



STC

Newsletter

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1. Meeting of the TB Experts for compilation of TB control training manual for SAARC member countries.
2. Seminar on Production, Marketing/ Distribution and Quality Control of Anti-TB Drugs in the Region.
3. Workshop for formulation of guidelines of coordination in Government and Private Sector/NGO initiatives of TB Control.

Letters to the Editor



Inauguration of Sixth Governing Board Meeting of SAARC TB Centre and Seminar on Pilot Demonstration Areas of TB Control in Member Countries by Hon'ble Minister for Health, His Majesty's Government of Nepal
Mr. Arjun Narshingh K.C.

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
1997

SAARC TUBERCULOSIS PUBLICATION

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STC NEWS

Report of the Sixth Meeting of the Governing Board of STC and Seminar on Pilot Demonstration Areas of TB Control in Member Countries, (Kathmandu 7-10 January, 1997)

At the invitation of the Director, SAARC Tuberculosis Centre (STC), the Sixth Meeting of the Governing Board of the STC succeeded by Seminar on Pilot Demonstration Areas of TB Control in Member Countries was held on 7th-10th, January 1997. The Meeting was attended by Members of the Governing Board from all Member States except Sri Lanka. The SAARC Secretariat was represented by Ms. K. C. Namgyel, Director.

The Meeting was inaugurated by Hon'ble Minister for Health, His Majesty's Government of Nepal, Mr. Arjun Narsingh K.C. Welcoming the participants, the Hon'ble Minister emphasized the need for enhanced cooperation among the Member States for prevention and control of Tuberculosis.

National TB Programmes are facing great challenge to control this peculiar disease. Since duration of treatment is long, many patients do not complete full course, which leads to many problems including emergence of drug resistance Tuberculosis. He expressed confidence that collective wisdom & concerted efforts from member countries will be able to help National Tuberculosis Programmes to tackle with this problem effectively.

Dr. D. S. Bam, Director of STC extended a warm welcome to delegates.

The inaugural ceremony was chaired by Mr. G. N. Ojha, Secretary of Health, MOH, His Majesty's Government of Nepal.

Review of the Progress of the Centre:

The Board reviewed the progress in the implementation of the decisions taken at the Fifth Meeting of the Governing Board and formulated following programmes for the next year:

Programme for the year 1997-98:

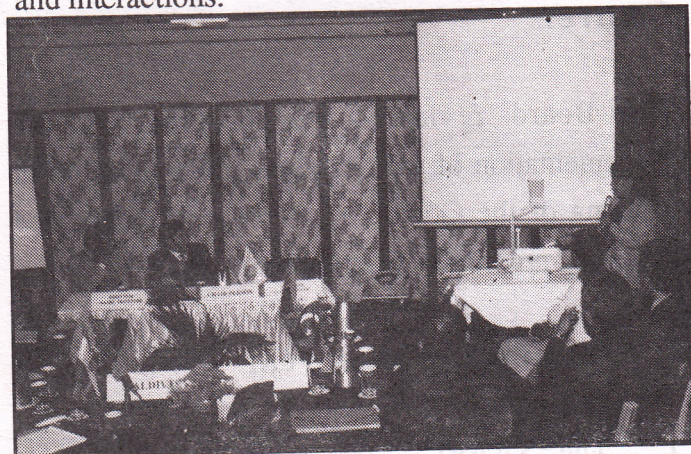
1. The SAARC training programme for strengthening IEC activities.
2. Workshop relating to research on TB/HIV in Member Countries.
3. Trainers' training for TB programme managers.
4. Seminar on Socio-anthropological research studies in the field of Tuberculosis.
5. Other regular activities like Publication of STC Newsletter and other documents etc. □

Report of the Seminar on Pilot Demonstration Areas of TB Control in Member Countries:

A Two day SAARC Seminar on Pilot Demonstration Areas of TB Control in Member Countries was held in Kathmandu on 9-10 January 1997. Delegates from Bangladesh, India, Bhutan, Maldives, Nepal and Pakistan participated in the Seminar. The purpose of the Seminar was to exchange experiences

of revised strategy of TB control in SAARC Member Countries.

The seminar began with presentations on pilot demonstration areas of TB control in member countries. All participants presented their country paper which was followed by detailed discussions and interactions.



The Recommendations made in the Seminar:

1. SAARC Member Countries should develop a strategy on defaulters tracing to achieve high cure rate under National Tuberculosis Programme (NTP).
2. National Tuberculosis Programmes of Member Countries should intensify their efforts to strengthening information, education and communication, related to Tuberculosis at all levels.
3. Even in those countries where through successful control measures good results have been achieved, it is important to maintain the commitment to sustain the achievements.
4. The progress of Pilot Demonstration Areas may be compiled and disseminated by the STC on regular basis for the information of experts in Member Countries.

5. National TB Control Programme of Member Countries should develop an strategy to involve private sector for the appropriate management of TB cases considering that large number of TB patients are being entertained by them.
6. Experience of revised strategy should be shared among Member Countries in the form of exchange of case studies and documents.

Name list of the participants:

1. Dr. A. Md. Imanuzzaman,
Chest Specialist, Professor of Respiratory Medicine, Institute of Diseases of Chest Hospital, Dhaka, Bangladesh
2. Dr. Pem Namgyel,
Ministry of Health and Education
Thimphu, Bhutan.
3. Dr. P. Biswal
DGHS, Ministry of Health & Family Welfare
New Delhi, India.
4. Mr. Ibrahim Shaheem
Dy. Director,
Disease Control & Prevention
Dept. of Public Health, MOH, Male,
Maldives.
5. Dr. Pushpa Malla
Chest Physician,
National TB Centre, Nepal.
6. Mr. Abdul Qadir
Embassy of Pakistan,
Kathmandu, Nepal.
7. Dr. D. S. Bam,
Director, STC
8. Dr. P. Kumar,
Dy. Director, STC.

