MC-1

SAARC

STC

Newsletter

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For further information, please contact:

c/o NATIONAL TUBERCULOSIS CENTRE
SAARC Tuberculosis Centre
Thimi, Bhaktapur, Nepal.
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SAARC Tuberculosis Centre Office at NTC Building, Thimi, Bhaktapur (Kathmandu), Nepal.

The Forty-four World Health Assembly (1991) recognising the growing importance of tuberculosis and the potential for cost effective control using currently available mehods, endorsed a global Tuberculosis Control Stretegies. (See Inside).

SAARC Tuberculosis Centre Newsletter is published every six months and reports on the work, decisions, important meetings of the Centre and recent important informations on Tuberculosis.

SAARC TUBERCULOSIS CENTRE Publication

Editor: Dr. T. M. Shakya,
Director,
SAARC Tuberculosis Centre

1. INTRODUCTION:

1.1 The Objectives of the Newsletter:

(1) To provide information on the SAARC Tuberculosis Centre's activity,
and
(2) To facilitate co-ordination and contact among the member countries of SAARC with regard to tuberculosis control programme.

This is the first issue in which informations on the two Governing Board Meetings of the SAARC Tuberculosis Center (S.T.C.), those of 10th meeting of the Technical Committee on Health and Population Activities, informations on Global situation of Tuberculosis and some informations on Tuberculosis situation of India are being published.

To fulfill the second objective, contributions from the concerned units or departments of SAARC countries are essential.

All those concerned with tuberculosis control programme in the SAARC countries, are therefore humbly requested to help STC by providing documentation on tuberculosis control measures of the respective countries which will certainly of mutual benefit by exchanging informations and experiences.

If you have any short piece of infromations on tuberculosis or letters to editor, they can also be inserted in the Newsletter.

Your contribution count much to make the Newsletter which circulate to other countries also apart from the member countries of SAARC.

2. REVIEW OF RECORDS:

Health and Population Activities is one of the five areas originally identified for cooperation under the aegis of SAARC .

Five priority areas were selected initially for cooperation in the prevention and control of diseases were;

: Malaria
: Tuberculosis
: Leprosy
: Diarrheal Diseases
and
: Human Rabies.

Situation papers were prepared by all member countries on these disease. A sixth area Maternal and Child-health was initiated in 1986. Prevention of Disability and Rehabilitation of the Disable was identified as a seventh priority area for cooperation in 1989.

The establishment Tuberculosisr Regional Centres for and Malaria received active consideration of the Technical Committee and Member Government. It was finally decided at the fifth SAARC Summit held in Male in November 1990 that the SAARC Tuberculosis Center would be set up in Nepal and that necessary steps to establish it should be taken up urgently.

3. SAARC TUBERCULOSIS CENTRE:

RATIONAL:

The second meeting of the Foreign Minisers of South Asian Countries held at Male 1984- suggested formulation of specific project aiming at co-operation between member countries. It was felt desirable to have a regional project pertaining to one of the five diseases control areas already identified by the working group on Health and Population Activities. Accordingly, SAARC Regional Tuberculosis Centre (STC) in Nepal was proposed and established.

3.1 Organization of the S.T.C.: The centre was decided to be located at the National Tuberculosis Centre Building, Thimi, Bhaktapur, Nepal.

3.2 Organizational Structure: S.T.C.: functions with a Governing Board, one Director with 3 main divisions of the S.T.C. namely ;

(a) Information, Communication and Coordination Division,

(b) Research, Training and Evaluation Division and

(c) Epidemiological Division in the S.T.C.

Governing Board of the SAARC Tuberculosis Centre (STC).

The Governing Board composes of 8 members - one from each members state as nominated by the respective Government. In addition, the Director of STC shall be the Ex-office Member Secretary of the board. The Governing Board formulates policies and oversee the functioning of the Regional Institution.

The board shall meet in Nepal at least once a year prior to the meeting of the Technical Committee on Health and Population Activities.

4. OBJECTIVES OF SAARC TUBERCULOSIS CENTRE (STC):

4.1 Main: to work towards prevention and control of tuberculosis in the region by co-ordinating the efforts of the National Tuberculosis Control Programme of the member countries.

4.2 Functions of STC:

4.2.1. To act as Regional Co-ordinator for National Tuberculosis Program (NTP) in the region by exchanging informations on related activities.

