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37th Union World Conference on Lung Health: Global Responsibilities in Investing in the Health Workforce
November 1, 2006

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[START RECORDING]

ASMA EL SONY, M.D., Ph.D.: Good evening, ladies and gentlemen. The director of Stop TB WHO Dr. Mario Raviglione, Dr. Marcos Espinal and Dr. Nils the executive director of the Union. Dear colleagues, good evening.

In the name of those who face the greatest challenges of global burden of disease — tuberculosis, tuberculosis/HIV, tuberculosis and MDR, XDR and other debilitating lung and public health problems, I greet you. For those who experience critical shortages of human resources, those who have fewer than 2.3 doctors, nurses and midwives per thousand people, for those being let down by the inability and indecisiveness of those in charge to tackle the human resources crisis, I greet you and welcome you to the Paris conference. My name is Asma El Sony; I come from Sudan, the largest country in the Africa and one of the least developed, very rich with resources and burdened with conflicts. I am among the team that launched a successful MTB program in the [inaudible] region with the Norwegian Heart and Lung Association as our development partner. As our main technical advisor for the WHO and the Union. Our work has been one that [inaudible] we [inaudible] with a model and experience and initiated comprehensive lung health approach project with our partners.

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Ladies and gentlemen, if poverty cannot be eradicated without a sound macroeconomic context, breaking the shackles of healthcare cannot be achieved without stronger focus on human resources. Most economists agree that it is a nation's human resources, not its financial capital or material resources that ultimately determine the [inaudible] and pace of its economic and social development.

Human resources is crucial and key to the success and delivery of the MDGs to combat TB, TB/HIV/AIDS and malaria and to intensify the response on MDR and XDR-TB. To reduce child mortality and improve maternal health, human resources are the most significant constraint on the free-health-related MDGs. Ladies and gentlemen, we need to have the right people in the right place at the right time to deliver accessible, equitable, effective and affordable services. We need to face the [inaudible] challenges facing the health systems and global workforce.

The global achievements of case detection of 60-percent and a treatment success rate of 83-percent in a decade is a great achievement by countries, the World Health Organization and the Stop TB Partners, despite the variation in progress among different countries. The establishment of the Global Tuberculosis Monitoring and Surveillance System by the World Health Organization in the 1990s is another outstanding achievement that enabled us to have insight on

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progress and trend over time. We are fortunate again at this date to have financial mechanisms in place, such as those at the Global Fund, to allow countries to receive funding for health system infrastructures, supplies and drugs to compliment their own investments in health. However, we have at the same time a human resource crisis present in many countries, and that is jeopardizing the implementation of healthcare programs. The highly indebted poor countries — the HIPC program was launched by the multilateral financial agencies in 1996 to alleviate the debt of poor countries and the MDGs declaration, which has been adopted by international forums as in the United Nations General Assembly, the [inaudible] that the two major agendas and their joined implementation — I repeat, joined implementation — cannot be over emphasized. Moreover, the HIPC process is making fresh resources available to the under-financed health sectors, as it requires that some 20-percent of resources made available to the eligible countries be directed to health sector.

The health-related MDGs will not be achieved if countries cannot successfully address the issues of human resources. There is a lack of qualified health personnel due to the limited capacity to produce them and to retain those who have been trained and, in the case of Africa, is due to the losses from AIDS, TB and malaria, irrelevant and outdated education mechanisms and content, poor capacity to regulate

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profession practice, insufficiently attractive incentive system and ineffective management policies and practices. So the situation is critical and we need to recognize and act urgently.

Ladies and gentlemen, the performance of the health sector will only be good as the performance of the men and women who provide the services from the DOTS supervisor, the admissions staff to the more specialized health personnel. Why this has long been met with systematic neglect by the policy makers, by donors and by countries remains to be questioned, explained and addressed. Stakeholders, including the TB patients, health providers and governments must be involved in the entire planning process to facilitate the human resource development and planning. That is, everyone must be involved. Whether the explanation lies in their complexity, their multisectoral nature, their political content or their lack of ready-made solutions, the fact is that health workforce issues have been overlooked by countries and by the international community until now. We must take the matter more seriously and with more responsibility. The World Health Organization, the World Bank and the International Organization for Migration (IOM) has developed a full working program to produce and disseminate sound policy advice. Again, the United Nations Educational, Scientific and Cultural Organization, the

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UNESCO, must start a consultative meeting on improving collaboration between health professionals, governments and other stakeholders in human resources for health development. Strategies for human resources for health and development have been developed. The take-up and implementation by countries is weak. Countries and governments need to recognize that they have a crucial role to play.

Ladies and gentlemen, the human resource development is a process, it's not a blueprint, and will be successful only if the main stakeholders participate in it. Dumbed-down policy development simply does not work in this area where professional not only value their autonomy, but have the social and political capacity to defend it. Some countries have succeeded in adjusting their workforce to the health and service needs of their population. That may be a way out for those who look for immediate benefits, but the long-term reward of health workforce that does the right things and does them well is likely to be well worth the investment and is the duty of all of you present here, all of you important people in this important meeting.

Lastly, let me share with you three lessons regarding this which I have learned over the years. First, for health to have a transformative effect, a transformative effect on people and communities, the prospect of its realization must galvanize energy, ingenuity and resources from within the

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poor communities we serve, from us poor communities to really have [inaudible] participate and actively contribute, invest money and material resources and seek meaningful solutions to problems. It will not do to simply deliver health services to passive populations, even if the availability of health services is a necessary condition to maintaining good health.

Second, the development of effective human resources for health systems is constrained by various elements of the health systems. These constraints may effect the operation of the health system itself, but the broader economic, political and social systems also have important impacts. Establishing a nurturing environment whereby we can keep existing personnel and attract those overseas is paramount to stem the tide of the devastating phenomena of the brain drain.

Thirdly, funding may be an important issue, but how those funds are used may be of equal importance. If the focus is on health outcomes and the prosperity of one's nation, self-destructive and selfish practices such as deliberating losing those [inaudible] on political or any other irrelevant basis must be eliminated. Local partners and governments have a moral duty to uphold the interests of those they serve above their own. Thank you.

[Applause]

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May I call upon Marcos? Oh, okay. Right, so may I call about Professor Michel Kazatchkine, the ambassador of France in the fight against AIDS and communicable diseases, to read the message from the President of the Republic of France?

[Applause]

KAZATCHKINE MICHEL M.D.: I shall be speaking French. [French Spoken]

[Applause]

ASMA EL SONY, M.D., Ph.D.: We thank Dr. Michel and the President for his speech. May I call upon Dr. Marcos Espinal, the executive secretary of Stop TB, to introduce Dr. Jorge Sampaio, the UN secretary general Special Envoy to Stop TB?

MARCOS ESPINAL, M.D., Ph.D.: Good afternoon colleagues. My name is Marcos Espinal. I'm an executive secretary of the Stop TB Partnership, a global coalition of more than 500 partners around the world, all united to fight TB. This afternoon I am delighted to introduce the UN secretary general Special Envoy to Stop TB, Dr. Jorge Sampaio. Dr. Sampaio was appointed in May 2006 as the first UN secretary general special envoy. Dr. Sampaio's main objective is to build awareness to heighten TB into the political and developmental agendas of our national and international leaders. If we want to meet the Millenium

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Development Goals, we need to insert TB into the developmental and political agendas. We cannot tolerate TB to be neglected anymore.

Dr. Sampaio, in 1995, was selected President of Portugal and was sworn in as President in March 1996. He was re-elected five years later in 2001. During the last decade, President Sampaio has made important contributions to several issues related to European affairs, including substance abuse, HIV/AIDS, human rights and independence for [inaudible].

