

**37th Union World Conference on Lung Health:
From DOTS to the Stop TB Strategy-
Building on Achievements for Future Planning:
Implementation and Scale-Up of the Stop TB Strategy:
Experiences from Countries:
Part II
October 31, 2006**

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[START RECORDING]

MALE SPEAKER: Good afternoon. Good afternoon. My

[inaudible] TB in India. I've been given this responsibility to [inaudible] by the organizers and really try to [inaudible] and I try to give justice to this [inaudible]. We like to continue from the morning - the experiences from the country [inaudible] and scaling up of the Stop TB strategy. The two important topics for the presentations now in this session are involving patients and communities as well as engaging all care providers.

At the same time, we'll have presentation from the Stop TB Partnership and ACSM Working Group - how it can fit to serve the purpose of empowering patients in communities and as well as perhaps it can play a role also in involving all other care providers also.

And so we'll have three presentations and discussions will be after all presentations, I think, so that [inaudible] made appropriate rather than going [inaudible] question and answer after each presentation. So because this is very - I don't think this is a new area. Each country [inaudible] used to implement [inaudible] this communication strategy or advocacy but in the present - from the Stop TB Partnership [inaudible] as one of the components of the strategies to implement in a

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focused manner and that's what is required and that's what - as in the morning, we must have said we are worried about 2005 targets, so the real approach to get that is the involvement of the community and how to involve them, so that's what we're going to discuss in these presentations.

I think without wasting time, we should go for the [inaudible] I should introduce the presenters. The first presenter is Mr. Case Gordon. He is from the World Care Council and also he's representative of communities and another will be representing on the report from the task force on community involvement and the TB Control. Mr. Francis Adatu from Uganda [inaudible] is something different because it's - and then Mr. Paul Sommerfeld is the chair of the ACSM Working Group - going to present how it can fit in the job and then Jan Voskens from KNCV so after these four presentations, we'll have the discussions. So I request the first presenter, Mr. Case Gordon from the World Care Council, to please.

CASE GORDON: Thank you, doctor. Good afternoon, everybody. My name is Case Gordon. I'm a former MDR [misspelled?] patient. I'm still around. Through the process - I won't tell you about it, but through the long process, I began to become aware that people with tuberculosis, living with tuberculosis or have had tuberculosis, need to begin to organize - need to begin to

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participate, need to begin building bridges with their healthcare providers, need to begin to understand what treatment is all about. Within that, what their responsibilities are and within that, what their rights should be as well.

Over the last couple of years in fact, this is a birthday in some respects, two years ago, I think tomorrow, Dr. Phil Hopewell, who's sitting over there, came up to me and asked me if I wanted to be involved in the writing committee of what would ultimately become the new International Standards for Tuberculosis Care and it sounded a little bit interesting until he said three magic words - he said we're going to try to take a patient-centered approach. Right away, I said yes. I had been reading up on tuberculosis for a few years prior to that while popping my pills and feeling that [inaudible] but when I heard a patient-centered approach, I decided that this was very much an approach that was worth pursuing.

To make a long story short, I began getting involved with this - the writing committee for the standards and also at the same time, began realizing that the methodical approach that Phil was taking was indeed good, that we as members of the community, people who are on treatment - we too needed to begin to develop our own systems, our own tools. Out of all of that came an idea to develop a document that would be our own - nice

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and big - I like that one - we had the idea of doing a charter of our rights and our responsibilities. The two words actually go hand in hand as charter and standards but we didn't want to write it ourselves and so we started putting out calls - there's a few of my colleagues here and I'll introduce you in a minute, we put out basically calls to draft. We asked people around the world to send in ideas - to send in what you felt, what you thought would be or should be your right and what is your responsibility.

We did that about seven times, many drafts and over just about 1,000 people from all over the place sent in little e-mails, snippets of paper, recipes and everything else and we synthesized them over many months. Over the last year, this is - the patient's charter and the standards have been slowly moving along towards being discussed, adopted, approved, stamped and now we're looking at implementation- very nice photo, very nice words but they don't say anything unless we begin to actually work with you folks here to make what's in here and in the standards happen. And it's not just saying oh, this is good, we'll do it. It's sitting down and developing in each country and in each community a methodical approach to get this into reality. Nice words won't happen unless we work together.

What is in here, we feel - the communities, is just that -

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a tool, a tool to begin to reach out to the providers, to the clinicians, to all of you to sit down at a table and figure out how, together, we can implement the standards and the charter - they're tandem documents. To do so, there's a few people here I'd like to perhaps stand up - folks, can we just stand on up? I'm going to pass the microphone to a couple of them. Here's some of my colleagues from around the world. We've all been through TB treatment. When they all heard or became involved with the charter, they all said yes. This is something we can work with in my community, in my village, in my town and they began to organize in their communities.

I'm now going to pass the microphone to two of them, who will give you a little bit more insight from their communities, from their country, but all of us would like to reach out to you and ask, over the next couple of days, if we can sit down and drink some coffee, some tea - have whatever and start talking about how concretely in each country we can begin to promote and implement this with the standards. The two go together and we need to make sure that this happens. If we're going to reach some of the goals in the Global Plan and make Element 5 of the Stop TB strategy more than just nice words, we need to work at it and we'd like to do this with you as partners. I thank you and I'd like to pass the mic to Nizu [misspelled?] and Steve. They'll introduce themselves a little

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bit more in detail and I thank you very much and I'll pass not only the mic but the charter. Thank you again.

[Applause]

NIZU: Good afternoon. My name is Nizu and I come from [inaudible], which is a small state in the far Northeast corner of India, at the bottom of Burma. Professionally, I'm a trainer in conflict transformation and our region, which is very closely connected with China, Nepal, Tibet, Burma, Bangladesh, and Putan [misspelled?], as you know, has an extremely high prevalence of TB. This is so because of the precarious mountain [inaudible] and extreme mobility of the population. We have huge problems with drug addiction as well an important transit point for heroin trafficking. We also have a history of 56 years of armed conflict, which has resulted in [inaudible] excess [misspelled?] of human rights, and abuse, and displacement of people. My work as an NGO consultant has given me the opportunity to travel to defend situations in the world, in setting up HIV care projects and when I was working with the Australian Aborigine people in central Australia, I was found to have acquired TB.

Fortunately, I was detected TB in Australia and I managed to go through an extremely very excellent medical health care, but it was also a traumatic experience for me because this TB

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treatment hampered my visa processes and it was a difficult experience.