4.2.2 To collect, analyze and disseminate all relevant informations regarding the latest development and findings in the field of tuberculosis in the region and elsewhere.

4.2.3. To establish networking arrangement among NTP and to conduct surveys and researches etc.

4.2.4. To initiate and undertake and coordinate the Research and Training related to TB control programme in the region.

4.2.5. To assist in harmonization of policies and strategies in TB control.

4.2.6. To strive for adequate supply of anti TB drugs and other related supplies at low cost.

5. NATIONAL TUBERCULOSIS CENTRE (N.T.C.) In Kathmandu.

It was built with the technical and grant aid of the Government of the friendly nation Japan for strengthening the National Tuberculosis Control Programme in Nepal.

The signing in the agreement in this respect between the two countries was done in April 1987.

The laying of the foundation stone of N.T.C. building began on 20th. March 1988 by the then Prime Minister Marich Man Singh Shrestha and the building was graciously inaugurated by His Majesty the King Birendra Bir Bikram Shah Dev on 14th. Dec. 1989.

6. S.T.C. News:

Decisions Taken At:

6. FIRST GOVERNING BOARD MEETING OF STC.

At the invitation of His Majesty's Government of Nepal the Governing Board of the SAARC Tuberculosis Centre, held its first meeting in Katmandu on 24-25 March 1992. The meeting was inaugurated by the Hon'ble Minister of State for Health of His Majesty's Government of Nepal, Dr. Ram Baran Yadav. As per the established SAARC practice, member representing Nepal in the Governing Board, Dr. Thir Man Shakya, was elected as a Chairman. The list of participants in the meeting and the agenda as adopted appear in Annex - I and II respectively.

6.1. Matters relating to the Governing Board of the STC.

The meeting considered the draft rules of procedures for the Governing Board in regards to its functioning, formulation of policies and the financial regulations.

6.2. Programme for the year 1992/93.

The Board considered the programmes to be undertaken in the years 1992/93 and recommended the following:

a) Compilation and printing of directory of TB hospitals, TB Training Institutions, Clinics, Centres in the SAARC countries.

b) Compilation and Printing of the list of TB and chest specialists in the SAARC countries.

c) Collection of books, journals etc. on tuberculosis and chest diseases.

d) Seminar for Tuberculosis Programme Managers - one participants from each member state.

Objectives - to exchange information and experience gained in the countries of the region to facilitate coordination and cooperation among the SAARC countries with respect to Tuberculosis Control Programme.

6.3. Budget Provision for the years 1992/93 and 1993/94.

The Board endorsed the Institutional Cost Budget for the years 1992/93 and 1993/94 (as proposed in the Document in Annex - IV and V respectively).

6.4. Remittance of Contributions by the Member States.

The member States would be requested to make their contribution to the Centre as per the apportionment in the Document (in Annex - V). The requests would be sent to member countries by the Director of STC through the SAARC Secretariat after the budget would be approved by the Standing Committee.

6.5. Agenda Items 9, 10 and 11 could not be taken up because of shortage of time and were deferred until the next meeting.

6.6. Any other matter.

Another meeting of the Governing Board is proposed to be held sometime in October 1992 to take up the items which could not be discussed as well as to select professional staff.

6.7. Vote of Thanks.

Members of the Governing Board expressed their high appreciation to the Chairman of the Board for guiding the work of the Board to a successful conclusion. They also expressed their profound gratitude to His Majesty's Government of Nepal for the generous hospitaliy extended to the Members of the Governing Board and the excellent arrangements made for the meeting.

7. The 10th Meeting of the Technical Committee on health and Population Activities:

It was held in Dhaka on 20-22 June 1992 under the chairmanship of the Secretary, Ministry of Health and welfare, Government of the People's Republic of Bangladesh. The committee considered the report of the First Meeting of the Governing Board of the STC and decided to endorse the budget estimate for the year 1992/93.

8. SEMINAR ON CLINICAL AND SURGICAL ASPECTS OF TUBERCULOSIS

At the invitation of His Majesty's Government of Nepal, SAARC Seminar on Surgical and Clinical Aspects of Tuberculosis was held in Kathmandu on 22-23 December 1991. The Seminar was inaugurated by Hon'ble Ram Baran Yadav, Minister of State for Health, at

the SAARC Secretariat who, in his inaugural address, emphasized on the need to have greater cooperation amongst the SAARC member countries in the fight against tuberculosis. The Seminar was attended by participants from Bangladesh, India, Maldives, Nepal, Pakistan and Sri Lank.

