

SEA-CD-126  
Distribution: Limited

# Cross-border Control of AIDS, TB, Malaria and Kala-azar in Pilot Districts of **Bangladesh** and **India**

*A Joint Plan of Action*

WHO Project: ICP OSD 001



World Health Organization  
Regional Office for South-East Asia  
New Delhi



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## EXECUTIVE SUMMARY

Globalization and trade combined with socio-economic disparities have resulted in increased migration across international borders in South-East Asia. Bangladesh, Bhutan and India have a large U-shaped international border with frequent migration of persons to both the sides. Health services in the border districts are poor and inadequate especially in the peripheral areas. Communicable diseases like HIV/AIDS, tuberculosis, malaria and kala-azar pose major challenges particularly in the border areas and require synchronization of the intervention measures. The paradigm of cross border control of these communicable diseases needs integrated and co-ordinated approach.

Realizing the seriousness of the situation, Health Ministers of the South-East Asia Region (SEAR) called upon WHO to assist in developing a strategy for the control of communicable diseases prevalent in the border districts. The Inter-country meeting held at Kathmandu, Nepal, from 6 to 9 March 2001 identified four priority communicable diseases namely HIV/AIDS, tuberculosis, malaria and kala-azar for control because of their impact on poverty, requiring improved equity in health for sustainable progress and development. It was also decided as a pilot project initial implementation be carried out in eleven adjacent districts of the countries of Bangladesh, Bhutan, India and Nepal through a joint plan of action. Accordingly, a joint plan of action between the selected pilot districts of Bangladesh (Sylhet) and India (Jaintia Hill-Meghalaya), has been developed to address the cross-border diseases problem and to initiate co-ordinated control strategy to augment local level efforts, during 2002-03.

The main objectives are to:

- (1) agree on the coherent technical policies in relation to control of priority communicable diseases of HIV/AIDS, tuberculosis, malaria and kala-azar and establish an effective net-working for cross border collaboration;
- (2) implement interventions related to the prevention and control of communicable diseases in pilot districts at borders in order to reduce

the diseases burden and improve the health status of the people in general;

- (3) document the disease control strategies and approaches for priority communicable diseases including multi-disease surveillance mechanism in the cross border pilot district clusters.

Situation analysis of two districts each of Bangladesh and India was carried out by field visits. This was followed by in-depth discussions in a consensus meeting held at Sylhet, Bangladesh from 2-3 April, 2002 which formed the basis for finalization of joint plan of action. Major areas of work are 1) situation analysis, 2) advocacy and co-ordination, 3) capacity building and 4) programme implementation, monitoring and evaluation.

Nodal points at District/State (region)/National and District co-ordination committees for Bangladesh and India were agreed upon during the consensus meeting. The district profiles for the two districts, the problem of selected communicable diseases and their control status have been summarized in the enclosed table. However, this needs to be updated on an on going manner.

The training programme as envisaged for Bangladesh-India collaboration will be carried out and information exchange mechanism established. Although the international border between Bangladesh and India is porous, as a large number of individuals cross the border unofficially, but there are official restrictions for visits in two countries. It was thus considered appropriate to involve the immigration officials from both the countries, so that the health officials of both the selected project districts can meet periodically as per programme of cross border disease control. In epidemic situations there will be a need for emergency meeting or communication among both the project districts health officials (from Bangladesh and India) and the immigration officials can help to facilitate for such meeting. It has been agreed to strengthen the district health system including health services infrastructure more so in peripheral border and inaccessible areas. All the national disease control programmes need to be fully implemented in both the project districts. Priority may be given to start DOTS strategy in Jaintia Hill district under the Revised National Tuberculosis Control Programme of India. In Sylhet district DOTS strategy has been started but the case detection rate is very low. It is expected that all the components of the control programme on HIV / AIDS, TB, malaria and kala-azar will be fully implemented in border

districts and cross border collaboration established for case management and interventions for prevention and control including synchronization by the adjacent districts of neighbouring countries A set of monitoring indicators and targets of the programme has been specified. A set of monitoring indicators and targets of the programme has been specified.

