

Third SEAR/WPR Bi-Regional Meeting on Control of Communicable Diseases

*Chiang Mai, Thailand,
18–20 November 1998*



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

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CONTENTS

	<i>Page</i>
1. INTRODUCTION	1
2. OBJECTIVES	1
3. PROCEEDINGS	2
3.1 Participants	2
3.2 Opening Ceremony	2
3.3 Plenary Sessions and Group Work	3
3.4 Closing Ceremony	3
4. STATUS, ACTIONS TAKEN AND ISSUES OF COMMUNICABLE DISEASES IN SEAR/WPR REGIONS	3
4.1 Control of Communicable Diseases	3
4.2 Issues related to Migration and Health	4
4.3 Poliomyelitis	4
4.4 Cholera	5
4.5 Malaria	5
4.6 STD and HIV/AIDS	6
4.7 Tuberculosis	7
5. PROPOSALS FOR FURTHER ACTION	8
5.1 Poliomyelitis Eradication	8
5.2 Cholera	8
5.3 Malaria	8
5.4 STD/HIV	9
5.5 Tuberculosis	9
6. CONCLUSIONS	10

Annexes

1. List of Participants	11
2. Programme	15
3. Total AFP Cases Reported, Confirmed Poliomyelitis Cases and Wild Virus-Associated Cases, Western Pacific Region, 1993-1997	17
4. Supplementary Immunization in Western Pacific Region intensifies during the last stages of Poliomyelitis Eradication, 1990-1998	18
5. NIDs and SNIDs South-East Asia Region 1994 - 1998	19
6. Classification of AFP Cases and Key Surveillance Indicators, 1997 and 1998	21

1. INTRODUCTION

With several countries of the Western Pacific Region (WPR) and the South-East Asian Region (SEAR) sharing borders and frequent cross-border movements, the need for a coordinated approach to the prevention and control of communicable diseases was recognized several years ago. So far, two bi-regional meetings, the first in New Delhi in October 1996, and the second in Beijing in October 1997 have been organized, to provide a forum for discussions on cross-border communicable diseases **control** activities.

The Third Bi-regional Meeting on Control of Communicable Diseases was held in Chiang Mai, Thailand, from 18 to 20 November 1998. The agenda was extended to cover tuberculosis, besides poliomyelitis, malaria, cholera, and sexually transmitted diseases, including HIV/AIDS. The participating countries were: Cambodia; China; Lao People's Democratic Republic; **Malaysia**; Republic of Korea; Vietnam; Democratic People's Republic of Korea; India; Myanmar; Nepal, and Thailand.

2. OBJECTIVES

The main objective of the Third Bi-regional Meeting on Control of Communicable Diseases was to provide a forum to discuss approaches to the prevention and control of communicable diseases in border areas.

The specific objectives were to:

- (1) Review the progress of implementation of policies, strategies and recommendations of the second bi-regional meeting i.e. to highlight success stories and lessons learned;
- (2) Share country-specific technical and advocacy experience in the prevention and control of communicable diseases, in order to identify the most successful interventions, such as house-to-house polio immunization activities in selected areas;
- (3) Review the financial and technical support of partner/international agencies for advocacy promotion, and monitoring and evaluation of cross-border activities;
- (4) Review cooperation mechanisms for rapid information exchange related to disease surveillance and control at the local level between countries of neighbouring regions in the context of local capacity-building and sustainability;
- (5) Initiate and advocate operable joint activities for the control of communicable diseases, and
- (6) Identify the need for studies related to cross-border control of communicable diseases.

3. PROCEEDINGS

3.1 Participants

The meeting was attended by 30 participants from 11 countries (Cambodia, China, Democratic People's Republic of Korea, India, Lao People's Democratic Republic, Malaysia, Myanmar, Nepal, Republic of Korea, Vietnam and Thailand). The complete list of participants can be found in Annex 1.

Dr Dr Supachai Rerks-ngarm from Thailand was nominated as Chairman of the meeting, Ms Chun Kang from Republic of Korea as Co-chair, and Dr A.C. Dhariwal from India as Rapporteur.

3.2 Opening Ceremony

The opening ceremony was addressed by Mr Kamron Na-Lamphun, Deputy Minister of Public Health, Thailand, Mr Pakdi Ratanaphol, Deputy Governor Chiang Mai, Thailand, Dr S.T. Han, Regional Director, WPR, and Dr Uton Muchtar Rafei, Regional Director, SEAR, all of whom made opening remarks.

