Asian Epilepsy Academy
Strategic Retreat & Business Meeting 2013

Date & Time: 11th January 2013 (Friday), 0800 hrs to 1730 hrs

Venue: Lyrebird Room, Level 3
Grand Copthorne Waterfront Hotel Singapore
392 Havelock Road, Singapore 169663

Participants:

ASEPA Executive Committee

Chairman:	Shih-Hui LIM	(SH)
Members:	Wendyl D'SOUZA	(WD)
	Weiping LIAO	(WL)
	Dede GUNAWAN	(DG)
	Man Mohan MEHNDIRATTA	(MM)
	Yushi INOUE	(YI)
	Josephine GUTIERREZ	(JG)
Ex-officio:	Chong-Tin TAN	(CT)

CAOA Members

Chairman:	Byung-In LEE	(BL)
Secretary:	John DUNNE	(JD)
Treasurer:	Jing-Jane TSAI	(JJ)
Global Outreach:	Ernest SOMERVILLE	(ES)

ILAE Representative

ILAE Vice-President:	Tatsuya TANAKA	(TT)

1. Welcome Addresses

BL wished all a happy and prosperous 2013. ASEPA has made great contributions since its formation in 2003, with increasing activity related to the needs of our region and increasing chapter numbers. We need to innovate and develop new educational and training techniques, in addition to having an outcome-based approach.
2013 is the correct time to review our activities.

SH and CT have our deepest respect and gratitude for their massive and ongoing contributions. We also thank SH for his excellent organisation of this ASEPA retreat in Singapore.

SH welcomed the group back to Singapore, and hoped that we would have a productive and enjoyable experience.
We have a busy schedule with much to discuss. I will be chairing the meeting, with JD acting as secretary and taking minutes.
The objective is to improve the educational and training activities of ASEPA.
Are we making a difference? After 10 years of ASEPA activity it is timely to rethink our approach. Questions about whether the education we have provided so far is optimal and translated into clinical practice or not were highlighted after ES attended local epilepsy clinics after an ASEPA epilepsy syndrome workshop in China.
For this meeting, ASEPA members have been joined by the CAOA executive, the global campaign representative and TT as liaison to ILAE. Financial constraints prevented asking all CAOA members to attend, and the term of office of current CAOA members will soon end.
To redefine our mission, vision and priorities for the future, we need to take into account both the ILAE and CAOA aims and missions.

2. Review ILAE's Vision, Missions and Goals

(attachment: ILAE Strategic Plan July 2009)

TT reviewed the ILAE strategic plan of July 2009, with a particular focus on education of the regions.
Within Goal 1:

1.1.2 - capturing and using education material.
"Reach out to health professionals in all regions of the world who are taking care of persons with epilepsy by making it easier for them to access practice guidelines, classification schemes, consensus agreements, and learning opportunities."
For our region there is increased complexity because of extreme variations in available resources, many cultures and many languages. English for the time being is our only common language.
Aim 2 --"Stimulate and enhance international education and training that concentrates on the prevention, diagnosis, and treatment of epilepsy."
This is the most important point, encouraging local and regional groups as well as other healthcare professionals outside the ILAE. We need to deliver educational outreach for underserved areas and in a format consistent with the local needs.
Education for the regions is a top-level priority for ILAE, acknowledging the major

contributions of CT and SH, and acknowledging that ASEPA is regarded as highly effective by the ILAE executive and commission.

Within Goal 2:

"Aim 1 -- Work with local organizations, ILAE Chapters and Regional Commissions, the International Bureau for Epilepsy (IBE), and the World Health Organization (WHO) through the Global Campaign Against Epilepsy to catalog current practices of epilepsy care in specific regions and then to determine needs."

Within Goal 3: ILAE shall work to ensure its ongoing organizational and financial viability. We are all very proud of ASEPA's hard work and effective budgeting to obtain the most value within a modest budget.

SH and BL congratulated TT for recently having been re-elected as ILAE vice president.

TT stated that his goal was to make a bridge between Europe, the Americas, Africa and the Asian-Oceanian region.

3. Reflecting on CAOA's Aims and Missions

(Attachment: Aims and Missions of CAOA; CAOA Report for 2012)

BL described:

The CAOA primary aim:

To develop, stimulate, and coordinate the epileptology agenda in the Asian and Oceanian regions.

CAOA Missions:

(i) To advance and disseminate knowledge concerning the epilepsies throughout the Asian & Oceanian region

(ii) To improve education and training in the field of the epilepsies in Asia via the formation of the Asian Epilepsy Academy (ASEPA)

(iii) To organize the Asian Oceanian Epilepsy Congresses together with the International Director of Meetings and IBE's Regional Executive Committees

(iv) To facilitate clinically relevant epilepsy research in Asia

(v) To serve as a link between ILAE, IBE, WHO, regional medical organizations to promote prevention, diagnosis, treatment, advocacy and care for all persons suffering from these disorders in the Asian and Oceanian region

(vi) To promote the activities of local chapters, encourage similar policies and administrative structures and facilitate their involvement within the global ILAE agenda

(vii) To review epilepsy services and the size of the treatment gap in each country and aim to improve the former and reduce the latter.

The Current CAOA membership, at our first meeting in 2009, defined eight action plans:

(i) Construct CAOA and ASEPA Website linked with ILAE Web and regional Chapter Websites, and publish the CAOA Newsletter.

Achieved, with a need for further development and enhancement of both the website and Newsletter in future

(ii) Enhance education and training efforts and activities:
   a. continue to provide teaching courses and workshops in regions of need
   b. provide epilepsy fellowships for the nurturing of future epilepsy specialists for the region.
   c. continue to conduct EEG certification examination for the purpose of enhancing the standard of EEG recording and interpretation skills.

