Letter from the Director

RIT Steps toward End TB

Nobukatsu Ishikawa, Director

RIT is taking steps to strengthen its functions and capacity in operational research, innovation, new tool development, and an integrated approach to MDR-TB and LTBI, in response to the recommendations made by the external review and the End TB strategy. Discussions have also been made for the component of Universal Health Coverage (UHC) and Health System Strengthening (HSS) related to the TB control programme. We are sure that TB Control is a crucially important component of UHC and can contribute to strengthening the health system. We are documenting how TB control has contributed historically to the development of UHC and HSS in Japan.

Another topic on which I personally focus is participation or engagement of the patients.

In this regard, I would like to introduce the story of a TB patient named Shigeru Asahi (1913-1964) who was admitted to a national TB hospital in the 1950s with advanced disease. He was receiving 600 yen (then about US$1.75) monthly as a living allowance from the government in addition to free meals and medical treatment. The system of caring for TB patients had been basically set up, but was still inadequate. The allowance was unreasonably inadequate for a patient to maintain the minimum standards of healthy and cultured living guaranteed by the Constitution. After various actions to improve his miserable situation, he finally appealed his case to the Minister of Health and Welfare. During his final appeal to the Supreme Court, he died and was eventually defeated legally, though the case was strongly supported by the Patient Alliance and political parties. However, through his continuous appeal over 6 years, minimum necessities for a patient were examined in detail and afterward many amendments were made to the application of the Livelihood Protection Law for individuals. This was a historical achievement in the history of social welfare in Japan. It means that the Asahi case resulted in a success.

We still remember Malala Yousafzai, a young Pakistani, who had been shot in the head by a gunman but survived, and later received the Nobel Peace Prize in 2014. Her speech at the UN meeting is worth remembering: “One child, one teacher, one book and one pen can change the world”. I would add that one patient can change the world. Asahi, a victim of the epidemic and a weak and poor patient confined to bed, contributed to the advancement of a welfare society in Japan with full support of civil society.

We are often ignorant of the real needs of patients in their living and need to continuously learn from the patients and support their battles. We need to fight together with them to end TB. (Photos: Shigeru Asahi and his Chest X-ray)

End TB or Endless TB?

Kosuke Okada, Director, International Programs
JATA HQ

A new global TB strategy called “the End TB Strategy” sets quite an ambitious target for 2035: that the current TB incidence rate should be reduced to less than 10 cases per 100,000, which means a 90% reduction in the next two decades. It aims at TB Elimination, with 1 case per million by 2050. As milestones to achieve this target, annual rates of decline in incidence should be 10% per year, through optimizing current tools and pursuing universal health coverage and social protection for 2025. In addition, the reduction rates should be accelerated to 17% after 2025 by rolling out the use of new post-exposure vaccines and new anti-TB drugs.

It is true in theory that the targets could be achieved if the same TB control measures as in Western Europe or Japan after World War II are taken, but in these cases such rapid decline
rates were observed as a result of thorough implementation of the measures by concerted efforts in limited regions or countries. The End TB Strategy depends entirely on similar measures being taken all over the world.

I would like to take the example of Cambodia where RIT/JATA has long been working for NTP as an example to think of when considering the epidemiological impact of TB control (Figure). Starting with the introduction of the DOTS Strategy in hospitals where most of the smear positive patients were admitted for 3 months in 1994, NTP in Cambodia decentralized DOTS services to health centers from 1999 to 2005 so that around 1,000 medical facilities including 853 health centers could provide diagnosis and treatment for TB. As a result, the number of TB cases notified by NTP peaked in 2005 and declined gradually. In addition, according to two nationwide TB prevalence surveys in 2002 and 2011, a reduction by half in the prevalence rates of bacteriologically positive TB was observed (Bull. World Health Organ. 2014; 92: 573–581). In particular, the reduction in prevalence of TB cases with typical TB symptoms was significantly reduced compared to that of TB cases without symptoms. Yet, an annual rate of decline in incidence was estimated at only 4% by WHO. Cambodia had a population of 13 million at that time and an area of 180,000 square kilometers; roughly dividing by the number of 1,000 medical facilities, one DOTS health center served a population of 13,000 and 180 square kilometers. Other than Cambodia, were there any high-burden TB countries which have rapidly and intensively established many DOTS centers in the whole country? Cambodia is still using smear microscopy as the major diagnostic tool for TB, even though it is not the most sensitive method and it detects only a portion of the larger TB problem. However, Cambodia has tried to expand its TB services by providing good access to health centers and providing treatment services free of charge. In spite of this, there has been at most a 4% decline in TB incidence. It would seem that it is not easy to attain a 10% annual decline as targeted for 2025 in the End TB Strategy. In particular, the decline in prevalence in the middle-age and the elderly among whom recurrence or reactivation is usual was smaller than that in the young, which is quite similar to Japan where we are currently struggling with TB control in the elderly.

