WEEKLY EPIDEMIOLOGICAL REPORT
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Stop TB: TB anywhere is TB everywhere

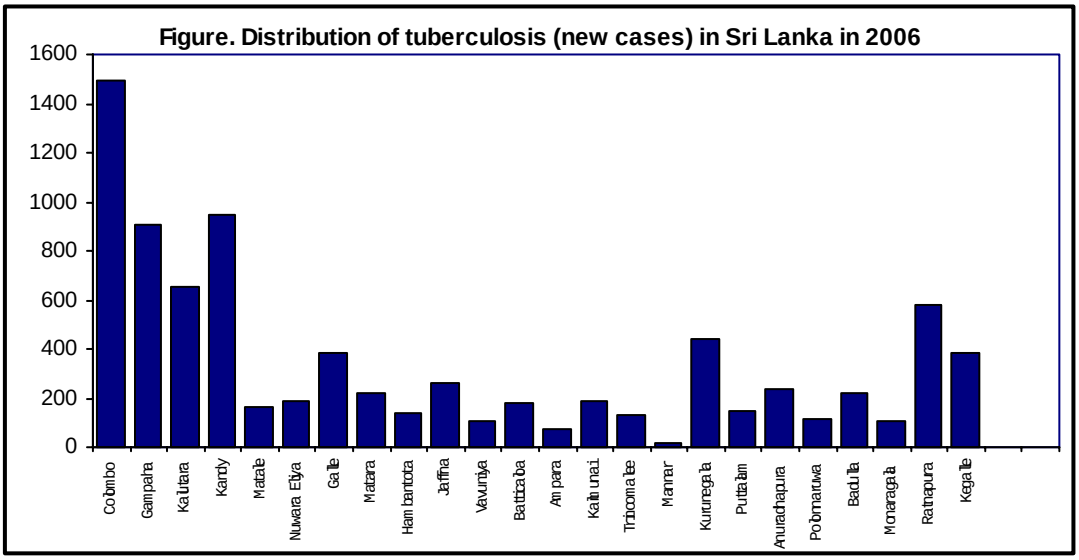
World Tuberculosis Day, which falls on the 24th March each year, is designed to build public awareness about the fact that tuberculosis today remains an epidemic in many parts of the world. It causes deaths of about 1.7 million people each year, mostly in the third world. 24th March commemorates the day in 1882 when Dr Robert Koch astounded the scientific community by announcing that he had discovered the cause of tuberculosis, the TB bacillus. At the time of Koch's announcement in Berlin, TB was raging through Europe and the Americas, causing the death of one out of every seven people. Koch's discovery opened the way towards diagnosing and curing tuberculosis.

In 1982, on the one-hundredth anniversary of Dr Koch's presentation, the International Union Against Tuberculosis and Lung Disease (IUATLD) proposed that the 24th March be proclaimed the official World TB Day. In 1996, the World Health Organization (WHO) joined with the IUATLD and a wide range of other concerned organizations to increase the impact of the World TB Day.

The theme for the World Tuberculosis Day 2007 is 'TB anywhere is TB everywhere'.

Tuberculosis (TB) is a contagious disease which spreads through the air. A person needs only to inhale a small number of TB bacilli to be infected. Left untreated, each person with active TB disease will infect on average between 10 and 15 people every year.

Someone in the world is newly infected with TB bacilli every second. Overall, one-third of the world's population is currently infected with the TB bacillus. 5-10% of people who are infected with TB bacilli (but who are not infected with HIV) become sick or infectious at



Source: The National Programme for Tuberculosis Control and Chest Diseases

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some time during their life. People with HIV and TB infection are much more likely to develop TB.

WHO estimates that the largest number of new TB cases in 2005 occurred in the South-East Asia Region, which accounted for 34% of incident cases globally. It is estimated that 1.6 million deaths resulted from TB in 2005. Both the highest number of deaths and the highest mortality per capita are in the Africa Region. The number of new cases arising each year is increasing globally and in the WHO regions of Africa, the Eastern Mediterranean and South-East Asia.

HIV and TB form a lethal combination, each speeding the other's progress. HIV weakens the immune system. Someone who is HIV-positive and infected with TB bacilli is many times more likely to become sick with TB than someone infected with TB bacilli who is HIV-negative. TB is a leading cause of death among people who are HIV-positive. In Africa, HIV is the single most important factor contributing to the increase in the incidence of TB since 1990.

Until 50 years ago, there were no medicines to cure TB. Now, strains that are resistant to a single drug have been documented in every country surveyed; what is more, strains of TB resistant to all major anti-TB drugs have emerged. Drug-resistant TB is caused by inconsistent or partial treatment, when patients do not take all their medicines regularly for the required period because they start to feel better, because doctors and health workers prescribe the wrong treatment regimens, or because the drug supply is unreliable. A particularly dangerous form of drug-resistant TB is multidrug-resistant TB (MDR-TB), which is defined as the disease caused by TB bacilli resistant to at least isoniazid and rifampicin, the two most powerful anti-TB drugs. Rates of MDR-TB are high in some countries, especially in the former Soviet Union, and threaten TB control efforts. While drug-resistant TB is generally treatable, it requires extensive chemotherapy (up to two years of treatment) with second-line anti-TB drugs which are more costly than first-line drugs, and which produce adverse drug reactions that are more severe, though manageable.