When I came home to Northeast India, I found that most people have TB, but would never talk about it. They were suffering silently and fearfully, so I began to engage myself fully in advocacy, particularly to reduce stigma and fear, and advocacy also for setting up services in places where it was most needed. I believe very strongly that active participation and involvement of Tb affected and infected communities is the way forward. Much isn't addressing TB and its related issues but in making TB program work in the ground. To me and [inaudible] of this communities, it's not about mobilizing them so that they come and access services that we create. It is not about having them appear in posters and IC [misspelled?] materials and it's not about having them come and share their life stories in meetings such as this. To me and [inaudible] of communities, it means engaging them in critical dialogues, creating space for them to ask difficult questions and drawing from them solutions to those questions. It means communities demanding services rather than receiving services. It means communities involved in monitoring the quality of services and even to the extent of communities running services themselves and I believe that the first step forward in achieving this ambitious goal is adopting and implementing the patient's charter in the real sense right

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there in the ground - not just in significant events like these meetings and to do this, I and others like me have a role to play and I want to just encourage you and remind you that we want to be actively involved - not just in implementation of your programs but in designing and planning your programs and walk with you hand in hand in the ground so that our collective dream of making this world a TB-free world will become real in our lifetime. Thank you.

[Applause]

STEVE AMOLA-AMOLA [misspelled?]: Good afternoon, ladies and gentlemen. My name's Steve Amola-Amola. I come from a very small country in the East African part of the world known as Kenya. I'm here on behalf of TB patient community organization known as Alliance for Care and Prevention of TB in Kenya. Probably one of [inaudible] eastern part of Africa, if not the whole of Africa, simply because I've never had any other TB patient organization really doing that much work and recognized by a body like this.

First of all, let me expressly thank the outgoing and incoming National TB Program managers in Kenya - Dr. Jekai [misspelled?] and Dr. Seteinei [misspelled?] respectively for giving us support to bring up this kind of organization, which has really stayed for a long period of time before coming to

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realization. They are very much understanding and I want to say thank you very much. Secondly, I'd like to thank my sponsors to this conference. It came as a dream because I never knew I would get this opportunity to come to France. Getting a visa from my country to France is a nightmare, but I'm particularly to a very small community but [inaudible] I made it and I'm here today with you to listen to me.

Having had from what my colleague has said, I will not go back to that. What I want to say is that we, as the community, affected by this disease - we appreciate the steps and the way forward that Stop TB Partnership is putting in place. For the strategy to work, I want to believe that there are a few things that must be also put in place besides just strengthening the infrastructure, focusing on the laboratory, and so on and so forth - we believe that we need to develop the capacity of the communities that are receiving the care that you are talking about. You all know that there is no [inaudible] problem that can benefit if the community consumes that kind of service are not informed. We believe if the TB community or the consumers of these services are left behind, then for sure, this strategy will just but remain here as a word of mouth.

The TB community offers you a three-pronged approach. One is to develop the infrastructure that will ensure that our TB care is done according to the standards. Two, we need to see TB

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patient organizations evolving right from the grassroots upwards, because it is in that background that we are going to realize that what you are doing has a meaning. We have to make sure that the TB patient understands what TB treatment is if you have forever to dream that you can fight against MDR-TB or to the [inaudible] DRTB. Thirdly, we want to envisage proper linkages and referral systems developed between the communities and the health care-providing facilities, because such kind of linkages or referrals will ensure that we don't lose people who are on treatment.

We know very well there is a lot of stigma around TB and unless this is addressed, then we are here for no purpose at all. It is therefore imperative that formation of TB community organizations be encouraged and [inaudible] in their countries where they already exist.

Why do we talk of TB patient organizations? One, we know it is important for doing the local advocacy around TB at the national levels. Two, such organizations will call for interest - national and international response to control TB because so many governments have [misspelled?] their signatures on the declarations but they don't implement. Three, these organizations can take local advocacy to higher levels to ensure resources for TB care and prevention become available. I remember in yesterday's [inaudible] sessions, when it came to a

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session where empowerment of patient community came about and the people were asked to give what they do in their own countries. I don't remember and I'm so sorry - with all due respect, that there was none that could come up and say we are doing this with this kind of organization. I think if it not - to blow our trumpet, it's only Kenya that actually talked about something like that.

I'd want to encourage all the national TB program leaders here that it is important that you involve TB community very meaningfully. We believe these organizations will ensure every clinician treats TB cases with all the respect it deserves. It will enhance case findings and [inaudible] TB treatment and thus reducing the risk of developing resistance.

Ladies and gentlemen, I don't want to bore you a lot of words but what you are trying to say today, when I came from Kenya, they told me tell that conference that [inaudible] Kenya is a TB community organization back here, which is calling lets Stop TB Partnership, WHO, why can't a council take support of this and let us show up as an example? Thank you very much.

[Applause]

MALE SPEAKER: Thank you, all participants who - for sharing their experiences and talking about the patient charter, their rights, their responsibilities and the importance for the

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involvement of these patients in the designing and the planning the activities for the TB [inaudible] their involvement, their importance. Thank you.

So I'd like to invite the next presenter now. Dr. Francis Adatu from Uganda. He will talk about [inaudible] the community involvement in TB control.

DR. FRANCIS ADATU: Thank you. Good afternoon. I must say I was listening with a lot of excitement because a few weeks back, when we were in Milan, we took a shot at this subject and we struggled with a lot terms and I am very happy with the way the terms are being used today. Communities affected by tuberculosis, organizations or persons affected by tuberculosis - so that we send the signal out correctly because it's been said the public health professionals alone with their TB experts and the governments might not have the solution to the TB problem until and when they involve the communities affected so I listen with a lot of interest and I found the case [misspelled?] for packaging this [misspelled?] [inaudible] in Milan [inaudible] everybody knows that since we are moving in the same direction.

So my simple task this afternoon is to present to you the report from the Task Force on Community Involvement in TB care and prevention. The background of this presentation is this -

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you are all aware of what was shown today or this morning that there is now a new Stop TB strategy, which was launched in March on the World TB Day 2006 and the mandate of this was given during the first [inaudible] subgroup meeting at [inaudible] last year and [inaudible] of WHO and the Stop TB Partnership. There was wide representation of relevant constituencies during this first meeting and in the subsequent meeting in Milan. Patients, community representatives from grassroots level - CSOs involved, NGOs, NTPs and other WHO departments involved in [inaudible] and the HIV/AIDS department.

