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Cross-Border Control of Priority Communicable Diseases

*Report of the Regional Consultation
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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
DOTS	Directly Observed Treatment, Short-course: the internationally recommended tuberculosis control strategy
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
NGO	Nongovernmental Organization
PBL	Problem-based learning
SAARC	South Asian Regional Cooperation
SARS	Severe Acute Respiratory Syndrome
SEAR	South-East Asia Region
SEARO	South-East Asia Regional Office

1. INTRODUCTION

Cross-border collaboration has been identified as a major priority by the South-East Asia Region (SEAR) requiring urgent responses at regional, national and most importantly local levels. Population movements on the border, especially those that involve illegal activities have been identified as the key factor contributing to the exacerbation of the problem of cross-border transmission of communicable diseases over the years. Moreover, the problem is affecting not only countries in the WHO SEA Region, such as Bangladesh, Bhutan, India, Indonesia, Myanmar, Timor-Leste and Thailand, but also countries in the Mekong Basin in Yunnan province of the People's Republic of China, Laos, Cambodia and Vietnam. To be effective, efforts to address problems such as HIV/AIDS, tuberculosis, malaria, and kala-azar require collaboration across borders between respective countries. Such efforts should not look at a disease in isolation but emphasize integrated, collaborative action. All relevant resources including government agencies (e.g. health, immigration, and police etc.), local NGOs and the community need to be fully mobilized and involved.

Many activities are needed at various levels prior to implementation of cross-border initiatives for control of HIV/AIDS, kala-azar, polio, SARS, TB and malaria. These include: an affirmation of the right of patients to receive essential drugs, bed-nets, health education, condoms and other commodities, regardless of citizenship or place of residence; links developed via regular cross-border meetings between respective programmes; developing joint strategies and programmes including a cross-border referral mechanism for malaria, TB and sexually-transmitted infections; a mapping of treatment centres namely DOTS sites for TB on both sides of the border; preparing standardized training materials, and establishing regular communication between two sides of the border.

In the past, a number of cross-border meetings have been supported and organized by WHO. However, cross-border collaboration needs to be institutionalized and action initiated most importantly at the local border areas. The role of WHO in this regard includes advocacy; providing technical support to Member countries, and mobilizing resources. Close collaboration with regional associations such as SAARC and countries in the Mekong Basin is expected to ensure sustainability of cross-border activities.

The specific objectives of the meeting were to:

- (1) Review the progress made so far in planning and implementing cross-border control of priority communicable diseases in the SEA Region;
- (2) Share experiences and lessons learned particularly from various pilot projects in border districts, and to identify key challenges undermining effective implementation at various border areas, and
- (3) Recommend follow-up actions at various levels, including the policy, programme and operational levels to further strengthen and expand cross-border initiatives.

2. OPENING SESSION

Dr Supang Chantavanich, Director, Institute of Asian Studies, Bangkok, Thailand welcomed participants from several Asian countries, WHO technical staff and temporary advisers, and staff of the Asian Research Center for Migration, Chulalongkorn University, Bangkok. The Asian Research Center was established in 1995 to gather information on the movement of people, causes and consequences of movement, and to develop positive reactions to these consequences in the field of health, academia, and politics. One of the major consequences of this movement was the spread of communicable diseases across borders. This negatively impacted the health and economy on both sides of these border areas. However, through collaborative actions and idea-sharing, these negative consequences could be minimized. Dr Chantavanich concluded by thanking all participants who were involved both directly and indirectly in this consultation.

Dr Bjorn Melgaard, the WHO Representative to Thailand, addressed the gathering on behalf of Dr Samlee Plianbangchang, Regional Director, WHO/SEAR, who was unable to attend. Communicable diseases were a major concern throughout the world. HIV alone had infected 40 million people worldwide and six million in South-East Asia. HIV had been spreading rapidly at border areas due in most part to prostitution and drug use. Additionally, tuberculosis was also emerging as one of the biggest killers of adults in this Region, claiming the lives of one million people every year in South-East Asia alone. As the battle raged on to control this disease, it was

becoming more and more drug resistant. Likewise, certain strains of malaria were also becoming drug resistant. As population movements increased for various reasons, such as economic, educational, and conflict, etc. the spread of these diseases also increased. These migrant populations were often subject to greater infection rates than the local populations due to lack of resources.

