

NEWSLETTER FROM KIYOSE



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Asia-Pacific Tuberculosis Workshop Held in Tokyo

with Twenty-Six Asia-Pacific Countries in Attendance

The first Asia-Pacific Tuberculosis Workshop, organized by WHO and JATA and sponsored by the Japanese Government and the Sasakawa Foundation, was held in Tokyo from November 29th to December 1st, 1993. It was the first time that almost all countries belonging to either the Western Pacific Region (WPR) or the South East Region (SEAR) met together in one place to discuss WHO's new tuberculosis control policy and strategies. Dr. A. Kochi, Tuberculosis Programme Manager of WHO headquarters and his staff of four, Regional Advisors from WPRO and SEARO, 4 temporary advisors from RIT, and 26 representatives from member countries including 8 RIT international training course ex-participants (listed below) attended along with 24 observers.

many Asian countries are a little behind in implementing WHO's new tuberculosis control policy and strategies. Therefore, there is an urgent need to improve and strengthen the NTP in many Asian countries before the spread of HIV infection.

WHO TB Control Policy Package

WHO is now strongly recommending the adoption of the following policy package:

- 1) Government commitment to a national tuberculosis programme with a central unit and integrated services.
- 2) Passive case-finding using smear microscopy and standardized case definitions.
- 3) Standardized short-course chemotherapy for, at least, all smear-positive cases, with supervised administration of the initial phase.
- 4) A system of regular drug supply.
- 5) A monitoring system for vigorous evaluation of case detection and treatment outcomes.

After spirited discussion in group workshops and plenary sessions, it was concluded that all nations should adopt the WHO policy package as early as possible. Accordingly, the first Asia-Pacific Tuberculosis Workshop has adopted the recommendations (Page 9) to strengthen NTP in each country.

(Dr. M. Aoki, Director)



Urgent Need to Strengthen NTP

Each country reported their present tuberculosis situation and the National Tuberculosis Programme status. It became clear that NTP is inadequate or inappropriate in many countries due to such obstacles as poor infrastructure, economic difficulties, shortage of health personnel, outdated NTP, existence of many private sectors. As a result, I think that

JATA

Eight RIT ex-participants as representatives

WPR] Dr. Kong Kim San (Cambodia/'93Advanced course), Dr. Viliame Bera Kaitani (Fiji/'87TB control course), Dr. Young Pyo Hong (Korea/'80Advanced course, Lecturer)
SEAR] Dr. A.K. Md Ahsan Ali (Bangladesh/'76TB control course, '80Advanced course), Dr. Abdu Manaf (Indonesia/'85Advanced course), Dr. Soe Myint (Myanmar/'76TB control course), Dr. C. Pitigala (Sri Lanka/'87Laboratory course, '91Advanced course), Dr. Daranee Wiriyakitjar (Thailand/'86TB control course, '90Advanced course)

Recommendations

of the Asia - Pacific Tuberculosis Workshop Tokyo, Japan, December 1, 1993

While considering the WHO global tuberculosis strategy and policy package, and examining the worsening epidemiological situation with respect to tuberculosis, the Asia-Pacific countries strongly recommend the following:

(1) Resource mobilization

The principal objective is to mobilize resources both internally and externally for national tuberculosis programmes.

(a) Internal resources:

The group recommends that every national authority provides higher allocations within the health sector for their national tuberculosis control programmes. To aid this process, programmes should determine what proportion of the national health budget they currently receive and set a target for a more reasonable allocation, if justified. Dialogue with local NGOs should be initiated to secure support to the NTP. Given the relative importance of tuberculosis, in relation to other diseases, it is recommended that the WHO country budget for tuberculosis be increased.

(b) External resources:

In addition to reallocation of existing internal resources, it is necessary to raise funds from external sources for initial upgrading of revised programme activities.

Possibilities of bilateral governmental assistance, international assistance (e.g., World Bank, Asian Development Bank) and cooperation with non-governmental organizations should be investigated.

Within the Asia-Pacific regions, a number of countries including Australia, Brunei, China, Hong Kong, Japan, Korea, Malaysia, New Zealand, Singapore and Thailand, have the resources to provide support to neighboring countries for revitalizing national programmes. These countries should also consider initiating or increasing direct support to the WHO Tuberculosis Programme to make possible global, interregional, regional and country-level activities for tools development, programme support, research and advocacy.

(2) Technical Cooperation

In order to develop plans for the design and implementation of the policy package, technical cooperation between national tuberculosis programmes and the World Health Organization is crucial. Possible areas for technical cooperation include: programme review, development of a plan of action, manual

preparation or revision, and programme monitoring. The type and extent of cooperation will vary depending on the needs of the country, and may be provided by WHO headquarters and/or the regional offices. The financial resources of the World Health Organization's Tuberculosis Programme for technical cooperation must be increased. In addition, the regional offices must be strengthened (both staffing and financing) in order to make this cooperation possible.

(3) Programme Manual

A tuberculosis programme manual must be developed or revised based on this policy package.

(4) Demonstration Areas

A key to successful development of national tuberculosis programmes is the initial implementation of the policy package in demonstration areas. Only when a high cure rate is achieved in these areas, should gradual expansion of control activities take place. The ultimate aim is national coverage. Demonstration areas can serve as training grounds for staff throughout the country, in the expansion phase. The manual may also be revised based on experiences in the demonstration areas, and then distributed throughout the country.

