



SAARC GUIDELINES FOR PARTNERSHIP
WITH
TRAVEL AGENCY
IN PREVENTION & CONTROL OF
TUBERCULOSIS AND HIV/AIDS



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2007



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First Edition : 2007

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PREFACE

Tuberculosis is a global problem. SAARC Region bears 22% of global population with 30.3% of the global burden of TB and numbers of HIV infected people living within the region is second highest after sub-Saharan Africa.

Our Centre gained experience for the awareness and advocacy on TB and HIV/AIDS control and prevention through Partnership with different partners like Media, School, Industry, Private Sector, Medical Colleges, Pharmacists, Man Power Agencies and Travel Agencies etc. These partnerships showed meaningful results, and these sectors played vital role for generating awareness among the people by propagating the messages on Tuberculosis and HIV/AIDS. In this regard, the Centre has been producing the Guidelines for partnership with most of the identified sectors. This Guideline for the partnership with Travel Agency is also expected to contribute for effective collaboration among the NTP, NACP and Travel Agencies

The statistics indicated that the 800 million international tourist arrivals in 2005, approximately 26% of the 800 million international journeys were, for visits to friends and relatives and for religious propose. The annual number of air passengers reached 2 billion in 2005, and passenger traffic is projected to grow by about 6% a year over the period 2006-2008. In 2005, 11.5 million passengers worldwide traveled on cruise ships. The International travel is undertaken by large and ever increasing numbers of people for professional, social, recreational and humanitarian reasons. More people travel greater distances and at great speed than ever before and this upward trend looks set to continue. Air travel, in particular over long distances, exposes passengers to a number of factors at source at transit and at destination that may have an effect on their health and well-being.

Travel agents are the leading distributors of travel products and services, which sell around 87% of cruises, 81% of all tours and packages, 51% of all airline tickets, 47% of all hotels stay, 45% of all car rentals. We are very much hopeful that Travel Agencies and tour operators can play vital role to make aware the large number of their clients about the TB and HIV/AIDS.

It is my expectation that the information contained in this Guideline will help to Travel Agencies and Programme Managers to recognize the role of Travel Agencies for TB and HIV/AIDS Control. This guideline will also help to develop close collaboration and partnership between NTP/NACP and Travel Agencies to create the awareness about travel diseases among the clients as internal and external tourists, which will be beneficial for both, the programmes and travelers.

I would like to appreciate the efforts made by our Deputy Director and Mrs. Meena K. Dhakal, SPA of STC to bring out this Guideline. I would also like to give thanks to all Professionals and GS Staff of STC for providing their inputs for this guideline.

I am confident that this publication will serve a very useful purpose to those engaged in efforts to control and prevent TB and HIV/AIDS and Travel Agencies to gain the knowledge on TB and HIV/AIDS and alert their clients regarding the risk of these diseases during travel and to take necessary precautions.



Dr. Kashi Kant Jha
Director

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
DOTS	Directly Observed Treatment Short-course
HIV	Human Immunodeficiency Virus
GO	Governmental Organization
INGOs	International Non-Governmental Organizations
MDR	Multi Drug Resistance
NTP	National Tuberculosis Control Programme
NGOs	Non-Governmental Organizations
STC	SAARC TB and HIV/AIDS Centre
SAARC	South Asian Association for Regional Cooperation
SS+	Sputum Smear Positive
TB	Tuberculosis
WHO	World Health Organization
UNWTO	United Nation of World Tourism Organization
CSW	Commercial Sex Worker
IDU	Injecting Drug User
MSM	Men Sex with Men
STIs	Sexually Transmitted Infections
PLWHA	People Living with HIV/AIDS
GPO	General Post Office
MTCT	Mother to child transmission
ART	Antiretroviral therapy

CHAPTER 1

INTRODUCTION:

1.1 SAARC Tuberculosis and HIV/AIDS Centre:

The SAARC Tuberculosis and HIV/AIDS Centre is one of the Regional Centre of SAARC working for prevention and control of TB and HIV/AIDS in the Region by coordinating the efforts of the National TB Control Programmes (NTPs) and National AIDS Control Programmes (NACPs) of Member Countries.

The Heads of the State or Government of the Member Countries of SAARC at their Fifth Summit held at Male from 22-23 November 1990 decided to set up that SAARC Tuberculosis Centre in Nepal. In this way the Centre was established at National Tuberculosis Centre building, Thimi, Bhaktapur Nepal in 1992 by formulating the rules and regulations and started its functioning since 1994.

The Thirty-first Session of Standing Committee of SAARC held in Dhaka on November 9-10, 2005 approved the renaming of the Centre as SAARC Tuberculosis and HIV/AIDS Centre.

1.2 Travel Agency:

Travel and tourism is now recognized as the world's largest industry. Continuing growth has created highly intense levels of competition within each level of its various sectors. The services and facilities we offer, therefore, need to be customer oriented rather than to those of the producer. Systematic management approach will reward those who are willing to make the necessary effort to study, plan, evaluate and innovate tourism.

Travel agency is an axis of the tourism. The tourism activities revolve around the travel agency. The tourism is the result of the movement of people from one place to another and travel agencies generate the movement. So a travel agency is the generator or creator of the tourism. It plays a crucial role in the tourism as a brain in the human body. A mad person can survive but his action, thinking and behavior may not be coordinated. In the same way, without travel agency, tourism will have no joint effort, no planning and no programming. We cannot imagine tourism

without travel agency because "tourism is the result of joint effort of the travel related jobs and travel agency joins them together to form a travel industry. To facilitate the travel is the objective of a travel agency. It is a business organization established to sell travel related service. Travel agency is the business of taking responsibility of tour and travel. The agencies collect service charge for taking responsibility. For this purpose, they coordinate between the enterprises and customers. They collect commission or service charge for the coordination work. As such, Travel agents are the commission agents. They are the bridge and fill the gap between the customer and service agencies or facilities they provide. The history of travel agency is not very old. Thomas Cook first developed the idea of travel agency in 1841. He arranged a railway trip for 570 members of his society. He reserved the railway sales and sold them. This reservation and selling gave him a new idea that "travel service can be sold, people are ready to pay for services; travel service can be a product, it can be produced and sold and business can be run". He learned that packaging of travel services should be a profitable business. Encouraged by the success of his venture Thomas Cook arranged similar ventures by chartering trains. Thomas Cook set up an office to arrange many more excursion trips on a fully commercial basis which is known as travel agency.

General Functions of Travel Agency:

As being commission agents, travel agencies perform unlimited varieties of work. With the introduction of new concepts of travel and tour, the function of modern travel agencies have widened. A travel agency carries two types of activities: 1. as a middleman 2. as an organizer. The most important function of a travel agency are given below:

1. Providing travel Information

A travel agent needs to provide necessary travel information to the general public. The interested tourists come to the office of the travel agent and ask all the information related to their proposed visit. Information, sought includes unlimited range of "here and there", including do's and don'ts of the destination.

