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Dr. Kashi Kant Jha, Director

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Dr. Lochana Shrestha, Epidemiologist

**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.

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Editorial

Appreciating the achievements and ongoing activities the 31st session of the Standing Committee of SAARC, held in Dhaka on November 9 – 10, 2005 approved renaming of the SAARC TB Centre, as SAARC TB & HIV/AIDS Centre. This Centre is working in coordination with NTPs and NACPs of Member States to achieve the Millennium Development Goals (MDGs) set for TB & HIV/AIDS.

After renaming SAARC-UNAIDS Expert Group Meeting was held to develop work plan for implementation of SAARC Regional Strategy on HIV/AIDS organized in Dhaka on April 22-23, 2006.

Following this work plan, the SAARC Secretariat in coordination with UNAIDS Regional Centre, Colombo had developed the proposal entitled “Scaling up the regional response to HIV and AIDS through South Asian Association for Regional Cooperation (SAARC)” addressing the urgent and emerging needs related to mobility and HIV in the region, which is the process to be submitted to GFATM, Round 6. STC had actively participated in regional technical review meeting, held to develop this proposal. Following the SAARC Regional TB/HIV co-infection strategy, STC has started to build up the coordination mechanism between TB & HIV programmes of Member States to initiate the TB/HIV collaborative activities in order to response the emerging formidable challenges in relation to TB/HIV.

The views expressed in this column “Special Articles and Technical Information” by named authors are solely the responsibility of those authors.
Report on Activities

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

1.1. Partnership Programme with Manpower Agencies


The objectives of the programme were:

- To make aware about situation of TB and HIV/AIDS through dissemination of updated information.

- To highlight the role of manpower agency in control and prevention of TB & HIV/AIDS.

- To seek cooperation & commitment in control and prevention of TB & HIV/AIDS.

- To make the manpower agencies to be a part of solution.

Opening Session

Dr. Nirakar Man Shrestha, Chief, Policy, Planning and International Cooperation Division, Ministry of Health and Population, Government of Nepal graced the programme as Chief Guest. Dr. Mahendra Bahadur Bista, Director General, Department of Health Services, Government of Nepal chaired the programme.

Dr. Kashi Kant Jha, Director, STC welcomed the chief guest, dignitaries and participants in the programme and highlighted the objective of the programme along with the introduction of the Centre. He briefed the “Situation of Tuberculosis and HIV/AIDS in the SAARC Region and Role of Manpower Agencies in Control of TB and HIV/AIDS”.

Mr. Nirmal Gurung, President, Nepal Association of Foreign Employment Agency gave remarks. He thanked STC for organizing first time thin activity particularly for them. He requested STC to expand awareness programme widely among them in future, because TB and HIV/AIDS is very prevalent in the society and awareness on TB and HIV/AIDS is very vital to the people who work in foreign employment.

Dr. Nirakar Man Shrestha addressed the gathering as Chief Guest. He appealed the participants to have more consciousness about TB and HIV/AIDS when they engage in their duty out of their home country.

Dr. Mahendra Bahadur Bista addressed the participants as Chairman. He highlighted the government services available for TB and HIV/AIDS.

Dr. S. S. Mishra, Director, NCASC, Ministry of Health and Population, Government of Nepal talked about the services available for the HIV/AIDS.

Dr. Rano Mal Piryani, Deputy Director, STC delivered vote of thanks. Dr. Piryani thanked Dr. Nirakar Man Shrestha for his presence in the programme as Chief Guest. He also thanked Dr. Mahendra Bahadur Bista for accepting to chair the programme. He thanked Mr. Nirmal Gurung, President, Nepal Association of Foreign Employment Agency for his cooperation and coordination to organize this programme. Dr. Piryani
thanked all participants, guest and officials for their support to make the programme success.

Programme was attended by eighty-five participants/representatives from fifty manpower agencies of Kathmandu and Executive Committee Members of Nepal Association of Foreign Employment Agency, Kathmandu.

Technical Session

Dr. Mohammad Akhtar, WHO Medical Officer for NTP, Nepal explained about the “Global Situation of TB”.

Dr. P. Malla, Acting Director, National TB Centre, Nepal presented “Situation of TB in Nepal and Diagnosis & Treatment facilities in the country”.

Dr. Rano Mal Piryani, Deputy Director, STC presented “Symptoms, diagnosis and treatment of TB”


Discussion on the issues was held after the completion of the presentations. Participants raised different queries about TB and HIV/AIDS. They expressed their personal views on diagnosis of HIV, collecting blood sample at airport, need of strong partnership programme, need of medical examination before proceeding abroad for work etc. Dr. K. K. Jha, Dr. Rano Mal Piryani, Dr. Pushpa Malla and Dr. Md. M. Rahman highlighted the possible solutions on issues raised by participants.

At the end of the programme Dr. Rano Mal Piryani, Deputy Director, STC delivered vote of thanks. Dr. Piryani thanked representatives of Manpower Agencies for their active participation and keen interest for partnership programme. He thanked the dignitaries from MoH & P, Dept. of Health Services, HIV/AIDS Control Programme, Government of Nepal for their support and cooperation.

1.2. Commemoration of World TB Day 2006


This day is commemorated annually on 24th March to mark the day, when Dr. Robert Koch announced his discovery of TB bacillus in Berlin (March 24, 1882). This year the theme was selected “Actions for life towards a world free of tuberculosis”.

The day was commemorated in all over the SAARC Member States.

Activities

a) Display of Banner

Banners with different messages of awareness about TB and HIV/AIDS were displayed at prominent places of the city and surrounding of the Academy Hall where the joint function of the World TB Day 2006 was organized.

b) Publication of Messages

Both the National Daily – The Rising Nepal (English) and The Gorkhapatra (Nepali) published the messages given by Hon’ble Minister, MoH & P, Government of Nepal, His Excellency Mr. Chenkyab Dorji, Secretary General SAARC, Hon’ble Assistant Minister and Secretary of MoH & P, Government of Nepal, Dr. M. B. Bista, Director General, Dept. of Health Services, Nepal and Dr. Pushpa Mall, Director, NTC/NTP, Nepal.
c) Rally

School students & teachers, Nursing College students, Social Volunteers, Health Workers, Local Leaders, Artists, Sport Personnel, Development Partners, Government Officials, National and International Dignitaries, NTC/NTP staff, STC staff participated in the rally. Sun-hats with message were distributed to all participants passerby during the rally. The rally was decorated with banners, placards, TB songs, Traditional parade etc. People gathered at Basantapur, Durbar Square where rally was inaugurated by Minister for Health and preceded towards the Academy to join the joint function. Candles were lighted in the memories of dead TB patients.

d) Joint Function

A joint function was organized at Academy Hall, Kamaladi to commemorate the Day on March 24, 2006 at 2 O’clock. Hon’ble Minister for Health and Population graced the programme as the Chief Guest. Hon’ble Assistant Minister for Health and Population graced the programme as a Guest.

Mr. Ramchandra Man Shigh, Secretary, Ministry of Health and Population chaired the programme.

Dr. Mahendra Bahadur Bista, Director General, Department of Health Services, Nepal, Dr. Kashi Kant Jha, Director, STC, Dr. Pushpa Malla, Director, NTC/NTP, Nepal, Mr. Mohamed Naseer, Director, SAARC Secretariat, Kathmandu, Dr. Kan Tun, WR Nepal, Hon’ble Prof. Dr. Bijaya Shrestha, Member, National Planning Commission, Nepal, Mr. Devendra Bahadur Pradhan, President, Nepal Anti-TB Association and Mr. Deep Raj Gurung, President, Dixa Daxa Award Trust, Nepal were on the dais along with the Chief Guest, Guest and Chairman of the programme.

Programme was started with distribution of the badges and sun-hat to the Chief Guest and dignitaries on the dais.

Dr. M. B. Bista, DG, Dept. of Health Services, delivered the welcome speech.

The Chief Guest inaugurated the programme by lighting the traditional oil lamp (Panas). He also started DOTS Plus Pilot Project by administering the anti-TB drugs to MDR TB patients. The Chief Guest also released the publications of SAARC TB and HIV/AIDS Centre and National TB Centre.

