



**REGIONAL MECHANISMS OF  
COMMUNICABLE DISEASE CONTROL  
IN ASIA AND EUROPE**

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Edited by: Sunkyoung LEE  
Peter LUTZ

Copyedited by: LEONG Wen Shan

Cover Design & Layout by: Furryfish Pte Ltd

A RESEARCH REPORT BY:

Marco LIVERANI, Piya HANVORAVONGCHAI and Richard COKER

London School of Hygiene and Tropical Medicine,  
Communicable Diseases Policy Research Group

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Please direct all inquiries to the publisher:

Asia-Europe Foundation (ASEF)  
31 Heng Mui Keng Terrace  
Singapore 119595  
T +65 6874 9700  
F +65 6872 1135  
[www.asef.org](http://www.asef.org)



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Part of this research report has been published as an article under the title “Communicable diseases and governance: A tale of two regions”, by Marco Liverani, Piya Hanvoravongchai and Richard J. Coker, in the “Global Public Health: An International Journal for Research, Policy and Practice”, Volume 7, Issue 6, 2012, Taylor & Francis Ltd, [www.tandfonline.com](http://www.tandfonline.com). An abstract of the article is reprinted with permission of the publisher and appears at the end of this report. It includes a link to the full article on the publisher’s website.

# [ EXECUTIVE SUMMARY ]

This report provides an overview of regional mechanisms of communicable disease prevention and control in the European and Asian contexts. Over the past decades, the consolidation of projects of political and economic co-operation in both regions has created institutional platforms for the shaping of public health policies and programmes beyond national borders. In Europe, the European Union (EU) has become an increasingly important actor for the co-ordination of national efforts. While response to public health threats largely remains a competence of EU Member States, the legal and organisational structure for interventions at the EU level has been considerably strengthened. The establishment of the European Centre for Disease Prevention and Control (ECDC) in 2005 was a significant step in this direction. In Southeast Asia, similar developments have been fostered by two main factors. First, as in Europe, the growth of institutions for political and economic co-operation has provided the bases for closer collaboration in public health. Second, geographic areas in the region that encompass more than one country, such as the Mekong Basin, have been particularly prone to disease outbreaks of international concern. Thus, the support and co-ordination of surveillance and response programmes in regional hotspots of epidemic activity has become a priority of funding agencies and health organisations. This report aims to gain an understanding of these developments, including an overview of institutional mechanisms for Asia-Europe cross-regional co-operation. In a comparative fashion, it aims to (1) outline the background context in both regions; (2) provide an overview of achievements, key issues and gaps; (3) map experience and expertise exchange between Asia and Europe; and (4) identify areas for future research and co-operation.

## Key Findings

■ In the European context there is a process of increasing rationalisation and centralisation of regional policies and programmes, driven by the leading role of the EU. In Southeast Asia, the situation is more fragmented, as many institutional actors and organisations are involved at the regional level, often with different agendas and approaches.

■ EU communicable disease policies are underpinned by a legal framework and regulatory processes, albeit in a rather unsystematic way and mainly through case law. In Southeast Asia, regional programmes are based on informal agreements and “soft law”.

■ Permanent institutions at the EU level facilitate continuity and consistency of regional activities. By contrast, most programmes in Southeast Asia have a temporary mandate. The latter approach is more flexible, but creates problems of capitalisation.

■ In Southeast Asia, there is a more comprehensive approach to regional co-operation in public health, ranging from co-ordination of national preparedness plans to the community level. In the EU, interventions and programmes tend to focus on high-level policy-making.

■ International co-operation in Southeast Asia is often based on a distinctive model of regional division of labour, whereby the initiative and sense of ownership of member countries is fostered and valued. In the EU, there is more emphasis on the authority and role of the central agencies — the European Commission, the ECDC and specialised agencies such as the European Medicines Agency (EMA) and the European Food Safety Authority (EFSA).

■ In the past decade, the establishment of platforms for dialogue and co-operation between the states of the European Union and Asia — such as the Asia-Europe Meeting (ASEM) process and the EU-ASEAN Dialogue — has provided new bases for inter-regional relations. While these agreements are based upon informal discussion and exchanges, they have great potential to promote and facilitate health co-operation across the two regions.

## Recommendations

■ In both regions, the policy drive to harmonise, integrate and co-ordinate ought to be balanced with a concern with differences between the capacities and economic needs of individual countries, sub-regional areas and local communities.

■ High population mobility across Asia and Europe, and the resulting risks of disease transmission, should be given more attention. Further research should examine past and current patterns of inter-regional mobility and their implications for the prevention and control of infectious diseases.

■ There is wide room for closer co-operation between Asian and European partners. For example, Asian experts have gained considerable experience in management of public health crises after the outbreaks of Severe Acute Respiratory Syndrome (SARS) and avian influenza H5N1; this can be a highly valuable resource to European experts and policy-makers. On the other hand, the EU model of supranational integration and health co-operation can provide a useful reference to Asian partners, also in consideration of current efforts to build an ASEAN Community by 2015.

■ There are already a number of successful collaborations between Asian and European partners. However, current initiatives tend to be short-termed. Long-term exchanges would foster deeper links between the two regions (e.g., postdoctoral fellowships, professional positions). Also, the institutionalisation of health co-operation at the highest-level of policy making would provide stronger bases to co-operation. In particular, the establishment of an ASEM regular meeting of health ministers would fill an important gap in the ASEM process.

## **INTRODUCTION**

The emergence or re-emergence of infectious diseases with pandemic potential has brought renewed attention to the key role of international collaboration and co-ordination.



The importance of international co-operation for the prevention and control of communicable diseases has long been recognised by governments and health authorities. Since the International Sanitary Conferences of the mid-19th century, it has become apparent that the wide spread of diseases cannot be only a matter of national governance but requires standard procedures, transnational communication channels and common agreements on the handling of infected travellers across borders (Howard-Jones 1975; Fidler 2005).

In the past decade, the emergence or re-emergence of infectious diseases with pandemic potential has brought renewed attention to the key role of international collaboration and co-ordination. Driven by these concerns, the World Health Organization (WHO) has made several efforts to strengthen global surveillance systems and promote the collective action of governments and national authorities. As former director of WHO's Communicable Diseases Programme David Heymann (2006) put it, the changing landscape of international health has intensified the need to place "global solidarity above national sovereignty".

Besides the global dimension of disease surveillance and control, international co-operation has also developed at the regional level. The regionalisation of public health policies has been driven by three main factors. First, geographic areas encompassing more than one country have been particularly prone to communicable diseases outbreaks. In recent years, for instance, Southeast Asia has been the epicentre of highly pathogenic diseases such as Severe Acute Respiratory Syndrome (SARS) and highly pathogenic avian influenza H5N1. Thus, the support and co-ordination of surveillance and response programmes in regional hotspots of epidemic activity has become a priority of funding agencies and health organisations. Second, since its establishment in 1948, the WHO has operated through a decentralised system of regional offices, which are responsible for health programmes and policies in six wide geographic areas (Africa, Americas, Eastern Mediterranean, Europe, Southeast Asia and Western Pacific). Third, the consolidation of projects of political and economic co-operation in several parts of the world has provided new institutional bases for the development of public health policies at the regional level. Indeed, the prevention

and control of infectious diseases has become an area of governance for regional organisations such as the European Union (EU), the Association of Southeast Asian Nations (ASEAN), the Asia-Pacific Economic Cooperation forum (APEC), the South Asian Association for Regional Cooperation (SAARC), the Caribbean Community (CARICOM) and the Southern Common Market (MERCOSUR).

This report aims to offer an overview of these developments in the European and Asian contexts. Despite many differences in health priorities and capacities, in both regions political developments and recent public health crises have contributed to strengthening mechanisms for international co-operation. The first part of the report focuses on the European context, discussing the evolution of EU policies from early interventions in the 1990s to the establishment of the European Centre for Disease Control and Prevention (ECDC). The second part examines regional co-operation in Southeast Asia, during and after the SARS crisis. The third part focuses on three institutional mechanisms for Asia-Europe co-operation in public health: the EU-ASEAN Dialogue, the Asia-Europe Meeting (ASEM) process and the EU International Cooperation framework. Finally, the last section provides a comparative analysis of regional mechanisms in Europe and Southeast Asia, with a number of recommendations to inform the research and policy agenda.

## Methodological Issues and Materials

This study was commissioned to examine regional mechanisms of communicable disease control in Asia and Europe. The research focus, on large and diverse units of analysis such as “Asia” and “Europe”, posed particular methodological challenges, also in consideration that the project was conducted under tight time constraints — between March 2010 and June 2010.<sup>1</sup> In light of this, we had to select a limited number of case studies in the two regions, which could however shed light on emerging trends and wider processes. In researching the subject at the European level, we found that the European Union is becoming a major part of the public health infrastructure in Europe; yet this development has largely been unexplored in public health studies (Greer and Mätzke 2012). Thus, we decided to focus on EU communicable disease policy, aware that other institutions have had a key role in promoting international co-operation in the region, especially the WHO Regional Office for Europe.