The objectives of this task force meeting were three - to reach consensus on the terminology used to describe the initiatives aimed at establishing partnership with communities. There are a lot of words to share [inaudible] and many times we discovered the words meant different things to different people in the room. Three was to present the results of the review of community involvement in TB control and discuss emerging issues. A review was conducted as [inaudible] in seven countries. Three is to do [misspelled?] consensus on draft guidelines on promotional community involvement in the TB control. I must hasten to add to that there is such a demand, both from the NTPs and the communities affected for direction in which to move so as to complement the already-made efforts.

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There [inaudible] chosen was a series of country reviews conducted - Bangladesh, Indonesia, Kenya, Malawi, Mexico, Philippines and Uganda. There's also literature reviews on issues related to patient empowerment in TB control and community involvement in TB control. [inaudible] summarized and discussed in a concept paper, which was disseminated to all the task force members before the meeting in Milan.

Then, consensus-building recommendations as [inaudible] by all task force members. The process was as follows. The Milan meeting, following [inaudible] of the concept paper, had to reach a consensus on broad recommendations and marketing [inaudible] abroad because we are living - it's a little open for each and everyone to be able to [inaudible] what would be worthwhile. Two, in order to speed up the process, it was agreed that forming of a writing committee would suffice [inaudible] by finalizing the first draft of the final regimen is to be conducted 8th to 10th November this year. Then the e-mail based finalization of the regimen by task force members. I have been following through e-mail - many have signed up for this regimen - this subject must be of great interest to many. Then endorsement by the advocacy communication and standardization mobilization subgroup or [misspelled?] the partnership at country level and at the subgroup.

The final regimen will focus on the following main areas:

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One - it should clearly identify the target audience, which is NTPs and what we traditionally call partners, which is civil society, patients and patient groups, local community, and whoever else puts [inaudible] in TB control. Number two, the regimen will also tackle [inaudible] of overarching principles with the clear definitions therein - the issues of subsidiary, the issues of sustainability, the issues of empowerment, and local ownership. I think everybody in this room is aware that ACSM is one of the weakest arms of many programs and we have been taking [inaudible] maybe once a quarter and I'm advised ACSM should be like climbing stairs until you reach the top. There's issues like human rights and individual responsibilities, social justice, solidarity, addressing stigma, all have to be embedded and reflected clearly in this coming day.

Then there are issues related to partnerships with patients, local community, civil society at different levels. No one says fix it all and align with flexibility of the NTPs. Final regimen, main areas of focus continued - it will be policy guidance for NTPs - they will be advising current NTP policies to include component 5 of the Stop TB partnerships, clearly elaborating [inaudible] and clearly elaborating principles to be adopted then.

The next is advocacy - ACSM - preparing strategy and

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operational plan for component 5 with specific deliverable objectives and targets - again, [inaudible] and principles based therein. Building capacity for component 5 and all other relevant areas for quality of TB control. When we do all this, we must not delay the [inaudible] elements, which determine a quality TB program. Developing ISC [misspelled?] and business [misspelled?] development strategies, methodologies, and materials for different levels and stakeholders. Those of you who are program managers like me, you know how attractive ISC areas are but if you are not careful, all the resources will go there and you'll remain with nothing to treat the patients. Last bullet is [inaudible] to component 5 - need to take into account special challenges, which are obtaining now, specifically TB/HIV.

You realize this morning Chris [misspelled?] [inaudible] presentation said there is little funding going towards TB/HIV but world over, [inaudible] disease - TB is the leading killer of HIV/AIDS clients [misspelled?] and this is not followed with [inaudible] resources. Now we have the problem of MDR and indeed MDXDR, we have the problem of indigenous populations, their movements, and lifestyles - with the special communities like prisons, IDPs, and refugees. This has to be put in context if we are to fully engage communities in TB control.

There's the issue of ensuring quality of service delivery -

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ensuring quality of a broad range of services provided at the community level, actions, and principles. As I said, no one-size-fits-all. There needs to be a rethink [misspelled?] at country level as to what you prioritize and what you put on the ground and with whom. We have the problem of briefcase NGOs. When we reviewed the Director in Uganda, there are over 3,000 NGOs. All of them with addresses but when we reached a really good percentage of them, they were not there. Then there is a need to establish M and E - a strong monitoring and evaluation system, which would enable us help to plan effectively for plan 5 - I mean component 5 and should be embodied in component 5. There are issues related to budgeting and financing. [inaudible] has always been a line in many NTPs or country plans, but I want to assure you that there is very little expertise in many programs to budget for this. It's a heavy cost item and indeed I'm very happy that there is now an ACSM group in the Stop TB Partnership.

This must be followed by [inaudible] operational [inaudible] to inform policy and inform going over guidelines so that we answer general or context-specific questions, which relate to community involvement.

Ladies and gentlemen, that is the end of the report. Now, what I'm presenting to you is a timeline for finalizing the document. As I said, there's a meeting overwriting committee

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scheduled [inaudible] next month to try and come up with a first draft. Then the draft will be circulated for comments among the taskforce and ACSM at country level and we expect the comments there in by mid-December '06. We hope to achieve endorsement of this document by ACSM subgroup at country level by mid-January '07. Then circulation to [inaudible] subgroup for discussion by mid-January also - [inaudible] endorsement by end of January and final editing and publication by the end of February 007.

As I said earlier, ladies and gentlemen, there is a demand for this document to guide community involvement so that we and those who have just spoken before me [inaudible] for the common good of the patient. Let's give TB a human face. Thank you very much.

[Applause]

MALE SPEAKER: Thank you, Dr. Francis, for presenting such a comprehensive report of the task force. And now I invite the next presenter, Dr. Paul Sommerfeld, he's the chair of the ACSM Working Group, to discuss how this working group can fit into the purpose.

DR. PAUL SOMMERFELD: First of all, before I start my own talk, I've been asked to make an announcement to avoid a

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confusion that may be happening. Apparently, somewhere in some of the programs about this conference, the main congress, it is suggested that the Treatment Action Group Meeting, which is happening tomorrow, has been cancelled. To avoid any confusion, it has not been cancelled and that's what I've been asked to say. There really is a meeting of the Treatment Action Group, which many of us - I know - have been invited and that it is taking place in the Hotel Meridien all day tomorrow over the road there from 9:00. So if you see anything to the contrary, forget it.