Today, I am pleased to say after a few months that special envoy has already made impact. In June 2006, he was introduced as a special envoy at UNGASS, the United Nations Global Assembly on AIDS. At the WHO, 66 regional committees for Africa — President Sampaio delivered the main keynote and was welcomed by all the ministers and reminded everyone that TB has a long way to go still. Last month, President Sampaio met with Mr. Bill Clinton, Former President of the United States, at the Clinton Summit to really remind all the world leaders that were at the Clinton Summit that TB cannot continue to be neglected.

On behalf of the Stop TB Partnership and the Union, I'd like to welcome President Sampaio, not before apologizing for his absence physically. President Sampaio underwent surgery for retinal detachment and he was not authorized to

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travel and take a plane; however, I am pleased to say that we hopefully have President Sampaio now live via video.

Is President Sampaio there?

DR. JORGE SAMPAIO: Yes.

MARCOS ESPINAL, M.D., Ph.D.: Mr. President —

DR. JORGE SAMPAIO: How are you, Marcos Espinal? Nice to see you.

MARCOS ESPINAL, M.D., Ph.D.: Nice to see you, too. We are all excited that you are able to join us today. I just introduced you. I'm not going to speak again. I'm going to pass the mike off to you. Thank you for joining us on behalf of the Union and the Stop TB Partnership and the Global Community on TB.

DR. JORGE SAMPAIO: First of all, I heard your presentation. I'm very happy that it is possible to at least be indirectly present at this important conference. I am so sorry I cannot attend, but Marcos explained the reasons and I hope that next week I will be in form to continue my activities. Let me greet the president of the Union and her for very interesting speech, which I had the opportunity to hear. Let me greet the work of the Union throughout so many decades and remind us all that we have this international day of TB on the 24th of March, 2007. It is the 125th anniversary of the discovery of the bacillus [inaudible] and I think that we could really, worldwide, have a major internationally

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based – nationally based also – campaign to definitely focus and continue the work that the WHO and the Stop TB Partnership and all the other agencies and workers throughout the world. Let me greet in a very modest way, in a very touching way, all those who suffer from TB. The president has just said it in very important words, and I give my solidarity to her words and, of course, to those who suffer. This is the main reason why we have as a theme for the International Tuberculosis Day on the 24th of March next year "TB Anywhere is TB Everywhere." We should have this motto in our heads and help all those that are investing to stop TB, all those who treat people to stop TB, all those who involve the community to stop TB, and to the communities and those who are fighting now the extreme threat to stop TB and who donate the skills to stop TB. For me, it has been an honor and I'm really very sorry that I cannot be present, but I do hope that modern technology can at least give you my speech. I did my best to address the main topic of this conference. It is a major topic because, as you mentioned, at the WHO Regional Meeting in Africa in August, all the ministers of health in bilateral meetings, whom I had the pleasure to meet, really what their focus was, was of course money is necessary, of course new vaccines, of course drug [inaudible] and all that, but we don't have the people at the community base. All the experiences in Africa or elsewhere that have,

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indeed, prepared people to be those who attack at least the combination of HIV and TB and TB, per se, we will obviously achieve the results, which Marcos Espinal has pointed out, the Millennium Development Goals. I wish the conference all the best. I will be [inaudible] next week I hope with you and others somewhere else in the world, but I wanted you to know that all your endeavors, all your efforts – I give my solidarity to all of that and now, since I have retired, as you have said, from a presidential office, I think that I am totally available to continue and to help this major work.

We cannot forget that 5,000 people die per day from TB. We cannot forget that things are getting worse, although we have very good news, as you will see in my speech. My best greetings to you all, my best greetings to the president of the Union, the secretary general and, of course, to my good friends Marcos Espinal and Mario Raviglione who are there at this moment. Thank you very much.

[Applause]

MARCOS ESPINAL, M.D., Ph.D.: Thank you very much, sir. We are delighted to have now the speech of President Sampaio, Global Responsibilities in Investing in the Health Workforce for Sustainable Health Systems. We thank President Sampaio for announcing the theme of World TB Day, "TB Anywhere is TB Everywhere." Thank you.

[Applause]

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Can we have the video please?

DR. JORGE SAMPAIO: Dr. Asma El Sony, president of the International Union Against TB and Lung Disease, Dr. Nils Billo, executive director of the delegates of IUATLD, ladies and gentlemen, dear friends. First of all, I would like to say a few words praising the miracles of technology. I felt really very sorry when I realized that I couldn't be with you on this very special occasion due to the expected retinal detachment surgery that prevented me from flying to Paris. I normally obey what doctors say. But in the end, I am most happy to have the opportunity to address the conference and to be present somehow thanks to the fantastic means of online communication.

Let me now underline that, as I was extremely pleased to accept the kind invitation to take part in the opening session of current 37th edition of the Union's Annual International Conference. May I extend to you all my warmest greetings? I was really very much looking forward to meeting you and to introducing myself.

As you might know, the United Nations Secretary General, Mr. Kofi Annan, has appointed me as his first Special Envoy to Stop Tuberculosis. It is, indeed, in this capacity that I am here today. Above all, my role as Special Envoy to Stop TB, as I see it, aims at helping in achieving the Millennium Development Goals, the MDGs, to have and I

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quote "halted and started to reverse the incidence of TB by 2015," as well as the Stop TB Partnership's 2015 targets "to half the prevalence and death rates from the 1990 baseline." This is why I consider that my action has to focus on giving additional political visibility to this sometimes neglected disease, on helping to generate public awareness about TB, and on continuing to persuade world leaders to play their part in fully funding and implementing the Global Plan to Stop TB 2006 to 2015.

My friends, we must not, after all, forget that TB is an emergency. It continues to kill 1.7 million people each year or 5,000 men, women and children every day. Nevertheless, we are talking about a curable disease. How could one refuse to become the spokesman for this pandemic and to fight against this civilizational shame?

Let me now, ladies and gentlemen and dear friends, share some thoughts with you on the subject I was asked to address here today. This subject is Global Responsibilities in Investing in the Healthcare Workforce for Sustainable Health. May I divide my presentation into three main parts? I will begin by outlining the progress made regarding the assumption of responsibilities in global health, particularly in the fight against infectious diseases such as HIV/AIDS, malaria and TB during the last years. Secondly, I will try to examine the problem of the healthcare workforce,

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particularly in low-income and high-burden disease countries. Thirdly, I would like to focus on some strategies that could better ensure a sustainable health policy, regarding its human component, in order to meet the MDG and the Stop TB Partnership's 2015 targets to control TB.

Let's get to the first part, in other words, the progress made in assuming global responsibilities in health, a major achievement. Health is a part of the global agenda. I really think that everybody will agree that today our issues are clearly on the global development agenda and they are seen as an increasingly global public goal – this is the good news. In the increasingly globalized world, [inaudible] migrations and fast movements of people at world-wide scale, public health issues, indeed, call for domestic policies, but also require international measures and an integrated regional approach as events overseas affect each country's health. Communicable diseases are a most obvious example of these external aspects of public health. That is, no single country can alone prevent or contain communicable diseases in order to protect the health of its population. This increasing awareness of cross-border and global issues in health is also expressed in the growing attention paid to health by non-health-sector entities, such as the World Bank, the United Nation, the European Union or the G8, as well as by the private corporate and charity sectors, such as the

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Bill & Melinda Gates Foundation, the Clinton Foundation, and the Global Business Coalition Initiative.