Observers:

1. Dr. Ian Smith,
Advisor, NTP, Nepal.
2. Dr. K. Osuga,
Team Leader, JAT for NTP, Phase II.
3. Dr. N. Yamada,
Expert ,, ,,
4. Dr. Yamasaki
Expert ,, ,,
5. Dr. K. B. Shrestha,
Senior Chest Physician,
NTC, Thimi.
6. Dr. M. K. Prasai,
Medical Officer,
NTC, Thimi.
7. Dr. S. B. Pande
Medical Officer
NTC, Thimi.
8. Dr. N. R. Sharma,
Medical Officer,
NTC, Thimi.
9. Dr. R. Pant
Medical Officer
NTC, Thimi. □

Report on SAARC Consultative Meeting on TB & AIDS.

Kathmandu, 23-25 Sept. 1996.

The SAARC consultative meeting was held in Kathmandu and delegates from Bangladesh, India, Maldives, Nepal and Pakistan participated in the meeting. The purpose of the meeting was to develop a regional strategy for TB and AIDS control in Member Countries.

The meeting was inaugurated by Mr. Ghana Nath Ojha, the Secretary for Health, His Majesty's

Government of Nepal. The inaugural ceremony was chaired by Dr. Kalyan Raj Pandey, the Director General of Department of Health Services, His Majesty's Government of Nepal. Ms. K.C.Namgyel, the Director, represented the SAARC Secretariat. Vote of thanks was given by the Dy. Director of STC, Dr. P. Kumar.



The Recommendations Made in the Meeting:

1. SAARC Member Countries recognising the Tuberculosis and HIV coepidemic as a serious development issue facing the region are committed to cooperating in major priority areas i.e. Advocacy, Training, Research and Care of Patients with HIV and TB.
2. SAARC Tuberculosis Centre will function as nodal centre to strengthen coordination and cooperation among Member Countries by smooth flow of information on TB and AIDS control to STC with feedback to the Member Countries.
3. Member Countries will each develop a five year action plan to control the epidemics with facility for annual review of the results and dissemination through the STC.
4. Member Countries will exchange experts on TB and AIDS control to gain experience from each others programmes.

5. An annual meeting on TB/AIDS will be held in the SAARC region in all Member Countries by rotation, to review progress of activities on TB and AIDS control, to review annual action plans for TB/HIV control in each country and to identify areas for collaboration.
6. The SAARC TB Centre will establish a referral laboratory for quality control.

Name list of the participants:

1. Dr. A. Md. Imanuzzaman,
Director, MDCP and
Project Director, FDTLCS, DGHS,
Dhaka, Bangladesh.
2. Dr. Musharraf Hussain,
Professor,
Dept. of Blood Transformation
Dhaka, Bangladesh.
3. Dr. G. R. Khatri,
DDG, TB
DGHS, New Delhi, India.
4. Dr. Mohammed Shankat
Asst. Director (T) NACO,
DGHS, New Delhi, India.
5. Mr. Ibrahim Shaheem
Dept. of Public Health
Male, Maldives.
6. Dr. Pushpa Malla
Chest Physician,
National TB Centre,
Bhaktapur, Nepal.
7. Dr. Prakash Aryal,
Director,
National Centre for AIDS & STD Control
Dept. of Health Services,
Kathmandu, Nepal.

8. Dr. Sharif Ahmad Khan,
Manager,
AIDS Control Programme
4 Khybar Road, Peshawar, Pakistan.

Observers:

1. Dr. Ian Smith,
Advisor, NTP, Nepal.
2. Dr. Bal Krishna Subedi,
Dy. Director,
National Centre for AIDS & STD Control
Dept. of Health Services,
Kathmandu, Nepal.

SAARC TB Centre:

1. Dr. D. S. Bam,
Director.
2. Dr. P. Kumar
Dy. Director.

Report on Study Tour of Dr. P. Kumar, Dy. Director of STC to Pakistan:

Dr. P. Kumar , Dy. Director, STC visited the National Tuberculosis Control Programme of Pakistan on 15 to 22 July 1996. *The purpose of the visit was :*

- To study National TB Control Programme of Pakistan.
- To study revised strategy of TB control by implementing DOTS in various sites in Pakistan.

- To observe progress of Multi-centric study on Primary-Drug Resistance under progress in Ojha Institute of Chest Diseases of Karachi, Pakistan.
5. National TB Directorate, Rawalpindi is keen to have strong coordination and cooperation with STC and ready to organise some of activities decided by the Governing Board of STC, if it is taken-up through SAARC Secretariat and Ministry of Foreign Affairs, Islamabad.

Some observations of Dr. Kumar's visit are as under:

1. Appropriate clinical, research and training facilities are available in Ojha Institute of Chest Diseases, Karachi. The Director of institute desired to provide training for laboratory staff to complete Primary Drug Resistance Study effectively. There is a strong scope for initiating and coordinating more research projects at this institute.
2. Revised strategy of TB control by implementing DOTS in *Nizamabad Chest Clinic* is an effective project, however, involvement of more peripheral centres within the project area will ease the burden on main centre as well as help to achieve high cure rate.
3. A valuable training material has been developed by Directorate of TB control N.W.F.P., Pakistan. TB control programme in Peshawar is running very well, DOTS project is running successfully with high cure rate.
4. Appropriate training and research facilities are available at TB centre, Rawalpindi, a federal level chest and TB institute. Laboratory facilities with adequate trained manpower is available which can be developed reference laboratory for TB control.
6. National TB Directorate wants that multi-centric study can be initiated at TB centre, Rawalpindi along with Ojha Institute of Chest Diseases, Karachi, considering the size of population of Pakistan. He also feels that a SAARC TB Association which can function as leader of Non Governmental Organizations (NGOs) working for TB control in Member Countries should be formed. TB Association, Punjab (Pakistan) desires to have annual SAARC TB conference every year in region after formulation of SAARC TB Association.
8. TB control efforts in Pakistan is in progress in all the areas. National guidelines and five year plan has been prepared. Revised strategy of TB control based on DOTS is in progress in Pilot Sites, training manuals for staff has been prepared and training programme based on this is in progress.
9. Officials of all visited centres appreciated, the role of STC in TB control and assure for full cooperation.