2 Preparation of Promotional Material

A travel agency can prepare promotional materials to motivate the potential travellers.

3. Developing New Ideas and Destination

A travel agency must work constantly to find out new ideas, new destinations and do the calculation of the cost. He must try to find out best destination and quality in the best price.

4. Reservation and Confirmation of the Services

The travel agencies, on behalf of its customer, reserve and confirm the services from the service agencies, such as booking of air, rail, hotel, etc. It provides the guarantee of the service to the customer and security to the service agencies.

5. Providing services:

Provide services as per customer's requirement, such as sightseeing, transfer, money change, insurance, etc.

6. Agreement and Negotiation of price

To provide the facility to the customer and to facilitate the service agency it does the agreement and fix the price.

7. Money Transfer:

Many travel agencies provide the service of money transfer. The service of travellers cheque, credit card, Union Money Transfer, etc are handled by travel agencies. Similarly when a customer buys a tour he does not require to carry heavy amount with him and it will help a tourist to enjoy the tour. At the same time it is also very safe to the service agency to have the guaranteed sale of the product.

CHAPTER 2

BACKGROUND ON TB AND HIV/AIDS

TB and HIV/AIDS are recognised as a major development problem in many parts of the world and the SAARC region is no exception. As national governments and international donors seek to address its challenges the importance of coordination at the regional level has been highlighted. The countries of South Asia have been linked by age old cultural, social and historical traditions and that these have enriched the interaction of ideas, values, cultures and philosophies among the people and the states that these commonalities constitute solid foundations for regional cooperation for addressing more effectively the economic and social needs of people. The size of the region, its diversity, the multitude of social and economic forces at work, in SAARC presents both opportunities and challenges to a regional approach.

SAARC Member States have their own National TB and National HIV and AIDS programmes in place with National strategies. They have different needs with a variety of interventions to address the epidemics.

2.1. EFFORTS OF SAARC TUBERCULOSIS AND HIV/AIDS CENTRE (STC)

2.1.1. SAARC Regional Strategy for TB/HIV Co-infection

The STC has developed the SAARC Regional Strategy for TB/HIV Co-infection under SAARC-Canada Regional TB and HIV/AIDS Project, which was approved during the Twelfth SAARC Summit for implementation in the Member States.

2.1.2. SAARC Regional Strategy for HIV/AIDS

The Joint SAARC-UNAIDS Regional Expert Group Meeting held in Dhaka from 4-6 April, 2005 developed draft SAARC Regional Strategies for HIV/AIDS and Thirty-first session of the Standing Committee during the 12th SAARC Summit approved it for implementation in the Member States.

2.1.3. Human Resource Development

To train the TB and HIV/AIDS Programme Managers and different level of health workers of the Region, the STC has been organizing different levels of Training Programmes on different aspects according to the requirement of Region on the recommendation of the Governing Boards, since 1994.

2.1.4. Policy, Strategy related Meetings, Workshops and Seminars

With the approval of the Standing Committees, the numbers of SAARC Seminars, Meetings, and Workshops related to the Tuberculosis, HIV/AIDS and Laboratory have been conducted. These forums suggested the useful recommendations for the benefit of the region.

2.1.5. Links with regional/international organizations in the field of TB and HIV/AIDS

The STC has been established its networking with regional and international organizations in the field of Tuberculosis and HIV/AIDS to achieve its objectives. The Centre is collaborating with the following organizations in the region and out of the region.

1. National TB Control Programme of the SAARC Region
2. National HIV/AIDS Programme of the SAARC Region
3. National TB Reference Laboratories of the SAARC Region
4. Technical collaboration with WHO/SEARO, New Delhi
5. Collaboration with UNAIDS
6. Technical Collaboration with IUATLD
7. Linkage with Experts (TB & HIV/AIDS) in the SAARC Region.

2.1.6. Research Activities

The numbers of research activities have been conducted by the STC in Member States. The findings of the researches are guiding to policy makers and concerned authority to take further necessary actions for controlling and prevention of TB and HIV/AIDS effectively. The finding of the research on TB and HIV/AIDS Co-infection conducted by STC in 2003 indicated a need of SAARC Regional Strategy on TB and HIV/AIDS Co-infection and developed the same in 2004.

Research Activities conducted by STC are:

1. First Round External Proficiency Testing of Smear Microscopy in National TB Reference Laboratories in SAARC Region - 2003
2. TB/HIV co-epidemic in the SAARC Region
3. Gender Differences among TB Patients in National TB Control Programmes within SAARC Countries-2004 (under the SAARC-Canada Regional TB & HIV/AIDS Project)
4. Multi-Drug Study of Primary Drug Resistance-2004
5. Second Round External Proficiency Testing of Smear Microscopy in National TB Reference Laboratories in SAARC Region-2004
6. Community based study to identify barriers in seeking health care in Tuberculosis Control Programme -2004
7. Third Round External Proficiency Testing of Smear Microscopy in National TB Reference Laboratories in SAARC Region - 2005
8. Barriers in seeking health care in TB control programme, an Institutional Based Pilot Study - 2005
9. Quality Assurance of Sputum Smear Microscopy in Private Laboratories-2005
10. Prevalence of HIV among Diagnosed TB Patients -2005 & 2006 in Nepal and Pakistan
11. Gender Disparity among TB suspects & new TB patients: a record based retrospective study

CHAPTER 3

TUBERCULOSIS BURDEN WITHIN SAARC REGION

Tuberculosis is one of the major public health problems in the SAARC region with immense socio-economic impacts. Almost 50% the adult population of this region has already been infected with *Mycobacterium tuberculosis* and is at risk of developing tuberculosis disease. In the year 2006, a total 1.7 million people all types TB disease were notified, of which about 0.7 million were smear positive and capable to spread the disease to others.

According to this estimate, SAARC region was bearing 30.3% of the total global new TB cases (with 23% of population share). India, Bangladesh, Pakistan and Afghanistan are occupying the 1st, 5th, 6th and 22nd position in the list of 22 high burden nations.

More than 75% of cases occur among 15-54 years age group, economically the most productive age group.

The following statistics indicates the situations and progress in the control and prevention of Tuberculosis and HIV/AIDS in the SAARC Region.

