

NEWS LETTER FROM KIYOSE

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RIT/JATA

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Universal Health Coverage and Tuberculosis Control

Nobukatsu Ishikawa, Director



UHC in the Post 2015 Development Agenda

UHC is the current new global wording for the major agenda for post MDGs. UHC aims to establish the system in which all people obtain the health services they need without suffering financial hardship when paying for them (WHO). It is essentially based on the concepts of health by the WHO declaration in 1948 on health as a fundamental human right and of primary health care (Health for All) in 1978. It aims to expand the health concept under the comprehensive social system and social protection under such things as the health insurance scheme. UHC aims to strengthen the social system beyond the health program or disease control.

Threat or opportunity?

However a worry among the people engaged in TB or infectious diseases for this political movement towards UHC is a budgetary shift. Financial support by the donors to the Global Fund for HIV, Malaria and TB might be shifting to strengthen UHC.

Although the majority of TB patients now can have much better access to free services including diagnosis and treatment, other financial burdens such as transportation cost or loss of daily wages lie heavily on the majority of them. Through UHC, the coverage of TB services can definitely be widely ensured. This is a long term opportunity.

A new post 2015 global TB strategy

WHO has drafted the post 2015 framework of the new TB strategy after the Stop TB Strategy (2006-2015), in line with

the new global movement of UHC in the post MDG development policy. This will be finalized in the World Health Assembly this coming May. Zero deaths, disease and suffering due to TB, i.e. a world free of TB is the vision with targets of 75% reduction of TB deaths and 50% reduction of TB incidence rate in 2025, compared with 2015. It sets up other very ambitious targets for 2035 as well. This draft is not as simple as DOTS or the Stop TB Strategy and covers very wide aspects of TB control. It is definitely ambitious and comprehensive, reflecting a broader concept of health. But no mention of DOTS is seen there. Some say DOTS is already accepted and established and others say DOTS is old-fashioned and should be done away with.

What has DOTS been?

DOTS has been a revolutionary concept in the history of the global combat against TB, and remains meaningful, though it might not be directly expressed in the draft. We need to examine its significance with our own experience; what has been achieved with DOTS? What has been good under DOTS?

In my own observations in many countries, the impact of DOTS has been so great and fantastic in the villages and towns of Bangladesh, Nepal, Philippines, Myanmar, Cambodia, Zambia, Kenya and Afghanistan. I am sure that the activities under DOTS should be continued or even expanded in the new strategy; otherwise the global TB situation will deteriorate.

TB control promotes UHC

Our experience has been that the TB program has been promoting UHC as a building block of the health system. TB volunteers in the village act as general health volunteers as well, though the entry point was TB. A standardized approach of evidence-based minimum essential technique, patient treatment until cure, recording, reporting and monitoring, is a model for health services. We need to claim the need and use of TB control as a building block for promoting UHC.

Post 2015 Global Tuberculosis Strategy Drafted

Kosuke Okada, Director, International Programs



With a WHO Strategic and Technical Advisory Group (STAG) meeting as its beginning, a draft of the Post 2015 Global Tuberculosis Strategy, which has been discussed in several international conferences, is being decided upon. I would like to take the opportunity to give you a brief outline of the latest version here. One of the key issues in the draft is whether or not a decline in TB incidence rate can be accelerated by pursuing Universal Health Coverage.

Can Universal Health Coverage contribute to accelerating the current decline in TB incidence rate?

To begin with, an overall presidential goal set by the Stop TB Partnership has been “Elimination of TB by 2050” which means less than 1 case per million populations. To achieve this long-term target, the draft sets a goal of “Less than 10 cases per 100,000 population by 2035” which seems ambitious to achieve, taking into account the fact that even Japan at present shows 17 notified cases per 100,000. The draft expects that an annual decline in the rate of TB incidence be 10% between 2015 and 2025, and it can accelerate to 17% after 2025 by new vaccines and prophylaxis (Fig 1). Because the current rate is estimated to be 2%, it may not be easy to accelerate to 10% at the same level as shown in European countries after World War II. The acceleration is anticipated through optimizing current tools, pursuing universal health coverage and social protection. We believe that the TB programme has been contributing to strengthening the health system, and vice versa in terms of human resource development, improved utilization of health facilities, community involvement, etc. To reach the milestones for 2025, a 50% reduction in TB incidence rate (less than 55/100,000 population), it is of great importance that the TB programme also ride the tide of the times of Universal Health Coverage. Another issue is whether or not new vaccines which can prevent the progression to TB disease can be put to practical use. We are awaiting the appearance of a revolutionary new vaccine effective for prophylaxis because it is said that nearly two billion people are infected with TB bacilli.