Name of Officials met during the visit:

Dr. Sardar Pervez,
Director, Directorate, TB Control, Rawalpindi
Pakistan.

Dr. Gajala Ansari,
Director, Ojha Institute of Chest Diseases, Karachi.
Dr. Md. Hussain Khan,
Medical Superintendent, TB Centre, Rawalpindi.

Dr. Aba Ahmed,
The National Co-ordinators,
TB Control Health Directorate, Karachi.

Dr. Amanullah Ansari,
The Additional Director,
Dr. Sabina Tashin,
Pathologist,
Dr. Muhammad Khalid,
M.O. Pathology Laboratory, and
Mr. Hussain Khan,
Administrative Officer,
Ojha Institute of Chest Diseases, Karachi.

Dr. Ahsan Siddiqi,
Dr. Rukhshanda Sultan,
Dr. Tauqi Anwar and
Dr. Syed Sallim Hussain
Nizamabad Chest Clinic, Karachi.

Dr. Iqbal Safi,
Dy. Director, CDC,
Directorate of TB Control, NWFP, Peshawar.

Dr. Abdul Ghafoor
Project Co-ordinator,
District TB Control Officer, Alfalah Street,
Peshawar.

Dr. Hussain Siddiqui,
Medical Officer,
Mr. Mazed Nichi,
Statistical Officer

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TB Centre, Rawalpindi.

Dr. Md. Azhan Hayat,
Medical Superintendent, TB Sanitarium, Samli,
Pakistan.

Dr. Md. Nawaz,
The Secretary General, Punjab TB Association,
Lahore, Pakistan.



(Dr. P. Kumar, Dy. Director, STC with
The Director, Dr. Sardar Pervez,
Medical Superintendent, Dr. Md. Hussain Khan (STC
Governing Board Member) and other staff of
Directorate TB Control, Rawalpindi.) □

News on Audit of STC Accounts:

A joint audit team which consisted Mr. Khandu, Deputy Chief Auditor, Royal Audit Authority, Bhutan and Mr. Nawal Kishor Yadav, Director, Office of the Auditor General, Nepal audited the accounts of SAARC TB Centre of the Fiscal Year 1995/96 on Nov. 3 to 5, 1996.

Special Articles & Technical Information on Tuberculosis

National Tuberculosis Control Programme in Maldives

Mr. Ibrahim Shaheem

Deputy Director

Disease Control & Prevention,

Department of Health, MOH,

Male, Maldives..

Introduction:

TB was identified as one of the major public health problems in the country as far as 1940's. Even before Maldives obtained the membership of WHO in 1965, efforts have been made jointly to assess the prevalence and to explore the epidemiological factors that are relevant to contribute the spread of TB in Maldives as well as to formulate strategies in controlling and preventing the disease in the country.

A preliminary study was conducted in 1974 jointly by Danish Scout Aid, WHO and the government of Maldives. This study indicated that there would be an estimated 35 TB cases for every thousand population.

Based on these findings and considering the importance of the disease and its burden, the TB control programme was launched in 1976 by the government which was financially supported by Danish Scout Aids and technically supported by WHO. The activities pertaining to control and prevention of TB, was fully integrated along with

leprosy and EPI activities that were than implemented under the TB Leprosy Control Programme.

Prior to launching of this programme a separate unit under the name of TB Clinic was established in 1966 in Male. The mandate of this facility was to implement activities to control and prevent the spread of TB in the country.

Standardized combined TB treatment was introduced to the country in 1980. Till than only drugs (INH+Thiacetazone) were administered to all those patients who were under going treatment at various islands. Till the revised of the Family Health Workers (FHWs) were made available at the island, the Island Chief has been charged to administer the tablets which has to be consumed in front of the Island Chief.

Poor living conditions such as over crowding and to large rating lack of awareness on causes and spread of the disease and the leading factors that have been

the major contributing factors that has lead the slow progress of the programme.

In some cases the nomadic pattern of consultation and treatment by different physicians at the same time by some "fresh cases" of TB has not only lead to loose confidence of initial service provider, but also has paved ways in developing resistance to initial phase of drug regimens.

Lack of external support specifically for TB Control Programme was one of the causes of the progress of the programme till 1990's. However, the emergence of other deadly diseases like HIV/AIDS has now posed additional attention to be diverted on strengthening the TB activities. Training on TB case finding and management has been conducted to various level of Health Worker. District management training has been provided internationally to several level staff of Regional Hospitals.

At present, in addition to tertiary care and management of TB at the central level (Indira Gandhi Memorial Hospital and the Chest Clinic in Male'), the four regional hospitals are now being equipped with similar facilities. Efforts are now been made to extend these services at least to atoll levels of health in the country.

The case finding and contact tracing activities as well as case management (sputum collection from suspects and contacts and providing treatment as per instruction provided) are now been carried out at all levels in the country.

