SAARC

STC Newsletter

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(Inauguration of Ninth Meeting of the Governing Board of SAARC TB Centre and Meeting for Formulation of Urban TB Control Programme in Member Countries)

Contents

2000 **We wish you all A Very Happy New Millennium for peace, progress and prosperity**

SAARC Tuberculosis Centre's Newsletter publishes every six-month and it includes reports on works, decisions of important meetings of the centre and recent information on tuberculosis.

SAARC Tuberculosis Publication

Address:
SAARC Tuberculosis Centre
(Thimi, Bhaktapur)
P.O. Box No. 9517, Kathmandu, Nepal
Tel: 631048, 632477, 632601
Fax: 00977-1-630061, E-mail: saarctb@mos.com.np

Chief Editor:
Dr. D. S. Bam
Director, STC

Editor:
Dr. P. Kumar
Deputy Director, STC

STC held its Ninth Meeting of the Governing Board

Ninth meeting of the Governing Board of SAARC TB Centre (STC) was held in Kathmandu on 27th October 1999. The meeting was inaugurated by the Hon'ble Dr. Ram Baran Yadav, Minister of Health and presided over by Mr. Shree Kant Regmi, Secretary for Health, His Majesty's Government of Nepal in a special function organised in Kathmandu.

In the inaugural function Dr. Yadav extended a warm welcome to the participants and appreciated the co-operation among Member States in prevention and control of tuberculosis. He also appreciated the special efforts of the SAARC TB Centre to check the dual infection of TB and HIV. He expressed confidence that the collective efforts of Member Countries would help in tackling this problem effectively.

His Excellency Mr. Nihal Rodrigo the Secretary General, SAARC addressed the meeting and informed that SAARC Member States have provided priority to TB control in the region and expressed appreciation on the role of STC being played in order to control of TB and HIV in the region.

Dr. D. S. Bam, Director, STC extended a warm welcome to the participants and guests. He paid his gratitude to the Hon'ble Minister of Health, Secretary of Health, His Excellency the Secretary General of SAARC and all National and International dignitaries.

Dr. K. R. Pandey, Director General, Department of Health Services of Nepal also addressed the meeting.

Dr. P. Kumar, Deputy Director, STC proposed vote of thanks.

The Board reviewed the progress in the implementation of the decisions taken at the Eighth Meeting of the Governing Board. The Director, STC presented the reports of the Centre on activities carried out since January 1999. By expressing satisfaction on the progress made by the centre, the Board recommended the following programmes for implementation during the year 2000:

1. *Trainers' Training in TB Programme Management*
2. *Public awareness and advocacy in relation to TB and HIV.*
3. *Workshop on operational research related to TB control in Member Countries*
4. *Expert meeting for standardizing training*

curriculum at the level of Directors of National TB Institutes.

5. *Strengthening the existing networking with training and research institutions in an effective manner.*

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SAARC Meeting to Formulate Urban TB Control Programme:

A one-day meeting was held on 29th Oct. 1999 with the objective to recommend the strategy for Urban TB Control Programme for Member Countries.

Dr. D. S. Bam, Director, STC welcomed the participants and requested for the better recommendations for the implementation of Urban TB Control Programme in the Member Countries.

Dr. P. Kumar, Dy. Director, STC highlighted on the objective of the meeting.

The following recommendations have been made:

I. Member Countries should formulate their urban TB programme by taking into consideration:

   1. Under privileged and those living in urban slums should form the focused group of attention.

   2. Depending upon the size of the slum, Microscopy Centres and DOTS centres, should be localized in the slum itself.

   3. For urban slums of smaller size, information regarding the location of nearest health facility offering diagnostic and curative facilities of TB should be widely publicised.

   4. Working hours of the service outlets specially drug distribution centre should be staggered to the convenience of users which in most of the cases may be early morning / late evening.

II. Medical colleges should be fully involved in all facets of TB programme. Regular, Continue Medical Education (CME) should be undertaken. Methodology to get referrals of chest symptomatics to microscopy centres should be formulated. Standard treatment regimens should be advocated.

III. TB programme and particularly DOTS should be prominently included in under graduate/postgraduate teaching / training programmes.

