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The TB Frontier: New Strategies, HIV Linkages, Threats, and Tools
Kaiser Family Foundation and Center for Strategic and International Studies
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J. STEPHEN MORRISON: Hi. Good afternoon and thank you all for joining us here at the lunch hour for this very important luncheon conference on the TB Frontier: New Strategies, HIV Linkage, Threats, and Tools.

This event is organized under the auspices of the CSIS, Center for Strategic and International Studies, HIV Aids Task Force, and as a joint effort with our very close friends, The Kaiser Family Foundation.

A side note, the Kaiser Family Foundation which has many special assets for use has a number of online facilities that are directly relevant to what we're doing today. Vis a vie TV, and its relationship to the issues we'll be covering. There's the Global Health Facts site and the Global Health Reports sites specifically.

I also want to single out before getting into the aims of the luncheon and introducing our speakers, I want to single out for special thanks a few key individuals who put this together. Kate Hoffler from CSIS has been indefatigable and marched us forward to this point over the last couple of months.

She's been joined by Shobana Romanchandran from Kaiser as well as Jennifer Cates, Vice President of Kaiser Family Foundation with whom we work very closely on a number of

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things. Nicole Shieg from WHO and Marcos Espinal from the Stop TB Executive Secretariat, both been very, very helpful and we're grateful to you for coming to us initially with the idea.

This idea began back in May at the Global Health Council session when we engaged with folks from WHO, who were visiting around the question of shouldn't we try to do something of exactly this type to try and reach an American audience and elevate the profile and the discussion around TB.

We have a remarkable line up of speakers on the critical issues connected to TB today. We have a very compressed time frame, so we'll be moving through our speakers in succession here. Our key note speakers include HIS EXCELLENCY PRESIDENT JORGE SAMPAIO, who is the U.N. Secretary General's special envoy to stop TB and former President of Portugal. He will speak to us in a moment on the evolving global leadership on TB with special reference to the global plan to stop TB. Thank you for joining us today President, I'll give a little bit more background on you in a moment.

He'll be followed by Senator Sherrod Brown, a key longstanding congressional champion of global TB efforts and he will speak to the agenda before Congress and his personal perspective on the evolution of this issue right after President Sampaio.

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We're also very honored to have with us Mark Dybul, the U.S. Global AIDS Coordinator, who will speak to the intersection and coordination or interface of TB/HIV AIDS efforts.

He'll be followed by Dr. Mario Raviglione from WHO, who will address the emerging threats from drug resistant TB including exceptionally drug resistance or XDR forms of TB.

Our close colleague at CSIS, Dr. Phil Nieburg will moderate a section of the program and will also speak to the world's needs in the evolving investments on new tools for diagnostics, vaccines and therapies.

At the close of this, we will have some parting comments from Dr. Irene Cook from USAID who is a member of the Stop TB Coordinating Board. We'll try to have all of this wrapped together by no later than 2pm. And I want to add one other note of thanks where, today this event is being web cast by the Kaiser Family Foundation in about 48 hours hence there will be a transcript posted on the website. You can access that, you can watch the stream.

Let me turn to our first speaker, President Sampaio. He is, as I mentioned, he has been since 2006, he has been the special envoy for the Global Plan to Stop TB. This is an important development.

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This is one in which really it signals the graduation of global TB efforts into a bigger political domain, to have been able to engage someone of the prestige and accomplishments in the political realm of President Sampaio.

He's also recently taken on a second role with the new Secretary General Ban Ki-moon dating back to April as a special representative- U.N. High Representative for the Alliance of Civilizations. This is an international initiative that seeks to promote reconciliations among religions, cultures and nations. He spoke to that issue yesterday at the Council on Foreign Relations here in Washington.

He has a very distinguished career. He began his career as a lawyer. He was a founding member of the Portuguese Social Left Movement, thereafter joined the Socialist Party. He was elected as a Deputy to Parliament for Lisbon, to the National Parliament in 1979.

He went from that to join the European Commission for Human Rights, and in 1989 was elected Mayor of Lisbon and re-elected four years hence to a second term.

He first was elected by popular poll as President in the Portuguese Republic in 1996 and re-elected in 2001. He gained quite a strong presence globally as the events in east Timor unfolded in that period. He was one of the key figures

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in trying to resolve that very dangerous crisis that many of you will recall.

He has a prodigious output intellectually in his writings. He also mentioned, just in conversation, that he comes to- from his youth, he had a very strong public health and medical background.

His father was a public health professional trained here in the United States at Johns Hopkins University, served at different stints at Harvard and elsewhere, and so President Sampaio brings both a public health and an American perspective on these issues, which is quite unusual, so, President if you'd like to come and join us here. We'd welcome your open presentation. Please welcome me in welcoming President.

[Applause]

HIS EXCELLENCY PRESIDENT JORGE SAMPAIO: Good afternoon. Thank you very much. I'm very grateful for those initial words and I'm obviously very grateful to CSIS and to the Kaiser Foundation for during this meeting, having me here. I won't say anything else on my past. You are always surprised when you hear someone else speak about your past and I'm a little bit surprised but in the good sense of the word.

So, my intervention is a little bit long but anyway. I wanted to have three main provocative questions, the first one being how to be control matters to human security.

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The second is, why making the case for the global to be control remains a kind of a catch 22 situation? And the third one is: Why we need to move from a global to a glocal approach to turn [inaudible] on health specialty be into deliverables.

So let me address the first one. In other words, how to be control matters to human security? Since the end of the cold war, the concept of security has clearly enlarged to encompass new threats and challenges well beyond military ones. Its scope has expanded as globalization has generated new opportunities, new risks and new vulnerabilities and of course many cross border issues.

And although human security in fact means different things for different people, there is a wide acceptance that new conflicts, interpersonal and intercommunity violence, international terrorism, poverty and [inaudible] and the impact of health crisis are part of a new human security agenda.

Regarding the case of communicable diseases, it is therefore clear that like international terrorism, for example, they attack countries not at their borders, but deep inside their national territory. The three biggest pandemics in our globalizing times, HIV/AIDS, TB and Malaria, therefore pose a global public threat.

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They are part of the everyday insecurities faced by the world's poor and excluded. But they are also a breeding ground for instability and conflict affecting global security.

And of course, therefore, global health matters on ethical, humanitarian and development grounds as well as for economic reasons. Health for all is a basic universal human right. Illnesses have devastating economic and social impact on all societies. A government that cannot insure the health of its people has failed its most fundamental responsibility.

Global health is also at the heart of every agenda for human development because it is the key to stability, security and peace at local, national, regional and global level. Our current context of new conflicts, pervasive poverty and escalating global flows brought the health and security fields closer together. Let me now focus on Tuberculosis threat to the global security.

The evidence is appalling, although most of the time ignored. Let's recap some data. TB is a curable disease. I insist on this point because of further references I'll make. It's a curable disease but as everybody knows it kills 4,400 people everyday. This means one person per 20 seconds.

TB is indeed a disease of poverty and virtually all TB deaths are in the developing world affecting mostly the most vulnerable, the poorest and undernourished. But there is a new

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situation here. And that is related to the new drug resistant strains of Tuberculosis as MDR-TB, multi drug resistant TB.

A form of TB that does not respond to standard drug treatment and an even worse situation, extensively multi resistant, the XDR-TB are now present in virtually every country around the world. And 450,000 new MDR-TB cases are estimated to occur every year.

Let me emphasize that multi drug resistant TB arises from poorly managed treatment. And that the extensively multi resistant is entirely man-made. Furthermore, TB is a leading killer among HIV infected people in developing countries with weakened immune systems, and a quarter of a million TB deaths are HIV associated.

It's this new synergy here that in the recent years has developed and it has in fact, unfortunately called greater attention to the TB subject perse.

So we are confronted with kind of a dramatic paradox. And the paradox is that people under any retroviral treatment of a non-curable disease eventually die from a curable disease. And therefore this is quite an unbearable situation.

You may recall the case of the Atlanta lawyer, Mr. Andrew Speaker, who this summer has helped to splash the acronym XDR-TB across the headlines.

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Indeed he was not the first to travel with TB since according to WHO and CDC records. Many other TB patients have traveled. And in some cases there has been transmission of the infection to other passengers but this was really a wake up case from which we can do and draw lessons.

The question we need to raise is not, in my view, what more can a country do to protect it's citizens from exposure to TB, because unlike people, diseases do not need a passport or a VISA to travel and to spread around and therefore we cannot build, for example, walls against outside disease threats.

Critical questions on the country are: What more can we do at a global level to improve diagnosis, treatment and prevention of this curable disease? What more can we do to save more that a million lives each year?

As a global pandemic, TB generates risks that have security implications. As it is an affordably curable disease these risks are unnecessary and therefore avoidable. Why therefore make our citizens and societies vulnerable to undesirable and volatile crisis?

How can we afford not to be very active in this field? Instead, indeed one can argue that epidemics have ever shaped world history: Black Death, Small Pox, Measles, Syphilis, Tuberculosis, AIDS.

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What is different now? Why should we characterize it with our eyes as we see things today? Because we know that WHO estimates that more than 40-percent of the 56 million deaths each year are avoidable given the existing knowledge, existing technologies and existing resources. This makes a lot of difference.

And secondly, there is a permanent risk of global pandemics because of globalization and the interconnection of the international system and because travel time between remote corners is measured in hours, the flow of goods, services and finance is transnational and information travels is of course fractions of a second.

Just as the outbreak of an epidemic in one corner of the world ultimately affects us all, so it is linked directly or indirectly to all the other major world issues such as conflicts, economic imbalances, the rich poor gap, population growth or the environment.

Therefore global TB control matters to human security because TB everywhere is in fact TB anywhere. So the second point is: Why, therefore, making the case for global TB country remains kind of a catch 22 situation?

So, remind you that in the '90s, 1990's outbreak of Drug Resistant TB cost \$1 billion to contain, \$1 billion to

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contain. Obvious lessons unfortunately were not learned and future outbreaks, such as XDR-TB were not prevented.

Research and development by G8 and other income countries are new tools to fight TB effectively has been neglected and under funded over more than 40 years.

