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MONTHLY E- BULLETIN OF ANANTHAPURI PHILATELIC ASSOCIATION, THIRUVANANTHAPURAM. Reg No.T-614/12

We meet every first Sunday At Hotel Poorna, Statue, Thiruvananthapuram At 2.30 p.m.

2nd Anniversary Issue

Editorial

Dear Friends,

This is the second annual issue of our bulletin. I hope that we were able to contribute our bit towards philately through this bulletin. The comments and feed backs coming from different parts of the country regarding this publication is most appreciable, inspiring me to continue publishing this bulletin.

On this occasion, I am thankful to the regular columists Col.(Dr) Jayanta Dutta, Dr.Anjali Dutta, Mr. Ilyas Patel etc. and for the news providers Mr.Suresh R from Bengaluru and Mr.Wolfgang Beyer from Germany. I am also thankful to my sub-editors Dr.Denny Unnikrishnan and Sreejesh Krishnan for their active support.

I express my sincere thanks to all readers and well-wishers for making this bulletin one among the best magazines in this category.

Thank you and wish you a Happy Holi.

Mohanachandran Nair
Mobile: 09387801948

Contents

Dear Reader,

Your feedback is most valuable to us. We invite your views, thoughts and suggestions regarding this e-bulletin.

Please send your feedback to: apa.tvpm@gmail.com

Editor

Awards won

Brasilia 2017: Bronze

INPEX 2017: Silver Bronze

Reader's Column

Dear Secretary APA,

Happy to note that the APA bulletin is completing two years and received two awards by this time. The contents in the APA bulletin are informative to enthusiastic Philatelists. Best wishes for the future editions and special thanks to APA office bearers and particularly Secretary for their efforts in making the editions of APA bulletin more lively and lovely, than some of the other bulletins which I have seen, striving purely on advertisements. APA bulletin is unique by its appearance, contents, information and is a reference material too.

My Best Wishes.

V.Syam Kumar,
Asstt. Vice President(Services),
GSTN, Aerocity, N.Delhi-110037

Dear Sir,

It's a pleasure for us to send congratulations and best wishes for the Second Annual issue of the Ananthapuri Stamp Bulletin to you in the name of the German Philatelic Federation (BDPh). We are looking forward for the next issues of this interest and important philatelic publication together with best wishes for friendly cooperation between Indian and German philatelists.

Kindest Regards,

Alfred Schmidt & **Wolfgang Beyer**
President (BDPh) Member (BDPh) & AIJP

Dear Mr.Nair,

Sending my best wishes on the release of Second Annual Issue of Ananthapuri Stamp Bulletin. Wishing you and all team members of APA a very Happy and colourful Holi.

Best regards

J.Jyoti
Rainbow Stamp News

New Indian Issues

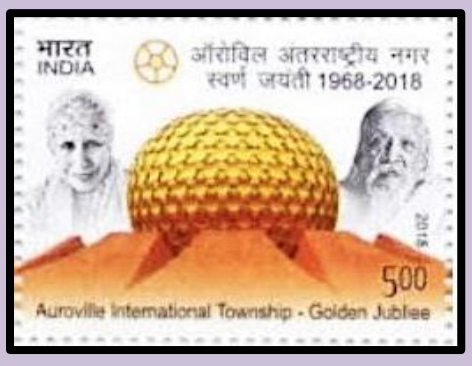
INDIA IRAN JOINT ISSUE
Deendayal Port, Kandla & Shahid Beheshti Port Chabahar

Stamps Rs.25.00 & Rs.5.00
Miniature Sheet Rs.30.00
Issued on 17.02.2018

B NAGI REDDI

Stamp Rs.5.00
Issued on 23.02.2018

AUROVILLE INTERNATIONAL TOWNSHIP



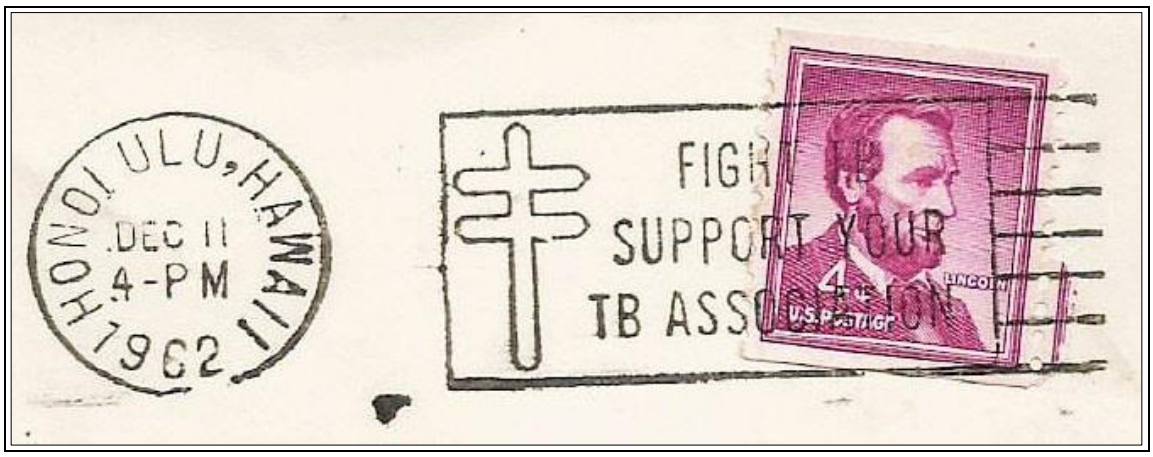
Stamp Rs.5.00
Issued on 25.02.2018

World TB Day

24 March 2018

By Ilyas Patel

Just a few years ago it was believed that TB was an old disease, and that it was no longer a problem in humans. But now because of such issues as drug resistance and HIV, it has become a major worldwide problem again. Worldwide more people die from the disease than from any other infectious disease. TB is an abbreviation of the word Tuberculosis and is how people often refer to the disease. It is caused by bacteria called Mycobacterium tuberculosis (M.tuberculosis).



Following Koch's discovery, the development of vaccines and effective drug treatment led to the belief that the disease was almost defeated. Indeed, at one point, the United Nations, predicted that tuberculosis (TB) would be eliminated worldwide by 2025. However, in the mid-1980s, TB cases began to rise worldwide, so much so, that in 1993, the World Health Organization (WHO) declared that TB was a global emergency; the first time that a disease had been labelled as such.

Background

Last year, WHO reported that 10.4 million people fell ill with TB and there were 1.8 million TB deaths in 2015, making it the top infectious killer worldwide. This disease is deeply rooted in populations where human rights and dignity are limited. While anyone can contract TB, the disease thrives among people living in poverty, communities and groups that are marginalized, and other vulnerable populations. These include: migrants, refugees, ethnic minorities, miners and others working and living in risk-prone settings, the elderly, marginalised women and children in many settings etc. Factors such as malnutrition, poor housing and sanitation, compounded by other risk factors such as tobacco and alcohol use and diabetes, affect vulnerability to TB and access to care. Furthermore, this access is often hindered by catastrophic costs associated with illness, seeking and staying in care, and lack of social protection, resulting in a vicious cycle of poverty and ill-health. The transmission of multidrug-resistant TB (MDR-TB) adds great urgency to these concerns.

Key facts

- Tuberculosis (TB) is one of the top 10 causes of death worldwide.
- In 2016, 10.4 million people fell ill with TB, and 1.7 million died from the disease (including 0.4 million among people with HIV). Over 95% of TB deaths occur in low- and middle-income countries.

- Seven countries account for 64% of the total, with India leading the count, followed by Indonesia, China, Philippines, Pakistan, Nigeria, and South Africa.
- In 2016, an estimated 1 million children became ill with TB and 250 000 children died of TB (including children with HIV associated TB).
- TB is a leading killer of HIV-positive people: in 2016, 40% of HIV deaths were due to TB.
- Multidrug-resistant TB (MDR-TB) remains a public health crisis and a health security threat. WHO estimates that there were 600 000 new cases with resistance to rifampicin – the most effective first-line drug, of which 490 000 had MDR-TB. Globally, TB incidence is falling at about 2% per year. This needs to accelerate to a 4–5% annual decline to reach the 2020 milestones of the End TB Strategy.
- An estimated 53 million lives were saved through TB diagnosis and treatment between 2000 and 2016.
- Ending the TB epidemic by 2030 is among the health targets of the Sustainable Development Goals.
- TB is among the top 3 causes of death for women aged 15 to 44.
- TB symptoms (cough, fever, night sweats, weight loss, etc.) may be mild for many months, and people ill with TB can infect up to 10-15 other people through close contact over the course of a year.
- TB is an airborne pathogen, meaning that the bacteria that cause TB can spread through the air from person to person.

Tuberculosis (**TB**)

Tuberculosis (TB) is an infectious disease usually caused by the bacterium *Mycobacterium tuberculosis* (MTB). Tuberculosis generally affects the lungs, but can also affect other parts of the body. Most infections do not have symptoms, in which case it is known as latent tuberculosis. About 10% of latent infections progress to active disease which, if left untreated, kills about half of those infected. The classic symptoms of active TB are a chronic cough with blood-containing sputum, fever, night sweats, and weight loss. The historical term "*consumption*" came about due to the weight loss. Infection of other organs can cause a wide range of symptoms.

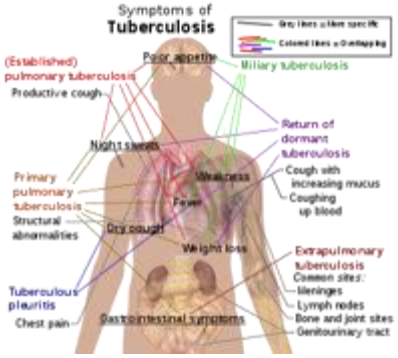
The *M. tuberculosis* complex (MTBC) includes four other TB-causing mycobacteria: *M. bovis*, *M. africanum*, *M. canetti*, and *M. microti*. *M. africanum* is not widespread, but it is a significant cause of tuberculosis in parts of Africa. *M. bovis* was once a common cause of tuberculosis, but the introduction of pasteurized milk has almost completely eliminated this as a public health problem in developed countries. *M. canetti* is rare and seems to be limited to the Horn of Africa, although a few cases have been seen in African emigrants. *M. microti* is also rare and is seen almost only in immunodeficient people, although its prevalence may be significantly underestimated.

Other known pathogenic mycobacteria include; *M. leprae*, *M. avium*, and *M. kansasii*. The latter two species are classified as "nontuberculous mycobacteria" (NTM). NTM cause neither TB nor leprosy, but they do cause pulmonary diseases that resemble TB.

Tuberculosis is spread through the air when people who have active TB in their lungs cough, spit, speak, or sneeze. People with latent TB do not spread the disease. Active infection occurs more often in people with HIV/AIDS and in those who smoke. Diagnosis of active TB is based on chest X-rays, as well as microscopic examination and culture of body fluids. Diagnosis of latent TB relies on the tuberculin skin test (TST) or blood tests.

Signs and symptoms

The main symptoms of variants and stages of tuberculosis are given, with many symptoms overlapping with other variants, while others are more (but not entirely) specific for certain variants. Multiple variants may be present simultaneously. Tuberculosis may infect any part of the body, but most commonly occurs in the lungs (known as pulmonary tuberculosis). Extrapulmonary TB occurs when tuberculosis develops outside of the lungs, although extra pulmonary TB may coexist with pulmonary TB. General signs and symptoms include fever, chills, night sweats, loss of appetite, weight loss, and fatigue. Significant nail clubbing may also occur.