All successful and increasing, using a variety of approaches, including the 2 day EEG teaching course format devised by ES and Andrew Bleasel.

(iii) Organize the Asian and Oceanian Epilepsy Congresses every 2 years.
The AOEC is ever increasing in quality and stature, including the recent excellent 9th AOEC in Manila. The publication of the AOEC Proceedings in Neurology Asia is because of CT's leadership and hard work.

(iv) Stimulate Clinical and Translational Research
Patrick Kwan has chaired a workshop and the taskforce and a Priority Document is being drafted.

(v) Promote New Chapter Formation
Vietnam in 2009, Sri Lanka in 2011, and further developments expected, possibly Myanmar in 2013, and Cambodia and Laos later. It is also very important to interact with non-chapter countries that have little resources and great needs.

(vi) Facilitate Global Campaign Against Epilepsy (GCAE) activities
Stakeholders meetings at the AOECs in Melbourne and Manila, chaired by ES, and Forums to reduce the treatment gap and exchange ideas – including the exploration of further demonstration projects in the region with the intent of proving cost effectiveness and influencing government decisions.

(vii) Facilitate Interactions and Communications among Chapters and Commissions
Many activities including the website, newsletter, chapter conventions, Congresses, publications and especially ASEPA activities contribute to this goal.

(viii) Initiate the "Asian and Oceanian Outstanding Achievement Epilepsy Award"
These important Awards have now been presented at the 8th and 9th AOECs, and a dinner honouring the recipients was held in Manila during the 9th AOEC.

In summary, most aims have been achieved, but we require further development of: communications across our region; collaborations in education and research; and further demonstration projects to improve the treatment gap.

4. Present and Discuss the Proposed ASEPA Vision, Mission and Educational Objectives

SH outlined ASEPA vision, mission and educational objectives.
Our vision: is to set the highest training and educational standards to improve epilepsy care.

Our mission: is to ensure health professionals acquire clinical competencies essential in the understanding, diagnosis and treatment of people with epilepsy.

Achieving this mission requires the application of a number of strategies and priorities:

(i) To be the premier distributor of epilepsy education and information
(ii) To set the standard for EEG practice
(iii) To train healthcare providers in the diagnosis and treatment of epilepsy
(iv) To enhance the scientific and training programmes of the regional epilepsy congresses
(v) To support the international organisation in pursuing its educational agenda.

5. Discuss ASEPA's Strengths, Weaknesses, Opportunities and Potential Threats

Strengths (discussion led by MM,WP,TT)

(i) The Asian Oceanian region is the largest in the world, comprising over 60 percentage of the world population.

(ii) Our region has great complexity, with heterogeneity of resources (including well-developed and rapidly developing countries) and a very variable treatment gap (< 20% in some countries and 80 to 90% in others).
Our region has a large wealth of talent, with highly qualified and motivated epilepsy health professionals, both in clinical care and basic research.

(iii) At least some antiepileptic drugs are affordable in most places.

(iv) ASEPA is cost-effective with clinical epilepsy and EEG workshops supported by good local logistics and ASEPA can maintain low costs in resource-limited countries.

(v) ASEPA activities are well planned and coordinated by SH, ASEPA Chair, and the ASEPA membership, and in combination with the CAOA, provide a wide representation for the region.

(vi) **SH** ASEPA has many talented contributors committed to help.

(vii) **CT** ASEPA has a wide variety of resources and interventions within the region, and our organisation has an excellent track record.

(viii) Despite the massive needs of people in our region, we have and continue to make a difference in education and training in treatment.

(ix) **JD** The strengths of our region include:
- Ours is the most vibrant and rapidly developing region on earth.
- Our ability to communicate and interact is unprecedented in world history;

telecommunications allow us now to interact as a community and work together more effectively - this allows training and education programs to flourish.
- Our diversity is our strength with different perspectives and insights.
-Our similarities also give us strength, including common goals and the building of strong friendships across our region.

Potential Weaknesses and Threats (discussion led by JD, WD, SH)

General regional weaknesses include:

(i) Extreme differences in basic health, infrastructure and educational resources, with the poorest nations without clean water, sanitation and basic health care.

(ii) Extreme inequalities exist not only between nations but also within single nations, with poor access to healthcare for minority groups and in remote regions, for example in the North West of Australia.

(iii) Geographic hurdles include difficulties in transport and access dictated by terrain and weather.

(iv) Epilepsy is one of many competing priorities, and a consequence our region has some of the largest epilepsy diagnosis, education and treatment gaps on earth.

(v) Epilepsy priorities vary widely, with region specific training initiatives, from establishing basic services with the help of NGOs to establishing epilepsy surgery services.

(vi) We have many languages and cultures, so there are no universally applicable educational materials and guidelines.

(vii) Medical training and neurology training vary markedly, some healthcare workers having poor clinical skills let alone EEG and epilepsy skills.

(viii) AEDs may be unavailable or unaffordable in many places.

(ix) There are different systems of governance, not only nationally but also within medical administrations. Some medical administrations are resistant to change and have a rigid hierarchy. Even corruption may be present; for example in Australia a large hospital with a private contractor is currently under investigation.

(x) National politics and policies can have a negative influence.

(xi) National superstitions and traditions may diminish the acceptance of modern medicine.

(xii) Past conflicts and prejudices can impair relationships between countries.

ASEPA- specific potential weaknesses

(i) ASEPA itself has an extreme resources gap, with financial limitations and no large corporate sponsors.

(ii) **ES** Our finances are directly controlled by the ILAE.