Table No. 1.: DOTS Population Coverage (%); SAARC Countries:

Countries	2001	2002	2003	2004	2005	2006
Afghanistan	-	-	-	-	81	NA
Bangladesh	95	95	99	99	99	99
Bhutan	100	100	100	90	90	100
India	45	52	67	84	84	100
Maldives	100	100	100	100	100	100
Nepal	84	89	94	100	100	100
Pakistan	24	45	63	79	79	100
Sri-Lanka	64	73	74	88	88	98
Regional	49	57	71	84	90	99

Table No. 2 : Treatment Success Rates, (%) DOTS Area, SAARC Region:

Countries	2001	2002	2003	2004	2005
Afghanistan	-	-	-	89	NA
Bangladesh	84	84	85	90	91
Bhutan	93	86	89	83	87
India	85	87	86	86	86
Maldives	97	95	91	91	85
Nepal	86	87	88	88	88
Pakistan	78	79	82	84	87
Sri-Lanka	80	81	81	85	86
Regional	86	85	85	87	87

Source: NTP, Country report except for Afghanistan, WHO-Global TB report 2007, Tuberculosis in SAARC region - An Update 2006

Table No. 3: Case Detection Rate (%) of New SS+ Cases, SAARC Region:

Countries	2001	2002	2003	2004	2005	2006
Afghanistan	-	-	-	-	44	NA
Bangladesh	28	33	33	44	59	71
Bhutan	26	31	32	73	73	74
India	47	50	54	60	61	66
Maldives	88	92	92	92	94	82
Nepal	69	70	71	71	70	64
Pakistan	7	13	18	25	38	51
Sri-Lanka	86	93	83	77	86	86
Regional	50	54	54	63	65	65

Source: NTP, Country report except for Afghanistan, WHO-Global TB report 2007, Tuberculosis in SAARC region - An Update 2006

Table No. 4: Case detection Rates of TB (2006) and treatment outcome (2005)
SAARC Region:

Country	Population	Case Detection Rate of New SS+cases (2006)	Treatment Outcome (2005)	
			Cure rate (%)	Treatment Success
Afghanistan	29,863,000	44.0	79.0	89.0
Bangladesh	140,701,449	71.0	90.6	91.5
Bhutan	672,425	74.1	80.4	87.4
India	1,114,200,000	66.0	83.0	86.0
Maldives	298,968	82.5	84.8	85.7
Nepal	25,665,984	64.2	86.8	88.0
Pakistan	161,164,000	51.0	74.0	87.0
Sri Lanka	20,473,000	86.2	79.2	86.3
Total	1,489,878,826	65.2	82.2	87.6

CHAPTER 4

HIV/AIDS IN THE SAARC REGION

All the SAARC countries are reporting cases of HIV, AIDS and the epidemic is spreading rapidly in most of the countries. India has the single largest proportion of HIV positive cases within its border. According to the available statistical information it is estimated that 2.6 million HIV infected people are living within the region second highest after Sub Saharan Africa.

The danger for SAARC region rests in the low 'general population' prevalence rates, which may be undermining the gravity of the situation. Such low rates conceal dangerously elevated 'concentrated' infection rates within high-risk groups such as CSW, MSM, IDU etc. The fact is that despite the low prevalence rates within this region, the factors are in place to spread HIV epidemic farther and faster than in any other region globally.

The existence of high-risk group behaviours, migrant workers, truckers, mobile populations in search of sexual pleasure, drugs, commerce, the unequal status of women, the lack of population awareness of 'basic' risks and prevention strategies, the trafficking of women and young girls within the sex trade, the high rates of STIs etc., all make for an explosion of HIV epidemic within the region.

CHAPTER 5

TB & HIV/AIDS Co-infection

The interaction of TB & HIV has implications for the public health approach to TB control amongst HIV infected people. Untreated HIV infection leads to progressive immune-deficiency and increased susceptibility to infections including TB. TB in high prevalence populations is a leading cause of mortality and morbidity, and HIV is driving the TB epidemic in many countries.

TB & HIV programmes therefore share mutual concerns: prevention of HIV should be a priority for TB control; TB care and prevention should be priority concerns of HIV/AIDS programmes. The public health approach to decreasing the burden of TB/HIV requires more effective delivery of available interventions by health service providers, with increased population coverage. Whereas previously HIV/AIDS programmes and TB programmes have largely pursued separate courses, they need to exploit synergies in supporting health service providers to deliver these. The following figure indicates the seriousness about these diseases:

Table No. 7: TB/HIV Co-infection in SAARC Region - 2005

Countries	Prevalence of HIV among new adult TB Cases
Afghanistan	<0.05
Bangladesh	0.1
Bhutan	0.2
India	5.2
Maldives	-
Nepal	2.4
Pakistan	0.6
Sri-Lanka	0.2

CHAPTER 6

FACTS & FIGURES ON TB, HIV/AIDS and TB/HIV Co-infection

6.1 Tuberculosis

- TB is caused by bacteria
- TB spreads by air
- TB is curable
- TB kills more youth and adults than other curable infectious disease.
- TB is a contagious disease but only people that are sick with pulmonary tuberculosis are infectious.
- Like the common colds, TB spreads through the air when infectious people cough, spit, talk or sneeze.
- Left untreated, a person with active TB can infect between 10 and 15 people every year.
- TB usually kills a person by gradually making holes in the lungs.
- Poverty increases the risk of tuberculosis; impoverishes its victims.
- 75% of victims are aged between 15-49 and are in the most economically productive years of their lives.
- DOTS restore health to young people who are in their most economically productive years.
- More than 90% of TB cases and deaths occur in low and middle-income countries.
- TB carries a direct cost to the health services (diagnosis, treatment and control)
- TB carries an indirect cost to the society, family and community.
- TB is the leading cause of death among people who are HIV positive.
- Someone who is HIV positive and infected with TB is 30 times more likely to become sick with TB than someone who is HIV negative.
- TB can be readily and inexpensively cured with DOTS.

- ❑ Every infectious patient cured reduced the risk to everyone of contracting TB.
- ❑ DOTS prevents new infections and the development of MDR-TB.
- ❑ There is no cure affordable to developing countries for some multi drug-resistant TB.
- ❑ From a public health prospective, poorly supervised, incomplete treatment of TB is worse than no treatment at all.
- ❑ Drug-resistant TB is more difficult and more expensive to treat and more likely to be fatal in developing countries.
- ❑ TB is the biggest infectious killer of young women.
- ❑ Women of reproductive age are more susceptible to sickness once infected with TB than are men of the same age.
- ❑ Women in this age group are also at great risk from HIV infection.
- ❑ TB kills more women than any single cause of maternal mortality.
- ❑ In some parts of the world, the stigma attached to TB leads to isolation, abandonment and divorce of women.
- ❑ Around 8.8 million people develop active TB each year in the World.
- ❑ Around 1.6 million deaths occur due to TB in each year
- ❑ More than 30% of global burden of TB in the SAARC Region.
- ❑ 1.7 million All types of TB cases were notified in the year 2006 in the SAARC Region.
- ❑ Average 4.1% died from TB in the SAARC Region.

