



STC

Newsletter

Vol. V

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Inaugural ceremony of "Workshop for Preparation of Health Education Materials to fulfill the need of the SAARC countries"
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SAARC Tuberculosis Centre's News Letter is published every six months. Reports on the works, decisions of important meetings of the centre and recent information on Tuberculosis

Director, Dy. Director and all
GS Staff of the centre
wish our readers

**A VERY HAPPY NEW
YEAR
1996**

SAARC TUBERCULOSIS PUBLICATION

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STC News:

WORKSHOP FOR PREPARATION OF HEALTH EDUCATION MATERIALS TO FULFILL THE NEED OF THE SAARC COUNTRIES, 17-19 OCT. 1995, KATHMANDU.

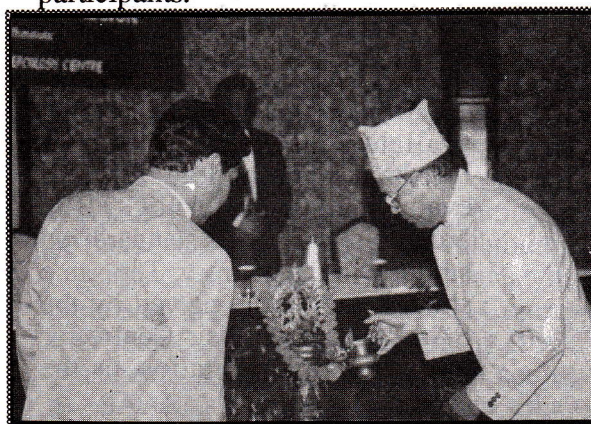
Tuberculosis currently kills three million people a year, and eight million new cases are occurring every year in the world. It is the world's foremost cause of death from a single disease. The prevalence of TB is very high in the South Asia Region. About three million 37% of the world's total of eight million new TB cases are arising annually in SAARC member countries. Experts estimate that the number of TB cases will rise sharply in the next few years due to its deadly link with AIDS. People infected with both HIV and TB bacillus have a 25-fold increased risk of developing this deadly disease. What is tragic is the fact that TB mostly affects the young and productive segments of the population of 15 to 45 years of age and accounts for about 700,000 (7 lakhs) deaths annually in our region. Yet it is a disease which is curable and preventable. Treatment of TB is one of the most cost-effective health interventions available. A strong need for effective Health Education on TB control could also facilitate in solving some of the major problems highlighted above.

The Workshop for Preparation of Health Education Materials to fulfill the need of the SAARC Region was held in Kathmandu on 17 - 19 October, 1995. Delegates from BANGLADESH, BHUTAN, INDIA, NEPAL, PAKISTAN and SRI LANKA participated in the workshop. The delegate from MALDIVES could not attend the workshop because of unavoidable circumstances.

The workshop was inaugurated by Mr. Ghana Nath Ojha, Secretary, Ministry of Health, His Majesty's Government of Nepal. Dr. D. S. Bam, Director, SAARC Tuberculosis Centre, welcomed the participants. Mr. Liaquat Ali Choudhury,

the Director, represented the SAARC Secretariat, Kathmandu.

Detailed presentations and discussions on National TB Control Programme and Health Education on TB were made by all participants.



The recommendations made in the workshop are as under:-

1. SAARC member countries must accord high priority to Health Education and Community involvement under their National Tuberculosis Control Programme to achieve the objectives.
2. Each SAARC member country should identify a senior level officer for IECTB at its National/Central level Health Education Organization.
3. The National Tuberculosis Control Programme of each SAARC member country should earmark adequate funds within their annual programme budget for Information Education and Communication (IEC) and related activities including IEC training.
4. Each member country should provide sufficient free time for telecasting/broadcasting Tuberculosis Health Education programmes on National/State Television and Radio at least three times a week on prime time.

