Letter from the New Director

Seiya Kato
Director

Greetings from Kiyose! I am Dr. Seiya Kato, Director of RIT/JATA. In April 2017, I took over the office from Dr. Ishikawa, who is currently a representative board member of JATA.

I would like to introduce myself briefly. In the first twelve years of my career, I worked as a chest physician. In the following seven years, I worked in local government as a medical officer. I joined RIT in 2000 and was dispatched to the Philippines as the project manager of a JICA for three years. After coming back to RIT, I mainly worked in domestic TB control and got the chance to work for international control programs such as a Pakistan TB project funded by JICA. My official services outside of RIT are as chairperson of the TB committee of the National Health Council, chairperson of the Prevention Committee of the Japanese Tuberculosis Society, and as a committee member of relevant organizations working for domestic or international tuberculosis control and research.

One of the recent great events in global TB control was “The first global ministerial conference” which was held on 16-17 November 2017 in Moscow. The aims of this conference were to accelerate the implementation of the WHO End TB Strategy and to inform the UN General Assembly High-Level Meeting (UNGA-HLM) on TB in 2018. A total of 114 countries, 79 ministers, 112 agencies, and more than 1,000 delegates participated. Japan’s Ministry of Health, Labour, and Welfare dispatched the Honorable Deputy Minister, Michiyoshi Takagi, and five officials. From RIT, Dr. Yamada and I attended the conference. Otsuka Pharmaceutical, NIPRO Corporation, and Eiken Chemical also dispatched delegates.

In the opening session, President Vladimir Putin of the Russian Federation; Amina J Mohammed, UN Deputy Secretary General; and Dr. Tedros Adhanom Ghebreyesus, WHO Director-General gave remarks.

The agenda was composed of four high-level plenaries (HLP) and eight parallel sessions and side meetings. The first HLP, “Ending the TB epidemic: perspectives from countries with highest TB and MDR-TB burdens,” was a discussion between eight ministers of such countries. The Second HLP, “Accelerating to End TB: perspectives of TB survivors and civil society,” was a discussion among TB survivors, representatives from private companies, WHO, the International Federation of Red Cross and Red Crescent Societies (IFRC), and NGOs. The third HLP was “Driving a multisectoral response: A dialog among leaders of UN, multilateral agencies, and bodies.” In the Ministerial parallel panel, Japan participated in the session on “sufficient and sustainable financing”: Japan is a global leader in its early adoption of UHC policies. Japan’s progressive move towards UHC started in the 1950s when the TB burden was extremely high, comparable to or even more than that of current high-burden countries. Japan simultaneously achieved both UHC and a rapid, more than 10% reduction in TB incidence at the same time during the 1960s, way ahead of economic development.

The fourth HLP was “Towards the 2018 UN General Assembly High-Level Meeting on TB, and developing a multisectoral accountability framework” with high officials of WHO regional offices together with Russia’s Minister of Health. In the end, the Moscow Declaration to End TB was adopted.

TB control is expected to accelerate with strong political commitment. RIT continues to make maximum effort as a reliable technical agency for international and domestic TB control.
UHC, social protection, and other countermeasures against TB in Japan -What brought about a 10% annual decline in TB Notification? No.2-

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We previously reported in this RIT newsletter that Japan experienced a 10% annual reduction in tuberculosis (TB) notifications from 1965 to 1978, such that the notification rates from 320.9 per 100,000 population level in 1965 rapidly went down to 70.0 in 1978, which was one of the largest TB notification reductions globally. We described what happened focusing on the following four aspects: 1) specific TB control activities, 2) medical system infrastructure, 3) policy, law, and research, and 4) other factors such as the social welfare mechanism and human resource development. As the second step, we tried again to brainstorm further what happened then and what kind of potential contributing factors existed among the RIT staff concerned, focusing upon the aspects we did not previously cover well. The preliminary results were also presented at the 48th UNION World Conference on Lung Health in Guadalajara, Mexico, in October 2017, as one of five presentations at workshop 09, “What we need to do for ending TB: adapting current progress to the framework of the End TB Strategy” [1]. This time we covered four additional possible contributing factors such as 1) roles of public health centers in TB control, 2) roles of Japanese “Health-in-All” policies, 3) roles of economic growth in Japan, and 4) other external factors such as housing space and family size changes.

