

**37th Union World Conference on Lung Health:
From DOTS to the Stop TB Strategy – Building on
Achievements for Future Planning:
Reports from the Stop TB Partnership Working Groups
October 31, 2006**

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DR. L.S. CHAUHAN: So, we would like to move this last session, which is Reports from the Stop TB Partnership and will be presented by the chairs. And we will have three presentations. One is on Childhood TB Subgroup by Robert Gie, M.D., then another on Task Force on Re-Tooling by the Chair of the Taskforce on Re-Tooling, Dr. Vinand Nantulya will present, and then the last presentation will be from the Outgoing Chair of the TB/HIV Working Group, Gijs Elzinga, M.D., Ph.D.; that is The Span of TB Control: To Eliminate a Global Emergency. So I think if everyone agrees, again in the same fashion, should we have questions answered with each of the presentations or after all presentations?

FEMALE SPEAKER 1: After each.

DR. L.S. CHAUHAN: After each presentation. Okay, fine. This time because it's so different so that if they have questions, answer after each presentation. So I will request the first speaker now, the Chair of the Childhood TB Subgroup, Dr. Robert, to kindly present his on Update on Policy Recommendations From the Childhood TB.

ROBERT GIE, M.D.: Thank you, Mr. Chairman. I'd like to thank the organizers of this symposium for giving me the opportunity to report back to you on what I would regard from

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childhood tuberculosis as a large movement in the last two years.

The childhood subgroup was formed two and one-half years ago from the Union of the World Health Organization, the NIH, the CDC, and people like myself who come from academic backgrounds and universities. So you can imagine how frightening it is for me as a university person to move into the world where everything is very uncertain for me. But the areas we have been working on, it's been in policy. The Childhood TB Working Group is a very small group of highly motivated volunteers and we have mostly been working at Union meetings or by email. And the areas we have been working in is the promotion of mainstreaming of childhood tuberculosis prevention and care as part of routine in TB activities. We've been looking at the recommended diagnoses. We've been working with others in developing child-friendly formulas of anti-TB drugs. We've engaged in trying to improve recording reporting. We're promoting operational research. And we're doing advocacy for childhood tuberculosis. So I would like to report on some of the areas and what we've achieved in those areas.

So the first thing was to mainstream childhood tuberculosis into routine anti-TB activities. To be able to do this, we had to develop the guidance of [inaudible] on the

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management of childhood tuberculosis as a consensus document. This we have now achieved and each of you that attend this conference will find that in your bag we have this guidance for your perusal and hopefully for your implementation. This has been a major source of our work, and from this we've been able to convince others that this is an important issue. We were able to influence the editor of the International Journal of Tuberculosis and Lung Disease. I cannot imagine why we were able to influence her to actually run an editorial in her journal. We've also been able to publish, in a serialized form, in four chapters of which the first two chapters have now been published in the International Journal of the [inaudible] and diagnosis of tuberculosis in children and anti-tuberculosis treatment in children. You will see this is published by the Stop TB Partnership and is an official statement. So we are starting to try and disseminate these guidelines to the risks of the tuberculosis world. We have still got a long way to go in the dissemination of these guidelines. And our next step is an actually fact to work through, the DOTS Expansion Working Group, which I must tell you has been a very, very positive experience for myself in promoting the uptake of NTPs and main policy recommendations. And we've now, as a group, been approached by various national TB programs and to helping

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them develop guidelines, which would be appropriate to their NTP program. So this is all very promising. While developing the guidelines, we realized that there were two areas that required a lot of work, the one area being drug dosages. And the first drug that we had a look at was efambitol [misspelled?]. And we commissioned literature review. And this was thoroughly investigated by a colleague of mine, Professor Peter Donald, and he wrote a review, which was accepted by the Subgroup and has now been officially published. And the review, which is very clear, that the dosages of efambitol we were using in children is far too low and that the dose now accepted is 20 mg/kg with a range of 15 mg/kg to 25 mg/kg. We now need to promote this new WH policy through that DOTS Expansion Working Group [inaudible] assistance. What has also become clear when we reviewed the literature of the drug dosage of the other anti-TB drugs also needs the same kind of review, and this will form part of the focus of our work in the future. The third area we got involved in, we saw that there was a lack of child-friendly formulations of anti-TB drugs. National TB program managers were approaching us and asking us if they go to the Global [misspelled?] Drug Facility there will be no childhood-friendly drugs available. So through sustainable data collection, through routine national TB recording, and

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reporting systems, we hope to be able to stimulate pharmaceutical companies to manufacture child-friendly drugs. Now most exciting has been an agreement of unit aid to support child-friendly formulations, and this has resulted in the first drugs to be scrutinized in the middle of this month and hopefully child-friendly formulations will become available to national TB programs through the Global Drug Facility. Improved recording and reporting is a dialect of good data on childhood tuberculosis in most TB countries. And this became very clear that if we weren't able to get children recorded and reported we would never know what the size of the epidemic was. We would never know how much drugs we would require for various age groups. So it became policy that, and I was most excited this morning to see it reported, that the routine recording and reporting of children in two age bands, 0 to 4 years and 5 to 14 years, will from now on become part of essential recording and reporting system. This is very exciting and I'm sure it's going to help a lot. It's also had other [inaudible], which we will be able to, by monitoring the children 0 to 4 years of age, be able to see what's happening with recent transmission of tuberculosis. Promoting operational research is the next part that we got protégée [misspelled?] research agenda to be developed. The protégée research has been completed. It has now been

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revised and our next step is disseminate it. We have once again been able to convince the editor to consider publishing this research agenda in the International Journal of Lung Disease, and hopefully this will occur in the near future, helping us with dissemination of what is required in the operational research of childhood tuberculosis. Advocacy for Children; being a part of the subgroup has created a number of possibilities to ensure that children are included in the activities. The most important one that we were able to get involved in was Thanks to Full, [misspelled?] as everybody has said many times, we were able to get involved in developing the international standards for tuberculosis care to ensure that children were included in every step. And this has happened. And I was quite pleased the other day. A lady came up to me and said, "I think I've seen you before. Aren't you the person that always says children should be included?" And I think that's exactly the involvement that we would like to see, that there is a face for childhood tuberculosis in all communities.

