



STC

Newsletter

Vol. XVII, No.1, Jan. – Jun. 2007



(Commemoration of World TB Day 2007)

Contents

Report on Activities

1. Public Awareness and Advocacy Programme on TB and HIV/AIDS:	Page No
• Partnership Program with School in Nepal -----	1
• Partnership Program with School and Media in Maldives -----	2
• World TB Day 2007 -----	3
2. On-site Training on DOTS Plus -----	4
3. SAARC Regional Consultative and Strategic Planning Meeting of HIV/AIDS -----	6

Brief News

• Participation in Health Fair (Swastha Mela)-----	7
• Short-term Training on Library Software-----	7
• Participation in DOTS Orientation to Media People-----	7
• Participation in Dissemination Meeting on Review of the Second Generation Surveillance on HIV and AIDS in Nepal-----	7
• Meeting with NTP and NACP Managers-----	8
• Participation in Technical Sub-committee Meeting -----	8
• Meeting with TFI & PAL Mission -----	8
• Participation in Joint Meeting -----	9
• Audit of STC Accounts 2006-----	9

Welcome and Farewell News

• Welcome to Hon'ble Mr. Giriraj Mani Pokharel, Minister for Health & Population, Nepal -----	10
• Health Dignitaries from Afghanistan-----	10
• H. E. Mr. Chenkyab Dorji, S.G., SAARC -----	10
• Prof. Mahendra P. Lama, JLN University, New Delhi -----	10
• Dr. Khalilur Rahman, Regional Advisor, WHO/SEARO, New Delhi -----	11
• Mr. Lila Prasad Sharma and Dr. Narayan Govinda Amatya -----	11

Appointment of New Professionals in STC

• Dr. V. S. Salhotra (India), Deputy Director-----	11
• Dr. Ajith Prasantha Weerakoon (Sri Lanka), R.O.-----	11
• Mr. Dhruba Kumar Khadka (Nepal), Microbiologist-----	9

Special Articles and Technical Information:

• Unusual Presentation of Miliary TB with Meningial Involvement by Dr. NG Amatya -----	12
• The Stop TB Strategy by Dr. K. K. Jha -----	13
• Tuberculosis and MDR TB by Dr. Lochana Shrestha-----	14
• HIV/AIDS in Children by Ajith Weerakoon -----	17

Abstracts -----	18
Proposed Programs -----	22
Editor's request -----	22

Editors:

Dr. V. S. Salhotra, Deputy Director
Dr. Lochana Shrestha, Epidemiologist
Dr. Ajith Weerakoon, Research Officer

Chief Editor:

Dr. Kashi Kant Jha, Director

STC Newsletter is a biannual publication of SAARC TB and HIV/AIDS Centre, it includes reports on activities, decisions of important meetings of the Centre and recent information on tuberculosis, HIV/AIDS and their control

For more information and correspondence, please contact

SAARC Tuberculosis and HIV/AIDS Centre, Thimi, Bhaktapur, G. P.O.Box No. 9517, Kathmandu, Nepal,
Tel: 00977-1-6632601, 6632477, 6631048, Fax: 00977-1-6634379, E-mail: saarctb@mos.com.np Website: www.saarctb.com.np



SAARC TB and HIV/AIDS Centre Newsletter

Vol. XVII No. 1

January - June 2007

Editorial

Adult HIV prevalence in SAARC region is less than 1%. It does not mean that prevalence has less risk, as the factors are in place to spread HIV epidemic farther and faster than in any other region globally. The epidemics in the SAARC region remain largely concentrated among the high risk groups such as injecting drug users, men who have sex with men, commercial sex workers and clients of sex workers and their sexual partners.

India is the most populous country in the SAARC Region. 2.5 million People are living with HIV/AIDS in the country, according to new estimates. The new 2006 estimates released by the National AIDS Control Organization (NACO), supported by UNAIDS and WHO, indicate that national adult HIV prevalence in India is approximately 0.36%, which corresponds to an estimated 2 million to 3.1 million people living with HIV in the country. These estimates are more accurate than those of previous years, as they are based on an expanded surveillance system and a revised and enhanced methodology.

HIV outbreaks among men who have sex with men are now becoming evident in India, Nepal and Pakistan. Also HIV outbreaks particularly among injecting drug users are being found in Afghanistan and Pakistan. In certain places of this region HIV epidemics had entered into the general population as infected cases of HIV/AIDS found to be increasing among children and women specially housewives.

Pursuant to a decision of the Twelfth Summit (Islamabad, January 2004) to observe the year 2004 as the "SAARC Awareness Year for TB and HIV/AIDS", different activities had been carried out by STC and number of activities were undertaken in Member States in observation of the year.

In 2004, SAARC signed a MoU with the Joint United Nations Program (UNAIDS) to help Member States strive towards the goals of HIV/AIDS prevention and ensuring care and support for those infected and affected by HIV/AIDS and developed Regional Strategy on HIV/AIDS, which was launched in 2006.

SAARC TB and HIV/AIDS Centre is supporting SAARC Member States to implement the Regional Strategy. In this regard a meeting was held in Maldives in June 2007 to discuss the evidence based activities done by HIV/AIDS control program of each Member States following the Regional Strategy and to share the best practices in relation to HIV/AIDS control for the better result.

Editorial Board:

Chief Editor:

Dr. Kashi Kant Jha

Editor:

Dr. V. S. Salhotra

Dr. Lochana Shrestha

Dr. Ajith Weerakoon

Editorial Board Members from the Member States:

Afghanistan

Dr. Hayat M. Ahmadzai

Bangladesh

Dr. Dr. Md. Abdul Awal Miah

Bhutan

Dr. Gado Tshering

India

Dr. L. S. Chauhan

Maldives

Mr. Ibrahim Shaheem

Nepal

Dr. Pushpa Malla

Pakistan

Dr. Hasan Sadiq

Sri Lanka

Dr. Chandra Sarukkali

Report on Activities

1. Public Awareness and Advocacy Programs on TB and HIV/AIDS

Partnership Program with Schools and Media

With School in Nepal

Partnership program with **School** in control of TB & HIV/AIDS was organized jointly by SAARC TB and HIV/AIDS Centre, NTP Nepal, Nepal Anti-TB Association, Central Office, Kalimati and Bal Deekshya Sadan Higher Secondary School, Gwarko, Lalitpur, Nepal on March 23, 2007. This programme was organized on the occasion of World TB Day 2007 which falls on 24th March every year. The participants had been sensitized and requested to participate in the coming activities to mark the World TB Day 2007.



Objectives

The general objective of the partnership programme is to enhance public awareness on TB and HIV/AIDS.

Opening Session

The session was held under the chairmanship of Mr. Shiva Shrestha, Principal of school. Mr. Dinesh Khanal, Teacher welcomed the participants, officials and other participants in the programme.

Mr. Devendra Pradhan, President, Nepal Anti-TB Association (NATA) addressed the gathering. He highlighted role of NATA in TB control and the role of students in control of tuberculosis in the community. Mr. Pradhan underscored the school health programme activities and seeking cooperation from the students.

Dr. Kashi Kant Jha, Director, SAARC TB and HIV/AIDS Centre (STC) extended a warm welcome to the participants. He highlighted the objective of the school partnership program in TB control and role of school students in control and prevention of TB & HIV/AIDS in the community. Dr. Jha presented detail about TB disease, its symptoms, diagnosis and treatment.

Dr. Pushpa Malla, Director, National Tuberculosis Centre (NTC) presented the situation of TB in Nepal and facilities provided by the Government to the people for diagnosis and treatment of TB disease in Nepal.