(5) Training

Implementation of the policy package will require training a large number of professionals. The WHO modules on "managing tuberculosis at the district level," have been found to be a useful instrument for training and should be adapted, if required, for use in some countries. Staff in demonstration areas must be given the first priority for training. Training for laboratory and other peripheral staff must also be strengthened.

(6) Advocacy

The low priority given to tuberculosis in a majority of the countries has resulted in inadequate funding and consequently lack of drugs. Advocacy efforts must be devised to improve the visibility of the problem and of the national tuberculosis programme in each country. Understanding of the burden of disease, the resulting impact on economic and social development, and the cost-effectiveness of the TB control strategy must be increased. The likely outcomes of these efforts include greater political commitment; financial and human resources; endorsement of technical policies by the medical community; and the trust of patients and of the community in the programme.

(Continued from page 2)

A 2 day mobile seminar, jointly organized with the Ministry of Health and Welfare, is conducted in 7 regions every year, covering all 47 prefectures. Each prefectural government in each region is responsible for organizing the seminars for the region every 6 - 9 years. Individual courses are conducted for PHNs preparing for an international cooperation programme. Seven PHNs have been trained, including Ms. Y. Nagata and Ms. T. Zama who are actively working in Nepal and in the Solomon Islands, respectively.

Our 50 year history of training nearly 3,000 PHNs in Japan has had a great impact on Japan's tuberculosis programme, not only in increased knowledge but in increased motivation to tackle tuberculosis problems.

(Continued from page 3)

Apart from the VE difference, it should be noted that the BCG vaccination programme had been neglected before 1972 when obligatory vaccination was instituted. Finally, the table shows a lower VE in persons who live in crowded housing. From this result, we can see the impact of crowding not only on the risk of infection, but also on the risk of clinical TB development.

Conclusions and Recommendations: 1) BCG vaccination in this area appears to be offering worthwhile protection against smear-positive pulmonary TB. 2) These results are not significantly different from those of the better controlled trials, even though it excludes the other types of TB for which BCG is known to be very effective. 3) The BCG vaccination programme should be continued as an integral part of the EPI in our country.

The Dynamics of Tuberculosis Control in Africa



Dr. Patrick A. Orege

Director, Alupe Leprosy and Skin Disease Research Centre, Kenya

I was trained at the Research Institute of Tuberculosis in 1980. At that time the trend of incidence and prevalence of TB could be predicted. Using a simulation model of the data obtained from Kenya in 1976, it was predicted that tuberculosis incidence and risk of infection would decrease to 90 % (1). To increase treatment coverage, one needs infrastructure such as provision of adequate peripheral laboratory services, backed by a central (referral) laboratory, availability of anti-tuberculosis drugs, and trained manpower. The political will must also be there. In Africa, although there could be political will, the bottlenecks are experienced in the availability of funds to run the programme, the availability trained manpower (few health workers still do opt to do TB work) and availability of the infrastructure. Tuberculosis control officers are often faced with untold hardship when faced with the above mentioned shortcomings that are realities in most of the control programmes in sub-saharan Africa.

The emergence of HIV infection in sub saharan Africa has not helped the already deteriorating situation. It is already predicted that the tools available for tuberculosis control will fail to restrain the increase in the incidence of tuberculosis due to HIV infection (3). Data from Tanzania has shown that between 1983-1989, there was 67% increase in the number of cases of all forms of tuberculosis, which are of particular concern because of their infectiousness. It is postulated that these increases could in part be due to HIV (2). similar increase have been noted from Malawi and Zambia (3), where the two diseases co-exist like in sub saharan Africa, the effect is expected to be catastrophic. the international community should therefore be called upon to make more resources available in order to strengthen national control programmes to be prepared to meet the new challenges that have been introduced in the tuberculosis control during the mid-eighties. Otherwise our prediction or reducing incidence of tuberculosis risk infection and TB mentality in Africa, will be nothing but a sweet dream.

(*'80 TB Control course*)

References:

- (1) Orege P.A.: The Epidemiometrics of Tuberculosis in Kenya: proceedings of Fifth Annual Medical Scientific Conference of KEMRI/KETRI, Nairobi: 190 - 198, 1984
- (2) J.F.Murray: Tuberculosis and Human Immunodeficiency Virus infection during the 1990's: Bulletin of IUATLD: 66, 21 - 25, 1991
- (3) Styblo K.: the impact of HIV infection on global epidemiology of tuberculosis: Bulletin of IUATLD: 66: 27 - 32, 1991

A Case-Control Study on the Effectiveness of BCG Vaccination in an Area of Iraq

Dr. Hikmat A. Aboud

Tuberculosis and Chest Diseases Centre
Wasit Governorate, Iraq

A case-control study was conducted at a consultant clinic for respiratory diseases in the Wasit Governorate, Iraq, to determine the protection conferred by BCG vaccination against smear-positive pulmonary tuberculosis. In this area, BCG coverage is now about 95%.

Materials and Methods: A total of 100 files of smear-positive pulmonary TB patients below 40 years of age were selected randomly. 300 controls with clear chest X-ray were selected from clinic patients, at a ratio of 3 controls to 1 case. Controls were matched by age, sex, social origin, nutritional status, place of residence, and other socioeconomic factors. BCG scars were checked for all cases and controls. Only those having a visible scar were considered to be BCG vaccinated, irrespective of the reported BCG vaccination history.