Mr Kamron Na-Lamphun, Deputy Minister, Public Health, Thailand, welcomed the participants, and thanked WHO for the support in organizing the meeting. He stressed the importance of prevention and control of cross-border communicable diseases, and highlighted the need to share information, to coordinate planning, and to mobilize support from partners. He also highlighted the success that this approach has had in polio eradication.

Mr Pakdi Ratanaphol, Deputy Governor, Chiang Mai, Thailand, welcomed the participants and wished everybody a fruitful meeting and a pleasant stay in Chiang Mai.

Dr S.T. Han, Regional Director, WHO/WPR, in his opening remarks highlighted some examples of cross-border coordination between the regions that have taken place since the second bi-regional meeting. In particular, he mentioned about the successful coordination between China and Myanmar that has resulted in coordinated immunization activities and improved surveillance. As a result, no further wild poliovirus-associated poliomyelitis cases have been reported on the China-Myanmar border. Dr Han went on to point out that HIV/AIDS and other STDs in border areas are closely tied to issues of migration or lack of employment and said that various measures are now being put in place to protect people against infection. Dr Han stated that tuberculosis has been added to the agenda because of the growing concern about emerging and re-emerging communicable diseases. He expressed the hope that the meeting would provide a forum to further improve communication systems across borders and rapid coordinated responses wherever needed. Dr Han said that the inclusion of malaria control on the agenda was also appropriate and in line with the WHO Director-General's priority for malaria. With drug resistance on the rise, the two regions can show that through a coordinated effort, malaria can be better controlled in affected countries. Dr Han highlighted the importance of rapid streamlined information exchange as a key to future success. He also highlighted the importance of involvement of district-and provincial-level staff in dealing with the problems in border areas and urged the participants to make great efforts to find ways of further collaboration and coordinated work. Dr Han, while thanking the participants, also wished them a productive meeting.

Dr Uton Muchtar Rafei, Regional Director, WHO/SEAR, summarized the progress made in polio eradication in SEAR. In particular, he highlighted the achievements of weekly reporting of acute flaccid paralysis (AFP) cases by all countries. He went on to state that many communicable diseases

remain a leading cause of death and a major public health problem worldwide. Despite this, the interest in communicable diseases has waned and therefore progress in communicable diseases control has slowed down. He also stressed the importance of quality of health care through comprehensive district health systems. The communities in border areas are particularly vulnerable and greater equity and improved health care delivery systems are urgently needed, especially in border areas. Dr Uton Muchtar Rafei stressed the need to strengthen the surveillance of communicable diseases including quick exchange of information at national, regional and international levels. Secondly, he said that a national and international infrastructure should be established to recognize, report, and respond to, disease threats and emergency situations. Thirdly, he called for operational research to further develop the prevention and control of communicable diseases. And fourthly, the prevention of communicable diseases should be strengthened on the basis of a common strategy. As for the dilemma between integrated approach and vertical systems, Dr Uton Muchtar Rafei stated that for time-bound programmes such as polio eradication, a vertical approach may be indicated. Dr Uton called for the establishment of resource networks to facilitate intercountry and interregional collaboration and to act as a direct link between research institutions and control programmes. He called on the participants to further discuss these issues and to suggest new initiatives for greater coherence and synchronization in the work. He wished all the participants success in their deliberations and a very pleasant stay in Chiang Mai.

3.3 Plenary Sessions and Group Work

Technical presentations and updates at the plenary session were followed by group discussions. The meeting also put forward recommendations for further action. (A detailed programme can be found in Annex 2).

3.4 Closing Ceremony

The meeting was closed after representatives of WPR and SEAR made closing remarks on behalf of their respective regional directors. A participant each from SEAR and WPR also expressed appreciation of being given the opportunity to participate in the meeting.

4. STATUS, ACTIONS TAKEN AND ISSUES OF COMMUNICABLE DISEASES IN SEAR/WPR REGIONS

4.1 Control of Communicable Diseases

Against the background of outbreaks of emerging and re-emerging diseases, and better ways of communication, global surveillance is becoming a key instrument to guide quick action. WHO has set up various networks to monitor issues such as antibiotic resistance and haemorrhagic fever. The current International Health Regulations, which call for notification of yellow fever, cholera, and plague, are being expanded into a global alert system. The scope is proposed to be widened through adoption of syndromic approach under the revised IHR. Such an alert system is taking advantage of modern ways of fast communication, including the Internet, to disseminate information. WHO is playing an active role in such an alert system, in addition to its role of setting standards and providing a forum for discussion.