Prof. (Dr.) A. K. Sharma Chairman of the Seminar, delivered a welcome address at the inaugural session. Dr. N.G. Amatya, Director of National Tuberculosis Centre, threw light on the objectives of the seminar while Prof. (Dr.) S. Ali Raja Gardazi from Pakistan spoke on behalf of the visiting delegates. A vote of thanks was proposed by Dr. T. M. Shakya of Nepal at the end of the inaugural session.

Mr. Arif Ayub, SAARC Director, also made his remarks at the inaugural session.

Recommendations:

1. The SAARC Tuberculosis Centre which is being established in Kathmandu in the near future should be equipped on the basis of the need felt with epidemiological, diagnostic, serological, research and training facilities.

2. Efforts should be made to establish National Centres in the respective SAARC countries which will maintain liaison with the Regional TB Centre at kathmandu.

3. Case finding should be supported by adequate laboratory and radiological facilities.

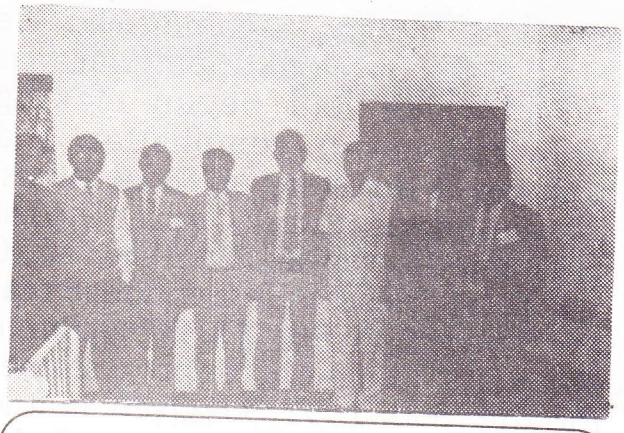
4. Efforts should be made to exchange data between the regional centre in Kathmandu and the national centre for documentation.

5. Short course regime of chemotherapy has been mutually agreed upon and efforts should be made for its implementation in the member countries.

6. All medical personnel treating tuberculosis patients should maintain their record in a register.

7. The meeting of technical experts on tuberculosis of SAARC countries should be held once a year to review the progress of work in this field.

8. The subject tuberculosis and chest diseases should be made a part of syllabus of Medical Colleges and Department of Tuberculosis and Chest Diseases should be established where they do not exist.



9. SECOND GOVERNING BOARD MEETING OF STC.

Decision Taken At:

9.1. Introduction;

At the invitation of His Majesty's Government of Nepal and the Director, STC, the Governing Board of SAARC Tuberculosis Centre (STC) held its

Second Meeting in Kathmandu on 21-22 April 1993. The Meeting was inaugurated by Mr. J. Upadhyay, Secretary, Ministry of Health of His Majesty's Government of Nepal. He expressed his hope that it would be much rewarding, if SAARC spirit could be built up by pooling one another's experiences and facilities available so as to benefit tuberculosis control programme of member countries.

9.2. As per the established SAARC practice, the Member representing Nepal in the Governing Board, Dr. Dirgh Singh Bam, was elected as Chairman of the Meeting. The List of Participants in the Meeting is at Annex - III

9.3. The Board reviewed the progress in the implementation of the decisions of the First Meeting of the Governing Board.

9.4. The Director, STC informed the Meeting that since his appointment as Director, he had begun making preparations for compilation and printing of directory of TB Hospitals, TB training institutes / centres and list of TB and chest specialists n the SAARC and chest diseases. He mentioned that the "Seminar for TB Programme Managers" as some of the programmes for the year 1992/93 given in the Report of the First Meeting of the the Governing Board, was likely to be held during 1993. He also informed the Meeting about recruitment of Professional and General Services Staff for the Centre, remittances of contributions by the Member States to the STC's Budget for 1992/93 and other developments since the First Meeting of the Governing Board.

9.5. The Director, STC introduced the Agenda item of determination of fields. Terms of Reference, emoluments, by furnishing details of coordination of research and training. The Board felt that in order to avoid duplication of work under each of these headings, the Member States should exchange data in the areas of research and training. It was, therefore, decided to forward the data on these subjects to Director, STC for compilation and circulation to Member States.