“Zero deaths, disease and suffering due to TB” as a VISION

Arguing points in framing the draft (Fig 2) were “VISION” and “GOAL”. The current words “End the Global TB Epidemic” were adopted as “GOAL”, although “Zero TB deaths” or “Elimination of TB as a public health problem” were proposed before. Instead of these, “Zero deaths, disease and suffering due to TB” was approved as the ultimate “VISION”, after the model of “Zero HIV” of the UNAIDS Strategy 2011-2015. For the global strategy, such an attractive catchphrase is needed so that everyone can understand what we are aiming at in simple and plain

words. In this context, the “VISION” means an ideal state and indicates the direction towards the goal.

“DOTS” disappearing from the headlines

There are three pillars upon which the strategy stands; 1) integrated, patient-centered care and prevention, 2) bold policies and supportive systems, and 3) intensified research and innovation. Special attention should be paid to the fact that “DOTS”, which was described in both the DOTS Strategy in 1994 and the Stop TB Strategy in 2006, is disappearing from the headlines. I mentioned the idea that “DOTS” should be left in the next strategy as well because of its importance in public health measures, although it might be out of date in the era of the patient-centered approach. Finally, however, it was deleted by the majority. The paternalism implicit in having the care provider observe the patient swallowing the medicines is no longer accepted in an era when a sensitivity for human rights is required at the same level as in developed countries. In such a sense, “patient support for regular drug-taking” in English is a good translation of DOTS into Japanese. In the near future, the term “DOTS” might be done away with all over the world; however, only Japan might make its own way for the time being, in a good sense, by correctly understanding what it really means.

Fig 1

Projected acceleration of TB incidence decline to target levels

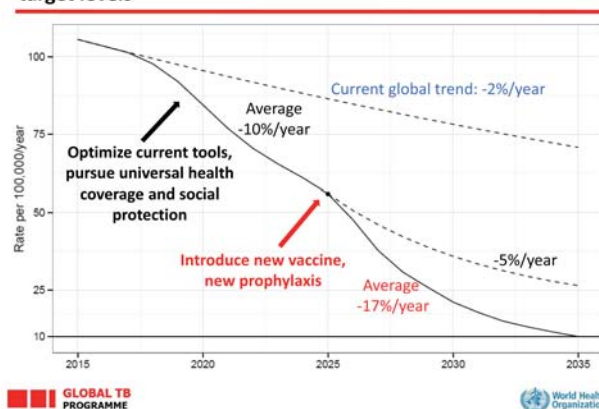
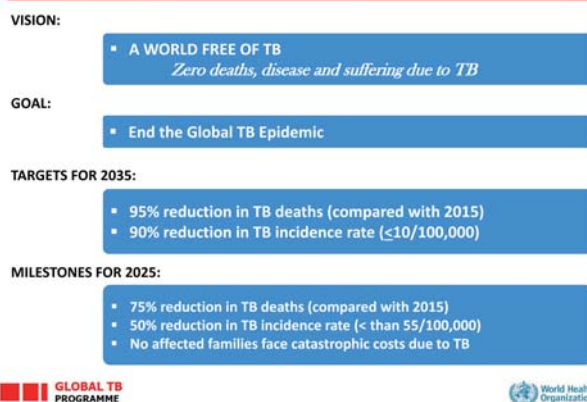


Fig 2

DRAFT Post-2015 TB Strategy at a glance



Risk Factors for TB Infection and Disease

Nobukatsu Ishikawa

Some people are at a higher risk for tuberculosis than others. If we are well aware of the risk factors, our activities will be more effective especially in finding, treating and preventing tuberculosis. The risk groups are seniors (old people), babies, HIV positive or AIDS patients, people with diabetes, cancer patients, people with kidney disease, people under autoimmune disease treatment, malnourished people, and people currently infected with TB or in close contact with TB patients. Currently attention is also given to social groups with poverty and abuse such as low income or homeless people, alcoholics, drug users, smokers, the people in special environments such as prisons or health care facilities, and migrants from the high prevalence areas.

