



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation<sup>1</sup>  
(Tip: Click on the binocular icon to search this document)

---

**39th Union World Conference on Lung Health  
Partnerships in Action: Engaging All Partners to Contribute To  
Effective Responses to the TB, HIV and MDR Epidemics  
October 18, 2008**

[START RECORDING]

**DUONG BUI DUC:** -- the MDP from the central level to the committee level. So we already have the strong relationship with the--between the MDP and the organization for some woman's union. I would note that the woman's union because by some surveillance in Vietnam, they saw that the women, they have the worst knowledge on TB.

Next, the Ministry of Education, three years ago, we put the knowledge on TB Program to the nation from the school. Next the Ministry of Police for the TB in the jail, especially in the rehabilitation center, especially in the south of Vietnam.

Beside it, we also have an international partner for the MDRTB. I would show you a chart for the--instead of a overview for the MDR Plan in Vietnam. A lot of activity need for a--carry out the MDR Plan in Vietnam. But we would like to know that we organized a three man action--a three man activity. First, administrative document development, next the human resources development and the last is the [inaudible].

And in the pink area you can see the name of the International Partnership who help us more extensive for our action. In detail, for the preparation step, first we organize this workshop on the program [inaudible] of drug resistance in the year 2005 supported by the WHO, Green Light Committee, KNCV and Royal Netherlands Embassy.

Next, we also organized a surveillance for the [inaudible] assisted activity testing in the year 2005, 2006. And activity corresponding to the result, we estimated in Vietnam the prevalence of the MDRTB cases is about—is more than 6,000 cases. But in some special areas, for example, in Ho Chi Minh City, we found that the MDRTBs is higher than the outer part of Vietnam.

The next is—we also organized the surveillance on circulation of second line drugs in the free market and MBCT and the second line drug, we're using in a popularity in private sector. MBCT, for example, in Ho Chi Minh City and in Hanoi, the Capital. That project is supported by KNCV--not only in grant--but also on technical assistance.

Beside the MDP—the MDP development for five year period from the year 2007 to—and 2011, the MDRTB has been put in the master plan. We decided to organize the pilot study for the MDR Plan in the five big cities, Hanoi, Can Tho, Thanh Hoa, Da Nang and Ho Chi Minh City and Hon Gai.

And the development plan sponsored by KNCV, WHO, CDC and we—and so invited two financial [inaudible] from the free company.

And the next activity is the administrative document. The Development Plan activity for the period 2007 and 2011 and were approved and founded by the Vietnamese Government, also Global Fund [inaudible] WHO, KNCV and UNICEF. Beside it, we also developed the National Guideline on MDRDP Activity and we

got the technical assistance from KNCV and WHO as first and this is Guideline is on printing.

Beside it, we also developed the Laboratory Standard Operation and Procedure. We got the support from Supranational Reference Laboratory [inaudible] from Australia.

By the support from Green Light Committee, the NTP in Vietnam contacted the second-line drug procurement with IDH. The other activity is the Infection Control Policy and attention to the legislation directing to HDR in using the second-line drug on treatment case is under development.

On Human Resources development, we are already organized a National Task Force with the full Triad and went for a study tour in Philippines, Likas and Korea. The Workforce formed the first [inaudible] site in Ho Chi Minh City where the prevalence of the MDRTB is higher—the highest in Vietnam.

We need four doctors, 16 nurses and three community consultants. And now we ordered this and personnel to Philippines, Likas for a field visit and our staff supported by WHO, Likas and Philippine NTBs for their study.

We also sent two doctors to Cambodia, the neighbor country to do a field visit also practice on management of the NPR in community and this trip supported by KNCV also Cambodia NTB. We also send laboratory technician to West China to study about infection control and by using the grant from KNCV we also trying three community consultants.

**LANA VELEBIT:** Two minutes.

**DUONG BUI DUC:** [Inaudible] in Ho Chi Minh, the NPR work will be in the year 2007 with 40 bed. The out treatment are going to set up the infection control in checking with the technical support from KNCV, DNV Norway and UCEF. We also operated the [inaudible] with the support by the PEPFAR granted through KNCV.

The challenges—now we're face with some challenges. First, the Task Force on [inaudible] and task force on [inaudible] they ship to our office—even though we have the money but we didn't—we have not done to use it due to the new [inaudible] in Minister of Health.

The [inaudible] of us—first we will reorganize national level of MDR DOT IV by finding the, and technical support from the Partnership. Next, to stick up the Financial Administrative [inaudible] with the Minister of Health. The task is the development and tentative solution for the funded—that we can use the money on time.

And the last is the Development and Technical Plan in Ho Chi Minh City. If the second-line drug come to us on February the year 2009 but MDR will not be ready to use.

And the next step of us, we will organize a meeting on this action for MDR project in Ho Chi Minh City with the Vietnam [inaudible] Organizations, KNCV, CDC, Cambodia and WHO on this November.

Next, we will still operate for the MDR [inaudible] in Ho Chi Minh City. And finally, training for MDR staff and also staff treatment for MDR patient en masse, the year 2009. And we will still have support from clinical management experiences from Cambodia NTP who proceeding of us.

Thank you for your attention.

**LANA VELEBIT:** Thank you. [Applause] So, unless we have burning questions or clarification now, we can go—continue and we can have full discussion after the series of presentations—the first set.

Next, we have Sok Thim—Dr. Sok Thim from Cambodia who is the Director of the Medical Research Institute.

**DR. SOK THIM:** Okay. First of all I would thank the session organizer that provided me the opportunity to attend this session. So I apologize that I send in the abstraction late so my abstract was not included in [laughs] the—just so you know I [inaudible] so, anyway.

I would like to present the Universal Access to the NPRTB in Cambodia that's partnering by the Cambodia Health Committee and we will also change our name to Global Health Community very soon.

The content of this presentation is one—I would like to update you a bit about the basic information about Cambodia and number two, it's about MDRTB Cambodia overview. And the three, it's about preliminary outcome and the last point is about conclusion.

Cambodia, as you know, that located in Southeast Asia with the approximately 13 million population with 181 square kilometer. We are one among the 22 top country high burden of TB. TB in Cambodian situation—the incident of all forms is about 500 per 100,000 population. Smear positive rate is 220 per 100k and the prevalence in all forms is 665 per 100,000 population and the mortality rate 92 per 100k.

For the TB and HIV—in the country the HIV positive among new TB were patient approximately 10-percent. This is the source collected by CENAT and the TB among HIV/AIDS patients is about 15-percent CENAT Source of 2007. But for—sorry for our program—that we start this program in 2004 to 2008.

We had two provincial program for the [inaudible] clinic. In Svay Rieng, as you see on the top one we have total HIV positive patients 1,404 from 2004 to 2008. We had 343 TB diagnosed among HIV positive cases—that's about 24-percent. And in the other province—also rural, near the beach of Cambodia in Kampong Trach we had a total of HIV positive patients is 1,200 and we 222 patient diagnosed is approximately 18-percent TB.

The detection rate—Cambodia as whole—this is for the National Program—the detection rate is 65.4-percent and the cure rate for the current situation is approximately 85-percent. But for our CHC Program—Cambodia has Community Program the new case detection rate approximately 25-percent in

the two catchment areas with the population approximately one million. And we have the cure rate of 95-percent.

MDRTB in Cambodia—I'd like to take this opportunity to say thank you to Dr. Didier Laureillard—you see with the white hair over there. He's the pioneer—is the one to develop the NDRTB Program for us—CAMELIA Study in Cambodia.

We found that approximately two-percent of the naive co-infected TB/HIV have MDRTB. And the other one for National TB Program they have done the [inaudible] survey in 2006 but the study is not yet complete. But the temporary result indicated 1.6-percent of new TB patients—never treated before, newly diagnosed with MDRTB. So we believe that among the relapsed and failure case the percentage seems to be higher.

And the history of MDRTB is such in Cambodia, CHC as the local NGO in Cambodia, we applied—we pioneered this MDRTB. We submitted the protocol to the Green Light Committee twice. First one is to have the treatment for CAMELIA Study—the clinical trial in Cambodia with the 30 patients we plan—based on our estimation by then.

And the second application is to get universal access to everybody in Cambodia to get MDR treatment. Because we feel guilty when we provide MDRTB treatment service to the people who participate in the study but we don't provide same service to other people who not participate in this study. That's why this current application is submitted and got approved.

We also receive financial support from UNITAD to sponsor the costs of treatment for 100 patients but for the other 30 patient was financially supported the clinical trial. We also receive private donation from a rich family in the United States and, you know, from operating NGOs to support the operational costs the patient [inaudible] The Green Light Committee has conducted—well, it's a 24 hour program and certainly one of the best.