Pulmonary

If a tuberculosis infection does become active, it most commonly involves the lungs (in about 90% of cases). Symptoms may include chest pain and a prolonged cough producing sputum. About 25% of people may not have any symptoms (i.e. they remain "asymptomatic"). Occasionally, people may cough up blood in small amounts, and in very rare cases, the infection may erode into the pulmonary artery or a Rasmussen's aneurysm, resulting in massive bleeding. Tuberculosis may become a chronic illness and cause extensive scarring in the upper lobes of the lungs. The upper lung lobes are more frequently affected by tuberculosis than the lower ones. The reason for this difference is not clear. It may be due to either better air flow, or poor lymph drainage within the upper lungs.

Extrapulmonary

In 15–20% of active cases, the infection spreads outside the lungs, causing other kinds of TB. These are collectively denoted as "extrapulmonary tuberculosis". Extrapulmonary TB occurs more commonly in immunosuppressed persons and young children. In those with HIV, this occurs in more than 50% of cases. Notable extrapulmonary infection sites include the pleura (in tuberculous pleurisy), the central nervous system (in tuberculous meningitis), the lymphatic system (in scrofula of the neck), the genitourinary system (in urogenital tuberculosis), and the bones and joints (in Pott's disease of the spine), among others.

Spread to lymph nodes is the most common. An ulcer originating from nearby infected lymph nodes may occur and is painless, slowly enlarging and has an appearance of "wash leather". When it spreads to the bones, it is known as "osseous tuberculosis", a form of osteomyelitis. A potentially more serious, widespread form of TB is called "disseminated tuberculosis", also known as miliary tuberculosis. Miliary TB currently makes up about 10% of extra pulmonary cases.

Causes

Mycobacteria

The main cause of TB is *Mycobacterium tuberculosis* (MTB), a small, aerobic, nonmotile bacillus. The high lipid content of this pathogen accounts for many of its unique clinical characteristics. It divides every 16 to 20 hours, which is an extremely slow rate compared with other bacteria, which usually divide in less than an hour. Mycobacteria have an outer membrane lipid bilayer. If a Gram stain is performed, MTB either stains very weakly "Gram-positive" or does not retain dye as a result of the high lipid and mycolic acid content of its cell wall. MTB can withstand weak disinfectants and survive in a dry state for weeks. In nature, the bacterium can grow only within the cells of a host organism, but *M. tuberculosis* can be cultured in the laboratory.

How do you get TB?

TB is spread from one person to another through the air. You get TB by breathing in TB bacteria that are in the air. Bacteria get released into the air by someone who already has the bacteria in their body.

Latent TB

The bacteria that usually cause the disease in humans, usually affect the lungs, but can affect other parts of the body. If you are infected with the bacteria you won't necessarily become sick, because you can have either latent TB or TB disease. People with latent TB do not feel sick and do not have any symptoms.

TB disease

TB disease is what happens when a person has latent TB and then becomes sick. Sometimes this is known as having active TB. Overall about 5 to 10% of people with latent TB, who do not receive treatment for it, will become sick at some time in their lives. Some people become sick soon after they have become infected, before their immune system (the part of the body that fights diseases) can fight the bacteria. Other people don't get sick at first but they get sick years later when their immune system becomes weak for another reason. This can be because they have an infection, such as HIV, or some other health problem. Some people are known to have a higher risk of becoming ill. These include:

- Infants and children aged less than 4 years
- People infected within the previous two years
- People infected with HIV
- People who have certain illnesses or conditions which affect their immune system, such as people with diabetes, and people with chronic renal failure.

What are the symptoms?

The symptoms depend on which area of the body has been infected. If someone has pulmonary disease, which is TB in the lungs, then they may have a bad cough that lasts longer than two weeks. They may also have pain in their chest and they may cough up blood or phlegm from deep inside their lungs. Other symptoms of TB include weakness or fatigue, weight loss, lack of appetite, chills, fever and night sweats.

Diagnosing TB

It is very difficult to diagnose TB by a person's symptoms on their own. This is because some other diseases have the same symptoms. A diagnosis is usually only certain when there is definite evidence of TB bacteria. Some of the TB tests used for diagnosis look directly for the bacteria. Others such as the chest X-ray look for the effect of the bacteria on the person suspected of having TB. Tests for diagnosis include the TB skin test, sputum microscopy, the culture test as well as the new Genexpert test. Major problems with the older tests are the lack of accuracy as well as the time they take. With newer tests a major issue is the cost.

History of tuberculosis and Timeline of tuberculosis

Egyptian mummy in the British Museum – tubercular decay has been found in the spine.

Tuberculosis has been present in humans since antiquity. The earliest unambiguous detection of *M. tuberculosis* involves evidence of the disease in the remains of bison in Wyoming dated to around 17,000 years ago. However, whether tuberculosis originated in bovines, then was transferred to humans, or whether it diverged from a common ancestor, is currently unclear. A comparison of the genes of *M. tuberculosis* complex (MTBC) in humans to MTBC in animals suggests humans did not acquire MTBC from animals during

animal domestication, as was previously believed. Both strains of the tuberculosis bacteria share a common ancestor, which could have infected humans even before the Neolithic Revolution. Skeletal remains show prehistoric humans (4000 BC) had TB, and researchers have found tubercular decay in the spines of Egyptian mummies dating from 3000–2400 BC. Genetic studies suggest TB was present in the Americas from about 100 AD.

Before the Industrial Revolution, folklore often associated tuberculosis with vampires. When one member of a family died from it, the other infected members would lose their health slowly. People believed this was caused by the original person with TB draining the life from the other family members.

Although the pulmonary form associated with tubercles was established as pathology by Richard Morton in 1689, due to the variety of its symptoms, TB was not identified as a single disease until the 1820s. It was not named "tuberculosis" until 1839, by J. L. Schönlein. During 1838–1845, Dr. John Croghan, the owner of Mammoth Cave, brought a number of people with tuberculosis into the cave in the hope of curing the disease with the constant temperature and purity of the cave air; they died within a year. Hermann Brehmer opened the first TB sanatorium in 1859 in Görbersdorf (now Sokołowsko), Silesia.

Robert Koch discovered the tuberculosis bacillus

The bacillus causing tuberculosis, *M. tuberculosis*, was identified and described on 24 March 1882 by Robert Koch. He received the Nobel Prize in physiology or medicine in 1905 for this discovery. Koch did not believe the bovine (cattle) and human tuberculosis diseases were similar, which delayed the recognition of infected milk as a source of infection. Later, the risk of transmission from this source was dramatically reduced by the invention of the pasteurization process. Koch announced a glycerine extract of the tubercle bacilli as a "remedy" for tuberculosis in 1890, calling it "tuberculin". While it was not effective, it was later successfully adapted as a screening test for the presence of pre-symptomatic tuberculosis. The World Tuberculosis Day is marked on 24 March each year, the anniversary of Koch's original scientific announcement.

Albert Calmette and Camille Guérin discovered TB vaccine BCG

Albert Calmette and Camille Guérin achieved the first genuine success in immunization against tuberculosis in 1906, using attenuated bovine-strain tuberculosis. It was called bacille Calmette–Guérin (BCG). The BCG vaccine was first used on humans in 1921 in France, but received widespread acceptance in the US, Great Britain, and Germany only after World War II.

Names

Tuberculosis has been known by many names from the technical to the familiar. *Phthisis* (Φθισις) is a Greek word for consumption, an old term for pulmonary tuberculosis; around 460 BCE, Hippocrates described phthisis as a disease of dry seasons. The abbreviation "TB" is short for *tubercle bacillus*. "Consumption" was the most common nineteenth century English word for the disease. The Latin root "con" meaning "completely" is linked to "sumere" meaning "to take up from under." In “The Life and Death of Mr. Badman” by John Bunyan, the author calls consumption "the captain of all these men of death." "Great white plague" has also been used.

Risk factors for tuberculosis

A number of factors make people more susceptible to TB infections. The most important risk factor globally is HIV; 13% of all people with TB are infected by the virus. This is a particular problem in sub-Saharan Africa, where rates of HIV are high. Of people without HIV who are infected with tuberculosis, about 5–10% develops active disease during their lifetimes; in contrast, 30% of those co-infected with HIV develop the active disease.

Tuberculosis is closely linked to both overcrowding and malnutrition, making it one of the principal diseases of poverty. Those at high risk thus include: people who inject illicit drugs, inhabitants and employees of locales where vulnerable people gather (e.g. prisons and homeless shelters), medically underprivileged and resource-poor communities, high-risk ethnic minorities, children in close contact with high-risk category patients, and health-care providers serving these patients.

Chronic lung disease is another significant risk factor. Silicosis increases the risk about 30-fold. Those who smoke cigarettes have nearly twice the risk of TB compared to nonsmokers. Other disease states can also increase the risk of developing tuberculosis. These include alcoholism and diabetes mellitus (three-fold increase). Genetic susceptibility also exists, for which the overall importance remains undefined.

Treatment

TB can usually be cured and more than twenty drugs have been developed. But most of the drugs were developed many years ago. The treatment usually consists of a combination of TB drugs that must be taken for at least six months. But the treatment will only be successful if the drugs are taken exactly as required for the entire length of time. The drugs are used in different combinations in different circumstances. For example, the five “first line” drugs are given to people who have never had treatment before. Some of the drugs have very severe side effects and are very difficult to take for such a long period of time. This is why there is an urgent need for new TB drugs to be developed. In addition many people are now resistant to one or more of the drugs.

Drug resistant TB

If someone has drug resistant TB it means that the bacteria in their body won’t be affected by certain drugs that they are resistant to. The drugs just won’t work. There are two main reasons why people develop it. It can be because the person doesn’t take their drugs properly. It can also be that the bacteria that they are infected with, have come from someone who has already got drug resistant TB. Being drug sensitive is the opposite of being drug resistant. If someone has drug resistant TB then they must change drugs. But usually they mustn’t have just one new drug. They need to have several new drugs and for it to be believed that they will all be effective. Drug susceptibility testing which is available in many countries, and is very important, provides information about which drugs a person is resistant to.

Prevention

Tuberculosis prevention and control efforts rely primarily on the vaccination of infants and the detection and appropriate treatment of active cases. The World Health Organization has achieved some success with improved treatment regimens, and a small decrease in case numbers. The US Preventive Services Task Force (USPSTF) recommends screening people who are at high risk for latent tuberculosis with either tuberculin skin tests or interferon-gamma release assays.

Vaccines

The only available vaccine as of 2011 is Bacillus Calmette-Guérin (BCG). In children it decreases the risk of getting the infection by 20% and the risk of infection turning into disease by nearly 60%. It is the most widely used vaccine worldwide, with more than 90% of all children being vaccinated. The immunity it induces decreases after about ten years. As tuberculosis is uncommon in most of Canada, the United Kingdom, and the United States, BCG is administered to only those people at high risk. Part of the reasoning against the use of the vaccine is that it makes the tuberculin skin test falsely positive, reducing the test's use in screening. A number of new vaccines are currently in development.

Public health

The World Health Organization declared TB a "global health emergency" in 1993, and in 2006, the Stop TB Partnership developed a Global Plan to Stop Tuberculosis that aimed to save 14 million lives between its launch and 2015. A number of targets they set were not achieved by 2015, mostly due to the increase in HIV-associated tuberculosis and the emergence of multiple drug-resistant tuberculosis. A tuberculosis classification system developed by the American Thoracic Society is used primarily in public health programs.