So ladies and gentleman, you can see that the group has been a very small group run by a full-time clinician like myself. And I think it shows that if you work through appropriate structures like the DOTS Expansion Working Group, you're actually able to achieve quite a lot. So in

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conclusion, I would say the relative advantage of the childhood subgroup has been in policy development. A friend pointed out to me that the ATS has been involved in policy development for 100 years and has only been involved in implementation [misspelled?] for 1 year. But I can say quite clearly that the Childhood TB Subgroup has been involved in policy development for 2 years and we've got no years of implementation. So is there any way we can see the way forward for the Childhood TB Working Group's policies to be implemented is our continued close collaborations with DOTS Expansion Working Group. We need to get this policy into practice.

Now, I would like to use this opportunity to invite you all and all those interested in childhood tuberculosis to our annual meeting, which is held tomorrow between 2 and 5. It's in room 330 and 301. On the agenda would be the Promotion of the Implementation of NTPs, Promoting Child-Friendly Formulations, What Topics We Need to Pursue in Reviewing, How to Make the Best of Routine [inaudible] Including HIV, Correct Doses for Children, Vaccine, Research, and any others that might need attention. I invite you all to this meeting.

And finally, I have to make some acknowledgments. To achieve the success in this area we need lots of guidance and

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you need a good secretariat. And I would like to thank Leo Poplunk [misspelled?] for his guidance and always opening the door for the Childhood TB Working Group. And I must publicly say that I think that I've got the best secretariat of anybody in Geneva [misspelled?]. I know he tells me I don't always do what he tells me to do, but at least I've got the best person, I believe, in Geneva helping me. Thanks very much [inaudible]. [Applause]. I promise to be a good boy next year.

And then lastly, I think it's very exciting when you read in the Stop TB Strategy this following sentence: That it is there to ensure equitable access of care of international standards to all TB patients, infectious and non-infectious, adults and children, with and without HIV, and with and without drug possessing TB. In this sort of atmosphere, it makes it very exciting for us to work.

Thank you very much for your time and attention.

DR. L.S. CHAUHAN: Thank you Dr. Robert Gie for such a nice presentation on mainstreaming childhood TB as a part of the National TB Program. Now, any questions, suggestions? Yes please, Dr. [inaudible] from Turkey.

Dr. [inaudible]: This area is top area that the universities or the [inaudible] are involved in subjects like this, so there is real problem in recording these cases or

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getting these cases into NTP and also to give right regimens, right drug regimens for these groups, because they are expressed and year round physicians, so expressed aren't always better for many people. So I think we must think about to get this kind of standup regimen and other things, then childhood TB and [inaudible] subjects to work with international pediatricians group and others because the pediatricians look to their international groups mostly. We do you think about this point, also as a university person, what do you think about this subject?

ROBERT GIE, M.D.: Thank you very much. I mean I have to add in to [inaudible] I am, as I said, a practicing clinician. But I think that's what makes it so very exciting is that part of the TB Subgroup is the IPA, International Pediatric Association. And the International Pediatric Association has invited me to go and give a presentation at the next international congress so that we can get endorsement from the IPA to this whole program including the international standards of care so that persons like yourself and myself can actually therefore have official documents which are endorsed by international organizations saying that this is the international standard of care that we should be practicing for children and these are the regimens that are recommended by the WHO and international organizations and

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these are the correct doses, etc., and these are the drug formulations that are available. I think it's a very exciting time because I think we moved into this area just at the right time as DOTS was changing over to the Stop TB Strategy. So I have to endorse what you're saying, but I think it's time things are going to change because they are going to be in documents to help us.

DR. L.S. CHAUHAN: I think I would like to add England [misspelled?] [inaudible] Pediatricians, the program, national program, and then a program that took the [inaudible] pediatrics redeveloped the guidelines. The full consensus of the [inaudible] Pediatrics. The diagnostic criteria, the diagnostic [inaudible] TB, as well as the treatment guidelines for pediatric TB here. Now the [inaudible] for pediatric TB. Even repentacin [misspelled?] in tablet form for 50 mg and 100 mg, they have now been [inaudible] level. And now it's in pediatric patient-based boxes for different weight [inaudible] designed with the help of the Indian Academy of Pediatrics, so that's important [inaudible]. And I think definitely we need to work still on the international standards of TB care. They have been also taken into [inaudible]. They designed that. And program is now following this.

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MAURICE MIDDLEBURG [MISSPELLED?]: Maurice Middleburg with the Global Health Counsel. Thank you very much for a very interesting presentation and for all the good work of your group. You identified the NTPs as the primary advocacy audience for moving forward with this report, but most of the contact with children takes place through maternal and child health programs or with child center MGAs. And I wonder what [inaudible] has given to working with the child survival programs of major donors, with the MCH programs administrates of health, and with the major PVAs that work on child survival.

ROBERT GIE, M.D.: Thank you very much. You will notice on the agenda tomorrow at our working group that's the first item is how are we going to do it. And if people like yourselves who've got this experience would come to the meeting and help us how to develop this program, we'd be very pleased. The reason why I am saying we will work through the DOTS Expansion Working Group because that's the group that has helped us the most thus far in getting [inaudible] done. But if we can include other people to help us, it would surely be very, very welcome.

MAURICE MIDDLEBURG: Thank you.