Public health centers spread nationwide, covering approximately 100,000 - 200,000 population in each of their catchment areas in Japan. They provide person-related services with strong emphasis on disease prevention including TB control, maternal and child health (MCH), vaccination, and health education. In addition, they provide services to improve the environment, including monitoring air and water quality, inspecting and licensing waterworks, beauty salons, barbers, food processing facilities, restaurants, hotels, clinics, and hospitals. Public health centers played key roles in driving communities to attend mass TB screenings towards “100% uptake of the TB screening” in close collaboration with local community organizations such as the TB Women’s Association. Public health centers introduced a TB patient registration system with TB patient registration cards in the early 1960s like the “NTP Treatment Card” in the current global practice. This paved the way for public health center staff to collect and assess TB control activities locally, i.e., they collected data from TB patient registration cards, summarized them, then assessed their TB activities. This was a kind of “data for action” public health practice.

We are able to observe a sample practice of “Health-in-all” (HiAP) policies in 1950s through 1960s in Japan, just several years after the end of World War II. For instance, the Ministry of Agriculture in Japan implemented a better agricultural management project and better living project nationwide to improve farmers’ agricultural management skills and living environments. Farmers’ incomes as a whole increased rapidly and their standardized mortality ratio (SMR) dropped sharply at that time. Sawauchi village, located in the depth of mountains in northern Japan, with a population of approximately 7,000 in the 1950s, was a sample for “HiAP.” The village was severely stricken by heavy snow in winter in addition to its poor economic conditions; the lowest household income average in these areas was combined with poor health, with the highest infant mortality rate (IMR) and highest suicide rate among the elderly in Japan. The mayor Masao Fukazawa remodeled the village organization, set up a health management division, assigned health staff including public health nurses, mobilized community organizations for transport, health, and housing, and strengthened technical assistance for mushroom cultivation to improve the income of the villagers just after he became the village major in 1952. The village successfully reduced the IMR within a few years and the transportation during the winter season was secured.

Economic growth happened from the 1960s and 1970s in Japan. The growth of the Ministry of Health’s budget was larger than that of the GNP (Figure 1). The national health insurance scheme that was established in 1961 further improved Japanese people’s access to health care facilities with the reduction of their out-of-pocket payments. In addition, household income increased at that time, which also probably improved access to health facilities.

Figure 1

Trend of GDP per capita in Japan
The large notification reduction from 1965 through 1978 among the young age group was observed, i.e., 15 ~ 30% annual reduction. Among others, TB infection in the young age group happened as a result of close, household contact. The number of household members reduced from approximately 4 to nearly 3, the proportion of nuclear family type households increased, and the floor space per dwelling increased. All of this may have worked to reduce the risk of TB infection among household contacts.

Taking both the previous and the current presentation findings into account, we may conclude that the TB-specific (e.g., BCG vaccination, intensive case finding) and non-specific (e.g., health education, community empowerment) interventions; quality-assured TB care backed up with research findings and human-resource development under rigid TB control legislation framework; economic development; and the National Health Insurance scheme most likely reduced economic barriers for the community to access to health facilities and contributed to the 10% TB notification reduction at that time in Japan (Figure 2).

Figure 2

[References]
Patient-Centered TB Care in Japan

Tamae Shimamura, Seiya Kato

The Japanese DOTS strategy was officially launched in 2003, based on some trials in urban settings that showed an improvement in treatment outcomes. The primary aim of the strategy is to “cure the patients who are in front of us.” It is a comprehensive supporting system for TB patients including DOT*. The system not only includes support through medication, it also encompasses medical, mental, emotional, and social support.

The targets are all patients, including smear negative and latent tuberculosis infection (LTBI) patients. For hospitalized patients, most of whom are smear positive pulmonary TB patients, support starts as “in-hospital DOTS,” which consist of three factors: patient education, medication support, and cooperation with health centers. Before the patient is discharged from the hospital or at the start of treatment in the outpatient department, a DOTS conference is held with the participation of hospital physicians, nurses, public nurses, and other staff concerned to create an individual patient support plan in community DOTS.

In the DOTS conference, the frequency and method of support for the individual patient are determined based on the assessment of the patient’s risk of interruption and/or default (Table 1).