I've been given this opportunity to talk about where we are today with the Working Group on this great mouthful of title - "Advocacy, Communication and Social Mobilization," which, not surprisingly, we translate as we're talking into the brief initials ACSM and one of the things I hope I'm going to be able to do in the next few minutes is to be able to clarify what this strange magical-sounding list of initials means and particularly because we are - we believe that we're the newest working group engaged within the Partnership. We only started at the beginning of last year. We believe, as a working group, we now have considerable impetus but we are conscious that particularly when we are talking about work at country level that what is advocacy, social mobilization, and communication has still not been fully integrated into the way in which

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national programs are thought about and planned. We believe that as much as you talk about the need for laboratory services as being essential to a decent national program, communication, social mobilization activities are just as important.

Now I've got to try to find out which I - the mouse - sorry, I was told something else would work but right. First of all - the problem of terminology. I'm afraid our working group - with our working group, you get a body, which lumps together in its title three terms, which everybody has their own view of what the phrases mean. So I want to tell you what I think they mean and I hope that they will be understandable to you as well in a similar way.

When we're talking about advocacy, we're talking about persuading decision-makers. Often that means governments but not only - of the importance of TB action. We're persuading people who control resources that TB is important. When we talk about communications, we're talking about using the media in all its forms to engage everybody, to inform, persuade, to generate action among all people - sometimes it may be particular target groups but it can in a country be the total public. About the - what is TB? Thirdly, social mobilization is about the active engagement - and I stress the word "empowering" - of the community in the fight against TB.

Now, sometimes that will mean if I put it in a slightly

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simpler way when I personally am talking about advocacy, I'm usually talking about trying to persuade somebody to open their purse strings and make some money available. When I'm talking about communication, social mobilization, I'm talking about the social aspects of action against this nasty disease. I'm talking about the social aspects of national programs.

Within our group, the working group of ACSM, in effect you have two linked working groups. Firstly, one half of us are concerned with global advocacy. Very evidently, that is essentially about the small, little task that if the global plan is to be met, of finding an extra \$56 billion dollars over the course of the next 10 years, which translates to the little task to finding only \$3 billion dollars extra every year. Now we do not see our job as being one of fund-raisers in the sense of writing lots of applications to places, but we do see our function as being the generation of political action, which will help to soften up potential donors to either give more than they already do or to come into the market - in the case of some - we believe there are some significant donors potentially who could be engaged in TB and who are not.

On the country-level side, we're concerned to introduce evidence-based - I stress evidence-based - we're talking about hard data, robust strategies for society and behavioral change and action at national, local, regional and community levels

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that will ensure access to treatments and care for all especially the poor, vulnerable, and hard-to-reach populations. That's what we believe we are about.

We have, within the global plan, there are some specific figures about what we think we are trying to do. So we're saying that by 2010, there will be TB advocacy organizations or coalitions active in at least 20 donor countries and 40 endemic countries and by 2015, by the end of the plan period, we will have done what is necessary to get that extra \$56 billion dollars. At country level, we certainly believe that by the end of the 10-year period, there should - ACSM methodologies should be fully developed and an implemented component Stop TB strategy.

In other words, it will be a normal automatic incorporated part of TB programs at global, national, and local levels and I would stress the one little bullet, sort of sub-bullet point here, as a step towards this target. We are hopeful and encouraging all endemic countries by the end of next year to have carried out an ACSM needs assessment from which a country 10-year strategy can be developed. We also believe that by the end of this plan period, that we will have advocacy organizations operating in a whole range of donor and endemic countries. Why bother? What do we actually think we're trying to do? We have all this advocacy, communication, social

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mobilization - it comes down to what particular country level, it comes down to case detection and helping maintain patients on treatment through the period of treatment.

If you engage communities, you get the messages about tuberculosis out through communities. That is a way to lengthen the arm and the impact of national programs. That is the way in which you will help people to come forward to present themselves as potential patients. It will also help dramatically to combat stigma and discrimination in communities because it becomes an issue, which is being openly discussed, properly presented with the correct messages attached. It is a route to empower people who themselves aren't affected by the disease. They are going often to be the best communicators and social mobilizers that you have available to you. Whoops - no, I'm not sure I know how to get this to go back but I just wanted to stress that obviously the last bullet point was also about saying ACSM is about mobilizing resources.

Our working group has gone through a period of restructuring over the course of the last three or four months and I just want to tell you where we are at the moment. This working group comprises some 162 individuals whose names are on our list at the moment, from all over the world, and between them, they represent some 90 different organizations. Normal working groups just get one core group. We, as ourselves, have

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two. So we have one core group for that country level activity and another core group for the global advocacy and so far, we have some nine task forces that either have recently been formed or have been drawn into the working group, including the most recent one on communication issues associated with all of the XDR story. And I'm very happy that with two previous speakers who just preceded me, gave you reports from two of those nine task forces.

I'm not sure how legible this is going to be at the back of the room, but this is our current organigram - if I just try and use the pointer facility here - this gives you, I hope, more clearly the fact that this is a group with two halves to it - two sides. Each side has a core group. There are - each side has some specific task forces.

So you've just heard from the one on community-based care, Francis Adatu has given you a report from them and Case Gordon gave you a report from this group a few moments ago. On this side, we have task forces on media events - that means providing materials for training of - enhancing journalistic activity around TB and also focusing attention on particular events as they occur. Business engagement - concern with increasing the private sector involvement, commercial sector involvement in TB activity and we have, at the moment, small groups looking at issues about getting messages through the G8

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meetings and trying to make sure that the European Commission starts spending much more like its fair share of contribution to the TB needs but we also have some groups, which cross those two halves. One group, which is about building national partnerships - Stop TB Partnerships - in countries both in donor and in high burden countries. They incidentally are having a meeting to develop - working on the development of a handbook on how to do it and then they're meeting here tomorrow in the morning and then there is - come back to the - it's the most important. But there is also the one on XDR, which has most recently come out of the meeting only two weeks ago that was held in Geneva on developing action against XDR.

But coming back to this task force - throughout all of our work, we say it is extremely important to have very full patient advocate engagement but we also have been very concerned that patient advocates should not be sort of iconic members helping to give a fig leaf of respectability to all the other activities. They should also be engaged in real activity, a real job of work where they can be most effective and that is especially true of the area of national advocacy. In other words, in endemic and high-burden countries, becoming engaged and persuading the governments in those countries to provide the resources necessary and to give the priority that will support the national programs in being able to do the job of

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work that they are there to do. We have seen a fairly rapid increase over the last two years, on the country level side of our activities - so where only four years ago there were only two countries that claimed to have an ACSM activity, within their national program, we now know of at least 19. Similarly, four years ago, there were only a couple of programs that had got anything out of the Global Fund but now and through round 1 and notably round 5, we're now up to some 18 countries, which either have or are about to receive grants from the Global Fund. The 18, by the way, should not be equated exactly with the 19 in the previous slide.