5. The SAARC Tuberculosis Centre should develop its capacity to provide training for senior level officers in IECTB within the SAARC region. Meanwhile STC should explore with the Government of India on possibilities of organizing such courses at its Central Health Education Bureau(CHEB) to meet the immediate needs.
6. Each SAARC member country should critically review the available materials, formal & informal methodologies and evaluation system for IEC TB in order to formulate its standardized strategy in the country. The same should then be reviewed by the SAARC Tuberculosis Centre for uniform implementation in the region.
7. STC should identify a suitable date to observe as "SAARC TB Day" in all the member countries.
8. SAARC Audio Visual Exchange (SAVE) facility should be utilized for dissemination of IECTB information in the region.
9. STC should organize periodic inter-country study visits of NTCP and IEC experts of the member countries within the region.
10. STC should organize a follow-up workshop during the next financial year (1996-97) to review the action taken on the **recommendations** of 1995 workshop.
11. Member countries should be committed to sending research and other IEC TB reports to STC for dissemination to other member countries.

The recommendations were presented by Dr. Rinchen Chopel, the participant from Bhutan in the concluding ceremony chaired by Dr. Durga Prasad Manandhar, Special Secretary, Ministry of Health, HMG/Nepal.

On behalf of the participants, Dr. S. V. Dharan, the participant from India, expressed her appreciation to the STC for successfully organizing of the workshop and for excellent hospitality extended to the participants.

The meeting concluded with a **Vote of thanks** by Dr. P. Kumar, Deputy Director, STC.

Name list of the participants in the Workshop:

Dr. A. K. Md. Ahsan Ali,
Director, Mycobacterial Disease Control
Dhaka, Bangladesh.

Mr. Khondker Mahjuzul Haque
Project Director,
Bureau of Health Education,
Dhaka, Bangladesh.

Dr. Rinchen Chopel,
Programme Director,
IECH, Bureau, Ministry of Health &
Education, Thimpu, Bhutan.

Dr. Ashok Kumar,
Asst. Director General (TB)
Dte. General of Health Services,
New Delhi, India.

Dr. S. V. Dharan,
Director,
Central Health Education Bureau,
New Delhi, India.

Dr. Pushpa Malla,
Health Education Incharge,
National Tuberculosis Centre,
Thimi, Bhaktapru, Nepal.

Dr. Naresh Pratap KC
Medical Officer,
National Tuberculosis Centre,
Thimi, Bhaktapru, Nepal.

Dr. Rajendra Wagle
Medical Officer,
National Health Training Centre,
Teku, Kathmandu.

Mr. Nanda Man Sthapit,
Senior Health Education Officer,
National Health Education, Information
and Communication Centre,
Teku, Kathmandu.

Mrs. Mussrat Qayyum,
Assistant Health Education Officer,
Central Government of TB Centre,
Rawalpindi, Pakistan.

Dr. (Mrs.) V. R. Weeraratne,
District Tuberculosis Control Office,
Central Chest Clinic,
Colombo, Sri Lanka.

Dr. D. S. Bam,
Director,
SAARC Tuberculosis Centre,
Thimi, Bhaktapur, Nepal.

Dr. P. Kumar,
Deputy Director,
SAARC Tuberculosis Centre,
Thimi, Bhaktapur, Nepal.

Dr. Ian Smith,
Advisor for NTP,
National Tuberculosis Programme,
Thimi, Bhaktapur, Nepal.

Dr. Bhabana Shrestha,
Chief Medical Officer,
GENETUP, Kathmandu, Nepal.

Ms. Helen Pool,
Health Educationalist,
Mid-western Region, Surkhet, Nepal.

DEVELOPMENT OF PILOT DEMONSTRATION SITE:

STC is developing a **Pilot Demonstration Site** in Barhabise Health Centre. The selection was done after the visiting of other 3 sites in the country. There were some pre-requisites to be fulfilled before selection of the site, such as population coverage of the site, present situation of existing health facilities, involvement of NGOs or INGOs, cost effectiveness etc. Taking into consideration of all these things, we have selected the site of **Pilot Demonstration** at Barhabise Health Centre. The District Health Officer (DHO) of Sindhupalchok district and Incharge of the Barhabise Health Centre will be the key persons to implement the study programme with close coordination of STC.