Dr. Lochana Shrestha, Epidemiologist, STC explained about HIV/AIDS and its situation in SAARC Region.

Following the presentation, discussion (question-answer) session started. Participants took part in this session very enthusiastically.

The programme concluded with the remarks of Chairperson. He expressed happiness and appreciated the efforts of STC to involve school students in spreading messages on awareness. He also expressed commitment to help in spreading

awareness messages to the people. He thanked all participants for their presence and to STC, NTC and NATA for selection of their school for this activity.

At the end of the programme Director, STC thanked all for their participation, cooperation and support.

The program was attended by 150 participants.

With School and Media in Maldives



Partnership program with **School and Media** in control of TB & HIV/AIDS was organized jointly by Government of Maldives and SAARC TB and HIV/AIDS Centre, Nepal on June 13, 2007.

Objectives

The general objective of the partnership program is to enhance public awareness on TB and HIV/AIDS.

Opening of Session

Mr. Ibrahim Shaheem, Deputy Director-General, Department of Public Health, Maldives, chaired the opening session of the program. Dr. Ahmed Razeem, Deputy Director General, Medical Services, Ministry of Health, Maldives and Dr. Ahmed Jamsheed Mohamed, Senior Medical Officer, DPH, Maldives jointly inaugurated the program.

Mr. Shaheem extended a warm welcome to the participants, delegates and STC officials in the program. In continuation to the inaugural address, Mr. Shaheem presented an informative and provocative story regarding the importance of conveying the correct and actual message to general people in relation to TB and HIV/AIDS.

Dr. Jamsheed Mohamed expressed his thanks to the participants from school, scouts and media agencies and STC.

Dr. Kashi Kant Jha, Director, STC also extended a warm welcome and highlighted the importance of the partnership programme in TB and HIV/AIDS control in the community. Dr. Jha emphasized the role of media agencies to propagate the right message at the right place in the right time to the right people.

Ms. Shameema Hussain highlighted the Situation of TB control in Maldives. She explained the sign & symptoms of TB and additional information about this disease.

Dr. Rameez and Mr. Hameed arranged an AIDS game about transmission of HIV to impart the knowledge to the participants.

Dr. Lochana Shrestha, Epidemiologist, STC presented global and regional situation of HIV/AIDS. She highlighted the importance of response towards TB and HIV/AIDS epidemic, as window of opportunity is closing down in compare to increasing problem worldwide.

Following the presentations interaction between participants and facilitators was held.

The session concluded with the remarks from chairperson. He informed the participants that 1st case of HIV was detected in 1991 in Maldives and now there is good network and communication system for monitoring the situation.

Around 50 participants from School, Media and Scouts were participated in the program.

World TB Day 2007

The Theme for World TB Day 2007 - "TB anywhere is TB everywhere"



On 24 March, worldwide, people took part in the World TB Day campaign – a day of social action and awareness.

SAARC TB and HIV/AIDS Centre Commemorated the World TB Day 2007 on 24 March by organizing various activities in collaboration with National TB Control Programme of Nepal.

The theme for World TB Day 2007 was "TB anywhere is TB everywhere." The theme conveyed messages of urgency and shared responsibility, and contains supporting sub-messages focused on the call for increased investment, stronger community involvement, strengthened research and development, and action against emerging threats such as TB/HIV and XDR-TB.

The Day has been commemorated annually on 24th March to make the day, when Dr. Robert Koch announced discovery of TB bacillus in Berlin in 1882.

Activities carried out

a) Display of Banner

STC displayed the World TB Day banners with slogan, theme and messages for the benefit of the general people.

b) Publication of Articles

Articles from STC related to TB were published in National dailies on the occasion of World TB Day.

c) Rally

A rally of students, social & political activists, celebrities, health volunteers/workers, government officials and general people was organized in Kathmandu. First time on this occasion Rickshaw Rally was organized. STC took part in this rally with banner, flag and placard.

d) Exhibition

An exhibition of STC activities was displayed at the BICC, Kathmandu. In the exhibition, general information on TB, achievements and activities of STC and information related to Member States were displayed. Emphasis was given on Partnership Programs for awareness which was highly appreciated by visitors as well as Chief Guest (Minister of Health and Population).

f) Distribution of Publications

STC publications (brochure, calendar etc.) were distributed to the visitors of the exhibition for their information on TB and HIV/AIDS.

g) Joint Function

A function was organized at BICC, Kathmandu jointly by National TB Centre, Government of Nepal, SAARC TB and HIV/AIDS Centre, Directorate of Health Services, World Health Organization, LHL, and Nepal Anti-TB Association to commemorate the Day on March 24, 2007.

Hon'ble Mr. Amik Sherchan, Deputy Prime Minister, Minister for Health and Population, Government of Nepal graced the function as Chief Guest and the function was chaired by Mr. Ram Chandra Man Singh, Secretary for Health, Government of Nepal.

Dr. Sarala Malla, Director General, Department of Health Services delivered welcome address. The chief guest inaugurated the program by lighting the traditional oil lamp (Panas).

Following the inauguration, publications from STC and NTC were released by the Chief Guest.

Dr. Pushpa Malla, Director, National Tuberculosis Centre explained the National TB control program of Nepal.

In the function, remarks were given by H. E. Mr. Chenkyab Dorji, Secretary General, SAARC, Dr. Kan Tun, WR Nepal, Mr. Devendra Bahadur Pradhan, President, NATA and Dr. Mahesh Maskey, Advisor, MoH & P.

The Chief Guest awarded different persons for their remarkable contributions in the field of TB control in Nepal. After distribution of award the Chief Guest addressed the function.

Dr. Kashi Kant Jha, Director, SAARC TB and HIV/AIDS Centre delivered Vote of Thanks.

The program was concluded with the remarks of the Chairperson, Mr. Ram Chandra Man Singh, Secretary, Ministry of Health & Population.

After completion of the program all the participants observed the exhibition with Chief Guest and other dignitaries.

On-site Training on DOTS Plus

On the request of NTP, Bhutan STC organized "On-site Training on DOTS Plus" from 12th to 17th March 2007 for a team of 3 participants from Bhutan. The program was facilitated jointly by SAARC TB & HIV/AIDS Centre and National Tuberculosis Centre, Nepal. The participants were Dr. Pema Choden Bhutia, District Medical Officer, Mr. Leki Dorji, TB In-charge from Eastern Bhutan, Mr. Deki Phuntsho, In-charge, Primary Health Centre.

Objectives

The objectives of the program were:

- To provide knowledge on DOTS Plus activities to improve case finding and case holding



Participants at the Bhaktapur DOTS Centre

- To expose participants on the TB laboratory works in SAARC TB and HIV/AIDS Centre and DOTS Plus treatment activities of NTP, Nepal

- To provide knowledge on Management of MDR-TB

Dr. Kashi Kant Jha, Director, STC gave instructions to the participants and facilitators as a Course Director.

Dr. Lochana Shrestha, Epidemiologist, STC, Dr. S. S. Jha, Medical Officer, NTC, Nepal, Mr. Dhruva Kumar Khada, Medical Technologist, Mr. Kailash Bahadur Karki, Training Officer, STC and Mr. P. Bhandari, Computer Technician, STC facilitated the participants in different aspects of the training.

Course Contents

- Orientation on STC and NTP activities
- Quality Control and Quality Assurance on Sputum Smear Microscopy
- Field Visit to DOTS and DOTS Plus Centres and Sub-centres
- Management of MDR TB Cases
- Recording, Reporting and Follow up of TB Patients under DOTS

Institutions and persons visited

1. Dr. Pushpa Malla, Director, Dr. S. S. Jha, Medical Officer, Mr. Dhruva Kumar Khada, Medical Technologist at National TB Centre – DOTS Plus Clinic.

