State of Tuberculosis in Bangladesh

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Dr. Obaidur Rob, Country Director, Population Council: Vital registration system should be introduced in the NTP to find out accurate statistical data which is the key to control. The Health department of the government will be the main actor, not the NGOs. We must reform our health sector otherwise our next generation will not survive. The whole TB programme is a vertical programme which requires further examination for improvement.

Faruque Ahmed, Director, BRAC Health Programme (BHP): Sustainable political commitment is the prime issue for the success of NTP. This can be ensured through two ways. First, by mobilizing resources both domestic and international and Second, by mobilizing the partnership programmes. In Bangladesh the national budget is not adequate for the health sector. The government allocates lesser budgets for education and health than for defence. Another issue is that the government officials may not utilize this budget efficiently or put it in the right places. I propose local partnership, share resources and more advocacies at the national level.

Monitoring at local level especially in district and sub-district level is needed for successful sustainability of TB controlling programme. I also propose that as owners of garments industries have a significant role to play on TB controlling issues, they should be part of the Partnership.

Dr. Asif Mujtaba Mahmud, Associate Profrssor, Respiratory Medicine, National Institute of Diseases of Chest and Hospital: Over the last three years, the Government of Bangladesh is not associated with "World TB Day", perhaps, because, it is not on the government's priority list. The NGO and other partners like BRAC have kept World TB Day going. The media also focuses on TB only occasionally. WHO focuses on TB Days in cities like Paris, New York, etc, but not in Bangladesh. I recommend creating focus on World TB day on the government priority list. Celebrities from the younger generation may act as ambassador who will convey the message to the people. Media has to play its role in creating this priority.

Afsan Chowdhury, Director, Advocacy and Human Rights Unit, BRAC: I would emphasise on both national level policy making advocacy activities and behavioural change related actions at the field level. Both need to be conducted and with equal emphasis. BRAC has conducted 3 small pilot advocacy projects in the rural areas and initial outcomes are positive. I strongly recommend more emphasis on Partnership which is a critical issue. We must recognize that the existing partnership is not adequate and we must work towards building a more effective one.

Prof. Dr. Mirza Mohammad Hiron, Associate Professor, National Institute of Diseases of Chest and Hospital (NIDCH): There are several delivery modes. BRAC is implementing the DOTS by the Shasthaya Shebika and different organisations are implementing the same through village doctors. They are treating about 35% of the cases. The treatment activities are the task of the village doctors not of the Shasthaya Shebika who monitors the side effects of drugs. BRAC staff is doing sputum smear examination but the rest 45% who have developed extensive tuberculosis go to private practitioners for treatment. I would also like to ask why BRAC has not involved doctors or technicians to control the tuberculosis.

Abdul-Muyeed Chowdhury, Executive Director, BRAC: In response to the health service provider issue (whether Community Health workers are good for TB programme) raised by Dr. Hiron, I would say that it is a question of resources, not just money but also human resources. Today, we are dealing with 35% smear positive tuberculosis cases. The rest 65% will automatically come forward.

Dr. Zafrullah Chowdhury, Projects Coordinator, Ganoshasthaya Kendro: The Government has to produce drugs for TB cure that will be more cost effective. If we ourselves produce the drugs, it will cost say Tk 200 per month compared to Tk 1000 per month now The Government has to force pharmaceutical companies to produce TB drugs. Medical officers as well as students should have clear knowledge about TB and necessary steps and training should be taken for this. Socializing the health issue rather than medicalizing it will ensure sustainability.

Major General Dr. A.S.M Motiur Rahman (Rtd.), Chief Advisor of national HIV/AIDS programm and Chairman, Technical committee, National Aids Committee: On the matter of MDR (Multi-drug Resistant) TB, I think the doctors, private practitioners and clinics have responsibility for its advocacy. I would also suggest creating linkage among the disease control programmes such as HIV/ AIDS and Tuberculosis.

Tahmina Aziz, Director, (MBDC and Line Director-TB and Leprosy Control Program): I would recommend we take aggressive approach for TB control which would be very helpful for us. The approach of all sectors of private practitioners, hospitals, educational institutions, community peoples, community leaders, political leaders and imams (clerics) should be addressed.

I would however differ in my opinion with Obayedur Rab. The tuberculosis programme is not a vertical programme. At the same time I propose the integration of other health programmes with tuberculosis control programme. I would also like to add that the family planning issue should be given the same priority.

Dr. Khandoker Ezazul Haque, National Consultant, WHO: I would suggest the implementation strategy of partners who are working on the same issue. Dr. Viqarunnessa may explain about homogeneous strategy and guidelines not only for advocacy, communication and social mobilization but effective implementation of whole programmes, monitoring system and for evaluation.

