



INTERNATIONAL MONETARY FUND
WORLD BANK GROUP

The Annual Meeting of IMF & World Bank Civil Society Forum

Host:

Stop TB Partnership Japan
(Special Purpose NPO)

Date:

October 11, 2012
9 a.m. to 10:30 a.m.

Venues:

Tokyo International Forum
Hall D1

Theme:

Human Resources Development for International Health in future,
reviewing International Training Courses on TB Control.

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Back Ground Information of International Training Course on TB Control	

1. Concept:

Theme:

Human Resources Development for International Health in future, reviewing International Training Courses on TB Control.

Purposes and Background:

In addition to economic development, a stable society enabling a high level of human security is needed for the sound development of a society or a country. For this reason, the strengthening of the health services through adequate investment has been advocated. The development of human resources is a central component in the health policy, as argued recently by WHO. This health policy is confronting complicated and diversified problems that have been emerging as a consequence of rapid change in the global economic situation, demographic and epidemiologic transitions, and environmental and climate changes, as well as changes in people's way of thinking. To properly address these issues, it is urgent that we ensure sufficient human resources with high capability in the health sector in every country.

This forum will discuss the issue of developing human health resources from the viewpoint of how it should be achieved and what could be done for it, taking the experience of the international training course for TB control in Japan as an example.

Main Foci of Discussion:

- What are the achievements and lessons of the one-disease-oriented, vertical program on bilateral cooperation by Japan in health?
- The vertical approach has been criticized from the viewpoint of the optimum allocation of resources and the sustainability. Also, its limitations have been pointed out. How can these problems be addressed now?
- Japan has a long tradition and the world's greatest achievements in human resource cultivation for TB control. What are the impacts and lessons?
- Can technical know-how's obtained from the experience in TB control be applied to other health areas, or more comprehensively, to the overall health system? Similarly, how can the experience and the human capacity that have been established in TB control be utilized in other health areas?
- Is it possible for TB control and other health areas to communicate better so that they can reciprocally improve upon each other? If this is possible, what is the most effective approach?
- What were the achievements gained and lessons learnt from the MDG strategy?
- What health policy is needed in the post-MDG era, and how should we approach human resource development in the latter? What roles can Japan play on those realms?

2. Program :

Chairperson:

Toru Mori

Director Emeritus, Research Institute of Tuberculosis, Japan
Anti-Tuberculosis Association Board Representative, Stop TB
Partnership Japan

Plenary presentation:

Tadao Shimao

Adviser, Japan Anti-Tuberculosis Association

Presentations:

Akira Shimouchi

Vice Director, Research Institute of Tuberculosis, Japan Anti-Tuberculosis
Association Board Member, Stop TB Partnership Japan

Richard D'Meza

Former Director, National Tuberculosis Control Programme
Ministry of Public Health and Population The Republic of Haiti

Hideo Maeda

Deputy Director General for Technical affairs,
Tokyo Metropolitan Government, Bureau of Social Welfare and
Public Health

Mitsuo Isono

Senior Advisor for Health Sector, Japan International Cooperation Agency

Reshad Khaled

Head of Board, Director in Chief,
Medical Association KENSHIKAI Reshad Clinic
Karez Health and Educational services

Eiji Marui

Professor, University of Human Arts and Sciences

Shiro Konuma

Director, Global Health Policy Division, International Cooperation Bureau,
Ministry of Foreign Affairs

3. Profile:

Tadao Shimao

Adviser, Japan Anti-Tuberculosis Association

1948: Graduated from Tokyo University School of Medicine.

1949: Medical staff of Japan Anti-TB Association(JATA).

1975-84: Director, RIT, JATA.

1990-1993: Chairman, Board of Directors, JATA.

1994-2001: President, JATA

2001- : Adviser, JATA.

2000-2006: Chairman, Board of directors, Japan Foundation for AIDS Prevention.

2006-2011: President, JFAP.

1975-85: Member of Executive Committee of IUAT(Last 4 years its Chairman).

1987-90: Executive Board member, WHO.

Toru Mori

Director Emeritus, Research Institute of Tuberculosis, Japan Anti-Tuberculosis Association.

Board Representative, Stop TB Partnership Japan

Dr. Toru Mori, MD, PhD, Chair of the Symposium, is a tuberculosis expert. He was formerly Director of Research Institute of Tuberculosis, Japan Anti-Tuberculosis Association, that he served about 40 years. Currently, he is Director Emeritus of the same Institute, and also Representative Chair of the Executive Board of Stop Tb Partnership Japan.

Akira Shimouchi

Vice Director, Research Institute of Tuberculosis, Japan Anti-Tuberculosis Association Board Member, Stop TB Partnership Japan

Dr. Shimouchi as Vice Director, RIT, Director International Program, JATA, currently he is engaged in TB projects in Myanmar, Cambodia, Indonesia and Philippines, previously for Yemen and Nepal. He used to work as Medical Officer for acute respiratory infections for WHO Western Pacific Region, as Director of Public Health Office, rural area of Kyoto Prefecture and Medical Officer for Infectious Disease Control for Osaka City Public Health Office.

Richard D'Meza

Former Director, National Tuberculosis Control Programme Ministry of Public Health and Population The Republic of Haiti

Medical Doctor. **University :** 1967 – 1973 : Diploma of Doctor in Medecine, Faculté de Médecine et de Pharmacie, Port-au-Prince, Haïti. 1997 -2002 : Licence in Management, Université Quisqueya,

Haïti.

Cours postuniversitaires : Gestion de programme TB : 1987, Kiyose, Japon.

Développement de Protocole d'étude : 1989, Montréal, Mac Gill University. Gestion de programme TB : 2005, Cotonou, Bénin. Prise en charge TB-VIH: 2005, Sondalo, Italie.

Prise en charge TB MDR: 2006, Hinche, Haïti. Prise en Charge PVVIH : 2007, Hinche, Haïti.

Prise en charge TB MDR: 2010, Santo Domingo, République Dominicaine.

Stages cliniques en maladies respiratoires : Sanatorium de Port-au-Prince : 1973-1975. Hôpital Forlanini, Rome, Italie : 1976. Centre hospitalier Thoracique de Montreal. Canada, 1989.

Postes occupés : 1973 -1975 : Résidence au Sanatorium de Port-au-Prince. 1976 – 1978 : Médecin au Sanatorium de P-au-P. 1978 – 1980 : Médecin-chef, Hôpital Tabou, Côte d'Ivoire. 1980 – 1986 : Médecin au Sanatorium de P-au-P. 1986 – 1990 : Chef de service de Médecine au Sanatorium de P-au-P. 1990 – 1994 : Médecin, Clinique TB , CDS.

1994 – 2004 : Clinique Privée. Novembre 2004 – Septembre 2012 : Coordonnateur PNLT.

Hideo Maeda

Deputy Director General for Technical affairs, Tokyo Metropolitan Government, Bureau of Social Welfare and Public Health

M.D., M.P.H. Born in 1955, Graduate from Nippon Medical School in 1982.

Tokyo Metropolitan Government finding employment in 1983 Achieved International tuberculosis training course in 1990. After working at metropolitan hospital, public health center, bureau of social welfare & public health duty, incumbent than 2012

Mitsuo Isono

Senior Advisor for Health Sector, Japan International Cooperation Agency

Graduated from Tohoku University, School of Medicine in 1980 and got PhD in 1987.

Finished the residency as a medical doctor in the Tohoku University hospital.

After 21 years experiences as neurosurgeon in Oita Medical University, retired the position of the associated professor in 2003. Thereafter, started to work in the field of international cooperation and became senior advisor for health sector of JICA in 2009 after 2 years assignment as the visiting senior advisor. From 2006 up to now, working as the chief advisor of JICA TB control project in Afghanistan.

Khaled Reshad

Head of Board, Director in Chief, Medical Association KENSHIKAI Reshad Clinic Karez Health and Educational services

Graduated from the Kyoto University Medical College in 1976. After worked at some hospitals in western Japan, opened Reshad Clinic in Shimada City Shizuoka prefecture in 1993. Launched Afghanistan NGO "Karez" in 2002 working on medical and educational services. Contributing to the

community medicine in Shimada City, continued volunteer-medical-service activities for suburb villages. Awarded the 61th Japanese Public Health Award, and other prizes.

Eiji Marui

Professor, University of Human Arts and Sciences

Juntendo University School of Medicine, Dept of Public Health(2000-2012), Research Institute, International Medical Center Japan(1996-2000), University of Tokyo, Dept of Epidemiology and School of International Health(1977-1996)

Shiro Konuma

Director, Global Health Policy Division, International Cooperation Bureau, Ministry of Foreign Affairs

Graduated from Faculty of Medicine, the University of Tokyo in 1992, worked for the University of Toyo Hospital before entering the Ministry of Foreign Affairs of Japan in 1994. In 1996, he studied at INSEAD in France. Prior to taking on his current role, he was Counsellor of the Permanent Mission of Japan in Geneva, responsible for development and macro-economic issues in the WTO and other trade related organizations.

4. Plenary Presentations:

Importance of Human Resources in Health Program from Experiences of International
Training Course on TB Control Organized by JICA and RIT, JATA

Dr. Tadao Shimao

Dr. Mori (Chair): Thank you for coming to this symposium on human resource development for international health of the future, reviewing international training course for tuberculosis control.

Japan has a long tradition in training tuberculosis experts from developing countries at the Research Institute of Tuberculosis, sponsored by JICA.

Needless to say, the program had a tremendous impact on tuberculosis control of countries and also internationally, through the enhanced capability of the trained staff that was sometimes enforced by the effective combination with a technical cooperation project by JICA. However, we should pay more attention to the fact that the enhanced capability on tuberculosis benefits not only TB control, but other areas or the health system, or health in general.

In the following presentations and discussions we will see how it is possible and how to enhance that possibility in actual settings.

We would like to start the session with the introductory lecture by Dr Shimao. Dr Shimao is an Advisor of JATA, and, having more than 60 years career in tuberculosis research and services in Japan and worldwide, he is still a real mentor on TB matters. He will give us an overview of the importance of human resource in health programs from a historical perspective of recent TB control.

Dr. Shimao: Good morning, ladies and gentlemen. Thank you, Mr. Chairman. I'd like to talk about the importance of human resources in health programs based on my experience on international training courses on TB control organized by JICA and RIT JATA.

The 1970's and 1980's were really the winter days, which were the difficult days, for global TB control. Due to marked progress in TB chemotherapy first in the late 1950's, the development of combined-usage of isoniazid, streptomycin and PAS, then, in the 1970's, the initial four-drug combination isoniazid, rifampicin, pyrazinamide, and streptomycin or ethambutol, followed by four months of isoniazid and rifampicin, it has become possible to cure nearly all of the TB cases in industrialized countries.

However, TB in developing countries was neglected in spite of the magnitude of this problem. In 1978, "Health for All by the Year 2000" was announced in Al-Mata, and the "primary health care" concept was proposed to achieve this target.

Japan supported global TB programs during the winter days of TB. Under the primary healthcare concept, all disease control programs should be integrated into primary healthcare, but, regrettably, the development of primary healthcare was very slow. But Japan assisted global TB control during this period, first by initiating an international training course on TB control in 1963, just one year before World Bank and IMF had their last meeting in Tokyo. Then, Japan assisted in global TB control by starting bilateral technical cooperation and grant aid programs for TB control in developing countries, such as Afghanistan, Yemen, Nepal, the Philippines, Cambodia.

