

NEWSLETTER FROM KIYOSE



No. 6, June 1993

Research Institute of Tuberculosis, JATA
3-1-24 Matsuyama, Kiyose-shi, Tokyo 204 Japan

JATA Organized Symposium "TB & AIDS" in Tokyo

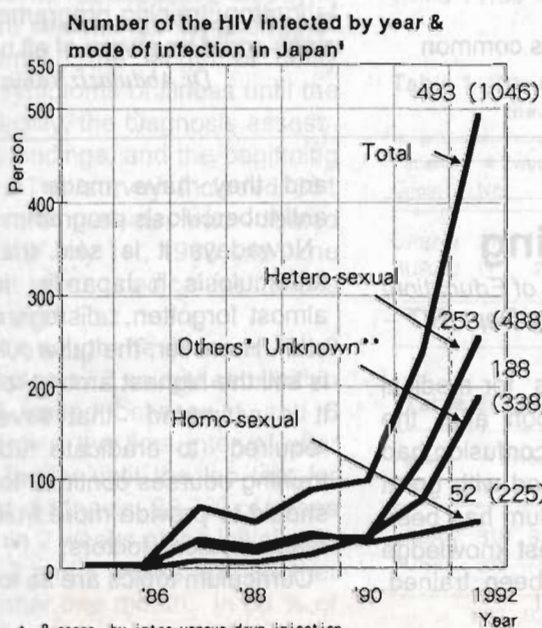


(Photo: JATA)

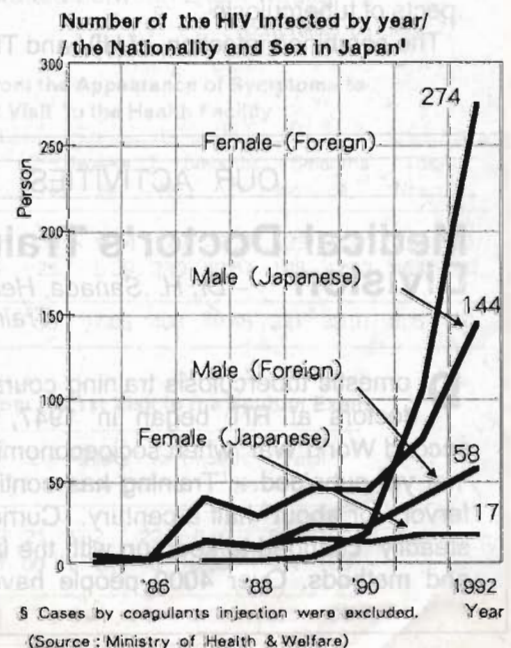
The "Tuberculosis and AIDS" symposium was held in Tokyo on March 12, 1993, with more than 450 people in attendance. This was the second international symposium sponsored by JATA and the Mainichi Newspapers, a leading Japanese news organization. Following last year's symposium "International Medical Cooperation on TB", it focussed on tuberculosis problems both in Japan and throughout the world. Four symposists were Dr.A. Kochi, head of TB unit, WHO headquarters, Dr.P. Smith of Stanford University, U.S.A., Dr. S. Ozaki of Ministry of Health and Welfare, and Dr. M. Aoki, Director of RIT. Dr.T. Shimao of JATA coordinated the symposium. The Mainichi summary of the symposium was featured on one tall page of the newspaper, making a big impression on many people.

TB & AIDS cases in Japan

The accumulated number of HIV infected individuals at the end of 1992 in Japan was reported to be 2,731, which is not as many as that in other developed countries. This number includes 1,685 cases infected by blood coagulant which had occurred before 1989. Excluding cases of HIV infection by blood coagulant, nearly half of the cases are in young foreigners from



* 8 cases by intra-venous drug injection.
** 82% were foreigners infected abroad.
(): Accumulated number



¹ Cases by coagulants injection were excluded.
(Source: Ministry of Health & Welfare)

Asian countries. The number of HIV cases almost doubled during 1992, necessitating strict monitoring of the spread of the HIV infection and the introduction of prevention campaigns. There have been fewer than 10 cases of tuberculosis associated with HIV infection in Japan. One of the reasons for this is that the majority of the HIV cases infected by blood coagulant were in the younger generation, which has a low rate of tuberculosis infection.

Japan needs to prepare for a gradual spread of domestic HIV infection, and medical staff will play an important role. However, most Japanese doctors and health staff have never dealt with this disease. So, it was strongly recommended at the Symposium that medical personnel should acquire clear and unbiased knowledge of TB-HIV problems.