The CHC MDRTB Program Overview—we can use the overall view of using successful community based TB program and research infrastructure to provide universal access to MDRTB care. The infrastructure and communication—this is the elements—the special important element for the program like the first starting point.

We define the MDR treatment site in Cambodia—the whole Cambodia, as you know, that we have 181,000 square kilometer. We plan for eight MDRTB treatment sites but generally we establish six sites now and two more to go soon. Totally we have 39 isolation rooms available and we break this into the hospital based and the community based treatment. You see that we have 51-percent of our patients treated is hospital based and for 49-percent of our patient were treated at the community base.

Following up—why we created this network—the network is to be called—MDRTB in Cambodia is very new so not very many body know there's space for available. So we created this

network in Cambodia from the national level up to the provincial level up to the [inaudible] and [inaudible] and also among the NGO working at the community base. And we also provide training education to the public and the medical professional.

And we also established a case-load system and we also developed the responsive acts, you know. Based on—when we help—received a call or case alert, we go immediately to the site where they call us. We do the site visit, we do the sputum collection, we do case preparation.

**LANA VELEBIT:** Two minutes, Dr. Thim.

**SOK THIM:** Okay, sorry—sorry. We have a—we also initiate the MDRTB Management Committees as you can see in this slide. And we have this case finding. We give priority to Category One, Category Two and Closed Contacts. For the case preparation we do like this—we have diagnosis patient's chart, education screening, infection control, adherence, MMC Committee and merging and [inaudible].

For the lab tests at the base line periodically controlled during the treatment. And we have this. And for the screening of the close contact—as you see this is the reason why we do the screening and we take this very seriously at the community levels.

This is the DOT marks you know. When the DOT supporter or patient supporter provide—first off they have to take. The

pink is for the evening and the green one is for the morning--  
so this one--green.

And this is the treatment regimen. I'm sorry because  
of the time constraint. This is the treatment contract part of  
the program initiative. And this is the in-patient--of the  
element of the program.

And the out-patient--we have two different kind of out-  
patient consideration in our program. Those who has been newly  
diagnosed and treated at the community--where we call it out-  
patient also, but those who were treated at the hospital and  
then discharged home we also call it out-patient.

This is the isolation we build at home, you know.  
Patient doesn't have to be away from the house but it has to  
well ventilated.

And out-patient--this is the criteria that we use to  
manage the out-patient. And this is the outcome we have so  
far. We have 79 case notifications and 60-percent are put are  
treatments and we have 64--four die on therapy. We've had four  
cures so far.

And the conclusion is that we have a mixing approach.  
Hospitalized base and community base is the new tool to really  
respond to the need of the patient. And we feel that it is a  
need for a new viral TB drug with less side effect, you know  
that the second-line can have very terrible side effect and  
very long term treatment. We should have less side effect,  
less combination and low cost.

Flexible and practical treatment strategy can reduce much of the adherence issues, like you see the mixing hospital approach and community approach but when we doing this the cost has been doubled. And we need in Cambodia rapid culture and DST.

So, this is the acknowledgement to our staff. Thank you so much.

**LANA VELEBIT:** Thank you. [Applause] We'll move on to Dr. Rostislav Mitrofanov for Partners in Health in Russia.

**DR. ROSTISLAV MITROFANOV:** Good afternoon, colleagues. I would like to thank the previous presenters with their presentations because we actually are without consulting but we have similar structure of our presentations. But each country has its different problems.

So, I'm a physician from Russia working there as a TB Coordinator for Partners in Health Boston, United States. At the same time I'm a part time scientific researcher for Novosibirsk TB Research Institute and Certified TB Specialist licensed to practice in Russia. Later in the presentation it will become clear why it's kind of an important combination.

Russia—or better to say—Soviet Union had established in 1930s specialized medical services—federal TB services with long history. It was one of the revolutionary steps in health reforms at that time and when authorities provided nationalized private resources for TB patient's treatment. And most important of achievements from that time we have right now that

we have around 9,000 TB doctors and interesting that we have five federal TB Research Institutes—it's important facts.

Tuberculosis was—the situation with tuberculosis was always a problem in Russia but with the dissolution of Soviet Union TB epidemiology dramatically worsened. We have around have 8,000 primary MDR cases per year so in order to fight this epidemic we have planned to enroll our 24,000 MDRTB patients to the treatment. And 24 territories of Russia out of 88 already approved for treatment of 6,000 patients and we have—we're looking forward to approve a few more.

Why Russia existing TB services need to be approved by Green Light Committee which everybody probably knows that it is International Committee which supervises assuring quality second-line drugs for lower prices to the regions and countries which demonstrated preparedness to treat MDRTB by international standards.

I think it's necessary to mention that one of the reasons that after collapse of the Soviet Union, TB services were disintegrated. And especially was significant disruption of regular drug supply which forced our doctors to practice some treatment which were far away from standards.

Regions and civilian population in Tomsk Region were selected by International NGOs for urgent TB assistance. This territory is equal to State of Montana or approximately 60-percent territory of France with scarce population of one million people.

This is the history of development of this project from 1996. And at the beginning of this project the situation with delivery of drugs through official channels was so poor that some drugs were delivered by suitcases from NGOs.

And here numbers of Tuberculosis incidence which you can see you see is quite high. In Russia, in general—which is red—it is relatively stable for last years. And you may notice that Siberian Region which is light blue has significantly higher TB incidence and Tomsk Region which belongs to Siberia has lower TB incidence and have appears not to be rising by the Siberian Regions in general have rising.

So, percentage of MDRTB among new cases in Tomsk is quite impressive they hit up to 17-percent which is describes situation for people which is in TB control.

Retrospectively we can call this as Phase One Organization of this NDRTB component for Tomsk Project. Right now we have approximately 1,200 patients on treatment and 630 of them completed treatment. The results of the first cohort of 244 patients shows that almost 78-percent had treatment success and together with other PIH partners and health projects in the world, especially in Peru it demonstrates that the NDRTB treatment can be very successful.

We have a lot of information such as articles and internet resources which describe Tomsk Project quite thoroughly. I just want to underline that key elements to success are just straight DOT treatment in urban and rural

settings, aggressive treatment by second-line drugs over the NDRTB and also intensive and effective treatment of adverse events.

Also, key element was the organization of daily social support for out-patient treated MDRTB patients when they are new negative. It was a priority to PIH to organize out-patient treatment and also some managerial improvement which allowed us to have steady drug supply for prison and civilian population. We assisted of creation central to drug warehouse for this whole Tomsk Territory and it provided on demand all medications, we've had no interruptions for drugs.

**LANA VELEBIT:** Two minutes, Ross.

**DR. ROSTISLAV MITROFANOV:** Okay. Some obstacles we met since the implementation of this project was not in an empty place. We were working with doctors with certain experience and was a large TB community with their own approaches for treatment.

So we had accounted that all of our positive experience we've had difficulties to provide it as feedback for high level policy to be instituted. As well as we couldn't secure additional resources from local authorities because they said if you have donor money we—implied actually that if you have donor money territory we not—less eager to provide our own resources.

Since we have different approaches which were different from TB services in Russia, we decided that it would be good

experience for TB specialist in Russia to be trained and exposed to Tomsk experience. After communications with five TB Research Institutes we organized 10 day training for all 88 territories—five trainings with each institute. And we had a big support from Ministry of Health and Ministry of Justice in Russia and Academy of Medical Science which issued special executive orders which allowed the staff to participate in such trainings.

And general support Eli Lily Foundation made possible to conduct this training with high international standards and this is a picture of actual training in one of the Institutes.

**LANA VELEBIT:** One minute.

**DR. ROSTISLAV MITROFANOV:** Okay. That was fast.

[Laughs] After we realized that our trainees which obtained knowledge they had lack of laboratories to implement knowledge in their own territories when they went back. So after conversations with Novosibirsk TB Research Institute it was made a decision to—and we are right now creating the International Training Center based on this Institute in the process of creation.

Which will allow after that [inaudible] my authority for trainers and trainees and also facilitate issue of instructions and executive orders for other territories which helped to fight these kinds of problems.

Further activities of this training center based on Tomsk experience and Federal Power of Authority with this

International—for this Novosibirsk TB Institute will be—I'll address this as management of MDRTB—also experience of TB HIV infection and Interdepartmental Confederation of Business and Civilians.

While realizing this project, we found that valid projects are always important for MDR treatment implementation by international standard because each territory differs and involvement in an NGO in this process it has a positive influence on this.