The information and experiences will be shared between the participating district, by establishing the mechanism of "information exchange," including on occurrence of epidemic of communicable diseases. The programme will be reviewed during periodic inter country meeting. Implementation status and experiences will be documented and based on the lessons learnt programme shall be extended subsequently to additional border districts and diseases according to local priority.



## 1. INTRODUCTION

It is estimated that nearly one billion people move across international borders every year. In South East Asian countries like Bangladesh and India, population movement has increased manifold in recent years because of trade and commerce, employment potential, education, pilgrimage, migration of labour forces in development projects and agriculture. Bangladesh had low HIV prevalence about 10 years back, but is now experiencing increasing trend in HIV infection among various population groups. A large number of persons from Sylhet are working in U. K. This group often visit their home land and are likely to be source of HIV infection. STIs and HIV are common in Jaintia Hill district, of Meghalaya, India

Tuberculosis and malaria are of major public health concerns in most of South Asian countries, including Bangladesh and India, as these are widely prevalent in these countries. Malaria with high proportion of *P. falciparum* is a public health problem with epidemic potential in both the districts. Chloroquine resistant *P. falciparum* has been observed in nearby areas of Jaintia Hill district of Meghalaya State, India. Treatment of tuberculosis, care and support for AIDS and management of STI in border areas require specific attention. Kala-azar is not endemic in two project districts, although during the pre DDT era some areas of north eastern states of India were endemic for kala-azar. However, there is an urgent need of co-operation between the countries to address the specific cross border issues related to combat tuberculosis, malaria and HIV/AIDS. Keeping this in view, WHO has initiated a programme on cross border control of priority communicable diseases, in 11 selected pilot districts of Bangladesh, Bhutan, India and Nepal. The present joint plan of action for Bangladesh and India is part of this activity.

WHO had earlier organized several border meetings between 1995-98, for SEAR countries for cross-border control of malaria and kala-azar. Inter-country meeting on cross-border problems held in Kathmandu, Nepal, from 6-9 March 2001 emphasized the need for development and implementation

of Joint Plans of Action (J.P.A.) to control the priority communicable diseases namely HIV/AIDS, tuberculosis, malaria and kala-azar. This activity was further emphasized and endorsed during a series of inter-country meetings held in New-Delhi (July 2001) and Maldives (August 2001) and at 54th session of SEA Regional Committee (Sept.2001) as these diseases have significant impact on poverty and pose special control problem along international borders, including Bhutan and India. Provision of treatment facilities for patients from cross border, synchronization of diseases control strategies and sharing of information would help a great deal in achieving the targets of disease control and improving rational use of resources at the country and the regional level. It is envisaged that development of Joint Plans of Action and establishment of an effective mechanism to enable respective Program Managers to communicate directly, as and when necessary, for implementing program activities would be extremely useful. The Program managers need to share essential information regarding disease outbreak and routine surveillance. The support from the World Health Organization would be of technical nature to augment Government efforts in strengthening the existing District Health System to control the priority communicable diseases.

In the initial phase, the approach would be to implement the Joint Plans of Action in the Districts identified in the Kathmandu meeting and eventually this will scale up to the other cross-border districts. Opportunities from international and bilateral organizations active at the border districts will be utilized. to strengthen this cross-border collaboration initiative. The services of NGOs, will be availed mainly for IEC.

The following border districts of Bangladesh and India have been selected as pilot districts for the cross-border control of HIV/AIDS, tuberculosis and malaria.

Bangladesh      Sylhet

India              Jaintia Hill, Meghalya state

A brief on these pilot districts including back ground information, health services infrastructure and data on tuberculosis, malaria and STIs, HIV/AIDS and their control status is given in Annex 2.

## **2. RATIONALE FOR CROSS BORDER INTERVENTIONS ALONG BANGLADESH-INDIA BORDER**

Though international movement between Bangladesh and India is restricted, yet, there is large scale migration of people because of a number of developmental projects, industries and trade and agriculture work. Health services along the borders are by and large of poor quality as compared to other central parts of the districts, because of inherent difficulties in putting the infrastructures in position and making health care delivery services effective. Eco-epidemiological pattern on either sides of the international border between the projects districts is often similar, which make the transmission dynamics of vector borne communicable diseases, almost identical. Malaria transmission has common physical and biological characteristics, requiring synchronization of vector control activities. Epidemic response mechanism especially for malaria as well as for other epidemic-prone communicable diseases need to be established in the selected project districts. The information exchange on disease outbreaks is part of this project.