Compared to the situation that existed in the 1970s, TB control has made tremendous progress both in terms of disease reduction (reduction of morbidity

and mortality) as well as improving the quality and quantity of preventive measures. As of 1995 statistics the prevalence of TB among the population has been deducted to as low as 0.66 per 1000 population. Even with the additional burden, if the programme can be further strengthened with adequate resources available, the programme can be managed to a level where it no longer become a public health burden.

Vision:

It is envisaged that, the current prevalence rate will be reduced to less than 0.1/1000 by the year 2005 and that all health facilities will have the capability and facilities to carry out bacteriological diagnosis, with an efficient management as well as follow up system at island, atoll and regional level. There should also a separate ward at hospitals for those who require hospitalized care.

Objectives:

Specific objective of this programme is to reduce the incidence and prevalence of TB from 0.66/1000 population to 0.01/1000 by the year 2005.

Policy:

The existing policy of using the standardized WHO regimens will be further enforced and maintained. Private practitioners will be allowed to carry out diagnosis and treatment of TB as per protocol and guidelines formulated by Chest Clinic / Department of Public Health.

The existing policy of central registration will be maintained. The active and passive case finding activities as well as treatment will be fully decentralized. The quality of diagnosis and other

activities will be monitored and evaluated at central regional and atoll level.

and allocate enough resources to cope with the above stated objectives.

Strategies:

- Decentralization of TB control activities, mainly case detection and case management to all Health Centre levels in order to increase early case detection and case finding activities.
- Introduction and expansion of chemoprophylaxis for children considered as contacts or all those children who are exposed to infection.
- Intensification of case finding activities at all identified hyper endemic areas through decentralized system.
- Carrying out regular follow-up activities by regional level teams to assure quality of services undertaken.
- Setup mechanisms in order to evaluate the TB programme.
- Reduce transmission of TB caused by the other factors / causes such as HIV.
- Establishment of better facilities at Regional/Tertiary levels for those who require hospitalized treatment.
- Developing of close coordination and cooperation with NGO, and other organization

Sustain the BCG coverage above 95 % for all new borns.

Some Health Statistics of Maldives:

Population:

• Total Population (1995 estimate)	249,281
• Population of Male (Census 1995 preliminary)	62,973
• Maternal Mortality (per 100000)	202
• Sex Ratio (1995)	105
• Crude Birth Rate(per '000)	28
• Crude Death Rate(per '000)	5
• Infant Mortality Rate(per '000)	32
• Still Birth Rate (per '000)	22

Health:

• Population per practicing doctor	2,493
• Population per Staff-nurse	1,994
• Health Expenditure as percentage of National Budget	9.6 %
• Per Capita Health Expenditure (in Rf)	642.2
• No.of Hospital bed	305
• Population per Hospital bed	817

Revised National Tuberculosis Control Programme of Bangladesh

*Dr. Abu Md. Imanuzzaman,
Professor of Respiratory Medicine
Institute of Diseases of Chest & Hospital,
Dhaka, Bangladesh.*

Introduction:

Tuberculosis is one of the major public health problem in Bangladesh. It is estimated that the prevalence of the disease is 5 per 1000 which would make more than 150,000 new cases every year. Tuberculosis services started as a vertical programme in 1965. 44 Tuberculosis clinics, 8 Segregation Hospitals throughout the country formed the service delivery. Tuberculosis Control was combined to Leprosy Control in 1976. Both services were partially integrated into primary health in 1980. However, this integration did not contribute to any improvement of the results, case findings was less than 10 % of the estimated cases and treatment completion rate less than 40 %.

To improve the efficiency of the services the Government of the People's Republic of Bangladesh, launched a Project titled "Further Development of TB & Leprosy Control Services in Bangladesh" in December 1991. This project is the largest component of the Fourth Population and Health Project financed by IDA. The project implementation period is six years with a budget of about 28 million US dollars.

Objectives and Strategies:

The objective is to cure 85 % of new smear positive pulmonary tuberculosis patients (instead of the

present 40%) & to find 70% of those cases (instead of the present less than 10%). The sputum smear conversion of new positive pulmonary cases should be 85% at two months of treatment.

In order to achieve the above objectives, the main strategies are followings:

- Ensure effective chemotherapy to all patients;
- Promote early detection of sputum smear positive tuberculosis;
- Organize treatment delivery upto union level;
- Introduce a standardized recording and reporting system;
- Monitor results of treatment and evaluate progress of the programme by means of quarterly cohort analysis;
- Provide regular training and refresher course for all staff involved;
- Strengthen cooperation between Government of Bangladesh and non-governmental organizations involved in tuberculosis control.
- Coordinate tuberculosis control activities with leprosy control activities integrating them to PHC throughout the country.

Programme Administration:

The Project Director is the Director of Mycobacterial Disease Control. He is assisted by technical and

administrative staff. At the divisional level, the programme is supported by Divisional Director Health and Divisional Consultant TB & Leprosy. At the district level Civil Surgeon is responsible for implementation of National Tuberculosis Control Programme and at thana level Thana Health and Family Planning Officer is solely responsible for NTP.

Staff Development:

Entire staff at all levels involved in Tuberculosis Control Programme have been trained prior to expansion of the project.

A total number of 24,039 health manpower have been trained till the end of Nov. 1996. Medical Officer are trained for one week WHO training modules. Divisional Directors and Civil Surgeons have received one day orientation. Laboratory Technicians have received one weeks training. Mid level staff have received 3 days and field staff 2 days training.

National guidelines for tuberculosis control and technical guidelines for Laboratory Services were developed and distributed.

Fellowship:

A total of about 102 persons availed of WHO fellowships. Most of the fellowships came under one week study tours.