The End TB Strategy aims at delivery of services available to all TB patients through attaining universal health coverage. However, another issue revealed in the prevalence surveys was that 40-70% of bacteriologically positive TB cases did not present typical TB symptoms such as cough for more than 2 weeks. Although they may not be highly infectious, they may remain undiagnosed in the community until they seek medical care by themselves due to their worsening symptoms.

A further limitation of the current strategy is also shown in the prevalence survey in Cambodia, 2011; 90% of presumptive TB participants in the survey answered that they had taken some action to seek medical care including consulting private practitioners. This fact implies that we usually begin to seek medical care when we become aware of our bad health in this day and age when some medical services are readily available. Unfortunately however, according to the survey 52 (5.5%) of 951 persons who had consulted public health facilities were newly diagnosed as bacteriologically positive TB. Above all, what we should do at medical facilities is to provide correct diagnosis for these patients by taking advantage of their health seeking behaviors. To do so, I am wondering if we should widely use more sensitive diagnostics than smear microscopy, such as actively using chest radiography for screening purposes because of its high sensitivity. Furthermore, as can be seen in many countries, most presumptive TB cases visit private care providers with good accessibility so public-private partnership for TB control should be strengthened to detect TB at an earlier stage.

It is a long and arduous road ahead of us to end the TB epidemic, but it is not impossible to achieve our targets, if we promote these things; 1) to ensure the early diagnosis of TB for presumptive TB patients who complain of respiratory symptoms and seek care at public or private medical facilities including community-based programmes 2) to promote patient referral from private to public care providers by strengthening public-private partnership in TB control, and to support strengthening of the diagnostic capacity in the private sector if necessary, and finally, 3) to strengthen active case detection in high risk groups including asymptomatic persons.
Eliminating Catastrophic Patient Costs due to TB
Working towards Zero Suffering

Nobuyuki Nishikiori,
Coordinator, Stop TB and Leprosy Elimination
World Health Organization Regional Officer for the Western Pacific

Focus on the suffering of patients

As a public health response to the TB epidemic, previous global TB strategies have focused on the epidemiological control of TB. However, after the progress in reducing the TB burden over the last few decades, we must expand our focus beyond epidemiological indicators to also encompass consequences of the disease including the suffering of our patients. TB patients suffer from the disease in a multi-faceted manner: physically, mentally, spiritually and socio-economically. It has been a challenge, as well as a dream, for all TB care providers to organize patient-centred, holistic care around patients to the greatest extent possible.

While envisioning such comprehensive care as a long-term goal, WHO’s new global strategy, The End TB Strategy, now brings attention to the issue of the financial burden of patients—“no affected families facing catastrophic costs due to TB” is now a global target in the new era of TB control.

Catastrophic financial burden of patients

Although basic TB services are available free of charge in almost all countries, TB patients continue suffering from a heavy financial burden. A systematic review showed that families with TB patients in low- and middle-income countries lost more than half of their household annual income due to TB (1). Importantly, about half of the economic burden is incurred before patients are diagnosed, implying that reducing costs for TB services cannot fully address the issue (Figure 1). Loss of income and direct expenses trigger a downward spiral whereby the patient is less able to complete treatment, more likely to have repeat episodes, and more likely to develop drug resistance resulting in more expensive and arduous treatment.

Figure 1. Distribution of medical and other expenditures and income loss, before and during TB treatment. (1)

Seizing opportunities—the global move towards Universal Health Coverage

Eliminating patient catastrophic cost can only be achieved by ensuring sufficient financial risk protection for people to access quality TB services in the context of universal health coverage (UHC).