In the Asian context, the situation is more fragmented. While regional integration in Europe is driven by a process of increasing centralisation, under the patronage and leading role of the European Commission, in Asia many organisations are involved in the promotion of health co-operation at different sub-regional levels, including the Association of South East Asian Nations (ASEAN), the South Asia Association for Regional Cooperation (SAARC) and the forum for Asia Pacific Economic Cooperation (APEC), along with the WHO Regional Office for South-East Asia and the WHO Regional Office for the Western Pacific. Given this complexity, we limited the analysis to Southeast Asia and the role of ASEAN in particular. The rationale behind this choice is that Southeast Asia has recently been the epicentre of diseases of international concern, such as SARS and H5N1, which have required closer international co-operation and innovation in public health approaches. In particular, ASEAN has emerged as an important and constructive player for the co-ordination and integration of regional activities. In addition to ASEAN, many other organisations are active in regional programmes, including research institutes, governmental and non-governmental agencies. While the aim is not to draw a comprehensive map of all initiatives, we briefly presented three examples of recent programmes that can illustrate wider issues at the regional level: the Mekong Basin Disease

Surveillance Network (MBDS), the Greater Mekong Subregion Communicable Disease Control Project (GMS-CDC) and the Surveillance and Investigation of Epidemic Situations in South-East Asia (SISEA) project of the Institut Pasteur Network. While these three programmes were established under different organisational and institutional arrangements, they have all been driven by a pledge to strengthen regional integration.

Finally, this research set out to document cross-regional co-operation across Europe and Asia. Again, this is a broad and complex issue, which includes a diverse range of institutional arrangements, including bilateral agreements, various forms of collaborations between international organisations and individual countries, and inter-regional platforms. We focused on inter-regional platforms, as we were mainly interested in broad region-to-region processes, in keeping with the overall objectives of the study.

To gain an understanding of the aforementioned developments, we relied on various sources of empirical material, including “grey literature” in English language, which is available in the public domain (e.g., reports and legal and policy documents), academic articles, conference papers and semi-structured interviews with key informants in relevant institutional settings. Face-to-face interviews were conducted at the ASEAN Secretariat in Jakarta, Indonesia. Phone interviews were conducted with experts and policy-makers at the ECDC, the Directorate General for Health and Consumers of the European Commission. Interviews were also conducted with key informants at the Institut Pasteur, the Asian Development Bank, and the Mekong Basin Disease Surveillance Programme.<sup>2</sup>

<sup>1</sup> The manuscript was updated and revised in October 2012.

<sup>2</sup> Extracts from this report were included in two published articles (Liverani et al. 2012; Liverani and Coker 2012).

## **REGIONAL INTEGRATION IN EUROPE**

The consolidation of the process of European integration has provided an important political platform to shape public health strategies at the regional level.

# REGIONAL INTEGRATION IN EUROPE

In the past two decades, the consolidation of the process of European integration has provided an important political platform to shape public health strategies at the regional level. While until the early 1990s health policy had a marginal role in the overall framework of the European Community, after the establishment of the European Union in 1992 public health has become a more prominent item on the agenda of European policy-makers. This development can be explained as a result of different factors, including growing mobility of people and traded goods within the European space

**Technological advances in electronic communications enabled the creation of new linkages between research centres, institutions and individual practitioners across wide geographic areas.**

as well as the policy impact of public health crises such as bovine spongiform encephalopathy (BSE), better known as “mad cow” disease, and the threats of pandemic influenza and bio-terrorism. In 2005, the establishment of the European Centre for Disease Prevention and Control (ECDC) has further contributed to the “Europeanisation” of communicable disease control by providing the EU with a centralised structure that co-ordinates European surveillance networks. The following section aims to offer an overview of these processes, from early developments to the foundation of the ECDC.

## Early Developments

National networks for prevention and control of communicable diseases have existed in Europe since the post-World War II period. In line with World Health Organization (WHO) recommendations, in the 1950s health authorities in some countries established national centres for collection, analysis and report of epidemiological and virological information. For many years, however, efforts were highly fragmented. A detailed review published by WHO Regional Office for Europe in 1984 noted that national standards were very different and there were few exchanges across national borders (Velimerovic 1984).

During the 1980s, this situation began to change. Technological advances in electronic communications enabled the creation of new linkages between research centres, institutions and individual practitioners across wide geographic areas. Under the initiative of directors of national surveillance centres, a number of networks were established to monitor and study the epidemiology of specific diseases at the European level, including HIV/AIDS (EuroHIV), tuberculosis (EuroTB), legionella infections (EWGLI) and food-borne infections (SALMNET). At the same time, the European Community supported experimental projects on disease surveillance. The network Eurosentinel (1987–1991), funded by the European Commission under the second Framework Programme for research and development, aimed to create an international system of sentinel practices and thus to produce a “unique knowledge which is only available through comparisons of health status, patterns of care, resources, and expenditure in different countries” (WHO 1990). While the implementation of Eurosentinel highlighted many

differences in diagnostic criteria and systems of classifications, the comparative analysis of data on four diseases (influenza, mumps, measles and HIV) contributed to better understanding epidemiological trends across Europe. In addition, Eurosentinel laid down the bases for the development of similar schemes in the following years, such as the ENS-CARE Influenza system and the European Influenza Surveillance Scheme (EISS). ENS-CARE Influenza was created in the early 1990s under the initiative of WHO Europe and with the technical support of DG-XIII Telecommunications of the European Commission. ENS-CARE consisted of an electronic network of national influenza centres that provided information for national administrations and public health institutions. It also established an early warning system based on epidemiological data that were collected by national institutes and WHO Europe (Fleming and Cohen 1996). Following this experience, EISS was launched in 1996. Over the years, EISS has involved thousands of sentinel physicians and influenza reference laboratories in several countries. Most notably, it has brought many improvements in the management of international collaboration, including the definition of common rules for reporting clinical incidence, the use of quality control programmes, and more efficient exchange of epidemiological information through the website. Similar to its predecessors, however, the early implementation of EISS faced some important technical challenges, such as the difficulty to aggregate and compare data that are inevitably influenced by context-dependent variables, such as differences in healthcare systems, patterns of medical consultation and reporting behaviours (Fleming et al. 2003) as well as the problem of securing sustained funding for surveillance.

In the 1990s, European co-operation on communicable diseases was further enhanced as a result of two important developments. On the one hand, directors of national surveillance centres established in 1994 an informal advisory body to work with the European Commission and set up a European framework for communicable disease surveillance. Subsequently, this Charter Group developed new tools to support disease surveillance at the European level, including a printed and electronic surveillance bulletin called Eurosurveillance and a high-level training programme in field epidemiology called European Programme for Intervention Epidemiology Training (EPIET), which was aimed to create a cadre of senior epidemiologists sharing common methods and language. On the other

hand, after the establishment of the European Union in 1992, the institutions of the European Community significantly increased their commitment to public health policy (MacLehose et al. 2002; Reintjes 2008). This development can be explained in light of three convergent phenomena. First, the growing mobility of people and traded goods within the EU has facilitated the transnational spread of diseases and thus required increased co-operation and the harmonisation of surveillance procedures. This need has become more urgent after the latest rounds of enlargement, which expanded the EU to 27 Member States and radically changed its geopolitical configuration (Coker et al. 2004).

**The growing mobility of people and traded goods within the EU has facilitated the transnational spread of diseases and thus required increased co-operation and the harmonisation of surveillance procedures.**

Second, as the EU moves from a single economic market to a more political process of integration, public health is becoming more relevant on the agenda of European policy-makers. While the actual response to public health threats largely remains a competence and responsibility of EU Member States, the legal bases for community planning and interventions in this area have considerably been strengthened, although in a rather unsystematic way and mainly through case law (McKee and Mossialos 2006; Greer 2008; Lamping and Steffen 2009).<sup>3</sup> Third, the public health emergency of BSE in the late 1990s, as well subsequent threats of pandemic influenza, SARS, and bioterrorism, have provided further impetus to the development of transnational mechanisms for surveillance and response.

In this changing context, in 1998 the European Parliament and the Council of the European Union made a formal decision to set up a European policy network for epidemiological surveillance and control of communicable diseases, and a new early warning and response system (European Parliament and the Council 1998).<sup>4</sup> Following this decision, the Commission set up new Dedicated Surveillance Networks (DSN) or improved networks that were already in operation. In practice, each network collects and analyses data on specific diseases beyond routine surveillance, including detection of novel strains for the study of resistance mechanisms (Ternhag et al. 2004). In addition, a web-based Early Warning and Response System (EWRS) was established to ensure rapid communication in case of public health emergencies of international concern (European Commission 2007, 2009).

## THE EARLY WARNING AND RESPONSE SYSTEM (EWRS)

The access to the system is secured and is limited to the formally appointed contact points. [...] following notification from Member States, the contact point receives a login and a password from the Commission to access the system, and full authorisation to write and read messages. When a message is posted on the system, it is automatically circulated to all EWRS contact points, and the network (Commission, Member States, acceding and the EEA countries, and ECDC) is informed at the same time of how the situation is progressing and of the measures planned or undertaken at national level to respond to the specific event (Guglielmetti et al. 2006).

<sup>3</sup> The consolidated version of the Lisbon Treaty (2008) states that the European Union “shall encourage co-operation between the Member States to improve the complementarity of their health services in cross-border areas” (TFEU, Article 168).

<sup>4</sup> The criteria for selection of communicable disease to be covered by the European surveillance network were: 1) diseases that cause, or have the potential to cause, significant morbidity and/or mortality across the Community, especially where the prevention of the diseases requires a global approach to co-ordination; 2) diseases where the exchange of information may provide early warning of threats to public health; 3) rare and serious diseases which would not be recognised at national level and where the pooling of data would allow hypothesis generation from a wider knowledge base; 4) diseases for which effective preventive measures are available with a protective health gain; 5) diseases for which a comparison by Member States would contribute to the evaluation of national and Community programmes (European Commission 2000).

