

# NEWSLETTER FROM KIIYOSE



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The Research Institute of Tuberculosis, JATA  
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## Seventy years' Dedication to Tuberculosis Research by Dr. Iwasaki

Dr. Tatsuro Iwasaki, Director Emeritus, RIT, passed away in his ninetieth year due to cancer of the prostate on July 5th, 1997, after two weeks' hospital stay. He was an honorary member of the Japanese Society for Tuberculosis and IUATLD. Although he was aware of his illness, he was an active research scientist until the last moment of his life. Just two weeks before being hospitalized he appeared at the Institute as usual and talked with his young colleagues about tuberculosis research. Recently he completed a thorough review of tuberculosis research, which will appear in the forthcoming issue of "Kekkaku" as his posthumous paper.

Born in 1907 to a local private practitioner in a town in Shizuoka prefecture, Dr. Iwasaki spent his childhood and young adult years in this area near Mt. Fuji. After his graduation from the School of Medicine, University of Tokyo, in 1931, he specialized first in internal medicine, and then embarked on his life work of studies in tuberculosis pathology. In 1940 he joined RIT which had been just founded, as invited by the



late Dr. Oka, his teacher, and the late Dr. Kumabe. He made heroic efforts to establish a base for this new institution under difficult wartime conditions. In 1957 he became Director of RIT, succeeding Dr. Kumabe, and remained director until 1975 when he was succeeded by Dr. Shimao.

Dr. Iwasaki's scientific activities covered the entire area of tuberculosis pathology, from the very basic aspects to complex clinical and control-oriented issues. His work was always closely related to the patients and to tuberculosis control, beyond purely academic

matters. The same could be said of his predecessors, Dr. Oka and Dr. Kumabe.

Perhaps his most important contribution was in his studies of TB pathology under chemotherapy, conducted in the early days of TB chemotherapy. The results of this work formed the basis of TB disease classification, and also became a guide for interpreting treatment effect on individual patients.

One of his most significant monographs was "Pathology of Tuberculosis" (in Japanese), published in 1961. The book has been almost a bible for tuberculosis students

since its publication. He revised this book 40 years after the first publication, updating with new findings and with his own new views. In his last years he was occupied with new TB problems, such as the pathogenesis of tuberculosis in HIV infected subjects, and the problem and development of TB observed with CT.

International cooperation for tuberculosis control was another serious concern for him. As Director of RIT, Dr. Iwasaki began in the early 1960s to establish standardized international training courses, guided



largely by trial and error. Though his prewar medical training in Japan was conducted largely in German, he trained himself in English so that he could give lectures in English for the courses. Every student of the courses was moved with his wide knowledge and deep insight over tuberculosis spoken in his own plain English. As a member of scientific committees and an editorial board



member of its bulletin for many years, Dr. Iwasaki contributed much to the International Union against Tuberculosis. As Director of RIT, he made the special lecture on the World Tuberculosis Conference of the Union in 1973. As one of the expert committee members of Tuberculosis Unit of WHO, he prepared the 9th report of the committee of 1973 which formed the basis for WHO tuberculosis control policy until recently.

Dr. Iwasaki went through the great changes in the TB situation in pre- and post-war Japan, and was always a great leader in the fight against TB, both spiritually and technically. He trained more than 14,000 doctors, public health nurses, X-ray technicians and

other specialists from all over the country during 50 years. While he was not a brilliant orator, every word of his lectures was so meaningful that students concentrated their attention so as not to miss it. No one



could compete with him in chest X-ray reading, because of his comprehensive pathological background and familiarity with both TB and non-TB conditions. With all of his expertise in the techniques, however, he was more acutely aware of the limits of X-ray diagnosis in tuberculosis control as well as in clinical practice than anyone else. Everyone who was closely acquainted with Dr. Iwasaki was impressed by such a rational and flexible way of thinking. In the same way, he also had a superb sense of epidemiology.