The situation in Japan is similar to that in many Asian countries in two ways - HIV has not spread widely until just recently and full preparation for combatting the spread are not in place. As stressed in the Symposium, if HIV infection spreads before the establishment and active implementation of NTP in countries with high prevalence of tuberculosis infection, the results will be tragic. HIV infection has started to increase rapidly in Asian countries, so, it is strongly advised that preparations be made to counter the spread of HIV infection.

(M. Aoki, RIT)

Recently, I have been promoted as Superintendent and Head of Tuberculosis Control and Training Institute, Dhaka and we are now going to start SCC (2RZEH/4HR) with the assistance of the World Bank as the national control regimen.

Through this newsletter, give my greetings and blessings to my friends and teachers.

Domo Arigato.

Dr. Iqbal Hasan Mahmood, Bangladesh ('85C, '90A)

When I returned to Bangladesh after the course in Kiyose in 1988, I was given a warm reception at Dhaka airport, by my family members, and the next morning, I was informed very tactfully that my father and younger brother had died. This was very sad news. So my visit to Japan was both the best enjoyment and the most cruel tragedy in my life. For a long time, I will remember September with joy and I will remember February with sorrow.

Dr. Hanif Uddin, Bangladesh ('90L)

Ohayo Gozaimasu and warm greetings from Egypt. I gained very good TB control knowledge and skills that, I hope, would enable me to overcome the difficulties facing the efforts of TB Control in my work place, the Assiut Chest Hospital.

I'd like to express my thanks to JATA, JICA staff, JATA staff & participants, and last but not the least, the shining stars of RIT in Kiyose.

Ja Mata.

Dr. Neyazi Ayad Zaka El Dabh / Egypt ('91C)

NEWSPLETTER FROM KIYOSE is a vital link between the ex-participants and our beloved RIT. It also provides me useful information on various aspects of tuberculosis

The combined infection of HIV and TB is common

among young people (19 to 35 yrs.) in this part of India, viz IMP HAL, Manipur, where I am working as a TB specialist, and this scourge is going to assume greater dimensions in the near future. The latest available scientific study on HIV and TB at RIT would be of immense treasure to me to widen my knowledge on this subject, which was not included in the curriculum at the time of my training course. This would better equip me and my fellow colleagues with technical know-how to combat this deadly disease.

I need much more information on HIV and TB.

Dr. Irom Ibopishak Singh / India ('85A)

TB Control in my province has improved a lot using strategies learned from the course. The prevalence in 1991 was 66.07/100,000 and is very much lower than the five year(1986-90) average of 96.41/100,000. Much work has yet to be done, especially to correct the use of anti-TB drugs without proper sputum examination. Many suspected cases are negative on laboratory examination because of the history of irregular drug intake. We hope that we can put a stop to this common practice.

Dr. Norman C. Tanchuan / Philippines ('89C)

Dear classmates, instructors and RIT staff, NEWSLETTER FROM KIYOSE connects me more with RIT and its activities. However, I wish to hear more from ex-participants.

Our NTP was integrated into the curriculum of the laboratory training programme of the Health Institute. A workshop was held for developing the laboratory programme and several specialists from different health fields and from the National Institute of TB Control participated. As a result, knowledge and skills which we learned at RIT have been inserted into the laboratory training programme, and laboratory technicians could be aware of all new techniques.

Dr. Abdulaziz Yahia Najmaddin / Yemen ('90L)

OUR ACTIVITIES

Medical Doctor's Training Division

- Dr. H. Sanada, Head of Education/
Training Dept., RIT -

Domestic tuberculosis training courses for medical doctors at RIT began in 1947, soon after the second World War when socioeconomic confusion had not yet subsided. Training has continued with great fervor for about half a century. Curriculum has been steadily changed to keep up with the latest knowledge and methods. Over 4000 people have been trained,

and they have made a significant contribution to anti-tuberculosis programmes in Japan.

Nowadays it is said that since the prevalence of tuberculosis in Japan is low, the disease has been almost forgotten, disregarded by people and medical staff. However, the tuberculosis mortality rate in Japan is still the highest among communicable diseases, and it is estimated that several more decades will be required to eradicate tuberculosis in Japan. The training courses continue to have an important role and should to provide more fruitful and effective training for many medical doctors.