IV. Coordination should be established with all government/ private health agencies so as to ensure referral of chest symptomatic to microscopy centres, propagating sputum microcopy as a primary tool of

diagnosis and following prescribed treatment regimens. They should also be requested to report in the prescribed country reporting performa and these reports should be included in the country report.

V. Floating population should be prescribed only non-rifampicin-based regimens.

VI. Involvement of industries, private practitioners, and NGOs in specific areas of TB control programme should be attempted without compromising the quality component.

VII. Joint IEC campaign should be formulated in collaboration with the AIDS programme.

After deliberations the final points have been taken into considerations and recommendation were made for effective implementation urban TB control programme in member countries.

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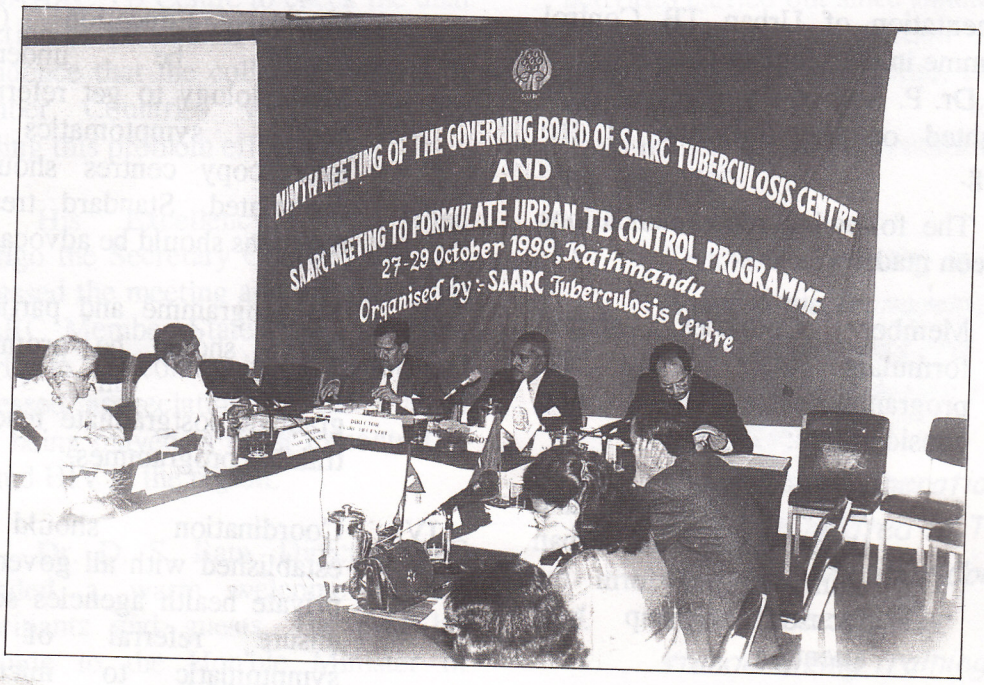

(Scientific Session of the Meeting)

SAARC Seminar on

Gender and Sociological Issues related to TB:

(Inaugural function of the Seminar)

SAARC TB Centre organised a two-day seminar on Gender and Sociological Issues related to TB from 27th to 28th July 1999. Experts in the field of TB control and Sociology from Bangladesh, India, Nepal and Pakistan participated in the seminar.

The objectives of the seminar were:

- to review social, cultural and biological differences in the occurrence of TB between men and women.
- to propose an improvement in TB control by addressing the different needs of women and men as well as social-cultural variation.
- to analyse effect of these issues on achievement of DOTS.
- to recommend future areas of research on gender and sociological issues related to TB.

The seminar was inaugurated by Hon'ble Dr. Ram Baran Yadav, Minister of Health and presided over by Mr.

Shree Kant Regmi, Secretary of Health, His Majesty's Government of Nepal.

His Excellency Mr. Nihal Rodrigo, Secretary General, SAARC addressed the seminar and informed that exchange of experience and expertise would be helpful in strengthening the efforts of Member Countries to control this disease. He also emphasized the need of initiating gender specific efforts to deal with this problem effectively.

