e-Health Bulletin
Issue No. 6 I JULY to DECEMBER 2014

ASEAN WHO Signing Ceremony (18 September 2014)

BETTER HEALTH FOR ASEAN COMMUNITY BEYOND 2015

The ASEAN Health Ministers gathered together for their 12th Meeting in Ha Noi, Viet Nam from 18-19 September to discuss regional health concerns with the theme of "Better Health for ASEAN Community Beyond 2015".

The two-day event discussed the ways forward in accelerating the contribution of the ASEAN Health Sector in achieving the ASEAN Community 2015; the progress of the implementation of the ASEAN Strategic Framework on Health Development from 2010-2015; and It was started with the Preparatory Senior Officials Meeting (PrepSOM) for 12th AHMM on 15 September 2014 and followed by the PrepSOM for the 6th ASEAN Plus Three Health Ministers Meeting and PrepSOM for the 5th ASEAN-China Health Ministers Meeting on 16 September 2014. Four side meetings were held on 17 September 2014 namely: (i) Expanding Health Insurance Coverage for Informal Sector, (ii) Emerging Infectious Diseases Prevention and Control, (iii) Advocacy on sustainable financing for HIV/AIDS in ASEAN Countries and (iv) Policy response for the ageing.

The 12th AHMM opening ceremony on 18 September 2014 was graced by H.E. Nguyen Tan Dung, Prime Minister of Viet Nam and attended by H.E. Le Luong Minh, Secretary-General of ASEAN, H.E. Prof. Dr. Nguyen Thi Kim Tien, Minister of Health of Viet Nam, ASEAN Health Ministers, Dr. Poonam Khetrapa Singh, Regional Director of WHO South-East Asia Regional Office (SEARO), Dr. Shin Young-soo, Regional Director of WHO Western Pacific Regional Office (WPRO) and representatives of ASEAN Secretariat, International Organisations.

During the opening ceremony, the ASEAN-WHO MOU 2014-2017 was signed by the Secretary General of ASEAN and respective Regional Director of WHO SEARO and WPRO. The signed ASEAN-WHO MOU will provide a good opportunity for enhancing collaboration to address issues of common interest for better health in the region. In the retreat session in the morning, the Ministers exchanged views on ways to Strengthen primary health care towards universal health coverage. Then at the 12th AHMM, the Ministers adopted the four clusters for ASEAN Post-2015 Health Development Agenda namely: (i) Promoting healthy lifestyles, (ii) Responding to all hazards and emerging threats, (iii) Strengthening health system and access to care and (iv) Ensuring food safety.

The 12th AHMM was then followed by the 6th ASEAN Plus Three Health Ministers Meeting held in the morning of 19 September 2014. In this meeting the Ministers exchanged views to strengthen the primary health care for prevention and control of NCD. Furthermore, the 5th ASEAN-China Health Ministers Meeting was held in the afternoon and in this meeting the ASEAN Health Ministers Plus China discussed the follow up from the MOU between the Governments of the Member States of ASEAN and the Government of the People's Republic of China on Health Cooperation which was signed at the 11th AHMM in Phuket in 2012. The Ministers then exchanged views on the Multi sectoral collaboration for the prevention and control of emerging infectious diseases. The next 13th AHMM and related Meeting will be held in Bandar Seri Begawan, Brunei Darussalam in 2016.

JOINT STATEMENT
12TH ASEAN HEALTH MINISTERS MEETING
18 September 2014, Ha Noi, Viet Nam

WE, the Ministers of Health of ASEAN Member States (AMS), representing Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, the Lao People's Democratic Republic, Malaysia, the Republic of the Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand, and the Socialist Republic of Viet Nam, convened the 12th ASEAN Health Ministers Meeting (AHMM) on18 September 2014 in Ha Noi, Viet Nam.

We welcome the United Nations Conference on Sustainable Development in 2012, Rio de Janeiro document entitled, "The Future We Want", which commits to strengthen health systems towards the provision of equitable, universal health coverage and promote affordable access to prevention, treatment, care and support related to noncommunicable diseases (NCD), and to establish or strengthen multi-sectoral national policies for the prevention and control of NCD.

We commit to the Bandar Seri Begawan Declaration on Noncommunicable Diseases in ASEAN which was adopted by the Leaders of ASEAN at the 23rd ASEAN Summit held in Brunei Darussalam in October 2013.

We acknowledged the efforts made by the Senior Officials Meeting on Health Development (SOMHD), the 10 subsidiary bodies on health, and relevant networks in implementing the ASEAN Strategic Framework on Health Development for 2010 to 2015 as endorsed by the 10th AHMM, and fulfilling the 55 health action lines stipulated in the ASEAN Socio-Cultural Blueprint.

We and all health officials will continue implementing the commitments made by the 11th AHMM to overcome the challenges to health and to make use of opportunities to achieve goals for better health for ASEAN people.

With our ultimate goal of achieving better health for the ASEAN community beyond 2015 through the efforts of AMS to better serve their people, we have discussed and exchanged views on health priorities to be jointly addressed by AMS and agree to the following resolutions:

1. We pledge our firm commitment to the vision "A Healthy, Caring, and Sustainable ASEAN Community" and mission statement agreed upon by AMS with the four clusters of a) promoting healthy lifestyle; b) responding to all hazards and emerging threats; c) strengthening health system and access to care; and d) ensuring food safety. We commit to attain the goals of the ASEAN Post-2015 Health Development Agenda and to task SOMHD to develop a new mechanism to strengthen ASEAN health cooperation.