The global thrust towards UHC presents great opportunities to advance TB control. UHC envisions all people having access to quality health services without financial hardship. UHC can only be achieved through adequate, fair and sustainable financing for quality-assured health services with progressive and equitable population coverage.

TB control programmes have been contributing to the goal of UHC through the provision of essential TB services from the central referral level to the most peripheral level through the primary health care network. The packages of TB services are well defined and composed of scientifically proven, cost-effective and high-impact interventions. With often earmarked vertical funding and a results-based monitoring and evaluation framework supported by a strong surveillance system, TB programmes have demonstrated tangible public health impacts that further attracted donor investments.

However, with epidemiological, socioeconomic and health system transitions, it is becoming an imperative for TB control programmes to improve efficiency and sustainability in the context of health sector reforms towards UHC, while protecting the gains achieved in the past. The transition of TB control financing is especially urgent in countries where major external donors are withdrawing.

Seizing opportunities—expanding the scope of social protection in favour of TB patients

Since the majority of patient financial burden is caused by indirect costs including lost income, UHC policies to address costs for medical care are insufficient to solve the issue. It is therefore critical to progressively extend social protection in favour of TB patients.

There are three areas of action (2):

a. schemes for compensating the financial burden associated with illness such as sickness insurance, disability pensions, social welfare payments, other cash transfers, vouchers or food packages;

b. legislation to protect people with TB from discrimination such as expulsion from workplaces, educational or health institutions, transport systems or housing; and

c. instruments to protect and promote human rights, including addressing stigma and discrimination, with special attention to gender, ethnicity and protection of vulnerable groups.

The first area, which can be regarded as the social protection floor, includes various national and subnational schemes to fulfill the right to social security. In 2012, the International Labour Conference almost unanimously adopted Social Protection Floors Recommendation, 2012. The recommendation, together with key international instruments, has the potential to expand social protection in favour of patients and families affected by TB. The recommendation clearly states the need to ensure access to essential health care and basic income security for people who are unable to earn sufficient income, in particular in cases of sickness. The second and third areas also require effective policy dialogue and negotiations with national entities such as those in charge of labour, education and civil affairs. (Continued to page 4)
Delamanid

Takashi Yoshiyama,
Fukujyu Hospital, JATA

Delamanid (commercial name is Deltyba®) is a drug for the treatment of multi-drug-resistant tuberculosis (MDR-TB, that is, tuberculosis cases whose bacilli were resistant to Isoniazid and Rifampin). It works by blocking the synthesis of mycolic acids in Mycobacterium tuberculosis, the organism which causes tuberculosis, thus destabilizing its cell wall. Its usefulness is shown in the article by Gler, M. T. et al. (“Delamanid for Multidrug-Resistant Pulmonary Tuberculosis”. New England Journal of Medicine 366 (23): 2151–2160.), in which there was a significantly higher proportion of culture negativity of MDR-TB cases at two months after starting treatment with Delamanid and background drugs in comparison to those that were treated with placebo and background drugs. A non-randomized open label observational study also showed a higher proportion of cure and higher proportion of culture conversion among extensively drug resistant tuberculosis (XDR-TB, that is, MDR-TB cases whose bacilli were resistant to an injectable drug such as Kanamycin and Fluoroquinolone such as Levofloxacin) cases that were treated with Delamanid and background drugs for six months or more, in comparison to those that were treated with placebo or shorter treatment with Delamanid for less than two months and background drugs by Skripconoka V et al. (Delamanid improves outcomes and reduces mortality in multidrug-resistant tuberculosis. European Respiratory Journal. 2013 Jun; 41(6): 1393-400.)

Anti-tuberculosis drugs were mainly developed in the 1940s and 1950s after Streptomycin. Rifampin came to be commercially used beginning in the 1970s and its use as the standard regimen has changed the treatment of tuberculosis drastically. Treatment of tuberculosis usually needed 18 months before the days of Rifampin but a standard regimen including Isoniazid and Rifampin shortened the duration to nine months, and the addition of Pyrazinamide, which was developed in the 1950s, contributed to further shortening of duration of treatment of tuberculosis to six months.