Dr. D. S. Bam, Director, STC extended a warm welcome to the distinguished guests and participants of the seminar. He paid his gratitude to the Hon'ble Minister, Secretary, His Excellency and all National and International dignitaries presented in the seminar.

Dr. P. Jagota, Director, National TB Institute, Bangalore, India addressed the gathering on behalf of participants.

Dr. P. Kumar, Deputy Director, STC proposed vote of thanks.

The following recommendations have been made:

- SAARC Member States should respond to the epidemic of TB in women in three ways:
    - promote awareness about the impact of TB in women through advocacy activities at the regional and national level.
    - determine the main factors contributing to the observaed differences between women and men through a planned and coordinated programme of research.
    - ensure that operational aspects of NTP activities are gender sensitive.

Some more specific recommendations have also been made on advocacy, Research and operational.

In the seminar DOTS in Hard to Access Areas were also discussed by the participants under the management of Nuffield Institute for Health on July 29, 1999. ----------❑----------

Dr. Bam elected to Board of Directors of IUATLD

Dr. D. S. Bam, Director, SAARC TB Centre has been elected to the Board of Directors of International Union Against Tuberculosis and Lung Diseases (IUATLD).

The board of directors consists of 14 members, six elected on the basis of individual capacity and evaluation, six as continental representatives and two from among the present and outgoing executive chairmen of the organization.

Dr. Bam was elected to board of directors under the individual capacity at the IUATLD's 30th general convention held in Madrid in Sept. 1999. The general convention was participated by senior specialists of lung diseases from more than 120 countries of the world.

Special Articles and Technical Information on Tuberculosis

D O T S in I n d i a

Dr. (Mrs) P. Jagota, Director, National TB Institute, Bangalore

National TB Control Programme:

One person dies from TB in India every minute, more than 1000 people every day, 500,000 every year. TB affects primarily people in their most productive years of life and is more common among poor populations. India contributes about 1/3rd of the global burden of tuberculosis. Every year, there are approximately 2 million new cases in the country, of which approximately 1 million are newly smear-positive and therefore highly infectious.

Around 1.5 million TB cases are detected every year under the programme of which about 20-25% is sputum-positive and rest are sputum negative patients. It is estimated that almost an equal number of TB cases are detected and treated by NGO-Governmental Organisations and Private Practitioners. Trend of the TB cases in the country reported under the programme over last several years has been more or less static.

TB-HIV Dual Infection:

The experts opine that the epidemiological situation with regard to tuberculosis will deteriorate further with the spread of HIV as it has happened in other countries. An individual, suffering from AIDS, has 10 times increased risk of developing TB disease. Around 60% of the AIDS cases reported in India have evidence of active TB.

The Response:

To combat the problem of tuberculosis, Govt. of India launched the National Tuberculosis Control Programme (NTCP) in 1962 on a 50-50 sharing basis between Centre and State with an objective to detect as many cases as possible and effectively treat them so as to render infectious cases as non-infectious. The Programme is integrated with primary health care infrastructure and is implemented through a network of 446 District TB Centres, 330 TB Clinics and about 47,600 beds. From 1998, drugs are being supplied on 100% central support basis, part as commodity assistance (with World Bank) and part as cash grant. Treatment is offered on domiciliary basis free of cost. Sputum +ve cases are treated with SCC drugs in SCC districts. The districts not covered under the SCC provide standard regimen to both sputum +ve and other cases. About 30% of the cases notified complete the course of chemotherapy.

Programme Review – 1992:

Though the programme has been in operation since 1962, it has not made any significant epidemiological impact on problem of TB. The programme was

reviewed by an Expert Committee in 1992 and their salient findings were:

- Less than 40% of patients completed the treatment
- Inadequate budget and insufficient managerial capacity
- Shortage of drugs
- Emphasis on X-ray diagnosis resulting in inaccurate diagnosis
- Poor quality sputum microscopy
- Multiplicity of treatment regimens.

