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39th Union World Conference on Lung Health Special Guest Lecture and Awards Ceremony: Health Systems and Sustainable Developments October 17, 2008

[START RECORDING - 00:00:04]

S. BERTEL SQUIRE: Ladies and gentlemen. I would ask you to take your seats. So, it's my great pleasure to welcome you all to this inaugural session of the 39th Annual World Conference on Lung Health. It is, in fact, a great honor for me to address you as president of the union. I'm deeply conscious of the fact that I'm following in very august footsteps in the form of Asma El Sony and Ann Fanning. I doubt that I will live up to their weight.

I had the privilege of growing up in a professional sense in the era when the unions influence really started to make an impact at country level. For me, that was in the early 1990s when I was head of the department of medicine in Lilongwe, Malawi, and at that point, the standardized approach to TB management had been rolled out across the country in accordance with the five arms of this DOTS strategy. The benefits were obvious and very motivating for the whole of the health sector. It was, however, also a very challenging time, because just as the DOTS success was becoming apparent, the effects of HIV and deepening poverty began to take their toll on the health system and as a consequence, the TB program suffered. It was clear to me as a young physician; however, that there was something special about the driving force behind the DOTS strategy at the time and that was the union. I'm

proud to say that it motivated me to become an individual member.

Since those days in Malawi from my position as an academic physician at the School of Tropical Medicine in Liverpool, I've had the pleasure of continuing to work with my colleagues in Malawi and as the years have gone by, with other colleagues working in TB control around the world. Those of you who know me and the work that I've pursued will know that I am passionate about the needs of the millions of people around the globe who live in poverty and I'm passionate about their rights to much easier, earlier and free access to TB diagnosis and treatment. My work has always resonated with the mission and values of the union, which has continuously expressed its solidarity with the poor in the way that it goes about achieving its mission of promoting lung health in low and middle income countries.

It's a happy coincidence, therefore, that today is international day for the eradication of poverty. As president of the union, I'm delighted to stand shoulder to shoulder with the ideals expressed in the naming of such a day. The union today has changed dramatically from the organization that I joined 14 years ago, in one sense. It's grown into a vigorous, muscular professional organization with increasing influence extending beyond tuberculosis and lung health and into wider

growth and change is an energetic institute. Many of us previously called it the secretariat. Much of the credit for this growth goes to the unstinting energy and vision of our executive director, Dr. Nils Billo. In another sense, however, the organization has not changed. It's still an organization that defines itself and its global reach by its membership. The union membership is the lifeblood of the union's independence and the source of inspiration for its innovations. As the union goes forward from today, I pledge myself wholeheartedly to all our members. I pledge myself to the current and future individual members of our four scientific sections, tobacco control, HIV, lung health, and tuberculosis. All of these are ably supported by the institute membership and communications expertise that we now have and all of these have counterparts in the departments of tobacco control, HIV, lung health, and tuberculosis within the institute.

I also pledge myself to the current and future organizational and constituent members. Some of you may not really have it clear in your minds that in addition to our individual membership, the union is a federation of professional respiratory and anti-TB society from around the globe, our constituent members. I applaud those constituent members for their support. I urge them to stay with us and I urge all of you to reach out and encourage more organizations

needed. We are especially looking at national level for patients' organizations, nursing and other health professional organizations, HIV organizations, and tobacco control organizations to join us.

Finally ladies and gentlemen, as my final message for this world conference, I pledge myself to the continued mission of the union to work for the poor of the world. Thank you very much. [Applause]

It's now a pleasure for me to introduce Mr. Louis-Charles Viossat who is the ambassador for the fight against AIDS and communicable diseases. While I try to use my broken french, I would urge those of you who need translation from french to English to put your headphones on now. That way there will be less rustling by the time the ambassador takes the podium. So, Mr. Louis-Charles Viossat is from the french ministry of foreign and European affairs. He has taken time out of a busy schedule and we thank him very much for coming here to support the endeavors, missions and values of the union. So, ladies and gentlemen, please welcome Ambassador Chase de la Lutte [French speaking 00:06:53 – 00:06:58] [Applause]

LOUIS-CHARLES VIOSSAT: Ladies and gentlemen, it's a real pleasure and a great honor to be here today with you in Paris at the opening session of this world conference and I

kind invitation. I want to convey the apologies of Mr. [inaudible 00:07:31], state secretary for a corporation in Francophonique, who was not able to be here today but Minister [inaudible 00:07:38] asked me to read a message on his behalf and I turn now to French. [French speaking 00:07:44 - 00:12:10] [Applause]

S. BERTEL SQUIRE: So, it's now a further pleasure for me to introduce Dr. Jacob Kumaresan. Many of you will remember Jacob when he was executive secretary of the Stop TB Partnership and that's also the time when I first met him, first in Montreal when he treated us to a lecture which involved rupees under the seats. I don't know if you remember that, Jacob. Equally further, he presided over very successful Stop TB Forum in New Delhi. Prior to that, though, if I may take you back, Jacob was born in India and his education was at QPAK [misspelled? 00:12:56] Medical College. He went on to Tulane University and from there worked in Zimbabwe, moving onto the WHO, the Stop TB Partnership, and from the Stop TB Partnership went on to the Trachoma Initiative and has recently taken up the position of director of the WHO center on health and development, so please welcome Dr. Jacob Kumaresan. [Applause]

JACOB KUMARESAN, MD, PhD, MPH: Thanks for the introduction, Bertel. My dear friends and colleagues, it gives

evening and to deliver the special guest lecture at the inaugural session of the 39th Union World Conference on Lung Health.