Curriculum topics are as follows: (Continued on page 7)

Consumer's Will versus Political Will in Tuberculosis Work

Dr. N.L.Maskey, Nepal ('75A)



I was trained at RIT in 1975, when I believed I would fight against tuberculosis in Nepal successfully with the knowledge I gained. However, tuberculosis situation in the high prevalence countries has not changed much, although quite a battalion of tubercle-bacilli fighters in those countries have been produced by RIT.

Why then it is so? The three main obstacles that constraint with tuberculosis programme conditions are the triangular cross-section of poverty, lack of education and ancient communal social taboos. Unless these conditions are scrutinized in a microscopic way and measures taken to improve them, tuberculosis service in programme condition will see little success. WHO introduced the system of having the Ministers of Health of the respective countries participate in the regional committee meetings to make the "Political will" strong, but it could be made to work better if plan and policy were tailored to suit the taste of the majority in rural communities.

I would like to give a few examples where "consumer's will" has worked in the Nepal context. NGO has involved women organizations, where all women

unified to ban alcohol consumption in Lamjung district. Government requests to refrain from smoking in public places went without much effect, whereas student communities could ban it in school premises. When there was insufficiency of anti-tubercular drugs, the community could raise few paisa from PAN-takers (betel-leaf chewing) and from PAN shops sufficient to buy anti-tuberculosis drugs for that area.

My experience in my home country tells me that NTP, tailored and made, did not fit in well with programme-field conditions because of lack of basic, efficient management systems at the grass-roots level. It is but natural for any manufacturer or producer to see his commodity sold in the market and to do so he does feasibility study of consumer's interest beforehand. I go to buy my necessities in that shop where I am attracted. The simplest attraction depends upon the reliability of the shop, fresh stock, nice, human behaviour of salesmen, constant pricing of commodities. Most important, the shop stay open all the time, and I do not have to stand in a queue to be attended because of lack of man-power. These are the simple ethics of "Buying and Selling".

Therefore, if we have to have a tuberculosis service commodity sold in the community, that particular community from "buying point of view" should have easy access for qualitative service. If we work on "Health for all" we should generate interest primarily in the community for "All for health".

Delay analysis in Bolivia

Dr. Oscar Lanza, Bolivia ('88C)

The backgrounds of 1509 tuberculosis cases were examined in a longitudinal retrospective survey in Bolivia. Of those, 825 were selected as sample representative cases to determine the length of delay between the time of first symptoms of illness until the first visit to some health facility, the diagnosis assessment based on laboratory findings, and the beginning of patient chemotherapy. The survey included 361 urban patients and 464 rural patients, who initiated their treatments between the July 1st, 1988 and June 30th, 1989, in 11 different urban medical institutions and 2 rural health centers of La Paz.

Out of 100 patients, just 4 sought health care with 2 weeks of the onset of symptoms, 7 sought care within 2 to 4 weeks, while 49 waited between 1 and 6 months. (Table 1) Regarding the time interval after the 1st visit to a health facility until the lab test for confirmation of the clinical diagnosis, 82.7% of cases received confirmation within 2 weeks of the initial visit, while 8.6% took between 2 and 4 weeks and another 8.6 % had results in just after one month. In 88 % of urban patients, clinical diagnosis was confirmed by

lab test within 2 weeks, while in rural patients it was 78.66 %. On the average, the delay to receive lab confirmation was around 8 days with a SD of 1.58. (Table 2)

Regarding the time interval from the confirmation to the start of treatment, 88.97 % of cases started treatment before 2 weeks after the result was given, while 11.03 % waited between 2 to 4 weeks.

(Continued on page 8)

Table 1 Time from the Appearance of Symptoms to the 1st Visit to the Health Facility

Patient Origin	< 2weeks		2 - 4weeks		1 - 6months		> 6months		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
URBAN	27	7.48	33	9.14	178	49.31	123	34.07	316	100
RURAL	11	2.37	25	5.39	230	49.57	198	42.67	464	100
	38	4.61	58	7.03	408	49.45	321	38.91	825	100

Table 2 Time from the 1st Visit to the Sputum Exam

Patient Origin	< 2weeks		2 - 4weeks		> 1month		Total	
	No.	%	No.	%	No.	%	No.	%
URBAN	318	88.09	21	5.82	22	6.09	361	100
RURAL	365	78.76	50	10.78	49	10.56	464	100
	683	82.79	71	8.61	71	8.61	825	100

(Source : AIS Bolivia Survey 1990)

WHO Document : TB & HIV Infection

(WHO/TB/92.166)