The Stop TB Partnership Global Plan to stop TB 2006-2015 has identified an annual research funding shortfall of something like 900 million dollars to deliver urgently needed new diagnostic drugs and a vaccine.

Moreover, the recent global response plan launched by WHO and its partners a few months ago calls for an additional 170 million U.S. dollars a year in this millennium if new tools to face XDR, the great new menace, are to be developed quickly.

At present, according again, WHO figures, the total cost of global plan to stop TB for the ten year period 2006-2015 inclusive of the additional new component to face XTR-TB is estimated at 67 billion dollars, of which 25 billion is currently available, leaving a funding gap of something around 42 billion dollars.

Although this is a big gap, let us bear in mind that it has to be filled both by donor countries and by endemic countries. The Global Plan contains a blueprint for a series of actions to be implemented by endemic countries in order to reach the MDG of halting and starting reverse incidents of TB

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as well as the Stop TB Partnership targets of having prevalence in mortality with regard to the 1990 baseline.

In my view, it is obviously more affordable to fill this gap than to pay for the economic and social loss produced by the epidemics. However, advocacy for global TB control seems sometimes like a catch 22 situation.

To claim that TB poses risks that have security implications we need to recognize TB as a health emergency. But to recognize TB as a health emergency we need to acknowledge TB as a threat to human security.

This vicious circle makes political support of global TB control a restless battle, on the one hand, because there are many other global issues competing to be highly placed with justifiable reasons, on the global agenda. On the other hand, because among global health issues, the white plague as TB was called in the past, has not achieved iconic status, if I can put it in this way.

This is why, in my capacity as United Nations Special Envoy to Stop TB apart from carrying on several contacts with decision and opinion makers, and I've been doing this for the last year, I have insisted on the need for significant scaling up of advocacy, communication and social mobilization for TB.

And this is where this meeting gains great importance. We need to generate political, social and behavioral change at

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every level. We need to create social pressure and political accountability to shape policy agendas and mobilize the \$67 billion for the period from 2006 to 2015 for TB control.

Experience does show that celebrities and public icons can do a lot to engage public support to mobilize people and to raise awareness. This is why, for example, I am really very happy that the international soccer player Luis Figo, whom you probably know, has agreed to be a TB speaker.

And I very much hope that we can display a massive world wide campaign for TB to mobilize political, social and financial resources led by him.

We need, therefore, to break the vicious circle that makes TB a neglected disease. TB is an affordably curable disease, but it still kills 1.6 million people annually. Far more than the number killed in the natural or man made catastrophes that make headlines.

The third and final point, why do we need to move from a global to a glocal approach to turn the Millennium Development Goals on health, especially TB, into deliverables? In spite of spectacular progress in health achieved during the 20th century, good health is in equably distributed.

Moving into the 21st century, we need to recognize that half of the world's population has been left behind, carrying a vast burden of preventable diseases. But can we avoid, or at

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least reduce it? Can we do more? Can we do better? Yes, yes we can. We should, we must do more, faster and better.

For technical security reasons, because we live in a world of open borders where new strategies of risk control management are needed to protect our citizens against external shocks, and for efficiency arguments, because it is a good investment. May I use the word? It pays from a cost benefit view point.

And for political reasons because global health security is increasingly recognized as a public and indivisible good which needs to be a top priority on the global agenda and for ethical reasons because protecting the health of human kind and reducing the unsustainable health disparities require international cooperation and shared responsibility.

Well, your Excellencies, ladies and gentlemen. Health and human security are, therefore, in my view, and I think in many views of those who are here, are central matters of human survival in the 21st century.

As the risk of pandemics is global, we need to energize global health as a human security priority. We need urgent additional action to meet health related MDG's as well as improved international cooperation to meet specific HIV/AIDS, TB and Malaria targets.

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In my view, we need indeed to think globally, but we need to deliver to act local. Therefore, a results oriented approach of global health challenges and threats requires a glocal strategy. By glocal, I mean a people centered approach, a focus on empowerment and ownership.

Even if TB control has to be seen as a global public good for health, comprehensive TB control rests on the ability of national TB programs to successfully identify and treat patients.

This for me is a very, very important point. I repeat the ability of national TB programs to successfully identify and treat patients. Therefore, adequate coordination between international input and domestic action and policies is a critical point in achieving global TB control.

And to make progress, it is crucial to sustain country leadership and ownership for TB control in the contents of the three ones principle, one national plan, one authority and one monitoring and evaluation system.

I will leave to the WHO experts here today more technical and explanations on the elements of the Stop TB strategy, which of course underpins the Global Plan to Stop TB. This strategy builds around DOTS, the case management approach promoted internationally for over a decade and that remains the fundamental approach for TB treatment.

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But I could not finish without stressing, if you allow me Chairman, two additional critical points. Firstly, there needs to improve coordination in the fight against AIDS and TB is a critical point in improving health worldwide.

It is sobering to recognize that only 0.5-percent of estimated HIV patients are currently tested for TB. And only 7-percent of TB patients are tested for HIV worldwide.

This is really a shockingly dramatic shortcoming. To control TB in high HIV settings, far more collaboration between TB and HIV/AIDS programs must be implemented. And this is why greeting Ambassador here now today I met him at the beginning of this year, and praising the presence of the Senator who has given great part of his time to this.

I will be with others suggesting and eventually proposing that if there is a General Assembly meeting on the MDG goals. We should have the possibility to discuss the combination of efforts on HIV and TB together.

We should have a part of that assembly dedicated to this or another kind of feature within the same assembly, because I have seen in Africa, that when there is a new awareness in combining these two programs, in other words, not vertical, but horizontally, you not only increase the detection and the cure of TB, you at least continue to make it possible

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for those who are on antiretrovirals not to be infected by TB and therefore increasing the living possibilities.

So, the major influential stake holders, I begin by the European Union, the World Bank, the Global Fund, UNAIDS, WHO, USAIDS, OGAC, foundations, companies, associations, PEPFAR, NGOs, we should lay down in fact concrete steps for global coordination of TB and HIV activities.

And this is so important because at the end of the day, no matter the way and the path we follow, it is the citizen that is the end and the object of our initiative. And I think that we can, in fact, save money if we coordinate better, if we do have this capacity to horizontalize, if I can use the word, these two programs in their respective aspects I have mentioned before.

I think we can eventually succeed in taking this meeting within the General Assembly if it takes place. Secondly, the needs, and I think this is again a very basic problem, and I'm happy to address it here in this meeting and at the Senate of the United States.

We have a dramatic need to strengthen health systems worldwide because this is a key issue in achieving most of the health related Millennium Development Goals. And this requires improving infrastructures, investing laboratories and

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addressing the lack of health workers facing many developing countries.

Without prompt and coordinated action, the shortage will worsen. It is very impressive, ladies and gentlemen, to hear the Health Minister of Malawi, where I was March this year, launching the National TB Emergency Plan, telling me that there were more Malawian doctors and nurses in Manchester, Great Britain, than in the whole of Malawi, although they had trained them to be and stay in Malawi.

This is a totally new thing. It has gotten worse and worse. So we have to find the mechanism to assure at least that some of this capacity is used to develop the funding that we are doing, or the institutions are doing in their prospective areas. I think it is one of the most challenging aspects that we can have.

So ladies and gentlemen, your Excellencies, we need to develop new and more effective capabilities to address health security priorities. This requires strong political leadership, appropriate financial resources, new partnerships and a global strategy. Investing in TB control, therefore, is a pilot case pioneering the emergence of a new paradigm of human security and this will contribute to reducing fears and to generating public confidence.

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In my view, it will be and can be a win-win cooperation strategy providing clear leadership to the first mover. To my mind, this is, I must say with some emotion, this is a natural role to be played jointly by the United States of America and the European Union as a way of strengthening trans-Atlantic cooperation. Many thanks for your attention. [Applause]

J. STEPHEN MORRISON: Thank you, your Excellency. We are of course here at Congress at a very early point and very important moment around the debate of the reauthorization of PEPFAR and these points that you raise around the intersection, the interface between the two which Mark will be addressing in his comments.

These are issues which can begin to be addressed systematically in that reauthorization process and CSIS will be issuing a paper on this subject in the coming months. Our next speaker, Senator Sherrod Brown is a very important champion on this issue and broader issues around public health.

And these champions within Congress, the core personalities who bring the passion and the vision and the long term commitment around both domestic and global public health issues are absolutely essential to moving our agenda forward.

He was elected in November of '06 to the Senate. Prior to that served in the house where he distinguished himself in

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many ways, which I will mention in a moment, prior to that he served as Ohio Secretary of State from 1983 to 1990.

He has acquired a special expertise on Tuberculosis. He has visited Russia and Haiti. He has been in prisons. He has schooled himself on many of the more difficult issues that have emerged.

He has taken the lead in trying to put a focus on what it means to begin to anticipate the impact to MDR and XDR-TB. He, in 2003, was honored as the National Public Health Legislator of the Year for his work on antibiotic resistance. He's been very active in this last year in the appropriations process on TB, in continuing to strengthen the CDCs operations and the Global Fund, and in introducing The Comprehensive TB Elimination Act of '07, and joining in some of the other very important legislation.

Senator Brown, thank you so much for being with us today and thank you for your leadership on this issue.

[Applause]

SENATOR SHERROD BROWN (D-OHIO): Mr. Morrison, thank you and Ambassador Dybul, thank you, and it's a pleasure to see you again. Thank you very much, President Sampaio, to get to meet you. We were comparing one of my favorites living authors is a Portuguese named Jose Saramago, and he was telling us another author that's just as good, writes in Portuguese. I

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don't read Portuguese, but he said he's translated, so thank you for that.

And Dr. Raviglione, thank you for your terrific work. About and especially thank you as activists, those of you that are NGO, those of you that are congressional staff.

The opportunities you have on public health and to change this world in the next 20 years are huge and take advantage of them. The passion that Mr. Morrison said that I have about Tuberculosis came in large part, because I was able to observe up close how this disease, this dreadful disease, ravages too many people, mostly the poor, mostly the developing world, of course, as we know.