These factors increase the chance of infection and/or disease development. Among these, HIV/AIDS is the most commonly known, together with close contacts, but currently more attention is being given to the people with diabetes and smokers who have not been given importance before.

There are two aspects of risk of TB, namely RR (relative risk) and PAF (population attributable fraction). For diabetics, relative risk is 2-4 times higher than in non-diabetics but constitutes 7.5% of the patients on the average in the 22 high burden countries. The PAF depends on the country or group. For example, PAF of diabetes among the people aged 35-64 years is 48% of the patients in South Texas and NE Mexico. Diabetes is now a disease of the poor as well as the rich, and a threat to TB disease.

A mathematical model shows the potential importance of 3 factors; in India 40% of TB can be attributed to smoking and 15% to diabetes. Preventive actions against these factors could reduce TB.

Risk factor	Relative risk	PAF (%)
HIV infection	20 – 35	11.0
Under-nutrition	3.1 – 3.3	26.9
Diabetes	2.3 – 4.3	7.5
Alcohol abuse	1.9 – 4.6	9.8
Cigarette smoking	1.6 – 2.5	15.8
Indoor air pollution	0.6 – 3.4	22.2

Source: Lancet. 2010 May 22; 375(9728):1814-29, WHO.int/bulletin/volumes/89/5/10-085738.pdf

STOP TB Hands on Laboratory Practice Management for HIV and MDR TB Course: 2012 Report

Jacqueline Jepkemboi Limo, Kenya



We all live and work in a changing world where new laws, new policies, new ideas and new approaches are introduced. New problems and new solutions are sought. Japan is an example of one of the countries which adopted new technologies to solve problems. I must have been the happiest person in the world when I received the news that I had been accepted to attend the group training course in Japan 2012. The Stop TB hands on Laboratory Practice Management for HIV and MDR TB group training course opened up new opportunities for me to meet other participants from Zambia, China, Myanmar, Afghanistan, Cambodia and The Philippines. The course was scheduled for September 20th to December 2012.

First all participants were introduced to orientation courses and lectures at TIC, JICA. Here the participants learned about the political, culture and economic system in Japan. Later we moved to the Research Institute of Tuberculosis based in Kiyose. This was to be our home for the next 10 weeks. For 10 weeks participants were given comprehensive lectures coupled with hands on training. The objective of the training was to acquire the latest knowledge and skills on AFB smear microscopy, culture, DST, and to develop managerial skills as well as to acquire new diagnostic techniques through hands on training. As a staff at NTRLI paid full attention to all the lectures and training as it introduced new skills and techniques directly related to my work.

The hallmark was developing the action plan which was to be implemented when we arrived in our countries.

Did I forget anything? No! The tours: Tauns (Capilia Company) in Numazu and the Olympus Factory in Nagano. Then came Hiroshima (Peace Memorial Park and the Radiation Effects Institute), Osaka and Kyoto tours! It was the most amazing tour ever!

On behalf of all participants, all thanks goes to Matsumoto-san, Takarai-san, Narita-san, Mr.&Ms. Iki-san, and above all the RIT/JICA team for the great time we had!

Long live RIT/JICA!

Tobacco and Tuberculosis

Smoking and Tuberculosis in AFACT

Norio Yamada, Director, Center for International Cooperation and Global TB Information



As mentioned in the feature article of this issue, smoking is one of the risk factors for tuberculosis as well as for other health problems such as lung cancer and ischemic heart diseases. We would like to report briefly activities related to this issue which we observed in Japan this year.