And all this efforts could be described in four directions. When we were acting together with authorities it was vertical cooperation. When—right now an institute involved in studying of Tomsk Project results in parallel cooperation and when we inviting other territories to study our experience in Tomsk its horizontal cooperation and our NGO Institute cooperation could attract new stakeholders to be control.

And at the end I will say that I would kind of advocate to down-shifting of NGO specialists which will be involved in state activities, in activities of certain institutes. It will help them to more promptly to react on changing conditions in MDRTB control. Thank you.

**LANA VELEBIT:** Thank you. [Applause] And last in this section, we have Dr. Agnes Gebhart from KNCV in the Netherlands.

**DR. AGNES GEBHARD:** Good afternoon. So, I've been listening with so much interest to the presentations before.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Because we heard a presentation from Vietnam which is about a project which is actually still in the preparation phase moving towards real problematic of treatment of management of MDRTB. We heard about Cambodia which is really getting it done now for the first period.

And we heard about the long standing established program which is not spreading it's wings and providing opportunities for others. Now, I would like to give a perspective from a Technical Assistance Agency realizing that there many more perspectives on this.

The outline of my presentation—I will start the Partnership Challenge, a grassroots experience, steps in the partnering process, technical assistant needs for problematic management of drug resistant TB, TA and Program Phases and how does it work in practice.

Well, I will not go through that because we heard sufficiently from that I would say and if we time enough we will also some food for discussion.

Now this practical experience is about an integrated rural development project—small project which was taking place half way the 90s in Central Vietnam. I came working for a partnership of seven Dutch NGOs who were doing a project in a provinces in Central Vietnam.

What was the partnership about? It was about integrated rural development which has many aspects. And that's why the partnership approach was needed because it was

in this capacity building of the local government, so the local government and mass organizations were involved. It was about new integrated development approaches so that first five TA was necessary.

This complementary strength of those participating organizations pooled funding which allowed technical assistance put on the ground to have people on the ground there. And the special projects environment working with Vietnam made the pooling of experiences of all those organizations worthwhile.

Now, the principles and mechanisms of collaboration were described in MOUs and each partner expected something out of this based on what was described in the project document. And this strategic approach was agreed—it was agreed there would be bottom-up methods which would then be further developed on the spot.

Well, I said there were seven Dutch NGOs from different walks of life, I would say. The Vietnamese partners were equally diverse and what happened? The project was indeed implemented between 1994 and 1997. And some important elements have shown to be sustainable and still on-going there. Part of the projects expanded to six other provinces and it's actually still continuing in three provinces.

Some elements of the project were taken up by the National NTP nation-wide, like strengthening of base health systems in mountainous areas. And the project catalyzed relations between the province and many other developments and

supporting agencies. All in all, quite a successful endeavor I would say.

But the partnership of seven Dutch NGOs which initiated it all did not survive the second project year. One of them took over, and in the end the administrator, one of them to go over but the partnership fell apart.

Now what happened? Content wise it was all described in the three year framework for integrated rural development but everybody had his own interpretations of this framework. The need for partnership was agreed by all, the memorandum of understanding many people had different interpretation of that. The expectations among the partners of what they would get out of it was very different and the strategic approaches turned out not to be reconcilable.

The organizations involved had all different values, philosophies and organizational cultures. So, all in all a worthwhile experience for all sides but as a partnership it was short-living.

Now, if we go into the partnership process it's only one theoretic slide here. There should be something like a shared vision or common goals. Then, each organization which I here depict with yellow—on my computer—it's yellow and the blue one. Each organization does its own situational assessment, environmental and stakeholders assessment and identifies possible partners.

And then possible partners go into it together which makes yellow and blue become green and explore the organizational values, philosophies, culture. They identify common goals and agenda and they decide that there's indeed something they could go do together in which each organization has something to win and each organization has something to give. Then, of course, how you define objectives, et cetera and you start your joint activities.

This model adjusted from the International Institute of Rural Reconstruction from the Philippines. Important here is that also periodic evaluation of the partnership is joining them.

Now, I would like to come a little bit to what the specific needs are for technical assistance for the development and maintenance of starting up and maintenance of programs for Programmatic Management of drug resistant TB. And then it's important that you—how do you say—that you define three phases that is really different from the preparation phase, from the start-up phase and the consideration phase.

I would like to underline that generally there's a gross underestimation for the need for a TA. Presently, I'm representing KNCV, the Green Light Committee and so I see many applications and what you see is that there a real need for technical assistance in each and every aspect of the control and the NRTB.

So, in the beginning it is about the design and implementation of drug resistant surveys in different groups of patients in order to be able to design new regimen and to have a rational approach to treatments—laboratory capacity building, your first workshops, sensitizing people, getting the ideas, then strategic planning, mobilization of financing. But also addressing TB/HIV to be controlled in prisons, public, private mixed DOTS as applicable in the country.

I'm convinced that in all this there's an important role for the program and for the national TB Program or the Ministry of Health or whoever is the pivotal organization pulling this wagon. That indeed they should not only pull their own wagon but they should also should guide and be active in the management of their technical assistance and their technical assistant's partners.

And then there's a task for the technical assistant's agencies to coordinate their efforts, not only with the program but also between each other.

**LANA VELEBIT:** Two minutes.

**DR. AGNES GEBHART:** Okay. Now, in the—similarly there are in the start-up phase all kinds of issues which need attention, for example, also the data management, the drug quality and procurement and coordination. And in the expansion phase you have seen what that entails from the Tomsk example.

So, what is very important to realize, is of course, that not one organization can provide all the TA which is

needed. TA agencies can decide to diversify themselves or to make strategic partnerships with other organizations. For each, whatever you want to chose or want to do, a long term commitment is needed.

I already said the coordination between those technical assistant partners is necessary but what is very, very necessary is that they coordinate their messages. So if the one says that is should be like this, the other shouldn't say it should be like that. There should be a real coordination and then it's the National TB Program who should orchestrate this coordination. Okay, I'll put in an example—I'll shove it out.

What I would like to talk about that it is not only—sorry—yeah—that's it's not only the countries which do their coordination but also—or partnering and part of it but also technical assistance agencies. And I would like to the example of Partners in Health for [inaudible] who is working with Partners in Health and KNCV TB Foundation.

We have a common vision, like a world free of MDRTB, we do our own situational assessments and environmental stakeholder assessment and we identify possible partners and that made us meet and sit together and see how we as organizations can strengthen our effort to result in earlier reaching of the goal of a world free of MDRTB.

We found common ground, like in research capacity building for Programmatic Management of drug resistant TB and

we defined some strategic approaches. For example, we all agree that we should be working evidence based and that we support and work in line the WHO Guidelines on drug resistant TB. We have specific contributions and we develop some joint activities, our research is ongoing, a e-room, sharing of training of and health education materials but also this symposium together with Lana and [inaudible].

So I have here some food for discussion. I would like to give three statements to you. One is the main national stakeholder should play an active role to identify needs and opportunities and select and invite partners and guide the process of partnership building and coordination. The program is at the steering wheel.

TA providers have an obligation to tune their voices in the direction of Minister of Health or the NTP and funded jointly develop median term strategic national development plan is an important tool to achieve and fund these effective partnerships. Thank you.

**LANA VELEBIT:** Thank you. [Applause] So, we're going to take 15 minutes for discussion and then move on to the second section. Do we have any question? I welcome anyone who has questions to come up to the microphone.

While someone comes up I have question for Dr. Duong Bui Duc, if you don't mind. I'm not sure if he's sitting.

I was curious—if I take the prerogative to ask the first question. Where is Dr. Duc? There he is.

You mentioned that the visits are connection with the Latvia and Philippines experience. And how do you see—I'm curious, how do you see that continuing. Do you see there being a need there being a need for continuing communication with those teams? And I'm thinking of what kind of funding will be needed to support also that kind of collaboration?

**DUONG BUI DUC:** As you know, in Vietnam the MDRTB crisis is so many years ago. But throughout the former leader, at that time we just implemented those strategy for the home patient. But now Vietnam did nearly escape from the [inaudible] government. And so from the community that meet for the treatment for MDR. And in the mass media, especially in newspaper, lots of patient, they call for MDR projects.

So, we are for this, so we have not marked experiences from the organization on management of MDR. So, we have to meet the answers from all the partners around the world. For example, last year--because the NTP in Vietnam through the intervention from KNCV and from WHO in Vietnam, we are less in deaths then last year.

And, so, in Philippines and my neighbor in Cambodia they yet ahead of us so many step. So, by [inaudible] especially from KNCV we send people to the country to study how to manage, how to organize the MDR and so we aren't so good then the MDR as in the master plan and lucky for us after one disapproval by the Global Fund but the next step—the plan of us approved by Global Fund.