There's a statement that goes as follows: "Blessed are those who deliver short speeches, for they shall be invited again." [Laughter] I want to thank Dr. Nils Billo and Michael Kimerling for inviting me. It's good to be in Paris and back at the union again, and I intend to be invited again. [Laughter]

The June 2005 issue of the *New England Journal of Medicine* reported on a case of pneumonia in a 17-year old girl who was treated with local antibiotics at a local clinic. She returned a week later, her right side of the face had dropped, her right arm and legs were paralyzed and she was aphasic. A chest radiograph revealed hydropneumothorax and a brain scan showed pheresis. Following a rapid diagnosis and a combination of IV antibiotics, she recovered fully thanks to the health systems and the people who mandate. The diagnosis was tsunami lung, a very rare condition which hopefully happens very rarely. Although this was a successful case, we do not know whether the thing was happening in other parts of the world or whether people were undetected and died. My question to you now is: Is the health systems an asset or is it a liability?

How many of you would say it is an asset? Show me your

Okay. I'm not here to change your opinions. I'm here to give you an assessment of what I feel. Lung health composes a wide range of conditions from acute infection such as pneumonia and bronchitis to chronic conditions such as asthma and chronic obstructive pulmonary diseases. According to the latest WHO estimates of 2007, there are 300 million people who have asthma, 210 million who have chronic obstructive pulmonary disease, and there are millions who have allergic rhinitis and other undiagnosed respiratory conditions.

If you look at the death toll, acute respiratory infections alone account for 4 million deaths per year and tuberculosis accounts for 1.5 million deaths. Now how can we manage or even cope with such a large burden? But there is a way forward and that is through collaborations and partnerships.

The Stop TB Partnership is a good example of this collaboration which occurred since 2000 to realize the goal of eliminating tuberculosis as a public health problem and started as a very small number of individuals and institutions working together. As you can see in the graph, less than 100 in the year 2000 but it evolved due to excellent people who are now working there to a network of international organizations, countries, donors, public sector, private sector, governmental, non-governmental organizations working together to achieve a

What is equity? Equity is the absence of avoidable or remedy build differences in populations or groups defined socially, economically, demographically or geographically. Now health inequalities, health equities, does not involve only inequalities in health but it's also a failure of the system to avoid and overcome such inequalities. Now, I would like to review the literature which is available on health equity and lung diseases in the following areas: Distribution, access to care, diagnosis, treatment, and treatment outcome.

Now we all know that TB is a disease of poverty. The poorer populations are two times more likely to have TB, three times less likely to have access to care, four times less likely to complete TB treatment, and five times more likely to incur impoverishing payments for TB care, and this was work done by Tim Evans.

We also know that the highest TB rates per capita in Africa and the vast majority of TB deaths happen in the developing world, mostly in Asia. Now this map shows you the distribution of the world wide TB incidence but if you go deeper into this the red sections and the yellow sections are the ones which are so called high burden countries, the incidence is higher in the rural areas but if you look at the developed world which is U.K. and other low incidence countries, the incidence is largely in the urban areas. Now in

African Americans are eight times higher than U.S. born white population.

Now the same kind of original variation is also seen in asthma prevalence and this data here shows that the rates in children 13-14 years old is about four to five times lesser in Southeast Asia and Eastern Europe as compared to North America and [inaudible 00:20:00] and if you go into one region and you can look here at the rates of Mexico, it's three times lesser than that of Brazil and Brazil is half that of Peru, so you can see the vast variations in the asthma lifetime prevalence in the same groups of children and mortality has the same issues. The average is 0.18 per 100,000 but look at the vast differentials between Czech Republic and the United Kingdom at the bottom, a full fold differential.

We know this very well that TB rates can be influenced by socioeconomic factors such as biological, behavioral, social, and environmental and this work shows that with decreasing socioeconomic status, meaning increasing crowding, lesser income, more poverty, and unemployment, the rates of TB increases twofold to fourfold.

Moving on to access to care, the pathway to care for poor people is very complex and influenced by economic, sociocultural factors such as stigma, geographic distances, and health system responsiveness. The data from ministry of health

diagnosis and therefore initiation of treatment was due to financial reasons. Despite the availability of services, the poor do not have the means to access it.

Now this data is similar kind of data for the asthma treatment. You can see the vast variation between the cost of treatment between Algeria and [inaudible 00:21:54]. It's about a fourfold increase and ironically the people who have to pay more have no, or very limited, access to health insurance. Again, this is an anomaly which can be prevented.

