Greetings from Kiyose!

The year 2018 was a memorable year for RIT and JATA as well. On behalf of JATA, I had the honor of giving a speech at the Civil Society Hearing of the United Nations High Level Meeting (UNHLM) on tuberculosis (refer to the next page). I was assigned as a member of the Strategic Technical Advisory Group (STAG) of WHO HQ; their meeting took place in connection with the Civil Society Hearing in NY. Through these opportunities, we were expected to contribute to the End TB Strategy utilizing our experience during the TB pandemic era. In relation to the UNHLM, JATA committed domestic advocacy campaigns such as media briefings on TB, the Lightning of Tokyo Tower during UNHLM, etc., together with related organizations.

In the WHO Western Pacific Region, we participated in the NTP managers meeting held in Manila, the Workshop on the End TB Strategy Pillar 2 held in Korea and the WHO Collaborating Center’s Meeting at Ho Chi Minh City in Vietnam. We also provided technical support to Myanmar, Nepal, Cambodia, Mongolia, etc. for the prevalence surveys and drug resistance surveys.

At the global conference of the International Union Against Tuberculosis and Lung Diseases (The Union) at the Hague, Netherlands in October, H.LH. Princess Akishino, Patroness of JATA, was honored as an honorary member of the Union. During the conference, she actively participated in symposiums and workshops including the one entitled “How universal health coverage and TB responses combine to end TB: lessons learnt from country-level experiences,” which was organized by JATA. RIT also funded a “Student Late Breaker Session” in the conference and supported travel expenses in the form of scholarships for the presenters from low income countries. We are pleased that Dr. Kosuke Okada, Director, Department of International Programmes, JATA was re-elected to the board of Directors of the Union.

For the next fiscal year, RIT/JATA will strengthen international cooperation together with public and private partners. As for the international training courses funded by JICA, the number of applicants was not as large as was expected. Maybe it was because information on recruitment for the applicants didn’t reach the TB section of the Health Departments of respective countries, as it was sent from JICA to the Department of Foreign Affairs in respective countries together with all kinds of training programs. We would expect responsible persons of the TB section to refer the information to the section in charge.

The End TB strategy requires innovations. Delamanid from Otsuka, TB-LAMP from Eiken and Genoscholar from Nipro are already endorsed by WHO. The Sensitive LAM detection tool which is development by FUJI FILM and FIND is expected to detect more TB patients especially among PLWH. The X-ray CAD system being developed by FUJI-LUNIT has excellent accuracy in detecting TB patients and will contribute to case detection by screening with X-ray.

OPC-167832, which is a novel anti-TB drug being developed by Otsuka, works using a different mechanism from currently existing anti-TB drugs. They may constitute a “Universal regimen”, which can be applied to any TB patient regardless of drug sensitivity. RIT/JATA would like to find opportunities to support these products.

We would like to work with anyone in this network to contribute to the End TB Strategy and SDGs.
United Nations High Level Meeting  
—Contribution of Japan—

Selya Kato  
Director

It was a historical event the United Nations High Level Meeting (UNHLM) focused on tuberculosis in September 2018. H.E. Mr. Koro Bessho, Ambassador and Permanent Representative of Japan to the UN, was co-facilitator for preparing the political declaration together with H.E. Mr. Walton Alfonso Webson, Ambassador and Permanent Representative of Antigua and Barbuda, which are island countries in the Caribbean Sea.

In advance of the main meeting, a Civil Society Hearing was held at the UN headquarters on June 4. I had the honor of giving a five minute speech as a representative of JATA. The manuscript of my speech is as follows:

ит is my great honor and privilege to be here and share the experience of TB control in Japan. The TB burden in Japan was so high that the incidence rate of TB in 1951 was approximately 700/100,000 population, which was higher than that of most current high burden countries.

Owing to maximum efforts through collaboration among multiple sectors, the incidence was reduced by approximately 10% annually between 1965 and 1978. I would like to focus on a few items based on our experience.