(iii) ASEPA has a limited workforce. The number of people able to devote time and energy to epilepsy education and training is relatively low within our region. ASEPA is dependent on a relatively small group of people who do most of the work (as is so often the case with many organisations).

(iv) The magnitude of our task can make ASEPA activities seem to be insignificant, and our limited resources must be deployed to a region within which the majority of the world's population lives.

(v) **CT** Leadership issues may also become a potential threat. A four-year term is good, but can also the bad if the leadership is inadequate; much can decline or collapse over a four-year period. We do not have a good succession plan for continuation of our activities, and the composition of membership needs to be clarified to ensure a balance of representation across the region.

(vi) **CT** The potential negative influence of pharmaceutical companies

(vii) **CT** Competitions and rivalry with various training approaches within a country and between countries.

(viii) **SH** As an example, the Indian Academy of Neurology wished to arrange their own epilepsy school with ASEPA assistance, but without with consultation and collaboration with the Indian Epilepsy Society.

(ix) **ES** Caution is required to ensure our goals are not excessive or unrealistic, since we cannot be a provider of all epilepsy education and training. Organisations such as ASEPA "owning" epilepsy training and education may stifle positive developments, so flexibility is required.

(x) **SH** The Chinese Ministry of Health has decided to run its own EEG examination, replacing the ASEPA EEG Certification Examination, though this may be a positive development. **WP** endorsed this indicating that that the government has acknowledged the value of ASEPA EEG certification, and has proceeded to support the development of a national EEG examination strategy.

(xi) **CT** indicated that our region has no natural sense of community, with complex religious, cultural and geographic differences. Asia is a geographic region rather than a cohesive community.

(xii) **ES** described how our diversity can create misunderstandings between countries, including cultural differences that may lead to inadvertent errors in behaviour and approach.

(xiii) **CT** ASEPA is an appendage of the CAOA and this in turn is an appendage of the ILAE. This creates the potential threat that the central body can dominate the agenda.

(xiv) **CT** indicated that commercial groups may organise other events for commercial purposes without ASEPA involvement or direction.

Opportunities

BL

(i) Promoting interactions with local chapters and the regional representatives is essential.
(ii) We need to have more practice-oriented educational measures and need to apply outcome measures.
(iii) We need to have a focused programme on creating new chapters
(iv) We need to compensate for the relative lessening of pharmaceutical support compared to other regions. Fund raising activity for ASEPA is a priority.
(v) We should encourage English Sessions at chapter conventions

JD Whilst our region is very diverse, our communities have many common goals, and economic development combined with telecommunications open opportunities for a cohesive approach. Rapid changes are occurring, such as the recent appointment of a woman president in Korea.

SH/JD Whilst the EEG certification is a beginning rather than comprehensive training, it is an excellent beginning and impetus for increasing skills, and can be followed up with mentoring after the certification.
It is possible to offer ongoing mentoring via email. For example, this has been useful in Sarawak and Australia.

JG The regulation and accrediting process is a serious business, and it is important to check the accreditation processes and requirements of local chapters.
For example in the Philippines, the PLAE works for epilepsy but the certifying body is the Filipino Neurological Association. We should coordinate with whoever determines certification within the country.

ES In Canada EEG certification is linked with the ability to raise a bill for EEG; with the certification process introduced first and then it evolved to become a benchmark for competency and claiming rebates.

CT The Middle East has major educational opportunities. Iran has a population of about 80 million people, and requires support.

ES asked about possible interaction with VIREPA and the education commissions of the various ILAE regions.

JJ Summarise strategies to formulate the action plan and document priorities.

6. Critique & Make Recommendations to the Educational Methods used in ASEPA's Teaching Courses and Workshops

(Attachments: ASEPA Teaching Workshops-2011; ASEPA Report 2012/ASEPA Planned Activities 2013)

SH The various types of teaching strategy include:

(i) 1, 1.5 and two-day courses *vs.* one week summer/winter school courses
(ii) Teaching courses *vs.* workshops
(iii) Didactic *vs.* interactive small group teaching courses
(iv) Case discussion format with key themes, questions and answers, and discussion
(v) Assessment and feedback after courses is important
(vi) Long-term follow-up of outcome after completion of the course

Examples of these differing formats employed in 2012 include: ASEPA Epilepsy Syndrome workshops, the 2-day EEG teaching courses in Cochin and Penang (comprising 30 min lecture and then one hour of small group tutorials), and the 1.5 day Status Epilepticus course in Chongqing, China.

ES What are the local educational needs? We deliver what we think the participants need to know, but does it change local practice? What are the language barriers, including the lectures? The quality of translating and interpreting can vary from place to place. The goals of ASEPA and the global campaign significantly overlap.

How are ASEPA courses determined?

SH indicated that decisions are guided by a combination of our goal to serve the whole region, particularly areas of greatest need, and considering requests from individual chapters.

He outlined a request from Bangladesh, with the initial proposal to a teaching course on video EEG monitoring. However, Mannon, the local chapter head, indicated what was more important was the need for a basic teaching course EEG, given the patchy and poor practice of EEG reading in Bangladesh. Now we plan to provide a basic EEG course.

There is a need for setting learning objectives:
- Targeted audience education
- Learning objectives
- End of the course survey to determine whether learning objectives have been achieved or not.