And the opportunities we have at relatively low cost to deal with this huge public health issue is something that I hope these opportunities, I hope that you will seize the moment, because you all are in positions as NGOs, as congressional staff, as people who care about social and economic justice in this country and around the world. You really can matter in this whole issue.

About when I was a senior in high school, 35 or so years ago, or a little more than that, my dad was a general, similar to the President Sampaio's father, my father was a General Practice Physician, did a lot of public health kind of work.

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And he and I were driving around Mansfield, a mid-western town of about 50 thousand people, Mansfield, OH in those days. And we drove by this little brick building and I said, that looks like it's closing.

And he said, yes, it's called the Beatty Clinic. And he said, it's a Tuberculosis Clinic and we don't have Tuberculosis in Mansfield anymore, and so we're closing this clinic.

And I never really thought about Tuberculosis much again except when you read novels and you'd read about people dying of Consumption, that was the word for Tuberculosis mostly in the 19th century.

And it's been, of course, an age old disease, but I didn't think about it much until Joanne Carter of a group called RESULTS, it's an advocacy group in Washington, came to me and said, you know, our government does almost nothing about TB. And we need to really launch this effort in the House of Representatives.

I'd vaguely remembered at the time that, President Sampaio mentioned this that in New York City, in the early '90s there was a drug resistant TB outbreak that the public health authorities in our country were simply not prepared for, for understandable reasons, and especially because it afflicts people that especially in those days, as it afflicts the

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poorest and the most disadvantaged immigrants, the population that's fairly invisible to most of us that dress like this.

And so we didn't pay the attention to it and it cost the city of New York about a billion dollars to cure many, many people and some died from this disease called Drug Resistant Tuberculosis, as he pointed out, a disease created by human kind, because we don't treat Tuberculosis, regular Tuberculosis as appropriately and as perfectly as we strive to do.

But I hadn't thought about it much, and so in the mid to late 1990s we began the process of amending Foreign Operations Bills until we got to the point where we are today, which is really raising the visibility of Tuberculosis and engaging the international community.

Obviously other things were going on at the same time around the world, around our country, but it was really the public health officials and places like the World Health Organization, and I thank you for that, for making Tuberculosis, putting it on the public agenda the way it has been although not nearly as, frankly, as well as it should have been.

And when you think about TB, just a few numbers, and most of you know these and I won't bore you with this, but about one third of the world's population, 2 billion people roughly, carry the Tuberculosis bacteria in their bodies.

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Most will never get sick from it, but those that are malnourished, those particularly, as Ambassador Dybul works so hard on those particularly that have HIV/AIDS. Those who are in a weakened state in their lives because they're elderly and their poor, their malnourished, are much more likely to have those TB bacteria blossom, if you will, into full blown Tuberculosis.

In our country there 10 to 15 million estimated people who carry that bacteria also. Many of them immigrants, not nearly all of them, and most of them will never get Tuberculosis, but they can and in the end they can spread it at some point.

So, it is absolutely one of the premiere public health issues of our time. And when President Sampaio talked about passion for this issue, I invite any of you that get the opportunity, and most don't, I understand, to go to a place like Haiti and visit Dr. Farmer in his clinics. If you've read "Mountains Beyond Mountains" that will give you the flavor certainly by Tracy Kidder about what has happened in Haiti with public health especially.

I met a 14 year old boy that he was treating who had Potts disease, which is a Tuberculosis of the spine. I guess of the spine, of the bones. This young boy will never sit up

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straight, if he was cured at all because he had this terrible TB that ate into his spinal column.

And then I was in Siberia in a prison camp in this city. I was a Russian major in college and I got the opportunity to sort of use my Russian until I ran out of words, which was fairly quickly with my vocabulary, but, in a prison, to meet a group of about 15 inmates in this part of [inaudible].

They had gathered Tuberculosis patients from all the prisons in the region, so this prison was a prison, a prison to be sure, but one with all TB patients. I talked to about 15 of them who thought they were going to die. They had Multi Drug Resistant TB and they were cured.

Prisoners are a little easier to cure because you can make them take their medicine everyday and you can observe them taking it. But the problem is so much one, not of cost, although we've been way to stingy in this country as other wealthy countries have done a bit better, but not as well as they should either, in providing the resources to do this.

But as most of you know, TB can be cured for as little as \$20 or \$30 or \$40 in the developing world. Drug Resistant TB created again by an incorrect way of treating it cost 10 times that, or more like 100 times that, and the Excessively

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Drug Resistant TB is wildly more expensive and too often incurable in some cases.

But we, as I think you know, the cure for Tuberculosis is taking a drug, taking a series of usually four medications once a day for six months. And Drug Resistant TB much more than that, but once a day for six months.

So, the beauty, if there is any of Tuberculosis treatment, is that you really can help to use it to build a public infrastructure. Where you have trained people, not nurses or doctors, no necessarily nurses or doctors, but trained health care workers that go to people's huts and go to their villages and try to get them to the clinics and so they interface, interact every single day for six months.

And you can see what that can do for public health. For everything from taking care of pregnant women to taking care of small children to taking care of families with preventive care and the real kind of public health that we need to do around the world.

So, my goal always with Tuberculosis control and Tuberculosis work is, how do we internationally build a public health infrastructure that can go beyond just Tuberculosis and it's really out of my league. To work more on it than that, it's really in the league of so many of these distinguished doctors and activists, as all of you are.

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There is a real, now I'll just close with giving you a few things that have happened to give me a real sense of optimism. Again, this country was barely aware, certainly Andrew Speakers, as the President of Portugal pointed out, has made TB more, made Americans a bit more knowledgeable.

But this country was barely aware of Tuberculosis existing in the world 10 years ago. We're still not aware enough, but our government finally has responded, generally bipartisanly, I found some very conservative Republicans that want to join with progressive Democrats on dealing with these public health issues.

I'm going to give you a couple of examples. First of all, we were spending in the Foreign Operations Bill, about \$90 million, \$80 or \$90 million prior to this year. The house added I believe \$50 million. We added an amendment \$90 million, the amendment I had.

It was not even voted on in the Senate, it was agreed to by both parties after some kind of behind the scenes work, but a lot of interest from leaders in both parties on that additional \$90 million. That's very, very helpful obviously.

We've also seen the Stop TB Now Act initiative by Gordon Smith, Republican from Oregon, Barbara Boxer, Democrat from California, to address the global epidemic that passed the

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Senate Foreign Relations Committee and the House Foreign Relations Committee.

Sam Brownback, a very conservative Republican from Kansas and I had an amendment that is now signed into law on the Food and Drug Administration Reauthorization Act that incentivizes the Pharmaceutical Companies.

We give them something, I rarely want to give the Pharmaceutical Companies anything, but we gave them something in return for their, in terms of accelerating FDA approval, in return for their investing and successfully developing a drug for neglected tropical diseases.

So, if they find another drug for vaccine or cure or something for TB or any other neglected disease, West Nile Virus, or whatever, the drug company gets a windfall in a sense, financially on one of their blockbuster drugs or accelerating their approval process.

So it's a way that, I think, will really matter among the poorest of the poor in the developing world. A group of people that don't attract, for good reason, I don't blame the drug companies for this, they don't attract, obviously, drug company investment otherwise.

And then in the Health Education Labor Pension Committee of which I sit, Senator Hutchinson, Senator Kennedy and I have introduced the Comprehensive TB Elimination Act of

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2007 as 1551. We're working to get that bill marked up. I think we will be successful with that.

The bill has key provisions for enhancing research and demonstration projects to eliminate TB in the U.S. This is the, sort of partner bill. This is the domestic. The Boxer/Gordon Smith Bill is the international issue. It increases funding for diagnostic and treatment tools, for new vaccines, for studies of at risk population and research in the relationship between TB and HIV/AIDS.

Also, the World Bank, several of us met last week and a half, two weeks ago with the President of the World Bank. They've done particularly good work on TB in China and India. As the President pointed out, you said 4,000 people a day die of TB and in India alone its 500 people a day.

And India hasn't yet had the explosion of HIV that will just cause, obviously, many, many, many more deaths that way. So, we're making terrific progress, but I wouldn't say terrific, we're making good progress.

We need to make terrific progress. Your involvement is, again, as NGOs, as congressional staff, we really, really need you to continue your activism and turn it up. Go back to your offices, talk to the people you know in this institution and international health people and turn the volume up and turn the pressure on.

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The activism that you can show in this issue, we do know what we have to do. A stronger investment in TB can avoid a global catastrophe and lead a global response. And I'll close with one of my, and I don't need it with this group perhaps, but one of my favorite quotes comes from a Mississippi Civil Rights Leader that said, don't tell me what you believe. Show me what you do and I'll tell you what you believe. That's why you're here. We're counting on you. We need you're activism and I thank you very much. [Applause]

J. STEPHEN MORRISON: Thank you so much Senator Brown. I want to mention, after we have completed [interposing] after we've run through the cycle of presentations we will be opening the floor for comments and questions. Hopefully we will have time for a good dialog there.

I think we saw ample evidence in the Senator's presentation on just how much the global space has opened up as a domain for creative cooperation across party lines and one that offers us the opportunity to bring in religious personalities and business interests and new foundations and new advocacy groups.

I'm going to introduce our colleague Philip Nieburg here in a moment and he will take over the proceedings. Before I do that I just want to thank Mark Dybul and Mario Raviglione

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for being with us today. Phil will do the introductions but I personally thank you so much for being with us.

Phil Nieburg is a doctor and a public health expert. He's trained in Pediatrics, Pediatric Infectious Disease. He's had a long career, a long and very distinguished career at CDC, initially largely focused on refugee and famine relief issues and others of resource poor populations. Dating back to '91 when he began working on HIV and TB programs including involvement in TB/HIV co-infection epidemiology research in both Asia and Africa.

His final assignment in Atlanta was Associate Director for Science of CDC's National Center for HIV/STD and TB prevention. Phil first began working with us early in this decade as a liaison with CDC when we were building our relationship actively with CDC in the period that we launched the task force on HIV.