1. How to create patient-centered TB care and prevention

The national TB control guidelines and related legislation clearly described the need for a multi-sectoral approach and roles of relevant organizations. In our program, health centers have final responsibility for TB control in their jurisdictional areas, while not only medical facilities, but also organizations from other sectors such as schools, workplaces, welfare facilities, correctional facilities, community-based organizations and women’s associations work to provide case finding and patient-centered support with consent of the patients. At the field level, it is important to provide training including basic knowledge of TB, skills for patient support and human rights as well. For quality service, health centers prepare notebooks for patient records and convene regular meetings in order to share information on individual patients. This patient centered multi-disciplinary approach leads to effective and efficient allocation of available resources in the area, which, we believe, is applicable in a resource limited setting.

2. Financial implications from our history

What we would like to share with you is that ample investment to TB control successfully reduced both TB incidence and financial burden of TB in the subsequent decades. During high TB incidence times, as many tools as available were introduced on a nationwide scale with ensured quality. Overall resources used for these efforts were significant, but it resulted in a rapid decline of incidence, which implies financial benefit. The medical cost of TB comprised 27% of all medical expenditures in 1955, while it decreased to 3.6% in 1975, an almost 90% decline in 20 years.

Next, we would like to emphasize that the adequate combination of TB specific public funds, currently covered by the Global Fund in many countries, and universal health coverage, now being paid by domestic funds, is important because it produced synergistic effects for both TB control and health system development. In our history, establishment of public health insurance increased detection of symptomatic diseases by lowering financial barriers to medical consultation. TB-specific publicly funded subsidies accelerated participation of the private sector in the TB control program, and the checking mechanism for publicly funded subsidies enforced registration and standardized TB care for patients. This private-public partnership has been functioning very well in Japan. It is also noted that allocation of public funds to TB medical care promoted sound development of public health insurance, the Japanese version of UHC, since the TB burden was so heavy in those days that covering all the medical costs for TB by health insurance was difficult. In conclusion, our history suggests that each country needs to consider appropriate combinations of TB-specific budget and UHC budget in order to maximize their synergetic effects in ending TB.

3. Highlight the childhood TB issue

It is estimated globally that children comprise 10% of all TB cases and one out of seven TB deaths, however, childhood TB was less prioritized than that of adults in the global TB control program, because of less infectivity. Childhood TB is difficult to diagnose because most cases have bacteriologically negative results. We need better diagnostics without sputum samples and child-friendly anti-TB treatment, through strengthening research and development.

In order to highlight the childhood TB issue, the global TB community and each country should discuss setting up the indicators for promoting a childhood TB control program. The incidence rate of childhood TB is a good indicator of a successful TB control program. When the overall decline rate of incidence was 10% in Japan, that of childhood TB was 15 to 30%, which implies that addressing childhood TB would contribute to an overall decline in TB incidence. Thank you very much for your attention.

The UNHLM, held on September 26, was composed of a plenary panel and a multi-sectoral stakeholder panel. Participants are not allowed to go across the two panels, because of security reasons. At the beginning of the plenary panel, María Fernanda Espinosa Garcés, President-elect of the 73rd session of the UN General Assembly, announced adoption of the Political Declaration of the Fight Against Tuberculosis “United to End Tuberculosis: An Urgent Global Response to a Global Epidemic”. The key elements of the political declaration as summarized by WHO were as follows:
One day before the UNHLM, Nikkei Inc, a Japanese newspaper company, organized an event entitled "Accelerating Global TB Response Through Technical Innovation". JATA was one of the co-organizers of the event. Dr. Shigeru Omi, Regional Director Emeritus of WHO/WPRO was moderator. The panelists were from WHO HQ, the Stop TB partnership, the Global Fund, USAID, JICA, GHIT, TB Alliance, and myself from JATA. Prof. Keizo Takemi, Member of the House of Councilors made final remarks. There were comprehensive discussions on technical innovation for the End TB Strategy.

One of the challenges is how to maintain political momentum. Minister Kato mentioned that the Japanese government will follow up through the G20 summit in Osaka, TICAD 7 in Yokohama, and UNHLM for UHC 2019 in NY. JATA will also follow up together with global and domestic partners.