As has been the case for many morphologists, Dr. Iwasaki was a great artist. Finding time out of his busy schedule, he painted many pictures, in oil and in water colors, and left with us a lot of lovely works. Like himself, his art works always warmed the heart. Some of them were used on the cover of "Fukujuji" (Double-Barred Cross), the official organ of the Japan Anti-Tuberculosis Association for some years and were very popular among readers. You can still see him, through his self-portrait in the drawing room in our Institute. He portrayed himself as a stern scientist with a warm heart, which is very true to the man he was.

Toru Mori, MD, Director, RIT



## Her Imperial Highness Princess Akishino Visits Nepal

The National Tuberculosis Centre (NTC) in Kathmandu Nepal was constructed in 1989 with the financial support from the Government of Japan. It is now the headquarters of the National Tuberculosis Programme (NTP), carrying out important activities for controlling tuberculosis.

The TB project by JICA has been operated for 10 years, providing technical assistance to the NTP. The project has been implemented by six Japanese experts with local staff based at the NTC and the Regional Tuberculosis Centre (RTC) in the Western Region.

On 28 February 1997, Her Imperial Highness Princess Akishino, the Patroness of the Japan Anti-Tuberculosis Association (JATA), visited the NTC. Dr. D.S. Bam, ex-participant, and I had a privilege to show her around the facilities. She visited the out-patient department and the TB programme management section of the NTC. As the chief advisor of the JICA TB Project, I made a brief presentation on the tuberculosis situation and how the Japanese project is being carried out in Nepal.



February was a busy month with the NTP evaluation by the international experts from WHO, IUATLD, RIT and other organizations, followed by the National Seminar on TB. But the visit by Her Imperial Highness Princess Akishino made a positive impact and encouraged those struggling to fight tuberculosis in Nepal.

Dr. K. Osuga, Chief Advisor for the JICA Tuberculosis Control Project in Nepal

### TRAINING COURSE REPORT

## Group Training Course for National Tuberculosis Programme Management, FY 1997 (May 12 – June 20, 1997)

It has been a privilege for me to be a part of this Group Training Course with colleagues from all over the world. I have experienced the wonderful hospitality of the Japanese people; the loves, the cares, the humility and the respect they have shown to me, remain deeply engraved in my heart.

To the participants of this course, I have to say; Where would I have found such a diversity of culture, behavior, and accents? Most of all, you made the Japanese lessons enjoyable.

Thank you all. Dozo yoroshiku onegai shimasu.

By Dr. Lorna Nshuti Kijjambu, Uganda



# 1996 TB Laboratory Control Services Course

(Oct 28, 1996 – Feb 16, 1997) by course participants

In October 1996, we traveled from different countries to Japan for the training course in Tuberculosis Control Laboratory Services. This was our first time to understand Japan, her customs and cultures. We found the Japanese language very interesting but difficult.

We will not forget dormitory life, with Sergeant Ito's commands to observe the TV time limit and the curfew. He was very strict but if we followed the rules, he was very good and kind. One day, each of us found a big apple on the table, a present from him and his wife. Now we call them Oto-san (father) and Oka-san(mother).

Living together in the dormitory, we discovered that one of us doesn't know how to cook, wash clothes, or iron. Another lovely mother becomes his teacher, kicking and snapping at him as if he were her own child. He ended up showing the most improvement of all of us!

One of us never forgot to greet the young Japanese girls with a BIG smile. Now he has Takusan (many) girl-friends, while his newborn baby *Narita* awaits his return.

We never forget life in the dormitory where we lived together as a family.

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We all came from different parts of the world but joined as one at RIT in Kiyose where for 4.5 months we interacted with each other. Each one of us is unique in our own way – So much so that even exposure to this new environment failed to conceal it.

There are those who did not leave the comfort of their room for fear of spending money. There were those who were shopping endlessly as though they are returning home the next day. And there were those who just knew how to smile without saying a word when talked to. Anyway, all of us came to understand the word, "jalan-jalan"!

Whatever that was seen and done in Japan, all of us are returning home with one common goal, that is to upgrade our TB lab.



Coming to Japan, our apprehension was changed into security. Four different countries in one group meet three other groups for one objective: controlling tuberculosis with high quality laboratory work.