2. We pledge to strengthen primary health care in order to achieve universal health coverage in AMS and increase access to primary health care for ASEAN people. We ensure the availability and timely provision of essential medicines and cost effective health technologies at all levels of health facilities to achieve Goal 3 of Sustainable Development Goals: ensure healthy lives and promote well-being for all at all ages. We commit to build up sufficient capacity of well-trained, motivated health workers, especially at community level to provide services to meet health needs of people in AMS.
3. We welcome advocacy efforts to achieve universal health coverage and will strive to further elevate and strengthen the commitment by working through to highest regional fora.
4. We reaffirm our commitment to accelerate actions to address the risk factors for NCD taking into consideration cost-effective interventions including to promote community-based management of NCD and promote collaboration in research and development on health promotion, and healthy lifestyle in AMS.
5. We commit to develop efficient and sustainable national health financing systems in order to enable nationals to access health services without suffering financial hardship. We shall focus on strengthening health financing schemes and accelerate the expansion of national health care coverage in providing adequate basic health packages, such as reproductive health, maternal, newborn and child health services relevant to each AMS. We shall mobilise social resources, such as community health workers and conduct community-based programmes to provide basic healthcare, to inform and encourage people to stay healthy and prevent diseases and injuries.
6. We promote equitable access to healthcare for all groups within each Member State by reducing gender, geographical, social and financial barriers at all levels. We commit to provide adequate and effective health services for the poor, ethnic minorities and other vulnerable groups including children, youth, and women especially in disadvantaged and remote areas. We reaffirm quality as a crucial element in the provision of healthcare.
7. We commit to promote access to good, safe, quality, efficacious and affordable essential medicines within the national health care systems as well as rational use of medicines in AMS. We also agree to facilitate research and cross country information sharing on strategies to increase access to medicines including pricing policy and the use of Trade-Related Aspects of the Intellectual Property Rights (TRIPS) flexibilities particularly for high-cost essential drugs. We encourage exchange of experience in integrating safe, effective and quality Traditional Medicine, Complementary and Alternative Medicine (TM/CAM) into the national healthcare system, where applicable, and across other sectors.
8. We reaffirm our commitment to continue reducing maternal and child mortality including strengthening local capacity management for emergency obstetric and neonatal services.
9. We recognise that global and regional financial resources for HIV and AIDS prevention and control have been reduced significantly in recent years. We, therefore commit to mobilise and diversify all resources at national, regional and international levels to sustain and improve the achievement in curbing HIV and AIDS new infections, prevalence, and deaths, and to accelerate progress in achieving the ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths and the Millennium Development Goal 6 relevant to HIV and AIDS. Further, to achieve the commitment to the Declaration there is a need to review, where appropriate, the HIV and AIDS programmes, policies and progress towards ending HIV and AIDS as a public health threat.
10. We commit to strengthen cooperation on Emerging Infectious Diseases (EIDs) prevention and control and pandemic preparedness through improving health capacity in surveillance and outbreak investigation. We further commit to promote collaboration in the control of trans-boundary EIDs through sharing and exchanging information including efficient referral mechanism among AMS.
11. We commit to strengthen national food control systems and work together to contribute towards safe and quality food in the ASEAN Community. We recognise risk assessment as an important tool to provide scientific input in developing evidence- based food safety measures, and shall build capacity for integrated ASEAN risk assessment through the ASEAN Risk Assessment Centre for Food Safety (ARAC).
12. We commit to advocate Health in All Policies (HiAP) to ASEAN Political- Security Community (APSC) and ASEAN Economic Community (AEC), so that they may collectively tackle social injustice and health inequity that cause ill health. We are fully aware that health development is a shared responsibility, therefore close collaboration with non-health sector and participation of the people, communities and institutions are prerequisite to achieve healthy ASEAN.

We look forward to further joint collaboration in health development at our next Meeting in Brunei Darussalam in 2016.

JOINT STATEMENT OF THE 6TH ASEAN PLUS THREE HEALTH MINISTERS MEETING

19 September 2014, Ha Noi, Viet Nam

1. WE, the Ministers/Heads of Delegations responsible for health of ASEAN Plus Three Countries, representing Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, the Lao People's Democratic Republic, Malaysia, the Republic Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand, the Socialist Republic of Viet Nam, the People's Republic of China, Japan, and the Republic of Korea, convened the 6th ASEAN Plus Three Health Ministers Meeting on 19 September in 2014 in Ha Noi, Viet Nam, in the spirit of unity and with the ultimate goal to achieve quality of health for all ASEAN Plus Three citizens.

2. We discuss progress in implementing joint activities in the health sector, especially in strengthening Primary Health Care for Prevention and Control of Noncommunicable Diseases (NCD) and shared our concerns and commitments to strengthening our cooperation.

3. We acknowledge our efforts of the ASEAN Plus Three health cooperation to collectively advocate and facilitate further social and economic measures to halt and reverse the increasing trends on modifiable risk factors of NCD. We recognise the need to strengthen the prevention and control of NCD, risk factors and underlying determinants through people-centered primary health care and Universal Health Coverage (UHC). We also note that mental health is an important cause of morbidity and contribute to the global NCD burden, for which there is a need to provide equitable access to effective programmes and health-care interventions.

4. We undertake to work closely to promote an enabling environment to facilitate healthy lifestyles and choices and to strengthen primary health care system for NCD prevention and control. We re-affirm our commitment to the Global Action Plan for the Prevention and Control of NCD 2013-2020 endorsed by the 66th World Health Assembly in 2013 as well as Bandar Seri Begawan Declaration on Noncommunicable Diseases adopted at the 23rd ASEAN Summit in 2013.

5. We note the efforts of ASEAN Plus Three health cooperation in the areas of traditional medicine, health-related issues of ageing, NCD, disaster health management, maternal and child health, pandemic preparedness and response, communicable diseases and emerging infectious diseases. We also note the continuous progress made in the ASEAN Plus Three health cooperation through the ASEAN Plus Three Field Epidemiology Training Network (FETN), ASEAN Plus Three Partnership Laboratories (APL), Animal and Human Health Cooperation, Risk Communication, and through the project activities addressing specific disease-interventions including malaria, rabies and dengue.

6. We express our concerns on the ongoing threat of the Emerging Infectious Diseases (EIDs) and we encourage the Plus Three Countries to continue supporting the EIDs Programme that has brought fruitful collaboration.

7. We acknowledge the efforts of ASEAN Plus Three health cooperation in calling for rabies elimination by 2020 through the adopted ASEAN Rabies Elimination Strategy with engagement of the government and other stakeholders to support capacity strengthening and cooperation of both animal health and human health under the ones' health approach.