The individual supporting plan is revised as needed through discussion in the DOTS conference.

In 2014, Infectious Disease Control Law was revised. The added item mentions that heath centers are authorized to delegate patients’ support to another organization, such as a clinic. The national TB prevention guideline states that national and local government should strengthen coordination: 1) among facilities such as health centers, medical facilities, social welfare facilities, pharmacies, etc., as well as 2) among concerned professionals such as nurses, pharmacists, etc. The Ministry of Health, Labour, and Welfare issued a notice that the director of a health center is designated as a supporter regardless of his/her profession for the purpose of patient-centered care. Treatment supporters provide support for individual patients, but health centers have final responsibility when an issue such as interruption of drug administration arises. The DOTS cooperator who is close to the patient may support drug administration on a daily basis. Medication notebooks are used by all those involved in community DOTS to share information regarding medication, examination results, and relevant of information about the patient and support provided by the treatment supporters. In some areas, notebooks in other languages are prepared and used. Fig.1 shows the conceptual diagram of community DOTS. The major players are TB hospitals and Health centers. TB hospitals are at the center of the regional coordination framework for TB medical care. Health centers are key players in comprehensive patient support, which we call Japanese DOTS.

We are starting research on collaboration to “Comprehensive Community Care System,” a new scheme proposed by the government that allows the aged population to reside in their own communities for as long as possible. Involving caregivers in patient support for adherence has already been attempted. This could be applied to strengthen case findings by sensitizing TB alerts to caregivers and medical professionals to TB, and asking them to check for TB.

<table>
<thead>
<tr>
<th>Table 1 Assessment items for default</th>
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<tbody>
<tr>
<td>➢ Status of the patients</td>
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<tr>
<td>• Acceptance/ recognition of the disease</td>
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<tr>
<td>• Difficulty of visiting to medical facility</td>
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<tr>
<td>• Inmate, unstable living condition, living in homeless shelter</td>
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<tr>
<td>• Mental disorder, dementia, drug abuse, alcoholism</td>
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<tr>
<td>➢ Past history</td>
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<tr>
<td>• History of TB treatment default</td>
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<tr>
<td>➢ Disease condition</td>
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<tr>
<td>• Slow improvement: slow smear/ culture negative conversion, slow improvement of clinical symptoms</td>
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<tr>
<td>• Clinical deterioration during treatment</td>
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<tr>
<td>• Adverse reaction to TB drug</td>
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<tr>
<td>• Irremovable TB: drug resistant, serious disease, serious complications</td>
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Fig.1 Conceptual diagram of Community DOTS

Coordination and collaboration are key for patient-centered care and prevention. We expect that the Japanese DOTS strategy will be able to serve as a model for patient-centered care and prevention, which is one of the three pillars of the End TB Strategy.
"International Course on AIDS Prevention and Care in Asia" in 1995 focused my work on TB/HIV collaborative activities and I learned more about epidemiology.

The second course was "Group training course in National Tuberculosis Programme Management" in 2004, which gave me a chance to make important milestones for TB control in Myanmar. Scientifically sound nationwide TB Prevalence survey, Drug Resistant TB Surveys and Knowledge, Attitude and Practice on TB study, and pilot studies supportive for policy making were able to be conducted. My career developed while I worked in the National TB Program (NTP), Department of Health, Ministry of Health from 1990 to 2014. I became the Program Manager of NTP in 2009, was promoted to Director (Disease Control) in 2014, and was recently promoted as Deputy Director General (Disease Control) in December 2017. This is the very first time that a woman will occupy this position in my country. I am responsible for all HIV, TB, Vector-borne Diseases, Neglected Tropical Diseases, and Non-communicable Diseases. The last point, not the least, I want to make here is that my Sensei from RIT are always close to me and helping me to end TB in Myanmar. However, I also need to end other diseases as targeted in the Sustainable Development Goal with my strong Disease Control team together with implementing partners, development partners, and technical assistance from Japan in many ways. It is a long journey, but in this position, I hope I can lead to the path towards the destination and always thank RIT/JATA, which gave me knowledge, courage, and strength.