Management

Treatment of TB uses antibiotics to kill the bacteria. Effective TB treatment is difficult, due to the unusual structure and chemical composition of the mycobacterial cell wall, which hinders the entry of drugs and makes many antibiotics ineffective. The two antibiotics most commonly used are isoniazid and rifampicin, and treatments can be prolonged, taking several months. Latent TB treatment usually employs a single antibiotic, while active TB disease is best treated with combinations of several antibiotics to reduce the risk of the bacteria developing antibiotic resistance. People with latent infections are also treated to prevent them from progressing to active TB disease later in life. Directly observed therapy, i.e., having a health care provider watch the person take their medications, is recommended by the WHO in an effort to reduce the number of people not appropriately taking antibiotics. The evidence to support this practice over people simply taking their medications independently is of poor quality. There is no strong evidence indicating that directly observed therapy improves the number of people who were cured or the number of people who complete their medicine. Moderate quality evidence suggests that there is also no difference if people are observed at home versus at a clinic, or by a family member versus a health care worker. Methods to remind people of the importance of treatment and appointments may result in a small but important improvement.

New onset

The recommended treatment of new-onset pulmonary tuberculosis, as of 2010, is six months of a combination of antibiotics containing rifampicin, isoniazid, pyrazinamide, and ethambutol for the first two months, and only rifampicin and isoniazid for the last four months. Where resistance to isoniazid is high, ethambutol may be added for the last four months as an alternative.

Recurrent disease

If tuberculosis recurs, testing to determine which antibiotics it is sensitive to is important before determining treatment. If multiple drug-resistant TB (MDR-TB) is detected, treatment with at least four effective antibiotics for 18 to 24 months is recommended.

Medication resistance

Primary resistance occurs when a person becomes infected with a resistant strain of TB. A person with fully susceptible MTB may develop secondary (acquired) resistance during therapy because of inadequate treatment, not taking the prescribed regimen appropriately (lack of compliance), or using low-quality medication. Drug-resistant TB is a serious public health issue in many developing countries, as its treatment is longer and requires more expensive drugs. MDR-TB is defined as resistance to the two most effective first-line TB drugs: rifampicin and isoniazid. Extensively drug-resistant TB is also resistant to three or more of the six classes of second-line drugs. Totally drug-resistant TB is resistant to all currently used drugs. It was first observed in 2003 in Italy, but not widely reported until 2012, and has also been found in Iran and India. Bedaquiline is tentatively supported for use in multiple drug-resistant TB.

XDR-TB is a term sometimes used to define *extensively resistant* TB, and constitutes one in ten cases of MDR-TB. Cases of XDR TB have been identified in more than 90% of countries.

Statistics

The statistics for TB show how there are very different levels of TB in different parts of the world. Not only national governments, but organisations such as the World Health Organisation (WHO) are making significant efforts to End TB.

The countries known as the "high burden countries" are those with the highest level of disease. They include India, Indonesia, China and Nigeria. Many countries are now making greater efforts to combat TB. In India the government recently announced that its aim is to eradicate the disease by 2025. It has also announced a new strategic plan, the National Strategic Plan 2017 – 2025 setting out how it plans to achieve this. South Africa is another country greatly affected, and this is mainly because of the very high levels of HIV.

TB in India

TB Burden in India

India accounts for about a quarter of the global TB burden as shown below.

- In 2016 an estimated 28 lakh cases occurred and 4.5 lakh people died due to TB.
- In 2016, and as a result of new information being available, the GoI together with the World Health Organisation revised upwards the estimates for the burden of TB in India.
- Worldwide India is the country with the highest burden of both TB and MDR TB. There are an estimated 79,000 multi-drug resistant TB patients among the notified cases of pulmonary TB each year.
- India is also the country with the second highest number (after South Africa) of the estimated HIV associated TB

TB treatment & care

TB treatment & care in India is provided in the public sector by the government's Revised National TB Control Programme (RNTCP) as well as through private sector health providers. The private sector is very large, and it is believed that more than half of all TB patients are cared for in the private sector. In 2016 the RNTCP notified 17.5 lakh TB patients from both the private and public sector. Of these some 3 lakh patients were from the private sector but it was estimated that a further 15 lakh patients in the private sector were not notified and were seeking care outside the public sector. There were also 33,820 patients notified who had drug resistant TB. However, these are still only preliminary revisions and more changes are quite possible when India conducts its first national TB prevalence survey in 2017 – 2018.

There are many reasons why people in India seek care from the private sector.

These include:

- poor knowledge of TB;
- poor knowledge of services available through the national public program;
- the convenience of services in the private sector;
- a desire for confidentiality;
- a desire for personalised care.

"Many people are unaware that all the medicines needed to treat TB patients are available free of cost at Indian government hospitals. Most people tend to spend huge amounts in private hospitals."

National Strategic Plan 2012 – 2017

There have been a number of five year National Strategic Plans (NSP)s since the start of the RNTCP. This ambitious plan, the NSP 2012 – 2017, had the aim of achieving universal access to quality diagnosis and treatment. Before this there was little treatment available through the RNTCP for the treatment of drug resistant TB. A number of significant improvements were made during the five years of the plan. These included:

Complete geographical coverage: Complete geographical coverage for diagnostic and treatment services for multi-drug resistant TB was achieved in 2013. A total of 93,000 people with MDR TB were diagnosed and had been given treatment for drug resistant TB by 2015. Also, the National AIDS Control Organisation (NACO) had collaborated with the RNTCP and had made HIV-TB collaboration effective. Most TB patients registered by the RNTCP were receiving HIV screening and 90% of HIV positive TB patients were receiving anti-retroviral treatment.

Banning of sero-diagnostic tests: In June 2012, the Govt. prohibited the import and sale of sero-diagnostic tests for TB. It is now believed that this has saved countless people from having inaccurate results. Another government order in May 2012 made it compulsory for health care providers to notify every TB case they diagnosed. Since TB became a notifiable disease private providers have notified more than 700,000 people but many more people than that are believed to have been treated outside the public sector.

The Elimination of TB in India

In March 2017 the Government of India (GoI) announced that the new aim with regard to TB in India was the elimination of TB by 2025. "Ensuring affordable and quality healthcare to the population is a priority for the government and we are committed to achieving zero TB deaths and therefore we need to re-strategize, think afresh and have to be aggressive in our approach to end TB by 2025" *Shri J P Nadda, Union Minister of Health and Family Welfare.*

Elimination as defined by the World Health Organisation (WHO), means that there should be less than 1 case of TB for a population of a million people. In view of the current TB burden in India, there is a great deal that needs to be done if elimination is to be achieved by 2025.

Shortly after the announcement of the aim of elimination, the GoI published the new National Strategic Plan 2017 – 2025, setting out how it plans to achieve the elimination of TB in India.

Development of Nikshay

The Central TB Division developed a case based and web based system called "Nikshay". This helped with the reporting of all TB cases. It was scaled up nationally.

Standards for TB Care in India

The Standards for TB Care in India was also developed and it was published in 2014. The Standards describe what should be done, and the TB treatment and care that should be provided throughout India, including what should be provided in the private sector.

Reaching the private sector

Despite the improvements that had already been made:

There had continued to be concern about the standard of care provided in the private sector. Delays in diagnosis, the use of multiple nonstandard regimens for inappropriate lengths of time, the lack of a way to ensure the full course of treatment was being taken, and the recording of treatment outcomes were just some of the issues.

So in 2016 the RNTCP published revised technical and operational guidance. The new guidelines did not replace the previous guidance (the Standards of TB Care in India), but they provide updated recommendations. They also make it absolutely clear that the guidance applies to the private sector as well as the public sector. The strategic vision of the RNTCP is to lay down guidelines and norms for TB care in the country. So the principle of the RNTCP is that they should extend public services to privately managed patients. The decision was also made to introduce a daily TB treatment regimen as directed by the Indian Supreme Court. The new anti TB drug bedaquiline for the treatment of drug resistant TB is also to be made available initially in five states.

For diagnosis the GoI has set up more than 600 CB-NAAT laboratories, and has enhanced their capacity with highly sensitive diagnostic services. CB-NAAT is the name given in India to Cartridge Based Nucleic Acid Amplification tests such as Genexpert and TrueNat.

National Strategic Plan (NSP) 2017 – 2025

One of the main changes in this strategic plan is that the emphasis is going to be on reaching patients seeking care from private providers. So this NSP builds on the work already done with the new RNTCP operating guidelines. The RNTCP will also be helping private providers to provide quality care and treatment, rather than encouraging the private providers to send their patients to get care from the RNTCP.

The NSP plans to provide incentives to private providers for following the standard protocols for diagnosis and treatment as well as for notifying the government of cases. Also patients referred to the government will receive a cash transfer to compensate them for the direct and indirect costs of undergoing treatment and as an incentive to complete treatment. This has already been trialed in some pilot projects.

“When I visited the largest slum in Mumbai with over one million people, I saw a model of care that seems to work whereby private practioners are empowered to detect and report TB cases through the support of an NGO and patients are mobilized to access TB services through the incentive of vouchers” *Dr Mario Raviglione, Director WHO Global TB Programme.*

The cost of implementing the new NSP is estimated at US$ 2.5 billion over the first three years. This is a large increase over the budget for the current NSP. The work set out in the National Strategic Plan has been arranged in four strategic areas, which can be described as:

- Detect
- Treat
- Prevent and
- Build

Public health efforts

The World Health Organization, Bill and Melinda Gates Foundation, and US government are subsidizing a fast-acting diagnostic tuberculosis test for use in low- and middle-income countries. In addition to being fast-acting, the test can determine if there is resistance to the antibiotic rifampicin which may indicate multi-drug resistant tuberculosis and is accurate in those who are also infected with HIV. Many resource-poor places as of 2011 have access to only sputum microscopy.

India had the highest total number of TB cases worldwide in 2010, in part due to poor disease management within the private and public health care sector. Programs such as the Revised National Tuberculosis Control Program are working to reduce TB levels amongst people receiving public health care.

A 2014 the EIU-healthcare report that the need to address apathy and urging for increased funding. The report cites among others Lucica Ditui "[TB] is like an orphan. It has been neglected even in countries with a high burden and often forgotten by donors and those investing in health interventions."

Slow progress has led to frustration, expressed by the executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria – Mark Dybul: "we have the tools to end TB as a pandemic and public health threat on the planet, but we are not doing it." Several international organizations are pushing for more transparency in treatment, and more countries are implementing mandatory reporting of cases to the government, although adherence is often sketchy.

Research

The BCG vaccine has limitations, and research to develop new TB vaccines is ongoing. A number of potential candidates are currently in phase I and II clinical trials. Two main approaches are being used to attempt to improve the efficacy of available vaccines. One approach involves adding a subunit vaccine to BCG, while the other strategy is attempting to create new and better live vaccines. MVA85A, an example of a subunit vaccine,

currently in trials in South Africa, is based on a genetically modified vaccinia virus. Vaccines are hoped to play a significant role in treatment of both latent and active disease.

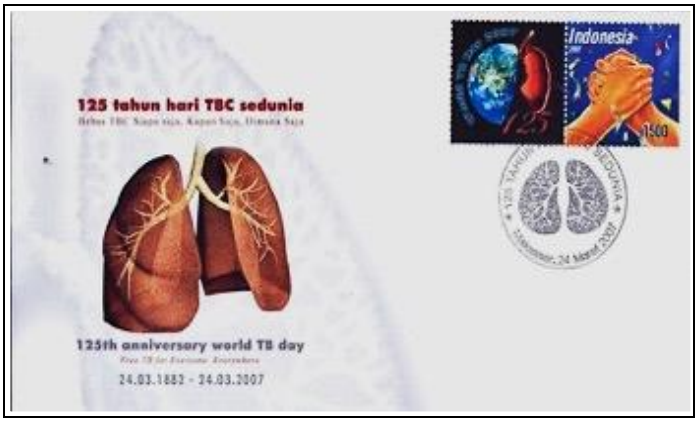
To encourage further discovery, researchers and policymakers are promoting new economic models of vaccine development, including prizes, tax incentives, and advance market commitments. A number of groups, including the Stop TB Partnership, the South African Tuberculosis Vaccine Initiative, and the Aeras Global TB Vaccine Foundation, are involved with research. Among these, the Aeras Global TB Vaccine Foundation received a gift of more than $280 million (US) from the Bill and Melinda Gates Foundation to develop and license an improved vaccine against tuberculosis for use in high burden countries.