Alumni News: Dr. Wang Li Xia received the Dr. Karel Styblo medallion and a certificate of application from KNCV and talked in the UN High-Level meeting in New York

Dr. Wang Li Xia attended the advanced course on TB control in 1999. We are pleased inform you that she received the Dr. Karel Styblo medallion and a certificate of appreciation from KNCV. She contributed to TB control in China and globally.

She served in TB control in China for many years. As mentioned by KNCV (https://www.kncvtbc.org/en/2018/10/27/prestigious-kncv-award-presented-to-dr-wang-lixia-and-dr-yogan-pillay/), she contributed to the introduction of various innovations, including the introduction of electric recording and reporting, MDR-TB treatment programmes, molecular diagnostics and active case-finding in China. She also contributed to international policy development as a member of the WHO Strategic Technical Advisory Committee.


Sometime we would like to hear above her long time experience in the TB control programme and her views of future TB control strategies in this newsletter.

Message from the Regional Advisor - Continuous learning is the key to a successful TB programme -

Tauhid Islam
Coordinator
End TB and Leprosy Unit
WHO Regional Office for the Western Pacific

I started my career in TB in the Bangladesh national TB Control programme. I realized that the staff at the front line is the lifeline of the programme. Staffs need to be taken care of. They need to be trained and retrained properly. The programme also needs to keep them motivated. Obviously there are many ways to train, many ways to keep them motivated.

Over last ten years, I worked at the different levels of WHO: Country Office, Regional Office and Headquarters, which gave me the opportunity to visit the TB programmes of many countries of different Regions. It became evident that continuous learning and improvement remains the key of the TB programme especially considering the current context of newer diagnostics, drugs and policies. The TB community needs to embrace innovations quickly. We all know that incorporating the 'new' takes time. But we need to remember that our delayed actions translate into loss of human lives.

There is an ongoing debate about how effective the conventional training programme is. Poorly planned training programmes may be a waste of time, energy and resources. Training programmes are not all about 'technical content'. The training programme should be task based; agenda should be developed as per the need. Adult learning techniques need to be incorporated, such as interactive presentations, exercises, group work and role play. Most importantly a follow up and evaluation mechanism need to be part and parcel of a training programme.
The Research Institute of Tuberculosis (RIT) Japan offers international training programmes on TB every year. I had been hearing a lot about this course since I started my TB carrier in Bangladesh. Many of the TB programme leaders in Bangladesh were trained in an RIT training course. In 2014, I had the chance to attend the course as faculty for programmatic management of multi drug-resistant TB. I realized the very good background preparation of the training course. Participants’ profiles were reviewed beforehand to customize the training curriculum, and as a facilitator I received the opportunity to plan my session to make it interactive, including exercises, group work and role play. The training programme also had a built-in monitoring and follow up mechanism.

Today, in 2019, TB should be an ancient disease of the past. So why is this ancient disease still with us? It’s time to ask ourselves some hard questions. It’s time to learn from successful experiences and embrace innovations. TB is preventable and curable - surely, we can, and must, do better.

**Primary Health Care and Tuberculosis Control in Japan**

Kazuhiro Uchimura  
Department of Epidemiology and Clinical Research

**National health insurance system in Japan**

Japan has managed to attain Universal Health Care (UHC) through the health insurance system. The National Health Insurance Act was established in 1958 and all municipalities started the national health insurance programme in 1961. The achievement of this universal health insurance system has been heralded as a great success story of UHC.

However, is this success story a model for countries that are trying to achieve UHC in the future? Japan’s health insurance system is established by payment of a premium from the people. On the other hand, OXFAM, an international NGO fighting poverty, produced a report in which it pointed out that “No country in the world has achieved anything close to UHC using voluntary insurance” and, “For those who recognize the pitfalls of voluntary schemes, social health insurance (SHI) has become an increasingly popular alternative. However, while SHI has worked to achieve UHC in a number of high-income countries, attempts to replicate the same kind of employment-based models in low- and middle-income countries have proved unsuccessful.” The OXFAM report (C Averill and A Marriott. "Universal Health Coverage: Why health insurance schemes are leaving the poor behind" Great Britain, Oxfam. (2013) https://www.oxfam.org/en/research/universal-health-coverage) advised that developing countries should not necessarily try to incorporate the “UHC via health insurance model” of the high-income countries. The OXFAM report also recommended to high-income countries that and multilateral organizations stop promoting inappropriate approaches in the name of UHC, especially private and community-based voluntary health insurance schemes.