9.6. The Director, STC introduced Networking agreement of National Tuberculosis Programme. The Board agreed that the Networking arrangement on Tuberculosis Control Programmes would prove very useful to Member States. It was, therefore, decided to send names of Focal Points, designated from each Member State, to the Director, STC through the SAARC Secretariat for the purpose of establishing Networking Arrangement. The board also agreed to designate the National Tuberculosis Centre (NTC) as the coordinating institution in the proposed Networking arrangement between National Institutions of Member States engaged in this field.

9.7. In this connection, the Director, STC proposed a Questionnaire on "General Health Service and Tuberculosis Control". The Board agreed that the informations/data in the Questionnaire would be very useful to the Member States. It was, therefore, decided to forward the Questionnaire, duly completed, to the Director, STC for compilation and circulation to Member States.

9.8. The Board was informed by the Director, STC, the approved Programmes for the years 1992/93 as given at para 4 of the Report of the First Meeting of the Governing Board, could not be undertaken due to administrative and financial constraints. He, therefore, proposed that the approved programmes of the First Meeting be included in the Programmes of the year 1993/94.

9.9. The Board agreed that was an urgent need to recruit the General Services Staff for the centre as soon as possible for its smooth and effective functioning. They reviewed the staff strength, phasewise and decided to approve the enhanced emoluments for the General Services Staff.

9.10. The Governing Board discussed that progress made in recruitment of Deputy Director for the STC and felt that the last date for submission of applications for the post of Deputy Director circulated to Member States through the SAARC Secretariat, i.e. 15 April 1993, was too short for advertising and receiving sufficient applications. The Board, therefore, decided to extend both the time for submitting applications for the post of Deputy Director by the candidates to their respective Government upto 30 June 1993, and the time for submitting applications to the STC, Nepal, by the respective Member States upto 31 July 1993.

9.11. The Board agreed with the suggestion of the Director, STC to hold another Meeting of the Governing Board to select the professional staff and discuss matters requiring urgent attention.

9.12. The Board approved the programme Budget for STC for the financial year 1993/94 as proposed in the document in Annex - IV and recommended the same for consideration of the Technical Committee on Health and Population Activities. The requests would be sent to Member States by the Director of STC through the SAARC Secretariat after the Budget would be approved by the Standing Committee.

10. 11th Meeting of Health and Population Activities.

The Eleventh Meeting of the Technical Committee on Health and Population Activities was held in Thimpu from 30 April to 2 May 1993, under the Chairmanship of Dasho Sangay Ngedup, Director General of Health Services, Royal Gov ernment of Bhutan. The Eleventh Technical Committee, on reviewing the Report of the Second Meeting of the Governing Board of the SAARC Tuberculosis Centre (STC) presented by its Director, Dr. T. M. Shakya, endorsed it with the following

observation for the consideration of the Eighteenth Session of the Standing Committee:

In spite of a substantial surplus amount of fund (amount US $40,000) unutilised from the 1992/93 budget, there was an almost twofold increase in the institutional cost budget projected for 1993/94. Although these funds, if unutilised, will be credited to the Member States, thereby reducing heir subsequent contribution, it was noted that this may be an unnecessary blocking of funds which could be utilised by the Member States of other activities.

11. RECENT INFORMATION FROM W.H.O.:

11. Global Tuberculosis Situation:

11.1. Tuberculosis is the foremost cause of death from a single infectious agent. One third of the world's population is infected with tubercle bacilli.

8 million new cases develop each year, 3 million deaths occur each year from tuberculosis.

It is a major global health problem - especially serious in the developing world where 95% of cases occur, 80% of them in persons who are in the most productive year (15 to 59 years) and where it causes over 25% of avoidable deaths.

11.2. The already serious tuberculosis situation is deteriorating as the epidemic of HIV infection spreads. In 1992 the global cumulative number of persons thus infected is estimated to be 4.4 million, almost 3.5 million of them in Sub-Saharan Africa. There has been an estimated total of about 300,000 cases of HIV infected tuberculosis in 1990. It is estimated that half a million people will develop HIV related tuberculosis in 1995 and the figure for the year 2000 is likely to reach one million. A particular case of concern is the resulting potential for increased tuberculosis transmission, and thus a continued worsening of the problem. Within a five year period, the annual number of cases:

- in Zambia - nearly triples.
- in Malawi - more than doubled.
- in Burundi - increased by 40% .
- in United Republic of Tanzania - increased by 60% .