HIV/AIDS transmission are related to social and behavioural In Sylhet district of Bangladesh people have been migrating to U. K. for better employment and trade opportunities. Every year they visit their homes in Sylhet for few weeks. Their socio-economic status is higher than local people. The role of this group of population in the transmission of communicable diseases is has not been studied. They are likely to be put in an different environment away from their regular home in U.K., leading the change of behaviours like indulging in unprotected sex with multiple partners, injecting drug abuse, thereby making them vulnerable to HIV infection. Jaintia Hill district of India has high potential for HIV transmission not only among high risk group, but also among general population. Bangladesh and India have already launched control programs on these diseases, based on WHO strategies and guidelines. But in the implementation stage, there are some variations because of the different health care delivery systems operating in individual countries, drug policy for treatment of diseases and insecticide policy for vector control.

Meghalaya state is yet to start DOTS strategy for tuberculosis control, under Revised National Tuberculosis Control Programme, where as in Sylhet DOTS strategy is in operation with involvement of NGO for case finding.

Control of HIV/AIDS, tuberculosis and malaria can be best controlled in border areas with partnership approach among the countries. It is in this context that the Joint Plan of Action between Bangladesh and India for control of priority communicable diseases has been initiated. This bilateral and horizontal networking mechanism will enhance sharing and learning process to control priority communicable disease

### **3. GOALS AND OBJECTIVES**

Cross border control of priority communicable diseases aims at institutionalization of collaborative mechanism among border districts of South-East Asian countries. integrated approach for control of AIDS, Tuberculosis and will be taken on pilot basis in 11 districts of four mentioned countries. This includes inter-alia provision of treatment facilities for patients from across border, synchronisation of intervention and establishment of information exchange mechanism especially at local levels

The project aims to control priority diseases in border areas, by enhancing collaboration to improve the health status of the people living in border areas by reducing the disease burden, thereby leading to improvement in their economic status. The National disease control programmes of HIV/AIDS, TB, and Malaria are in operation and will be strengthened (includes starting of DOTS in Jaintia Hill Meghalaya) an integrated manner by Bangladesh and India giving priority to border areas.

For this purpose Bangladesh and India have agreed to:

- (1) on coherent technical policies relating to cross border case management and interventions for prevention and control;
- (2) finalize joint plan of action for cross border control of priority communicable diseases in selected pilot districts of Bangladesh and India, and
- (3) follow similar technical and operational guidelines to implement integrated disease control in cross border districts.

#### **4. STRATEGIES AND APPROACHES**

The cross-border Joint Plan of Action with the following objectives will be implemented through the District Health System and essential program support would be provided from the respective Governments in addition to the technical backup from the WHO. The strategies to be followed for achieving the above objectives are:

- (1) Coherent technical policies relating to cross border interventions for control of priority communicable diseases (malaria, tuberculosis, and HIV/STD/AIDS) will be implemented to establish effective cross-border collaboration;
- (2) To strengthen the implementation of interventions related to the prevention and control of communicable diseases during the period 2002-2003 in order to reduce the disease burden and improve the health status of the people, in general, and
- (3) To synchronize the disease control strategies and implementation of integrated approaches for priority communicable diseases and establishing multi-disease surveillance mechanism in the cross border pilot district clusters.

The above strategy will be implemented through the following approaches.

- (1) Pilot Districts (Sylhet and Jaintia Hill) on either side of the border between Bangladesh and India will constitute one district cluster for cross border collaboration on control of HIV/AIDS, tuberculosis and malaria.
- (2) District Nodal point and a District Coordination Committee in each district have been constituted to oversee the process and progress of implementation.
- (3) The District Health System will be strengthened to address the cross-border problems of priority communicable diseases with the essential technical support from the WHO to augment local level and govt. efforts for disease control /interventions.
- (4) District Health Authorities on either side of the border will communicate with their counter-parts, using the easiest and

available means of communication. They will share essential information and hold meetings twice a year for exchange of data and share experiences.