And now we have money and so we have assistance from our friend—international friend and we believe in the future. We will organize and so we will manage the MDR Plan in Vietnam so well. Yeah.

**LANA VELEBIT:** Thank you. Would you come to the microphone so we can hear you?

**MALE SPEAKER 1:** I think my voice is voice is strong enough.

**LANA VELEBIT:** Okay. Sir, it's for the video. If you don't mind we want to see you. [Chuckles]

**MALE SPEAKER 1:** Thank you for your continuing assistance. I think I have two questions. One for the Doctor still standing. Cambodia, I think, if I'm not mistaken, I thought I saw a picture of—I don't know if whether it's an isolation—small house for MDR at community level.

One, I would like to understand how possible it is and cost effective it is. Because if you have it at a community level it means that maybe it might just be used by that particular family but not by many others.

The other one is to the colleagues from Russia. I don't know who owns that project. The ownership it seems doesn't coming up very strong—hence maybe the Russia government in terms of support. I was looking at extended support against internal support. I know Russia gives out a lot money externally. What about the internal component? How's the

funding going on and the disintegration of the Soviet Union has any bearing on the same. Thank you.

**LANA VELEBIT:** Sok Thim, would you come to the podium, please. So, the first question for Sok Thim.

**SOK THIM:** Thank you for the question. I think because we have ten million issues to discuss in the ten minutes so I did not show every aspect of the community base.

As you see in the pictures, you can see that that particular family has built due to their own resources. And if you see a rich one, you have a concrete isolation room. If you have a medium one, you can have thatch roof with bamboo wall. And if you go to the very poor and you can see a hut with the plastic roofs. I think this month in November, I will show that kind of presentation in Vietnam so you see the different aspect of how we design the isolation room at the community level based on family resources.

We have one support team strategy is that if the family could not afford, then the program it take initiative but we have to share whatever the family can share they have to come up as a partnership. But the initiative have to come from both party. We look at the infection control issues—that the patient we look at from their own resource affordable.

So the answer is that, yes, different family resource, can build a different kind of isolation room based on the income of the family and family evaluation. And we have extra resources to support those who cannot afford it.

And we also using the—we call the Relation Health Supporting Group in the community. Because in each village we have selected two people—one male and one female to be the key person in that village so we use that kind of network to support the initiative to support the patient, not only for the project period but in the long-term it's the same. Thank you.

**LANA VELEBIT:** Thank you. Dr. Mitrofanov now.

**DR. ROSTISLAV MITROFANOV:** Thank you for your question. First question was about Russia which became right now a donor in the international community and wrote correctly that funding goes for internal things.

I just want to underline that Russia claims that it has big financial resources and it's right now politically and financially very active abroad. Inside it's also we feel that TB services and other services have a lot of new equipment and also medications. But seems they are working very strict system of budgeting. Sometimes it takes up to two years to change certain lines for funding. For example Partners in Health increased social support for TB patients and if this line is not in a budget of certain territory it takes sometimes up to two year to get some funding from the internal local money to finance this line.

And, of course, after dissolution of Soviet Union, dramatic decrease of funds to TB services hurt them a lot but I think that in recent time it was increased—my colleagues could correct me—around 20 times more then it was. Right now it's

around 1.2 trillion of rubles which is, I think equal to \$300 million or something which is a significant amount.

**LANA VELEBIT:** Thank you. We'll take a few more questions. We have six minutes.

**MALE SPEAKER:** Thank you so much. My question is to Professor Duc and I—oh, sorry Dr. Sok Thim. I appreciate that in Cambodia you mixed the community based DOTS as well some of the patient's initial treatment at the hospital. So for the people who were treated at home, was the treatment outcome better given the under equipped infection control measures in hospitals and things. And the people who were treated in the hospitals did they manifest anymore infectious diseases.

And the second question is to Professor Duc. In Vietnam did you incorporate community based DOTS—a mixed approach—I mean community based or home based as well as the clinical approach. Thank you.

**SOK THIM:** Because my memory is so short I get to answer first. [Laughter]. So, thank you for a really important question. This comes up into operational research, and we are still compiling all the data. And we will have a big show on this maybe next year. But, yes, for sure we have treated the patients who are admitted in the hospital for a certain period of time and a group of patients that was treated at home. They respond to the treatment and the outcome—we compare on the very unofficial, we see that those who are treated at home have a

very, very fast recovery, and it goes to work quickly compared to the group of people who were treated at the hospital.

Plus, we don't have any patients who have severe bacterial infections at home. This is compared to the group that was treated at the hospital, we have about 10- to 20-percent of them having severe bacterial infections from the hospital bacteria situations. It is a very big issue.

So, it is a big challenge for the people who treat the patients in the hospital for the moment. We tend to think that if the patient is well-educated and they understand being treated at home is better because when they take the drug they feel better, they can do something. They walk around, not just sleeping on the bed. In the hospital, because of the infection control nature, the staff and everything, they take their mission very seriously at the hospital, compared the community level where people live in the village, very isolated, not like in the city. So, they can work in their own field behind the house and do that, so the house becomes like part of the recovery. So, this has been noticed. Next year we will show that kind of data. Thank you.

**AGNES GEBHARD:** Thank you. Dr. Bui.

**DUONG BUI DUC:** Thank you for your question. I would amend that the role of the community on the directly observed treatment performance and now today, focus is by the NTP.

I would explain clearly a little bit because in the back, a lot of the local leaders of the NTP, they'd like to get

the best result in treatment. So, they don't like use the community—yes, the community—based on that treatment, even though we only learned lot of lessons from Thailand and other countries in the world. But, in comparison with the region, the region in Vietnam, the cure rate is more than 90-percent.

So, in comparison with the previous results, if there is use in the community, yes, the result is a little bit lower. But now the NTP understands because everything changed in Vietnam. A lot of people they don't like working in the field and they migrate to the big city for work. So, they don't stay as stable as before, meaning that the temporary resistant proportion is higher than before. So, the NTP, they understand that's now a problem, and they moved the policy. They like using the community for the DOTS, yes.

**LANA VELEBIT:** Thank you. Two more short questions, short responses, please.

**ROHAPTION ZIZI:** Thank you. My name is Rohaption Zizi [misspelled?] of Ghana. I don't know where the question should go—maybe to the Green Light Committee. Probably I'll just ask to the partners in here with Russia. I think when I was entering this meeting, my main interest was to see how countries are managing, in terms of treatment success. I think what I do believe is that the program that keeps the patient alive will attract more patients, rather than the program that kills more people.

But I was actually impressed—I think in Russia—that probably you are curing more cases. The figure you gave was about 54-percent. My interest, because I'm coming from a country that wants to start a DOTS plus program, but I think we want to make sure we're doing a program that will actually cure more patients than kills more patients.

I don't know you manage to have a good treatment outcome. Is it the regimen you are using—is it the management of the complications of patients that are on treatment, or—I think I just want to learn from you how you managed it, because I think that's important for us to learn. Probably you may have better money than most of our countries, but probably the basics cannot use too much money. Thank you.

**LANA VELEBIT:** Can I pass that to Dr. Gebhard? Thank you.

**AGNES GEBHARD:** Thank you very much for this question. Actually, I think that there are many issues which go into this one question. One is that the results, which are presented, the first results, which were presented from the GLC pilots, of which Tom is one of the first—the first results were not so very encouraging. We had something between 50- and 70-percent, just over 60-percent cure rates, which, of course, may lead to thoughts as you say. If you have such a low cure rate, you create maybe a lot more resistance. What do those cases do? They're spreading it around and other people die. So, what is the gain of your program, from the point that a patient would

like to be cured and would like to take any chance which there is to get cured?

But, at this moment, the first cohorts consisted of people who had been treated many, many, many times and for a long time living as a chronic case and taking any drug which was available to them. This probably created a lot of drug-resistant strains, multi-drug resistant. Not just resistant to two drugs, but resistant to six or to eight drugs.

So, you can expect that in a country which starts a programmatic management of TB, even with very good drugs and good regimens, you will first have a period in which your treatment results will be maybe a little bit disappointing, but later on you will see that, in programs which are running well, they can reach something like 80-percent and maybe even more. We will see in the future.

So, definitely in programs in countries where there is not widespread use of the second-line drugs, especially the economizing, compromising and the higher generations or the newer generations, fluoroquinolones. In those countries, you will expect that you basically are able to cure nearly everybody.

So, it very much depends on the situation. In Russia, where you have this longstanding use of all kinds of second-line drugs in the past, or that you are starting in a country like Tanzania, which doesn't have any second-line drugs except

for maybe ciprofloxacin, which is no longer used for it, which has just a very small and weak effect for TB.