6.2. HIV/AIDS

- ❑ There is no treatment available in the world to cure AIDS.
- ❑ There is no vaccine available in the world to prevent HIV infection.
- ❑ HIV is the fastest growing serious health condition.
- ❑ The number of HIV infections per year is increasing rapidly.
- ❑ The number of AIDS related deaths per year is rising.
- ❑ There are about 40 million people in world having HIV infection or AIDS.

- ❑ People having HIV infection may show manifestation of AIDS only after 5-10 years.
- ❑ Even though the HIV infected individual seems healthy, he or she is capable of spreading HIV to others.
- ❑ People Living with HIV around 40.3 Million in the world.
- ❑ New Infectious (2005) around 4.9 million in the World.
- ❑ Deaths due to AIDS (2005) around 3.1 million in the world.
- ❑ Around 14 million people are co-infected with TB and HIV in the world.
- ❑ Estimated people Living with HIV is around 2.64 million in the Region.

6.3 TB/HIV Co-infection:

- ❑ HIV increases a person's susceptibility to infection with Mycobacterium tuberculosis.
- ❑ In a person infected with M. Tuberculosis, HIV is a potential cause of progression of tuberculosis infection to active diseases.
- ❑ An individual infected with HIV, has a 30-50 times increased risk of developing TB, than a person who is not infected with HIV.

SECTION - III

GUIDELINES

FOR

PARTNERSHIP PROGRAMME WITH

TRAVEL AGENCIES

FOR

CONTROL AND PREVENTION OF

TB AND HIV/AIDS.

CHAPTER 7

WHAT IS PARTNERSHIP?

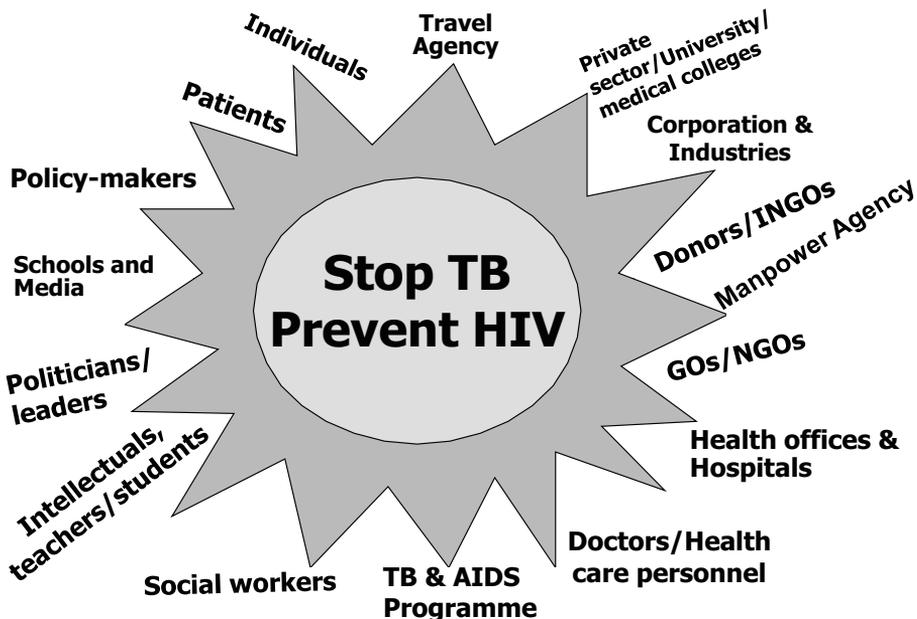
The Partnership is relation of two or more autonomous bodies for working, sharing each others experiences and support to achieve a common mutually beneficial vision. The Partnership may include shorter-term, Lung term and specific projects for desired goals of field.

CHAPTER 8

WHY PARTNERSHIP PROGRAMME FOR CONTROL AND PREVENTION OF TB AND HIV/AIDS

- ❑ TB and HIV/AIDS are the major public health problem of the SAARC Member States. The region bears about 30.3% of global burden of TB, and numbers of HIV infected people Living within the region is second highest after sub-Saharan Africa.
- ❑ Only Government Sector's efforts will not be able to solve the problem of diseases in the country.
- ❑ Coordination and partnership with Governmental Organizations and Non Governmental Organizations and other possible sectors are important to address the challenges of TB and HIV/AIDS in the country.

TB and HIV/AIDS Control Our Shared Responsibility



CHAPTER 9

WHY PARTNERSHIP WITH TRAVEL AGENCIES?

Tuberculosis still remains a serious health problem in South Asia. We can not afford to be complacent. If we continue with poorly functioning TB control programmes; we will be facing a serious problem of MDR TB and HIV/AIDS for TB Control.

In the same way, the HIV/AIDS epidemic is different from most other epidemics and diseases; there are many difficult factors prevalent in the World, which are the main hurdles for the governmental and non governmental organizations working for the control and prevention of HIV/AIDS. Those factors are extensive poverty & illiteracy, high mobility, low status of women, trafficking of women & girls into sex work, injecting drug users etc. Since most of the people in the community are unaware about the mode of transmission of HIV/AIDS, they are vulnerable towards HIV/AIDS.

The experience shows that it may not be possible to achieve desired success in increasing awareness without partnerships. Therefore, the STC has identified Travel Agencies as a potential sector to be involved in this mission along with other partners like school students, medical colleges, industry workers, private practitioners, pharmacists, manpower agencies.

Therefore, Travel Agencies can be regarded as a potential sector/group that could spread/propagate the messages on Tuberculosis and HIV/AIDS and its control & prevention among their client/groups, according to following nature of works;

- ❑ Deal with the clients belonging various sectors as travelers (politicians, bureaucrats, business men, intellectuals, social service providers, legal services providers, students, teachers, journalists, health care providers, engineers, Human rights etc.).
- ❑ To sort out the many travel options, tourists and business people often turn to travel agents, who assess their needs and help them make the best possible travel arrangements. Also, many major cruise lines, resorts, and specially travel groups use travel agents to promote travel packages to millions of people every year.