Another important point concerns progress achieved in mobilizing resources. Apart from commitment to further support for the Global Fund to Fight AIDS, TB and Malaria, the international community is engaged in developing innovative financing mechanisms, such as the International Finance Facility and the Unit Aid [misspelled?], which — as you know — in an international drug purchase facility being established by France, Brazil, Chile, Norway and the United Kingdom, funded by an international [inaudible] solidarity levy. However, regarding TB, there is still much to do to fully fund the Global Plan to Stop TB 2006 to 2015. Additional resources have to be mobilized. Despite the remaining problems, I do think these examples are obvious indicators of health moving up the global agenda and, thus, being considered part of a minimum for a decent world.

In my view, we have good reasons to be optimistic. At the international level, there is a clearer political commitment and a strong public awareness and more resources are available. These more favorable conditions give renewed impetus to the fight against infectious diseases, but it also creates added responsibilities with a view to producing better results. Our shared aim, dear friends, our common commitment and our motto has to be to do more, to do faster,

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and to do better — more, fast and better — since emergencies like TB cannot wait.

Now let's get to the second point, the critical problem of the healthcare workforce, particularly in low-income and high-burden disease countries. Let's begin by taking two examples, TB and the African Region. Firstly, as you all well know — but probably not the average person — TB is an affordably preventable, curable disease. The medicines that cure TB cost about $12 per case of illness. Secondly, let me remind you that that African Region has the highest TB per capita burden. Although having only 11-percent of the world's population, Africa contributes approximately with 25-percent of TB cases. For example, in 2004, about 2.3 million people fell ill with TB in the African Region where TB incidence is rising at over 4-percent a year, fueled by the HIV epidemic; 34 of the 46 member states in the region face an estimated TB prevalence rate of 300 per 100,000 in the population, and 9 countries are among the 22 global TB high-burden countries. Now, what is my point? Apparently, TB could be thought of as a not-too-difficult global health problem, as it is an affordably preventable, curable disease. But in reality, it is quite a complex one; therefore, we can ask why. It is mainly because of all the problems related to poverty, malnutrition and sanitation shared by all developing countries, but also because of the lack of infrastructures.

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By infrastructures, I mean physical, institutional and human components of the healthcare system. Because of infrastructure gaps, millions of people die every year.

Let me concentrate on the human resources component, the blood really of the entire healthcare system. Of course, there is a severe shortage of physicians, nurses and healthcare workers in many places around the world. I ought to emphasize that the crisis in human resources for the health is one of the greatest challenges for TB control and for the Millennium Development Goals in general. To overcome this shortfall, action is dramatically needed at every level of the health system — programs, partnerships and global stakeholders.

Let me tell you a story. I had the opportunity to attend a WHO African Regional Committee last August in Addis Ababa where I met several African ministers of health on a bilateral basis. If I had to summarize shared remarks, I would say that they all pointed out the lack of human resources at every level as a major — if not the main — problem. In this respect, I particularly remember how a minister from a big country put it bluntly to me, asking me if I knew that there were more doctors in a large hospital in Lisbon than in all his country with twice the population of Portugal and 10 times bigger. Moreover, they all complained about lack of appropriate training and asked for help in this

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regard. They all mentioned difficulties in recruitment and retention because of disincentives of the work environment. All complained about the brain drain that draws away health professionals. I recall this personal experience because, in my view, it gives quite an accurate picture of the global health workforce crisis going on, particularly in low-income, high disease burden countries. As you probably know, the shortage is about 4.3 million healthcare workers of all sorts. But in Africa, this problem is much more acute because while they have about 25-percent of the global disease burden, only 1.3-percent of the world's healthcare workers actually work there. These figures show quite well how the global burden and resources are unequally distributed with huge disparities. We also find the same inequalities within the countries themselves between urban and rural areas, as existing resources tend to be clustered in the urban areas. This is the bad news.

Now I would like to end this point, again, with some good news. The good news is the success stories about ways of overcoming these problems. In this respect, may I briefly recall the Ethiopian experience in training family healthcare people? Firstly, Ethiopian policy makers have identified main areas of action — for example, maternal health, child health, HIV, TB and malaria — and decided to focus on primary healthcare, particularly in the rural areas. Secondly, they

made a double decision to concentrate training in low-level and mid-level health extension workers and to train as many as possible. With this strategy, they were able to train 9,900 people in two years and deploy them. The whole plan aims at achieving a total of 30,000 trained health workers over the next two years. How could they produce such stimulating results in so short a time? [Inaudible] when I heard from the responsible people it was by a bottom-up approach. They did it by a bottom-up approach that was realistic, but ambitious and based on the use of existing assets. For example, instead of starting by building nursing schools, they used existing technical and vocational training centers so that it was like a shortcut. They invested in outcomes of infrastructure in tangible ways, banking on increasing the horizontal caring capacity of the health system. They also based theirs strategy on the will of individual communities to develop a sense of ownership of their own infrastructure, on engaging people in achieving improvements in order to guarantee the sustainability of health systems. I think all of us can learn from this Ethiopian experience. Of course, there is a huge difference between our developed countries and countries in Africa, Asia or South America, as well as between countries within these regions, but solving global health problems means sharing

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experiences and designing and implementing common strategies that are better to overcome gaps and the challenges we face.

Now let me go back to the third part. If you remember, it relates to the strategies that could better ensure a sustainable health policy regarding its human component. In order to meet Millennium Development Goals, the MDGs, and Stop TB Partnership targets, there is indeed a critical need to strengthen the workforce to improve global lung health.

Let me start by stressing that the Global Plan to Stop TB 2006 to 2015 outlines increasing human resources capacity as a priority TB-control activity over the next 10 years. Let me tell you and remind you there is a funding gap of over $30 billion United States dollars for the Global Plan and a strong need for increased funding of global TB control generally in Europe, as well as in Africa. But tackling the human resource crisis goes beyond TB control alone. To address this problem, at least three aspects have to be considered. Firstly, it requires the implementation of human resource development strategy in the public health sector, i.e. more attractive career and salary structures and improved training, of course, as well as the establishment of partnerships with communities and all healthcare providers in order to use and engage all available human resources.

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Allow me to emphasize clearly that, in my personal view, equal access to health for all is a matter of human rights and only democracies offer rights. By this I mean that there has to be national health infrastructures so that we can make sure that poor people have rights and have access to these rights. Therefore, an overall human resources strategy in the health sector has to be designed by governments who are really responsible for it. This is to say that the private and corporate sectors, NGOs, charities, associations and foundations have, indeed, an important part to play in the health field, but that action, in my view, has to occur within public policies defined and coordinated by governments.

Secondly, it requires the enforcement of international action on health education and training. Health education remains, for me, a critical point because it is the basis of everything, a way of empowering people in preventing health problems. Education in health is, in a way, as important as treating diseases.

Now, regarding training — needless to stress, there must be better coordination of international actions and initiatives to avoid overlaps and gaps and to ensure that they meet real needs of people. In this respect, I do think that national health authorities and national health policy makers have a most important role to play, not only in

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strengthening the feeling of ownership, but also in ensuring the long-term sustainability of efforts and of the results.

Thirdly, it requires a broad, multilateral framework on migrations and for the cross-border movement of people preventing the brain drain from poor to rich countries. As is well known, this problem is particularly acute in essential social services such as education and health. While domestic policies to increase the incentives and opportunities for skilled labor to remain at home are an important part of the solution, it has also been suggested that the industrialized countries should coordinate their hiring policies with developing countries facing such skill shortages in essential services. Dear friends, measures to stimulate a process of a somewhat skill circulation such as training, tax incentives to stimulate the return of skilled migrants to their home countries, et cetera, et cetera, could be considered because it would benefit both industrialized and developing countries. The former could still continue to hire skill labor from developing countries. The latter could also benefit from this circulation without being deprived of the [inaudible] of workers that they need most and without suffering the loss from the investment in training. The adoption of a kind of, let me say, code of good practices for healthcare worker migration could be a useful tool to prevent the permanent brain drain from poor to rich countries and to

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stimulate the return of the skilled migrants to their home countries.