HIV-ASSOCIATED TUBERCULOSIS IN DEVELOPING COUNTRIES: EPIDEMIOLOGY AND STRATEGIES FOR PREVENTION

by J. P. Narain, M. C. Raviglione, A. Kochi

— Contents —

1. INTRODUCTION
2. EPIDEMIOLOGY
 - 1) Incidence 2) HIV seroprevalence 3) TB in patients with AIDS
 - 4) Impact on Health services 5) Infectiousness 6) mortality
- 3 STRATEGIES FOR PREVENTION

Current status on TB-HIV infection has been reviewed and strategies of TB control in developing countries are summarized in consideration of HIV epidemic in the WHO document. Safety and the role of BCG is endorsed irrespective of HIV status of the infants. Preventive chemotherapy to dually infected persons is encouraged. The list of references is also of great use. This article appeared in "Tuberculosis and Lung Disease (Vol. 73, No.6,1992)", IUATLD official journal.

(To request a copy - see page 8)

The association between tuberculosis and HIV is a great public health and socio-economic threat, particularly in the developing world. WHO estimates that in 1992, over 4 million people (4.6 million in 1992) had been infected with both Mycobacterium tuberculosis and HIV; 95 % of them were in developing countries. The association between tuberculosis and HIV is evident from the high incidence of tuberculosis, estimated at 5-8% per year among HIV-infected persons, the high HIV seroprevalence among patients with tuberculosis, the high occurrence of tuberculosis among AIDS patients, and the coincidence of increased tuberculosis notifications with the spreading of the HIV epidemic in several African countries. (Fig. 1)

The impact of the two epidemics on resource-poor countries has ominous social and medical implications, and the already overstretched health services now have to face a tremendously increasing tuberculosis problem. HIV infection worsens the tuberculosis situation by

increasing reactivation of latent tuberculosis infection in dually infected persons as well as by favouring rapid progression of new infection in the HIV-infected. This also results in an increase of the risk of infection and a subsequent increase of cases in the general population.

Estimated Global Distribution of Adults Infected with HIV and TB

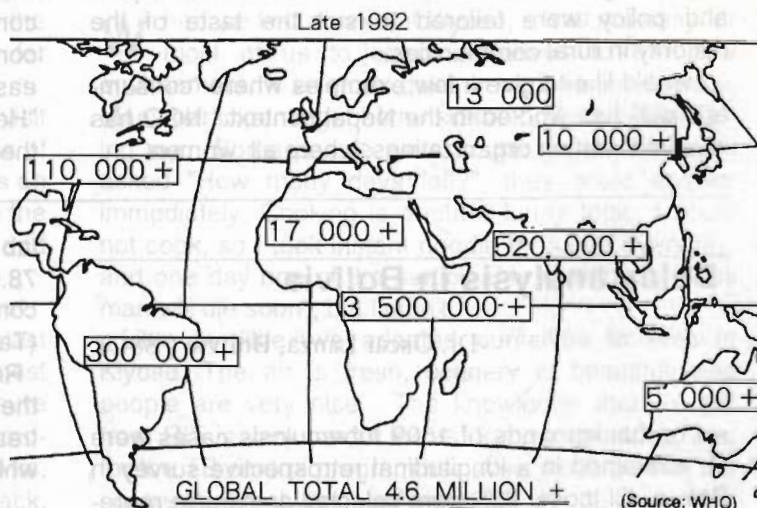
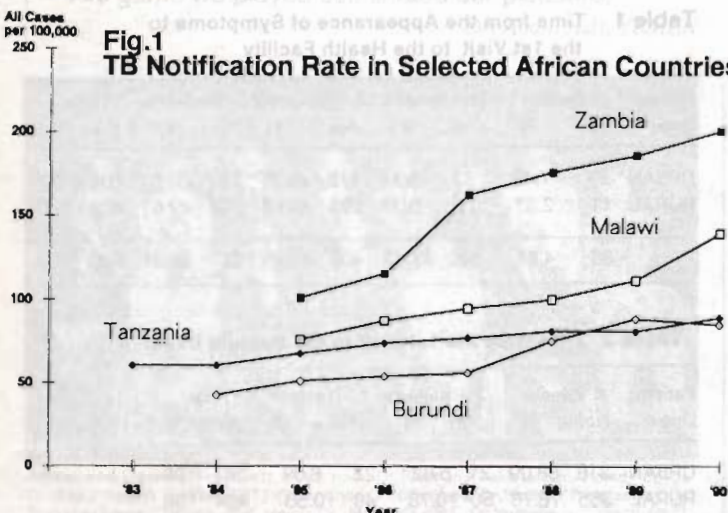


Fig.1
TB Notification Rate in Selected African Countries



* Some Sab-Saharan African countries have a currently increase in TB notification due to HIV infection epidemic.