This group is - some haven't yet started but they're about to get monies and not all of these 18 are high-burden countries but what is important here is the method of action of the Working Group that on the country level side, my good friend Roberto Tapia [misspelled?], the vice chair and Todd [inaudible] from the secretariat organized a number of seminars to assist national program officers understand what we're talking about with social mobilization, et cetera, and to prepare bids to the Global Fund.

So there was a tutoring process, which has paid off. We, obviously, like everyone else here, is waiting to hear exactly how successful we have been in round 6 but we are optimistic that by sometime late tomorrow when the news comes to us, that

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figure of 18 will be notably larger than it looks today. Some of those who were successful in round 5 were Indonesia with a budget over a couple of years of some \$9 million dollars; Nigeria was \$7 million dollar budget for ACSM activity; Zimbabwe, Bangladesh, Democratic Republic of Congo, Brazil and the Gambia. I find it rather interesting actually that the Gambia, which is, relatively speaking, a small country, gets .8 almost as much as Brazil, which must be 100 times bigger than the Gambia, but I'm sure we will be working on that in years to come.

Again, just to go over again some of the task forces and particularly to say one of the roles of our working group is to encourage effective interaction between all the many people around the world who are involved in advocacy and we're very conscious that there are lots of good advocates doing lots of good things but we don't always know what each other is doing and so we are developing a new Web site, which you can reach by going onto the Stop TB's Web site and find your way through to ACSM. And you will find a very nice new Web site, which increasingly will have some very interesting and effective information on it and that links also with our taskforce on media events led by Tim Frans [misspelled?] and [inaudible] and they will be likely to be leading to lots of activity here around supporting more media and more effective and more

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coordinated media activity around TB-related events and stories.

Business engagement, I talked about but it is worth mentioning that it has been done in conjunction with the World Economic Forum that they have - that it is Francois Benici [misspelled?] from the World Economic Forum who's leading our taskforce on business engagement so we're looking forward to a lot more interaction with the big commercial sector. Building national partnerships, I mentioned and here you see the Web site of Stop TB Canada but within that task force, there are bodies from both donor and recipient countries.

That gives you some idea of our targets for all of us and the photo is slightly out of date, there should be one woman in there - Angela Marple from Germany should be in that picture and I think we seemed to have found a rather old [inaudible] picture of the G8 leaders but that bunch of the people from whom we will liberate our \$56 billion or most of it.

Now I come again to stress yet again the importance of that task force in the middle of my organigram, which says that patient advocacy is extremely important and important not just as making the right noises from time to time and being a little bit of a gad fly to our own debates but also important as being the best-placed people to undertake work to persuade their own governments of the need and I won't share with you today

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anything about their terms of reference. They're in the midst of being developed but we have already two patient vice presidents of the Working Group [inaudible] and [inaudible] and they are now in the process of putting this national advocacy group together. And I stress it will be in the middle of our working group relating to both sides so it will be treated as a taskforce both at the country level and of the global advocacy aspects of our work as well as having their own particular job of work to give a new impetus to national advocacy activity.

So lastly, if some of this has made you feel interested, don't feel shy about joining the Working Group on this wonderful mouthful - Advocacy, Communication, and Social Mobilization, and if you send an e-mail to that address or if you can find her during this conference, [inaudible], please do so. Thank you very much.

[Applause]

MALE SPEAKER: Thank you, Mr. Sommerfield, for such a nice and detailed presentation and a core and touching message that is let us give them partners to ACSM activities as we're giving them partners to lab activities. That's important. So I request now Mr. Jan Voskens from KNCV to present [inaudible] all health care providers - an approach to health system strengthening.

Jan, please.

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JAN VOSKEN, MPH: Thank you, Mr. Chairman. Good afternoon, ladies and gentlemen. After having heard about the perspective - from the patients' view and the community view, I would like to share also the perspective of the other providers. What is the use and why are we going to involve all those providers? What is the - actually, the terms of reference and why are we going to do that? I also discuss a little bit about the current status of the public/private partnerships focusing in Southeast Asia, also about [inaudible] results, achievements, and the barriers. What has been developed as an answer to the barriers that we experience in expending the public/private mix? Then, what are the lessons learned for health system strengthening involving all the providers in TB control? And lastly, I would like to talk about plans and the next steps of - for public/private partnerships.

If we ask patients where they go for treatment when they experience symptoms of TB, they're not all going to the NTP - the National TB program. Many of them go to other providers and this is clearly illustrated by the findings of the prevalence survey in Indonesia a few years ago, where it was found that patients, except for going to the health center where the NTP is positioned, they also go to hospitals and they also go to private petitioners. They also go to informal providers, which

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are not put in this picture. They [inaudible] patients go to many providers outside the NTP. It is also clear that this is one country where you can see there's a difference between the different parts of the country like Sumatra and the Eastern Islands and [inaudible], which are highly populated where patients tend to go to hospitals. In the Eastern Islands, most people go to public health centers because the access is better.

Who are the private and the public partners? In China and Indonesia, these are mainly hospitals. Many patients go to hospitals. Fifty-percent of patients started treatment in hospitals. They also pick providers, which are not organized and they are huge numbers. It is India, Indonesia, Bangladesh, Philippines and other countries. Medical colleges - they are big providers in India. Most of the countries also have NGOs that provide TB services for patients. Then, of course, the corporate sector - the businesses, the workplace, the big factories where many workers are working and suffering from TB but are not diagnosed and not treated. Then there are the other public providers like the other ministries, the prisons, the health insurance facilities in India, Indonesia, Bangladesh and the Philippines. They all do different things.

These are tasks [misspelled?] that are developed by the PPN subgroup where you can see that the different providers can do

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different tasks. Like for instance, the NTP is responsible for - not only for the clinical functions but also for the public health functions. The public or private PPN - those agencies can do most of the activities except direct [misspelled?] supply and a stewardship. Then the individual private physicians and hospitals - they provide the clinical care that usually cannot do the public health functions like the tracing and recording, reporting, et cetera. The private or public laboratories, they have also a limited function in the TB program and it has to be defined for every provider separately what they can do best.