Now, dear friends, thank you very much for your patience until now. Let me end with some final remarks. As United Nations Secretary General Special Envoy to Stop TB, I am committed to developing new ways of supporting the fight against TB. To ensure that my role is productive, I will be working closely with the WHO and the Stop TB Partnership, which are heading the fight against TB. But I will not neglect regular, direct contacts with both national and local authorities, private and public partners and with the civil society, non-governmental organizations and individuals working together to achieve, ultimately, a world free of TB. In this regard, your own input, dear friends, is invaluable. You can count on my committed efforts to increase advocacy to focus United Nations' attention to TB control in general and TB control in the context of the universal access principle. I will spare no effort to continue to advocate the mobilization of additional resources for TB control, to reinforce international and national commitments for TB control, and to ensure that money goes to those in great need. Of course, much has to be done in order to reach out to political leaders to prioritize TB control and address the human resource problem. TB is still not a number one priority in international, political and development agendas.

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There is a need to raise the profile of TB and to de-stigmatize TB. There is a need for enhanced collaboration to bring all players in the TB control field together, together to make a cohesive effort in the fight against TB. There is a need for a strong TB movement to answer the TB crisis, equivalent to that for HIV/AIDS. The International AIDS Society, IAS, is the world's leading independent association of HIV/AIDS professionals. I do think a similar movement for TB is needed. Count on me to support your efforts in order to reinforce the Union — a way of calling on strength through unity. Thank you very much for you kind attention.

[Applause]

ASMA EL SONY, M.D., Ph.D.: An important speech from an important man who was the head of the Student Union in Lisbon University, who fought as a President for human rights and democracy and who is the right person to fight with us for a world free of TB. May I call on Dr. Mario Raviglione, the director of the Stop TB Department?

MARIO RAVIGLIONE, Ph.D., M.P.H.: Dear Asma, Dear Nils, Marcos, Winston, cher Michel, President Sampaio perhaps still connected perhaps, colleagues and friends — on behalf of the World Health Organization, I am happy to welcome every one of you TB controllers, TB researchers, financial partners, community and patient representatives, NGOs, government officials — all of you. Every year we convene

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here in Paris to exchange ideas, to share information, to learn from each other. This is ever more necessary now in 2006, given the recent threat of XDR-TB. We at WHO have been working with our member states — behind the scenes sometimes and leading from the front on other occasions — in developing the necessary responses and policies that, in the end, must strengthen, one, our TB control and care efforts with what we have available and, two, must stimulate much stronger investment in research to have the better tools that we all want to have available.

Ladies and gentlemen, the theme of this year is Strengthening Human Resources. It resonates today strongly with the challenges that we are facing. We need more people, many more people, as you just heard from President Sampaio, and more people who know more. We need quality and we need quantity. What we especially need is young professionals, young nurses, young doctors, you policy makers and young community leaders who can fuel the innovations and the transformations that are necessary to create those breakthroughs that will deliver, in the end, life-saving cures and universal access for all suffering from TB in this world. Yes, universal and equal access to the best available diagnostics, to the best treatments, to the best preventive measures, since our aim is only one and is that of curing people, avoiding deaths and relieving suffering.

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Talking about the young health workforce, it is my pleasure to introduce to you one of my young colleagues, Abigail Wright, who — at the World Health Organization — works on TB drug resistance and has been instrumental in the last few years in developing MDR-TB surveillance policies and, more recently, in the efforts to face XDR-TB. Abigail joined us five years ago and has proven to be an asset to WHO. She is one of our young staff that we nurture and that will carry — we hope — the torch for the decades to come. Abigail, if you want to join me —

[Applause]

ABIGAIL WRIGHT: Thank you, Mario, for that kind introduction. I am honored to be with all of you here in Paris to open the 37th Union World Conference on Lung Health. When Nils asked me to spend a few minutes discussing my commitment to public health, initially I panicked wondering what I could say to a room full of people who have committed their lives to this field when I have been working in public health for less than a decade. But, I suppose that is the point; I represent the new generation.

I took a rather circuitous route to public health in the first place by way of studying comparative literature. I moved to the Indian subcontinent at 19 to study Sanskrit. While there, I lived with a family, a family of 10 people in a one-bedroom house for almost 3 years. They were the most

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profound years of my life. I witnessed the completely preventable deaths of two members of the family I lived with and the death of three women in my village in childbirth, all because healthcare was not easily accessible where we lived. During that year, I decided that art and literature were not possible without life, education and livelihood. I decided I could always read and study literature, but I needed to spend the majority of my time serving the public in a very practical way. I was a fundamental decision, and it was about responsibility. I needed a job that would serve people and improve lives and the more lives, the better.

I could have worked in water infrastructure, public education, city planning or economics; it almost didn't really matter. But I chose health because I witnessed its absence and it had an impact on me, so the decision was very simple. I started working at WHO in the Stop TB Department in Drug Resistance five years ago. While working at WHO, I've had the opportunity to work with many of you. At my first Union meeting, I was almost beside myself with shock at all of the dissent within the TB community. Different agencies and different people have different views on TB control should be implemented. I figured it was difficult enough to raise the profile of one disease — why should the believers fight amongst themselves? But what I eventually realized is that dissent arises when people are passionate

and because there isn't simply one answer. This was an aspect of dynamism. Dynamism and very effective coordination of end goals is what has brought TB very justifiably to the front of the platform, and, as a result, exciting movement is taking place. I'll give you one example. When I started at WHO, treatment of MDR in the public sector was still controversial. At the start, there were five DOTS-Plus pilot projects and now 40 countries are treating MDR-TB according to international guidelines. The goal is to treat 800,000 people and more with MDR-TB over the next 10 years. Several countries are now reporting treatment outcomes almost as high as those for susceptible TB – if that isn't inspiring, than I don't know what is. The possibilities in improving global health have grown infinitely in the short time that I have worked in this field with the advent of new funding opportunities and new partners and new commitments to getting better drugs and technology to patients. But increasing opportunities do, however, make the task more complex. It means that we have to work even harder and organize ourselves and our systems more effectively than before to deliver services to people. A lot of the work that needs to be done is hard, it is not glamorous, and the reward is not immediate. But it is what we do. I am inspired by the commitment of the people I work with on a daily basis, but we need more of these people if we are going to do what we say

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we're going to do. We need to figure out a way to find those people, train and mentor those people, and put and keep them in the right places.

My choice of public health was arbitrary. The work I do may not be as enjoyable as the study of literature, [chuckles] and there will always be times when I'm tired and I'm frustrated. But when people work together and public health policy is implemented and it works, it certainly is a beautiful thing. That is what keeps me motivated. In the future, I will remain committed to public health and to TB. It doesn't mean that I will always work in it, but I will continue to serve the public and I will be a better public servant for my time spent in the TB community. Thank you.

[Applause]

I'd like now to introduce another young colleague, Heather Ignatius from the TB Alliance to come and speak.

[Applause]

HEATHER IGNATIUS, M.A.: Thank you, Abby. It is an honor to be here. My name is Heather Ignatius, and I work in the Policy Department at the Global Alliance for TB Drug Development. I'm also the secretary for the New Drugs working group of the Stop TB Partnership.