**Primary health care approaches to UHC**

What can we learn from the experience of Japan? In achieving UHC in Japan, the role of Primary Health Care (PHC) was just as significant. However, it has also been pointed out that the role of PHC approaches to community health in Japan’s achieving UHC has been underestimated. In fact, if we do not have a robust primary health care system, any health insurance system will not be able to deliver adequate medical services to the people. Now, the World Health Organization (WHO) is again highlighting the inseparable role of PHC in achieving UHC.

In the declaration of the International Conference on Primary Health Care held in Alma Ata, Kazakhstan in 1978, PHC was defined as “essential health care” that is based on “scientifically sound and socially acceptable methods and technology, which make universal health care accessible to all individuals and families in a community”. Four principles for PHC have been proposed by the former WHO Regional Director Leo Kaprio.  
① Needs based approach: Health care should be related to the needs of the population.  
② Community participation: Consumers should participate, individually and collectively, in the planning and implementation of healthcare.  
③ Use of existing resources: The fullest use must be made of available resources.  
④ Holistic approach: PHC is not an isolated approach, but the most local part of a comprehensive health system.

**Tuberculosis control activities and PHC**

At a previous workshop of the UNION World Conference, Dr. Akihiro Ohkado reported the factors that contributed to the 10% reduction of tuberculosis (TB) notification rate in Japan. He pointed out that strong political leadership and commitment at the central government level in the national effort to improve public health played an important role. He also pointed out that multi-sectoral, multi-dimensional interventions had improved various social determinants of health at that time. These interventions are considered to be the “Holistic approach” of the four principles for PHC. It is noteworthy that the multi-sectoral interventions included the strengthening of activities of public health centers. In other words, strengthening PHC by the principle of a “Holistic approach” strengthened the functions of the public health center, and as a result, enhanced tuberculosis control activities. Conversely, is there any role that TB control played in strengthening PHC? TB control had taken place long before the Alma Ata Declaration, and we argue that TB control activities were guided by ethos very similar to PHC. We will introduce the role of the public health center in TB control that may have strengthened PHC.
1. Early detection through mass screening via health education: Public health centers collaborated with community organizations (e.g. TB women’s organizations established in the 1950’s), and organized lectures, showed movies, distributed pamphlets to the general public on TB and encouraged people to go to mass chest X-ray screening. “100% uptake” became a slogan, and some municipalities accomplished this target, amazingly. This collaboration with community organizations may have strengthened “Community participation” for PHC. 

2. Patient management and use of data: the TB patient registration card developed by a research team in 1959. This registration card was first piloted in 216 public health centers, then another 200 public health centers in the following year, and nationally rolled out in 1961. Demographic information, mode of detection, treatment history, diagnosis, treatment status, family contact details, home visits, etc. were recorded on the registration card by public health nurses. Public health center staff can handle patients’ data easily. As a result, public health center staff not only became used to taking statistics but also analyzed the patients data by themselves at the public health center level and used it for the control programme. These activities may have strengthened the evidence based programme.

3. Visiting TB patient by public health nurses: Public health nurses visited TB patients to support patients’ medication, provide knowledge on TB, and educate on importance of treatment completion. They performed preliminary investigations for contact examination. Sometimes they also consulted about family affairs and economic problems beyond medical assistance. Visiting TB patients by public health nurses was not only strengthening TB control activities but also played the role of listening to the “voice” of the community. These activities may have strengthened the “Need based approach” for PHC.

**Public health center, TB control and primary health care**

UHC and TB response have not a one-way, but an interactive association. UHC strengthens the TB control activity and vice versa. Figure 1 summarizes the hypothetical relationship between public health centers, TB control programme and primary health care. TB control activities based on the public health centers and public health nurses may strengthen PHC and has the possibility of application to countries that are trying to achieve UHC.