## The European Centre for Disease Prevention and Control (ECDC)

**The creation of ECDC reflects an important change in EU policies on communicable diseases. Physically located in a dedicated building near Stockholm and staffed with about 300 professionals, the Centre embodies the shift from a fragmented process to centralisation.**

In 2005 the EU strategy on communicable diseases control was further consolidated after the establishment of the European Centre for Disease Prevention and Control (ECDC), an independent agency of the European Commission, with the mandate “to identify, assess and communicate current and emerging threats to human health from communicable diseases” (European Parliament and the Council 2004). According to its founding regulation, this new centre has a wide range of tasks, including the collection and analysis of relevant scientific data, the management

of dedicated surveillance networks, the maintenance of databases for epidemiological surveillance, and the technical and scientific evaluation of prevention and control measures at the EU level.<sup>5</sup> In the long term, the Centre aims to standardise methods and improve reporting in all EU countries, especially with regard to case definitions, data collections, laboratory protocols and classifications.

The creation of ECDC reflects an important change in EU policies on communicable diseases. Physically located in a dedicated building near Stockholm and staffed with about 300 professionals, the Centre embodies the shift from a fragmented process to centralisation. Since its foundation, the Centre has gradually incorporated the co-ordination of services and activities which were initially organised through a variety of different arrangements and responsibilities, including the Disease Surveillance Networks (see Table 1), the European Programme for Intervention Epidemiology Training (EPIET) and the bulletin Eurosurveillance. As the multi-annual plan for the years 2007–2013 states, the ECDC aims to become “the focal point for communicable disease surveillance in the European Union and the authoritative point of reference for strengthening surveillance systems in the Member States” (ECDC2008). This goal, moreover, is part of a wider two-pronged strategy on communicable diseases control

<sup>5</sup> To perform these tasks, the Centre is structured in four technical units: (1) Scientific Advice; (2) Surveillance; (3) Preparedness and Response; and (4) Health Communication.

whereby the ECDC is charged with risk assessment while the European Commission is charged with risk management, in shared responsibility with the EU/EEA Member States. In the event of public health threats of supranational concern, the ECDC shall provide a risk assessment to the Commission (namely, the Health Threats Unit of DG Health and Consumers), which has the mandate to support response and co-ordinate the action of Member States, in accordance with the principle of subsidiarity.<sup>6</sup>

Table 1. **Dedicated Surveillance Networks**

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### **Antimicrobial resistance and healthcare-associated infections**

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European Antimicrobial Resistance Surveillance Network (EARS-Net)  
European Surveillance of Antimicrobial Consumption Network (ESAC-Net)  
Healthcare-Associated Infections Network (HAI-Net)

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### **Food- and waterborne diseases and zoonoses**

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European Food- and Waterborne Disease and Zoonoses Network (FWD-Net)  
European Legionnaires' Disease Surveillance Network (ELDSNet)

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### **HIV, STI, and blood-borne viruses**

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European HIV/AIDS Surveillance Network  
European Network for STI Surveillance  
European Hepatitis B and C Surveillance Network

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### **Influenza**

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European Influenza Surveillance Network (EISN)

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### **Tuberculosis**

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European Tuberculosis Surveillance Network

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### **Vaccine preventable diseases and invasive bacterial infections**

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European Invasive Bacterial Disease Surveillance Network (EU-IBD)  
European Network for Pertussis Surveillance  
European Diphtheria Surveillance Network (EDSN)  
European surveillance network for selected vaccine-preventable diseases (EUVAC-Net)

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<sup>6</sup> In EU law, the principle of subsidiarity maintains that the European Union should perform only those tasks that cannot be performed effectively at a more immediate or local level. More specifically, "Under the principle of subsidiarity, in areas which do not fall within its exclusive competence, the Union shall act only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States, either at central level or at regional and local level, but can rather, by reason of the scale or effects of the proposed action, be better achieved at Union level" (TFEU 2008).



## Achievements and Challenges

**The consolidation of disease surveillance networks and their integration under a single body (ECDC) has contributed to improved monitoring and analysis of epidemiological patterns across a wide and diverse geographic space.**

EU policies on infectious diseases are still evolving and taking shape. Over the past decade, the consolidation of disease surveillance networks and their integration under a single body (ECDC) has contributed to improved monitoring and analysis of epidemiological patterns across a wide and diverse geographic space. EU agencies have also provided timely and authoritative scientific guidance to promote harmonisation in areas where coherence of approaches is crucial, such as pandemic preparedness plans. In co-operation with Member States and the WHO, the ECDC and the European Commission have developed advanced tools to evaluate, strengthen and harmonise national plans for moderate or severe pandemics, including “acid tests”, planning assumptions and agreed preparedness indicators (ECDC 2012). Such efforts are most needed to assist member countries that have less resources, expertise and public health capacities.

Yet, the establishment of a truly supranational framework for disease surveillance and control in Europe faces many challenges. First, disease monitoring may still be obscured by a variety of factors that affect data quality, such as differences in

case definitions, access to or use of microbiological tests, care-seeking behaviours and referral practices (Ammon and de Valk 2006). In addition, surveillance networks may have different classifications from the ones that are used at the national level; age grouping can also vary between, for example, the WHO and a European network for the same disease (Ternhag et al. 2004). To address this gap, since 2002 the European Commission has issued guidelines for comparable case definitions, which are periodically updated as a result of changing epidemiological trends or new scientific knowledge (European Commission 2002). The work of the ECDC has also contributed to more uniformity in protocols and standards. However, a report noted that “additional extensive work is needed to improve the quality and comparability of EU-wide disease surveillance data” (ECDC 2008). Today, the ECDC has successfully implemented a common platform for integrated data management and analysis called the European Surveillance System (TESSy), but there is still much work to do in order to harmonise data collection and reporting practices across Member States.

Second, the EU has developed a solid structure for expert advice and risk assessment, but has still very limited authority to co-ordinate responses. Indeed, recommendations on risk management so far have hardly resulted in coherent strategies across Europe, as illustrated by major discrepancies in national responses to pandemic influenza H1N1 in 2009 (UK Health Protection Agency 2010a). Furthermore, despite many efforts of the European Commission, national ministries of health have failed to agree on the creation of a European stockpile of antivirals, which could be strategically distributed in the event of pandemic influenza. Regardless of the debated public health benefits of antiviral stockpiling, this failure indicates that prospects for large-scale public health interventions

at the European level are limited (European Union 2006). Current plans to develop a mechanism for joint procurement of vaccines might provide an alternative instrument to redress imbalances between Member States and thus show the added value of interventions at the EU level (see box below). However, concerns have been expressed that such agreements should be carefully tailored to the individual needs and public health capacities in each country (UK Health Protection Agency 2010b).

## JOINT PROCUREMENT OF VACCINES IN THE EU

Since the emergence of the threat of influenza A (H1N1), the Commission has urged all Member States to cooperate closely to ensure that there are no gaps in vaccination coverage, which would compromise overall pandemic preparedness in the European Union. In order to promote equitable access to vaccines against pandemic (H1N1) 2009 influenza, the Commission has worked on joint procurement arrangements with those Member States that have expressed an interest to participate.

There are several benefits for contracting authorities engaging in joint procurement arrangements, including lower prices, administrative cost savings and the pooling of different expertise between the participating authorities. Agreements also included the possibility of resale between Member States of any excess amounts of vaccine (European Commission 2009).

## **REGIONAL INTEGRATION IN SOUTHEAST ASIA**

The rapid spread of SARS and avian influenza across national borders has emphasised the need for increased co-ordination and co-operation amongst governments in Southeast Asia.

# REGIONAL INTEGRATION IN SOUTHEAST ASIA

**D**espite sustained national and international efforts and important achievements, many regions in Asia still suffer from heavy public health burdens — especially where “an interplay of socioeconomic, environmental and behavioural factors as well as population movements, foster the spread of communicable diseases, both within and across borders, and threaten international health security” (Narain and Bhatia 2010:162). In recent years, Southeast Asia in particular has been the epicentre of disease outbreaks of international concerns such as SARS and highly pathogenic avian influenza H5N1 (Coker et al. 2011). While SARS was contained in June 2003, avian influenza is still a public health threat (WHO 2010).

The challenge of communicable diseases in Southeast Asia has triggered a large international response. Philanthropic foundations, non-governmental organisations (NGOs), research institutes, government agencies and regional organisations have supported and implemented programmes to strengthen public health capacities in the region, including surveillance and response mechanisms. In addition, the rapid spread of SARS and avian influenza across national borders has emphasised the need for increased co-ordination and co-operation amongst governments in Southeast Asia. To this aim, several programmes have included specific schemes to promote collective action in areas that are particularly prone to epidemic outbreaks, such as the Mekong Basin. On the other hand, the consolidation of projects for political and economic integration in the region has provided new institutional bases for the implementation of public health programmes at the regional level. In different ways, organisations such as the Association of Southeast Asia Nations (ASEAN), the Ayeyawady-Chao Phraya-Mekong Economic Cooperation Strategy

(ACMECS), and the Asia-Pacific Economic Cooperation forum (APEC) have all endorsed transnational co-operation for the prevention and control of communicable diseases.

