a call for proposals in the next three years, from 2011–2013. In 2011 in particular, a research officer from the Research Directorate-General of the EC called Asian participants’ attention to projects centred on "potentially new and re-emerging epidemics."
Summary of discussion

Boosting the impact of healthy tourism and travel

In addition to the areas and topics covered by related research, some participants contributed additional elements for consideration to boost the impact of the healthy tourism and travel initiative.

In response to a question about whether the related research made any specific recommendations for STDs (sexually transmitted diseases) in healthy tourism, the presenter answered that the research was not particularly meant to propose specific recommendations, but intended to highlight the public health promotion programmes. However, in future exercises, each destination will focus on one topic, thus concentrating resources and developing a sustainable programme. Human and natural disasters were also suggested as additional topics for consideration.

In order to better reflect the real conditions in developing a framework for healthy tourism and to provide a comprehensive guideline to policy makers, other elements were further identified. First, the flow of information should be facilitated by multiple sectors, and not only by the ministries of health and tourism. Secondly, in the guidelines, the focus should cover every point to the final destination, such as departure and arrival areas in airports. Lastly, the consideration of specific local culture was suggested. With regard to attracting more proactive participation from the business sector, a participant suggested certification for the corporate tourism sector, issued by the local government. The presenter stated that there was indeed strong interest from the private sector in considering the healthy tourism initiative as part of their CSR (Corporate Social Responsibility).

Consideration of social/cultural issues in research

In general, participants found the research on gender dimensions in the prevention and management of selected infectious diseases enlightening in providing further aspects for consideration to both researchers and policy makers.

Although the aim of this presentation was to give an overview of the research, interest in sharing more information about the data collection in terms of
methods and data analysis arose among the participants. It was also stressed that, based on general outcomes from gender studies, putting the results into practice should reflect locally oriented specificities.

**EC’s mechanisms of prioritising and defining research areas**

The EC identifies priorities in areas of research from different sources. The EC also takes advice from an advisory committee comprising renowned scientists and other stakeholders, and from the programme committee, which includes members designated by all Member States associated with the FP7. Other practices include the EC’s participation in international conferences, the organisation of workshops with ad-hoc experts and consultation with the public and other funding agencies. The EC presents published topics to National Contact points, who relay the information to the scientific community and various stakeholders.

**EC’s position in the management of intellectual property (IP) for research**

The Commission, as a funding agency for research, does not intervene in IP issues, but encourages each consortium to take responsibility for this and considers IP issues in an international context.

**EC’s international cooperation in infectious diseases**

Despite the EU’s goodwill in engaging non-EU regions and countries in the Seventh Framework Programme (FP7), it was noted that there are still some obstacles for these players in terms of access to the information and lobbying. In particular, the EC representative admitted difficulties faced by non-EU parties in receiving information about the FP7, and stated that the percentage of grants awarded to Asian partners is relatively low. However, he reiterated that the limited budget does not hinder the impact of the research.

While representatives from the ASEAN Secretariat welcomed the good news on ASEAN’s successful application for FP7 proposals, a strong interest arose in further exploring the opportunity to collaborate on cross-regional research between the ASEAN and the EC.

It is clear that Asia and Europe have different expertise and professional environments in research fields. However, participants agreed that the nature of infectious diseases provides an opportunity to strengthen cross-regional
cooperation by learning from each other. In addition, scientific results will provide a firm base for further integration and cooperation, boosted by permanent institutions, for example, the establishment of an Asia-EU research centre for infectious diseases.

**Concluding Remarks**

Regional institutions and their mechanisms have proved their effectiveness, especially during a period of several outbreaks of infectious diseases. However, challenges remain in the arenas of communication with citizens and gaining or maintaining the public’s trust in institutional initiatives and programmes (e.g. vaccination). In addressing and dealing with cross-regional issues in Asia and Europe, a huge obstacle is that each member has different mandates and cultural backgrounds. Overcoming these differences can be achieved not by harmonising two regions, but by attempting to learn from each other and identify priorities. For this reason, the ASEF-initiated research study on regional integration and infectious diseases provides a good overview and useful comparison of regional mechanisms.

Based on the recommendations from the research and discussions during the expert meeting, further areas of collaboration between Asia and Europe can include research cooperation on topics such as anti-viral and medical-counter measures for vaccinations, the mobilisation of outsiders and partners of health sector, and business continuity across society in order to protect public health and minimise social disruption.

It was noteworthy that both Asia and Europe are committed to integrating the “One Health” approach into their policies, encompassing the animal, veterinary and human health sectors. In addition, the importance of facilitating cross-sector collaboration was widely supported by participants.

The ASEF Public Health Network was recognised as a platform which provides a significant initiative in Asia-Europe regional collaboration and integration on infectious diseases, and participants stressed the importance of its continuous contribution to bi-regional dialogue.
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* Speakers and moderators’ designations and organisations are based on the information available at the time of the workshop in May 2010.

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About the Asia-Europe Foundation

The Asia-Europe Foundation (ASEF) promotes greater mutual understanding between Asia and Europe through intellectual, cultural and people-to-people exchanges. Through ASEF, civil society concerns are included as a vital component of deliberations of the Asia-Europe Meeting (ASEM*). ASEF was established in February 1997 by the participating governments of ASEM and has since implemented over 450 projects, engaging over 15,000 direct participants as well as reaching out to a much wider audience in Asia and Europe. www.asef.org

* ASEM now brings together 46 member states (Australia, Austria, Belgium, Brunei Darussalam, Bulgaria, Cambodia, China, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Indonesia, India, Ireland, Italy, Japan, Korea, Laos, Latvia, Lithuania, Luxembourg, Malaysia, Malta, Mongolia, Myanmar, the Netherlands, New Zealand, Pakistan, the Philippines, Poland, Portugal, Romania, Russia, Singapore, Slovakia, Slovenia, Spain, Sweden, Thailand, United Kingdom, Vietnam) plus the European Commission and the ASEAN Secretariat. www.aseminfoboard.org

About the Asia-Europe Meeting

The Asia-Europe Meeting (ASEM) is an informal process of dialogue and cooperation. It brings together Australia, Austria, Belgium, Brunei Darussalam, Bulgaria, Cambodia, China, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Indonesia, India, Ireland, Italy, Japan, Korea, Laos, Latvia, Lithuania, Luxembourg, Malaysia, Malta, Mongolia, Myanmar, the Netherlands, New Zealand, Pakistan, the Philippines, Poland, Portugal, Romania, Russia, Singapore, Slovakia, Slovenia, Spain, Sweden, Thailand, United Kingdom, Vietnam) plus the European Commission and the ASEAN Secretariat. www.aseminforboard.org
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