Engaging the care providers is one of the major components of the Stop TB strategy not only focusing on the before but actually to all the elements of the Stop TB partnership, Stop TB strategy empowering people with TB/HIV and communities but also contributing to the health system strengthening. Actually, it also addresses number two and number one. We will focus this presentation on Southeast Asia because most of the initiatives regarding public/private partnerships have been undertaken here. The PPN situation in other countries is different. In India, Indonesia, [inaudible] Nepal - the mission [misspelled?] policy also already includes public/private partnerships and they're already scaling up the initiatives. In Bangladesh, the policy is in place and there's widespread involvement of NGOs

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and several pilots already started to involve PPs. In Sri Lanka, Thailand and [inaudible], they are still in a very early stage and [inaudible] actually there are no drugs in the private sector available so PPN is not an issue.

What has been the public health's impact of PPNs so far? From the pilot projects in this region, we have seen very, very good success. The quality of care has improved a lot. Success rates, in general, are above 85-percent. Also the case detection has increased between 10- to 50-percent. From studies done in Bangalore and in Myanmar, it turns out that PPN also reaches the poor. It is not often assumed that only the rich people go to private providers but it seemed that also the poor are going to private providers because they are nearby and easily accessible and 50-percent of the patients in the [inaudible] study were from the lower social economic strata. In Myanmar, it was two-thirds of the patients treated by the private GPs were from the poor groups.

There's also considerable financial protection. When there is public/private mix, when the private providers are included in the guest [misspelled?] program, there is a \$50 to \$100 reduction for patients for treatment because they would have spent it in the private sector buying drugs, also paying consultation fees to the specialists. So having PPN has a huge impact on the health condition.

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Here's an example from Indonesia that just illustrates the success if you have a good public/private mix in place. Here you see a patient with a treatment observer next to him, a private specialist supported by a [inaudible] consisting of district and provincial, and even national NTP stuff. Often, there is the question - is it cost effective because many people consider PPN to be expensive. There have been done - some studies mainly by Katherine Floyd on PPN in India, Philippines and South Africa, and it was found there that the PPN is clearly cost effective. It is affordable and compared to treatment providers through the NTP, the similar or the lower cost per patient treated and also similar or better cost effectiveness.

This is the evidence we can use but focus it to decision makers. There are many funding sources for public/private partnerships. First of all, it should be there from the ministries although their contribution is still very low, from Global Fund - that's a big opportunity that we have, [inaudible] now [inaudible] and CIDA [misspelled?], national and international NGOs, and of course, the corporate sector. Not all of these sources are being used so far because there has to be done a lot of focusing.

The challenges for public/private partnerships, I think, the main issue is that both sectors have a low level of trust.

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There's a kind of - yeah, fear of working together because NTPs are often worried that working together with private sector will compromise their program and there's also a problem between the approaches of the private providers, which often have a clinical view on TB and the public health perspective that NTP managers and NTP staff members.

There seems to be also seems to be a problem in scaling up to successful pilot projects that have been started in several countries and the biggest challenge, I think, is how to invest in human resources because the numbers are enormous. If you look, for instance, only in Indonesia where you have the private providers more than two or 300,000 - they are not even known. In a big country like India, it would be even more so the investments that have to be made are considerable but we have no choice because from the discussion this morning, [inaudible] if you have to be ready for MDR that is being, I think, being, produced or being sourced but mainly by the private sector because they are not doing the jobs [misspelled?] as we would like to do them.

This illustrates the different views of the clinicians in the private sector and the public health workers. They're talking often different languages. They often do not hear each other and maybe it's a matter of communication that has to be started before we can involve other providers. The [inaudible]

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to public/private partnership expansion that were identified in the subgroup meeting of the PPN [inaudible], there seems to be a lack of commitment from NTPs to start - to embark on public/private partnerships. It has also limited capacity - people don't know how to do it. There's lack of staff, there's no time, there are [inaudible] dose expansion. Motivation is often low and many people in NTP do not know how to do [misspelled?] this kind of providers because they are from a different world.

There's also a lack of tools, lack of guidelines, lack of training materials, and training tools and also how to [inaudible] to the other sectors was not known by that time and also brought forward the lack of technical assistance, lack of technical support available to support countries in starting up pilot projects. This was all identified during a subgroup meeting last year - 2005.

What has been done by the subgroup? What has been done by the people working in the counties on public/private partnerships? [inaudible] guidelines that have been developed as a response to the [inaudible]. Of course you have the Stop TB Goal [misspelled?] plan. You have the Stop TB Partnership that talks about public/private partnerships, which [misspelled?] very much help you or the people in the field to start. We have the TB technical application - also considerable

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part on public/private partnerships. We have documents from [inaudible], PPT, and [inaudible] and group reports. It's not enough. We need more.

We have now, since the beginning of this year, a concise [misspelled?] document that explains the generic steps that you make - guidelines - what should be done to initiate public/private partnerships and a very powerful tool developed by Phil Hopewell and his group - the International Standards of TB Care, that I expect will be the key to open the door to many sectors and particularly the specialists and providers that have a different concept on TB control.

And lastly, we have a document engaging all public and private care providers in TB [misspelled?] control, it has been - it came out - I think recently - last week. We also have a tool in development - it's called the National Situation Analysis Tool to enact [misspelled?] the providers and to give [inaudible] on what should be done in a country to initiate public/private partnerships. I think also a very important tool will be the planning and budgeting tool that is currently being developed by Katherine Floyd and has been pilot-tested as in these all very important tools to at least plan and enforce all the structures in the health system.

What are the lessons for the health system strengthening from the public/private partnership? So far - the general

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constraints on health system - we all know there's a health resource crisis - lack of staff and the big challenge - how you can help reinforce all the other sectors, all the other workers that are there and ready to help but are not yet able to do so because they are not yet linked up to the program. We have lead [misspelled?] government stewardship and ministry of health, especially if we use the private sector. Many providers are eliminated from the public health responsibilities. They do the clinical thing, but they do not report and they do not trace patients when they drop out and still patients waste a large part of the limited resources on poor-quality health care.

These are all general constraints that are faced by the health system and I think from our PPP - PPN experiences, so far we have valuable lessons that could also be used for HIV, malaria, and other disease control programs. First of all - how to build capacity in the public sector, the private [misspelled?] and all providers. For instance - the Situation Analysis Tool that I just mentioned - the practical approach is to map [inaudible] also the management framework involve our sectors - how to do it, what are the steps necessary to approach another provider and to get involved in the TB control program, also proper compensation systems because when they are involved, they also need to compensate for the work they do.

The second lesson learned is the sensitization of private

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healthcare providers to take on new health staffs [misspelled?] including purveyance like standardized recording and reporting system. Another lesson is the improved linking and referral system that has been developed [inaudible] for patients - for instance, detected in hospitals then being referred for treatment to clinics. The standardized quality tests shows [misspelled?] us a low cost across the health system. I think these are all very important lessons that are valuable for health system strengthening.