11.3. The current tuberculosis / HIV situation in the South East Asia and Western Pacific Region is similar to that in Africa 5 - 7 years ago. Since 2/3 of the world's tuberculosis infected population is in Asia, entry of HIV into that population will result in huge increases in HIV associated tuberculosis and a rapid deterioration of the situation in the coming years. In Bombay - HIV seropositive among tuberculosis patients increased from 2% in 1989 to 10-15% in the past 2 years. In northern Thailand: where HIV seroprevalence in tuberculosis patients increased from 5% in late 1989 to 14% in early 1991.

11.4. Fortunately however, it appears that increase in tuberculosis cases does not necessarily lead to increased transmission of the disease in community if a country has an effective control programme. In United Republic of Tanzania - where more than 85% of

infectious cases are successfully treated and 70% of such cases are detected , there has not been an increase in the prevalence of infection in the last 5 years, despite a case 70% rise in the number of cases.

11.5. A second major problem is the emergency of drug resistant bacilli particularly those resistant to both INH and Rifampicin. In all regions of the world, drug resistance poses a serious problem and mortality among multidrug resistant tuberculosis patient is very high. However, in the meantime, provision of short course chemotherapy specially for smear positive patients, supervision of the initial part of therapy, the use of adequate retreatment regimens will limit the spread of resistant tuberculosis.

* Report by the Director General of WHO in Forth Sixth World Health Assembly.

WHO A 46113, 24 March 1993.

11.6. Global Tuberculosis Control Strategy.

The Forty-fore World Health Assembly (1991), recognizing the growing importance of tuberculosis and the potential for cost effective control using currently available methods, endorsed a global tuberculosis strategy and established the following two objective for global control:

To treat successfully 85% of detected smear positive cases and to detect 70% of such cases by the year 2000.

TUBERCULOSIS DRUG RESISTANCE.

The very high rate of secondary resistance to both INH and Refampicin is particularly serious, with long term implications as these patients will transmit a virtually incurable form of disease within the community.

11.6. TUBERCULOSIS IN INDIA - as reported by WHO (1992).

Prevalence of infection among children 0-9 years old :- 3.1% - 11.2%. 50% of the population 20 years and above are infected (1980). No clear evidence of substantial change in this pattern. Annual Risk of Infection: 0.6% to 2.3%.

Disease prevalence:

As specific estimated by NTI about 870,000 new smear positive cases of tuberculosis may have occurred in 1992. If the current average annual risk of infections is 1.7%, 1.6% million new cases (all forms) and 714,000 new smear positive cases of tuberculosis may occur annually.

The majority of tuberculosis cases in India occur below the age of 45 years, with about 75% of the diagnosed cases between 15 and 44 years old. 2/3rd of the cases are estimated to occur among males but tuberculosis taken a proportionally much higher tool on young age females than among young males. More than 50% of female cases occur before age 34.

Mortality:

Total mortality due to TB is uncertain. Tuberculosis mortality is estimated by NTI to have been 69 to 95 per 100,000 in 1961-68 and 41 per

100,000 in 1977-81 or over 35,000 tuberculosis deaths annually.

AIDS and Tuberculosis in India:

The AIDS Programme estimated that currently there are 750,000 persons infected with HIV in the country and that there will be 5 million in the year 2000. Assuming half of these people are also infected with tuberculosis and that the break down rate from tuberculosis infection to disease among dually infected individuals is 10% per year, more than 35,000 HIV related tuberculosis cases annually at the end of decade.

* Joint Government - WHO, Evaluation of Tuberculosis Programme in India - (Sept. 1992).

Annex - I

First Meeting of the Governing Board of
the SAARC Tuberculosis Centre (STC)
Kathmandu, March 24-25, 1992.

LIST OF PARTICIPANTS.

Bangladesh.

Prof. A.K.M. Shamsul Haque,
Director,
Inst. of the Disease of the Chest and Hospital,
Mohakali, Dhaka.

Bhutan.

Dr. J. Norbhu,
Director,
Dept. of Health Services.

India.

Dr. S.P. Tripathy,
Director-General,
Indian Council of Medical Research.

Nepal.

Dr. T.M. Shakya,
Deputy director, NTC.