In January 2017, we had the opportunity to meet ex-participants in Thailand and Cambodia as JICA follow-up cooperation for ex-participants, which aims at hearing about the impacts of the training and taking comments for the further improvement of the courses from ex-participants as well as providing updated knowledge/skills. The visiting team was led by Ms. Sakamoto (Director, Human Development Division, Tokyo International Centre, JICA), who was joined by Ms. Jogenji (JICA) and three staff members of RIT (Ms. Matsumoto, Dr. Ohkado, and myself).

We interviewed more than 30 ex-participants and are delighted to directly confirm RIT and Japan's contribution to world TB control. NTP directors in both countries are ex-participants. The NTP director in Thailand described attending the course as a life-changing event because she decided to pursue NTP as her main professional career, which she had not imagined before the course. In Cambodia, we heard that the course expanded ex-participants' careers from being clinicians to more active TB control program officers with broader understandings of public health.

As of 2015, the JICA training course is formally called the "JICA Knowledge Co-Creation Program." The concept of "Co-Creation" implies that the courses do not teach participants in one way but aim at building knowledge/skills in more interactive manners such as through sharing experiences and discussion among participants and between participants and lecturers. It is recognized that this concept has been long exercised since the beginning of the course in 1963 and emphasized as one of their several unique attributes.

After hearing from ex-participants, we organized the seminar. Dr. Ohkado and Ms. Matsumoto provided lectures on “TB control and UHC” focusing on experience in Japan and the new laboratory guidelines, respectively. Ex-participants presented the current situations of NTP and we had fruitful discussions on country-specific issues of these topics.

We hope the courses will be continued, as the ex-participants recommended.

Voices from RIT Alumni
As an alumnus of International training courses at the RIT/JATA

Thandar Lwin
Deputy Director General (Disease Control), Department of Public Health Ministry of Health and Sports, Myanmar (1995 AIDS, 2004 TB Advanced)

I am very pleased to express my gratitude in this newsletter from Kiyose. I have attended two training courses: firstly, the
and made some recommendations to NTP authority. The research results were published in a national journal (The Chest and Heart Association of Bangladesh).

On the basis of my previous background and activities, JICA and RIT authority invited me as a facilitator in the last TB Control Course 2017. On the first day, I disseminated my research findings among the participants. So many questions were asked by the participants, and I gave answers clearly. On the second and third day I was present as an observer and facilitator where I made valuable comments on participant’s research proposals and action plans. I was proud to be a facilitator for the JICA Training Course. As a facilitator, I liked to share my experience of TB control in Bangladesh with other participants. Last year, I also participated in the Training Course of Infection Control in the hospital organized by JICA in Tokyo International Center.

Lastly, I am grateful to JICA and RIT for giving me the opportunity to join the training course as a Facilitator.

On behalf of the course participants from Afghanistan, Kenya, Liberia, and Philippines, I would like to extend my sincerest gratitude to the following individuals who, in many ways, made the program a success:

Dr. N. Ishikawa - Director, Research Institute of Tuberculosis (RIT); Ms. H. Matsumoto – Course Director/Deputy Chief Director, Centre for International Cooperation and Global TB Information; Ms. N.Chika - Co-facilitator; and Ms. Takarai - Training Coordinator.

I couldn’t describe your enthusiasm from the time we arrived here in Japan until the last day as we prepare to say
goodbye. You have been a constant source of empowerment and inspiration every single day of our tutorials at RIT. You have engaged us not only in the practical application of laboratory procedures, but also in lessons that go beyond laboratory work, e.g. study trip.

Too often as we progress through the “ropes of life,” we tend not to invest the time to express our gratitude and authentic value for the support you so eagerly shared for our growth, not only as trainees but most especially as global citizens of different nationalities.

The fight towards the achievement of the End TB strategy could not be complete without Quality Laboratory Diagnosis. In this regard, the knowledge you imparted on TB epidemiology, TB diagnostic procedures such as TB Microscopy, Culture and DST, GeneXpert, Line Probe Assays, and other molecular techniques are relevant for the improvement of our existing practices. These practices are assured and measured by way of Quality Assurance implementation.

I salute your organized and systematic approach towards the delivery of the training objectives through coordinated activities of Matsueda San, Takarai San, Matsumoto Sensei, and Chika Sensei to mention but a few.