And fortunately for us, after his retirement he joined CSIS as a Senior Associate and we've relied very extensively upon his depth of technical expertise and perspective on many of these different issues for which we at CSIS do need a lot of support of this kind Phil. So the floor is yours and thank you. [Applause]

PHILIP NIEBURG, M.D.: Thanks Steve. I appreciate that. Good afternoon everyone. I've been away from D.C. for

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awhile so it's nice to see familiar faces and begin to make some reconnections. I also want to thank Kaiser Family Foundation and CSIS and the Stop TB Initiative for arranging various pieces of this session.

What we're going to do today, for the next brief while, is to go through three sets of technical issues. TB/HIV co-infection, merging threats such as MDR-TB and XDR-TB and the third one was I will talk briefly about the need for new tools. And then Irene Koek will have some closing remarks and hopefully we'll have a chance for questions and answers at that point.

The good news and the bad news is that there is no Power Point facility here. The other part of the bad news part is that for two of us there are hand outs that we use for the presentations.

So, let me start right away with our first panelist. Doctor Mark Dybuls is a specialist in both Internal Medicine and Infectious Diseases. And he served as the U.S. Global AIDS Coordinator since early 2006, holding the rank of Ambassador. Before this role of leading the implementation of PEPFAR, the President's Emergency Plan for AIDS Relief, he served at the Deputy Global AIDS Coordinator.

Prior to that, he served in a number of important positions within the National Institutes of Health and the

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Department of Health and Human Services. Mark and I first met while I was working in CDC for the Global AIDS Plan, the CDC Global AIDS Program.

At that point Mark was the lead planning person for the Department of Health and Human Services Initiative on the Prevention of Mother to Child Transmission of HIV. And even before that role was completed, he began his major role in the planning of what would eventually become the PEPFAR.

Over the last four years he's helped to plan and then oversee the implementation of PEPFAR, a program involving obviously lots of difficult logistics and a lot of political sensitivities. Mark has great people skills and a really good intuition about what could be accomplished at various difficult situations.

I've watched Mark with a lot of admiration as he has successfully kept PEPFAR moving forward in very constructive ways in the face of these complexities. I give you Mark Dybul.
[Applause]

AMBASSADOR MARK DYBUL, M.D.: Thanks very much Phil. Your Excellency, thank you for coming to Washington and for highlighting Tuberculosis. I was in Portugal this summer and saw your previous residence. So trading in that residence for a suitcase to travel around and promote TB is much, much appreciated by the world community.

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I'd like to thank Senator Brown. I actually had the great privilege of being with Senator Brown when he was at Paul Farmer's place. You could see that he wasn't interested only as a policy maker, but from his heart had a deep, deep concern for this young man with Potts Disease.

It's what I think policy makers and politicians do best when they lead from their hearts and I think that's what President Bush does on these global issues and I had the great opportunity to see Senator Brown do that as well.

And also as a Congressman, Senator Brown helped us understand the need to enhance our activity around HIV/TB. Joanne is here and she and he were very important in helping us focus a little bit more on the issue and we appreciate that.

I'd like to thank Steve, CSIS and Jen, who I see here from Kaiser. For both of you, if I appear at another event this week, you have to start paying me. And also to the Gates Foundation who I imagine is involved in this somehow. I see Todd sitting there.

I think we don't need to spend a lot of time in here because I think everyone knows the intimate link between HIV and Tuberculosis. TB is the leading cause of death in Sub-Saharan Africa for people with HIV/AIDS.

So it is HIV/AIDS. Tuberculosis is HIV/AIDS. You all know that people don't die from AIDS itself, they die from

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opportunistic infections caused by the virus's effect on the immune system and that in many places in Tuberculosis. In many places around the world there is a 50-percent co-infection rate between HIV and TB and the hardest hit countries in Sub-Saharan Africa in any event.

And when you're talking about that type of overlap, it's clear that HIV/TB is a critical component of the President's Emergency Plan for Aids Relief. It must be.

As a result of that, we've increased our commitment, and again I thank Senator Brown and other members of the Congress actually. Senator Brownback and Joanne for helping us focus a little bit more on it.

In 2004 through PEPFAR we were funding around \$19 million in HIV/TB work. Last year was \$120 million. And that was actually and additional \$50 million that was added after important conversations up here.

That is in addition to the resources that come through USAIDS accounts which are also very important to combat Tuberculosis generally. So HIV/TB is a component of that and we look to AID globally as the leader for Tuberculosis more generally, whereas we deal with HIV/TB.

And of course CDC is very much involved both for implementation of PEPFAR but also as a key technical partner working with USAID. So the U.S. Government itself in the last

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six months I think, has come together in a much more dramatic way, a much more cohesive way so that we can jointly contribute to the fight against HIV/AIDS.

And in the end, the successes that we're seeing are a result of partnership and I want to talk about that partnership because WHO has been a key component in that.

And I want to talk about a couple of opportunities, both financial, but I think more importantly, the opportunities to push this agenda forward, the need for joint HIV/TB activities and then talk about a couple of the challenges.

I think the most important part of this partnership for the U.S. Government as a whole, again PEPFAR, USAID, CDC is the whole, has been the World Health Organization. Any of you who've been in country know that the countries look to the World Health Organization as the premiere health institution to help guide what they do.

And so we've had a close partner in developing a closer relationship with WHO in particular the Stop TB Program, but importantly also on the HIV/TB arena where Kevin DeCock is enhancing activities which I think is extremely important.

Some of the activities in '07 were supporting WHO activities and again that's how we see our role, supporting the activity of WHO. I have \$2.2 million for policy development technical assistance, monitor and evaluation, and then another

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\$4.5 million in particular related to global fund grants to help move things through the green light committee and to help global fund grants move forward.

The global fund has about \$1.4 billion in Tuberculosis grants. Another part of the U.S. Government's contribution to global TB is 30-percent of every one of those TB grants comes from the American people through our contributions to the global funds. We're very much active through this technical support mechanism to make sure that those dollars are effectively utilized in the partnership with the World Health Organization, Stop TB and the Green Light Committee to help ensure that those grants function well is a very important thing. Again, as His Excellency was saying, the importance of bringing the pieces together in partnership is essential.

As a part of this, I think last year we had two of the most important meetings, this might be saying it a little too strongly, but two very important meetings related to TB in particular.

The nexus between HIV/TB last year co-sponsored by the World Health Organization, ourselves, USAID and importantly the Gates Foundation which helped bring these pieces together as they often do. And what we did was bring people back from a number of the countries globally to actually sit down and look at lessons learned.

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See what is working, what is not working, try to see how we could, as His Excellency said, take that in terms of benchmarks and moving the ball forward. As a follow on to that in our joint implementers meeting for HIV/AIDS in Kigali in June, also co-sponsored by the World Health Organization, the Global Fund, UNAIDS, Gates didn't do this one but do pretty much everything else.

We actually had a side meeting, I can't remember how many countries were there, but we were expecting about 25 people to show. Over 100 people showed up and I think there were 25 or 30 countries represented.

So again, to try to go country by country and talk about how we make programs work together through partnership. I have to say, the success so far is rather eye popping if you look at it, in my own view anyway.

As part of the partnership with the World Health Organization we identify three countries to go in to see how we would begin to put HIV and TB programs together. And those were Rwanda, Kenya and Ethiopia.

Pretty much over the course of a year, and this, I don't want to say this is all us. This is not the World Health Organization. These are the people in country, these are the Africans, these are the countries through governments and non-governmental organizations.

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In Rwanda they are now testing 88-percent of TB patients for HIV/AIDS. 88-percent. 61-percent of co-infected people are receiving Cotrimoxazol. 36-percent have access to antiretroviral therapy. That's pretty much in the course of a year and a half.

In Kenya, testing increased from 41-percent to 78-percent among TB patients for HIV/AIDS. Cotrim went from 39-percent to 85-percent. Antiretroviral therapy availability went from 19-percent to 33-percent. It's extraordinary. That just shows what can happen if you put the pieces together.

And that's what we need to do more and more of and we're going to concentrate. And that's why these sessions are so important, as His Excellency said, to actually learn from these and see how you move from talking about it to actually implementing to get those types of numbers, 78-percent, 88-percent, 95-percent.

I think one of the key, I have actually been in a hospital in Kericho, Kenya, rural Kenya, the district hospital where they actually have 100-percent TB/HIV coverage.

And they did it in a year. And they did it by sticking a TB clinic in the same place they have an HIV clinic and the cross- you know, it's from here to that door.

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These are the types of things people are doing and creating that we need to learn from and expand. And I think these partnerships are going to be key to do it.

Now, His Excellency and Senator Brown mentioned XDR-TB. I think XDR-TB is a global phenomenon, it is not just an HIV/AIDS, TB activity. It actually exists in Eastern Europe where there's not as much cross over between HIV and TB.

It exists actually in this country for 20 years. The concern has been, because of HIV that we're moving from kind of a stable, basal low rate to a quantum leap in XDR-TB as we saw in deep Sub-Saharan Africa.

And that's because of HIV. That's because people are HIV positive, have weakened immune systems and are more susceptible and they can actually, probably, the transmission as you're sitting a bunch of immunocompromised people next to people with Tuberculosis is probably leading to something we don't want.

That's bad collaboration. That's bad coordination and we don't want that. And so HIV I think is really prompted us to look at XDR-TB in deep southern Africa and we are trying to respond as rapidly as possible including with diagnosis.

But, you know, diagnosis doesn't treat XDR-TB, it just tells us there's a problem. We need to have better Tuberculosis programs so that we know where the problem- we

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need the diagnosis of course to know the magnitude of the problem, but we need better programs and that's why we are trying to expand our joint HIV/TB activities.

We have an initial read from our country operations plans of around \$150 million dollars for 2008. I think that's a little low. We'll see what we can do to bump it up. But I also want to emphasize that when we give you these numbers in terms of what we're doing for HIV/TB.

That's what we have calculated that is specifically for HIV/TB. We are missing and not capturing a lot of activity. So, for example, a lot of counseling and testing, a lot of laboratory support, a lot of care were missing. So the numbers are certainly much higher than that, and we'll look to do what we can to expand them any more.

I think as we look to the future we not only need to coordinate in these impressive ways to take these lessons from Kenya, to take these lessons from Rwanda.