Moving on to diagnosis, this particular data shows us that eight countries in the world account for 60-percent of the undetected TB cases in the world in 2006. Now there are two points to note here. The majority of the countries are lower income countries, probably with poor infrastructure and health systems. The second point here is there is a huge differential even in this data but in the eight countries and India has six times more missed cases as compared to Bangladesh and South Africa.

Let's look at the treatment disparities. This is work done by Christy Hanson and then put into a framework by Peter Tugwell, and basically shows us that the ratio between the poor and the poorest in terms of actual effectiveness following treatment is fourfold. The poorest ratio is 4-percent and you can see that even better illustrated in this graph here that

higher but the number of poor who actually complete treatment is four times lesser than the non poor.

I'll move on to smoking. Smoking is more common in poor men as defined by income, education, social classes, than the rich man in all countries. Now this is data from Chinai, my hometown in India, and you can see here that the illiterate and the people who have less than six years of education have a threefold increase in smoking rates as compared to those who have higher education. The people on the lower right of the socioeconomic ladder are burdened disproportionately.

Now what about services provided to the smokers? The interventions and policies have a significant decrease on smoking trends in higher income groups and this is data from Norwegian men over 35 years and it shows that there's been a greater impact on people with a higher income as compared to those with a lower income. Again, poorer socioeconomic groups suffer the consequences of tobacco use more than the richer.

Now another inequity which we see largely today is about where people live which affects their health and chances of leading a flourishing life. The year 2007 for the first time, half of the world's population started living in urban settings. Now urbanization can be a positive determinant of health in appropriate circumstances. However, if rapid and unplanned urbanization occurs, there's a lot of problems and

This is data from Gambia which shows that the people who have been suspected to have asthma in the rural and urban areas is much higher in the urban areas but those who are actually diagnosed were about fourfold higher in the urban areas.

Now if you look at the Philippines data on tuberculosis, the national average is 300 per 100,000 but in the urban areas whether you're poor or non poor, you have a much higher rate of tuberculosis.

These are the consequences of rapid urbanization trends in the world today and cities are becoming predominantly the mode of living and this trend is irreversible. U.N. Habitat estimates that by the year 2030, three out of five people will be living in urban areas and by the year of 2050, three out of four will be living in urban areas. This is a phenomenon which is irreversible and if we consider that rapid, unplanned urbanization is happening, you will see the similar kind of data where the urban poor have much higher rates of tuberculosis and other infectious diseases as compared to the urban non poor.

Now I hope I've convinced you enough with this data. You can go on and on about this data because there's so much of work done in these areas but health inequities are the embodiment of social inequality. It is not due to individual

discrimination and inadequate public policies. Do you agree with me? Very good.

A Sunday school teacher asked the question why should your children be quiet in church on Sunday? And she got a very surprising answer. A five year old came and whispered into her ear saying "because the adults are sleeping." [Laughter] I hope that's not the case! [Laughter] Because this is the better part and this is where I want you to listen more carefully.

Now why does health systems matter? Well, the primary responsibility of public health systems can be seen as a main venture in health care for all including the poor. And the health systems can act by promoting health equity, to influencing investment decisions and public policies across government sectors and ability to address the social determinants which is the cost of health inequities. It can also indirectly affect through individual and community empowerment and we can see I'd like to press with some examples of that today.

Now we all know about the health system challenges and this is not new to us. If you look at the scale, safe, proven, and cheap interventions are not reaching the poor. If you look at the scope, comprehensive health services according to the needs and expectations of people are not usual. If you look at

with lesser needs. And if you look at protection, too many are still not receiving the benefits due to the encounters with the health system and finally the system's capabilities, we all know about this, can our systems cope with new challenges like XTR and MDR-TB?

Now how can the health systems become more equitable, fair and inclusive? Global health context has changed dramatically over the past decades. While progress has been made on several of the fronts and I won't go through this because all of you have read about this and have probably researched on this, the response to the health sector is not changing adequately as the world is changing. The health system seems to be drifting from one short-term priority to the next, increasingly becoming fragmented and without a sense of direction. Now, not all the blame is due to the health sector. There are circumstances and trends which go beyond the health sector, for example, the structural adjustment programs.

Now WHO has done a lot of work on the potential risks and opportunities in all these areas and I'd like to focus on the opportunities in two of these areas. I'll start with the decentralization and we talk about increased local ownership and commitment to selected priorities.

Now, this is a wonderful graph and it shows what happened in an urban setting for 300 [inaudible 00:30:34] TB

So, the bar on the blue is pre-decentralization and the bar on the red is post-decentralization. Now, look at the amount of people who completed treatment, it's much higher. The defaulter rate is much lower. Now you would all agree that this is better health outcomes, even after decentralization.

Another one, which is the increased role of the private sector and the NGO sectors, and the opportunity is to increase the involvement of the private sector by providing quality TB treatment and this is data from India after five years of implementing the public private mixed project, you can see that in three out of the five centers studied, the case detection rates over the five years by the private sector had doubled and that remarkable.