Drawing a comprehensive map of such a diverse landscape of public health programmes would be a daunting task. In the previous section, we have seen that regional integration of communicable diseases policies in Europe is driven by a process of increasing centralisation and rationalisation, under the patronage and leading role of the European Commission. Unlike the European context, in Southeast Asia there is a patchwork of overlapping initiatives, often underpinned by different approaches, timeframes and agenda (see Table 2).

Table 2. **Some examples of regional programmes in Southeast Asia**

<b>Mekong Basin Disease Surveillance Project (MBDS)</b>			
<b>Timeframe</b>	<b>Activities</b>	<b>Main Funder</b>	<b>Coverage</b>
I : 2000–2003 II : 2003–2007 III : 2007–2010	Surveillance, training, capacity building, information sharing	Rockefeller Foundation	Cambodia, China, Laos, Myanmar, Thailand and Vietnam
<b>Surveillance and Investigation of Epidemic Situations in South-East Asia Project (SISEA)</b>			
<b>Timeframe</b>	<b>Activities</b>	<b>Main Funder</b>	<b>Coverage</b>
2006–2011	Surveillance, training, capacity building	French Development Bank	Cambodia, China, Laos and Vietnam
<b>Greater Mekong Subregion Communicable Disease Control Project (GMS-CDC)</b>			
<b>Timeframe</b>	<b>Activities</b>	<b>Main Funder</b>	<b>Coverage</b>
2005–2009	Surveillance, capacity building, information sharing, training	Asian Development Bank	Cambodia, Laos and Vietnam
<b>South East Asia Infectious Disease Clinical Research Network (SEAICRN)</b>			
<b>Timeframe</b>	<b>Activities</b>	<b>Main Funder</b>	<b>Coverage</b>
2005–2010	Research	US National Institutes of Health; Wellcome Trust, UK	Indonesia, Singapore, Thailand and Vietnam
<b>Asian Partnership on Emerging Infectious Diseases Research (APEIR)</b>			
<b>Timeframe</b>	<b>Activities</b>	<b>Main Funder</b>	<b>Coverage</b>
2007 - present	Research, policy analysis	Canada's International Development Research Centre (IDRC)	Cambodia, China, Indonesia, Thailand and Vietnam
<b>ASEAN+3 EID Programme</b>			
<b>Timeframe</b>	<b>Activities</b>	<b>Main Funder</b>	<b>Coverage</b>
I: 2004–2005 II: 2007–2009	Surveillance, capacity building, policy analysis, training, information sharing	AusAID	Brunei, Cambodia, China, Indonesia, Japan, Korea, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam

Given this complexity, we focused on a selection of examples and developments, which can shed light on wider regional dynamics and processes. In the following sections, we first provide a brief overview of three recent programmes for communicable diseases control, which have all been characterised by a focus on regional integration. We then examine the role of the Association of Southeast Asia Nations (ASEAN) and its Emerging Infectious Diseases (EID) Programme. As we observed, especially after the SARS outbreak, this organisation has become an important institutional actor for the development and co-ordination of public health strategies at the regional level.

## Regional Projects

### 1) The Mekong Basin Disease Surveillance Project (MBDS)

The Mekong Basin Diseases Surveillance (MBDS) is a regional surveillance project, which was established in 2001 by the health ministries of Cambodia, China, Laos, Myanmar, Thailand and Vietnam, with the financial support of the Rockefeller Foundation. The initial project was structured around three main objectives and lasted until the end of 2010. In particular, MBDS aimed to (1) strengthen sub-regional disease surveillance and information exchange, (2) strengthen human resource development in field epidemiology, (3) establish sustainable national capacities in disease surveillance, outbreak investigation and response, and (4) provide information for health and social policy to reduce burden arising from priority diseases.

The project was supported by a communication infrastructure linking countries at the national, provincial, district, community and village levels. Members relied on a system of periodic reports and cross-border meetings to facilitate information exchange and build trust between parties. As documented in evaluations, this project has been a successful example of regional co-operation and provided effective support to the implementation of the new International Health Regulations in participating countries (Kimball et al. 2008). Moreover, it operated through an innovative model of regional division of labour, whereby each member country was responsible for individual components of the overall framework: cross-border co-operation (Laos), human-animal sector interface and community-based surveillance (Vietnam), human resources development (Thailand), information and communication technology capacities (Cambodia), risk communication (Myanmar), and laboratory capacities (China). The project was completed in 2010; plans are currently being discussed to establish MBDS as a permanent foundation.

## 2) Greater Mekong Subregion Communicable Disease Control Project (GMS-CDC)

The Greater Mekong Subregion CDC project was launched in 2005 as a joint initiative of the WHO and the Asian Development Bank, which provided the largest share of the USD38 million budget. This project spanned over a period of five years and involved Cambodia, Lao PDR and Vietnam. It aimed to strengthen national health capacities — including institutional structures, health policy, laboratory facilities and human resources — and to develop integrated systems of disease surveillance, response, and preparedness. At the same time, the project aimed to establish sustainable transnational co-operation through the endorsement of a common legal framework, the support of joint research projects, and the co-ordination of control measures across national borders. The whole approach was underpinned by “the three pillars of the regional co-operation” (ADB 2008): (1) regional strategy, policy and mechanism for regional co-operation, (2) knowledge management and human resource development, and (3) cross-border operations and health services.

Joint research projects have been one of the most successful outcomes of the GMS-CDC project. During its five years of operations, GMS-CDC linked together research institutions in Cambodia, Laos and Vietnam. The public health programme has been completed, but the project website (<http://www.gms-cdc.org>) is still active and provides updates on infectious diseases and related events at the regional level, including outbreaks notifications, notices of scientific meetings and technical documents.

## 3) Surveillance and Investigation of Epidemic Situations in South-East Asia (SISEA)

In 2006, the Institut Pasteur established the SISEA project in partnership with the French Development Agency (AFD) to develop surveillance and response to pathogenic agents with epidemic potential in Southeast Asia. The project was also aimed to strengthen collaborations between laboratories of the Institut Pasteur Network in Cambodia, China and Vietnam, plus the National Center for Laboratory and Epidemiology (NCLE) in Laos.

SISEA had three public health objectives: (1) improving the diagnostic capabilities of national referential laboratories and integrating them into a network, (2) strengthening national epidemiological surveillance systems, and (3) strengthening co-ordination at the national and regional levels. Furthermore, the project combined public health interventions (e.g., surveillance activities) with an investigative approach and the production of scientific output, in keeping with the strong research tradition of the Institut Pasteur. It also promoted development and sharing of technical expertise in participating institutes, including mobility of health professionals and scientists through international training programmes. It was completed in 2011.

## ASEAN and SARS

The Association of Southeast Asian Nations (ASEAN) was established in 1967, when the prime ministers of five countries — Indonesia, Malaysia, the Philippines, Singapore and Thailand — signed a political agreement in Bangkok, Thailand to initiate a process of co-operation and thus to “accelerate the economic growth, social progress and cultural development in the region through joint endeavours in the spirit of equality and partnership” (ASEAN 1967). Although negotiations between member countries have always been dominated by the principle of non-interference, based on the absolute primacy of national sovereignty (the so-called “ASEAN way”), over its 40 years of existence ASEAN has contributed to important political achievements. For example, since 1967 there have been no major armed confrontation between ASEAN countries, and in early 1990s the organisation was instrumental in bringing peace between Vietnam and Cambodia after a decade-long conflict. Also, as the Cold War ended, ASEAN provided a platform to engage China and other major players in East Asia in a wider regional framework (Acharya 2007). Indeed, ASEAN has progressively enlarged to include 10 Southeast Asian nations as well as China, Japan and Korea in bilateral agreements known as the ASEAN+3 process. Moreover, beyond core political and economic issues, ASEAN countries have co-operated in other areas, such as environment, education, security and migration.

After the SARS outbreak in 2003, public health has become more prominent in ASEAN regional policies. As Thomas (2006) observed, “SARS demonstrated how quickly a domestic issue could transcend national boundaries and how, at the regional level, time and space were compressed, requiring faster response times and a better understanding of the situation in neighbouring countries”. In this context,

ASEAN leaders demonstrated an unprecedented level of co-ordination (Curley and Thomas 2004). In April 2003 the Health Ministers of ASEAN countries agreed on a joint statement to foster “the sharing of experience and best practices between countries” and requested the ASEAN secretariat to develop an action plan for regional co-operation (ASEAN 2003a). Similar to the organisational structure of the MBDS project, specific tasks were allocated to individual countries. In particular, the ministers agreed to “request Indonesia, as co-ordinator of the ASEAN Disease Surveillance Network, to look into using the website to support the exchange of information among ASEAN and the +3 Countries”, to request Thailand, as the co-ordinator of the ASEAN Epidemiologic Network, “to strengthen regional capacity for epidemiological surveillance”, and to request Malaysia “to implement the ASEAN project on Strengthening Laboratory Capacity and Quality Assurance for Disease Surveillance” (ASEAN 2003a). In the following months and until the containment of the disease, political leaders and health officials agreed on other actions concerning the exchange of information, co-operation among front-line enforcement agencies (e.g. health, customs, labour, and transport agencies), and the harmonisation of travel procedures to ensure proper health screening at entry points.