2. Dr. Bhawana Shrestha, Director and other staff at German Nepal Tuberculosis Project.
3. Ms. Janak Kumari Dhakal – District TB and Leprosy Assistant and other staff at Bhaktapur DOTS Centre.

Presentation of Findings

Dr. Pema Choden Bhutia presented findings of their training on behalf of the team. She also submitted a report of training titled “Tour Report on DOTS Follow up Training at SAARC TB and HIV/AIDS Centre, Nepal from 12th – 17th March 2007”.

At the end of programme a meeting was held in STC with participants, facilitators and Director of STC. Participants recalled the knowledge they gained during their training and they made the comments that this would be really a very useful and practicable one. They expressed their capabilities to manage MDR TB at their places when they start DOTS Plus in Bhutan. They expressed their satisfaction over course contents, accommodation arrangement, hospitality and coordination. Participants recommended STC to organize such program for health workers for all SAARC Member States. At the end participants were awarded Certificates

(from page no. 6)

Finalization Meeting of National Strategic Plan on HIV/AIDS of Maldives – 2007

Prior to the meeting on SAARC Regional Consultative and Strategic Planning of HIV/AIDS Programme Managers, this meeting was organized on June 10, 2007 on the invitation of Department of Public Health, Ministry of Health, Maldives. Meeting was attended by STC officials and authorities of Department of Public Health, Maldives. This meeting helped the organizers to gather the required information to discuss on different aspects of strategic plan on HIV/AIDS. It also helped to review the regional strategic plan on HIV/AIDS.



SAARC Regional Consultative and Strategic Planning Meeting of HIV/AIDS Program Managers

11 – 12 June, 2007, Male Maldives

SAARC Regional Consultative & Strategic Planning Meeting of HIV/AIDS Program Managers was organized jointly by SAARC TB and HIV/AIDS Centre, Nepal and Government of Maldives from 11 to 12 June, 2007 in Male.

The overall objective of the meeting was to discuss the evidence based activities done by HIV/AIDS control program of each SAARC Member States, following the SAARC regional strategy on HIV/AIDS and to share the best practices in relation to HIV/AIDS control for the better result.

Participants from HIV/AIDS control program & Medical Services Department of Maldives and Media people attended the meeting. Along with the HIV/AIDS Program Managers of different Member Countries of SAARC, there were 30 participants who attended the meeting.

Opening Session

Dr. Sheena Moosa, Director General of Health Services, Ministry of Health, Maldives inaugurated the meeting as Chief Guest. Mr. Ibrahim Shaheem, Deputy Director General, Department of Public Health, Maldives extended a warm welcome to the participants, delegates and officials in the meeting.

Dr. Kashi Kant Jha presented the objective of the meeting and highlighted the importance of combined efforts and response towards emerging HIV/AIDS epidemic in the Region.



Following the inauguration, participants discussed the matter and components of the agenda in detail. The inputs of every participant were taken to prepare the recommendations and out-comes of the meeting.

Outcomes

The participants agreed for provision of priority on the focused areas of regional strategy in National Strategy Plan on HIV/AIDS of each SAARC Member States. Considering the high mobility of the people between the countries, all expressed the importance of accessible and acceptable interventions targeted to migrant people which help to minimize the risk of entry of HIV into the country. The meeting also addressed the importance of enhancement of preventive services, fostering of enabling environment of HIV/AIDS. (see more report in page no. 5)

Brief News

1. Participation in Health Fair (Swastha Mela)

Dr. Iwamura Memorial Hospital and Research Centre (IMHRC), Sallaghari, Bhaktapur, Nepal organized a three day Health Fair (Swastha Mela) which was inaugurated on January 18, 2007. This fair was organized to make the people aware on their own health. So the theme of the fair was – My Health is My Wealth (Mero Swastha Mero Sampatti).

The fair was decorated by different health related stalls with different information for people to remain healthy. Stalls were arranged by SAARC TB and HIV/AIDS Centre, National TB Centre, Netra Jyoti Sangh, Himalayan Herbal, Himalaya Vidhya Mandir, Nepal Family Planning Association, Nepal Red-cross Society, Blood Donors' Association, Korea Friendship Hospital, Nepal Heart Foundation, Khopo Poly-technique, Khopo Campus, Siddhi Memorial Academy, Child Support Programme, District Public Health Office and many other organizations.

STC distributed different publications on the request of visitors during the fair.

The programme was presided by Mr. Neel Krishna Tamrakar, Managing Director, IMHRC.

2. Short-term Training on Library Software:

A short-term training on library software was organized in STC on 29 January 2007. Expert of the software from New Delhi, Mr. Rohit Mahajan gave introductory training to STC staff about the software, its introduction, usefulness and operating



methodology. STC had installed (Soft-link Library Automation) Alice Software.

3. Participation in DOTS Orientation for Media People

DOTS orientation for Media People was organized by NTC on March 20, 2007 at NTC Training Building, Thimi, Bhaktapur. Dr. Kashi Kant Jha, Director, SAARC TB and HIV/AIDS Centre presented on the Role of Media in National Tuberculosis Control Programme. This programme was addressed by Director and Senior Medical Officer of NTC. This programme was organized to sensitize the media people to write about TB control on the occasion of World TB Day 2007.

4. Participation in Dissemination Meeting on Review of the Second Generation Surveillance on HIV and AIDS in Nepal

On the invitation of NCASC, Government of Nepal a meeting was held at Kupandol, Lalitpur on the

above subject. Dr. Kashi Kant Jha, Director, and Dr. Lochana Shrestha, Epidemiologist from SAARC TB and HIV/AIDS Centre participated in the meeting. Dr. Jha addressed the meeting and highlighted the need to follow regional surveillance based on regional strategy on HIV/AIDS.

5. Meeting with NTP and NACP Managers

Regional Meeting on CCM Strengthening and Round 7 – South and West Asia Cluster was organized jointly by Global Fund, WHO, UNAIDS, GTZ and UNDP from 20 to 23 March 2007 in Kathmandu. NTP and NACP Managers of the region were gathered to participate in the meeting. During that opportunity STC organized a special meeting with the NTP and NACP managers of SAARC Member States to discuss on future plan and activities of SAARC TB and HIV/AIDS Centre on 22 March 2007 in Kathmandu. The managers' team visited STC after completion of the meeting to observe the functioning of the Centre.

6. Participation in Technical Subcommittee Meeting

On the invitation of National TB Centre, Nepal Dr. Kashi Kant Jha, Director and Dr. Lochana Shrestha, Epidemiologist, STC participated in Technical Subcommittee Meeting for TB component of GFATM Round 7. In the meeting programme proposal in TB and HIV collaborative activities components were prepared.

7. Meeting with TFI & PAL Mission

A Mission from WHO visited Nepal on the implementation of Tobacco Free Initiatives (TFI)



activities through the Practical Approach to Lung Health (PAL) from 21 – 25 May, 2007. During their visit a meeting with mission was organized by National TB Centre and SAARC TB and HIV/AIDS Centre on May 23, 2007 at Thimi, Bhaktapur.

The objective of the meeting was to initiate the development of TB & tobacco control activities through PAL in Nepal.

The meeting discussed about how TB control and tobacco control are presently organized in Nepal. The meeting also discussed and agreed with national experts, health officials and partners on the development of integrated TB and tobacco control activities through PAL and formulated a Plan of Action. They also discussed on development of action plan to develop and implement TB & tobacco control activities through PAL–Nepal.

