REPORT
SEAR/WPR BIREGIONAL MEETING ON
CONTROL OF COMMUNICABLE DISEASES
Beijing, China
30-31 October 1997

Manila, Philippines
April 1998
REPORT

SEAR/WPR BIREGIONAL MEETING ON
CONTROL OF COMMUNICABLE DISEASES

Convened by the
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NOTE

The views expressed in this report are those of the participants in the SEAR/WPR Biregional Meeting on Control of Communicable Diseases and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the Regional Office for the Western Pacific of the World Health Organization for governments of Member States of the South-East Asia and Western Pacific Regions and for the participants in the SEAR/WPR Biregional Meeting on Control of Communicable Diseases which was held from 30 to 31 October 1997 in Beijing, China.
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A first biregional meeting on the control of communicable diseases was held in New Delhi, India, in October 1996. At the end of this meeting, a recommendation was made to hold the meeting on an annual basis to improve the exchange of experiences in the prevention and control of communicable diseases in both the South-East Asia and the Western Pacific Regions.

The objective of the second meeting was to provide a forum for exchange and cooperation on communicable diseases prevention and control among countries of the two regions. The meeting was attended by 37 participants from 10 countries.

The discussions concentrated on issues in prevention and control of poliomyelitis, malaria, cholera and STD, HIV/AIDS. Although substantial were noted in the exchange of information and implementation of coordinated interventions between countries, numerous issues and proposals for further action were identified.

It was decided to organize a third meeting in 1998 in Thailand.
1. INTRODUCTION

Both the South-East Asia and the Western Pacific Regions have well developed communicable disease prevention and control programmes, although coordination between these Regions can be reinforced.

Timetables for implementation of activities may sometimes differ between countries, creating potential operational problems as in the case of national immunization days (NIDs). In addition, movements between countries facilitate the transmission of major communicable diseases and it is perceived that a better exchange of information on successful preventive interventions between countries will be beneficial for programme implementation in the two Regions. A first meeting was held in the South-East Asia Regional Office, New Delhi, in October 1996 and participating countries were Cambodia, China, the Lao People’s Democratic Republic, Myanmar and Thailand. At the end of this meeting, a recommendation was made to continue to have such meetings on a yearly basis to improve exchange of experiences in the prevention and control of communicable diseases in both the South-East Asia and Western Pacific Regions.

It was decided for this year’s meeting to invite, in addition to last year participants, the Democratic People’s Republic of Korea, India, Nepal, Thailand, the Republic of Korea, and Viet Nam and the agenda was extended to cover poliomyelitis, malaria, cholera, sexually transmitted diseases, including HIV/AIDS.

2. OBJECTIVES

The objective of this second meeting was to provide a forum for exchange and cooperation on communicable diseases prevention and control among countries of the WHO South-East Asia and Western Pacific Regions.

Specific objectives were identified as:

(1) to review the progress made in implementation of the recommendations of the first biregional meeting on the prevention and control of communicable diseases;

(2) to share country-specific technical experience on the prevention and control of communicable diseases especially, HIV/AIDS/STD; poliomyelitis and vaccine-preventable disease; malaria, cholera; and to identify the most successful interventions for promotion within countries of neighbouring regions;

(3) to agree on policies and strategies that should be further developed or reinforced to improve the prevention and control of communicable diseases;

(4) to discuss specific issues to ensure that the planning and management of communicable disease prevention and control, including operational research, are well coordinated; and
(5) to further reinforce the means of rapid exchange of disease surveillance and control information among countries of neighbouring regions.

3. PROCEEDING

3.1 Participants

The meeting was attended by 37 participants from 10 countries (Cambodia, China, the Democratic People's Republic of Korea, the Lao People's Democratic Republic, the Republic of Korea, Viet Nam, India, Myanmar, Nepal and Thailand). The technical programme of the meeting consisted of plenary presentations, discussions and group work.

Dr Durga Prasad Manandhar from Nepal was nominated as Chairman of the meeting, Dr Chen Xianyi of China as Vice-Chairman and Ms Ly Nareth from Cambodia as Rapporteur.

3.2 Opening ceremony

The opening ceremony was attended by Professor Yin Dakui, Vice-Minister of Health from the Republic of China and the Regional Directors of South-East Asia and Western Pacific Regions, namely Dr Uton Muchtar Rafei and Dr S.T. Han, all of whom presented their opening remarks.