The global TB program was re-evaluated in the 1990's, mainly through the efforts of Dr. Kochi who is here today. Why? The four reasons can be: Firstly, an increase of TB due to the HIV epidemic, particularly in Africa; Secondly, the success of short-course chemotherapy under field

conditions in East Africa; and, by using the new health index DALY, TB control was found to be one of the most cost-effective health interventions and World Bank started to give loans to the National TB Program in China; Thirdly, there was an increase of MDRTB; Fourthly, another important factor was the movement of population from high to low TB prevalence countries, and therefore, in low-prevalence countries, the majority of TB patients were overseas-born patients.

A resolution to strengthen TB programs was approved at the World Health Organization, World Health Assembly, in 1991. Dr. Kochi played a very important role in this resolution, and progress thereafter. The resolution to cure 85% of newly detected smear-positive pulmonary cases and to detect 70% of such cases by the year 2000 was adopted at the World Health Assembly in 1991.

How to achieve this target? One way is to cooperate with national TB programs in TB high-prevalence countries; secondly, strengthening operation research; and thirdly, promoting research and development. In 1994, WHO started the DOTS strategy of TB control, in which governments should give top priority to TB programs and case-finding by direct-smear microscopy for symptomatic cases. Thirdly, the treatment of TB cases with a standardized regimen of chemotherapy, and drug-taking be supervised. Fourthly, procurement and distribution of TB drugs to the outskirts of the country. Finally, a TB registration and reporting system that provides an evaluation of treatment outcome by cohort analysis.

In 2000, the G8 summit was held in Okinawa, Japan, and in this G8 summit meeting then-Prime Minister Mori proposed to cooperate on infectious disease control in developing countries and all G8 summit countries concurred. In the next year, 2001, a United Nations General Assembly Special Session was held on the HIV epidemic. In the following year, 2002, Global Fund for AIDS, TB, and Malaria was founded. In the following year, 2003, the global fund started operations.

But new hurdles for global TB control also appeared during the same period. One is that the move of the population from TB high-prevalence to TB low-prevalence countries has continued. Second is the changing disease pattern of TB under the impact of the HIV epidemic. As you know, among HIV-infected persons, the hypersensitivity just decreases. That causes less caseous degeneration, less cavity formation and decrease of smear-positive pulmonary TB cases and an increase of the smear-negative pulmonary TB cases. So, there is a need for X-ray and other new technologies to detect smear-negative TB cases. And there was a further increase in the MDRTB cases during this period.

Another important topic is the development of new TB drugs. Among currently used TB drugs, rifampicin is the newest. However, it was developed in 1966, so that means that, in the past 46 years, no new TB drugs have arrived. But now, new potent TB drugs, quinolones and rifapentine, are already available and at least three or four other new potent TB drugs are now in phase III or phase IIB of clinical trials. One of them, Delamanid, was developed by Otsuka Pharmaceutical Company in Japan. In a few years, all of these new drugs could be used to treat MDRTB, but not only will it treat MDRTB, there is a good chance that it might be possible to shorten the duration of

chemotherapy. Currently, it is six months but it can be reduced to three to four months. Also, it can be used as a drug to treat latent TB infection. Currently available drugs are only isoniazid and rifapentine. Moreover, there may be another good chance to treat TB cases complicated with HIV, because Delamanid seems to have no drug interaction with existing antiretroviral drugs.

But we have to think of the characteristics of TB control. TB is a chronic infectious disease, and sustained efforts for several decades are needed to control TB in high-prevalence countries. It ranges from case detection to treatment and prevention. It requires drug procurement and delivery systems, supervision of drug-taking, registration and reporting systems, and eventually development of health systems. TB control could also be a good model for control of NCD's, as shown by the experiences of Japan.

Human resources are the key to success of national TB control programs. In Japan, we started training staff to engage in a national TB program soon after the war. In 1946, one year after the end of the war, we started to train public health nurses and in 1948 we started training doctors to engage in TB control. Staff with excellent knowledge of tuberculosis engaging enthusiastically in a national TB control program is a key to success of Japan's national TB control program. We actually succeeded in national TB control and started international training on TB control, as I said, in 1963, in cooperation with the then-OTCA, also known as JICA.

We have a fifty-year history of international TB training. The course has been jointly organized by the WHO and JICA since 1967. The curriculum was modified several times to align with the changes in WHO's policy and the situation on TB. However, operation research has been a key element of the training course, at least in the past 20 years. Already, 2182 participants from 97 countries in the world have completed the course and they are working at the frontlines of TB control around the world. They are the key personnel for the future success of new global TB control in the coming decades.

Thank you.

Dr. Mori: Dr. Shimao, thank you very much for this wonderful introduction.

**Importance of Human Resources
in Health Program from
Experiences of International
Training Course on TB Control
Organized by JICA and RIT, JATA**

Dr. Tadao SHIMAO
Adviser, JATA
Director emeritus, RIT

1970s and 80s.

Winter period for Global TB Control

- **Due to marked progress in TB chemotherapy, it had become possible to cure nearly all TB cases in industrialised countries, however, TB in developing countries were neglected in spite of the real magnitude of the problem.**
- **In 1978, "Health for all by the year 2000" was announced in Al-Mata, and "primary health care" concept was proposed to achieve HFA.**

**Japan supported global TB program
during the winter period.**

- **Under PHC concept, all disease control programs should be integrated into PHC, however, its growth was very slow.**
- **Japan assisted global TB control during this period by ① initiating international training course on TB control in 1963, and ② starting bilateral technical cooperation and grant aid program in TB control of developing countries such as Afghanistan, Yemen, Nepal, The Philippines, Cambodia, etc.**

**Global TB problem was
re-evaluated in 1990s.**

- **Increase of TB due to HIV epidemic, in particular, in Africa.**
- **Success of SCC under field conditions in East Africa.**
- **By using new health index DALY, TB control was found to be one of most cost-effective health interventions, and WB started to give loan to NTP in China.**
- **Increase of MDRTB.**
- **Move of population from high to low TB prevalence countries.**

**Resolution to intensify TB program in
WHA in 1991 and Progress hereafter.**

- **Resolution to cure 85% of newly detected S+PTB and to detect 70% of such cases by the year 2000 was adopted in WHA in 1991.**
- **How to achieve the target : ① Cooperate with NTP of TB high prevalence countries, ② Strengthen OR, and ③ Promote research and development.**
- **1994 : WHO started DOTS strategy of TB control.**
- **2000 : G8 summit agreed to cooperate in infectious diseases control in developing countries.**
- **2001 : UNGASS was held for HIV epidemic.**
- **2002 : Global fund for AIDS, TB and Malaria was founded.**
- **2003 : GF started to work.**

**New hurdles for global TB control
appeared during the same period.**

- **Move of the population from TB high prevalence to low prevalence countries has continued.**
- **Changes in the disease pattern of TB under the impact of HIV epidemic → decline of S+PTB → increase of S-PTB → Need for X-ray and new technologies to detect TB**
- **Further increase of MDRTB**

Development of new TB drugs

- ***Among currently used drugs, RFP was newest, however, it was developed in 1966.***
- ***Now, as new potent drugs against TB, new chinolons and rifapentine were already developed.***
- ***At least 3 other new potent drugs are now in phase III or II B of the clinical trial. One of them, Delamanid, was developed by Otsuka Pharmaceutical Industry, Japan.***
- ***In a near future, they could be used to treat MDRTB, then, may be able to shorten the duration of treatment period and be used as a drug to treat latent TB infection.***

Peculiarities of TB Control

- ***TB is a chronic infectious disease, and sustained efforts for several decades are needed to control TB in high prevalence countries.***
- ***It ranges from case detection to treatment and prevention.***
- ***It requires drug procurement and delivery system, supervision of drug-taking, registration and reporting, and eventually development of health system itself.***
- ***TB control could be a good model for control of NCD, too, as shown by experiences in Japan.***

Human resources are the key to the success of NTP

- ***In Japan , we started training of staff engaging in NTP soon after the War, as the staff with excellent knowledge on TB and engaging enthusiastically in NTP is the key to success of NTP of Japan.***
- ***We succeeded in Japan, and started international training on TB control in 1963 in cooperation with then OTCA (currently JICA).***

International training course on TB control, 50years anniversary in 2012.

- ***The course was jointly organized by WHO and JICA since 1967.***
- ***Curriculum was modified several times in accordance with the changes in WHO policy and situation of TB, however, OR was the key element of the course in the past 20 years.***
- ***2182 participants from 97 countries of the world have already completed the course, and working in the global front line of TB control, and they are the key personnel for the future success of new global TB control in the coming decade.***

5-1. Presentations:

Experiences in International Training Courses on TB Control for 50 years in Japan

Dr. Akira Shimouch

Dr. Mori (Chair): Now, let's move on to the presentation of the symposium speaker. Our first speaker is Dr Shimouchi, vice-Director of RIT, JATA, and a responsible person for the management of the international training course in RIT. He will make presentation on the past, present, and future of the course.

Dr. Shimouchi: Earlier, Dr. Shimao mentioned an important matter. I'll just repeat that, and then add some other slides.

About the initiation of RIT training course: It was held in 1963, the first one ran for six months. The curriculum was the English version of the in-country training course for doctors, based on experiences of Japan. Seven participants took part in the course, mainly from Asian countries. At the same time, it strengthened the teaching capacity of RIT. WHO Western Pacific Region offered RIT staff the opportunity to be trained in other countries. It was decided that the course was to be jointly sponsored by WHO and JICA. Thus, the framework of cooperation of WHO and the Japanese government was established.

As for the characteristics of the RIT training course, we follow the global standard on knowledge, skills and strategy recommended by WHO, such as the WHO DOTS strategy and STOP TB strategy, and we have many lecturers who are internationally-recognized persons from WHO, CDC, and IUATLD.

Based on our own experiences of TB control in Japan and international cooperation through JICA in other Asian and African countries, we used those skills in the course. We emphasized hands-on training, that is, operation research or laboratory skills, to obtain skills to cope with new problems. The course is long enough to acquire the skills: 10 weeks for laboratory and three months for intermediate-level TB coordinators. They stay in a dormitory for exchanges of information with other participants and close tutoring by RIT staff. Those RIT staffs gain rich experiences through JICA projects in other Asian and African countries.

We organize field visits to observe well-organized health programs in Japan, and we have a nationwide network of public health centers to implement TB and other MCH (Maternal and Child Health) or other infectious disease control programs.

The prefectural governments, JATA branches, and Anti-TB Women's Associations wholeheartedly welcomed the participants and exchanged views and experiences in the fight against TB. Participants were impressed with them and motivated.

The ideal training is counterpart training. Short-term training, even for three months, is one part of human resources development. One ideal method is so-called "counterpart training," in the wordings of JICA. When a JICA project is running in one country, it is allowed to invite technical staffs to participate in training courses in Japan to strengthen their capabilities. After the training course, the trainee has chances to observe the way Japanese experts work in the country in routine service in any program. It is a golden opportunity for him or her to learn from experts in knowledge, attitude,

and practice in the field.

As for the impact of training courses, quantity and quality and success stories of course graduates would be considered. More than 2000 participants from 97 countries received training, and graduates are now working actively at the front lines in the global fight against TB. If the outcome of the action plan for operation research prepared at the training course needs to be evaluated, it could be followed up in a proactive manner. Graduates receive a newsletter from RIT every year to update their knowledge and to maintain a sense of unity and network until their retirement or for the rest of their lifetime.

Some graduates were promoted to higher posts such as National TB Manager, Director-General of Health, and even Minister of Health. JICA officially has a follow-up scheme to visit few countries at a time to interview graduates regularly.

I'd like to mention some anecdotal cases. As part of JICA follow-up activities two years ago, I visited several graduates in China. They were all motivated and were continuing to work proactively to make contributions to the TB program at the provincial and national levels. They are national TB program managers and provincial TB program managers.

One example is the Minister of Health from Mozambique's visit to JATA headquarters. He reported that he utilized his skill in statistical analysis for other diseases. That skill gave him the opportunity to work on other health problems and eventually led to his promotion to Minister of Health.