However, the history of treatment of tuberculosis is the history of acquisition of drug resistance. With the use of one drug treatment, some of the tuberculosis cases were cured but the remaining persons still had tuberculosis and that person’s bacilli became resistant to the drug used. It is common to treat tuberculosis cases without knowing the drug susceptibility and if Isoniazid resistant tuberculosis patients were treated with Isoniazid and Rifampin, the bacilli of these patients became resistant to Rifampin also. In the early 1950s when the problem of acquiring drug resistance was not highly recognized, many tuberculosis patients became resistant to Isoniazid and without knowing the drug susceptibility pattern, Isoniazid resistant tuberculosis patients acquired drug resistance to Rifampin by the standard treatment.

For the treatment of MDR and non XDR-TB cases, we need to have a well-managed tuberculosis control system. Cegielski JP et al pointed out that the risk of becoming XDR after MDR treatment is higher if the management system is not following the Green Light Committee framework (Extensive drug resistance acquired during treatment of multidrug-resistant tuberculosis. Clin Infect Dis. 2014 Oct 15;59(8):1049-63.) At the same time, poor treatment of XDR TB with new drugs shows high risk of acquiring drug resistance unless we are sure of the drug susceptibility pattern of cases that will be treated with new drugs. For the treatment of MDR TB, no drug susceptibility test to second line drugs was routinely done because we had no choice of drugs. The commonly used drugs were Ethambutol, Pyrazinamide, Kanamycin, Levofloxacin, Ethionamide or Prothionamide, Cycloserine and PAS. However, new drugs should be used with the information of drug susceptibility testing to second line drugs in order to avoid the risk of monotherapy, because multi drug therapy including resistant drugs only is the same as monotherapy.

We are now at the stage of introducing several new drugs. Bedaquiline was accepted in the United States in 2012 and Linezolid is commonly used as an antibiotic against Vancomycin resistant enterococcus and other resistant bacteria and is on the market. SQ109 is at the stage of phase 2 trial. There are several drugs which belong to the same kind of drugs as Delamanid, such as Pretomanid. Also there are several drugs which belong to the same kind of drugs as Linezolid, such as Sutezolid. We are sure that Delamanid and Linezolid can be used together. Also Bedaquiline and Linezolid can be used together. However, we have no knowledge on co-treatment using both Bedaquiline and Delamanid. In this phase of introduction of new drugs, we must use new drugs with careful consideration to avoid the risk of acquiring resistance to new drugs, which occurred in the 1970s at the time of introduction of Rifampin.

(Continued from page 3)

Eliminating patient catastrophic costs—a flagship action of the End TB Strategy

Eliminating patient catastrophic costs, and the associated global target, represent a prominent feature of the End TB Strategy making it very unique from the previous global strategies. Much emphasis has been given in this area in the draft Regional Strategy for Action on Implementation of the End TB Strategy in the Western Pacific.

Persistent, constant and long-term advocacy is fundamental for sustainable TB care financing as well as strengthening social protection. Empowerment and capacity-building of claim-holders—particularly patients and families affected by TB—and forming a wider societal coalition to fight the disease are also critical to advocate sustainable social protection for patients and families in need.

References:
Message from the Facilitator of the TB Control Course

Mohammad Yahya Abdurazak, Iraq

I am a doctor from Baghdad, Iraq, working as a consultant internist & pulmonologist in the specialized center for chest and respiratory disease center, Department of Public Health, Ministry of Health.

I have participated in many advocacy, communication and social mobilization activities that focused on TB control, many private and public mix training activities and worked to finalizing Iraqi guidelines in TB control and management, and also finalized the Iraqi national strategic plan for the period 2015 -2019. I also introduced the TB control strategy and DOTS in the medical students’ curriculum in Iraq.

By working as a deputy manager for the national TB control program in Iraq, I participated in putting SOPs related to crises and special situations related to internally displaced populations, refugees and returnees and also helped with the introduction of the SMS program to communicate with MDR TB patients and with IDP.

I was awarded an Honorary Member’s certificate from the Research Institute of Tuberculosis, JATA on 30th July 2010. After participating in the Stop TB Action Training Course –To strengthen capacity in operational research to implement effective interventions at The RIT, Kiyose, Japan.

After that I worked very hard so that I could publish 7 articles in different Iraqi journals, I participated in many local conferences, and Participated as a Researcher in the 45th Union World Conference on Lung Health in Barcelona, Spain, 2014, by presenting the research entitled “Diabetic tuberculosis cases characteristics in Baghdad”.