I've been asked to speak to you today about why, as a young person, I have chosen to work in TB. As the youngest person, I think, on the panel, I hope that provides a truly

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unique experience for you. It is widely recognized that youth offers an idealistic, optimistic and hopeful outlook on life. I would like to share with you a quote from the American writer Pearl Buck. She write, "The young do not enough to be prudent and, therefore, they attempt the impossible and achieve it generation after generation." Since I can assume that I have not been invited here today to impart the vast wisdom of my experiences about the fields of TB and global health, I will offer you what I can as a young person – unabashed idealism, optimism and hope for our field.

I was a complete newcomer to the health field, let alone to TB when I started at the TB Alliance two years ago. The Union Conference in 2004 was my first real introduction to this community, and I was struck by how small and how cohesive it seemed. This is an appealing concept to someone on a mission to save the world. It means that each one of us makes a difference; every on of our efforts is essential and crucial to the success of this endeavor. However, as a person who grew up steeped in a culture of technology in California's Silicon Valley, the one thing that I couldn't help but notice was that new technologies for TB are clearly absent. I often hear the phrase, "TB is curable." But for so many people suffering from TB, that is simply not the case. We are fighting a disease this millennium with last millennium's tools. Despite our best efforts, many people

suffering from TB do not receive treatment. In many countries, healthcare systems are overwhelmed by the amount of time and effort needed to treat TB with the tools we have today. The Global Plan to Stop TB acknowledges that without new diagnostics, drugs and vaccines, it will be impossible to achieve our goal of eliminating this disease as a public health threat. The good news is that we are closer today than we have been in decades to having new technologies to diagnosis, treat and prevent TB. This is a critical juncture for our community in which the investments of recent years will come to fruition only if we can secure sufficient resources and commitment, both political and financial. We must keep our eyes on the prize.

I would like to share with you an experience that I had while coordinating the development of the New Drug section of the Global Plan last year. On a teleconference of the committee that was writing, the following language was proposed. "It is conceivable that the course of TB therapy could be reduced even to 10 to 12 days before 2050." A few members of the committee took issue with this statement, pointing out that while the plan should be aspirational, it should also steer clear of hyperbole if were to be credible. I was inspired by the response from one of the members of the group; he said, "Hyperbole? No. This is reality. In fact, forget 2050 — we will have a regimen that short long before

then." It is this spirit of determination that fuels innovation. For those of us who have grown up in the age of technology, one thing seems certain – innovation is a product of time and dedication only. We have great faith that innovation will come, that no obstacle is insurmountable, and that our ability to succeed is dependent only on the amount of resources and dedication that we are willing to commit to our endeavors. Part of that is youth talking, but there is something to be said for a optimistic and determined attitude leading to a self-fulfilling prophecy. As Pearl Buck noted, "Some of the greatest problem solving has been accomplished by people too uninformed to be discouraged." Sometimes the biggest obstacle to a breakthrough can simply be our mindset.

So based on my experiences in my short career in global health, I will end with what I accept as truth. I know that in my lifetime I will see eradicated. I know that the people in this room will be critical to the achievement of that goal. I know that our small, but growing community, committed and working together to find solutions can make a major impact on the health of so many. Perhaps it is that my optimism is a byproduct of communicating these messages to policy makers or perhaps it naiveté, but I hope that it helps some of you remember the reasons why you initially chose this field as well. Thank you.

[Applause]

I would also like to invite Nevin Wilson from the Union to come up and share his experiences.

[Applause]

DR. NEVIN WILSON: Distinguished guests, ladies and gentlemen — good evening. My name is Nevin Wilson and I am from that great subcontinent of India, which also hosts a third of the world's TB burden. Human resource issues are a system-wide constraint to the successful implementation of health initiatives. This year the theme for the 37th World Conference is Strengthening Human Resources for Better Lung Health.

I am privileged to stand before you this evening both as a witness to and a beneficiary of this process. I was asked to present myself as a case study of this process of human resource strengthening and to do this is three parts, my past, the present and the future. The process itself has included different interventions at different times. The highlight of these was a Junior Consultancy Program that I did with the Union.

First, my past. This is the period from 1989 to 2001, a period of 11 years when I served as a medical officer in a very rural primary healthcare setting working with a vulnerable tribal community in the forests of South India. It was a time of intense work. I used to see more than 15,000 patients a year. It was a time of anger, of

frustration and sometimes of despair. I would characterize this period as a time of passion with very little perspective.

Then the present — this is the period from 2000 to 2006. The first three years I worked with the WHO supporting the Revised National TB Control Program in India in the state of Tamilnadu. This was a population of 65 million and I had the intense privilege and success of working with this program and see it rapidly expand to cover the entire 65 million in the population in just a little over a year. The last three years was with the Union. I started with them as a junior consultant, then moved on to become a full-time international consultant, and now serve as the director of the Union's Resource Center for the Southeast and Western Pacific Regions located in New Delhi, India. This period of intense learning by doing has strengthened existing skills and developed new ones. The passion has been challenged and channeled and has also developed perspective.

Now, to the future. I would like to thank the many colleagues and friends, patients I have met and worked with and lastly, my family for their patience with me and their investment in me. The avenue of opportunity to work likewise with other healthcare workers and strengthen human resources within health services now stretches ahead of me. I will endeavor to do my best. Thank you.

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[Applause]

I now invite [inaudible] to the podium.

[Applause]

MALE SPEAKER: Thank you so much. I have a long list to say thanks. As a human resource, I would especially love to thank [inaudible] who developed my capacity to be here on this stage to speak on this issue. I would also like to Dr. [inaudible] Shaw, Dr. Hassan Sadac [misspelled?], our National TB Control Program managers, who invested in me a lot to build my capacity and provided backup support to be here. I also wanted to say thanks to my dearest friend, Dr. [inaudible], who is sitting here, who helped me a lot to understand the TB issue and the other health issues. I also want to thank WHO, Dr. Mario, Marcos and Union for providing me with this opportunity to speak on this issue. I am the human resource developed by you all. I also especially want to thank my dearest colleagues, the patients who are suffering with the TB and TB/HIV. They are my source, they are my backup support, and they are my passion to work with.

As we all know, the issue of the TB and TB/HIV is not a new issue, and we all know that TB is a silent killer. The patient of TB and HIV should understand that these are two issues, but these are the two sides of the same picture. Though there is no need of comparison, there is a need to understand that HIV is more privileged, having a lot more

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resources, ideas and activism. There are a lot of investments in HIV, but TB is still in the dark and in infant phase. As we heard, we are getting into the 125th anniversary, but we are still having the same tools. We need to have new tools. We are having the same tools, old tools and medicines that are not addressing the current needs like MDR and XDR-TB. TB needs to be romanticized for quite action to assist the TB and TB/HIV issue. We are all experiencing a lot of deaths. I lost a number of my family members due to this disease. Patient like me and others who are suffering from many issues and from stigma and discrimination that is increasing day by day. Patients are still suffering for the new diagnosis, new vaccines and new drugs. Again, there is a need to have joint efforts and the need is there to have joint initiatives to address this issue. There are a lot of echoes addressing and emphasizing the involvement of religious leaders, policy makers, NGOs and different networks, but where are the patients? They are still less visible, they are still less active and they still are less accessed. They are still waiting for new tools, new drugs, more money and resources. On behalf of the patients infected and affected with TB and TB/HIV, I want to offer patient support to WHO, to Global Fund, to Union, to UNAIDS and other agencies. I am looking for their supports to involve us in

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the designing, implementation, monitoring and other activities.