On other occasions, I met two graduates in Bangkok. They participated in our course in the 1960's. Both were already retired but they were still active in diagnosing TB in government clinics as part-time staffs. They served more than 40 years and are still relied upon by health staffs at the clinics.

For TB control and health systems strengthening, components of TB control range, as Dr. Shimao mentioned, from case detection to community empowerment with health volunteers, the strengthening of diagnostic tools such as TB microscopy with quality assurance, treatment support, drug procurement and distribution, infection control, recording, reporting, monitoring analysis, and prevention.

Thus, a TB control program contains all aspects of health programs and is a model for other disease control programs such as those for HIV, malaria, and other communicable disease and non-communicable diseases. Therefore, all health programs need human resource development.

In coping with new problems, some Asian countries such as Thailand, Nepal, and China have shown a reduction in new TB notification rates. Priority activities in these countries may shift to other health problems. The policies and technologies recommended in developing and developed countries are becoming similar. If we look at demographic changes and the epidemiological situations of health problems, we recognize a global transition to an aging population and an increase in non-communicable diseases, some of them such as diabetes are associated with TB. We could utilize Japan's current experience in coping with TB among the elderly and those with some

risk factors such as diabetes in future training courses.

Conclusion and way forward: the method and organization of RIT's international training course on TB have been established through the efforts of the past 50 years. Its results and impacts were well appreciated. RIT has been well equipped with know-how's on human resource development for TB control. In the near future, we need to cope with other health problems: other communicable diseases and non-communicable diseases and MCH. However, the same principles of human resource development could be applied: provide health staffs with knowledge and skills on how to assess problems, initiate activities, evaluate any problems, and strengthen motivation. When an opportunity is available, based on its experiences, RIT would be able to participate in efforts to develop training strategy or training curricula or modules with experts on other health problems and health systems enhancements. Thank you.

Dr. Mori: Thank you, Dr Shimouchi. He has pointed out the importance of human capacity development, and through many years of activities for these purposes, RIT could achieve a deep commitment to global tuberculosis control.

EXPERIENCES IN INTERNATIONAL TRAINING COURSES ON TUBERCULOSIS CONTROL FOR 50 YEARS IN JAPAN

Akira Shimouchi
Research Institute of Tuberculosis (RIT)
Japan Anti-Tuberculosis Association (JATA)

Initiation of RIT training course

The first RIT course was held in 1963 for 6 months. Curriculum was the English version of domestic training course for doctors. (based on experiences in Japan)
Seven participated in the course, the Philippines (3), Thailand(2), 1 each from Malaysia, Indonesia.

To strengthen teaching capacity of RIT, WHO/WPR offered RIT staff with opportunity to be trained in other countries. It was decided that the course was to be jointly sponsored by WHO and OTCA (JICA).

Thus the framework of cooperation of WHO and Japanese Government was established.

Characteristics of RIT Training Course

- Follow global standard of knowledge, skills and strategy recommended such as WHO DOTS Strategy, STOP TB Strategy and lecturers from WHO, CDC, IUATLD, etc.
- Based on own experiences of TB control in Japan and international cooperation (JICA),
- Hands on training (operational research or laboratory skills) to obtain skills to cope with problems.
- Long enough to obtain skills (10 weeks, 3 months)
- Stay in dormitory for exchange of information with other participants and close tutoring by RIT staff.
- RIT staff have rich experiences through JICA projects.

Characteristics of RIT Training Course (continued)

- Field visit to observe well organized health programs in Japan.
- We have nationwide network of public health centers to implement TB and other health programs.
- The prefectural government, JATA branches and Anti-TB Women's associations whole-heartedly welcomed the participants, exchanged views and experiences in the fight against TB.
- Participants were impressed with them and motivated.

Ideal training "counter part training"

Short term training is one part of human resource development.

One ideal way is "counter part training".

When JICA project is running in one country, it is allowed to invite technical staff to participate in training course to strengthen their capability.

After the training course, the trainee has chances to observe the way Japanese experts work in the country in routine service.

It is the golden opportunity for him/her to learn from experts in knowledge, attitude and practice in the field.

Impact of training courses

Quantity and quality, success story of course graduates
2189 participants from 97 countries.

Graduates are now working actively in the front line of the global fight against TB. If outcome of action plan or operational research prepared at the training course need to be evaluated, it could be followed-up.

Graduates receive News letter from RIT every year to up-date knowledge and keep sense of unity/network.

Some were promoted to higher post such as National TB Manager, Director General of Health and even Minister of Health.

JICA has follow-up scheme to visit a few countries at one time to interview graduates regularly (every several years) for official evaluation.

Anecdotal evaluation

As JICA follow-up activities, two years ago, the speaker visited several graduates in China.

They were well motivated continue to work actively and contribute to TB program at provincial and national level.

One example, Minister of Health, Mozambique visited JATA HQ and reported that he utilized his skill of statistical analysis for other diseases. The skill gave him opportunity to work for other health problems and eventually leads to promotion.

In other occasions, two graduates in Bangkok. They participated in 1960s. Both were retired, but still active in diagnosing TB in government clinics as part time staff.

They served more than 40 years and are still relied on by health staff.

TB control and health system strengthening

Components of TB control ranges from case detection through community empowerment with health volunteers, strengthen diagnostic tools such as TB microscopy with quality assurance, treatment support, drug procurement and distribution, infection control, recording, reporting, monitoring and analysis, and prevention.

Thus, TB control programme, containing all aspects of health programme, is a model for other disease control: such as other communicable diseases and non communicable diseases.

Then all health programmes need human resource development.

Cope with New Problems

- Some Asian countries show reduction of TB notification rate, such as Thailand, Nepal, China. Priority of activities in these countries may shift to other health problems.
- The policy and technology recommended in developing countries and developed countries are getting closer.
- If we see demographic change and epidemiologic situations of health problems, we recognize global transition of ageing population and increase in non-communicable diseases of which are associated with TB.
- We could utilize the current Japan's experience for coping with TB among the elderly and some risk factors such as diabetes in future training courses.

Conclusion : Way forward

Method and organization of RIT international training course on TB have been established through the past 50 years of efforts.

Its results and impacts were well appreciated. RIT has been well equipped with know-how of human resource development for TB control.

In near future, we need to cope with other health problems; other communicable diseases and non communicable diseases and MCH.

However the same principles of human resource development could be applied. Provide health staff with knowledge, skills on how to assess problems, initiate activities and evaluate any particular health problems, and motivation.

When opportunity is available, based on its experiences, RIT would be able to participate in efforts of developing training strategy or "training curriculum/modules" with experts on other health problems under HSS.

5-2. Presentations:

HAITI

Dr. Richard D'Meza

Dr. Mori(Chair): Our next speaker is an international guest from Republic of Haiti, and an ex-participant of the RIT training course in 1987, Dr Richard D'Meza. After the course he became manager of the national TB program and he has contributed greatly to the TB control of the Republic of Haiti which was seriously affected by natural disaster in 2010. Dr D'Meza will be presenting a model of achievement for training in an actual setting of the health system in a developing country.

Dr. D'Meza: Good morning, everybody. My presentation slides are in French, because I thought that we'd have a translator. I'll try to present it in English.

For those who do not know, Haiti is a little country. You see, in green, we share the Island Hispaniola with Dominican Republic. It's near Cuba, Jamaica, and Puerto Rico in the Caribbean. The area is 27,000 square kilometers and we have a population of about 10 million. It's highly and densely populated. The capital is Port-au-Prince. The urban population covers 48%. Men live for about 60 years, women for 63 years, and the per capita revenue is about 650 USD. More than 77% of the population lives on less than \$2 a day. People who can read are about 49% of the population. The population increase is about 2% per year, and 30% of the population have no access to health centers.

The health indicators are very poor; the maternal mortality rate is three hundred per 100,000 births. The mortality of children under five years is 87 per 1,000. Children with chronic malnutrition comprise 22.7% of all children. The prevalence of HIV in the general population is 2.2%. It's a very bad situation.

We'll speak now specifically about TB. We have only the estimates of the WHO for 2011, where the mortality is about 38 per 100,000. About 4,000 people are dying from TB each year. The prevalence is 31,000 people who have TB in the country. The rate is about 300 per 100,000 people. As for the incidence, we have every year 23,000 new TB cases. But you have seen that there is a very large confidence interval for prevalence and incidence. For the incidence of TB with HIV, you have 4,000 people every year, and the rate is 43 per 100,000. The case detection rate is about 64%.

The problem we have is that we have never had a prevalence study to validate these estimates. So, we have estimates from WHO and from CDC. Everybody comes with his own estimate. That's why we need some prevalence study to be sure what the real rates are.

The trend of case-finding from 2004 to 2010 is that you have the same curve. There's no very large increase in TB of all forms. The green line is for smear-negative TB, and you see that it has decreased. The country has high HIV prevalence, and we also have a lot of smear-negative pulmonary cases. It might be due to lack of diagnosis by X-ray and sputum culture test. We don't have the means to diagnose these cases. It's the same for extrapulmonary TB cases. It's a flat line. These did not increase over the years. It's always the same numbers, because there are no means to diagnose these cases.

We began the project with money from the Global Fund during 2005 to 2009, and the problem, you see, is that there was not a very large impact of this money in the country in terms of

TB case detection.

We see that we have now social determinants of TB. We not only have to struggle against the disease, but equally we have to struggle against the social determinants of the disease, because it is a very, very poor country. For the social determinants, we have HIV infection and the economic situation of the population. You can decrease the mortality, the incidence and morbidity by addressing the inequalities between groups of population, because it is the poorest groups that suffer from TB.

About how to get the money: the problem is not whether to spend the money on a developing country. It's about how to spend the money on this developing country. You can spend a lot of money and can have no increase in case detection rate. So, before you go to a country you have to have a very good project and the project must be made with the population and with the government of this country. This is very important for us. We need, now, to have a good evaluation of this program to understand what we can do with this external funding and the results of this external funding.

This is my second stay in Japan. The first was in 1987 for the JICA course at RIT. I spent about two and a half months in Kiyose. It was a very, very good experience. When we are in Haiti, what we know about Japan is Toyota and Nissan. When you come, you see, I don't know how to say in English --- the civilization. There is a very good civilization. People are very -- how do you say that in English? You may feel something very fine, when you see a very good civilization, an ancient civilization.

As we can see, it's absolutely necessary to continue with this course, because of the new problems with tuberculosis: infection and co-infection with TB, MDRTB, migratory movement, and co-morbidities also. We know that diabetes is increasing in the world, and we'll have a lot of people with diabetes and TB. We hope that the collaboration between RESULTS and the STOP TB Partnership Japan will continue with Haiti. We have had the LAMP program. We introduced the LAMP method. We have more than ten technicians that have the capacity to do the task, and we hope that it will continue.

Also, we hope that we can do the prevalence survey. I don't know if we can, but it's very important for us to know and to have new methods to diagnose TB in the country, because smear is not enough. We have to have new methods to diagnose smear-negative TB, and to know really how many people are suffering from TB in the country.

My last slide shows the four flames for peace, love, faith and hope. We expect from this Conference that we can continue the global collaboration with RESULT and Japanese Stop TB Partnership. Thank you very much.

Dr. Mori: Thank you, Dr. D'Meza. As mentioned by Dr D'Meza, Stop TB Partnership Japan, together with Results Japan, another NPO, have been cooperating with Haiti on TB control, and now we are seeking for a possibility to expand it in various ways, so that the cooperation in TB could be

shown useful in strengthening the health system of the country. Towards the end, Dr. D'Meza spoke about the need for improving diagnosis on TB in Haiti, particularly patients who are not smear positive, and he referred to a new diagnostic technology, i.e., LAMP method, introduced to Haiti, under cooperation with our organizations, RESULTS and Stop TB Partnership Japan. I think many people here are not familiar with the LAMP method. Today, we have the company people that developed this method, and we would like them to explain this method.