Revised National Tuberculosis Control Programme (RNTCP):

Based on the findings and recommendations of the review, the Government of India evolved a revised strategy with the objective of curing at least 85% of new sputum positive patients and detecting at least 70% of such patients. The RNTCP is an application to India of the WHO-recommended strategy of DOTS (Directly Observed Treatment, Short-course). DOTS, in turn, is largely based on research done at the National Tuberculosis Institute, Bangalore and the Tuberculosis Research Centre, ICMR, Chennai. The components of the strategy are:

i. Political and administrative commitment at all levels
ii. Diagnosis through quality sputum microscopy of patients attending peripheral health facilities
iii. Uninterrupted supply of Short-course Chemotherapy drugs, which are given in patient-wise boxes
iv. Direct observation of treatment through involvement of peripheral health functionaries, NGOs and community volunteers and
v. Systematic monitoring, evaluation and supervision at all levels.

The revised strategy was initially pilot tested in 1993 in a population of 2.35 million and it showed remarkable success. The RNTCP was then extended to a population of 13.85 million to assess its operational feasibility. Having proved both its technical and operational feasibility, a soft loan of US $ 142 million was negotiated with the World Bank and the credit agreement was signed with IDA in June 1997. The RNTCP is being implemented in 102 districts of the country covering a population of 271 million in a phased manner. Another 203 Short Course Chemotherapy (SCC) districts with a population of 447 million are being strengthened as a transitional step for introduction of revised strategy at a later state.

RNTCP has been expanding rapidly in recent months. Until mid-1998, it covered 20 million populations, As on date, the coverage is more than 135 million. It is anticipated that another 130 million populations will be covered by early 2000.

DFID Assistance:

Department for International Development (DFID) has reached an agreement with the Government of India to support the TB Control Programme for five years by implementing RNTCP in the entire state of Andhra Pradesh. DFID is also providing assistance for strengthening Central TB Division.

DANIDA Support:

DANIDA has started RNTCP in the state of Orissa at cost of Rs. 31.95 crore over a period of five years. The coverage will be also in a phased manner. Presently, three districts – Mayurbhanj, Keonjhar and Sundergarh are implementing the revised strategy. During 1999 another three districts will be covered under the revised strategy. a mid-term review of DANIDA supported project was successfully conducted in April-May 1999. DANIDA has been requested to take-up the entire State of Orissa for implementation of RNTCP.

Involvement of NGO:

Involvement of NGOs and private practitioners in the National Tuberculosis Control Programme is of vital importance as a good proportion of patients seek treatment from them. Programme encourages participation of NGOs/PPs in programme implementation. Under the RNTCP, it is proposed to ensure full involvement of NGOs in different activities of TB control, with selection and monitoring of performance being done at District/State levels. Depending on the capacity of the NGOs it is being proposed to involve them at appropriate levels in planning, programming, implementation, IEC and evaluation of RNTCP.

Accomplishments of the Programme:

- Good quality of diagnosis. As is expected in a well-functioning programme, half of patients have had laboratory confirmation of their disease (positive smears), compared with less than one in 4 in the previous programme.
- Good quality of treatment. In the RNTCP, 8 out of 10 patients have been successfully treated, compared with fewer than 4 out of 10 in the previous programme.
- Reduce death rate of about 5% as compared to the modest estimate of 20% in NTCP.
- The above have been possible because high quality technical and training materials were produced and distributed to the district level, more than 25, 000 health staff were trained using a modular, train-the trainer approach and uninterrupted drug supply has been ensured in the programme.
- More than 1,30,000 patients have been put on treatment till date, nearly half of them in the past 12 months.
- Treatment out comes of more than 59,000 cases available till now indicate cure rate of more than 80% as compared to about 40% completion rate in the earlier programme.
- By curing patients and hence stopping tuberculosis at the source, the RNTCP has prevented more than 100,000 tuberculosis infections and saved more than 15,000 lives.