Autumn to winter makes us on the go. From early morning preparing food, laundry, attending lectures, and performing lab work until the wee hours of the next morning. The computer was tough, but still we have persevered. For four and a half months, the menu changes and still we are able to fight and be the winner to ourselves.

One, an African from Malawi enjoys having discussions with new Japanese friends in Nihongo. One, a religious man from Yemen, is now proud to be a good chef and promised himself to cook a Japanese menu for his family. One, a meek physician from Mongolia is able to communicate with her contagious and beautiful smile. One, a Filipino from Barangay mountain of Cebu city, has mothered us all regardless of nationality.

As the programme drew to a close, all of us gained a good knowledge of TB control through high quality laboratory work. Each of us are returning to our different abode to continue to bring success in controlling and fighting the dreadful Acid-fast bacilli, armed with freshly acquired techniques from RIT-JATA, Kiyose.

# Directors

## No.2

*In this column, the director of NTP (among RIT alumni/alumnae) introduces their activities.*

### Dr. Loekman Hakim Siregar

Chief of Subdirectorates of Tuberculosis, CDC & EH, Ministry of Health (as from 1996), **Indonesia**



NTP was established in 1969. Treating with standard regimens (HRE/5H2R2) achieved a 50-80% cure rate through health centers. The coverage remained low due to many factors such as limited resources available at that time.

After conducting some assessments and participating in a WHO-Indonesian joint NTP evaluation in April 1994, Indonesia organized two demonstration areas in Jambi and East Java provinces to implement WHO strategies. With a

conversion rate of more than 80% and a cure rate of more than 89%, the new strategy was extended to the entire nation.

Indonesia has 27 provinces with 185 million people, residing in 5 big islands and 1,300 small islands with 300 ethnic groups of different local dialects, customs, religions and beliefs. But Indonesian language is used nationwide, and the Indonesian are united under the Pancasila philosophy.

In August 1994, JATA sponsored a TB seminar in Ciloto, West Java. The decision makers in the public sector from all 27 provinces, along with Kiyose alumni, attended the one day seminar. Another mobile seminar was organized by JATA and the Indonesian government at the end of 1996.

In 1995/96 the new strategy was introduced. The basic unit (BU) or health centers group consists of one Puskesmas Rujukan Mikroskopik (PRM) as laboratory referral unit and 3-5 surrounding Satellite Health Centers, and covers 50,000 to 150,000 people. Using this strategy, it is

not necessary to recruit 7,000 laboratory technicians with binocular microscopes. A cross check system is introduced to maintain laboratory quality. In order to serve 7,000 health centers, 1,860 BUs will be developed gradually within 5 years. Centers without satellites (728) are called Puskesmas Pelaksana Mandiri (PPM) and are acting as BU.

Organizing a new TB control strategy is not easy. Good planning is required, and the commitment of decision makers is crucial. They must be made aware that TB is the second most important major disease, and at the same time it is the new reemerging disease.

Training of doctors, nurses and lab technicians is done according to the number of new BU established. WHO training modules were revised, making them simple and easy to use. A single TB manual was developed to replace the old 5-book set, and distributed to all personnel in charge of TB control nationwide.

Procurement of high quality TB drugs at reasonable prices is needed for a national TB programme. The impress system is used to guarantee the availability of drugs in time. Using a buffer stock system ensures no delay in supply, and that no expired drugs exist at most peripheral units. At least four drugs regimens of SCC (2HRZE / 4H3R3 ; 2HRZES / HRZE / 5H3R3E3) must be administered to prevent development of resistant strains and to maintain a high cure rate.

Especially in the first 2 months of treatment, the drugs must be swallowed in front of health workers or volunteers. This DOTS strategy is varied depending on the local area situation.

Records are maintained by PRM. Reporting is prepared at the district level and sent to the provincial level on a quarterly basis.

Routine evaluation followed by corrective action is needed to improve on current performance. To achieve the target of 85% cure and 70% coverage, a multisectoral approach must be conducted with close collaboration between inter-programme and inter-sectoral bodies. This is crucial because at present the NTP coverage is limited to the health centers only.