Results: The first row of the table shows that the overall protective Vaccine Efficacy (VE) was estimated as 58% with 95% confidence limits of 33.5% - 73.5%. The table also shows a VE of 70% in males and 53% in females. Although this difference is not statistically significant, it may be possible that physiological stresses work unfavorably towards females of reproductive age, because of pregnancy, labour and lactation. Concerning age factors, it is shown that the highest VE was seen in the 10 - 19 year bracket followed by the 30 - 39 year bracket. The absence of protection for ages 0 - 9 years may be due to the small sample size and uncertainty of diagnosis of smear-positive pulmonary TB in children. Also note that the more sensitive parameters of protectivity in this age group such as miliary TB and TB meningitis are not included in this study. VE is higher in urban than rural areas. Although statistically insignificant, it is possible that the difference is caused by the gap in socioeconomic status between two areas and also by the lower technical proficiency in vaccination administration in rural areas. (Continued to page 9)

(*'80 TB Control course*)

Table. Summary of Results. Number of Cases and Controls by BCG History

	Cases		Controls			Test VE	p	
	Total	BCG(+)	BCG(-)	Total	BCG(+)			BCG(-)
Total	100	46	54	300	201	99	58.0%	0.0003
Sex								
Male	29	14	15	87	66	21	70.3%	0.0005
Female	71	32	39	213	135	78	52.6%	0.0066
Age Group								
0 - 9 yrs	2	1	1	6	3	3	0.0%	-
10 - 19	41	22	19	123	101	22	74.8%	0.0003
20 - 29	32	18	14	96	65	31	38.7%	0.2397
30 - 39	25	5	20	75	32	43	66.4%	0.0421
Area Type								
Urban	57	28	29	171	129	42	68.6%	0.0002
Rural	43	18	25	129	72	57	43.0%	0.1126
Living Condition								
Crowded	61	27	34	183	112	71	49.7%	0.0206
Not	39	19	20	117	89	28	70.1%	0.0014
VE: Vaccine Efficacy							p: Probability for VE equal to zero	

The 17th IUATLD Eastern Regional Conference

Bangkok, Thailand, 1-4 November, 1993

The 17th IUATLD Eastern Regional Conference on Tuberculosis and Respiratory Diseases was held in Bangkok, Thailand, from November 1st to 4th, 1993, with approximate 500 people in attendance. The president of the conference was Dr. Songhram Supcharoen. Dr. Supcharoen, Dr. Waith Areecheon, secretary general of organizing committee and Dr. Thavisakdi Bamrungrakul, associate secretary general, are the RIT participants.



Basic Problems and Strategies in the HIV Prevalent Era

First, Her Royal Highness Princess Mahachakri Sirindhorn presided over the opening ceremony and gave an address. The conference began with the following plenary lectures; A Global Tuberculosis Problem by Dr. N. Billo (IUATLD) and the Impact of HIV Infection on Tuberculosis by Dr. A. Kochi (WHO). Both were comprehensive and well presented lectures dealing with basic problems and strategies in the HIV prevalent era.

Tuberculosis is already a big burden and would become even more serious in developing countries where HIV is prevalent because HIV infection increases the reactivation of latent tuberculosis infection. In some industrialized countries, tuberculosis has



From left, Mr. Sagal, Yemen ('92 Laboratory course), Dr. Al-Matali, Yemen, Dr. Seita (RIT) and Dr. Enarson (IUATLD)

been forgotten and has returned with multi-drug resistance, a result of neglected and deficient national control programmes. Recently, WHO has estimated that in the year 2000 about 1.4 million HIV associated TB cases would occur. However, there is encouraging evidence of efficient tuberculosis control programmes. For instance, in the successful Tanzanian tuberculosis control programme, tuberculin survey data shows that infection prevalence may not increase even while the number of new case is increasing year by year due to the HIV epidemic.

Asia is now also experiencing a rapidly spreading



HIV epidemic featuring a relatively high tuberculosis prevalence. Dr. Kochi mentioned that TB control programmes must be strengthened to limit the impact of HIV infection on the TB situation. Dr. Billo cited that it is the responsibility of governments, WHO, NGO's and specialists in the field of tuberculosis to use the available resources to fight this disease.

Importance of Operational Research in System Development

After the plenary lectures, there were over 150 interesting presentations. Because I work for the International Tuberculosis Information Centre of RIT, I joined sessions on epidemiology and NTP, including; "Can We Control TB by the Year 2000?", "National Tuberculosis Control Programme" and "Intensification of Case Finding and Short Course Chemotherapy through Primary Health Care". In the first session, Dr. Mori (RIT) made a presentation on the tuberculosis control programme and the anticipation of the elimination of tuberculosis. Dr. Ishikawa, in the third session, presented his paper on the importance of operational research in system development. WHO recently established a new strategy package, but further discussion is needed on how to install the new system recommended by WHO and IUATLD, into

*Excerpts from Recommendations
of the 17th Eastern Regional Conference on
Tuberculosis and Respiratory Diseases*

[Tuberculosis]

1. Member associations of the Region are requested to:

- a.** review and comment upon the protocol for surveillance of drug resistance in their national tuberculosis programmes currently under development by IUATLD and WHO,
- b.** review and comment upon the protocol for surveillance of HIV infection in tuberculosis patients currently under development by IUATLD and WHO,
- c.** contribute to an evaluation of the magnitude of the problem of tuberculosis in the region by:
 - (i)** assembling available information in the region from national prevalence surveys, tuberculin surveys, and routine information on tuberculosis notifications,
 - (ii)** analysing the reliability, applicability and methodology of these data,
- d.** provide a full report on the history and subsequent development of the mutual assistance programme in the region from its commencement in the 1960s.