Although WHO often organized cross-border meetings, local action did not always follow. It was imperative that active collaboration and project implementation took place. Two main areas of focus were: strengthening of health services at border areas, and developing an adequate educational plan at border sites.

Lastly, Associate Professor Jeerasak Nopakun, Vice-President, Chulalongkorn University, Bangkok, spoke on behalf of the University. The main goals of Chulalongkorn were to break new ground, as well as to research and to share knowledge towards the prosperity of the society. As technology advanced, communication and exchange of goods were facilitated. Conversely, however, people and therefore diseases were also easily transferred between countries. Chulalongkorn was committed to collaboration in combating these issues.

3. TECHNICAL SESSION

3.1 Intensification of Cross-Border Collaboration in Control of Priority Communicable Diseases

Dr Ying-Ru Lo, Medical Officer (AIDS), WHO/SEARO urged sensitivity and understanding when working on cross-border collaboration, as it inherently encompassed politics. Due to globalization, trade, tourism and improved infrastructure for movement, both legal and illegal cross-border movements were increasing. Most of these movements involved young, single adult males who moved with the hope of finding work. They were often unfamiliar with other cultures and languages; and being out of their safety net they were also susceptible to alcohol, drugs and prostitution. The cross-border spread of disease had increased due to several factors. Some of these were: lower diagnosis; less treatment; inconsistent treatments across borders; lack of data in these areas; inadequate health facilities; language barriers; remote areas that were poorly accessible; dichotomy between national and local policies, and lack of authority at the district level.

Based on the severity of this problem, WHO had established three main priorities at these border areas: (i) recognition of health problems; (ii) commitment to all individuals in these areas, and (iii) coherent policies for diagnosis and control.

WHO had been making progress in cross-border disease control since 1998 and would continue to play a significant role in the future. It will continue to advocate on behalf of this problem, facilitate collaboration between countries, provide technical support, expertise and materials where appropriate, and continue to be instrumental in the preparation, implementation, monitoring and evaluation of pilot projects at borders between Nepal, India and Bangladesh and between Myanmar and Thailand.

3.2 Cross-Border Population Movements and their Implications for Communicable Disease Control

Dr Supang Chantavanich presented some background information on migration and its effect on cross-border disease control. Migration was defined as a large number of people moving a significant distance from their origins, for an extended period of time. Migration could be voluntary in the case of labour, education, and health or it could be forced because of differences in ideology, race, politics, and religion or because of disaster or development. Forced migration often led to one of the four main labels: (i) Refugees - people who fled persecution across borders; (ii) Internal Displaced Persons - fled persecution/conflict but remained in the same country; (iii) Asylum seekers - fled persecution/conflict but did not received refugee status, and (iv) Person of Concern- fled for political/ideological reasons.

These migrants were at a high risk for malaria, TB, filariasis, dengue fever, diarrhoea, HIV/AIDS, and SARS to mention only a few. Some of the most vulnerable migrants were ethnic minorities, children, commercial sex workers, agricultural workers, fishermen and truck drivers. High-risk areas included border areas, border towns, transit points, seaports, construction sites, and cattle markets. Access to health services was often limited for these migrants due to location and foreigner status, etc.

Various challenges abounded in this issue of cross-border disease transmission. Individually, migrants were in higher-risk situations with less adequate support and resources. At national and regional levels, progress was

impeded by increased population movement, political and armed conflict, human trafficking, poor cross-border collaboration, and misguided media exposure.

3.3 Cross-Border Control of Communicable Diseases: Some Success Stories

Ms Pawana Wienrawee, Technical Director, Programme for Appropriate Technology in Health (PATH), Thailand presented a description of the project "Promdan: Source-Destination Intervention to Promote Migrant Health 1999-2003." The target group of this project was Khmer migrant workers who came from Preyveng, Cambodia to work in Rayong, Thailand. This migrant community was estimated at approximately 7 000 individuals who were frequently moving back and forth between the two cities. Most of the migrants came to earn money, while others were enticed by the chance to see the world, gain more freedom, or to just have fun. However, these hopes were also accompanied by fears. Some migrants feared returning home empty-handed, some worried about the different culture and language, while others were worried about feeling lonely, getting sick or being arrested.

