We are very pleased to tell that the RIT has been granted the Foreign Minister’s Prize 2014 for its contribution to global human development through the international training courses for the last 52 years. Let us be delighted together with all alumni for this honorable event.

The international training course at the RIT in Kiyose City started in 1963. The courses have gained global fame for many reasons, including the high quality content of the curriculum with competent teachers and facilitators, and also the great contribution to the global fight against TB by the course participants all over the world. The number of participants trained for TB control now is now 2246 from 97 countries. Many of them continued and are still continuing working for TB. Some have been promoted as Director of Health, and three became Minister of Health in their countries.

Since the 1930s, Kiyose, a small town, has become a center of TB care and research in Japan. During the 1940s and 50s, before effective chemotherapy was available, over 5000 patients a year were hospitalized in Kiyose, a town whose inhabitants numbered only 20 thousand. Due to its good geographical location not far from the center of the Tokyo Metropolis and its natural environment with large woods, the town was suitable for TB treatment and over 13 sanatorium and health institutions including RIT were built one after another.

Most of the TB institutions have changed their primary area of work to meet with the current health and social needs, including rehabilitative or geriatric care. Universities and Colleges for Nursing, Social Services and Pharmacology have been constructed. The key mission which has been Kiyose’s culture for caring for the sick and handicapped has been maintained.

Kiyose is now known as an international town for her commitment to international cooperation, mainly through the international training courses by the RIT. Kiyose International Club is active, and citizens organize various events welcoming the foreign visitors including the RIT course participants.

Kiyose has developed because of humans who suffer, fight and overcome life threatening diseases, and because of successful efforts to achieve the betterment of health in the world. Kiyose city has been committed to global peace, having declared a Nuclear Free Local Authority since 1982.

Mr. Shibuya, Mayor of Kiyose City, together with groups of citizens, has currently started a campaign aimed at making Kiyose a World Cultural Heritage Site as a health and peace promoting town.

The RIT Alumni are all welcome to join in this movement and let us enjoy our partnership which started from a tiny town.
All We Need to Know in Public Health, We can Learn from Tuberculosis Care

Akihiro Seita,
Director of Health
UNRWA (United Nations Relief and Works Agency for Palestine Refugees in the Near East)
Headquarters, Amman, Jordan

One year ago, I wrote an editorial with the title: “All we need to know in public health, we can learn from tuberculosis care: lessons for non-communicable disease.” After working in tuberculosis care for more than 20 years, this provocative title represents my candid feelings about the universality and transferability of the TB care approach to other public health issues – particularly in non-communicable disease (NCD) care.

My history working in TB care dates back to 1987, when I first joined the Research Institute of Tuberculosis (RIT) in Tokyo, where I worked until 1995. While at RIT, I traveled to Yemen for the JICA tuberculosis project, living there from 1990 to 1993. After my tenure at RIT, I began at the WHO Regional Office for the Eastern Mediterranean in Cairo in 1995, where I stayed until joining UNRWA in 2010.

I was fortunate enough to be involved with TB care at a very exciting time, witnessing the birth of DOTS in the early 90s, which fundamentally changed not only the public health community’s approach to TB care worldwide, but more importantly, the way we think and work on massive public health issues.

Prior to DOTS, there was no universal approach to TB care; every practitioner had their own terminology and their own methods. Today, because of DOTS, we have a standardized, global strategy, common targets and indicators. To those of you wondering what relevance this 20 year old story has in today’s world, with a drastically different burden of disease and patient profile, I challenge you to make a list of how many health programs can answer these two simple questions. Once more, your list will likely be short. In fact, worldwide, many countries know how many NCD patients they have, but very few are able to track what happens with them.

One of the most important questions to tackle a public health problem that we asked while developing the DOTS approach. In the early days of DOTS, we continued to ask one simple question: “What are the priorities in this public health issue?” Our answer was clear: patients, their care, and finding a cure. Curing patients is, after all, our goal. However, to cure patients, we need health facilities with diagnostic, treatment and reporting capabilities. How could we do that for TB patients at health facilities? We found our answer in DOTS.

We used this same approach at UNRWA. “What is the most important issue among UNRWA patients?” Our answer was clear: non-communicable diseases. NCDs account for 70% of all deaths among Palestine refugees. Caring for and curing NCDs is our goal in this situation. UNRWA has 138 health centers, so our question was: “how do we care for NCD patients at our health centers?” We have found our answer in the Family Health Team (FHT).