DR. L.S. CHAUHAN: Any other questions? Okay. Thank you Dr. Robert Gie. I am going right to Dr. Vinand Nantulya,

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the Chair of Task Force on Re-Tooling for his presentation.
Dr. Nantulya..

VINAND NANTULYA: Good afternoon to you. I ask you to welcome me to this wonderful community of TB. Some of you knew me in my previous life as the Senior Health Advisor to the Global Fund. Now I am fully with you.

What I plan to do is to share with you and to wet your appetite for a process that was kicked off by the Stop TB Partnership Coordinating Board. And the reason why that happened is this, that for the first time in the TB community, we have a pipeline of promising tools, and this pipeline is on the way. In the case of vaccines, if I start from the bottom here, we expect a new vaccine by 2014 so says the Global Plan. In the case of medicines, we are expecting new medicines or in application of existing medicines for the treatment of TB. And we are getting this starting from 10 and thereafter; there are several products in the pipeline.

With regard to the medicines, there are drugs that will be coming not as single application drugs, but drugs that are to be used in combination, some of them, with existing drugs that we have to improve two things, the efficacy and the try and shorten the treatment costs.

In the case of diagnostics, there are three different levels. We are expecting that the different level, i.e. the

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national reference level tree. The peripheral [inaudible] district hospital level, the health center where microscopy is the main diagnostic tool, and at the clinic where there is no laboratory diagnoses undertaken at present. All those three levels, they hope that they are new tools that are coming. They are tools for the lowest level where at present we don't have in that level to diagnosis this. And we expect a liquid-based antigen protection test to be made available by 2009. And we expect an antibody acid by 2011.

At the peripheral laboratory level where sputum microscopy is the main study, we are first going to have an incremental improvement in the use of this sputum microscopy by way of [inaudible] microscopy, by way of [inaudible] microscopy, or low cost fluorescence, and which treatment. And this is coming within beginning of 2008 and 2009. And we are expecting additional improvements including the introduction of a molecular test for TB by 2011. In the case of the reference level to level, we are already expecting tools next year. We are expecting the speciation test for specie identification. We are expecting to spread the use of the liquid culture for diagnosis and for blood sensitivity testing. We are getting into the use of the phage-based tests for [inaudible] sensitivity testing.

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These tools are going into the demonstration phase, and they will be made available anywhere between 2007 and 2008 and in adults. So this is good news. However, the good news also brings problems. One is that these are coming soon. Two, that there are challenges ahead in adopting these tools. And three, that rapid adoptions would require that we start planning and preparing for these tools now. This was their reason that the coordinating board had a sitting in Assisi in November 2005 and decided to establish a task force, which they termed the Re-Tooling Task Force, which was to prepare the TB community for the adoption, introduction, and implantation of new or improved diagnostics, drugs, and vaccines as they become available. It has clear terms of reference. One: To develop a framework or guideline to guide the discussions by the various stakeholders at various levels, global and national, to consolidate the information from the tools working groups, to create dialogue among stakeholders, and to facilitate the mobilization of resources. It is also expected to consolidate lesson learned from various innovations, to facilitate the fast tracking of incorporation of these tools in WHO and national policy, enhance communication among working groups, and facilitate the introduction of operations research and generate evidence on how the new tools are working. The composition of the

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task force is as follows: We have good working group members designated by the chairs. We have the key subgroups, namely laboratory, GDF, and poverty. We have representation of the national TB program managers from high-burden countries. We got a WHO Stop TB Department and other WHO relevant departments. And we've got a Stop TB Partnership Secretariat that serves as the secretary of the group. What have we been able to do? In the short time that we have been in existence, starting from July, we had a face-to-face meeting in Geneva with the task force group. We agreed to produce a framework document to guide the discussions at national and global levels. We commissioned MSH to work with us in starting the drafting of the document under the guidance of a core a group within the task force. And we have had weekly teleconferences since then. We are expecting to complete the drafting of this tonight to be presented to the coordinating board at its meeting in November in Dakota [misspelled?] Why do we need this guide? The guide is meant to provide a common framework to discuss the adoption of new tools for TB control; it is meant to identify some key issues that need to be addressed to accelerate the adoption, introduction, and implementation of the new tools; and to provide guidance on what actions are needed for the adoption access and proper use of these tools by the community. Here are the following

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key elements: When we talk about availability of tools in the context of the task force, we are talking about the tools that have already, in the case of diagnostics, been introduced in national disease-controlled programs of a few selected countries and where they have shown that they can be used efficiently and at the same time all they have value in a real life situation. And for the drugs, is that the drugs have gone through phase III. Next key element: The document identifies key challenges to adoption and implementation of new technologies. It proposes key principles to facilitate appropriate and timely adoption and implementation of these tools and provides an overview of technical and operational considerations both for the global level partners and the national level partners. The document also provides an ascites of annexes. One is an overview of selected new medicines, diagnostics, and vaccines that are in the pipeline. A listing of key actions for the adoption and implementation of each technology category. I.e. for diagnostics, for drugs, or for vaccine. There is an illustrative genetic timeline for adoption, introduction, and implementation, and there is a list of key readings that provide more detailed discussions of the issues and the road maps of addressing those issues. These are the contents of that report. The report is going to be read after the

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coordinating board gives approval, in which case then we shall embark on the following: First, we need to expand the task force membership. So we need additional national TB program managers on the task force. We need members of WHO essential medicines and policy group on the task force. We need additional members for ACSM, DOTS+, and DOTS expansion working groups on the task force, because this is a practical thing. We now are going to be implementing the dissemination of this document because after the coordinating board has approved, we are going to disseminate this document in a number of ways because the intended recipients of this document are yourselves and those outside here. Then, we shall embark on the development of additional documents and guidelines, which include the guidance on stakeholder engagement. I think that was touched on some time this afternoon. We shall be updating the pipeline chart so that all the stakeholders know what is coming and when it is coming. We shall be putting in place a re-tooling monitoring and evaluation framework. We shall be developing illustrative timelines for post regulatory processes. And we shall then also produce recommendations specific for each new tool that will be coming up for adoption. It's a full program. I'm sorry I can't give you copies. I have copies that are in draft form, but I am not authorized to give you

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until after A, we have finalized the version that goes to the coordinating board, and B, after the coordinating board has approved it. Only then can you have it, but all I can tell you is that it is good news for this Stop TB movement. Thank you very much.