In August 2013, the 10th conference of AFACT was held. It was organized by JATA, the Japan Society and the Japan NGO Council on Tobacco or Health. The president of the conference is Dr. Shimao, Director Emeritus, RIT, JATA. According to the organizers, 758 persons from 42 countries were registered in the conference. There were 19 symposia in the conference. Out of them, 4 sessions addressed illness specific issues. Smoking and Tuberculosis was discussed at one of these symposia. Dr. Mori, Director Emeritus, RIT, and Dr. CC Leung, Department of Health, Hong Kong, China, chaired the session and 4 papers were presented. In the symposium, Dr. Leung presented his epidemiologic study of the influence of tobacco on transmission, clinical breakdown and relapse. Dr. Fu, WHO and Dr. Bam presented recommendations and country experiences of tobacco cessation interventions for TB patients. From Japan, Dr. Komukai, ex-participant in the international training course, and Dr. Mori presented the smoking habits of TB patients in Osaka and in Japan respectively. You can obtain the information on the conference from the website (<http://www.apact.jp/>) including presentation data from the symposium. During the conference, a satellite workshop, "Action planning and Training of National TB Programme (NTP) Managers on Integrating Brief Tobacco Interventions into the TB treatment Programme in Primary Care" was carried out. It was organized by WHO and sponsored by the Ministry of Health, Labour and Welfare, Japan. Two persons (one from the national TB control program and the other from the anti-tobacco programme) participated in the workshop from Cambodia and Nepal. Dr. Fu, WHO and Dr. Okada, head of international programs, JATA facilitated the sessions and the participants developed plans for anti-smoking activities for TB patients in their countries. In the international training course at Kiyose, a session on tobacco and tuberculosis was included as mentioned here by Dr. Ohkado.

Tobacco and TB Session Starts at Kiyose

Akihiro Ohkado, Dept. of Epidemiology and Clinical Research



The health hazards of tobacco smoking have been well recognized globally but the link between tobacco and tuberculosis has not been emphasized until recently. Historically, researchers showed that tobacco smoking was attributable to the risk of getting tuberculosis decades ago, but it has mostly been undermined. Such an atmosphere has been drastically changed in the TB world over the past approximately 15 years after a series of publications indicated the links of these two global epidemics. It is well known that tobacco causes a wide range of diseases, e.g., malignancies, cardiovascular diseases including apoplexy, asthma, chronic obstructive lung disease (COPD), and fetal death. Quite a few scientific papers underpinned the fact that the risk of both getting tuberculosis infection and disease increases significantly through active tobacco smoking. They also showed that passive smoking increases the risk of getting tuberculosis disease. It is noteworthy that the risk remained after adjustment for alcohol use and socioeconomic status. Active tobacco smoking also contributes to increasing the risk of TB relapse and mortality. In response to the accumulating evidence on the hazards of tobacco for tuberculosis, the International Union against Tuberculosis and Lung Disease published a tobacco cessation intervention guide document targeting tuberculosis patients in 2008, fully revised in 2010. This guide is intended to show a feasible and easy way to do counseling on smoking cessation and on creating a smoke-free environment at home. Pulmonary tuberculosis patients are likely to be ready to quit smoking because their lungs suffer. The health workers are privileged to offer advice on quitting smoking during the full course of treatment, i.e., for six months at least. This offers the health workers the opportunities to repeat the advice to smokers. An intervention of smoking cessation advice to tuberculosis patients in Sudan indicated that 54% of 308 smoking patients given this advice quit smoking successfully during the treatment course, while only 14% quit it without interventions. Now, we are at the crossroads to choose which way to go as health professionals. One way is to keep our eyes closed to the problems and do nothing, and the other is to open our eyes and hearts to fight this immense health hazard. Tobacco-related diseases are mainly non-infectious diseases. The interventions to tackle both tobacco and tuberculosis could be a great example of bridging non-infectious disease control activities and communicable disease control activities. The international training course at Kiyose has allocated one session for this topic since 2011. I believe we will soon be able to share our experiences to fight these two epidemics here in Kiyose.

Kiyose and TB

Tadao Shimao, Director Emeritus



I send Greetings from RIT, Kiyose, as the only staff member of RIT who participated from the very beginning of the international course held in 1963 and still does now. TB has been under control in Japan, however, it was highly prevalent in the 1950s, and at that time there were 15 TB hospitals in Kiyose and altogether about 5,000 TB patients were under treatment. Kiyose was then synonymous with TB in Japan. Why were there so many TB hospitals in Kiyose ?