- (5) Synchronization of disease control interventions at the District and State/Regional levels will be carried out in a co-ordinated manner.
- (6) Programme Implementation will be monitored using a set of core indicators and experiences gained will be documented at the planning, implementation and evaluation stage.
- (7) The cross-border initiative under this Joint Plan of Action need to establish linkages within the control programs of these diseases at the national/ regional/state and district levels. The process would include creation of cross-border referral system in order to promote "access to treatment" and ensure availability of drugs from health facilities of the peripheral border areas.
- (8) Wherever the community shares common language and culture, it is important to standardize the IEC materials for better access to information and raising of awareness of the people, at large. Disease control interventions also need to be synchronized, based on the epidemiological pattern and transmission potentials. This would benefit the programs in achieving cumulative impact and help rational use of scarce resources.
- (9) To enhance local partnerships and collaboration, the cross-border initiatives will need to explore the available non-government and private sector services contributing to the communicable diseases control programs.

## **5. BROAD ACTIVITIES AT BORDER AREAS**

### **5.1 Situation Analysis**

#### ***Sylhet district of Bangladesh***

Sylhet district has a population of 2.6 million and has 11 Thanas (sub-districts). Three Thanas are bordering Jaintia Hills district of Meghalaya state.

These 3 Thanas are: Companigonj (Pop-132 000); Jaintiapur (Pop-125 000); and Goainghat (Pop-201 700).

### **Malaria**

The entire district belongs to high malaria endemic zone. In each of these Thanas there is a 31 Bed hospital (Thana Health Complex) staffed with 9 Medical Officers, Nurses, Para-medics and a good number of filed staff for program implementation.

During 2001 a total of 887 laboratory confirmed malaria cases were detected of which 37% were reportedly *P. falciparum*. Main approach to malaria control is Early Diagnosis and Prompt Treatment (EDPT). Some of the bordering areas are marshy and low-lying and are prone to epidemic outbreaks of malaria. Since 1995, there had been focal epidemic outbreaks almost every year. Chloroquine and Primaquine are used for treatment of cases. Main vector is the An. dirus and An. maculatus group is recently reported as a vector. Malathion is sprayed for control of outbreak and Impregnated Bed nets (treated with Deltamethrin) are introduced on pilot basis.

Sylhet district is not in the Kala-azar endemic area.

### **Tuberculosis**

A total of 942 cases of Tuberculosis were detected during 2001. HEED, an American NGO is working for TB control in collaboration with the government. HEED has raised volunteers for (?) active case detection at the community level (one male/female volunteer for 4000 population). DOTS coverage is about 30%, treatment completion rate is 94.2% and the Cure Rate is 84%. Estimated Sputum positive rate is 1.1/1000.

### **HIV/AIDS**

HIV screening facilities are available in the Microbiology Department of Sylhet MAG Osmani Medical College and hospital. A total of 299 referred patients were screened out of which 18 (later 15 confirmed) were found HIV positive

and one reportedly developed full-blown AIDS. All these positive cases were immigrants, who were working outside the country.

### **Jaintia Hill District in Meghalaya State, India**

#### **Malaria**

Jaintia Hill District has a population of 0.3 million. In addition to one District Hospital, there are 3 Community Health Centres (CHCs) and 18 Primary Health Centres (PHCs). Out of the 18 PHCs, 3 PHCs/CHCs are bordering Sylhet district of Bangladesh. The population of these three PHCs and malaria cases detected during 2000 is given in the Table below:

**Table.** Malaria cases in three PHCs in Jaintia Hills District-2000

PHC/CHC	Population	Malaria cases (2000)	P.f cases (2000)
1. Nonggtalang CHC	7835	44	0
2. Dawki PHC	8696	109	7
3. Umikiang PHC	8877	46	5
<b>Total</b>	<b>25408</b>	<b>299</b>	<b>12</b>

Diagnosis of malaria cases is done as per clinical features (signs and symptoms) in the community and parasitological examination at the microscopic centres in all PHCs. At the community level Drug Distribution Centres (DDC) and Fever Treatment Depots (FTD) are giving chloroquine to all fever cases. The remote places however do not have any microscopic facilities and Dipsticks may be useful for early diagnosis of *P. falciparum* malaria cases. Cross-checking of blood slides is carried out at the Regional Office for Health and Family Welfare, Shillong. Chloroquine and Primaquine are used for the treatment of uncomplicated malaria cases. Severe and complicated cases are treated with Quinine. *An. minimus* is the main vector. DDT spraying is carried out for vector control. Insecticide Treated Mosquito Nets (ITMN) have been introduced in limited scale, on a pilot basis.