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United Efforts to Control TB and HIV/AIDS in South Asia

Dr. P. Kumar, Deputy Director, SAARC TB Centre

1. Introduction:

Tuberculosis (TB) and the Human Immuno-deficiency Virus (HIV) individually and collectively pose a serious public health challenge in the SAARC Region. Morbidity and mortality attributable to both infections are already large and there is a possibility of further sharp rise in the near future. Together they present a huge financial and social burden to our member countries. There is no doubt about an urgent need to develop an effective strategy to tackle this situation. For this purpose, there is a need to focus our attention on the following issues related to this problem:

2. Immediate Attention:

- To review the trends of the TB & HIV epidemics in the Region.
- To recommend a combined approach for effective control of the dual epidemic.
- To identify the main technical and managerial challenges for TB and HIV control.
- To formulate an agenda for collaboration of National Programmes with other sectors like industries, tourism, trade and transport, labour, schools and active non-governmental agencies working for control of these diseases.
- To develop regional strategy and country specific action plans for advocacy and community participation.

The HIV epidemic has increased the need to focus on identification and successful treatment of infectious TB cases. The TB and HIV epidemics will lead to an increase in incidence and mortality from TB and HIV. Additional HIV related TB cases will pose a serious threat to the already over burdened General Health Services and public health programmes in member countries. Unfortunately, these epidemics have not yet been dealt with seriously and effectively. If we cannot improve now we will be facing an even more serious problem of HIV/AIDS and increasing spread of multi-drug resistant TB in our communities.

3. The Epidemiological Trends of TB and HIV/AIDS:

By the end of 1998, according to new estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), the number of people living with HIV (the virus that causes AIDS) will have grown to 33.4 million, 10% more than just one year

ago. The epidemic has not been overcome anywhere. Virtually every country in the world has seen new infections in 1998 and the epidemic is frankly out of control in many places.

under age 15, which brings the number of children now alive with HIV to 1.2 million. Most of them are thought to have acquired their infection from their mother before or at birth, or through

AIDS and HIV Infections in SAARC Member Countries as of 1 June 1999

Country	Reported AIDS Cases	Estimated HIV Infections	HIVInfection Rate per 100000 Popⁿ.
Bangladesh	10	21,000	16
Bhutan	1	< 100	<16
India	6252	4,000,000	418
Maldives	5	< 100	<25
Nepal	183	25,000	66
Pakistan	59	5,000	22
Sri Lanka	77	6,000	32
Total	**6587**	**4057200**	**16-418**

More than 95% of all HIV infected people now live in the developing world, which had like wise experienced 95% of all deaths to date from AIDS, largely among young adults who would normally be in their peak productive and reproductive years. The multiple repercussions of these deaths are reaching crisis level in some parts of the world. Whether measured against the yardstick of deteriorating child survival, crumbling life expectancy, overburdened health care systems, increasing orphaned, or bottom-line losses to business, AIDS has posed a bigger threat to development ever posed by any other disease.

According to new UNAIDS/WHO estimates, 11 men, women and children around the world were infected per minute during 1998 – close to 6 million people in all. One-tenth of newly infected people were

breast-feeding.

Altogether, since the start of the epidemic around two decades ago, HIV has infected more than 47 million people. And though it is a slow-acting virus that can take a decade or more to cause severe illness and death, HIV has already cost the lives of nearly 14 million adults and children.

An estimated 2.5 million of these deaths occurred during 1998, more than ever before in a single year.

Tuberculosis is a public health problem all over the world. WHO has already declared TB as global emergency because about 1900 million people (1/3 of the world population) are infected with this organism. Each year 8 million new TB cases occur and around 3 million die from this disease worldwide.

The 40% of global burden of TB is in SAARC member countries. More than 3 million new TB cases occur and about 1 million die every year due to this serious but curable disease. TB affects the most productive age groups of the population. National TB Control Programmes are in operation in all member countries, Experts acknowledge that due to in-adequate TB programmes, the TB and HIV/ AIDS co-epidemic and emergence of multi-drugs resistant TB infection is going to create an even great disease.