DR. L.S. CHAUHAN: Thank you Dr. Nantulya for this information on the new tools [inaudible]. Yes, please.

MALE SPEAKER 1: [inaudible] thank you very much. I share in the excitement, and as I look at the plan that has been developed, I'm stuck by one missing link. That is the assumption that we have the capacity right now to rapidly move into the phase III trials. I would propose to you that if right now, here today, I were to say we have three promising drugs that in combination to cure TB in four months, we would be struggling with how to fund and resource that very necessary phase III trial that the group is, indeed, requiring appropriately before we implement it into program action, so I would invite the group, when you get together tonight, to highlight that as a missing link that needs to be retold fairly quickly. I believe that on Saturday we're expecting to hear from the Treatment Action Group, the dismal situation of the Globe, in spending for TB resources and research and development and how much more we need to do in that. But I share with you in the excitement

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of all the very promising things that we could be evaluating soon. The last comment I would like to share is that in light of the pressures of extensively resistant tuberculosis, we're going to be challenged to consider and struggle through how would you evaluate some of the drugs on a compassionate protocol basis and not have to wait for the usual events to take place. We, and need I say, have spoken with individuals from FDA who tell us number one it can be done, it has been done, and most recently [inaudible] released a new drug for multidrug or resistant HIV last July and it was evaluated on shorter than usual timeframe. And we're going to need to challenge ourselves also to think along these lines so that we can make the progress that's a bit more remarkable than had been stated, but great job. I'm glad that you're here with us full-time.

VINAND NANTULYA: [Laughter] Thank you. The first statement I concur with you, and I'll take that message to Group, is my colleague from TB Global Drug LIS [misspelled?] is here want to... Is Nina in here? Okay. She may want to give a comment on that, but we'll take your point as constructive. The second point is acceleration. Absolutely so! We need to accelerate the process now. The timeline I've given you in that chart, that timeline has already been overtaken. For instances, in diagnostics, the demonstration

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phase that was supposed to start next year is starting now. So because of the urgency to move these tools in the field, we need to accelerate the process. Nine, do you have a comment? No. She doesn't. She agrees with the discernment. Thank you.

DR. L.S. CHAUHAN: Yes, Dr. Robert, please?

PHILL HOPEWELL: Phil Hopewell, San Francisco. Both your presentations, Vinand and Dr. Rob Gie's presentations, point out that things are changing fairly rapidly or have the potential for changing fairly rapidly anyway, and in several presentations today, the international standards for tuberculosis care have been mentioned. That was a fairly arduous process in putting those together. And when one thinks of standards, one thinks of things that are somewhat set in stone. But I'd like to point out, as has been illustrated by your presentation particularly and also by Rob's, that standards need to change. And so what we intend to do with the international standards is to reconvene at least a portion of the committee that worked on the standards originally, provide surveillance of the areas in which we developed standards, and try to on an annual basis update these so that they incorporate the new changes, the advances that you've outline, some of the changes that Rob described, and make this truly a living document. And I think that's

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sort of an important generic point that has to be made that these days hopefully things will be changing rapidly and there need to be mechanisms in place to enable rapid changes in the documents recommendations/guidelines that are all related to TB care and control.

DR. L.S. CHAUHAN: Yes, please.

JOHN RITTERHOFF: John Ritterhoff, CDC and also with the Stop TB Lab Subgroup. I did want to second, this is an important topic in relation to some of your slides on the new diagnostics and I think this is a big question. I think there is a concern among a lot of the laboratory people that we're over simplifying the solution and looking at new diagnostics and we forget that some of the big differences between industrialized countries and a lot of the high-burden countries is the fact that the industrialized countries also have universal laboratory standards and regulations that govern this testing. And I think it's something, we have to work on new diagnostics, but we also have to strengthen the laboratory system in general. If they're going to be able to successfully implement these diagnostics. We're already hearing stories, some things we've experienced in our system with the liquid culture systems where we found that 2-percent to 4-percent of all our TB cases were due to laboratory contamination in the United States. This is where you have

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the universal regulations, high credentials, doctoral level requirements for any laboratory [inaudible]. So I think this is an important topic. I think sometimes it's underestimated. And I also think that the TB community is not going to be able to do this alone. They need to work with the other communities and really have universal laboratory quality standards.

VINAND NANTULYA: First, Philip, nice to see you. I agree with you. This process has got to be a continuing [inaudible] process. Yes. This morning I woke up and I was asking my self, I said, "well, maybe one of these days I will just write an article about the following:" that the diagnosis is expensive. Yes? Tryout extensive diagnosis and you will see the difference. The strengthening of laboratory studies is absolutely critical if the re-tooling in diagnostics is going to succeed, and so the idea of the re-tooling is to stimulate discussion at local and global levels to start thinking about the various processes and this document does touch up on that and we shall be saying more about that in subsequent documents because the state of preparedness of laboratory services will influence the speed and success of the re-tooling of the diagnostic services. FIND [misspelled?] has got a project proposal that was endorsed at the Clinton [misspelled?] Foundation. If you

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have looked at our web site, where we are going to look at this in particular for [inaudible] in Africa starting with a pilot of the model in Roganda[misspelled]? to see how you can prepare laboratories for introduction of these tools when they become available, but it's not going to be simple. It's not going to be cheap, but the price is worth it because the cost of not doing so is much, much bigger than that.