Health is receiving much attention today. There is a growing interest in unifying our actions together. Now, the public sector leadership does not displace the responsibilities and capabilities of the other sector. As you can see in this graph of the number of top TB partners a year ago, 62-percent of them were from the non-governmental sector. And this means close to 400 partners who are willing to work together with government, academics, the corporate sector, to provide comprehensive universal care. And this is unprecedented. I am sure you will agree with me that despite all the challenges that are significant opportunities that are viable options for

Now I will move on to some ideas of how lung health can contribute to health system strengthening. I'd like to talk about [inaudible 00:32:47], the first one is governance. As I mentioned before, there are more funds available for the health than ever before but it means that we have to have effective governance in order to achieve results. We have to engage all the care providers. We have to provide quality of care for patients and finally we need to empower the communities.

This again is a wonderful graph. It's the data on the costs and by the process of funding over a six-year period. Now look at the scale of increase in funding from close to about half a billion to about 2.2, reducing the graphs you can see that it's a threefold increase over a six-year period.

Now I would like you to focus on the last bar which is the black section and that is purely government funds. And this is very important for us to understand that developing countries today are not aid dependent. Global aid is important and will supplement and support those countries which are making slow progress but that is not the main state. Real progress will come when there is better governance and investments from all countries. Of course, as you can see here, the global fund and other new mechanisms have supported what the developing countries can do.

This decade has also seen an increase in the number of

solidarity and we heard from our French delegate today about the French development funds. This is another one which is the international health partnership which was launched in September of last year by the U.K. Prime Minister Gordon Brown and Norwegian Prime Minister Jens Stoltenberg in response to the challenges of reaching the health-related MDGs. There is a need to align this increase in funds according to country priorities in order to improve the governance architecture. The investments are going to be in building and strengthening of health services which are crucial for scaling up coverage and for the use of health systems. As you can see in the red centerpiece, the outputs which are expected are in the areas of health system strengthening and governance, human resources, medical products, and information are the four areas which I expect are to produce some results.

International cooperation of this nature will accelerate the conversion of the health systems through better channeling of funds which are available today. And there are funds which are available today and I'm told that Ethiopia and Mozambique are the first ones which will benefit from these kinds of resources which are available for health system strengthening. So, today we cannot argue and say that we don't have money for the health system strengthening. We need to find a way to build on these kinds of opportunities.

Okay I will now like to give you an example of another program in which I worked. This is the Tacoma Program and the health services in Ghana has this problem, especially in the northern part of the country and they trained a number of health workers to do these simple 15-minute surgery of the eyelid and had them placed in all the health services in the northern part of Ghana but as you can see from the data in 2001, they were only able to do approximately 300 to 400 surgeries a year, much lower than what was needed, then they started working with the local community to find out why people are not accessing the services which are available at the health facilities. The sad story was that most of these people were elderly and need to walk several hours to days to reach the health facility and therefore preferred to stay back in their yards, really suffering from redness and pain. Their eyelashes are pointing inwards and they can't do anything about it. Once they discussed this with the chief of villages, one particular village chief said that come and do the surgery in my compound and we will see how many people will come there and this actually increased the number of cases which happened to be willing to come and have surgeries done, so this kind of initiative by one village chief then spread around the whole district and you can see how the data increased and they were able to do 10,000 and 12,000—1,000 to 1,200 surgeries per year.

We need to empower the people who are most impacted by the disparities to find local solutions. This kind of community participation and social participation in policy and service delivery can bring positive results and strengthen the health systems. This was additional to what the health systems could have provided.

Now the second area where we need to probably invest is to improve the laboratory network and we all know about the gaps in case detection and that needs to be addressed urgently, again this is a policy failure. The limitations and the tools have to be addressed and more importantly this should be seen as a strategic opportunity, not only for TB control, but for better health systems in general.

Now the TB program also has done a lot of work in establishing supranational difference laboratories, but I'm most impressed by the work which has been done by the top TB partnership in response to the XGR and MDR cases where they have developed a very aggressive global response and this is to establish 43 new laboratories in two years, perform 4 million cultures, save more than 135,000 lives at a cost of $2.1 billion, and this is on public Web site and this is what the top TB partnership has decided to do.

Now investment in these kinds of healthcare systems based on the principles of primary health care and approach is

laboratories, go down to national, and then go down to prevention and district level. Now this is what WHO is looking to do, to revitalize the primary health care approach and is talking about four reforms in these areas, with universal coverage, ensuring health equity, service delivery around people's needs, public policy for healthier communities, and leadership which is both inclusive and participatory.

The third area which I think we should probably do is to gather very good evidence. The WHO's commission on social determinant of health released its report earlier this year in August and it made three key recommendations, and one of them is to measure and understand the problem and assess the impact of action. Now, no data, we all know, means that there is no recognition of the problem. Good data, on the other hand, is essential to understand the scale of the problems, to assess the impact of interventions, and monitor progress. Acknowledging that there is a problem and ensuring that health inequity is measured within countries and globally is a vital platform for action.