Training has already been started from 27 December 1995 with orientation training for health volunteers and community leaders for awareness. The training based on the modules developed by WHO to health staff has been done from 16-20 Jan. 1996. The Registration of Cases will probably be started February. 1996.

CELEBRATION OF SAARC DECADE:

In December 1995, SAARC celebrated its first decade anniversary by organizing various activities. On this auspicious occasion STC also got an opportunity to be included in the grand photo exhibition organized by SAARC Secretariat at its premises. SAARC Tuberculosis Centre, was established in Kathmandu in 1992. This centre is the second regional centre of SAARC. Similar types of the other regional centres are SAARC Agricultural Information Centre (SAIC) in Bangladesh, 1988, SAARC Documentation Centre (SDC) in India, 1994 and SAARC Meteorological Research Centre (SMRC) in Bangladesh, 1995.

THE 18th EASTERN REGIONAL CONFERENCE OF TUBERCULOSIS AND RESPIRATORY DISEASES OF IUATLD, DHAKA, BANGLADESH, 1995.

Director, Dr. D. S. Bam and Deputy Director, Dr. P. Kumar of STC participated IUATLD conference in Dhaka. This was the first participation of the STC in IUATLD regional conference. The Director and Deputy Director were requested by organizers to chair the scientific sessions. The Director chaired the scientific session on 28/11/95 while on Deputy Director chaired a session on Role of NGOs in TB Control on 29/11/95. The Deputy Director also presented a paper on Role of STC in TB Control in the region. The role of STC was widely appreciated in the conference.

Special Articles and Technical Information on Tuberculosis

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME IN NEPAL

Dr. Dirgh Singh Bam
Director
National Tuberculosis Centre

Goal

The overall goal of the National Tuberculosis Programme is to reduce the mortality, morbidity and transmission of tuberculosis to such a level that it is no longer a public health problem.

Strategies

Whilst recognizing the important role of socioeconomic development in the decline of tuberculosis, the National Tuberculosis Control Programme (NTP) also recognizes that the specific strategy of diagnosis and cure of infectious cases assists in the control of this disease.

The main activities of the NTP include the following:

- Ensure effective chemotherapy is provided to all patients, for the recommended duration of 6 - 8 months.
- Promote early detection of infectious pulmonary cases on the basis of sputum smear examination.
- Establish a network of microscopy centres, and a system for ensuring quality of sputum smear examination.
- Organize treatment delivery and supervision of programme activities at various levels of the health system through the general health services of the country, in an integrated way.
- Ensure continuous drug supply to treatment centres by establishing a system for national procurement, storage, distribution, monitoring and quality control of anti-tuberculosis drugs, through the logistic

management system of the department of health services.

- Establish a standard system of recording and reporting in line with integrated health management information system of the department of health services.
- Monitor the results of treatment and evaluate progress of the programme by means of quarterly cohort analysis.
- Provide continuous training and supervision for all staff involved in the NTP, at various levels of the health system, in close co-operation with the National Health Training Centre.
- Strengthen cooperation between NGOs, bilateral aid agencies and donors involved in the NTP.
- Coordinate NTP activities with other Primary Health Care activities carried out in the country, especially leprosy and AIDS/STD programme.

These are achieved by the provision of a permanent and countrywide NTP, integrated in the basic health services, and assisted by national and international NGOs, bilateral aid agencies, and donor agencies.