4.2 Issues related to Migration and Health

Cross-border movements, be it in the form of tourism, trade, investments, drug trafficking or human trafficking, all pose special health risks, that need to be addressed. In general, people living across the border in neighbouring countries, live in rather poor living conditions, and have limited access to health services. In addition, language problems, illegality, stigmatization, and other factors contribute to further deterioration of the health situation of cross-border populations. Outreach programmes and specially tailored health interventions, set within the larger context of the social environment, are needed to improve the lives of people living in border areas.

4.3 Poliomyelitis

In the Western Pacific Region, no new wild-poliovirus-associated case of poliomyelitis has been detected since March 1997, under conditions of high quality surveillance. There is good reason to believe that indigenous wild poliovirus transmission in the Western Pacific Region has finally ceased.

As at 1 October 1998, 5 963 cases of acute flaccid paralysis (AFP) with onset in 1997 were reported in the Western Pacific Region, 83% had two stool samples taken within 14 days of onset. In 1998, 3 307 AFP cases with onset were reported in the Region. Eighty six per cent had two stool samples taken within 14 days of onset. Nine wild poliovirus-associated poliomyelitis cases have been reported with onset in 1997. Eight of these cases originated from Cambodia in the same area as in 1996. The ninth wild poliovirus-associated case was reported from the central region of Viet Nam. By the end of 1997, all countries had reached the level of AFP and laboratory surveillance quality which enables them to confirm only those AFP cases where wild poliovirus was detected in stool samples; therefore, the total number of poliomyelitis cases reported in the Region for 1997 was only nine. This contrasts with 6 000 poliomyelitis cases reported throughout the Region in 1990. The last poliomyelitis case reported in the Region had onset of paralysis on 19 March 1997 in Cambodia. Surveillance and supplementary immunization activities were intensified throughout 1997 and 1998. As a result, even though over 8 000 AFP cases have been investigated throughout the Region since the onset of the last poliomyelitis case on 19 March 1997, no new cases of poliomyelitis have been detected. Therefore the regional total for polio is zero cases for 1998, under conditions of high quality surveillance. (See Annex 3 for more details). It has been the experience in the Western Pacific Region that efforts to eradicate the last few remaining wild polioviruses are far more intense than at the beginning of the polio eradication initiative (See Annex 4).

SEAR has made enormous progress in polio eradication activities in the past year. As of October 1998, all countries have conducted three or more NIDs except Nepal (2), Maldives (1), DPR Korea (1) and all are planning more supplementary immunization activities in 1998-1999 (Annex 5). AFP surveillance has improved vastly in 1998, especially in India, Myanmar and Thailand. As of 6 November 1998, the regional non-polio AFP rate is 0.85. Stool collection rates have also improved in 1998, 61% of all AFP cases had two stool specimens collected within 14 days after onset, and 87% had at least one specimen collected (See Annex 6). Wild poliovirus is thought to be mainly circulating in India, Bangladesh and Nepal, but vigilance in other countries needs to be kept up. Continuation of NIDs and further improvement of AFP surveillance are key to reaching the elimination target.

4.4 Cholera

Improved surveillance for cholera was reported both in WPR and SEAR. In addition, in WPR, the case fatality rate has decreased from 6.3% in 1991 to 1.4% in 1997. In SEAR, five countries (India, Indonesia, Nepal, Sri Lanka and Thailand) have reported cholera, and three of these (India, Nepal and Sri Lanka) report on a weekly basis. Control efforts are being strengthened through the establishment of WHO collaborating centres, rapid response teams in each country, better case management and better surveillance. The achievement of control efforts and case management have led to reduction in case fatality rates. Immediate cross-border notification, and better transparency are, however, equally important to decrease the burden of disease, and the high economic loss often suffered by countries which are affected. Control efforts will also need to address the problem of changing serotypes.

4.5 Malaria

The Western Pacific Region reported that there are nine malarious countries in the Region with a total population at risk for malaria of 107 842 000. During 1997, there were 442 000 microscopically-confirmed and 2.4 million clinically-diagnosed cases reported. For the Region as a whole, there has been a significant reduction of confirmed cases since 1993. Six of the nine endemic countries have already attained the regional goal of reducing malaria morbidity by 50% that was set for the year 2000.

Solomon Islands and Papua New Guinea have the highest incidence in the Western Pacific Region.

All nine countries have active malaria control programmes. The main malaria control

strategies are selective vector control; insecticide-treated mosquito nets, and good quality diagnosis and treatment.

For countries in the Western Pacific Region the main problem areas are along the borders between Cambodia, Lao PDR, China, Thailand and Myanmar, as well as along the borders separating the two Malaysian states of Sabah and Sarawak from Indonesia. Recently, there also has been a major malaria outbreak along South Korea's northern border.