In order to respond to this urgent problem, the highest priority must be given to strengthening tuberculosis control programmes in the countries where they are poorly developed and where the prevalence of HIV and tuberculosis infections is high.

Strategies to be taken are;

- 1) Improving the **cure rate** by early diagnosis and prompt treatment of tuberculosis patients,
- 2) **BCG vaccination**, which is endorsed to be fairly safe and useful irrespective of HIV status of infants,
- 3) **Preventive chemotherapy** among HIV-infected individuals, which is considered as the most critical intervention that would help to limit the expected increase in clinical tuberculosis from the pool of HIV and tuberculosis co-infected individuals.

Reviewer : N.Ishikawa

“ What’s the Problem of NTP ? ”

Various Approaches to Integration



Dr. Shoichi Endo, lecturer
(Director, Ashikaga Health Centre,
Tochigi, Japan)

Following is a report of some parts of hot discussion in a session “evaluation of NTP” of the 1992 Advanced Course.

Importance of supervisory team

Dr. Suryanarayana of India opened the discussion presenting the District Tuberculosis Programme, covering 1 - 2 million population in the area, fully integrated into general health service and emphasized the important role of the supervisory team which consists of a medical officer, a laboratory technician, a public health nurse.

Need coordination between curative and preventive service

Dr. Ali of Egypt presented his problem. In his country the boundary of the responsible areas of curative service and preventive service was clearly marked from ministry to periphery level and there was practically no interaction between the two services. Once a patient with respiratory symptom is referred by the rural health unit to the dispensary or hospital, treatment is given exclusively by the curative service and no feedback of the patient progress is made to the rural health unit. As a result, no follow-up service is provided, and the treatment completion or cure rate is unsatisfactory. This discouraged the rural health units in referring patients to dispensaries. Furthermore, the doctors at the dispensaries and hospitals diagnose and treat patients by their own standards and methods, therefore the statistics gathered on this basis can not be used for scientific evaluation of the programme. In order to provide effective tuberculosis service there must be good cooperation and coordination between the two services. Since the two services were vertically separated, the issue was a matter of policy making at the national level. The minister or the policy makers had to be convinced of the weakness of vertical programme and the advantage of integrated services. It was proposed that one approach would be to reveal the poor performance in case-finding and treatment services to the policy makers. Since the national figures were not reliable, Dr. Ali had to collect data in his own area by conducting several studies such as tuberculin survey among infants and young children to estimate annual risk of infection. Patient's

delay is a good indicator for evaluation of case-finding services and completion rate of treatment (Cohort study). This kind of evaluation had to be continuously presented to policy makers in order to guide them for better programme.

Poor international information network

Dr. Portal of EL Salvador said that his problem was that his country was isolated from international information network. In this regard, this course provides an excellent opportunity. In fact, there were a number of responsible officers for NTP of various countries who attended this course and applied the knowledge which they acquired during the course. WHO may provide technical assistance to improve NTP, sending a number of publication of tuberculosis and consultants upon request of the country.

Fear of clinicians

Dr. Suryanarayana commented that if an attempt was made to change tuberculosis programme from clinical approach to public health approach, clinicians might resist the change because of the fear that they might lose jobs. It was important to show clinicians their important role in NTP such as training of staff, technical assistance, treatment of problem cases.

Hospital or ambulatory treatment?

Dr. Mohamed of Tanzania presented the case of hospitalization of sputum positive cases for 2 months in Tanzania. This provoked active arguments. Dr. Suryanarayana said that Madras study clearly showed there was no difference in treatment result of the cases as well as infection and incidence of disease among the family members between hospital and ambulatory treatment, and if hospitalized, the patients might lose job and income. Dr. Portal joined this argument mentioning high cost of treatment and possibility of patient's losing their jobs. Dr. Mohamed then explained the hospitalization contributed great deal to provide the effective education and motivation for the patients in treatment, preventing treatment drop-out and obtaining high cure rate after discharge from hospital. Besides, since houses are widely scattered in rural Tanzania, follow-up or defaulter action for the patients who failed to collect drug was extremely difficult. The hospital beds did not need the facilities and equipment of as high grade as the beds for acute or severe diseases.

