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Operational Guidelines on Cross-Border Control of Priority Communicable Diseases

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Contents

Developing Policies and Operationalizing Cross-Border Control of Priority Communicable Diseases at Border Districts

1. INTRODUCTION

Diseases like malaria, kala-azar and tuberculosis are prevalent throughout Asia. These diseases not only thrive among populations, but also often cross territorial boundaries and spread to other countries, bringing in more sickness, suffering, economic deprivation and deaths.

As a result of globalization and because of socioeconomic disparities prevailing in the Region, the countries depend on each other for education, trade and commerce to a large extent. People also travel from one country to another for pilgrimage or vacation. Poverty and lack of income generation activities within the country also result in migration of young men and women from one country to other.

In the earlier days, travel between these countries was undertaken mostly on foot which kept the volume of migration low, hence the spread of diseases was considerably less. Diseases like malaria, kala-azar and tuberculosis spread slowly between the countries mainly through the labourers and pilgrims who travelled in small groups over shorter distances. But with increase in population, building of more roads, more employment potential, human migration between these countries has considerably increased and along with the increasing volume of migration between the countries, the chance of contact and spread of diseases have considerably increased.

All these factors of human migration and incidences of associated diseases problems necessitate the establishment of intercountry cooperative effort to manage transborder health problems. A consensus on a common policy and strategy and development of joint action plan is needed to address

the migration-related health problems. In the process, various disease control programmes which are in operation in the countries, need to be upgraded and strengthened, a system of collaboration introduced between the countries in terms of content, delivery, uniformity in application and synchronized operational timing.

2. WHY FOCUS ON BORDER AREAS?

Besides HIV/AIDS which first made its appearance in the Region over the past 15 years, malaria, kala-azar and tuberculosis have been endemic in the Region for centuries, but have undergone some changes over time period. Malarial parasites have developed drug resistance, vectors have developed resistance to insecticides and the spread of more virulent forms of P.Falciparum has created a serious situation for effective tackling. Kala-azar had almost disappeared once, but it has not only reappeared but has spread widely over Bangladesh, India and Nepal. Bacilli causing TB have also shown some resistance to drugs.

Although considerable expansion of health services has taken place in these countries and significant gains have been made in terms of reduction of morbidity and mortality, but those living in the peripheries and border districts remain marginalized and do not have access to such services.

Social conditions such as poverty, ignorance and illiteracy often act as a barrier for the demand and acceptance of health services in these regions.

Awareness for demand generation and curative/preventive services is considerably low and the reach of print as well as electronic media is almost negligible. Interpersonal communication is the only tool to reach the people with the necessary health messages, but this is also considerably restricted due to the nature of the terrain and the absence of adequate health infrastructure or NGOs.

The social customs, behaviour and languages vary considerably in the border areas and one who crosses the border, encounters difficulty in acceptance in the migrated district and often remains ignorant about the existing heath facilities or where to seek for care when ill.

All these factors create an anomalous situation inasmuch as the disease spread remains unabated whereas utilization or provision of control programme does not match the rapid and evolving nature of the health problems.

3. OBJECTIVES OF CROSS-BORDER INTERVENTIONS

Enhancing border health collaboration between Bangladesh, Bhutan, India and Nepal for improving the health of the people living in the border areas of these countries with emphasis on reduction of morbidity and mortality due to malaria, kala-azar, tuberculosis and HIV/AIDS requires the two adjacent countries to:

- Agree on coherent technical policies relating to cross-border interventions.
- Finalize joint plans of action related to the prevention and control of communicable diseases: HIV/AIDS, TB, malaria and kala-azar, and
- Agree upon the technical and operational guidelines on planning and implementing integrated control of priority communicable diseases in cross-border districts.

In order to achieve these objectives, it is considered necessary to carry out the following:

(a) Strengthening of border health collaboration through capacity building of district heath organisations, development of human resources, ensuring adequate support from the national budget, adoption of uniform, synchronized preventive cum curative action process for disease control activities, and establishment of a system of information exchange across the borders.