Damien Foundation gives emphasis on village doctors but BRAC gives emphasis on Shasthaya Shebika. In this circumstance I propose strong advocacy for developing a homogeneous partnership system which will ultimately help us in effective implementation.

Prof. Dr. Md. Mostafizur Rahman, Director and Head, Department of Respiratory Medicine, National Institute of Diseases of Chest and Hospital (NIDCH): Due to lack of knowledge and awareness, people take drugs without consultation with a specialist. And sometimes they suffer from the side affect of wrong treatment. About 60 to 80 patients who are admitted to hospitals are suffering from MDR-TB. This MDR-TB creates another MDR-TB case which will not respond to the conventional TB drug. In our country for the diagnosis and treatment of MDR-TB there is no laboratory facility.

Dr. M. A. Hamid Salim, Country Director and Medical Advisor, Damien Foundation, Bangladesh: I would like to clarify about the village doctor's involvement at the community level. We have trained 13 thousand village doctors whose task is to only identify TB suspect cases. In each Union we have identified 6 DOTS providers who are proving DOTS to the patient. These village doctors are not directly involved with the diagnosis or prescribing drugs to the TB patient. The diagnosis and treatment are done only at the Upazila Health Complex. The village doctors are only facilitating access of suspect cases at the community level & providing DOTS at the community level to ensure compliance with the DOTS regime.

Runia Mowla, Coordinator, Engender Health: The gender aspect of DOTS management must be examined and addressed. There is no special attention to women and many women may be kept away from treatment of any disease because of our poor social and economic situation.

Concluding remarks by Dr. Vikarunnessa Begum:

At the end of the discussion session, Dr. Vikarunnessa, responded to some of the issues raised.

On the question of Sustainability of the NTP programme we have integrated the TB control programme with general health service and it is not a vertical programme. At the Upazila level we have trained 1 doctor and 1 Medical official and conducted 6 days basic training course for the laboratory technician to learn diagnosis and examine the sputum. We also provide 3 days training to the mid level worker and the field level worker for 1 day. Without giving training they do not start any DOTS any where. This basic training is pre-conditional to the initiation of DOTS.

All those facilities are provided by the government for the upazila level but not for the NGOs. For ensuring sustainability of the TB control programme in future, we will start the peripheral laboratory chain in the country to develop capacity.

For Supervision and monitoring issues, we have organized a training programme to the junior consultants with USAID assistance. We have trained them for 3 days in different batches on supervision and monitoring of the NTP programme. We have also developed district level supervisory team which includes the district Civil Surgeon. The district level peripheral team will supervise the upazila level and observe how the programme is running as well as the treatment pattern of the patient. The team members will first educate the patient and then start the treatment. For this reason the treatment success rate has reached 90% in DOTS.

The NTP also has prepared a plan to involve the family welfare assistants (FWAs). We have also decided to incorporate TB programme in the curriculum of medical students, nursing student and others. All those activities will help sustain the programme.

On the question of treatment and diagnosis facilities for garments workers in different industries, we are performing some activities jointly with other NGOs in some garments factories but not as a sectoral activity.

Finally, she discussed about the cost of medicine. NTP is getting about 50% of the drug as free. 25% is coming from the government and 25% from the Global Fund.

Summarising the workshop, the Editor of The Daily Star Mr. Mahfuz Anam said that the roundtable was on a subject of great concern for all. Should the TB situation fail to be arrested there could be a health catastrophe beyond our ability to contain. To prevent such a situation he called for a national alliance, which would go beyond the Government and the NGOs and the donors.

Mr. Mahfuz Anam then said that he was pledging full support of his paper and that he would personally be involved in any initiative, which could improve the situation concerning TB in Bangladesh.

Mr. Abdul-Muyeed Chowdhury thanked the Daily Star for its support in holding the roundtable and also for extending support to the fight against TB.

The meeting was declared over after this.

Prof. Dr. M Amanullah, MP

Dr. Tahmina Aziz

Dr. Vikarunnessa

Maj. Gen Dr. ASM Motiur Rahman (Rtd)

Prof. Md Mostafizur Rahman

Dr. Marijke Becx-Bleumink

Dr. Shaila Rodrigues

Dr. Dinesh Nair

Frank Paulin

Abdul-Muyeed Chowdhury

Dr. Salehuddin Ahmed

Dr. Zafrullah Chowdhury

Dr. Sakhawat Hossain

Dr. AK Md. Ahsan Ali

Dr. Mirza Mohammad Hiron

Dr. Sadia Dilshad Parveen

Dr. K. Zaman

Dr. Makhduma Nargis

Dr. Asif Mujtaba Mahmud

Dr. Md. Abdul Hamid Salim

Dr. Mohammad Iqbal

Shaikh Abdud Daiyan

Faruque Ahmed

Afsan Chowdhury

What is Tuberculosis?