### **Tuberculosis**

DOTS for Tuberculosis has not yet been introduced. Meghalaya state is preparing to launch the DOTS programme in phases throughout the districts. During 2000, a total of 438 cases of TB were registered for treatment out of which 46 were sputum positive.

### **HIV/AIDS**

The district has not reported any HIV positive case. However, about 100 trucks loaded with coal cross the international boundary at Dawki every day. The state of Meghalaya has reported 65 HIV positive cases (Blood donors 13, I/V Drug users 15, STD 3, Antenatal 2 and others 32). There were 9 full-blown AIDS cases up to March 2001. There is no Blood Bank facility at the District Hospital, Jewai (Hqs. of Jaintia Hills District).

A review of the status of selected communicable diseases will be carried out periodically to assess health services available, the service providers, their capacities and mechanisms in place for cross border communication and control along the border.

## **5.2 Advocacy and Coordination (Annex 1, Tables 1 and 2)**

District level nodal point is responsible for implementation of all the components of the cross border disease control project and his areas of activity include:

- Co-ordination between the district level programme officers for HIV/AIDS, TB, and Malaria.
- Training of district staff involved in cross border disease control.
- Act as Secretary to the District co-ordination committee.
- Compilation of quarterly reports for exchange of information with his counterpart in the neighbouring cross border district.
- Participate and lead the team in cross border 6 monthly /yearly meeting in the neighbouring district. These meeting will be organized alternatively in two countries.

State level Nodal point will provide administrative support to the district Nodal point, strengthen the disease control programmes in the district. In case of Bangladesh there is regional level nodal officer. National level nodal officer will be a policy making body and for co-ordinate in the strengthening of the programmes on these priority communicable diseases.

An officer or society is to be nominated by the Government for flow of funds and inputs from outside agencies. The constitution of such focal points and committees will form the basis to implement the programme on cross border control of AIDS, TB, and Malaria.

Recommendations with respect to above area of work were made in a meeting held at Sylhet, 2-3 April 2002.

### ***Establishing information exchange mechanism***

Establishment of Information exchange between the adjacent trans- border districts of Bangladesh and India is the one of the important activity of cross border disease control of HIV/AIDS, TB and Malaria.

This area of the work has the following components;

- (1) Exchange of quarterly reports in a simple and precise format between the border districts by post and fax. The guidelines and the format for exchange of the information are given separately. In case of epidemic of any communicable disease the information is to be exchanged urgently telephonically.
- (2) Half yearly inter -district meetings will be held alternatively in Bangladesh and India. This meeting will review the disease control program of all these diseases with special reference to cross border disease control. Strong and weak points will also be identified to improve program management and strengthen the cross border disease control process.
- (3) Inter country meeting will be held at the end of each year to review the progress of cross border disease control program, make recommendations for strengthening and for expansion of the programme to other districts. Malaria transmission potential,

including epidemics is high in North-East States of India, as a whole, and the northern border of Sylhet has similar situation. There are specific entry points like Tamavil for trade between the two countries. There are truckers halting points also, thereby increasing the vulnerability for HIV transmission.

### **5.3 Capacity Building** *(Annex 1, Table 3)*

Capacity building has the components of training on integrated control of HIV/AIDS, TB, malaria and kala-azar and on the mechanism of information exchange on cross border disease control of the priority communicable diseases.

Training module/material has to be prepared, based on technical and operational guidelines on integrated disease control and information exchange mechanism between the identified districts across border. This training activity will be carried during 2002.

Four Core trainers (2 from each of 2 project districts of Bangladesh and India) will undergo five days trainers training on educational technology and training module/material at a training centre of excellence. These core-trainers will train district level program officers for AIDS, TB, and malaria, medical officers from border and other selected primary health centres & Thana level Medical officers, superintendents of and identified medical officers from hospitals, senior paramedicals, NGOs and immigration officers. Duration of this training program will be for three days. 40 participants from each of the two project districts of Bangladesh and India will be trained in four batches of 20 each. Additional officers and health staff can be trained.

