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**38th Union World Conference on Lung Health
South Africa and International Tobacco Control: Fighting for
the FCTC and Awards Ceremony
November 9, 2007**

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ASMA EL SONY, PH.D.: Mrs. Tshabalala-Misimang, the Minister of Health of South Africa, Mr. Pierre Uys, distinguished guests, health activists, dear colleagues, ladies and gentlemen. My name is Asma El Sony, I come from Africa, I was among the team that launched a successful National Tuberculosis Program in Sudan, at the East Mediterranean Region with the Norwegian Heart and Lung Association as our development partner, the Union and the World Health Organization as technical advisors.

Ladies and gentlemen with immense pride and joy I welcome you to the 38th Union World Conference here at Cape Town, confronting the challenges of HIV and MDR-TB in tuberculosis prevention and care.

Sixteen years back I joined the Union as a junior member. Over the years, I witnessed this organization evolving and growing, contributing to the Stop TB Partnership and moving from tuberculosis control towards a broader public health approach, tackling all the time in close collaboration with other international entities, the global challenges of health that impede our move to reach the millennium development goals. Such as strengthening health systems, paying more attention to child lung health, prioritizing tobacco and asthma control and preventing TB, HIV, MDR and XTR-TB to hinder and stop our march.

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Ladies and gentlemen the union research led to the development of directly observed treatment strategy for TB control, which has been used to treat more than 22 million tuberculosis patients in 183 countries. The World Health Organization has declared in the 19th of March 2007 that the global tuberculosis epidemic has leveled off for the first time since the World Health Organization adopted DOTS formally and declared TB as a public health emergency in 1993.

The Global Tuberculosis Control Report released by the World Health Organization finds that the percentage of the world's population struck by TB peaked in 2004 and then held steady in 2005. We need to congratulate TB patients, TB patients associations who are the real stakeholders, the countries and national TB managers and international partners for this great achievement. But we need to remind ourselves that the focus is improving case detection and particularly in Africa.

Ladies and gentlemen tuberculosis is an airborne infectious disease that is preventable and curable. Ladies and gentlemen, tuberculosis is the main killer of people living with HIV. Ladies and gentlemen we cannot control HIV without controlling TB.

Drug resistant TB poses a grave and growing threat to global public health which we as nations must take action to address. We held a Just Stop TB symposium organized by the

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World Health Organization on XTR-TB TB/HIV that excluding South Africa and the previous Soviet Union appreciable under funding for MDR and XTR still exists. Effective public health response to MDR XTR's requires accelerated efforts and [inaudible] engagement by multiple sectors of the society.

All of us, patients, health activists, providers, health officials, policy makers, international partners and researchers share a responsibility to take action now to prevent further transmission.

In Africa, in Africa and Asia and Latin America heavy burden of tobacco and asthma and the flare up of tuberculosis with HIV/Aids a pandemic and MDR XTR are great challenges which we have to halt.

Ladies and gentlemen lung diseases among children are still one of the commonest causes of under five morbidity. It is not war that kills our children; it is the forgotten lung diseases in children. UNICEF, the Union and the World Health Organization and all partners have to do more.

The non-holistic look at human resources needs, the lack of qualified health workforce, the full access to medication and the inefficient and forgotten primary healthcare. [Inaudible] health system and poverty are central health challenges that render the African region off track in regards to the MDGs. [Inaudible] health system and poverties, ladies and gentlemen are our main problem. Equitable access to

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the new tools of TB control, [inaudible] strategies in TB control and lung health is our need. We need to prove our [inaudible] progress against TB and poverty. We need to prove our progress against lung diseases and poverty.

Ladies and gentlemen I sincerely hope that this opportunity to come around the table once more and this time the Union Global Conference for the first time is in Africa. It is indeed an opportunity to dwell on these urgent issues and share our experiences and find solutions and increase our knowledge on how to reduce the global burden of lung diseases and to help achieve the MDGs.