The emergence of extensively drug-resistant (XDR) TB, particularly in settings where many TB patients are also infected with HIV, poses a serious threat to TB control, and confirms the urgent need to strengthen basic TB control and to apply the new WHO guidelines for the programmatic management of drug-resistant TB.

The Global Plan to Stop TB

In 2006, WHO launched the new Stop TB Strategy. The core of this strategy is DOTS, the TB control approach launched by WHO in 1995. Since its launch, more than 22 million patients have been treated under DOTS-based services. The new six-point strategy builds on this success, while recognizing the key challenges of TB/HIV and MDR-TB. It also responds to access, equity and quality constraints, and adopts evidence-based innovations in engaging with private health-care providers, empowering affected people and communities and helping to strengthen health systems and promote research.

The six components of the Stop TB Strategy are:

Pursuing high-quality DOTS expansion and enhancement. Making high-quality services widely available and accessible to all those who need them, including the poorest and most vulnerable, requires DOTS expansion to even the remotest areas. In 2004, 183 countries (including all 22 of the high-burden countries which account for 80% of the world's TB cases) were implementing DOTS in at least a part of the country.

Addressing TB/HIV, MDR-TB and other challenges. Addressing TB/HIV, MDR-TB and other challenges requires much greater action and input than DOTS implementation and is essential to achieving the targets set for 2015, including the United Nations Millennium Development Goal relating to TB (Goal 6; Target 8).

Contributing to health system strengthening. National TB control programmes must contribute to overall strategies to advance financing, planning, management, information and supply systems and innovative service delivery scale-up.

Engaging all care providers. TB patients seek care from a wide array of health-care providers. To be able to reach all patients and to ensure that they receive high-quality care, all types of health-care providers should be engaged.

Empowering people and communities with TB. Community TB care projects have shown how people and communities can undertake some essential TB control tasks. These networks can mobilize civil societies and also ensure political support and long-term sustainability for TB control programmes.

Enabling and promoting research. While the current tools can control TB, improved practices and elimination will depend on new diagnostics, drugs and vaccines.

The Stop TB Strategy is to be implemented over the next 10 years. The Global Plan is a comprehensive assessment of the action and resources needed to implement the Stop TB Strategy and to achieve the targets mentioned below.

- Millennium Development Goal (MDG) 6, Target 8: Halt and begin to reverse the incidence of TB by 2015
- by 2005: detect at least 70% of new sputum smear-positive TB cases and cure at least 85% of these cases
- by 2015: reduce TB prevalence and death rates by 50% relative to 1990
- by 2050: eliminate TB as a public health problem (1 case per million population)

It is envisaged that the strategy will enable health authorities to dramatically reduce the global burden of TB by 2015.

Table 1: Vaccine-preventable diseases & AFP

17th - 23rd March 2007 (12th Week)

Disease	No. of Cases by Province								Number of cases during current week in 2007	Number of cases during same week in 2006	Total number of cases to date in 2007	Total number of cases to date in 2006	Difference between the number of cases to date between 2007 & 2006
	W	C	S	NE	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	00	00	00	00	00	00	00	00	02	19	40	-52.5%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00.0%
Measles	00	00	00	00	00	00	00	00	00	02	13	06	116.6%
Tetanus	00	00	00	00	00	00	00	00	00	00	09	11	-18.2%
Whooping Cough	00	00	00	00	00	00	00	00	00	05	13	21	-38.1%
Tuberculosis	96	00	06	20	02	00	07	44	175	374	2219	2567	-13.5%

Table 2: Diseases under Special Surveillance

17th - 23rd March 2007 (12th Week)

Disease	No. of Cases by Province								Number of cases during current week in 2007	Number of cases during same week in 2006	Total number of cases to date in 2007	Total number of cases to date in 2006	Difference between the number of cases to date between 2007 & 2006
	W	C	S	NE	NW	NC	U	Sab					
DF/DHF*	20	05	02	01	00	01	02	04	35	181	1442	2646	-45.5%
Encephalitis	01 GM=1	01 GL=1	00	02 VA=1 MU=1	00	00	00	00	04	04	60	30	+100.0%
Human Rabies	00	00	00	00	00	00	00	00	00	01	20	17	+17.6%

Table 3: Newly introduced Notifiable Diseases

17th - 23rd March 2007 (12th Week)

Disease	No. of Cases by Province								Number of cases during current week in 2007	Total number of cases to date in 2007
	W	C	S	NE	NW	NC	U	Sab		
Chickenpox	21	06	12	02	04	05	02	12	64	736
Meningitis	00	00	00	00	00	00	00	00	00	46
Mumps	06 CB=2 GM=1 KL=3	16 ML=16	01 MT=1	04 TR=4	00	00	03 BD=2 MO=1	04 KG=3 RP=1	34	198

*DF / DHF refers to Dengue Fever / Dengue Haemorrhagic Fever.
NA= Not Available.