Interprogram groups include public and private hospitals, clinics, health education units, training center units, food and drug control units, laboratory centers and medical faculty. Intersectoral groups include the Ministry of Home Affairs, the Ministry of Social Welfare, the Indonesian Medical Association, PDPI or chest specialists, and the NGO on TB (Indonesian Association Against Tuberculosis or PPTI).

## Tuberculosis in Low Endemic Countries

### An International Seminar on "Prevention, Treatment and Research"

This seminar was held in Tokyo on 17-18 March 1997 and was attended by more than 400 health staff; doctors, public health nurses and others mainly from public health centres at the front line of tuberculosis control in Japan. The main purpose was to learn from experiences in tuberculosis control in other developed countries where the incidence of TB is already low, and to apply this knowledge to the current and to the future situation in Japan. Speakers were invited from Europe and the USA, as well as from Japan. The main points are summarized below.

#### **"Tuberculosis control programme in low prevalence setting" by Dr. J.F. Broekmans, Director of Royal Netherlands Tuberculosis Association:**

In a low prevalence situation, physicians lose TB contact experience. The general public also becomes ignorant of the disease. Politicians do not care about the disease.

In the Netherlands, the TB control budget is decentralized. Yet the public health people are still responsible for TB control and must maintain the programme for the foreseeable future until TB is eliminated. Thus, the central task is to concentrate experts and assure quality of service in municipal public health centres where preventive and curative



services are available. Collaboration between chest physicians and public health centre staff doctors and public health nurses is important. Most treatment in the Netherlands is self-administered. But some high risk groups such as drug abusers and homeless people require a DOTS system. Health staff must continue to work to attract the interest of the public and to maintain the necessary authority to secure funds for the programme through objective evaluation and advocacy.

#### **"BCG Vaccination in Low Prevalence Countries" by Dr. Eero Tala, Department of Diseases of the Chest, Turku University, Finland**

Even in controlled clinical trials the effectiveness of BCG has varied from 80 per cent to nil. However, the prevailing consensus continues to be that BCG vaccination at birth gives good protection against serious and often fatal forms of childhood tuberculosis.

Consequently, in high prevalence areas of tuberculosis, mass BCG vaccination programmes are indicated, although they have a low epidemiological impact.



In industrialized countries, criteria have recently been adopted to permit cessation of mass BCG vaccination, and the BCG vaccination programmes are being phased out. Only people at high risk are given BCG. At present, evidence is accumulating which demonstrates that tuberculin skin sensitivity and protective immunity are different concepts, and that environmental Mycobacterium interfere with BCG and that BCG revaccination(s) have limited value.

Criteria for and against BCG must be evaluated and decisions made at the local level. Although the current freeze-dried BCG vaccine is an improvement over the previous liquid preparations, a far more effective new tuberculosis vaccine than the existing BCG is needed if the global tuberculosis situation is to be improved by vaccination.





**"New Drugs for the Treatment and Prevention of Tuberculosis" by Dr. Richard J. O'Brien, Chief, research and Evaluation Branch, Division of Tuberculosis Elimination, Centers for Disease Control and Prevention, USA**

**Need for New Drugs:** In tuberculosis control, there are three reasons for needing new drugs (1) to improve current treatment by providing for regimens and treatment schemes which improve compliance, (2) to improve the treatment of drug resistant cases, and (3) to provide for better chemoprophylaxis.

**Drugs Related to Existing Anti-Tuberculosis Drugs :** Rifabutin, rifapentin and KRM-1648 all have a longer half-life and greater *in vitro* activity against *M. tuberculosis* than rifampin does. Rifabutin is approved for tuberculosis treatment in a number of countries and is being evaluated in an international trial for tuberculosis preventive therapy in HIV-infected persons. Experimental studies have suggested that, in combination with isoniazid, a 3-month regimen with weekly administration of rifapentin would be highly effective. It is suggested that KRM-1648, a long-acting rifamycin, might shorten current treatment regimens.