4. Availing Regional Cooperation:

The South Asian Association for Regional Cooperation (SAARC) has established SAARC TB Centre, which is mandated to work for control for TB/HIV since 1996. His Excellency the Secretary General SAARC **Mr. Nihal Rodrigo** has accorded high priority for prevention and control of HIV/AIDS and TB in the Region. He has initiated intensive action in this regard. SAARC Secretariat has organised presentation and discussion on status and trend of TB and HIV/AIDS in SAARC Countries in the SAARC Secretariat on 31st August 1999 and requested all the sectors to coordinate and cooperate for the cause of the control of these diseases. He has also taken up the matter from friendly nations for seeking their support in this regard. SAARC – CIDA (Canadian International Development Agency) cooperation for TB/HIV control is in the process of approval.

11th SAARC Summit will be held in Kathmandu. We have to utilise this opportunity and address the issue of control of HIV/AIDS and TB during the Summit. If we can get an appropriate recommendation during the summit it would be extremely useful or may proved as milestone in the direction of control of these serious diseases, which would be able to save large number of valuable lives in the region.

5. Strategy of Prevention and Control:

Fortunately, a decade of solid experience shows that HIV transmission can be reduced through a mix of prevention approaches that reinforce one another, designed with the help of the target audience and delivered over a long time period. In combination, the following approaches have helped communities to achieve a downturn in HIV incidence.

- Measures to ensure the safety of blood transfusions and other procedures in health care settings

- Frank information about how to prevent transmission through sex and drug injection

- Building of skills for condom use, sexual negotiation and the making of critical decisions

- Readily available prevention tools (condoms, sterile needles, etc.)

- Prompt, user-friendly treatment for gonorrhea and other sexually transmitted disease, which significantly increase the HIV transmission risk.

- Initiatives to encourage safer behaviour through support by friends and families.

In order to address these issues and create an "enabling environment" for safer behaviour, a range of legal, economic and other structural measures may need to be taken. For example, to make condoms more affordable, a government can subsidize them or at least reduce import duties on them. In order to decrease opportunities for risk, employers can allow staff to be accompanied by their spouses when posted to other cities or countries. To discourage recourse to commercial sex, large-scale campaigns to promote respect for women can be coupled with greater educational and employment opportunities for young rural women. People with HIV infection can be helped to acknowledge their status and protect their partners by a legal and cultural environment that shields them from discrimination and safeguards their human rights.

The aim of TB control programmes must be to reduce mortality, morbidity and transmission of the disease from infectious cases to their contacts, ultimately thereby reducing the incidence of the disease and the risk of new infection until TB no longer poses a significant public health hazard.

The recommended strategy to control TB is Directly Observed Treatment Short-course (DOTS) which can reduce the incidence of TB is to detect by sputum smear examination and cure by effective short course chemotherapy as many infectious cases as possible.

6. Need of the time:

HIV/AIDS and TB have posed a serious challenge to all the experts and control programmes. The achievements of the effort put in this direction have not been proved sufficient. There is a strong need to wage a war against these enemies collectively and immediately. Advocacy and Community participation is the basic key factor to control the spread of HIV/AIDS. This need continuos wide spread and rapid publicity of the disease and the preventive measures like safe sexual behaviour and use of condoms with all available means in every possible group and the people in society.

One of the important reasons of the spread of the disease is the ignorance of the people about it. Therefore, basic educational programmes to mobilise the hole population is the need of the hours. In addition to his special efforts should be made to the vulnerable groups like commercial sex workers, injecting drug users, migrant workers, people involved in trade and transport like truckers sailors people involved in tourism industries and youths.

Combined awareness and education programmes by department of health with industry tourism, schools, trade and transports, social welfare organisations and women welfare organisations may be proved very useful.

We have to come together and make all community and everybody aware about the disease and the preventive measures.

DOTS has been proved the most strong weapon to control tuberculosis. We have to expand DOTS to all TB patients in all areas of the region in order to have effective TB control.

7. Role of SAARC TB Centre:

HIV/ AIDS and TB epidemics are spreading in accelerating speed in all SAARC countries. These epidemics are related with issues of poverty, illiteracy, lack of awareness about causes, prevention and control measures. As a result people of the region may have to pay a heavy cost in terms of economic loss and social disintegration.

Consequences of this epidemic of HIV-TB co-infection on national TB programmes in member countries include increased case-loads, low TB cure rates, high case fatality rates during treatment, under-diagnosis of TB, high default rates due to adverse drug reactions and increased emergence of drug resistant TB. Hence, early TB and HIV diagnosis, treatment and management are increasingly vital in the management of the dual epidemics in South Asia.