8. We re-emphasise the significance of UHC, following the joint statement made by the 5th ASEAN Plus Three Health Ministers Meeting (APTHMM) in July 2012 in Phuket, Thailand, to improve the well-being of all citizens and to achieve sustainable development and equity for our society. We advocate UHC as one of the health priorities in the ASEAN Post-2015 Health Development Agenda and welcome the establishment of the ASEAN Plus Three UHC Network. We urge the Network to accelerate the implementation of its action plan and activities. We welcome advocacy efforts to achieve UHC and will strive to further elevate and strengthen commitment by working through highest regional fora including ASEAN Plus Three Summit.

9. We share the view to strengthen health financing scheme and expansion the health coverage, where appropriate, in each ASEAN Plus Three Country. We also reaffirm to share experiences in increasing technical capacity to develop affordable systems of health financing in order to reduce out-of-pocket payment and ensuring quality health services. We aspire to improve the access to essential medicines and cost effective health technologies to diagnose and treat medical problems. We commit to build up a sufficient capacity of well- trained health workers at all levels to provide appropriate and adequate services to our people.

10. We appreciate the ASEAN Plus Three cooperation on HIV and AIDS, especially the efforts in Getting to Zero New HIV infections, Zero Discrimination and Zero AIDS-related Deaths. We express our concerns on the decreasing global budget for HIV and AIDS, and as such, share the view to have long-term and sustainable cooperation of ASEAN Plus Three on HIV and AIDS. We also note the need to strengthen cooperation on building capacity and surveillance on HIV and AIDS and enhancing HIV and AIDS prevention and control activities in the border areas.

11. We recognise that ASEAN Plus Three countries are now facing an aging population, and its health related issues. We appreciate initiatives on Active Aging led by Japan within ASEAN, including the ASEAN-Japan Regional Conference on Active Ageing and ASEAN-Japan High Level Officials Meeting on Caring Societies. We welcome the outcomes of those meetings and expect to build a sustainable collaborative network among ASEAN Plus Three Countries.

12. We recognise that health development is a shared responsibility. Hence, inclusive participation of other sectors in the policy development process is a requirement for Health in All Policies (HiAP).

13. We share the view in further strengthening the ASEAN Secretariat and jointly working in overcoming the challenges, and at the same time, promote a sense of belonging and identity among ASEAN people.

14. We also welcome the ASEAN Health Initiative, which would contribute to the improvement of health in ASEAN, proposed at the ASEAN-Japan Commemorative Summit Meeting in December 2013. We support this Initiative by Japan which is in alignment with the priority health issues in ASEAN.

15. We reaffirm the importance of strengthening capacity in Disaster Health Management in ASEAN which was newly identified as an area for collaboration and reflected as a priority area in the ASEAN Post-2015 Health Development Agenda. We welcome Japan's initiative to strengthen Disaster Health Management capacity in ASEAN.

16. We acknowledge the support of development partners, World Health Organization, Asian Development Bank, Global Fund, bilateral development partners, civil society organisations and private sectors and commit to collaborate closely with them in the future.

17. We confirm our ASEAN Post-2015 Health Development Agenda through the ASEAN Plus Three Senior Official Meeting of Health Development (SOMHD) in the implementation of relevant work plans, enhancing multi- sectoral stakeholders engagement, information sharing and mobilisation of technical and financial support from ASEAN Plus Three Countries and dialogue partners. We acknowledge the need to pursue stronger commitments and cooperation from other sectors in addressing cross-cutting issues that has implication to the health sector including disaster management and humanitarian assistance, regional mechanism in responding to impacts of pandemics or other biological health threats, access to medicines and health care and non-communicable diseases.

We look forward to further exchanges of views and joint cooperation in health development at our next meeting in Brunei Darussalam in 2016.

JOINT STATEMENT
5TH ASEAN-CHINA HEALTH MINISTERS MEETING
19 September 2014, Ha Noi, Viet Nam

1. WE, the Ministers of Health of ASEAN Member States (AMS), representing Brunei Darussalam, the Kingdom of Cambodia, the Republic of Indonesia, the Lao People's Democratic Republic, Malaysia, the Republic of the Union of Myanmar, the Republic of the Philippines, the Republic of Singapore, the Kingdom of Thailand, the Socialist Republic of Viet Nam and the People's Republic of China, convened the 5th ASEAN-China Health Ministers Meeting on 19 September 2014 in Ha Noi, Viet Nam. We share our concerns and express our commitment to strengthen our cooperation in the spirit of governments and people of ASEAN and China.
2. We express concern on the rising trend of Emerging Infectious Diseases (EIDs) in recent years that negatively impact the health and socio-economic development of all countries within the region, especially the occurrence of avian influenza H7N9, H5N1. We are also concerned of the potential threats from other emerging infectious diseases in particular MERS-CoV and Ebola. In response to the current outbreak of Ebola in Western Africa, we strongly urge alertness and rigorous preparedness amongst AMS Plus China through the International Health Regulation 2005 mechanism.
3. We understand that surveillance, health quarantine and timely sharing of information and experience are vital to effectively control EIDs. We recognise that multi- sectoral collaboration will enhance ability to carry out prevention and control measures since most of the EIDs originate from zoonotic diseases, therefore the collaboration between the animal health, cross-border protection agencies and the public health sectors is crucial. We commit to advocate and work closely with other sectors within and between countries to control the EIDs.
4. We recognise that the international trade of food leads to many benefits to consumers and contributes significantly to economic development. The increased volume of food traded globally poses an increased risk of food contamination across national borders. In order to ensure food safety and protect consumers' health, we need to establish cooperation in risk assessment and enhance the effectiveness of responsive measures to manage food safety issues or crisis through rapid exchange of information and sharing experiences.
5. We realise that drug resistant malaria is rising in many countries in the region which challenges malaria elimination and it may create a resurgence of malaria in some areas. We understand the movement of people between countries may contribute towards the spread of drug-resistant malaria. We acknowledge the value of adopting rapid diagnostic testing and Artemisinin-based Combination Therapy (ACT) in malaria control in endemic areas both for local people and mobile population to prevent the occurrence of drug resistant malaria and ensuring drug compliance.
6. We note the progress made in ASEAN and China cooperation in tobacco control and commit to reduce the use of tobacco. We also note the need to strengthen the capacity of countries to design, implement, monitor and evaluate tobacco control programmes.
7. We acknowledge the effort of ASEAN and China collaboration to implement the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases (A/RES/66/2) as well as Bandar Seri Begawan Declaration on Noncommunicable Diseases adopted at the 23rd ASEAN Summit in 2013. We commit to promote collaboration in capacity building, experience sharing and research on the prevention and control of noncommunicable diseases.
8. We welcome ASEAN-China cooperation in communicable disease prevention and control, especially the collaboration on malaria, dengue fever, HIV and AIDS, and plague prevention and control in the border areas.
9. We commit to strengthen the ASEAN-China cooperation on capacity building for public health personnel in the region. China will work closely with AMS to implement both management and technical training programmes which contribute to strengthening regional capacity in public health.
10. We commit to strengthen the ASEAN-China cooperation in traditional medicine and its contribution to universal health care, where applicable. We realise the importance of cooperation and the sharing of information to support the quality, safety and efficacy of traditional medicine; and protection and conservation of indigenous health resources, including traditional knowledge and bio-resources. We welcome the sharing of experiences on using traditional medicine in strengthening primary health care.
11. We commit to implement the ASEAN-China MOU on health cooperation and task the ASEAN-China SOMHD to expedite the finalisation and operationalisation of the Plan of Action.