**Broad-Spectrum Antibiotics with Anti-Mycobacterial Activity :** The quinolone antibiotics such as ofloxacin, ciprofloxacin, sparfloxacin and levofloxacin are under clinical trials. Macrolide derivatives, clarithromycin and azithromycin have been approved for prophylaxis against MAC in HIV-infection. However, no macrolide antibiotics with significant activity against *M. tuberculosis* have been identified.

**Conclusion :** Without a significant change in the present environment, progress in new drug development for tuberculosis may continue to be slow. Innovative collaborative relationships between the public sector and individual companies, as well as provision of public funding, are required to stimulate greater private sector interest in tuberculosis.

**"Epidemiological Issue in Tuberculosis in Low Incidence Countries and Challenges for a Research Agenda" by Dr. Hans L. Rieder, Chief, Tuberculosis Division of the International Union Against Tuberculosis and Lung Disease, Paris, France.**

The present trend of the median age of tuberculosis patients shifting progressively to higher ages reflects that the risk of infection has been declining rapidly, sparing younger cohorts from ever becoming infected. As tuberculosis recedes, outbreaks surrounding index cases become increasingly identifiable. Furthermore, differences in disease risk between different population segments become increasingly apparent and allow more targeted interventions.

Incident rate of infection with the human immunodeficiency virus (HIV) has remained low in the general population of most industrialized countries, but is high in certain segments of the population, particularly among injecting drug users. Thus, groups at a particular risk of HIV infection can generally be identified.

**Research Priorities :** If all strains isolated in a society are made available for typing by Restriction Fragment Length Polymorphism (RFLP) techniques, relatedness studies can help to determine the basic reproduction ratio, i.e., the ratio between an index case and the number of secondary cases. If this ratio exceeds 1, an epidemic ensues; if it is less than 1, the epidemic is regarded as in decline, since each case produces less than one secondary case. Such attempts are already being made in the Netherlands and allow a much better appreciation of the dynamics of tuberculosis transmission and epidemiology.

The genome project, i.e., the complete mapping of the entire genome of *Mycobacterium tuberculosis* is well under the way and expected to be completed by the end of the year.

Knowledge of the genome will open numerous avenues for improved diagnosis, for intervention strategies, and for the understanding of virulence. In addition to the above international guest speakers, seven national experts gave lectures on current issues in chemotherapy, BCG, chemoprophylaxis, contact screening, patient follow-up, tuberculosis control in urban areas, and HIV/TB.



## Seminars and Conferences assisted by JATA and RIT Outreach schemes

National seminars and conferences are currently being sponsored by JATA and RIT with their own special funds to promote training and TB advocacy in each country.

### Cambodia

The Annual Tuberculosis Conference and Workshop was held in Cambodia from 24 to 26 February, 1997, sponsored by RIT. Dr.M.Aoki, Dr.Yuthichai Kesetjaroen (Thai), Ms.M.Horie (Medical technologist) and Ms.N.Sasaki (RIT) attended. Nearly 120 participants attended the seminar in Phnom Penh. This seminar was unique in that not only doctors but also the same number of laboratory technicians and provincial health directors were participated. This was made possible by the fine cooperation among Cambodian NTP staff. It was most impressive that First Prime Minister His Royal Highness Prince Ranariddh and Second Prime Minister, H.E. Mr. Hun Sen attended both the opening and the closing ceremonies.

Tuberculosis is one of the top priority health problems in Cambodia. Participants shared problems and achievements of activity through the reporting and presentation of provinces and



Ministry of Health. They were eager in question to Dr. Aoki and Dr. Yuthichai to learn from both lecturers' rich experiences as possible as they can. Laboratory technicians discussed the problems of laboratory services separately from the doctors' group and learned about the importance of quality control.