Dr. Mori (Eiken, Ltd): My name is Yasuyoshi Mori. I am a scientist working at Japanese private company called Eiken Chemical. We at Eiken Chemical have developed a novel nucleic acid test system named LAMP that is simple enough to be used in resource-limited environment in the developing world. The LAMP system enables us to detect pathogens in clinical samples without using expensive equipments or well-trained operators. Actually, the LAMP system for TB diagnosis has been used in the Republic of Haiti since 2011 under the cooperation of Japanese NPO's Results Japan and stop TB partnership Japan and it was shown that TB-LAMP could be used quite easily in Haiti by local laboratory staffs after a brief training. So, from the position of a private sector company, we Eiken would like to contribute to improve global health and to human resource development by widely delivering the LAMP system to developing countries.

Dr Richard D'Meza
HAITI

Haiti



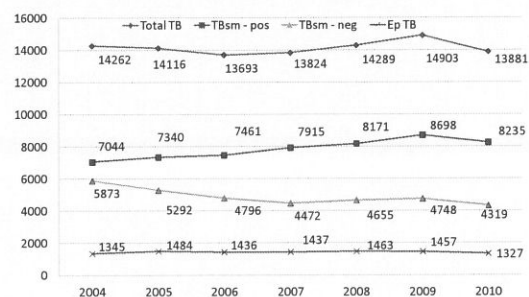
- Superficie : 27,750 Km²
- Population : 10 Millions
- Capitale : Port-au-Prince
- Population urbaine : 48 %
- Espérance de vie à la naissance : H : 60 ans ; F: 63 ans
- Revenu annuel per capita : 650 \$
- Population avec moins de 2 \$ par jour: 77 %
- Taux d'alphabétisation : 49 %
- Taux de croissance annuelle de la population : 2 %
- 30 % sans accès aux soins de santé

- Taux de mortalité maternelle pour 100,000 naissances vivantes : 300
- Mortalité des moins de 5 ans pour 1000 naissances vivantes : 87
- Malnutrition chronique : 22,7 % des enfants
- Prévalence du VIH dans la population générale: 2,2 %

Estimations OMS 2011

	Nombre (Milliers)		Taux pour 100,000	
		()		()
Mortality (excludes HIV+TB)	3.9	(3.7-4.1)	38	(36-40)
Prevalence (includes HIV+TB)	31	(15-52)	307	(152-517)
Incidence (includes HIV+TB)	23	(19-27)	222	(183-265)
Incidence (HIV+TB)	4.4	(3.6-5.2)	43	(35-52)
Case detection, all forms (%)	64	(53-77)		

Tendance du dépistage de 2004 à 2010



- Pour réduire l'incidence, il faut s'attaquer aux éléments propulseurs de l'épidémie et aux déterminants sociaux de la TB.
- Spécialement l'infection par le VIH et, les conditions sociales et économiques qui déterminent à la fois le décours de l'épidémie et l'exposition à ses facteurs de risque.
- Répondre aux injustices en matière d'incidence, de mortalité et de morbidité dues à la TB entre les différents groupes de population, les performances des systèmes de santé dans la délivrance d'interventions de diagnostic et de traitement et les conséquences financières pour les personnes recourant aux soins.
- La réalisation des OMD de TB exige l'extension des efforts de lutte contre la TB au-delà d'une « affaire courante » vers une réponse aux déterminants sociaux.

- Le financement basé sur les performances entraîne une discrimination à l'égard des pays les plus vulnérables qui n'atteignent pas les cibles car ils ont besoin d'un soutien plus fondamental pour leurs systèmes de santé en raison des contraintes structurelles : faible accessibilité, des barrières financières, culturelles ou sociales.
- Urgence d'évaluations indépendantes des progrès réels de la lutte anti TB et d'analyses complètes des problèmes du terrain qui permettent d'adapter les interventions et les cibles aux contextes spécifiques.

- 2ème séjour au Japon
- 1987, Cours de Gestion de Programme TB
- Apport inestimable dans ma carrière
- Nécessité de poursuivre cet enseignement spécialisé en raison des nouveaux défis de la TB : co infection TB /VIH, TBMDR, mouvements migratoires, co-morbidités.
- Espoir de poursuivre la collaboration avec RESULTS et Stop TB Partnership du Japon

MERCI A TOUS
Cardons allumées les flammes de la paix, de l'amour, de la foi et de l'espoir



5-3. Presentations:

Significance of local Government Officials' Participation in international TB training course

Dr. Hideo Maeda

Dr. Mori(Chair): Our next speaker, Dr Maeda, who is Director General at Health of Tokyo Metropolitan Government, is also an ex-participant of the RIT course. Unfortunately, because of the unexpected change in schedule of the Parliament that is convening currently, he could not come today, and instead, he sent me a note and comments. I am going to read it..

Dr. Maeda (Message) I would like to show you an example of how significant the international training on TB was for the local government officials like myself. I attended the international training course for tuberculosis control at RIT in 1990. At that time Japan was in an economic upturn, and immigrants, i.e., students and workers from Asian countries, were increasing steeply. As a result, the number of overseas-born TB patients was also increasing. The Tokyo Metropolitan Government began to consider drastic measures for this new health issue. As part of this effort, I was sent to this training. To me, following points were especially significant as a local government official.

1. Way of thinking: To view problems not only from local government perspective, but also from a global perspective.
2. A realization that major health problems are essentially common globally.
3. A clue to international collaboration with overseas government and experts for solving common health problems.


Since then, I have been working mainly on infectious diseases control at the Tokyo metropolitan government. I had the opportunity to develop a new program for the fight against infectious diseases based on the Asian Network of Major Cities 21 Project. This project aims to build a regular and strong network between healthcare professionals from major Asian cities, sharing specific experiences, and through the training of personnel.

In this program, collaborative research and surveys related to preventive measures for each infectious disease were implemented. As the first topic of study we chose TB control, which was launched in 2005 by the Tokyo Metropolitan Government.

Currently, many cities in Japan are implementing projects of international amity, in such areas as education and industry. Health is becoming a new issue in the program and the municipalities should consider the opportunities to internationally train their staffs.

Significance of local government officials' participation in international tuberculosis training course.

Hideo Maeda M.D.
Tokyo Metropolitan Government



Background


- I have received the training in the year 1990.
- At the time, Japan was in an economic breakthrough, and more and more students and workers were immigrating from abroad.
- Foreign TB cases from Asian countries were increasing rapidly.
- Japanese local governments faced for the first time the problem of the foreigners' TB.
- Tokyo Metropolitan Government recognized the importance of this issue, and began to consider drastic measures.

Significance of local government officials' participation in international tuberculosis training course

1. I learned how to work with the world standard health measures, not at the local level.
2. I recognized that the essence of major health problem is common throughout the world.
3. I learned how to solve the common health problem in cooperation with the foreign colleagues .
4. I found it important for us, the local

ANMC21
 Countermeasures to Combat Infectious Diseases

Countermeasures to Combat Infectious Diseases in Asia



Details of the project

Building a regular and strong network by health professionals (Doctors & Researchers)

- 1) Communication framework among administrative, research and medical institutions
- 2) Sharing specific experiences, including clinical features, expertise and know-how
- 3) Training of specialized personnel

Details of the project

2. The Joint Research and Survey

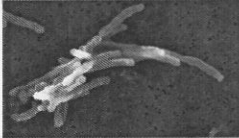
- 1) To identify unknown pathogenic organisms
- 2) To identify infection routes
- 3) To establish appropriate medical treatments and upgrade epidemic prevention measures

Agreed upon by the ANMC21 at the 4th Plenary Meeting in Jakarta in 2004

The Joint Research and Survey on TB
Hanoi, Jakarta, Seoul, Taipei, Tokyo
(2008-Planning /2009-Launch)

Launch of the Joint Research and Survey on TB

1. Fact-finding survey on high-risk groups for tuberculosis in each city
2. Fact-finding survey on organizations in each city that provide tuberculosis prevention/treatment



Cities participated
(5 cities)
○Hanoi
○Jakarta ○Seoul
○Taipei ○Tokyo

Conclusion

Currently, many cities in Japan has been implementing projects of international friendship.

Each municipality has gained many achievements through the exchange in education and industry.

High achievement is expected in the field of health in the future.

For this purpose, the municipality should send personnel to the training actively.

It will contribute greatly to the

Tokyo Metropolitan Government

ANM 21
Countermeasures to Combat Infectious Diseases

Thank you for your attention!

5-4. Presentations:

A report on the application of the TB International training to The Local and home treatment

Dr. Mitsuo Isono / Dr. Reshad Khaled

Dr. Mori(Chair): We have still another ex-participant of the RIT course who was scheduled to be here as a speaker, i.e., Dr Khaled Reshad. He is originally from Afghanistan and now holds Japanese nationality. As you see in his bio, he was trained at RIT, worked for a JICA project in Yemen, and has been very active locally and internationally. Today, unfortunately he apologizes for not being able to come, but fortunately we have Dr Isono here in his place. Dr Isono is recently completed the Afghan Project of JICA. Dr Isono, please.

Dr. Isono: Thank you, chairman. In the absence of Dr. Reshad Khaled, who has been a great mentor to me during my work in Afghanistan, I would like to present his speech on a report concerning the application of TB international training to local and home treatments.

Firstly, I'd like to briefly show the situation in Afghanistan. Although there has been significant progress in the last ten years, still the social conditions in Afghanistan are very bad, as in Haiti. You can see some major health indicators like infant mortality rate, under-5 mortality and maternal mortality rate here. Still, there are a lot of very, very bad conditions.

Moreover, a shortage of human resources for medical personnel has always been a critical problem in Afghanistan for these ten years. This slide shows the number of medical personnel in 2002, just after the Taliban era, as compared to Japan. As you see, there were only about 2,000 doctors and 2,000 nurses nationwide. I think this is nothing.

The shortage of medical personnel in Afghanistan is the same for national TB programs. I started to work in Afghanistan from 2006, but there were only five primary staffs at the Ministry to work for TB programs. Fortunately, the training course in Japan developed key and core staffs in the National Tuberculosis Control Program (NTP) in Afghanistan.

From 2004 to 2011, 16 NTP key staffs participated in the training course in Japan. Ten participated in TB control training. They are almost all medical doctors, central staffs working for NTP, or maybe TB coordinators in the key provinces. Another six laboratory technicians participated in the training for laboratory techniques. Now, those six staffs are working at the National Reference Laboratory or key regional reference laboratories. So, the training courses in Japan have contributed to developing the framework of this program. This was very important. Subsequently, local training systems have been developed by these NTP staffs. Now, so many doctors, nurses and community health workers can participate on local training for TB.

From this point forwards, based on Dr. Reshad's experience in his own clinic in Afghanistan, I'd like to show the application of the knowledge and capacity gained from local TB control programs to general health services at the community level. This slide shows the activities of his clinic, which is called Karez Clinic. It's located in a rural area in southern Afghanistan, serving as a primary healthcare facility. As you see, most of the patients are female and children. This is a typical primary healthcare facility in rural Afghanistan. The main diseases are acute infectious diseases, not tuberculosis: acute respiratory infections or acute watery diarrhea. These are the main diseases in these primary healthcare facilities.

Also, immunizations or vaccinations are the most important tasks in those primary healthcare facilities. These include BCG, polio, penta, measles, and tetanus. This clinic can provide immunizations not only at the clinic but also by outreach programs. As you see, huge numbers of vaccinations have been done in these six years by this clinic. This is a tremendous achievement.