The day before yesterday most of you were here at this [inaudible] African Region Conference and today we are here at the 38th Union World Conference highlighting the urgent need of collaborative and joint global efforts to conquer the world and African health challenges.

Ladies and gentlemen, what I witnessed yesterday is unbelievable. I was immensely touched and overwhelmed. The Treatment Action Campaign, the Aids and Rights Alliance, the South African Treatment Access Movement and hundreds of organizations from South Africa and all southern Africa, ladies and gentlemen of over 5,000 people living with HIV came to meet us. Came to make it clear to governments in Africa, to governments throughout the world and across the world, came to

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tell you important people sitting here what is done is not enough.

What they ask for is simple, ladies and gentlemen. Getting people living with HIV just tested for TB. Getting people living with TB tested for HIV. They are asking you to integrate and decentralize the TB and HIV services. They would like to see improvement of infection control. They want you to act fast and prevent and treat TB/HIV, prevent and treat MDR, XTR and TB. They're telling us and the world, enough is enough. Telling us people are dying out there. Telling us no more talk, they need action. They need implementation. Believe me nobody can stop that march, the march of action and no more talk. And thank you. [Applause]

Ladies and gentlemen welcome with me Mr. Uys, the member of the Executive Council in Cape Town.

PIERRE UYS: President El Sony, the Executive Director Dr. Billo, our honorable minister our director general that's here, delegates, ladies and gentlemen good evening from our side. I'm the politician responsible in the western [inaudible] for health so you will allow me to say welcome to you all in the Western Cape and in Cape Town.

I'm really delighted to see the many people that's here from across the world to share your knowledge and to share your information, but also to help us to confront the challenges of TB, HIV and AIDS. But thank you very much to the organizers

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deciding on this location. It's very important to be in South Africa and it's important to be in the Western Cape and in Cape Town. And I think it's a very important statement that you make in the world.

In the Western Cape we have 5.3 million people. And it's important just to reflect on that because tuberculosis incidents are also the highest in South Africa. It's now 1,041 per 100,000 of the population. When we started to measure XDR and that was only in January of this year and to test for that, we now have 64 cases of XDR in the Western Cape of who 20 people already died.

And just to illustrate to you that we see it as very serious what's happening here. But there's a lot of effort going into fighting tuberculosis preventing treatment and care. And every year you can see an incremental increase also in the detection rate and it's now just over 70-percent, but also the cure rate. And although the target is 85-percent the cure rate, we are now over 72-percent and hopefully this year for 2006 and hopefully for this year it will again increase.

With our enhanced program that we've implemented nationally and also in the Western Cape we have a team of people working extremely hard to do what we must do for the people of this province of course within in the framework of the national guidelines.

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But this is not about the Western Cape and myself this evening. I'm here to introduce to you the National Minister of Health, Dr. Manto Tshabalala-Misimang. Our minister was appointed as minister in June 1999 so it's some time ago. Minister studied she matriculated in South Africa after that studied at the University of Ford Hare, BA degree, then a medical qualification at the First Leningrad Medical Institute. That was not all, after that she obtained a diploma in obstetrics and gynecology at the University of Dar Es Salaam. She went further and studied for her master's degree at the University of Antwerp. But before '94 she played a very important role in the struggle against Apartheid and improving the quality of health of people outside and inside South Africa. And she was in exile for many years.

After 1994 she played a very active role in the governance structures and she was elected as Member of Parliament in 1994. The president then saw it fit to promote her and she was the Deputy Minister of Justice in 1996 through 1999. And I believe that's very important. Internationally she played a very important role and of course in Africa. She was one of the former members of the board of the Global Fund. We all know the Global Fund to fight HIV and AIDS, malaria and tuberculosis.