Conclusive meeting was also organized to discuss on work agenda with the NTP team, tobacco control team, MoH & P and PHC key persons, representatives of university and other relevant people/partners involved in TB control, tobacco control or PAL development and implementation in Nepal.

8. Participation in Joint meeting

A Technical Consultation Meeting on Scaling-up HIV testing and counseling in Asia and the Pacific was organized jointly by WHO, UNICEF and UNAIDS in Phnom Penh, Cambodia from 4 to 6 June, 2007.

On behalf of SAARC Dr. Lochana Shrestha, Epidemiologist, SAARC TB and HIV/AIDS Centre participated in the meeting. Dr. Shrestha emphasized on the importance of Public Private Coordination in scaling up of TB and HIV/AIDS Program. She also gave emphasis on Operational Research for increasing the acceptance of scaling up of voluntary counseling and testing.

Along with 73 participants from 12 countries, representatives from the WHO, UNICEF, Joint United Nations Program on HIV/AIDS (UNAIDS),

SPC, SAARC and civil society participated in the meeting.

The meeting discussed critical actions required to scale up access to HIV testing and counseling in Asia and the Pacific towards Universal Access. Participants reviewed HIV testing and counseling policies and practices in different settings and contexts in Asia and the Pacific.

9. Audit of STC Accounts 2006

A joint Audit Team (JAT) 2006 consisting of Mr. Rokhum Lalremruata, Controller of Accounts, Ministry of External Affairs, New Delhi, India and Mr. Ibrahim Fuad, Financial Audit Manager, Maldives Audit Office, Male', Maldives audited the annual accounts and related activities of SAARC Tuberculosis and HIV/AIDS Centres on June 23, 2007 in Kathmandu for the year 2006.

(from page no. 12)

Mr. Dhruba Kumar Khadka (Nepal), B. Sc., M.Sc.



Mr. Khadka joined SAARC TB & HIV/AIDS Centre in the post of Microbiologist on June 5, 2007. He did his M.Sc. in Tropical Medicine (Medical Microbiology) from Mahidol University, Bangkok, Thailand in 2005.

He is in medical laboratory services since 1981. He started his career from Government Service. Before joining in STC he was in NTC in the post of Senior Medical Technologist from 1993. He has got several trainings in different countries in the field of Tuberculosis Laboratory and earned lot of experience in this field.

STC staff welcomed Mr. Khadka in STC family.

Appointment of GS Staff

STC family also welcomed some General Services Staff in different vacant posts in this year.

Welcome News

Welcome to Hon'ble Mr. Giriraj Mani Pokharel, Minister for Health and Population Government of Nepal.

SAARC Tuberculosis & HIV/AIDS Centre Family has the honor to welcome Mr. Pokharel and extends the best wishes for his successful mission.



Visit of Health Dignitaries from Afghanistan



Dr. Kashi Kant Jha, Director, along with the staff of STC welcomed the dignitaries from Member States in SAARC TB and HIV/AIDS Centre on 22 March 2007.

Dr. Hayat M. Ahmadzai, Director,
NTP, Afghanistan
Mirwais Sarah, Program Officer, UNDP,
Afghanistan
Dr. Stanekzai, Director General, MRCA and Dr.
Saifur Rehman, Director, NACP

The team observed the functioning of the Centre and expressed their happiness and mentioned in the visitors' book that "To-day, we are very happy to visit SAARC TB and HIV/AIDS Centre. What we have learned that no one can work independently and the SAARC will help to bring the experience of neighboring countries in identifying the fight against this disease. This is why communicable diseases recognize no border. On this occasion

of World TB Day with theme "TB any where is TB Every Where" we urged the member countries to work closely to fight against TB and HIV/AIDS."

Visit of H. E. Mr. Chenkyab Dorji, Secretary General, SAARC



STC family welcomed His Excellency Mr. Chenkyab Dorji, Secretary General, SAARC on May 17, 2007 in the Centre. His Excellency observed the functioning of the Centre by visiting all the sections in the Centre. H. E. appreciated the activities done by the Centre and encouraged the staff to do the work more efficiently in future.

Visit of Prof. Mahendra P. Lama, JLN University, New Delhi

Mr. Lama visited STC on 22 May 2007 to know the activities of the Centre. Objective and activities of the Centre were briefly explained and publications were handed over to him for more information about SAARC TB and HIV/AIDS Centre. He appreciated

the activities carried out by the Centre and expressed happiness for friendly behavior and importance given to the public who visit the Centre.

Visit of Dr. Khalilur Rahman, Regional Advisor, WHO/SEARO, New Delhi

Dr. Rahman visited STC on May 23, 2007 and observed the functioning of the Centre. He discussed with the Director, STC about the plan and programs of the Centre and advised to integrate TB & Tobacco in coming year. In this connection he assured STC that WHO may help to work on this issue in the SAARC Region. He expressed happiness on his visit to SAARC TB and HIV/AIDS Centre and appreciated the achievements of the Centre.

Visit of Mr. Lila Prasad Sharma and Dr. Narayan Govinda Amatya

Dr. Kashi Kant Jha, Director and staff of STC welcomed Mr. Sharma and Dr. Amatya at STC on 28 May 2007 with very joyful and happiness. Both the personality had given responsibility to establish SAARC TB and HIV/AIDS Centre in Nepal in 1992. The Centre is indebted to both of them forever. Mr. Sharma and Dr. Amatya expressed happiness and appreciated the progress done by the Centre. They also appreciated the expert ability of STC staff.

Mr. Sharma and Dr. Amatya were assigned for performing Performance Audit of SAARC TB and HIV/AIDS Centre.

Appointment of New Staff at STC

Dr. V. S. Salhotra (India), M.B.,B.S., M.D.



Dr. Salhotra joined SAARC TB & HIV/AIDS Centre in the post of Deputy Director on June 21, 2007. He did his Graduation in Medicine from University College of Medical Sciences, Delhi, India and completed his Post Graduation in Preventive & Social Medicine from Lady Hardinge Medical College, Delhi, India.

He started his service in Government as Medical Officer in Central Government Health Scheme, MoH & FW, Government of India. He has a long clinical experience. Dr. Salhotra worked for National Tuberculosis Control Programme at central level and carried out his responsibility in the areas of implementation of DOTS, procurement & logistics as well as TB/HIV coordination & formulation & implementation of Pediatric DOTS guidelines. He is an avid reader and cricket enthusiast. STC staff welcomed him in STC family.

Dr. Ajith Prasantha Weerakoon (Sri Lanka), M.B., B.S., M. Sc.



Dr. Ajith Weerakoon joined SAARC TB and HIV/AIDS Centre as Research Officer on May 31, 2007. He obtained Masters of Science in Community Medicine from Post Graduate Institute of Medicine, University of Colombo, Sri Lanka. He started his career as a Divisional Director of Health Services at Kandy District, Sri Lanka. He worked as Regional Epidemiologist and Medical Officer of Maternal and Child Health in various districts in the country. He is a life member of the Indian Association of Epidemiologist (NICD India, New Delhi). He has conducted many researches on Alcohol and Drug Abuse, Maternal Morbidity, HIV/AIDS and Domestic Violence in the Estate sector in Sri Lanka and published the findings. STC staff welcomed him in STC family.

A Case Record

Unusual Presentation of Miliary TB with Meningial Involvement

Dr. N. G. Amatya, Dr. Nirmala Rai, Dr. Sudhir N. Shrestha, Dr. Suraj Rana

A case has been recorded in Kalimati Chest Hospital with unusual presentation of Miliary Tuberculosis with Meningial involvement of a male/28, father two children.