In June 2003 Southeast Asia was declared SARS-free (Heymann 2006). Although decisions reached in the ASEAN+3 meetings were largely reactive, they were essential to organise and co-ordinate containment measures across national borders.<sup>7</sup> Also, they created capacities, infrastructures and an information-sharing network that can be, and has been, used in the event of other regional public health emergencies (Curley and Thomas 2004).



## The ASEAN+3 Emerging Infectious Diseases (EID) Programme

**The Emerging Infectious Disease Programme of ASEAN+3, set up in 2004 to provide an additional instrument for infectious disease control in Southeast Asia, has been a positive outcome of early efforts towards regional co-operation.**

The Emerging Infectious Disease Programme of ASEAN+3, set up in 2004 to provide an additional instrument for infectious disease control in Southeast Asia, has been a positive outcome of early efforts towards regional co-operation. Supported by the Australian Agency for International Development (AusAID), this programme has developed many activities to strengthen health capacities, including training courses, seminars and workshops, promotion of closer links between human and animal health sectors, and exchanges of staff between laboratories in the region. In addition, the project website has served as a platform for sharing epidemiological data and surveillance information across Member States.

The EID Programme adopted an effective approach to address public health issues at the regional

level. Similar to the management of SARS, member countries were responsible for individual projects in the overall strategic plan. Furthermore, the programme developed innovative projects to address the social, economic and cultural dimensions of communicable diseases in Southeast Asia, including projects on gender-specific risk factors, the involvement of local communities, and disease prevention and control in holiday destinations.

In addition to the EID programme, the ASEAN Secretariat co-ordinates a range of activities on planning and preparedness for pandemic influenza. In 2007, a working group on pandemic preparedness was established with the support of the United States Agency for International Development (USAID) to conduct multi-sector evaluations of national preparedness plans and provide technical advice. Further, the Japanese government provided the ASEAN Secretariat with a stockpile of 500,000 courses of antivirals (Tamiflu) plus a large quantity of personal protective equipment, to be transferred to ASEAN member countries in the event of pandemic influenza. As part of these initiatives, in 2007 the ASEAN Secretariat, the government of Cambodia, the WHO, the government of Japan and selected logistics companies jointly conducted a simulation exercise called PanStop, to practise and evaluate the ability of various partners to work together in a rapid containment operation. This simulation was followed by other exercises in 2008 (the Philippines) and 2009 (Malaysia), which assessed the level of preparedness and co-ordination in individual countries.

<sup>7</sup> In April 2003 ASEAN made a bilateral agreement with China to exchange epidemiological data, carry out joint training programmes, sponsor high-level symposia and undertake common measures for immigration and customs control. In addition, China pledged RMB10 million to establish a special fund for bilateral co-operation programmes on SARS control and prevention (ASEAN 2003b).

## Achievements and Challenges

Regional programmes and the involvement of ASEAN have contributed to the establishment of more effective mechanisms for the prevention and control of communicable diseases in Southeast Asia. In the past few years, ASEAN member countries have made real progress in monitoring pandemic preparedness and developing multi-sector response plans.<sup>8</sup> However, key challenges remain:

1) The regionalisation of communicable diseases control in Southeast Asia is a patchwork of overlapping initiatives with different approaches, organisational structures and timeframes. This fragmentation may reflect conflicting priorities of donor countries or institutions (Calain 2007), and may work against effective and efficient regional co-operation.

2) Many health professionals in the region recognised the need for enhanced co-ordination between programmes; yet there are no established mechanisms to enable collective action.<sup>9</sup> Incidentally, informal exchanges and collaborations existed between the three sub-regional programmes that were briefly presented (MBDS, GMS-CDC, and SISEA). However, lack of co-ordination remains a concern in many other contexts.

3) The ASEAN Secretariat is well positioned to play a crucial role in promoting co-ordination and closer links between different stakeholders, agencies, policies and programmes. However, there are two major obstacles. First, unlike the EU, ASEAN has weak legal authority over national sovereignties. While the adoption of the ASEAN Charter in 2007 has strengthened the legal status of the organisation, it has also reasserted the

fundamental principle of non-interference in domestic affairs of member countries. As a result, the ASEAN Secretariat might lack power to deal effectively with a politically sensitive issue such as infectious disease control. Second, public health and social issues in general still have a relatively low profile in the overall ASEAN agenda, which has hitherto centred mainly on economic integration. To be sure, one of the fundamental principles of the ASEAN Charter is “to enhance the well-being and livelihood of the peoples of ASEAN by providing them with equitable access to opportunities for human development, social welfare and justice”. However, there are no further references to health or healthcare in any articles of the Charter (ASEAN 2008b).

4) In Southeast Asia, the WHO has long supported public health programmes at the regional level. However, there are considerable differences between the coverage of WHO Regional Offices and the geographic scope of other organisations in the region, resulting in further fragmentation and incoherence between programmes. For example, while three ASEAN+3 countries are members of the WHO Regional Office for South-East Asia (Indonesia, Myanmar and Thailand), the other ASEAN+3 countries are members of the WHO Regional Office for the Western Pacific. Likewise, countries involved in regional initiatives such as GMS-CDC and MBDS are split between the two WHO regional offices. To bridge this gap, the WHO has implemented broad strategies covering both WHO regions, such as the Asia Pacific Strategy for Emerging Diseases (APSED). This ambitious programme was

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<sup>8</sup> In April 2010, at the 16th ASEAN Summit in Hanoi, Vietnam, ASEAN heads of state reaffirmed their commitment to regional co-operation on pandemic preparedness and asked national authorities to develop a regional preparedness plan.

<sup>9</sup> The Memorandum of Understanding on the Mekong Basin Disease Surveillance project recognised that “there are many other existing co-operating mechanisms on disease surveillance and partnership building is one of the main focuses of this project” (MBDS 2001).

designed to serve as a roadmap to strengthen core surveillance and response capacities, and thus help countries meet the requirements of the new International Health Regulations. As the action plan states, the focus on Asia Pacific was underpinned by the awareness that “the countries of the Asia Pacific Region are interconnected, they face similar threats to health, and their protection from those threats is only as strong as the weakest link” (WHO 2005). However, the feasibility of a common strategy in such a vast and diverse geopolitical space, spanning from India to New Zealand, remains problematic.

5) The SARS experience has taught an important lesson on the value of regional co-operation. Nonetheless, the drive to enhance integration, harmonisation and coherence of regional policies and approaches ought to be balanced with a careful consideration of the needs and capacities of individual countries, provinces and communities. Differing political and economic needs across the region (Pongcharoensuk et al. 2011), as well as imbalances between health systems and priorities, cannot be neglected in the process towards further integration.

**The SARS experience has taught an important lesson on the value of regional co-operation. Nonetheless, the drive to enhance integration, harmonisation and coherence of regional policies and approaches ought to be balanced with a careful consideration of the needs and capacities of individual countries, provinces and communities.**

## **INTER-REGIONAL CO-OPERATION**

Inter-regional organisations have the potential to become key institutional actors in the landscape of international health, complementing the efforts of governments and other international organisations.

# INTER-REGIONAL CO-OPERATION

In the past decade, the consolidation of political relations between the states of the European Union and Asia has provided further institutional support for international co-operation in public health. After the outbreaks of SARS and avian influenza H5N1, prevention and control of communicable disease has often been discussed at inter-regional summits and high-level meetings. In such contexts, a range of initiatives have been launched to foster the sharing of knowledge and experience between health professionals and policy makers in Europe and Asia. In addition, plans to develop more integrated transregional approaches to surveillance, preparedness and response have been discussed. While these discussions are still at a very early stage, inter-regional organisations have the potential to become key institutional actors in the landscape of international health, complementing the efforts of governments and other international organisations.

The following section provides an overview of experience and expertise exchange between Asia and Europe, with a focus on three main contexts for inter-regional co-operation: the EU-ASEAN Dialogue, the Asia-Europe Meeting (ASEM) and EU International Development programmes.

## EU-ASEAN Dialogue

The beginning of inter-regional relations between the European Union and ASEAN dates back to the 1978, when ASEAN foreign ministers agreed to initiate a formal process of co-operation with the European Economic Community (EEC). This decision was institutionalised in 1980 after the signature of the ASEAN-EEC Cooperation Agreement. Supervised by the EC-ASEAN Joint Co-operation Committee (JCC), the EU-ASEAN relationship today is pursued through inter-regional ministerial meetings and individual co-operation agreements (Gilson 2005).

Over the years, the EU-ASEAN relation has expanded to cover a wide range of policy domains, including trade, environmental issues, social and cultural development, and international terrorism. In the aftermath of recent public health threats, the need for closer co-operation in this area has been emphasised at summits and ministerial meetings. For instance, signatories to the Nuremberg Declaration in 2007 pledged to “promote closer co-operation to address the spread of communicable and infectious diseases, including HIV/AIDS, SARS and avian influenza at the sub-regional, regional and global levels” (EU2007.de 2007). Likewise, at the 17th ASEAN-EU Ministerial Meeting, held on 27–28 May 2009 in Phnom Penh, Cambodia, the ministers agreed to “intensify co-operation on infectious diseases such as HIV/AIDS, avian influenza and other high-risk pathogens, through cross-sectoral co-operation and integrated approaches to surveillance, prevention, risk mitigation, timely response and communication, with the objective of enhancing regional capacity and preparedness” (Council of the European Union 2009).