- ❑ To make people aware about major public health problems of TB and HIV/AIDS, how they are transmitted and also the messages precautions. They also can explain the importance of response towards TB and HIV/AIDS epidemic as window of opportunity is closing down. HIV/AIDS could be taken as a chronic manageable disease and preventable sexually transmitted disease because of availability of ART treatment other preventive methods.
- ❑ To prepare promotional material to motivate the potential travellers. They can prepare reading materials to give information incorporating the information on TB and HIV/AIDS. In this respect they may prepare, programme itineraries, brochures, fliers etc.
- ❑ In general, travel agents give advice on destinations and make arrangements for transportation, hotel accommodations, car rentals, tours, and recreation. They also may advise on weather conditions, restaurants, and tourist attractions. For international travel, agents also provide information on customs regulations, required papers and currency exchange rates.
- ❑ Travel agents consult a variety of published and computer-based sources for information on departure and arrival times, fares, and hotel ratings and accommodations. They may visit hotels, resorts, and restaurants to evaluate comfort, cleanliness and quality of food and service so that they can propose suitable recommendations to their clients.
- ❑ Travel agents spend most of their time behind a desk conferring with clients, completing paperwork, contacting airlines and hotels for travel arrangements, and promoting group tours.
- ❑ Travel agents are the leading distributors of travel products and services. Travel agents sell more than:
 - 87% of cruises
 - 81% of all tours and packages
 - 51% of all airline tickets
 - 47% of all hotels stay
 - 45% of all car rentals

- ❑ **Tourism Employment in India:** The people employed directly and indirectly by the tourism sector in India: almost 42 million (or 8.78% of total employment - Jan 07)
- ❑ **Tourism Employment in Maldives:** The Maldivian tourist economy employs about 5,000 immigrant workers.
- ❑ Apart from other relevant information regarding travel, the travel Industry can provide general information to travelers on TB and HIV/AIDS, preventive measures and ways and means to control the two killer diseases.

CHAPTER 10

SOME FACTS AND FIGURES ON TRAVEL AND TOURS

- ❑ According to the World Tourism Organization (UNWTO), of the 800 million international tourist arrivals in 2005, air transport represented 45% of arrivals and transport over water accounted for 7%. Travel by air and by sea expose passengers to a number of factors that may have an impact on health.
- ❑ Approximately 26% of the 800 million international journeys in the year 2005 were for visits to friends and relatives and for religious propose.
- ❑ According to the International Civil Aviation Organization, the annual number of air passengers reached 2 billion in 2005, and passenger traffic is projected to grow by about 6% a year over the period 2006-2008.
- ❑ The international migration rose from 120 millions in 1990 to 190 million in 2005. In many countries immigrants now constitute more than 20% of the population. Immigrants increasingly travel to their place of origin to visit friends and relatives.
- ❑ The International travel is undertaken by large and ever increasing numbers of people for professional, social, recreational and humanitarian. More people travel greater distances and at great speed than ever before and this upward trend looks set to continue.
- ❑ Air travel, in particular over long distances, exposes passengers to a number of factors that may have an effect on their health and well-being.
- ❑ Transmission of tuberculosis (TB) on board commercial aircraft during long distance flights was reported during the 1980s, but no case of active TB disease resulting from exposure on board has been identified subsequently.
- ❑ Nevertheless, increasing air travel and the emergence of multi-drug-resistant and extensively drug-resistant TB require continuing vigilance to avoid the spread of infection during air travel.

- ❑ The passenger shipping industry (cruise ships and ferries) has expanded considerably in recent decades. In 2005, 11.5 million passengers worldwide traveled on cruise ships. Cruise itineraries include all continents including areas that are not easily accessible by other means of travel.
- ❑ Travel Statistics as on October 19, 2006.

Region	Year		
	2005	2006	% Change
South Asia	3,270,445	3,824,144	16.9

Country/Destination	Period	Year		
		2005	2006	% Change
Bhutan	Jan-Jul	5,882	7,546	28.3
India	Jan-Aug	2,454,352	2,785,328	13.5
Maldives	Jan-Sep	263,467	434,987	65.1
Nepal	Jan-Sep	184,695	190,796	3.3

CHAPTER 11

OBJECTIVES OF PARTNERSHIP WITH TRAVEL AGENCIES

The Regional strategy/guideline for partnership programme with Travel Agencies will help to understand the situation of TB and HIV/AIDS at the National Level and Regional Level through the Travel agencies and make travelers aware through contact of Travel Agencies.

Specific objectives :

- ❑ To make aware the Travel Agencies of the country about the problem of the TB and HIV/AIDS through the National Programmes.
- ❑ To involve travel agencies and educate (advocate) through them, their clients, about the TB and HIV/AIDS.

CHAPTER 12

GUIDELINES FOR PARTNERSHIP PROGRAMME WITH TRAVEL AGENCIES

The Guideline may help to establish partnership with Travel Agencies to make them conscious along with their clients (domestics and international tourists) through awareness and advocacy on communicable diseases like TB and HIV/AIDS. Such Partnership can channel to make aware large numbers of population on TB and HIV/AIDS, who is involved in tourism sector directly & indirectly to save their lives along with their community/circle.

12.1. For NTP/HIV/AIDS Programme Managers to establish partnership

12.1.1. Plan the yearly list of activities for partnership Programme with Travel Agencies.

- ❑ Organize training to impart General information of TB and HIV/AIDS to enable them to convince their supporting staff, clients and other connected business organization.
- ❑ Organize interaction programmes, meetings etc.
- ❑ Organize awareness-raising and "infotainment" events.

12.1.2 Establish a contact list of participants/invitees of Travel Agencies Name, address, phone number, fax number etc.

12.1.3 Invite the Travel Agencies with agenda, background materials and planned activity. It will help them to discuss within their organizations. Highlight the achievements and problems of the programmes and level of desired support from them.

12.1.4 Identify the suitable place/venue, appropriate time/occasion/week to organize the orientation/training programme, and ***educate them on the subject of risk of following travel diseases and its precautions to enable them to convey the same to their clients;***

- ☞ **Risk for travelers on HIV/AIDS;** due to the lack of knowledge in relation to risk and preventive measures and the fact that travels and tourism enhance the probability of having sex with casual

partners increase the risk of exposure to sexually transmitted infections. In some developed countries, a large proportion of sexually transmitted infections now occur as result of unprotected sexual intercourse during international/domestic travel. In addition to transmission through sexual inter course, some of these infections can be passed from an infected mother to her unborn or newborn baby. Hepatitis B, HIV and syphilis are also transmitted through transfusion of contaminated blood or blood products and the use of contaminated needles.

Precautions

- ❑ A man should always use a condom during sexual intercourse, each time, from start to finish.
- ❑ A woman can also protect herself from sexually transmitted infections by using a female condom-essentially, a vaginal pouch-which is now commercially available in some countries.
- ❑ It is essential to avoid injecting drugs for non-medical purposes, and particularly to avoid any type needle-sharing to reduce the risk of acquiring hepatitis, HIV, syphilis and other infections from contaminated needles and blood.
- ❑ Medical injections using unsterilized equipment are also a possible source of infection. If an injection is essential, the traveler should try to ensure that the needle and syringe come from sterile package or have been sterilized properly by steam or boiling water.
- ☞ **Risk for travelers on Tuberculosis;** this airborne disease is transmitted from person to person by aerosol and droplets from the nose and mouth. Long term travellers, more than three months to a country with a higher incidence of Tuberculosis than their own may have a risk of infection comparable to that for local resident. As well as the duration of the visit, living conditions are important in determining the risk of infections.