But as Senator Brown has said with some of his legislation, bi-partisan legislation, we also need to push to the frontiers of new drugs. Many of you know we have not had a new TB drug in 50 years.

But fortunately through a consortium we have some. On an aside, we want to make sure we don't wind up with that with HIV. And we need a vaccine. And there's progress here too.

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We need to push on these fronts as well 'cause ultimately we're sticking our finger in a dam no matter what we do if we don't have these.

And again, I commend the Gates Foundation and many others in these public/private partnerships that have developed to help move some of this forward. I want to end by talking about some of the challenges, because there's been success, and we learn from the success actually, what some of the challenges are. I want to just end on a couple of them.

The first challenge is politics. I don't mean partisan politics, I mean health politics. The notion that everyone running around in countries are altruistic and in the health field and just want to do good.

That's true, but politics gets into everything. And we have a couple of problems. One is opt-out testing. Just like for prevention of mother to child transmission, until we have opt-out testing in Tuberculosis clinics, we will not tackle the problem of HIV/TB. And while we've had some success in moving some- Rwanda and Kenya's success is firmly rooted in opt-out testing.

But we also need to take that to the next step. We shouldn't just be testing people that are TB positive for HIV, we should be testing every person who walks into a TB clinic for HIV. And the reason is actually relatively simple.

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If you're in a developing country and you haven't heard as much as you need to about AIDS but you've known about Tuberculosis your whole life and you're losing weight and you're not feeling well, chances are pretty good you might go to a TB clinic.

And in fact, one of the most extraordinary pieces of data I've seen is that in a couple of clinics that it's been looked at, while 50-percent of the people who walk into a TB clinic are TB positive, 80-percent who walk in are HIV positive.

So you can actually have more HIV positive than TB positive. So we're missing key opportunities by not testing everyone who walks into the clinic. And there's been progress here to move in that direction but it's something that we absolutely need to do.

The other political piece is integration. You know, Tanzania has moved towards an opt-out approach, but not very aggressively and I was at a TB clinic and I asked the doctor if he was going to adopt it and he said, "No, I don't do HIV." And even though the policy was there, he had no intention of doing it because he doesn't do it.

And this is a problem we see in our own government, but I think abroad as well and I understand it. People are afraid in the TB community that they're going to be overcome by this

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big behemoth of AIDS, and we've got to do a better job of managing those political things.

And I think Your Excellency is someone who has lived in the political world for so long, can help us maneuver and manage some of these important areas. WHO in the end will be the key for this, because people look to WHO for how we can manage these health systems.

So I think we need to recognize the reality on the ground if we're going to tackle it. And I think we have some very good examples in Kenya and Rwanda.

Systems is of course a key issue and so as we're building HIV/AIDS systems we have to ensure that we're also building general health systems which actually we are doing, and there are data on this now.

And we believe TB is part of it. But it's a challenge to tackle TB and HIV and all the other things that need to be tackled does require enhanced systems.

One of the things we're trying to do to support some of this is build supply systems, build clinics, support expansion of staff. If you build a supply system for antiretroviral drugs you can use the same supply system for Tuberculosis. You can use, in fact that's what we're doing. If you build warehouses and put in computer systems. So we've got to strengthen the systems.

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And we also have to, taking off one of the political problems of integration between the TB communities and the HIV communities. We have to integrate the human resources better. And that's part of the building of the whole system.

The third thing I would say is a challenge is creativity. As in HIV/AIDS I've been talking about this on HIV prevention. We're still doing things we used to do 20 years ago in HIV prevention. We're still doing the same approach to TB that we've been doing for 20 years. We need to be creative.

You know, I've been saying for three years we should develop a voucher system. We can pay for the TB treatment for anyone who's HIV positive in our focus countries. Why isn't there a voucher system so that you can relieve the normal TB system of half of its burden for HIV/AIDS, or something like it? Think creative.

We need to think creatively about how we not only do systems, but think creatively about how we integrate, rather than being stuck in our silo to old systems. And to be honest, I don't think we've seen enough of that. But Rwanda and Kenya have some pretty creative approaches and what excited me about the meeting in Kigali is the interest among others in trying to continue these pursuits.

But I think in the end we know what to do here. We know how to do it. We now have fantastic examples and it's

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just working together to get it done. Partnership is the way we're going to do this and partnership is essential.

I know the commitment of the President to the diseases that are killing so many people around the world. It does come from his heart and we are going to continue to move on these programs.

It is an example of politics and policy at its best. And, you know, as he's been saying lately, what we're engaged in, in PEPFAR, in the President's Malaria Initiative, in these TB activities, in the Millennium Challenge Corporation, in doubling resources for development under his leadership, in quadrupling them for Africa, is nothing short of the greatest humanitarian effort in a long time. And it's all of these pieces together and we need to put all of the pieces together.

But it's not just a humanitarian partnership with people in Africa. It also changes the perspective of people in Africa, gives them a new window into who we are as a people. It tells them a lot about what we stand for.

It tells them that we stand with them. And as President Bush has said frequently recently, it's also good for our National character. It helps us develop as who we are to be involved in these activities.

So all of these noble works that we're engaged in and actually ennobling works that we're engaged in, have just begun

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and we need to improve what we're doing and enhance what we're doing.

And we're delighted to have such extraordinary partners as His Excellency, the former President of Portugal, World Health Organization and here in this country, CSIS, Kaiser Foundation, RESULTS and all of you who care about these diseases.

So, I can't promise you the world but I can promise you we're going to do everything we can to do our part to combat these diseases. Thanks very much. [Applause]

PHILIP NIEBURG, M.D.: Thanks a lot, Mark. By the way, you mentioned that the example of behaviors of TB health workers who do HIV, and I don't think you probably agree that that behavior challenge is on both sides. That in lots of HIV related programs, people are unwilling to routinely test for TB.

Okay, our next speaker, Dr. Mario Raviglione is also trained in Internal Medicine and Infectious Disease. He was appointed Director of the World Health Organization Stop TB program in 2003 and he's been a member of the Stop TB Partnership Coordinating Board since 2001.

Dr. Raviglione began with WHO in 1991, initially working on TB epidemiology and TB/HIV co-infection in Europe, later becoming responsible for setting up WHO's Global Drug

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Resistant Surveillance Project, and it's then new TB surveillance and monitoring system.

From 1999 to 2003 he was in charge of WHO's Tuberculosis Strategy and Operations Activities including surveillance and program monitoring, research on community and private practitioner involvement in TB control, TB/HIV co-infection, management of Multidrug-resistant TB in developing countries and worldwide expansion of the DOTS program, obviously a lot of things on his plate.

Currently is director of the Stop TB Department. He is responsible for all of WHO's TB strategies and policies. Working with experts at all levels of the organization. He's had a lot of important articles published in health journals and books and he's served as visiting professor at a number of well known universities.

There are two examples, maybe three examples of Dr. Raviglione's excellent writing among the handouts. I've never met him personally before today, but I've long appreciated his work.

In fact, because of the very clear presentation of the issues in what he writes, I view several of his articles in the public health teaching I do at the University of Virginia. They've been very helpful. So I'm pleased to welcome Dr. Raviglione to this conference. [Applause]

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MARIO RAVIGLIONE, M.D.: So thank you, thank you very much for these nice words. Ladies and gentlemen and colleagues, President Sampaio it's a real honor to be here in the middle of such distinguished individuals who have done, are doing and I'm sure will do more and more for domestic and for global TB control.

You have a handout. You may follow some of the numbers I'm going to throw to you just to give you a perception of the situation in the world, particularly focusing in the end towards the XDR and MDR-TB epidemic.

Indeed, Tuberculosis is a major killer, a major tragedy for humanity. If you look at the sheer numbers in that slide that I have there at the bottom of the front page, you will see what the numbers are and you see what we are talking about.

First of all, President Sampaio has already mentioned some of these numbers. We talked about 8.8 million new cases every year and 1.6 million of these cases basically dying. It translates into 4,500 everyday.

So how much is- since I'm supposed to talk particularly about MDR and XDR- how much is the percentage of these cases that are Multidrug and Extensively Drug Resistant, i.e. very difficult to treat, very difficult to cure. They are in the area of 400,000 cases per year of which we believe 116,000, roughly speaking, are dying every year.

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What concerns XDR-TB, the situation is too new to be able to quantify it in a proper way. In the next six months we plan to release a new report that will for the first time look at the number of countries where we have actually representative data on XDR-TB and I will go into more detail about what XDR and what MDR-TB are for those that are not completely informed.

And finally the HIV associated to Tuberculosis issue that Ambassador Dybul was just talking about. Here we are dealing with at least 600,000 cases every year of which 200,000 or so dying.

Now, globally speaking, in general terms, about 60-percent of the cases in general, in TB come from Asia. About 28-percent of the cases come from Africa. When you look at rates per 100,000 capita, then you will see, and I cannot show you the slide here, but you will see that the highest rates by far are those in Africa.

But the rates in Asia, in Eastern Europe, in Latin America are high enough to give you those types of absolute numbers that I was summarizing. Now what are we trying to achieve globally? What are the big targets that we've established?

You see that in one of the slides there. The Millennium Development Goal is our primary goal, primary aim

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and we talk there about having halted and begun to reverse the incidents of TB. And I will show you in another slide later on in fact, what the present trend is.

The present trend has been in towards, on the increase up to a certain point, we believe 2005, where perhaps we start to see some decline.

And then there are other targets that have been set by the Stop TB Partnership, particularly the build on the Millennium Development Goal/ but quantified in a more precise way as 50-percent decline in prevalence and 50-percent declining in mortality comparing 1992 to 2015, which is the date of the Millennium Development Goal.

And so what is the strategy and what is the plan that we are using worldwide to achieve this target? Well the strategy is half shown in this slide here but I can easily summarize the two coins that are missing because I had something nice coming up, popping up in the middle, which is the box. But you can see there that there are six components of this Stop TB Strategy as we call it.

The first one remains, that of implementing proper basic TB control measures, without which we cannot even aim at addressing MDR-TB or XDR-TB, and this is what we call the DOTS approach, the DOTS strategy, case detection in a way, treatment in a way, standardized treatment done under supervision, drug

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supply system that works and the issue of monitoring and evaluating what is going on.