Now again, this is excellent work done by the WHO TB program, and credit needs to go to Dr. Mario Raviglioni. I don't know whether he's here. In the early 1990s he was responsible for the surveillance department when this was put together. As you can see, this kind of data is now being

exactly where you are globally. And this is not done by one agency alone. This is not WHO alone. This is active participation of the several top TB partners who are contributing to the collection of the data. It also has to be presented in a very simple way and in an innovative way so that it's easily understandable for policy makers so they can make some informed decisions. And again, these kinds of data is not easy to find in many other disease control programs.

In all that we do, we have to have a stronger focus on social determinants and that requires more public health research. Operations research provides decision makers with the information to enable them to improve program performance and there are several successful global programs who have seriously invested in operations research. The Onchocerciasis Program, which was to eliminate river blindness deliberately satisfied 10- to 15-percent of their funds for operations research. Now I'm please to see in the Web site of the Global Fund that they have recognized the role of operations research and strongly encouraged the countries to write proposals with an operations research component, but there is one area, the outpatient research must be aligned to national health priorities.

And I like the work done by the eastern Mediterranean region of WHO since 2000 they have tried to build the capacity

this in the 2001 June TDR News. What they have done is remarkable. They have put together a very successful program where the program implementers and researchers both national as well as international contributed to every stage of the research, identifying the problem, design of the research protocol, dissemination of the results, and utilization of the findings.

Now I would like to conclude by saying that health systems are of the solution. It should not be seen as part of the problem. We have to put people at the center of the health care and such kind of an approach will improve the community health. If you want to narrow down the health inequalities, we need to measure it and then we need people to take action. Natural incremental work is not the answer. We need to have wide ranging initiatives with public policies resources committed to address health inequities. Better quality of life will be provided if we can find what those inequities are and use the systems to deliver appropriate interventions to those who are marginalized, and this is what is embodied in the Thailand Chatter which was adopted by the European region of WHO this year in August in a meeting and they have put more emphasis and priority in health systems strengthening, based on the primary health care model. Now, I'd like to tell you two sentences about the work which we do. This is the Center for

reduce health inequities in urban settings, and this is a deliberate position which was taken by some visionary people 10 years ago, to look at research which will identify the health inequities, but secondly, looking at governments which will address them through the mayors and other policymakers in urban settings.

Before I end, I want to thank my two friends Don Edison [misspelled? 00:45:46] and Ian Fuyat [misspelled? 00:45:47] who helped me with this presentation, but I'd like to leave you with a thought. All of us make choices in life, now you have a choice to make today. You heard about health inequities, you heard that there is some data, which is unavailable, but not routinely collected data, which [inaudible 00:46:06] inequities. All of us are called to do some good work to impact upon the poor and you are called upon to do work on lung health, and you're committed to do that goal.

I'd like to ask you that you make a strategic choice, that in your work, as you go back from this conference, you will try to find a means of address the inequities. If we don't, we will be reaching whom we have reached in the past, and by so doing, you will contribute to the better health of your fellow citizens and leave a legacy of a better world for our future generations to follow. Thank you very much.

[Applause]

S. BERTEL SQUIRE: Jacob, thank you very much indeed, a very stimulating lecture, certainly for me, I'm sure for you. Clearly a topic dear to mine and many other people's hearts in the audience, so we may be just a round — a further found of applause for Jacob Kumaresan. [Applause]

So, that concludes our special guest lecture, with that enticing question about health systems and inequity. I think Jacob has given us a call to arms. We change gear now and move onto the award ceremony of the Union, and I wonder if I could have the slides back again. I think you're fed up with looking at me. [Laughter] So, the Union awards were established to recognize exceptional contributions to tuberculosis and lung disease, and the first of these awards that we're going to move onto tonight is the Union Scientific Award, and I'd like to introduce and ask Michael Kimerling, Dr. Michael Kimerling, who chairs the Union's coordinating committee on scientific affairs, to make the first.

DR. MICHAEL KIMERLING: Thank you, Bertie, and welcome everyone to the conference at Paris, and excuse my voice. Jacob, you didn't talk about laryngitis in your data on urban health. Anyway, it was befitting — I'm very happy to be able to present this award. The Union Scientific Award is avoided to a researcher — a young researcher under the age of 45, who's made a significant contribution to the research literature.

discussion in his emphasis on operational research and what it has to offer programs in terms of development and enhancing their effectiveness. The prize is to be awarded to Dr. Ronnie Zachariah. In his place tonight is Mr. Tony Reed, because Ronnie couldn't make it. Dr. Zachariah went to medical school in Nigeria and did diploma degrees in both London and at the University of Dublin. He completed his Ph.D. in 2004 at the University of Amsterdam where he did his doctoral research on many aspects of health care in rural Malawi, including HIV/AIDS, TB, TB/HIV, and STI.

Currently, Dr. Zachariah is the director of operational research and documentation for Médecins Sans Frontières in Brussels, Belgium. The paper he's being cited for was published in 2007, in which he discussed the importance, or the relationship of ART therapy to TB care, and he showed no decline in mortality when ARV therapy is delayed and instituted after TB care is completed at least the first initial phase. This result was a big shocking to the community, who was not clear about the sequencing of TB in HIV care, so this raised many issues, and it's for this paper that he's recognized tonight. So, I would like to invite Mr. Tony Reed to accept the award for Dr. Zachariah. Thank you very much. [Applause]

TONY REED: Thank you all very much. I'm very sorry that Ronnie could not be here. I'm a colleague of his, and I

to choose between his desire to be here with his TB colleagues, and to be with his sister who is getting this week in India. So he asked me to convey this message.