A new research will be presented in the 46th Union World Conference on Lung Health that will be held in Cape Town, South Africa, also 2 studies will be presented in the ERS Amsterdam 2015 International Congress.

This year, I have been selected to the post of a facilitator of the JICA International TB Training Course 2015 entitled “Training in strengthening of tuberculosis control toward MDGs and TB elimination” to support participants’ proposal development on their operational research or action plans, for the period of 5th to 11th July.

So I got the opportunity to visit RIT for the second time, to meet the experts from RIT and to meet Dr. Ishikawa and, most importantly, to meet Princess Akishino, Patroness of JATA.

I spent a very good time with all the participants, sharing with them my experience as a previous participant in this course, presenting a few lectures to them and discussing their proposals with them.

Message from the Facilitator of the TB Laboratory Course

Keerataya Ngamlert, Thailand

I was a participant in the Laboratory Training Course in 2007. Since then I have been invited as a facilitator six times. I am honored and feel very privileged to be given such a role. From the beginning, I told myself that I would do my best to be the most effective facilitator as much as I possibly can. I think being an ex-participant is the best starting point for a facilitator. Knowing the workshop process from the inside gives me more confidence to step in and do the job myself.

The skills and knowledge that I gained as a participant, including my experience in TB laboratory work, have been utilized to help the participants move through the laboratory practice processes and improve their skills. Most of my responsibilities have been focused on the training of smear examination, TB culture and drug susceptibility testing in the practice session. I have been a guide to help and encourage each participant to improve their skills and knowledge especially in smear examination which is still the key method used for detecting infectious TB cases. I really appreciate each participant’s skill improvement and their good cooperation. I also enjoyed other precious moments together with the participants during our free time, such as cooking and eating food, talking in general and sometimes going to visit famous places together.

Being a facilitator of the TB Laboratory training course has truly been rewarding. I have had a chance to keep up to date with new knowledge from experts and to share experience with the participants. It is my pleasure to help in this training and work with Ms Matsumoto and RIT-JATA staffs. I have learned so many systematic processes from their excellent management of the laboratory training course. I would like to extend my warmest gratitude to RIT-JATA and JICA for affording me this opportunity and continued warm hospitality. I will do my best to help the course for developing effective human resources of TB laboratory services.
Training Course Report at RIT

Laboratory Management Training for Indonesia

Hiroko Matsumoto,
Center for Int’l Cooperation and Global TB Information

In 2015 April 6 to 11, we had a special training for Laboratory Management for Indonesia. Eight participants came from Ministry of Health and three different national reference laboratories. It was run by means of the Indonesian Global Fund budget.

Objectives of the training are
- To improve the knowledge management of TB laboratory at the National Referral Laboratory in order to plan, manage, and evaluate laboratory program activities.
- To increase the technical capacity of laboratory personnel at the National Referral Laboratory and efficiently assume the responsibilities as the manager of Quality Assurance in Indonesia

- Specific objective are to learn about
  1. Laboratory Network Management
  2. External Quality Assurance Management
  3. Human Resources of Laboratory Management

The participants were excellent and they already had a good grasp of their problems. We discussed their problems and tried to come up with solutions. Participants compiled those solutions and prepared action plans.

We are happy to be able to contribute to the country planning. We wish the Indonesian government success for TB control.

If you have a certain budget and clear objectives for training, it might be possible to organize a special training. If so, please contact us. You are always welcome.

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Training Course Report at RIT

Tuberculosis Control Administration Training for China

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

The training course on “Tuberculosis Control Administration” was held at RIT from 20 to 29 January, 2015. The course was funded by the Japan International Cooperation Agency (JICA). JICA conducted a project which was aimed at strengthening for planning control and implementation capacity for public health problems in China and to promote information exchange, and to encourage contact and communication between Japanese and Chinese administrative officers.

Ten participants from China who work for controlling infectious diseases as administrative officers attended the course. The participants received lectures under 3 broad categories: (1) “Historical and current efforts by the Japanese government for combating TB”, (2) “Information management for TB control” and (3) “Action plan development”. (1) “Historical and current effort by the Japanese government for combating TB” covered “History of Japanese governmental effort for combating TB”, “Current effort by Japanese government for combating TB”, “Overall governmental system of controlling infectious diseases in Japan”, “Japanese DOTS”, “TB Molecular Epidemiology”, “Post MDGs (World trend)”, “TB control among high risk groups”, “MDR-TB” and “Child TB”. (2) “Information management for TB control” consisted of “Utilization for the TB surveillance system”.