Professor Yin Dakui, Vice Minister of Health from the Republic of China welcomed the participants to the meeting and congratulated WHO for organizing the meeting. Professor Yin Dakui reaffirmed the priority given for many years by the Chinese Government to the prevention and control of communicable diseases. This attention given to communicable diseases prevention and control in China has led to the eradication of smallpox and the control of cholera, measles, diphtheria, encephalitis, malaria and schistosomiasis. Professor Yin Dakui pointed out that for the last 10 years, the expanded programme on immunization (EPI) has also been a priority and, as a result, no indigenous poliomyelitis case has been found since 1994. However, he recognized that new challenges are still ahead, with the emergence of AIDS and other re-emerging diseases and that controlling these diseases will require collaboration between neighbouring countries.

Dr Uton Muchtar Rafei, Regional Director, South-East Asia Region, indicated that the meeting was very timely and stressed that WHO attaches great significance to the prevention and control of communicable diseases in border areas. Dr Rafei mentioned that several regional and biregional meetings have been organized in the past to develop strategies to control cross-border transmission of diseases among countries in the regions. At these meetings, recommendations had stressed the importance of follow-up, not only at national level, but also at local level in order to ensure that sustainable and effective measures are taken at the specific border areas involved. In this context, Dr Rafei stated that the first biregional meeting had been a significant milestone in the endeavour to strengthen the control of communicable diseases which affect people from both regions.

Dr Rafei briefly described the problems in countries of the South-East Region concerning malaria, HIV/AIDS and poliomyelitis eradication. He encouraged the participants to work towards improved coordination at national and regional levels as well as intercountry collaboration.
Addressing the meeting, Dr S.T. Han, Regional Director, Western Pacific Region, welcomed the opportunity to tackle health problems that are shared in the border areas between the two regions. Dr Han stressed that cross-border coordination and cooperation between the two regions had substantially improved since the previous meeting and that more technical issues such as cholera and malaria, had been added to the agenda this year because of the growing concern about a number of emerging and re-emerging communicable diseases that have affected both Regions. He hoped that the meeting could discuss ways to improve communication systems and offer rapid response in a coordinated fashion whenever possible.

Dr Han also emphasized that some of the features of border areas actually make populations in these zones more vulnerable to communicable diseases. He concluded that, although the regions may differ in policies, strategies and schedule of activities for communicable disease control, public health workers in both regions have a joint responsibility for the people who live in the border areas. He urged participants of the meeting to make great efforts to find ways of collaborating and coordinating their work.

3.3 Closing ceremony

The meeting was closed by the Regional Directors from South-East Asia Region and the Western Pacific Region, Dr Rafei and Dr Han, who both congratulated the participants for their contributions. It was proposed that a third meeting be organized in November 1998.

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

4.1 Poliomyelitis

Both the South-East Asia and Western Pacific Regions are fully committed to accelerating activities to ensure global eradication of poliomyelitis by 2000. Since the last meeting, there has been considerable progress in cooperation and coordination in surveillance and supplementary immunization. China and Myanmar held a second border meeting in Kunming, and synchronized their sub-national immunization days (SNIDs) and national immunization days (NIDs) in their border areas of Yunnan province, and Shan and Kachin states. Cambodia conducted NIDs and high-risk response immunization including areas along its border with Thailand that had been previously inaccessible. The Democratic People's Republic of Korea expressed a need to coordinate supplementary immunization with China and Russia. Thailand has revised the dates for NIDs, to synchronize more closely with its neighbours. Cambodia and Thailand identified special groups, such as refugees, as a common area of concern, and agreed to strengthen AFP surveillance and immunization among these groups.

4.2 Cholera

The seventh worldwide pandemic of cholera, caused by the El Tor biotype of Vibrio cholerae O1, which started in Sulawesi, Indonesia in 1961, is still continuing in the South-East Asia and Western Pacific Regions. In the 1990s, a peak in the reported cholera cases and deaths in Asia was experienced in 1994, with a total of almost 70,000 cases and 1,300 deaths reported to WHO. In 1996, 13,441 cases and 153 deaths due to cholera were officially reported to WHO from South-East Asia Region and Western Pacific Region countries and areas.
In 1992, a new cause of cholera, *Vibrio cholerae* O139 emerged in the Bay of Bengal in India. It spread rapidly to neighbouring countries causing large outbreaks in 1993 when it was reported from seven countries in Asia. Its incidence appeared to be declining in 1994 (five countries reporting), 1995 and 1996 (one country reporting each year). However, since WHO does not require separate reporting for *V. cholerae* O139, it remains unclear what proportion of all cases have been caused by this serogroup. Of special concern is the fact that previous exposure to *V. cholerae* O1 does not provide protective immunity to *V. cholerae* O139. It can, therefore, spread fast and has the potential to cause large outbreaks.