2. Member association of the Region should encourage governments to:

- a.** identify tuberculosis as a priority in,
 - (i)** national plans and budgets,
 - (ii)** international collaborative activities.
- b.** ensure that national tuberculosis programmes comply with the new global tuberculosis control strategy developed by IUATLD and adopted by the WHO in view of the HIV epidemic, to achieve at least 85% treatment cure rate of sputum smear-positive patients detected, through the introduction of short-course chemotherapy, as the prime objective of all tuberculosis control programmes.
- c.** implement in an orderly fashion this strategy, by taking into consideration the existing health services system. Once the 85% cure rate is achieved, the programme should start to expand case finding activities to detect and treat more cases.
- d.** continue BCG vaccination of the newborn, unless the infants have AIDS-related symptoms.

existing programmes and on how the system can be improved. In this regard, these symposia provided useful ideas on the present situation in various countries, and on system development methodology such as small sized pilot projects and action research. The reported experience could be applied in other nations.

Other key topics were HIV and Drug resistance. One symposium and oral presentation session were completely given to HIV. Studies of drug resistance were presented from 6 developing countries. I was especially impressed with the study conducted in Nepal because its samples were selected from patients under the age of 20 in order to remove patients with unrevealed previous treatment history.



Dr. Aoki greeting

TB Nurse Conference and Ex-participants Reunion Party

For the first time in this region, a TB Nurse Conference was held. Fourteen nurses from 6 countries confirmed the importance of nurses' role in a successful Tuberculosis Control Programme, which requires the contributions of many different professionals. Ms. T. Yamashita, in charge of domestic training courses for public health nurses, which has 50 year history at RIT, spoke about "Education for PHNs Working in Tuberculosis Control Programme in Japan". Many professional colleagues including nurses over the world were encouraged to attend the First World TB Nurse Conference in the upcoming IUATLD World Conference in Mainz.

We had 54 RIT ex-participants from 17 countries and Dr. D.A. Enarson (lecturer from IUATLD) attended the reunion party. This gathering made us realize afresh our close relationship with each other and the large impact of our training course on tuberculosis control programmes worldwide. I believe we can continue to contribute to fighting tuberculosis through this human network. Many ex-participants have very important roles in their NTP. We also enjoyed a RIT slide show, featuring various staff members and the dormitory which were rebuilt 4 years ago. Of course, Mr. Ito of the dormitory also appeared on the screen.

RIT ex-participants met at the Reunion Party



This conference did not only provide an opportunity to gain academic knowledge from many excellent specialists, but it also served to improve our friendships and the international human network for the fight against tuberculosis. I offer my congratulations to the organizers for a success of the conference. The next Eastern Regional Conference will be held in Australia possibly in 1995. I am looking forward to meeting many friends again at that time.

(Dr. N. Yamada, Int'l Cooperation Dept.)

1993 Advanced Course (May 17 - June 25, 1993)

Twelve medical doctors from 12 countries successfully completed the Group Training Course in Tuberculosis Control for Administrative Medical Officers 1993.

“After 11 years I have seen significant changes in Japan and at RIT, such as a very high socio-economic status and rapidly developed advanced technology. RIT now occupies a beautiful new building, featuring a new dormitory with all modern facilities, including a telephone in each room and an international public telephone. At the institute, all subject material represents completely up-to-date knowledge. Global tuberculosis problems were discussed in the class using these new materials; the central theme of the course was how to evaluate a national tuberculosis control programme.

Field trips to Hiroshima, Nagoya, Osaka, Aichi and Mie prefectures, including exotic Pearl Island were exciting and gave me the opportunity to experience Japanese culture and get closer to Japanese people. I shall never forget Hiroshima, where on August 6th, 1945 during the 2nd World War the first Atomic Bomb was used. It should never be used again anywhere in the world. Hiroshima is now called a city of International Peace and Culture.” *Dr. Dirgh Singh Bam, Nepal*



Advanced Course From left-1st row: Dr. R. Komatsu (Japan) Dr. G. M. Ilmolelian (Tanzania) Dr. Aoki (RIT) Dr. P. Chaulet (Lecturer) Dr. R. Prasanthong (Thailand) 2nd: Dr. Kim San Kong (Cambodia) Dr. J. Perea (Peru) Dr. Liam C. K. (Malaysia) Dr. D. S. Bam (Nepal) Dr. A. M. A. Al Kibssi (Yemen) Ms. Y. Minemura (Coordinator) Dr. Seita (RIT) 3rd: Dr. J. C. Fuentes (Philippines) Dr. Razin A. S. (Bangladesh) Dr. A. M. Afifi (Egypt) Dr. Kwon D. W. (Korea) Dr. Matsuda (RIT) Dr. Ishikawa (RIT)

From Ms. Y. Minemura,

JICA Coordinator, to the 1993 course participants:

“Konnichiwa. It's has already been nine months since we shook hands instead of saying 'good-by'. Despite the short time we were together I also learnt a lot and was left with wonderful memories. It was a pity I couldn't go on a trip with you. However, this time, I was able to accompany the Laboratory Course participants since my relatives are all getting better. Do you still remember the 'Shiki no uta' which we sang together at the HITC Garden Party? With my carelessness, some doctors succeeded in escaping from it. I wish you great success in your task, and believe we will see again sometime.”