So, I think that you should look at the situation per country, and it also means that the regimens which can be used safely, with good results—in countries with a low level of initial second-line drug resistance—those regimens can be much cheaper, much simpler and less toxic than the regimens used in countries where you have an initial level of drug resistance of six or seven or eight drugs. Does this answer your question?

**LANA VELEBIT:** You can continue talking after perhaps. And one last question for this section.

**JOSEPH:** Thank you very much. My name is Joseph [inaudible], and I come from Kenya. Thank you very much for sharing your experiences in Vietnam and also your experiences with partnership.

Now, obviously MDR-TB is a great threat to TB control in high-volume settings, but, as the old saying goes, prevention is better than cure. And what I saw missing in this presentation is this—where is the balance between treating those who have MDR-TB and laying a lot of investment in the preventive aspects of MDR-TB control, given that MDR-TB is preventable? It's failure of providers following guidelines and failure of patients following treatment guidelines. Thank you.

**LANA VELEBIT:** Would anyone like to comment? I know your experience is also with TB, not just MDR-TB. I don't know if you'd like to comment.

**DUONG BUI DUC:** Here you have come to the point [laughter]. I think the best way to prevent MDR-TB is through strengthening so-called chemotherapy right now, through using it in the right ways, and following the guidelines.

So, when their system has been strengthened and that has been implemented and the patient complies with the policy, if everybody—not only the patient, but the doctor, the nurse, the patient, the patient supporter, the communities, and the businessmen in the world—complies with that procedure, then we can treat the simple TB diseases.

But come to our knowledge that MDR-TB is—you all know that it's a man-made disease. To some extent this can be prevented, but it is too late now to rely on that because of many of us malpracticing in the past because we don't pave the way to a better drug program or utilize the best knowledge that we should to treat care for our patients who first have simple TB disease and then develop into MDR disease.

This we just picked up from the negligence we have had in the past. So, the MDR-TB right now is the result of our negligence in the past—directly or indirectly, it is. So, the best way to prevent it is to now look back at our regular TB program. We strengthen it and fix it, assess the weakness in it, and if you see any flaw, fix it, okay? [Inaudible] and

then we can prevent the MDR-TB. I think this is the best I can say [laughter].

**LANA VELEBIT:** Thank you. Okay, so next we're going to go onto another set of presentations, starting with Dr. Guiliano Gargioni of Switzerland.

**GIULIANO GARGIONI:** Good afternoon. I am working with the Stop TB Department of WHO, and what I would like to share this afternoon with you is our experience in participation in the partnering process at the country level, particularly in situations where NGOs, civil society, and faith-based organizations play a very significant role in contributing to the health services.

First of all, I would like to take a kind of snapshot of the situation of global health today. All of us will agree easily that the situation of global health has changed dramatically. There are now many partners, or at least many actors, that are trying to contribute to provide responses to global health needs in many different areas, in the area of advocacy, of prevention, of service delivery, of research and development.

The involvement in health of non-governmental organizations is a fact. We could gather, most likely, all these actors under the definition of non-state sector providers or not-for-profit providers. Together with them, we see today a significant participation of civil society.

What is underlined is effort. These efforts—which are not only the technical efforts of the governments and ministries of health, but the efforts of all the other partners—can be there at the same time because of shared values and goals, because of an attempt to have a mutual understanding, commitment, and the recognition that each partner may bring some comparative advantages to the common goal of fighting diseases.

So, I would summarize briefly some of the main challenges we are facing today in global health. I need to mention first the human resource crisis with the external and internal brain drain and the obvious need to engage all the healthcare providers.

Secondly, I will mention a kind of paradoxical situation, in terms of financial resources. We have moved from a situation where there was competition for our scarce resources to a situation in which we have the paradox of low absorptive capacity at the country level.

And then we have the issue of adherence to treatment, which I'd like to mention more as the problem of continuum of care from the health services to the family, with an opportunity, of course, for the family to relay back easily to the services, and the issue of quality of care.

We have then the issue not just of the geographic coverage of services, but the issue of actual access and utilization of these services. This requires that services are

designed around the patient and her or his family, and it requires the involvement of civil society.

In preparing the global guidelines for community involvement, in WHO, we have clearly seen that the partnering movement, the partnering approach, is not just a matter of sound organizational arrangements; it's a matter of a vision. This came out very clearly also from the presentation of Agnes.

So, what should this vision be? What we have seen in reviewing a number of countries is that at the core of these shared responsibilities is the recognition of the dignity of each person, and the fact that there is already social solidarity that people live and through which people face the struggle for the common good of the society.

Being healthy is certainly part of this common good, but there is also concrete direction to the process of partnering and these are particularly important when a government decides to approach what I called before the non-state sector. This principle says that a higher institutional level of the society like, for example, a government, should support and promote what a lesser form of social organizations can do in order to contribute to the common good.

This, in social justice, is known as the principle of subsidiary, and it clearly defines what should be the principle underlying a partnership approach. Examples of a subsidiary approach have been in WHO, certainly the inclusion of a community empowerment as an essential component of the Stop TB

strategy. And this is an element that addresses directly the issue of the continuum of care and of quality of care at the community level.

Then we are also trying to encourage, as much as we can, partnering with the non-state health services provider in order to improve access and the utilization of services. These are three examples taken from an African context in Uganda, from Asian context in Bangladesh, and from Mexico.

Recently, WHO carried out a specific review on the situation of the collaboration between the faith-based organizations and the healthcare sector, and this gave amazing results. Out of the review of over 100 case studies, it came out that at every age, faith-based organizations covered about 40-percent of healthcare in Africa alone, so they're clearly very significant partners in primary healthcare and significant partners who want to strengthen the health systems. It goes without saying that this is a partner that we can hardly do without if we want to achieve the MDGs.

The findings of this report, which is titled "Building from Common Foundations," situation of FBOs—but many of these findings extend apply also to NGOs. The situation is that they often operate outside the governmental planning, and they are generally unrecognized, so they don't get an adequate share of public resources. There is indeed a recommendation from global health initiatives that they should be including in funding, but when we look at the share or the proportion of funds—for

example, these [inaudible] by the Global Fund that have gone today—to faith-based organizations against the 40-percent of the national services they provide, this share is only 5-percent.

So, it is perhaps a very good thing for governments, but certainly not a just situation. Yet, we know that in a way all the partners have mentioned, all the actors have mentioned working towards a common goal. This common goal is the fact that communities maybe better cared for.

In the Stop TB Department at WHO we can only mention a very long and very positive experience of collaboration of FBOs and NGOs, and very often we have recognized the comparative advantage related to the fact that these organizations often operate in the most disadvantaged areas or within complex humanitarian emergencies. And they work there precisely because of their values and motivations. So, we have now a clear policy of encouragement, and whenever we can we try to capitalize the partnering approach at the country level.

As a result of these various reports and studies and experiences in country reviews, there are clear WHO recommendations now on how to engage with FBOs and NGOs in national health planning. It is realistic to include these actors in national plans because, as I said, they provide 40-percent of the overall healthcare delivery. The healthcare they provide and their role should be seen as complementary to the healthcare provided by the public sector.

I would like to draw your attention to the third bullet, which I think is very important. It is a government's role to ensure that services are delivered. It is not the government's role to ensure that the government is the only or the sole healthcare provider. So, this is very important because it implies that the government should also favor and support other healthcare providers.

And again, the fourth point is that this shouldn't be a big problem because the governments are already dealing with mixed economies in health. I will not focus now on the private provision of services, but rather on how we can summarize the main issues around the partnering approach.

Governments should recognize and support, as part of the public system, other actors that institutionally do not belong to the state. In a shorter sentence, they should recognize the public function of private initiatives. This can happen if partnerships are based on common goals and on mutual respect for each one's identity and roles. A real partnership can make the most of what each partner can contribute, so we see synergy as well as complementarity.

This is a point that is challenging. We have to move from a paradigm of competition towards a paradigm of mutual support and collaboration. So, when we say these things, clearly we are not in the domain, we are not in the area of technical arrangements or organizational arrangements; we are in the domain of decisions that are of an ethical and political

nature that we believe cannot be postponed at this point in time.

This is only to mention what an example of a partnering approach is that has been followed in several countries, in which we can recognize three phases—it has more or less already been mentioned for—so an exploration in which we built a common vision and the identification and the beginning of a dialogue among various potential partners. The important mapping of resources that should match what a national plan is for TB control or for TB/HIV collaborative activities, or for MDR-TB control.

It is important because this is stage that is very much synergistic with the proposals to the global fund, and we have several examples—one will follow my presentation—of how this synergy between NGOs, government and informational organizations can actually be an added value for the country proposal to the Global Fund.