Other animals

Mycobacteria infect many different animals, including birds, rodents and reptiles. The subspecies *Mycobacterium tuberculosis*, though, is rarely present in wild animals. An effort to eradicate bovine tuberculosis caused by *Mycobacterium bovis* from the cattle and deer herds of New Zealand has been relatively successful. Efforts in Great Britain have been less successful. As of 2015, tuberculosis appears to be widespread among captive elephants in the US. It is believed that the animals originally acquired the disease from humans, a process called reverse zoonosis. Because the disease can spread through the air to infect both humans and other animals, it is a public health concern affecting circuses and zoos.

World Tuberculosis Day - 24 March 2017

World TB Day celebrated on 24 March each year, is an opportunity to raise awareness about the burden of tuberculosis (TB) worldwide and the status of TB prevention and care efforts. It is also an opportunity to mobilize political and social commitment for further progress in efforts to end TB.



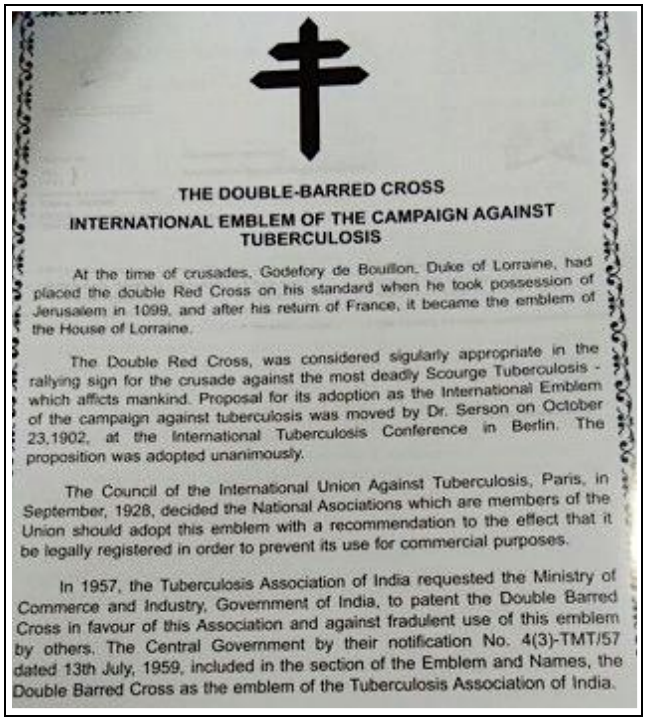
Unite to End TB: Leave no one behind

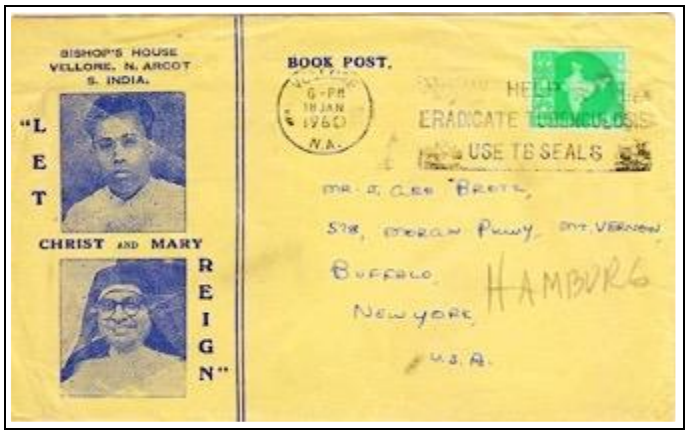
2017 is the second year of a two-year "Unite to End TB" campaign for World TB Day. This year, WHO will place a special focus on uniting efforts to "Leave No One Behind", including actions to address stigma, discrimination, marginalisation and overcome barriers to access care. The Sustainable Development agenda embraces the principle of ensuring no one is left behind in an effort to transform the world and improve people's lives for the better. Addressing the health needs of the disadvantaged, the marginalised, those out of reach of the health system will mean improving access to health services for everyone. This is essential in order to reach the target of ending TB by 2030 as part of the UN Sustainable Development Goals and the WHO End TB Strategy.

World TB Day provides the platform for affected persons and communities, civil society organizations, health-care providers, policy makers, development partners and others to advocate, discuss and plan further collaboration to fulfil the promise of reaching all people with quality TB prevention and care services, as well as enabling TB prevention through multisectoral development efforts.

The Tuberculosis Association of India

The Tuberculosis Association of India (TAI) has been serving the cause of tuberculosis since 1939. It is one of the oldest and largest voluntary organizations having its affiliates all over the country. It was set up in February, 1939 as a registered society by incorporating the King Emperor's Anti-Tuberculosis Fund and King George Thanks-giving (Anti-Tuberculosis) Fund. Her Excellency the Marchioness of Linlithgow was the first President of the Association when the Tuberculosis Association of India was established on February 23, 1939.



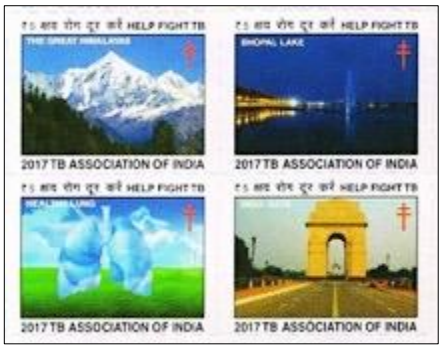


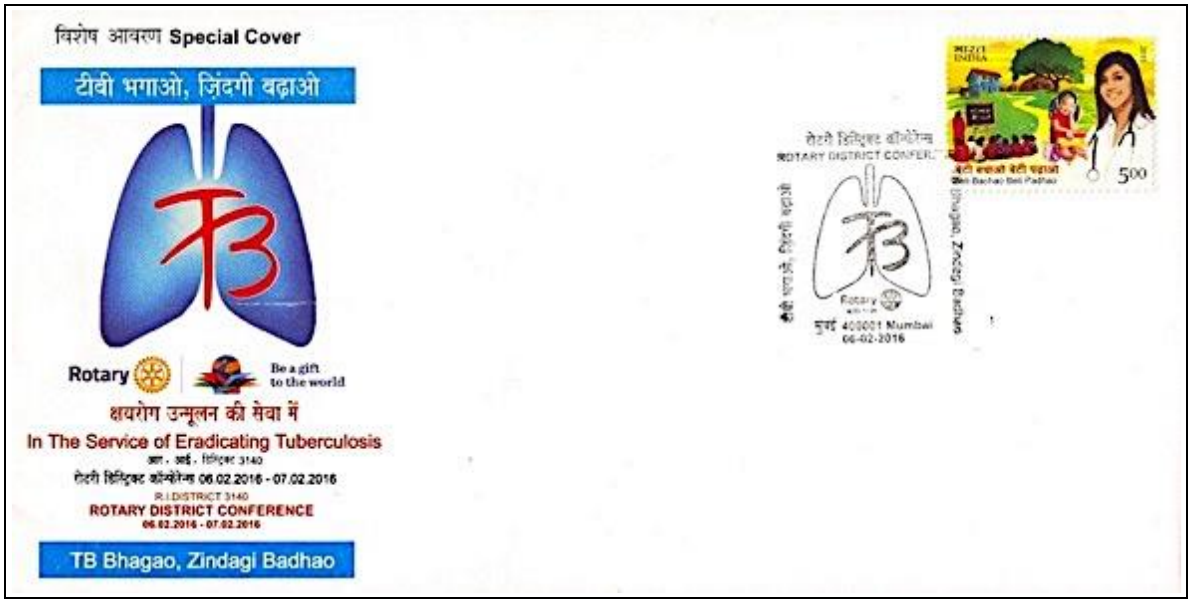
(Image courtesy: Ebay.com)

Its aims and objectives are:

- The prevention, control, treatment and relief of tuberculosis.
- The encouragement of and assistance in the establishment throughout India of State Associations having objectives similar in whole or in part to those of the Association.
- The affiliation or control of and the rendering of assistance to any institution having objectives similar in whole or in part to the objects of the Association.
- The undertaking of the Research and Investigation on subjects concerning tuberculosis and allied chest diseases.
- The doing of all such things as are incidental or conducive to the attainment of the above objectives.

Every year TB Association of India publishes four TB seals on various themes. For the year 2017 theme stamps seals were:





Acknowledgments: *This philatelic article is prepared using information available at following web sites for the purpose of distribution of knowledge with no commercial motive;*

https://www.tbfacts.org/tb/
https://www.tbfacts.org/tb-india/
https://en.wikipedia.org/wiki/Tuberculosis
https://www.medicalnewstoday.com/articles/8856.php
http://www.who.int/campaigns/tb-day/2017/event/en/
http://tbassnindia.org/

The author thankfully acknowledges all source of information. All Meghdoot postcard images are from the collection of Prathmesh Patel, Anand and all philatelic illustrations are from the collection of Prakash Jambudi, Ahmedabad. The author is thankful to both philatelic friends to permit him to prepare this article.

News in brief

NEXT PCI MEETING AT CHENNAI

The next Philatelic Congress of India (PCI) meeting will be held at Chennai on 28th and 29th April, 2018.

The South India Philatelic Association will be organising Seminars/Presentations on Saturday, 28th April, 2018 in association with the Philatelic Congress of India at ABK AOTS DOSOKAI, Chennai Office, Chateau D'Ampa-3rd Floor, 110 Nelson Manickam Road, Aminjikarai, Chennai-600029.

Programme

10.00 am - Registration
10.30 am to 11.30 am - Presentation on 'India 1854 Two Annas Stamps' by Mr.Markand Dave
11.30 am to 12.15 pm - Presentation on 'Philatelic Research: Methods & Tools' by Mr.Madhukar Jhingan
12.15 pm to 12.45 pm - Seminar on Postal History by Madhukar Deogawanka

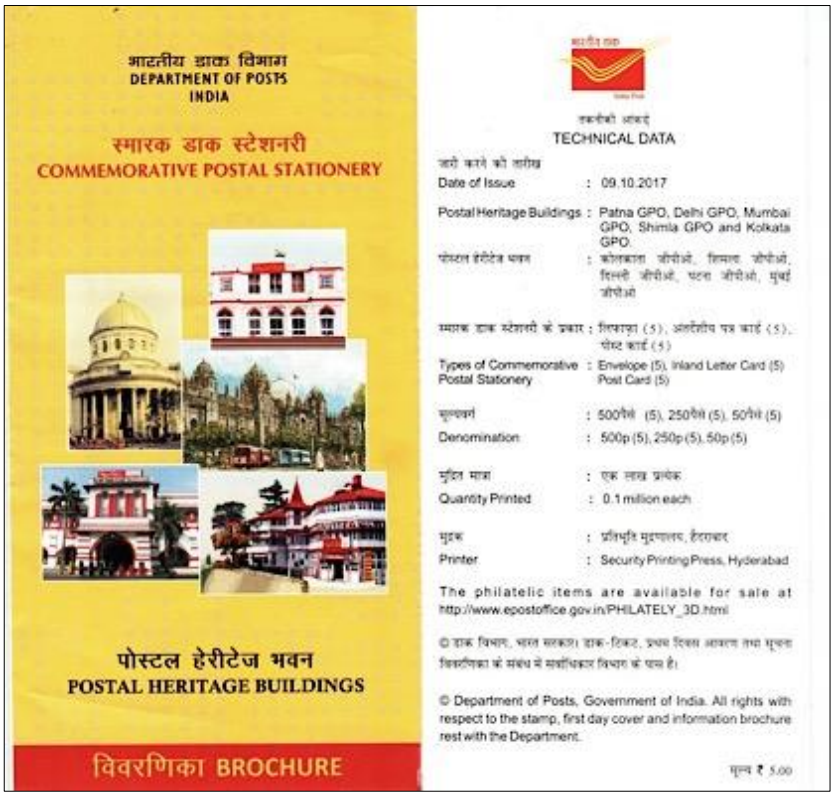
ANNUAL GENERAL BODY MEETING

The Annual General Body Meeting of PCI will be held on Sunday, 29th April, 2018 at Majestic Hall, Regenta Central Deccan Hotel, 36, Royapettah High Road, Royapettah, Chennai-600014.