In the SEA countries, the annual incidence declined sharply from over 110 million before the control campaign in 1950s to as low as 0.228 million in 1965. Malaria re-emerged in mid 1970s and at present about 1.2 billion people in eight countries were at risk. Though three million cases were reported each year, the actual number was estimated to be 20 million or six to seven times higher. Of these, more than 30 000 of all ages die. About 130 million people are living in drug-resistant areas.

The trends in the SEA Region indicate slow decline during the last 20 years. The incidence was 6.3 per 100 000 in 1975 and since 1982 the incidence ranges between 2.0 to 2.8 per 100 000. In spite of efforts by national governments, no further decline has been reported.

Malaria in border areas continues to be a problem. In many cases these are forested areas where the population is highly mobile; many are non-immunes coming from non-malarious areas to work as loggers, miners or smugglers. Health services are usually inadequate or in some cases non-existent. There are generally no malaria control activities and mosquito nets are not readily available. The presence of multidrug-resistant falciparum malaria combined with the lack of adequate diagnostic

services makes treatment difficult and expensive. The main source of antimalarial drugs is usually through private pharmacies or drug sellers. The drug supply is limited and the quality is often low. All these factors contribute to what is often a very dangerous situation.

The current understanding of malaria as a product of multiple factors clearly implies that malaria control must be a shared responsibility, going beyond the health sector alone. Malaria control as part of health development requires holistic, multisectoral, multidisciplinary approaches that have brought new challenges to countries and opened new avenues for collaboration through broad-based partnerships for achieving common goals. Hence, efforts to solve the common problem of malaria in border areas, particularly the epicentres of multidrug-resistant malaria, without addressing bi-regional collaboration will have limited success.

Resource networks are seen as a way to optimize regional expertise and experience, and they should act as a direct link between research institutions and the malaria control programme. These networks, composed of multidisciplinary experts, would provide direct support to malaria control operations, be involved in policy formulation, and be accessible to Member States from neighbouring regions.

Epidemiological surveillance is a prerequisite to effective prevention and control of communicable diseases. In the absence of surveillance, disease outbreaks may not be recognized in the early stages. And, by the time they are, intervention may no longer be effective. Continuous monitoring for early signals of outbreaks and ability to respond rapidly and effectively are, therefore, areas that require special attention by the health care system at all levels. Information technology must be fully utilized towards achieving effective surveillance and sustainable activities of disease control particularly sharing information on epidemics in border areas.

4.6 STD and HIV/AIDS

As of the end of 1997, 94 000 cumulative HIV cases and 2 900 AIDS cases were reported in WPR. These figures hide the reality, because of the vast underreporting and underdiagnosing. In WPR, the real prevalence of HIV is estimated as being seven times higher and the AIDS incidence five times higher. This underlines the importance of data analysis from HIV sentinel surveillance. WPR is projecting 1.5 million HIV cases by the year 2000, and an yearly AIDS incidence at 60 000.

HIV transmission is heterogenous in WPR. There is a decreasing trend in homosexual transmission, a stabilization in the transmission by IV drug use in the past five years, and a steady increase in heterosexual transmission. The IV drug use transmission is especially important in China, Malaysia and Vietnam. In general, the infection rate in WPR in the adult population is below 1% (3% in Cambodia). Some countries are experiencing an increase in HIV (China, Laos, PNG), others seem to have reached a plateau (Malaysia, Brunei, Macao), others show a decrease in cases (Australia and New Zealand) or do not experience an epidemic at all (Philippines, Japan, and Republic of Korea).

In the South-East Asia Region, the first AIDS case was reported in 1984. Since then, nearly 90 000 cases have been reported in the Region as of November 1998, nearly 95% reported from Thailand, India and Myanmar. HIV is now spreading rapidly and it has been further estimated that 5.5 million people are already infected with HIV. The impact of AIDS is therefore expected to continue well into the next century.

Among the population most vulnerable to HIV are those who are socially marginalized in the society and are often discriminated against on the basis of economic status, gender, educational level

or occupational status. In this category come individuals who frequently migrate within or outside the country for economic and other reasons. They live alone without families in a risky environment and without social control. Differences in cultural aspects and lack of access to information and health services accentuate their vulnerability. Moreover, populations in border areas have been shown to have higher rates of HIV infection than those inside the country such as in Myanmar towns bordering Thailand, Southern Vietnam at border with Cambodia, northern Vietnam at the border with China and western Cambodia at the border with Thailand. Interventions at border areas are therefore a priority.