Then, of course, we have the management of the partnership, the implementation of activities, and at some point, if there is real local ownership for this initiative, we will end up having a kind of institutionalization with formal agreements and so on.

The first picture on the right is about a patient living in a very remote area in Swaziland—this is a presentation that will follow mine—being reached on a regular basis by sisters of community ministries, a faith-based

organization that goes very far to visit each of these patients. On the occasion of the partnering meeting in the capital city of Swaziland, it was said for the first time and was able to be discussed directly with government officials.

A similar initiative, with perhaps a different focus, which I would like to mention now, is the one of Peru where the partnership provided a national plan and a national answer to the problem of TB. It clearly entailed a construction process for the partnership, but it is really to get a space for dialogue and coordination. And of interest is the fact that there are obviously practical achievements, practical results. For example, local governments in Peru have now included badges for TB prevention and control activities, so the public is much more aware about the disease and the preventive measures.

My final slide is about the role that the WHO, with also the support from the Stop TB Partnership, can play at the country level. Of course, we try to explore at the country level the role of a neutral body and advisor. We support also with our own facilitation the efforts of partners towards partnership building. We work to catalyze and to mobilize resources through the interaction with Global Health Initiatives and donor agencies. We regularly coordinate technical assistance with partners, and we promote and support capacity building within the non-state sectors.

And, of course, we are ready to engage as partners ourselves at the strategic and technical level and/or we are

ready to serve as the host organization providing the partnership secretariat and legal status. This is obviously a choice of the country. Thank you [applause].

**LANA VELEBIT:** And next we have Themba Dlamini from Swaziland.

**THEMBA DLAMINI:** Good afternoon, ladies and gentleman. I'm Themba Dlamini, the National TB Program Manager from Swaziland. I'm just going to be sharing with you the Swaziland experience on how we formed the Stop TB Partnership.

My presentation will follow this outline. I'll just give you a brief background of the TB situation in the country, the rationale for forming the partnership, how we went about forming the partnership and what outcomes we desired, then a bit of achievements, challenges and the next step.

Swaziland is a small country in the Southeast of Sub-Saharan Africa. It is a small country, like you can see there, which is landlocked. It's bordered by Mozambique in the East and the rest by South Africa. But this is Swaziland. I thought maybe it would make it bigger so that people don't just remember somebody talking about partnership that occurred in a small dot. So, that's the country.

Before I actually continue with my presentation, I'd like to say that in Swaziland TB is a huge public health problem. We are faced with big challenges, especially with the high prevalence of HIV and AIDS. And for quite some time the government of Swaziland hasn't been putting TB as a priority,

so it has been one of the most neglected diseases in the country, exactly on the margins.

What you are going to see on the next slide is really very disappointing, but I would like to show you that there is a lot we are working around. The problem is huge, but we are putting many strategies in place in response, one of them being the formation of this Stop TB Partnership.

This is the situation in Swaziland. We reported 9,636 cases in 2007. That brings the notification rate to about 1,100 per 100,000. We registered 60 MDR cases. The case detection rate is at 57-percent and treatment success at 42-percent. The HIV prevalence among TB patients is 79-percent. I know somebody has talked about this, whether we are killing people or something, but just like I have just mentioned, really TB hasn't been in the mainstream until about two years ago, when the government started realizing that there was a huge problem in the country. So, we are not killing people.

The rationale in getting different partners—some of the issues Dr. Gargioni has already mentioned are very generic. One, we realized as a country that we are being faced with a huge TB and TB/HIV burden, and that the anticipated performance indicators are way below the recommended global targets. And now Swaziland has got this ambitious plan to reach these targets before 2011.

So, now, without bringing everybody together like we have, these organizations, the FBOs, the NGOs and the civil

society are providing these services, actually even in the most remote areas. But most of the time you find that they are not even realized and their efforts are not really coordinated. It is like the right arm not knowing what the other arm is doing. So, now this is a first step to say that everybody is here providing services, and more than 40-percent of the services are being provided by these organizations, so let's come together and work together so that we know we follow one framework, we follow one country strategy plan.

And again, the public sector needs to be complemented by these organizations. Once again, to the previous presentation, the public sector is there to make sure that services are provided, but it doesn't mean that all the services are provided by the public sector, so we realized that we needed to form this partnership.

So, we started by building the vision. It started by recognizing the high burden of the problem in the country, and then as the Ministry through the NTP invited national and international partners to a dialogue to say, here, we have a huge problem in this country. What can we do together?

And then we identified partners with whom we were already doing something on TB. Some were already doing something on HIV and AIDS, but they could still integrate some TB activities within their settings. And then we had a dialogue forum, which was supported by WHO, and then we did a service mapping and analysis of the TB services provided by all

these organizations, looking at comparative advantages and competencies of some of these organizations. Some of these FBOs and NGOs were not doing anything in TB, but they had the potential to start doing something. So, in that dialogue we are looking at what is the comparative advantage you have and what is the potential of doing some TB activities.

Now, after having agreed that everybody's playing a role and everyone is doing something somewhere, let's meet together now and prepare a plan to see what we need for resources. In looking at the partners themselves, their comparative strengths, we put them in clinical and non-clinical areas.

Okay, some can do clinical activities, some can do non-clinical activities. And then after having agreed that we are forming this partnership, we needed to develop the core principles, goals and objectives of this partnership. But what is important here is that it has to follow the strategy direction. So, we presented the country's strategic direction to the partners and whoever wanted to contribute and do some activities must follow that so that it is coordinated and it is uniform and of standard. That way, we avoid everybody doing something anywhere. So, we agreed on that.

We then developed a partnership framework—okay, this is how the partnership is going to be operating. Then, after having agreed on that, we said, now partners who were ready to implement, who were commissioned to implement—others were

already implementing anyway, but it was a matter of not knowing what they were doing and in a very uncoordinated manner.

Then we said, how are we going to monitor and evaluate the activities of this partnership? We are still using the NTP indicators and monitoring tools; however, we are now in the process of developing a component that is going to be specific for the partnership.

What is it that we want to come up with? Obviously, we want to see increased access to TB and HIV services at all levels, down to the community level. And then in the health system we want to see a strong national coalition in response to TB and HIV, everybody taking part—whatever has good skills or competencies, for a certain portion of the problems, has actually come on board.

And then, together as a coalition, we must mobilize resources for these partners because some partners are willing to implement some activities, but they don't have even the basics in terms of resources, so we need to get some resources for them. We thought this would bring more accountability to the NTP so that we would improve the situation in the country and I won't come back here again and present 42-percent treatment success [laughter] and people will think we are killing people, so that's the idea so that really, even the partnership will not say, now we are putting everything in place, but why are we not improving? It will put us to be accountable.

Nonetheless, we already have a few achievements that I can mention here. We already have the full involvement of the government. The government has agreed on the framework that we have developed. We have it to the ministry and they looked at it, and it has been endorsed. We can start working on it. And then in principle again, we have, as a partnership, agreed on the framework to place the partnership on. We have already submitted an integrated application for funds to Global Fund. It was the NTP together with the partners in making the application.

Overall, obviously, those small achievements will come with some challenges. We still have a challenge in that the partnership is still very young. It hasn't even finished a year, but we are already thinking ahead on how we are going to sustain it because a partnership is very delicate. You need to make sure that you maintain it all the time.

And in the partnership we want to be equal, but definitely there will be small partners, in terms of activities they're implementing, and others will be coming with the funding. The challenge is to make sure that everybody feels a part of that partnership. We still have this challenge to make sure that the activities are implemented in a coordinated manner so that the NTP still remains responsible for the activities and makes sure they are implemented according to the national guidelines and standards. And again, even though we have applied to Global Fund, it is just the beginning.

We need to continuously make sure that we mobilize funds for these partners, because we don't want to see a situation where a partner has been doing a very good job and then all of a sudden that partner is not there when the people have already gotten use to the services from that partner.

Then the next step is we want to formally launch the partnership. As I said, in principle, we have agreed, but we need to bring in everybody and then launch the partnership. We still have the problem of housing the partnership, where we're going to coordinate the activities of the partnership. And then again, the mobilization of funds and advocacy—we want to advocate for more political commitment here. As you can see from the indicators I showed in the beginning, this should be an emergency.

So, we want the country to really declare TB an emergency so that we can really access funds in a really extraordinary manner so that we can address those huge challenges I mentioned in the beginning.

And then we are planning to review the implementation of the plan after one year, which is February of next year. Thank you very much [applause].

**LANA VELEBIT:** Thank you. The next speak is Ezio Santos Filho from Brazil—you're nervous? Okay, Cristina Boaretto from Brazil.