What are the plans and next steps? The last slide of my presentation. First of all, there's clearly a need for more technical assistance for PPN country planning because many countries are still struggling to develop a work plan and design the strategic steps toward [misspelled?] an operational plan - three-fourths of the providers. Therefore, we need development of a generic PPN strategy and operational guidelines. They cannot be detailed because the situation in every country will be different and in every situation will be different but at least there are some generic structures that can be used by program managers. This can be based on the documents that I just mentioned a few slides before.

Then the next thing to do is to develop national PPN strategies and guidelines. Another activity to explain for the near future is the planning workshop in the region. There will

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be a planning workshop for the [inaudible] region and African region in February next year and of course, a [inaudible] for public/private mix to [inaudible] why the implementation - and this is mainly directed to the decision makers. The second thing is the human resource development. I already explained that we need to involve much more people. The numbers are enormous and therefore, we need to make a plan. More [inaudible] is needed. We need focal points for public/private mix activities. We need external TA. Regional training for focal points and national PPN consultants - there's a PPN consultant course planned for April 2007 [inaudible] in the next year but we will at least deliver some consultants to provide technical assistance but then the next [inaudible] is to train all the [inaudible] stuff on interacting with the partners at the operational level.

The third thing to do with the sourcing and the planning is the dissemination of the International Standards of TB Care. They have been pilot-tested in a few countries, but now we need to go to other countries and disseminate, explain this [inaudible] provide us in order to convince them to apply the International Standards of TB Care and just disseminating will not do the job. We really have to convince people to do it, but I'm quite optimistic because it has been produced by international consensus and ATS is highly respected by, for

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instance, specialists in developing countries so it's a very, very powerful tool and I'm very optimistic that it will work.

Then the next step would be to include ICC, NP, and in-service training in the medical schools, in the nursing schools, et cetera. Then, what needs to be done for ICC - what are the steps for dissemination, what are the steps for implementation to do it, to change the behavior of the other providers? I know the last activity is the hospital linkage, the public/private mix of [inaudible] hospitals, which have made an issue in China where hospitals play a very important role and also in Indonesia in providing care to patients.

There will be a post-graduate course tomorrow on hospital dose linkage in this event and there's also plans to develop operational guidelines for hospital linkage. Early next year, there will be a workshop in Asia where we will gather all the evidence base from hospital linkage activities and come up with a good guidance document and operational guidelines for hospital involvement.

The last thing that - the PPB needs to be monitored and fairly rated regularly. PPN should be assessed in every country [inaudible]. PPN indicators that are now being developed need to be implemented so we can measure evaluated [misspelled?] monitor what we are doing so we can adapt our strategies. There needs to be done some operational research on issues that have

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not been solved yet. For instance, the cost effectiveness has been proven in three countries but we have to look at other settings is for instance involving the private practitioners of [misspelled?] cost effective approach, [inaudible] Public Partnership [inaudible] for instance [inaudible] important issues and last but not least all the experiences, all the evidence has to be documented and to be used for focusing but also to learn from it and to expense public/private partnership in order to achieve the Millennium Development goals.

I'm sure NTPs will not be able to do the job alone. There are many more providers that can support programs even if all the providers can support or strengthen the health system by doing tasks that cannot be done by NTP. Thank you very much.

[Applause]

MALE SPEAKER: Thank you, Dr. Jan. Thank you very much. May I invite now all the speakers on the [inaudible] so we can have some question and answer session. You have another 15 minutes. Yes, please [inaudible] discussion, ask the physicians any question [inaudible]. Yes, yes, Dr. [inaudible]?

FEMALE SPEAKER: I'm [inaudible]. I'm from the World Economic Forum. Thank you, all the speakers, for touching up on all the issues that are really close to my heart. While we are

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on the - whether it's the PPN initiatives or the ACSM work or the patients' charter or whatever, I think it's really important that we, as external agencies, are maybe in the capacity of implementing pilots, replicating them elsewhere and scaling them up. But I think it's really important that they get institutionalized by the public sector and I see that as a big challenge and all the work that I've done in the past two years on PPN and now with the business sector, it's really essential that the public sector institutionalizes those lessons that we learn through the pilots that are done by external agencies. Thanks.

MALE SPEAKER: [inaudible] from Pakistan and first of all, I want to thank the organizers because I'm seeing a lot - many community representatives, which we were missing last year. So a lot - many congratulations to the organizers. I have not many points to discuss but I [inaudible] and just ask Dr. Jan first, with reference to the PPN, I think the missing link is the informal health practitioners. In our country, we have a lot - many so-called fake like traditional but traditional practitioners, a lot many people are attending and going there and they didn't know about the TB, particularly these traditional practitioners, and there's no data included in that. And the second question is not a question - it's a

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[inaudible] like with reference to the patient empowerment and involvement, there are a lot many purchases going on and my question is - anybody can respond, particularly if Case wants to respond on that, I think [inaudible] to involve patients at global and national levels and we are having discussions on grassroots level like top down approach and bottom up approach so both of the approaches have their good and bad and which is effective, as far as our experience is concerned, we want to have more enrollment of patients, especially the TB patients and community involvement. And the link is the missing, especially at the country level. It might be good if somebody from other countries can reflect on - is there any strategy to involve patients and grassroots community at country level to say to share the comments particularly at the policy level, at the national TB Control Program level? Thanks so much.

CASE GORDON: I think - I feel again that I think there's a major challenge in involving the informal providers so, first of all, due to big numbers and secondly to the fact that they are unorganized. I think there's no recipe but the only thing that we have is experience is from pilot programs like in Bangladesh where, for instance, the village - doctors are involved in [inaudible] identification and also treatment that with this will give us the tools and the guidelines how to

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continue, how to scale up involvement of the informal providers and in many countries, they play very important roles in [inaudible] TB control program and they could also help us solve the human resources crisis that they have in the government programs. There are people that are willing, that are motivated but that do not have the skills. So if we would learn from the experience that we have in several countries and also could identify the tasks that these providers, these informal providers could perform to support NTP, this would help us in solving the human resources crisis.

MALE SPEAKER: If I could maybe respond to points Pervase [misspelled?]. I think that when one talks about if [inaudible] I'm listening to somebody like Jan Voskens, I am interested in thinking when we're talking about public/private mix, it sounds a bit strange. I'm interested in, does that really mean engaging all providers and I'm conscious [misspelled?] sitting next to Dr. [inaudible] initiative that my own little organization is involved in - in the Urban DOTS program in [inaudible] Dr. [inaudible] and the national program stimulating is what started these pilot programs in four Indian cities.