TB Control Course From left-1st row: Ms. J. Kato (Japan) Dr. L. C. David (Philippines) Dr. A. D. Nageswari (India) Dr. V. S. Lofranco (Philippines) Dr. Aoki (RIT) Dr. S. Nataniyom (Thailand) Dr. R. Odeke (Uganda) Ms. E. Imamura (Japan) 2nd: Dr. T. Masood (Pakistan) Dr. I. Kosasih (Indonesia) Dr. Y. R. T. Al-Athwary (Yemen) Dr. Xue Qi-Jun (China) Dr. Kim. S. K. (Korea) Dr. A. K. M. S. Alam (Bangladesh) Mr. A. R. Tuladhar (Nepal, Individual Course) Dr. K. Jayawong (Laos) Dr. S. N. Ally (Tanzania) Dr. P. V. D. S. Francis (Sri Lanka) 3rd: Dr. O. A. R. Badeeb (Yemen) Dr. Ms. Y. Henmi (Coordinator) Dr. H. A. Sanabria Rojas (Peru) Dr. P. N. Songolo (Zambia) Dr. Z. M. A. El-Zoghbi (Egypt) Mr. K. F. Konare (Solomon Islands) Dr. N. W. Hamlet (Scotland) 4th: Dr. Matsuda (RIT) Mr. S. L. Kandel (Nepal) Dr. Ishikawa (RIT) Dr. R. O. Laing (Lecturer)

From Ms. Y. Henmi,

JICA Coordinator, to the 1993 Course Participants

“How are you doing now? The four months in Kiyose seem to have passed in a flash. We really experienced a lot, didn't we? Remember I mistook 'anti-tuberculosis women's society' for 'anti-women's society'. And the Scottish dance was a great hit everywhere. I am now serving as a coordinator for the 'Crime Prevention Senior Seminar' training course. Participants include people such as Superintendents, Judges and Public Prosecutors. I am exited about this new course. While looking at the flowers you gave me, I can't help wondering when we will meet again. I appreciate each person who has sent a letter to me, and I wish you every success in your work.”

1993 TB Control Course

(July 5 - Oct. 15, 1993)

Twenty-three participants from 21 countries to the Group Training Course in Tuberculosis Control (II) 1993 comment:

The 4 month stay in Japan seemed to be quite something to us.

We realized how big the TB' problem is:

“how serious TB situation is, especially in developing countries in relation to HIV.” (Tanzania),

and how important the management is:

“I have never been exposed to how to be a manager.”

We also realized how difficult cooking is:

“Cooking was the worst part of the training.” (Zambia),

and

how disciplined Japanese are:

“Some passengers are even sleeping in standing position inside the running trains.” (Nepal)

Anyhow, we wish we could 'do our best'.

Individual Training Courses Participants

Dr. R. M. M. Yasunaga (Brazil/TB Control & Epidemiology/Sept. 16 - Oct. 18, 1993)

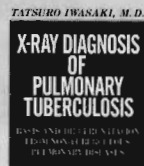
Dr. L. Y. Wan, Dr. H. W. Zhao, Dr. F. D. Zhang, Dr. Y. L. Chen, Dr. D. R. Tang (China/TB Control / June 10 - 25, 1993)

Mr. S. L. Kandel (Nepal/TB Control & Health Education/Oct. 16 - Nov. 17, 1993)

Mr. A. R. Tuladhar (Nepal/TB Control Programme & Public Health Management / Aug. 12 - Dec. 1, 1993)

X-RAY DIAGNOSIS OF PULMONARY TUBERCULOSIS : Basis and Differentiation from Non-Tuberculosis Pulmonary Diseases

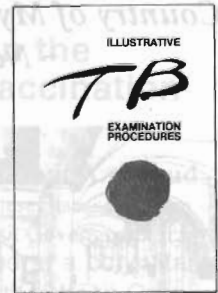
By *T.Iwasaki*, Director Emeritus, RIT
Published by RIT



The chest radiography for tuberculosis case-finding is widely used in many nations, often causing over diagnoses and confusion among clinicians in interpreting the shadows. This text book includes examples of over 100 chest X-ray pictures including cases of both pulmonary tuberculosis and non-tuberculosis diseases, as well as providing essential, basic knowledge of X-ray diagnosis of these diseases. This book will help clinicians to understand better how X-ray can be effectively utilized in diagnosis.

ILLUSTRATIVE TB EXAMINATION PROCEDURES

By *A.Fujiki*, International Cooperation
Dept. RIT
Published by JICA/RIT



This booklet is focused on the fundamental procedures of tuberculosis examinations written in simple step-by-step explanations with many illustrations. This booklet can be easily utilized by anyone who wants to learn the examination techniques.

