

Report of the first Asia-Pacific influenza summit, Asia-Pacific Alliance for the Control of Influenza (APACI), Bangkok, 12–13 June 2012

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On June 12–13, 2012, the Asia-Pacific Alliance for the Control of Influenza (APACI) convened jointly with the Influenza Foundation of Thailand and the Thailand Department of Disease Control, the First Asia-Pacific Influenza Summit. The objectives of the meeting were to review the current state of official influenza control policies in Asia-Pacific countries; identify, summarize and communicate influenza control strategies that have successfully increased vaccine

uptake in the region; develop policy and advocacy approaches to improve influenza vaccine uptake in high-risk groups and healthcare workers in the region; and establish collaborative relationships to promote best practices for the control of influenza. In moving forward, the challenge for the region will be establishing collaborations able to effectively communicate risk and key messages about influenza vaccination.

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Introduction

Awareness of the public health burden of influenza continues to develop in the Asia-Pacific region. There is, however, no consensus on the best way to prevent and treat the disease and to ensure that policies for the control of influenza, including the use of seasonal influenza vaccines, specific treatments and effective communication strategies are in place.

Against this background, and a need for a coordinated approach to influenza advocacy, the Asia-Pacific Alliance for the Control of Influenza (APACI) was established in 2002, with a mission to reduce the burden of disease within the Asia-Pacific region. The changing influenza landscape following the 2009 pandemic required APACI to move from an informal structure to a company limited by guarantee and registered in Hong Kong as a not-for-profit organisation in April 2011. It has a vision to be a lead organisation on influenza education in the Asia-Pacific region. Full members are now from nine countries: Australia, China, Hong Kong, India, Indonesia, Korea, New Zealand, Philippines and Thailand.

To encourage regional discussion on influenza control, APACI held the First Asia-Pacific Influenza Summit on 12–13th June in Bangkok, Thailand, with the objectives to:

- Review the current state of official influenza control policies in Asia-Pacific countries.
- Identify, summarize and communicate influenza control strategies that have successfully increased vaccine uptake in the region.
- Develop policy and advocacy approaches to improve influenza vaccine uptake in high-risk groups and healthcare workers in the region.
- Establish collaborative relationships to promote best practices for the control of influenza.

The Summit brought together over 200 representatives of healthcare professional groups from over 13 countries in the region. They included clinicians (31%), health authorities (23%), scientists (16%) and industry (22%). Fifteen regional and international experts, including the co-chair of the US National Influenza Vaccine Summit, either addressed the audience or led the discussion on aspects of the fight against influenza.

Two discussion sessions were held providing a consensus on influenza vaccine policy and the risk groups whom should receive influenza vaccination. Each session was preceded by short expert presentations to focus the discussion led by a panel of international experts.

A third discussion group attempted to review the policy and risk-group issues identified. An expert panel led the discussion, evolving a consensus on the way forward with the development of a comprehensive influenza vaccination strategy for the Asia-Pacific region.

Following this Summit, APACI will continue to work with its summit partners, the Influenza Foundation of Thailand, The Ministry of Public Health, Thailand, and the World Health Organization (WHO). APACI will also support the network of Influenza Foundations and allied organisations that have been formed in the region. Partnership expansion and collaboration are pivotal to raising the awareness of influenza and making a difference with its control.

Policy

The Summit opened with an overview of the influenza vaccine policies and guidelines in the Asia-Pacific region from Dr Supamit Chunsuttiwat, Department of Disease Control, Ministry of Public Health, Thailand. These varied widely, from countries with surveillance systems, knowledge of the burden of disease and influenza control strategies in place; to those with no control strategies. There remain a few countries where influenza surveillance is rudimentary, the burden of disease from influenza is not well defined, and policies for seasonal influenza vaccine use do not exist. Bridging the gaps and implementing policies present a number of challenges which can only be overcome by international collaborations.

This was followed by an update by Dr John Tam, Global Influenza Programme, WHO, on the latest WHO recommendations for influenza vaccination.^{1,2} Pregnant women are now identified as the highest priority group to receive seasonal influenza vaccine. There were four other priority groups (healthcare workers, children aged 6 months to 5 years, people aged 65 or more and people with pre-existing chronic illnesses), but each country needs to decide its own prioritisation for these. The priority groups were well accepted by symposium participants generally. However, recommendations need to be translated into policy and that policy then needs to be implemented.