In this context, both parties have launched new initiatives to foster co-operation across the regions. Since 2006, for instance, European and Asian scientists have participated in joint research projects as part of the EU Framework Programmes for research and development.<sup>10</sup> In addition, workshops and seminars to share experience and knowledge between health professionals and scientists have been held in Asia and Europe. For example, in July 2009 the Singapore Immunology Network organised an Expert Meeting in Singapore on vector-borne infectious diseases involving more than 200 researchers from both the EU and Southeast Asia.

## Asia-Europe Meeting (ASEM)

The Asia-Europe Meeting (ASEM) is another platform for the development of political and economic co-operation between European and Asian states. This multilateral channel for inter-regional dialogue was established in 1996, after the first Asia-Europe summit in Bangkok, Thailand, and has progressively expanded to involve all EU countries, the ASEAN+3 countries as well as India, Pakistan, Mongolia, Russia, Australia, New Zealand, Bangladesh, Norway and Switzerland. The ASEM process is based on biannual meetings of the heads of state, but is constantly enlivened by economic, cultural and social initiatives, such as the People's Forum and the Interfaith Dialogue (Dent 2004).

In the ASEM context, public health was also identified as a key sector for co-operation. In October 2008, at the 7th ASEM Summit in Beijing, China, the political leaders of 16 Asian and 27 European countries committed to promote bi-regional co-operation on prevention and control of pandemic influenza. The Initiative for Rapid Containment of Pandemic Influenza, launched in May 2009 at the 9th ASEM Foreign Ministers' Meeting in Hanoi, Vietnam, was the first outcome of this dialogue. The initiative is funded by the Japanese government and has two components: (1) a regional stockpile of antivirals for ASEM partners, stored in Singapore, which will be distributed in the event of pandemic influenza by the WHO in collaboration with the Japan International Cooperation System (JICS); (2) a public health network to promote co-operation between stakeholders and experts in Asia and Europe, which is managed by the Asia-Europe Foundation (ASEF), the only permanent physical institution under the ASEM framework. The public health network had

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<sup>10</sup> The EU Framework Programmes are multi-annual funding schemes to promote and support transnational co-operation in scientific research. While the largest share of the budget is allocated to research networks within the European Research Area, funds are available to support collaborations with non-EU partners.

a thematic working group on infectious diseases and regional integration, which supported studies and expert meetings on this topic, including the research project from which this report draws. The ASEF Network has also a thematic working group on multi-sector pandemic preparedness and response, which focuses on building pandemic scenarios and developing strategies.

## EU-Asia Co-operation

The International Development framework of the EU is another instrument for inter-regional co-operation on communicable diseases prevention and control. In 2007, a communication of the European Commission stressed the need to support the strengthening of public health capacities in Asia, especially with regard to avian influenza:

The Commission has regularly indicated since 2005 that its support to address the Avian Influenza (AI) crisis included a mid- and long-term vision: to link crisis response and development, to invest in institutional building and regional/global networking, to contribute in a sustainable way to epidemics and zoonosis control and to rehabilitate affected sectors. Hence the Commission will pursue its co-operation with Asian and Central Asian countries on Highly Pathogenic and Emerging Diseases (HPED). Assistance will continue in the area of Avian Influenza control through sectoral dialogue, the reinforcement of veterinary and human health services at regional level, and the improvements needed at national level to facilitate regional integration.

— European Commission, “Regional Strategy for EU-Asia Cooperation” (2007–2013)

In 2008 this programmatic statement was followed by a decision to support a regional programme on highly pathogenic emerging diseases in Asia, in collaboration with the WHO, the International Organization for Animal Health (OIE) and the Food and Agriculture Organization of the United Nations (FAO). It must be noted that this programme is characterised by a strong emphasis on the promotion of regional integration, including interventions to assist the ASEAN and SAARC Secretariats to strengthen health capacities at the regional level (European Commission 2011). More specifically, the programme aims to establish regional co-ordination mechanisms for control of highly pathogenic and emerging diseases, to improve regional laboratory diagnostic capacities, and to strengthen surveillance and response capacity including regional networking. However, unlike initiatives within the frameworks of the EU-ASEAN Dialogue and the ASEM process, this programme is based on a donor-recipient relationship, rather than equal partnership.

Finally, the European Commission has initiated a number of external collaborations in the food sector, such as the programme “Better Training for Safer Food” of the Directorate General for Health and Consumers. This programme provides training on the functioning of the Rapid Alert System for Food and Feed (RASFF), a surveillance tool that allows the European Commission and EU Member States to share information and take immediate action when dangerous food or feed is detected on the market or at the border. The RASFF network includes only European countries; however, the European Commission has organised workshops for participants in Africa, South America and Southeast Asia, with a view to introducing a similar system in other regions of the world. These workshops also include training on EU food law, animal health and welfare, and plant health regulations, to enable compliance with EU requirements and thus facilitate access of traded goods to the EU market (European Commission 2009).

# [ CONCLUSIONS ]

This report has examined regional and cross-regional mechanisms of communicable diseases prevention and control in Europe and Asia, with a focus on underlying institutional structures. It has discussed examples of good practice, challenges and prospects for the future. However, this is not a comprehensive analysis: while the report covers issues and developments that have a regional relevance, it has inevitably overlooked some important aspects. In particular, future research on the Asian context should focus on the role and activities of SAARC and APEC, as both organisations have played an important role in supporting regional programmes

for infectious disease prevention and control. Further, a comparative analysis of SAARC, APEC and ASEAN would provide useful insights on the ways in which different institutional developments are influencing regional health co-operation in Asia.

Aware of these limitations, we summarise our findings and draw some conclusions by comparing approaches to regional integration in Europe and Southeast Asia. As we can see in Table 3, our analysis illustrates the emergence of two distinctive patterns of communicable disease control in the two regions:

Table 3. **Regional mechanisms for communicable disease control in Europe and Southeast Asia**

<u>Europe</u>	<u>Southeast Asia</u>
Process of rationalisation, driven by the leading role of the European Union; harmonisation and co-ordination	Patchwork of different initiatives, often underpinned by different approaches and agenda; lack of synergies
Legal framework, but unsystematic and mainly through case law; International Health Regulations	Soft law, informal agreements; International Health Regulations
Permanent institutions. Continuity, but also “path dependence”	Temporary arrangements. Problem of capitalisation, sustainability, and consistency
Emphasis on the central agencies	Reliance on the initiative and expertise of member countries
Focus on high-level policies (national plans, national health agencies)	Focus on high-level policies, but also community level and social issues



- In Europe, there is a clear process of rationalisation and centralisation at the regional level, directed by the leading role of the EU.<sup>11</sup> This process facilitates the harmonisation of public health policies and the joint action of Member States. By contrast, in Southeast Asia there is a patchwork of independent initiatives, which are often informed by differing agendas and timeframes, resulting in duplication of efforts, overlapping of regional events and a general lack of synergies. Also, the geopolitical scope of such initiatives is considerably different, even at the sub-regional level of the Mekong Basin.
- In Europe, a legal framework and regulatory processes underpin the authority of the EU, although in a rather unsystematic way. In Southeast Asia, programmes on communicable diseases control are mainly based on “soft law” and informal agreements such as Memoranda of Understanding, in keeping with the “ASEAN way”. The adoption of the ASEAN Charter in 2007 has strengthened the legal status of ASEAN, but there are still no legal provisions on public health. Thus, the ASEAN Secretariat might lack sufficient power to implement effective regional policies in a sensitive policy domain such as public health. In both Asia and Europe, however, the International Health Regulations (2005) provide a shared legal instrument to strengthen prevention and control of communicable diseases.
- The existence of permanent institutions at the EU level facilitates continuity and consistency of activities.

Yet, it can also produce path dependence<sup>12</sup> and lack of flexibility in case of emergencies (Greer 2008). Conversely, most programmes in Southeast Asia have a temporary mandate, usually no longer than five or six years. This approach is more flexible but cannot ensure continuity and capitalisation on previous experiences.

- In the European context, there is increasing emphasis on the role and authority of central agencies: the European Commission and ECDC as well as other EU health agencies such as the European Medicines Agency (EMA) and the European Food Safety Authority (EFSA). This approach facilitates harmonisation and concerted action, but has also the potential to encourage disinvestments at the national level, as national authorities may erroneously assume that responsibility for disease surveillance and control is shifting to the EU.<sup>13</sup> In Southeast Asia, regional programmes have a decentralised structure, characterised by a regional division of labour in which countries are responsible for specific projects. The initiative of participating countries is valued, and their sense of ownership is a central part of the organisation of regional programmes.
- In Europe, regional co-ordination of disease surveillance and response activities tends to focus on the central level of national plans and surveillance systems. In Southeast Asia, regional programmes have often involved a wider range of stakeholders, from central governments and authorities to local communities.

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<sup>11</sup> In some countries this development is counterbalanced by a process of devolution at the sub-national level (see, for instance, Rowland 2006).

<sup>12</sup> In the social sciences and political theory, the concept of path dependence is used to explain the persistence of suboptimal outcomes as a result of decisions made in the past: “Once a country or region has started down a track, the costs of reversal are very high. There will be other choice points, but the entrenchments of certain institutional arrangements obstruct an easy reversal of the initial choice” (Levi 1997, 28).