Sri Lanka.

Dr. (Mrs.) C. Pitigala,
Director,
Respiratory Disease Control Program.

Director, STC and Member Secretary of the Board.

Dr. N.G. Amatya.

SAARC Secretariat.

Mr. Q.A.M.A. Rahim,
Director.

Annex - II

First Meeting of the Governing Board of the SAARC Tuberculosis Centre (STC)

Kathmandu, March 24-25, 1992.

AGENDA.

1. Opening of the Meeting.
2. Election of Chairman.
3. Adoption of the Agenda.
4. Matters relating to the Governing Board of the STC-Rules or procedure in regard to its functioning, formulation of policies, financial regulations, etc.
5. Matters relating to Professional and General Service Staff of STC - determination of their criteria, modalities of their recruitment phase-wise as decided by the Standing Committee at its 15th. Session in Colombo.
6. Programme for the years 1992 and 1993.
7. Budget provision for the year 1992-93 and 1993-94.
8. Remittance of Contributions by the Member States.
9. Estimate of Programme-Cost for the first and second financial years.
10. Determination of Fields, Terms of Reference, Emoluments, Duration and Modalities of Recruitment of Consultants.
11. Finalization of details relating to research, training, coordination and personnel.
12. Any other matter.
13. Adoption of the Report.

STC-19.DOC.

Annex - III

Second Meeting of the Governing Board of
the SAARC Tuberculosis Centre (STC)
Kathmandu, 21-22 April 1993.
LIST OF PARTICIPANTS.

Bangladesh.

Dr. A.K.M. Mosleh Uddin,
Director, Chest Diseases Institute and Hospital,
Mohakhali, Dhaka.

Bhutan.

Dr. J. Norbhu,
Director, Department of Health Services.
Thimpu

India.

Dr. Prahlad Kumar,
Assistant Director-General,
Ministry of Health and Family Welfare
New Delhi.

Maldives

Mr. Ibrahim Shaheem,
Programme Coordinator,
Department of Public health,
Male'.

Nepal.

Dr., Dirgh Singh Bam,
Deputy director, NTC and
Chairman, Governing Board of STC,
C/O. National Tuberculosis Centre,
Thimi, Bhaktapur.

Mr. Dipendra Bista,
Section Officer (SAARC)
Ministry of Foreign Affairs
Kathmandu.

Sri Lanka.

Dr. (Mrs.) C. Pitigala,
Director, Respiratory Disease Control Program.
Welisara, Ragma.

Director, STC and Member Secretary of the Board.

Dr. T.M. Shakya.

SAARC Secretariat.

Mr. Humayun A. Kamal,,
Director.

Annex - IV

SAARC Tuberculosis Centre (STC)
National Tuberculosis Centre Building
Thimi, Bhaktapur (Kathmandu), Nepal.

Proposed Programme Costs Budget of STC for the Financial Year 1993/94.

S.No.	Activities	Amount in NRs.
i)	Compilation and printing of the directory of TB Hospital, TB training institutions / clinics / centres in the SAARC Countries.	
ii)	Compilation and printing of the list of TB and Chest Specialists in the SAARC Countries.	
iii)	Collection of books, journals, reports ect. on tuberculosis and Chest Diseases.	
iv)	Collection and distribution of information on National Tuberculosis Control Programmes in the SAARC countries.	90,000.00
v)	Networking arrangement on Tuberculosis Control Programme in the SAARC countries.	60,000.00
vi)	Seminar for Tuberculosis Programme Manager.	400,000.00
vii)	Circulation of information on research activities in the SAARC countries.	60,000.00
viii)	STC Newsletters.	100,000.00
ix)	Acquisition of books and journals on Tuberculosis and Chest Diseases.	20,000.00
x)	Purchase of books on Tuberculosis and Chest Diseases.	60,000.00
xi)	Subscriptions of journals, magazines and newspapers.	100,000.00
	Total:	890,000.00

Annex - V

CONTRIBUTIONS TOWARDS INSTITUTIONAL COST OF THE STC BY MEMBER COUNTRIES

Year 1993-94.

Total Budget in US $: 69,035.00
NRs. : 2,940,925.00

		US Dollars.
Bangladesh	6.81%	4701.34
Bhutan	3.00%	2071.07
India	19.26%	13296.30
Maldives	3.00%	2071.07
Nepal	46.81%	32315.69
Pakistan	14.31%	9879.00
Sri Lanka	6.81%	4701.34

Conversion Rate : US $ 1 = NRs. 42.60

BUDGET DOC.