Objectives

By the year 1999, the following general objectives will be met:

1. 85 % of new sputum smear positive patients will complete a regimen of short course chemotherapy, with

evidence of bacteriological cure.
(current 40 %)

2. 70 % of people estimated to develop sputum smear positive pulmonary TB will be diagnosed, registered, and commence treatment. (current 50 %)

To achieve these general objectives, the following **specific objectives** will be met:

- a) A nationally approved regimen of supervised Short Course Chemotherapy for patients with TB will be available in all districts, at peripheral treatment centres in the hills and the Terai, and at the district centre in the mountains.
- b) 90% of staff of the Basic Health Services involved in TB control will have received training in TB control, based on the national manual.
- c) A standardized recording and reporting system will be in use throughout the country, in accordance with the health management information system of the department of health services.
- d) A system for cohort analysis of treatment outcome for each district and region will be established.
- e) Microscopy centres will be established in each district, for every 100,000 people.
- f) A system of continuous quality control of sputum smears at the regional level will be established for all microscopy centres, with less than 10% false positives and false negatives.
- g) Primary resistance to at least one drug will be found in less than 5% of new sputum positive patients.
- h) Regional and district stores will never have less than 4 months stock of TB medicines.
- i) The national budget for the NTP will have increased to 4% of national health expenditure.

Policies

The following policies define implementation of NTP activities:

Existing Policies

- a) Passive case finding based on sputum smear microscopy of symptomatic at health institutions within the basic health services.
- b) Priority of diagnosis and treatment for people with sputum smear positive pulmonary TB.
- c) Ambulatory unsupervised treatment (i.e. not observed by a health worker) of all new TB patients with a nationally approved regimen of short course chemotherapy.
- d) Free sputum examination and TB medicines
- e) Monitoring of treatment by sputum smear microscopy in accordance with the national protocol.
- f) Cohort analysis to assess outcome of treatment and quality of NTP.

Proposed New Policies

- g) NTP targets for districts will not be based on number of cases to be diagnosed, but on percentage of cases to complete treatment.
- h) Directly observed therapy for all patients taking the nationally approved SCC regimen.
- i) Culture and sensitivity of mycobacteria restricted to retreatment patients and for national surveillance of primary resistance, and carried out in accordance with nationally approved protocol at regional and national reference laboratories.

For Further Consideration

- j) National notification of all cases of tuberculosis, with a computerized national register maintained at the NTC.

NATIONAL TUBERCULOSIS CONTROL PROGRAMME IN BANGLADESH

Dr. A. K. Md. Ahsan Ali,
Director,
Mycobacterial Disease Control &
Project Director, Further Development of TB & Leprosy Control Services,
Directorate of Health Services, MOH & FW,
Dhaka, Bangladesh

I. BACKGROUND INFORMATION

Bangladesh is situated in the South-East Asia having an area of 143,998 sq.kms. It has a population of 111 million people. Population density is the highest amongst the world :939 per sq. Km 80 % of the population live in rural areas, the annual growth rate is 2.16 % Gross National Product was 220 US\$ per capita in 1991.

Administratively the country is divided into 6 divisions, 64 districts and 497 thanas (including urban thanas)

II. NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Tuberculosis is one of the major public health problems in Bangladesh. It is estimated that the prevalence of the disease is 5 per 1000, which could make more than 150,000 new cases every year. Tuberculosis services started as a vertical programme since 1965 with 44 tuberculosis clinics, 8 segregation hospitals and 4 tuberculosis hospitals throughout the country which form the service delivery, tuberculosis control was combined to leprosy control in 1976. Both services were partially integrated into primary health care in 1980. Out of 460 thana health complexes 126 offered tuberculosis services. However, this integration did not contribute to any improvement of the results: case finding was less than 10 % of estimated cases and treatment completion rate less than 40 %. To improve the efficiency of the service the Government of the People's Republic of Bangladesh launched a project titled "Further Development of Tuberculosis and Leprosy Control Services" in December 1991. This Project is one of the largest component of the Fourth Population and Health Project financed by IDA (International Development Agency) and Netherlands. The project implementation period is six years with a

budget provision of 28 million US Dollars. The implementing technical agency is WHO. The project follows the guideline of WHO in tuberculosis control. The patient registration started since November 1993. Gradually the project will cover the whole country.