The first presentation was from Dr. Pushpa Malla, Director, NTC/NTP. She presented status and achievement of National TB Control Programme in Nepal.

After presentation from NTP Director, awards were distributed by Chief Guest and Guest to different personnel for their remarkable contributions in the field of TB control.

Remarks were given by WR, Nepal, President, NATA, Director, SAARC Secretariat, Member, National Planning Commission, Hon’ble Minister and Assistant Minister of Health and Population, Nepal, Secretary of Health and Population.

At the end of the programme Dr. Kashi Kant Jha, Director, STC offered vote of thanks.

e) Exhibition
The Chief Guest of the programme inaugurated the exhibition on TB control activities. The exhibition was arranged by National TB Centre and SAARC TB & HIV/AIDS Centre supported by the NGOs and INGOs working for control of TB in Nepal at different level.

In the exhibition STC displayed the photographic presentations of the different activities done in control of TB and HIV/AIDS in the SAARC Member States and information related with awareness. Dr. Kashi Kant Jha, Director explained the information displayed in STC exhibition to the Chief Guest, Guest and general visitors. The exhibition was highly appreciated.

1.3. Partnership with Pharmacists in Bhutan

The SAARC Tuberculosis and HIV/AIDS Centre organized a partnership programme with pharmacists in collaboration with Ministry of Health, Royal Government of Bhutan in Thimphu on June 24, 2006. The objective of the programme was to enhance the public awareness on TB and HIV/AIDS and its prevention and control.

The programme was also organized with a view to disseminate update information on TB and HIV/AIDS and their control programmes to the pharmacists. In other approach, the programme was organized to strengthen cooperation and commitment from the pharmacists in prevention and control of HIV/AIDS through awareness building and encouraging healthy life style practice by improving case detection through early referring of TB suspects, cooperation and supervision in case holding management.

Dr. Ugyen Dophu, Medical Director, JDWNRH, Thimphu chaired the programme and declared the session open.

Dr. Lungten Z Wanchuk, NTP Manager, Bhutan delivered welcome address and explained the STC activities organized jointly in collaboration with NTP, Bhutan. She also presented “Situation of TB in Bhutan & Diagnostic & Treatment Policies of NTP, Bhutan” and “Involvement of Pharmacists in Bhutan”. Her presentation was focused on the following messages:

- Pharmacists are partners
- No sale of Anti TB Drugs
- Help us and help TB patients

Dr. Kashi Kant Jha, Director, STC presented “Introduction of STC & Situation of TB & HIV/AIDS in SAARC Region”. He described the need of partnership programme with pharmacists in control & prevention of TB and HIV/AIDS.

Dr. Lochana Shrestha, Epidemiologist, STC presented “Impact of HIV/AIDS on TB Control and General Information about HIV & AIDS”.

Dr. Rano Mal Piryani, Consultant for HIV/AIDS & TB in STC presented “Role of Pharmacists in Control of TB & HIV/AIDS”. He informed the participant pharmacists that they are the first point of contact for seeking health care services in the community by the patients.

After the presentations, discussion session was held. In the discussion many relevant issues were discussed. In this context, NTP Manager, Bhutan replied the queries.

Around 50 pharmacists, both from public and private sector from all over the Bhutan attended the program with great enthusiasm as being the first of its kind.

The participants urged the following matters to the organizers:

- Awareness programmes for pharmacist needs to be organized in Region.
- List of TB service facilities should be made available to pharmacists to refer TB suspects.
- IEC materials for TB & HIV/AIDS may be provided to them for display and distribution.
- Certificate to participants needs to be provided.

Dr. Ugyen Dophu, Chairperson thanked the pharmacists for their presence in programme and their commitment for TB & HIV/AIDS control. He emphasized the pharmacists not to sell anti TB medicines. He thanked STC Director and his team for taking such an initiative in Bhutan.
Dr. Kashi Kant Jha, Director, STC delivered vote of thanks. He expressed gratitude to the Royal Government of Bhutan, Hon'ble Dr. Gado Tshering, Secretary for Health, Dr. Ugyen Dophu, Chairperson, Dr. Lungten, NTP Manager, participants, speakers, staff of NTP Bhutan and media people.

The programme was widely covered by the electronic and press media. Interview of Director, STC Dr. K. K. Jha and NTP Programme Manager Dr. Lungten were broadcasted on National Television.


The Second Meeting of the Group of Experts on finalization of a Work Plan for the SAARC Regional Strategy on HIV/AIDS was held in Dhaka on 22-23 April 2006. All Member States except Nepal participated in the Meeting. Representatives of UNAIDS, UNICEF, WHO, UNFPA, UNODC, UNIFEM, ADB and World Bank were also present at the meeting. The meeting was chaired by Prof. Dr. Md. Shahadat Hossain, Director General of Health Services.

Mr. A. K.M. Zafar Ullah Khan, Secretary, Ministry of Health and Family Welfare of Bangladesh inaugurated the Meeting. In inaugural address he expressed the commitment of the Government of Bangladesh to work with other SAARC Member States in preparing a regional response against HIV/AIDS.

Mr. Nazrul Islam, Director (SAARC), Ministry of Foreign Affairs, Bangladesh welcomed the Member State delegation to Dhaka.

Mr. Mohamed Naseer, Director, SAARC Secretariat recapitulated the initiatives taken by SAARC in dealing with the HIV/AIDS pandemic.

Dr. Mohammed Ali Bhuiyan, the representative of UNAIDS highlighted the enormous threat posed to development and economic growth of Member States by over growing HIV/AIDS epidemic and the urgent need for SAARC Member States to collaborate amongst one another to avert it.

Prof. Dr. Md. Shahadat Hossain, Director General of Health Services addressed the delegates as chairperson of the opening ceremony. He shed light on the process that led to the evolution of the SAARC Regional Strategy on HIV/AIDS. He also highlighted the measures taken by the Government in responding to the HIV/AIDS prevention.

Dr. Kashi Kant Jha, Director, SAARC TB and HIV/AIDS Centre, Kathmandu delivered Vote of Thanks on behalf of visiting Member States delegations. Dr. Jha thanked the Government of Bangladesh for organizing this meeting and Member States for their participation in it. He also thanked the UNAIDS and its co-sponsors for their continued support in developing the SAARC Regional Strategy on HIV/AIDS.

Mr. Mohamed Naseer, Director, SAARC Secretariat opened the discussion in the meeting. The meeting adopted the agenda and selected themes for discussion. Dr. Rano Mal Piryani, Consultant, SAARC TB and HIV/AIDS Centre highlighted the objectives of the meeting to facilitate focused discussions on agenda items. Meeting reviewed the Regional Strategy and the Implementation Plan and proposed a detailed Work Plan for 2006-2010 for the SAARC Regional Strategy on HIV/AIDS. The meeting recommended the venue for 3rd meeting. The recommended venue is either Maldives or SAARC Secretariat, Kathmandu in the first quarter of 2007.

At the end of the meeting Mr. Oscar Kerketta, the Leader of the Delegation of India proposed Vote of Thanks at the Closing Ceremony.

The Chairperson declared the meeting closed.
3. SAARC Regional Training of Trainers (ToT) on DOTS Plus in Nepal

STC organized Training of Trainers (ToT) on DOTS Plus in Kathmandu from 23 to 27 May 2006. The programme was organized jointly by National TB Centre, Ministry of Health and Population, Government of Nepal and SAARC TB and HIV/AIDS Centre with the objectives to strengthen the capacity of TB control workers in managing MDR TB, implementation and evaluation of DOTS Plus programme and be able to provide training to health care providers at their work place.

Opening Session

Dr. Nirakar Man Shrestha, Officiating Secretary for Health, Ministry of Health and Population, Nepal graced the opening session as Chief Guest.
Dr. Kashi Kant Jha, Director, STC welcomed the Chief Guest, guests and participants in the programme. Dr. Jha expressed gratitude to the Member States, SAARC Secretary General and Directors of SAARC Secretariat for their support, guidance and cooperation. Dr. Jha highlighted the situation and achievements of TB control programme in the SAARC Region since the implementation of DOTS strategy. He explained the problem of MDR TB in the Region and need of training to solve this problem.