Some Information about SAARC Countries.

BASIC INDICATORS OF SAARC COUNTRIES.:

	Population (Millions) Mid. 1991.	Area (Thousands of Sq. kilometer)	GNP per Capita Year 1991	Life Expectancy Year 1991
1. Bangladesh	110.6	144	220	51
2. Bhutan	1.5	47	180	48
3. India	866.5	3288	330	60
4. Maldives	0.221	-	460	62
5. Nepal	19.4	141	180	53
6. Pakistan	115.8	796	400	55
7. Sri-Lanka	17.2	66	500	71

SOURCE: World Development Report 1993.
investing in Health .
published for World Bank.

Tuberculosis Incidence Rate per 100,000 population (1990).

(Source : World Development Report 1993)

1. Bangladesh	220.
2. India	220.
3. Pakistan	150.
4. Nepal	167.
5. Sri Lanka	167.

Central Government Expenditure (Percentage of Total Expenditure)

	Defense		Education		Health	
	1980	1991	1980	1991	1980	1991
1. Bangladesh:	9.4	10.1	11.5	11.2	6.4	4.8
2. Bhutan:	0.0	0.0	12.8	10.7	5.0	4.8
3. India:	19.8	17.0	1.9	2.5	1.6	1.6
4. Nepal:	6.7	5.9	9.9	10.9	3.9	4.7
5. Pakistan	30.6	27.9	2.7	1.6	1.5	1.1
6. Sri Lanka:	1.7	9.4	6.7	8.3	4.9	4.8

Source : World Development Report 1993.

Tuberculosis making a comeback in US

Washington, Oct 8 (AFP) :
Tuberculosis, which, had been receding for decades, has made a comeback since 1985, mainly among the poor and victims of AIDS, according to a congressional report made public Thursday.

From 1953, when a tuberculosis tracking system was first put into effect in the United States, and 1984, the number of cases in the United States declined 74 per cent.

The decline slowed in 1985 and subsequently the trend reversed: the 26,673 cases reported in 1992 represented a 20 per cent increase from 1985.

The resurgence is due to the fact that strains of the tuberculosis bacillus have become more resistant to antibiotics, which were developed in the 1940s.

The Congress' Office of Technological Evaluation estimates that between 10 and 15 Americans are carrying the bacteria. In its latent state, tuberculosis is not contagious, although it is contagious in its active stage, which occurs in 10 per cent of cases.

"Being born outside the United States, being homeless, a substance abuser, being incarcerated, or being a migrant worker is a risk factor for tuberculosis," the report said.

A third of the world's population carries the bacteria that causes tuberculosis, so tourism and economic migrations will make it difficult to reverse its spread quickly, according to the report.

But the report advocated better controls of migrants. "Even in the last year. the centers for Disease Control and Prevention (CDC) noted its own failure to implement recent TB control recommendations, largely to a lack of resources," it said.

"Over the years, TB has gradually shifted from a disease broadly distributed over the whole population to one that is more narrowly concentrated among certain portions of the population," it added.

The more populous states are proportionally more affected. The report said 43 per cent of the cases have been reported in urban zones even though they represent only 18 per cent of the population.

In 1991, 71 per cent of the new cases were among minorities - blacks, Hispanics and Asians. The most affected are people 25 to 44 years old.

The poor are among the most at risk. About half the cases reported in New York were among the homeless. tuberculosis also has ravaged prison populations because of the close quarters and poor ventillation.

Prisoners have between a six and 11 times greater chance of contracting tuberculosis, the report found.

AIDS victims chances of getting the disease increase eight per cent a year because of their weakened immune system.

Short-course treatment of tuberculosis

Tuberculosis (TB) kills or debilitates more adults ages 15-59 than any other disease and is responsible for about 2 to 4 percent of the burden of disease. It is the single leading cause of death in developing countries, accounting for about 2 million deaths a year, or approximately 5 percent of all deaths and 25 percent of

preventable adult deaths in those countries. More women of childbearing age die from TB than from causes associated with pregnancy and childbirth. More than half of the world's population is infected with the TB bacillus. People who are malnourished or have another severe illness are at particular risk for TB, as are those infected with HIV. the relationship between TB and HIV is highly significant, as each person infected with HIV and TB could infect twelve other persons with TB per year.