Prior to reform, care was fragmented, siloed, and inconsistent. Care did not take a lifestyle and behavioral approach; rather, it was reactionary and consisted of providing treatment for already existing health issues. The FHT approach means that now, each refugee family has their own family care team composed of a doctor and a nurse which provides consistent and continuing care to the entire family, mimicking the relationship I have with my doctor. This approach is particularly relevant in NCD care, as prevention and treatment is lifelong and multifaceted. So far, health reform has been a success! Our first two health centers implemented FHT in 2012, and today, more than 80 health centers are implementing FHT.

Another fundamental question asked during the early days of DOTS was: “how many patients do we have, and what happens to them?” We used the cohort analysis tool to find our answer, which was brilliant, given its success. Again, I ask you to make a list of how many global health programs can answer these two simple questions. Once more, your list will likely be short. In fact, worldwide, many countries know how many NCD patients they have, but very few are able to track what happens with them.

(Continued to page 3)
Experience of a New POC NAT Method for Diagnosing TB in Haiti

Toru Mori,
Director Emeritus

Taijin Kaku,
Ishibashi Clinic, formerly Mycobacterial Reference Laboratory, RIT

In January, 2010, the Republic of Haiti was attacked by a great earthquake of magnitude 7.0 that seriously hit the capital city and surrounding areas. The National Sanatorium of Port au Prince in the city, as well as the National Sanatorium of Siguenau, were totally destroyed. After the disaster, Dr Mori and Dr Kaku visited Haiti in early 2011. We met our ex-participants from Haiti, i.e., Drs Richard D’Meza (then NTP Manager, Advanced 1987) and Madge Dorcelus (NTP officer, Control 2009), and discussed what should be done to restore the affected TB control activities of the country. We agreed that it would be to strengthen case-finding with the use of a new technology that was more sensitive than the conventional smear microscopy, i.e., the LAMP method (Eiken Chemicals, Tokyo). This is a point of care technology of nucleic acid amplification (NAT) that is very user-friendly, requiring no high skill in molecular technology.

The system had been tested at RIT and it had been shown that the sensitivity against smear-negative and culture-positive cases was 56% which was comparable to the Gene-Xpert. The system has been already approved in Japan for routine use. On our next visit in late 2011 we brought two sets of LAMP-TB systems with an adequate number of kits. The tool was tested in two hospitals by the local laboratory technicians after a training of only 3 days. They had had no experience at all with NAT, but they easily became familiar with the procedure of this new test. The test was performed with the specimens that were used for routine sputum microscopy for diagnosing TB in normal daily services. The time spent to complete one test was about one hour.

During several weeks a total of 440 specimens were tested for diagnosis. Among them there were 86 smear-positive cases compared with 100 LAMP-positive ones. This means that the use of the LAMP method could increase the case yield by 16%. At the same time 2/86 smear-positive and LAMP-negative cases could be cases with non-tuberculous mycobacteria. This pilot test was expanded to another two hospitals, where different groups of patients including children, extra-pulmonary cases, and HIV positive cases.

Having done the pilot test as described above, in 2013 we proceeded to a more rigorous trial to determine the performance of this new technology in the Haitian setting, i.e., comparison of LAMP with culture examinations as well as with smear microscopy, so that the findings could be applied more widely to the high burden settings of the world. The trial has confirmed the previous results; sensitivity against smear-positive cases was 99.1%, and that against smear-negative and culture-positive 51.2%, and specificity against smear- and culture-negative cases was 99.0%.

With its high performance and user-friendliness as described above, the LAMP TB could respond to the demand of the post 2015 Global TB strategy in strengthening case-detection. It is our sincere hope that this new POC technology will be widely employed in Haiti and other high-burden countries to further enhance the TB control programme.

At NTP office, Mori (left), D’ Meza, and Kaku (right)

(Continued from page 2)

Once again, taking a page from TB and DOTS, we introduced a cohort analysis element to our NCD care through our e-health system (electronic medical records), introduced in 2009, and one that we hope will be another brilliant success. This allows us to track how many patients we have, how many come for care regularly, and how many patients have their diabetes under control. To our knowledge, it was the first large scale adoption of a cohort analysis approach to NCDs. To date, we have published six scientific papers on this approach, and our cohort analysis was featured in the Lancet.

While my experience in PHC and NCD care and control is still quite limited, I am convinced that in the history of TB care, we have discovered a universally applicable approach to today’s biggest public health problems. After all, I do not think it is a coincidence that the President of the World Bank and the Director of the United States Center for Disease Control and Prevention are known for their expertise in TB care.