Similarly there will be four batches of 20 each from two districts of India. Other international and bilateral agencies working in border areas will be involved in training and their field staff will be trained.

### **5.4 Programme Implementation Monitoring and Evaluation** *(Annex 1, Tables 4 and 5)*

The specific disease control program for AIDS, TB and Malaria are in operation in both the countries and it is expected that all the components of the programme implementation will be strengthened in project border districts with particular emphasis in border primary health centres and health post. The services for DOTS strategy for TB, syndromic management of STI, care and support for AIDS and diagnosis and treatment of Malaria (including sever and complicated cases) will be available for patients from across the border. The information on cross border patients treated can be collected, compiled and exchanged with each other.

Referral system for Tuberculosis patients on the line of "transfer in and out" followed under the DOTS program will be used for identification and referral cards will be provided to cross border patients of tuberculosis for continuation of treatment.

Synchronization of vector control of malaria will be carried out on the basis of seasonality of the disease, vectors bionomics and operational feasibility. Most of Indian North Eastern states have started Insecticide Treated Bed Net Programme on pilot basis especially in interior and inaccessible areas. The same can be extended to border PHCs of Jaintia Hill. Similarly Northern area of Sylhet Bangladesh may start the bed net programme to synchronize vector control on pilot basis in border villages. Tea gardens health facilities in Sylhet district may be explored for their involvement. Epidemic response mechanism needs to be established in both the districts/countries.

Condom promotion for HIV prevention will be carried out at selected entry points, like truckers halting points with active involvement of NGOs. Families of border villages of Sylhet can be covered for "Family Health Awareness Campaign" as carried out in Indian districts. Common IEC package will be developed for HIV/AIDS, STI and TB keeping in view the socio-cultural milieu on both side of the border.

Indicators and targets given separately will monitor the Programme implementation in addition to the programme specific (AIDS, TB and Malaria) monitoring and evaluation indicators. Reports on cross border disease control will be analyzed and disseminated to district, state and national health authorities. Periodic site visits will be made by National/WHO personnel to provide supportive supervision. An expert group will carry out independent

appraisal at the end of 2003 before the inter-country meeting. All the programme activities and findings of appraisal will be documented which will make basis for further expansion of the cross border disease control activities.

## 6. INDICATORS AND TARGETS (*Annex 2*)

The programme for cross border control of communicable diseases is to follow a process based approach during the initial stages of its implementation. It is important to analyse strong points and weaknesses both quantitatively and qualitatively. Such information and experiences are to be shared periodically among selected cross border pilot district cluster to attain and sustain goals and objectives of the programme. Process, indicators and targets have been prepared according to the strategies and approaches for the implementation and are given separately.

All the four countries are having national control programmes for HIV/AIDS, TB, Malaria and Kala-azar. The indicators and targets for monitoring the implementation activities are incorporated within the disease control programme for each of the four diseases. However, minimum and common indicators and targets as per analysis of the available epidemiological data, control status and field visits to eleven pilot districts are given below.

### ***Process indicators***

- Situation analysis                      2<sup>nd</sup> quarter, 2002 in 11 districts
- Operational Guidelines                -do-
- Finalization of
- Joint Plan of Action                    -do-
- Identification of nodal points        -do-
- and committees
- Flow of funds as per plan            3<sup>rd</sup> quarter 2002
- Programme implementation
- strengthening of different components in the district

- cross-border collaboration exchange of information

### ***Disease specific outcome indicators***

#### **Tuberculosis**

By adoption of DOTS strategy for TB control-

- Cure Rate >85%
- New Sputum positive detection rate >70%
- Sputum conversion rate of >90% after initial intensive phase of treatment

#### **HIV/AIDS**

- Increasing level of awareness and behaviour change among long distance truckers and CSW at identified border points.
- 100% condom use by the high risk group.
- Syndromic management of STI-availability, accessibility and utilization

#### **Malaria**

Transmission dynamics of malaria beings local and focal phenomena the indicators and targets should be for limited areas, for example health centre or border village. This will be the basis for synchronization of vector control on either side of border. All the four countries have adopted global strategy on malaria control with further strengthening by Role Back Malaria initiatives Eco-epidemiological study and control status of malaria in border areas of eleven pilot districts pointed out that any one or more of the following indicators and targets may be used as per goals, objectives, strategies and approaches adopted.