One of the biggest problems in this migrant community was the high risk for acquiring HIV (3.7%). Some factors leading to this were as follows: single men, men travelling without their wives, a lot of cash paid at one time, and low availability of condoms.

The goal of this project was to intervene in order to curb the spread of HIV in this community. First, they hoped to increase the community's awareness about the problem and the use of condoms. Additionally, the project aimed to increase access to health services, immunizations, vaccinations, and immigrant registration. The project also looked to help the community in family planning. Attempts were also made to aid the social-economic-cultural aspects of the community. PATH looked to increase communication/bonding among migrants and between migrants and their families. Migrants were also helped in formulating a savings plan and creating investment schemes in Preyveng. PATH was also instrumental in promoting cultural understanding between the people of Thailand and Cambodia. On the level of advocacy, the project worked to increase communication between Thai authorities and the migrants. Also, relations between service providers on both sides of the border were created. Lastly, a Cambodian

Community Centre (Drop-in centre) was established to help in settling the migrants.

The project has and continues to yield several positive outcomes. The community's knowledge of HIV/AIDS has increased significantly, coupled with the increased availability of condoms, and consistent use of condoms (self-reported). Additionally, the migrants have greater access to health services, with full coverage of all antenatal and post-delivery cases. Contraceptive use has increased from 42.7% to 53%. As a result the community has achieved a higher level of health. Community and familial connections/bonding have increased. Finally, the collaboration between health systems and services in the area has increased.

Although the project was highly successful, there were some challenges in its implementation. For example, there were political stumbling blocks in the labour registration process. The illegality of migrants getting pregnant leads to health problems. The process of monitoring and managing migration is not adequate and no comprehensive referral system is in place. Finally, migrants need a representative body in order to highlight their needs and handle an often stigmatizing and stereotyping media.

With the completion of this part of the project, several lessons were learned. It is essential that a multi-dimensional partnership be created for the success of the project and for the benefit of the target group. Additionally, a sufficient amount of time and project continuity must exist. In conclusion, it is important to remember that this effort is more than a health project, it is foremost an exercise in humanity and the formation of a "culture of peace."

Following the presentation some comments were raised. A question was raised on the method of referral and follow-up on migrants. Ms Pawana responded that individuals with confirmed diseases were recommended to visit a clinic upon return to their country.

3.4 Integrated Control of Diseases at District Level along Border Areas: Lessons Learned

Dr Thomas Koenig, WHO Temporary Adviser, spoke about the WHO project ICP OSD 001. This project consisted of 11 pilot districts at border areas in Bangladesh, Bhutan, Nepal and India. The goal of this particular project was

to institutionalize cross-border collaboration and information exchange between these countries in relation to controlling HIV, TB, malaria, and kala-azar. This project was set to start in 2001 and to cover situational analysis, advocacy coordination, information exchange, capacity-building, implementation, monitoring and evaluation.

In 2003 an assessment was performed in the pilot district to evaluate the progress. A Joint Plan of Action was finalized and signed by all sides except India. Also, the governments had been effectively collaborating with NGOs. Task forces were created that focused on disease prevention. Although the project did produce some results and was a step in the right direction there were also some miscalculations. First, the magnitude and the scope of the project were far too ambitious and expectations were too high. Commitment on all sides needs to be increased. In addition, there was difficulty in the passing of information between different levels within each country. Likewise the district levels are in need of capacity-building in order to acquire the ability to implement policies fully. The high level and frequency of health worker turnover severely impedes the continuity of the project. Lastly, WHO itself needs to monitor the project more closely at all levels. In order to ensure a successful outcome these areas need to be improved.

In response to the presentation, participants made some comments. First, government policies were difficult to be influenced, e.g. failure of India to sign the Memorandum of Understanding (MoU). Also, expectations were often too high on some countries' ability to embrace changes in policy because of the sheer size of the administration and its limiting bureaucracy. It was also suggested that at meetings such as this, the participant group should include experts of each disease group from each country.