Expansion of the Project:

The implementation of NTP started in 4 thanas in Nov. 1993. The project has expanded to 307 thanas by Nov. 1996. The present coverage under the Project is 92.1 million population which represents, 66.7% of the country. The four NGOs (BRAC,

Damien Foundation, HEED and DBLM) have started the project implementation in tuberculosis from 1994 presently covered 110 thanas by Nov. 1996. Population coverage is 33 million, 23.9% of the country.

The 44 TB Clinics have started the project implementation on a small scale in the municipal thanas and Sadar thanas, where they are situated.

Operational Accomplishments:

1. Case finding:

From the 4th quarter 1993 to 3rd quarter 1996 the total number of registered cases in Government implemented thanas were 23,378. Out of them 13,474 were new smear positive cases, 8,203 are new smear negative, 628 are relapse and 1073 are extra pulmonary tuberculosis.

Out of 44 TB clinics, 58,647 tuberculosis cases reported by the end of 3rd quarter 1996. 21,662 are new smear positive 33,168 are new smear negative 637 and 3180 are relapses and extra pulmonary tuberculosis respectively.

To summarize the case finding activities it has been noted that a total of 93,271 cases of tuberculosis has been detected since Nov. 1993 to 3rd quarter of 1996. Out of which 44980 are new smear positive, 1481 are relapses, 4,611 are extra pulmonary tuberculosis and 42,199 are new smear negative. Mostly 25-44 age groups are affected and males are predominant than females.

Treatment Results:

Out of total 1022 pulmonary smear positive cases, 702 cases were cured upto 2nd quarter of 1995

through government thana health complexes, the percentage of cure is 69%. TB treatment is given free of charge to the patients. Infectious cases receive short course chemotherapy (duration 8 months treatment category I and II) and non infectious cases one years chemotherapy (Category III). These different treatment categories are WHO recommendations. The strategy of treatment delivery to infectious cases is DOTS(Directly Observed Treatment Short-course). This strategy is the only way to guarantee cure rates.

The smear conversion of TB patients is 82% at 2/3 months of the short of the treatment during 1993-96.

2/3 months' smear conversion of new smear positive tuberculosis cases (period 1993-1996)(total amount 24727)

Smear negative	20385 (82.44%)
Defaulted	1779(7.19%)
Transferred out	554(2.24%)
Died	617(2.50%)
Smear positive	1392(5.63%)

NGO Cooperation:

The government has signed a memorandum of understanding with the Leprosy Coordination Committee (LCC) and BRAC concerning cooperation in the tuberculosis and leprosy services. The LCC represents eleven NGOs who together are responsible for Leprosy Control in 23 districts covering 195 thanas and 7 urban areas. Damien Foundation and Danish Bangladesh Leprosy Mission (DBLM) under the umbrella of LCC have started tuberculosis control in some districts. BRAC has started in Mymensingh, Dinajpur and Bogra since December 1994.

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Supervision:

The central level staff has visited once most of the project thanas, several NGO facilities, TB Clinics and hospitals through out the country. The visits were mainly carried out by WHO consultant. The supervision by divisional consultants and by district medical officers is regular. At the thana level Thana Health and Family Planning Officers/Medical Officers supervise their respective thanas.

A computerized supervisory plan has been made, so that it is easy to follow the realization of the supervisory visits. A supervisory check list has been developed and utilized to facilitate the work.

Recording and Reporting:

A standardized recording and reporting system for TB control has been established to have the epidemiological impact of the disease. Reports on case finding, smear conversion and treatment outcome are sent quarterly from the implementing areas to the central level. A feedback of the results are sent to those areas again.

IEC Activities:

IEC activities have been limited to printing of posters, leaflets and stickers and on interviews on TB and Leprosy. A professional advertising agency was hired to prepare material and TV programmes on TB and Leprosy. Advocacy meetings have been organized at district level. Scouts, teachers, local politicians and NGOs are involved in health education and awareness campaigns.

Recently TV spots and radio jingles have been broadcasted and these are proposed to be continued periodically in 1996.

Drugs and Logistics:

Two emergency drug consignment from WHO were received in 1994. Drug procurement for 1994-95 was done by the GOB through local competitive bidding (LCB). In 1996 the drugs will be ordered through international competitive bidding (ICB) by GOB.

The quantity of drugs has been sufficient. Also the distribution has been adequately functioning. The Distribution of drugs and other materials has been directly from the central level to the thana level. The district stores are used as intermediate stores. The project delivers the drugs on quarterly or six monthly basis to the district stores. From there the TH & FPOs have to collect their drugs.

The quantity of drugs to the respective thanas is checked by the central level. The amount of drugs is based on the number of cases treated in the previous quarter allowing for a reserve stock for 3 months,

for this purpose a drug request form has been developed for the thana level.

Transport:

34 motorcycles were received in 1993 and distributed in 1994 and 1995. The motorcycles are distributed through a hire purchase system to District Medical Officers, Junior Consultants and TH&FPOs and Medical Officer at thana level for supervision.

200 bicycles were received in 1995. They are distributed to Leprosy Control Assistants involved in TB Control Programme.

Conclusion

Through NTP being integrated in general health services it needs constant supervision and monitoring to achieve the cure rate to over 85%. DOTS is really possible in Bangladesh with adequate health staff and infrastructure to have good treatment results.