"I would like to express my sincere gratitude to the Union for this prize. I'm especially happy that it gives recognition and new credibility to the role of program-oriented operational research in shaping policy and practice for managing TB in resource-limited settings. I consider this award recognition of all MSF workers, our partners, community workers, and TB patients, and this honors us as very much a shared one. As we continue to face challenges in both the patient and program levels, and taking care of TB patients, particularly those co-infected with HIV or suffering from MDR or TB, the absence of political will and support for TB can be a significant bottleneck for opening new projects. I would therefore like to take this opportunity to specifically appeal to the Chinese government to allow MSF teams to access MDR TB patients who have been waiting for more than a year for a formal green light.

I would like to thank my friends and colleagues, especially from Malawi, and particularly Professor Felix Salaniponi in the National TB Control Program, and I extend special gratitude to Professor AD Harris [misspelled? 00:52:37] who introduced me and MSF to operational research, and to

the years, and from whom I have taken inspiration and direction. I would like to close by indicating that the money from this prize will be used to contribute towards an educational fund for TB/HIV orphans." Thank you very much from Ronnie and from MSF. [Applause]

S. BERTEL SQUIRE: Thank you, Michael. So the next prize is the Union Carol Stebo Public Health Prize [misspelled? 00:53:23], which acknowledges a health worker, physician, or lay person, for contributions to tuberculosis control or non-tuberculous lung disease, and it's a great pleasure to announce that the recipient this year is Chief Austin Obiefuna, from the Afro Global Alliance in Ghana. [Applause]

Chief Austin Arinze Obiefuna, has demonstrated a leadership role has demonstrated a leadership role and a strong crusading spirit in the fight against tuberculosis. He maintains this belief that if an individual is effected, the community is effected, and so the entire globe, meaning that TB knows no boundary. In 2003, he established the Afro Global Alliance in Ghana, and started the formation of the Stop TB Partnership in Ghana in 2005, which was inaugurated in 2007 with membership of over 100 NGOs.

He specialized in journalism management and health education consultancy from Oomoji [misspelled? 00:54:38] in Indymedia [misspelled? 00:54:40], North LGA, in an amber state

founder and president of the Afro Global Alliance International, and the national coordinator of Stop TB Ghana. Chief Austin has played enormous roles in the fight against TB through innovative initiatives like the TB Voice Network he founded in 2007, which happens to be the first patient led group in Ghana, aimed at demystifying TB. The Global TB Candlelight Medication, also in 2007, which is a grassroots program, helped to shape the face of TB by eliminating stigma.

He's presented papers on TB control in conferences, and has worked as a WHO consultant on establishing national stop-TB partnerships. Now, he’s leading the advocacy role of declaring TB as a national emergency in Ghana, involving traditional authorities in TB control, and he’s involved in the establishment of a supranational laboratory in the West African region. So, I call on Chief Austin to receive the Carol Stebo [00:55:51] Prize. [Applause].

CHIEF AUSTIN ARINSE ABIYAFUNA: Thank you very much. I wish to thank the Union for this award. To me it’s a two, special two. I want to thank my organization, Afro Global Alliance, for their support, and other bodies like the TB Voice Network, the Ghana Health Service, the National Tuberculosis Control Program, Ghana and there is one person too that, if you [inaudible 00:56:49] develop the success of this award, [inaudible 00:56:55], and he's the one and only Dr. Bolsu

opportunity to tell him that I appreciate him a lot. Thank you very much. [Applause]

And the prize for this award, I'm going to use it still continue the advocacy work of making sure that the government declare TB as a national emergency in Ghana. Thank you.

S. BERTEL SQUIRE: We move on now, ladies and gentlemen, to the Princess Chichibu Global TB Memorial Award, and I'd invite at this stage, Dr. Tadao Shimao, director emeritus of RIT JATA, and senior advisor to the Japanese Anti-Tuberculosis Association.

TADAO SHIMAO: Distinguished participants of the 39th Union World Conference on Lung Health. Ladies and gentlemen, it is my great pleasure to donate this year's Princess Chichibu Memorial TB Global Award to the person I'm funding, but before doing so, allow me to speak briefly about Princess Chichibu. Her highness Princess Chichibu had been the Patroness of Japan's chief association since its foundation in 1939, until her death in 1995, for 56 years. In 1940, one year after she started to serve as the Patroness of JATA, her husband, Prince Chichibu. Her younger brother, the former Emperor Showa, got TB and despite the best then available treatment by attending physicians, and good care taken care by her highness, Prince Chichibu finally passed away in 1953 after a 13-year struggle against tuberculosis. While she had to take care of her

patroness of JATA, and she had devoted herself, after his death — she had devoted herself for the fight against TB, and encouraged those who were working against TB.