3.5 Emerging Infections: Need for Cross-Border Collaboration

Dr Brian Doberstyn, WHO Temporary Adviser and former WHO Representative to Thailand, and Director, Disease Control, WHO Regional Office for the Western Pacific, made a presentation on infectious diseases, mainly SARS, and WHO's and the international community's role in combating the infection. An emerging infection is one that either originates from a previously unknown organism, is a previously contained infection, or is one that has modified from its previous form. Changing environments, genetic

mutations, species jumps, failed containment programmes or bio-terrorism can all act as catalysts for the spread of a new infection. In order to successfully control such an event, collaboration must occur at all levels: district- district, country- country, regional networks, extra-regional networks and international leaders e.g. WHO.

In the example of SARS, the infection spread with extreme speed infecting 8 000 and killing 800 people in less than six months. Individual cases led to infections of others, sometimes spreading to more than 10 other countries. International communication and aid was vital in containing SARS. Heads of State stayed in regular contact and multiple country meetings were held frequently. ASEAN held a series of meetings and the Asian Development Bank allocated funds to support the experts. International agencies like the CDC and EPICENTRE provided technical support and laboratories. Various governments including Japan, Australia, and America provided funds. WHO activated its Global Outbreak Alert and Response Network. This association of laboratories, epidemiologists and specialists proved invaluable in containing SARS.

After the SARS outbreak the strengths and limitations of WHO became more evident. Its positives are its increased credibility in fostering partnerships and its access to high-level national governments. Also, WHO has a global network of staff and experts in place who can communicate via a hi-tech system of communication. On the other hand, WHO is limited by insufficient funding, duplicated, non-uniform efforts, lack of regional authority, bureaucracy and slowness of response.

Several key lessons were learned from the SARS epidemic. The international epidemiological capability needs to be augmented; this includes the upgrading of laboratories. Also, better infection control hospitals must be established in Asia. Health institutes must deal with the media more effectively. The world must be more prepared with experts, supplies and focal points. Lastly, there is no place for cover-ups; all information must be shared.

Following the presentation some comments were made. Some participants believed that there were too many regional networks and they should be consolidated with WHO support. One participant pointed out that in the case of SARS and avian flu, it would be advantageous if WHO had some involvement in animal health or had an expert on the link between

animal infections and human infections. Also, international health regulations needed to be finalized. It was pointed out that the collaboration initiated between countries during the SARS outbreak should be carried over to other diseases. Lastly, it was decided that for purity of definition and role, WHO should be considered a “leader”, and not a “broker”.

4. SMALL GROUP DISCUSSIONS

4.1 Gaps and Needs in Cross-Border Collaboration

Four groups were formed with representatives of relevant countries to discuss:

- (1) Bangladesh, China, Myanmar and Thailand.
- (2) Bangladesh, Bhutan and Nepal.
- (3) Indonesia and Timor-Leste.
- (4) Cambodia, Laos and Thailand.

Participants in each group discussed the gaps and needs about their respective borders in five technical areas: (i) situational analyses; (ii) advocacy and coordination mechanisms; (iii) information exchange mechanisms; (iv) capacity-building, and (v) programme implementation, and monitoring and evaluation. The summary of results of the small-group discussion is as follows. (The detail of discussions of each group are in Annex 2).

- *Situation Analysis:* All participants agreed that there was no system in place for joint analysis or for cross-border epidemic warnings. A greater focus on developing standardized surveillance system and outbreak investigation will improve the quality of situation analysis on the border. Academic cooperation among countries will be the key to success.

In addition, local security was identified as one of the key elements in developing sustainable situation analysis on both sides of the border. Access to target groups for situation analysis was usually limited, as border areas were normally restricted areas. Also, there were difficulties in a joint effort on situation analysis at the lower levels due to language barriers. Political understanding and tolerance are also vital to cross-border collaboration for disease control.

- *Advocacy and coordination mechanisms:* A common working definition of “collaboration” was key to the building of this type of mechanisms. Policies needed to be agreed upon at the national level, and then comprehensively disseminated down to the operational levels. Focal points for advocacy and collaboration on each border area might help.