As you see, in these slides, the majority of the daily activity in this clinic is not oriented to TB control. It's mainly immunization and treatment of acute infectious diseases, but Dr. Reshad always feels that all healthcare staffs have developed their capacity through local TB training, because this local TB training includes the community approach as one of the main components of this curriculum.

This slide shows health education given by community health workers to mothers in these primary healthcare facilities. This is the most important task of community health workers in these primary healthcare facilities. These workers could obtain their skills and knowledge to conduct this kind of training through the community approach at local TB training. It might be said that local TB training indirectly brought contributions or benefits to local primary healthcare services at the community level.

These are the activities of his clinic in Japan, not in Afghanistan. This slide shows the activities of home visit, home visit care, home visit nursing, or nursing homes. These interventions are not available in Afghanistan, but Dr. Reshad wants to conduct this community intervention in Afghanistan. Although this is a very big challenge for him, he is very sure that he can do it because his staffs are already capable of doing this kind of intervention through local TB control training.

This is his conclusion: The JATA international training courses at RIT had a positive effect not only on TB activities but also on general aspects of community health. Thank you very much.

Dr. Mori: Thank you, Dr. Isono.

A report on the application of the TB International training to the local and home treatment.

Medical Association KENSHIKAI Reshad Clinic
Karez Health and Educational services
Head of Board, Director in Chief
Dr. Khaled Reshad

Afghanistan Economy and Social Development Index

Item	Afghan Indexes by international organization	Japanese Indexes
GNI /person (US\$, Afghanistan : 2007 Japan : 2008)	250	39,632
Infant Mortality Rate (/1000 birth)	77	1.2
Under 5 Mortality Rate (/1000 birth)	97	0.7
Maternal Mortality Rate (/100000 population)	327	3.5
Children aged <5 years: Under weight for age (%)	39	None
Birth Attended by Health personnel (%)	32.4	100

Afghanistan unicef, AFG, Hdr, WHO 2010 (2007)
Japan Cabinet Office, Government of Japan: Annual Report on National Accounts 2008
National Institute of Population and Social Security Research

Afghanistan Number of Medical personnel

	male	female	total	/100,000 population	Japan /100,000 population
Doctor	1,598	605	2,203	8.12	212.9
Nurse	2,034	566	2,600	9.59	912.9
Midwife	22	467	489	1.8	20.3
Community health worker	859	467	1,326	4.89	34.7
Total	4,513	2,105	6,618	24.4	

Afghanistan National Medical Resource Research 2002
Japan The Ministry of Health, Labor and Welfare 2008
Japanese Nursing Association 2009

Significance of the training course in Japan

- The training courses in Japan have developed key or core staffs in National Tuberculosis control Program (NTP), Afghanistan.

From 2004 to 2011

16 NTP staffs participated in the training course in Japan.

10: TB control training

NTP staffs

6: Laboratory training

Staffs in National reference lab and regional reference labs

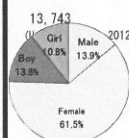
- The training courses in Japan have contributed to develop the framework of the program.

The activities of Karez Clinic in Afghanistan

Patients

(person) 42,194
Male
 186,489
 Boy (less than 5 years old) 41,634
Girl (less than 5 years old) 32,473
 total 302,790

patients of suburb villages



Structure of patient illness

From Jun. 2003 to Aug. 2012 (person)

ARI-Cough & cold (no pneumonia)	63670
ARI-ENT	45404
Acute watery diarrhoea	26504
Urinary tract infections	23109
Psychiatric disorders(PTSD)	19928
ARI-Pneumonia	15114
Urinary disorders	9571
Acute bloody diarrhoea	9452
Others	166514

Karez Health and Educational services

The activities of Karez Clinic in Afghanistan

From Sep. 2006 to Aug. 2012

<Vaccination>

It inoculates to a 0 to 2-year-old child for precautions against infectious disease.

	Visit inoculation	Inoculation at the clinic	Total
BCG	1465	5228	6693
Polio	4543	15410	19971
Mixed vaccine	3320	12325	14981
Measles	3320	4867	6580
Total	11336	37830	49166

<Tetanus>

The woman (from 15 years old to 45 years old) of a pregnancy marriageable age is inoculated for the precautions against infectious disease by childbirth.

	Visit inoculation	Inoculation at the clinic	Total
Pregnant	629	7686	8315
Not pregnant	1452	21393	22845
Total	2081	29079	31160

Tetanus



Polio



Karez Health and Educational services

Health Education to the mothers was performed in 183,630 persons to protect them from infectious diseases.



Karez
Health and Educational services

Reshad Clinic Home-visit medical treatment

Home-visit treatment annual average
306 times/year (32 persons/year)

Management of In-Home Medical care	72.5%
Home-visit care	73.7%
Home-visit nursing	38.4%
Home bathing service	9.5%
Short stay service	29.8%
Home-visit rehabilitation	14.6%
Outpatient Rehabilitation	23.0%

Death at home	27cases (58.7%)
Death at nursing home	4cases (8.7%)
Death at hospital	15cases (32.6%)

2006~2011

Conclusion

The JATA international training courses and the trainees had a positive effect not only in the TB activities but also in the general aspects on the community health.

Thank you for your attention.

5-5. Presentations:

International Health and Human Development

Prof. Eiji Marui

Dr. Mori (Chair): After the presentations of 3 ex-participants, I would like to invite international health expert outside tuberculosis, and listen to their views on the human resource development and the effort of Japan and RIT for it, from a broader perspective.

Firstly, may I invite Professor Marui. He was and is an instructor of public health in a medical schools and universities, and has substantial experience on international health.

Prof. Marui: My name is Marui. I work primarily for universities as just mentioned, and, in that sense, I am more on the side that produces producers and such people and no users of human resources. With regard to human resource training, the 3 elements that are required to move forward world health projects, that is, what we want is a project that has a good balance of knowledge and skills, and these 3 elements are what I always keep in mind.

Left is knowledge of epidemiology. This is quantitative, objective, and rational assessment. This technology will form the basis of knowledge. On the right is medical anthropology. Perhaps it would be better to call this medical sociology. This is knowledge or assessment that takes into consideration anthropological quality and history, such as cultural history. I believe that this therefore might be a very relevant field if you will, in that, it takes the counterpart into consideration, whereas epidemiology makes cold assessments. So, I believe that these two quantitative and qualitative knowledges, and another, which is the above, that is, political economics, are needed indispensably in the field of world health. We need to understand the situation properly, and understand the inter-relationships. Very roughly speaking, I think that we need to understand the inter-relationships of money and power.

It is very important to understand this properly, and this meeting recently of IMF and World Bank also indeed spoke on investment to world health, so this issue of money and issue of politics are very important. When training human resource, if one focuses too much on only the technology aspect, there will be issues of hardship in the actual field, so we have been devising a human resource training program that strikes a good balance of these 3 elements.

As one of the human resource training programs in Japan, there was a course on world health that was created at the graduate school of Tokyo University about 17 years ago in 1995 or so, and I was involved for the longest time on this course from the initial stages. Young people who come from this course are very active at international organizations, and I believe that this program is starting to show results.

However, with regard to human resource training in Japan, there are very many females today. The ratio of male to female is thus very skewed. Another is that, when the person is young, that is, when the person is a student, s/he is involved in activities with much interest, but such people are very few in number in reality. I believe that this also is tied to the fact that Japan's financial support to world health has been decreased; however, there is the big issue from before that the career path of people who have worked in world health have not done so well in Japan. This problem

still remains unsolved.

Therefore, there is the issue of whether to train human resource in Japan or train them abroad. I think that there also is the thinking that, when you want to do international work, it may be better to receive training at an international training organization. However, in this case, there is the other topic, which is another of today's topics, which is the issue of trainees leaving Japan. Actually, in the case of Japan, everybody comes back to Japan; they want to come back; however, in terms of a global issue, when you train human resource abroad, those may not come back to Japan, which is a problem.

This is a big issue, but, when you think about sustainability, the earlier slide was a triangle but I would like to think that this also would be a triangle or pyramid. First is the issue of people. It's about how much motivation a person has, and how much leadership quality a person has; meaning, all is dependent on the person.

Another point that will probably be very important is whether the person has this. At the lower right, we have been talking about various diagnostic technologies, biotechnologies, and testing methods in international courses of the Research Institute of Tuberculosis, and it is about how to execute specialist skills. However, at the same time, what is very important is system, which is at the bottom left. This is the system in Japan. This is really Japan's support system, and without this, even if the person has motivation, this person would get lost in the country or in the organization, so I believe that support and building an organization and system are indispensable.

Therefore, what is important for human resource training is not only training of people, rather what is important is having the tool or weapon that will allow the people to work. I think that we also need to probably have a system that will make the people live up to their potential.

Therefore, even in the international course for example at the Research Institute for Tuberculosis, this course has produced to date more than 2,000 people. At the same time, Japan Anti-Tuberculosis Association and Research Institute of Tuberculosis will begin to create a support-type system for that country. This is not only an issue of Research Institute of Tuberculosis; it is about how the other country can create a system that can make the best usage of human resource. I believe that this will become a very big problem. Without this, we think that human resource in developed countries that acquired and developed advanced tools will not return to Japan.

Lastly, I would like to discuss something briefly. Many of you in Japan would know this very well already; recently Professor Yamanaka received the Nobel Prize. Shibasaburo Kitasato, who was a candidate in 1852 for the first Nobel prize, was born in the Edo period, and he developed a serum therapy in epidemiology through research with Behring under Koch. However, after 4 years, he was offered a position in the US but he returned to Japan.

His belief was that basic research will definitely lead to national interest and development of the country, which led him to return to Japan. He got a strong conviction to return to Japan, and, at the same time, this is very important but Yukichi Fukuzawa, who later established Keio University, asked other businessmen and had those businessmen invest, and he created in Shiba a two-story

infectious diseases laboratory. So, even if Kitasato has much ambition, unless Fukuzawa and others create a support system in Japan, Kitasato would have never returned to Japan. He would not have been able to return to Japan, I believe. And this is also one of the things that Kitasato thought about, and what was realized was vaccine development and so forth. Moving basic medical technology development forwards, this leads to earnings.

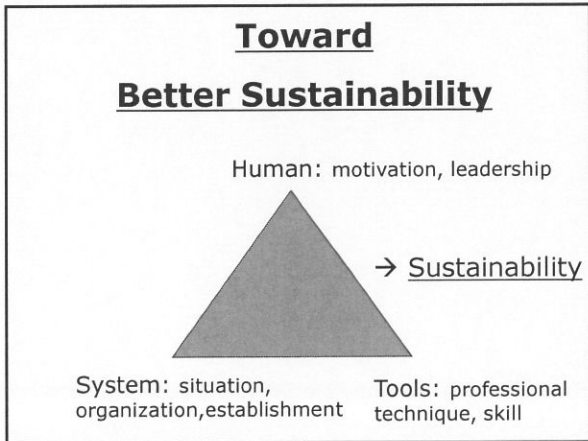
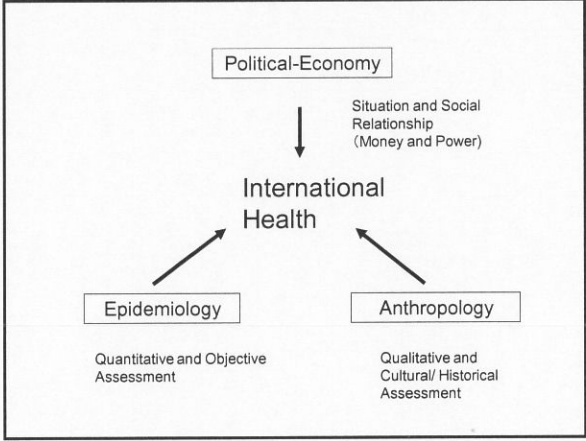
Japan was able to have a system at earlier on in the Meiji period that properly brings people back home who studied technology and knowledge overseas. This kind of historical lesson should be referenced today in the many developing countries, and, without this, I believe that, for example, researchers who studied research in countries like the US will not be able to return to Japan. There definitely is no simple way to resolve this; however, it is about how to create a system that not only trains human resource but a system that also bring such people on board, and a system and environment where such human resource can conduct research and activities properly. We need to think about this, and we believe that this is very important.