JERRY FRIEDLAND: Thank you. I'm Jerry Friedland from New Haven, Connecticut and [inaudible] South Africa. I would like to make a suggestion if I may about the Task Force and it's composition of membership in the era of HIV/TB co-infection and TB/HIV collaboration and integration. It doesn't seem like there's sufficient representation from the HIV side of this very, very important interaction. I wonder if the Task Force might be strengthened by the inclusion of additional people or person from the HIV world.

VINAND NANTULYA: Point taken. I shall fill-out the TB/HIV Working Group because these memberships are coming from working groups.

DR. L.S. CHAUHAN: Thank you. Thank you very much Dr. Nantulya. Then, we'll have the final presentation on The Span of TB Control: To Eliminate a Global Emergency, Dr. Gijs Elzinga, M.D., Ph.D.

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GIJS ELZINGA, M.D., Ph.D.: Mr. Chauhan, colleagues, friends, let me start to express my appreciation for the opportunity to, what [inaudible] called, have a [inaudible] today. {Inaudible} my appreciation for being involved in tuberculosis control for about 13 years. And I mean that seriously. It has been a great experience. When I sent this title of this [inaudible] to [inaudible] to ask his opinion about this title he said, "Well, it looks fine, but please explain to be what means spent." I was a bit surprised because he is sort a linguistic person. He knows a lot about the English language, much more than I do. But by spend, I mean how wide you have to throw the net in order to catch the fish that you want to catch and the fish you want to catch is elimination of tuberculosis. And I hope that this presentation will clarify the meaning of that word. When you are at that point in time that you're overfilling 13 years of involvement in tuberculosis control a number of questions spring to mind. Those questions are very simple. The answers are not. And I stratify that a bit in the following. So I am now at 2006 and what you do at such a moment, you look back and you look forth. And when you look back you wonder, what sort of progress has been made over that period in terms of efforts and in terms of impact. And also when you look forward, try to learn a bit from what you have seen

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and what has happened for the future and think about what should happen and how to do that. And that is the significance of the arrows that link the efforts with the impact with the what and with the how. So I just followed that simple sequence of questions and come to a bit more complexed answers. These answers are very personal, so it is just my view and I would be happy if you would disagree with those so then we have something to discuss about. So let's first go into the efforts. And what I'll show you is the shortest summary of what I could find of a success story is this. So I started at the moment in time that I became involved in tuberculosis. It was in 1993 and I didn't know anything about TB control at all and I needed to chair a meeting in London. It was just succeeding the London School of Topical Hygiene meeting, Back to the Future, I think it was called. And it was a so called card meeting. And there was a lunchtime just between the end of the meeting and the start of [inaudible] Richard Blumgard [misspelled?] present in this room took me to lunch on Charlotte Street. I knew Charlotte Street very well because I had been working in at University College, which is very close to [inaudible] Street where the [inaudible] School is. And that was about the start and in the end of the day, in the evening, I found myself on the BBC News at 9:00 calling a global emergency of

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something I did know very little about. But they taught me quite a lot. And as I said, appreciate very much what I've learned over those 13 years. And what you see here is sort of milestones that I could think of easy in the beginning because 1991 the targets were set, the 70-percent and 85-percent, especially in this room, very regularly today and yesterday, and then some initiatives, the global emergency that I mentioned, the control framework that would then finally become the DOTS Strategy, the monitoring systems were set up and thought of, and I think it was in Oslo [misspelled?], and then I think this frame became too small to see what sort of developments took on. And the red line you see there is one component of the finances. So the drawn red line is the finances that come from the developing agencies expenditure growing up to 400,000,000, so every year. This is the timeframe underneath. And I drew a dotted line what I expected would be in the extension [inaudible] to 1991 when the targets were established by the World Health Assembly. Success story... This success story makes people believe that the TB program is a distended model of a successful partnership. And we think because they say that we are that, we think that we are a very good, successful partnership. And I think that we are right. But we are not as good as we think, I think. So let's go into that.

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Because of the [inaudible] limitations also in that time, and I'm not pointing fingers because I'm part, very [inaudible] part of the history since 1993. But let's first look at one thing, TB/HIV for instance. I have been responsible. I will end my chairmanship now for TB/HIV that started as a working group at least in 2000 or 2001 formally, first working group meeting. At the time of the London meeting, 1993, it was already in that [inaudible] at the London school, Back to the Future, well know that HIV was a high-risk factor for TB. There were a couple of complications. One of those [inaudible] I think he is present. I saw him walking around in the room. But there were others warning that this was an upcoming disaster. And when the targets were not met we noticed that, in 1997 I think, about 1996 we were afraid that we would not meet the 2000, later the 2005 targets. We at the London Ad hoc Cte meeting, the London Ad hoc Cte meeting that I advised about, for instance, the global [inaudible] facility and many other things that have been implemented [inaudible]. Within that report at London Ad hoc Cte meeting, there was no mention of HIV/AIDS. And I plotted here just to remind ourselves of what we had apparently missed there, I plotted her the number of people living with HIV/AIDS at that time. And you'll see that there were already over 25,000,000 people living with HIV/AIDS. And

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then when the partnership came into existence after the compromise and [inaudible] turnover of the WHO let a global program through the partnership, then TB/HIV came into existence. And it has been, I can testify that from personal experience, a very, very slow implementation. So that was not so easy. That was not a success story. Still, we have seen the reports yesterday and today. It is not at the level where it should be. The second example, human resources for health. The human resources for health nowadays, today, yesterday, and almost in two years or so flagged as an enormous problem. They were already flagged as an enormous problem in the London Ad hoc committee. They were listed there, but there was little action taken. And when in 2002 we looked at 2005, the next date for the same targets of 2000, we thought again, "Well, human resources for health, if not even a problem, it is a health work crisis." And it took until 2005 STAG before Taskforce was established that we should address health system strengthening, now working very hard on that. And in the left upper corner here, you see a pyramid, what I call a pyramid. You can call it anything. The pyramid reflects the composition of the kind of human resources that we need to deliver the interventions to the patients. And on the top of the pyramid, is the programmatic part. So that are the people running the national program