The first TB hospital, Kiyose Byoin (Hospital) was opened in 1931 just in front of RIT. This hospital was constructed by the Tokyo Prefectural government, and because of the stigma which then existed against TB, certainly there was opposition to its construction. As Kiyose was a village without a doctor then, the head of Kiyose Hospital promised villagers to send their medical staff in case of an emergency, and finally succeeded in getting approval from the head of Kiyose village. The area where Kiyose Hospital was constructed was on the southern side of the Seibu Railway of Kiyose village, where copse and pine forests existed and few people lived in this area. Pine trees were then believed to be useful to treat TB cases in a sanatorium.

Since once a TB hospital is completed, because of the stigma against TB, nobody wants to build a new house next to the hospital, if another agency wished to construct a new TB hospital, it was easy to purchase land near a TB hospital. As TB was a serious health problem, several other agencies wished to build a TB hospital, and when World War II ended in 1945, there were already 13 TB hospitals and related institutions in Kiyose.

TB was highly prevalent in Japan soon after the end of the War due to the miserable situation of hygiene, foods and housing, and the shortage of TB beds was serious. TB patients who wanted to be treated in a TB hospital had to wait on the average half a year, and many died during this waiting period. Another 4 TB hospitals were opened between 1945 and 1955, and already existing TB hospitals increased the number of beds, thus there were 15 TB hospitals with approximately 5000 beds in Kiyose in 1955.

I graduated from Tokyo University School of Medicine, in

1943, and after a 1 year internship, joined JATA as a medical doctor. However, I contracted TB at the end of 1950, and stayed in the TB ward of RIT from January 1951 until October 1953. In those days, the traffic was very inconvenient to and within Kiyose. The Seibu Railway was a double-track only up to Hoya, and after Hoya, there was a single track, with only 2 carriage trains every 30 minutes. In Kiyose, no bus service was available then.

Among many TB hospitals in Kiyose, 3 were eminent in their clinical research capacity including chemotherapy and surgical treatment; they were two national hospitals (Tokyo and Kiyose) and the hospital attached to RIT, and they had played a key role in the development of TB treatment. This is the reason why many TB patients want to be treated in Kiyose, and in fact, many TB patients were cured in Kiyose. For them, the name of Kiyose will be remembered forever.

In RIT, several domestic training courses on TB control for doctors, X-ray and laboratory technicians, public health nurses, nurses and administrative staff working in TB control have been held since 1948, and nearly 40 thousand persons stayed in Kiyose and received training. For them, Kiyose is a spiritual home town.

The international training course in English started in 1963, and approximately 2200 staff from 97 countries engaged in TB control have been trained in RIT, Kiyose, ex-trainees of RIT meet on certain occasions such as international conferences and duty visits. There are frequent alumni meetings, in which RIT, Kiyose is remembered.

Kiyose is a spiritual home town not only for domestic TB patients and health workers engaged in TB control in Japan, but also for those who are working in TB control in the whole world.

The mayor of the Kiyose City, Mr. Shibuya K is now trying to have Kiyose named officially as a global heritage site for TB.



TICAD V Symposium: “Towards Zero Tuberculosis in Africa: How can we make it possible?”

Kuniko Murakami, Chief, International Training Division

Stop TB Partnership Japan (STBJ) and JATA held the symposium as an official side event of the 5th Tokyo International Conference on African Development (TICAD V), in Yokohama on May 31, 2013.

Dr. Toru Mori, the representative director of STBJ, gave opening remarks and Dr. Nobukatsu Ishikawa, a chairperson and the director of RIT, opened the sessions. He addressed the TB situation in sub-Saharan Africa.

“All the other regions seem able to attain the Millennium Development Goals (MDGs) target in TB control to halve their TB mortality rate by 2015; however, the African region is not on track.”

The chairperson introduced the JICA international TB training courses as a major contributor to human resource development for global TB control since 1964. Two TB control officers from African countries were invited to present on the TB situation in Africa; both of them were JICA training participants from the 2013 course.

Dr. Agere Onyango Eliud from the Ministry of Public Health and Sanitation of Kenya presented the TB situation in Kenya.