We look forward to further exchange of views and joint collaboration in health development at our next meeting in Brunei Darussalam in 2016.

22ND ATFOA MEETING IN MANDALAY CITY, MYANMAR

ASEAN Task Force on AIDS (ATFOA) was established in 1993 as directed by the 4th ASEAN Summit in Singapore. It aims to promote regional cooperation and partnership in combating HIV and AIDS by strengthening regional response capability and capacity and ASEAN partnership with regional and international and civil society organizations.

Since then, annual meeting of ATFOA has been organized and the last 21st ATFOA Meeting was conducted in Malacca, Malaysia in September last year. 22nd ATFOA Meeting was organized in Hotel Shwe Pyi Thar, Mandalay City, Myanmar from 24-26 of June this year.

On 23 June, one day prior to ATFOA Meeting, an important meeting between ATFOA and UNAIDS was conducted in same hotel where all participants discussed on draft MOU between ATFOA and UNAIDS partnership.

In the evening, the Business Dinner was offered by host country, Myanmar, where the heads of delegates from all member states attended and discussed to have consensus on proposed agenda prepared by ASEAN Secretariat office for 22nd ATFOA Meeting that would be conducted from 24 to 26 June.

The first day of ATFOA Meeting was started on 24 June at around 9:00 where (24) participants of ATFOA Focal Points from ASEAN member states, (3) participants from ASEAN Secretariat Office and (4) participants from UNAIDS, UNICEF, WHO and International Alliance attended.

An official opening ceremony was done where Union Minister for Health, Ministry of Health, Chief Minister of Mandalay Region and other minsters, officials from Ministry of Health, and other invited guests also presented in addition to participants from ASEAN Member States. Union Minister for Health, Myanmar and ATFOA chair from Lao PDR gave opening speech and remarks at opening ceremony respectively.

Just before business session was started, the report of outgoing chair (Lao PDR) was adopted and handover of chairmanship between Lao PDR and Malaysia was done. Then the business session was continued up to late afternoon according to agenda.

The topics under discussion included Key Outcomes from ASEAN Related Meetings [ASEAN Secretariat], Follow-up from 21st ATFOA Meeting [ASEAN Secretariat], Updates on HIV/AIDS Related Activities Implemented by Other Sectoral Bodies (ASEAN Secretariat or Chairperson of Subsidiary Body or Representative of the Subsidiary Body), ATFOA Partnership Building [Presentations/Inputs to Operation Planning], Update on the Progress of the Implementation of AWP IV 2011-2015.

A welcome dinner and cultural show was offered by host country on that evening in front of hotel. Each participant was received a souvenir presented by host country. 2nd day of ATFOA Meeting was

continued on 25 June at 9:00 am. The topics under discussion included continuation of Update on the Progress of the Implementation of AWP IV 2011-2015, Updates on ASEAN Cities Getting to Zeros, Review AWP 4 and Identification of Key Priorities for 2014 – 2015 [Chair/ Vice Chair], Identification of Priority Areas Beyond 2015 [Chair & ASEAN Secretariat] and Resource Mobilization [Chair/Vice Chair]. The business session was finished around 4:00 pm as sightseeing tour was already planned by host country. One of the interesting places of sightseeing tour was very popular 100 years old U Paing Bridge which was made of genuine teak.

The 3rd and last day of ATFOA Meeting was continued on 26 June starting from about 9:00 am. The topics under discussion included Monitoring and Evaluation [ASEAN Secretariat], ATFOA Side Meeting at the 12th AHMM, Date and Venue of the 23rd ATFOA Meeting, Consideration for Adoption of the 22nd ATFOA Report [Chair and ASEAN Secretariat]. All participants agreed to organize 23rd ATFOA Meeting in Philippine in 2015. Venue will be decided by host country later. Then closing ceremony was done and 22nd ATFOA Meeting was successfully finished.

Again, sightseeing tour to some of the famous places was arranged by host country including Mandalay Old Place, Mandalay Hill. A dinner was then offered by host country.

PROGRESS IN IMPROVING MATERNAL, INFANT AND YOUNG CHILD NUTRITION (MIYCN) IN BRUNEI DARUSSALAM

Brunei Darussalam has come a long way in advancing the health of women and children in the country. High quality health care together with improvement in living standards, in levels of education and increasing empowerment of women has allowed Brunei Darussalam to achieve the targets of MDG 4 and 5 well before 2015.

The Maternal and Child Health (MCH) Services provide free health care for all women and children residing in the country, regardless of citizenship. This policy, together with the quality of the country's obstetrics care, has resulted in consistently low maternal mortality ratio (MMR) that is comparable to other developed countries. Similarly, the under-5 mortality rate has steadily declined over the past few decades to 7 per 1000 live births in 2012 - much of which is attributable to the Expanded Program on Immunization.