The international course at the Research Institute for Tuberculosis has played a very important role in the training of human resource, and we are very well aware of the continuous support for such courses was provided by the Research Institute for Tuberculosis. We strongly hope that this course will continue to remain a system for Japan, and continue to become an international system. This ends our presentation. Thank you.

Dr. Mori: Thank you, Professor Marui.

International Health and Human Development

MARUI Eiji
University of Human Arts and Sciences



Dr. KITASATO Shibasaburo(1852-1931)

- A Pioneer in Immunology
- Research at Berlin University with Berling under Koch for 4 years
- He offered a position from Oxford and Philadelphia
- But, he return to Japan with all odds
- By help of Fukuzawa (founder of Keio University) and some businessmen
- He established Research Institute of Infectious Diseases
- His belief was the improvement of basic sciences would strongly help nation's power in the world.

5-6. Presentations:

Dr. Shiro Konuma

Dr. Mori(Chair): Our final speaker is Dr. Konuma. Dr. Konuma is a medical doctor and an active diplomat, with the Ministry of Foreign Affairs.

Dr. Konuma: Thank you, I've got three issues to touch upon in my presentation. Firstly, lessons, or one of the lessons, from the MDGs, Millenium Development Goals. Secondly, the prospects for post-MDGs, and thirdly, Japan's strategy and role in these issues.

Firstly, on the lessons or one of the lessons of MDGs. As you know, MDGs have 8 goals, 21 targets, and more than 60 indicators. They are very clear, and clear enough on where political and financial resources should be directed. So, they have pretty much worked out for resource mobilization, and also worked well for tracking achievements, and then, in turn, for further resources mobilization. It worked as a very good cycle. It coincided with the emergence of philanthropy, and as a result, over the last decade health resources tripled. This was really good. And as a result, we have succeeded in containing AIDS. For maternal and newborn health, still some countries, especially sub-Saharan African countries are behind but many countries have a good track record on maternal mortality rate and infant mortality rate. They are MDGs 4 and 5.

But we have to look at the other side of the coin concerning MDGs. They may have lacked a comprehensive strategic approach, and some important areas were neglected. And, people tend to think that MDGs are all targets that they have to aim for, and forget others. I can name two. Firstly, reproductive health. Now the MDGs have reproductive health as MDG 5B, but initially it was not included in the MDGs. Finally, in 2007, after a seven-year effort by IPPF and UNFPA it was included in the MDGs. Now, this year, the UK took on the leadership to fight for family planning. They organized a July 11 family planning summit.

Secondly, in nutrition. The MDGs point out these issues only for children under five, but to complement this, a scale-up nutrition initiative was formed to address the first 1,000 days from inception, to include pregnant women. But the ICPD, International Conference on Population Development, in 1994 already pointed out the importance of covering both pregnant women and children.

One of the lessons we have drawn is that we have to declare targets, but we have to be strategic and comprehensive, and even determined to tackle socially or culturally very difficult issues such as reproductive health. This is one of the lessons drawn from the MDGs.

Post-MDGs: we are approaching the 2015 deadlines and discussion on post-MDGs is beginning. I'm not in a position to project results of negotiations, but what I can say is that we have to base this on the lessons learned from the MDGs. The current situation needs us to do so. That is, we have to be aware of the emergence or, more precisely, of the emerging recognition of the importance of NCDs, non-communicative diseases. NCDs are the leading causes of death. NCD deaths reach approximately 36 million deaths annually, compared to 1.8 million by HIV/AIDs. Even in Africa, there are 2.86 million deaths by NCD's compared to 1.2 million by HIV/AIDS.

It might not seem fair to compare a group of diseases to a single disease, but through

economic growth, especially in Africa where we see an average of 5% economic growth, societies and countries are changing. NCDs will become more and more important. So, against this backdrop: UN Secretary General Ban held a high-level meeting on NCD's at which more than 130 heads of states gathered. The leaders decided to tackle the NCDs. In other words, we have to tackle not only the politically important health burdens but also the real health burdens.

What should we do post-MDGs? We have to continue to fight the unfinished businesses of MDGs. We still lag behind on MDGs 4 and 5. And we have to tackle emerging business. This is what we have to do at post-MDGs.

In terms of assistance, we have to think of how to bridge current approaches to MDGs, such as vertical silo approaches to maternal and newborn health and others, to next approaches, in order to respond to a wide variety of diseases, maybe by integrating vertical programs into primary healthcare systems. This is one of the core components of health system strengthening towards universal health coverage. Already there exists diplomatic initiative for universal health coverage that is driven by the Global Health and Foreign Policy Initiative. This initiative is led by 7 countries including Norway, France, Thailand, Indonesia, South Africa and Senegal, and they are trying to table the UN resolution on universal health coverage to mainstream universal health coverage in post-MDGs. Already these several initiatives have been implemented.

Finally, Japan's strategy in MDG's and post-MDGs. Firstly, on resources, we have to continue to do a lot of work on MDG's. In 2010, Japan has already committed to more than 5 billion dollars over five years, for areas including water and sanitation, and maternal and newborn health. We have to steadily implement this commitment. On the post-MDG's, we have to lead discussions on making them work for everybody. To all health burdens and to all people -- that is, to mainstream health system's thinking toward universal coverage. That is the preparation for post-MDG's that Japan has to do.

Again, health system strengthening toward UHC should be the focus. And we have to prepare our own current assistance for health systems, strengthening what is already being done by the international course for tuberculosis. I need advice from, and would like to cooperate closely with the Research Institute of TB, Japan Anti-TB Association and STOP TB Partnership of Japan for health system strengthening. Thank you very much.

Dr. Mori: Thank you, Dr. Konuma.

6. Questions & Answers

Dr. Mori(Chair): We wish to begin our Q&A and debate sessions. We have still about 25 minutes left for these sessions. Firstly, we wish to receive questions for each speaker or comments to the speakers. Please raise your hand and ask your question.

Female Audience Member: Good morning. Excellent presentations. I'm a pediatrician from Washington, DC. My question to the gentleman from Haiti is, after the earthquake, was there an upsurge in TB cases and how was it handled?

Dr. D'MEZA: If I understand you, I think we have every year about 1,400 or 1,500 TB cases, but the problem is, as I discussed in my presentation, that we do not have the means to diagnose TB in children accurately. We don't have X-rays, we don't have culture tests. People working in the TB health centers are not physicians or nurses. They are people we are trained to do smears and treat people only when the smear is positive. So, we have only limited information regarding the changes in the number of new TB patients after the disaster, especially on children.

Dr. Kochi: Basically I have a comment and two questions. For these TB courses in Japan, I am a participant, a graduate. It has trained more than 2,000 people from almost 100 countries. It's a good course to train technicians. The question is, what do you want to do? Do you want to continue to train many people as technicians? They stay, then they help. It's very important work. Or, do you want to really move forward more strategically? Are you going to train some people who will actually be leaders in their particular area, in their particular countries? You know, focused investment.

Whereas, I'm just wondering, for me, I've been out of Japan for a very long time. It's a great country, producing great technicians, great cuisine, but very few people have been thinking strategically and moving very boldly. So I'm wondering, what does Japan want to do? Do you want to be old Japan, to train good technicians, in good technical conditions? It's great work. Probably, it doesn't make any difference on the whole.

Here, I think, as a Japanese community, where do you want to go in terms of international health? This TB training is a very good thing in the 20th century. However, are we going to continue this in the 21st century or not? It's a very strategic question. We have to think about the strengths and weaknesses of Japan. I don't think Japan has the capacity or resources to train the leaders at this stage. I'm teaching at several universities, and am really disappointed in the quality of students. This is sort of a fundamental question. If you want to have a new Japan, we have to change. This is one thing.

My question is in that case. Prof.Marui, I think what you spoke about applies domestically as well. There is no difference between international health and a domestic one. It's the same skill. This is one of the big myths. It is a really negative myth for international health and domestic health. If you cannot do a good job domestically, there is no way you can do a good job in international health. However, if you do a good job domestically it's not necessarily true that you can do a good job in

international health.

The second thing is, for Dr. Konuma, among other things, I don't know, but Japan probably is, partly because of Prof. Takemi and others, a part of this new movement of universal health coverage. I'm supposed to talk tomorrow. It reminds me of the mid-1970's, when primary healthcare emerged. I won't go on, but I'll talk about that tomorrow.

But one point is, again, do you think Japan, besides giving money, can really contribute to these areas? For example, about ten years ago, one of the assistants, she's a deputy of USAID who came to JICA and asked very tough questions on health systems. Do you have any health economists, really, who know, in Japan? Basically, there are only a few -- one or two. So moving toward this universal health coverage, which probably involves health financing and human resources as issues that will become dominant, I'm not sure Japan has kind of so-called potential experts. Why are you putting money into these things?

These are the things in my recommendations to the Foreign Ministry. They hate me. I ask "Why do you spread yourself so thinly without any strategic benefits?" Because you want to dance with the United States? Because the US's policy is this, so Japan is going to supplement very thinly? Or do you want to say, "OK, these are our areas and strengths. We won't do other areas. We'll do these areas."? It's kind of a Scandinavian style, OK? They are very clear: "We don't do this. We won't do that. We do this." Japan is completely the opposite. It's like a Chinese restaurant menu. You can have everything. No one gives a damn, when they accept Japanese money. There is no strategic political influence. This diagram, I'm really frustrated, looking particularly at Japanese ODA's. Do they have brains? Have they been sleeping since the mid-20th century?

Dr. Konuma, I'm worrying about what you told me... or is it deja-vu? A stupid mistake you're going to do again. Japan's a dog coming with a cheque, asking no serious questions or doing any serious negotiations. It's a laughing stock. What are you going to do?

Dr. Shimouchi: Firstly, about the RIT training course in the past and the future. In the past we have had a so-called advanced course. We invited those who had graduated once for leadership training again. It was finished, but we hope it could be reinstated. In the same way, in the domestic course, we also do TB training for many doctors and nurses. But also we invite only several persons for leader training for three weeks. One term is for one week, three times each year. It has been conducted for more than twenty years. I was one of the participants. They are the advocates of the TB program in each area of Japan. So, in the future, I'd suggest that TB may not be the highest priority. In those countries, the priority may be the stronger health system engineering combined with others, but we can organize or arrange the program for whatever the need appears to be in all of the participating countries.

Dr. Kochi: My strength is in tuberculosis. The TB community is really not exciting. So the good thing is that TB has the best data. There are two things. If you get trained in tuberculosis control, both in

politics as well as on data, as well as the people, you really can learn a lot. With that skill you can move to a new field. This is very, very good training. So don't stick to tuberculosis. It's not exciting to work on tuberculosis for three, five years. It's very good training, both domestically and internationally. Also, likewise, some good programs like in Peru. Most of the people in the Ministry of Health who move up usually come from tuberculosis, because the TB program is one of the best programs. So they got trained and exposed, but also they know how to do the politics. So in that sense I think for Afghanistan and for Japan, at different levels, TB control has lots of potential for application to elsewhere. In this sense, TB control programs, this course, has quite a lot of potential to move toward something else.

Dr. Shimouchi: Thank you for your advice. We will consider it in future.