In view of the continuous threat of the seventh cholera pandemic and the occurrence of the new strain of *V. cholerae* O139, cholera control efforts in the South-East Asia and Western Pacific Regions have been accelerated. Epidemiological surveillance, early detection of the disease, rapid information exchange, provision of prompt treatment and implementation of control measures to prevent the spread of the disease are among the necessities to reduce the potential risk of a cholera epidemic causing widespread harm.

During the present decade, cholera case fatality rates in Asia have declined considerably and the decline has been progressive. Improved preparedness of participating countries against cholera outbreaks, as well as effective diarrhoea case management in general, are responsible for this decline.

However, cholera outbreaks continue to occur most commonly in circumstances where improvements in environmental conditions, including water supply and sanitation facilities, are still needed. Frequent population movement in border areas creates challenges for disease control when host and environmental conditions are compromised. People crossing the borders also often do not utilize the available health services which may be poorly established.

### 4.3 Malaria

Some of the important border malaria problems in the South-East Asia and Western Pacific Regions are found where there is a gradient of incidence across the border, because malaria has been controlled on one side, but not on the other. The problem is aggravated by extensive population movements and becomes particularly severe in cases of armed conflict, smuggling and illegal population movements.

In recent years, the malaria situation has improved substantially in China and Viet Nam and somewhat in Thailand and Cambodia, while it has remained unchanged or has worsened slightly in most of the other endemic countries in the continental parts of South-East Asia and Western Pacific Regions. In these countries, malaria mainly affects poor rural populations, settled or nomadic, as well as migrants, refugees, military forces and people engaged in frontier economic activities in forests and forest fringes. In a number of foci from Myanmar in the west to Viet Nam in the east and including southern China, multidrug resistance adds to the severity of the malaria problems. WHO meetings focusing on border malaria control in the South-East Asia and Western Pacific Regions were held in Kunming, China, in 1993, in Manila, Philippines in 1996 and in Chiang Mai, Thailand, in 1997. In all these meetings, the need for collaboration on malaria control in border areas was recommended, with particular emphasis on prevention and control of epidemics in migrant populations. The recommendations of these meetings have been followed up through a number of initiatives during 1997. Issues and recent progress in cross-border cooperation have been identified by the meeting.

The meetings, exchange of information and joint activities which have taken place on the borders of Thailand and Myanmar, Viet Nam and the Lao People's Democratic Republic borders and between Bhutan, India, and Nepal are good examples of neighbouring countries having decided that cooperation is in their mutual interest. It is expected that the cooperation will lead to a reduction in the importation of cases into the country which has malaria under control and
strengthening of capabilities and implementation in some areas of the country whose control
programme is less advanced.

At present, the northern and eastern part of the Thai-Cambodian border is witnessing
extensive population movements with associated malaria problems. The two national
programmes are in almost permanent contact about the situation, and this is one of the factors
which, together with mobilization of resources and sound interventions, has contributed to
limiting the burden of morbidity and mortality in an area which for years has been notorious for
multidrug resistance and high incidence of complicated malaria.

The situation in Myanmar gives rise to considerable concern. All the neighbouring
countries are either successfully controlling malaria or can foresee considerable reduction in
transmission thanks to financial input and technical strengthening. In this situation, there is a
risk that northern Myanmar, with little access to needed support, could become a seedbed of
multidrug-resistant parasites for neighbouring countries, greatly jeopardizing the sustainability
of their malaria control efforts. Neighbouring countries, other international organizations and
WHO should mobilize the international community to recognize that the citizens of Myanmar
have the same rights as others to adequate prevention and treatment of malaria.

On the Korean peninsula, where a resurgence of vivax malaria in the northern part of the
Republic of Korea has been noted, there is a need to strengthen exchange of information which
could be the starting point for cooperation for control, if a need for this is identified.