Annual incidence rates of all forms of clinical TB vary from 50 to 260 per 100,000 in the developing world; more than half of these cases are infectious (sputumsmear-positive). For most forms of TB, 50 to 60 percent of those infected will die if untreated. All ages are at risk, but the peak is in young adulthood. In Sub-Saharan Africa the annual risks of infection remain high, partly because of poverty and overcrowding (which are risk factors for TB) and partly because any decrease in the annual risk of infection is offset by the HIV epidemic. In India and Sub-Saharan Africa TB is the leading cause of death and the biggest contributor to the disease burden; it is responsible for about 8 to 11 percent of the DALYs lost in the 15-59 age group.

There are two effective approaches to treating TB: short-course chemotherapy, which uses three to five drugs over six to eight months, and the "standard" course of two to three drugs taken over twelve to eighteen months. Drugs for the short course cost about $50 to $80 per patient. Those for the standard course cost only $10 to $15, but the cost per death averted is higher because only 30 percent of patients complete treatment and are cured, as against 60 percent for the short course. Other benefits of the short course include a smaller number of resistant organisms and less need for expensive retreatment. (This discussion applies to the treatment of sputum-smear-positive TB. Once other forms of TB have been identified, treatment costs should be similar except for serious forms of smear-negativeTB.)

Walk-in treatment is less expensive than hospitalization, but if this care cannot be closely monitored (as in many rural areas), hospitalization may be more cost-effective. The program described is modeled on passive case investigation, assuming that a person with TB will have symptoms such as cough and weight loss and will seek care and that infected persons discovered by active searches will be less likely to continue treatment than those who seek care. Although the BCG vaccination is important in TB control for children, its effectiveness in adults is still under investigation.

The cost of treatment is less than $10 per DALY in all chemotherapy scenarios. It is estimated that tuberculosis treatment of infectious (smear-positive) individuals prevents one to four new cases by stopping transmission. the positive externalities of short-course chemotherapy explain in part the extremely favorable cost-effectiveness and justify government intervention. Because the cost of drugs, at $50 to $80 per patient, is probably too high for the poor, public subsidy is especially warranted for low-income households.

Source:- World Development Report 1993

World Development Report 1993

Burdenof five major diseases by age of incidence and sex, 1990

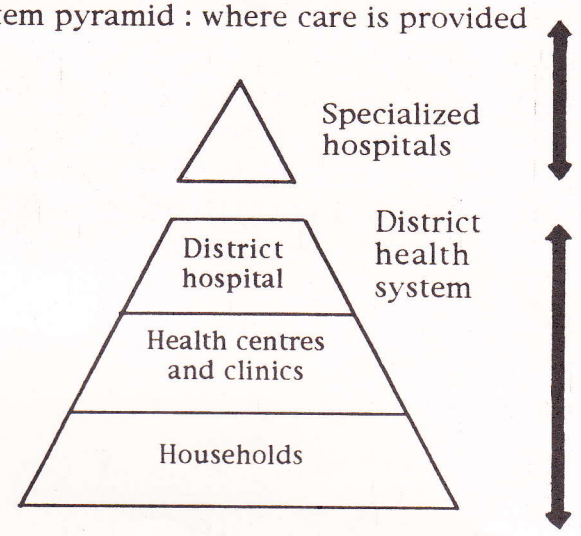
(millions of DALYs)

	Age (years)					
Disease and sex	0-4	5-15	15-44	45-59	60+	Total
Diarrhea						
Male	42.1	4.6	2.8	0.4	0.2	50.2
Female	40.7	4.8	2.8	0.4	0.3	48.9
Worm infection						
Male	0.2	10.6	1.6	0.5	0.1	13.1
Female	0.1	9.2	0.9	0.5	0.1	10.9
Tuberculosis						
Male	1.2	3.1	13.4	6.2	2.6	26.5
Female	1.3	3.8	10.9	2.8	1.2	20.0
Ischemic heart disease						
Male	0.1	0.1	3.6	8.1	13.1	25.0
Female	**	**	1.2	3.2	13.0	17.5

** Less than 0.05 million
Note: DALY disability-adjusted life year.
Source: World Bank data

Most health care should take place toward the bottom of this pyramid.

Figure 6.1 The health system pyramid : where care is provided



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