All participants agreed that good relationship between local authorities on both sides of the border was key to all other technical coordination and collaboration. Such relationship was yet to develop at certain border areas, while it needed to be strengthened in other areas. The participants felt that there were insufficient district-to-district collaboration mechanisms. Regular meetings between local disease control officers posted at the border was imperative. They also felt that such collaboration at certain borders was a daunting task. Therefore, an agreement at the highest intergovernmental level or a Memorandum of Understanding (MoU) would be instrumental in such development.

- *Information exchange mechanisms:* Vital information essential for decision-making was lacking on both sides of the border. Accuracy of such information was also questionable. Long-term support for information exchange was still insufficient. At certain borders, the participants felt that information exchange was non-existence.

The technical aspects of information collection and sharing needed to be developed. A common system for early outbreak detection, quarantine, and referral needed to be developed, and health workers on both sides of the border trained. Information from both NGOs and government sources needed to be collected and shared by people on both sides of the border.

Political commitment from governments at all levels was essential if such mechanism was to be fully developed and sustained.

- *Capacity-building:* All participants agreed that there was a need for a clear joint action plan for cross-border disease control for priority diseases before collaborative capacity-building could be planned. The technical aspects of disease control and prevention such as standardized definitions, outbreak detection, surveillance system, and referral system, including the necessary manuals or job aids, must already exist before coordinated training activities at all levels can be planned.

Training curricula and other materials must be developed specifically for target trainees at borders. In addition, the participants pointed out the inappropriate selection of trainees as an important gap that needed to be corrected.

- *Programme implementation, and monitoring and evaluation:* The participants pointed out that disease control project sustainability was problematic. A joint work plan approved by all involved must be created with consistent indicators. A comprehensive system for monitoring and evaluation, and a standardized case definition, case management, vector control, and referral system were also essential.

In addition to technical development, programme implementation, and monitoring and evaluation, also needed commitment from both sides of borders. More funds must be allocated for the programme. Political commitment was also necessary if the programme was to be successful.

4.2 Group Discussion on Four Topics

Four groups were formed with the task of covering four different aspects of cross-border collaboration: (i) Situation analysis; (ii) Advocacy and coordination mechanisms; (iii) Information exchange mechanisms, and Capacity-building.

Group I focused its discussions on the *situational analysis* between cross-border areas. It highlighted certain components to be fully understood including geography, demography, health systems involving both public and private sectors, security, and disease in border areas. Members of the Group examined the legal aspects of immigration, information transfer, migrant rights and authorization of local authorities. The importance of surveillance and collection of necessary information, e.g. migration patterns, epidemiology of diseases, was also identified. Standardized baseline information must be available, and updated regularly for immediate implementation and monitoring and evaluation of activities.

To be able to achieve the above mentioned goal, the group believed that:

These issues should be examined at three different levels: local, national and international. Lastly, the issue of an international organization, that is, WHO acting as a “broker” between governments, for example, ministries of health, and ministries of foreign affairs, and other organizations such as the International Organization for Migration (IOM) and NGOs, as well as academic community also be looked at. This would lead to the production of necessary tools or methodology for situation analysis, planning and implementation of disease control on both sides of an international border. The Group also discussed the importance of human resources from outside, as well as funding for human resource capacity-building.

Group II looked at *advocacy and coordination mechanisms* between cross-border areas. Again this group broke the subject into three different levels: local, national and international.

At the local level, joint meetings among health officials, specific agreements or MoUs, identification of focal points, critical review of coordination mechanisms, and involvement of the local population, were the important points of discussion.

At the national level, four main areas were discussed. In order to develop comprehensive advocacy and coordination, the national sector must ensure sustainable funding, hold multisectoral meetings, support local activities, and ensure government commitment for the sustainability of the project.

At the international level, priorities needed to be identified and an action plan developed which would allow for the coordination of all the three organizational levels. This international collaboration should include all willing international organizations.