But I can say ladies and gentlemen as working with our minister she's the champion in driving a fight and the cause

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for prevention treatment and care of TB and tuberculosis in South Africa. She just announced that today to us in a national house council meeting that in adjustment estimates there's an additional amount of 400 million rand that has been allocated to the provinces and we're very fortunate to get 55 million rand of that to strengthen this effort towards prevention treatment and care. It's really my pleasure to ask the minister to come to the podium and address you. And I ask Dr. Manto Tshabalala-Misimang to address you. Thank you.

[Applause]

MINISTER MANTO TSHABALALA-MISIMANG, M.D.: Good evening colleagues, President of the International Union against Tuberculosis and Lung Disease, Madam Sony, distinguished guests; ladies and gentlemen it is indeed an honor for me to be part of the official opening ceremony of this conference which is held in South Africa for the first time. We did have the honor of hosting the Africa Region conference in 2002. And I have also technical assistance on TB from the Union since 1996. To this affect I'd like to express our gratitude to the Union and we hope that this partnership will continue in years to come.

We expect that there will be fruit for discussions about the important role that tobacco control can play in the prevention of lung diseases. We believe that South Africa has indeed played a critical role in the development and adoption

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of the Framework Convention on Tobacco Control which we have ratified. As you know, the South African government has been widely acknowledged as a leader in the effort to stop the use of tobacco products. And I'm sure that advocate Patricia Lambert will attest to this in her presentation later this evening.

We are now amending our tobacco control law to address loop holes and increase fines relating to the violation of the law. This conference takes place at the time when our country and the region are faced with the increasing burden of TB and extensive drug resistant TB. Given the movement of patients across our borders in the region, we must work together to control the spread of this disease. As the theme of this conference the forecast is on drug resistant TB and HIV. I sincerely hope that the deliberations at this conference will provide guidance on [inaudible] in how to strengthen prevention and management strategies for drug resistance. And I underscore give guidance.

South Africa has developed a National Strategic Plan for TB 2007-2011. Amongst other things the plan acknowledges the relationship between TB and AIDS, HIV and AIDS and provides for interventions to deal with the challenges of the core infection.

The plan requires that all patients be offered voluntary HIV counseling and testing, voluntary. Those who

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test HIV positive receive full coverage and package of care for HIV and AIDS including antiretroviral treatment for those who are eligible. On the other hand, HIV positive patients receive routine screening for TB treatment for those with TB and preventive therapy for those found not to have TB.

Pointing fingers at each other about how drug resistant TB developed is not going to be useful. We have to work together to improve treatment literacy and encourage people with TB to complete that treatment. If we put all our energies on improving treatment literacy there'll be little need for us to argue about enforced hospitalization. I must of course emphasize that the vast majority of XDR-TB patients in South Africa are in hospital voluntarily. The hospitalization period lasts for at least six months. Then after they are discharged for ambulatory care at the nearest health facility with ongoing treatment and psychosocial support is provided.

We believe that enforced hospitalization of patients with XDR-TB is only justifiable as a last resort within a human rights framework both for the patients and the communities after all reasonable voluntary measures to our surveyed patients have failed.

One of the major factors that have contributed to the rise of the drug resistant TB is the lack of innovation with regards to diagnostics and drugs for TB. It is an indictment that the drugs currently available for TB were invented several

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decades ago. And we know the reason why. I wish to call on all and everyone to advocate for greater investment in research and development of both diagnostics and drugs for TB.

In the meantime we have to go back to basics and emphasize health promotion and prevention for tuberculosis. This includes reinforcing hygiene education and encouraging proper ventilation. At the department of Health of South Africa while working with other partners in the social circle cluster to address the challenges of poverty that compound the problem of TB in our country. We have to deal with the challenges of inadequate housing, proper nutrition and other factors that contribute to the spread of tuberculosis.

In conclusion I'd like to ask all gathered here tonight to continue to work towards prioritization of TB. Let us work together towards the realization of the vision of healthy communities, free from pain and suffering. Obviously as we prioritize TB we should not forget that there are other diseases as well. Thank you very much. [Applause]

ASMA EL SONY, PH.D.: We thank the Minister of Health of South Africa for her presence with us and very important speech. May I call upon Professor Saloojee, an international expert on tobacco. His great efforts are known to all of us.