(Continued on page 7)

1992 Advanced Course

(May 18 – June 26, 1992)

"KIYOSE-Recipé"

The title may sound strange. So it is! But we were more than a single dish. Our menu contained "alphabetically" Bangladesh, Brazil, Egypt, El-Salvador, India, Pakistan, Paraguay, Philippine, Tanzania, Thailand and Yemen. We were "Seasoned" with some Japanese participants.

We started "business" immediately the following day. In the "menu" were workshops, seminars, lectures, discussions, evaluation session, and observation tours. Our great "Chef" was no other person than Dr. Ishikawa, with the patronage of Dr. Matsuda.

The programme was well blended and flavoured to meet everyone's taste. The knowledge "fresh from the garden" was presented to us. Every effort was made to make group discussions fruitful. Workshops were well-orchestrated. Our courteous "Sensei" were always ready to help, lectures were designed to meet our requirements. Discussions were geared-up to reach the tempo. We shared our experiences. We had the opportunity to attend the annual meeting of JATA and learned about its activities, including the women union activity in community participation for the fight against tuberculosis.

On 1st June our study tour week started with a visit to Hiroshima. Deeply affected with the gigantic loss of human souls and the sad devastation of the city as an aftermath of A-bombing, one could not but admire the people for their success in rebuilding the city and getting over the disaster.

Our days in Kiyose started approaching its end. Country Evaluation and Action Plan were the last ingredients in our recipe, and probably the most delicious! It was at the same time we had the pleasure of having dinner at Dr. Ishikawa's home, the atmosphere was homely and intimate. The food was Mrs. Ishikawa's invention with the mystic Oriental Smack. The game we played culminated our pleasure.

Dr. Abdul Aziz, YEMEN



Advanced Course From left - 1st row: Dr.Rehman/Pakistan, Dr.Ahmed/Egypt, Dr. Aziz/Yemen, Dr.Aoki/RIT, Dr.Hernandez/Philippines, Dr.Bhuiya/Bangladesh, Dr. Suryanarayana/Yemen, 2nd row: Dr. Matsuda/RIT, Dr.Yoshiyama/Japan (RIT), Dr.Ferreira/Brazil, Dr. Romero/Paraguay, Dr. Mohamed/Tanzania, Dr.Kungsworn/Thailand, Dr.Portal/El Salvador, Ms.Imazumi/JICA coordinator



Control Course From left - 1st row: Dr.Chi/China, Dr.Cruz/Philippines, Dr.Emiroglu/Turkey, Dr.Teleron/Philippines, Dr.Aoki/RIT, Dr.Gunzareth/Tanzania, Ms.Nagata/Japan, Dr. Murray/WHO lecturer, Dr.Matsuda/RIT, 2nd row: Dr.Bale/Papua New Guinea, Dr.Upadhyay/Nepal, Dr.Ansari/Pakistan, Dr.Torrice/Bolivia, Dr.Do/Vietnam, Dr.Hyder/Bangladesh, Dr. Lagahid/Philippines, Dr.Mishra/Nepal, Dr.Al-Musawa/Yemen, 3rd row: Dr.Gombogaram/Mongolia, Dr.Vollepore/India, Dr.Baruah/India, Dr.Gondwe/Malawi, Dr.Vinua/Philippines, Dr. An/China, Dr.Rientraitat/Thailand, Dr.Cruz Gonzalez/Nicaragua, 4th row: Dr.Lew/Korea, Dr.Lujan/Peru, Dr.Yamada/Japan (RIT), Dr.Al-Abssi/Yemen

1992 Control Course

(June 29, – October 9, 1992)

Second Home Town in My Life

When we first arrived at Kiyose, it was not easy for most of us to adapt ourselves to the new environment. It is more quiet here than in Hachioji. Many participants got home sick and of course including me. Some people were counting down. When I asked "How many days left?", they could answer immediately. Cooking is another funny topic, I could not cook, so I took instant noodle for lunch everyday, and one day one of the participants said loudly "This man will die soon", but I didn't.

Little by little, we adapted ourselves to lives in Kiyose. The air is fresh, scenery is beautiful, and people are very nice. The knowledge that we got from RIT is very useful for us, for our countries, and for the TB control programme. Also we hope that the cooperation between our countries will be expanded indefinitely. And because of JICA, JATA and RIT that brought us from every corner of the world to see each other in Kiyose. The trip to Niigata, Sado Island, Gotennba, Tohoku and Matsumoto is memorable and unforgettable. I have learned and would like to say that Kiyose is my second home town, and the period of time during my stay in Kiyose is the most impressive in my life.