4.4 Sexually transmitted diseases, HIV and AIDS

Sexually transmitted diseases (STD), including HIV/AIDS, are highly prevalent in Asia
and the Pacific. HIV transmission is increasing, with rates reaching up to 2% of the adult
population in selected countries (Thailand and Cambodia). There is now evidence that
heterosexual transmission is the most predominant mode of spread in many areas of Asia and it
is estimated that the prevalence of HIV infection will more than double in Asia by 2000.

The meeting reviewed the STD and HIV/AIDS epidemiological situation and programme
implementation in general and that relating to cross border population movement in particular.
The review included programmes in Cambodia, China, India, the Lao People's Democratic
Republic, Myanmar, Nepal, the Republic of Korea, Thailand and Viet Nam.

It was noted that populations in Asia are moving across land and sea borders in increasing
numbers (see Annex 5). Expanding economies, international trade and commerce support this
growth in population mobility, which is also facilitated by the increasing number of truckers
moving along international highways. There are also high levels of maritime trade, and seamen
on fishing vessels travel widely in the region.

Mobility, in particular temporary and short-term travel, and the presence of high-risk
environments have been demonstrated to be risk factors for the spread of HIV. In Asia, more
and more evidence exists showing an association between population mobility and vulnerability
to HIV. Since opportunities for casual sex and drug use may occur frequently en route, itinerant
people may adopt high-risk behaviour that otherwise might not occur. Therefore, extremely
mobile population groups such as travellers, fishermen, traders, factory workers, construction
workers and other migrant workers tend to have high HIV prevalence.

Poverty and lack of any viable alternative sources of income also push many young
women in the region towards prostitution. Many such women travel abroad in search of work
opportunities that may involve prostitution. Some young women are trafficked to neighbouring
countries and forced into prostitution. The practice of prostitution abroad has often been
associated with a greater risk of HIV transmission.
Other factors which promote HIV transmission include migrating populations being away from home, family and community; lack of social control; cultural and language differences; limited access to preventive care and social services; and often the illegal status of mobile populations which increase their vulnerability to HIV acquisition.

Interventions to reduce the vulnerability of all types of mobile population should be considered in all countries because mobile groups may serve as "bridges" between high-risk and low-risk populations, thereby creating the potential for the widespread diffusion of HIV. Interventions are needed to reduce the vulnerability of populations traversing cross-border areas. Well-travelled border towns and ports are catchment areas for many different types of traveller passing through them and are, therefore, appropriate and convenient sites for intervention.

Governments recognize population movements across borders as an important phenomenon and bilateral discussions to address this issue are already being conducted between Viet Nam and Cambodia, Thailand and Myanmar, India and Nepal, and Thailand and Malaysia.

5. PROPOSALS FOR FURTHER ACTION

5.1 Poliomyelitis eradication

(1) Border areas should be targeted for improvement of AFP surveillance and routine immunization, given that these areas are often remote and less accessible, and receive a lower level of resources than urban areas.

(2) Although there has been some improvement in the exchange of surveillance data as a result of the last biregional meeting in New Delhi, there is still much progress to be made in providing prompt, useful information for action to neighbouring countries. WHO has a useful role to play in providing surveillance information rapidly, both formally and informally. The use of the internet has facilitated this process, and where available should be used for rapid communication between countries through the WHO offices, with copies sent to the respective regional offices.

(3) The cross-border coordination of NIDs has been successfully undertaken between regions by China and Myanmar, and by countries within both regions. Joint planning activities between countries, involving operational staff from border areas, and with involvement of WHO and other international partners (such as the China-Myanmar meeting planned from 6 to 7 November 1997), is the most useful approach.

(4) Regardless of whether a poliomyelitis case is considered as imported or indigenous, similar investigation and large-scale action is needed, especially since one wild poliovirus case indicates widespread circulation of the virus.

(5) Cross-border coordination of poliomyelitis laboratory network activities should be considered where appropriate, particularly in the provision of training and equipment.

(6) Continued strong international support is needed to maintain high quality surveillance and to facilitate coordinating activities.
5.2 Cholera

(1) For a better understanding of the disease, greater precision in trends is required. This needs uniform case recognition, laboratory diagnosis and improved reporting. Better description of the population at risk, population affected and place of occurrence of the disease would improve understanding of the trends.

(2) Case recognition is required for identifying cases and for uniform reporting. This will facilitate detection of impending outbreaks of cholera and trigger the initiation of timely and appropriate control measures. Patients above five years of age with severe diarrhoea and dehydration will most likely meet the criteria for starting action.