1 Seita A, Harries AD, “All we need to know in public health we can learn from tuberculosis care: lessons for non-communicable disease”, INT J TUBERC LUNG DIS 17 (4): 429-430
2 United Nations Relief and Works Agency for Palestine Refugees in the Near East
Prevalence Surveys of TB -Some of the Lessons Learnt-

Norio Yamada,
Director,
Center for Int’l Cooperation and Global TB Information

Reduction of prevalence of TB disease by 50% from 1990 to 2015 is one of the Stop TB partnership targets. Prevalence surveys aim at measuring prevalence of bacteriologically-positive pulmonary TB diseases directly. It is recommended that taking into account feasibility, TB cases to be targeted in prevalence surveys be limited to pulmonary TB cases among the non-child population (age 15 years or over). In prevalence surveys, TB screening is carried out for the general population at survey sites selected by sampling methods. TB screening consists of interviews of symptoms and CXR examination. From participants with either TB symptoms or CXR abnormal shadow, sputum specimens are collected and examined with both smear and culture examination. This TB diagnostic strategy is recommended to identify bacteriologically confirmed cases accurately regardless of severity. To carry out a prevalence survey with standardized methods, the WHO Global Task Force on Impact Measurement has developed the technical handbook with partner agencies including RIT/JATA.

While the primary objective of the prevalence survey is measuring prevalence, it has been recognized that surveys also provide information useful for assessing the effects of TB control and developing future strategies for reducing TB. In this article, I would like to focus on this aspect mainly by utilizing findings from prevalence surveys for which RIT/JATA provided technical support.

1. What type of TB cases are dominant in prevalent cases?

Figure-1 shows prevalence of bacteriologically-positive cases by smear status. It shows that smear-negative culture positive cases are much more than smear-positive cases. It is different from situations in clinical settings where TB patients with typical symptoms are common. This might indicate that it is necessary to do early case finding to reduce prevalence of TB more rapidly, and that diagnostic tools more sensitive than smear examination, such as CXR and molecular diagnosis are required.

2. Health seeking behavior: Where are TB cases missed by the NTP? What is likely to be related to delayed diagnosis?

WHO estimated that CDR for all forms of TB was 64% in 2013. This indicates that it is necessary for us to know where one third of cases are, which are missed by the NTP. The prevalence survey may be able to provide some hint regarding this question. Interviews about facilities for previous TB treatment and common facilities for seeking care for chronic cough are usually included in prevalence surveys. In Myanmar, the national prevalence survey in 2009/2010 shows about 20% of participants mention the local pharmacy as a place to seek care. Based on this finding, the NTP and JICA established a model area of referral system of presumptive TB from the local pharmacy to NTP diagnostic facilities.

3. Effects and limitations of basic DOTS strategy

Prevalence surveys were carried out in 2002 and 2011 in Cambodia. During the period between the two surveys, DOTS was expanded widely by introducing it at the health centre level. Before this expansion, TB control service at health centres was not available. Therefore the change in prevalence of TB should reflect at least partly the effects of improved access to TB control service based on DOTS. Both smear-positive and bacteriologically-positive cases declined significantly. When we see the change in prevalence of smear-positive cases by symptom status, prevalence of smear-positive TB cases with typical TB symptoms is reduced by 56 % while prevalence of those without non-typical symptoms decrease by only 7% (Figure-2). This might indicate that the DOTS strategy based on passive case finding contributes to reduction of prevalence of symptomatic cases. However the finding might also indicate some innovation for early case finding is required to reduce prevalence more rapidly.

Figure-1 Prevalence of bacteriologically-positive TB by smear status

Figure-2 Prevalence of smear-positive cases by symptom status, Cambodia, 2002 and 2011

References:
We should thank you and congratulate you on the last issue of News Letter from Kiyose, No.29, February 2014, that introduces the post-2015 global TB strategy (now labeled ‘End TB strategy’).

We feel like taking this opportunity to dispel some of the misgivings about the “disappearance of DOTS” from the End TB strategy as expressed there.

In order to prompt countries to tackle major problems like TB/HIV and MDR-TB which were not addressed under the DOTS strategy, DOTS had to evolve into the Stop TB Strategy. And now, the major global concerns of stagnating TB case notification and too slow a decline in TB incidence require its further progression to the End TB Strategy. To package all the components in a manner that is easy to communicate (which was a strong point of the DOTS strategy), the original five components of DOTS and the six components of the Stop TB Strategy had to be dispersed under the three pillars of the new strategy. Thus, the first component of DOTS – government commitment – is now expanded significantly in the form of Pillar 2. In addition, government stewardship, M&E, community engagement, ethics and human rights which are essential across all the components of the strategy are now the cross-cutting principles. Early diagnosis, treatment of all forms of TB and patient support (which incorporates much more than simply DOT) along with prevention are all covered under Pillar 1 while Pillar 3 is all about research.