**Figure 1**
**Hypothetical relationship between public health center, TB control programme and primary health care**

<table>
<thead>
<tr>
<th>Needs based approach</th>
<th>Community participation</th>
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<tr>
<td>Strengthen public health nurse activity</td>
<td>Promote participation of community</td>
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<th>Holistic approach</th>
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<td>Health in All</td>
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**Message from the Course Director**

**Yohhei Hamada**
**JICA advisor for the TB Control Program in the Philippines**

In the TB Control Course last year, I had the privilege to serve as a course director. I would like to take this opportunity to report on the international TB control course in 2018 as well as share my current work as a JICA advisor for the TB Control Program in the Philippines.

The international TB Control Course in 2018 entitled “Ending TB in the era of Universal Health Coverage” was successfully held at RIT from 29 May to 13 July, 2018. The course welcomed 13 participants from 10 countries: Afghanistan, China, Iraq, Kenya, The Philippines, Solomon Islands, Thailand, Timor-Leste, Zambia, and Japan. The course was funded by the Japan International Cooperation Agency with substantial support from various partners including the World Health Organization.

Through the comprehensive set of lectures including new and advancing topics such as Universal Health Coverage, the participants enhanced their knowledge and skills substantially. This was clear from their final action proposals, with selection of topics highly relevant to TB control in their respective countries with inclusion of new and innovative topics. As one of the organizers, I hope that the course helped participants advancing TB control in their own countries.

Currently, I’m working as a JICA advisor for the TB Control Program in the Philippines, to give technical assistance in several areas. One of my tasks is to support development of national guidelines on the programmatic management of latent tuberculosis infection in light of the updated WHO policy published in 2018. The national consultative workshop was held last December and we discussed new recommendations such as expansion of target groups for preventive treatment and use of shorter treatment regimens. Based on the consultation, the guidelines are now under development. This assignment has also given me a chance to meet and collaborate with alumni of the training course. I’m really excited, having witnessed the great network of the alumni leading TB control in the Philippines at the national and sub-national levels. I look forward to seeing and collaborating further with alumni of the TB training course in the near future.
BACKGROUND

Zambia is ranked among the countries with high-burden of TB and HIV in the world. In partnership and collaboration with the Ministry of Health through the National TB Program (NTP), JATA Zambia was established in 2008 to help mitigate the spread of TB in the communities. So far JATA has implemented 3 projects in Lusaka and Chongwe districts over the last 10 years: in Lusaka District at 3 health facilities: Bauleni, Chilenje and Chelstone Clinics and in Chongwe district at 4 facilities; Chongwe District Hospital, Chongwe Rural Health Center (RHC), Kanakantapa RHC and Ngwerere RHC.

STRATEGIC APPROACHES

In line with the Zambia National Strategic Plan (NSP) drawing from the global strategies to end TB, JATA Zambia mainly utilized two approaches, namely: the community and technical approaches.

Community Approach: Community volunteers play an important role in building bridges between health services and their community. The health facilities in the project sites recruited community volunteers from catchment areas and trained the individuals to help raise TB/HIV awareness, provide referrals for presumptive TB cases to the health facility for diagnosis, facilitate early case detection through contact tracing and supervise treatment of TB patients.

Technical Approach: JATA Zambia aims to develop capacity of both individual health workers and institutional resources. Trainings were conducted to enhance skills to manage TB. Medical equipment was donated, in addition to renovation/construction of facilities at the project sites to meet the community’s demand for quality of TB services.

IMPLEMENTED ACTIVITIES THROUGHOUT THE PROJECTS

Community: Community sensitizations were conducted focusing on the knowledge, attitudes and practices in the community to identify prevailing myths and misconceptions. To complement the sensitizations, door-to-door visits were conducted to reach more people with TB/HIV awareness messages. Identified presumptive clients were referred to the facility while diagnosed clients were monitored in the community using DOTS. Bacteriologically confirmed clients were prioritized for contact tracing to enhance early case detection. To keep the volunteers motivated in these activities, incentive programs such as revolving loans and technical assistance for home gardening were offered.

Technical: The JATA project conducted regular capacity building trainings for various health professionals such as for laboratory personnel on TB laboratory, radiographers on X-ray film taking, clinicians on reading X-ray films and for nurses such as training of trainers, for training of community volunteers.