(3) The importance of strengthening border surveillance for cholera was recognized. The use of maps to locate an outbreak could be a useful tool to alert the neighbouring areas. This will enable prompt action in treatment of cases and control of an epidemic. Clustering of cases would necessitate prompt sharing of information through available communication channels, such as telephone, fax and e-mail.

(4) During outbreaks, an emergency meeting of concerned parties involving local district health authorities as well as national experts can be very useful for prompt sharing of information, provision of technical collaboration (for example, laboratory reagents, diagnostic kits, ORS and other supplies as well as consultants) and coordination of action for the containment of the epidemic. This meeting should be in addition to regular meetings for information exchange and for planning and coordinating control measures for cholera and other communicable diseases.

5.3 Malaria

(1) Border malaria control should be an integral component of national malaria control strategies and should be addressed in the plans of action of national malaria control programmes.

(2) Mechanisms of information exchange should be adopted as recommended by previous meetings. Information exchange can be done more rapidly and regularly and in more geographical detail using modern systems of data management, Internet and e-mail. WHO is called upon to set up a biregional system of information exchange, providing regular detailed information on border areas. Such an exchange of information should not be restricted to the national level and mechanisms created by WHO. It should be carried out on a routine basis by exchange of reports between neighbouring districts and provinces, and as an emergency in case of epidemics in border areas.

(3) Countries should develop or strengthen epidemic warning and reporting systems as part of epidemiological surveillance in order to detect signs of impending epidemics and facilitate timely control measures.

(4) When possible, vector control operations in high-risk border areas should be coordinated and synchronized.

(5) When possible and necessary, countries should cooperate bilaterally to set up border malaria clinics, which could provide curative services of good quality as well as screen and treat migrants before they cross the border.

(6) Border meetings should be organized bilaterally and multilaterally, to cover the borders where problems have been identified, and where it can be foreseen that the meetings can lead to concrete malaria control action. These meetings should include local staff, programme
managers and concerned authorities and take place near the border, so that mutual learning through field visits can be included.

(7) Technical and operational cooperation among Cambodia, China, the Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam, to control malaria in areas with multidrug-resistant \textit{P. falciparum}, should be strengthened by developing project proposals and requesting partner support.

(8) In some border areas, health authorities on both sides already collaborate, for example on synchronization of NIDS or on surveillance. Malaria control could join such cooperation, whenever local conditions make this feasible.

(9) Apart from cooperation on border malaria control, there is a need for interregional cooperation on malaria training and research. In research, there are already a number of mechanisms to strengthen international cooperation, the leading organizations being Southeast Asian Ministers of Education Organizations (SEAMEO) and Tropical Disease Research (TDR). There is also a need to strengthen WHO’s involvement in training on a biregional basis. Recently, the main activities in training covering the two regions have been part of the Asian Collaborative Training (ACT) Malaria initiative based in Thailand.

5.4 Sexually transmitted diseases, HIV and AIDS

The meeting suggested the following follow-up actions for consideration by Member States, international partners and nongovernmental organizations:

(1) Member States are encouraged to identify on the map the sites along the border, including “hot spots”, where population movements are occurring, so that policy-makers are reminded of the magnitude of the problem and appropriate intervention to be taken on priority basis.

(2) National STD/AIDS programmes should integrate AIDS prevention and care, targeted at mobile populations, as a part of overall national AIDS control strategies. This would include the development of culturally acceptable education programmes in the dialect of the concerned populations and of peer and outreach education programmes.

(3) Population groups who are contracted through labour ministries to work in other countries should be offered pre-departure education programmes, by integrating HIV/AIDS into the existing employee orientation programmes. Such programmes should be developed by employers in the private sector, such as transport and shipping companies which also take employees for work overseas.

(4) HIV prevention interventions, targeted to border crossing areas, could take advantage of the idle time of travellers waiting for border clearance. Such interventions, with particular attention given to sex workers, could include education, provision of STD treatment services and access to affordable condoms.

(5) Action should be taken to make prevention, care and social services available in host countries to all migrant workers, whatever their status. Governments should promote and support nongovernmental organizations who are working in this area.