“Kenya ranks as 15th among the 22 high TB burden countries. The TB/HIV co-infection rate is as high as 39% and there is also the issue of the emergence of MDR. We share borders with five countries and there are 500,000 Somali refugees on the border, where many TB defaulters had been observed. On the other hand, the Kenyan government has improved the health infrastructure in recent years, and raised staff allocations to the adequate level. Both approaches positively affected the TB Programme. The NTP recently established a web based reporting system with tablet equipment, and it raised their data reliability.”



Mr. Abdelrahman Abadi from the Ministry of Health of Sudan presented the TB situation in Sudan.

“We have the third highest TB prevalence rate in the Eastern Mediterranean Region. Although we seem to have made some achievements towards MDGs in TB prevalence rate and mortality rate, our case detection rate is still low and recently TB treatment outcome also worsened, with a high defaulter rate of 12% in 2010. The major challenge we face is the low level of awareness on health issues among the local population, which causes stigma. Therefore, we made efforts toward health education in the community by providing IEC materials, and also strengthened defaulter tracing. One way we did this was through utilizing mobile devices. We also started primary steps toward universal health coverage and TB control in Sudan.”



Murakami introduced three kinds of Japanese TB related projects in Zambia.

“Infectious disease control including TB was one of the items recommended in the health section of the 2008 Yokohama Declaration. Three Japanese TB related projects in Zambia were conducted under the framework of the declaration. The first JATA project targeted in an urban community in the capital. We set up a community center to find TB cases earlier, and also provided treatment support by trained community health workers. Forty-seven percent of the total 1686 TB suspects were diagnosed with TB in two years. We had a 20% increase in treatment success and 17% decrease in default.”



Secondly, AMDA-MINDS, a Japanese NGO, operated their project in urban areas, and they targeted more children. The trained TB supporters helped the prevention and education for the child TB cases through home visits. Referral services they provided strongly contributed to earlier diagnosis in the targeted areas.



The third was a JICA project operated by the National Center for Global Health and Medicine. They started a mobile Anti-Retroviral Treatment (ART) project as phase I in 2006 and



expanded nationwide as phase II in 2009, engaging all health care providers, from the national level to the communities. Their activities mainly focused on ART expansion but they also showed a positive effect on TB management. The project utilized existing TB treatment unit areas to provide their mobile ART service as one of the TB/HIV collaboration approaches that also improved TB treatment outcome.

We can conclude that all three projects had some aspects of strengthening the health system through community mobilization, improvement of accessibility, and collaborating with existing systems.”

Two presenters reported technological development for TB from Japan.

Dr. Shinichi Kojiya from Eiken Chemical Co., Ltd. mentioned a new diagnosis technology, “The PURE TB LAMP” method, as one form of gene amplification technology. Dr. Yasuhiro Yasutomi from "the Primate Medical Science Research Center" reported the progress on a new vaccine for nasal mucosa developed using human parainfluenza type 2 virus (hPIV2). These technologies are expected to be in use in the near future.

Dr. Shigeru Omi, former Regional Director, Western Pacific Regional Office, WHO, spoke from the viewpoint of global health policy and TB control.

“We agreed that Universal Health Coverage is the key concept that should underpin the global health effort for many years to come. We know that many debates have taken place so far as to whether a vertical disease control program like the TB program may hamper the strengthening of the health system. However, I’m sure that everybody by this time has agreed that this disease specific control can go hand in hand with health system development. The issue is how to translate both vertical and horizontal programs into reality.



Today we realized that our political commitment exists, and that our community participation is very active. We heard about the potential development of new diagnostic tools. All the elements needed for success were there. I believe we can make gains for many years to come in the area of TB control, if we all put our wisdom together and if we put our resources together.”

Chairperson: How can zero TB can be possible in Africa?

Dr. Agere: We need to stop the transmission by early diagnosis.

Dr. Abadi: Community participation is crucial to reduce

stigma.

Dr. Murakami: It’s possible if all international societies don’t forget about TB in Africa.

Mr. Kojiya: We supply excellent, accurate, easy diagnostics.

Dr. Yasutomi: Our task is to make a vaccine.