We will strengthen you. We will never let you down. We are your support and you are our support. We demand more involvement of TB and TB/HIV patients and have patients charted, which is like here. We have patients charted and this is one of the tools that can be implemented and this is one of the keys that we can take with us and go with this. We also want to see our friends, relatives, children, husbands, wives, sisters, brothers who can remain with us if we have the cure for the disease. This is only because if we invest more in research, as [inaudible] has done a great, great assessment of the donations. We are just having $2.6 billion for 10 years to invest on research. We need more of an investment so we can have more active research and we can develop new, quick tools. We need quick, new drugs now, not after 10, 15 or 20 years.

I want to close with a famous quote, which is shared by Carol and she said I should also say this, "Nothing for us without us." I also want to emphasize on the quotes that come from the community people, which I am representing here. "Patients are not part of the problem; they are part of the solution." They also said, "Patients are not useless, they are used less." You can use us. We can provide you support and we can achieve the TB-free society. Believe in us and

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trust in us. We will give you results beyond your expectations. Love you all, thank you so much.

[Applause]

ASMA EL SONY, M.D., Ph.D.: Now we will move to the awards ceremony and the Union Scientific Prize of $2,000 USD is awarded to a researcher under 45 years of age for work on tuberculosis or non-tuberculosis lung disease during the past two years. Our winner for the Scientific Prize is Dr. Stephen Lawn. The focus of Dr. Lawn's research is HIV-associated tuberculosis in the era of antiretroviral treatment. He is a 40-year-old clinician, funded by the United Kingdom Welcome Trust. Dr. Lawn is based at the University of Cape Town, South Africa where he is a research associate at the [inaudible] HIV Center and senior lecturer in infectious and tropical diseases. His research on tuberculosis and TB/HIV has led to the publication of 16 articles in journals such as the *Lancet*, the *AIDS*, and the *British Medical Journal* over the past two years. His findings have offered important insights into our understanding of the impact of HIV on the incidence of TB and have made a vital contribution to our knowledge of the incidence, risk factors and impact of the TB on antiretroviral programs.

A native or Britain, Dr. Lawn completed his medical training at the University of Nottingham Medical School. He

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conducted his doctoral research at the US Centers for Disease Prevention and Control prior to moving to South Africa in 2005. He held appointments in the UK and spent four years in Ghana where he taught at the University of Science Technology and also conducted training for the Ghana National TB Control Program. With his clinical expertise, epidemiological skills, laboratory training and public health experience, Dr. Lawn is poised to make outstanding contributions towards our understanding of the TB/HIV epidemic. The Union is pleased to award you, Dr. Lawn. Please come to the presidium.

[Applause]

STEPHEN LAWN, M.D.: I'm very grateful to the Union and its presiding officers for this award. It is tremendous encouragement for our ongoing work in South Africa, but it reminds me of two important things. Firstly, research is teamwork and I must acknowledge my phenomenal colleagues Professor Robin Wood [misspelled?], Dr. Linda Gail-Becker, Dr. Metasan Badry [misspelled?], and Dr. Landon Meyer [misspelled?] for their phenomenal contribution to the work that I'm being acknowledged for.

Secondly, the fact that we're being able to do so much research in Cape Town reflects the fact that there is one heck of a TB problem in the countries of Southern Africa. In some of the communities where I work, rates are now approaching 2,000 per 100,000 per year. That is almost

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unprecedented. In 2005, the WHO declared a regional emergency, mandating urgent and extraordinary actions. I find it a pressure upon myself and my other colleagues working in South Africa that we must find solutions to this urgent problem, and we will continue to try and make inroads to find those urgent solutions. Thank you.

[Applause]

ASMA EL SONY, M.D., Ph.D.: May I ask Mr. Sesumo Kenaco [misspelled?] to present the Princess Chichibu Global Tuberculosis Memorial Award.

SUSUMO KENACO: Good evening, ladies and gentlemen. The Princess Chichibu Memorial TB Global Award has been given yearly since 1998 by Japan's Anti-TB Association in collaboration with the International Union against Tuberculosis and Lung Disease in recognition of the distinguished achievements of a selected individual whose work has made a great contribution to international anti-tuberculosis activities. The selection is made according to the recommendation of the [inaudible] Committee of the Union. The late Princess Chichibu lost her husband, Prince Chichibu, due to tuberculosis when no modern TB drugs were yet available. Her sorrow and grief moved her to devote herself throughout her life to the prevention of TB and the promotion of TB control activities, both nationally and globally, as the patroness of JATA. This award is established based upon

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her will to make this world free of TB so that nobody should suffer from TB and lose his or her life due to this disease.

The winner of the award for 2006 is Dr. Thomas Frieden for his outstanding leadership in promoting the global combat against TB, both within the US and internationally. Dr. Frieden was instrumental in turning the tide of the TB epidemic in New York City in the early 1990s, reducing reported cases of TB overall and halting an epidemic of multi-drug resistant TB. Dr. Frieden inspired much civil expansion of the DOTS strategy in India, improving access to care, quality of diagnosis, treatment success and saving hundreds of thousands of lives. He currently carries on his work with [inaudible] as a commissioner of health and mental hygiene of New York City. Because of these achievements and others too numerous to mention at this time, I, on behalf of Princess Akishino, currently patroness of JETA, would like to present the award to Dr. Frieden. This year it is a special honor because, as many of you know, Princess Akishino welcomed the birth of her son on September 6, 2006. Dr. Frejera [misspelled?], would you come forward to accept this year's award on behalf Frieden?

[Applause] [Laughter]

MALE SPEAKER: Thank you.

[Applause]

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Dr. Frieden was not able to be here today, but he asked me to transmit this message to all of you.

I thank the Japan Anti-Tuberculosis Association and the International Union against Tuberculosis and Lung Disease for this honor. I dedicate this year's Princess Chichibu Memorial TB Global Award to tuberculosis control workers everywhere. Tuberculosis control is about persistence every single day on the frontlines of the epidemic. Our success comes one patient at a time. It is the overburdened health worker who, when a patient mentions a cough, thinks tuberculosis and orders a sputum sample for diagnosis. It is the lab technician, despite hours of peering in a microscope, rigorously examines each smear for the full five minutes. It is the procurement and logistics officer who obtained quality anti-tuberculosis drugs, ensuring that they are available when a patient needs them. It is the treatment of [inaudible], often a volunteer who builds a human bond with patients that not only facilitates cure, but re-knits the fabric of society. Direct observation is the cornerstone of the DOTS strategy and is the only method proven to ensure a high cure rate on a community-wide program basis. Tuberculosis is a constant reminder that we are all connected by the air that we breathe. Patients with tuberculosis are often rejected by their communities because of fears of infection. Tuberculosis control workers deserve credit and

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full support for their work not just because it is ethically the right thing to do, but because also it is only by supporting them that we are able to provide the high-quality, convenient care to patients that is necessary to stop the TB epidemic.

Tuberculosis is preventable and curable and in many parts of the world, tuberculosis is being controlled. However, we still have far to go. Tuberculosis control is hard work that requires energy and persistence by both patients and programs. Front-line tuberculosis control is not glamorous, but today it is our single most important strategy to ensure that patients are diagnosed, treated and cured. Persistence is key. Tuberculosis can be controlled when appropriate policies are implemented, followed and continued. Thank you very much.

[Applause]

ASMA EL SONY, M.D., Ph.D.: May I call upon Professor [inaudible], the co-editor of the *International Journal* to introduce the winner?

[Applause]

FEMALE SPEAKER: Madame President, distinguished guests, ladies and gentlemen – it is a great pleasure and honor for me to introduce Professor Margaret Becklake as the Union medalist in recognition for her contributions to world lung health. Professor Becklake, known to her friends as

Margo, graduated from the University of Witwatersrand, Johannesberg. She then pursued her medical training at a post-graduate medical school at Hammersmith Hospital in London, England. She then returned to teach in her own medical school after her training in England. At that time, she also worked as the physiologist to the Miner's [inaudible] in Johannesberg where she developed the Lung Function Laboratory and conducted clinical and epidemiological studies in almost half-a-million miners.