Experiences show that interventions for preventing HIV in border areas must involve the target population in the planning and implementation of programmes. Among many such initiatives which have led to behaviour change include the Ranong-Kauthang project on the Thai-Myanmar border and the Raxaul intervention at the India-Nepal border. The former project was initiated by World Vision Thailand with support from AusAID to provide interventions among sex workers. But later the service was expanded to other population groups in the border area, such as fishermen, and also to many other towns. The approach is a model for other similar situations as it tries to involve the target population in all aspects of planning, and interventions and health and disease prevention services are integrated into primary health care. This bottom-up approach has been successful in increasing the knowledge of Myanmar fishermen regarding HIV/AIDS and has brought about positive changes in behaviours of target population resulting in a decrease in STDs in the area as compared to the situation before the interventions. Such experiences at border areas must be shared among countries and the approach expanded to other areas.

4.7 Tuberculosis

Tuberculosis is a major health problem in Asia and the Pacific, representing about 65% of the global disease burden. It has increased in many countries in these areas mainly due to lack of government commitment for national TB programmes and due to the impact of HIV on tuberculosis, particularly in Northern Thailand and parts of India. Mobile population and migrant workers from high tuberculosis-prevalence countries to low-prevalence countries is also one of the reasons for the re-emergence of tuberculosis in these areas. Tuberculosis among migrant workers and the mobile population accounts for around 10-20% of total tuberculosis patients in countries such as China, Hongkong, Malaysia and Singapore. In general, vulnerability to TB is higher in border areas, with an increased risk for incomplete TB treatment and TB resistance.

DOTS has been proven to be the best way not only to treat tuberculosis patients successfully but also to prevent the emergence of drug resistance. Since the DOTS strategy includes provision of free anti-TB drugs to tuberculosis patients and development of good recording and reporting system for monitoring and surveillance, implementation and expansion of DOTS strategy in each of the cross-border countries is crucial to approach the problem of tuberculosis in border areas. At present, no guidelines or mechanisms have been developed within the DOTS framework for tuberculosis patients among mobile populations in cross-border areas in terms of case detection, referral of patients and management of tuberculosis.

It is said that the ASEAN TB Initiative would facilitate the information exchange and enhancement of surveillance for tuberculosis patients among mobile populations in cross-border areas.

5. PROPOSALS FOR FURTHER ACTION

5.1 Poliomyelitis Eradication

There have been four China-Myanmar cross-border meetings since 1996, which have resulted in exchange of surveillance information, and coordination and joint planning of NIDs/SNIDs. These successful meetings can be considered as models for others. However, there has been little or no exchange of information outside these meetings.

- (1) The call for information exchange as made at the Second Bi-regional Meeting should be reconfirmed.
- (2) AFP surveillance data including performance indicators from all border areas should be mapped at least every six months and be made available to neighbouring countries through WHO's coordination. In addition, when polio cases are detected in a country, a spot map and the details of the cases should be made immediately available to neighbouring countries for appropriate action.
- (3) NID planning and advocacy should include migrant populations and the provision of extra vaccine in border areas. Budgets should be adapted accordingly.
- (4) Wherever possible, the supplementary immunization should be synchronized with neighbouring countries. However, if it is not possible to synchronize the whole country, activities should, at a minimum, be synchronized in border areas.
- (5) In the first quarter of 1999, countries with WHO's and other international organizations' collaboration should establish a cross-border polio task force to plan and coordinate polio eradication activities, including surveillance, in border areas. Priority should be given to the Pakistan-China border, the China-DPRK border, and appropriate borders between EMR and SEAR.

5.2 Cholera

WPR and SEAR countries have made considerable progress in the reporting of cholera cases though case-fatality rates remain high in some areas. As there are some sensitivities concerning the reporting of cholera due to the potential economic implications, local authorities at border areas will require national authorization to rapidly share information on outbreaks of severe diarrhoea, in order to facilitate institution of appropriate and timely treatment measures with the objective of reducing case fatality rates.

In order to encourage prompt public health control measures, in the event of an outbreak in a border area, national governments are advised to authorize rapid district-level sharing of information on outbreaks of severe diarrhoea, including cholera. There is need for strengthening case management in order to reduce case fatality rates.

5.3 Malaria

The protocol for malaria control in areas with multidrug resistance, and the Asian Collaborative Training Network for Malaria (ACTMalaria) are two major initiatives towards coordinating malaria control in the two regions.

- (1) The call for WHO's leadership, as made in the Second Bi-regional Meeting, to facilitate a bi-regional information exchange system, in partnership with Member States, was reiterated.
- (2) Within the framework of Roll Back Malaria, WHO is requested to work with governments to develop specific information exchange mechanisms.
- (3) Any malaria control initiatives in border areas must be synchronized between neighbouring countries.