Finally, although I know that the word thank you is not enough, but I cordially would like to say "thank you", and dedicate this contribution to Dr. Aoki, Dr. Mori, Dr. Ishikawa, Dr.Matsuda, Ohmura-san, Suga-san, JICA staff, JATA staff, RIT Staff, and also the staff of JATA branches.

I shall never forget all of you. Domo Arigato Gozaimashita.

Dr. Pavongsak Rientraitat, Thailand

1992 Laboratory Course (October 26, 1992 - February 12, 1993)

Get Together, Get Better

Coming Together is the beginning

We come from 7 different countries for one purpose: To control tuberculosis by laboratory works. Different culture with different ideas, that makes Fujiki-san, our course leader, drive crazy and have a headache.

Keeping Together is Progress

Fujiki-san is like a good chef of RIT restaurant "Laboratory Course", keeping us in her kitchen to make a delicious food of us. She always works very hard and takes time in cooking us with sugar and spices. But still she cannot change even our natural flavours in everyday life:

One from Yemen always enjoy eating bread which resulted in big stomach.

One from Cambodia is always surprized about the lab. techniques since she never worked in the laboratory.

One from Nepal has many ideas to prepare a delicious food.

One from Thailand lives with shopping to buy things good and cheeeeaapp!

One from Solomon Islands survives in the cool temperature with a blanket in his bed, that's why he is the last one to come to the class in the morning.

One from the Philippines has a good background about laboratory work, that's why she has good ideas and

understands well about this course programme.

One from Indonesia survives by joke everywhere, but in the class, his mouth is locked.

In the last of the programme, all of us have a better taste with much more knowledge about the tuberculosis control, especially in laboratory works.

Working Together is Success

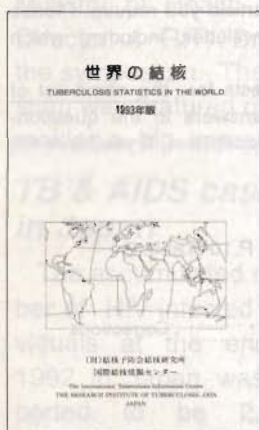
We are all going back to our countries and working for the success of the Tuberculosis Control Programme with our newly acquired flavours from Kiyose.

Course participants



From left - 1st row: Ms. Tanthatsawat/Thailand, Dr. Aoki/RIT, Ms. Singson/Philippines, Ms. Vuthea/Cambodia, 2nd row: Ms. Fujiki/RIT, Mr. Poudyal/Nepal, Mr. Sagal/Yemen, Mr. Dede/Solomon Islands, Mr. Mardji/Indonesia

NEW PUBLICATION



TUBERCULOSIS STATISTICS IN THE WORLD

International Tuberculosis Information Centre, RIT
pp. 47, 25.5 x 18cm

TUBERCULOSIS STATISTICS IN THE WORLD, published by ITIC in April 1993, is a data book covering the current status of tuberculosis - trends,

incidence, mortality etc. - for nearly 130 nations worldwide. The information, collected by ITIC, mainly based on a report from each nation. Many charts would help you understand the situation at a glance. Tuberculosis Statistics by County in each region is attached. Short comments are written in Japanese and tables and charts are in English.

(To request a copy - see page 8)

(Continued from page 2)

Basic tuberculosis knowledge; Present tuberculosis epidemiology status; Tuberculosis control strategies;

Tubercle bacilli and laboratory work; X-ray reading; Tuberculosis pathology; Chemotherapy; Differential diagnosis of chest diseases

Courses are as follows:

Long term course (4 weeks); Short term course (10 days); Chest X-ray reading course (4 days); Special Advanced TB Control Programme Course (16 days) Other courses: Course for medical students (5 days); Course for Administrative officers (4 days); Course for medical technologists (6 days)

(Continued from page 5)

As majority of patients were engaged in agriculture, the two month hospital stay did not affect their income so much. Financial burdens to the country and the patients were not so large as expected. Dr. Mori of RIT showed that the difference in cost and benefit ratio for hospital and ambulatory treatments was smaller if all factors above mentioned were taken into account. Though hospital and ambulatory treatments are proved to be equally effective, it was agreed that when it came to application, the development of health services, social conditions particularly accessibility to medical facilities, patient's acceptance of the services etc. had to be taken into consideration.

(Continued from page 3)

In urban areas 97.5 % started treatment before 2 weeks, waiting on average 2 days. In rural areas, figures show that 82.33 % started treatment before 2 weeks, waiting an average of 8 days. In general the waiting time was 5 days with a SD of 4.3. (Table 3)

Results of the study show longer delay for women than for men.