These diseases trace the patterns of human movement throughout the world without regard to national boundaries. Migrants are particularly vulnerable populations. Their living conditions and the nature of their employment place them at risk of many health problems, especially HIV and TB. Migrant populations within and beyond South Asia (e.g., seasonal, permanent, temporary, voluntary and forced, internal and international) also hasten the spread of HIV/AIDS and TB. National initiatives to cope with the dual epidemic in South Asia must be supplemented by regional one which are not confined by political boundaries.

Considering the seriousness of TB epidemic in the region, the member countries established a SAARC TB Centre in 1992 with the objective of prevention and control of TB. The centre has also been mandated to work for prevention and control of HIV and TB co-epidemic since 1996 and following major activities have been organised by centre since than in this regard.

SAARC Consultative Meeting on TB and AIDS:

Considering the seriousness of the co-epidemic of TB & HIV/AIDS, SAARC TB Centre organized SAARC Consultative Meeting on TB & AIDS on 23-25 Sept. 1996. It has been decided in the meeting that SAARC TB Centre will function as nodal centre for collection and dissemination of information in this regard.

Workshop relating to Research in TB and HIV:

A workshop relating to Research in TB and HIV in SAARC Member Countries was organized by STC on 28th & 29th Oct. 1997 and an action plan for Research in this field was discussed. Member Countries have agreed to work intensively to cope with the problem of TB & HIV/AIDS.

To take a wholistic approach to this problem advocacy, training, community based service delivery and research were identified as the major areas of collaboration both at intra and inter country levels.

SAARC Training Programme for Strengthening IEC Activities with Special Emphasis on TB and HIV:

In compliance to the decision of the Sixth Meeting of the Governing Board, SAARC Tuberculosis Centre organised a two week Training Programme for "Strengthening Information Education and Communication (IEC) Activities with Special Emphasis on TB and HIV" from 10th to 23rd February 1998 in Central Health Education Bureau, New Delhi, India, with following objectives.

- Describe different components of IEC in raising awareness and promoting health behaviour.
- Discuss the health situation in relation to TB and HIV in the SAARC region for assessing communication needs of the communities/clients.
- Describe various stages of IEC planning, implementation and evaluation.
- Identify different media and their role in prevention and control of TB and HIV.
- Identify various IEC strategies for high-risk groups such as, child labour, industrial workers, migratory groups, population below the poverty, sex workers, peddlers, intra-venous drug users.
- Share IEC experiments and experiences undertaken including innovative approaches among various SAARC countries to discuss the capacity building activities required for promoting IEC in health.
- Prepare an action plan for implementation of IEC activities by the participants in their respective countries.

SAARC-CIDA Workshop on TB and HIV Control:

SAARC-CIDA signed a Memorandum of Understanding (MOU) for cooperation in July 1997. It has been agreed to develop a project to address TB and HIV/AIDS. The aim of the project would be to look at the dual epidemics in order to obtain a better understanding of the best practices being adopted in the concerted management of TB and HIV/AIDS containment in SAARC member countries currently confronting both epidemics.

The project will be implemented over four years and will include the following components:

- Regional Epidemiological & Laboratory database and Information Network
- Policy and Communications

➢ Regional Laboratory

To develop a detailed project design a SAARC – CIDA workshop was organised from 1-5 March 1999 at SAARC TB Centre, Kathmandu, Nepal and the experts from, SAARC Member Countries, Health Canada, SAARC TB Centre along with the representative of CIDA and SAARC Secretariat participated at the workshop. The project document was drafted by incorporating the major components of the project.

8. Initiatives of Advocacy and Community Participation by SAARC Secretariat:

An advocacy programme was organised in SAARC Secretariat on 31st August 1999 under guidance of the Secretary General of SAARC. This was attended by a large number of executives including representatives of UN organisations and Diplomatic Missions, officials of His Majesty's Government of Nepal, Journalists, Industrialists and staff of Secretariat and the Centre. The programme was widely covered by various media. In addition, articles were written by Dr. P. Kumar, Deputy Director in Newspapers to generate public awareness as well as to get community support for prevention and control of TB and HIV/AIDS in the Region. We are also planning to have such joint programmes with Industries, Tourism and Media.