Dr. Omi: Of course it is possible as long as the combination of all the necessary elements is put in place.

Contributions from the floor

-Ms. Emiko Takagai from the Stop TB Partnership Promoting the Parliamentary Federation mentioned the importance of Japan’s international cooperation on global TB control.

-Mr. Shiro Konuma from the Ministry of Foreign Affairs of Japan, introduced the "Japan International Health Policy 2011-2015" and stated that the Japanese Government promotes universal health coverage (UHC).

-Dr. Kazushi Yamauchi from the Ministry of Health, Labour and Welfare of Japan, emphasized the importance of collaborations, partnerships and continued commitment by all partners.

-Mr. Yosuke Kobayashi from JICA HQ, indicated that strengthening of human resources was the core of JICA’s efforts to support developing countries including health management. He concluded that there can be a transformative impact as many partners bring innovations and investments.

The chairperson summarized the session.

“There is no magic way to eliminate TB in one second and the combined efforts, which include technical advancement, support from communities, and human resource development, are essential to make the TB Zero possible. We as Japanese can provide our lessons of the TB pandemic which was discovered through economic development, like the current African situation.”



At the end of the symposium, all of the attendees promised to continue to fight toward TB elimination.



Forty two Delegates from Thailand Visited RIT on 11 June 2012: a Long-time Collaboration between RIT and Thailand

Norio Yamada

Thai public health delegates led by Dr. Somsak Akksilp, Deputy Director General, Dept. of Diseases Control visited RIT as part of a study visit to Japan. 42 Members including Dr. Chawetsan, NTP manager, received lectures on the NTP and public health development in Japan. Dr. Ishikawa, Director, RIT and Ms. Nagata, Chief, Public Health Nurses Training Division, talked about the topics with them. We had a good discussion focusing on the health system in Japan between the delegates and lecturers. Thailand and RIT have had collaboration for a long time. When we look at the history of the JICA international training course at RIT, two of the participants in the first course in 1963 are Dr. Thavisakdi Bamrungtrakul and Dr. Srinat Visalvethaya from Thailand. Since then, 146 Thai health professionals have participated in the training course at RIT. In terms of field research, since 1996, RIT has been carrying out collaborative research activities on TB/HIV in Chaing Rai Province, the most northern province of Thailand. Most recently RIT has been engaged in technical assistance for national TB prevalence survey. In December 2012, we had a one week training/workshop for data analysis on the prevalence survey at RIT. 17 persons involved in the prevalence survey, including some of ex-participants in the international training, joined it. I think it is one good example of long term collaboration with participants in the Kiyose courses.



Staff Movements

Left RIT/JATA:

Dr. Keiko Inaba

Newly joined/back to RIT/JATA:

Ms. Yuka Inoue, Ms. Yumi Toyama, Ms. Emiko Kanai,

Ms. Yukari Takemura

Overseas office:

Dr. Masaki Ota, Ms. Mami Kon, Ms. Toyama (Ethiopia/JICA project office)

Ms. Inoue (RIT/JATA Philippines office)

Ms. Kanako Koyama (RIT/JATA Zambia office)

Dr Karam Shah Honored with Princess Chichibu Memorial TB Global Award 2013



(Photo: the Union)

Dr. Syed Karam Shah, Pakistan, was honored with the Princess Chichibu Memorial TB Global Award for his outstanding contribution to global tuberculosis control. He is a Kiyose alumnus from 1987. This prize is given to a person annually who has shown great achievements in anti-tuberculosis activities. Dr. Karam Shah is the former manager of the NTP in Pakistan and currently the cluster Coordinator for Communicable Diseases, WHO, Afghanistan. He was presented the award by Dr. Toru Mori on behalf of RIT/JATA, during the opening ceremony of the 44th Union World Conference held in Paris on October 31, 2013.

RIT Alumnae Who Play an Important Role: WHO-SEAR Meeting at Bangkok 2014



Somsak/Thailand, Thanda Lwin/Myanmar, Ishikawa, Onozaki/WHO, Akramul/BRAC, Chawetsan/Thailand, Hyder/Regional Advisor of SEARO

You are welcome to send us your news and voices!
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