Dr. Mori(Chair): Thank you. Dr. Kochi, who just spoke, is also a graduate of our training course.

Dr. Konuma: Just a quick response to the question and doubts posed by Dr. Kochi. In terms of universal health coverage and post-MDG's, we have now currently three out of eight areas in MDG's that are health-related, but this might not happen for post-MDG's. More on growth, more on environment. So we have to concentrate on one or two issues. Universal health coverage is key. It's deja vu, but it is

Dr. Kochi: Can Japan contribute something to that?

Dr. Konuma: Frankly, I'm quite doubtful about that. We don't have health economists who can work abroad, but we have lots of health economists who work for Japan. So it's an idea to connect

Dr. Kochi: Sure. I talked to Dr. Takemi and Dr. Shibuya. It's good.

Dr. Konuma: But Professor Shibuya, neither, he is not a health economist. He is a health data expert.

Dr. Kochi: Yes, but other people work together? What I'm hearing from my old colleague Landscape is changing, and I'm wondering if you know, for example, that health economics is nothing special. Simple macroeconomics, but for health, basically. So, if you have these human resources in other areas that can be mobilized, it's a different story. So far, in the paper that I read, I didn't see that point.

Dr. Konuma: That paper is very good, but how can we take away lessons? How to take away

lessons, how to make materials to be taught and courses to be possibly organized by Japan? It's a very hard task. I totally agree with you. So the role of Ministries is to unite or connect those already existing good health economists in the OECD and in WHO, to Japanese health experts. We have to educate young talents.

The second question, the portion of health in our bilateral assistance is only 2.7%, much lower compared to more than 25% of the USA or 15% of the UK. They are dominant in global health areas, in every area -- infectious disease, maternal and newborn health, family planning, and even health economics. One of the very good contributions in kind to the Indonesian government, which is trying to achieve UHC, is contribution in kind by DFID.

He's working as an advisor to the Ministry of Health of Indonesia. Fortunately, a young person working for him, the DFID contribution in kind, is a Japanese health economist. So maybe we might focus on this kind of assistance and increase the number of assistance -- because we don't have a market yet. Because we've got only 2.7% of bilateral, so the market is very small. So the task is to increase the market for the Japanese experts who would like to work abroad. Prepare the market. And I think the current government policy is in this direction, as they would like to set up the five-year strategy for life innovation, where Japan commits to contribute to the world through bioscience innovation, including health.

Dr. Kochi: One possibility is, one of the things I was asked some questions on when teaching, it struck me, it's very difficult to get real raw data, particularly money data, from the Ministry of Health. In other countries, it's much easier to access this. Lots of university researchers have much better access to write a paper and review or criticize or praise. In Japan, the government is really holding on to information so that academics, unless they have to go abroad, they can't get that kind of training. So if this government is much more open to releasing these data, there are lots of ways that Japanese academics or institutions can work on domestic issues. There is a straightforward application to international health and health systems.

Dr. Konuma: I totally agree with you. The pricing of medicine and the fee schedule is source of the power of the Ministry of Health. This is why we don't have health technology assessment, an HTA organization here in Japan. They may apply HTA to some area or marginal area of medicines and they are exploring possibility. But still we don't have HTA, though HTA is an international trend. France has established Haute Autorité de Santé. UK has already a very good working NICE, outsourcing the pricing to British academics, and based on this experience, they've established an international division in NICE to teach HTA to other countries, and Asian countries are now introducing HTA. So this is an area that we have to catch up on. Scarce disclosed information on the pricing, but at least we've got a quasi-value-based pricing, so maybe we have to connect all these effort and we should be involved in this global movement, because Japanese pharmaceutical companies would like to enter the market of Asian countries. We have to move in this direction.

Otherwise, we will not survive. This is what I think you have to do, and this is why I ask for advice from all of you, and especially from Dr. Kochi. Advice, please.

Dr. Mori(Chair): Thank you. It will soon be the time. In closing, Ishii, you have extensive experience at JICA doing human resource development among other programs. Any closing remarks?

Mr. Ishii: I've been working for JICA for the last 30 years, but it's shorter than the life of the international TB control training program conducted by RIT. What I want to stress in this meeting is the great advantage of this international TB training course.

JICA has a kind of regulation to control the long life of training programs. If the training course continues for ten years, we try to terminate it. But as an exception, the training course of this international TB training program lasted for more than the last 30 years. This means it has overcome the challenge of JICA regulations to last at least three times longer. So some secrets are lying in the program.

I remember the negotiation of JATA and RIT with JICA administration at that time that the innovation of the training program was the key message from RIT and JATA and to prolong that training program. But still, I'm wondering, what is the secret behind it? Why does the RIT training program attract international participants? Eventually, the demand or need in developing countries for that international training course became huge.

At the moment, I'm working on human resources for health programs on the global level as well as on the Asian regional level. We discuss lots of causes of the current problem of human resource issues in health: the shortage of this number, the poor quality, and the poor distribution. The strongest need or comments for human resources, especially working in rural or remote areas, is the demand for proper supervision, which supports health professionals working in remote areas. So supportive supervision is the key word to strengthen or to support human resources for health workers in remote areas. Again, I realized that the secret or advantage this international TB control program provided was this system of supportive supervision which RIT had been providing to the alumni of the courses constantly through its global network.

As Dr. Marui mentioned, we need some kind of system, which strengthens the human resource. But if we use the simple advanced IT technology, it's very easy to connect a health personnel working in remote areas to the international center of TB who can provide the right advice to the workforce working in these remote areas. I want to take this secret not only in the TB area but also, as Dr. Kochi mentioned, we should apply this kind of system which was developed by the RIT training program, the supportive supervision program, to all HRH, human resources for health area. That's what I think; this is my message. Thank you very much.

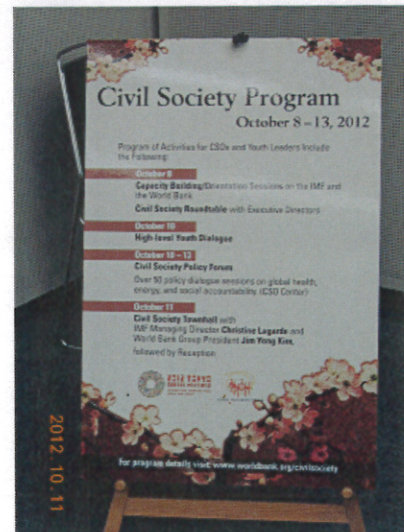
Dr. Mori(Chair): Mr. Ishii, thank you. Having started with Dr. Kochi's difficult challenge, we enjoyed

a passionate discussion. With Mr. Ishii's comments, we would like to conclude this meeting. We still have many things to discuss and think about, and we believe that those matters have come to the surface again. Thank you very much.

Dr. Konuma: I might have had a very sensitive intervention during the question and answer, so please do not quote them outside of this room. Please.

Dr. Mori(Chair): My apologies; there is one more item. There was a message, a congratulatory telex to this meeting from Mr. Jun Matsumoto, Deputy Secretary-General of the Liberal Democratic Party. He says, "We sincerely appreciate all of your hard work". Thank you very much.

7. Photograph





8. Appendix

Back Ground Information of International Training Course on TB Control

Ceremony and Symposium for the 50th Anniversary of the International Training Course on Tuberculosis Control -- Human-Resource Development for a "TB-Free World"

On 26 July 2012, the Ceremony and Symposium for the 50th Anniversary of the International Training Course on Tuberculosis Control was held at the International Conference Hall, JICA Research Institute, Tokyo.

The year 2012 marks the 50th anniversary of the International Training Course in Tuberculosis Control, which started in 1963 at the Research Institute of Tuberculosis (RIT), the Japan Anti-Tuberculosis Association (JATA), sponsored by the Japan International Cooperation Agency (JICA). Over the past 50 years, more than 2,000 medical professionals from 97 countries have attended and completed the training courses. They are now working as leaders in tuberculosis control and other health sectors in their own countries. Many of them are also playing active roles in international organizations.

The RIT has been making great efforts to manage this training project, which is part of JICA's Official Development Assistance (ODA), utilizing its specialized facilities, equipment, and technical capabilities for tuberculosis control. This project has been highly appreciated worldwide.

The symposium opened with a talk on the WHO TB strategy (DOTS strategy and Stop TB strategy 2006-2015) by Dr. Osuga (Medical Officer, Stop TB and Leprosy Elimination, WHO Western Pacific Regional Office). He stressed the importance of human-resource development, and remarked that those who can manage TB control could also be competent over various other sectors, especially in building a partnership among stakeholders.

Dr. Yamada Norio (Head, Department of International Cooperation, Research Institute of Tuberculosis) presented an overview of the International training course from its beginning until now. The curricula have been modified according to the changing TB situation and the principles of TB strategy during the last 50 years. However, two important features have not changed throughout, as pointed out by Yamada. 1) Japan's experience in TB control forms the basis of the training, together with the contemporary international standards. In addition to the international lecturers provided by WPRO, Japanese

lecturers who are the experts in Japan's TB control program support the course. 2) The training focuses both on the latest knowledge and techniques for TB control and on capacity building for problem analysis, planning, and evaluation that can be applied to the each country's situation and health system strengthening.

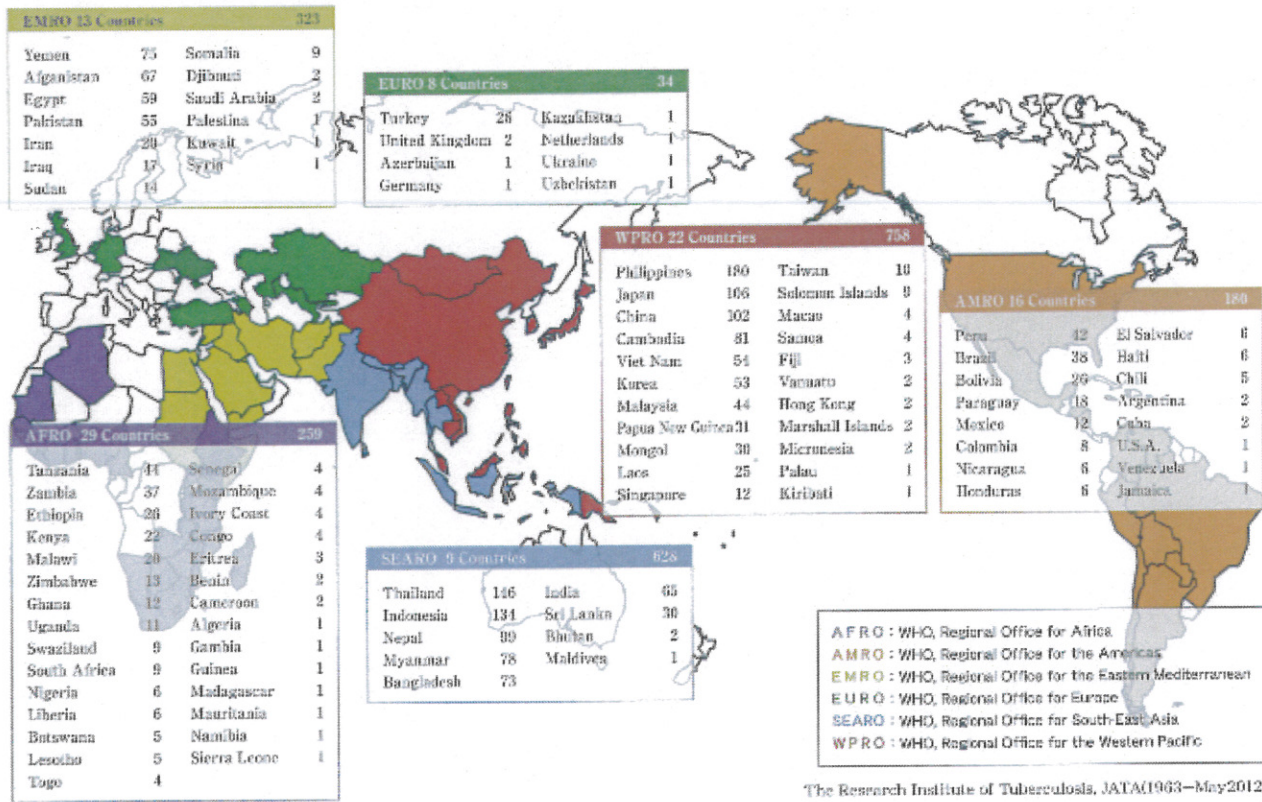
Two course graduates, one from Indonesia (Dr. Tjandra Yoga Aditama; Director General, Disease Control & Environmental Health, Ministry of Health) and the other from Uganda (Dr. Frank Mugabe Rwabinumi, Ag; Programme Manager, National TB and Leprosy Control Programme, Ministry of Health) were invited to share their experiences. After graduation, they became policy makers and program managers in their own countries.