They also participated in study tours, traveling to Osaka (Aira area which has many day laborers and has the highest TB incidence) and Kyoto (National Hospital Organization Minami-Kyoto Hospital). At Airin, they learnt health support. At Minami-Kyoto Hospital, they had a lecture not only on child TB but also the importance of medical support network in a wide area.

All participants improved remarkably their capacity to understand their current TB problem and they found out how to solve these problems by studying Japanese TB history and knowledge.

Finally, the participants in this course hope to work well, contribute to their National TB Program and finish their action plans successfully.
Message from a participant

2014 Group Training Course
In Tuberculosis Laboratory Management for Achievement of MDGs Targets

Vital Nkake Mbula,
D.R.Congo

Here, I mention the highlights of our academic experience and best learning moments.

After being received by officials of JICA in TIC, we received guidance for living in Japan during the time of our training.

The actual training began at RIT where we were received by officials and got to know the program participants of this course.

We admired the quality of the scientific presentations and practices, the program organization and management. This allowed us to understand and assimilate the objectives and purpose of the training.

We gained the latest knowledge and skills on culture, DST, and new diagnostic techniques through hands on training and developed the management skills required so that we as laboratory managers can overcome our problems and seek available solutions to optimize laboratory performance.

This is very important given the crucial role of the laboratory in the fight against TB in our respective countries and the world.

The training we have received has not only been scientific but also social, cultural and historical. We learned through our trainers and those who guided us on principles of Japanese life and we found their disciplined ways very interesting and an important model to follow because this is what has made Japanese people what they are today in global leadership.

Special thanks to the team of trainers and in particular to Ms. H. Matsumoto, Ms. Takarai, Ms. Narita, Ms. Matsueda and Ms. Nok (Tailand). I would like to thank course participants Rahmatullah K.A. (Afghanistan), Rahman M.A. (Bangladesh), Boramey S. (Cambodia) Lemarkoko E.S. and Kariuki B.G. (Kenya), Aye Myo K. (Myanmar), Reyes L.T. (The Philippines) and Sun Jiao (China).

I believe that this is the best laboratory management training in the fight against TB and request to both the Japanese people through its leaders, and to JICA, JATA and RIT to continue their support for the benefit of peoples in need around the world.

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Message from a participant

2015 Group Training Course
in Strengthening of TB Control toward MDGs and TB Elimination

Admire Simbarashe Murongazvombo,
Zambia

—Excerpt from speech on behalf of the participants—

It is a great honour that I report on the training course on behalf of my esteemed colleagues on this historic occasion. Like a journey in a Shinkansen, looking back in time I see this three month course as a memorable journey. For 82 days we eagerly opened our ears as we heard the good news from the Gospel of Ending TB as told by RIT. Indeed we have tasted the very flavour of RIT’s excellence in global Anti-TB activities right from the source. May RIT therefore continue to bear the fruits of excellence.

It is in the same vein that I would like to express my utmost gratitude to the Government of Japan through JICA and JATA/RIT for having taken upon themselves to generously equip us, participants from high TB burden and mostly resource limited settings, with the necessary skills to combat this global emergency in line with meeting both 2015 and post 2015 targets. Beyond any reasonable doubt, it is now clear that we, the participants should gear ourselves up to translate this newly acquired understanding of TB control into action as we return back to our countries.

I would also like to extend our appreciation to the Honourable Mayor of Kiyose, Mr Shibuya who heartily welcomed us to his magnificent city; the Director of RIT, Dr Ishikawa, whose leadership is par excellence; Course Director Dr Hiroo, whose commitment to the fulfillment of the training syllabus was astounding, and Course Coordinator Ms Takarai, whose enthusiasm and motherly care is unforgettable. To all RIT staff at large, your sweat and effort is greatly treasured.