Lastly, the Group discussed the need and importance of having a focal point both at the local level, and at the district and provincial level. Such focal points needed to ensure preparedness for any potential disease outbreak. They needed to respond immediately in order to inform all levels on both sides of the border, as well as the media. Lastly, they needed to assign specific tasks to appropriate technical units.

Group III looked at **information exchange** across borders. Three situations were reviewed: (i) cross-border movement; (ii) migration, and (iii) international travellers. These three situations should be kept in mind when developing specific plans for information-sharing. The important aspects of information-sharing were: regular meetings and outbreak task forces, designated focal points, various mediums of information exchange, statistical reports, collection and sharing of migration data, referrals, and collaboration with the media. Additionally, the Group discussed the importance of an international agency such as WHO taking the leading role in case of outbreaks. Lastly, ASEAN should continue to develop and utilize the network for information exchange.

Group IV set out to discuss **capacity-building**. In order to build useful skills, the group members proposed that four different target groups, as well as the skills necessary for cross-border collaboration, be identified.

- (1) Health staff posted at international borders should have the following skills:
 - Technical skills according to the national disease control programme, especially case definition, disease management, surveillance and outbreak investigation, and vector and its control;
 - Communication and networking skills, especially skills essential in dealing with the media, as well as other governmental agencies and allies, for example NGOs;
 - Managerial and coordination skills, for example, decision-making, and logistics, and
 - Training skills for different target groups, using different educational approaches.
- (2) Non-health government staff
 - Communication and coordination skills, in respect of both allies and beneficiaries;
 - Basic epidemiology, early case detection, case management, reporting and epidemic alert;

- The importance of their roles and responsibilities (attitudes and behaviours), and
 - Resource mobilization at the local level.
- (3) Beneficiaries and volunteers should be trained on:
- Environmental hygiene, vector control and disease prevention measures;
 - The importance of their roles, legal rights, and responsibilities (attitudes and behaviours), and
 - Access to health care services.
- (4) Nongovernmental organizations
- Communication and coordination skills, in respect of both allies and beneficiaries;
 - Networking skills;
 - Basic epidemiology, case detection, management and epidemic alert, and
 - The importance of their roles and responsibilities (attitudes and behaviours) in early case detection and management.

The curriculum for each group would be created using participatory approach, that is, obtaining input from experts, target groups, and the government. Different training packages and educational approaches should be considered for different target groups. Local institutions and existing networks should be used for training needs assessment. Training techniques that ensure skills development, for example, performance –based training, problem-based learning (PBL), and other participatory learning methods, should be used.

In relation to project implementation, monitoring and evaluation, several key points were identified. For project success the following aspects were found to be critical: standardization of disease control measures and indicators, information exchange mechanisms and surveillance, standardized reporting system, and a comprehensive joint action plan.

5. RECOMMENDATIONS

5.1 For Countries

- (5) **Situation analyses** to assess the current situation of cross-border control of priority communicable diseases (CDs) in selected border areas, using rapid assessment and response tools should be conducted, acknowledging that control activities of non-vectorborne CDs are not limited to border districts but should take into consideration types and patterns of population **migration**;
- (6) Implementation of existing Memoranda of Understanding on cross-border control of priority CDs and Agreements on Performance of Work on cross-border pilot projects should be reinforced;
- (7) **National resources** should be allocated and, if needed, **external resources** should be mobilized for cross-border control of priority CDs through other agencies such as GFATM, and development partners;
- (8) Responsible and dedicated **focal person (s) should be designated, at national and local levels** for cross-border control of priority CDs to coordinate among national programmes;
- (9) **Local authorities** including the Customs Immigration Quarantine (CIQ) officials and **communities** in border areas should be empowered to exchange information to plan and implement control measures across borders;
- (10) Work should be done on the **standardization** of case definitions, case management, reporting and surveillance systems, and outbreak alert and responses where appropriate, as well as on **synchronization** of vector and certain control measures in border areas;
- (11) Border populations and migrants should be included in the existing **surveillance** as well as in planning, management, monitoring and evaluation systems;
- (12) An **information exchange mechanism** should be established through periodic meetings at national and local levels, and through exchange of regular, standardized reports;

- (13) A training **needs assessment** should be conducted and development and adaptation of a **core training package** be undertaken for skills development involving beneficiaries and implementers in the process, and
- (14) National capacity should be increased in establishing or strengthening simple **early warning and response systems** for disease outbreaks through training of epidemiologists in field epidemiology.