The Chief Guest Dr. Nirakar Man Shrestha declared the training open and addressed the gathering. He emphasized on sustaining of DOTS strategy in TB control programme which minimize the chances of developing MDR TB. Dr. Shrestha appreciated the role played by STC and NTC in management of MDR TB in appropriate time.

Dr. Pushpa Malla, Director, NTC/NTP explained about the DOTS Plus project being implemented in Nepal. She thanked STC for organizing the training on DOTS Plus and giving opportunity to be a co-organizer of this training.

On behalf of the participants Dr. K. A. I. U. Imbulana, participant from Sri Lanka addressed the gathering. He appreciated the arrangements made for the training and thanked STC for organizing such an important training.

Dr. Rano Mal Piryani, Consultant, STC conducted the opening session.

Technical session:

Proceeding of the programme:

Chairperson: Dr. P. Malla
Co-chairperson: Dr. R. Pant

Technical session started with the introduction of the participants and facilitators. Dr. Lobzang Droji and Mr. Tashi Wangdi from Bhutan, Dr. Nirmal Shakya, Dr. Shyam Krishna Shrestha, Dr. Laila Lama and Dr. Ghan Shyam Jha, from Nepal, Dr. Abdulla Afeef, Ms. Aishath Zeenath, from Maldives and Dr. K. A. Indrajeeva U. Imbulana, and Dr. S. J. A. S. Silva from Sri Lanka participated in the training.

Dr. S. C. Verma, Director, RTC, Pokhara, Dr. Rajendra Pant, RHD, Central Region, Dr. B. P. Rijal, AP, TUTH, Kathmandu, Dr. N. R. Sharma, Bir Hospital, Kathmandu, Dr. S. S. Jha, MO, NTC, Mr. B. N. Gyawali, Stat. Officer, RHD, Eastern Region, Dhankuta, Mr. D. K. Khadka, Sr. Med. Tech. NTC, and Mr. S. L. Kandel, TB Coordinator, NTC facilitated the training.

Dr. Kashi Kant Jha, Director, STC and Dr. Pushpa Malla, Director, NTC/NTP managed the training as Course Director.
Dr. Rano Mal Piryani, Coordinated the programme and Mr. K. B. Karki, TO, and Mr. P. Bhandari, Comp. Tech. worked as co-coordinator of the training. The programme was also supported by Mr. K. B. Basnet, Adm. Officer, Mr. G. L. Joshi, Accountant, Ms. M. K. Dhakal, PA and Mr. H. K. Maharjan, Comp. Assistant.

**Methodology of Training**

Training was based on the module. In addition to module other important topics were also discussed. Following were the major components of the training.

- Module reading
- Interaction and discussion on the exercises
- Technical presentations
- Field visit
- Presentation of reports


Dr. Sarat Chandra Verma presented “Overview on Case Finding & Case Holding”. Mr. Shyam Kandel presented “Overview on Logistic Management for DOTS Plus”. Dr. Basista Prasad Rijal and Dr. D. K. Khadka presented “Overview on Role of Lab in DOTS Plus”.

Dr. N. R. Sharma and Dr. S. C. Verma, presented “Overview of Adverse Effects of Drugs used in treatment of MDR TB”. Mr. B. N. Gyawali presented “Overview on Recording & Reporting on DOTS Plus”.

Participants visited DOTS Plus Centre located at NTC and observed the clinical management for the treatment of MDR TB, recording and reporting procedures. The participants also visited different sections of NTC and STC and observed the functioning.

Participants visited DOTS Plus Reference Lab Centre at GENETUP and DOTS Plus Sub-centre at NATA and observed the lab and sub-centre. They discussed with the staff about functioning of the lab and clinic. Dr. Bhawana Shrestha, briefed the functioning of the lab and clinic. They also talked with the MDR TB patients.

Participants visited DOTS Plus Sub-centre at Nepal Medical College, Jorpati, Kathmandu and observed the centre. They discussed with staff and patients as well. Prof. Dr. Ramesh Chokhani, explained the functioning of the centre.

Presentation of Field Report was held on fifth day of the training under the chairpersonship of Dr. Pushpa Malla, Director, NTC/NTP, Nepal. Participants presented field reports and discussed on the matters observed during the visit to DOTS Plus Centre and Sub-centres.

The training was evaluated by distributing the questionnaire prepared by STC.

Closing session was held under the chairmanship of Dr. K. K. Jha at the second half of the last day. Dr. Tashi Wandi from Bhutan gave remarks on behalf of the participants. He appreciated the management of training and hospitality provided to them. He thanked STC and NTC for excellent organization of training. On behalf of the facilitators, Dr. Rajendra Pant expressed their happiness and satisfaction with the enthusiasm and interest shown by the participants during training. He thanked STC and NTC for providing opportunity to facilitate the program.

Host of Honour Dr. Pushpa Malla thanked the participants for their feedback which will be the guidance to NTC for updating the DOTS Plus Centre, Sub-centres and for reviewing the manual.

Dr. Kashi Kant Jha appreciated the passion of the participants in this training. He assured the participants that the feedback given by them will certainly be entertained to improve the modalities of programme to be organized in future. He expressed his satisfaction
that the training will certainly be beneficial to them & to the Member States.

Dr. Jha expressed gratitude to Secretary General, and Directors of SAARC for their guidance and support to organize the training. He thanked Government of Nepal, Ministry of Health & Population, Ministry of Foreign Affairs, Nepal participants and facilitators for their cooperation to complete the programme successfully. He thanked Dr. Malla, Director, NTC/NTP for active support and cooperation and staff of both the Centre for their help to make the training a grand success.

Certificates were distributed to the participants, facilitators & coordinators.

4. SAARC Regional Training of Trainers (ToT) on Quality Assurance (QA) in Sputum Microscopy in Bhutan

SAARC Regional ToT on QA in Sputum Microscopy was organized by SAARC TB and HIV/AIDS Centre in collaboration with National TB Control Programme, Ministry of Health, Royal Government of Bhutan in Paro from June 19 to 23, 2006. The objectives of the Training was to update the knowledge and strengthen skills of the participants on QA in sputum microscopy and to make participants proficient to impart training on QA on sputum microscopy to district level laboratory supervisors.

Opening Session

Dr. Gado Tshering, Secretary for Health, Ministry of Health, Royal Government of Bhutan graced the session as Chief Guest.

Dr. Lungten Z. Wangchuk, Programme Manager, NTP Bhutan delivered the welcome address. Dr. Wangchuk welcomed the delegates from SAARC Member States, Resource Person from WHO, Facilitators and STC officials & other dignitaries in the programme. She also highlighted about the ToT on QA which was organized jointly by STC and NTP Bhutan.
Dr. Rano Mal Piryani, Consultant for HIV/AIDS & TB highlighted the importance of this training.

Dr. N. Selvakumar, Resource Person from WHO (Dy. Director, TRC, Chennai) presented importance of QA in TB diagnosis.

Dr. Gado Tshering, Secretary for Health, MoH, Royal Government of Bhutan declared the training open. He informed the participants that health care is provided to all citizens free of cost in Bhutan. Dr. Tshering emphasized the development of human resource in QA in TB lab network and strengthening of overall quality of programme. He appreciated the role played by SAARC and STC in TB and HIV/AIDS programme and thanked Member States for giving opportunity to organize this training in Bhutan.

Dr. Tashi Choden form Paro District Hospital conducted the programme.

Technical Session

Dr. Ashwin S. Sanghvi from India chaired the session. Participants and facilitators introduced themselves.

Mr. Kinley Penjor, Medical Lab Tech., JDWNRH, Thimphu, Bhutan, Mr. Rixin Jamtsho, Medical Lab Tech., Regional Referral Hospital, Mongar, Bhutan, Mr. Sangay Wangchuk, Lab. Tech., Geleyphu Central Regional Referral Hospital, Bhutan, Ms. Thuji Wangmo, Medical Lab Tech., Public Health Lab., MoH, Thimphu, Bhutan, Mr. Sherub Tenzing, Medical Lab. Tech., District Hospital Paro, Bhutan, Mr. Dechen Zangmo, TB In-charge, District Hospital Paro, Bhutan, Dr. Ashwin S. Sanghiv, Director, State Training and Demonstration Centre, Civil Hospital, Ahmedabad, India, Dr. Farrukh Anwar, Pathologist, TB Reference Lab., Services, NWFP, City Hospital, Kohat, Peshawar, Pakistan and Dr. N. Selvakumar from WHO participated in the training as participants and resource facilitators.