To my fellow participants, I say indeed you have proved that though we come from different cultural and geographical settings, all of us are just one family of brothers and sisters. You showed great teamwork and zeal like that of ants. May we continue in this spirit of oneness and be in touch with one another in future. Punctuated with experiences ranging from moments of intense teaching, group and individual work to the wonderful exposure to the unique Japanese culture and language, this training will forever be an unforgettable part of our lives. Congratulations! We have fought a good fight and have finished the race.

Finally, I say to everyone who made this training a reality “Arigatou gozaimashita”/THANK YOU/“Mazvita” (In Shona language Zimbabwe). “Kami no gokago o!” May God bless you!
Welcome Message
The Union APRC 2017, Tokyo

Toru Mori,
President, APRC 2017

It is our great pleasure to invite you to the 6th Conference of the International Union against Tuberculosis and Lung Disease, Asia Pacific Region, which will be held in Tokyo, Japan, on 22 - 25 March 2017.

The theme of this conference is “TB free Asia Pacific -Accelerate Steps toward Healthier Lungs-”, which is in accordance with the post-2015 Global Strategy in the fight against TB and which should also impact lung health issues other than TB. Furthermore, the above fight against TB which is in line with universal health coverage will significantly benefit health services in general.

The countries and areas of the Asia Pacific Region, one of the seven Regions under the Union, account for a quarter of the global toll of TB. In addition, the recent changes in the clinical and epidemiological picture of TB and other lung disease have been remarkable; i.e., rapid aging of the patients, socioeconomically marginalized people, increasing attention to TB in children, claims for wider use of advanced technologies, and the tobacco problem as a basic human rights issue.

The 2017 conference sessions will address these problems in Asia Pacific settings from clinical, preventive, and research points of view, emphasizing the shared responsibilities of people, governments, and industries on both affected and donor sides.

For the above purposes, the conference will provide opportunities to learn about the facts and relevant solutions, to exchange experiences and views among participants, and to discover opportunities and challenges of their own, thus strengthening the networks of all those involved in these common targets in the Region.

Finally, we welcome you to Tokyo, which not only offers modern and convenient venues for scientific activities, but will also present you with a fantastic environment of spring days, the best season of the year with its cherry blossoms, as well as the fascinating traditional Japanese culture, and wonderful cuisine with delicious sake.

We look forward to seeing you in Tokyo in 2017.

News from Sindhupalchok, Heavily Quake-hit area of Nepal

We have received an mail from Dr. Sagar Kumar Rajbhandari in response to a sympathy mail from RIT. Dr. Sagar is a Kiyose Alumni who took the course in 1998 and is now a responsible person for the recovery of the damaged area as District Health Officer of Sindhupalchok.

“Respected Dr Ishikawa san, Namaste. Thank you for your kind sympathy and support to me and the people of Sindhupalchok. In Sindhupalchok, out of 80 health institutions 66 have been completely damaged by the earthquake. We are trying to cope with this tragedy. My hospital has been damaged so we are working in an outside field hospital. Hopefully we will work in a hospital compound using tents. We have lost 1 Auxiliary Health Worker, 5 Field Community Health Volunteers, and also 14 health workers were severely injured. Thanks to all overseas supports, including Japanese friends, the Japanese Red Cross, JICA and other agencies which supported us. Some of them are supporting me in restructuring the Barahi Sub-Health Post. I miss you and thank you once again to all the staffs of Kiyose.”

We focus our concern on the people in Nepal and Dr. Sagar, and really hope and pray that the area and health institutions under him should be recovered as soon as possible.

Nepal Post Disaster Recovery Support

JATA raised a relief fund for the earthquake disaster hit Nepal in April and May, 2015. Since this September, the generous donation has mainly supported earthquake recovery and relief efforts run by a local NGO, Japan-Nepal Health & TB Research Association (JANTRA).

This post disaster recovery support project in Kathmandu valley is targeted at ethnic minorities, vulnerable and marginalized communities including TB patients affected by the disaster, and includes such activities as maintenance of medical equipment in health institutions, psycho-social counseling training and nutrition support.

Staff Movements

Newly joined/back to RIT/JATA:
Mr. Tetsuhiro Sugamoto

Overseas office:
<RIT/JATA, Cambodia> Mr. S.Kobayashi
<JICA Project, Kenya> Mr. T.Miura

You are welcome to send us your news and voices!

NEWS LETTER FROM KIYOSE

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