Miliary Tuberculosis is almost due to Hamatogenous spread of Tuberculosis bacilli. Although Military Tuberculosis is becoming less due to early case detection of the tuberculosis and treatment before the hematogenous spread occur but cases are being reported in many hospital settings. Although in children it may be due to recent primary infection but in adults it may be due to either recent infection or reactivation of old disseminated foci. The lesions are usually yellowish granuloma 1 to 2 mm in diameter that resembles miliary seed (thus the term miliary is coined).

A high index of suspicion is required for the diagnosis of miliary tuberculosis. In most cases Tuberculin Test (PPD) is negative up to 50% cases. Only chest radiography reveals military reticular nodular pattern. Sputum smear is negative in 80% of cases. If untreated the case is lethal but if properly treated can be cured. We are presenting a rare case seen in adult with meningial involvement. Patient was presented at the Kalimati Chest Hospital with the following complains:

1. Fever
2. Weight Loss
3. Generalize Weakness
4. Semi Conscious State
5. Unable to move legs & hands
6. Unable to speak

Author's address:

Dr. N. G. Amatya, Medical Director
Kalimati Chest Hospital
Kathmandu, Nepal
E-mail: nata@antitb.wlink.com.np, Fax: 0097714270019

On admission his condition was very poor, intermittent type of fever, goes up to 101.5, unable to take anything by mouth. Patient's condition was very poor. There were signs of meningial involvement with paraplegia of legs & unable to speak, neck rigidity was present, planter were up going. His recent chest X-ray showed Miliary PULTB. Patient was referred from National TB Centre, Thimi, Nepal. He is of an India origin and Muslim religion from Kolkata working in Herbal Factory in Kathmandu.

His sputum could not be examined as he was unable to cough out sputum. He was put on Cat I regimen and streptomycin was added (0.5gm) I/M once daily. Treated on conservative line, I/V line with 5% dextrose & DNS was started. Steroids (20mg) TDS & nerve tonics were added.

Most surprisingly he improved so rapidly within 3 weeks; he could speak & walk by himself. He developed bed sore on buttock but improved quickly with daily dressing.

He was started on oral feeding. After 4 weeks dramatic improvement, he wanted to be discharged to go to his native place with his wife. So he discharged on 06/11/30 with the following advice to contact DOTS clinic in Kolkatta & do continue treatment for 8 months. Vitamins & apetone were added.

Conclusion

Although military tuberculosis with meningial involvement is difficult to treat & response is very erratic. After full course of treatment some neurological sequels remain in most of the patients. But this young Muslim patient from India, Kolkatta working in Nepal is a rare case of such dramatic improvement without any neurological deficit within short period of time.

The Stop TB Strategy

Dr. K. K. Jha
Director, SAARC TB and HIV/AIDS Centre

With the widespread implementation of DOTS strategy in the SAARC region, the major progress in tuberculosis control has been seen in the past decade.

Tuberculosis control demands a comprehensive and sustained response, complementing measures to address the social and environmental factors that increase the risk of developing TB. Also it needs to address the emerging global HIV epidemic and MDR-TB which have had a variable impact in countries in this region.

Building on current achievements and in accordance with the 2005 World Health Assembly resolution on sustainable financing for TB control, the major task for the next decade is to achieve the millennium development goal and related Stop TB Partnership targets for TB control which has been set for 2015. To meet these targets for TB control with sustaining existing achievements and addressing remaining challenges and constraints more effectively, the coherent strategy needs to be on place. Following this the new Stop TB strategy was formulated in 2006. It is not a different strategy from DOTS, but only expansion of the strategy to achieve the MDGs and related STOP TB partnership targets for TB control. The, new Stop TB strategy has six principal components:

1. Pursue high quality DOTS expansion and enhancement
2. Address TB/HIV and MDR –TB and other special challenges
3. Contribute to health system strengthening
4. Engage all care providers
5. Empower people with TB, and Communities
6. Enable and promote research

The main focus of Stop TB Strategy is on making the best use of currently available tools for diagnosis, treatment and prevention of TB and of the improved tools that are likely to become available through research and development.

This strategy sets out the steps that National TB control Programmes and their partners need to take which shall be assisted actively by all stakeholders. This strategy must be aligned with individual countries' own strategies to control TB, in the country context.

National TB Control Programmes (NTPs) of SAARC Member States adopted this strategy and have either initiated or are implementing several of the additional interventions under this broadened strategy. Alongside intensified efforts to improve the quality of services, programmes are strengthening partnerships with other providers, particularly nongovernmental organizations, private health sectors, medical teaching institutes.

In addition, most of the member states are planning and implementing interventions to address TB/HIV and MDR-TB following Stop TB strategy. To improve the uptake of available services NTPs are focusing on implementation of community based initiatives and community care interventions.

The Stop TB strategy presented the framework for the coordinated and collaborative efforts of all the partners working on TB control, which need to be followed by all the national TB control Programmes to control TB in the region with the achievement of MDG targets. This strategy is also viewed as a key component for broader international, national and local strategic interaction and interventions in relation to control of TB worldwide.

Tuberculosis and MDR-TB

Dr. Lochana Shrestha,
Epidemiologist, STC

Tuberculosis is a curable disease that kills millions in the developing world and it offers a glaring example of global inequalities in access to health care. Drugs to fight tuberculosis (TB) have been in existence for 50 years, and deaths from TB are rare in rich countries. Yet TB kills 5,000 people every day, nearly 2 million people per year. More than 2 billion people, almost one-third of the world's population, are infected with the microbes that cause TB.

If TB patients on treatment do not take medication at the prescribed time in adequate dosage or are unable to complete the full course of treatment, their tuberculosis may become resistant to those medications. To avoid the development of resistant TB, WHO recommended DOTS whereby patients typically take TB medications under the supervision of health workers.

Over the past 15 years, however, incomplete TB treatments - due to shortages of medicines and medical personnel, faulty prescriptions, inadequate treatment taken by the patients due to poverty, civil disruptions, and socioeconomic barriers for patients - have led to a proliferation of strains of tuberculosis resistant to at least two (Rif. & INH) or more TB medications. TB caused by these strains also known as multi-drug resistant tuberculosis, or **MDR-TB**.

MDR-TB can be treated and cured. But treatment regimens are complicated, lengthy and expensive. Medications that are currently available can produce crippling side effects and are less effective than drugs for non-resistant TB. If left untreated, however, MDR-TB not only kills the patients but can spread to other people, where it may develop additional drug resistance.

Fight against MDR-TB

DOTS is the internationally recommended strategy for TB control and it prevents the emergence of drug resistance in drug-susceptible cases, while in patients with MDRTB, this treatment yields inadequate cure rates. Treating MDRTB with second-line drugs may cure >65% of patients and stop ongoing transmission. In 1999, WHO and partner agencies launched **DOTS-Plus to manage MDRTB** in resource-limited settings. In 2000, The Stop TB Working Group on DOTS-Plus for MDR-TB (WG), created the Green Light Committee (GLC) to increase access to second-line drugs while ensuring their rational use.

Some of the requirements for endorsement of GLC include a well-functioning DOTS program, long-term political commitment, rational case-finding strategies, and diagnosis of MDRTB through quality-assured culture and drug susceptibility testing (DST), treatment strategies that use second-line drugs under proper management conditions, uninterrupted supply of quality-assured second-line drugs, and a recording and reporting system designed for MDRTB control programs. There is evidence that misuse of second-line anti-TB drugs will result in further resistance to second-line drugs, creating incurable forms of tuberculosis.

If second line drugs are misused or mismanaged, extensively drug-resistant TB (XDR-TB) can develop. Because XDR-TB is resistant to first and second-line drugs, treatment options are seriously limited and so are the chances of cure.