Table No. 1. Training on TB and Leprosy 1993-1996 (November)

Category of Manpower	No. of Staff Trained				Total
	1993	1994	1995	1996	
Divisional Director, Civil Surgeon, Dep. Civil Surgeon	10	18	40	0	68
TH&FPO, MO (TB/Lep Designated)	52	187	652	165	1056
TB Clinic Consultant, MO TB Clinic, National Consultants	41	40	44	0	125
Mid-Level Staff	42	326	1617	950	2935
Field Level Staff	220	2007	14842	2550	19619
Laboratory Technicians	29	66	91	50	236
Total	394	2644	17286	3715	24039

**Table No. 2. Case-finding of Tuberculosis in Bangladesh
(period 1993 - 3rd quarter 1996)**

Reporting Unit	New Smear Positive	Relapse	New Smear Negative	Extra Pulmonary	Total
Thana Health Complex	13474	628	8203	1073	23378
Tuberculosis Clinic	21662	637	33168	3180	58647
NGOs	9844	216	828	358	11246
Total	44980	1481	42199	4611	93271

Status and Trend of TB and HIV/AIDS Co-epidemic in SAARC Countries

*Dr. Prahlad Kumar
Dy. Director
SAARC Tuberculosis Centre
Kathmandu, Nepal.*

I. Introduction:

Tuberculosis (TB) and the Human Immuno Deficiency Virus (HIV) together 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 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 reason, we have to focus our attention on the following issues related to this problem:

- 1) To review the trends of the TB & HIV epidemics in the Region.
- 2) To discuss the interaction of HIV and TB and their impact.
- 3) To recommend an approach for effective control of the dual epidemic.
- 4) To identify the main technical and managerial challenges for TB treatment in people with HIV.
- 5) To formulate an agenda for collaboration of NTPs with National AIDS Programmes.
- 6) To develop country specific action plans for managing the epidemics.

The HIV epidemic has increased the need to focus on identification and successful treatment of infectious TB cases. The TB and HIV co-epidemic

will lead to an increase in incidence and mortality from TB. 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, the TB epidemic has not yet been dealt with seriously and effectively. If we cannot improve now we will be facing an even more serious problem with the increasing spread of multi-drug resistant TB in our communities.

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

Tuberculosis is as old as the human race and has been creating problems since then all over the world. Over the last fifteen years the HIV/AIDS epidemic has emerged world wide. The epidemiology of TB and HIV/AIDS varies widely around the world and the capacity of health systems is also different. Globally TB is increasing in both prevalence as well as incidence. AIDS cases are also increasing. During the last decade the interaction of TB and HIV/AIDS has become increasingly recognized. The time has come to strengthen our efforts on HIV and TB prevention, AIDS patient care and TB patient care. Communities, Governments, Public and Private Health Agencies have to work against TB and HIV/AIDS collectively to make a maximum impact.

III. The TB Epidemic:

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 world wide.

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, however the results in these programmes have been far below the expectations. 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.

Table 1: Estimated TB Incidence During 1996 in SAARC Countries

Country	Estimated TB Incidence in Million	Rate/100000 Population
Bangladesh	0.31	241
Bhutan	0.004	241
India	2.33	246
Maldives	0.0001	241
Nepal	0.05	241
Pakistan	0.36	254
Sri Lanka	0.04	241
Total	3.094	241-254

IV. The HIV/ AIDS Epidemic

World-wide, 2.7 million people are expected to become newly infected with HIV in 1996 alone and 1.1 million adults will die of AIDS. Approximately

60 % of HIV positive adults develop AIDS within 12-13 years of infection. Once they do, their average survival time is approximately 6 months in developing countries and around three years in developed countries.

Every day, there are around 8,500 new HIV infections of that, about 1,000 occur in children under 15 years of age. Most of the remaining occur in their economic and reproductive life. An increasing proportion are in women, now representing 42 % of HIV infections, over half are in young people under 25 years old. All together, nearly 8 million people, including 1.5 million children under 15, have already developed AIDS since the epidemic began and nearly 6 million have died.

Notification of Cases of AIDS in the SAARC Region up to 1 December 1995 are shown in Table 2. there is considerable under reporting of AIDS & HIV.

Table 2; HIV/AIDS Infections IN SAARC Member Countries As Of 31 Aug. 1996.

Country	Reported HIV/AIDS Cases		Estimated HIV Infection
	HIV infected Cases	AIDS Cases	
Bangladesh	63	10	<20000
Bhutan	00	00	75
India	45866	2639	1500000
Maldives	10	5	60
Nepal	463	52	5000
Pakistan	268	59	5000
Sri Lanka	NA	52	6000
Total	46670	2817	1536135

Source: WHO/SEARO

V. The TB/HIV Co-epidemic:-

The relationship between TB and AIDS is a relatively new chapter in the history of HIV. The AIDS epidemic began to be well recognized in about 1981, but the association with active TB was not noted until around 1984 when the Miami group first

described it in Haitians. Subsequently, it was reported in injecting drug users in the US in 1984 and 1986, in Africans in 1986, and in homosexuals in 1986 and 1987.

In comparison to TB, the Human Immunodeficiency Virus (HIV) epidemic is a relatively small problem numerically, affecting about 14 million people. At present, approximately 6 million people are co-infected with both TB and HIV (figure 1). However, fewer than half that number are ever treated at all, and fewer than a quarter receive successful treatment. In addition, like TB itself, the problem is growing. New TB cases attributable to HIV co-infection are estimated at 300,000 in 1990 (4% of total new TB cases) and are expected to increase to around 1.4 million cases per year by 2000, equivalent to about 14% of expected TB cases.

Factors of Resurgence to TB:-

It is important to remember that, although HIV may compound the problem of TB, accelerate it and call attention to it, the majority of people with TB worldwide are not infected with HIV. HIV and AIDS have clearly played a role in the recent resurgence of TB, but they are not the only factors. The previous decline in prevalence of the disease has led, in some countries, to a reduction in the resources available for its control. For the same reasons, physicians are less well educated about it than before. Social changes such as increased substance abuse have also had a considerable impact, as has the emergence of drug-resistant organisms.

Both the TB and HIV pandemics are major public health concerns, each deserving priority on the international health agenda and requiring specific

measures for prevention, control and patient care. HIV has been the subject of an intensive international effort aimed at prevention and reduction of personal impact.