The Project strategy emphasizes the following fields:

1. Case-finding
2. Treatment
3. Staff development
4. Supervision
5. Supply of drugs and diagnostic materials.
6. Recording and Reporting system
7. Role of NGOs.

1. Case finding:

Tuberculosis case finding is passive. Symptomatic patients report to the Thana Health Complex. A smear microscopy of sputum is undertaken for the symptomatic. If the smear is positive the treatment is started. If the smear is negative three times the patients is referred to a doctor for decision.

2. Treatment

The patients are put on three different treatment categories: new smear positive cases, new smear negative cases plus extra pulmonary cases and re treatment cases. The priority is to treat and cure new smear positive cases to cut the chain of infection in the community. The treatment is supervised daily by a health worker during the first two months. The regimen for new smear positive cases is 2 months Isoniazid, Rifampicin, Pyrizinamide and Ethambutol by 6 months Isoniazid with Thiacetazone.

3. Staff Development

All staff performing duties in Tuberculosis and Leprosy Control has to be trained. A National guideline for tuberculosis control with objectives and strategies with clear instructions for case finding and diagnosis including treatment and a manual of smear microscopy for laboratory techniques were printed and distributed since inception of the programme. Training of staff of organized at central, district and thana levels. Medical Officers are trained with WHO modules "Managing tuberculosis at district level" for one week. Mid level staff is trained for two (2) days at the district level. Field level Staff is trained for one day for tuberculosis at thana level. Laboratory technicians are trained for six (6) days in smear microscopy with the laboratory guideline. A total of 12,715 health staff of different categories have been trained between August 1993 and August 1995 on various designed courses.

4. Supervision

Supervision is a key element to the success of the project for supervision the divisional consultants have received jeep, the district and thana level supervision doctors a motorcycle and supervising field staff will receive a bicycle. A supervisory check list has been developed to facilitate the work, the national and divisional level consultants have started supervisory visits to project thanas. These staff attend monthly meeting at HQ to discuss problems..

5. Supply of Drugs and Diagnostic Materials:

Previously a constant shortage of drugs contributed to the poor patient compliance there was no uniform guideline for treatment. Drugs were purchased partly by the central level partly locally. Presently this project has fund to treat every tuberculosis patient of the country. The supply system has been developed. The drugs and other supplies are purchased by the central level, distributed to the Thana Health Complex on quarterly

basis depending on the number of estimated patients during a quarter.

6. Recording and Reporting System :

A standardized recording and reporting system is established. Information on case finding and treatment results is reported by quarterly cohorts to the central unit, which compiles the data. A total of 21077 tuberculosis cases, out of which 10334 are pulmonary smear positive were reported from 4th quarter of 1993 to 2nd quarter of 1995. The age and sex distribution shows that males are more effected than females and the younger adults between age 25 to 34 are more affected by tuberculosis. The sputum conversion rate (85 thanas) at 2/3 months was 87% from the last quarter of 1993 till 1st quarter of 1995. 8 months final treatment results of new smear positive tuberculosis cases from 13 thanas shows the cure rate to 77.96%.

7. Role of NGOs

Several NGO's have carried out tuberculosis and leprosy activities in Bangladesh. It is being planned to incorporate their activities into the National Mycobacterial Disease Control Programme allowing them to take full responsibility of case finding and treatment in certain areas of the country.

III. CONCLUSION

In Bangladesh though the function of Thana Health Complex (THC) has been widely strengthened and the integration of tuberculosis programme into PHC is potentially possible, the performance upto the present is adequate and more experiences has been accumulating to the programme. To further strengthen TB and Leprosy Control Services in Bangladesh through Fourth Population and Health Project a constant support from the executing agency as well as from the donors are necessary to make it a success.

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NATIONAL TUBERCULOSIS CONTROL PROGRAMME IN BHUTAN:

Dr. Pem Namgyal
Programme Manager
NTCP, Bhutan.

