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**MULTIDISEASE SURVEILLANCE –  
CROSS-BORDER COLLABORATION**

## 1. MULTIDISEASE SURVEILLANCE

Countries in the SEA Region are often faced with epidemics and outbreaks of diseases. Emergencies are common. Increased travel and trade has enhanced the risk of spread of infections, health problems and diseases. Health security must be given priority attention in response to this emerging threat.

Surveillance and timely response are necessary to mitigate human suffering and economic burden resulting from epidemics and outbreaks. During the last two years, countries in the Region witnessed more than 20 major epidemics, including cholera, diarrhoeal diseases, dengue/DHF, malaria, Japanese B encephalitis, anthrax, rabies, hand-foot-and-mouth disease and a mysterious disease with symptoms of encephalitis. WHO provided technical support to countries during some of these epidemics in the form of consultants, technical guidelines, diagnostic kits and reagents. Information on the epidemics was shared with other countries when appropriate.

A weekly outbreak verification list (OVL) is compiled to alert WHO Representatives in the countries, selected institutions and individuals. The information is derived from multiple sources (Government, private and media). Since the initial information is unconfirmed, it is shared only with a limited audience to prevent unnecessary panic and any unwarranted trade or economic impact. It acts as a trigger for further rapid action and follow up. Once confirmed, the information is shared more widely. An effective mechanism is through weekly epidemiological report. In addition to infectious diseases, its scope needs to be enlarged to include health conditions related to food safety and environmental hazards.

Regional and national capacity development in disease surveillance and response are being intensified. WHO has played a key role in developing a two-year Field Epidemiology Training Programme (FETP) in India, Indonesia and Thailand. The training given in these programmes is of international quality. The FETP was reviewed in February 2000 and a follow-up seminar in May 2001 updated its achievements.

In order to build the capacity of health care at all levels and enhance the pace of capacity development, WHO has supported training programmes of three months' duration at NICD in India during the last six years. WHO has conducted intercountry training courses on epidemic preparedness and response in India, Indonesia, Myanmar and Nepal. The course content was refined with suitable adaptations which included case studies from the countries of SE Asia Region. These intercountry courses have been followed by similar courses in the Member Countries as a part of national capacity building. WHO is now developing a five-day training course to increase capacity in disease surveillance for the staff working at the district and sub-district levels.

To strengthen the health system at the district and sub-district level, two draft training guidelines have been prepared for the basic health workers and the doctors working at the primary health care level for improvement in the management of priority communicable diseases. These guidelines have adopted a systems approach in integrated management, and are being peer reviewed, prior to field testing. The guidelines, when used, will strengthen the response to epidemics and outbreaks.

In addition to training, capacity development is promoted by WHO through networking of laboratories and institutions who exchange information on a regular basis. CD Alert is a monthly newsletter published by the National Institute of Communicable Diseases (NICD) in India, EWARS (Early Warning Reporting System) is established in Indonesia, a weekly epidemiological bulletin is issued by Sri Lanka, and East Timor which brings out information regularly. In addition, websites have been established through regional mechanisms, including MBDS (Mekong Basic Disease Surveillance) website and BBIN (Bhutan, Bangladesh, India, Nepal) website. The Regional Office has also established a websites. Rapid information exchange will be a very effective means to increase capacity and respond to disease epidemics.

In collaboration with Member Countries and working in partnership with the states following emergencies, WHO helped to convert challenges into opportunities. Following the supercyclone in Orissa, staff in all the districts affected by cyclone were trained, formats were made available, and technical guidelines given to improve management. The experience was very convincing to the decision-makers, health authorities and the staff. Consequently, all the districts in the state were involved. At present, a state-wide disease surveillance and response system is in operation for more than one year. As a result, major epidemics could be controlled/averted. Following the earthquake in Gujarat state in India, the health infrastructure was completely destroyed in one district and partially destroyed in four others. WHO collaborated with the Government of India and the State of Gujarat in medical relief by redeployment of several staff members in the affected district and succeeded in averting major epidemics. An epidemiological cell was established, which could serve as an excellent entry point to strengthen disease surveillance system in the State.