Her major concern was to organize women for the fight against tuberculosis, as it was her firm belief that if women were acquainted with tuberculosis, then she could protect her family and neighbors from the damage caused by tuberculosis. Finally, in 1975, the National Federation of the Women's organization engaging in the Fight Against Tuberculosis was organized, and this organization has been working in close cooperation with the central and local governments, first in tuberculosis, and now improving health in general.

Her Highness Chichibu also showed keen interest in international cooperation in TB control. This year, 2008, is the 45th anniversary of the international training course organized at RIT, JATA, and since its very beginning, in 1953, she organized a reception to the course participants, and had a talk with them and encouraged their activities. In 1980, she visited Nepal through the invitation by Nepal Anti-TB Association, and observed field activities and talked to them and encouraged the staff working in the TB control project. After her visit, the corporation of Japan, in the western part of Nepal, was integrated to the corporation of National TB Control Program, and the National TB Institute was constructed

the center for TB control in Nepal, but also in sub [misspelled? 01:02:00] countries.

Recognizing great contribution of her Highness Princess Chichibu, not only in TB control in Japan, but also for global TB control, Japan Anti TB Association created Princess Chichibu Memorial TB awards, including this TB global award, in 1998. Now it is my great honor and pleasure, representing Japan's TB Association, to donate this year's Princess Chichibu Memorial TB Global Award to Professor Anne Fanning, for her great contribution in TB control, research, and education, teaching on TB not only in Canada and North America, but also in the world; including her activities as president of the International Union Against Tuberculosis and Lung Disease, from 2000-2003. Professor Anne Fanning, would you mind to come up? [Applause]. This is the certificate, and signed by Princess Akishino, the new patroness succeeding Princess Chichibu. [Applause].

ANN FANNING Thank you very much.

TADAO SHIMAO: And this is the — [laughter] — double crescendo of [inaudible 01:03:33] campaign.

ANN FANNING Oh perfect! Thank you very much. Thank you. [Applause].

TADAO SHIMAO.: Congratulations.

ANN FANNING Professor Shimao, thank you from the

am inspired by the story of the devotion of the late Princess Chichibu, and by the work that the Japanese Anti TB Association has done for so many years, and to learn of the Japanese government's further commitment to the center to explore health inequities. I commit to you that if I live long enough, I will try to earn this award, and I want to tell you that I have earned it on the shoulders of giants who humble me, and it will be put into a trust fund at my university to inspire young people to global health careers. Thank you. [Applause].

S. BERTEL SQUIRE: We now move onto the award of the Stop TB Partnership Pachón Prize, and I'd like to call on Dr. Marcos Espinal, executive secretary of the Stop TB Partnership to make the presentation. [Applause].

MARCOS ESPINAL: Good evening, everyone. It is a pleasure to introduce Mr. Doo Yun Kim [misspelled? 01:05:57], chairman of the Pachon Foundation, who has been sponsoring this award for the last three years. Mr. Kim? [Applause].

DOO YUN KIM: Good afternoon. Ladies and gentlemen, on behalf of the Pachon Foundation, I'm thrilled to be here to award the Stop TB Partnership Pachon Prize, to the individuals and organizations devoted to the fight against tuberculosis. This is the third awards ceremony since we became a partner of Stop TB Partnership. We are pleased to see attention to the prize growing every year, and the selection committee putting

prize was established in memory of Jon Gun Li [misspelled? 01:07:18], who founded the pharmaceutical company in South Korea in 1941. He paid special attention to TB and his company became a leading manufacturer of anti-TB drugs. By decreasing his personal assets, Mr. Li established the Pachon Foundation in 1973 with the aim of supporting students in financial need and donate funds to biomedical institutions.

His legacy has been maintained, as it should. I am proud to say this prize is very much in line with the founder's wishes. The Pachon Prize is a humble attempt to recognize achievements of people who work day and night in communities, laboratories, health ministries, and beyond, to bringing the dream of a TB free world a step closer. We hope the prize recognizes winners for what they have done and also inspired them to move forward and freely [misspelled? 01:09:09] implement the global plan to stop TB. We all know TB can strike anyone, anywhere. So the credit for fighting this disease should go to those who are on the front lines, no matter where, no matter who, no matter where.

With this in mind, I'm delighted to give the floor to Dr. Marcos Espinal, executive secretary of the Stop TB Partnership, for the announcement of the winners of the 2008 Stop TB Partnership Pachon Prize. Thank you.

MARCOS ESPINAL: Thank you, Chairman Kim. Again, let

Foundation Award to be given at this ceremony. The coordinating board of the Stop TB Partnership decided to award the Pachon Partnership Award to two outstanding members of the TB community. As per recommendations of the panel assigned by the coordinating board, our first awardee is Dr. Heming Björna [misspelled? 01:10:45] of Sosios in Salute [misspelled? 01:10:55]. [Applause]. It is indeed a great pleasure to award Dr. Heming Björna this award for remarkable achievements in the development and subsequent international expansion of community based multidrug resistance to tuberculosis treatment in a resource poor setting.