The National Tuberculosis Control Programme (NTCP) is a fully integrated control activity within the overall general health services of the country. At the central level in the directorate of health, the programme has a programme manager and an assistant. There are no other vertical staff for this programme. In the district it is run entirely by the District Medical Officer, DMO, and the District Health Supervisory Officer, DHSO.

i) Objectives of the NTCP

The following are the objectives of the National Tuberculosis Control Programme:

By the year 2000.

- to achieve at least 80 % case detection rate,
- to achieve at least 85 % cure rate,
- to achieve and sustain 100% BCG coverage, and
- to reduce the prevalence of TB to 1/1000 population.

The strategies adopted are to implement nation-wide short course chemotherapy to all forms of tuberculosis, passive and early case detection through existing health facilities through appropriate case detection approach, strengthening laboratory services, strengthening of reporting and recording system, and by enhanced information, education and communication efforts.

ii) Present situation:

Bhutan has an estimated Annual Risk of Infection, ARI, of 1.5 % (Bleikar, 1991) and an estimated population of 600,000. From the 1994 data on tuberculosis, the annual prevalence of tuberculosis (all forms) is estimated to be 3.0/1000 population, an annual incidence of about 1.8/1000 population and a annual

bacillary incidence for 1994 of 0.5/1000. Of the total cases reported for 1994, 76.4 % were pulmonary tuberculosis and, of the pulmonary tuberculosis, 39.5 % were sputum positives.

iii) Chemotherapy of TB patients:

In line with the WHO recommendation on short course chemotherapy, the following are adopted for the NTCP of Bhutan:

CAT I Patients:
2SHRZ/6HT

CAT II Patients:
2SHRZE/1HRZE/5RHE

CAT IPatients:
2HRZ/6HT

As a matter of policy, for all those sputum positive cases, they are to be admitted till they become sputum negative. As not all basic health units are equipped to carry out sputum microscopy competently, any suspected case must be referred to the nearest hospital for diagnosis and initial intensive chemotherapy. However, it does not preclude the possibility of carrying out the initial intensive phase chemotherapy even at a BHU level.

iv) Drug supply organization:

Even the supply of anti tuberculosis drug is integrated within the overall drug supply to all health centres. The National Essential Drugs Programme is responsible for quantification, procurement and supply of drugs to all health facilities. All first line anti-TB drugs are available in all hospitals, and combined tablets of INH/TZN is available even at the BHU and dispensary level. In the National Referral Hospital, Thimpu, even second-line anti-TB drugs such as

ethionamide, cycloserine are made available when required.

v) Reporting:

In all health facilities, as of 1994, standard register (as per WHO recommendation) for recording of TB patients is used. From the BHUs, monthly reports are sent to the district hospital from where it is compiled and sent on a quarterly basis to the Programme Office.

vi) Laboratory services:

All hospitals are equipped with sputum microscopy facility. Although some do it, as a general rule at present the BHUs do not carry out sputum microscopy. However, the staff of the BHUs are trained to at least a sputum slide for despatch to their nearest hospital for examination.

The Public Health Laboratory (PHL) in Thimpu is responsible for the training and quality assurance for microscopy services

in the country. It is also only in PHL that at present sputum culture and sensitivity facility exist.

viii) Supervision:

At the district level, the District Medical Officer is responsible for the supervision at all levels. The Programme Management at the headquarter is responsible for the overall planning, implementation, monitoring and evaluation of progress of control activities at a national level. Annual meeting with all DMOs, DHSO, and all those concerned with TB control is conducted in order to review the activities, progress of programme implementation and the problems that are faced in the day to day implementation of control activities. The district under the DMO conduct at least one round of training for their district health workers as part of their continuing education.

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Proposed Programme of STC

1. Fifth meeting of the STC Governing Board, March 12, 13, 14, 1996.
2. Training Programme for Regional/District TB Programme Coordinators, April 1996.
3. Training for Laboratory Technician on TB Bacteriology, June 1996.