In 1957, Margo and her family moved to Montreal where she began her long and illustrious career at the McGill University. She spent the first 10 years in the Department of Medicine at McGill among a group of very prominent researchers with names such Ronald Christie, David Bates and Peter Perry. However, she made her mark in physiology by improving our understanding of the cardiopulmonary response to exercise and the mechanism of airway dysfunction. However, the most important part of her career came in 1967 when she joined the Department of Epidemiology at McGill. She established the Respiratory Epidemiology Unit where she carried out many studies on the health affect of asbestos exposure in Quebec miners and millers. She made significant contributions to the understanding of occupational and environmental lung diseases. She demonstrated that clinically significant airflow limitation can occur in

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workers exposed to asbestos and grain dust and that these effects are independent of smoking. She established for the first time that chronic airway disease can occur as the result of organic and inorganic dust exposure. She drew our attention to the variation in lung function between individuals and between populations and the importance of standardization of lung function measurements in distinguishing between signals and noise. She also taught us gender differences in the effect of exposure and in lung diseases. Margo has been very active in many professional societies, as you can see. She was a president of the College of Physicians and Surgeons of Quebec, the president of Canadian Thoracic Society and, as you can see, she has been on grants review committees and acted as advisor to the International Labor Office at WHO. She has been on the Editorial Board for a number of journals including our own journal.

Her major contribution, however, has been in the area of international lung health, for which she has been awarded the Union Medal today. Margo was among those first few who were in China, visited and taught as early as 1973. She remains strongly linked with South Africa, her mother country, and in 1984 she returned to Johannesberg where she established the Epidemiology Unit in the National Institute for Occupational Health and conducted many studies in

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foundries and grain mills. She supervised many graduate students from developing countries attending the McGill University and established a [inaudible] McGill Research Affiliation. She also has been the director of the Summer Epidemiology Course in the McGill University for many years. This course is important because this is the course attended by many international students. The other important contribution is that she has been the curriculum co-director of the Union and ATS-sponsored International Respiratory Epidemiology Course in many countries such as Mexico, Kenya, South Africa and Chile. She is still teaching the Basic Techniques in Lung Health Course in the Congress today. It is therefore not surprising that Margo has received many rewards. One of the things of note is that she has been a career investigator on the Medical Research Council of Canada for a prolonged period of 25 years. She is a fellow of the Royal Society of Canada and received the distinguished Achievement Award of the American Thoracic Society and also the World Lung Health Award of the American Thoracic Society and Doctor of Human Letters from the University of Massachusetts, Lowell.

As a teacher Margo is loved, admired and respected. She often seeks out young researchers and scientists and gives them personal advice and encouragement. I was one of those fortunate ones who learned a great deal from her,

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particularly in reviewing manuscripts. She taught us to be always positive and constructive. She is a devoted wife, mother, grandmother and a very gracious host. Her home is always open to her students and friends. Professor Becklake has dedicated her life's work to the treatment and prevention of lung diseases and through her extensive teaching and research activities in developed and developing countries, she disseminated knowledge and skills to improve global lung health. To me, there is no one more deserving than Professor Becklake to receive the Union Medal. Ladies and gentlemen, may I present Professor Becklake?

[Applause]

MARGARET BECKLAKE, M.D.: I was quite overwhelmed to receive a letter from our president a few weeks ago informing me that the Union's Board of Directors had decided to award me the Union Medal at this year's conference. In my reply, I told her how deeply honored I felt to be so selected by the Union, which, as a member I — and many others — cherish, respect and try to support. The program of this conference, topics, speakers and participants in a measure of the Union's worldwide openness of spirit and concern for its mission across political boundaries, often difficult, to reach those touched by TB and lung diseases in all their modern day complexities.

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My first contact with the Union was when I was invited to prepare a paper on occupational lung disease, and, of course, TB can also be an occupational lung disease. At a time when the Union was seeking to change its name from IUAT (Internal Union against Tuberculosis) to IUATLD – and Lung Disease – a reflection of the belief in the 1970s that TB was on the wane globally – how wrong. The invitation was from the first Union's Committee on Lung Disease, whose members where Jacques [inaudible] from Paris, John Murray from the US, Peter Maclem [misspelled?] from Canada, and Anne Woolcock [misspelled?] from Australia, all of whom had worked and/or were committed to the Union's mission in low-income countries. This year the conference theme no strengthening resources to improve lung health and – as a member of the lung disease section of Union – I believe perhaps one of our most useful contributions to the Union's activity has been to do just that in a very modest way, compared to what others have done, but to strengthen human resources to improve lung health. I'm referring to the short-term courses, which [inaudible] mentioned, in Respiratory Methods for the Promotion of Young Lung Health. The title, if I remember correctly, was the brain child of Don Ennerson [misspelled?], supported by a Union publication of the same name – I wish I had brought a copy of the book to show you – authored by Ennerson, Kennedy, David Miller and [inaudible] Becky

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[misspelled?]. Courses were held in a number of countries. I was concerned, actually, only with the four that were held in Kenya and one in South Africa.

It has been a great pleasure to me to meet a number of those who had attended those courses at this conference. One was Joseph Odhiambo of the Kenya Medical Research Institute, who also studied at McGill University where, as Moira said, I now work. He has been working now for several years in the CD US AIDS program. In other words, I think training in one area of research and one area of description is perfectly transferrable to another. So I guess that is the lung disease contribution to TB.

Being a member of the Union and working in lung disease has been a most enriching experience for me personally, and I have so many people to thank and a very special thank you to the Union Board of Directors for choosing to honor me with this very beautiful medal. Thank you. [Applause]

ASMA EL SONY, M.D., Ph.D.: May I ask Marcos to come and present the Stop TB Partnership Kochon Prize?

MARCOS ESPINAL, M.D., Ph.D.: Thank you, Asma. I'm delighted and honored to present the first Stop TB Partnership Kochon Award. The Stop TB Partnership has joined forces with the Kochon Foundation of the Republic of Korea to honor those who work endless hours and achieve outstanding

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success in the fight against TB, those who work for a world free of tuberculosis.

The first award consists of a medal that is going to be awarded today in a medallic prize of $65,000. To tell you a little bit on the award and this history of that, I am please to call Mr. Doo-Hyun Kim, chairman of the Kochon Foundation, to the podium to say a few words. Mr. Kim?

DOO-HYUN KIM: Executive directors, distinguished guests, ladies and gentlemen — on behalf of the Kochon Foundation, I would like to welcome you to the awards ceremony for the Stop TB Partnership Kochon prize. We would like to extend our most sincere congratulations to this year's prize winners as the first [inaudible]. The Stop TB Partnership Kochon Prize, supported by the Kochon Foundation of South Korea, will be given annually to individuals or organizations who have contributed in an extraordinary way to the effort to eliminate tuberculosis. If the Stop TB Partnership's Global Plan is truly found and truly implemented, we will find the tools to vanquish this terrible disease. The Kochon Foundation has inaugurated this prize as a way of recognizing and rewarding those who have worked [inaudible] of efforts to execute the Global Plan and to eliminate TB. In 1919, a man named [inaudible] was born in an impoverished family in [inaudible], a small family village in the province of [inaudible] in Korea. Also, he was unable

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to receive a higher education. His native intelligence and the power of [inaudible] helped him to transform the drug store that he opened in 1941 into a successful manufacturing company, [inaudible], Pharmaceutical Corporation. As his company's success grew, the late Chairman Lee became increasingly aware of the price barriers standing in the way of most of Korea's access to life-saving medications, among them, anti-TB drugs. At the time, most of such drugs were imported, which drove prices higher. Lee initiated the first production in Korea of anti-TB drugs such as [inaudible]. With Lee's success came a desire to give back to the community. He began simply, helping his employees to attend night school. Then, in 1973, he created the Kochon Foundation. It granted scholarships and funded the research with assets that burgeoned from a modest $20,000 USD at its inception to $35 million USD in 2005. Chairman [inaudible] Lee passed away in 1993, but left a last legacy. He bequeathed his remaining personal assets to the Kochon Foundation. The Kochon Foundation is proud to partner with the Stop TB Partnership in awarding this prize. The Stop TB Partnership, an alliance of more than 500 organizations, countries and individuals united in the fight against TB is housed within the World Health Organization's headquarters in Geneva. Both the foundation and the partnership agree it is

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extremely important to recognize the many people whose varied efforts are helping to win the global fight against TB.