**CRISTINA BOARETTO:** We will divide our presentation into short parts. I will speak from the governmental

perspective, and Ezio will speak from the civil society perspective.

Brazil is a large country, situated in Latin America. It has a population of around 189 million people, including lots of local diversities in a huge continental dimension, 8.5 million kilometers, 189 million people. There are 80,000 TB cases a year, and 94,000 cases were estimated by WHO in 2007. Of which, 70-percent of the cases are concentrated in 315 municipalities. There are 5,000 TB deaths per year, and 20-percent of all TB deaths are among AIDS patients.

During the last few years the TB incidence in Brazil has shown a little decrease, as you can see. It is around 40 per 100 million. The mortality rate, as well as the incidence rate, shows the same thing, this slow decrease. The last rating in 2006 was 2.5 deaths per 100 million people.

The Brazilian healthcare system provides free and universal access to all Brazilians based on the primary healthcare, in which 80 million people are covered by their family healthcare program. SUS, as it is called, is a public health system composed of 64,000 ambulatory health services; 45,000 of them are family healthcare units and 5,800 are hospital units.

It is this [inaudible] tendency which shows the implementation increase of the family health program in the municipalities. Now, around 100-percent of the municipalities

have this program. However, unfortunately the program is not yet accessed by everyone.

The public healthcare system is composed by one national health council, 27 federal state councils, and 5,642 district councils. Each municipality has its own district council. These councils are combined by governmental institutions, healthcare professionals, entities and civil society, which are responsible for analyzing and liberate and monitoring public health policies.

As a result of this composition, we can obtain and interactive and inclusive healthcare system that helps decrease social, gender and racial inequities.

Why is it so important to engage all partners? National AIDS Program experience—Brazil has a large governmental experience on prevention and the care policies. The public health system introduced the human right discussion as a value. This process contributed to strengthening the national response to the HIV/AIDS epidemic.

We can say that Brazil, as of first experience, is doing a governmental incentive to strengthen civil society organizations implementing and monitoring the AIDS program.

For example, CAMS, a commission of social movement, composed of 20 entities, was created by the government to extend the participation and dialogue to all the social movements, like homeless people, the student movement and [inaudible] on AIDS issues.

The national TB program experience—it was the national program control to globally funded contexts. It stimulates the strengths of the civil society and the faith-based organization movement, with the objective of extending the access to healthcare services and improving the quality of them.

The participation of non-governmental organizations contributes in fighting against the stigma and prejudice that patients with HIV and tuberculosis are subjected to. They work together with the healthcare services in social spaces like churches, schools, community centers, et cetera, in order to get a better view of two disease, mitigating prejudice and facilitating prevention and early detection.

We can all look at the Brazilian Stop TB Partnership as an example of an actual partnership that joins 88 [misspelled?] representative organizations of several social segments fighting against tuberculosis. They support governmental actions with scientific knowledge, experience and financial resources.

In conclusion, I can say that the civil society participation in the healthcare system can increase access and improve the quality of the services. Due to it, this participation helps to increase citizenship and democracy in society. Thank you [applause].

**LANA VELEBIT:** And now, Ezio Santos Filho.

**EZIO T. SANTOS FILHO:** I'm not going to do a slides presentation, but try to make it a little more live. Actually,

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

this room is perfect for MDR replication and so we should do some infection control and open the doors, because this is horribly warm here. Although I come from a tropical country, I hate locked doors and windows. Where we are working with TB, we should not have that. I suggest we open the doors.

Anyway, the idea of the obstacles we are facing regarding the establishment of the partnership in Brazil is the fact that we have to have in mind that we have, as Cristina showed, a huge country. To give you an idea, the whole of European, Scandinavia included, could fit in the country. Brazil itself is larger than the continental U.S. if you exclude Alaska. The country really has several different regions and realities, and we have the challenge of dealing with so many differences.

Although most of the TB epidemic is concentrated in large, metropolitan areas, we have been having a kind of difficulty—until 2004, I would say—in having a clear policy for tuberculosis, which I pointed out in the report I released here, in Paris, in 2006 during the conference about the TB policies.

The TB policies in Brazil until 2003, I would say that at least they were extremely confusing because since 1999 it was suggested that DOTS should be implemented, but most people would not be willing to implement DOTS in the country. The idea was that we have had the chance to change some key

individuals in some aspect, and the policies since 2004 have improved immensely.

Because of this new scenario, we could have a field for a corporation that allowed Brazil, for example, to create a CCM that designed the Brazil TB project to the Global Fund, which is now being implemented. By March it will be the end of the second year—that's a one-and-a-half year implementation. And there was the creation of the partnership in November of 2004. I think Brazil, if not the oldest partnership in the world, local partners, it's one of the oldest. The secretary of the partnership is sitting here.

I will focus in the few minutes that I would like to bring to you—the idea is how you build this partnership. I would like to remind you also of one presentation that I did two years ago here in Paris as well, complaining about the situation of the partnership because, at the time, the partnership was formed by a few institutions and some private agencies, but basically the partnership would be funded by the government only.

So, it was a very unequal partnership where the government put up the money—even international private agencies would be participating in that, but would not put a penny in, not even to pay for their tickets to go to a meeting. So, the government was paying the whole bill. This was not a kind of fair partnership. I think the bill has to be shared with partners.

And what has been done in the last years is that we started to increase partnering with different actors. So, we improved a lot the partnering with academia. I should highlight that in Brazil we have a huge social mobilization. I started during the first social mobilization back in 2000 in Brazil, and then we created a forum of TB [inaudible] in Rio and then other opportunities.

And then the Global Fund Project has created recently what is called the metropolitan committees for the Global Fund, and there are activists in all the metropolitan areas, which have roughly half the burden of TB in the country. It is concentrated there. We have community participants in all of these committees.

So, there is a huge social mobilization. I think the scenario has changed completely from 2002 to present. In 2002, when I started, we started from ground zero. There was no mobilization. Nobody was talking about TB, and there was no political willingness. I remember a meeting I had with some representatives of the national TB program at the time; they said they were not willing to have activists putting their nose into TB. That was a statement that I heard in Brazil back in 2003—that means five years ago—so that shows how the picture has changed. But the thing is that we have changed a lot, so I am extremely optimistic.

The partnership now has eight segments. We have the governmental segment, which includes all the three levels of

government, the federal, state and municipal level. We have the two NGO segments, NGO for activism and the other one that we call for care. And these two segments also include PWAs and people affected by TB. We have the private sector. We have academia. We have faith-based organizations. We have the labor unions. And we have international institutions, such as bilateral and multilateral agencies. The idea is to be engaging other partners, to contribute in that, and to start working in other fields. I think that we should highlight, should repeat something that Cristina has posed in her presentation, which is that Brazil has a unified healthcare system, so in that public sector in Brazil, anybody who comes to the private sector doesn't spend a penny.

It doesn't matter if you are a taxpayer or if you are a foreigner living in Brazil illegally, you have full access to treatment, no matter how much it will cost. It can be a very expensive AIDS treatment or a cancer treatment. You are not supposed to present any of the contribution. It is a universal healthcare system.

Another excellent aspect about Brazil is that TB medications are not available in private pharmacies, so if you need TB medication, you have to go to the public system. If you have the money, you may go to a private clinician, but he or she will have to prescribe for you and you have to go to the public clinic, enroll yourself, get listed and then get the medication, because you won't find any isoniazid or rifampin.

You may find some rifampin or ethambutol in some pharmacies, but it's not likely. That is one of the reasons why we have such a low prevalence of MDR-TB.

But the thing is, also as you presented earlier, it is the role of the state to monitor the services and Brazil, although it has universal access, it's among the 22 high-burden countries. And why is that? It's because services are bad and because policies are not clearly implemented. This started to change back in 2004, but this means only four years. For a country the size of hours and with the disparities and differences, we have to deal with several obstacles that make this integration more difficult.

But basically, the idea is that we do not want to replicate any effort. I think the scenario that we have now, which is absolutely different than a few years ago, like having a TB project which is acting to expand TB treatment in the 11 metropolitan areas which have basically half the burden of the country. We have social mobilization throughout the country. We have clear policies by the Ministry of Health. We have engagement at the state and municipal level. We have the private sector starting together. It's the idea that we can share and multiple these efforts by working together, but not trying to create a scenario of restrictions and political restrictions.

So, we are moving forward quite fast. I'm very optimistic about our future. I believe that Brazil will be

soon leaving the list of high-burden countries, but hopefully we are not going to jump into the MDR countries. The national inquiry is not ready yet, but we are hopeful we are not going to be jumping onto the MDR list.