However, with the increasing burden of non-communicable diseases and obesity in the country, one of our priority goals now is to further improve the nutritional status of the Bruneian people, in particular that of women and children.

During the 1990s, all 4 government hospitals in Brunei Darussalam adopted the Baby Friendly Hospital Initiative (WHO/ UNICEF 1991). As part of this initiative, WHO-led Training of Trainers lactation management course was conducted in 1999 which subsequently led to the training of nearly 1000 health care workers. Two years later, the National Breastfeeding Policy was endorsed whereby exclusive breastfeeding is recommended up to 6 months of age with continued breastfeeding to two years of age along with the introduction of appropriate complementary foods.

The impact of this policy could be seen from the improvement in the exclusive breastfeeding rates among women in the country. In 1999, exclusive breastfeeding rate among mothers who attended postnatal clinics at six weeks follow-up was found to be only 12.4%. A decade later, the National Health and Nutritional Status Survey (NHANSS 2009) found that the exclusive breastfeeding rate from birth to six months was 26.7%. Despite this increase, the rate is still less than expected.

A major milestone in the country's endeavor to improve the national exclusive breastfeeding rate is the introduction of the new Maternity Leave Regulation 2011 whereby the duration of paid maternity leave was extended from 8 weeks to 15 weeks. This extension aims to facilitate exclusive breastfeeding practice among women in employment.

An early indication of the positive impact of this extension is shown in a 2012 study that involves 3479 women from 5 MCH clinics. It found that the rate of exclusive breastfeeding to 6 months among women working in the government sector increases from 26.1% in 2010 to 32.1% in 2011 - a 6% increase following the introduction of the new maternity leave regulation.

In February 2013, another major milestone was achieved when the Ministry of Health established the Maternal, Infant and Young Child Nutrition (MIYCN) Taskforce with a mandate to strategically plan and implement effective nutrition and related training programs in an integrated fashion towards improving the health, nutrition and well-being of infants and young children (0-5 years) and the health and well-being of women in the reproductive age group. Its goals are aligned to the nutrition goals or targets identified in the Comprehensive Implementation Plan on MIYCN (WHO, 2012).

Under the MIYCN Taskforce Framework, four key strategies for Brunei Darussalam have been identified:

1. Education, training, monitoring, research and evaluation.
2. Implementation of the International Code of Marketing of Breastmilk Substitutes (WHO,1981).
3. Creating supportive breastfeeding friendly environments in the communities and workplaces.
4. Making all health facilities mother and child friendly.

The MIYCN Taskforce recently carried out a WHO/UNICEF Train the Trainers 40-hour Course in Breastfeeding Counseling from 20 to 25 January 2014. The new cohort of trainers will be expected to continue the running of the 20-hour Lactation Management course for health care workers. At Universiti Brunei Darussalam, the 20-hour Lactation Management Course has also been incorporated into the curriculum of Nursing and Midwifery Diploma.

Plans to engage international partner (IBFAN-ICDC) have also been initiated to support the taskforce in developing a local guideline on the Code of Marketing of Breastmilk Substitutes. The taskforce will also be working closely with non-health sector partners to increase the number of appropriate, purpose-built breastfeeding friendly facilities in all government and non-government buildings as well as public premises and commercial centres.

Within the Ministry of Health, inter-departmental collaborations are in place to continuously roll out trainings for capacity-building as well as to work towards accreditation of mother and child friendly facilities.

WORKING TOGETHER TOWARDS RABIES-FREE ASEAN

In support of the recent global observance of the World Rabies Day on September 28, ASEAN demonstrated its continued support in accelerating the goal of a 'rabies-free ASEAN by 2020' through the endorsement of the 'ASEAN Rabies Elimination Strategy' (ARES). This document was jointly endorsed by the 36th ASEAN Ministerial Meeting on Agriculture and Forestry (AMAF) and the 12th ASEAN Health Ministers Meeting (AHMM) that were respectively held in Nay Pyi Taw, Myanmar and Ha Noi, Viet Nam.

This joint endorsement of ARES is clearly a manifestation of ASEAN's resolve and commitment for the elimination of rabies, which is a widespread, neglected and under-reported zoonosis with an almost 100% case fatality rate in animals and humans. This disease causes a significant social and economic burden in many countries worldwide. Every year, between 50,000 and 70,000 people die of rabies in various conditions. The majority of rabies cases globally occur in children.

Rabies is endemic in the canine population in majority of ASEAN Member States. Nearly all of the human rabies cases are due to bites from rabid dogs. Controlling the disease in dogs, primarily through mass dog vaccination, is a cost effective way to prevent rabies in humans.

The ARES has been developed to provide a strategic framework for the reduction and ultimate eradication of rabies in ASEAN Member States. The strategy describes an integrated 'One Health' or multi-sectoral, multi-stakeholder and multi-disciplinary approach that brings together the necessary socio-cultural, technical, organizational and political pillars to address this disease.

Cognizant of the significant role of partners in the development and implementation of the strategy, ASEAN's appreciation through the AMAF and AHMM was extended to the Food and Agriculture Organisation of the United Nations (FAO), World Organisation for Animal Health (OIE), World Health Organisation (WHO), World Animal Protection, and Global Alliance for Rabies Control, for their untiring efforts and valuable support in achieving rabies-free ASEAN by 2020.

On the other hand, Viet Nam, the lead country for rabies control, through its Ministers on Agriculture and Rural Development (MARD) and Health (MOH), have further expressed confidence that through ARES, cooperation and collaboration between and among member states and other stakeholders will be strengthened. They also recognized that this is a significant contribution of ASEAN in the annual observance of World Rabies Day every 28 September.

The World Rabies Day is an annual global movement to unite everyone in the fight against rabies. The 2014 theme of "together against rabies" emphasised the importance of controlling the disease at-source by vaccinating dogs to prevent human deaths.

THE ESTABLISHMENT OF ASEAN REFERENCE SUBSTANCES (ARS)

Pharmaceutical reference substances are substances prepared for use as standard in testing and required for comparative analytical methods which are included in a manufacturer's specifications or pharmacopoeia monographs. ASEAN Reference Substances (ARS) are established as part of regional cooperation on pharmaceuticals among ASEAN member countries. The project was initiated in 1980 with the aim of providing the member countries with low-cost reference substances of established quality.