Dr. N. Selvakumar, Dy Director & Head, Mycobacteriology Division, TRC, Chennai, India facilitated the training programme as Resource Person.

Dr. Kashi Kant Jha, Director, STC facilitated the training programme as Course Director.

Dr. Rano Mal Piryani presented “Objective and Methodology” of the training along with “Components & Functions of Laboratory Network in SAARC Region”.

Dr. Lungten, presented the “Overview on National TB Lab. Network under NTP Bhutan”.

Dr. Selvakumar, presented “Role of Bacteriology in Control of TB”.

Dr. Rano Mal Piryani from STC, Dr. Lungten Z. Wangchuk from Bhutan, Dr. Lochana Shrestha, Epidemiologist, STC, Mr. Dhruva Kumar Khadka, Sr. Medical Technologist, NTC facilitated the programme.

Field visit programme was organized to exhibit on the spot activities of QA of TB Laboratory. The team visited District Hospital, Paro Lab., Gidakom Hospital Lab., Public Health Lab., Thimphu (National TB Ref. Lab.) Participants and facilitators observed the laboratories and discussed with lab staff about QA. Field reports were also presented in this technical session.

Dr. Kashi Kant Jha, Director, STC presented "Introduction of STC and Situation of TB in SAARC Region".

Before completion, evaluation of the training was conducted by distributing the questionnaires.

Closing Session

Dr. Gado Tshering, Secretary for Health, Ministry of Health, Royal Government of Bhutan graced the session as Chief Guest.

Dr. Kashi Kant Jha, Director, STC addressed the gathering and highlighted the importance of collaborative efforts in control of TB and HIV/AIDS in the Region.

Dr. Rano Mal Piryani presented recommendations prepared by the participants and handed over copy of the report to Dr. Gado Tshering, Secretary, Ministry of
Health, Bhutan. As a Chief Guest, Dr. Tshering distributed Certificates along with Group Photos and CD contained training materials to the participants and facilitators.

In the session Dr. Selvakumar, Mr. Rixin and Dr. Gado Tshering gave the remarks in the session. Dr. Lungten offered vote of thanks.

Brief News

1. Briefing to the Ministers

Dr. Kashi Kant Jha, Director, Dr. Rano Mal Piryani Deputy Director and Dr. Md. M. Rahman met the State Minister of Health and Population, Government of Nepal on February 2, 2006 and briefed the achievements and activities of the Centre for control of TB and HIV/AIDS in the Region.

Similarly the Director STC briefed about the Centre to the Assistant Minister for Health and Population on February 10, 2006 and to the Secretary of Health and Population on February 13, 2006.

2. Participation in the Expert Grop Meeting

Dr. Kashi Kant Jha, Director, STC participated in the Expert Group Meeting for revision of salary and allowance of Regional Centre. Dr. Jha presented the recommendations and inputs on behalf of the SAARC Regional Centres in the meeting (STC, SIC, SAIC, SMRC, SDC, SCZMC and SHRDC) held at SAARC Secretariat, Kathmandu on March 17, 2006.

STC is supporting Member States to implement DOTS strategy to control TB in the Region. Dr. Iwamura Memorial Hospital and Research Centre (IMHRC), Sallaghari, Bhaktapur, Nepal invited STC to support in opening DOTS Centre in their Hospital. Dr. Kashi Kant Jha, Director, STC inaugurated DOTS centre at IMHRC on the occasion of World TB Day 2006 on March 21, 2006. Speaking as Chief Guest, Dr. Jha highlighted the activities of SAARC TB and HIV/AIDS Centre and support being provided to private sector in control of TB and HIV/AIDS. Dr. Jha appreciated the contribution of IMHRC in the field of TB and chest diseases in Nepal.

The programme was chaired by Me. Neel Krishna Tamrakar, MD. Dr. Pushpa Malla, Director, NTC/NTP, Nepal, Dr. N. G. Amatya, former Director, STC/NTC, CDO, Bhaktapur district, Mr. Raju Mrigendra Joshi, Director, IMHRC, Dr. J. P. Jaisawal, Medical Director, IMHRC also spoke on the various aspects of TB and the activities of the IMHRC.

3. Inauguration of DOTS Centre

STC is supporting Member States to implement DOTS strategy to control TB in the Region. Dr. Iwamura Memorial Hospital and Research Centre (IMHRC), Sallaghari, Bhaktapur, Nepal invited STC to support in opening DOTS Centre in their Hospital. Dr. Kashi Kant Jha, Director, STC inaugurated DOTS centre at IMHRC on the occasion of World TB Day 2006 on March 21, 2006. Speaking as Chief Guest, Dr. Jha highlighted the activities of SAARC TB and HIV/AIDS Centre and support being provided to private sector in control of TB and HIV/AIDS. Dr. Jha appreciated the contribution of IMHRC in the field of TB and chest diseases in Nepal.

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Inauguration of the DOTS centre was done by providing anti-TB drugs to a new SS positive TB patient.
4. Key Stakeholders’ Meeting on TB/HIV Programmes Collaboration

On the invitation of Health Research and Social Development Forum (HERD), Kathmandu, Dr. Kashi Kant Jha, Director and Dr. Rano Mal Piryani, Deputy Director from STC participated in meeting among key stakeholders' of TB and HIV programmes held at National TB Centre (NTC), Bhaktapur on May 9, 2006. The meeting was jointly chaired by the Directors of NTC and National Centre for AIDS/STD Control (NCASC). The objective of the meeting was to bring key stakeholders together to discuss on issues of TB/HIV collaboration.

The meeting agreed to form a National level Core-team comprising of 7-9 members. To develop ToR for this core-team a task group of four members from WHO, FHI, STC and HERD has been formed.

5. Facilitation in Training


Dr. Lochana Shrestha, Epidemiologist, STC also facilitated the orientation training on “Surveillance of HIV infection in patients with tuberculosis” organized by National TB Centre and WHO, Nepal on 5 June 2006.

6. Participation in Workshop

Dr. Lochana Shrestha, Epidemiologist, STC participated in “Workshop on National Paediatric ART Programme Micro Planning organized by UNICEF, Pulchowk, Nepal from 12 to 13 June 2006. There was a discussion about National Pediatric Guideline on ART and National Pediatric ART action Plan. Since she was a member of Task Group for development of this guideline from the beginning, she has provided the advice for the linkage with PMTCT interventions and adult ART centres. Under the National Paediatric action plan, concurrence achieved on capacity building with the development of training manuals, ToT training, procurement and distribution, monitoring and evaluation plan, strategies for strengthening linkages and partnerships with PMTCT and ART programme.


On the invitation from SAARC Secretariat, Director, Consultant and Epidemiologist from STC attended the Regional Technical Review Meeting convened by the SAARC Secretariat in participation with UNDP/RCC on June 28-29, 2006 at SAARC Secretariat auditorium, Kathmandu.

Following the endorsement of the SAARC Regional Strategy on HIV and AIDS (2006-2010) and the development of the work plan, the SAARC Secretariat in participation with UNDP Regional Centre in Colombo (RCC) had initiated efforts to prepare a regional proposal entitled “Scaling up the regional response to HIV and AIDS through South Asian Association for Regional Cooperation (SAARC)” with addressing the urgent and emerging needs related to mobility and HIV in the Region. This proposal was planned to submit to the 6th Round call by GFATM. This proposal planned SAARC as the Principal Recipient and UNDP, RCC as the Management Support and proposed to implement the activities in the participating countries through sub-recipients (SR).

At the meeting, representatives from National Tuberculosis and HIV/AIDS control programmes of SAARC countries and regional UN organizations like UNICEF, UNIFEM and UNFPA were invited. Representatives from Nepal, Bhutan, Maldives, Sri Lanka and UN organizations were present at the meeting.