Notice to our STC Newsletter readers:

STC Newsletter Welcomes letters to the editor. Responses and Comments, regarding the information, reports etc. included in this issue are most desirable. Letters may be edited for reasons of clarity or space.

Thank you very much

- Editor

INDICATORS FOR EFFECTIVE TUBERCULOSIS CONTROL

Case finding indicators:

Absolute number of all newly notified cases by disease classification and:

- proportion of pulmonary smear positive out of all newly notified cases
- proportion of pulmonary smear negative out of all newly notified cases
- proportion of extra-pulmonary cases out of all newly notified cases

Absolute number of newly notified cases by patient category:

- new cases
- relapse
- age and sex specified breakdown of notified new smear positive cases

Case put on re treatment, other than relapses, or transferred in from other treatment areas should be included in the district registers. However, to avoid duplicate reports, they should not be included in reports of new cases or relapse. It is important that the indicators on new cases and treatment results are used for programme assessment at all levels: central regional and district/country level.

Case notification rate of PTB+ cases

- New PTB+ cases notified during a given year per 100,000 population (based on the official population estimate for the year studied)

Treatment indicators

The progress towards the overall objective of 85 % cure rate can be measured by cohort analysis of data from the standard district register. All indicators listed below provide relevant information on programme activities.

- **Cure Rate:** Number of new sputum smear positive cases who completed treatment and had at least two negative sputum smear results, one of which at completion of treatment, out of the total of new smear positive cases registered for treatment.

- **Treatment Completion Rate:** Number of new sputum smear positive cases who completed treatment, with negative smears at the end of the initial phase, but with no or only one negative sputum examination in the continuation phase, and none at the end of treatment, out of the total number of new smear positive cases registered for treatment.
- **Death Rate:** Number of new sputum smear positive cases who died during treatment, regardless of cause, out of the total number of new smear positive cases registered for treatment.
- **Failure Rate:** Number of new sputum smear positive cases who remained or became again smear positive at five months or later during treatment, out of the total number of new smear positive cases registered for treatment.
- **Defaulter Rate:** Number of sputum smear positive cases who have interrupted treatment two months or more, out of the total of new smear positive cases registered for treatment.
- **Transferred out Rate:** Number of new sputum smear positive cases who were transferred to another region or province during the course of treatment, out of the total of new smear positive cases registered for treatment.

The same system should be used to evaluate results of re treatment regimens:

In addition to these six possible outcomes of treatment, the smear conversion rate at two months provides an early assessment of the effectiveness of treatment/treatment services in the initial phase:

- **Smear conversion Rate:** Number of new smear positive cases who were negative at the end of the second month of the initial phase of SCC, out of all new smear positive cases registered in the respective time period.

Source: W H O Tuberculosis Programme, Framework for Effective Tuberculosis Control, WHO/TB/94.1

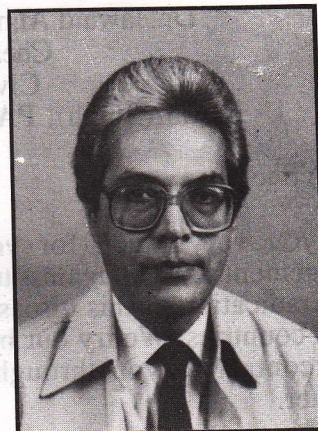
Wel-come News:

WEL COME TO NEW SECRETARY GENERAL OF SAARC SECRETARIAT

The Director, Deputy Director and all GS Staff of the STC have pleasure to welcome His Excellency Mr. Syed Naeemuddin Hasan, the Secretary General of SAARC Secretariat.

HE. Mr. Syed Naeemuddin Hasan has taken over the charge as the Secretary General of SAARC Secretariat from January 1, 1996.

