

Tuberculosis control in Bangladesh

SIR,—Tuberculosis (TB) remains an important cause of morbidity and mortality in developing countries, with 7 million new infections and 2.5 million deaths a year. The burden of TB is greatest in adults, more than three-quarters of cases arising in the 15–59 age group.¹ Since most infections are in adult males, who are the breadwinners, the impact on families is immense.² Unfortunately, this disease tends not to attract much attention, mainly because of low cure rates, frustrations with the efficacy of BCG, and dwindling international interest.

In Bangladesh, 0.5% of the population is estimated to be sputum smear-positive, and this proportion has not decreased over the past 25–30 years. The national tuberculosis control programme is urban-based, with fifty-seven hospitals and clinics, and only about 25% of patients attending these completing treatment. More than 80% of Bangladeshis live in rural areas and the programme is not integrated with the government rural health-care efforts. In a society where utilisation of health services is low and where TB is a dreaded disease carrying a social stigma, it is unlikely that many patients will turn up at the urban treatment centres. Patients need to be identified and treated in their own homes.

In 1984 the Bangladesh Rural Advancement Committee (BRAC), a non-governmental organisation, started a community-based TB control programme in a rural area with a population of 220 000.³ Illiterate female village-based health workers were trained. One of their tasks was TB control and they collected sputum from suspected cases, which were then tested with a microscope. Smear-positive patients were immediately given a standard treatment course by the village health worker (isoniazid, streptomycin injections for 60 days followed by isoniazid and thiacetazone). The health worker administered the injections and drugs, which were supplied by BRAC. To ensure compliance a deposit of Tk 100 (\$3) was taken by BRAC, and when the treatment course was completed the patient was given back Tk 75. Tk 25 was given to the health worker for her services. She receives no other incentive other than, to motivate collection of sputum samples, Tk 50 for each smear-positive case detected.

Between 1984 and 1989, 2932 sputum samples were collected; 280 (9.5%) were positive for acid-fast bacilli, 80% being from males. Treatment was started in 264, 60% completed treatment and 8% dropped out; the remainder died, left the district, or were referred elsewhere. The cost (\$108 per case) is less than that in other programmes such as those in India or Tanzania.⁴

The BRAC programme has demystified the treatment of TB in Bangladesh and the committee plans to expand coverage to 2 million or so by the end of 1993.

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