We would like to reproduce a paragraph from the End TB strategy document which builds on DOT and goes beyond. DOT was perceived by some as authoritative, mechanical supervision of patients while they swallow the medicines. We therefore wanted to stress the need for support along with supervision, as in the text below:

“Build patient-centred support into the management of tuberculosis. Patient-centred care and support, sensitive and responsive to patients’ educational, emotional and material needs, is fundamental to the new global tuberculosis strategy. Supportive treatment supervision by treatment partners is essential; it helps patients to take their medication regularly and to complete treatment, thus facilitating their cure and preventing the development of drug resistance. Supervision must be carried out in a context-specific and patient-sensitive manner. Patient-centred supervision and support must also help identify and address factors that may lead to treatment interruption. It must help alleviate stigma and discrimination. Patient support needs to extend beyond health facilities to patients’ homes, families, workplaces and communities. Treatment and support must also extend beyond cure to address any sequelae associated with tuberculosis. Examples of patient-centred support include providing treatment partners trained by health services and acceptable to the patient; access to social protection, use of information and communication technology for providing information, education and incentives to patients; and the setting up of mechanisms for patient and peer groups to exchange information and experiences.”

You will probably appreciate that we could not have continued to use the label DOTS and package it with very different components essential today to address the problem of TB. As you rightly say, the fact remains that all activities under DOTS will have to continue, and more need to be added to achieve what we hope to achieve. The picture below depicts the logical evolution of DOTS into the Stop TB and then the End TB strategy.
Update on the Current Training Course
-Active participation of alumna/alumnus as a facilitator-

Susumu Hirao,
Center for Int'l Cooperation and Global TB Information

The 2014 “Training Course in Strengthening of Tuberculosis Control toward MDGs and TB Elimination” was held at RIT for 12 weeks from 12 May to 1 August, 2014. Nineteen participants attended the course from 13 countries: Afghanistan, Cambodia, China, Kenya, Mozambique, Myanmar, Pakistan, Papua New Guinea, The Philippines, Sudan, Zambia, Zimbabwe and Japan. The course was funded by the Japan International Cooperation Agency with substantial support from various partners: the United States Centers for Disease Control and Prevention, and the World Health Organization. The participants received a wide range of lectures under 4 broad categories: TB epidemiology, TB clinical and laboratory management, international TB strategy and operational research (OR) proposal development. All of the participants devoted themselves to the course, and through this course they improved remarkably in their capacity to assess their current TB program. During the course, they also participated in study tours, traveling to Osaka, Kyoto and Iwate. During their stay in Iwate, they visited Yamada town where the catastrophic tsunami hit. The Imperial Highness Princess Akishino, Patroness ofJATA, invited the participants to meet her and discuss with her their work and life in Tokyo.

One of the special aspects of this year is inviting one alumna or alumnus as a facilitator. This year, Dr. Enos Okumu Masini, 2010 alumnus from Kenya was selected and he played an important role in the protocol for developing the participants’ OR. He also gave 4 mini lectures entitled “self-introduction and presenting OR”, “how to be a good presenter”, “developing clinical guidelines” and “how to prepare a paper for publication”. He supported not only protocol development but also the advising of participants.

The next course in 2015 will include a plan to invite one alumna or alumnus as a facilitator like this year. The course director will send emails to alumni from 2007 to 2013. Applicants are requested to meet all three conditions below:

1. Actual achievement of your operational research: You have finished your operational research, and your work has either been published or accepted in an international journal.

   Publications in local journals or international academic conference presentations (i.e. at the international Union conference) may also be considered.

2. You have continued to work for the National TB Program after you completed our JICA training course.

3. You can expect permission from your supervisor to travel.

The organizers hope that the course has helped the participants to update their knowledge of TB and basic epidemiology and obtain knowledge and skill in research especially operational research. The facilitators are also thankful for the good cooperation of the participants during the tutoring sessions. It was a privilege to work with them.

Finally, we hope that the participants in this course work well, contribute to their National TB Program and finish their operational research successfully.