5.2 For WHO

- (1) **Situation analyses** should be facilitated to assess the current situation of cross-border control of priority CDs using rapid assessment and response tools, acknowledging that cross-border activities of non-vectorborne CDs are not limited to border districts but should take into consideration types and patterns of population migration;
- (2) **High-level advocacy** should be facilitated with Ministries of Health, Ministries of Home Affairs, Ministries of Foreign Affairs and Ministries of Labour for cross-border control of priority CDs towards signing and implementation of Memoranda of Understanding (bilateral or sub-regional) utilizing existing global and regional networks such as ASEAN, SAARC and the Global Alert and Response Network;
- (3) Member States should be supported in **mobilizing resources** for cross-border control of priority CDs from agencies such as GFATM and other development partners;
- (4) A **focal unit and person** should immediately be designated at the WHO Regional Office for cross-border control of priority CDs, and efforts made to speed up the adoption of International Health Regulations by the World Health Assembly and to coordinate among technical units and with country offices;
- (5) Work should be undertaken with countries on the **standardization** of case definitions, case management, reporting and surveillance across countries and **synchronization** of vector control measures,;
- (6) Member States should be encouraged to include **border populations** and **migrants** in the **existing surveillance**, as well as in planning, management, monitoring, supervision and evaluation systems;

- (7) A “clearing house” for documents, reports, data base on cross-border assessments, response, ongoing implementation, monitoring and evaluation should be established as an **information exchange mechanism** in WHO regional offices and selected country offices;
- (8) A **communications person** should be assigned at **WHO regional offices** and **selected country offices** to interact with the **media** on epidemic alert and cross-border control of priority CDs across countries;
- (9) A **needs-based core training package** should be developed skills development involving beneficiaries and implementers in the process, which can be locally adjusted to specific circumstances;
- (10) The regional expertise of WHO should be strengthened in **veterinary public health**, and
- (11) WHO should take the lead in strengthening national and regional networks of **epidemiologic alert and response** for the management of disease outbreaks.

Annex 1 PROGRAMME

17 March 2004

- 0900–0930 hrs Welcome Speech
Dr Supang Chantavanich, Director, Institute of Asian Studies

Dr Samlee Plianbangchang, Regional Director, WHO/South-East Asia Region

Remarks by Dr Bjorn Melgaard, WHO Representative to Thailand

Opening Remarks by Associate Professor Jeerasak Nopakun, Vice-President, Chulalongkorn University, Bangkok
- 0930–0950 hrs Intensification of cross-border collaboration in control of priority communicable diseases
Dr Ying-Ru Lo, WHO/SEARO Medical Officer (AIDS)
- 1030–1100 hrs Objectives of the Meeting, Announcement of Chairpersons and Co-Chairpersons and Administrative Concerns
- 1100–1130 hrs Cross-border Population Movements and Implication to Communicable Disease Control
Dr Supang Chantavanich, Director, Institute of Asian Studies, Chulalongkorn University
- 1130–1200 hrs Cross-border control of communicable diseases: Some success stories
Ms Pawana Wienrawee, Technical Director, PATH
- 1300–1330 hrs Integrated control of diseases at district level along the border areas: Lessons learned
Dr Thomas Koenig

1330–1600 hrs Break-out session: Status of cross-border priority communicable diseases and issues to be addresses at each border area

- Bangladesh, China, Myanmar, Thailand
- Bangladesh, Bhutan, Nepal
- Indonesia, Timor-Leste
- Cambodia, Laos, Thailand

1600–1700 hrs Presentation of findings, questions and answers

18 March 2004

0900–0930 hrs Reflections and general discussions

0930–0950 hrs Emerging infections: Need for cross-border collaboration
Dr Brian Doberstyn

0950–1000 hrs Questions and Answers

1000–1230 hrs Break-out session: Group work: identifying way forward in each border area including proposed activities, collaboration mechanism, resource mobilization in four groups:

- Situational Analysis
- Advocacy and Coordination Mechanisms
- Information Exchange Mechanisms
- Capacity-building

1330–1430 hrs Presentation of findings and discussions in Break-out session

1500–1645 hrs Presentation of Draft Recommendations and discussions

1645 hrs Closing

Annex 2

RESULTS OF GROUP DISCUSSION

	Group 1	Group 2	Group 3	Group 4
Situational Analysis	<ul style="list-style-type: none"> • Insufficient information on local diseases • Inadequate access to target groups • No system for joint analysis or for cross-border epidemic warnings • Difficulties in collaboration on the lower levels due to language barriers. 	<ul style="list-style-type: none"> • Lack of current data analysis • Lack of political understanding and authorization. 	<ul style="list-style-type: none"> • Local security is key to develop cross-border cooperation. • A greater focus on priority diseases needed. • Surveillance and outbreak investigation needs improvement. • Academic cooperation will help to inform the population and improve health systems. 	<ul style="list-style-type: none"> • Coordination of all border areas and personnel is a daunting task.
Advocacy and Coordination Mechanisms	<ul style="list-style-type: none"> • Lack of long-term support. • Relationships between local authorities on both sides of the border need strengthening. • Policies need to be agreed upon at the national level; then comprehensively disseminated down to operational levels. 	<ul style="list-style-type: none"> • Agreements and MoUs need to be finalized and acted upon. • Focal points in cross-border areas to be identified. 	<ul style="list-style-type: none"> • The absence of definition of collaboration. • Working groups to be established to propose standardized activities. 	<ul style="list-style-type: none"> • Insufficient district-to-district collaboration mechanisms. • Health facilities on both sides need to provide care for all.
Information Exchange Mechanisms	<ul style="list-style-type: none"> • Lack of information at borders • Accuracy of existing information questionable. • Information needs to be collected on both sides and exchanged on a regular basis. • Information should be extrapolated from both NGOs and govt. sources and • Rumored outbreaks should be investigated first-hand. 	<ul style="list-style-type: none"> • Authorization and legality of policies and agreements must be respected. • The technical aspects of information collection and sharing need to be developed. 	<ul style="list-style-type: none"> • Presently, no information exchange exists, so information gathering and exchange needs to happen at all levels between these countries. 	<ul style="list-style-type: none"> • The system of early outbreak detection, quarantine, and referrals needs to be developed. • Information exchange needs to be expanded to all cross-border sites. • Information dissemination within and between countries needs improvement.

	Group 1	Group 2	Group 3	Group 4
Capacity-building	<ul style="list-style-type: none"> • The lack of training curricula and materials • Inappropriate selection of trainees. 	<ul style="list-style-type: none"> • Lack of proper training materials • Lack of coordinated training activities at all levels. 	<ul style="list-style-type: none"> • Lack of training materials need to be developed • Cross-border training activities need to be conducted. 	<ul style="list-style-type: none"> • More visits and meetings need to be conducted across borders, especially at the district level. • Clear joint action plan needs to be developed to increase technical expertise on both sides of borders • Local officials need to understand policies developed at the national/ international level.
Programme Implementation, Monitoring and Evaluation	<ul style="list-style-type: none"> • Project sustainability is problematic • Lack of systematic monitoring and evaluation • Absence of a referral system. 	<ul style="list-style-type: none"> • Standardization of case- definitions, case management and vector control is essential. • A comprehensive system of monitoring and evaluation needs to be developed. 	<ul style="list-style-type: none"> • A joint work plan must be created with consistent indicators. 	<ul style="list-style-type: none"> • Standardized control activities need to be developed. • More funds for programmes. • MoUs should be developed and implemented.
General Comments	<ul style="list-style-type: none"> • The importance of proper handling of the media, outbreak and warning systems, political commitment, • Empowerment at the district level • Inclusion of beneficiaries in meetings. 	<ul style="list-style-type: none"> • There is a lack of high-level intergovernmental commitment. 	<ul style="list-style-type: none"> • Since collaboration here is in its infancy, it is imperative that yearly meetings occur at all levels. • How can countries quickly release national data while still following government guidelines? 	

Annex 3

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