After the usual programmes and approval of audited accounts for the previous two financial years (2015-16 & 2016-17), election of new office bearers for the next two years will take place.

BROCHURE FOR POSTAL STATIONERY

For the first time in the Indian Postal History, The Department of Post issued a brochure for the Commemorative Postal Stationery issued on Postal Heritage Buildings.



First Stamps and early Postal History of Ceylon


By Col. J Dutta & Dr. Anjali Dutta

Sri Lanka, known as Ceylon before 22 May 1972, is an island country in South Asia, located about 31 km off the southern coast of India.

For some 2,000 years the island was ruled as a local kingdom. In 1517 the Portuguese founded a fort at the port city of Colombo and gradually extended their control over the coastal areas. In 1638 the Dutch made a treaty with Rajasinghe II, the king of Kandy, to get rid of the Portuguese. By 1660 the Dutch controlled the whole island except the kingdom of Kandy and it was not until 1656 that Colombo fell.

In 1659, the British sea captain Robert Knox landed by chance in Sri Lanka and was captured by the king of Kandy. He escaped 19 years later and wrote an account of his stay. This helped to bring the island to the attention of the British**.** In 1796 Great Britain occupied the coastal areas of the island (which they called Ceylon). In 1802 the Netherlands ceded the parts of the island they still occupied to Great Britain by the Treaty of Amiens. The remainder of the island, the Kingdom of Kandy, was occupied by Great Britain in 1815 and the native king of Kandy was deposed and exiled.

A nationalist political movement arose in the country in the early 20th century with the aim of obtaining political independence, which was eventually granted by the British after peaceful negotiations on 4th February 1948. On 22nd May 1972 the name Ceylon was changed to Sri Lanka.

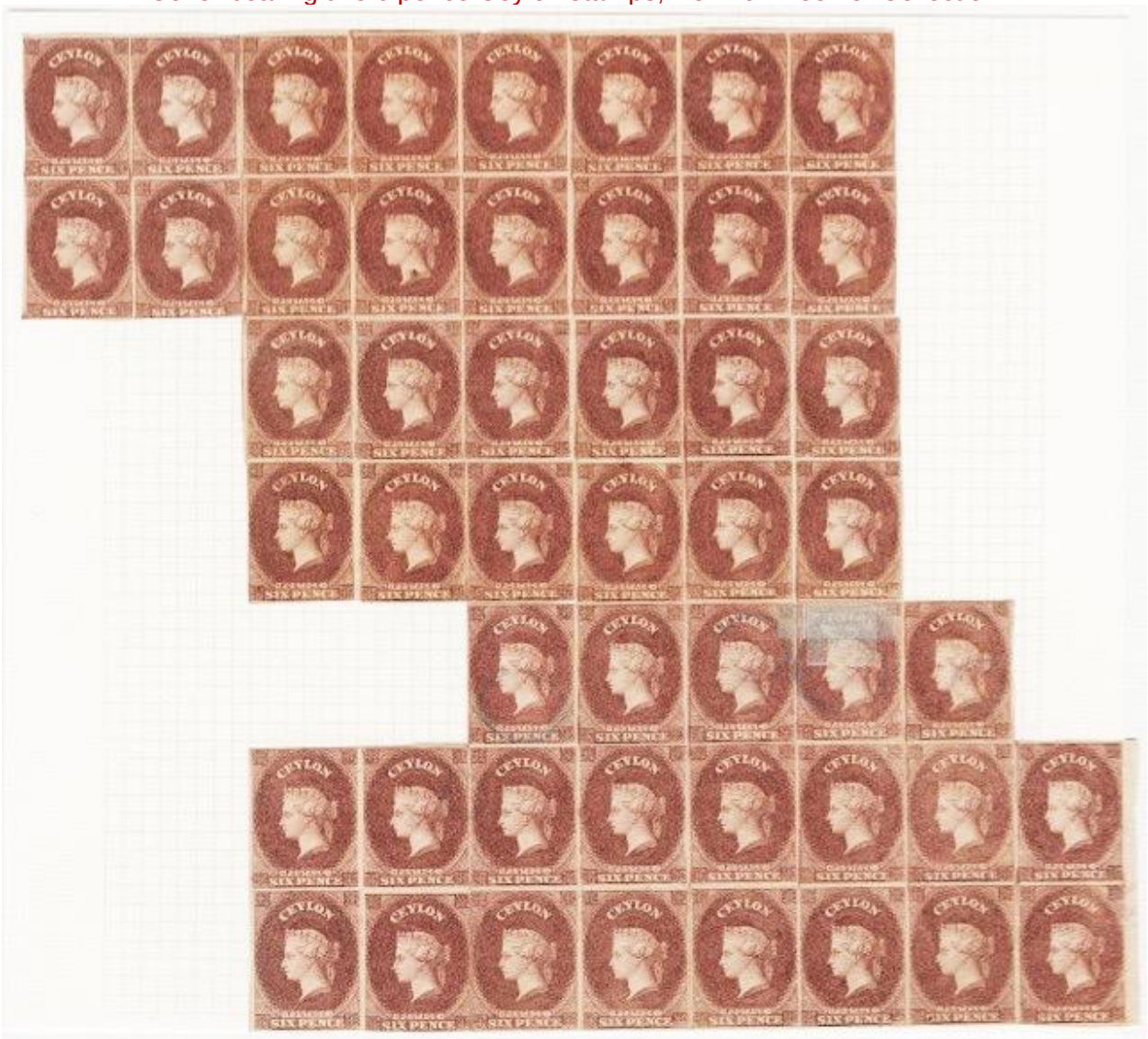
In 1798 the Dutch opened five post offices in the districts under their control. In 1799, they published the first postal regulations and postage rates. The Dutch East India Company operated the Postal service, which was not meant for the public but for official use. The first postmaster was appointed in 1802 and handstamps were first supplied in 1813. The first mail coach service in Asia was inaugurated in Ceylon in 1836. The service linked Colombo and Kandy.

The first stamps for Ceylon were issued on 1 April 1857. The stamp features a portrait of Queen Victoria and is brown in colour. It is a 6 pence value used to send a half-ounce letter from Ceylon to England. Eight more stamps were issued in year 1857, all featuring the portrait of Queen Victoria. One of the 5 stamps that were issued on 23rd April 1859 is considered to be the most valuable stamp in Sri Lanka. It is the 4 pence dull rose.

6 pence purple-brown, Queen Victoria issue 1857and 4 pence dull rose of 1859, Joseph Hackmey collection.

In the Spink Shreves auction of 22 October 2010 the 4 pence carried a listing of $75,000 - 100,000.

Cover bearing two 6 pence Ceylon stamps, Heinrich-Koehler Collection



6 pence purple brown on star watermarked blued paper plate proof in state III Heinrich-Koehler Collection

The Joseph Hackmey Philatelic Collection of Classic Ceylon is an award winning collection, which is also the most expensive and the most popular collection of classic Ceylon stamps among philatelists. Two of the most notable pieces that are part of this collection include a single copy of the 4 pence dull rose, and an envelope sent from Kandy to London with two 4 pence dull rose stamps and a 1-pence blue stamp also bearing the image of Queen Victoria on it. Aside from the Joseph Hackmey Philatelic Collection of Ceylon, another significant philatelic collection is the Alexander Reid collection. One of the most significant stamps in this collection is a rare 20th century Rs.1,000 revenue stamp, which was in production between the years 1912 and 1925. The stamp features a portrait of King George V, who was an enthusiastic philatelist, and as of now its worth lies between $12,000 and $24,000. The Sir Ernest De Silva collection is another notable collection of Ceylonese and Sri Lankan stamps.

Cover sent from Kandy to London, marked "Via Marseilles", bearing two 4d dull rose stamps and a 1d blue, each cancelled by an oval of bars and the two 4d stamps clearly tied by a red London Paid arrival datestamp. Addressed to John Gordon (the Gordon correspondence is well-documented) the reverse shows the red "kandy/post-paid" datestamp, Joseph Hackmey collection. In the Spink Shreves auction of 22 October 2010 carried a listing of $75,000-100,000.

King George V Rs. 1,000 revenue stamp

1857-1863 issues

1859 issues

150th Anniversary of the First Postage Stamp of Sri Lanka 1857-2007

Miniature sheet of 160th Anniversary of the First Postage Stamp of Sri Lanka

References

1. Geoff F Oxley, The Postal History of Ceylon 1795 – 1857, Ceylon Study Circle of GB, 1996, ISBN 0952814919
2. Edward B Proud, The Postal History of Ceylon, 2006, ISB

Knowledge Bank

GLOSSARY OF PHILATELIC TERMS

Air Hole Flaw Technical term for an uncoloured area, usually circular, which appears accidentally in a coloured portion of a stamp design.

Air Letter Forms Special letter forms impressed with a six penny stamp issued in GB in 1943 to facilitate the writing and handling of air mail letters.

Airgraph Special letter form used by GB during WW2 for forces mail overseas which was microfilmed and then reproduced on arrival at destination.

Airmail Any form of correspondence transmitted by air, Airmail Labels Member countries of the UPU adopt a standardised blue label for affixing to correspondence sent by air to facilitate easy recognition, also known as etiquettes (q.v)

Airmail Letter Card A folded letter sheet for British Armed Forces in WW2

Airmail Stamps Postage stamps expressly providing for prepayment of postage on air borne mail.

Airway Letter Stamps Stamps issued by British European Airways since 1951 and also for a while by Cambrian Airways, for the carriage of letters between airports and for posting on arrival.

Airstream A service of the British Post Office introduced in 1986 for the bulk posting of airmail packets using postage paid impression and a distinctive label.

Albino Impression A colourless (uninked) impression of either a stamp (usually embossed) or of an overprint or surcharge.

Album Book designed to house stamps etc.

ALF Automatic Letter Facing machine that prepares mail for automatic cancelling.

All-Over Watermark A single device or pattern covering the whole sheet of paper.

Alpha and Beta Flaws Terms to describe flaws in lithographed stamps. An Alpha Flaw is one which builds up on the litho stone during the early processes of stamp production. A Beta flaw is one which occurs later because of wear on the stone.

Alphabet Great Britain's first line engraved issues had letters printed in the bottom corners. These, over time, came from four sets of hand punches having distinctive type faces, known as Alphabets I, II, III, IV (q.v Check Letters).

All Up Service A scheme introduced in 1937 whereby all letter mail sent from the UK to Commonwealth Countries was sent by air at no additional cost to surface rates of postage.