Early case detection (rapid diagnosis) and prompt treatment:

- Reduction in morbidity with no or minimum mortality,
- proportion of *P. falciparum* <50% in known *P. falciparum* areas,

- proportion of severe and complicated malaria cases to total falciparum cases <10%,
- Slide Positivity Rate (sample size >50) of <10% in clinical/passive surveillance setting and <2% in areas of active surveillance,
- establishment of epidemic response mechanism – prediction, early detection and control of epidemics with rapid communication to cross border district.

**Intervention measures**

- Population covered with Insecticide Treated Bed Nets- increase in coverage by about 10% of the population every year.
- High risk approach for intensive intervention (Selective Indoor Residual Insecticide Spray etc.).

**Qualitative Indicators**

- Partnerships to improve equity in health for sustainable progress and development,
- Community involvement,
- Inter-sectoral approach including environment management.
- Status of attributes laid advocacy and leadership.

Evaluation of surveillance parameters may be used to monitor multi-disease surveillance and exchange of information between the cross border districts.













## Annex 2

### PROGRAMME MANAGEMENT

#### 1. Sharing of information- General guidelines

##### *The problem*

Communicable diseases like Malaria, Kala-azar, Tuberculosis and HIV/AIDS are widely prevalent in developing countries including South East Asia. These diseases are of major public health concern, for which specific disease prevention and control programmes are being carried out in the respective countries. International borders constitute a specific epidemiological paradigm for these diseases due to increase in migration for economic reasons (trade, tourism and employment), education, pilgrimage. Eco-epidemiological conditions for transmission of vector borne diseases are often identical on either side of the border. Trafficking of girls is a socio-economic problem and as such poses a serious threat for spreading of HIV. Health services remain weak in these peripheral areas.

Some of the examples of special problems related to the cross border potential for communicable diseases transmission and their control are given below.

Terai area of southern Nepal and northern Uttar Pradesh-India constitute a single eco-epidemiological paradigm for transmission potential of malaria, requiring synchronization of intervention measures. Bihar- India and Nepal border have kala-azar problem. Nepal & India has some identified areas leading to increase in vulnerability to HIV (trade route & truckers halting place at Raxual in East Champaran-Bihar and Birgunj-Nepal). Therefore, the cluster of districts across the international border has to be prepared for agreement on the coherent technical policies relating to control of priority communicable diseases (Malaria, Kala-azar, Tuberculosis and HIV/AIDS) and establish effective cross border collaboration; identification of area specific

intervention measures related to the prevention and control of communicable diseases in order to reduce the disease burden and improve the health status of the people, in general; and synchronization the disease control strategies and implementation of integrated approaches for priority communicable diseases and multi-disease surveillance mechanism in the cross border districts clusters.

### **Approaches**

While periodic meetings and interactions help in exchange of information, sharing of experiences and learning of positive points for improvement of the programmes, the periodic exchange of reports is essential for cross border collaboration.

All the countries are having built-in surveillance system with respect to the diseases control programmes. Such reporting mechanism in each country/district is not required to be changed or modified, but should be strengthened as such to make it meaningful to support appropriate action to control the diseases. Such a strength will not only augment the strength of the existing programmes, but also make a sound basis for the exchange of information across border.

Cross border control of priority communicable diseases envisages regular exchange of information on the four diseases namely malaria, kala-azar, tuberculosis, HIV/AIDS/STI, and epidemic/outbreak (as and when it occurs). The frequency of sending the reports across border would be quarterly, in addition to 6 monthly meeting and annual review when all the other aspects of the control programme on these diseases will be exchanged. This is to ensure that participating district health authorities from across the border become fully aware about the different component of the programme implementation. Information to be exchanged includes status of drug resistance to micro-organism (Pf. resistance); vector resistance to insecticides, indoor insecticide spray schedule, position regarding the vacancy of health staff especially in border areas and future plans to overcome the constraints.

Following will illustrate about the areas of co-operation with out any additional resources.