Professor Hitoshi Oshitani, Tohoku University Graduate School of Medicine, Japan, discussed the evidence gaps for informing policy development. Clearly, influenza vaccine use is related to the awareness of the burden of disease. In countries with good levels of vaccine uptake, good diagnostic capacity and good surveillance systems are key factors in driving the vaccine use. In limited-resource countries, support for influenza diagnosis, surveillance and vaccination has to compete with other health priorities, and strategies need to be developed to address this.

Professor Woo Joo Kim, Department of Internal Medicine, Korea University Guro Hospital, Korea, extended the

discussion on knowledge gaps for informing policy. A major issue is determining duration of protection following vaccination. This information is important in planning country-specific vaccine programmes as the seasonal patterns and duration of influenza virus circulation vary widely in the region. Knowing more about the quality and duration of protection would help decisions about which vaccine formulation to use and when it should be delivered.³

Dr Bram Palache, on behalf of the IFPMA Influenza Vaccine Supply (IVS) International Task Force, Geneva, Switzerland, focused on the substantial differences between countries across the region that exist in vaccine use. Research has shown that government recommendations on vaccine use have a positive effect on vaccine uptake, but that reimbursement and effective communications were more influential. Clearly all of these need to be addressed to improve vaccine use.⁴

Priority groups

Professor Janet McElhaney, University of British Columbia, USA, reviewed the five recognised high-risk groups for severe influenza, for which influenza vaccination is especially important. There was a general consensus that these risk groups are relevant in all countries in the region. However, there were some concerns expressed about a lack of data on efficacy and effectiveness of influenza vaccination within some of the risk groups, especially younger children under 2 years of age and the elderly. Despite this, in view of the evidence gained from elsewhere, we should not delay advocating vaccination in these groups. It was recognised that cost-effectiveness data need to be gathered for individual countries to inform decisions about subsidised vaccinations.

There are also benefits of vaccination that extend beyond just preventing influenza and its complications in the recipient. Dr Allison McGeer, Mount Sinai Hospital, Canada, discussed the vaccination of pregnant women leading to healthier infants and protecting against influenza in early life. Also Associate Professor Tawee Chotipitayasunondh, Queen Sirikit National Institute of Child Health, Ministry of Public Health, Thailand, presented data that showed vaccinating children has the potential to reduce virus circulation and protect others in the community.

For the 20–64 year age group with chronic illnesses, the burden of disease is much higher than previously recognised and is similar to the burden among those 65 years and older. Improving vaccination in this group would improve the quality of life for these people, who have many remaining productive years. For individuals 65 years and older, the benefit of vaccination in improving health was noted, leading to an improved quality of life and reduced burden on the health system.

Healthcare workers are a prime example of secondary benefits from vaccination, where the main role of vaccination is in protecting their patients rather than themselves.

The identification of and the communication of the benefits of vaccination to all of these priority groups present many challenges. These include how to get wider recognition of the importance of influenza vaccination, achieve government endorsement, improve access to affordable vaccines, get healthcare practitioners to recommend and deliver vaccines and get patients and parents to ask for and accept vaccination.

The discussion, contributed by Dr Litjen Tan, Director, Medicine and Public Health, American Medical Association, USA, and Dr Cornelia Betsch, University of Erfurt, Germany, identified the need to improve communication with specialists, general practitioners, other immunisation providers and the public.⁵ Recommendations from healthcare providers are critical motivators for vaccination, and there are many missed opportunities for vaccination in groups such as pregnant women and those with chronic illnesses when they visit healthcare providers. Patients also need information about the benefits of vaccination, but it must be delivered effectively. Proper communication of risk is pivotal, and the utilisation of the newer media tools including social media is gaining in relevance.⁶

Lastly, Dr Wonchat Subhachaturas, President, World Medical Association, discussed healthcare workers as posing a special challenge. There was a consensus that it is important to provide healthcare workers with information on the benefits of vaccination to themselves and their patients, reassure them about vaccine safety and make vaccine accessible and at no cost. Unfortunately, although high rates of voluntary healthcare worker influenza vaccination have been achieved in some Asia-Pacific countries, in many others this has still not been sufficient to achieve good vaccine uptake. Mandatory vaccination programmes have proven to be successful and well accepted in the US and parts of Canada. A range of approaches will clearly be needed across the region.

Successful strategies

The Summit concluded with a panel discussion led by Professor's David Smith, Cissy Kartasmita, Janet McElhane, Dr Allison McGeer and Dr John Tam that considered the many challenges to defining a way forward for influenza control in the Asia Pacific region.