The trainings were facilitated by internal and external experts. Further, X-ray reading sessions were conducted to provide a platform to assess the skills and competence in reading chest x-rays. Regular monitoring visits to cross-check the TB registers assessed the performance of the facilities and helped improve recording and reporting. Regular support was provided by hosting data review meetings at district and provincial levels to review performance and set targets.

10 YEARS ANNIVERSARY

To review the progress and milestones reached over the last years, JATA held a 10th year anniversary on 14th September 2018. The 10th anniversary was graced by Dr. Jabina Mulwanda, the permanent Secretary for Health Services of the Ministry of Health, Zambia, and Dr. Nobukatsu Ishikawa, the Director Emeritus of RIT/JATA.

Message from a Participant

2017 Group Training Course
In Quality Laboratory Management for Tuberculosis in Universal Health Coverage (UHC)
- Applied for Global Threatening Disease Control-

“A Worthwhile Journey”
Catherine Ann Penilla Low SACOPON
The Philippines

We remember walking through the corridors of this institute full of mixed emotions on what awaited us and also being unfamiliar with one another. All of us were looking forward to heaps of knowledge and skills ahead and deeply imagining the possible challenges. Excitement was obvious in the faces of the participants who were picturing in advance what the whole new experiences would be like and at the same time, being anxious about the duration away from their families. We could not have imagined that men who had never touched cooking utensils would be very good cooks by the end of the course.
As the days passed the lectures and practices became more interesting. Smear preparation, media preparation, culture and identification of mycobacteria - these experiences will not be forgotten. The engagement and continuous support from the lecturers to ensure that we got enough was obvious throughout the course. The visit to the elementary school was joyous, and then came home stay where every participant enjoyed the Japanese culture and way of life, and to cap it off, the study trip to Hiroshima, Radiation Effects Research Foundation, Osaka Institute of Public Health, JATA Osaka Hospital and lastly Kyoto heritage sites will forever remain in our memory.

When the lighter parts were over, the ever transforming action plan workshops picked up the momentum that kept us engaged in group discussions just to ensure that no one was left behind. One of the highlights of the training was the microteaching lesson that made us nervous, but taught us to be more effective teachers.

It was a tough but a worthwhile journey with no regret. We believe that with all this experience gained, we should put it into action to positively change the TB world. The bonds built during the training should forever remain. This has been a great opportunity for all of us. We started as strangers and left as great friends. We believe this was not only an opportunity to learn, but also to gain new friends from across the globe. This has been more than just a training to learn technical expertise on quality laboratory management but also a journey through accepting the diversity of cultural existence and learning from each other's experiences, expertise, and problems. We may not have been able to go through all these successfully without the very hardworking, passionate, and patient mentors, facilitators, training coordinator, and all the staff at the Research Institute of Tuberculosis.

It was honored to join the course “Ending TB in the Era of Universal Health Coverage 2018” which was funded by JICA and organized in a great manner by RIT. Many activities that we experienced during this course, including workshops, group discussions, presentations, tutoring sessions, etc., trained us on how to analyze problems and perform “think-do-present” operational research. It was a good chance to expand our minds when we shared experiences with participants from various countries. We learned to accept the differences between each of us, and to help each other all the time. Other than the knowledge we gained, we all had the great honor and the highest privilege to meet Her Imperial Highness Princess Akishino, patroness of JATA. I believe that it was a very special and remarkable moment for all of us. During the 45 day period, we stayed at RIT in Kiyose city, which is a peaceful city with lots of trees, in the rain season and the weather was charming. When the course started, beautiful Hydrangeas were blooming all over the city. We really enjoyed a good life there with participants from many different cultures. We studied and discussed course materials together, learned how to cook, shared our food together, and took turns cleaning and using our shared kitchen. Finally, we formed really good friendships. We were also taken really good care of by Takarai san, who always helped us during our stay. I appreciated all of these valuable and unforgettable moments. The lecturers were so great and worked so hard for the participants, empowering them with knowledge and support. This course taught me so many things that will help me in my future.

All thankfulness goes to Dr. Hamada, Dr. Hirao and all RIT staff who supervised our Progress and pushed us for better situations with positive energy.

Never forget Japanese people with their kind hospitality, politeness, punctuality, and discipline; they deserve all of our respect.