At the beginning of the project, five countries were involved, namely Indonesia, Malaysia, Philippines, Singapore and Thailand. During 2003-2009, five more members, namely Viet Nam, Lao PDR, Myanmar, Cambodia and Brunei Darussalam participated. The required reference substances were proposed by the member countries. The list of substances to be prepared is prioritized according to the need in the region. The responsible country for each substance is designated to carry out the testing of bulk materials in accordance to pharmacopeia monograph and to manage for collaboration among the member countries. The analytical results of the proposed substances were evaluated and approved in ARS group meetings or via the ARS website, www.aseanrs.org. The adopted ARS were distributed to all member countries as needed. To date, 206 ARSs have been adopted among which the first, second and third batch substances are 150, 48 and 8 substances, respectively.

The training on the production of ARS has been periodically conducted in Thailand for understanding of establishment process of ARS and collaboration management in ARS group. The project was funded by United Nation Development Program (UNDP), with technical support from WHO during 1982-1991. Japan Pharmaceutical Manufacturers Association (JPMA) has continued the financial support for this project since 1992. The advantage of this project was improving of ARS laboratory competency.

JOURNEY TO THE DEVELOPMENT OF BRUNEI DARUSSALAM NATIONAL MULTISECTORAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES (BRUMAP-NCDS) 2013-2018

1. In Brunei Darussalam, the epidemiologic transition and the shift of burden of diseases from communicable to noncommunicable diseases (NCDs) has since provided major impetus in tackling NCDs at the national level. This is reflected at the highest political level where the Government of His Majesty the Sultan and Yang Di-Pertuan Negara Brunei Darussalam has called upon all stakeholders, including non-health sectors, to undertake effective and sustainable actions in order to promote healthy lifestyle and prevent NCDs.

2. Over the past decades, there have been various programmes initiated by the Ministry of Health on the prevention and control of NCDs. However, it was recognised that further efforts were needed to engage non-health sectors in strengthening NCD prevention and control initiatives, as ultimately a health enabling environment lies upon the policies of other non-health sectors such as schools, transport, trade, agriculture, town planning amongst others.

3. With the forethought leadership of the Minister of Health, the **National NCD Prevention and Control Strategic Planning Committee** was set up in April 2012. At its inception, this National NCD Committee was tasked to work towards strengthening NCD initiatives and specifically the development of a National Strategic Action Plan on NCD Prevention and Control with emphasis on common risk factors approach. The "whole of society" approach is also given prominence in-line with WHO recommendations by stressing on multisectoral actions and active participation from various

stakeholders and organisations within and outside of the Ministry of Health as being the key for successful NCD intervention.

4. During the construct of this National Strategic Action Plan, multisectoral consultancies were held in 2012 and 2013 which was attended by senior technical officers from various ministries including the Prime Minister Office, Ministry of Education, Industries and Primary Resource, Communication, Finance, Foreign Affairs and Trade, Religious Affairs, and Development. The multisectoral consultancies hosted active discussions, explored opinions and generated innovative solutions from the various ministries and departments. Recommendations were assessed on their feasibility and effectiveness based on research evidences and past experiences in local and overseas settings. Based on these assessments, actions were prioritised and compiled into the Draft National Strategic Action Plan.

5. In addition, feedbacks were also gathered from a public forum on healthy eating and living was held at the community level co-hosted by the Women's Council and the Ministry of Health. Further inputs from senior management meeting of permanent secretaries from various ministries was held to gather buy-ins were also considered and incorporated in refining key recommendations in strengthening the NCD prevention efforts.

6. The drafting team of the National Strategic Action Plan on NCD Prevention and Control then undertook a working trip to the WHO Western Pacific Regional Office to discuss intensively, finalise the technical details and align the Draft National Strategic Action Plan with regional and global NCD action plans.

7. On 20 September 2013, **the Brunei Darussalam Multisectoral Action Plan for the prevention and control of Noncommunicable Diseases (BruMap- NCDs) 2013-2018** was completed and successfully launched by His Royal Highness Duli Pengiran Muda 'Abdul Malik ibni Kebawah Duli Yang Maha Mulia Paduka Seri Baginda Sultan Haji Hassanal Bolkiah Mu'izzaddin Waddaulah.

8. The **BruMap-NCDs** embraced the overall Vision 2035 of the Ministry of Health 'Together Towards A Healthy Nation'. It provides practical guideline on the implementation of NCDs prevention and control by the government, private and civil society sectors with the overarching mission to prevent and control NCDs through enabling healthier environments as well as reducing risk factors and better management. The goal of BruMAP-NCD is fully aligned to the global target of a 25% relative reduction in premature mortality from NCDs by 2025 which has been translated to 18% relative reduction by 2018 in Brunei Darussalam.

9. The framework of BruMap-NCDs is built upon two key strategic themes, namely I) improving health through enabling environment and healthy choices; and II) improving health through enhancing the continuum of care for NCDs. Within the two key strategic themes are five objectives to 1) reduce tobacco use, 2) promote balanced and healthy diet, 3) increase physical activity, 4) identify people at risk for NCDs and 5) improve quality of care and outcome of NCDs management.

10. The strategic themes and objectives in BruMAP-NCDs are supported by five pillars of enablers which are policy & legislations; human resources; patient empowerment; effective communication and research & innovation. Further direction is provided through a set of recommended actions for the Ministry of Health, other ministries and stakeholders which are outlined in the multisectoral action plan. Detail guidance for implementing the actions for each objective are provided as annexes in the BruMap-NCDs.