Conclusion: These findings lead to a re-examination of the performance and strategy of the National Health System and the impact of the National Tuberculosis Control Programme.

Table 3 Time from Confirmation of Diagnosis to Start of Treatment

Patient Origin	< 2weeks		2 - 4weeks		Total	
	No.	%	No.	%	No.	%
URBAN	352	97.51	9	2.49	361	100
RURAL	382	82.33	82	17.67	464	100
	734	88.97	91	11.03	825	100

Dr. Aoki Chaired the 68th Meeting of the Japanese Society for Tuberculosis

The 68th Meeting of the Japanese Society for Tuberculosis was held in Tokyo on April 5th and 6th, 1993 with over 500 in attendance. Eighteen RIT staff presented their research achievements. The programme was specially intended to encourage the members to turn their attention to all tuberculosis fields, not exclusively toward their specialities. Two of the 4 main symposia were dedicated to rapidly improving tuberculosis researchers. Others were "International Cooperation in Tuberculosis - World Strategies and Japan's Role", chaired by Dr. Ishikawa of RIT, and "Changes of Pulmonary Tuberculosis". Dr. Aoki gave a special lecture on "TB in Japan from the Worldwide Point of View". There was a poster exhibition of dually infected cases of HIV and microbacterium in Japan, the first display of this kind in Japan. The Japanese Society for Tuberculosis was established in 1923 and has a membership of about 2,700 people.

New JICA Project in Yemen

A JICA TB project just started in Yemen in February 1993 following successful completion of the project from 1983 with establishment of a basis for NTP. Dr. M.Aoki of RIT had visited the country to formulate this new 5-year project designed to expand NTP to new areas after the nation's unification, and to promote the integration of NTP into PHC. Dr.T.Yoshiyama of RIT has been sent with his family to work in Yemen as a project leader.

Bangkok Workshop on TB and PHC

International Workshop on TB Control in the context of PHC in Asian countries was held on 3rd to 5th February, 1993 at AIHD, Mahidol University, Bangkok. The meeting was very important since it was the first meeting in Asia for sharing achievements and problems in the development of TB control on PHC. Over sixty administrators, officers in charge and scholars of TB control PHC programmes from 13 countries participated. The RIT, AIHD and TB Division of Thai Government co-hosted the meeting. In addition to case studies of all participant countries on how much TB control had been achieved on the basis of PHC, issues of medical in each supply, community participation and research methodologies were also discussed.

Individual Training Courses Participants

- Dr. S.P.Khanna (INDIA /Evaluating the Planning of TB Control in Urban Area / Oct.28 - Nov.22, 1991)
- Dr. G.Mishra (NEPAL /Chest Radiology / Oct.10 - Dec.11, 1992)
- Dr. P.Bhandari (NEPAL/Computer Analysis/Sept.7 - Nov.27, 1992)

Staff News

Welcome:

- Mr. H.Honda (Administration Dept.)
- Dr. R.Komatsu (Epidemiology Div.)
- Mr. S.Mizuno (Pathology Div.)

Farewell:

- Dr. S.Kyogoku (Epidemiology Div.)
- Dr. A.Hayashi (Epidemiology Div.)
- Dr. T.Takahashi (Pathology Div.)
- Mr. T.Toyama (Administration Dept.) [to Head Office]
- Mr. A.Yamazaki (Administration Dept.) [to Head Office]

Announcement

- To request a copy of publications on pages 4 and 7, please write to the editor giving the title of the article you require. Please add your comments regarding the newsletter, including which article interested you most.
- We received more than 100 requests for the name list of ex-participants and lecturers with the answers to the questionnaires. Thank you very much for your cooperation. If you have not requested one, please write to the editor.

Corrections

NEWSLETTER FROM KIYOSE No.5, P.10, Table 2

	2HRZE/6HT	29	
Highest	2HRZES/1HRZE/5H ₂ R ₂ E ₂	79	: Corrections
	2HRZES/1HRZE/5HRE	76	
Higher	2HRZ/2HR	35.5	
	2HRZ/2H ₂ R ₂	28.5	
	2H ₂ R ₂ Z/2H ₂ R ₂	16.5	
	2HRZ/6HE	34	
	2HRZ/6HT	25	
Low	Second line drugs	-	

* in US \$

Your news and voices are always welcome!

NEWSLETTER FROM KIYOSE

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