9. Role of CII (Confederation of Industries of India) in HIV control:

CII is doing a commendable job in the direction of prevention and control of HIV. They have organised a number of training for trainers' and community awareness programme in this direction. An useful communication materials on AIDS in the workplace and the community has been produced by CII which had been proved very useful and effective. This material contain Flip charts, Leaflets, Posters, Stickers and Pay cheque envelopes.

This material is used by medical, paramedical, personnel department and community workers for conducting awareness and education programmes. This also include information and materials for discussion on AIDS in the workplaces, How to live positively with AIDS and Safer sex behaviours and use of condoms. Stickers and Posters with useful messages to be put on gates of industries worker canteens, tea-shops, youth clubs, STC centres, public places and other places used by community have been proved very useful in generating community awareness.

We have planned a joint SAARC-CII programme to replicate this in other member countries to begin with Nepal where STC is located.

10. Appeal for United Efforts:

Now the time has come to work collectively to defeat the enemies of mankind (HIV/AIDS and TB). We all individually and collectively should sincerely make all possible efforts to give our positive contributions to prevent HIV/AIDS and to control TB.

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Wel-come News

Director, Deputy Director and GS Staff of the STC welcomed Dr. Tadao Shimao, President, Japan Anti-TB Association, Tokyo on 24th Nov. 1999 at the STC. Dr. Shimao was accompanied by the group of team members of Japan Women Study Group. The group observed the activities of STC.

Proposed Programmes:

1. Trainers' Training in TB Programme Management
2. Public Awareness and Advocacy in relation to TB and HIV
3. Workshop on Operational Research related to TB control in Member Countries

Letters to Editors:

To the Editor:

✉..... I am highly thankful to you for sending regularly the SAARC bulleting to me. I am working as Senior Consultant, Professor & Head of Department of TB and Chest Diseases, Pt. B.D. Sharma, PGIMS, Rohtak.....

Dr. K. B. Gupta,
Professor & Head, Senior Consultant
Chest & Tuberculosis Department,
PGIMS & Hospital, Rohtak – 124 001,
India.

✉ Thank you very much for sending the various issues of STC Newsletter and revised Directory of TB Institutions and specialists in SAARC Member Countries .....

Dr. Imtiaz Ali,
Prof. & Head,
Deptt. of Community Medicine,
SK Institute of Medical Sciences,
Srinagar – 190 011, India.

✉ Thank you for the STC Newsletter, IX No. 2 July 1999 and the Directory. These publications are highly useful.....

Dr. D. R. Nagpaul
Vice Chairman
The Tuberculosis Association of India.

✉ I just do not know how to convey our grateful thanks to you for the dedication and devotion with which you have been bringing out the STC Newsletter with lots of information, statistics. Indeed it is quiet interesting to go through the contents of the STC Newsletter which covers the information on Tuberculosis in India, Pakistan, Sri Lanka, Bangladesh and Nepal .....

Lion Dr. G. Subhram
Medical Officer,
Gandhi TB Clinic, Anakapalle 531 001,
India.

✉..... We are sure that the STC Newsletter and Directory will be highly appreciated by the readers.....

Dr. Gushekar
Lt. Col.
Offr i/c Library
Armed Force Medical College, Pune – 10, India.

✉.....We received the STC Newsletter and Directory. When are you visiting TRC? You are welcome at any time.

Dr. P. R. Narayanan
TRC, Chennai – 600 031, India.

Dear Readers,

✍

Thank you very much for sending the letters of encouragement and acknowledgements.

The letters received under the name of the editor is always considered as guidelines for the ensuing issues of the STC Newsletter. Please do not forget to write us.

Regarding the updating of the Directory of TB institutions & Specialists in SAARC Member Countries, we will try to include more and more names in the list of the TB and Chest Specialists, in next edition. Please send more information on this issue.

Thank you very much.

- Editor