

A Cross-Sectional Study from China Community Health Advocates

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Abstract

On June 15, 2007, the 2005 revision of the International Health Regulations went into effect and became binding law for 196 nations, including all of the World Health Organization's Member States. According to the IHR, a public health emergency of international concern is "an extraordinary incident that may present a public health danger to other nations through the international transmission of illness and may necessitate an international coordinated response. Any public health incident that satisfies any two of the subsequent four criteria must be reported to the WHO, according to the IHR. Is this incident likely to have a negative impact on public health; is it unusual or unexpected; may it spread internationally; and could there be travel and trade restrictions as a result of this occurrence. Declaring a PHEIC is meant to draw attention to those urgent public health threats that could travel over international boundaries and represent a hazard to people everywhere and "demand coordinated mobilisation of extraordinary resources by the international community" for prevention and response.

Keywords: Health statistics; Health system policy analysis; Global health**Received:** 01-July-2022, Manuscript No. Iphspr-22-13003; **Editor assigned:** 04-July-2022, PreQC No. Iphspr-22- 13003; **Reviewed:** 18-July-2022, QC No. Iphspr-22-13003; **Revised:** 21-July-2022, Manuscript No. Iphspr-22- 13003 (R); **Published:** 28-July-2022, DOI: 10.36648/2254-9137.22.9.132

Introduction

The WHO Director-General has the authority to declare a PHEIC. The 2009 H1N1 influenza pandemic, the 2014 polio outbreak, the 2014 Ebola outbreak in West Africa, and the 2016 Zika virus outbreak are the four PHEICs that have been proclaimed to far [1]. Even though the poliovirus is not a new or emerging pathogen, the polio PHEIC announcement establishes an intriguing and admirable precedent [2]. The PHEIC published on May 5, 2014, mentions the recurrence of polio following its nearly complete eradication, other nations that require a coordinated international reaction Five years after it was first declared; just this PHEIC is still in force [3]. In light of the poliovirus history, how does the worldwide measles status compare to the four PHEIC criteria? First, might this incident have a major influence on public health? The announcement of the expected number of measles deaths worldwide was met with a great deal of excitement [4]. The US CDC, GAVI, UNICEF, and WHO applauded the 84% drop in measles deaths from the first time that there had been fewer measles deaths globally documented in a specific year in a joint press release. In 2016, the Americas—the only region to have

eradicated the measles—celebrated this accomplishment [5]. The Americas set a precedent for the rest of the globe by being the first region to eradicate smallpox, polio, and measles. The current situation is highlighted by the failure to maintain the elimination of the measles, which contrasts sharply with earlier successes. Both Germany and Russia resumed measles transmission in the European Region for more than months after having previously stopped for months, and Europe had record numbers of cases with deaths in thirdly, is there a chance that it may spread internationally? The 2014 epidemic in the Philippines is probably the most recent example of how the measles virus can move quickly throughout the world [6]. The majority of the nation's contributing to the Measles Nucleotide Surveillance database was exposed to the B3 measles genotype during this outbreak [7]. The measles outbreaks in the Philippines and Thailand are giving people an unsettling sense of déjà vu because imports are currently overpowering all nations in the Western Pacific Region that had been confirmed to have eradicated the disease. Similar to the Venezuelan outbreak, which began in 2002 and spread to neighbouring nations, the biggest effects were felt in Brazil, where PAHO reported confirmed cases and 12 fatalities in just

over a year, especially among vulnerable Indigenous groups [8]. Since then, outbreaks have continued to spread, hitting countries in the Americas. Measles is only one type of infectious disease that can spread. This is visually demonstrated by contrasting the basic reproduction number for measles, or the average number of secondary cases brought on by the introduction of one infectious case into a community that is fully susceptible. Fourth, are trade and travel restrictions a possibility? Although several verified countries have made it obvious that international employees, business and leisure travellers, and economic migrants are a key source of virus importation, it is difficult to imagine any government imposing travel or trade restrictions based on existing measles epidemiology. Recently, some nations have even suggested that foreign travellers should be required to show documentation of their measles vaccination or immunity in order to obtain a visa or enter their country. The need for extraordinary resources is a crucial aspect of a PHEIC. When compared to the expense of prevention, battling measles is highly expensive. However, the need to continue eradication justifies this level of response [9]. The scenario in the Americas and Europe starkly demonstrates what happens when a few nations miss the mark: everyone pays the enormous direct and opportunistic health costs, not to mention the personal misery, as a result of measles epidemics that other nations have given them. The IHR is the finest, and possibly the only, mechanism for properly addressing this predicament, therefore why hasn't measles previously been designated a PHEIC? When compared to previous public health crises, why do measles-related efforts from international donors, the United Nations, and national governments receive such little support [10].

Discussion

Technical professionals involved in every area of measles elimination have acknowledged the public health urgency of the current worldwide measles situation [11]. Globally, what we see is a predictable outcome of the system we have established: periods of relative calm followed by widespread measles outbreaks, frequently affecting older age groups than historically affected, which eat up a significant portion of public health resources and erode confidence in immunisation [12]. The six chairpersons of the Regional Verification Commissions for Measles and Rubella Elimination discussed the compelling epidemiological, economic, and ethical arguments for setting a global measles eradication goal in a recent call to action [13]. They fervently argued that it was urgent that exceptional coordinated efforts be made to ensure that no child dies of measles worldwide. Three of the four diagnostic criteria seem to have been met, and the situation is deteriorating right now, putting many young lives in great danger [14]. Using a PHEIC statement the need for the international community to rapidly encourage communication innovation to effectively engage migrants and travellers on the risks of measles as well as the benefits and safety of immunisation; to refocus weary donors on the incredible return that increased investment in measles immunisation and accelerated elimination achievement would deliver; and to urgently strengthen health systems to ensure that