Disease surveillance and response should be seen as integral to health system development. It is necessary to coordinate the response to priority communicable diseases, many of which occur as epidemics and outbreaks, in order to control their spread, and reduce excess mortality and adverse economic impact. The rapid development of antimicrobial drug resistance is undermining the efficacy of available treatment and development of new effective drugs is not able to keep pace with the problem of antimicrobial drug resistance. Monitoring of antimicrobial drug resistance is important and should be a part of health security.

Specialized surveillance systems, surveillance of risk factors, behaviour surveillance and surveillance for food safety and environmental hazards are becoming increasingly relevant. However, many data collected have similarity, the person who collects the variety of information is the same and the respondent from whom information is gathered is also the same. When the health systems are weak, it is difficult to sustain separate surveillance system for individual diseases. A solution to explore is to try multidisease surveillance. This is particularly relevant to disease surveillance at the district and subdistrict levels.

## **1. CROSS-BORDER COLLABORATION**

Cross-border problems in health include the risk of spread of communicable diseases which include malaria, kala-azar, Japanese encephalitis, tuberculosis, HIV/AIDS. There is increasing concern about the occurrence and spread of these diseases and other health problems as a result of increased travel, migration, lack of effective coordination in implementation and inadequate and inefficient health care delivery. Poverty, overcrowded living conditions, social problems, increased consumption of alcohol and loneliness add to the risk of increased intensity and occurrence of these diseases.

Mekong Region (Myanmar, Thailand, Cambodia, Vietnam, Younan province in Peoples Republic of China and Lao PDR) is emerging as an epicentre for multi-drug resistance in malaria. This is seriously affecting health and has an adverse impact on development. Cross-border risks from HIV/AIDS have multiplied due to increase in vulnerability enhanced by the heightened risk of sexual contacts during migration or while travelling.

People who migrate are generally poor and live in overcrowded conditions, making them vulnerable to TB infection. The problem of TB is worsened, since the drug regimes may be different across the international border, patients may be difficult to trace for follow up and may not be eligible for treatment because of nationality status. Diseases like malaria, Japanese encephalitis and kala-azar differ in their endemicity in different districts and, therefore, cross-border efforts have to focus on different priority diseases in different districts based on the epidemiological pattern.

The cross-border problems have been expressed as a priority concern in different forums. These were discussed in the 17<sup>th</sup> and 18<sup>th</sup> Meeting of the Ministers of Health of the countries of the SEA Region, held in Yangon, Myanmar, and Kathmandu, Nepal. This was also discussed at the 53rd Session of the Regional Committee for SEA Region held in New Delhi, India. Recognizing the seriousness of the problems, a high-level task force has identified cross-border problems as a priority theme to be addressed through intercountry cooperation mechanism in the 2002-2003 biennium.

WHO has served as a neutral international agency with a mandate to facilitate cross-border collaboration. It started with advocacy for cross-border collaboration on a biregional basis. Regional mechanisms like SAARC and Mekong sub-regional collaboration have been utilized to facilitate the task. The focus has been enlarged from a single disease to include several priority diseases. Joint action plans have been developed and resources have been mobilized with development of partnerships on a bilateral or multilateral basis. WHO is establishing staff positions in strategic locations in the Mekong region to facilitate the work of cross border collaboration on an ongoing basis.

It has been possible to organize synchronized national immunization days for eradication of polio. Surveillance has been more effective and investigation of cases of suspected polio is facilitated through cross-border collaboration. Through Mekong Basin disease surveillance a website for information exchange on priority communicable diseases has been established. Common protocols have been developed for monitoring of multi-drug resistant malaria. Joint plans of action and technical guidelines were finalized for cross-border collaboration on malaria, kala-azar, HIV/AIDS and TB control in selected border districts in Bangladesh, Bhutan, India and Nepal. This is promoted through the SAARC mechanism in collaboration with several partners. Institutional networking has been proposed to provide technical support to the programme in selected districts. These institutions will help in capacity-building through training, laboratory support and information sharing. Cross-border collaboration is increasingly focusing on district level efforts and action. Partnerships are being established to strengthen cross-border collaboration. Within the framework of regional and bi-regional collaboration, and the context of health policy at the national levels, there is an increasing focus on the interstate and cross-district collaboration with a view to ensure that the benefits of such initiatives accrue at the grass-roots level.