Sources:

Weekly Return of Communicable Diseases:
Diphtheria, Measles, Tetanus, Whooping Cough, Human Rabies, Dengue Haemorrhagic Fever, Japanese Encephalitis, Chickenpox, Meningitis, Mumps.

Special Surveillance:
Acute Flaccid Paralysis.

National Control Program for Tuberculosis and Chest Diseases:
Tuberculosis.

Details by districts are given in Table 5.

Provinces: W=Western, C=Central, S=Southern, NE=North & East, NC=North Central, NW=North Western, U=Uva, Sab=Sabaragamuwa.

DPDHS Divisions: CB=Colombo, GM=Gampaha, KL=Kalutara, KD=Kandy, ML=Matale, NE=Nuwara Eliya, GL=Galle, HB=Hambantota, MT=Matara, JF=Jaffna, KN=Killinochchi, MN=Mannar, VA=Vavuniya, MU=Mullaitivu, BT=Batticaloa, AM=Ampara, TR=Trincomalee, KM=Kalmunai, KR=Kurunegala, PU=Puttalam, AP=Anuradhapura, PO=Polonnaruwa, BD=Badulla, MO=Moneragala, RP=Ratnapura, KG=Kegalle.

Table 4: Laboratory Surveillance of Dengue Fever

17th - 23rd March 2007 (12th Week)

Samples	Number tested	Number positive *	Serotypes				
			D_1	D_2	D_3	D_4	Negative
Number for current week	11	00	00	00	00	00	00
Total number to date in 2007	221	10	00	02	02	00	05

Source: Genetech Molecular Diagnostics & School of Gene Technology, Colombo. * Not all positives are subjected to serotyping.

Table 5: Selected notifiable diseases reported by Medical Officers of Health
17th - 23rd March 2007 (12th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptos-pirosis		Typhus Fever		Viral Hepatitis		Returns Re-ceived Timely**
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	11	425	09	55	00	03	05	26	17	37	05	33	00	01	00	10	**100**
Gampaha	04	162	01	52	01	08	01	45	00	02	06	56	00	06	00	32	**50**
Kalutara	05	108	01	67	00	01	02	16	00	11	01	31	00	01	01	24	**55**
Kandy	04	178	02	44	00	02	03	20	01	05	00	28	02	22	00	79	**45**
Matale	01	50	02	54	00	03	00	05	00	03	00	13	00	03	03	49	**50**
Nuwara Eliya	00	18	01	40	00	00	00	24	00	366	01	06	02	18	02	72	**29**
Galle	00	42	03	34	01	05	00	04	00	03	00	19	01	16	01	07	**69**
Hambantota	01	19	02	14	00	00	00	07	03	04	00	15	00	15	00	07	**36**
Matara	01	44	01	59	00	02	00	14	00	04	04	45	08	89	00	07	**69**
Jaffna	00	05	00	29	00	02	00	194	00	00	00	00	00	73	00	06	**00**
Kilinochchi	00	00	00	00	00	00	00	02	00	00	00	00	00	02	00	02	**00**
Mannar	00	07	00	11	00	00	01	31	00	00	00	00	00	00	00	04	**25**
Vavuniya	00	10	00	11	01	01	00	08	00	06	00	02	00	00	00	03	**75**
Mullaitivu	00	00	01	05	01	03	01	10	00	00	00	00	00	00	00	00	**60**
Batticaloa	01	08	01	45	00	03	00	12	00	02	00	00	00	00	11	113	**55**
Ampara	00	01	02	25	00	00	00	03	00	00	00	00	00	00	01	08	**29**
Trincomalee	00	23	02	23	00	01	00	09	00	17	00	01	01	01	08	17	**56**
Kurunegala	00	112	03	62	00	00	01	18	00	04	00	09	00	23	00	09	**28**
Puttalam	00	60	00	23	00	09	01	21	00	00	01	05	00	00	01	36	**44**
Anuradhapura	01	16	00	23	00	05	02	14	00	02	00	09	01	12	00	18	**58**
Polonnaruwa	00	20	01	41	00	02	00	03	00	00	01	12	00	00	00	03	**43**
Badulla	01	13	06	103	00	00	02	23	00	08	00	15	03	30	06	68	**60**
Monaragala	01	06	02	53	00	00	00	12	00	00	00	15	00	18	01	06	**60**
Ratnapura	03	54	27	168	00	07	02	25	00	06	00	18	00	05	01	24	**63**
Kegalle	01	59	03	44	00	03	00	13	00	03	02	29	00	09	01	19	**45**
Kalmunai	00	02	00	29	00	00	00	05	00	00	00	00	00	00	01	59	**15**
SRI LANKA	**35**	**1442**	**70**	**1114**	**04**	**60**	**21**	**564**	**21**	**483**	**21**	**361**	**18**	**344**	**38**	**682**	**65**

Source: Weekly Returns of Communicable Diseases (WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 31 Mar. 2007. Total number of reporting units = 290. Number of reporting units data provided for the current week: 188.
A = Cases reported during the current week. **B** = Cumulative cases for the year.

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to chepid@sltnet.lk.

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