Mr. Hasan started his career as Lecturer of Political Science and Public Administration at the Government College, Lahore. He joined the Foreign Service of Pakistan in 1966. Since then he has served at various positions at the Ministry of Foreign Affairs, Islamabad and in Pakistan Missions abroad. Countries of Mr. Hasan's posting include Turkey, Iraq, Yugoslavia, Czechoslovakia and Saudi Arabia.



HE. Mr. Syed Naeemuddin Hasan
Secretary General
SAARC Secretariat

Visit of SAARC TB Centre

by:

Dr. R. Kochi,
Director,
Global Tuberculosis Programme,
W.H.O. Headquarter, Geneva.

Dr. M.V.H.Gunaratne,
Regional Advisor on Communicable
Diseases in the Region,
SEARO, WHO, New Delhi.

Dr. J. Kumarasen,
WHO, Geneva.

Dr. (Mrs) C. Pitigala,
Director,
Respiratory Disease Control Programme,
Walisara, Sri Lanka.

Editorial Board of STC Newsletter

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Editor: Dr. P. Kumar

Members: D. M. Gurung, P. Bhandari, Ram Kumar KC,
K. B. Karki, G. L. Joshi

Letters to the Editor:

I received your Newsletter which is indeed surprising for me but I appreciate your efforts, this Newsletter is indeed informative. I would like to contribute to this Newsletter, please keep me informed about activities of SAARC TB Centre, as we should work together to eradicate TB in SAARC countries.

Dr. Jawaid Ahmed Sheikh,
Chest Specialist
Civil Hospital,
Badin (Sindh), PAKISTAN.

Dear Dr. Sheikh,

Thank you very much for your strong encouragement to fight against tuberculosis for the eradication of this disease from our SAARC countries. We try our best to keep regular contact to you through our *STC Newsletter*.

Thank you again.

- Editor

I find the *STC Newsletter* is extremely informative for P.G. Students and Tuberculosis workers.

Dr. (Prof.) K. C. Mohanty
Department of Tuberculosis & Respiratory
Diseases

Sir J.J. Group of Hospitals, Bombay,
Maharashtra, INDIA.

Dear Prof. Mohanty,

Thank you for your acceptance of our *STC Newsletter*.

- Editor

Thank you very much for your *STC Newsletter* No. 1 Volm. IV. Day by day the *STC Newsletter* is improving and I think it will definitely help to fight combinely against TB in this region.

Dr. Md. Azizur Rahman,
Junior Consultant,
TB Clinic, Bogra,
BANGLADESH

Dear Dr. Rahman,

Thank you very much for your letter regarding our *STC Newsletter*.

- Editor

It is a great pleasure for me to receive a copy of *STC Newsletter*. This is both informative and educative. The presentation of the document on the whole is very impressive.

Dr. P. Jagota,
Addl. Director NTI, Bangalore,
INDIA

Dear Dr. Jagota,

Thank you very much for your letter regarding *STC Newsletter* and proceeding report. We try our best to send our publications to NTI, Bangalore regularly.

- Editor

It is knowledgeable and informative for effective TB control not only the national but regional and

Dr. Abrar Ali Khan,
Sr. Medical Officer, Institute of Chest
Diseases, Kotri,
PAKISTAN

Dear Dr. Khan,

Thank you very much for your letter. We try our best to send our publication regularly to our best thinkers.

- Editor

I am in receipt of your *STC Newsletter* of July 1995 and while going through this I found it very informative and interesting. The article written by Dr. P. Kumar and Dr. Mukherjee is indeed a good academic material.

Dr. S. D. Purohit,
Principal & Controller,
Deptt. of Chest & TB JLN Medical College,
Ajmer, INDIA.

Dear Dr. Purohit,

Thank you very much for your letter regarding *STC Newsletter*, we hope your suggestions & comments are very much valuable to improve our *STC Newsletter*.

- Editor

Kindly Join Us to Fight Against Tuberculosis to Control this Disease from SAARC Member Countries

- SAARC Tuberculosis Centre

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