VI. The Solution:

• A dual strategy for a dual epidemic:-

Close collaboration and cooperation between TB and AIDS programmes is vital since the two epidemics are so intimately linked. However, TB and HIV/AIDS are distinct health problems and different strategies are needed to address them, although both are dealing with people who need care & support.

- prevention of new HIV infection to slow the spread of HIV/AIDS and
- cure of active TB disease should be the highest priority of control of this coepidemic.

VI a. HIV/AIDS prevention:

There are over 14 million people alive today with HIV infection, and the HIV epidemic is growing at a rate of over 8500 infections a day. Because HIV is primarily transmitted through sexual intercourse, most of those infected are young adults and people in early middle age- the parents, workers and leaders of society. To make matters worse, 9 out of 10 people with HIV live in a developing country. As a result, the epidemic is threatening the very process of development.

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 gonorrhoea 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.

VIb. Principles and Strategy of Tuberculosis Control:

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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. Where TB prevalence has already been reduced to very low levels, and if resources are sufficient, this basic control strategy can be supplemented by preventive chemotherapy of infected (no yet diseased) individuals to sterilize their TB infection.

The recommended strategy to 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. The basic elements of the recommended policy for TB control are the same for countries with both high and low prevalence of HIV and can be summarized, in brief, as :

- * Government commitment to a TB programme aiming at Nation-wide coverage, as a permanent health system activity, integrated into the existing health structure with technical leadership from a central unit.
- * Proper identification and treatment of infectious (sputum smear positive) cases. Case detection should normally be through passive case-finding, that is, the detection of sputum smear positive cases among those persons who present to the health care system because of symptoms. If resources permit, infectious cases can be identified also by culture after microscopy to identify more cases which have the likelihood of becoming highly infectious.
- * Supervised administration of short course chemotherapy with Rifampicin containing

regimens, meeting approved recommendations, to at least all sputum smear positive cases.

- * Accurate registration of each patient, with monitoring and regular evaluation of the progress during treatment and outcome of each case and with careful classification into new and previously-treated cases for the purposes of regimen prescription and for cohort evaluation of treatment outcomes.
- * Maintenance of a regular drug supply of all essential anti-TB drugs.

Already these elements are being successfully applied by a number of National TB programmes in developing countries. The interplay of HIV and TB do not alter the principles or techniques for the control of TB, but HIV quickly exposes any inadequacies in TB control because it compromises immune response and telescopes the rate at which disease develops. It is critical therefore that governments act to ensure that good TB control practice are in place and are strengthened, if at all possible before the HIV epidemic progress.

VII. Agenda for Collaboration of TB Programmes with AIDS Programme.

Well-functioning national TB programmes can collaborate with all parts of a health system to train health workers and support health institutions to deal successfully with TB in an HIV-prevalent setting. They can help carry out HIV/TB related research. They can join with AIDS programme to provide training on TB/HIV for primary care workers health institution staff and private practitioners dealing with co-infected partners and communities. Where appropriate, they can provide help with TB screening and testing centres as well as provide technical assistance in establishing preventive therapy programmes in special settings for co-infected persons. In selected settings they can

help train health workers with counseling of partings on HIV/TB issues. With AIDS programme staff, they can train health workers to recognize and properly treat opportunistic infections other than TB in HIV infected persons.

Therefore, strong collaboration of TB and AIDS control programmes are needed in following areas:

a. Advocacy:

The severity and implications of both the AIDS and TB pandemics can be taken into account by the public information and education activities of both national AIDS and TB Programmes. The objective should be to achieve a good widespread understanding of the burden and the strategy to deal with these epidemics. Policy makers at the country level need a clear conception of how the epidemics interact and the rational steps that can be taken for most effective HIV and TB prevention and treatment and AIDS care.

b. Training:

In most countries, health workers should receive basic information on control and prevention of both TB and HIV and basic information about care for AIDS patients. National TB staff could prepare basic training programmes for health workers to better recognize and know how to refer TB suspects for confirmation of diagnosis and entry to treatment. Likewise, they could prepare training programmes for TB workers at districts and national level to be knowledgeable about and able to provide better technical and supervisory support to general health workers dealing with HIV/TB cases. At the regional/inter country level, national TB programme

managers and national AIDS programme manager should meet to exchange experiences, materials and insight into problems and successes, and to define further areas where collaboration between the programmes at the district level and above can enhance the support available to health services and health institutions to deal with appropriate prevention and care activities.

Where there is a high or rising level of HIV infection and TB programme are being strengthened, training on HIV issues could be provided to district and higher level TB managers.

c. Improved AIDS Care and prevention of associated TB:

AIDS programmes are exploring different options to cope with the large increase in AIDS cases predicted in many areas. This includes development of home or community based care programmes for AIDS patients which may be complementary to hospitalization. The objective is to provide low cost, humane and effective care for the growing numbers of AIDS patients in many poor communities.

d. Research:

Operational research is needed to develop and test practice for coping with health service overload created by TB and HIV/AIDS in both poor and middle income country settings. Priority topic areas include effective alternative supervision methods for TB chemotherapy (including use of single dose or combination drug forms), improved clinical diagnosis protocols for HIV-associated TB, and better, rapid TB programme evaluation techniques (such as smear conversion reporting and cohort analysis). In addition, the research can be usefully further done on the topics of cost effectiveness of

TB treatment in HIV infected persons, preventive therapy, appropriate TB screening practice, education materials, and education messages and materials to encourage voluntary HIV testing and counseling in health workers.

Considering the seriousness of the coepidemic 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 and this is the first publication in compliance of the decision made in the above mentioned meeting.