The first winners of the Stop TB Partnership and Kochon Prize to Stop TB are two exemplary individuals, Mr. Winstone Zulu of Zambia —

[Applause]

— and Dr. L.S. Chauhan of India.

[Applause]

Let me again extend my sincere congratulations to these winners. Thank you very much.

[Applause]

MARCOS ESPINAL, M.D., Ph.D.: Thank you, Chairman Kim. Now the two winners — the coordinating board of the Stop TB Partnership, upon recommendation of the selection committee, awarded the Stop TB Partnership Kochon Foundation Award to L.S. Chauhan from the India Ministry of Health and Family Welfare. Dr. Chauhan of India Ministry of Health is a hard-driving leader who, since 2002, has directed expansion of the DOTS program in his country. As deputy director general and program manager of the National TB Control Program, he has been the driving force in dramatically increasing coverage and quality of the TB services in India, the country that bears the world's highest TB burden. By March 2006, 1.1 billion people — 100-percent of the population — were covered by the TB program, growing more

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quickly than any other TB control program in the world. His accomplishment is remarkable not only because of the lives saved in India itself, but also because of the example that he has set for other countries. It is hoped that in coming years the Stop TB Partnership Kochon Award will recognize others whose methods and contributions are as groundbreaking and diverse as those of this year's recipients. Let me call Mr. Chauhan to the podium.

[Applause]

DR. L.S. CHAUHAN: Dignitaries and [inaudible], ladies and gentlemen, I am deeply honored and humbled by this personal recognition of being awarding the Kochon Prize. I am grateful to the International Committee of the Stop TB Partnership and Kochon Foundation for this award. While accepting this prize, I gratefully acknowledge the efforts and commitment of all the front-line TB workers of India. We have [inaudible] hard over the past decade to achieve 100-percent [inaudible] DOTS coverage in India, as well as to maintain case detections and quality of care for TB. I express my deep gratitude to the TB team in India, which has untiringly worked with me for the success of the program. This recognition today has strengthened our resolve and determination in the fight against TB. With the commitment of front-line workers and the highest level of the political and [inaudible] support, the program is [inaudible]. It is

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beyond doubt that humanity's war on TB would be won in India. I would like to take this opportunity to also recognize the part played by the partners and donors in our [inaudible] and [inaudible] their continued support. Thank you. Thank you very much.

[Applause]

MARCOS ESPINAL, M.D., Ph.D.: Thank you very much. The board decided that another winner will be given the award today, Winstone Zulu. Most of you all know about Winstone.

[Applause]

Winstone is a dynamic speaker and a tireless advocate at the forefront of the TB/HIV battle. As one of 13 children in a Zambian family, he contracted HIV and later TB in 1997. Although his tuberculosis was cured, his four brothers were not so fortunate. All of them contracted and died of tuberculosis. Winstone Zulu has demonstrated personal courage by disclosing his HIV status and advocating for improved TB/HIV collaborative activities to treat two diseases in one patient. He is a co-founder of the [inaudible] program for [inaudible] counseling, which is a provider of HIV/AIDS counseling in Zambia. He was co-president of TBTV.org, one of the first organizations for patients with TB. He is the South African representative for TB Alert, a British and international charity dedicated to stopping TB worldwide.

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Ladies and gentlemen, Mr. Winstone Zulu.

[Applause]

WINSTONE ZULU: Thank you very much, Dr. Marcos. Thank you very much to the Stop TB Partnership and thank you to WHO. I have, as well, a whole list of people to thank because doing work around TB is not one individual's task and you cannot say I have achieved this alone. I think this needs teamwork. There are a number of organizations that I have to mention that I have worked with and we have gone around to talk to policymakers and lawmakers in many countries around the world. We have visited four of the G8 countries and their parliaments and congress and so on in trying to bring the human face of TB to them. So I would like to thank the Lobby Organization [inaudible], the Stop TB Partnership, the World Health Organization (WHO) for making it possible for me to share my story of living with HIV/TB coinfection. Without these partners, I wouldn't have been able to visit and talk to law and policy makers around the globe. There have been times when I've visited congressional offices in the US where staff did not know that TB was an epidemic. I have seen disbelief when they learn that TB kills almost 2 million people every year. I have seen jaws drop when it is pointed out that a classic case of TB can be cured with drugs that cost less than $20. I have often mused that if the international community waged the war on TB and

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to quote somebody who is not anyone's favorite perhaps, "If we waged a war on TB and stayed the course until the job was done, only a fraction of the resources being used to [inaudible] war in Iraq would be needed."

[Applause]

The international community seems to be very eager to impose sanctions and leave war options, including the use of force, on the table on the so-called rogue states. Yet, the same international community does little to stop the genocide caused by governments' lack of action on diseases like TB.

[Applause]

Many African governments appended their signatures on the TB Emergency Declaration in Africa; very few have taken actions to support those declarations. When governments behave like that, lives are lost needlessly. It is no different than a man called Chemical Ali who gassed his own cities in Iraq. While it is true that governments cannot fight epidemics on their own, they need to provide leadership and the bulk of resources that are needed. Civil society and other interested parties can and do a lot of good work, but that is not reason for governments' deadly inaction on this issue. Those that aspire for offices that are meant to provide leadership must do so when they get into the office. Lack of resources should not be an excuse. [Inaudible] that we're always talking about human resources, I'm surprised

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that very few governments give or are willing to give support to WHO to provide technical assistance. So in a country like Zambia, we do have TB drugs, but we have very few human resources to make sure that the patients take their drugs well.

I would like to conclude by once more thanking the Partnership, WHO, RESULTS and especially those invisible individuals, those behind the scenes in Geneva and Washington who heroically face the nightmare of trying to communicate with me. I can very difficult. [Laughter] I would like to mention just a few names. If I don't mention your name, please, it's not because you're not important. I'd like to thank [inaudible] at the Partnership, [inaudible] and your teams at RESULTS; you are the ones who are truly fighting TB. I would also like to thank someone who is not here, [inaudible] who has always stood by my side. He was the founder of [inaudible] Counseling and gives me support whenever I'm on the verge of collapse. A very special thanks to Patrick Bertrand [misspelled?] formerly Massive Effort [misspelled?], but now it's called – what is it called? [Laughter] Global Health Advocates, I like Massive Efforts – for bringing and awareness to me of the link between TB and HIV. Lastly, I wish to pay special tribute to my wife and family who spend several months of every year on their own as

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I go around the world giving TB a human face. Thank you very much.

[Applause]

ASMA EL SONY, M.D., Ph.D.: Thank you ladies and gentlemen. Now you are invited to the cocktail reception at level four, Salon Concorde [misspelled?].

[Applause]

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