5.4 STD/HIV

There has been increasing exchange between countries on STD/HIV/AIDS prevention and care issues but much needs to be done, particularly to promote and encourage information flow across borders. There have also been several cross-border HIV/AIDS interventions and efforts should be taken to build on these examples. In this context, countries should encourage local and international NGOs to support cross-border intervention in critical areas as well as intervention targeted at mobile populations in general.

The Second Bi-regional Meeting made comprehensive recommendations to deal with HIV and AIDS in border areas. Governments are encouraged to review the proposals made, as little action has been taken on many of these recommendations.

Particular attention should be paid to promoting exchange of experience between NGOs, exchange of IEC materials for cross-border populations, and delivery of STD/AIDS care services across borders. Also, in dealing with mobile populations, governments are encouraged to consider specific interventions for seafarers and, where vulnerable groups have been identified, to develop specific activities to reduce the risk of HIV infection.

5.5 Tuberculosis

TB was for the first time included in the WPR-SEAR Bi-regional Meeting. The meeting agreed that DOTS strategies which have been successfully introduced and expanded in most of the countries in the two regions, are the best way to control TB. It was also recognized that currently the available information on TB in border areas is insufficient.

- (1) Exchange of information and surveillance data on tuberculosis across borders, including treatment facilities available and drug resistance, should be enhanced.
- (2) The DOTS model for tuberculosis control should be developed and applied by all concerned Member Countries for cross-border populations. This should be an integral part of national tuberculosis control. This should also include a referral system between cross-border areas for case detection, treatment, defaulter-tracing and analysis of treatment outcome.
- (3) WHO should collaborate with countries to develop technical guidelines for tuberculosis control in cross-border areas. The guidelines should include a unified information system, details of the treatment regimen, and mechanisms for Directly Observed Treatment, addressing specific needs for mobile populations.
- (4) Countries should encourage local or international NGOs to establish special projects for tuberculosis among mobile populations within the DOTS framework.

- (5) When possible and necessary, border meetings and/or training across borders should be organized to discuss operational issues, to enhance cooperation and to ensure that the same policies are applied.

6. CONCLUSIONS

Given that the recommendations of the first and second bi-regional meetings were very comprehensive, the third meeting was mainly concerned with reviewing the actions taken as a result of these meetings.

Where possible, specific activities were identified where progress could be achieved in 1999. While there are many wider issues regarding communicable diseases among migrant populations, this meeting mainly focused on issues to be addressed at border areas between the SEA and WPR regions, and on the common border with one country from the Eastern Mediterranean Region (EMR).

Rapid exchange of information at district level was seen as crucial to allow countries to take timely and appropriate action in case of an outbreak. In addition, all governments should ensure that border-level health staff are made aware of the need to exchange information.

The first bi-regional meeting mainly focused upon polio eradication which has very specific strategies and targets shared by every country in the world. These bi-regional meetings have been very successful in coordinating polio eradication between the two regions. However bi-regional coordination for control of other communicable diseases will require much greater efforts. These would include capacity-building and facilitating information exchange for integrated control of communicable diseases within the health infrastructure in border areas. Budgets should be adapted accordingly.

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Annex 2
PROGRAMME

Wednesday, 18 November 1998

	Opening Session	
08:00 – 08:30 hr	Registration	
08:30 hr	Inaugural Session	
	Opening address	Dr Uton Muchtar Rafei Regional Director WHO, South-East Asia Region
		Dr S.T. Han Regional Director WHO, Western Pacific Region
	Welcome address	Mr Pakdi Ratanaphol Deputy Governor of Chiang Mai
	Inaugural address	H.E. Mr Kamron Na-Lamphun Deputy Minister of Public Health Government of Thailand
	Introduction of participants	Dr Imam Mochny Acting Chief, EPI WHO/SEARO
	Announcements	
	Nomination of Chairperson, Co-Chairperson & Rapporteur	
	Business Session	
09:45 – 12:00 hr	General Overview	
	– International Disease Surveillance including polio & International Health Regulation	Dr Vijay Kumar / Dr Imam Mochny
	– Social, Economic & Health related migration in SEA Region	Dr Supang Chantavanich
	Discussion	
13:30 – 15:00 hr	Regional perspective	
	– Polio Eradication	Dr Jos Vandelaer/Dr Julian Bilous