Heming Björna is the founding director of Sosios in Salu, Sukul South Peru [misspelled? 01:11:20], A Lima based organization that has had significant impact on policies for prevention and treatment of drug resistance to tuberculosis and HIV, and provide the training and technical assistance around the world. He is a leader in international health and social medicine. Dr. Björna is an authority on programmatic approaches to the control of multi drug resistant TB, and a longtime advocate for community based primary care. He's the author of numerous publications related to TB control and treatment methods, and he's currently a co investigator in a multi institutional grant funded by the US National Institute of Health to study the epidemiology of multi drug resistant TB

Medicine, National University of Trohiyu [misspelled? 01:12:08] in Peru, and his MPH in 1992 from the Joint Center for Public Health Studies College of Medicine, University of Wales, UK. Please join me in welcoming Dr. Björna. [Applause].

HEMING BJÖRNA, M.D., M.P.H.: Good evening, everyone. On behalf of the whole Sosios in Salu Team, I would like to thank the selection committee for awarding us this prize. Many of the individuals in the institution — we are grateful to for their unconditional support to accomplish our mission, however, because of time constraints, I will not be able to mention each and every one of them, but I'm sure that they know that we are now thinking of them with gratitude. I must say how grateful we are to the great partners in health family around the world, with whom each day we seek to spread the pragmatic solidarity network in support of MDR TB treatment for patients. My special recognition to the staff of the Peruvian Ministry of Health for allowing us to collaborate with them and fight against resistant tuberculosis in Peru. Finally, my special gratitude to the health promoters, members of the community within, and with them we work. They are the depositories and brilliant translators of many of the lessons learned. [Spanish Spoken 01:14:30 - 01:14:48]. Thank you very much. [Applause].

MARCOS ESPINAL: Okay. Now I have the great pleasure to — which I would never expect that I was going to do that in

of what we have today known as treatment for tuberculosis. For groundbreaking research that led to the development of the current treatment for TB, for having remarkably contributed to improvement in the chemotherapy of micro bacteria in TB, we — many of us grew up with his research, we have learned a lot from him, and I believe we all should be grateful for his contribution. Denis Mitchinson, has had a distinguished career in tuberculosis research, beginning with his pioneering studies on anti-tuberculosis chemotherapy, more than half a century ago. The author of 245 scientific papers. [Applause]

He's the recipient of many awards, including the Weather Parts Prize Medal [misspelled? 01:16:29] Royal College of Physicians, the Philip Medal, Chest and Heart Association, the Medal of Honor, International Unit Against Tuberculosis and Lung Disease, the Presidential Award, American Thoracic Society, the Severy Sullivan [misspelled? 01:16:44] Medal, Phoenix Lung Health Association [misspelled? 01:16:48], and the British Thoracic Society Medal. A graduate of Trinity College at Cambridge in the University College Hospital Medical School, he completed post-graduate studies in pathology, before beginning studies on extractomizing [misspelled? 01:17:03] and Bronton Hospital [misspelled? 01:17:04], in 1947, as one of the three people on the regional bacteriological committee. In 1956, he was appointed director of the Medical Research Council

Royal Post Graduate Medical School in Hammersmith, now Imperial College. In that role he was responsible for the design of groundbreaking randomized trials in Madras, India, comparing inpatient and outpatient treatment of TB, the first major studies of lung care.

In 1985, Dr. Mitchensen retired from his position, but not from science. He continued his work in Hammersmith for four years before moving to St. George University of London, where he has continued an active career in tuberculosis research. Ladies and gentlemen, professor emeritus, Dennis Mitchensen. What a great honor. [Long Applause].

DENIS MITCHONSIN, Ph.D., M.D.: This is a great honor to me, but my thoughts go back some 60 years to when I started taking an interest in TB, pretty largely by change I may say. But at that time, this was a disease that killed half of the people who developed it, where you had young people developing tuberculous meningitis, who inevitably died an unpleasant painful death. Now we have weapons that we can hope eventually to eliminate the disease but that has been a huge endeavor with a very large number of people all over the world contributing and, although I hope I have played a part in this, I would not, for a moment, say that there are others who have played at least an important, and in many ways, more important part. In particular, I would draw your attention to Professor Wallace

unfortunately not well enough now to receive medals, but these are the people who really altered the world of tuberculosis.

I must thank the Union for its work. I remember when it started, as a little organization almost in a hole in the corner in the way it started, now a very different situation and I must thank the Union and also the – Dr. Pachón and the Foundation, for this very generous gift. Thank you. [Applause].

HYMING BJÖRNA , MD, MPH: Thank you very much. [Applause].

S. BERTEL SQUIRE: So, ladies and gentlemen, that concludes our inaugural session for this conference. It only remains for me to thank and congratulate all of those who stood at this podium tonight. I wish you all, in the audience, a very successful and constructive conference, and I urge you to think forward to Cancun, December 2009, where the theme of our conference will be poverty and lung health. I welcome you, to the cocktail reception, there should be signs as you leave the auditorium, and I urge you please to return your headsets. [Laughter] If you don't, the Union suffers. [Laughter] Thank you. [Applause]

[END RECORDING]