Ordering Books

"X-Ray Diagnosis of Pulmonary TB" and "Illustrative TB Examination Procedures" are available through RIT. If you want a copy, please send COUPON - REponse INTERNATIONAL, equivalent to US\$ 3 for each copy. (This coupon may be purchased at your local post offices.) To order the other books, contact the publishers directly.

MANAGING TUBERCULOSIS AT DISTRICT LEVEL published by the Tuberculosis Programme of WHO

(TUB/WHO) is a self study training module explaining all District TB Coordinator activities such as registering cases, starting treatment, monitoring and making reports. This module was developed for one week training course and is the only textbook documenting the most recent WHO model of tuberculosis control.

TREATMENT OF TUBERCULOSIS: GUIDELINES FOR NATIONAL PROGRAMMES

is a comprehensive treatment manual by TUB/WHO which covers the recent standardized chemotherapeutic regimens and treatment monitoring. HIV infection complications and drug costs are also included. This is the best and most brief booklet explaining recent treatment regimens. [For ordering, contact the Distribution and Sales, WHO]

The World Bank reviewed health sector activities particularly with regard to cost-effectiveness by introducing a new indicator, "the Disability Adjusted Life Year" (DALY). The latest WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH is its review report which mentioned the WHO model of chemotherapy of smear positive cases as one of the most cost-effective interventions in health care. This review is a strong encouragement of Tuberculosis Control Programmes.

DISEASE CONTROL PRIORITIES IN DEVELOPING COUNTRIES by World Bank

is a detailed report of this review. Prof. C.J.Murray, one of RIT's lecturers, reviewed the Tuberculosis Control Section. This is primarily intended for libraries, but the well-summarized tuberculosis part is very informative for every one concerned with tuberculosis control. [For information, contact your local WORLD BANK publications distributor or branch of Oxford University Press]

The following three publications are invaluable resources for all health professionals. The first two are the comprehensive books dealing with all aspects of tuberculosis and the last one is a report of the third annual public health forum in 1993 titled 'Tuberculosis - Back to the Future', focusing on tuberculosis in developing countries and organized by the London School of Hygiene & Tropical Medicine.

CLINICAL TUBERCULOSIS

Edited by *P.D.O.Davies*

Published by **CHAPMAN & HALL MEDICAL**

Excerpts from the book: " .. There is also detailed coverage of recent concerns such as those of drug resistance, migration, environmental mycobacteria and the disease in HIV-infected individuals. The issue of disease prevention and control in both low- and high-prevalence countries is discussed. The arguments for and against the use of the BCG are considered. In addition there is a section looking at new diagnostic techniques in development."

TUBERCULOSIS: A Comprehensive International Approach

Edited by *Lee B. Reichman, Earl S. Hershfield*

Published by **MARCEL DEKKER, INC.**

(Volume 66 of a series of Lung Biology in Health and Disease)

Excerpts from the book: " .. the first of its kind to deal with tuberculosis in both developed and developing countries, thoroughly examines the disease from historical theoretical, and practical perspectives."

TUBERCULOSIS: BACK TO THE FUTURE

Edited by *John D.H.Porter and Keith P.W.J.McAdam*

Published by **JOHN WILEY & SONS LTD.**

Country of My Memories - National TB Center in Kabul



Patient's waiting room, National TB Center, Kabul (by Dr. Iwasaki)

On my first visit to Afghanistan for a medical cooperation programme in 1968, the country was an empire. By the time the programme actually began in 1974, the Emperor had been exiled. A Japanese medical team, headed

by Dr.A.Kochi, present Tuberculosis Programme Manager of WHO, had stayed in Kabul until just before the Soviet Union's military forces came into the country. During those years the Afghan government changed several times, some times by the assassination or imprisonment of its rulers. Fortunately, the general inhabitants were not much involved in these conflicts. However, as governments changed the people on the Afghan side who were responsible for the programme also changed. In spite of such difficult circumstances, the programme was implemented effectively, and finally a new National Tuberculosis Center was established with the cooperation of the Japanese government in 1979. However, in that same year, the pro-Russian Afghan government invited Russian military forces to their country. Eventually, guerilla bands succeeded in expelling the foreign troops. Against our expectation of peace, the battle for hegemony continues among the guerilla bands. This time, general inhabitants are involved and have fallen into desperate conditions. The National Tuberculosis Center was destroyed by rockets.

It is difficult for me to understand why the leaders of the guerilla bands were so short-sighted as to destroy their own country and nation. I had expected to visit Afghanistan for a tenth time to confirm the results of the tuberculosis control programme and also to see once again many historical monuments of the country

FROM FORMER COURSE DIRECTERS

Dr. Shoko Imamura

It is a great pleasure for me to communicate through the Newsletter. I congratulate your energetic activities directed forward the improvement and the success of the TB control programme in your respective countries. I am 76 years old now and still working in several fields. Over the last 20 years, I have been seeing TB patients once a week at a clinic in the municipal dispensary located in a slum area with one of the highest TB prevalence rates in Japan. Although it only affects a small area, I plan to continue to pour my life into it. Wishing you all the best and success in TB control in your area.