Management of multi-drug resistant tuberculosis (MDR-TB) is one of the six components of the new WHO Stop TB strategy. In settings of minimal drug resistance, preventing spread of drug-resistant TB by effective, complete treatment of new TB patients is more efficient and less costly than treatment of

drug resistant TB. Therefore, prevention must be the highest priority for TB control programs. However, many countries with well functioning TB control programs, with significant problems of drug-resistant TB need to take specific measures gradually to incorporate appropriate strategies for treatment of this form of tuberculosis into their programs and prevent propagation of drug-resistant TB. Management of MDR-TB under programmatic conditions is feasible and cost-effective when implemented in the context of a well-functioning DOTS programme based on WHO policy guidelines. There should be good laboratory capacity for diagnosis of MDR-TB, monitoring of treatment response and DRS to implement DOTS PLUS.

Situation of MDR-TB in SAARC region:

For the National Tuberculosis Programme (NTP) in all member states the first priority remains prevention of acquired drug resistance through effective implementation of DOTS. However, national TB programmes are faced with the challenge of growing pool of patients with MDR-TB. Two countries in the Region India and Nepal have been participating in successive rounds of DRS held since the late 1990s. MDR-TB rates reported from countries in the Region are as shown in the table below. Isolated reports of higher levels of MDR-TB are reported mainly from hospital settings.

Table 1 Estimated number and prevalence of MDR-TB in SAARC member states (2004)

Country	MDR-TB in new cases		MDR-TB in re-treatment cases	
	Number	Percentage	Number	Percentage
Countries with anti TB drug resistance surveys				
India	44653	2.4%		
Nepal	647	1.3%	847	20.5%
Countries without anti TB drug resistance surveys				
Bangladesh	5699	1.8%	1517	14.4%
Bhutan	41	1.8%	16	14.5%
Maldives	2	1.5%	1	14.5%
Sri-Lanka	211	1.7%	88	14.5%

Table 2 Multi-drug resistance rates

Country	Year	Prevalence of multi-drug resistance among new cases
India (Wardha, Maharashtra)	2001	0.5%
India (Raichur, Karnataka)	1999	2.5%
India (N. Arcot, Tamil Nadu)	1999	2.8%
Nepal	2001	1.3%

India and Nepal have established DOTS Plus projects according to international guidelines, in close consultation with the Green Light Committee. DOTS Plus projects have also been

planned in Bhutan, Bangladesh and Sri Lanka. There is an urgent need to build the capacity of National laboratories to diagnose patients with MDR-TB.

Key Achievements

Draft **operational guidelines for the management of MDR-TB** were prepared in Bangladesh

MDR-TB guidelines and training materials were developed; a Green Light Committee approved DOTS PLUS project was initiated in Delhi, India.

Green Light Committee approved DOTS PLUS project was initiated in Nepal and first external review of this project was conducted. Also training of selected staff was undertaken in preparation for drug-resistance survey.

References:

1. *Tuberculosis control in the South East region WHO 2006*
2. *CDC Morbidity and Mortality Weekly Report. Emergence of Mycobacterium tuberculosis with Extensive Resistance to Second-Line Drugs— Worldwide, 2000—2004 (March 24, 2006 / 55(11);301-305)*
3. *Zignol M, Hosseini MS, Wright A, Weezenbeek CL, Nunn P, Watt CJ, et al. Global incidence of multidrug-resistant tuberculosis. J Infect Dis. 2006;194:479-85.*
4. *World Health Organization. Treatment of tuberculosis: guidelines for national programmes. 3rd ed. Geneva: The Organization; 2003. Publication WHO/CDS/2003.313. Available from http://www.who.int/tb/publications/cds_tb_2003_313/en/index.html*
5. *van Deun A, Salim MA, Das AP, Bastian I, Portaels F. Results of a standardised regimen for multidrug-resistant tuberculosis in Bangladesh. Int J Tuberc Lung Dis. 2004;8:560-7.*
6. *Leimane V, Riekstina V, Holtz TH, Zarovska E, Skripconoka V, Thorpe LE, et al. Clinical outcome of individualised treatment of multidrug-resistant tuberculosis in Latvia: a retrospective cohort study. Lancet. 2005;365:318-26.*
7. *Mukherjee JS, Rich ML, Socci AR, Joseph JK, Viru FA, Shin SS, et al. Programmes and principles in treatment of multidrug-resistant tuberculosis. Lancet. 2004;363:474-81.*
8. *World Health Organization. Guidelines for establishing DOTS-Plus pilot projects for the management of multidrug-resistant tuberculosis. Geneva: The Organization; 2000. Publication WHO/CDS/TB/2000.279. Available from <http://www.who.int/docstore/gtb/publications/dotsplus/dotspluspilot-2000-279/english/index.htm>*
9. *Gupta R, Cegielski JP, Espinal MA, Henkens M, Kim JY, Lambregts-van Weezenbeek CS, et al. Increasing transparency in partnerships for health—introducing the Green Light Committee. Trop Med Int Health. 2002;7:970-6.*

HIV/AIDS and Children

Dr Ajith Weerakoon
Research Officer, STC

One of the most tragic aspects of the HIV/AIDS pandemic has been the infection of children. Without treatment thousands die as a result of AIDS. In addition, million more children who are not infected with HIV are indirectly affected by the epidemic, as a result of the death and disability that AIDS causes in their families.

At the end of 2006, there were 2.3 million children living with HIV around the world. Over half a million children became newly infected with HIV in 2006 .⁽¹⁾

Of the 2.9 million people who died of AIDS during 2006, over one in ten were children. Every hour, forty children die as a result of AIDS.

Most children living with HIV around 9 out of 10 live in Sub Saharan Africa, the region of the world where AIDS has taken its greatest toll. Large numbers of children with HIV also live in the South East Asia. ⁽¹⁾

It is estimated that 30 to 50 percent of HIV-infected pregnant women will give birth to an infected baby in the absence of treatment. The probability that the infant will be infected depends on the level of HIV, the stage of HIV infection, and the current phenotype of HIV in the mother her immune competence, premature birth and chorio-amnionitis. ⁽²⁾

Of infected infants, 30 to 50 per cent are infected during the birth process and another 15 to 20 percent through breast feeding. Infants infected from their mothers follow one of two courses: rapid progression with early death within a month of birth, or a slow course lasting years and some cases into adolescents. Infants infected *in utero* tend to experience rapid progression whereas those infected during the birth process or infected

through breast milk tend to experience a slower course, extending in many case well beyond 2 years.⁽³⁾

In Africa, studies revealed that one in three newborns infected with HIV die before the age of one, over half die before reaching their second birthday, and most are dead before they are five years old. ⁽⁴⁾

Whereas, in developed countries, preventive measures ensure that the mother to child transmission of HIV infection is relatively rare. This emphasizes that with proper intervention the infection and deaths of many children in developing countries might easily be avoided.

Mother-to-child-transmission of HIV accounts for the vast majority of children who are infected with HIV. HIV can also be transmitted through breast milk. Apart from mother-to-child transmission, some children acquire HIV in medical settings; for instance, through contaminated needles or blood transfusions where infected blood is used. For older children, sexual activity and drug use present a risk. Children are exposed to HIV through sexual abuse and rape. This is a significant problem in many areas. For instance, in some parts of Africa, the myth that HIV can be cured through sex with a virgin has led to a large number of rapes – sometimes of very young children- by HIV infected men. ⁽⁵⁾

In some cases, young children are coerced into sex work, which can put them at a very high risk of becoming infected with HIV and other STIs.