JD Key issues are to have:

(i) practical goals, no matter how small. Small changes make a large difference - accurate diagnosis and initiation of treatment
(ii) Targeted efforts at an educational level relevant to the particular region. Different countries of our region have very different priorities depending on local needs and resources. For example, in Sri Lanka epilepsy surgery programme has been facilitated, whereas in the Kimberley region of Western Australia and in Timor Leste, training regional health nurses is the priority.
(iii) Courses with didactic lectures to provide practical clinical information/handouts on key topics elevate the profile of epilepsy and build relationships.
(iv) a case based approach to deliver the best learning opportunities
(v) all workshops and courses provide language specific educational materials that are distributed to those attending
(vi) an iterative process, not simply flying in and flying out, but following on with e-mails and perhaps Skype access to clinical and EEG mentoring and advice.
(vii) mentoring post training, for example teleconferencing.
(viii) incremental processes, including building capacity, as has been well shown in the Philippines, Indonesia, India and China.
(ix) recruitment of local colleagues to become involved in education and training efforts.
(x) an influence on government policy, as Josephine and Eleanor have been shown in the Philippines, SH with the EEG Certification course in China, and by ES in Timor Leste.

MM. Teaching courses vs. workshops. Teaching courses comprise didactic lectures characteristically with little interaction, whilst workshops by definition have interactions and tend to be more practical, with a hands-on and problem-solving approach.
All acknowledged that problem solving and interaction were superior for education, particularly cased-based discussion methods.

CT Both didactic and interactive formats have strength, with the keys being the goals, the content and impact. People have a thirst for knowledge.

Whilst small group interactions are optimal and outcomes are of higher quality; this approach is labour intensive, there are language and cultural barriers, and some students may be initially reluctant to engage in more interactive approaches.

In Laos educational material available so poor that didactic lecture notes in themselves become an important as education resources.

In Myanmar, long-term teaching and mentoring of key local people requires financing and a budget, like in the Philippines where educators come back monthly to check on progress and reach out to a wider group of people.

DG Didactic lectures still have an important role in opening peoples minds to the possibilities, given that many audiences have a limited opportunity to here international lecturers, and ASEPA educational workshops can change people's perceptions, aspirations and goals.

Long intervals between educational opportunities is a limiting factor, and involving local teachers and increasing their skills is important.

JD Visiting Professorship

The didactic ASEPA epilepsy syndrome workshops serve an important role in elevating the profile of epilepsy, building relationships and for providing didactic clinical information/handouts, but can only do so much.

The proposal of a visiting professor has previously been raised by **DG** on a number of occasions.

After the Syndrome workshop, one of the faculty to stay on as a visiting professor for several days at a centre to provide mentorship, having established that personal relationship during the ASEPA Epilepsy workshop; with practical interactions in the clinics and the EEG lab.

ES Clinical epilepsy courses can successfully have an interactive format similar to the 2-day EEG course by using cased-based discussions and a problem-oriented approach.

Each topic is covered in 40 minutes:
- a 5-minute case presentation with questions is delivered to the whole group;
- then 15 minutes of small group discussion facilitated by leaders who are provided with a tutorial guide with information covering the questions;
- Then a 10-minute discussion to engage and summarise the opinions of all tables;
- and finally a 10-minute didactic summary presentation, with the provision of a handout.
Repetition is an important factor in consolidating the learning experience.

The clinical questions are very practical, for example “Can I have a baby?” The questions cover a specific syllabus and are targeted to cover topics of the greatest relevance and importance for the participants.

Local input into case-based discussions with local mentors and facilitators could be successful. The audience of similar courses has been mainly neurology trainees and general neurologist wishing to enhance and update their knowledge of epilepsy.

WP The small group and case-based approach could work well in China, with the help of local faculty.

ASEPA teaching in China is very successful with three different initiatives:

a. EEG Certification - learning and preparation for the Exam has practically important outcomes in the quality EEG reading at the coalface.
   Now government policy has been influenced, and the Chinese government has proceeded to develop a local EEG certification examination. Shi Chuo Li considers this especially important for technicians to have passed the national competency examination, with ASEPA certification examination continuing in parallel.

CT felt that the development of an EEG certification in China was a manifestation of the success and powerful impact of the ASEPA EEG certification examination.

b. ASEPA Epilepsy Syndrome Workshops. These very successful and are welcomed by the local participants. They provide structured epileptology knowledge, increase the profile of epilepsy care, and some doctors re-attend these courses to consolidate and increasing their knowledge.

Positive outcomes are evident. For example in Harbin there has been important improvement in epilepsy care since the syndrome workshop in 2011.

Translation of lectures/educational material has been to a very high standard.

We could continue to organise two types of lectures:

- Lectures informing the audience with an overview, for example, the ASEPA Epilepsy Syndrome workshops
- Lectures by which the audience learns details on specific methodology, for example how to use investigations and management protocols, these with more discussion and interactions.

c. Special courses. Examples are the presurgical evaluation and imaging courses. These provide a detailed learning experience and have been both welcome and very successful.

JJ indicated that a paradigm shift was needed, with a change from teacher-oriented to audience-oriented teaching. He stressed the importance of determining local needs and pitching education at the level of locals.

YI There are many educational teaching course formats and needs can change.
Didactic educational teaching courses are needed in some places, and then can evolve and become more case-based and with an incremental approach.
This depends on the individual chapter and it is critical to work with the locals.

DG Target audiences may be general practitioners and primary health carers or specialists
Each country and region may have specific needs, for example the development of primary epilepsy care vs. an epilepsy surgery program.
Training requires both the basic training and then a longer period of mentorship and support.

JG Didactic educational lectures can provide a useful reference and solid foundation, and for most countries play an important role in epilepsy congresses and meetings. Case-based and interactive learning is best, but faculty involvement is intensive and it more suitable for smaller meetings and workshops.