And then you have the other elements there that address specifically with certain specific policies the issue of TB/HIV, the issue of Multidrug-resistant TB, the contribution to our systems, the engagement of the private sector, and the two points that you are missing there, which is the engagement of communities which we consider paramount.

And I'm so happy to see here representative of NGOs and communities at large that really we need in TB as they are needed in HIV and as they have been mobilized for HIV. We still are not at the same level when it comes to TB.

Until the HIV community and the HIV community start integrating their own aims and their own efforts in a way that everyone understands if you have TB you might have HIV. If you have HIV, especially in Africa, you will possibly die of Tuberculosis with a very high frequency.

And then the sixth element that calls simply for new tools. What we have today is good enough to avoid deaths. We are saving so many lives and we have saved so many lives with the DOT strategy in the past 10 years, but is not enough to really target seriously elimination of Tuberculosis at a certain point.

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And so there is a big call in the Stop TB strategy for the development of this new tool. On the right there you have the Global Plan to Stop TB. That is a partnership plan, I'm pretty sure Iran Cook who is the chair of the Stop TB Partnership will be addressing it. We have the executive secretary of the partnership here that is my colleague, Marcos Espinal.

This plan calls, in brief, for something around today, \$6 to \$7 Billion dollars on average every year until 2015. You may think it is a lot. It is one tenth of what the HIV community needs to treat and to prevent HIV in the world. So it is not a lot.

It's something absolutely feasible and a good part of that money, let me just put it clear to you, is actually what the endemic countries are contributing today to the fight against Tuberculosis, so not everything fortunately has to come from international bodies.

Now, what are the results so far? This is a little complicated if you don't have the slide, but just to tell you that as I mentioned before, the incidents of Tuberculosis is probably, is probably peaking.

This is perhaps largely due to the peaking of the HIV epidemic for those that believe that based on the estimate that

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we have in Africa, because that was the part that was pushing the TB epidemic up in the last few years.

If we really confirm that in the next four or five years we'll be, or the TB community will be praised at the one that has reached the Millennium Development Goal probably years ahead of time.

On the right you have the situation about Tuberculosis deaths. It's a little complicated again, I don't want to waste a lot of time but there is the possibility and there is the chance of achieving the halving of the Tuberculosis deaths between 1990 and 2015.

By 2015, only though if the Global Plan that I was mentioning before, is fully implemented. Let me also say that if you prolong that curve that you see in the graph until 2050, our mathematical models are telling us that yes, it will go down but we will go down to a point that is about hundred time the elimination point which another Partnership target by 2050 to have an incidence of TB which is less than one per million population elimination level.

So is a hundred times with current tools what we can actually anticipate to get. So that is again, another demonstration of the absolute necessity of new tools, not only to diagnose, not only to treat, but also perhaps to prevent TB

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and eventually, I do believe that the vaccine is going to be the final solution here for the Tuberculosis problem.

Now, let me get you into the MDR-TB thing. And the MDR-TB issue starts by telling you that globally the big, high burden countries for Multidrug-resistant TB resistance to at least the fundamental first line drugs against Tuberculosis are essentially in the former Soviet Union and in parts of China. That part of China that has not done enough until the early 2000 to implement proper TB control.

And then there are disseminated foresights here and there. The rates, or rather the percentages in these countries are extremely high. We are talking about 10, 15-percent of all cases of TB having Multidrug-resistant TB. That means, once again, a chance of curing which is much reduced, especially if there is no access to proper second line drugs that are used in those cases.

The next thing that comes is that of XDR-TB, Extensively Drug Resistant TB. And this is the famous story regarding Mr. Speaker. And the case of Mr. Speaker that has rendered XDR-TB such a global issue, everyone was talking about not only in the U.S., but also in some countries of Europe, that felt that they were touched by the travel of Mr. Speaker into Italy, for instance, Greece and France.

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Now, XDR-TB was defined for the first time about a year and a half ago in a report that I think in our community is now pretty famous, published in the MMWR in cooperation with our friends at CDC, defined what it is, is essentially drug resistance to first line drugs, meaning what we call MDR-TB plus additional drug resistance to the second line drugs that are used to treat MDR-TB.

It means, in other words that you are left potentially with nothing available or one or two weak drugs, when we actually need four or five drugs to address this type of disease.

And that means going back to the pre-antibiotic era of the 1940s, until Streptomycin was discovered in this country, as you know, by Waksman and Schatz in 1943 if I remember correctly.

So, it's a dangerous situation that we are dealing with, and the countries that have reported it now, we collect data constantly, are forty-one as of today. Forty-one countries around the world have notified at least a case, have confirmed at least a case of XDR-TB.

And you see in the map there that there is, I would say, a large concentration of these countries in Europe, in North America of course, and in other middle income countries.

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Why is that? For two reasons, one is that these countries have the ability of second line drugs that are not available in Africa at the moment in a majority of the countries of Africa. And so without antibiotics you don't have a resistance.

And second, they have a capacity to diagnose XDR-TB which requires laboratories. And you will see in my final slide, that I'm going to say the bottle-neck today is laboratories and without laboratories MDR or XDR do not exist. The only thing you can document is the bacilli in the sputum and that's it.

And so, in that slide you also had a window there that was supposed to pop up in the presentation that says, that talks, about the global reality of Tuberculosis in the U.S.A. Talking to our colleagues as CDC, I just want to make a point that I think is crucial.

That TB control in the world is TB control in countries of the world and that in the U.S. there is a peculiar need to continue supporting domestic TB control efforts at the same time support global TB control efforts.

If you look at the numbers here, it tells you, I mean, the numbers tell you everything. More than half of the cases in this country are now among the foreign born, 73-percent of all MDR-TB cases that are going down regularly, but 73-percent

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today are in the foreign born and 75-percent of recent XDR-TB cases are in the foreign born.

That's not to say that you can control TB by closing the borders at all. By saying that basically there are people traveling back and forth in every country of this global village that can import and export strains such as this one. And therefore the response has to be global, but it has to be compounded with very strong domestic programs everywhere.

Finally I want to touch still on the XDR-TB and mention that the famous, for us at least, outbreak in South Africa in the KwaZulu-Natal province underlines that the HIV control and care effort are essentially at high risk if people that are HIV positive are then subject to the risk of then developing something like XDR-TB.

You may save their lives with antiretrovirals, they will lose their lives to XDR-TB, therefore, once again the need to integrate as much as possible. I'm using this word, abusing this word in fact is to combine the interventions as much as possible in such a way that both these epidemics can be put under control.

Now, the last two slides of my presentation are on the response plan. There is a response plan for XDR-TB. And if you look at the list of items that have been by the Global Community and the Global Expert Community that met in Geneva a

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year ago, that they have been defined. They speak quite clearly.

The first one is basically ensuring access to quality TB care and control as well as to quality HIV care and control to all people that are at risk. This is once again the only way to prevent MDR-TB and XDR-TB. Just make sure that the basics of TB control are there. Without those it's useless to go after the case of MDR and XDR thinking that you're turning the tap off when you're producing other cases by bad TB control practices. So that's the first point.

The second one is the existing cases of MDR and XDR have the right to cure, have the right to have access to the proper treatment.

The third point is the laboratory bottle-neck I was talking about before. Without it, we don't have MDR, we don't have XDR-TB. Simply they don't exist, because you cannot diagnose them. Enhance the surveillance systems, infection control.

The KwaZulu-Natal outbreak pretty much showed that infection control practices are inadequate. And this is South Africa. So let alone the rest of the countries that are much less developed in their own system than South Africa is.

And infection control in hospitals is paramount among especially HIV positive in the places where the HIV community,

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HIV positive people are frequently numerous because you will allow the spread of opportunistic infections as well as Tuberculosis.

We have to do much more public awareness of the problem and that's what we are talking about here. We have to look into ethical issues and human rights issues. The case of Mr. Speaker and other cases that popped up in the U.S. and other parts of the world call really for considerations of ethical nature.

How much can we do compulsory treatment? How much do we do compulsory isolation, et cetera, et cetera. So it touches really on a variety of issues, and finally the research. Component, once again, that has been, I would say, brutally exposed by the XDR-TB epidemic where we find ourselves without capacity to diagnose rapidly, without capacity to treat these patients and without the vaccine that would have prevented everything.

There is a mistake the Global Response Plan that I indicate there is actually for the next bi-annual and is off \$2 billion which is part of the Global Plan anyway.

So, in conclusion, I think we can conclude many things here but number one, XDR-TB and MDR-TB are a powerful wake-up call and telling us that essentially the status-quo is simply not acceptable and that we have really to do more.

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We have to stop the spread of this disease by essentially ensuring good TB care to everyone and by taking care of those existing cases, and we have to do a scale out of this intervention to treat MDR-TB that are well thought because if we fail on this scale out, we are going to create additional resistance.

So now we have XDR-TB which is resistance to second line drugs, some of them. We might easily go into a situation which we have seen in Italy and in Germany already, where cases are resistant to everything.

So there is no more chance. There is no more drug in the pipeline that will address this issue for the next at least three or four or five years.

And finally, the bottle-necks must be addressed. And they are a number, but drug procurement, drug registration in countries, laboratory capacity, political and community engagement, all of this element that have been mentioned throughout are essential.

So ladies and gentlemen, I think it is quite clear to my mind, at least, that this is an emergency. Is a real public health emergency and we must all work together, all the people represented here as Mark Dybul was saying before with the [inaudible] community and so on that in order to face this epidemic and in order to have an intervention that in the end

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will work in controlling the spread of what is today a major threat to public health in the world. Thank you very much.

[Applause]

PHILIP NIEBURG, M.D.: Thanks a lot Dr. Raviglione. We're going to change the schedule a little bit. Dr. Dybul has to leave in a couple of minutes so we thought, before I do my short presentation, we'd open the floor for questions for him and for Dr. Raviglione. So if you have any quick questions to raise to either of the presenters so far? Peg?

PEG WILLINGHAM: [Inaudible] TB, HIV vaccines and Malaria vaccines, which is very important. [Inaudible]

PHILIP NIEBURG, M.D.: Okay, thanks, any other questions or comments for the speakers? Okay, in the back.