<table>
<thead>
<tr>
<th>Country</th>
<th>Operational research proposal title</th>
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<tbody>
<tr>
<td>Afghanistan</td>
<td>Exploring the role of TB awareness raising events on knowledge, attitude and practice among women of reproductive age on TB in Afghanistan</td>
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<tr>
<td>Cambodia</td>
<td>Implementation and associated outcomes of a new TB diagnostic algorithm in Kampong Thom Province, Cambodia</td>
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<tr>
<td>China 1 (c/p)</td>
<td>Reasons for defaulting from multi-drug resistant tuberculosis treatment in Hebei Province</td>
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<tr>
<td>China 2 (c/p)</td>
<td>Factors associated with TB patients’ delay in seeking diagnosis among internal migrants in China, 2012</td>
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<td>Kenya 1</td>
<td>Delay in MDR TB treatment initiation in Kenya</td>
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<td>Kenya 2</td>
<td>Factors contributing to high mortality in TB/HIV co-infected patients in Kisu County, Kenya</td>
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<tr>
<td>Mozambique</td>
<td>Impact of community-based systematic contact screening on TB notification in Mozambique: an interventional study</td>
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<tr>
<td>Myanmar</td>
<td>Impact of TB mobile team on early case detection and TB treatment outcome in Magway township</td>
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<tr>
<td>Pakistan</td>
<td>Delay in initiation of Treatment for MDR-Tuberculosis patients at Fatima Jinnah Chest &amp; General Hospital Quetta</td>
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<tr>
<td>Papua New Guinea</td>
<td>Factors associated with high default rate among new sputum smear positive cases registered in national capital district, Papua New Guinea, 2013</td>
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<tr>
<td>Philippines</td>
<td>Private practice in Cordillera, Philippines: A peek into their current practices on TB management</td>
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<td>Sudan</td>
<td>Survey on knowledge, attitudes and practices on TB case management among private medical practitioners in Nalya City, South Darfur State, Sudan.</td>
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<td>Zambia</td>
<td>Mortality among smear positive pulmonary TB/HIV co-infected patients enrolled for care in Eastern Province, Zambia.</td>
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<td>Zambia</td>
<td>Assessment of factors associated with defaulting rate among new pulmonary TB patients in Mpika district, Zambia</td>
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<td>Zimbabwe</td>
<td>To evaluate the magnitude of TB management by private practitioners in Manicaland Province, Zimbabwe</td>
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<td>China 3</td>
<td>Risk factors of the previous treatment default in MDR-TB patients in Shenyang city</td>
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<td>Japan 1</td>
<td>Impact of Mycobacterium tuberculosis infection on Japanese expatriates</td>
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<td>Japan 2</td>
<td>Assessment of the TB diagnostic process associated with low case detection in South Sudan</td>
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<tr>
<td>Japan 3</td>
<td>The impact of supportive supervision on quality improvement of tuberculosis smear microscopy in Kinshasa, Democratic Republic of Congo</td>
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Japan has always been the place where the TB laboratory staff is aiming to be trained. And being part of the National TB Reference Laboratory, where almost all laboratory procedures have been taught and performed, I was excited to see, “What more does Japan have to offer for me?”

In our first week in TIC, where we had our orientation to the JICA program, I was astonished with Japan’s rich culture, traditions, political and economic system, as the speakers fervently introduced them to us. The journey to learn more of TB laboratory techniques happened in the Research Institute of Tuberculosis. For 10 weeks, TB laboratory specialists shared their expertise through giving comprehensive lectures coupled with hands on training on AFB microscopy, culture, DST and the new diagnostic tools. The sessions on Biosafety, Project Management Cycle, Microteaching and development of an Action Plan were ones that I found exciting. But what I really appreciate most is the way the training was managed. Concise yet complete in essence; multifaceted yet systematically approached.

The excitement continued with the different “out-of-school” activities such as our Japanese class, Kiyose events set by the Mayor for us and the Home Stay experience with the Hippo Club, that make us feel part of a Japanese family; the tours in Hiroshima (Peace Memorial Park and Radiation Effects Institute), Osaka, Kyoto and gazing at Mt. Fuji while riding on the Shinkansen Bullet Train…were truly awesome!

Now I’m coming up with the conclusion...Japan has so much more to offer; not only technical skills but interpersonal development among colleagues with the same goal: to combat TB.

On behalf of all participants from Afghanistan, Bangladesh, Cambodia, Kenya and Myanmar, my heartfelt thanks to Matsumoto-san, Narita-san and Nok-san, for imparting their knowledge and skills; to Takarai-san for being our mother during our stay and most of all to the RIT/JICA team for this great opportunity and the memorable experience we had.