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and reaching out to the services that have to deliver the interventions. But the real problem in numbers and in quality I think is in particular in the big part, the underlying part of the general health services that needs to deliver these interventions. With the general health services, I include also the private sector. And still I think we haven't focused on the programatic part thereof. But we have very little input yet, and we do not really know how to address the general health services from the TB perspective. Maybe we should not address it from the TB perspective but we should look for alliances that can help us to build that workforce in countries. There are some commonalities. Commonalities between TB/HIV and trying to learn lessons, you see, because I'm just following my points and my efforts and impact on work and how for the future, trying to learn lessons to see if we can learn something for the future. There are commonalities between TB/HIV and HRH (Human Resources for Health). Both of them are crucial for TB control. We will all indescibe [misspelled?] that, underscore that. And they both, the fact that they were not addressed in time, with no ado [misspelled?], to a lack of knowledge. We knew that there were problems. In the case of TB/HIV, that knowledge was strategically ignored, and in the case of Human Resources for Health, we were slow in

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implementing or trying to implement interventions. It may be that they have the commonality that they require actors outside the program for implementation and that is not so easy for a program like tuberculosis control to do that. What is also a reality for both, I think, is that the STB Partnership helped in tabling these issues. So with respect to some answer to my question about what sort of efforts have been achieved since 1993 until 2006, I think the efforts rose exponentially in most areas and we should be proud of that. And this holds true for the program so that the partners in the program, the structure, the strategy, the actions, all of that, and also the finances. We have far too little as Mark keeps telling us, and that is true. But on the other hand, we have achieved in substantial increase. But we have also turned a blind eye for at least two important topics, and that is TB/HIV and Human Resources for Health. And we have to reflect on that when we think about the future because there was no, as far I could see, explicit reason why we did that. It might have been that outside program collaboration is a difficult thing to do for programs, also for the TB program. And it may also be that it's difficult to find the know how, how to do that, how to interact with these actors at the global level, at regional level, and at the country level. Next question; impact. What has been the impact of

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all these efforts? Well, I did not know anything about tuberculosis and know now a little I think, but the first lesson that was taught to me was that we have targets and you have to pursue those targets. And the targets are case finding and treatment, successful treatment. And those targets were established by the World Health Assembly, 70-percent and 85-percent. And we know that it will cost the TB incidence decrease of something like 7-percent. Now this is the logic. So it does not really matter whether you find cases or you cure them, they weigh the same in the final calculation. So if you detect 70-percent of the cases that are estimated in a certain country and you cure 85-percent, you at the end of the day cure almost 60-percent of all estimated cases and this leads to a decrease of 7-percent, so I had -7-percent. That 7-percent is a bit flexible in history. Sometimes you'll read 6-percent and sometimes you'll read 7-percent to 8-percent. And these are based on assumptions and model calculations. You can do this very simple arithmetic not only for the targets. You can do it for any case detection rate and any cure rate. Let's take for instances 2004, we are now much further. We are almost 60-percent case detection and close to 85-percent cure rate, so the number goes up. But let's take 2004. I have the number available. So 43.5-percent of all TB patients cures,

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and Mark points out of course that these are not all TB cases because it is HIV positive, etc., but let's take that for a minute. And this would lead to a TB incidence change of -5-percent, so that is the theory. This is the effects [inaudible] several times and we know that because we are all following this year by year and we look at these graphs regularly because we want to see that impact. We want to see these black dots going down and the do not go down. The do not go down yet. So Mario [inaudible] told us yesterday it will go down because the impact will come, the logic will tell us that it has to go down. And we had some promise today. But when you look at the numbers, this is the simple number, the TB incidence change in 2004, the predicted one is -5-percent, the reported one, this includes the [inaudible] Africa, and Soviet Union, so it goes to regions were there have been problems with TB incidences to some extent of well known reasons. So when you include them, there is a 12.6-percent increase and when you exclude those, there is a small decrease in TB incidents. But it is nothing like the predicted number. You can do the calculation, the product of case detection and cure rate for any country. So maybe we're looking at too big a level, too metro. We go to the more specific thing and we take these graphs that we greatly find every year and that very nice report that the people in

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Geneva make for us. This is the calculation based on those graphs. Those are the graphs of frequent success and DOTS detection rate. Okay. So what you find on the horizontal axis is again the same product of case detection and cure rate. We are over 60-percent over our cure rate is a green line. To the right of that line you'll find all the countries that effectively have reached the targets, so this is the double set that Chris was mentioning this morning, so do not take into account the oval. This is just an overall description; and to the left, the countries that have not yet reached that. And you see that there is an enormous scatter. So what you see in this graph is that countries vary a lot with respect of TB incidences change. That is on the vertical axis. Some countries go up to +10-percent almost. Other countries go down to even below -10-percent. But that doesn't seem to be a very strong trend. You can do of course some calculation for that and you can find a very low correlation coefficient for that. And you'll see because there are blue diamonds and there are red dots that this holds true for Africa high and the formerly Soviet Union equally as well as for the rest of the world. Yes, they are going to scatter. So there are a number of possible explanations for this. It may be that the data is not good. That is of course the first thing to think about, no good