I would like to extend my deep gratitude to all the people involved for their kind dedication, for the time we’ve shared, and for the good friendships we made. I am certain that all of these things will help us to plan our future path in our countries.

Doumo arigatou gozaimasu.

Message from a Participant

2018 Group Training Course
Ending Tuberculosis in the Era of Universal Health Coverage (UHC)

Ahmed Majid Ahmed AL-ISMEE
Iraq

Ahmed Majid Ahmed AL-ISMEE
Iraq

It was honored to join the course “Ending TB in the Era of Universal Health Coverage 2018” which was funded by JICA and organized in a great manner by RIT. Many activities that we experienced during this course, including workshops, group discussions, presentations, tutoring sessions, etc., trained us on how to analyze problems and perform “think-do-present” operational research. It was a good chance to expand our minds when we shared experiences with participants from various countries. We learned to accept the differences between each of us, and to help each other all the time. Other than the knowledge we gained, we all had the great honor and the highest privilege to meet Her Imperial Highness Princess Akishino, patroness of JATA. I believe that it was a very special and remarkable moment for all of us. During the 45 day period, we stayed at RIT in Kiyose city, which is a peaceful city with lots of trees, in the rain season and the weather was charming. When the course started, beautiful Hydrangeas were blooming all over the city. We really enjoyed a good life there with participants from many different cultures. We studied and discussed course materials together, learned how to cook, shared our food together, and took turns cleaning and using our shared kitchen. Finally, we formed really good friendships. We were also taken really good care of by Takarai san, who always helped us during our stay. I appreciated all of these valuable and unforgettable moments. The lecturers were so great and worked so hard for the participants, empowering them with knowledge and support. This course taught me so many things that will help me in my future.

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Doumo arigatou gozaimasu.
We are pleased to inform you that JICA TB training courses (formally called JICA Knowledge Co-creation programs) have been renewed for three years (2019-2021). As in previous years, two courses will be carried out. One course is “Ending TB in the Era of Universal Health Coverage toward Sustainable Development Goals” and the other is “Ending TB and AMR in the Era of UHC - Hands-on Knowledge and Skill Development for Laboratory Leaders”. As the titles indicate, the courses cover not only the TB program but also issues related to UHC/SDGs. For example, in “Ending TB in the Era of Universal Health Coverage toward Sustainable Development Goals”, issues related to the current movement of TB control and SDGs, such as multisectoral approaches and the UNHLM declaration, will be covered as well as the content of the 2018 course. We would also like to continue to highlight Japan’s experience of 10% annual reduction and possible contributing factors, which can be adopted as innovative approaches in countries which currently have a high burden of TB. We expect the course to contribute to End TB and UHC/SDGs.

We hope that the courses will have many applicants so that the opportunities for human resource development through JICA courses will be utilized effectively.

Here, we would like to indicate our appreciation for the support of the courses by Kiyose city local government and the citizens of Kiyose. Volunteers provide Japanese learning courses and home stay programs for participants. This year three participants spoke at the Kiyose International TB meeting. The meeting was organized by Kiyose city, the Japan BCG laboratory, and RIT/JATA to make Kiyose citizens familiar with global TB issues and the historical relationship of Kiyose city to tuberculosis research and control programs. Kiyose city is a place where medical facilities and institutes related to Tuberculosis has been located for a long time, since the pre-chemotherapy era. The three participants talked about the TB situations in their countries in a panel discussion facilitated by Dr Kato (Director, RIT) following opening remarks by Mr. Shibuya, Mayor of Kiyose city, and lectures by Dr Mori (Director Emeritus). The meeting also provided an opportunity for interaction between citizens of Kiyose and the course participants.

Recent News:
TB Courses have been renewed for 3 years (2019-2021)

Norio Yamada
Centre for Int'l Cooperation and Global TB Information

Newly joined RIT/JATA:
Ms. Kanako Toyosaki
Ms. Naomi Mochizuki

Overseas Office:
Ms. Mochizuki (JATA Myanmar Office)

Left RIT/JATA:
Ms. Sayaka Oguri (RIT/Zambia Office)

You are welcome to send us your news and voices!