(Contact address: 2-6-40 Matsuyama, Kiyose-shi, Tokyo 204)

Dr. Akira Takase

I trust you and your families are happy and healthy. Luckily, I have been quite well. As the saying goes, "Time flies like an arrow," with this year passing, it is hard to believe that about 30 years have passed since the international training courses started. As for myself, I became 66 years old last Christmas eve. And I am still working as the director of Shibuya Dispensary of JATA. The Dispensary works as an outpatient clinic for respiratory diseases and conducts mass survey for general inhabitants or school children. I hope that this year



proves to be a good year for you.

(Contact address: Shibuya Dispensary, 1-20-24 Shibuya, Shibuya-ku, Tokyo 150)

Ms. Yuriko Kichizi (Ichimura) former RIT staff

I am glad to hear that Kiyose course participants of some 20 years ago continue to be active in their home countries. I remember clearly the very good time we had together during a brief Japanese language lesson every morning at RIT. I also fondly remember field trips to Kyoto and Tohoku. I wish we could meet again sometime.

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which is at the midpoint of the Silk Road.

I believe peace is necessary for effective tuberculosis control. (Dr. T. Iwasaki, Director-Emeritus)

Class Room Now

The Up-dated Curriculum: "Computer" & "Training Module"

From 1993's TB Control Course, we started two new sessions; one is the computer session and the other is the training module session.

In computer classes, participants learn how to prepare reports using the Word Perfect® word-processing programme. This year we had one desktop and six notebook computers for participant use. Country evaluation reports and action plans, major tasks in our courses, are written using the

computers. We are now planning to increase the number of computers and to introduce a spreadsheet type programme, Lotus 1 - 2 - 3®, for making tables and graphs.

The WHO module, Managing TB at District Level (page 7) is used in the training module session. The module is provided to all participants. Class style is exactly same as the original WHO workgroup class: explanation, self-study and summarization. Because of time limitations, we could not offer the whole one week session, but we covered the main parts of this module. These sessions will be strengthened in 1994.

(Dr. M. Matsuda, Int'l Training Div. Chief)

Recommendations

of the Asia - Pacific Tuberculosis Workshop Tokyo, Japan, December 1, 1993

While considering the WHO global tuberculosis strategy and policy package, and examining the worsening epidemiological situation with respect to tuberculosis, the Asia-Pacific countries strongly recommend the following:

(1) Resource mobilization

The principal objective is to mobilize resources both internally and externally for national tuberculosis programmes.

(a) Internal resources:

The group recommends that every national authority provides higher allocations within the health sector for their national tuberculosis control programmes. To aid this process, programmes should determine what proportion of the national health budget they currently receive and set a target for a more reasonable allocation, if justified. Dialogue with local NGOs should be initiated to secure support to the NTP. Given the relative importance of tuberculosis, in relation to other diseases, it is recommended that the WHO country budget for tuberculosis be increased.

(b) External resources:

In addition to reallocation of existing internal resources, it is necessary to raise funds from external sources for initial upgrading of revised programme activities.

Possibilities of bilateral governmental assistance, international assistance (e.g., World Bank, Asian Development Bank) and cooperation with non-governmental organizations should be investigated.

Within the Asia-Pacific regions, a number of countries including Australia, Brunei, China, Hong Kong, Japan, Korea, Malaysia, New Zealand, Singapore and Thailand, have the resources to provide support to neighboring countries for revitalizing national programmes. These countries should also consider initiating or increasing direct support to the WHO Tuberculosis Programme to make possible global, interregional, regional and country-level activities for tools development, programme support, research and advocacy.

(2) Technical Cooperation

In order to develop plans for the design and implementation of the policy package, technical cooperation between national tuberculosis programmes and the World Health Organization is crucial. Possible areas for technical cooperation include: programme review, development of a plan of action, manual

preparation or revision, and programme monitoring. The type and extent of cooperation will vary depending on the needs of the country, and may be provided by WHO headquarters and/or the regional offices. The financial resources of the World Health Organization's Tuberculosis Programme for technical cooperation must be increased. In addition, the regional offices must be strengthened (both staffing and financing) in order to make this cooperation possible.

(3) Programme Manual

A tuberculosis programme manual must be developed or revised based on this policy package.

(4) Demonstration Areas

A key to successful development of national tuberculosis programmes is the initial implementation of the policy package in demonstration areas. Only when a high cure rate is achieved in these areas, should gradual expansion of control activities take place. The ultimate aim is national coverage. Demonstration areas can serve as training grounds for staff throughout the country, in the expansion phase. The manual may also be revised based on experiences in the demonstration areas, and then distributed throughout the country.

(5) Training

Implementation of the policy package will require training a large number of professionals. The WHO modules on "managing tuberculosis at the district level," have been found to be a useful instrument for training and should be adapted, if required, for use in some countries. Staff in demonstration areas must be given the first priority for training. Training for laboratory and other peripheral staff must also be strengthened.

(6) Advocacy

The low priority given to tuberculosis in a majority of the countries has resulted in inadequate funding and consequently lack of drugs. Advocacy efforts must be devised to improve the visibility of the problem and of the national tuberculosis programme in each country. Understanding of the burden of disease, the resulting impact on economic and social development, and the cost-effectiveness of the TB control strategy must be increased. The likely outcomes of these efforts include greater political commitment; financial and human resources; endorsement of technical policies by the medical community; and the trust of patients and of the community in the programme.