You make me feel authentically supported when you say, “Please let me know how I can be helpful” and genuinely mean it. Also, the excitement you express to co-learn with me rather than just teach makes me feel like a partner in this learning experience, when it is so easy to feel like “a sponge that can only absorb.”

As an educator, you have succeeded in your role in heightening my knowledge in academics. You promoted an environment where I felt like I was not just able to share my contribution, but also know it was actually considered and appreciated.

Thank you for being genuine. Thank you for seeing me as a partner in learning and sharing. Thank you for being you. Thank you for being one of the few great teachers out there. May you inspire others to achieve the greatness you have.

Message from a Participant
2017 Group Training Course In Ending Tuberculosis in the Era of Universal Health Coverage (UHC)

Fakhri Rasha Thameen
Iraq

I express my heartfelt gratitude and I am deeply honored to have had this wonderful chance to take part in the (Ending TB in the era of UHC 2017) training course, which was funded by JICA and organized successfully by RIT. We spent a wonderful time, together with participants from 14 countries in valuable lectures, workshops, group discussion, presentations, and field trips sharing the Japanese experience against TB disease and implementation of DOTs strategy. I have learned much important information through being in a team environment, sharing experiences with participants from various countries and accepting the differences between us.

The lecturers were super-humans who worked so hard for the participants empowering them with knowledge and support. These two months taught me so much that will help me in my future.

My great gratitude is to Dr. Hirao, who monitored our progress and pushed us for better situations with positive energy.

We also had an unforgettable visit with privilege to Her Imperial Highness Princess Akishino, patroness of JATA; we enjoyed her prestigious hospitality.

On our trip to Yokohama city, we learned how to manage TB disease in homeless people and how to directly observe TB patients. We also enjoyed Yokohama beach.

The other trip was to Nagano (by bullet train, Shinkansen) where we learned about community-based TB control and home visit medical care. All the people there were kind and proud of their achievements, and I am sure all the participants will take advantage of these achievements.

The RIT staff helped us draft proposals for operational research to implement in our countries for better futures.

My journey with this institute, “research institute of tuberculosis,” has been one of the most memorable moments of my life. When we arrived in Japan, we were strangers and felt sad because we had left our families and home, but our mum “Takarai san” tried to help us in everything ~shopping, cooking, transport, and enjoying the weekends.

We stayed in Kiyose, a calm, peaceful, beautiful place including its people and nature.

Of course, we will never forget Japanese people with their kind hospitality, politeness, punctuality, and discipline; they deserve to be respected.

All of those mentioned above make Japan as a home away from our homes.

It was really a great and unique experience. Thank you very much.
Recent News  
From RIT International Training Course Alumni

Centre for Int’l Cooperation and Global TB Information

◇Successful careers◇
Dr. Thandar Lwin (1995 AIDS course, 2003 Advance course)  
Deputy Director General (Disease Control),  
Department of Public Health, Ministry of Health and Sports,  
Myanmar

Dr. Maureen Kamene Kimwuye (2014 control course)  
NTP manager, Kenya

Dr. Mugabe Frank Rwabinumi (2008 control course)  
NTP manager, Uganda

Dr. Phalin Kamolwat (1996 control course)  
NTP manager (Director of Bureau of Tuberculosis), Thailand

◇Award winner◇
Dr. Fakhri Rasha Thameen (2017 control course from Iraq)  
Certificate of Appreciation for getting the highest mark in the training course by the Iraqi Ministry of Health (She gave a message about the control course in 2017; please see page 7).

The above news may not cover all due to limited information. If you know other alumni news, please send it to the email below.  
kokusai@jata.or.jp

Next year, editors may ask alumni to write messages about how to utilize the knowledge and skills gained during the training course in one’s career.

Greetings from Overseas Office

RIT/JATA Philippines, Inc. (RJPI) Office

RIT/JATA Zambia Office

Staff Movements

Newly joined RIT/JATA:
Ms. Mikiko Araki
Ms. Yuko Matsuoka

Overseas Office:
Ms. Matsuoka (RIT/JATA Zambia Office)  
Ms. Araki (JATA Myanmar Office)

Left RIT/JATA:
Mr. Shigeo Kobayashi  
Mr. Takashi Miura  
Mr. Akira Watanabe

You are welcome to send us your news and voices!