Ambulance Bag Plastic bag used since the 1980s by the Post Office to seal and forward damaged or broken packets in transit: similarly a paper envelope used by the Post Office before the advent of plastic.

Ambulant Postmark denoting a Travelling Post Office.

Anaglyph Printing in two colours to give a three-dimensional effect.

Anaglyptography Form of machine engraving which gives an appearance of relief to a print through use of parallel waved lines.

Anchor Printing terminology for a rivet, nail or screw used to fix a printing plate to a wooden or metal mount.

Anchor Watermark Watermark used in certain issues of Great Britain and Colonies. An Anchor is shown in many stamp papers.

Anhyphenate Without a hyphen.

Aniline Water soluble and fugitive ink with a dye base that runs when wetted and fluoresces under a UV lamp.

(to be continued….)

STAMP TALK

by PENNY BLACK

THE WORLD'S FIRST OFFICAL POSTAGE STAMP

By Prof. Dr. Vra. Saathappan
Professor of Civil Engineering, VJEC, Chemperi, Kerala-670632.

I am **PENNY BLACK**, the world's first official postage stamp issued for a public postal system, talking to you. **Sir Rowland Hill**, an educationist is considered to be my father. Hill saw the irregularities in the, then existing postal system of Great Britain, which caused negative revenue for the government and issued a pamphlet titled **"Post Office Reforms; Its Importance and Practicability"** on 13th February in the year 1837, which insisted on a uniform postage irrespective of the weight of the letter and the distance of delivery.

Sir Rowland Hill my creator

Hill also gave an idea of issuing an envelope for carrying letters. Hill's concept was accepted and he was given a two year contract to run the system. Hill along with Mr.Henry Cole ran a competition to find a good design for me. 2600 entries were received and none was convincing to Hill. So finally, Hill made a rough sketch about how I must look like, along with instructions and his signature.

Rough sketch done by Hill with instructions to the designer along with his Signature

Used Mulready cover with myself and Maltese Cross cancellation

William Wyon Medal

Finally Hill launched my services in all post offices on 1st May, 1840 along with an envelope designed by the artist Mr. William Mulready. I was issued for public use on 6th May, 1840. I was bearing the profile of the British Monarch, Queen Victoria. This idea of the profile of the monarch on me was conceived in the thoughts of Sir Rowland Hill.

The profile of Queen Victoria which was printed on me was engraved by Mr. Charles and Mr. Fredrick Heath, based on the sketch provided by Mr. Henry Corbould. In turn, the sketch was based on the cameo-like head by Mr. William Wyon, which was designed for a medal

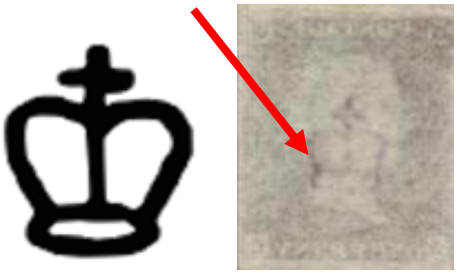
used to commemorate the visit of Queen Victoria to the city of London in 1837, the year of Her coronation.

I was printed using the line engraved printing method from 11 plates numbered 1 to 11. Plate No.1 deteriorated quickly and was repaired to such an extent that it is generally considered as two separate plates -No.1a and No.1b - making 12 plates in total from which I was printed. Each plate consisted of 240 stamps of me in 20 rows and 12 columns. My position on the sheet was identified by two letters in the front bottom corners. The left corner letter identifies the row and the right corner identifies the column.(i.e) AA,AB,AC…….AL for top row BA,BB,...BL for second row and so on till the bottom row as TA,TB,TC,……TL.(There were 240 pence in a Pound (£), 12 pence to a shilling and 20 shillings to a Pound.) Thus 1 full sheet of me (240 stamps) will cost one Pound, ½ sheet of me (120) cost 10 shillings, and one row of me (12) cost a shilling.

AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL
BA	BB	BC	BD	BE	BF	BG	BH	BI	BJ	BK	BL
CA											BL
DA											DL
EA											EL
FA											FL
GA											GL
HA											HL
IA											IL
JA											JL
etc											etc
.											.
.											.
.											.
RA											RL
SA				SE							SL
TA	TB	TC	TD	TE	TF	TG	TH	TI	TJ	TK	TL

I had two corner letters (bottom left and bottom right). Myself with letters SE is shown here, as well as my position on the sheet.

To prevent forgery, I had a small crown watermark on my back and check letters in front bottom corners. I was printed in 2,86,700 sheets in a year totaling to 68,808,000 stamps. I am not a rare stamp but finding me in a good condition with uniform margin is very rare.



Crown watermark and its visibility at the back of me

I was issued for official usage with letters V R at the top corners

In addition to the general issue, my design was little modified to be used for official, government mails. The new design was produced, with the letters "V" and "R" replacing the crosses in the top corners.

I was initially cancelled by a red Maltese Cross cancellation, however this was difficult to see and easy to remove. Changing to black ink cancellation was still more difficult to see. Hence I was **replaced by Penny Red** and printed from the 12th plate from January 1841.

Initially, Hill decided that my size should be 3/4 inch square, but altered the dimensions to 3/4 inch wide by 7/8 inch tall (approx 19 x 22 mm) to accommodate the writing at the bottom. The word "POSTAGE" at the top of the design distinguishes it from a revenue stamp, "ONE PENNY." at the bottom shows the amount pre-paid for postage of the

Complete sheet of Myself (12x20)

Maltese cross cancellation, on me in red and on my replacement (Penny Red) in black

stamped letter. The background has a finely engraved engine turnings. The two upper corners hold Maltese crosses with radiant solar discs at their centre, the lower corner letters show the position of the stamp in the printed sheet, from "A A" at top left to "T L" at bottom right.

To separate me from the sheet as a single stamp, scissors or some sharp instrument was used. Stamps from Mr. Henry Archer's perforation trials were issued in the last few months of 1850. UK government purchased the perforation machine from Henry in 1853. Perforation of postage stamps began in January 1854 and the first officially perforated stamps were issued in February 1854.

The black ink cancellation on my replacement (Penny Red) was much more effective and harder to remove. The re-use of stamps with the un-cancelled portions of two stamps to form an unused whole impression continued and in 1864 the stars in the top corners were replaced by the check letters, as they appeared in the lower corners, **but in reverse order.**

Since I was the world's first stamp, country's name was not printed on me. So in remembrance of me, till today

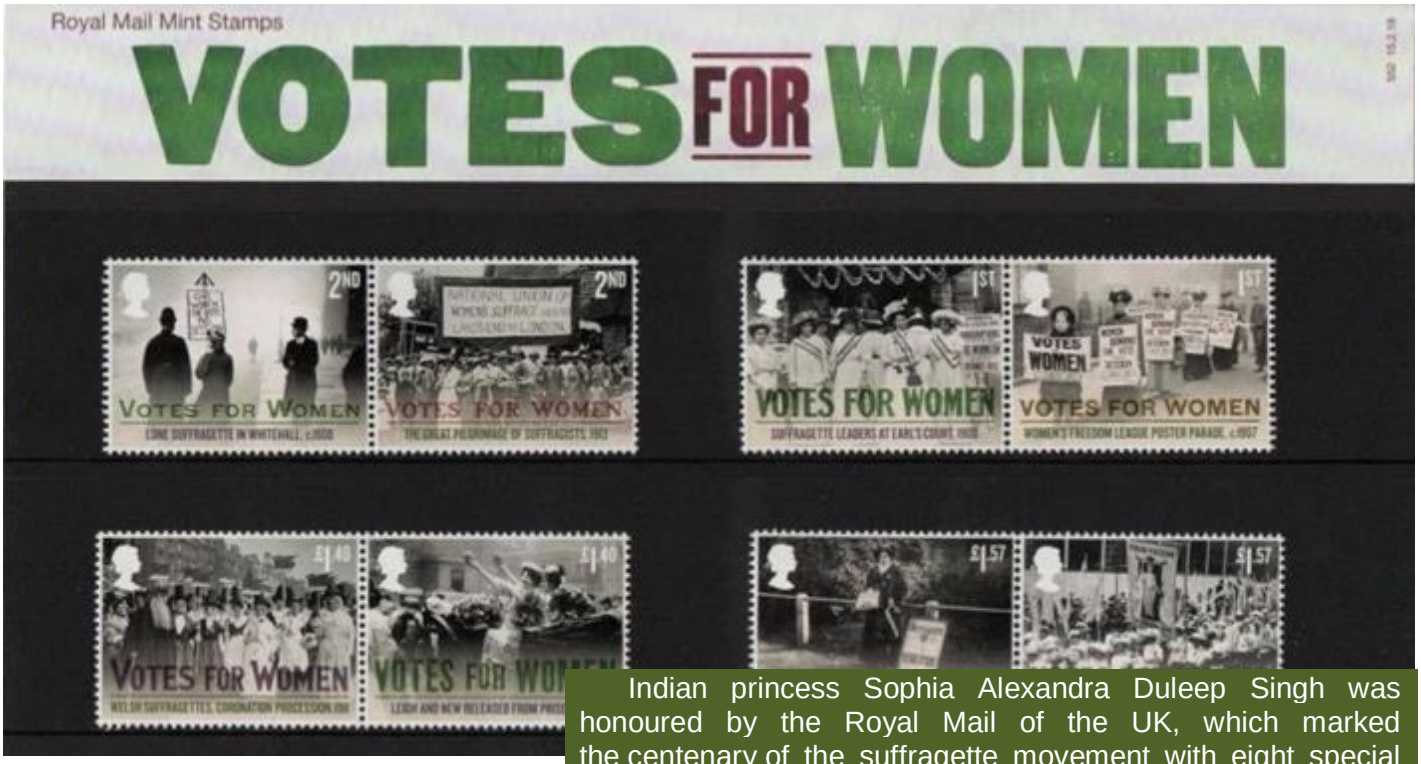
This is Jacob Perkins' press, which printed my sister, Two Pence Blue and me, This "D" cylinder press patented in 1819, is now on display at the British Library, London.

My sister, Two Pence Blue. Well centered Block of Four.

all British stamps bear a profile of the reigning monarch somewhere on the design looking always towards the left. When I was born, I was called as a **postage label**, not as a stamp. I have a sister, two pence blue who was born after 2 days, on 8th May, 1840.

I shall meet you again on some other occasion. **Thank you friend. See you.**

India Abroad



Indian princess Sophia Alexandra Duleep Singh was honoured by the Royal Mail of the UK, which marked the centenary of the suffragette movement with eight special stamps. Princess Sophia Alexandra Duleep Singh, (August 8 1876-August 22 1948), the daughter of Maharajah Duleep Singh, is the only woman, who has one among the eight stamps to herself.

The image shows Princess Sophia "selling copies of the WSPU newspaper The Suffragette in April 1913. A member of the Women's Tax Resistance League, (whose official motto was 'No Taxation Without Representation'), the princess appeared in court on several occasions after refusing to pay taxes." The stamps feature original photographs of campaigning in the decade before the right to vote was passed with the 1918 Representation of the People Act.

Israel honoured Indian Cavalry for their help in World War I in Eretz by issuing a commemorative stamp on the occasion of its centenary. The stamp was issued on 6th February, 2018.