JG Epilepsy manager course for general practitioners. JG described the approach used in the Philippines epilepsy manager course for general practitioners on basic epilepsy diagnosis and treatment.
The course comprises:

- an intensive two days of lectures with comprehensive coverage
- then a follow-up visit to the clinics one month afterwards.
- This visit indicates that the take up of the educational materials from the lectures is not optimal.
- 3-4 visits are often required to consolidate the teaching and learning experience. It takes a while for practice to change, with limitations including the busyness of practitioners, and the lack of time for developing new strategies.

Supervision and follow-up with case discussions, including history and video, have been very helpful.

BL agreed, indicating the importance of engaging local chapters as facilitators and for follow-up.

SH asked about using the Philippines model in Myanmar.
CT was uncertain, although there is much enthusiasm in Myanmar, with 13 neurologists. We can learn as we go along.

SH No one size fits all. The location, target audience, the duration of stay of both the audience and teachers, teaching methods etc. will vary. Topics covered and teaching methods used will depend on infrastructure, facilities and finances.

ALL
We can try to develop a flexible approach with:

(i) Defining educational objectives depending on target audience and local needs
(ii) Educational course/workshops, with a format (didactic and/or interactive case-based) and content appropriate to the local needs, available resources and time.
(iii) Ongoing updating of the programme contents.
(iv) all workshops and courses provide language specific educational materials that are distributed to those attending
(v) feedback post-workshop; end of course survey
(vi) ± visiting professorship for 2-3 days following the workshop to provide mentoring in clinical skills, EEG or both.
(vii) Recruitment of local colleagues to become involved in education and training efforts
(viii) Follow-up will be the responsibility of mainly the local chapters and with local educators. Aim to have an ongoing follow-up, as described by JG.
(ix) Ongoing educational supervision and mentoring; training and supporting the local educators via email and possibly teleconferencing, strengthening the development of personal relationships and local teaching.
(x) Follow-up consolidation workshops.

CT We are hoping to amplify knowledge by training the trainees to train others, who in turn will amplify knowledge by ongoing training of more local people.

WD Ongoing educational supervision is required, particularly if we are trying to change behaviour and management practices.

People's perceptions improve with new knowledge, but then this new knowledge dissipates with time.
Repetition is of key importance with follow-up in order to establish new practices and knowledge.

JD/TT The EEG teaching courses and Certification examination was an important start for increasingly EEG skills, and that follow up via e-mail contact after certification would be possible as well as continuing medical education online.

JJ Training the trainer provides the ability to build local capacity. An educator course or having a key regional person trained in epilepsy and with ongoing support. It is important to develop local capacity to educate and mentor others in the in the region.

JG/JJ <u>How do we measure educational outcomes of ASEPA?</u>
We can monitor the number of epilepsy trainees and specialists.
Program evaluation is relatively easy but this requires local follow-up.

ES indicated that there were difficulties: in resource poor areas measuring outcome is very difficult. In contrast, if the capability to do good outcome measures is present, then the resources are usually already available for good epilepsy care.
How many courses are required per year and what are the limiting factors of doing more?

7. Evaluate ASEPA's Educational Activities during AOECs & IEC

AOECs

<u>AOEC pre-Congress workshops and didactic lectures</u>

SH ASEPA workshops and lectures as a part of the AOECs have been ongoing since the 5th AOEC in Bangkok, 2004.
He outlined the pre-Congress workshops at the 9th AOEC in Manila, including the tranSHational research, drug-resistant epilepsy, the Seino Memorial lecture and five other didactic lectures.

CT These lectures were recorded, and were to be uploaded on the website. This expands the potential audience for these important educational didactic lectures.

JD This excellent lecture resource is not well known and needs to be advertised more generally, including in chapter websites and publications. We should provide provide links for people to access this material, including those who were unable to attend the Congress.

CT Significant delays in website development and in uploading lectures have occurred. Some lecturers were reluctant to give permission to have their talks uploaded.

TT mentioned this was sometimes for copyright reasons.

CT The AOEC pre-Congress workshops often have a focus on basic sciences.

These topics are difficult to present standalone because of costs and their highly specialized and specific content that is less applicable to a more general audience.
However, these highly specialized topics our very important for education, and expert faculty attending the AOEC anyway can to share their knowledge.
Examples include epilepsy and memory, animal models of epilepsy. These workshops may also attract different delegates these topics.
The didactic lectures were Professor Seino's idea, and these attract the greatest audiences because the topics are chosen to have wide and general interest.
Other AOEC parallel sessions have smaller audiences.

TT indicated the importance of including basic science in the programs, including but not exclusive to the workshops.

CT Note that the European Epilepsy Congresses also incorporate more basic educational sessions.
ASEPA has organized more basic educational courses throughout the region, going to areas of need since many people do not have have the resources and opportunities to attending major congresses like the AOEC.

ES At the 8th AOEC in Melbourne, a pre-congress 2-day EEG training course was also delivered, and again the faculty was in Melbourne for the AOEC anyway.
This can make it attractive to run the EEG course in conjunction with the AOEC, and it may be an incentive for some to attend the AOEC.

CT / SH One of the problems with a pre-Congress 2-day EEG training course is that it extends the duration of the AOEC Congress too much.

BL *In summary, we all agree that the AOEC pre-Congress workshops and didactic lectures are logically structured and should continue as is.*

<u>Publication of the AOEC proceedings</u>

CT asked whether the publication of the AOEC proceedings was worth continuing with or not.
WD/JD endorsed the current approach, since it provided excellent educational materials to a very wide audience through *Epilepsy Asia*, both the hardcopy Journal and its free website. (http://www.neurology-asia.org/index.php).

International Epilepsy Congress.