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- Excerpted from the address at the closing ceremony-

I feel honored to give the closing ceremony speech on behalf of the participants. Today’s event reminds me of 82 days ago being in this same place gathered for the opening ceremony. At that time the whole course seemed like it would take ages but as I stand here today and look back it seems like just last week that we came here. I would like to extend my gratitude to the RIT staff for the wonderful input throughout the course, what we have learnt and the knowledge we have amassed cannot be understated. To JICA and Japanese government for affording us this opportunity we are indeed grateful. Many thanks to the Mayor and citizens of Kiyose city for welcoming us into their wonderful city. The experience of Japan and Japanese culture has been incredible in Kiyose, our home away from home.

Let me also take this opportunity to extend my congratulations to my fellow participants for completing this course successfully. When we started it seemed like we were beginning a long journey but as I stand here I realize that actually today is the beginning of this journey. Let me encourage my colleagues by saying this: it has been said that the beginning of success is when we implement the knowledge that we have. What we have learnt, may we implement back in our countries as long as it is feasible and applicable to our settings.

I would like to take this opportunity to say thank you to the Course Coordinator Takarai-San. You made life for us here in Japan easier and you made sure we were well taken care of. Farewell to Japan, to RIT staff and JICA staff. My fellow participants, let's keep in touch. I wish you safe travels and a happy reunion with you family, friends and loved ones. May God bless you all. Goodbye. Mufambe zvakanaka (go well).
Message from New Course Director
Susumu Hirao,
Center for Int’l Cooperation and Global TB Information

Dear all,

In 2014, I was assigned to be a course director of the TB Control Course. To the readers, almost all of you do not know me because I started working at RIT from 2011, just after attending the course in 2011. For this reason, I would like to introduce myself.

After graduating medical school in 2000, I worked as a chest physician after finishing residency in University Hospital for 2 years. From 2002 to 2003, I worked at Fukujuti hospital next door to RIT. In 2005, I entered Liverpool School of Tropical Medicine in England for a master’s course of tropical medicine. During that time I went to Nigeria for my master’s thesis. I compared same day smear method and WHO method for diagnosing pulmonary TB by sputum smears. I received a Master’s degree in 2006 and went back to Japan for a PhD course. In 2009, I received my PhD degree with the thesis title “The effect of clarithromycin on the inflammatory response caused by Mycoplasma pneumoniae extract”. After that I continued working as a chest physician and saw not only TB patients but also respiratory diseases patients. In 2011, I participated in the training course and started working as described above. I was assistant course director in 2012, co-course director in 2013 and course director in 2014.

My specialty is chest X-ray interpretation. I had lectures in Bangladesh, Cambodia, Myanmar, Nepal, Zambia and Japan. I am making self-study material for chest X-ray interpretation. I hope to have finished it when you read this letter.

I went and will continue to go to many countries for business trips, for example Bangladesh, Cambodia, Nepal, Zambia and the Union conference. If you see me somewhere in the world, please feel free to talk to me.

Dr. Osada died, succeeded by Prof. Kudoh

Dr. Osada died, who was the Chairman of the Board of Directors of JATA, passed away in March 2014 at the age of 74 due to gastric cancer. He had taken the initiative in improving and reorienting JATA as a health promoting organization and also

You are welcome to send us your news and voices!

NEWS LETTER FROM KIYOSE

Publisher: N.Ishikawa, Director
Editor: N.Yamada, T. Kubota

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Dr. Norihiro Umemura, who was RIT course director from 1986-1988, passed away in October 2013. He committed his life to international cooperation particularly for Nepal where he worked through the JICA project and on his own. According to his bereaved wife Michiko Umemura who donated the inheritance to RIT/JATA, the Dr. Umemura Memorial Fund has been set up at RIT for the activities in research and programs including the work for Nepal.

Umemura Memorial Fund Set up

Dr. Kuniko Murakami, Ms. Yuka Inoue
Newly joined/back to RIT/JATA:
Mr. Shigeo Kobayashi, Ms. Noriyo Shimoya, Mr. Takashi Miura, Mr. Akira Watanabe

Overseas office:
〈RIT/JATA, Zambia〉 Ms. Yukari Takemura
〈RIT/JATA, Cambodia〉 Mr. S. Kobayashi
〈JICA project, Kenya〉 Mr. T. Miura

Staff Movements

Left RIT/JATA:
Dr. Kuniko Murakami, Ms. Yuka Inoue

You are welcome to send us your news and voices!