Dr. Kashi Kant Jha, Director, STC presented “Status of TB, HIV/AIDS and TB/HIV co-infection in the SAARC Region” and “On going collaborative activities between TB and HIV/AIDS to address co-infection in the Region”.

8. Participation in Meeting

Dr. Lochana Shrestha, Epidemiologist, STC participated in preparatory meeting on TB/HIV collaborative guidelines on June 30, 2006 held at NCASC, Kathmandu. The objective of the meeting was to formulate guidelines for TB/HIV collaborative programmes. She also attended the meeting on Policy and Strategy Guidelines on TB/HIV organized by NCASC held at NHTC on July 23, 2006 with the objective to develop policy and strategy guidelines on TB/HIV collaborative activities.
Welcome News

Welcome to Hon’ble Mr. Amik Sherchan, Deputy Prime Minister & Minister for Health and Population, Government of Nepal

SAARC Tuberculosis and HIV/AIDS Centre family has the honor to welcome him and extends best wishes for his successful mission.

Appointment of new Epidemiologist

Dr. Lochana Shrestha, (Nepal)
M.B. B. S., M.D., M. I. P.H.

Dr. Shrestha joined SAARC TB and HIV/AIDS Centre as Epidemiologist on June 1, 2006. She has obtained her M. D. in Community Medicine from Kasturba Medical College, Manipal, India. She has done M.I.P.H. (Master in International Public Health) from the University of Sydney, Australia.

She started her career as a Medical Officer at Tribhun University, Teaching Hospital, Kathmandu. She worked as Physician at ADRA, Banepa, Lecturer at Manipal Medical College, Pokhara, Assistant Professor at Nepal Medical College Hospital, Kathmandu, Assistant Professor at National Open College, Kathmandu for Health Care Management Course, Programme Officer (Focal Person) for Care and Support, Monitoring, Evaluation & Surveillance, Research at National Centre for AIDS and STD Control, Kathmandu under GFATM. She has got memberships of different I/NGOs, NPHA, Rotary Club Swoyambhu & International AIDS Society..

STC staff welcomed her in STC family.

Visit of STC by

Miss Ashita Lohiya

Under the SAARC Internship Programme, Miss Ashita Lohiya, Second year, BA, LLB student of National Law School of India, University, Bangalore, visited STC on February 16, 2006. She observed the activities of the Centre and acquainted with problems of TB and HIV/AIDS in the Region and the efforts of the Member States to control these diseases in the Region.

Mr. & Mrs. Rajiv Chander, Director, SAARC

Director and Staff of SAARC TB and HIV/AIDS Centre welcomed Mr. & Mrs. Chander at STC on March 3, 2006. Mr. & Mrs. Chander were on observation visit to STC. They observed the functioning of the Centre and appreciated the
activities performed by the Centre in the field of TB and HIV/AIDS control for the benefit of the people of the Region. STC is grateful to Mr. & Mrs. Chander for their kind visit to STC.

Dr. Steven W. Honeyman, and Dr. Kokila Vaidya

Dr. Honeyman, Country Representative and Dr. Kokila Vaidya, Chief Technical Advisor. Population Services International, Nepal (PSI/Nepal) visited STC on May 17, 2006. Director and Staff of the Centre welcomed them. They observed the Centre and expressed their appreciation for the development of the Centre. Both of them expressed their views to be a partner in future for strengthening of regional initiative in the field of TB and HIV/AIDS. STC is very much thankful to them for their visit to STC.

Dr. David Mosca

Dr. David Mosca, from International Organization of Migration, Kenya, visited STC on June 8, 2006. Dr. Kashi Kant Jha, Director, STC and staff of the Centre welcomed Dr. Mosca and briefed about the SAARC TB and HIV/AIDS Centre.

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**Farewell News**

Dr. Christian Gunneberg, WHO MO for NTP Nepal

In honor of Dr. Gunneberg a farewell programme was organized at NTC on February 23, 2006. Dr. Gunneberg, WHO Medical Officer for NTP left Nepal after 4 years of his service in TB control in Nepal. He has worked as pioneer for DOTS in Nepal and visited most of the parts of the country. His contribution in urban TB programme is highly appreciated in Nepal. He has done lots of work in TB and HIV/AIDS as a good planner and quick decision makers.

Dr. Gunneberg's contribution in SAARC TB and HIV/AIDS Centre is highly appreciated. He has supported STC in different technical matters during his tenure. STC wishes him and his family a bright future and every success in their future life.

Dr. Md. M. Rahman, Epidemiologist, STC

Dr. Md. M. Rahman, Epidemiologist (Bangladesh) completed his tenure on March 21, 2006 at SAARC TB and HIV/AIDS Centre. He served the Centre for 4 years. He was appointed as Epidemiologist on 22 March 2002. A farewell programme was organized in honor of Dr. Rahman in STC on March 21, 2006.
Dr. P. Malla, Director, NTP/NTC Dr. Kashi Kant Jha, Director, STC awarded outgoing professional by letter of appreciation and souvenirs as Token-of-Love.

STC is very much thankful to Dr. Rahman for his contributions to the Centre and wishes him a great success in coming days. STC is very much grateful to Government of Bangladesh for sending such an energetic professional to STC.

We wish him and his family a bright & prosperous future.

In the same programme Dr. B. P. Rijal, Microbiologist, STC was also honored by letter of appreciation and souvenir. Dr. Rijal served the Centre for 3 years. He was appointed as Microbiologist on 8 March 2002. His tenure was completed on 7 March 2005.

Dr. Rano Mal Piryani, Deputy Director, completed his tenure on April 10, 2006. He served the Centre for 3 years. He was appointed as Deputy Director on 11 April 2003.

STC is very much thankful to Dr. Piryani for his contributions to the Centre. During his period many exemplary achievements have been done. We wish him a great success in coming days. STC is very much grateful to Government of Pakistan for sending such a proficient professional to STC.

We wish him and his family a bright & prosperous future.
In connection to HIV and AIDS, Nepal at present is in concentrated epidemic and verge of entering towards the generalized epidemic, since the number of women and children living with HIV/AIDS found to be increased year wise, according to reported cases to National Centre for AIDS and STD Control (NCASC).

In order to response this problem and to halt the new HIV/AIDS infections among the people in future, by decreasing the children born with HIV from HIV infected mother. Nepal Government had launched and implemented the “Comprehensive PMTCT services” in 3 different hospitals selected on the basis of recommended criteria with support from UNICEF since February 2005. The service package includes specific core interventions with focusing on HIV counseling and testing, provision of ARV drugs for mother at onset of labor and child after delivery. Before implementation training on PMTCT/VCT/HIV testing and logistic support with PMTCT (Prevention of Mother to Child Transmission) drugs/test kits was done with the development of training manuals, guidelines, and IEC materials on PMTCT in advance. In addition hospital staffs, stakeholders and community orientation on PMTCT was done.

After one year implementation, analysis of the information obtained through reported data monthly from the sites showed that HIV prevalence among pregnant women was 0.26% which was higher than the previous national figure i.e. 0.2%. 79.5% of the antenatal cases received pre test counseling and among them 84.3% entered for the HIV testing. Among the 25 positive pregnant women, 60% delivered and received the ARV drugs while the remaining was in antenatal stage.

In the second phase, Nepal government had implemented the comprehensive PMTCT service package in four other government hospitals at different corners of the country with the support from GFATM and UNICEF.

Sustainable logistic support, strengthening of monitoring and supervision, strong commitment of the staffs, development of efficient network/linkages with PLWHA group is the required areas to be strengthened.

HIV/AIDS in Women
(Feminization of HIV Epidemic)

Dr. Lochana Shrestha
Epidemiologist, STC

In the last decade, HIV infection has emerged as one of the most serious development challenges for the world. The epidemic remains extremely dynamic, growing and changing character as the virus exploits new opportunities for transmission. In just 25 years, HIV has spread relentlessly from a few widely scattered “hot spots” to virtually every country in the world. Current estimates suggest that at the end of 2005, 38.6 (33.4-46.0) million people around the world were living with HIV. An estimated 4.1 (3.4-6.2) million people acquired the HIV virus (infection) in 2005. The AIDS epidemic claimed 2.8 (2.4-3.3) million lives in 2005.