Precautions

- Travelers should avoid close contact with known tuberculosis patients.
- Patients under treatment should not travel until treating physician has documented by laboratory examination of sputum, that the patient is not infectious and therefore of no risk to others.
- Travelers should get general check up done after returning from journey.

12.1.5 The NTP/NACP may utilize some special Occasions related to the tourism like World Tourism Day, Film Festivals, National/Regional/international Conferences on travel and tourism etc. in the country to involve and the people make aware more effectively for the support TB and HIV/AIDS Control Programme.

12.1.6 Get further commitment from the partners for the continued collaboration to educate to mobilize citizens on TB and HIV/AIDS, who go abroad for education and work and are away from their families for long periods of time. More information is needed on the risk behaviors that these citizens may engage in while they are away from the support of their families.

12.2 FOR TRAVEL AGENCY TO PARTICIPATE IN THE PARTNERSHIP PROGRAMME

12.2.1 Collection of General Information

Collection of the information on TB and HIV/AIDS through the interaction programme, meeting, interview, publication etc. about the :

- Symptoms and way of transmission of these diseases,
- Current situation of TB and HIV/AIDS in the World, SAARC Region, Country or any specific area/s of the country.
- Control and preventive policy and strategy of the country,
- Diagnosis and treatment facilities available in the community etc.

12.2.2 Ensure for the contribution

Ensure your commitment for partnership to support the programmes which can help to save the life of huge numbers of people from the Tuberculosis and HIV/AIDS through the awareness and advocacy within your organization, among the clients, interconnected business houses related to travel and tours.

- ❑ First gain the knowledge of TB & HIV/AIDS by collaborating with TB and HIV/AIDS Programme
- ❑ Consider the issues as matter of discussion, within their organization, among the staff members, for their information and them make aware about the situation of TB and HIV/AIDS in the society.
- ❑ Provide information on TB and HIV/AIDS with advice to take necessary precautions to their clients during the travel and stay in abroad. When traveling abroad, traveler can show their interest about information on the travel diseases and treatment during travel for safe travel.
- ❑ Convey traveler regarding risks of infectious diseases like TB and HIV/AIDS, preventative measures with information of treatment facilities available in the country or location.

12.2.3 How to make clients (travellers) aware?

➤ By conversation with client:

Depending on the travel destination, traveller may be exposed to a number of infectious diseases; like tuberculosis, HIV/AIDS, malaria, hepatitis etc. by the various factors, such as stay in remote rural areas, have close contact with local population etc. as well as behaviour of the travellers.

Travel Agents can make their clients aware that the HIV/AIDS is a hazard disease which is listed in top of the list in travel disease. TB also is a communicable and curable disease but it is also equal danger if treatment is not completed or inadequate treatment taken may cause MDR TB in the patients. Generally, precautions can greatly reduce the risk of exposure to infectious agents and should

always be taken by visitors to any destinations where there is significant risk of exposure of communicable diseases like;

❑ **Airborne diseases:**

Airborne diseases are transmitted from person to person by aerosol and droplets from the nose and mouth. The risk of infection can be reduced by avoiding close contact with people in crowded and enclosed places. The Tuberculosis is also airborne disease.

❑ **Sexually transmitted diseases:**

Sexually transmitted diseases are transmitted from person to person through unsafe sexual practices. The risk of infection can be reduced by avoiding casual and unprotected sexual intercourse and by use of condoms. The HIV/AIDS is also sexually transmitted diseases.

❑ **Bloodborne diseases:**

Bloodborne diseases are passed by direct contact with infected blood or other body fluids. The risk of infection can be reduced by avoiding unsafe blood and by avoiding the use of potentially contaminated needles and syringes for injection or any other medical or cosmetic procedure that penetrates the skin. The HIV/AIDS is also a bloodbone disease.

➔ **By providing reading materials to the clients:**

Demand the reading materials (pamphlet, newsletter, journals, statistical reports etc.) from Programme Managers of TB and HIV/AIDS Control Programme and provide these materials to the clients, for upgrading their knowledge by utilizing their waiting period who will visit travel agency to make their travel arrangement.

➔ **By informal discussion with clients:**

The travel agencies, specially ticketing/desk officers can take the issue as matter of discussion with their clients. They handle the persons belonging to different fields and professions. Starting with informal discussion general information on TB and HIV can be provided to the client.

Such informal discussions also help to draw their attention for necessary precautions and support the programmes through their own field for control and prevention of these diseases.

12.2.3.1 HIV/AIDS is not just a health problem:

HIV/AIDS are not just a health problem; it has grave social and economic consequences as well.

➤ Socio and Economic impact on HIV/AIDS:

- ❑ AIDS is primarily a sexually transmitted disease; it mainly strikes adolescents, young adults and those in early middle age, killing the very people on whom society relies for production and reproduction.
- ❑ AIDS kills people in the prime stage of life, people who labour in the field and factories, who run important services like schools, hospitals, corporations and governments.
- ❑ Growing absenteeism and replacements (usually by unskilled ones) due to death from AIDS among the workforce strike at the root of industrial productivity and profitability.
- ❑ Actually HIV/AIDS is an important issue for workplace and challenge for development.

➤ Affects economic growth and social Development in work place:

- ❑ Reduced supply of labour.
- ❑ Loss of skilled and experienced workers.
- ❑ Absenteeism and early retirement.
- ❑ Stigmatization and discrimination against workers with HIV.
- ❑ Increased labour costs for employees, from health insurance to retraining.
- ❑ Reduced productivity leading to negative impact on economic growth.

- ❑ Social protection systems and health services under pressure
- ❑ Loss of family income and household productivity, exacerbating poverty.
- ❑ Early entry of children into active employment.
- ❑ Pressure on girls and women to resort to providing sexual favours in order to survive.

➔ **Impact on households/families:**

Presence of HIV/AIDS will dissolve the family:

- ❑ As parents die children are sent to relatives for care and upbringing.
- ❑ Loss of Family income: affected person cannot earn. Other person also has to divert more time and effort away from income generating activities.
- ❑ Care related expenses and expense after death (funeral expense) push affected house deeper into poverty.
- ❑ Household suffer from food security.
- ❑ Children (especially the girls) are removed from schools because of inability to bear the expenses of education and also to take care of the affected parents.