Prevention of childhood HIV /AIDS

The main way to stop children becoming infected is to prevent mother- to child transmission. Mother to child transmission of HIV is almost entirely

avoidable, given appropriate intervention. These measures (which include giving antiretroviral drugs to a mother during pregnancy, and to her child once it is born) can reduce the risk of mother-to-child transmission from 20-45% to less than 2%. Unfortunately, prevention of mother-to-child transmission services fail to reach most women in resource poor countries. In 2005, only 9% of pregnant women in resource poor countries were offered any sort of prevention services. ⁽⁵⁾

The use of sterile medical equipments and screened blood products can help to prevent children becoming infected through medical transmission. In Romania, more than 10,000 new babies and young children were infected with HIV from contaminated injections and unscreened blood transfusion between 1987 and 1991. ⁽⁶⁾

In regard to preventing infection through sexual activity and drug use, the most effective way that can be done is to prevent children from having sex or from using drugs. All children and young people should receive sexual health and HIV education considering cultural aspect of the individual countries. In addition to that they should receive life skill based education so that they know how to tackle undesirable situations.

References:

- (1) UNAIDS/WHO (2006, December), *AIDS Epidemic Update*.
- (2) Newell et al. (1997) *Prevention of mother - to - child transmission of HIV-1 infection AIDS, 11(supplement A)-S165-S172*.
- (3) *Oxford Text book of Public Health IV Edition pp -1465*
- (4) Newell M-L et al (2004, 2nd October), 'Mortality of infected and uninfected infants born to HIV-infected mothers in Africa: a pooled analysis', *The Lancet* 364(9441)
- (5) *BBC News (October 2006), 'Staging sex myths to save Zimbabwe's girls'*.
- (6) *Human Rights Watch (2006, August), Romania's Failure to Protect and Support Children and Youth Living with HIV'*

Abstracts

1. Health-seeking behaviour of new smear-positive TB patients under a DOTS programme in Tamil Nadu, India, 2003

Authors: Selvam, Jerard M.; Wares F.; Perumal M.; Gopi P.G.; Sudha G.; Chandrasekaran V.; Santha T.

Source: The International Journal of Tuberculosis and Lung Disease, Volume 11, Number 2, February 2007, pp. 161-167(7)

Publisher : International Union Against Tuberculosis and Lung Disease

Abstract

BACKGROUND: Although case detection is above 70% in Tamil Nadu after DOTS implementation, an assessment of the timeliness of patient diagnosis and treatment is still needed.

OBJECTIVE: To study the health-seeking behaviour of new smear-positive pulmonary tuberculosis (PTB) patients treated at government facilities.

METHODS: New smear-positive patients diagnosed and treated between January and March 2003 in government facilities of randomly selected blocks in Tamil Nadu were interviewed using a semi-structured interview schedule.

RESULTS: Of 601 patients interviewed, 65% contacted a provider within 28 days. The first contact was governmental for 47% and non-governmental for 53%. Median total, patient and provider delays were respectively 62, 28 and 28 days; provider delay was 9 days with government and 50 with private provider. In multivariate analysis, patient delay was significantly associated with smoking ($P < 0.001$) and mode of travel ($P < 0.01$), and provider delay with first consultation with a private provider ($P < 0.001$) and distance >5 km from the health facility ($P < 0.01$). Twenty-five per cent of patients took more than two actions before diagnosis.

CONCLUSION: Community awareness of TB needs to be increased. Greater private sector involvement in the Revised National Tuberculosis Control Programme is essential to reduce provider delay. Referral and sputum transportation to the diagnostic facility should be given priority.

Keywords: tuberculosis; health seeking behaviour; delay; India

2. Impact of drug-resistant tuberculosis on the survival of HIV-infected patients

Authors: Sungkanuparph S.; Eampokalap B.; Chottanapund S.; Thongyen S.; Manosuthi W.

Source: The International Journal of Tuberculosis and Lung Disease, Volume 11, Number 3, March 2007, pp. 325-330(6)

Publisher: International Union Against Tuberculosis and Lung Disease

Abstract

OBJECTIVE: To determine the effect of drug-resistant tuberculosis (TB) on the survival of human immunodeficiency virus (HIV) infected patients in an area with a high prevalence of TB.

DESIGN: Retrospective cohort study.

RESULTS: Of 225 HIV-TB patients with a mean age of 35.8 years, 72.4% were male. The median CD4 cell count at TB diagnosis was 44 cells/mm. Sixty per cent presented with extra-pulmonary TB (EPTB).

Sixty-three (28%) patients were infected with *Mycobacterium tuberculosis* resistant to at least one drug; respectively 16.4%, 9.3%, 5.3% and 12.9% were resistant to isoniazid (INH), rifampicin (RMP), ethambutol and streptomycin, and 14 (6.2%) had multidrug-resistant TB (MDR-TB). During a median follow-up of 11.5 months, 4% died. From Kaplan-Meier analysis, INH resistance, RMP resistance and MDR-TB were associated with shorter survival (log-rank test, $P < 0.005$). Cox's proportional hazard model showed that MDR-TB (hazard ratio [HR] 11.7; 95% CI 2.1-64.9), not receiving antiretroviral therapy (ART) (HR 7.9; 95%CI 1.5-43.1) and EPTB (HR 5.1; 95%CI 1.9-25.9) were significant risk factors for death.

CONCLUSION: MDR-TB and EPTB substantially reduce survival among patients co-infected with HIV and TB. Early detection and optimal treatment of MDR-TB are crucial. ART significantly prolongs survival and should be initiated in HIV-TB co-infected patients.

Keywords: tuberculosis; drug resistance; survival; HIV; AIDS.

3. Surveillance of anti-tuberculosis drug resistance in Ernakulam District, Kerala State, South India

Authors: Joseph, M.R.; Shoby, C.T.; Amma, G.R.; Chauhan, L.S.; Paramasivan, C.N.

Source: The International Journal of Tuberculosis and Lung Disease, Volume 11, Number 4, April 2007, pp. 443-449(7)

Publisher: International Union Against Tuberculosis and Lung Disease

Abstract

SETTING: This is the first report on drug resistance surveillance (DRS) in Ernakulam District, Kerala, South India, based on a standard protocol from World Health Organization (WHO) guidelines.

OBJECTIVES: To determine the level of drug resistance among smear-positive pulmonary

tuberculosis (PTB) patients with no history of previous treatment in Ernakulam District, Kerala State.

DESIGN: Two additional sputum samples were collected from all consecutive new smear-positive PTB cases registered under the revised National TB Control Programme (RNTCP) formulated by the Government of India. The generic protocol developed by the Central TB Division for district level DRS in accordance with WHO guidelines was followed. Training of laboratory staff and other health personnel, periodic monitoring and quality assurance of laboratory work were carried out by the Tuberculosis Research Centre, Chennai.

RESULTS: A total of 305 (88.7%) sputum samples were positive for culture. Resistance to any drug was seen in 27.9% and multidrug-resistant tuberculosis (MDR-TB) was observed in 2%. Monoresistance to rifampicin and streptomycin was observed in respectively 1% and 17% of cases, and 27.1% resistance was observed to any drug in the younger age group.

CONCLUSION: MDR-TB is within expected ranges in Ernakulam District. Further studies that include the private sector are needed in the state among different age groups.

Keywords: TB; drug resistance surveillance; Kerala

4. Treatment outcome cohort analysis in an integrated DOTS and DOTS-Plus TB program in Latvia [Short Communication]

Authors: Riekstina V.; Leimane V.; Holtz T.H.; Leimans J.; Wells C.D.