CT The IEC usually has a morning educational programme, and this used to be organised by EREPA. At the Rome meeting the Educational Commission took on the responsibility for the educational programme for forthcoming IEC in Montréal.

Recently ASEPA has been asked to contribute a 90 min educational session to the IEC Montréal, and ALADE has been asked to contribute a 90-minute session in Spanish.

We support for the ILAE educational agenda, and those already attending the Montréal Congress could be involved in an ASEPA badged educational session.

JD indicated that it was disappointing that the regional commissions were not involved from the outset rather than late and with little notice. This would have allowed a more cohesive approach. If we provide a 90 min teaching course, then this needs to be a part of a coordinated teaching effort.

Whilst ALADE organizing a Spanish-speaking session was relevant to many people from the Americas, ASEPA could provide an English patient speaking session but with content more relevant to the Asian-Oceanian region.

BL We are able to provide high-quality general as well as regional specific epilepsy teaching.

CT favoured a teaching course with specific relevance to or highlighting differences in epilepsy issues in the Asian-Oceanian region, perhaps cultural, systemic diseases manifesting seizures or dilemmas in epilepsy care.

YI Other possible topics include the genetic heterogeneity of the region, or Asia specific illnesses like tropical diseases. **WP** agreed.

SH suggested Ethical issues or problem-oriented issues such as clinical dilemmas.

JG suggested clinical dilemmas in treatment such as antiepileptic drug allergies and the treatment of HIV.

Postscript*: it was decided to have a teaching course on "Dilemmas in AED Usage" with 4 speakers who are already speaking at IEC (including BI Lee, CT Tan and SH Lim)*

8. Discuss the Future and Format of ASEPA EEG Certification Examination.

(Attachments: Report of ASEPA-ASNA EEX Exam; Information on ASEPA EEG Certification; Part 2 EEG Examination Schedule)

SH Aim: to set and improve the standard of practice of Electroencephalography (EEG) in the Asian Oceanian region.
Organisation:
This EEG Certification process sets a minimum standard rather than the highest standard.
The EEG Certification Examining Board, chaired by SH, has members representing ILAE chapters and ASNA members from throughout the region.
The examination commenced in 2005, in collaboration with ASNA, for candidates in the region; in 2009 was established in China in collaboration with the China Association Against Epilepsy; in 2012 was held in India in collaboration with the Indian Epilepsy Society.

The Examination is applicable to both neurophysiology technicians and doctors.
Certification serves as an important recognition of competencies, and has an increasing influence throughout our region.

Examiners come from multiple countries and we try to have local and international ASEPA examiners.

Content

(i) Part one - comprises a written examination of 150 multiple-choice questions, similar the American board examination format.
There are three sections: EEG recording techniques and instruments, normal EEG, abnormal EEG including non-epileptiform and epileptiform abnormalities. Long-term EEG monitoring, and the use of EEG in seizures and non-seizure disorders are covered. All 3 sections must be passed, with the mark for each being a minimum of 50% and the average mark for the three sections ≥50%.

(ii) Part two - an oral examination with two 30-minute stations:
   a. the candidate showing two of their own EEGs displayed on their laptops and with written reports for assessment
   b. 20 unseen EEG samples are shown to test for recognition of normal and abnormal EEG patterns and their significance.

The candidate must pass both stations with at least 60%, with a combined average mark ≥65%.

Results:

(i) Part 1: 318 of 517 have passed (61.5%)
(ii) Part 2: 168 of 243 have passed (69.1%).

These figures include people who have initially failed and have set the examinations again.

Questions to be asked:

(i) is there a future for the EEG Certification Examination?
(ii) Should we continue with the part one and two components?
(iii) Is the structure of Part 1 and 2 appropriate?
(iv) Are the passing marks appropriate?
(v) Is the organisation of the examinations optimal?

JD/CT The organisation and structure of the examinations are logical and sensible, including the pass marks, albeit arbitrary but logical and fair.

CT The Part 2 examination gives too many marks for the written report rather than the actual EEG findings. CT suggests altering the proportion of the final mark so that the report is not overrepresented

SH proposed reducing the proportion of the mark for the report from 40% to 30%. ***All agreed***.

JG indicated that the Part 2 two unseen EEGs could have more paediatric content.

ES The certification examination may have several goals, including providing an incentive to learn, protecting the community from poor EEG reading, and pitching difficulty a level that doesn't discourage education.

DG said that the Indonesian candidates were mostly younger people who were eager to learn. **SH** The younger candidates who initially failed tended to re-sit the examination.

SH The Examination fees are US$120 for Part 1 and US$150 for Part 2. These Exam fees are used sometimes to offset the travel costs of examiners, and any balance is sent to **CT** for banking into the bank account of the Malaysian Society of Neurosciences, to support ASNA and Neurology Asia, the official ASNA journal.

CT This is a small funding stream, but increasing the fees could disadvantage many candidates - for example, in Vietnam income was on average US$100 per month, and flying to sit the examination is expensive. He is aware of a Vietnamese candidate who sat the examination twice, and was unable to stay for the AOEC because it was too expensive. This indicates how greatly the examination is valued.

9. Review the Aims, Application Process and Selection of Candidates for ASEPA Fellowships

CT History The ASEPA fellowships have been offered since 2003. Various courses and workshops are no substitute for a period of on-the-job training, ideally for one year but at least for six months.
In 2003, the Epilepsy Research Foundation of Japan was very generous in sponsoring the 1-year fellowship in Shizuoka, and even had preparations in place for the Fellowship accommodation. This was an excellent and generous initiative has been of great value.