- A disease caused by a bacteria/ bacilli called Mycobacterium tuberculosis.
- There are two types of TB according to the location of infection: 1) Pulmonary TB or lungs TB and 2) Extra-pulmonary TB or TB that affect any part of the body other than lung (such as bones, glands, pleura, lymph nodes, spine, joints, genito-urinary tract, nervous system and intestine).
- Pulmonary TB is the infectious one that occurs in about 80% of cases.
- Transmission of pulmonary TB occurs by spreading of TB bacilli into the air mainly through coughing, spitting and sneezing by a patient.

Key symptom of Pulmonary TB

- Cough for three weeks or more

Other symptoms

- Fever
- Lethargy
- Loss of appetite

TB Infection and TB Disease

TB infection is different from TB disease. People with TB infection (without disease) have the bacilli in their body. They are not sick because the germ in their body remains inactive. People with TB disease are sick from bacilli that are active and multiplying in their body. They usually have one or more of the symptoms of TB. These people can transmit the infection to others. Medication can cure TB disease.

Who are at risk?

- Those suffering from
  - malnutrition
  - alcoholism
  - diabetes
  - kidney failure.
  - a weakened immune systems (such as people living with HIV/AIDS)
- Heavy smokers.
- Low income group due to crowded housing conditions and poor nutritional status.
- Those living/working in nursing homes, prisons, industries, homeless shelters, drug abusers treatment centres.

Global TB Burden-2005

According to WHO estimates,

- 1.7 million deaths (928/100,000). 98% of these deaths in the developing world.
- Almost 230,000 deaths due to TB/HIV.
- 8.8 million new cases (140/100,000) including 674,000 TB/HIV cases; 80% in 22 high-burden countries.
- 15.4 million prevent cases (245/100,000)

Bangladesh scenario

Although not reported among government statistics, tuberculosis was believed to be an increasingly serious health problem during the 1980's, with 90,000 deaths and 110,000 new cases occurring annually. It was commonly said 'jakkha holey rakkha nai', meaning 'death is certain once you have TB'.

Even now Tuberculosis (TB) remains one of the leading causes of adult mortality and preventable death in Bangladesh. WHO ranks Bangladesh fifth among the world's 22 high-burden TB Countries. According to recent estimates more than 300,000 new cases and 70,000 TB-related deaths occur annually in Bangladesh.

Current status of TB in Bangladesh

Indicators	Rates
Incidence of all TB cases	221/100,000 population
Incidence of all new smears positive TB cases	99/100,000 population
Prevalence of sputum positive TB cases	188/100,000 population
TB mortality of all cases	52/100,000 population
TB cases with HIV+ (adult aged 15-49)	0.1%

Source: Fact sheet on World Stop TB Day 2005, National Tuberculosis Control Program (NTP)

TB services in Bangladesh

Bangladesh TB services began in 1965 in 44 TB clinics, 8 segregation hospitals and 4 TB hospitals. From 1986 - 1991. TB services were gradually expanded to 124 Upazila Health Complexes. In 1993, the Government of Bangladesh (GoB) launched the Directly Observed Treatment Short-course (DOTS) strategy. The National Tuberculosis Control Program (NTP) is a consulting government body. NTP started DOTS field implementation in November 1993 in 4 pilot Upazilas and progressively expanded to all 460 Upazilas by June 1998. Now the NTP's geographical coverage is 99% of Bangladesh, including the metropolitan cities Dhaka, Chittagong, Rajshahi and Khulna.

A Memorandum of Understanding (MoU) was established to assign NGOs specific geographic areas (district/ upazilas/ city/ wards) in which they would implement DOTS using their own facilities and staff. Under this program, the GoB provides guidelines, medicines, laboratory consumables, training of trainers, technical trainings, documentation and communication materials.

Sustaining the achievement

The currently reported success rates may be maintained only with difficulty when additional non-traditional partners are involved in the near future. There is room for improving the quality of services delivered by NGOs especially in metropolitan city areas. It will be vital to maintain the high cure rate by further enhancing DOTS under regular and strict supervision by the providers.

High cure Rate

High cure rate of TB case has to be ensured by 2015. An uninterrupted supply of anti-TB drugs can increase the treatment success rate to ensure high cure rate. Increasing case detection rates to 70% and above and achieving Millennium Development Goal (MDGs) targets to TB.

Millennium Development Goals (MDGs)

The case detection rate needs to be improved to 70% by 2015 to achieve the MDG target and strong effects needed to maintain the treatment success rate at 85%.