So, I think these are some ideas I would like to bring with you. I wish we have at least five minutes discussion. But I would just like to point out something that you also mentioned earlier, which is very important, regarding the faith-based organizations. I think they are crucial and they have always been crucial in the fight against AIDS. The faith-based organizations deliver services much more than most of the states in the developing world. They are crucial and we have to partner with them.

But one of the reasons why they receive 5-percent of the funding is because they are self-funded. They are self-funded. The faith-based organizations have their own agendas. That is not wrong. On the contrary, everybody has their own agenda, any institution, any government, any agency, any faith-based organization, or any activist. Everybody has an agenda. But the thing is that we have to never see the other partner as a potential threat or a potential obstacle, but we should really try to partner with others that we are not used to.

In Brazil, for example, we have a huge prejudice against partnering with the private sector. The governmental sector has real obstacles to partner with the private sector, and constitutionally, in the country, it's a duty of the state

to provide healthcare. When you try to fundraise in any private institution, they say, well, this is a state obligation. We should not put in a penny because the state should provide it. This is constitutionally said, so that's the point. We have to partner and learn from the different perspectives how we can move forward. I hope we can have at least a few minutes of discussion. Cheers [applause].

**LANA VELEBIT:** Thank you. Yes, we have about four minutes left. Before I can make some closing comments, are there any questions for any of the speakers? Please come up.

**MALE SPEAKER:** You need to come to the mic.

**LANA VELEBIT:** The lady in the back, please, would you come up to the microphone so we can hear your question and also for the video? Please, we'd love for you to come up. Please come up after. The gentleman behind you also had a question.

**FEMALE SPEAKER:** I want to say I was really impressed by the talks, especially by the example given by the systematic approach to partnering in Swaziland, but also by the call by Giuliano about the role of the Stop TB Partnership, WHO in coordinating partners. I have some recent experiences in countries where international partners, with the best intentions, put teams and come with a lot of money.

It's very difficult for the government, even if they feel ownership, to tell those partners who bring so much money to build capacity within the framework, the national plans which have been mentioned, and not allow them to have their own

agenda. I was in a country with four international partners investing in lab capacity building, not within the framework of a laboratory network approach in that country, not even within the concept of MDR-TB case filing within that country.

A fifth partner said, I don't want to be involved anymore because we are not bringing money, we are bringing expertise, but they don't need us anymore. And just today I heard that a sixth partner brought in \$2 million and took over some of the responsibilities already taken up by this international partnership within the country.

So, it's very difficult for Ministries of Health, for countries, to resist the money coming in. And although I fully support your call for the Stop TB Partnership, the question is who is going to force those partners to really collaborate? So, I would say that at the board meeting and within our discussions with donors we should require from partners that if they step into a country, they sit at least together, discuss their agendas, and then together discuss with the governments. We have two CCMS, but there are too many countries which are becoming an unsustainable mess because of so many well-intentioned, but conflicting agendas. Thank you [applause].

**EZIO T. SANTOS FILHO:** Thank you for this question. I will try to provide perhaps the beginning of an answer. I think we could say, based on the experiences that are ongoing at this point in time, that we have two cornerstones for a

partnering progress. The first one is really building the vision. It's really the dialogue about the vision.

The dialogue about the vision of the partnership means that at any given time during the life of the partnership, whenever there is an issue, people have to go back to those principles and understand why they decided to work together and for what purpose. I participated and I was quite impressed in the first partnering meeting—it would be also important to know for all of you here—after a single visit that we paid to Swaziland, the process has been going on, on its own, including the preparation of legal documents and so on.

It was impressive to see how the representatives that came to the dialogue, to the meeting, were saying they would be able to avail such an amount of financial resources. As partners, they say, we have absolutely no financial resources, but we have the human resources, so they, too, understand that alone they can do nothing—because even money alone can do nothing—but together they can achieve something.

And the second cornerstone is a plan, a national plan that should be agreed upon. The point is that it is no longer possible that the plan is designed only by the government, but people should be involved right at the time of designing the plan and then, of course, in the implementation.

**LANA VELEBIT:** And the last comment, please?

**MALE SPEAKER:** Thank you first to my brother from Swaziland. I think the Chinese say, don't be scared to move

slowly, but to be static. If you're not moving, then there's a problem. But if you're moving slowly, it's okay.

Then as you are doing your plans, I think don't forget the baseline. Most of us have had these interventions, then we go back and we go back and we find that we don't have the baseline data. Then what are we achieving? How is there a road map?

My question is that you have received Global Fund. What has the Global Fund imparted on your TB data, and what's your strategy, in terms of the immigrants? I know Swaziland is surrounded by both Mozambique on this side and South Africa, where you have a lot of MDR, with due respect to my next-door neighbor there.

And then to my colleague from Brazil not having the drug in the private sector—now we're talking about the [inaudible]—is it public or private partnership? Don't you create an area for black marketing where you go somewhere and then you end up looking for these drugs somewhere because you don't have to go to the public sector? Thank you.

**LANA VELEBIT:** Perhaps we could have some quick comments and then you can continue outside.

**THEMBA DLAMINI:** The first question on the Global Fund. We got Global Fund Round 3, and we have actually made some tremendous strides. Looking at those figures, as appalling as they look, but if you look where we have come from in the last two years, 19-percent of treatment success, just two years

later we are at 42-percent. The main financial assistance we are getting from the Global Fund, but we are seeing a lot of other partners now coming in after having seen that we have such a big problem.

Coming into the handling of the cross-border issues, with Mozambique, we signed a Memorandum of Understanding that Swazis who go to Mozambique will be treated free of charge for TB and same with Mozambiquans in Swaziland, but we do have some problems with Mozambique because they speak Portuguese and there's a bit of problem there. But with South Africa we really have a good relationship. If a patient leaves South Africa for Swaziland, they notify the NTP and then we go to trace the patient if he doesn't show up, and then visa versa when they're going to South Africa. I think those were the two questions.

**LANA VELEBIT:** Would you like to address the comment about Brazil?

**EZIO T. SANTOS FILHO:** About partnering? Well, that's what we are trying to improve. But regarding the private services, I think that's not an issue. The majority of people affected by TB in Brazil are poor and we want to keep the unified healthcare system going, actually growing and being more stabilized and being more effective. That's what we want. The principal client for purchase of medication in Brazil is the state.

Basically, the state purchases the medication for TB and distributes them. Many of the medications are nationally produced by public laboratories. Somehow we want to keep it that way. Obviously, there will be a medication for MDR-TB that we will have to import, but we are obviously in the process of negotiations. Basically, when we talk about large public health programs and the provision of medications such as the HIV and AIDS program, it's funded by the state. Who would pay for something which is free and it's available on the shelf of our public health clinics? Nobody does that.

If you can get the medication for free, why should you pay for that? It is there. But again, what we want to do is to enhance and empower and make the unified health system go further. Thank you.

**LANA VELEBIT:** Thank you. And Dr. Gebhard wanted to make one more comment and then we'll close.

**AGNES GEBHARD:** I would like to go one step further, from the point just raised by Kitty [misspelled?] and answered by you. The pivotal point in the management of partnerships is a strategic plan. I think that has been agreed upon. But the point of a strategic plan is also that it should not be too rigid. The partnership should be able to absorb new partners and to adjust activities towards the needs, towards new needs, and to absorb new money.

So, you were very rightly talking about the partnership management, which usually would consist of meetings two times a

year or something with representatives of those partners in which the strategic plan, the long-term plan, can be revised. And if you are able to revise the plan in a structured manner, then if another partner comes in—like the \$2 million just referred to—then they can be referred to that next meeting and they join the partnership and they sign up with the plan.

I also know it's not always that easy, but we have some experience with the running of those partnerships, or participating in those partnerships, in different countries and really the clue to this all is regular meeting and regular revision of your plans.

**LANA VELEBIT:** Okay, thank you. Well, if we could have questions after the discussion. We have to wrap up. I just want to thank everyone for participating. We've had the opportunity to hear about a series of experiences with their own richness and detail, but there are some common themes. I just wanted to highlight one that seems important to mention, which perhaps is going to be permanent challenge for all these partnerships to make sure that the key participants, the key actors, are at the table or are invited newly to the table as partnerships evolve. These, of course, must include the governments, whose authority is not replaceable by any other actors.

Actors that have deep and continuous reach into the lives of patients in their communities; of course, agencies that may be able to connect programs or providers to

specialized technical resources, and finally, of course, activists who can be watchdogs and keep all of us honest in our partnerships.

So, these are many lessons to be gathered from these experiences, but there are certainly many more to be learned together. On behalf of all the coordinators, we want to thank you and we wish you the best in all your partnerships [applause].

[END RECORDING]