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data. It may be that we haven't waited sufficiently long and that the TB incidence change will come in 5 years' time also. It may be that there are other factors that are important and the question is, of course, can we already tell now what is going on and can we adapt to that so that we do not turn a blind eye from messages that may be here or may not be here? So impact, well there has been an impressive progress toward targets and we note the acceleration from 2000 onward. In my interpretation, this has to do with the creation of the Stop TB Partnership and effect. What happens is I think in efforts and organizations is that sometimes you have to go through a mutation to go to a new extra level of ability, of capacity. That has happened with the TB program and it has accelerated. We know that this is going up very rapidly to the 70-percent case detection, so that is impressive, but there has been little change in TB incidence globally, much less than predicted, and also outside the critical areas of Sub-Saharan Africa and the former Soviet Union. And there is an enormous country to country variation. Questions as I said: Reliable data? Do we need to wait longer? Is there no impact? Or are there other factors with a large impact? So what we can do is we can just go to the more micro side of things and try to find countries where the data are reliable and look at countries where we have some timeline. Then we

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can, indeed, deal maybe to some extent with the questions of reliable data and the time you have to wait to see the impact. So that may be then used for what do we need to do looking at two countries. I have without any bias, of course, selected the Netherlands of one of the countries that we could look at and the other one is a country where the KNCV has been and is very active and is now doing a very extensive study precisely to find out the reason why TB incidence does not change in Vietnam. So there are good data. And I start off with my home country. This is what I have, from my home country, borrowed from the KNCV. And there has been very disease-specific mortality registration since 1900. I could, for that reason, also have chosen Wales I think, or Sweden, or some other western European country. They have the same data and they show the same message. And then since 1950 there is morbidity data so the amount of data and the reliability even further increases. And what I tried to derive from that is of course the TB incidence change. And I tried to do that before chemotherapy was around and after chemotherapy was around. And I was helped by famous works of Cal Styblo [misspelled?] and you get numbers for that, you see. In Cal Styblo's book, first edition I think, 1984, thereafter the second edition and added to that in 1991, you'll find before 1940 3.5-

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percent annual decrease in TB incidents before the first World War and between the two World Wars 5.7-percent going down without antibiotics going down in TB incidents. And after 1950, there appears to be an acceleration. Now the speed is -12-percent, so this percent has decreased. The minus sign is in the decrease in the title. Interestingly enough in the book of Styblo, you'll find many other examples. And I picked out a study from the Eskimos. And the Eskimos before the introduction of chemotherapy had a very high death rate and very little change in that death rate, so it was a constant and very extremely high level. And after the introduction of chemotherapy, Styblo reports that there is a decrease in TB incidents of 17-percent, [inaudible] predicts that there can be due to case finding and treatment if you have 100-percent for both a decrease rate of TB incidence of 17-percent. So the messages here are I think that before introduction of chemotherapy in the Netherlands other factors have contributed to the decrease of tuberculosis and in the case of the Eskimos, there is probably a mix. And yesterday, [inaudible] told me that there has indeed been a study comparing and the study that showed the impacts in the Eskimos in chemotherapy looking at a controlled group and there were also substantial decreases in incidence in the controlled group, so the question here is

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what the implementation is. But it points to use that there are other factors involved in these examples. Let's go to Vietnam. What we know from Vietnam that it has been in the target zone since 1996, so if we need to wait for longer than ten years, I am fearing that it may be difficult to [inaudible] girls if you have to wait so long for impact for treatment to take off. It has been there since 1996, for ten years. So reach the targets. And when you look at the notification rates, so look again at the incidents. The incidents have been stable since 1996 and 1997, so no change in TB incidents. And I'm going now to show a slide that is different from the one that Trish showed this morning about Vietnam, and all these slides of data from Vietnam come from the KNCV. This shows that when you look at this distribution of where and what groups of the population, the annual incidence rate goes up and where it goes down. And you see in the group, as Chris presented this morning, you men 15 to 34, there is an enormous increase in TB incidence cancelling fully the beneficial effects that you see in the middle-aged groups in women and men. But these people, these young men, live in remote areas, which makes it very unlikely and other data of the KNCV support [inaudible] that HIV is responsible for that in this country. And the answer that KNCV gave me for what is then the reason, the reason is that "We do not

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know. We do not know what is going on." But the effect is that at the country level being in the target zone for ten years does not lead over that period of time to reduction of TB incidence. So what do we think then of this? Well this is my personal opinion. TB incidence changes downwards. I think there is a lot of evidence that tells us that and I still believe that that is the case, but we should rule out the consequences of that and I come to that, goes down with case finding and treatment. But it can go up- or downwards by socio-economic factors, and that is through mechanisms that we do not really fully understand. And those mechanisms are active outside Sub-Saharan Africa and the former Soviet Union. And what they do so not only in those areas. It's not just eight of the eight and then there it's not very well understood phenomenon in the former Soviet Union, but what it does effectively it is limiting the Stop TB impact. But they are, for TB control, of substantial importance. And therefore, I think that we need to reveal the impact and the nature of these efforts. And we need to address these factors in strategy, in advocacy, and in interventions. How? Well, we have the global plan and we have the WHO recommended Stop TB Strategy. And we listened yesterday listened to reports from all sorts of countries and regions how these six components are implemented, so this strategy is pursued

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vigorously and I think that is right. I think this strategy should be pushed vigorously, but I think that if you believe that other factors are active that it may well be that without the Stop TB efforts, and I include in that abroad series of efforts, maybe not only DOTS, but also other effective mechanisms of dealing with TB. Without those efforts, TB would probably rise because we believe that case finding and treatment leads to a decrease of TB and no one is telling us that the baseline is just [inaudible], the baseline from which you have to pound these impacts can go up. And it is not unlikely that it goes up. So those activities must be extended and improved rapidly in particular [inaudible] Africa, very good reasons for [inaudible] for TB/HIV. There is a very dangerous area for multidrug persistence like in other areas and extreme drug resistance. In that approach, we should always have the patient at the center because you can only reach the impact in the population where you reach the patient because that is the key to the population. And you can only think that it is successful when you have better tools and better service delivery. So those are the prerequisites to affect that. But you see that I have three little dots at the end of the title of this frame. And I think that we should also push socioeconomic prevention. That is not in the standards of