### Indonesia

The Second JATA International Itinerant Seminar in Indonesia, the One-Day TB Seminar, was conducted on 12 December 1996 at Jaya Ankor near Jakarta. 76 participants attended the seminar, including 14 RIT international training course alumni and non-medical personnel such as World Bank officers. The lecturers were Dr. S. Spinaci (WHO/GTB), Dr. L. Parkkali (IUATLD; Case-finding, case-holding and cohort analysis), Dr. L. H. Siregal (NTP; New policy of NTP in Indonesia), Dr. T. Shimao (JATA; An experience in some countries, How to invite private sector into NTP) and Dr. M. Wada (RIT; SCC). In the seminar, the animation video, "DOTS, Key of Global TB Control Strategy", (supervised by Dr. Shimao) was shown to the participants.





## Vietnam

The Annual Tuberculosis Conference and Workshop was carried out successfully from 17 to 19 February 1997 in Hanoi. The workshop was jointly organized by RIT, JATA and the National Institute for Tuberculosis and Respiratory Diseases (NITRD). 135 doctors and laboratory technicians participated from all over Vietnam, most of whom are working at district / provincial level.

Overseas lecturers were; Dr. T. Mori (RIT; Global TB epidemiology), Ms. A. Fujiki (RIT; Quality control system for smear examination), Dr. Y. P. Hong (KIT, Korea; Principle of TB treatment) and Dr. Pacharee (Chieng Rai Hospital, Thailand; HIV / TB). Other staff included Ms. K. Miyamoto (RIT) and Mr. A. Yoshida (JATA).

On the first day, TB activity reports were presented from different provinces. On the second



day, lectures were given by overseas resource persons separately for medical group and laboratory group. On the third day, an action plan from each province was presented

## Sri Lanka

To assess the current TB control status in Sri Lanka, the government, WHO and RIT conducted a joint review of the National Tuberculosis Programme in March 1997 and held a national seminar to discuss the review results on 24 March, World TB Day.

The review team consisted of Dr. C. Pitigala ( Director, Respiratory Disease Control Programme) and 4 other health staff from Sri Lanka, WHO Consultants; Dr. A.K. Chakraborty, Dr. R. Sarin, Dr. Md Khurshid Alam Hyder, WHO staff, Dr. M.V.H. Gunarathe, Dr. I. Smith and RIT staff; Ms. A. Fujiki and Dr. A. Shimouchi. (Dr. Pitigara, Dr. Hyder and Dr. Smith are graduates of RIT training course.) Chest Clinic and health institution activities were observed at all levels in 3 provinces.

Main findings are as follows: Notification rate is about 32/100,000 with no significant reduction over the past 10 years. Health care infrastructure is well developed, TB drugs are adequately supplied to government health facilities and given free of charge to patients. For all categories of TB patients the standard regimen is 2RHZE/4RH. However, observed cure rates of new smear positive patients was 64%, and the default rate was 14%, which is not as efficient as expected given the current situation.



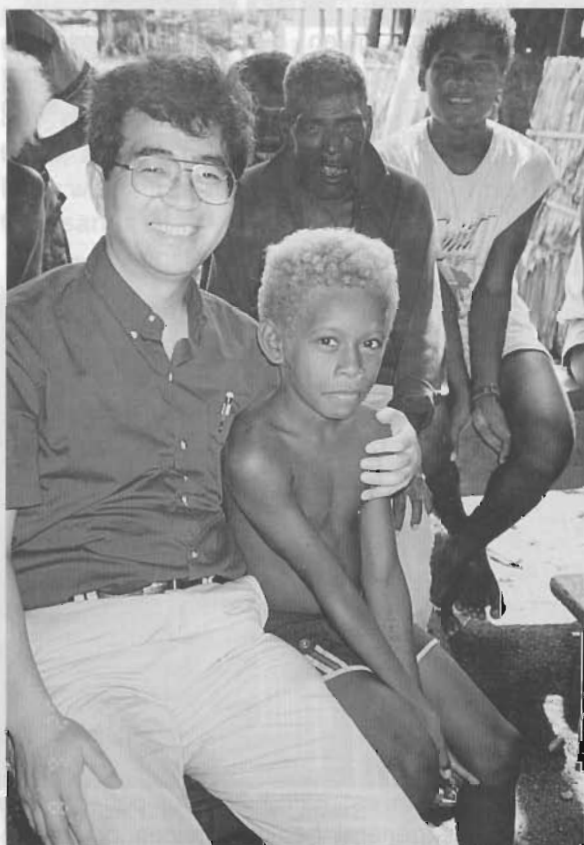
Furthermore, an estimated 35% of patients are managed in the general health services or private sector. These patients are not treated in accordance with national policies, nor are registered. Several improvements could be made. Record keeping was not always adequate or appropriate, and laboratory service quality control was not implemented. The main reasons for these problems are the **lack of supervision and the low priority given to the TB programme**. Main recommendations were (1) Strengthen supervision through creation/filling posts of staff at the central level, (2) Develop a plan for the integration of TB control into the general health services.

