Intercountry Cooperation: Cross-border Control of Priority Communicable Diseases
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Facilitating information exchange

Information essential for decision-making is lacking in the border areas. Further, very little of the available information is exchanged across the borders. There is insufficient political commitment or long-term support for information exchange.

Need for capacity building

Health staff, non-health government staff, beneficiaries and volunteers, NGOs, and other actors and stakeholders in the border areas lack the capacity and skills required for effective cross-border collaboration. Health staff lack the skills required under the national disease control programme, including basic epidemiology, early case detection, case management, reporting and epidemic alert. They and other actors lack skills such as environmental hygiene and vector control as well as managerial, coordination, networking, and resource mobilization skills.

Mobilizing resources

Cross-border initiatives are currently under-funded. National resource allocation is almost non-existent and support from donors is inadequate.

Coordination mechanisms between countries

Currently there are no mechanisms for the coordination of cross-border issues either at the local, national, or international level. There are no appointed focal points for coordination and sharing of information across the border, and there is very little contact between local authorities on either side of the border. At the international level, there is no mechanism such as a Memorandum of Understanding (MoU) for cooperation and sharing of information.

7. CONCLUSIONS

The need for cross-border collaboration for the control of communicable diseases is expected to grow in importance due to increased population movements and emerging and re-merging diseases. However, effective collaboration is difficult to achieve because of a multitude of reasons including the lack of political will and capacity, and the sensitive nature of border collaboration. Because of this it is important to proceed with extreme caution, one step at a time, building the capacity of the border areas along the way. Cross-border initiatives need to be tailor-made to fit the local circumstances in each area, after a thorough and exhaustive situation analysis.

While WHO could play a high level advocacy role to get the political commitment needed for institutionalizing cross-border collaboration and information exchange, countries must designate focal points at various levels - particularly at programme and operational levels - for exchange of information and for planning and implementing cross-border initiatives. All countries must be committed to work collaboratively to tackle cross-border problems and develop a policy that is reflected from central to the peripheral level.

Effective cross-border collaboration requires sustained funding. In addition to national resource allocation, external resource mobilization is required. WHO could support countries in mobilizing resources for cross-border control of priority communicable diseases from sources such as GFATM and building partnerships with other development partners, including regional associations such as ASEAN and SAARC.

1. BACKGROUND

Intercountry cooperation is an integral part of WHO’s collaborative efforts in the South-East Asia Region to support Member States in their national health development. It has proved to be an innovative and cost-effective approach to tackle common health issues of concern to more than one country in the Region by facilitating the sharing of experiences among countries and taking joint and complementary action. One important area for intercountry cooperation is cross-border collaboration for the control of priority communicable diseases, as identified by the Regional Committee for South-East Asia in 2000. The SEA Regional Office has implemented a number of activities on cross-border collaboration, including a plan of action under Supplementary Intercountry Programme (ICP II).

2. WHY DO WE NEED INTERCOUNTRY COOPERATION FOR CONTROL OF COMMUNICABLE DISEASES ACROSS BORDERS?

Disease transmission is high in border areas, particularly for priority communicable diseases. The risk of AIDS is linked with drug trade and trafficking of girls/women across borders. The existence and support from donors is inadequate. The situation is further complicated by the marginalization and criminalization of immigrants and their lack of legal rights which make them vulnerable to infectious diseases.

Disease control in border areas poses considerable difficulties and challenges. For example in implementing the DOTS strategy, due to frequent movements, patients cannot be directly observed. Thus the risk of treatment interruption is high. Often, bordering countries have differing drug regimens. Border areas lack in services such as sputum microscopy and mechanisms for treatment monitoring. This results in low cure rates and chances of MDR is high. In the case of Malaria, bordering countries often use different insecticides. There is very little coordination between the countries in vector control or in treatment regimens, and in drug resistance monitoring.

To make matters worse, border areas are low priority. Often there is a wide gap between national policies and action at border. In other words there is administrative inertia in translating policies down the hierarchy. Border areas often have weak public health infrastructure, which are inadequate to tackle the peculiar health problems in these areas.

Population movement across international borders, often illegal, is therefore a risk factor in the spread of diseases and dispersal of vectors. Migrants’ access to health services is often limited due to location, foreigner status, etc. Migration is particularly relevant to SEAR countries such as Bangladesh, Bhutan, India, Indonesia, Myanmar, Timor Leste and Thailand.

The profile of the people who cross borders include young people, often male, unmarried or without family. These include commercial sex workers, agricultural workers, fishermen, and truck drivers. High risk areas include border towns, transit points, seaports, construction sites, and cattle markets.