Coupled with the above growing numbers there is an increasing feminization of the epidemic, the increase in the proportion of women being affected by the epidemic continues. In 2005, 17.5 million [16.2–19.3 million] women were living with HIV—one million more than in 2003, while in 2000 they represented a much lower percentage of the total. Thirteen and a half million [12.5–15.1 million] of those women live in sub-Saharan Africa. The widening impact on women is apparent also in South and South-East Asia (where almost two million women now have HIV) and in Eastern Europe and Central Asia. HIV which is primarily transmitted sexually is spreading rapidly among reproductive aged women, who now represent 40 percent of all new HIV infections. (UNAIDS – an Update on HIV/AIDS, 2005).

The New survey data underscore the disproportionate impact of the AIDS epidemic on women, especially in sub-Saharan Africa where, on average, three women are HIV-infected for every two men. Among young people (15–24 years), that ratio widens considerably, to three young women for every young man get infection with HIV. Women in sub-Saharan Africa are infected more often a earlier in their lives than men.

In India, HIV prevalence of over 1% has been found in pregnant women in four of the industrialized western and southern states of India (specifically Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu,) and in the northeastern states of Manipur and Nagaland (NACO, 2004a). A significant proportion of new infections are occurring in women who are married and who have been infected by husbands who (either currently or in the past) frequented with sex workers.

In Nepal, currently, males account for 71 % of HIV/AIDS patients with the male: female ratio being 2.5:1. On year wise analysis of data on reported cases of male and female, it reflected to be increasing trend of infection among female along with male.

Vulnerability to HIV reflects an individual’s or community’s inability to control their risk of HIV infection. Poverty, gender inequality and displacement as a result of conflict or natural disasters are all examples of social and economic factors that can enhance people’s vulnerability to HIV infection. Risky behavior—often more than one form—continues to sustain serious AIDS epidemics in world. Women are compelled to involve in more than one risky behavior to earn a living in different circumstances. Accordingly they become the members of different high risk groups like sex workers, IDUS, migrants. In addition they are in risk as they are the partners of clients of sex workers, partners of infected IDUs, partners of infected migrants. Hence at the heart of many HIV/AIDS epidemics lie the women. The epidemic has also increased the burden of HIV and AIDS related care faced by women who are expected to provide care to family members. Those who are in risk behavior are originating from remote rural areas, are poorly educated and have little knowledge about HIV.

A number of factors place women at greater risk than men of contracting HIV/AIDS. Empirical evidence shows that men are four times more likely to transmit the virus to women than women are to men. Women are more likely than men to have asymptomatic, untreated STIs, which increases their susceptibility to HIV infection. Furthermore, women’s sex partners tend to be older than they are and thus more likely to be infected. Social norms that require female passivity and economic dependence on men as well as lack of legal empowerment make it difficult for women to insist on mutual fidelity or condom use. In addition, women may be exposed to HIV infection when they receive blood
transfusions to combat pregnancy-related anemia or hemorrhage.

**Gender inequalities that place the women in vulnerable to HIV:**

- Gender norms dictate that women and girls should be ignorant and passive about sex, which greatly constrains their inability to be informed about risk reduction and to negotiate condom use.
- Gender norms cast women as for reproductive and productive activities and man for economic actors and producers which place the women at passive role in all aspect.
- Gender role account for women having unequal access to and to control over the key productive resources such as education, income, land which influence their capacity to negotiate for safe sex and to cope with impact of disease.
- Women experience violence that contributes both directly and indirectly to their vulnerability.

Examples which show women are more vulnerable then men: in countries such as Malawi, Ethiopia, Tanzania, Zambia, and Zimbabwe, for every 15-19 year old boy who is infected, there are five or six girls infected in the same age group. In some societies, men seek out young girls whom they believe are virgins and free of HIV. Other studies have shown that some men believe that they can rid themselves of HIV by having sex with a virgin.

*Studies have shown that the interventions as below addressing to decrease the problem of HIV among women do work, such as:*

1. Education, STI treatment, and condoms targeted at commercial sex workers and truck drivers (Uganda, Democratic Republic of Congo and Kenya);
2. Social marketing of condoms (Brazil);
3. Systematic treatment of STIs (Tanzania); and
4. Voluntary testing and counseling (Rwanda).

Thailand has taken a multi-sectoral approach which has reduced the number of girls entering the sex industry, decreased brothel visits, and increased condom use, with dramatic impact on the rate of HIV infection. For example, since child prostitution is relatively high and HIV prevalence among sex workers is close to 30 percent, a national effort was initiated to eliminate entry into the sex industry by children under 18 years of age. Several projects are underway, including education and vocational training, which seem to have the best promise of reducing the number of girls entering the sex industry. This could be good example to implement the action in country context where the problem is there.

There should be women-controlled barrier methods for disease prevention and contraception which will be acceptable and comfortable to implement on their own. This will help to control the problem as a whole as now we are noticing that the problem is increasing among the women. Female condom is not accepted by many women in world and other research studies are underway to develop vaginal microbicides.

In order to achieve maximum Millennium Development Goals, gender inequality & empowering of women has to be focused with effective response to HIV/AIDS. Feminization of HIV epidemic, impacts at all aspect of human being with multiplying the infection.

**Information below indicates as presence of support for the prevalent feminization of HIV epidemic.**

<table>
<thead>
<tr>
<th>Percentage of youth aged 15-24 who correctly identify ways of preventing HIV transmission and who reject major misconceptions about HIV transmission**</th>
</tr>
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<tbody>
<tr>
<td>MALE: 33% (Country range: 7%-50% coverage), n_16</td>
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<table>
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<tr>
<th>Percentage of young males and females, aged 15-24, who are HIV infected***</th>
</tr>
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<tbody>
<tr>
<td>MALES: 1.4% (Measure of uncertainty: 1.1%-1.8%), (n_54)</td>
</tr>
<tr>
<td>FEMALES: 3.8% (Measure of uncertainty: 3.0%-4.7%),(n_54)</td>
</tr>
</tbody>
</table>

**Demographic and Health Survey/AIDS Indicator Survey, 2001-2005***

**UNAIDS/WHO 2005 Estimates for countries with generalized epidemics.**

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Migration, Mobility & HIV/AIDS

Dr. Rano Mal Piryani,
(Former Deputy Director)
SAARC TB & HIV/AIDS Centre
Kathmandu, Nepal.

Migration, mobility and HIV/AIDS are major global phenomenon. Since the beginning of HIV/AIDS epidemic, a concern of people at helm of affair has been that people moving between countries might be spreading HIV. Now it is recognized that migrants and mobile people are more vulnerable to HIV compared to those who do not move.

Movement of the people has been there since the dawn of human history. The phenomenon of hunting and gathering, nomadism and transhumance for seeking seasonal pasture are being as old as human social organization itself. These earliest forms of migration may have changed but the streams of migration are run perennially in every human society.

Migration and mobility has become indispensable feature of every modern society. The later half of twentieth century has witnessed major move of population both voluntary and involuntary across national and international contour, mostly due to a paradigm shift in socioeconomic and demographic setting in both developed, developing and under developed parts of the world. Migration and mobility are likely to continue to increase in years to come.

The agricultural development, industrialization and urbanization in developing countries have paved the way for more internal migration through out the countries. Since these developments have created more employment prospects at some places than other; the people far from across have rushed in to take opportunities to better their lives and livelihood.

International migration had more likely high chance of spreading HIV infection when the infection was in its early years, but at present when the incidence of infection is high, the internal migration also plays a important role in spreading out HIV infection even in the remotest part. The volume of internal infection is much larger than International migration.

There were an estimated 191 million migrants worldwide in 2005; women accounted for 49.6 per cent. Migrants comprise 3.0 per cent of the global population. There are roughly 30 to 40 million unauthorized migrants worldwide, comprising around 15 to 20 percent of the world's immigrant stock. 2-4 million people migrate permanently each year. A small but significant percentage of people who move across borders have been forced to seek refuge or asylum outside their country of origin. In 2005, the global number of refugees reached an estimated 8.4 million person. Hundreds of millions more people move within their countries each year; of these some 20-30 millions have been displaced because of wars, conflicts and human right abuse and others move in order to seek employment, to search for better living and working condition, or to join their family members.