YUSSUF SALOOJEE, PH.D.: Thank you. Honorable Minister, the President and Executive Director and members of the Union, the Embassy for Health for the Western Cape, the

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Director General of the Department of Health, distinguished guests, ladies and gentlemen. One of the more amazing feats of the last century is the ability of the tobacco industry to stay healthy while its customers get sick and die. Even as the annual global death toll from tobacco reached 5 million the transnational tobacco companies reported increased sales and profits. In 2005 this was a staggering \$365 billion.

The continued health of the industry is based upon many factors, but one vital issue is its ability to resist government regulation. All but a few governments have not given tobacco control the priority it deserves as a public health issue. However all that is about to change.

In 2003 the World Health Organization concluded negotiations on its first international treaty, The Framework Convention on Tobacco Control. The treaty came into force in 2005 and is one of the most rapidly embraced treaties in the history of the United Nations.

Our speaker tonight, advocate Patricia Lambert was a very influential and prominent figure at the FCTC negotiations. She led the South African delegation, was the representative of the Africa Region on the bureau and chaired sessions on intergovernmental negotiating body.

Advocate Lambert is a South African working currently as the director of the new International Legal Consortium at the Campaign for Tobacco-Free Kids, a non profit organization

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based in Washington D.C. The International Legal Consortium has been set up as part of the Bloomberg Global Initiative to Reduce Tobacco Use.

Before that advocate Lambert was a legal advisor to our Minister of Health and also to the South African Ministry of Justice. Her briefs have included not only tobacco control but the pharmaceutical industry and intellectual property rights, access to affordable healthcare and medicines, the regulation of medicines, the health and social ramifications of violence including sexual violence against women and children, women's reproductive health rights and access to health services, the health rights and needs of infants and children and the use of public private partnerships in health care. The wide range of issues in which advocate Lambert has been involved in reflects the interest as a human rights and labor lawyer.

A different perspective on advocate Lambert is provided by one of our largest circulation Sunday newspapers, "The Sunday Times". A correspondent of the newspaper described advocate Lambert as a "neo-Nazi nanny", advocate Lambert.

[Applause]

PATICIA LAMBERT, J.D.: Good evening Minister, good evening ladies and gentlemen. Thank you, Dr. Saloojee for your gracious introduction and for reminding all of us that tobacco control takes strength however you might label the individuals involved in it.

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And I want to thank the organizers too for inviting me to this conference to speak to you this evening about my country South Africa, about my continent Africa and about international tobacco control. It is an honor and a privilege for me to be here.

In deference to the fact that the members of the audience tonight are experts in tuberculosis and the prevention of illnesses related to TB and lung health I've included some basic slides on tobacco control so that you will be able to see the background that was there for the Framework Convention for Tobacco Control come about.

This is what the official publication of the World Health Organization for the FCTC looks like. For a number of decades now an ever growing number of individual countries including South Africa have been formulating policies for tobacco control. These policies have been and are being developed against the background of a substantial body of scientific proof that tobacco use in any form including a smokeless tobacco product like snouse is extremely harmful to the health of users. And in the case of smoking it is also extremely harmful to health of people who are in the vicinity of the smoker.

In country after country tobacco control policies are being implemented through legislation and also through campaigns directed at public awareness of the extreme dangers

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of tobacco use. Some of these campaigns have been moved by governments. The great majority however have been driven by committed civil society organizations and many governments reluctant to confront the seemingly all powerful tobacco industry were virtually forced by their citizens to take the tobacco epidemic and tobacco control seriously. And then what followed was inevitably legislation.

So domestic tobacco control is relatively strong, but the transnational tobacco companies do not need to respect international boundaries. After all they are exactly what their name suggests, transnational corporations. In consequence therefore national tobacco control measures while vital for every country are simply not enough to tackle the growing tobacco epidemic. International tobacco control efforts are essential. And I'm happy to say that these two now exist. They are at the heart of the world's first public treaty, the Framework Convention on Tobacco Control or as it is usually known the FCTC.