Dr. Mitsuo Isono (Senior Advisor, JICA) suggested that there should be various types of personnel with high capacity needed in order to build the TB control program structure to cover all countries in the developing world. This includes 1) leaders who implement and manage the central program, 2) policy planners at the level of the central government, 3) implementing and managing staff at the provincial level, and 4) staff conducting field operations in the peripheral health facilities. The RIT training course has mainly been targeting 1) and 2) for a limited number of participants. Items 3) and 4) require courses for a larger number of participants with shorter durations. This has been successfully realized by JICA in schemes such as third-country training.

Finally, Prof. Keizo Takemi, (Senior Fellow, Japan Center for International Exchange / Professor, Tokai University) commented on the significance of the international training course of tuberculosis from a viewpoint of the global health. Japan has contributed considerably to the promotion of integration of the disease-specific approaches to health system strengthening, but, as he pointed out, the health system strengthening has not always been successful in spite of the efforts in such areas as information and human resources. In the tuberculosis control community the effort in this direction has started as the DOTS in close partnership with primary health care that was proposed in the Global TB Strategy (2006), and Prof. Takemi suggested that we should watch carefully how this new approach proves effective, not only for tuberculosis control, but for enhancing health system in primary health.

International Training Courses

97 Countries, Alumni Network of 2,182 Professionals
(Including 297 participants of AIDS course from 19 countries)



The Research Institute of Tuberculosis, JATA(1963-May2012)

International training course on TB control.

Progress in 50 years and perspective.

Dr. Tadao SHIMAO
Adviser, JATA
Director emeritus, RIT

Priority of JATA activity

- *JATA was founded in 1939.*
- *In addition to the comprehensive research, model district and public-relations activities, training of medical and co-medical staff engaging in TB control are given top priority.*
- *Soon after its foundation, JATA started training courses for doctors, nurses and X-ray technicians.*
- *In accordance with the deterioration of war, JATA had to stop nearly all activities.*
- *After the end of World War II, JATA started research and clinical services and re-opened the training course for public health nurses in November 1946.*

Success of NTP depends on the quality of staff engaging in NTP

- *Training course for doctors was re-opened in 1948, overcoming several difficulties such as poor food, accommodation and traffic.*
- *Message of then director of RIT, Dr. Kumabe "we lost everything by losing war. Medical instruments and materials could be produced again if Japanese industry are revitalized, however, experts who can use these instruments could not be trained at once. Let us start training of staff engaging in NTP now."*
- *Our firm belief is a key to the success of NTP is a well-trained man-power with enthusiasm.*

Target of training : Training of staff engaging in NTP with enthusiasm provided with sufficient knowledge and technique on NTP

- *Curriculum of the training course such as high incidence of TB soon after TB primary infection theory, NTP composed of the theory, interpretation method of chest radiogram were most updated knowledge of TB science.*
- *Directors or doctors of HCs, doctors working in TB control of enterprises who were trained in RIT can serve as leaders of TB program in respective fields provided with most modern knowledge and technology on NTP.*
- *Their activities were major factor contributed to the success of NTP of Japan.*

Background of early 1960s

- *Japan recovered from the damage of World War II, and started income-doubling policy.*
- *In 1964, Japan hosted 18th Olympic Games in Tokyo.*
- *Organized TB control based on TB control law (1951) and introduction of TB registry and case management system (1961) started to work.*
- *Nearly all TB except far advanced severe cases could be cured by the combined use of INH, SM, PAS in industrialized countries including Japan.*
- *In developing countries, NTP could not be implemented due to lack of health infrastructure and financial resources, and TB was neglected.*

Japan converted from a recipient country to a donor country, and started international cooperation

- *Japan joined to Colombo plan in 1954, converted from a recipient to a donor country, and started international cooperation.*
- *The Japan was paying post-war reparation, and the budget for international cooperation was limited, and started cooperation by dispatching experts or accepting trainees.*
- *In 1960, I was sent to the UAR as an expert on TB to plan NTP under chemotherapy era, stayed there for 3 months.*
- *In 1962, OTCA was founded, and the international group training course was one of its priority functions.*

Initiation of international training course for TB control

- *OTCA requested RIT to initiate the training course on TB as one of its major activities.*
- *RIT accepted a public health nurse of Thailand in 1962 for the 6 months training in NTP. She went round several departments of RIT with success.*
- *Then director of RIT, Dr. Iwasaki, made up his mind to initiate the course encouraged by the success of training for Thai public health nurse.*
- *The first course was held from June 8, 1963 for 6 months, and the curriculum was the English version of domestic training course for doctors.*
- *Seven participated in the first course, 3 from the Philippines, 2 from Thailand, 1 from Malaysia and 1 from Indonesia.*

Strong concern and thoughtful consideration of WHO on the course

- *Dr JC Tao, WPRO, showed strong concern and thoughtful consideration on the course, started discussion with Dr. Iwasaki, the director of RIT, and donate scholarship to Dr Imamura, director, training department to the course in Praha and Dr Takase, chief, doctor's course to a seminar in Singapore.*
- *5th IUAT Regional conference was held in October 1966 in Tokyo, and Dr JC Tao, WPRO attended the meeting.*
- *After several thoughtful discussions between Drs. JC Tao and Iwasaki and OTCA, the course was jointly sponsored by WHO and OTCA.*

Reasons of success of the international training course in TB control (1)

- *Continuous enthusiasm and support of then OTCA later JICA on the manpower development program : In addition to the maintenance and revision of the course, new courses such as chest surgery, senior course and laboratory course were later newly added.*
- *Presence of excellent leader with flexibility, then director of RIT Dr. Iwasaki : decision for the initiation of the course, reception of the participants with faith, and decision making for curriculum change and collaboration with WHO.*

Reasons of success of the international training course in TB control (2)

- *Participation of WHO from the early stage of the training course : Presence and role played by Dr. JC Tao in WPRO*
- *It had become possible through WHO collaboration to change the curriculum of the course and invite world-well-known TB specialists as a lecturer of the course : Drs. Canetti, Fox, Toman, Rouillon, Styblo, Grzywosky, etc.)*
- *Japan Society for TB was also benefited through communication with the above TB specialists.*
- *Post-course study tour e.g. to Korea was also possible through participation of WHO.*

Reasons of success of the international training course in TB control (3)

- *HIH Princess Chichibu, then HIH Princess Akishino, patroness of JATA, organized a reception and encouraged participants for the success of global TB control.*
- *Mr. T. Shimazu, president of JATA, and Dr. M. Yamaguchi, chair of board of directors, JATA understand well the international significance of the course, and encouraged the staff of RIT.*
- *Conversion of the curriculum of the course: the English version of the domestic course
→epidemiology, NTP of developing countries
→DOTS, OR, TB with HIV→Expansion DOTS, TB with HIV, MDRTB, OR.*
- *OR has been one of major topic of the course.*

Reasons of success of the international training course (4)

- *Presence of international trainee in the RIT and their stay in the dormitory promoted the internationalization of the staff of RIT.*
- *During the field trip, the prefectural government, JATA branches and Anti-TB Women's associations of Niigata, Akita, Aomori, Iwate, Gunma, Mie, Hiroshima, Oosaka, Kyoto and Tokyo whole-heartedly welcomed the participants, exchanged views and experiences in the fight against TB.*

Changes in the global concern on TB and role played by Japan (1)

- *Interest on TB dropped down rapidly when most TB patients could be cured by the combined use of INH, SM and PAS since late 1950s. Japan started international training course on TB control in 1963.*
- *1970s-80s were hard days for TB, and during this period, short-course TB chemotherapy was introduced in industrialized countries. Japan assisted NTP of developing countries by bi-lateral technical cooperation and grant aid to Afghanistan, Yemen, Nepal, Philippines and Indonesia.*
- *Dr. Shimao started to serve as a member of executive board of WHO in 1987, Dr. Nakajima as DG since 1988 and Dr. Kochi chief medical officer, TUB, WHOHQ in 1989.*

Changes in the global concern on TB and role played by Japan (2)

- *TB problem was highly evaluated again in 1990s through ① increase of TB with HIV epidemic, ② success of SCC in field conditions of Africa, ③ NTP was found to be one of cost-effective health interventions by using new health index; DALY, and ④ increase of MDRTB.*
- *1991 : Resolution to strengthen TB control was adopted in WHA; saying 85% cure of detected new S+PTB, and 70% detection of such cases by the year 2000 through support to high TB incidence countries, intensifying OR, and research and development.*

Changes in the global concern on TB and role played by Japan (3)

- *1994: DOTS strategy of TB control. On the background of success of DOTS, presence of TB workers trained in RIT.*
- *2000 : In G8 summit held in Okinawa, then Prime minister of Japan, Mr. Mori, proposed the cooperation of G8 in the infectious disease control of developing countries, which is the major cause of poverty in these countries, and G8 approved.*
- *2001 : UNGASS was held to discuss HIV/AIDS and infectious diseases control.*
- *2002 : Global fund for AIDS, TB and Malaria was founded and started to work from 2003.*

How to cope with global TB in NCD era ?

- *2011·9 : NCD summit meeting was held in UNGA.*
- *Resolution was adopted to intensify NCD programs such as cancer, diabetes, CVD and RD caused by alcohol, smoking, inadequate nutrition and exercise.*
- *Discussion was raised how to spend money from Global Fund.*
- *How to maintain concern and budget for TB , which is still one of major health problem in least developing countries ? We are facing a difficult situation.*

Cooperation in TB control is one of favorite areas of Japan in international cooperation in health

- *TB is a chronic infectious disease, and sustained efforts for several decades are needed to control TB in high prevalence countries.*
- *Case detection → Treatment = Prevention*
- *Regular drug-taking for at least 6 months is needed to cure TB = Provision of drug procurement and delivery system, supervision of drug taking → Development of health system*
- *TB control is a model for control of NCDs as shown in health control of Japanese enterprises starting from TB control.*

Significance of the international training course on TB control held in RIT

- *Participants are now working actively in the front line of the global fight against TB utilizing their lessons learnt in RIT, and some were promoted to higher post such as DG and even minister of health.*
- *More than 2000 participants from ca. 100 countries of the world are a great treasure for Japan.*
- *“Kiyose” and “RIT” were inscribed as “Inward home” for those who once stayed and learnt in RIT, Kiyose.*

***Japan and international training
course on TB control***

- ***We started and sustained international training course convincing that manpower is a key to the success of NTP particularly in developing countries.***
- ***More than 2000 have been trained.***
- ***We can accept all regardless of religion and ethnicity.***
- ***If you want to evaluate the course, talk to any of the trainee.***

***Please give continued
support for international
training course in TB
control.***

Thank you.

Stop TB Partnership

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