(6) A supportive social environment should be created so that migrant populations including those in border areas, feel part of the community and are not discriminated against. By doing so they are more likely to have access to and use education and counselling programmes set up in most countries. For example, HIV testing policies are as applicable to migrant populations
as they are to the general population. Any type of mandatory testing of migrants will be counter productive and hence should be avoided.

(7) Cross-border interventions on both sides of the border, involving communities passing through and residing at border sites as well as nongovernmental organizations with the ability to work transnationally with the support of local governments offer more opportunities for success. Regular exchange of information and networking will facilitate joint planning and implementation of rational and coherent policies and programmes.

(8) Specific programmes should be developed to facilitate the reintegration of returning workers, particularly when they are known to be HIV-infected.

(9) WHO and UNAIDS should continue to support and coordinate efforts at country level in identifying population movements and reinforcing STD, HIV and AIDS prevention and care activities targeting mobile populations; to facilitate bilateral dialogue between countries; and to support the mobilization of resources.
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ANNEX 2

PROVISIONAL AGENDA

1. Opening ceremony

2. Regional overview of South-East Asia (SEAR) and Western Pacific (WPR)

3. Group work -
   (a) EPI (focusing on poliomyelitis eradication)
   (b) STDs, HIV and AIDS
   (c) Malaria
   (d) Cholera

   Presentation and discussion by country programme officers
   Summary of findings, conclusions and recommendations

4. Plenary session -

   Presentation of summary of findings, conclusions and recommendations
   of each working group

5. General conclusions and recommendations of the meeting

6. Closing ceremony

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
<td>Round 1</td>
<td>Round 2</td>
<td>Round 1</td>
</tr>
<tr>
<td>D. P. R. Korea</td>
<td>not done</td>
<td>not done</td>
<td>20 October 1997</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>not done</td>
<td>not done</td>
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ISSUES AND RECENT PROGRESS ON MALARIA IN CROSS BORDER COOPERATION

China and its borders with Viet Nam, Lao PDR and Myanmar

The important falciparum malaria problems are now concentrated in Yunnan and Hainan Provinces, where the majority of the 3568 falciparum malaria cases detected in 1996 were found. Yunnan Province borders on Myanmar, Lao People's Democratic Republic and Viet Nam, and there are indications that a large proportion of the recorded cases are imported or introduced, especially from Myanmar and Lao People's Democratic Republic. Both Hainan and Yunnan have multi-drug resistance.

Korean peninsula

Malaria seemed to have disappeared from the Republic of Korea in the 1970's, but in recent years a resurgence of vivax malaria has been recorded. In 1996, 1400 cases were diagnosed mainly in adults living in the northern part of the country.

Viet Nam and Lao People's Democratic Republic

There are indications that some malaria problems and epidemics are related to population movements across the border to Lao People's Democratic Republic especially in the northern part of Central Viet Nam. Multi-drug resistance is mainly a problem in the southern half of the country. In Lao People's Democratic Republic, most of the surface area is thinly populated highlands where malaria transmission is intense. Thus, malaria is the leading cause of morbidity and mortality, but it is not a specific border problem for Lao People's Democratic Republic. Large scale malaria control efforts, in particular, impregnated nets, are now underway. A Lao-Vietnamese cooperative malaria control project started in 1997; it includes strengthening of malaria control capabilities in Lao People's Democratic Republic and a demonstration project in one border district is included.

Cambodian-Thai border

In Cambodia, the main endemic areas are in forested regions near the western northern and eastern borders. Malaria control has been extremely difficult, especially in the west of the country because of security problems. Changes in the security situation are associated with increased population movements and thereby increased malaria. Pailin in the north-west is a notorious focus of drug-resistance, but the situation seems to have improved somewhat since the Thai Government succeeded in curbing the border movements some years ago. The recent fighting in O'Smach near the northern border to Thailand has lead to thousands of people moving across the border to Thailand and some of them have returned. Malaria control services on both sides of the border are tracking the population movements and deploying treatment services and impregnated nets as needed, they have so far succeeded in preventing major outbreaks. This process has been supported by regular exchange of information between the two national programmes concerned, through the WHO Representative Offices and directly. Most recently, the Cambodian programme supplied needed IEC material in Khmer language to Thailand.
Annex 4