In 2004, the Epilepsy Society of Australia also started a 1-year fellowship in Australia, funded an unrestricted grant from the pharmaceutical industry. This initiative was also of great value, although difficulties with fulfilling the strict English language examination requirements for working in Australian Hospitals excluded some candidates. Ongoing funding was withdrawn in recent years.

Organisation
Fellowships offers the best learning experience, but the funding and opportunities are relatively limited.
ASEPA and the Epilepsy Research Foundation of Japan Fellowships cost approximately US$6000, are advertised in June, and 12 to 15 people usually apply.

CT screens the applications, and together with the ASEPA Chair and CAOA Chair the successful candidates are selected. The process takes into account of applicants from areas of greatest need, where applicants want to go and the host institution.

The usual host institutions are Trivandrum, Shizuoka (particularly the candidates from China), Singapore, Kuala Lumpur and Australia. Shizuoka is an excellent host, and Dr Yagi still attends after his retirement to train the fellows.

Outcomes

So far they have been about 40 fellowships with an excellent record. Only two fellows have dropped out, one from Myanmar who spent three months in Japan and another from Bangladesh who migrated to Botswana. All others have completed their fellowships and then contributed in important ways to their countries of origin.

There is a need to develop further opportunities.

TT Japan is now offering a total of 5 epilepsy fellowships per year: two Japanese Epilepsy Society and three Epilepsy Research Foundation of Japan fellowships per year. Details of these fellowships can be found on the website and TT encourages all to invite trainees to apply.

The JES Fellowships have a candidate age limit of < 34 years and the Epilepsy Research Foundation of Japan fellowships of < 40 years.

JD ESA Asian-Oceanian Clinical Epileptology Observerships

The ESA is now offering 3-months clinical epileptology training observerships for early career clinicians from the Asian-Oceanian Region (two this year). The purpose is to offer clinical experience as an observer, and/or training in investigational aspects of epilepsy (e.g. EEG).

There is not age limit, but candidates must be within 5 years of completing local Neurology training. Whilst candidates must be proficient in conversational English, the strict working visa requirements will not apply, and the stipend of up to $10,000 should realistically cover airfare, accommodation and living expenses in Australia – possibly with a need for some local or ASEPA top-up funding.

JG indicated that one year is required for training, and fellowships in Japan have some language barriers.

TT indicated that English was spoken at the training centres, and language concerns should not discourage people from applying.

WD For the Australian observerships, obtaining a three months business was far more realistic and attainable than the one-year clinical working visa.

JD The Australian observerships will allow people to learn at Australian centres without the imposing barrier of the strict English exam.

BL We need to publicise these opportunities. Perhaps we need to have a specific committee determining the successful applicants, and focus on providing fellowships to developing countries of greatest need rather than more developed countries such as China.

JD/CT Whilst taking into account areas of greatest need, opportunities should be provided to candidates from all countries throughout the region. In China there are many areas of need. Chinese candidates should be supported in obtaining training outside China, given the different approaches and learning experience offered in different places.

MM It is important to encourage exchange of ideas and different approaches between countries, and this includes providing opportunities to candidates from all countries

throughout the region. WP, SH, CT and JD all support this.

ES There is also a need to consider the persons who were applying in terms of their access to training and the impact that obtaining training would have locally, and prioritising accordingly. All agree.

10. Discuss & Adopt the Financial Model for ASEPA's Educational Activities & Present the ASEPA 2013's Budget

(Attachment: ASEPA 2013 Budget)

SH We are funding 5 to 10 ASEPA educational courses per year. This pays for the economy airfares for ASEPA faculty (usually for four faculty), with the host city usually supporting meals, ground transport and accommodation, often with pharmaceutical companies contributing to the sponsorship of the venue.

In some countries, greater ASEPA/ILAE support is required. There are times when ASEPA funds both transport and accommodation

Sometimes pharmaceutical companies contribute – but only via unrestricted grants to avoid any conflicts of interest. Multiple pharmaceutical companies are asked to provide unrestricted support.

JG Pharmaceutical companies have educational agendas with budgets, and are open to ideas. This is an opportunity to support our educational initiatives. However, it is essential that we remain fully responsible for the scientific programme, that the pharmaceutical companies do not influence the scientific programme and the funds are donated as an educational grant.

CT Over the years ASEPA finances have changed. Initially funding Dr Seino raised the money, then later pharmaceutical contributions from multiple sources were obtained, and now we are largely dependent on the ILAE. Pharmaceutical support is diminishing.

YI. JES has supported Japanese speakers to attend ASEPA educational workshops and also has obtained some support for ASEPA from the pharmaceutical industry.

JD/CT/SH acknowledged the importance of this generous JES support.

YI asked whether it was possible for other chapters to similarly try and raise funds to support ASEPA.

SH Proposed ILAE budgets have progressively increased and are greater than actual spending. This trend is similar in all ILAE regions, including our own. A fraction of the proposed budget has been spent across the regions; but for CAOA/ASEPA actual expenditure calculations have some underestimates.

The ILAE executive regards ASEPA as efficient and cost-effective, providing major educational initiatives with a modest budget. We have excellent credibility and are ranked highly as providing balanced and appropriate funding requests.

For 2013 ASEPA have budgeted $78,000.

As long as we spend within the annual budget it is possible to provide additional courses.

Postscript: *ILAE has approved the CAOA's budget of US$133,000, which include the US$78,000 for the Education activities under ASEPA.*

11. Discuss Election Processes of CAOA Chair and Members

(Attachments: CAOA Chair MEMBERS 2013 amend.doc; CAOA Election rules summary.xls)

JD The opinions of our membership have been summarized and circulated in a draft document, together with a spreadsheet detailing all feedback received without identifying individual opinions.