Migration and mobility are not static phenomenon. Accordingly to International Organization for Migration they are best seen as a process with a stages comprising: source, transit, destination and return. Mobility itself is not a risk factor for HIV/AIDS; it is the situations that mobile people encountered and the behaviors possibly engaged during mobility and migration that increase vulnerability and risk. The most vulnerable mobile people are refugees, undocumented (without legal status) and women.

Migrants and mobile people may be highly marginalized while in transit, at destination, or on their return home. They may be subject to inequity,
discrimination, xenophobia, mistreatment, exploitation and harassment, and have little or no legal, communal or social protection. This increases vulnerability. They may have little or no access to HIV information, health services and means of prevention from HIV infection. This further increases vulnerability. They may avoid attention from authorities, even if that attention is meant to provide health services, or help to improve their conditions. Poverty and lack of resources are additional risk factors. Away from family and familial socio-cultural norms, monotony of daily work, a sense of social anonymity offering more sexual liberty and access to some disposable income force them to adopt risk behavior in the form of alcoholism and drug abuse and unprotected sex with persons with unknown sexual history making them more vulnerable to HIV infection.

Creating enabling environment for migrants and mobile population is important; several strategies are essential to establish such an environment. These are:: 1) Migrant and mobile friendly interventions, 2) Focusing on risk zones, destination communities & cross-border and regional responses, 3) Mobilizing communities of migrants and mobile people, 4) Increasing access to treatment, care and support, 5) Improving laws and regulations, 6) Including migrants and mobile people in strategic planning and 7) Supporting action-oriented operational research

References


(The writer can be reached at r_piryani@yahoo.com)
Abstracts

1. Multi-drug-resistant tuberculosis without HIV infection: success of individual therapy

E. Escudero, J.M. Pena, R. Alvarez-Sala, J.J. Vazquez, A. Ortega

Int J Tuberc Lung Dis 10(4):409-414
2006 The Union

Objective: To evaluate the results of the treatment of non-HIV-infected multi-drug-resistant tuberculosis (MDR-TB) patients admitted to a tuberculosis unit in a reference centre between June 1998 and December 2000.

Results: Twenty-five patients were studied (23 men). Empirical treatment was selected according to drug previously used an adjusted according to in vitro test results. Patients had previously received an average of 5.5 drugs and were resistant to an average of 4.7 drug. They were treated with a median number of four drugs (an injectable drug plus three oral drugs) for a median of 18 months. Ofloxacin and cycloserine was used in 17 cases (68%), ethionamide/prothionamide in 18 (72%) and para-amonosalicylic acid in 12 patients (48%). Psychological support and counseling was provided. Two patients required surgery. Globally, 21 patients (84%) met cure criteria. After a 24-month follow-up, non of the 21 patients who successfully completed treatment presented relapse or death.

Conclusion: MDR-TB is a curable disease in non-HIV-infected patients. Individualized treatment regimens should be based on treatment history and the study of in vitro susceptibility and by promoting a relationship with the patient that makes adherence t treatment easier and minimizes side effects.

2. Undetected burden of tuberculosis in a low-prevalence area

I. Baussano, M. Bugiani, D. Gregori, R. van Hest, A. Borraccino, R. Rosa, F. Merletti

Int J Tuberc Lung Dis 10(4):415-421
2006 The Union

Setting: Under-ascertainment and under-reporting of tuberculosis (TB) hampers surveillance and control. Case detection is improved by record linkage of case registers and under-reporting can be estimated by capture-recapture (CR) analysis.

Objectives: To assess the completeness of the TB registration systems and estimation of TB incidence and under-reporting in the Piedmont Region of Italy in 2001.

Methods: Record linkage of the ‘physician notification system’, the TB laboratory register and the hospital records register, and subsequent three-sample CR analysis.

Results: Record linkage identifies 657 TB cases; CR analysis estimated 47 (95% CI 31-71) unrecorded cases. Under-reporting of the ‘physician notification system’ was estimated at 21% (95% CI 20-23). The overall estimated TB incidence rate was 16.7 cases per 100,000 population (95% CI 16.3-17.3), varying according to the subset investigated: 12.7 for individuals from low TB prevalence countries and 214.1 for immigrants from high TB prevalence countries; 13.1 and 25.8 for persons aged < and ≥60 years, respectively; and 32.1 in Turin, the regional capital and 10.8 in the rest of the region.

Conclusions: When multiple recording systems are available, record linkage and CR analysis can be used to assess TB indigence and the completeness of different registers, contributing to a more accurate surveillance of local TB epidemiology.
3. Involvement of private practitioners in tuberculosis control in Ballabgarh, Northern India

A. Krishnan, S. K. Kapoor

Int J Tuberc Lung Dis 10(3):264-269
2006 The Union

Setting: The Revised National tuberculosis Control Programme (RNTCP) in India covered 70% of the population in 2003. However, the private sector, where a large proportion of tuberculosis (TB) patients are seen, does not have sufficient involvement in the programme.

Objective: To test the feasibility of involving private practitioners (PPs) in the RNTCP for identification and management of TB cases.

Design: PPs in Ballabgarh Block, Haryana, where identified and invited for training in RNTCP guidelines. They referred TB suspects for confirmation of diagnosis to nearby public facility. Patients could subsequently choose to return to their referring doctor or to the government facility. Patients and doctors were interviewed at the end of the project to assess their perceptions.

Results: Of 146 PPs, 72% were trained in RNTCP guidelines and 14 agreed to provide directly observed treatment (DOT). During the study period (May 2001-December 2003) 113 patients initiated treatment, leading to an incremental gain of 11.5% in case finding. The cure rate among the 113 sputum positive patients was 73%, and the default rate was 11.5%.

Conclusion: Involvement of private practitioners in TB control is possible and results in benefits for all stakeholders.

4. Evaluation of sputum-smear microscopy in the National Tuberculosis Control Programme in the north of Vietnam

N. T. Huong, B. D. Duong, N. N. Linh, L. N. Van, N. V. Co, J. F. Broekmans, F. G. Cobelens, M. W. Borgdorff

Int J Tuberc Lung Dis 10(3):277-282
2006 The Union

Objective: To assess the yield of sputum smear microscopy and sex differences in the National Tuberculosis Control Programme in the north of Vietnam.

Methods: Review of registers of 30 randomly selected laboratories (26 district, 4 provincial level).

Results: The average daily workload per technician was 4.4 examinations in district and 5.3 examinations in provincial laboratories. To find one smear-positive case, 9.7 suspects were examined and 29.3 smear done. The smear-positive rate (mean 10.3%) was higher among men (11.6%) than among women (8.4%, \( P < 0.001 \)). There were more men than women among tuberculosis (TB) suspects (male:female ratio 1.36, 95 % CI 1.19-1.54), but even more so among smear-positive patients (1.89, 95% CI 1.64-2.14), irrespective of specimen quality and number of smear examined. Three smear were examined for 18 055 suspects (61.7%). The incremental gain was 33.5% and 4.9% for the second and third smear examination, respectively; 186 (95% CI 160-221) smears needed to be examined to find one additional case of TB with a third serial examination.

Conclusion: The diagnostic process seemed generally efficient. The male:female ratios suggest higher TB incidence in men rather than lower access to TB facilities for women. The third smear examination could be omitted.

Tuberculosis drug resistance and treatment outcomes under DOTS settings in large cities in the Philippines

Int J Tuberc Lung Dis 10(3):283-289
2006 The Union

Setting: Two large cities in the Philippines.
Objectives: To describe the problems of drug-resistant tuberculosis (TB) in an urban setting, with special emphasis on their potential impact on the treatment services provided by the National TB Control Programme.

Design: Cross-sectional survey and cohort analysis of treatment outcomes.

Methods: All patients with positive sputum smear examination results in Cebu and Mandaue cities during the survey period were included. The survey procedures of the World Health Organization and the International Union Against Tuberculosis and Lung Disease were strictly applied. Treatment outcome data were also collected.