CHAPTER 13

OUTCOME OF THE PARTNERSHIP PROGRAMME WITH TRAVEL AGENCIES

- ❑ The partnership programme with Travel Agencies will help to establish close collaboration between NTP/NACP, and Travel Agencies for control activities on TB and HIV/AIDS.
- ❑ The travel agencies are able to gain the general knowledge on symptoms and way of transmission of the diseases, current situation of TB and HIV/AIDS in the SAARC Region, country or any specific area/s of the country and diagnosis and treatment facilities in the community etc., this information will be more useful to update their information bank.
- ❑ The Travel Agencies will be able to inform their clients and other linked organization about the situation of TB and HIV/AIDS, diagnosis & treatment facilities and prevention & control efforts correctly.
- ❑ The Travel Agencies will be able to give advice on "Safe travel" to their clients.
- ❑ The Programme Managers will able to spread awareness to citizens, tourists and immigrant workers to keep them safe from HIV, TB and other STIs, while away from their homes, through the partnership with Travel Agencies,

SECTION - IV

GENERAL INFORMATION TO THE TRAVEL AGENCIES

ON

TUBERCULOSIS, HIV/AIDS

AND

TB/HIV CO-INFECTION

CHAPTER 14

GENERAL INFORMATION ON TB

14.1 What is Tuberculosis (TB)?

Tuberculosis is a communicable disease caused by an organism called Mycobacterium tuberculosis. This organism is also called as tubercle bacilli. Usually they affect the lungs.

14.2 How does TB spread?

When a person with pulmonary TB coughs, sneezes, laughs, or talks tubercle bacilli are spread into the air in tiny droplets. People who are in close contact can breathe in these droplets and become infected.

14.3 What is a case of TB?

A patient in whom TB has been bacteriologically confirmed or diagnosed by a clinician.

14.4 How many types of TB are there?

There are two types of TB (according to organ/parts of the body affected):

Pulmonary TB -

When tuberculosis occurs in the lungs then it is called as pulmonary TB.

Extra-Pulmonary TB -

If TB affects organs other than lungs, such as lymph nodes, bones and joints, genitourinary tract, meninges, pleura, intestines etc. it is called as Extra Pulmonary TB.

14.5 What are the symptoms of pulmonary TB?

Symptoms of pulmonary TB include:

- Cough more than two weeks.
- Chest pain.
- Prolonged low-grade fever, especially in the evening.
- Loss of weight.

- Loss of appetite.
- Blood stained sputum.
- Night sweat.

14.6 Who are vulnerable to TB?

Following individuals are at risk of contracting infection and developing the disease because of their exposure to a patient with TB.

- Family and close contacts of the patients
- The elderly
- People who inject illicit drugs
- People who live or work in certain setting, such as nursing homes, prisons, shelters for the homeless or TB treatment centres
- People with HIV infection
- People addicted to alcohol
- Malnourished people
- People with poorly controlled Diabetes
- People having chronic lung diseases
- Smokers
- People suffering from cancers

14.7 How is TB detected?

Pulmonary TB can be detected by sputum examination. At present, microscopic examination of sputum is the best method for diagnosis of pulmonary TB. Chest X-ray may help in diagnosis of TB of the lungs. The smear microscopy is better method of diagnosis than X-ray because it is simple, easy to perform; less expensive and more reliable. Microscopy services are provided by the National Programmes free of cost.

14.8 How TB disease is treated?

Tuberculosis is a curable disease and treated with the oral drugs, sometimes together with injections. TB drugs are available, free of cost in all government health facilities. The total duration of treatment is 6 to 8 months. Treatment should not be discontinued before completion of full course. If treatment is interrupted before completion of full course the drug resistance may develop which is dangerous to the patient as well as to the community. Drug resistant TB is difficult to treat and very expensive.

14.9 How one can help TB patients understand more about their disease?

Patients are more likely to successfully complete their treatment if they understand about their disease and treatment. Patients are often afraid when they learn of their diagnosis, because they harbor misbeliefs such as TB is an incurable disease. Reassure them and provide them with proper and relevant information. Talking to individual patients or patients in groups and distribution of pamphlets and brochures containing basic TB information, should help to improve the patients knowledge on TB.

14.10 What is DOTS?

DOTS stands for Directly Observed Treatment, Short-course, which is the strategy to control TB by giving drugs to patients under direct observation of health workers. DOTS has been found 100% effective to cure TB and to prevent multi-drug resistance. DOTS ensures cure of diagnosed TB patients. It can also prevent relapse and death.

14.11 What are the benefits of DOTS?

The benefits for patients themselves are the increasing treatment completion resulting in rapid cure. Furthermore, case management under DOTS strategy can prevent death, sequel & relapse. Moreover, DOTS can reduce community transmission of tubercle bacilli as well as emergence of drug resistance strains. DOTS can;

- Prolong life and improve its quality
- Stop the spread of TB
- Prevent emergence of multi-drug resistance TB
- Reverse the trend of multi-drug resistance TB

14.12 What is Drug Resistance?

Drug resistant bacilli are the Mycobacterium tuberculosis bacilli, which are resistant to anti-tuberculosis drug and Multi-Drug resistant (MDR) bacilli are the bacilli that are resistant to more than one anti-tuberculosis drugs, specially the two main drugs- Isoniazid and Rifampicin.

14.13 How is MDR TB produced?

As with other forms of drug resistance, the phenomenon of MDR tuberculosis is entirely man-made.

Drug resistant bacilli are the consequences of human error in any of the following:

- Prescription of chemotherapy
- Management of drug supply
- Case management
- Process of drug delivery to the patient
- Non completion of full course of treatment

14.14 Treatment of MDR TB

Treatment of patients with MDR tuberculosis may have to involve second-line (reserve) drugs. These are drugs other than the standard essential anti-TB drugs. These reserve drugs are much more expensive, less effective and have many more side effects than standard drugs. They should only be made available to a specialized unit and not in the free market. It is the responsibility of National Health authorities to establish strong pharmaceutical regulations to limit the use of second-line drugs in order to prevent the emergence of drug resistance tuberculosis.

14.15 DOTS Plus Treatment

The DOTS PLUS programme offers second line drug treatment to patients who have failed first line Drug re-treatment (CAT_2) or who have culture proven Multiple Drug Resistant Tuberculosis (MDR-TB),(with Drug sensitivity Testing (DST) showing resistance to at least Rifampicin and Isoniazid).

The ultimate goal of the DOTS PLUS is to reduce the mortality the morbidity and the transmission of tuberculosis from these CHRONIC patients. Therefore, the DOTS PLUS Programme needs to be the part of the National Tuberculosis Programme.