11. The BruMap-NCDs can be downloaded from the website of Ministry of Health Brunei Darussalam at *http://www.moh.gov.bn/download/index.htm*

ASEAN WORLD AIDS DAY MESSAGE 2014

After almost three decades since HIV and AIDS first appeared in this region, varied pattern of disease transmission is seen across different countries. Some countries are showing an increasing trend; remains stable in others, while a few countries have been successful in reducing the incidence of HIV. The World Health Organization (WHO) estimated that globally, by the end of 2013, 35 million people are living with HIV with 2.1 million people becoming infected with HIV in 2013 alone. WHO also estimates that globally by 2030, HIV will be the eighth leading cause of all deaths and the third leading cause of death due to communicable, maternal, perinatal and nutritionally related diseases and conditions. It is clear that HIV will continue to remain a concern in the coming years. For this reason, the financing and provision of HIV and AIDS treatment and services should remain a major policy and programmatic issue in the development agenda. Whilst severe natural disasters, economic volatility, high levels of debt, and slow growth pose constraints to many ASEAN countries to invest maximally in human development, the gap between people's expectations and government budgetary allocations need to be closed. Domestic spending on HIV and AIDS among ASEAN countries is increasing.

The UNAIDS 2013 Global Report stated that, where the HIV epidemic is mainly highlighted in Asia, the key population particularly affected by HIV are: sex workers (SWs) and their clients; men who have sex with men (MSM); and people who use drugs (PWUD). For these groups, they are estimated to be 13, 19 and 22 times, respectively, more likely to be living with HIV than the general population. These most-affected groups are also more likely to have difficulties accessing the health and support services. By 2013, approximately 1.7 million people are living with HIV and AIDS (PLHA) in Southeast Asia, close to a third of these are women. Of the total PLHA, 46 per cent are adults eligible for antiretrovirals and only 57 per cent of them are receiving antiretrovirals (ARV).

This year, the ASEAN theme for World AIDS Day is: "Getting To Zero through Efficient & Sustainable HIV Response". As the world economic landscape changes, so does the HIV funding landscape. Donor funding has stagnated, and the limited resources available require more emphasis on value for money: funds spent for the greatest impact and in the most efficient way. The challenge posed by HIV/AIDS is further complicated by changing social patterns, weak health systems, high rates of tuberculosis, and increasing number of people engaged in high risk behaviors. Within this context, responses must take into account five key challenges which are :

i. political commitment;
ii. multisectoral support;
iii. public health surveillance and monitoring;
iv. evaluation; prevention; care, support, and treatment; and
v. health services delivery.

The sheer scale of the HIV/AIDS epidemic will require ongoing, dynamic cooperation among a broad coalition of stakeholders.

Discussions during the 5th ASEAN Plus Three Health Ministers Meeting in Phuket in July 2012 signalled a strong interest in Universal Health Coverage (UHC), when it requested the Senior Officials Meeting on Health Development to deliberate on the formation of an ASEAN Plus Three UHC Network (hereafter known as the Network). This is to allow "sharing and collectively building the national and regional capacity of its member countries to assess and manage equitable and efficient health systems to support UHC". UHC's tenets of universality and affordability make it as an important contributor to sustainable development. UHC should however not be measured by the robustness of the health systems and their financial sustainability alone, but also by a country's ability to ensure truly inclusive and universal access, i.e. to meet the needs of marginalised populations to improved health conditions. HIV and AIDS is an example of a health condition that affects certain population groups disproportionately, in terms of its health impact, adverse socio-economic effects, and overall progress in development

as well. Equity is central to the concept of UHC, making it a crucial consideration if we are to make any further progress in stopping new HIV infections, achieving High Level Meeting targets and bringing an end to AIDS.

Working closely with partners, ASEAN Member States must be able to implement evidence-based and cost-effective interventions that are allocated through fair and transparent process. There is a need for new financing mechanisms beyond the traditional concept of development assistance to move towards universal access to health care. Increased sense of ownership, as well as strong and effective involvement from goverments, civil society, communities, person living with HIV and health professionals are critical pre-conditions for an effective and efficient regional and global response.

Sustained financial, political and scientific commitment is key to ensuring that all relevant stakeholders play their part in coordinated efforts to expand HIV prevention and treatment interventions; integrate HIV/AIDS into broader health services; increase funding and improve human rights across vulnerable population, including reducing stigma and discrimination. In the fight against HIV and AIDS, historic gains have been achieved but key challenges remain. Only by responding to these challenges in an efficient and sustainable way can we "Get to Zero".

ASEAN Task Force On AIDS (ATFOA)
2014

ESTABLISHMENT OF ASEAN RISK ASSESSMENT CENTER (ARAC)

Background

1. The 10th Meeting of the AEGFS held on 3-5 December 2013 in Brunei Darussalam agreed on the establishment of ARAC proposed by Malaysia. Based on review of the initial draft Terms of Reference (TOR), the Meeting reaffirmed that ARAC should serve as a coordinating centre on risk assessment in ASEAN. It was agreed that the center will be located in Malaysia, which will also provide secretariat support to ARAC, subject to the approval of the 9th Senior Officials Meeting on Health Development (SOM HD) in June 2014 and the 12th ASEAN Health Minister Meeting (AHMM) in September 2014.

2. As a follow-up, the 10th Meeting of the AEGFS tasked Malaysia, with the assistance from ASEAN Secretariat, to formulate the Term of Reference of ARAC to be circulated to the AEGFS.

3. ASEAN Regional Integration Support by the EU (ARISE) has provided support on food safety issues addressed in ASEAN. Among others, ARISE supported AEGFS in the organization of an "Inception Workshop on Initiating an Integrated ASEAN Risk Assessment Mechanism" on 25-26 June 2013 in Kuala Lumpur to address the need and the mechanism for an integrated ASEAN food safety risk assessment. This workshop culminated in an initial draft Terms of Reference (TOR) for an ASEAN Risk Assessment Center that was subsequently presented to the 10th AEGFS, where representatives from ARISE were invited.

4. In addition, ARISE also supported a Study Tour to the European Food Safety Authority (EFSA), Parma, Italy which was held from 7-11 April 2014. Participants were AEGFS Focal Points from nine ASEAN Member States, representatives from SOMHD Thailand, Chair of ASEAN Consultative Committee on Standards and Quality - Prepared Foodstuff Product Working Group (ACCSQ-PFPWG), and relevant desk officers of ASEAN Secretariat. This Study Tour served as a platform that enabled ASEAN delegates to learn from European Union's experiences in performing risk assessment as well as discuss on how ASEAN risk assessment can move forward. As agreed by participating delegates, inputs/recommendations emanating from the wrap-up discussion during the study tour should be incorporated into the TOR and tasked Malaysia to modify the draft the TOR in the following sections:
   i. Mandate
   ii. Scope of Work
   iii. Structure and Functions

iv. Resources
v. Database
vi. Networking
vii. Mechanism and Management

5. The revised draft TOR has been circulated to AEGFS for its endorsement through ASEAN Secretariat and concurrence has been obtained. As of 23 May 2014, valuable comments and inputs were received from AMS, as appears in Appendix 1. Malaysia has incorporated all key inputs into the draft TOR (refer Appendix 2), while other comments will be tabled at the 11th AEGFS in October 2014.