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A 2 day mobile seminar, jointly organized with the Ministry of Health and Welfare, is conducted in 7 regions every year, covering all 47 prefectures. Each prefectural government in each region is responsible for organizing the seminars for the region every 6 - 9 years. Individual courses are conducted for PHNs preparing for an international cooperation programme. Seven PHNs have been trained, including Ms. Y. Nagata and Ms. T. Zama who are actively working in Nepal and in the Solomon Islands, respectively.

Our 50 year history of training nearly 3,000 PHNs in Japan has had a great impact on Japan's tuberculosis programme, not only in increased knowledge but in increased motivation to tackle tuberculosis problems.

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Apart from the VE difference, it should be noted that the BCG vaccination programme had been neglected before 1972 when obligatory vaccination was instituted. Finally, the table shows a lower VE in persons who live in crowded housing. From this result, we can see the impact of crowding not only on the risk of infection, but also on the risk of clinical TB development.

Conclusions and Recommendations: 1) BCG vaccination in this area appears to be offering worthwhile protection against smear-positive pulmonary TB. 2) These results are not significantly different from those of the better controlled trials, even though it excludes the other types of TB for which BCG is known to be very effective. 3) The BCG vaccination programme should be continued as an integral part of the EPI in our country.

In Remembrance

Dr. Tatsuji Ogawa died of pneumonia on February 15th, 1994. Throughout his 87 years he greatly contributed to the field of tuberculosis control through many academic achievements on Mycobacteria. His most significant achievements were the development of the Ogawa media with the corresponding culture methods, and the establishment of a quantitative culture method for tubercle bacilli from sputum specimens, which has been adopted in Japan as the standard culture examination technique. These achievements were made while he was working at RIT over the 13 years starting from 1940. He also contributed to training medical personnel from around the world in tuberculosis control by lecturing in the Laboratory Course from 1976 to 1988.



FROM FORMER COURSE DIRECTORS

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Dr. Norihiro Umemura

Dear colleagues,
DWhen I retired from RIT in 1990, I had never thought I would serve somewhere overseas. Actually, I have served in Solomon Islands and Fuji as a WHO short-term consultant on tuberculosis control for one month each in September and October of 1990. And I have been invited to Bolivia by Dr. Alfredo Ajata C. ('89 TB control course) two times to give lectures on the tuberculosis situation in Japan. The first lecture was presented to an informal meeting of chest physicians in 1990 in La Paz and Oruro and the second in 1992 was given on the occasion of the Second National Congress of Pneumology in Oruro. As Paraguay had asked Japan in 1992 to dispatch one physician to assist in the improvement of the tuberculosis control programme, I have been working for the national tuberculosis control programme since April 1993 with Dr. F. Romero ('92 Advanced course) in Asuncion, the capital city of Paraguay. There are a total of 9 RIT course ex-participants in Paraguay: 5 from the Advanced course and 5 from the TB control course, and one from the 1993 Laboratory course. I feel the loss of Dr. M. Aguayo ('86 TB control & '89 Advanced) passed away in 1991.



Dr. Umemura working with Dr. Portillo ('88 TB control course) (left) and Dr. Romero (right)

The NTP office is located in the 'Max Boettner' sanatorium, where 3 ex-participants are working as clinicians. These days we are struggling to develop a modern, rational surveillance system using a new computerized registry, and I'm enjoying the challenge. Another dream I have is to meet colleagues in their respective countries sometime in the near future.

Adios!

◇ Staff Overseas Visit ◇

Dr. Mori Meets Alumna in Kerala

r. T. Mori, Vice-Director and Dr. H. Hoshino met Dr. Kumari Indira ('89 individual course participant), on their visit to Kerala, India in December 1992. Kerala is a world famous state in India because of its high-performance health care despite of many of many economic difficulties. During their one week stay to complete a case study of the statewide tuberculosis control programme, they enjoyed the company of Dr. Indira together with her husband and children.



She cooperated with them in their field visit and data collection in a hectic schedule, and very interesting findings were efficiently obtained.

Congratulations

Ms. Y. Yamauchi (Yamada), Epidemiology Div., had a baby girl in September 1993.

Staff Working Overseas

Dr. M. Suchi (Epidemiology Div.): In the Philippines since Sept. 1993/JICA Public Health Development Project

Dr. T. Yoshiyama (Int'l Cooperation Dept.): In Yemen since May 1993/JICA Project for TB Control Programme II

Dr. R. Komatsu (Epidemiology Div.): In Nepal since July 1993/JICA Project for National TB Programme

Dr. H. Hoshino (Int'l Cooperation Dept.): In Nepal since Feb. 1993/JICA Project for National TB Programme

Staff News

Welcome:

Dr. M. Yoshikawa (Epidemiology Div.)

Ms. T. Endo (Administration Dept.)

Farewell:

Mr. M. Nakaoji (Radiological Technologists Training Div.) retired

Ms. N. Shimoji (Administration Dept.) retired

Attention

1. Dear Laboratory Course Ex-Participants:

Have you already mailed your completed "Questionnaire on Tuberculosis Laboratory Course" back to RIT? If not, we would very much appreciate your cooperation in evaluating our Laboratory Course. This survey is the first one conducted on this scale since the course was started in 1975. Thank you in advance.

2. Communication to RIT through Internet now available. (see below)

Your news and voices are always welcome!

NEWSLETTER FROM KIOSE

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