Challenges in the implementation of seasonal influenza vaccination programmes

The discussion commenced by reviewing the approaches used by selected countries for influenza vaccine guideline development and implementation within the Asia-Pacific

region. Australia experienced high demand and subsequent influenza vaccine shortages in the early 1990s, resulting in a major review of the implementation of their influenza vaccination programme. This later led to the formation of an alliance of influenza, public health experts, professional foundations, along with key clinicians from each Australian State, which is now called the Influenza Specialist Group (ISG). This group was industry funded and served to educate the key clinical opinion leaders, standardise the key messages on influenza, its severity and the benefits of vaccine nationally and essentially advocate for influenza vaccination. Australia had a pre-existing programme of free vaccination for people aged 65 years and over, but the introduction of free influenza vaccines for the high-risk groups under 65 years came at a later stage following the generation of cost-effectiveness data determined from robust evidence. This is an important prerequisite for policy changes in relation to supply of free influenza vaccination.

Vaccination in the Philippines was driven by the private market which historically used the Northern Hemisphere vaccine formulation. Following the review of available influenza surveillance data, prompted by APACI, it was recognised that this vaccine was being administered after the June/July peak in seasonal influenza activity, thus; in 2002, a change was made to the use of Southern Hemisphere formulation with administration prior to the June/July peak. The Philippines Foundation for Vaccination is a strong advocate for influenza vaccination in that country. The Philippines experience illustrates the need to understand the seasonality of influenza in each country to ensure the appropriate timing of vaccination and use of the most up to date influenza vaccine formulation.

Indonesia follows the WHO guidelines, but has no seasonal vaccination policy in place. The government encourages the vaccination of religious pilgrims although has no recommendations for compulsory vaccination, and has influenza vaccine manufacturing capacity for 200 000 doses of influenza vaccine annually which is administered to this group. There are no immediate plans for the further development of the policy; however, the Indonesian Influenza Foundation (IIF) is strongly advocating for this.

Malaysia recommends vaccination for healthcare workers, the 65 year and over risk group and travellers to the Hajj. However, influenza vaccine usage remains low.

Thailand is a regional success story as, since the formation of the Influenza Foundation of Thailand (IFT) in 2005, has moved from seasonal vaccination focus on healthcare workers and poultry cullers following the A(H5N1) outbreak to the adoption of the WHO guidelines in 2008 with free vaccine being given to the elderly >65 years and individuals with certain chronic conditions, then in 2010 to include pregnant women and children 6–23 months of age. Intro-

duction of this policy involved a review of local data for the burden of disease in Thailand, hospitalisation and the cost-effectiveness of vaccination. Key success factors were strong evidence of disease burden, a clear vaccination strategy, systematic vaccination management, close monitoring and evaluation, and effective public communication. Sustainability of their programme is associated not only with funding, but also with evidence that they achieve the strategic outcomes.

Clearly barriers to governments establishing a control policy for seasonal vaccination include the lack of seasonality of influenza in some countries so that there is no clear seasonal impact and greater difficulty in determining when to vaccinate and which vaccine to use and other confounding public health priority issues such as endemic and epidemic H5N1 in poultry populations. Vaccine access was also identified as an issue in relation to halal manufactured influenza vaccine, which was produced to meet the criteria for travellers to the Hajj and other religious pilgrimages.

Strategies for policy/guideline introduction

The WHO influenza control stance is for a country to (i) establish its burden of disease for influenza, (ii) introduce a control policy, (iii) implement vaccination, managing supply and demand and cost, and (iv) establish targets and measure outcomes.

The WHO guidelines have not been universally adopted in the region, even though the Member States through the World Health Assembly have agreed to introduce and increase the use of seasonal influenza vaccine.⁷ A target of 75% coverage for those 65 years and older was set for 2010 and only Korea, Australia and New Zealand have met this target. Countries have been encouraged by the WHO to establish influenza surveillance to help define their burden of disease; however, discussion questioned whether any more burden of disease data was really needed, when the published literature from Thailand, Singapore and Hong Kong already shows that the burden in the region is similar to that in countries with temperate climates.

It was suggested that some governments might be reluctant to introduce an influenza control policy as it would oblige them to fund it. A strategy was proposed to help get countries started whereby they would be supported by the WHO with enough vaccine to vaccinate 2% of their population. If then distributed to defined adult risk groups, measurable benefits should be achieved. This would allow an evidence-based, step by step expansion of the country vaccination programme.

Clearly a number of countries have entered into Technology Transfer agreements with the WHO and now have influenza vaccine manufacturing capacity. This has essentially been done to increase capacity for pandemic prepared-

ness; however, there appears to have been little thought given to the inter-pandemic sustainability of this capacity and the adoption of a seasonal influenza control strategy.