(b) Ensuring medical care to the migrant population irrespective of their nationality and legal status.

(c) Encouraging generation of knowledge and technologies for disease control as per prevailing local conditions, adoption and application by other country.

(d) Developing collaborating mechanisms for concerted action at national, state/region/division and district levels.

(e) Organizing a collaboration mechanism for extension to selected border districts for priority communicable diseases control programme and provision for expansion to all the border districts between the countries and to other disease problems.

4. HEALTH INFRASTRUCTURE AND ITS ROLE IN CROSS-BORDER INTERVENTIONS

Generally, there is a three-tier system of health services in most countries of the Region namely, national, state/regional/divisional and district levels.

The national level structure comprises the Ministry of Health and the Directorate-General of Health Services who are responsible for planning, standardization, funding, technical and material support, collaboration with other agencies, and monitoring and evaluation. National level programme managers are stationed at this level who actively guide state/regional officers for programme planning, funding, supply of materials, equipments, providing technical guidance and support to state/districts.

State/region/division level have programme officers who on the basis of guidelines issued at the national level, work out state/region specific plans, provide funding and technical support as received from the national level to the districts for execution and also supervise the work.

The district level health organization is headed by a civil surgeon or Chief Medical Officer and programme officers of HIV/AIDS, TB, malaria and kala-azar who work under his administrative/financial control. Implementation of the programme designed at the national level, approved/modified at state/division/ regional level, is done by the district level through health centres in rural areas or local bodies in urban areas. District programme officers review programme implementation, identify the constraints, work out a plan of action for upgradation of services as per national norms and seek support from the national/state budget or from external sources. A system of monitoring by the state/national level on the basis of reports and returns and discussions is in existence. A dialogue is on between the health authorities for

programme initiation, content, operational timing coincidence, and exchange of information.

The proposed cross-border programme for control of priority diseases could best be implemented through the district health authorities with approval and full operational support from national and state/regional level with mutually agreed plan of operation, uniform and homogenous application, strengthened with technical, financial and communication support.

5. MAJOR CONSTRAINTS AT BORDER AREAS

Border districts are in disadvantaged terrain, mostly hilly and forested, difficult to approach with few pockets reachable only by foot which is hazardous and time consuming. Health infrastructure in the border districts is usually inadequate in terms of manpower, quality, and supply is often irregular, interrupted and short. Majority of the people living in border areas belong to low income groups, with all the disadvantages associated with poverty, illiteracy and ignorance. Absence of opportunities for gainful employment round the year in local areas, force the people to look for income-generating activities outside the district, often migrating to neighbouring countries. It is mostly the young males who move out in search of jobs. Special groups of people involved in the migratory process are young women and girls. The other important group is of truck drivers and their helpers, who are at risk of HIV. Disease control programmes against HIV/AIDS, TB, malaria and kala-azar are in operation in all countries, but there are some differences in treatment regimens and disease control efforts are not synchronized with each other at any point of time. This is particularly relevant for border areas.

Most importantly, there is no system of communication between the cross-border districts for exchange of information, notification of disease outbreaks or initiation of control measures.

In view of these constraints at the border districts level, it is essential for the districts to develop consensus and adopt uniform control policies and to implement an integrated and coordinated disease control.

6. TECHNICAL POLICIES: A NEED FOR CONSENSUS

6.1 HIV/AIDS

Organization of community education programmes for infection prevention and control through the involvement of mass media as well as interpersonal communication is essential. Community involvement in this education process either directly or through NGOs is essential. Education should also focus on avoidance of stigma and discrimination.

Supply of and access to good quality condoms must be ensured in the border areas.

Sexually transmitted infections should be managed through syndromic approach both in the public as well as private sector. To ensure this, regular supplies of drugs should be ensured.