Myanmar-Thai border

Thirty-six per cent of the total population of Myanmar, live in high risk malaria areas, which are mainly near the borders to China, Lao People's Democratic Republic and Thailand. Population movements within the country and across international borders are important underlying factors. Because of lack of funding, the coverage by vector control is very low. On the other hand, the access to a variety of antimalarial drugs through private channels is easy, and severe multi-drug resistance has developed in a number of foci. In Thailand, the main problems now occur near the borders to Myanmar and Cambodia. While in 1991, 20% of the malaria cases were foreigners, the corresponding proportion in 1996, was 42%, the majority being citizens of Myanmar. Multi-drug resistance is now found mainly on the Myanmar border. In 1997, two border malaria meetings Thailand-Myanmar have been held, and joint malaria control activities inside Myanmar have been initiated. The establishment of malaria clinics to screen people crossing the border on the Myanmar side is under discussion between the two countries.

India, Nepal and Bhutan

India reports around two million malaria cases per year. The areas contributing most falciparum cases are Orissa and the seven North-Eastern States combined, where multi-drug resistant P. falciparum is now prevalent. Transmigration of labour populations from state to state is a major problem, but crossing of international borders which are generally not in highly endemic areas, is not. It is expected that with increased technical and financial inputs, malaria control in the north-east can be considerably strengthened in coming years. In Nepal, malaria is endemic in valleys and plains, but not in the border areas, which are generally above the altitude where transmission is possible. In recent years, the country has received over 80,000 displaced persons from Bhutan who have been settled in camps in an endemic area. The malaria problem in those camps has been checked by classical measures and is now decreasing. Through collaboration between India and Nepal and India and Bhutan, training in microscopy and other practical components of malaria control has been carried out.
## SEXUALLY TRANSMITTED DISEASES, HIV AND AIDS

Movement of population for transient labour - SEAR/WPR regions

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Country of destination</th>
<th>Type of labour</th>
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<tbody>
<tr>
<td>India</td>
<td>Buthan</td>
<td>Traders</td>
</tr>
<tr>
<td>China</td>
<td>Vietnam, Cambodia,</td>
<td>Traders</td>
</tr>
<tr>
<td></td>
<td>Japan, Thailand,</td>
<td>Business</td>
</tr>
<tr>
<td></td>
<td>Singapore</td>
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<tr>
<td></td>
<td>Myanmar</td>
<td>Farmers</td>
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<td>Qualified construction workers</td>
</tr>
<tr>
<td></td>
<td>Pakistan, Vietnam,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laos</td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Korea</td>
<td>Industry workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Labour force</td>
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<tr>
<td>Nepal</td>
<td>Korea, India, Malaysia</td>
<td>Unskilled industry workers</td>
</tr>
<tr>
<td>Philippines</td>
<td>Korea</td>
<td>House employees</td>
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<tr>
<td>Thailand</td>
<td>Singapore, Malaysia,</td>
<td>Unskilled construction workers</td>
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<td></td>
<td>Brunei, Japan</td>
<td></td>
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<tr>
<td>Vietnam</td>
<td>China, Cambodia, Laos,</td>
<td>Traders and construction</td>
</tr>
<tr>
<td></td>
<td>Korea</td>
<td>workers</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Thailand, Vietnam,</td>
<td>Construction workers and</td>
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<td>Malaysia</td>
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<tr>
<td>Myanmar</td>
<td>Thailand, Singapore,</td>
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<td></td>
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<td></td>
<td>Korea, Malaysia</td>
<td>Skilled labour</td>
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## Annex 5

### Movements of long-distance drivers - SEAR/WPR regions

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Country of destination</th>
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<tbody>
<tr>
<td>India</td>
<td>Nepal</td>
</tr>
<tr>
<td>China</td>
<td>Myanmar (stop at the border)</td>
</tr>
<tr>
<td></td>
<td>Vietnam</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Thailand (stop at the border)</td>
</tr>
<tr>
<td></td>
<td>Vietnam</td>
</tr>
<tr>
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</tr>
<tr>
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<td>Bangladesh</td>
</tr>
<tr>
<td>Nepal</td>
<td>India</td>
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### Movements of fishermen - SEAR/WPR regions

<table>
<thead>
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<th>Country of origin</th>
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<tbody>
<tr>
<td>Thailand</td>
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<td>Vietnam</td>
<td>Cambodia</td>
</tr>
<tr>
<td>Philippines</td>
<td>Indonesia</td>
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<td>Cambodia</td>
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## Movements of commercial sex workers - SEAR/WPR regions

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<th>Country of origin</th>
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