Wednesday, 18 November 1998

- | | |
|--|---------------------------------|
| – Cholera in the context of Integrated Disease Control | Dr Vijay Kumar/Dr Julian Bilous |
| – STD/AIDS | Dr Jai P. Narain/Dr G. Pomerol |
| – Malaria | Dr P.R. Arbani/Dr K. Palmer |
| – TB | Dr Jai P. Narain/Dr Ahn |

Discussion

15:15 – 15:30 hr Briefing on Group work

15:30 – 17:00 hr Group work

Thursday, 19 November 1998

08:00 – 12:00 hr Group work continues

13:30 – 15:00 hr Group work continues

15:15 – 17:00 hr Presentation of Group work

Friday, 20 November 1998

08:00-09:00 hr Presentation and discussion of draft recommendations (Rapporteur)

10:30 hr **Closing Session**

- Remarks by participant(s) from SEAR
- Remarks by participant(s) from WPR
- Closing remarks on behalf of RD/WPRO
- Closing remarks on behalf of RD/SEARO
- Closing remarks by Chairperson

13:30 hr Field trips

Annex 3

**TOTAL AFP CASES REPORTED, CONFIRMED POLIOMYELITIS CASES
AND WILD VIRUS-ASSOCIATED CASES, WESTERN PACIFIC REGION,
1993-1997**

Country	Total AFP cases reported					Confirmed as Polio					Wild virus isolated				
	1993	1994	1995	1996	1997	1993	1994	1995	1996	1997	1993	1994	1995	1996	1997
Cambodia	135	302	183	132	178	135	297	130	83	8	4	33	17	15	8
China	1 818	3 092	4 802	4 376	4 767	538	307	165	3	0	101	6	1 *	3 *	0
Lao PDR	9	11	16	41	76	7	6	8	21	0	0	0	0	1	0
Malaysia	1	17	13	32	86	0	0	0	3	0	0	0	0	0	0
Mongolia	**	0	0	19	18	2	0	0	0	0	**	0	0	0	0
PNG	16	13	13	22	39	0	2	1	6	0	0	0	0	0	0
Philippines	88	127	153	175	293	15	11	40	80	0	7	0	0	0	0
S.Pacific	0	1	3	6	12	0	0	0	0	0	0	0	0	0	0
Viet Nam	607	353	467	494	463	452	121	137	2	1	157	35	13	2	1
Others	1	1	0	3	31	0	0	0	0	0	0	0	0	0	0
TOTAL	2 675	3 917	5 650	5 300	5 963	1 149	744	481	198	9	269	74	31	21	9

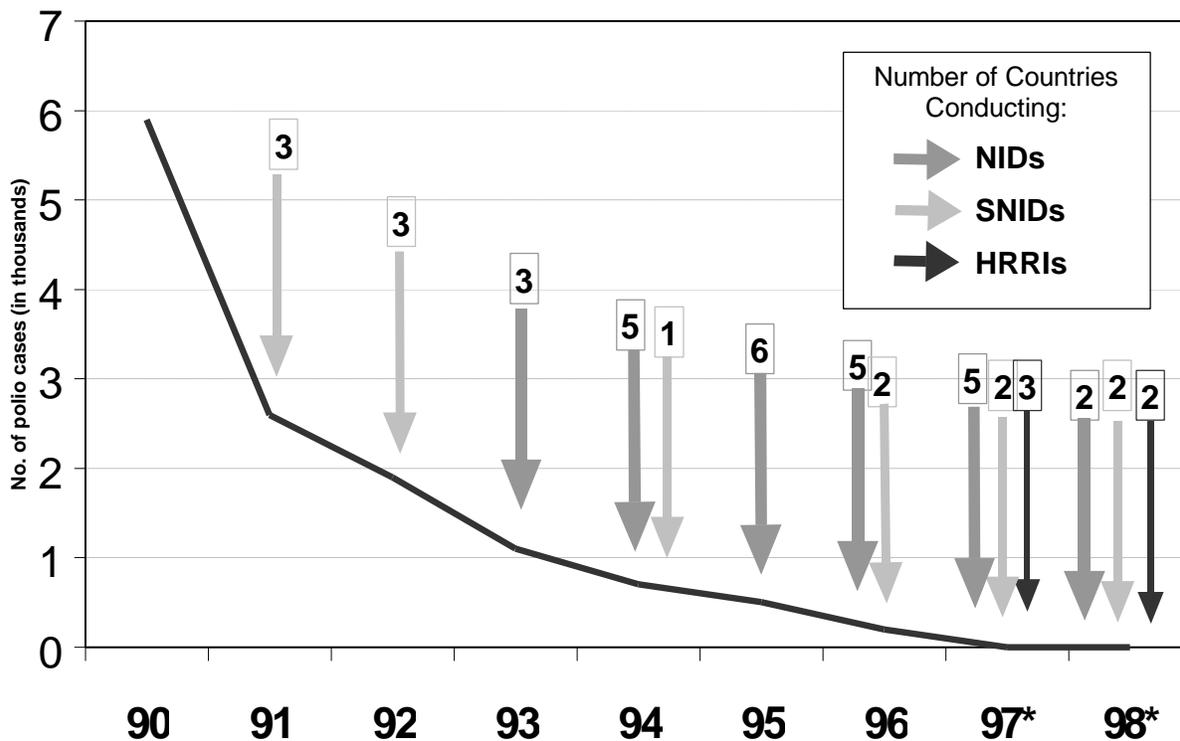
* China wild virus imported.