# Much Progress achieved in Solomon Islands

## 5 years achievement through the JICA project

Dr. N. Ishikawa

My first visit to the Solomon Islands was in the year of 1989. I worked there as a WHO consultant to review the TB programme. This country consists of small islands at the north east of Australia and east of PNG in the South Pacific. Guadalcanal, the biggest island, is very famous in Japan as the Japanese army was badly defeated there during the Second World War.



The Solomon Islands is a small country with about 300,000 in population. The most serious health problem is malaria, followed by tuberculosis. The number of new TB cases annually has been only about 300. The health infrastructure was fairly well established. I then proposed to JICA a project, expecting a considerable impact on the TB problem. As a result, this TB project was included in the JICA primary health care promotion project (1991-1996).

### TB situation in 1991

In the previous few years before the project started in 1991, the number of new cases of TB had been around 350 (about 130 for smear positive). The incidence rate had been about 100 (about 40 for smear positive)

per 100,000. Although a basic programme had been established with the initial 2-month hospitalisation followed by 7 month ambulatory treatment, the overall treatment completion rate was only 60%.

### Results of the project

Much progress has been made during the past 5 years in the development of a TB control system and in developing human resources.

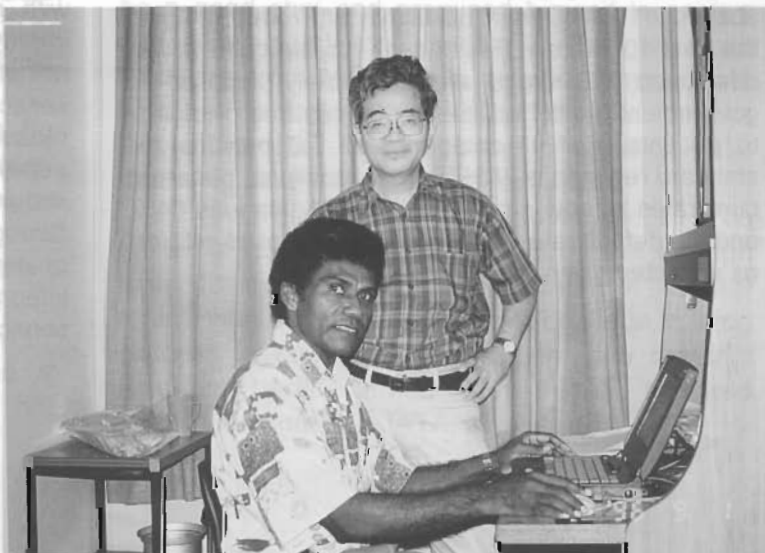
#### 1) Basic surveys:

Just after the initiation of the project, basic surveys were conducted on the initiatives of central NTP officers and provincial TB coordinators;

<Administrative analysis> Several periphery clinics were chosen, and on-going TB services were fully reviewed. Staff knowledge, diagnosis process and treatment procedure, registration, reporting and other TB-related aspects were assessed and analyzed with the local staff. This activity made central unit staff realize the reality of the situation at the periphery, which could not have been understood otherwise.

<Case finding delay analysis> Newly detected patients were interviewed about their process up to diagnosis and treatment. More than half the patients experienced a delay of 2 months or more until diagnosis. Health facility delay (after the initial contact) was longer than patient delay.