References:

1. *The HIV/AIDS and Tuberculosis Implications for TB Control;* WHO/TB/CARG(4)/94.4.
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3. *TB/HIV, A Clinical Manual, WHO/TB/96*
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5. *HIV and AIDS: Where is the epidemic going ? Bulletin of WHO, 1996, 74 (2): 121-129*
6. *Women and AIDS in South Asia: Report of Regional Workshop on AIDS Policy in South Asia, February 5-9, 1996, Kathmandu, Nepal.*
7. *Biomedical aspects of HIV and AIDS: John M. Dwyer, Current Science, Vol. 69, No. 10, 25 November 1995.*
8. *A deadly Partnership, Tuberculosis in the Era of HIV, WHO/TB/96.204.*

Wel Come News:

STC Visits:

- A team of Board Members consisting, *Dr. A. Md. Imanuzzaman, Bangladesh;* *Dr. P. Biswal, India;* *Mr. Ibrahim Shaheem, Maldives* and *Dr. P. Malla, Nepal* visited SAARC TB Centre on 10th January 1997. The Board Members were accompanied by **Mr. Ashok Atri**, Director, SAARC Secretariat. **Madam Atri** kindly agreed to visit the centre.
- The Director and all staff of the STC welcomed **Ms. Keri Nordheim Larsen**, Hon'ble Minister for Development Cooperation of **Norway**, in SAARC TB Centre on 23 Nov. 1996. Ms. Larsen observed the activities and reports of the centre.
- The STC welcomed the delegate of an European Commission **Mr. Luca Ferruzzi**, Tropical Forestry Consultant and **Mr. Fintan Glynn**, Economic Cooperation Consultant on 3 Dec. 1996. Dr. P. Kumar, Dy. Director, STC introduced the delegate with the staff members of the centre and presented activities of the centre.

Proposed Programmes of STC

1. **Workshop for Formulation of Guidelines of Co-ordination in Government and Private Sector/NGOs Initiatives of TB Control.**
2. **Seminar on Production, Marketing/Distribution and Quality Control of Anti-TB Drugs in the Region.**
3. **Meeting of TB Experts of Compilation of TB Control Training Manual for SAARC Member Countries.**

Letters to the Editor

The Editor,

✉a summary of the news contained in your STC Newsletter is also published in the Indian Journal of Tuberculosis, under news and notes, for the benefit of our readers. The test description regarding training activities could be better if a bit briefer. Allow me to congratulate you on the well brought out Directory of Tuberculosis Institutions and Specialists in SAARC Member Countries, which is bound to be very useful, specially because

is so handy.

Dr. D. R. Nagpaul,
Vice-Chairman,

The Tuberculosis Association of India
3 Red Cross Road, New Delhi - 110 001, India.

✉ We thankfully acknowledge the receipt of the publications.

The Medical Library
University of Jaffna,
Adiyapatham Road, Kokuvil, Jaffna.

✉ Thank you very much for sending STC Newsletter. Please supply me STC Newsletter and other publications regularly.

Dr. Nisar Khan
Village & Post Office, Kheshki, Payan, Tehsil &
District Nowshera
NWFP, Pakistan.

✉ Thank you for sending the Directory of TB Institutions & Specialists in SAARC Member Countries. I am pleased to see this. It has been brought out very well and would help to exchange

views between institutions and experts of the SAARC Member Countries.

Dr. R. C. Jain,
LRS Institute of TB and Allied Diseases
New Delhi, India.


✉ Received STC Newsletter and TB Directory. It provides useful information regarding TB control activities in the SAARC region.

Dr. S. U. Bhakta
State TB Officer
Municipal Corporation of Delhi
India.

✉ It was pleasure to go through the STC Newsletter. Vol. VI. I congratulate you and your dedicated team for this venture.

Dr. R. M. Thakkar
Director
Tuberculosis Research Centre Amargadh- 364 210
Gujarat, India.

Dear Readers,

 Thank you very much for sending acknowledgments about STC Newsletter Vol. VI. Your communication is source of our inspiration.

We have received many many letters from our other readers, regarding STC Newsletter, SAARC Directory of Tuberculosis Institutions & Specialists in SAARC Member Countries, and other publications of this centre. Specially the STC Newsletter is your publication, without your guidance and suggestions it is not possible to make a useful publication. We request all of you to kindly keep on guiding us.

It is regretted that, we could not publish all letters due to constraints of the space.

Free Publications of SAARC Tuberculosis Centre

1. STC Newsletter Vol I to VI.
2. Proceeding Reports
1st. Trainers' Training
TB Programme Managers
TB Control Through PHC
3. Directory of Tuberculosis Institutions & Specialists in SAARC Member Countries, Jan 1996.
4. Role of SAARC Tuberculosis Centre in TB Control - A pamphlet
5. NTPs in the SAARC Member Countries

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

Editorial Board of STC Newsletter

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Readers' Views on STC Newsletter

Section 1: Cover page, front: Please mark \surd in the appropriate box and give suggestions:

Design Fair Good Excellent

Colour Used Fair Good Excellent

Your suggestions:

Section 2: Inside pages Please write 'Y' for yes 'N' for no in appropriate box and give suggestions:

STC News Useful Sufficient Satisfactory

Special Articles and Technical Information on Tuberculosis:
Useful Sufficient Satisfactory

Welcome News:
Useful Sufficient Satisfactory

Proposed Programme:
Useful Sufficient Satisfactory

Letters to the Editor:
Useful Sufficient Satisfactory

Your suggestions:

Section 3: Cover page Back: Information given on this page.

Necessary Unnecessary Useful

Your suggestions:

Please fill-up the above form and send us in our address. Your suggestions will help us to improve the next issue. Name of the sender of above form will be included in our mailing list for free copy of STC Newsletter. Don't miss to write your name and address.



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