While no mandatory testing for HIV is recommended, facilities may be made available for voluntary counselling and testing.

Persons confirmed as HIV positive, must be provided care and support. Symptomatic treatment of opportunistic infections should also be ensured for such patients.

Sustained education may be provided to injecting drug users in border areas with advice to avoid use or sharing of syringes or needles.

The epidemic or the disease spread should be monitored through a system of surveillance on behavioural and sexually-transmitted diseases.

6.2 Tuberculosis

All countries have accepted DOTS as the TB control strategy. DOTS should also be expanded to the remote, peripheral and border districts.

Diagnostic facilities for identification of tubercle bacilli through sputum microscopy should be established in the border districts.

Uniform treatment regimens should be followed throughout the country including the border districts. This includes also the mode and duration of direct treatment observation.

All patients put on treatment should be provided a health card containing information on treatment provided, duration and results of sputum examinations. In addition, a bilingual referral card should be developed and provided to the patients with all information on treatment details so that after migration, the patient is able to continue treatment in the country on arrival on the basis of his card.

While each country may follow its own schedule of treatment as approved under the national policy, the migrated patient may be treated as per schedule already advised in his/her own country.

As HIV and TB are closely interrelated, a collaborative mechanism in the border districts need to be developed between these two programmes.

6.3 Malaria

Clinical diagnosis should be encouraged at first contact with malaria patients.

Any person suffering from fever in the last 72 hours with chill, rigor, sweating and headache may be suspected as a malaria case.

Confirmatory test may be carried out with peripheral blood smear examination or dipstick test if available.

Patients suffering from P.falciparum may receive chloroquine over three days. Patients not responding to chloroquine, may be treated with alternative drugs.

P.vivax malaria cases may be treated with chloroquine over three days.

Treatment failure malaria cases may be referred to district health authorities.

All complicated malaria cases with high fever, convulsion, shock and bleeding etc may be referred to higher health facilities.

6.4 Kala-azar

In kala-azar endemic areas, a person with irregular fever for more than two weeks, not responding to anti-malaria or anti-typhoid treatment, with splenomegaly, may be suspected for kala-azar.

Diagnosis of kala-azar may preferably be confirmed with K-39 dipstick tests. All kala-azar cases may preferably be treated with Miltefosine after it is cleared by the drug control authorities of the respective countries.

6.5 Policies of General Nature

In addition, the following policies of general nature are necessary:

- Coordinated actions and regular exchange of information between the borders;
- Sharing of health education materials produced in local language either side of the border;
- Regular cross border meetings between the bordering districts, and
- Provision for and access to treatment for those who seek treatment.

In order to achieve the aforementioned tasks, a system of networking across borders should be established, and the capacity of the health system built through training, provision of logistical support and strengthened programme management and monitoring systems.

7. A STEP-BY-STEP APPROACH TO OPERATIONALIZING CROSS-BORDER INTERVENTIONS

To implement technical policies in border areas as mentioned above, a systemic and step-by-step approach is required, starting with the planning process, followed by implementation , monitoring and evaluation.

7.1 Planning

(1) Situation analysis to estimate the nature and size of the problem.

A quick situational analysis at the selected district level through study of records, registers, reports, returns from local hospitals, dispensaries, and

discussions with district officials, private practitioners and the community will provide basic information about the existence of a particular disease problem, its size and impact. The situational analysis will also provide rough idea about the existence of the disease problem, ongoing programme activities ongoing, and the constraints in implementation of the cross-border interventions. A list of health facilities existing in the border districts should be prepared, including those in government as well as private sector or those provided by NGOs. These include DOTS centres, and health laboratories that could play an important role in programme implementation.

(2) Identification of existing services and resources

All health institutions such as hospitals, dispensaries, primary health centres, sub health centres are to be identified and listed for involvement in service delivery, preventive action and their cooperation to be sought in the pilot project.