** No data

Note : Latest available data from WPRO AFP Surveillance System as of 1 October 1998

Annex 4

**SUPPLEMENTARY IMMUNIZATION IN WESTERN PACIFIC REGION
INTENSIFIES DURING THE LAST STAGES OF POLIOMYELITIS
ERADICATION, 1990-1998 ***



*Data from WHO/WPRO CEIS system, as of 1 October 1998.

Annex 5
NIDS AND SNIDS
SOUTH-EAST ASIA REGION 1994 - 1998

Country	NIDs* 1994-1998	NIDs 1998-1999
Bangladesh	4	Dec 98 – Feb 99
Bhutan	1 NID, 2 SNID	Dec 98 – Jan 99
DPR Korea	1	Sept – Oct 98
India	3	Dec 98 – Jan 99
Indonesia	3	Sept – Oct 97 (SNID)
Maldives	1	Dec 98 – Jan 99
Myanmar	3	Dec 98 – Jan 99
Nepal	2	Dec 98 – Jan 99
Sri Lanka	3	Sept – Oct 98
Thailand	4	Dec 98 – Jan 99

* 186 200 000 children vaccinated in 1997 – 1998 NIDs

* Regional coverage > 95%

Annex 6

CLASSIFICATION OF AFP CASES AND KEY SURVEILLANCE INDICATORS, 1997 AND 1998

# AFP cases	1997								1998									
	AFP				AFP rate ²				Specimen Collection		AFP				AFP Rate ²		Specimen collection	
	Case classification				Total AFP rate	Non-polio AFP rate	% with 2 spec. w/in 14 days ³	% with any specimen	# AFP Cases	Case classification				Total AFP rate	Non-polio AFP rate	% with 2 spec. w/in 14 days ³	...	
	Polio ¹									Polio ¹								
Total	Wild Poliovirus	Discarded (non-polio AFP)	Pending	Total AFP rate	Non-polio AFP rate	% with 2 spec. w/in 14 days ³	% with any specimen	Total	Wild Poliovirus	Discarded (non-polio AFP)	Pending	Total AFP rate	Non-polio AFP rate	% with 2 spec. w/in 14 days ³	...			
244	173	6	71	0	0.48	0.14	34	93	385	195	2	90	100	0.90	0.21	49		
0	0	0	0	0	0.00	0.00	0	0	2	2	0	0	0	0.91	0.00	0		
3	0	0	1	2	0.04	0.01	0	100	0	0	0	0	0	0.00	0.00	0		
047	2 271	483	776	0	0.86	0.22	34	67	7 443	1 905	511	2 862	2 676	2.49	0.96	59		
232	379	0	853	0	1.89	1.31	54	92	632	76	0	527	29	1.15	0.96	77		
1	0	0	1	0	0.84	0.84	100	100	0	0	0	0	0	0.00	0.00	0		
172	55	0	117	0	1.11	0.75	58	98	137	17	0	74	46	1.04	0.56	70		
36	12	1	24	0	0.39	0.26	39	72	41	12	0	15	14	0.52	0.19	39		
115	0	0	115	0	2.12	2.12	45	82	76	0	0	59	17	1.65	1.28	76		
131	19	1	87	25	0.75	0.50	65	95	212	19	0	143	50	1.44	0.97	77		
981	2 909	491	2 045	27	0.95	0.39	41	77	8 928	2 226	513	3 770	2 932	2.01	0.85	61		

clinical classification system. #AFP cases = total polio + non-polio AFP + cases pending classification = no cases confirmed by clinical criteria only and cases with wild polio virus isolations.
¹ Polio cases. Expected rate is at least 1 case non-polio AFP per 100 000 children aged <15 years.
² # discarded (i.e. non-polio AFP) cases per 100 000 aged <15 years.
³ % with 2 adequate stool specimens collected within 14 days of paralysis onset; target ≥80%.