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care, the heart of the matter what we knew now in the implementation, but we should also reach out to the other side of prevention. We should not turn a blind eye for components that are important that influence TB incidence. And therefore, I think we should try to surface the impact of the socioeconomic factors on TB control and we should study them aggressively in order to reveal the precise nature and transform that knowledge. It will take time. Transform that knowledge to interventions. And then we have to position that socioeconomic prevention for TB in the overall Development agenda. And to do that, we can only reach that if we Foster Stop TB leadership through collaboration. So this is the title a bit extended of my [inaudible]. The Span of TB Control should not only include case finding and treatment, but also socioeconomic prevention to eliminate the global emergency, because at the end of the day there is just one question that requires an answer. Thank you so much. [Applause].

DR. L.S. CHAUHAN: Thank you Dr. Elzinga for such explicit presentation. So any additional comments, remarks or questions?

MALE SPEAKER 2: Hi sir, this was excellent. Thank you for a very thoughtful and provocative overview. I just wanted to jog my own memory, help me here, did the Eskimo

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data, is that the [inaudible] study relying very heavily on preventative therapy at a population basis, because if that's the case, I think there's a hidden nugget in there because as a community, do we have underutilized that as an intervention tool? But I just want to make sure that that's the type of information that you were eluding to.

GIJS ELZINGA, M.D., Ph.D.: I took this number for Styblo's book. And Styblo's comments were "This number you can expect maybe, maybe because you can reach out so intensively to the Eskimo population that you can reach 100-percent.

MALE SPEAKER 2: Right.

GIJS ELZINGA, M.D., Ph.D.: That was the comment.

DR. L.S. CHAUHAN: Yes, please.

MALE SPEAKER 3: I have no comment except that I agree fully with what you said and so it's really an impression to see that all these years spent in TB control you essentially give us what actually most of us are trying to do. So for that, I think I fully agree with you. I just wanted to thank you on behalf of the World Health Organization and all my colleagues that have worked with you for the past, as you said, 13 years because you have been inspiring to all of us and you have been able actually in many cases to push us further and to stimulate further

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research, further analysis, and for that I think you should be congratulated by all of us. Thank you. [Applause]

DR. L.S. CHAUHAN: Thank you sir. Thank you. I think just [inaudible] difficult task. Actually, the two important issues presented in the evening session, the first half and the second half, they have two different kinds of presentations. First we had for the Stop TB Partnership Strategy, the two components and [inaudible] communities and getting health care providers in that discussion and then in the last session we have two groups, the Update groups and the Working Groups. So the presentations are so far [inaudible] there. The Advocacy Communication [inaudible] Association [misspelled?]. This has clearly indicated that we need to scale up these activities if we want to achieve the set global targets of case detections, as well as the cure rates because without involving community, without involving patients perhaps it's not possible at all. So we have to think now on those lines. And as said by Dr. Paul, that we need to give the same importance to the ACS [misspelled?] and activities as we are talking about regarding the labs [inaudible], so at the same time we should talk of the [inaudible] activities. These need to address not only the case setting, but they need to involve the patients and address all those issues which are really

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important in the patient participation. That's important. So we have to think of those plans. The presentations naturally also have involvement for all of the care providers when we talk about, then we have to think about that it's not only that [inaudible] an elevator system [misspelled?], but we have to think of the other providers also. For example, in India we have different, I don't [inaudible], in different other countries they have their own system of medicine. We have [inaudible] systems now and then with Pakistan, my fellow from Pakistan, he raised the question of the involvement of traditional healers. So all have to be taking into account. And when we talk about community participations without the participation of all these providers which are a part of the community in whom the community have their faith. Without their involvement, perhaps we cannot think of the involvement of the community and simply we are talking that if we are not involving these people. Yes, what should be the area of their involvement? That has to be thought and that needs to be taken into consideration at the local level only. Coming to the last of these presentations of the Partnership Working Groups, perhaps there's update on the Childhood TB and the on the new tools are really, really impressing. And the information on [inaudible] of the new tools very shortly for which we have

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to be ready to plan and then to implement those is good news and similarly all countries need to work and for the Working Group on pediatric TB. They have to assist the countries in designing the programs for pediatric TB so that it becomes a part of the National TB Program. Yes, the last part. It's doesn't mean that we should feel discouraged that we are not reaching what we desire that the impact is not that good somehow. Because there are a number of explanation given already, but one of the explanations perhaps is that in these last ten years perhaps it was an extension of the DOTS program was there and now in most parts of the country the DOTS expansion has already occurred. So now, the global impact, then we can [inaudible] what can be exceptional of Vietnam [inaudible] from 1996; they're achieving those targets, but why there's no change in the incidence, but they need to be elaborated and discussed or some kind of study needs to be carried out there to find out what are those reasons. But the good news is that if, as it is said, that if we think of eliminating socioeconomic [inaudible] and what we think of achieving TB targets. The socioeconomic part has also been taking into consideration and implementing the Stop TB Strategy now [inaudible] as a comprehensive view. All components are to be taken care of while the present and by the implemented activities. Perhaps that will help us to

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achieve our argument objective that the TB then will after some time, if not in 2015, will by that time have achieved [inaudible] but after sometime after 2015 we can see that now we've sent out a global emergency. TB is not a global emergency. And let us go out with this positive thinking only. And if there is anything that anybody would like to add to this, then... No, nothing.

Okay then, I would like to thank all the speakers [applause] and the other participants. Thank you very much.

And we will break for the day and tomorrow at 8:30 perhaps all the sessions will start. Thank you very much.

[END RECORDING]

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