(3) Development of consensus and preparation of a joint and coordinated plan

A consensus meeting of various stakeholders in the cross-border districts should be organized to discuss health problems, policies and strategies required, and to prepare a plan of action with activities, time frame and resource requirements.

7.2 Implementation

(1) Establish a border coordination committee and a focal point

The national level authorities in each country comprise the Ministry of Health and Directorate of Health Services who will be responsible for programme approval, planning, standardization of technical and operational norms, allocation of funds, technical and material support, training, collaboration with other agencies, monitoring and evaluation. A national level focal officer will be designated to coordinate the activities.

State or regional level authorities will facilitate the operational programmes as planned and approved by the national authorities. Efforts are also to be made to coordinate the work in different selected districts, pass on the support received from national or external agencies and offer any help if requested for by the districts.

At the district level, the Civil Surgeon or the Chief Medical Officer will act as the focal point for the district and all information, and supplies for the programme will be handled by his office. He will also coordinate between the four district programme officers of HIV/AIDS, TB, malaria and kala-azar. He is to be trained in the concept of integrated diseases control programmes and also to act as a core trainer. All messages or information for communication across the border or to the state, regional and national level authorities will be processed at his level. Programme monitoring and evaluation will be part of his duties and he will also arrange/attend cross border meetings with his counterpart from the other side of the border.

The main role of the district level will be to carry out situational analysis based on population profile, estimation of the disease problem, review available resources and staff, arrange consensus meeting with stakeholders, mobilize resources, organize training and implement the programme as planned.

(2) Mobilization resources

Most of the funding required for the cross-border project is available from the national budget provision. External assistance may be sought for those elements which have not been budgeted for such as skill building, awareness generation, technical and material support. As the programme is to be carried out by the sanctioned staff strength, no additional manpower is to be sought. However, the district administration may fill up the posts, if lying vacant.

(3) Development of training material and conducting of training

Training materials covering different aspects of the programme should be prepared, based on the materials available with some modifications to suit local need, if any. A group of core trainers may be first trained who will further train the various programme personnel at the district level.

(4) Logistics management

Based on the work plan, the supplies must be procured which may include equipment, chemicals and medicines. A quick facility survey to find out those already available could be useful. The patient-held treatment cards and referral forms should also be printed after field testing. IEC materials must be developed, field-tested and printed in the local language.

7.3 Monitoring and Evaluation

(1) Setting up indicators and targets

Clear-cut indicators and targets in accordance with specific programmes should be established at the beginning of the projects at border level. Baseline data should be obtained followed by monitoring of the programmes periodically.

Monitoring on day-to-day basis could be done through supervisory visits, reports and meetings.

(2) Exchange of information, assessment of progress and reformulation of strategy

While the districts implementing the project will generate data on diseases control activities, a mechanism is to be established to share the data with the programme officers at state/regional as well as at the national level about the programme outcome and impact. A regular contact with cross-border districts is to be maintained for problem identification, working out joint strategy for control, synchronization of activities and referral of patients.

Dissemination meeting will be organized after two years of project implementation, review experiences, lessons learnt and decisions will be taken for any modification of the working plan, inclusion of other diseases control interventions or expansion to other districts. However, the ultimate aim will be to introduce integrated system of priority communicable diseases control all along the borders of the adjoining countries.

8. CONCLUSION

Because of increased travel between countries on account of tourism, commerce and education, chances of communicable diseases crossing territorial boundaries have increased and hence the need for joint action plans between countries to tackle these have become imperative. The border areas are particularly vulnerable to the spreads of such diseases. HIV/AIDS, malaria, kala-azar and tuberculosis are some of the specific diseases that need targeted trans-border interventions. The focus of the cross-border interventions is to finalize joint action plans, develop technical and operational guidelines, define the role of existing infrastructure, identify major constraints and adopt a step-by-step approach in operationalization. The guidelines provided in this document should help countries to plan, implement and monitor programmes at border level within the framework of an integrated and coordinated approach through consensus building across the borders.