Rational for ARAC in ASEAN

6. Risk assessment is an internationally recognized scientific tool in the development of food safety measures. It is becoming more important to support safe food production and facilitate regional and international trade. Under the World Trade Organisation (WTO) Agreement on Sanitary and Phytosanitary Measures (SPS Agreement), WTO member countries may impose more stringent food safety measures than international standards namely Codex Alimentarius standards provided there is scientific evidence i.e. risk assessment.

7. Currently, advancement on the implementation of risk assessment in ASEAN Member States (AMS) varies, where some countries with expertise are more advanced than others. This is reflected in the disparity in capacity and ability amongst AMS to generate and assess scientific input for risk-based interventions and regulatory approaches to food safety.

8. While at the ASEAN level, risk assessment activities are being undertaken through various initiatives by different ASEAN Sectoral bodies such as the Experts Working Group on the Harmonisation of Maximum Residue Limits (MRLs) of Pesticides, under the ASEAN Sectoral Working Group on Crops (ASWGC), which is within the purview of the Senior Officials Meeting of the ASEAN Ministers on Agriculture and Forestry (SOM AMAF).

9. As such, the is a need for the establishment of an integrated ASEAN risk assessment mechanism to coordinate scientific assessment on food safety issues of common interest in ASEAN and to promote the formulation of common management measures on these common food safety issues.

10. ASEAN Risk Assessment Center (ARAC) as a coordinating center for food safety risk assessment will facilitate:
    i. the provision of independent scientific opinion;
    ii. pooling and utilizing of scientific expertise across ASEAN;
    iii. development of complementary capabilities and capacities on risk assessment through networking with AMS and international organizations;
    iv. An exchange of scientific information; and
    v. Promoting of ASEAN common position on food safety issues based on risk assessment.

ARAC's Functions

11. The primary function of ARAC is to provide independent scientific opinion on food safety issues of common interest in ASEAN including during a crisis. This independence is ensured through the functional separation between risk assessment and risk management.

12. All requests for scientific opinion or risk assessment by risk management body at the ASEAN levels through ASEAN Sectoral bodies such as PFPWG will be submitted to AEGFS. AEGFS acting as the governing body of ARAC will coordinate, prioritise and commission risk assessment to ARAC.

13. ARAC will be hosted in the Ministry of Health, Malaysia and will consist of three (3) components:

i. Secretariat of ARAC

- has two (2) Technical Officers and one (1) Administrative Staff provided by the Ministry of Health Malaysia; and
- provide the needed support for the efficient functioning of the Scientific Committee and Scientific Panel.

ii. Scientific Committee

- composed of top scientists from AMS, with a high level of scientific competence and expertise on food safety. Each AMS shall nominate one (1) scientist to be appointed by AEGFS as committee member;
- review risk assessment request and identify experts required for the Scientific Panel from the ASEAN Risk Assessor database; and
- review and adopt scientific opinion from the Scientific Panel.

iii. Scientific Panel

- will be convened at the direction of the Scientific Committee on a need basis, and shall consist of qualified experts in the relevant field drawn from the ASEAN Risk Assessor database; and

- perform risk assessment and produce scientific opinion for adoption by Scientific Committee.

15. In addition, ARAC with support from ASEAN Secretariat will act as a platform for regional and international networking with relevant sector and organizations including relevant ASEAN Sectoral Bodies, WHO, FAO, EU, EFSA, APEC, etc. These networking will allow ARAC to tap scientific information and expertise for its risk assessment work.

Resources Mobilization and AMSs' Ownership

14. ARAC activities will be supported through contributions of required resources from ASEAN Member States. Additional assistance will be sought from international organisations and dialogue partners when required. Currently, ARISE has offered to provide support for piloting risk assessment activities, while ILSI will continue to support at the regional level to initiate and collect food consumption data.

15. Each AMS will nominate one scientist into the Scientific Committee that will review risk assessment request, identify experts from the ASEAN Risk Assessor database into the Scientific Panel to perform the risk assessment and adopt scientific opinion from the Scientific Panel.

16. AMS can nominate qualified experts (based on qualification/ requirements to be established) into the ASEAN Risk Assessors database and can be selected by Scientific Committee to perform assessment based on the identified risk.

17. Each AMS will also identify one (1) permanent and one (1) alternate Focal Point for Risk Assessment to act as a link between national food safety authority and national risk assessment body in the respective AMS, including support and promote of scientific information to assist ARAC's function.

18. In addition, AMSs can second Attachment Officer(s) to the ARAC, subject to AMS's concurrence.

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ASEAN e-Health Bulletin is produced semi-annually by the
ASEAN Secretariat · 70A Jl. Sisingamangaraja · Jakarta 12110 · Indonesia | Tel : (6221) 7262991, 7243372 · Fax : (6221) 7398234, 7243504
Coordinator: Health and Communicable Diseases Division of the ASEAN Secretariat
Editor: Dir. Enrique A. Tayag (Department of Health, Philippines) | **Focal Point:** Dir. Ivanhoe C. Escartin (Department of Health, Philippines)
Note: The articles were contributed by the focal point from each of the ASEAN health subsidiary bodies.
The Association of Southeast Asian Nations was established on 8 August 1967. The Member States of the Association are Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam. The ASEAN Secretariat is based in Jakarta, Indonesia.
General information on ASEAN appears online at the ASEAN Website: www.asean.org
Catalogue-in-Publication Data
ASEAN eHealth Bulletin. Jakarta: ASEAN Secretariat, September 2015
631.059 i 1. ASEAN - Public Health i 2. Health - Personal Health
ISSN 2301-6809