<sup>13</sup> In the aftermath of the 2009 pandemic, ECDC Director Mark Sprenger pointed out: “During the 2009 Pandemic we have relied on systems established prior to the Pandemic. Maintaining strong and well resourced Institutes of Public Health is vital to better prepare and react to the next crisis. Here, microbiology laboratories and epidemiologists are critical” (ECDC 2010).

## Recommendations

While differing approaches and institutional frameworks characterise regional developments in Europe and Asia, stakeholders in the two regions face similar challenges and issues, which should be given further attention in the research and policy agenda:

**There is wide room for closer inter-regional co-operation between Asian and European partners. Asian experts have gained considerable experience on the management of public health crises after SARS and the recurrent threat of avian influenza H5N1 — and this can be highly valuable to European partners.**

- The regionalisation of communicable disease policies cannot overlook specific needs in individual countries and communities. Discrepancies between policies and approaches are not only due to lack of political will or institutional gaps, but often result from differential access to resources or asymmetries in economic needs. Thus, the drive to co-ordinate and harmonise policy should be balanced with a careful consideration of different needs and resources at the national, provincial and community levels, including upstream economic drivers, health capacities, risk factors and health priorities.
- Communicable diseases cross national boundaries as well as the geopolitical frames of regional programmes or organisations such as the EU or ASEAN. In this respect, it must be noted that there is high population mobility across the two regions, including documented and undocumented labour migration, tourism, business trips, refugees, asylum seekers and temporary migrations of international students and professionals. According to Eurostat, the statistical office of the European Union, on 1 January 2008, 30.8 million foreign citizens

lived in the 27 EU Member States, of which 3.7 million were citizens of Asian countries (Eurostat 2009). Recent studies have brought renewed attention to the crucial links between migration, population mobility and communicable diseases (Gushulak 2004; MacPherson et al. 2007). Further research should examine past and current processes of inter-regional mobility, the transition of human populations between different risk environments, and the implications of these processes for the prevention and control of infectious diseases.

- There is wide room for closer inter-regional co-operation between Asian and European partners. Asian experts have gained considerable experience on the management of public health crises after SARS and the recurrent threat of avian influenza H5N1 — and this can be highly valuable to European partners. On the other hand, there is a well-established system of supranational governance in the EU, which can provide a structural model to the development of regional organisations in Asia, also in consideration of current efforts to build an ASEAN Community by 2015.<sup>14</sup>
- There are already valuable programmes of inter-regional co-operation between Asian and European partners, in association with institutional platforms such as ASEM and the EU-ASEAN dialogue. However, most initiatives tend to be short-termed, such as workshops, conferences and interim research exchanges. Long-term

**The institutionalisation of health co-operation at the highest level of policy making would ensure continuity of dialogue and exchanges. In particular, the establishment of an ASEM regular meeting of health ministers would fill an important gap in the ASEM process.**

exchanges would foster deeper links between the two regions (e.g., postdoctoral fellowships, professional positions). In the field of research, for example, the establishment of an inter-regional research centre for the study of emerging infectious diseases would further contribute to this purpose. Also, the institutionalisation of health co-operation at the highest level of policy making would ensure continuity of dialogue and exchanges. In particular, the establishment of an ASEM regular meeting of health ministers would fill an important gap in the ASEM process.

<sup>14</sup> According to the Declaration of ASEAN Concord II, signed by ASEAN governments in 2003, “An ASEAN Community shall be established comprising three pillars, namely, political and security co-operation, economic co-operation, and socio-cultural co-operation that are closely intertwined and mutually reinforcing for the purpose of ensuring durable peace, stability and shared prosperity in the region”. With regard to the pillars socio-cultural co-operation, the Declaration states that “ASEAN shall further intensify co-operation in the area of public health, including in the prevention and control of infectious diseases, such as HIV/AIDS and SARS, and support joint regional actions to increase access to affordable medicines” (ASEAN 2003c).

## Bibliography

- Acharya, A. (2007). ASEAN at 40: Mid-life rejuvenation?. *Foreign Affairs*, 15 August 2007.
- Ammon, A. and de Valk, C.H. (2007). Supranational surveillance in the EU. In M'ikanatha, N.M., Lynfield R., Van Beneden, C.A., de Valk, C.H. (eds.), *Infectious disease surveillance*. Oxford: Wiley-Blackwell.
- Calain, P. (2007). From the field side of the binoculars: a different view on global public health surveillance. *Health Policy and Planning*, 22(1), 13–20.
- Coker, R.J., Rifat, A., McKee, M. (2004). Health-care system frailties and public health control of communicable disease on the European Union's new eastern border. *The Lancet*, 363 (9418), 1389–1392.
- Coker, R.J., Hunter, B., Rudge, J., Liverani, M. and Hanvoravongchai, P. (2011). Emerging infectious diseases in South East Asia: regional challenges to control. *The Lancet*, 377(9765), 599–609.
- Curley, M., Thomas, N. (2004). Human security and public health in Southeast Asia: the SARS outbreak. *Australian Journal of International Affairs*, 58, 17–32.
- Dent, C. (2004). The Asia-Europe Meeting and inter-regionalism: Toward a theory of multilateral utility. *Asian Survey*, 44, 213–236.
- European Centre for Disease Prevention and Control [ECDC] (2010). ECDC Director attends ministerial meeting. Press release, 7 July. [http://ecdc.europa.eu/en/press/news/Lists/News/ECDC\\_DisForm.aspx?List=32e43ee8-e230-4424-a783-85742124029a&ID=375&MasterPage=1](http://ecdc.europa.eu/en/press/news/Lists/News/ECDC_DisForm.aspx?List=32e43ee8-e230-4424-a783-85742124029a&ID=375&MasterPage=1). Accessed on 24 July 2013.
- European Centre for Disease Prevention and Control [ECDC] (2012). Influenza pandemic and preparedness. [http://ecdc.europa.eu/en/healthtopics/pandemic\\_preparedness/Pages/index.aspx](http://ecdc.europa.eu/en/healthtopics/pandemic_preparedness/Pages/index.aspx). Accessed on 24 July 2013.
- European Commission (2002). Case definitions for reporting communicable diseases to the Community network. Official Journal of the European Communities (L86). Luxembourg: Publications Office of the European Union.
- European Commission (2007). Report from the Commission to the Council and the European Parliament on the operation of the Early Warning and Response Systems (EWRS) of the Community Network for the epidemiological surveillance and control of communicable diseases during 2004 and 2005. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2007:0121:FIN:EN:PDF>. Accessed on 24 July 2013.
- European Commission (2009). Report from the Commission to the Council and the European Parliament on the operation of the Early Warning and Response Systems (EWRS) of the Community Network for the epidemiological surveillance and control of communicable diseases during years 2006 and 2007. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0228:FIN:EN:PDF>. Accessed on 24 July 2013.
- European Commission (2011). Cross-border cooperation in animal and human health. EU Regional HPED Programme in Asia. Luxembourg: Publications Office of the European Union. [http://ec.europa.eu/europeaid/where/asia/regional-cooperation/animal-human-health/documents/11.05.10\\_euaid07a-1012\\_hped\\_brochure\\_lr\\_accessible\\_en.pdf](http://ec.europa.eu/europeaid/where/asia/regional-cooperation/animal-human-health/documents/11.05.10_euaid07a-1012_hped_brochure_lr_accessible_en.pdf). Accessed on 24 July 2013.
- European Union (2006). Influenza: Commissioner Kyprianou regrets failure to agree on EU anti-viral stockpile. Press release IP/06/732, 2 June. [http://europa.eu/rapid/press-release\\_IP-06-732\\_en.htm](http://europa.eu/rapid/press-release_IP-06-732_en.htm). Accessed on 24 July 2013.