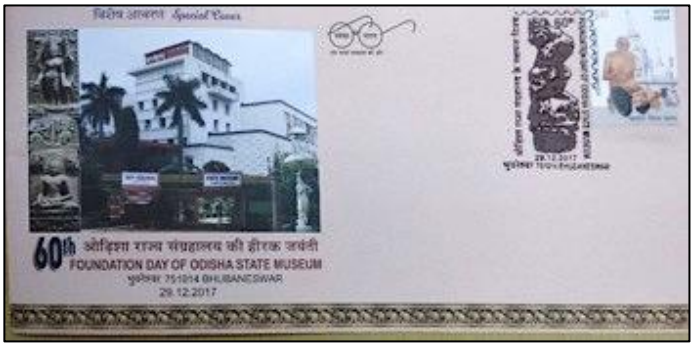
Bhutan issued stamps and miniature sheets on 21st February, 2018 celebrating 50 years of formal diplomatic relations and enduring friendship between Bhutan and India

To commemorate the 50th death anniversary of Sir Alfred Chester Beatty, Irish Post issued 4 stamps on 18th January, 2018 featuring his collection of paintings. Of the four stamps, one of them is from Indian theme depicting a painting of Shahjahan.

Beatty was born in New York in 1875 and became a mining magnate, philanthropist and one of the most successful businessmen of his generation. He was granted honorary Irish Citizenship in 1957.

Courtesey: Madhukar Jhingan, Stamps of India

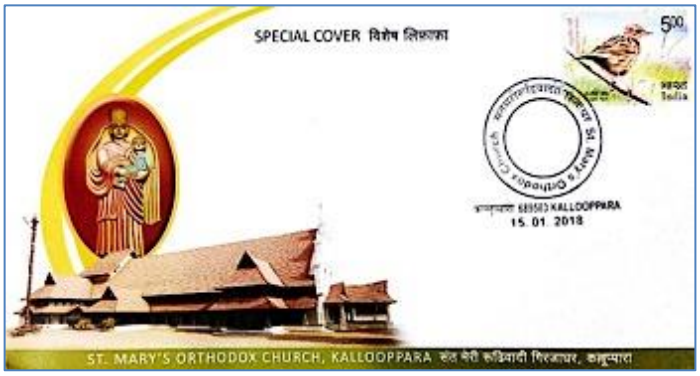
SPECIAL COVERS



BHUBANESWAR : 29 Dec 2017
Foundation Day of Odisha State Museum

UJJAIN : 05 Jan 2018
Shiv Mahotsav

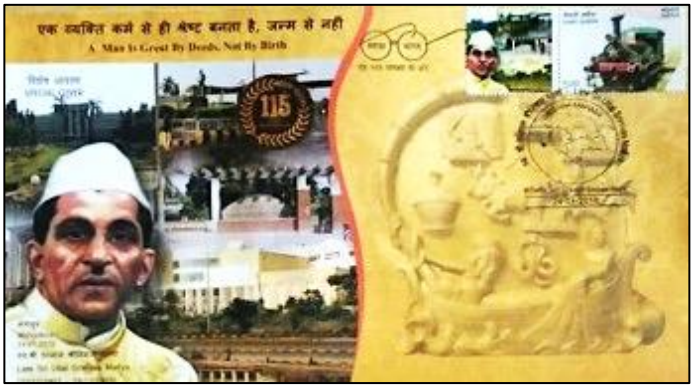
HAZARIBAG : 13 Jan 2018
Sri Ramakrishna Sarada Ashrama, Hazaribag



KALLOOPPARA : 15 Jan 2018
St. Mary's Orthodox Church, Kallooppara

ATTUR KARKALA : 18 Jan 2018
St Lawrence Basilica, Attur

ERNAKULAM : 22 Jan 2018
Kochi Muncipal Corporation



SRINIVAS NAGAR : 24 Jan 2018
Late Sri Ullal Srinivas Mallya

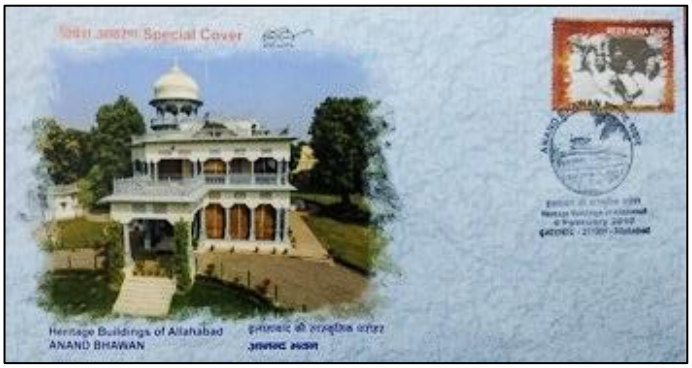
MUMBAI : 25 Jan 2018
The Association of Surgeons of India

KOLKATA : 26 Jan 2018
Tri celebrations – Ashrama, Vidyalaya, ITC

LAKKUNDI : 27 Jan 2018
Lakkundi Utsav 2018

KOTTAKKAL : 30 Jan 2018
Vaidyaratnam P.S. Varier

BENGALURU : 01 Feb 2018
Intnl. workshop on Prevention & Management of Homoglobinopathies & Hemophila

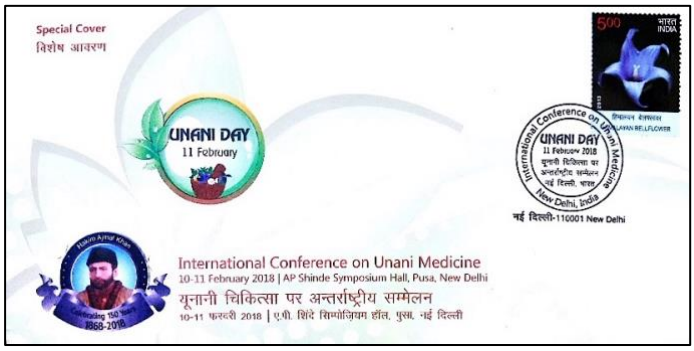


ALLAHABAD : 06 Feb 2018
Heritage Building of Allahabad Anand Bhawan

DHANBAD : 07 Feb 2018
DAV Public School, Koyla Nagar

BENGALURU : 10 Feb 2018
Century Club, Bangalore

RAJGIR : 10 Feb 2018
40th Blennial All India Conference, Rajgir

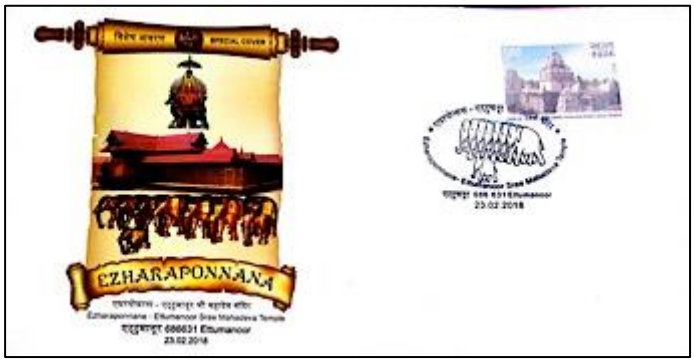


NEW DELHI : 11 Feb 2018
Intl Conference on Unani Medicine

ALLAHABAD : 16 Feb 2018
UP Orthocon 2018

SHRAVANABELAGOLA : 17 Feb 2018
Shree Bahubaliswamy Mahamasthabhisheka Mahotsava 2018

PATNA : 19 Feb 2018
All India Postal Badminton Tournament



ETTUMANOOR : 23 Feb 2018
Ezaraponnana – Ettumanoor Sree Mahadeva Temple

RAJRAPPA : 24 Feb 2018
Rajrappa Mahotsav

MANIPAL : 24 Feb 2018
T Upendra Pai – Co Founder of Syndicate Bank

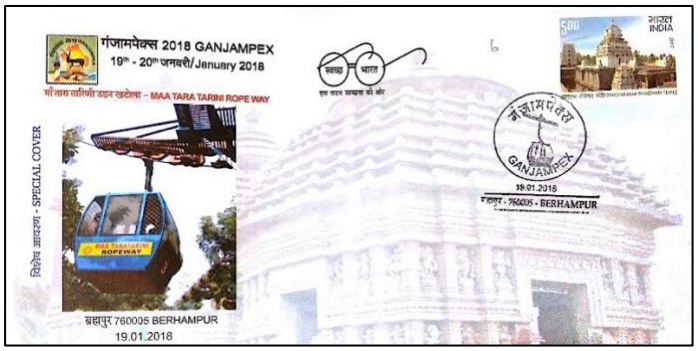
DEHRADUN: 24 Feb 2018
Spring Festival

BENGALURU : 27 Feb 2018
42nd Death Anniversary of K C Reddy

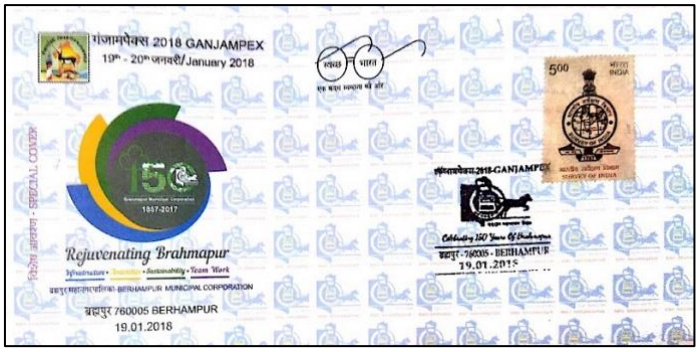
MOTIHARI : 03 FEB 2018
Mahatma Gandhi Memorial Pillar

MOTIHARI : 03 FEB 2018
Radhakrishan Sikaria Educational, Social & Spiritual Institution

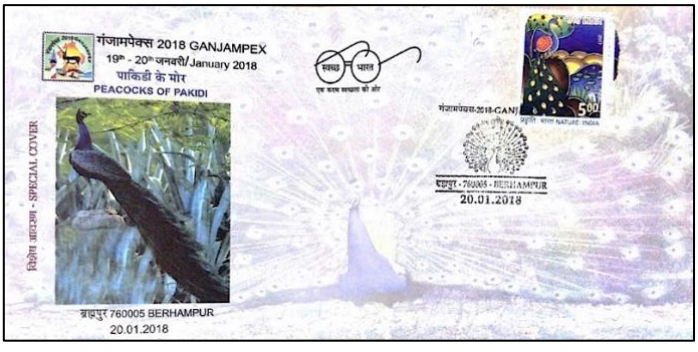
MOTIHARI : 04 FEB 2018
Kesaria Stupa



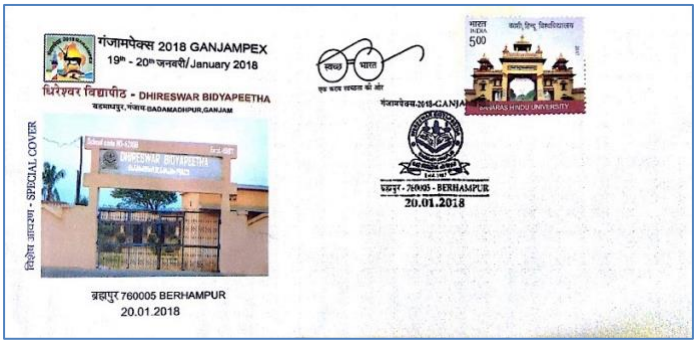
BERHAMPUR : 19 Jan 2018
Maa Tara Tarini Rope way



BERHAMPUR : 19 Jan 2018
Rejuvenating Brahmapur



BERHAMPUR : 20 Jan 2018
Peacocks of Pakidi



BERHAMPUR : 20 Jan 2018
Dhireswar Bidyapeetha

SURAT : 23 Feb 2018
Adopt a Homeless Pet

SURAT : 23 Feb 2018
Om Shri Satnam Saakshi

SURAT : 24 Feb 2018
Surat Muncipal Corporation

LAKSHAR : 27 Jan 2018
Mallavidha's Yodha – Shri Rattanlal Sharaf

LAKSHAR : 27 Jan 2018
Lakshmibhoi National Institute of Physical Eduction

LAKSHAR : 27 Jan 2018
Gwalior Vyapar Mela

BALANGIR : 08 Jan 2018
Koshal Kala Mandal, Balangir & Traditional "Panchavadya"