CHAPTER 15

GENERAL INFORMATION ON HIV/AIDS

15.1 What is HIV?

HIV stands for "Human Immunodeficiency Virus" which infects cells of the human immune system and impairs their function.

15.2 What is AIDS?

AIDS stands for 'Acquired Immune Deficiency Syndrome' and describes the collection of symptoms and infections associated with acquired deficiency of the immune system.

Infection with HIV has been established as the underlying cause of AIDS and it applies to the most advanced stage of HIV infection.

15.3 What are the symptoms of HIV infection?

Most people infected with HIV do not know that they have become infected, because no symptoms develop immediately after the initial infection. Some people have a glandular fever-like illness (with fever, rash, joint pains and enlarged lymph nodes), which can occur at the time of seroconversion. Seroconversion refers to the development of antibodies to HIV and usually takes place between 45 and 90 days after an infection has occurred.

The only way to determine whether HIV is present in a person's body is by doing an HIV test.

15.4 When does a person have AIDS?

After the initial asymptomatic period, the virus gradually becomes activated and breaks down the human body's natural defense mechanisms leaving it a prey to other opportunistic infections and other conditions including cancers that characterize AIDS.

15.5 How HIV is transmitted?

The main modes of HIV transmission are:

- Unprotected sexual intercourse (anal and vaginal) and oral sex;
- Contaminated blood and blood products, tissues and organs;
- Mother to child transmission (MTCT).

15.6 How HIV is not transmitted?

The following activities will not transmit the virus:

- Shaking hands, hugging or kissing;
- Coughing or sneezing;
- Sharing food, eating or drinking utensils;
- Visiting a hospital;
- Using common toilets or swimming pools;
- Getting bites of mosquitoes or other insects.
- Caring of AIDS patients also does not carry risk of HIV transmission.

15.7 HIV and AIDS can be PREVENTED

- By being mutually faithful to sex partner
- By using only HIV screened blood or blood products when required
- By using new Needles, Syringes, Blades, Razor
- By avoiding inject able drugs and needle sharing
- By using a condom (consistently and correctly) for safer sex
- By participating in PMTCT program for delivery of baby from HIV infected mother

15.8 How HIV is diagnosed?

HIV is diagnosed by clinical assessment and HIV testing. The usual HIV test is one that detects antibodies to HIV in the blood. Rarely, a single HIV test for an individual person may not be reliable. The usual recommendation in diagnosing HIV infection is therefore to perform two tests. Both should be positive for a diagnosis of HIV infection. When a person gets infected with HIV, the virus will start to attack his/her immune system.

15.9 Who are vulnerable to HIV?

Following Sub-Populations are at higher risk (PHR) of getting HIV infection of contracting infections and developing the disease because of their exposure to a patient with HIV.

- IDU
- Sex workers : street based and Non-street (institute) based

- Clients of sex workers
- Labor migrant / Transport workers
- MSM
- Partners of migrants / house wives
- Street children
- Uniform service

15.10 How HIV/AIDS is treated?

HIV positive individual needs ART only when he or she is symptomatic and/or there is evidence of significant immune system damage on clinical assessment.

Complete cure of HIV infection is not possible with presently available ARV drugs. Therefore, the aim of the treatment is to prolong and improve the quality of life by suppressing viral replication as long as possible.

The only regimens potent enough to reduce viral replication drastically and to prevent the emergence of resistance and treatment failure for a significant amount of time involve a combination of at least three antiretroviral drugs.

In co-infection with other diseases, treatment of Tuberculosis and other opportunistic infection may be more important than antiretroviral therapy.

CHAPTER 16

GENERAL INFORMATION OF TB/HIV CO-INFECTION

TB and HIV are closely interlinked. TB is a leading cause of HIV-related morbidity and mortality. HIV is the most important factor fuelling the TB epidemic in populations with a high HIV prevalence. Collaboration between TB and HIV/AIDS programmes is crucial in supporting general health services providers. These providers need support in delivering the full range of HIV and TB prevention and care interventions. To counteract the impact of HIV on TB, other interventions are required apart from effective TB case-finding and cure. These interventions include:

- ❑ Measures to decrease HIV transmission (e.g. promotion of condoms, treatment of sexually transmitted infections, voluntary counseling and HIV testing, safe intravenous drug use, reduction in the number of sexual partners, prevention of mother to child HIV transmission, HIV screening of blood for transfusion and application of universal HIV precautions by health care workers).
- ❑ Antiretroviral therapy (ART) (to improve or maintain immune function in people living with HIV infection).
- ❑ Care for people living with HIV infection (e.g. treatment of HIV-related diseases, prevention of HIV-related infections, TB prevention, palliative care and nutritional support).

16.1 HIV and TB-relation

HIV is the most potent risk factor for progression to active TB both in people with recently acquired infection and those with latent MTB infection. The annual risk of developing TB in HIV infected individuals co-infected with MTB is 5-10 %. Lifetime risk of development of active TB among co infected people (latent MTB and HIV) is 60% and among latent MTB infected individuals is 10%. HIV-positive TB patients also suffer increased morbidity from other HIV related diseases.

- ❑ Increasing TB cases among PLWHA augment the risk of TB transmission to the general community whether or not HIV infected.

- ❑ TB is the most common causes of HIV related illness and death. HIV not only increases the number of TB cases, but also alters the clinical course of TB disease.
- ❑ TB notifications have increased in population where both HIV infection and M. tuberculosis are common.

16.2 Impact of HIV/AIDS on TB control:

- ❑ Increased case load of active TB attributable to HIV.
- ❑ Increased HIV related morbidity and mortality in TB patients.
- ❑ Increased emergence of drug resistance.
- ❑ Higher default rates and lower cure rates.
- ❑ High rates of adverse drug reactions during TB treatment.
- ❑ Increased risk of TB transmission (including nosocomial transmission).
- ❑ Increased burden on TB services.

Delay of access to health services for TB suspects due to the stigma of HIV/AIDS.

16.3 Impact of TB on HIV:

- ❑ Increased case load of active TB among PLWHA
- ❑ TB may accelerate the progression of HIV-related immuno suppression
- ❑ Increased morbidity and mortality from TB among PLWHA
- ❑ Difficulties with diagnosing TB among PLWHA owing to the different clinical presentations of HIV related TB
- ❑ Increased burden on HIV services

For National data/information please contact your country

Programme Managers

National Tuberculosis Control Programme

National HIV/AIDS Control Programme

**For SAARC Regional Information on
TB and HIV/AIDS Please visit the Centre's**

Web site : www.saarctb.com.np

Or Contact;

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Published by:
SAARC Tuberculosis and HIV/AIDS Centre
Thimi, Bhaktapur.
G.P.O. Box No. 9517, Kathmandu, Nepal.