Regional Director malaria at Siliguri, W. Bengal, India is compiling separate information on malaria pertaining to the border areas of Japaiguri and Darjeeling district (annex1). This information should be sent to district focal point and shared with programme officers of Chukha and Samptsi districts of Bhutan. Similarly General Hospital at Pheuntsholing keeps separate records for non-nationals treated for malaria and tuberculosis. This data should also be passed on to the Chief Medical and Health Officer Jalpaiguri and Darjeeling. The participating districts may learn from the experience of each other; for example a system of prediction, early detection and response to epidemics practiced in a district (Jalpaiguri) may be studied with the objective of improving the system in Chukha and Samptsi districts in Bhutan.

Similar examples and experiences from Indo-Nepal border pilot districts and Bangladesh-India pilot districts may be helpful.

### ***Process***

#### **Cross-border reports**

It is not be necessary to send all the monthly/ quarterly reports to the participating district of neighbouring country. District level focal point i.e., Chief Health Officer is to compile a report on simple and precise format for onward transmission to the neighbouring district.

The following should be the characteristics of this report.

- (1) It will be a consolidated report on malaria, kala-azar, tuberculosis, HIV/AIDS/STI.
- (2) The data will be taken from the existing programme reports.
  - The report will have the following broad components.
    - Case management information:

- Severe and complicated malaria.
  - Tuberculosis
  - STI&AIDS
  - Morbidity profile of the district on malaria, kala-azar, STI, HIV, AIDS
  - Treatment policy and referral cards
- 
- Intervention measures for control:
    - Vector control
    - Condom promotion
    - I.E.C.
  - Information on disease outbreak (if any).
  - Any other information related cross border disease control.
  - Action expected or required from the district focal point across the border.

***Reporting units on non-nationals treated***

The district focal point, district co-ordination committee and working group are to identify the institutions in the district, who can maintain and compile separate records of non-national patients treated. These institutions may be hospitals (near border), Health Centres along the border. Such institutions may be few but should be carefully selected centres / hospitals which will act as sentinel sites to give an idea of treatment offered to cross border cases and also trend of patients availing of such services over a period of time This list of institutions should be on constant review, as it may be necessary to identify more of such institutes and delete the existing facilities.

A sample format is given below.

<b>I. Cross-border report selected communicable diseases</b>			
District	From-----	Quarter	
	To-----	-----	
Number of Institutions/hospitals units identified to record non-nationals for treatment and border health centres (Number of Reporting Units)-----		Number of reporting reported for the period	
<b>II. Cases detected and treated</b>			
Malaria	Kala-azar	TB	STI
Total			
Pf.			
S & C M* In district		From across border	
Control measures		(Give disease specific indicators as for as possible)	
<b>III. Outbreak</b>			
Disease (if any)	Suspected cases/deaths	Period	
<b>IV. Any other Information</b>			
<b>V. Action expected/ require from district focal point across border</b>			
Date-----	Signature Name and Designation		
Copy to-----			

## 2. Guidelines for filling the reporting format

- The National/ State focal point has to authorize the Chief Health Officer of the district for exchange of information as envisaged under cross border control of communicable diseases.
- Similar format has to be used by the participating districts.
- The information to be filled in is simple and self explanatory. However following points may be noted.

**Block I** District who is sending the report and the one who will receive the same. The frequency of reporting will be decided by the co-ordination committee of both the districts. It may be emphasized here that quarterly reporting is the minimum requirement. As mentioned in pre page the co-ordination committee has to decide on reporting unit i.e. who can maintain and send the number of non-nationals treated in their routine records and reports.

**Block II** In this block the total cases of malaria, kala-azar, tuberculosis, STD, HIV, AIDS are to be recorded separately for the district and for the identified reporting units separately. In case of malaria give separate data on *P. falciparum* cases, and Severe and Complicated Malaria. In control programmes i.e. DOTS strategy for TB provide the set indicators as per the programme.

**Block III** This pertains to the information on disease epidemic or natural disaster or any other public health emergency. A separate report will be appreciated.

**Block IV & V** are open-ended and may contain any relevant information. District co ordination committee and the district nodal officer will guide from time to time regarding the contents and frequency of this kind of information exchange.