Strategies for implementation

The lack of a common goal and unified messages were seen as barriers to influenza control strategy implementation. A country must believe that it wants to prevent influenza and if so focus on the tools that are needed to achieve this. There is a need for consistent messages to attract attention (e.g. the Western Australian 'Snot Funny' campaign) and/or to pull on the 'heart strings' (e.g. interviews with pregnant women who have had influenza). The need for a cultural change was repeatedly mentioned and referred to as 'health literacy', with public health professionals becoming more active and healthcare workers, as public health leaders, playing a greater role as influenza vaccine advocates. Overall there is a need to build general trust around vaccination, and this requires leadership from policy makers and healthcare professionals.

The management of adverse events following influenza vaccination was raised. The occurrence of febrile convulsions in children following vaccination with a seasonal vaccine in Australia led to both adverse media and a dramatic decline in paediatric vaccine uptake, as well as complicating the messages about the vaccination of children. We need to move from discussing the risks associated with vaccination to what is a 'balanced risk' between getting influenza and vaccination and give positive messages about the value of vaccination in 'promoting health' rather than the more negative messages about 'preventing disease'.

The implementation of control programmes should be as straight forward as possible. Adult vaccination strategies are often complex, while paediatric vaccination guidelines are relatively simple to introduce. The perception persists that vaccines are for kids. The US has moved towards a Universal Vaccination programme for children and adults as a way of capturing the risk groups difficult to target. Similarly adult vaccination campaigns targeted at all those aged 65 and over have been quite successful. In this group, it is important to emphasise the improvement in quality of life rather than duration (i.e. 'add life to years', rather than 'years to life'). Adults aged 19–64 years with chronic illness have been much more difficult to target, and we need to find more effective ways of reaching this group, again emphasising positive messages.

Healthcare workers continue to be a difficult group to educate. The education of medical students needs to occur early in their training, ensuring that they get themselves vaccinated. Unfortunately, in a number of countries over the past 10 years, increased education along with improved access to vaccination in healthcare settings has not led to an increase in vaccine uptake. The introduction of mandatory vaccination in the USA and Canada has led to increased

coverage from 45–95% in some hospitals; however, this has required a change in culture, where vaccination is accepted as a condition of patient safety, rather than just for the public and personal health benefits.

The way forward

The first Asia-Pacific Influenza Summit has facilitated the open and wide ranging discussion on influenza control policy issues and influenza vaccination policy implementation and has identified some of the tools needed by participants to assist with policy implementation and advocacy within their own countries in the region.

The formation of alliances to promote and implement influenza control policy is a strategy which has proved to be successful within individual countries and regionally. The first such alliance in the region was formed in Australia (healthcare professionals and non-government organisations) in the mid-1990s, then in New Zealand (Private/Public partnership involving the Ministry of Health) in 2000. The regional alliance, APACI, was formed in 2002 and has identified key opinion leaders in the region and assisted with the formation of Influenza Foundations in Thailand, India and Indonesia and supported other professional groups. Of significance, the Influenza Foundation of Thailand has been instrumental in influencing policy changes and increased vaccine uptake in their country. Additional APACI education initiatives have involved the development of a Website www.apaci.asia, an online regional newsletter 'Influenza' (formerly 'Asian Focus'), a regular media bulletin, translated influenza resources (available online) and collaborative research projects. APACI will continue to foster the development of new alliances and support existing alliances to promote influenza awareness in the region.

A major issue for the region involves the multiple influenza vaccine policies in existence in different countries, with varying adherence to WHO recommendations. Some countries have access to influenza vaccine, but without any policy in place to deliver vaccine to high-risk groups. Countries within the region need to agree on policy direction; however, there has been no consensus on how to move countries in this direction. The first Asia-Pacific Influenza Summit has contributed to a coordinated approach by promoting discussion between key organisations, policy makers and opinion leaders from the region and reinforcing the WHO recommendations on influenza vaccination. Future APACI meetings will build on what has been learnt, strengthen alliances and share influenza control strategies that have been successfully implemented in the region.

Influenza risk communication to policy makers, healthcare professionals and patients is an area of vaccine advocacy in need of improvement. Identifying the best ways to communicate the right messages to different cultural groups within diverse countries in the region is challenging. We recognise that different messaging will need to be used to address the concerns of pregnant women in comparison with diabetics and healthcare workers and, for example, those in China in comparison with those in India. Also, more effective ways of informing and engaging healthcare practitioners are required to ensure that they seek vaccination for themselves and that they advocate it to their patients. Clearly, as a part of influenza vaccine advocacy, APACI needs to develop its central role in risk communication and more effective messaging about influenza vaccination in the Asia-Pacific region.

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