BALANGIR : 09 Jan 2018
Tourist Place of Balangir : Harishankar Waterfall

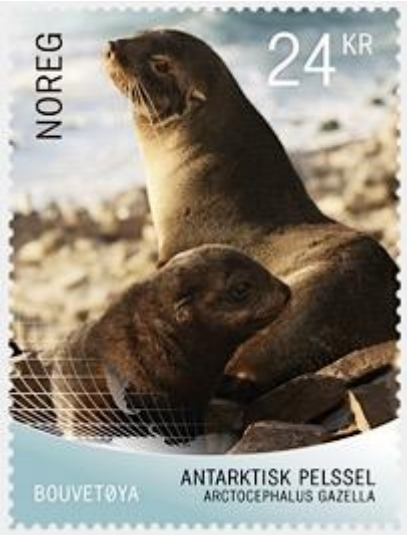
Courtesy: ***Sreejesh Krishnan***
Thiruvananthapuram

New Issues from Other Countries

ALAND

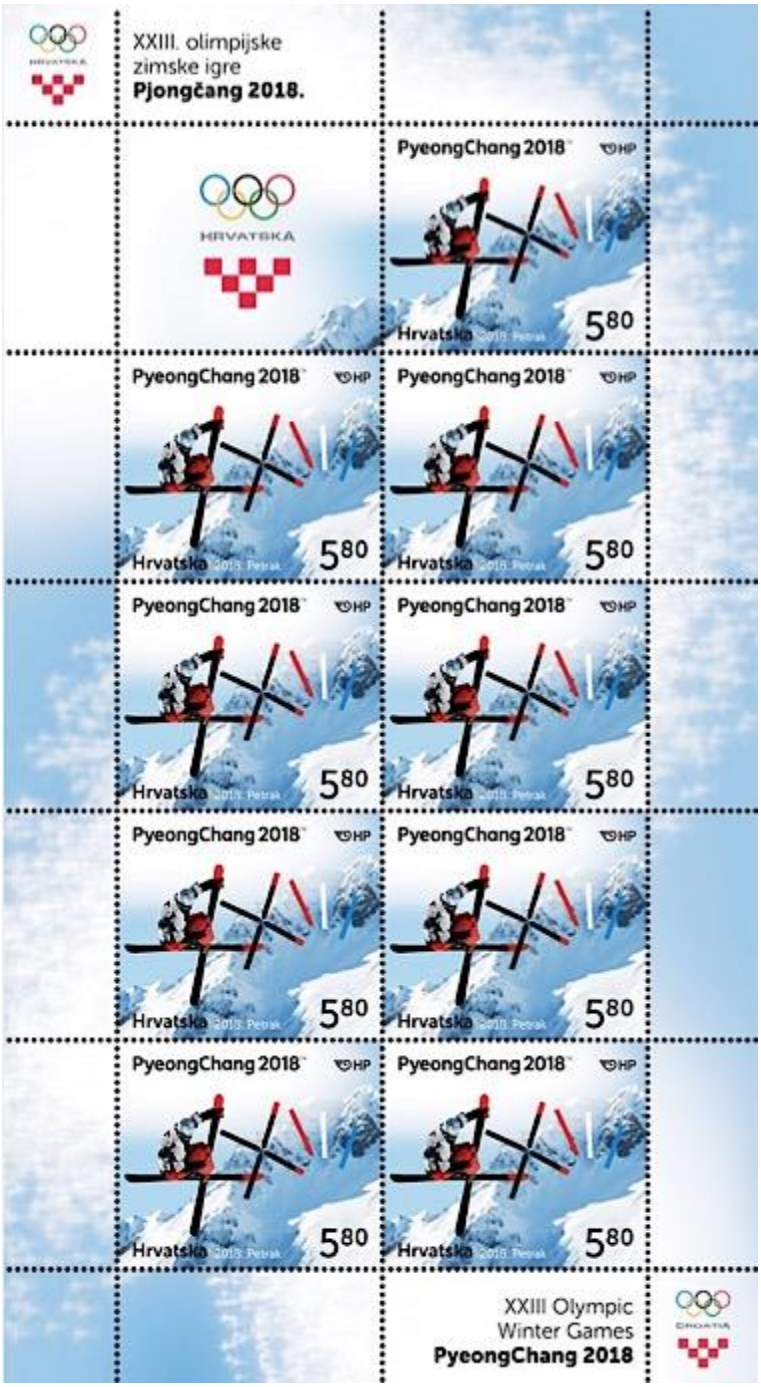
Sailing Ships
Issued on 01.02.2018

NORWAY



Bouvet Island
Issued on 16.02.2018

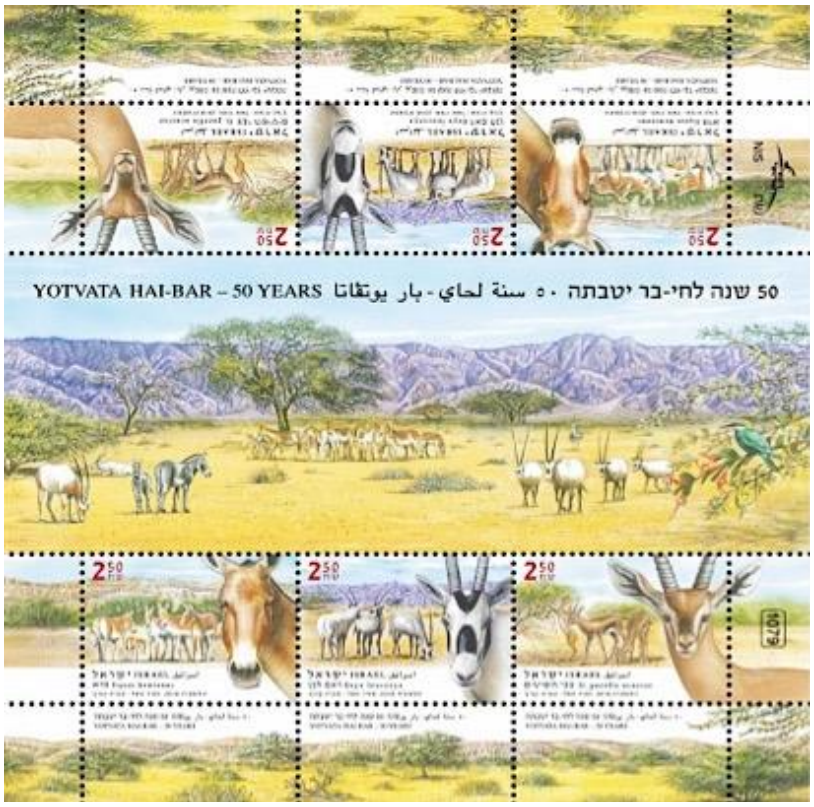
CROATIA



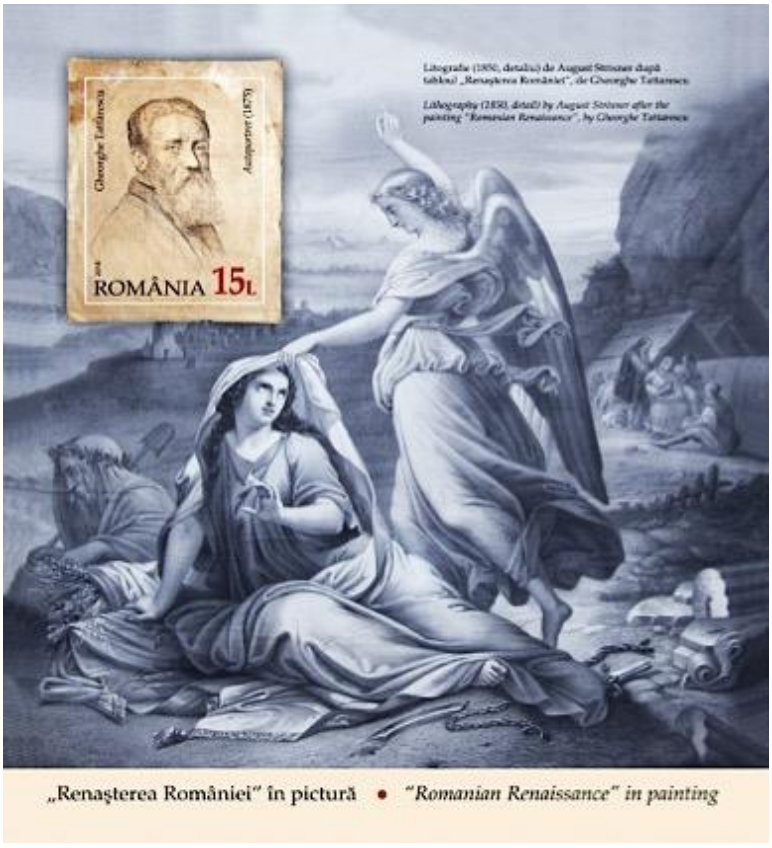
Winter Olympics
Issued on 07.02.2018

Image Courtesey: Wopa+

ISRAEL



Yotvata Hai-Bar – 50 Years
Issued on 06.02.2018



Romanian Renaissance
Issued on 16.02.2018

Forthcoming Events

INTERNATIONAL EXHIBITIONS

19 TO 21 MAY 2018

BIRDPEX-8

A specialised thematic exhibition BIRDPEX-8 will be held from 19th to 21st May, 2018 at Mondorf-les-Bains, Luxembourg as part of the philatelic exhibition EXPHIMO 2018 (yearly official thematic stamp exhibition of Luxembourg Philatelic Association) by thematic stamp collector club PHILCOLUX.

For details contact Mr. Roger Thill, Email:rogert@pt.lu

24 TO 27 MAY 2018

RMSS 2018

USA National Stamp Exhibition (RMSS 2018) will be held from 24th to 27th May, 2016 at Denver, Colorado, USA. Mr. Ajay Kumar Mittal is the National Commissioner for India.

Contact: Mobile 9811032311, 9311332311.
Email: ajaymittal1957@gmail.com

27 TO 31 MAY 2018

ISRAEL 2018

FIP World Stamp Championship Specialised Exhibition will be held from 27th to 31st May, 2018 at Jerusalem, Israel. The National Commissioner for India is Mrs. Damayanti M. Pittie.

Contact: Mobile: 9930367660,
Email: purchasemumbai@harinagar.co.in

15 TO 18 AUGUST 2018

PRAGA 2018

A Specialized World Stamp Exhibition will be held from 15th to 18th August, 2018 at Prague, Czechoslovakia. Mr. Rajan Jayakar is the National Commissioner for India.

Contact: Mobile: 9821072417
Email: rajanjayakar1948@gmail.com

Acknowledgement:

Rainbow Stamp News: February 2018 Vol. XI. No.122
The Hyderabad Hobby Magazine: February 2018.Vol.56/2

Forthcoming Issues of India

India-South Africa Joint issue (Deendayal Upadhyaya & Oliver R. Tambo)
Jyotirlinga Temples
Paika Rebellion (200 years)
Patna University
C. Kesavan
Swami Karpatri
K.R.Narayanan

Articles are invited from readers with illustrations to be published in this bulletin. Please send your write ups in MS Word only, to our email ID apa.tvpm@gmail.com. News and philatelic activities in your locality are also welcome. Philatelic Clubs and Associations may send their brief reports on day to day activities.

Editor

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