I have made the assumption that most of the people here tonight are not lawyers and so do not have a clear grasp of international law. So let me explain that the FCTC is an international treaty and as such has the force of law for all countries that choose to ratify or exceed to it. In fact it is useful to think that the FCTC stands equal to other treaties which may be familiar to people in the room. Like the

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Convention on the Rights of the Child, the Convention on the Elimination of all Forms of Discrimination Against Women, the Landmines Convention, the Climate Change Convention and others.

The objective of the FCTC is formulated in clear and simple language; it is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.

I would like to highlight the word devastating in this paragraph of the treaty. It is a strong word and it was deliberately chosen by the countries that drafted the treaty because it is accurate. In my view it is impossible to over estimate the significance of this treaty. It is a remarkable document that emerged as a result of a remarkable process. But that is not really surprising because tobacco is a remarkable product. Cigarettes are the only legal available consumer product that will kill people who use it in the ordinary way.

The FCTC represents a global effort to undo some of that harm, and is as Dr. Saloojee has pointed out, the world's public health treaty. And it is not coincidence or serendipity that the World Health Organization which has had treaty making powers since 1949 chose tobacco as the subject for its first and thus far only international piece of law.

Deaths from tobacco use are staggering. They outstrip deaths from TB and in combination with tuberculosis these

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figures become even more scary. Currently 4.9 million people die every year. That's approximately 13,400 people per day or 560 people every hour. By 2030 those figures will rise to 10 million people per year and what is most alarming is that 70-percent of those deaths will occur in developing countries.

Tobacco control is not a luxury. This is according to the World Health Organization Report on Tobacco and Poverty. It is not something that rich countries in the north need to be concerned about. It is a necessity for every country. The costs of tobacco use are enormous. It exacerbates poverty as a result of diverted family income. It causes health care costs, illness and premature death. And it is interesting to note and disturbing to note that tobacco consumption is highest among the poor not the rich because they proportionally spend a larger portion of their income on tobacco products.

The costs to governments too are enormous. There are increased health care costs, lost productivity due to illness and premature death especially of people in their middle years and gross environmental damage from pollution to deforestation.

The costs to society are similarly grave. If current trends persist about 500 million people who are alive today will be killed slowly by tobacco. Half of those will die in their productive middle years. And almost all of them will lose roughly 20 to 25 years of their productive lives.

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The World Bank estimates that the economic cost of tobacco use for any country is 11 times greater than the economic benefit to countries. We hear that the tobacco industry collects more tax for countries than almost any other group or stakeholder in a country. This is not true. The tobacco industry does not generate tax. Governments generate tax. The tobacco industry merely collects it. And if people give up smoking, the money that they would have spent on tobacco products doesn't disappear into the thin air; it stays within the country and is spent on other things. So there is no loss from tobacco control.

The FCTC, this is its current status. The areas in green represent those countries that are currently signed up for the FCTC. That number is currently 151 with the latest signature last month being Angola. It took two and a half years to negotiate the treaty. Negotiations began in October 2000 and ended in March 2003. The FCTC was adopted by the World Health Assembly in May of 2003. It opened for signature and ratification in June 2003. Before it could enter into force however, 40 ratifications were needed. They were obtained by November 2004 and the treaty entered into force in February 2005. This makes the FCTC one of the most rapidly embraced treaties in the history of the United Nations.

The FCTC is a remarkable and significant achievement in international public health. It is clearly a treaty whose time

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has come, it is needed. And judging by the number of countries that have agreed to be bound by it, it is wanted as well. It is a glorious success story but it did not come easily.