The thing that has impressed me most in [inaudible] about the project is that it hasn't been focused just on how do we

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get a few more DOTS provides. It hasn't been focused just on, how do we get a few private practitioners involved? It's been more so on identifying and involving literally all providers and that means, for example, in the public sector - the public sector is amazingly rich in clinics - certainly in the Indian context other than in the national TB program.

There are TB clinics but there are also [inaudible] services clinics, there are station care clinics, there are all sorts of different networks of clinics and all of these as well as the voluntary sector need to become engaged.

And secondly, your second point, in terms of patient involvement - I think one strong thing I would say, which I didn't include in my initial presentation is that I think that we are increasingly seeing more and more patient advocates and representatives present in our international governance and we are increasingly seeing opportunities for what is loosely called capacity building, training, increasing understanding of how to get things done as an advocate but what I am still not really seeing is much in the way of resources to be able to assist community and patient groups to actually do any advocacy in their own countries and that I think there is a severe lack of resources. We can train people to do the job, but unless there are resources, they are not in a position to actually do the job and that would be my main response back to you.

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But other than saying that the particular issue of informal sort of volunteer docs, providers, and such like community participants assisting in the process of helping patients through the long months of treatment again, that for me is a standard and normal part and is something that very much community-focused initiatives can provide and a very important supplement to what the normal national program on its own can supply.

MALE SPEAKER: [inaudible] supplement [inaudible] what the chairman has just said. What's probably not helping toward that structure and its [inaudible] is of various experiences from countries and as Jan was presenting, he said there seems to be a lack of trust to push forward this PPN. There is also inadequate [inaudible]. For example, in Uganda, we have the traditional Healers' Association basically formed on a [inaudible] to combat HIV/AIDS but they quickly came on board and they are members of the Stop TB Partnership, originally operating in 10 districts - now operating in 17 districts playing a fundamental role of suspicion and the referral of suspects because it is recognized that the majority of the clients, TB clients, first report to these extremely popular health workers. The second group was studied along with the pilot of the [inaudible] TB Care [inaudible] Strategy in 1

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district. They were [inaudible] right at the inception and oriented as to what we do in so-called TB control and they clearly admitted that they see a lot of these chronic coughers and they took on the role of referral and the district has sustained over the last eight years a high treatment success and a high case detection rate so what it calls - the informal sector needs to be recognized but formally the countries really need what is exactly the last two, which is a [inaudible] used guidelines on how to map out the existence of other providers. If this is done then they will be able to quickly and appropriately engage the informal sector.

MALE SPEAKER: Any other questions or suggestions? Yes please? Yes?

ALISTAIR REID [misspelled?]: Yes, Alistair Reid from UN AIDS. I know that or it's clear that most tuberculosis in the world is the kind in people who are not HIV infected yet a large proportion of the activism and community engagement in tuberculosis is coming from the communities that are co-infected. However, this issue is hardly touched upon at all in the ACSM working group strategic plan and hasn't really been discussed here. How can we build advocacy and activism for TB that doesn't increase the stigma for those who are not HIV-

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infected, yet also deals with these very real issues and fears of TB amongst people living with HIV?

MALE SPEAKER: I mean, I think that you touch on a very real issue and I think that it is an issue, which we talk about but I don't have an easy answer to you. That is to say, I am very conscious - there are many parts of the world from which we do not have patient activists who have had TB as opposed to TB and HIV and I think such people - [inaudible] such people, there are such activists but somehow I mean whether I - it's I think it's something that we are working on and I think and I hope that that's something perhaps, that will be discussed in the TAG meeting tomorrow. Because I think that many of us are conscious that on one hand, we're extremely grateful for the kind of extra additional energy, which has come to us because of co-infection and that there are many of the best advocates we know are people who come out of the world of co-infection of HIV and TB but on the other hand, as you say, that leaves out at least two-thirds - three-fourths of the TB world and there are many parts of the world where co-infection happily is not yet a major issue.

But I don't have a very good answer to you except to say yes, I think many of us were aware of it as an issue, but if you got some good ideas on how to respond to it, tell us more.

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MALE SPEAKER: Thank you. One more question.

GABY: I'm Gaby from Action Program in Nigeria, a PEPFAR funded program. My question and remark is to do with the continuing question of limitation of resources, resources, and resources for ACSM and many of the activities that we've talked about and I worry in the simple sense that I look at TB/HIV coordination and one of the key activities is joint planning between the TB group and the HIV group but I can still see like a kind of congregate [inaudible] everybody's own position. It's like I can see in many situations where there are a lot of resources in the HIV network that is [inaudible] engaged in the fight for TB because for dual infections, it's one patient that has two diseases and the HIV group almost globally still plans for ACSM with a lot of things not talked about on TB and I look at this as a peak opportunity for the TB group - I prefer to look at it as the same group that has the same problem even though there's a big number of people that are not necessarily dually infected but the resources that are available can still focus on the two groups because they have to be protected from contracting HIV. So they fall within the same group and this is a big opportunity for us to tap.

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MALE SPEAKER: Thank you. Yes, please?

MALE SPEAKER: Thank you. I want to come back to the involvement of all care providers and I think while Francis alluded to the implication of the traditional healers and there are a number of projects that try to involve those informal care providers or these traditional healers and unfortunately very few of these experiences are documented and written and I think it's - I want to make a call to all people in this room to try to document and to share these experiences. Some of them are very interesting. Others are complete failure, but I think both of them need to be documented, written and shared so that we can advance this agenda.

MALE SPEAKER: Thank you very much for this suggestion and that will help other countries if we have some documentation on the involvement of this because in what capacity they're involved, for example, it's - Dr. Paul was talking about the PPN project in [inaudible]. Here, what we are doing - these traditional healers - when we talk about the involvement [inaudible] in the community. People have [inaudible] them so they went to the traditional healers - why not use their hold on the community and then let them [inaudible]. It depends upon in what capacity they can be involved. They can be involved as

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the advocate in the community and they can be involved as the [inaudible] providers and that's what we are doing in different countries but yes, there's a need for documenting that so that each other can be benefited from those documented efforts and then they can be replicated in other countries also. I think it's time now - I would like to thank all the participants and speakers and [inaudible] and [inaudible] will be the [inaudible] again for the last session. Thank you.

[Applause]

[END OF RECORDING]