Source: The International Journal of Tuberculosis and Lung Disease, Volume 11, Number 5, May 2007, pp. 585-587(3)

Publisher: International Union Against Tuberculosis and Lung Disease

Abstract

International guidelines for treatment outcome analysis of tuberculosis cases have been published and are widely used. They do not, however, fully address the incorporation of multidrug-resistant

tuberculosis (MDR-TB) cases. Here we present an approach to cohort analysis of treatment outcomes for all registered TB cases, including MDR-TB cases. We analyzed all new pulmonary smear- and/or culture-positive cases registered in Latvia during 2002. Analysis of treatment outcomes at 24 months after initial case registration showed overall treatment success at 84%. This approach to outcome analysis is possible only for settings where MDR-TB treatment is established.

Keywords: tuberculosis; multidrug-resistant tuberculosis; treatment outcomes; cohort analysis

5. Ethical issues in research in low-income countries [Leading Article]

Authors: Benatar S.R.; Fleischer T.E.

Source: The International Journal of Tuberculosis and Lung Disease, Volume 11, Number 6, June 2007, pp. 617- 623(7)

Publisher: International Union Against Tuberculosis and Lung Disease

Abstract

During the twentieth century, spectacular developments in science, technology and medical practice coupled with economic growth have transformed health care and improved the lives of many people. Despite such progress, the world today is more inequitable than it was 50 years ago: disparities in wealth and health are widening inexorably, and infectious diseases are again becoming a major scourge and pose a threat to the lives of all. Hundreds of millions of people live in degrading poverty, with little, if any, access to health care. Recognition of this context in which much research takes place should sharpen our focus on the ethical requirements for research that could improve the health of a greater proportion of the world's population—one of the most pressing moral problems of our time.

The intense debate on ethical dilemmas associated with an expanding programme of clinical research in developing countries has revealed much common ground, but has also left

a residuum of controversy. We suggest that contested issues could be resolved by paying greater attention to different world views on the relationship between research and clinical care and by defining policies that both progressively improve the standard of care in research and link research to improved delivery of health care in developing countries.

Keywords: clinical research; ethics; low-income countries; exploitation.

6. Efficiency of a third serial sputum smear examination in the diagnosis of tuberculosis in Moldova and Uganda

Authors: Katamba A.; Laticevschi D.; Rieder H.L.

Source: The International Journal of Tuberculosis and Lung Disease, Volume 11, Number 6, June 2007, pp. 659-664(6)

Publisher: International Union Against Tuberculosis and Lung Disease

Abstract

SETTING: Twenty-four and 30 tuberculosis (TB) microscopy laboratories in Moldova and Uganda, respectively.

OBJECTIVE: To estimate the workload required to identify one additional case of TB with a third serial sputum smear examination.

METHODS: Retrospective laboratory register study to determine the prevalence and the incremental yield of TB cases from a third serial sputum smear examination among suspects in Moldova and Uganda, with the reciprocal of the product of these two fractions providing the number of examinations required to identify one additional TB case.

RESULTS: In Moldova, 9% (1141/12525) and in Uganda 20% (7280/36054) of suspects met the TB case definition with at least one positive sputum smear. The incremental yield from the third examination was 4% in Moldova and 3% in Uganda. To detect one additional TB case on a third smear, 273 examinations (95%CI 200-389) in Moldova and

175 (95%CI 153-222) in Uganda were thus required. This corresponded to an average of 11 days (8-16) and 7 days (6-9), respectively, to diagnose one additional case of TB.

CONCLUSION: In both countries, the third serial sputum smear examination was inefficient in diagnosing sputum smear-positive TB.

Keywords: case finding; incremental yield; microscopy; tuberculosis; workload.

7. A survey of TB services in hospitals in seven large cities in Asia and North Africa

Authors: Chiang C-Y.; Trébuq A.; Billo N.; Khortwong P.; Elmoghazy E.; Begum V.; Aditama T.Y.; Ansari A.; Baral S.C.; Vianzon R.G.

Source: The International Journal of Tuberculosis and Lung Disease, Volume 11, Number 7, July 2007, pp. 739-746(8)

Publisher: International Union Against Tuberculosis and Lung Disease

Abstract

SETTING: Hospitals in Bangkok, Cairo, Dhaka, Jakarta, Karachi, Kathmandu and Manila.

OBJECTIVES: To evaluate tuberculosis (TB) services provided in public and private hospitals in big cities.

DESIGN: A survey on TB services in hospitals was carried out in 2005 by visiting hospitals and face-to-face interviews. Selection criteria were determined for each city. All hospitals were included if feasible.

RESULTS: The number of hospitals included in the survey ranged from 52 in Bangkok to 106 in Jakarta. The proportion of private hospitals with access to a National Tuberculosis Programme (NTP) manual ranged from 8% in Jakarta to 89% in Bangkok. Private hospitals rarely functioned as a basic management unit (BMU) of the NTP, except in Bangkok. TB treatment was not always free of charge in BMU hospitals. The proportion of non-BMU

hospitals that never referred/reported TB patients to the NTP was substantial in Bangkok, Dhaka, Jakarta, Karachi and Manila. Non-BMU hospitals did not routinely use standard NTP regimens, especially in Jakarta, Karachi and Manila. In non-BMU hospitals, patient tracing mechanisms were generally lacking and treatment outcome was not known.

CONCLUSION: TB services provided in non-BMU hospitals were not satisfactory. NTPs need to involve non-BMU hospitals in TB control.

Keywords: TB; city; hospital.

8. TB-HIV co-infection in Eritrea [Short Communication]

Authors: Van der Werf M.J.; Sebhatu M.; Weldegergis T.; Tesfazion A.; Borgdorff M.W.

Source: The International Journal of Tuberculosis and Lung Disease,

Volume 11, Number 7, July 2007 , pp. 823-826(4)

Publisher: International Union Against Tuberculosis and Lung Disease

Abstract

We assessed the prevalence of tuberculosis (TB) human immunodeficiency virus (HIV) co-infection and identified risk factors for HIV infection in smear-positive TB patients diagnosed by the TB programme in Eritrea. Of 365 notified TB patients, 220 (60.3%) could be traced and provided a blood sample that was tested. Of these, 26 (11.8%, 95%CI 7.6-16.1) were HIV-infected. Risk factors were age, urban residence and schooling level. The data indicate that, starting with the urban areas, it is time for Eritrea to introduce HIV testing of all TB patients.

Keywords: tuberculosis; HIV infection; co-infection; Eritrea; epidemiology.

Proposed Programs

1. SAARC Regional Meeting of Managers of National TB and HIV/AIDS Control Program from SAARC Member States & SAARC Meeting of Group of Experts for Electronic and Print Media to develop the Mechanism/link to utilize the facility for dissemination of Information, education and Communication (IEC) information/materials on TB and HIV/AIDS in the region.
2. Community based Risk Behaviour Study on HIV/AIDS targeting women in Nepal.
3. SAARC Regional Training of Trainers on Management of Drug Resistant TB(DOTS Plus).
4. Fourth Round External Proficiency Testing in 9 Reference Laboratories.

Editor's Request

Dear Readers,

Thank you very much for sending acknowledgements of receiving the STC Newsletters. This is 1st issue of STC Newsletter for the year 2007. We request you to send suggestions and comments on this issue. Response from our readers always inspires us to improve the quality of our STC Newsletter. We also request our readers to send their valuable technical articles on TB and HIV/AIDS to include in STC Newsletter.

Thank you very much

- Editor

DOTS

(Directly Observed Treatment Short-course)

**DOTS is the best ever known strategy to cure TB
This program based strategy can control TB very effectively**

Postage Stamp

To

If undelivered, please return to:

**SAARC Tuberculosis and HIV/AIDS Centre
GPO Box No. 9517, Kathmandu
Nepal**