MALE SPEAKER 1: The question is; could the speakers; could Mario and Mark comment on Russia and the way that Russia is handling the XDR and MDR issues?

Did I hear that correctly? Thank you. Also, Mark, if you can comment with respect to Peg's question which really has to do with the reauthorization process right?

Do you have specific thoughts on the way that the reauthorization process might begin to push on these issues? And then we can come back to Russia. We've got two questions on the table.

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AMBASSADOR MARK DYBUL, M.D.: Well, for reauthorization, I mean, everyone in this room knows where we believe we should go, which is not mess with the current law very much because it pretty much has all the authorities you want.

Those pieces of language actually have to do with existing contributions from the U.S. Government to those programs. So it was a continuation of those programs that got bundled into the larger law.

So, if people thought it would be necessary to leave a window for an opportunity, I mean, that would be something to work with members on. But really the existing things grew out of existing commitments by the U.S. Government.

It wasn't a new commitment in any way and it all has to do with all the different dollar amounts that make up PEPFAR, which we don't have time to get into. There are actually about twenty different spigots and those were just some spigots that wound up in the law.

So our view of the legislation is, it's a very good piece of legislation, there's very little that needs to be modified. There a couple things that do need to be modified, and what's most important is to rapidly move to let ministries and others know that we'll be there.

I was just in Haiti last week and the first question from the Minister of Health was, "Can we plan on this existing

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next year?" I think implementing partners actually have a different view because they work with the U.S. Government more and they know the money's coming. But at the ministerial level there is some concern.

So, but we also need to think thoughtfully and see where there are opportunities to modify. So as President Bush has said, we're open to very bi-partisan conversation, we're going to work closely with Congress to develop a bi-partisan law. And I'm sure there are many thoughts on opportunities but this is a very specific one related to ongoing activity.

MALE SPEAKER 1: Do you have any comment on Russia?

AMBASSADOR MARK DYBUL, M.D.: No. We actually do have an HIV- there is a TB problem there, I think everyone knows that. Actually, ask Irene to comment more on it because the nexus between HIV/TB is nowhere near as pronounced in Russia as it is in Sub-Saharan Africa.

So most of our TB activity in Russia is actually something that's managed by USAID with technical and other relationships with CDC and a lot of it is supporting WHO.

MARIO RAVIGLIONE, M.D.: Well, just to add on Russia. Russia enjoys today a major loan of the World Bank that has been put in a good part to MDR-TB also, the MDR-TB covered, but the majority of the money is for strengthening of basic TB control practices.

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They also enjoy Global Fund money, but since they became recently a donor, they are going to return the funding to the Global Fund. I would say that there has been a difficult start in Russia.

And we have been involved right from the beginning in 1994, I remember my first trip actually to Moscow to try to convince the old nomenclature over there that, you know, TB control has to change.

We are succeeding in a way because there are many [inaudible] now, many regions of Russia, probably more than half, I can't remember exactly the number that are implementing proper TB control practices. However there are still impediments, there are impediments sometimes of philosophical nature in accepting strategies that they feel are not exactly in line with what they were thinking before.

And there are more practical impediments. The most recent one I was referring one bottle-necks drug registration, this is a major one because it has actually delayed by six months the implementation of treatment now with second line drugs for MDR and XDR-TB cases that are abundant in that particular country. And that is purely a drug registration issue in the country.

So, there are constant impediments due to the difficulties of working over there sometimes, with the

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mentality issues, sometimes with logistical issue. But, you know, there is a lot of work going on and definitely in the past five to ten years there has been a major change in overall TB control.

PHILIP NIEBURG, M.D.: Okay, thank you. I'm going to quickly go through the table on my handout. It's clear from the previous speakers that there are a number of technologic gaps in [inaudible] for TB control, and I was asked to talk for a few minutes about the need for new technologies to help in the efforts to control TB.

I'd like to actually acknowledge the help and encouragement of Peg Willingham, who just asked the question, who's in the audience, and who apparently knew I was going to be on this panel before I did.

The handout is really why we need new tools and put new tools on the table. And what I tried to do was to give it a sense of the magnitude, the size of the gaps and the number of the gaps that exist. So when you think about it in this way it's pretty intimidating.

So Column A on the left provides the TB status of any individual. So people can be uninfected, but susceptible to TB. The next line down, people can be infected buy with latent TB infection, which is not transmissible, not contagious, or next could be infected with active TB, which can be

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transmitted. And finally, people who have been successfully treated and are now cured.

Column B shows the clinical and public health goals for each of those groups. Column C is how to achieve the goals, what kind of steps need to be taken. And Column D is the obstacles and technical gaps.

So let's go back to A for a minute and I'd like to briefly go through each category going across the table this time from A to D. So, for example in the first line, people are uninfected but susceptible and the major goal both for individual health workers and for public health is to keep those people uninfected. That could theoretically be done by increasing their resistance to infection which could be done by a vaccine, except there isn't one. And actually, on the bottom, I noted on the bottom the obstacles on the far right column, which are technologic, I noted with an asterisk.

So, again, increasing resistance to infection can be done with a vaccine. Decreasing exposure to TB in the environment can be done by diagnosing active patients early, other patients.

But there's a real deficit in sensitive diagnostic tests. Another way is to effectively treating other people who have active TB. But as we've heard, there is an increasing circulation of drug resistant bacteria.

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The next group, the group of infected people back to Column A, people that have latent TB infection. The idea is to prevent their progression to active TB. One way to do that is to identify people early.

That requires sensitive diagnostic tests. We have some, but they're not good enough yet. To treat people with preventative therapy, an isoniazid, IPT, six to nine months isoniazid actually is reasonably effective at this point.

But to do that you need to rule out active disease. That is, you can't do that with people that have active Tuberculosis. And an obstacle there in terms of people in rural areas that don't have access to X-ray machines.

Another way is to increase the resistance that is to give a vaccine that slows the progression of TB or prevents the progression of TB from latent to active TB. Again, we're waiting for a vaccine for that to come along.

And finally is preventing those people from getting HIV/AIDS and there's a whole other set of issues, obstacles on the HIV side, which we're not going to deal with today.

The third category down is people with active TB. You need to treat them effectively, cure the patient and protect others in the community. So that requires early identification, which requires sensitive diagnostic tests, which again we have sort of, but not good enough yet.

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It requires treatment with an effective drug regimen. But we've heard already about the increase circulation of drug resistant bacilli. It requires insuring adherence to the regimen. That's obviously a behavioral obstacle, not a technical obstacle.

And again HIV is in there. It requires keeping those people from becoming infected with HIV, or if they are infected, treating them effectively with antiretroviral drugs.

And finally the last category of people who were infected and are now treated and cured. Those people still can get Tuberculosis. For some of those people when they get TB again it's a case of relapse of their original disease, which is a greater risk for HIV infected people. Or it may be acquiring a new infection, the second TB infection.

So, it's clear that closing the technologic gaps are not sufficient to control TB. We heard from Dr. Raviglione a long list of other obstacles, and so many things have to be done beyond fixing the technology.

Nevertheless, there are a lot of technologic gaps and it is clear a greater investment is needed to speed development of new tools, investment in research, investment in staffing, coordinated planning.

The kinds of coalitions that we've heard about from various speakers up to now need to be created and fostered to

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help fill those gaps. There's coalition between the private sector, government, foundations, NGOs, community groups and others on a long list that President Sampaio mentioned.

With that I'd like to close my presentation. I was just trying to give a flavor of the magnitude of the dilemma that's facing the health care community at this point in terms of TB tools.

And we'll open things up for questions now to anybody on the panel. Dr. Dybul had to leave, but he volunteered Irene Koek who's going to be a speaker in a couple of minutes, or Eugene McCray, one of my many ex-CDC bosses who's still at CDC. So it's possible to ask questions on PEPFAR as well.

Actually, I'd like to start with a question to President Sampaio, who mentioned the idea of the importance of high level leadership in terms of controlling Tuberculosis. In the HIV world there actually have been some important examples of high level involvement in national AIDS control programs.

I was wondering what you think, how it might be possible to foster the idea or to begin to get people at your level, at the Presidential level or the Prime Minister level involved in TB programs?

HIS EXCELLENCY PRESIDENT JORGE SAMPAIO: Thank you very much. The basic idea is to demonstrate that as far as HIV was concerned, it is in fact where leadership at the highest levels

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showed that this is a very serious challenge that can be met with general effort, produce results.

And the problem with TB as I see it is that in many places it is a hidden or forgotten illness. Take the case of my country, which we had a very serious TB crisis around the beginning of the last century until the thirties and the forties.

Although we lived in a dictatorship at the time, we did have a structure to control TB at every level. And so, in fact, it was one of the cases in which, although with not sufficient health services, in fact, there were TB control centers everywhere in the country and it totally declined.

With the revolution and democratic revolution coming in 1974, what happened was that this kind of structure was not necessarily needed anymore. TB was controlled, why should we continue with a separate system? So now we have a health system, we introduced this in the health system.

And it simply shows that although we have low levels and it is decreasing again, nevertheless it came back, because the former centers were tools of detection which no longer existed. And so coming in health centers with everything, in fact this specific point, did not work.

Second, a recent example was, there was the appearance of four cases of TB in the north of the country and there was a

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total, this is very recent mind you, this has about a month.

There was a total surprise. Why in this school?

What was happening? And the fact was that the doctor who was dealing with that simply did not notify the health service. And for four months a simple fact of notification did not work.

So, in other words, I always take examples from my country which is full of successes but it does have some problems. We should not be shy about telling this practical problem of a European country, so, let alone all of the others in the periphery of what we now call the European Union countries.

So, in fact, if we bring up the issue, bring up the issue that this is controllable, this is curable. We need of course, new vaccines, we need research, but this on the ground it's still as it was quite extensively explained here.

If you act on time, then it is a curable disease and it does not add to complications on others. And it does have to come from some, because if we have to fight for a month to have a paragraph on TB on some official declarations throughout the world, well, it's something which is quite difficult.