At the national and regional level, the issue of migration is complicated because of political sensitivities relating to population movement, human trafficking and limited cross-border collaboration in health.

Emerging diseases such as Avian Influenza have heightened the need for inter-country cooperation. During the mid 2004, avian influenza re-emerged among poultry in Asia, affecting three countries – China, Thailand, and Vietnam - within the space of a few weeks. SARS is another good example of an emerging disease with the potential for spreading rapidly via modern modes of transport. In a major outbreak last year, it spread rapidly, infecting 8,000 and killing 800 in less than 6 months; individual cases led to infections of others, sometimes spreading to more...
than 10 other countries. Intercountry cooperation, including sharing and exchange of information and expertise is vital to control and contain these diseases effectively.

3. INTERCOUNTRY COLLABORATION CAN WORK: A SUCCESS STORY ALONG THE THAI-CAMBODIA BORDER

The Promdan project demonstrates the feasibility and effective approach to intercountry cooperation. It was designed to promote migrant health, targeted at Khmer migrant workers, numbering about 7,000, moving to and from between Cambodia and Thailand, during 1999-2003.

The migrant population faced a high risk of acquiring HIV, with sero-prevalence rates of 3.7% among workers, and 22.9% among sex workers that they patronized. This risk was largely due to a unique set of social factors. Most migrants were single men or married men living away from their wives. In their line of work they spent long periods fishing on the high seas, on average about 12 days. When they returned tired to the shore they got paid for the entire duration they were at sea, leaving them with a relatively large amount of cash and free time in a pier area surrounded by brothels.

The Promdan project made use of multi-dimensional interventions to curb the spread of HIV in this community. Recognizing the social dimensions of the problem, the project aimed to deal with it in a holistic manner. Thus, while increasing awareness about the AIDS and promoting the use of condoms on the one hand, the project also simultaneously addressed the social-economic-cultural needs of the community. The interventions were tailored to the needs of the community. Condoms were made available through outlets on the boats and around the brothels. A politically-acceptable model was developed for intercountry immunization. Social interventions included fostering family connections, encouraging saving, and developing cultural understanding between Thai and Cambodian communities. The project was implemented through a multi-level partnership of government agencies, NGOs and private businesses.

The positive outcomes of the project included increased knowledge of HIV/AIDS in the community, increased availability of condoms, higher level of health and improved community and familial connections/bonding.

Some challenges in implementation included political stumbling blocks in the labour registration process, the illegality of migrants getting pregnant, and deficiencies in monitoring and managing migration.

4. IMPLEMENTATION OF CROSS-BORDER COLLABORATION IN THE SEA REGION

Intercountry cooperation for cross-border control of priority communicable diseases requires sensitivity and understanding as it inherently encompasses politics. It also requires special approaches because of the peculiar set of problems faced by border areas including inadequate health facilities, language barriers, remote areas that are poorly accessible, dichotomy between national and local policies, and lack of authority at the district level. Recognizing this, the Regional Office has adopted the following principles for cross-border control of priority communicable diseases:

- Formulating coherent policies for disease control for use on both sides of the border;
- Affirming the right of patients to receive services and medicines regardless of citizenship, place of residence and legal status;
- Building effective systems for exchange of information and expertise for joint planning and implementation;
- Cross-border control of priority communicable diseases is a difficult and complicated issue, needing bi- or multi-country collaboration. Moreover, border areas being remote and away from mainstream, lack the capacity for effective programme implementation and service delivery for existing and newly-emerging diseases. Thus cross-border projects must start modestly and build on the initial results.

5. LESSONS LEARNT

During two years of implementation of pilot projects, following lessons were learnt:

- Collaboration across border areas requires full cooperation and active participation from Governments on both sides of the border – not only at policy level but also at programme as well as operational levels.
- Control of communicable diseases across borders has to do, not only with health sector but a multilateral involvement at the country level including immigration, customs as well as NGOs active at border areas, and coordination between the countries based on Memoranda of Understanding, especially for establishing information exchange mechanisms across borders.
- Cross-border control of priority communicable diseases requires high level of commitment from participating countries and WHO in terms of human and financial resources. Even though commitment is often expressed at policy-level meetings, this does not get translated into action in the border areas.
- WHO, particularly at country level could play a facilitating and catalytic role among the countries in order to institutionalize intercountry cooperation. Similarly, there is a need to fully utilize the existing intercountry and interregional mechanisms such as ASEAN and SAARC.

6. ISSUES FOR CONSIDERATION

Political commitment and action at ground level

Even though political support for intercountry cooperation is often expressed in various forums, the translation of this support into policies has not been uniform in the countries. In most countries, due to “administrative inertia,” there has been very little action in the border districts.