<Tuberculin survey> A high case rate of TB suspects among children indicated that the risk of TB infection needed to be obtained. A tuberculin survey was conducted among school children without BCG scars. It was not easy to find unvaccinated children, as number of children was



small and BCG coverage was high. A tuberculin nurse often found only one child eligible for the test after walking a few hours in the bush! The risk of infection was estimated to be 0.75%.

**2) System development for new TB control**

<Demonstration area> The northern part of Malaita (island) Province was selected as a pilot demonstration of a new strategy. Various new approaches such as cough register, early case finding, registration, reporting and improved supervision were tested there under



the name of intensified area project (IAP). Periodic training workshops raised the skill and awareness of clinic nurses. As a result, a model system has been demonstrated with an 85% cure rate and improved case-finding.

This became one step toward national expansion. Some approaches were proved to be ineffective. For example, sputum smearing by clinic nurses proved to be inefficient because the frequency of smearing was too rare and the quality could not be maintained.

<Manuals> Based on trials including IAP in Malaita, new guidelines and manuals for NTP have been developed. They are (1)TB

**Laboratory Manual, (2)A Guide for Health Education to TB Patients, and (3)TB Control**

**Manual.** The last was made after several revisions according to the current WHO policy and framework, and is one of the most significant project accomplishments.

**3) Human resource development** Through this project, some key people have been empowered. They are now working as core human resources for NTP. Some of them are introduced here: **Mr. Kenneth Konare** (in charge of TB/Leprosy/AIDS Control Unit in the Ministry of Health, trained in 1994 control course), **Mr. Joshua Bulolo** (Unit staff, male nurse, trained at RIT in 1995), **Mr. Ben Dede** (in charge of the TB laboratory; trained in 1993 lab. course), **Dr. Alemaina** (Chairman of National TB Committee, trained in 1995 advanced course), **Dr. Pitakaka** (Pediatrician, and a potential future national committee member).

**Perspectives**

The project finished in August 1996 with a reasonably successful outcome. However, true success can be assessed in how long the established system and morale can be sustained



and improved. JICA and WHO must take responsibility for supporting this accomplishment through periodic follow up. RIT will be sending a post project follow up and review team in 1997 to assist the national training workshop.





XI Tuberculosis Conference on AIDS, held in Vancouver, Canada in July '96. Poster presentation on the RIT/JFAP AIDS course was made.

***RIT Home-page has been opened!!***

RIT has opened its home-page last September. Now, you can contact RIT in Kiyose from any place in the world through the internet.

**URL: <http://www.jata.or.jp>**

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**The RIT organization has been changed primarily by renaming departments and divisions. New designations are as follows:**

**Administration Department** : Division of General Affairs, Library and Information Management Div.

**Department of Basic Research** : Molecular Pathology Div., Immunology Div., Bacteriology Div., Radioisotope Study Div.

**Department of Applied Research** : Epidemiology Div., Clinical Research Div., Data Analysis Div.

**Department of International Cooperation** : Manpower Development Div., Project Development & Management Div.

**Department of Education and Training** : Medical Doctors Training Div., Radiological Technologists Training Div., Public Health Nurses Training Div.

Mr. H. Honda  
To JATA head office  
Mr. T. Yoshida  
To Daiichi Dispensary

**♣Promotion:**

Ms. T. Yamashita  
To Head, Dept. of Education and Training  
Dr. A. Shimouchi  
To Deputy Head of International Cooperation Department  
Ms. Y. Kazami  
To Chief, Library and Information Management Div.  
Dr. Y. Komatsu  
To Chief, Manpower Development Div.  
Ms. M. Ohmori  
To Chief, Data Analysis Div.  
Ms. N. Kobayashi  
To Chief, Public Health Nurses Training Div.

**Staff News**

**♣Welcome:**

Mr. N. Onozawa  
To Administration Department  
Ms. Y. Egawa  
To Administration Department  
Ms. N. Nakata  
To Department of Applied Research

**♣Farewell:**

Dr. M. Matsuda  
To University of Shizuoka  
Ms. K. Miyamoto  
To JATA Head Office

*Your news and voices are always welcome!*

**NEWSLETTER FROM KIOSE**

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