But this has been my kind of work this last year. I mean, this exists, it's a challenge, and there are ways to build the cure of this. Let's deal with it and let's end this

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so-called stigma that you don't mind saying that you have pneumonia or that you have other difficult and very serious illnesses. But in many countries you don't want to say that you have TB, because TB is still unfortunately connected with poverty.

My father, before being a public health man, was a General Practitioner. And I remember very well a well known family in our hometown and he diagnosis that the man had TB. And they never more spoke to my father, nevermore.

And it was a well known family. And I was a boy of eight or ten. Why don't they speak to you? Because they have TB and they don't recognize it.

So, this I think is long past but it's still something that is not necessarily recognizable. And you can imagine this in other countries where, of course, you then you have the, which kind of approach.

TB is inherited, so why should we declare that we have people appear at the centers when TB is already in a very, very dramatic situation, et cetera, et cetera.

This is why, of course, community workers, health centers play here a decisive role. But in many, many countries, first you cannot disguise this if you disguise this you're in trouble.

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You have to take the lead in saying this exists, there's a way to fight it and of course we have to reinforce the way which we do it. So it's always a problem of leadership, whether it's a small stone or it's a big disease.

MALE SPEAKER: Let me just follow up there. Where do you see the choices and opportunities for mobilizing high level leadership around the world? I mean, as you talk to leaders in China, or Africa, or Russia, or India or places where the gravity of what we've been talking about today is felt most profoundly.

I mean, you're the envoy who's really charged with galvanizing leadership and elevating the profile of this. What do you see as the best opportunities for building a new set of mobilized leaders?

HIS EXCELLENCY PRESIDENT JORGE SAMPAIO: It was mentioned before and I take this opportunity to thank all of those who are involved in this work and who are in this room today. And I greet your work as very important.

It's again a permanent kind of cross examination as if you were in a trial room, in the sense that you have to be brought to the evidence that this exists and you can't ignore it.

And of course it has to do with the medical community. You have to deal with doctors who have to be prepared to

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diagnose this immediately. What the General Practitioner is confronted with if he misses that opportunity to see what is happening, he misses a whole line of possible contagious procedure.

So, I think that we can't resolve doing very well in terms of the programs in assuming. And some of those you mentioned are doing quite well, others are not, and others are simply not seeing what they have, so I think we have to- if international statements, international mission, international gatherings like this one here today.

Of course, if reports come out of this, it's a help in a good direction. And this is why this meeting, for example, is extremely important. At the United States Senate, when an effort to fund TB moneys is on the way, and this I have to greet with great admiration because one's leadership and countries and of people in fact reflect the necessities on the ground, then we are of course doing well.

The second point, which is not totally referred here, and it was by Ambassador Dybul and others, is we must coordinate. Taxpayers have the right to understand that it's not the proliferation of very many types of funding, although it's remarkably good, the problem is you have to have sustainable funding, correct.

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But you have to be better in the way you coordinate the various programs, the various entities and the various bodies that are dealing with that. Ambassador Dybul mentioned one thing which I am approaching to- I am a lawyer by profession and a politician in retirement.

But I do think that from this year experience in reading, you have to see what is happening country after country, country after country. Who went there? What is the national ownership of this program? What are the indicators? What were the donors? Where are they working? How are they working?

How is the evaluation? And extract then the best practices, because if you don't have a national ownership, and of course accountability, and of course good governance and all of that is another political matter, but if you don't have that, you're missing the targets.

And this is a very emotional target, because even if we need new vaccines, even if you need new kinds of approaches, of course we do. But it's as you were saying it's not costly at the moment and if we attack at the first stages, if I'm saying technically correct things, if you attack at the first stage, you can have a victory.

So this is really impressive because there are many which we don't win over illness. This is one we can win. So

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we simply mustn't put it aside. That's the main political issue I think.

PHILIP NIEBURG, M.D.: Okay, we're just almost out of time and actually I'd like to invite Irene Koek to come up and give us some closing comments.

Miss Koek is here today wearing two hats. She's been the Director of Infectious Disease Division within the Global Health Bureau at the Agency for International Development since 1998.

That bureau supports work in infectious disease such as TB and Malaria, including Malaria vaccine. And work in childhood health issues such as water and sanitation related diseases.

During her long career at AID she's also served as a Technical Advisor for Population Health and Nutrition in USAID Policy Bureau where she led the cross agency team that developed the agencies infectious disease strategy.

Miss Koek has a Masters Degree from George Washington University and was recently elected to be the chairperson of the Stop TB Partnership Coordinating Board. Irene, please give us some closing comments. [Applause]

IRENE KOEK, M.D.: Thank you very much. I will be brief because I know time is short, but I wound up wearing both these hats of the Stop TB Partnership and USAID.

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I want to just put in perspective a couple things of where do we go from here. We've heard a lot today about the great challenges we have facing TB as President Sampaio said it is not only a public health issue.

It is a humanitarian issue, it's also a human security issue, but it's also a moral issue. We have the tools to stop TB and we need to take those tools to action. But also you've heard today, you've heard a lot about commitment, so we know we cannot and we don't need to and we will not step back from the challenge to stop TB.

Philip was talking a few minutes ago about some of the tools we have for TB, and you think about what do we need to do to really take this on. You need tools, you need a strategy and a plan. You need strong commitment and you also need strong partnerships. And I think we have many of those things in place. And I want to talk briefly about all of those.

The tools we have for TB are indeed blunt. And I think, as Phil was referring to earlier, we do not have a vaccine for TB.

The drugs we have, the last new drug was developed forty years ago. We have the diagnostic tool. We have those who work in diagnostic show us a picture of the microscope that was developed a hundred years ago. That is the primary instrument for diagnosing TB. These tools are blunt at best.

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That said we also do have a strategy for managing, for treating, for helping patients and for curing TB that we know works. That has cured millions and millions of people over the last ten years. We know the strategy works. We know we can put it into place. We can use the blunt tools we have to great effect.

At the same time, we need to invest in research now. Over the last several years we've had a great increase in research investments for TB after many, many years of neglect. We are at last seeing some things coming out of that research pipeline but now is the time that we need to continue that and be ready to take those tools as they come out of the pipeline and put them into use immediately and waste no time in that change.

We've also heard a lot about a number of actions being taken. Senator Brown, who's been a long term champion for TB and which we're very, very grateful for his leadership on TB, talked a lot about the work in Congress that's happening through a lot of work from a number of you in this room, but there is a lot of action being taken on the part of the U.S. Congress for TB and I think there is some momentum building there.

Dr. Dybul described the great increase that we've seen, even over the last year, in TB/HIV and in the connections

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between TB programs and HIV programs. And in many countries we're starting to see increased numbers of cross references. This is extraordinarily important.

We are seeing change there. For USAID's part, again I want to thank Mark for describing how nicely the U.S. Government agencies who are working in TB are working together. Between PEPFAR, USAID, CDC, and also NIH and others, we have a clear strategy working together and outstanding collaboration and I think that's really behooves us as we go forward. That each one of us has a clear role and we are working really well together and want to continue that partnership.

USAD is actually relatively new to TB. It's only been about the last ten years that we've had a substantial TB program, builds on our work in country.

We have a number of programs in cities, since it is a decentralized agency has programs in most developing countries. We're building on those country programs on our public health programs and really doing intensified TB work in many of the high burden countries that WHO has identified as well as a number of the MDR and XDR priority countries that Mario mentioned a few minutes ago.

What we're doing, we're working very closely with national TB programs to build strong TB programs. The number one thing we need to do.

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It's also working with partners like WHO and CDC and other agencies working on TB to really do everything we can to expand the tools and the strategies we have to attack TB and make sure those programs are effective at the country level, also working with research and other programs for the drug development and with WHO and CDC on other areas of research.

Those, that sort of comprehensive program is one I'm very proud of and one we need to continue and we will continue depending on what happens with Congress in the future.

Finally, a couple people have mentioned the Stop TB Partnership and one of the things we do as we move forward is partnership. We need a partnership that will bring us all together and move us forward in the same direction.

The Stop TB Partnership is really is an outstanding example of how an international partnership can work and work well. It brings together the research community implementers, countries, NGOs the activists, the universities, country representatives all sitting around the same table.

We've been able to come up with a clear consensus and a mandate for moving forward on what needs to be done with TB. It really does allow us to bring a very effective forum for making sure tools as they come out of the research pipeline and are quickly put into action, and issues at the country level inform

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not only research but what donors and technical agencies do in terms of their approach.

Partnership has had a really significant impact on some of the successes we've seen in TB in recent years. For example in 2001 when the Partnership was formally launched, only about 33 or something percent of the estimated TB cases were actually on treatment.

And only about 60-percent of those were successfully completing treatment. Projections were that the global targets for 2005 wouldn't be met until well after 2010. What the Partnership did really galvanized country action.

We helped national TB programs develop accelerated plans, helped countries secure Global Fund monies and other donor resources. Through the Global Drug Facility make sure that the drug stock outs were not going to be a problem for countries, and finally really, ultimately altered that trend line so that in 2005 we came very close to the target of 70-percent of cases being detected, 60-percent of it was the global average, much more closely in line with where we needed to be. But 84-percent on average of those cases were treated successfully.

As Mario mentioned, the Global Plan to Stop TB, which was something that was launched in 2006. And this is a ten year plan that really lays out what needs to be done.

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It's a road map for reaching the MDG and the Stop TB targets for TB, both in terms of implementation and case management as well as in research.

And it's a foundation for action on DOTS, on MDR-TB on TB/HIV, research and social mobilization. It's a living document. It's already in the face of recent data on XDR and MDR.

We've already revised the MDR section of that to really reflect what needs to be done. There's a clear strategy for, as Mario mentioned, for taking action on MDR and that's what we need to do.

If the plan is fully implemented and we will meet the target score globally, but full implementation means accelerated action from all of the partners. We know we can stop TB, we have a plan.

We, the leadership as represented here today, I think, really shows us that some of the momentum that we so desperately need is gaining. The pieces are in place, the momentum from leadership and Congress, people like President Sampaio from WHO and others. I think we can really take action against TB. Thank you very much.

[END RECORDING]

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