The proposed guidelines describe processes designed to best serve the needs of our large and complex region.
They include:
- The election of the CAOA chairperson
- The election of CAOA members and then the appointment of further members to ensure balanced regional Chapter representation.

Discussion regarding the few points without consensus approval was undertaken.

All in attendance agreed to the following alterations to the draft:
<u>CAOA Chairperson</u>.

- A person will usually serve for one term as Chairperson, but may be elected for a maximum of two terms. The chairperson is a key position, and whilst the chairperson will normally serve just one term, we should not limit our choices.

<u>CAOA Membership</u>.

- A total of *up to* 10 voting members are: the Chairperson, 4 elected CAOA members, up to 3 appointed voting CAOA members, the immediate past CAOA chair and the ASEPA chair

- Up to 3 appointed CAOA members to be selected by the Chairperson-elect and ILAE-executive after the election of CAOA members is completed.
    - The purpose for these appointed members is to ensure balanced regional Chapter representation, with the appointment of members of regions not represented after the election.
    - For example, the one-chapter-one-vote system for elected CAOA members may not give adequate weight to countries with the largest populations, such as China and India; to countries with large numbers of ILAE members/epileptologists; and to regions that may be excluded in the election process, such as the Oceania.

The CAOA members hold office for a period of 4 years, but the number of terms of service should not prevent members from serving further terms.

Information Officer - selected by chairperson-elect from CAOA members if they have the required skills. Otherwise, an *ex-officio* Information Officer may be specifically recruited for the position.

It was also felt optimal that for elections the CAOA should approach the regional chapters seeking potential candidates, and then the ILAE electoral committee proceed with the electoral process.

The final guidelines, now with all points agreed to by a minimum of 16 of 17 contributors, will be sent to the ILAE executive for consideration at their meeting.
TT will express our wish to implement these guidelines for this year's CAOA elections.

12. Discuss Appointment Process of Future ASEPA Members

<u>Membership</u>

SH Who decides on membership?

Currently ASEPA comprises the chairperson and six appointed members, with the goal of ensuring with the combined memberships of CAOA and ASEPA have as wide a possible representation across the region.
Ex-officio members include the CAOA and the immediate past ASEPA.

JD This approach is sensible, and it is not practical for every chapter to be represented.

CT We need to have active members rather than members having a passive and honorary role.

BL Each chapter needs to have contact persons, if not the chapter president, for CAOA and ASEPA business.

<u>Term of office</u>

Like CAOA, four years
ASEPA and CAOA terms of office do not currently coincide.

JG ASEPA activity is the major CAOA activity and there lack of coordination has disadvantages.

SH: ASEPA provides continuity of educational effort when CAOA office bearers change.

It was agreed that this arrangement has disadvantages, but also has some advantages in terms of overlapping terms.

13. Update on 10th AOEC

Derek Chan outlined the planning for the 10th AOEC, to be held in Singapore from 24-27 August 2014 in Singapore. The website is soon to go live.

SH outlined the history of the creation of the Congress logo that is regarded as excellent.

Derek Chan presented a summary of the composition of the main sessions, post-main sessions and parallel sessions including topics and some proposed speakers.

The main themes will be psychosocial aspects of epilepsy, the social and economic burden of epilepsy, markers of epilepsy, barriers to epilepsy surgery, AED resistance.

Post-main sessions will include psychiatric, comorbidity, neurophysiology, neurostimulation and generic antiepileptic drugs.

Parallel sessions themes will include epidemiology, education, research, CNS infection, metabolic conditions, epilepsy classification, living with antiepileptic drug side-effects, novel targets of future therapy, and a young investigators session – the same format as the very successful session as that instigated in Manila.

BL The young investigators session instituted in the Philippines was a great success.

In addition there will be video sessions, the debates, workshops and the Seino Memorial and ASEPA lectures.

Derek will send the Excel spreadsheet about the programme, proposed topics and proposed speakers.

Speaker selection will depend on the relevance of the topic, the skills of individual people, and the goal of being inclusive for the whole region.

14. Other Business

<u>ILAE Masterclass in India organized by a private company</u>

CT A company in India (SPIRANT Communication) has contacted the iLAE executive directly and asked ILAE to be a partner in organising a teaching programme in India call the “ILAE masterclass”. The ILAE executive have informed us and asked for our views.
This company can obtain funding from pharmaceutical industry, with the intention of working as an intermediary with the ILAE. They proposed that the ILAE provide American and European speakers, and they would sort out local faculty in India. The sponsoring drug company would determine who would attend. Neither ASEPA nor the Indian Epilepsy Society has been approached.

MM. The Medical Council of India has stringent rules and pharmaceutical companies cannot directly support doctors and so need to go through a third party. In this case, the lack of involvement of the Indian Epilepsy Society and the lack of transparency about the goal of the pharmaceutical company are disturbing.

All agreed that this arrangement should not be supported. The pharmaceutical company deciding who was to attend and the lack of a role the Indian Epilepsy Society or ASEPA are unacceptable. Even the proposal that International speakers are limited to those from the USA and Europe, as if the region does not have internationally recognised experts, is unfortunate. The process appears to be a device to use the ILAE brand name.

WP described how an Indian company had approached him previouSHy. It was organising a meeting in China, and at the last minute withdrew from the process.

<u>Japanese Epilepsy Society fellowships</u>

TT Japanese Epilepsy Society fellowships. We should encourage applications for these important positions.

Meeting closed

Recorded by John Dunne, Secretary, CAOA
Vetted by Shih Hui Lim, Chairman, ASEPA