every child born is reached with two potent doses of measles-containing vaccine; Should the international community mobilise "exceptional resources" to address this public health issue that has the ability to transcend borders and endanger people everywhere? If we heed the counsel Plato put in Socrates' mouth Shared information flow is essential for ensuring continuity of care delivery by social welfare institutions and the local hospital system during emergencies, which are frequently hampered by a lack of manpower and other resources. The legal and moral concerns that arise when private medical information is disclosed to individuals outside the healthcare system must be taken into account in structured operating procedures meant to ensure this flow of data. The many municipal service agencies can reach out to MVPs in advance of LPHE to give support and make sure their medical needs are met by identifying and locating them, for instance using GIS. By developing a pre-established network for effective management of data flow between health and local government agencies, the current study aims to address these problems [15].

Conclusion

Given its unique characteristics, hostile relations with neighbouring states, propensity for earthquakes as well as other mass casualty events from which all countries may suffer, and location at the eastern end of the Mediterranean, Israel can serve as an ideal model for studies dealing with emergency systems. In the unitary state of Israel, social welfare and medical care are provided as public goods. Four health funds offer the majority of healthcare services, which are governed by the government. The initial goal of this step was to identify anticipated knowledge gaps at the point where MVPs' demands meet those of the municipality's resources and emergency response plans. Key inequalities were found and described using a gap analysis. Representatives from the social welfare division of the Beer Shiva municipal government were questioned three times. The emergency volunteer coordinator and the computer officer were two of the respondents who worked for the local social welfare services. The third representative worked in a senior capacity for the engineering division's GIS unit. Representatives of the local municipal authority made it clear that, despite the municipality's wealth of resources, its staff lacks knowledge of MVPs and their home locations and is currently unable to assist those who need it most. Medical and clinical data might be incorporated in the same way as social welfare data from the municipality is now done in a GIS-based application for emergency usage. This section describes the methodology used to identify gaps between MVP needs and the institutions' current capacity to provide those requirements. Based on these deficiencies, a model for information sharing between health and local government organisations was developed, along with a standard operating procedure. The results of the gap analysis are shown. Needs from the literature review were compared to available and acceptable response capabilities, and when a need could not be satisfied, it was classified as a potential gap. The template had an Excel spread sheet layout. It will be distributed to all health funds,

which are in charge of gathering and saving pertinent data in the template throughout ordinary operations.

Acknowledgement

None.

Conflict of Interest

None.

References

- 1 Ximenes R, Amaku M, Lopez LF (2016) the risk of dengue for non-immune foreign visitors to the 2016 summer Olympic games in Rio de Janeiro, Brazil. *BMC Infect Dis* 16: 186.
- 2 Katz RL, Fernandez JA, McNabb SJ (2010) Disease surveillance, capacity building and implementation of the International Health Regulations. *BMC Public Health* 10: S1.
- 3 Kriss J, Stanescu A, Pistol A (2017) The World Health Organization measles programmatic risk assessment tool-Romania. *Risk Analysis* 37: 1096-1107.
- 4 Simons E, Ferrari M, Fricks J (2012) Assessment of the 2010 global measles mortality reduction goal: results from a model of surveillance data. *Lancet* 379: 2173-2178.
- 5 Del Fava E, Shkedy Z, Bechini A, Bonanni P, Manfredi P, et al. (2012) towards measles elimination in Italy: monitoring herd immunity by Bayesian mixture modelling of serological data. *Epidemics* 4: 124-131.
- 6 Staehelin C, Chernet A, Sydow V, Piso RJ, Suter-Riniker F, et al. (2019) Seroprotection rates of vaccine-preventable diseases among newly arrived Eritrean asylum seekers in Switzerland: a cross-sectional study. *J Travel Med* 26.
- 7 Larkin MA, Blackshields G, Brown NP, Chenna R, McGettigan PA, et al. (2007) Clustal W and Clustal X version 2.0. *Bioinformatics* 23: 2947-2948.
- 8 Cavalcanti LP, Vilar D, Souza Santos R, Teixeira MG (2011) Change in age pattern of persons with dengue, northeaster Brazil. *Emerg Infect Dis* 17: 132-134.
- 9 Zipprich J, Winter K, Hacker J, Xia D, Watt J, et al. (2015) Centers for Disease Control and Prevention (CDC): Measles outbreak--California. *MMWR Morb Mortal Wkly Rep* 64: 153-154.
- 10 Katz R (2009) Use of revised International Health Regulations during influenza A (H1N1) epidemic. *Emerg Infect Dis* 15: 1165-1170.
- 11 Gastanaduy PA, Budd J, Fisher N, Redd SB, Fletcher J, et al. (2016) A measles outbreak in an under immunized amish community in Ohio. *N Engl J Med* 375: 1343-1354.
- 12 King A, Varughese P, De Serres G, Tipples GA, Waters J, et al. (2004) Working group on measles E. Measles elimination in Canada. *J Infect Dis* 189 Suppl 1: S236-S242.
- 13 Burstein R, Henry NJ, Collison ML (2019) Mapping 123 million neonatal, infant and child deaths between 2000 and 2017. *Nature* 574: 353-438.
- 14 Krupinski EA, Berbaum KS, Caldwell RT, Scharz KM, Madsen MT, et al. (2012) Do long radiology workdays affect nodule detection in dynamic CT interpretation? *J Am Coll Radiol* 9: 191-198.
- 15 Gao S, Mioc D, Anton F, Yi X, Coleman DJ, et al. (2008) Online GIS services for mapping and sharing disease information. *Int J Health Geogr* 7: 8.