- Eurostat (2009). International migration flows. [http://epp.eurostat.ec.europa.eu/cache/ITY\\_SDDS/en/migr\\_flow\\_esms.htm](http://epp.eurostat.ec.europa.eu/cache/ITY_SDDS/en/migr_flow_esms.htm). Accessed on 24 July 2013.
- Fidler, D.P. (2005). From international Sanitary Conventions to global health security: The new International Health Regulations. *Chinese Journal of International Law*, 4, 325–392.
- Fleming, D.M. and Cohen J.M. (1996). Experience of European collaboration in influenza surveillance in the winter of 1993–1994. *Journal of Public Health*, 18, 133–142.
- Fleming, D.M., van der Velden, J. and Paget, W.J. (2003). The evolution of influenza surveillance in Europe and prospects for the next 10 years. *Vaccine*, 21, 1749–1753.
- Gilson, J. (2005). New Interregionalism? The EU and East Asia. *Journal of European Integration*, 27, 307–326.
- Greer, S.L. and Mätzke, M. (2012). Bacteria without borders: Communicable disease politics in Europe. *Journal of Health Politics, Policy and Law*, 37 (6), 887–914.
- Greer, S.L. (2008). Choosing paths in European Union health services policy: a political analysis of a critical juncture. *Journal of European Social Policy*, 18(3), 219–231.
- Guglielmetti, P., Coulombier, D., Thinus, G., Van Loock, F., Schreck, S. (2006). The Early Warning and Response System for communicable diseases in the EU: an overview from 1999 to 2005. *Eurosurveillance*, 11(12), ii–666.
- Gushulak, B. and MacPherson, D. (2004). Globalization of infectious diseases: The impact of migration. *Clinical Infectious Diseases*, 38(12), 1742–1748.
- Heymann, D. (2006). SARS and emerging infectious diseases: a challenge to place global solidarity above national sovereignty. *Annals Academy of Medicine Singapore*, 35, 350–353.
- Howard-Jones, N. (1975). *The scientific background of the International Sanitary Conferences 1851–1938*. Geneva: World Health Organization.
- Kimball, A.M., Moore, M., French, H.M., Arima, Y., Ungchusak, K., Wibulpolprasert, S., Taylor, T., Touch, S., Leventhal, A. (2008). Regional infectious disease surveillance networks and their potential to facilitate the implementation of the International Health Regulations. *Medical Clinics of North America*, 92(6), 1459–1471.
- Lamping, W. and Steffen, M. (2009). European Union and health policy: The “chaordic” dynamics of integration. *Social Science Quarterly*, 90(5), 1361–1379.
- Levi, M. (1997). A model, a method, and a map: Rational choice in comparative and historical analysis. In Lichbach, M.I., Zuckerman A.S. (eds.) *Comparative politics: Rationality, culture, and structure*. Cambridge: Cambridge University Press.
- Liverani, M. and Coker, R.J. (2012). Protecting Europe from diseases. From the International Sanitary Conferences to the ECDC. *Journal of Health Politics, Policy, and Law*, 37(6), 915–934.
- Liverani, M., Hanvoravongchai, P. and Coker, R.J. (2012). Communicable diseases and governance: a tale of two regions. *Global Public Health*, 7(6), 574–87.
- MacLehose, L., Brand, H., Camaroni, I., Fulop, N., Noel Gill, O., Reintjes, R., Schaefer, O., McKee, M. and Weinberg, J. (2001). Communicable disease outbreaks involving more than one country: systems approach to evaluating the response. *British Medical Journal*, 323(7317), 861–863.
- MacLehose, L., McKee, M., Weinberg, J. (2002). Responding to the challenge of communicable disease in Europe. *Science*, 295 (5562), 2047–2050.
- MacPherson, D., Gushulak, B., MacDonald, L. (2007). Health and foreign policy: influences of migration and population mobility. *Bulletin of the World Health Organization*, 85(3), 200–206.
- McKee, M. and Mossialos, E. (2006). Health policy and European law: Closing the gaps. *Public Health*, 120 (1), 16–21.
- McKee, M. (2005). European health policy: where now?. *European Journal of Public Health*, 15(6), 557–558.
- Narain, J.P. and Bhatia, R. (2010). The challenge of communicable diseases in the WHO South-East Asia Region. *Bulletin of the World Health Organization*, 88(3), 162.
- Pongcharoensuk, P., Adisasmito, W., Sat, L.M., Silkavute, P., Muchlisoh, L., Cong Hoat, P., Coker, R.J.

(2011). Avian and pandemic human influenza policy in South-East Asia: the interface between economic and public health imperatives. *Health Policy and Planning*. doi: 10.1093/heapol/czr056.

Reintjes, R. (2008). International and European responses to the threat of communicable diseases. In Coker, R.J., Rifat, A., McKee, M. (eds.), *Health systems and the challenge of communicable diseases*. Milton Keynes: Open University Press.

Rowland, D. (2006). Mapping communicable disease control administration in the UK. Between devolution and Europe. London: The Nuffield Trust.

Ternhag, A., Tegnell, A., Lesko, B., Skaerlund, K, Penttinen, P. (2004). Basic Surveillance Network, a European database for surveillance data on infectious diseases. *Eurosurveillance*, 9(7), 19–22.

Thomas, N. (2006). The Regionalization of avian Influenza in East Asia: Responding to the next pandemic(?). *Asian Survey*, 46(6), 917–936.

UK Health Protection Agency (2010a). Assessment report on the EU-wide response to pandemic (H1N1). Brussels: European Commission.

UK Health Protection Agency (2010b). Assessment report on the EU-wide pandemic vaccine strategies. Brussels: European Commission.

Velimerovic, B. (1984). *Infectious diseases in Europe: a fresh look*. Copenhagen: WHO Regional Office for Europe.

World Health Organization [WHO] (1990). Development of an international network of general practitioners (Eurosentinel). *Weekly Epidemiological Record*, 12 October 1990.

World Health Organization [WHO] (2003). Severe acute respiratory syndrome (SARS): Status of the outbreak and lessons for the immediate future. Geneva: World Health Organization. [http://www.who.int/csr/media/sars\\_wha.pdf](http://www.who.int/csr/media/sars_wha.pdf). Accessed on 24 July 2013.

World Health Organization [WHO] (2010). Avian influenza still a threat, Press Release, 24 March 2010. <http://www.wpro.who.int/mediacentre/releases/2010/20100324/en/index.html>. Accessed on 24 July 2013.

## Policy Documents

- Asian Development Bank [ADB] (2008). Greater Mekong Subregion Communicable Diseases Control Project. <http://www.gms-cdc.org/the-gms-cdc-project.html>. Accessed on 24 July 2013.
- ASEAN (1967). Bangkok Declaration. Jakarta: ASEAN Secretariat. <http://www.asean.org/component/zoo/item/the-asean-declaration-bangkok-declaration>. Accessed on 24 July 2013.
- ASEAN (2003a). Joint Statement of the ASEAN+3 Ministers of health special meeting on SARS, Kuala Lumpur, 26 April. Jakarta: ASEAN Secretariat. <http://www.asean.org/communities/asean-socio-cultural-community/item/joint-statement-asean-3-ministers-of-health-special-meeting-on-sars>. Accessed on 24 July 2013.
- ASEAN (2003b). Joint Statement of the special ASEAN-China leaders meeting on SARS, Bangkok, 29 April. Jakarta: ASEAN Secretariat. <http://www.fmprc.gov.cn/eng/topics/zgcydyhz/t26291.htm>. Accessed 24 July 2013.
- ASEAN (2003c). Declaration of ASEAN Concord II (Bali Concord). <http://www.asean.org/news/item/declaration-of-asean-concord-ii-bali-concord-ii>. Accessed 24 July 2013.
- ASEAN (2008a). ASEAN Regional strategy for the progressive control and eradication of HPAI (2008–2010). Jakarta: ASEAN Secretariat.
- ASEAN (2008b). Charter of the Association of Southeast Asian Nations. Jakarta: ASEAN Secretariat.
- Council of the European Union (2009). 17th ASEAN-EU Ministerial Meeting (AEMM) Joint Co-Chairman's Statement, 27–28 May 2009, Phnom Penh, Cambodia, (Press: 159; Nr: 10479/09). [http://www.consilium.europa.eu/uedocs/cms\\_data/docs/pressdata/en/er/108194.pdf](http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/er/108194.pdf). Accessed on 24 July 2013.
- ECDC (2008). ECDC strategic multi-annual programme 2007–2013. Stockholm: European Centre for Disease Prevention and Control.
- EU2007.de (2007). Nuremberg Declaration on an EU-ASEAN enhanced partnership. [http://www.eu2007.de/en/News/download\\_docs/Maerz/0314-RAA2/0315NurembergDeclaration.pdf](http://www.eu2007.de/en/News/download_docs/Maerz/0314-RAA2/0315NurembergDeclaration.pdf). Accessed on 24 July 2013.
- European Parliament and the Council (1998). Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 setting up a network for the epidemiological surveillance and control of communicable diseases in the Community. Official Journal of the European Communities (L 268/1), 3 October 1998.
- European Commission (2000). Commission Decision of 22 December 1999 on the communicable diseases to be progressively covered by the Community network under Decision No 2119/98/EC of the European Parliament and of the Council (2000/96/EC). Official Journal of the European Communities (L28/50), 3 February.
- European Commission (2000). Commission Decision of 22 December 1999 on the early warning and response system for the prevention and control of communicable diseases under Decision No. 2119/98/EC of the European Parliament and of the Council. Official Journal of the European Communities (L 21/32), 26 January.
- European Commission (2009). Better training for safer food: Report 2009. Luxembourg: Office for Official Publication of the European Communities.
- European Parliament and the Council (2004). Regulation (EC) No 851/2004 of the European Parliament and of the Council of 21 April 2004 establishing a European centre for disease prevention and control. Official Journal of the European Union (L 142/1), 30 April.
- Mekong Basin Disease Surveillance project [MBDS] (2001). Memorandum of Understanding. <http://www.mbdsoffice.com/mou.php>. Accessed on 24 July 2013.
- Treaty on the Functioning of the European Union [TFEU] (2008). Official Journal of the European Union (C 115/47), consolidated version, 9 May. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:en:PDF>. Accessed on 24 July 2013.
- World Health Organization [WHO] (2005). Asia Pacific Strategy for Emerging Diseases, WHO Regional Office for the Western Pacific. Geneva: World Health Organization.

## Article Abstract

Regional policies and programmes on communicable disease prevention and control are becoming an important component of global public health. In a comparative fashion, we examined the situation in the European and Southeast Asian contexts, with a focus on the underlying institutional and political backgrounds underpinning the regionalisation of planning and interventions. Our findings document the emergence of two distinctive models of regional integration. While in Europe there is a process of institutionalisation and centralisation, in Southeast Asia the landscape of regional cooperation is characterised by the proliferation of many provisional projects, based on loose agreements and a decentralised structure that emphasises the initiative and sense of ownership of member countries. These two approaches, we conclude, reflect wider differences of political culture between supranational integration in Europe and intergovernmental agreements in Southeast Asia.

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