Results: Of 306 cases enrolled, 255 were new cases, 28 were previously treated and for 23 treatment history was unknown. Of the new cases, 72.2% were pan-susceptible to all four first-line anti-tuberculosis drugs. Resistance in new cases was 16.9% to isoniazid (INH), 4.7% to rifampicin (RMP), 3.1% to ethambutol, 18.0% to streptomycin, and 3.9% to at least both INH and RMP (multidrug-resistant [MDR]). Over 90% of the new cases, either pan-susceptible or mono-resistant, were successfully treated with the standard regimen, but four of nine MDR new cases could not be cured.

Conclusion: The drug resistance level was high in this population, but treatment outcome using the standard treatment regimen was not seriously affected unless the patients were MDR.

6. A community-based TB drug susceptibility study in Mimika District, Papua Province, Indonesia


Int J Tuberc Lung Dis 10(2):167-171
2006 The Union

Setting: A district level tuberculosis (TB) control programme in Papua Province, Indonesia.

Objective: To determine the nature and extent of drug-resistant TB in newly diagnosed sputum smear-positive patients.

Methods: Sputum was collected from previously untreated smear-positive pulmonary TB patients diagnosed in the district over a 10-month period. Sputum specimens were processed and inoculated into a BACTEC MGIT960 tube. Isolates were identified by Ziehl Neelsen staining, hybridization with nucleic acid probes and biochemical investigations. Susceptibility testing was performed using the radiometric proportion method. Pyrazinamide testing was performed using the Wayne indirect method.

Results: One hundred and seven patients had sputum sent to a reference laboratory; 101 (94.4%) were culture-positive for Mycobacterium tuberculosis, with 87 (86.1%) fully sensitive to first-line anti-tuberculosis drugs. Two percent were multi-drug-resistant (MDR-TB) and 12 (11.9%) had other drug resistance. Each of the MDR-TB isolates was susceptible to amikacin, capreomycin, ciprofloxacin and para-aminosalicylic acid (PAS), but were resistant to rifabutin. One isolate was also resistant to ethionamide.

Conclusions: MDR-TB is present in Indonesia but is not a major problem for TB control in this district. Generalizability to other districts in Indonesia, particularly large urban areas, needs to be confirmed by future studies.
7. An alternative method for sputum storage and transport of Mycobacterium tuberculosis drug resistance surveys


Int J Tuberc Lung Dis 10(2):172-177
2006 The Union

Setting: A district level tuberculosis (TB) programme in Indonesia.

Objective: To evaluate whether a single sputum specimen could be stored by refrigeration for an extended period of time, then transported to a reference laboratory and successfully cultured for Mycobacterium tuberculosis.

Methods: Single sputum specimens were collected from newly diagnosed smear-positive pulmonary TB patients, refrigerated at the study site without addition of 1% cetapyridinium chloride, batched and sent to the reference laboratory, where they were decontaminated and inoculated into BACTEC MGIT 960 liquid media.

Results: One hundred and seven patients were enrolled. The median specimen storage time was 12 days (range 1-38) and median transportation time was 4 days (2-12). The median time from specimen collection until processing was 18 days (4-42). Only 4 (3.7%) specimens failed to grow Mycobacterium species and M. tuberculosis was isolated from 101 (94.4%) specimens. Six specimens with breakthrough contamination successfully grew M. tuberculosis after a second decontamination procedure.

Conclusions: Single sputum specimens collected at a without preservative and transported without refrigeration to a reference laboratory can yield a high positive culture rate. These findings offer potential logistic simplifications and cost savings for drug resistance surveys in low-resource countries.

8. Diagnosis smear-negative tuberculosis using case definitions and treatment response in HIV-infected adults

D. Wilson, J. Nachega, C. Morroni, R. Chaisson, G. Maartens

Int J Tuberc Lung Dis 10(1):31-38
2006 The Union

Objective: To assess the diagnostic utility of expanded case definitions for HIV-associated smear-negative pulmonary tuberculosis (PTB) and extra-pulmonary TB (EPTB), and to derive objective criteria for response to anti-tuberculosis treatment.

Design: A prospective cohort study of HIV-infected adults who met expanded clinical case definitions for smear-negative PTB and EPTB.

Methods: All participants were started on rifampicin-based anti-tuberculosis treatment after mycobacterial cultures from multiple sites. At weeks 2, 4 and 8, response to treatment (RTT) was assessed by measuring changes in weight, haemoglobin, C-reactive protein, Karnofsky performance score and symptom count ratio.

Results: Of 147 participants enrolled, 105 (71%) were diagnosed with definite (culture-positive) or probable (histological features) TB and 25 (17%) with possible TB (treatment response). The positive predictive value for the most common case definitions ranged from 89% to 96%. Significant improvements in all the RTT parameters occurred in the subjects with confirmed TB (p < 0.001). Clinically relevant RTT criteria were derived, two or more of which were met at week 8 in 97.5% of subjects with confirmed TB, 91.3% of subjects with possible TB and none of the subjects without TB.

Conclusion: Expanded case definitions could enhance the diagnosis of PTB and EPTB in HIV-infected adults in resource-limited setting. Using objective criteria, RTT can be assessed within 8 weeks of initiating anti-tuberculosis treatment.
Proposed Programmes

- SAARC Regional Training on Leadership and Strategic Management in TB and HIV/AIDS Control – India (tentative date 4 - 8 Sept. 2006)
- SAARC Regional Meeting of Managers of National TB Control Programme of SAARC Member States – Maldives (tentative date 10-12 Sept. 2006)
- SAARC Regional Training on Computer Based Data Management Applications for TB and HIV/AIDS Data Managers – Pakistan (tentative date 9-14 Oct. 2006)
- Third SAARC Regional Workshop on TB/HIV Co-infection (follow up of 2nd workshop) – Bangladesh (tentative date 6-8 Nov. 2006)
- SAARC Regional Workshop on Advocacy, Communications and Social Mobilization to prepare Strategic Plan - India

Editor’s Request

Dear Readers

We request you to send your valuable information on TB and HIV/AIDS, such as research papers, articles etc. to include in this Newsletter under the Special Articles and Technical Information. You can send your articles on saarctb@mos.com.np. This STC Newsletter is biannual publication of the Centre and circulated widely to health institutions, TB and HIV/AIDS institutions, chest specialists, medical/nursing colleges of SAARC Member States. It is also distributed to other countries and UN agencies & IUATLD. You can browse STC Newsletters in website www.saarctb.com.np for further information.

Your feedback is vital to make STC Newsletter more useful.

- Editor
The 37th Union World Conference on Lung Health

As per the request of the 37th Union World Conference on Lung Health, Paris 31st October to 4th November 2006, STC has published the programme highlights:

Stop TB Partnership symposium: Tuesday, 31 October
• From DOTS to Stop TB Strategy

Special guest lecture: Wednesday, 1 November 5.30 pm
• Global responsibilities in investing in the health workforce for sustainable health systems

3 Plenary sessions: Thursday- Saturday, 2-4 November
• Consequences of smoking and tobacco on lung disease in low-income countries
• Clinical trials: ethical issues in high-burden countries
• Avian influenza: how ready are the health systems to detect and manage the purported pandemic?

11 Post-graduate courses: Wednesday, 1 November
10 full- and 1½ day courses: human resource development plans, Epi methods for research, associating TB programmes with clinical trials or hospitals and more.

8 Workshops: Wednesday, 1 November
4 full day and 4 ½-day workshops: TB advocacy and social mobilization, tobacco cessation, electronic registration tools and more.

37 Symposia: Thursday-Saturday, 2-4 November
During three full days, delegates can choose from 37 sessions on topics ranging from access to antiretroviral treatment, migrants with TB, human resources for child lung health, tobacco control and the Union-managed FIDELIS projects and the Asthma Drug Facility.

Other features: Thursday-Saturday, 2-4 November
The commercial exhibition hall, scientific poster display area, Union village and annual Christmas Seals contest will be open on these dates.

Full details are available on the conference website: www.worldlunghealth.org
Sponsorship opportunities and booth reservations: paris2006@iuatld.org
Press information: press@iuatld.org

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World TB Day

The World TB Day is observed in commemoration of the discovery of TB bacillus on March 24, every year. The announcement of the discovery was done by Dr. Robert Koch on March 24, 1882.

If undelivered, please return to:

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