The negotiators of the treaty, people from 193 countries all knew going into the negotiations what I've outlined for you briefly this evening and more. Most, if not all were well versed in issues related to tobacco use and tobacco control. So it looked as if this would be a quick and easy process, but it wasn't. It should have been but it wasn't. It was a fight from beginning to end. And it was in many ways no ordinary fight. It was a fight between the small and the large, between the weak and the strong, between the poor and the rich. To illustrate my point I've selected three images that I hope will convey cross culturally the nature of the fight. This is the first image. This the second, and this third.

I'd now like to focus on the fight for the treaty and to do so from an African perspective. The negotiations for the treaty were held in Geneva, the headquarters of the WHO. During these intergovernmental meetings, the WHO as the secretariat for the negotiations organized regional meetings for each of the six regions. During one of the regional meetings for Africa it became clear that as a region Africa had some unique issues to deal with.

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Firstly most of the government representatives from Africa had little or no knowledge about the treaty making process. Most were public health specialists like yourselves not lawyers and certainly not lawyers with training in public international law. There was little or no understanding amongst us about the process, what the outcomes of the first meeting might be or how future meetings might unfold.

Secondly most of the public health experts were not experts on tobacco control. Most came from health promotion units in government departments and although they had knowledge of tobacco control they specialized in a wide variety of health promotion matters. Their knowledge of tobacco control could be categorized as general and shallow. There were exceptions but I'm drawing a broad picture here so that you'll get the point of the picture in front of you.

Thirdly some nations in Africa were consumers of tobacco products but there were also major leaf producing countries, Malawi, Zambia and Zimbabwe were the three largest. But Kenya, Tanzania and South Africa were also leaf producers and still are. Some of the leaf producing countries came to the negotiating table declaring loudly and persistently that as far as they were concerned tobacco control measures in their countries would be impossible. Not just unlikely, impossible.

Fourthly, not one of us had more than a scant knowledge at the time of the economics of tobacco control and we were

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therefore potentially vulnerable to lobbyists who were at pains to warn us that if we as African countries attempted to call for effective tobacco control measures we would be doing damage to our economies, some of which were already precarious.

Fifthly, most regions whether developing or developed country regions had several strong civil society organizations with meaningful and useful experience in tobacco control. They were conducting briefing sessions and lobbying their governments from the sidelines with the exception of South Africa and Nigeria there were almost no African NGOs with any track record in tobacco control.

Overall, as Africans by and large we felt that we were out of our depths. Towards the end of the negotiations Professor Adayday [misspelled?] a Kenyan international lawyer who was working as an advisor in the UN system at the time, told me that as far as international treaty making was concerned the position that we Africans had found ourselves in in October of 2000 was not the exception, it was the rule. He said that in all of his years with the UN system he had noticed that African countries were either absent from international negotiations that affected them or inadequately represented generally through no fault of their own.

In addition to our uniquely African problems we quickly identified another problem. There were bullies in the room, big, big bullies. There were countries present at the

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negotiations that appeared to be determined to insure that whatever came out of the negotiations would be either weak or irrelevant for effective tobacco control. Chief amongst these was the United States. And it wasn't hard for us to see why. The U.S. Government takes money from the tobacco industry for political campaigns and as the negotiations proceeded we grew to believe that they were more adept at representing the interests of the tobacco corporations than they were at representing the interests of public health. Other bullies or countries that were standing in the way of effective tobacco control measures included Germany, China, Mexico, Panama, Argentina, Pakistan and a few others. I name them here as an illustration that when taken together they more closely resembled the man with the rock than the man with the sling.

And then there was the tobacco industry itself. Representatives were to be found in the visitor's gallery at every single session and in between the sessions they lobbied vulnerable governments including African governments in the corridors of the meeting venue. The hostile governments, hostile to an effective treaty I mean, together with the self serving industry combined to make a formidable force the size of which I'm trying to capture in this picture.

By the last day of the first round of negotiations and there were six rounds in all, it occurred to me that if African countries were to make a meaningful contribution to the

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negotiations and to the health of our citizens, we would need to help ourselves first and to do so as a matter of urgency.

I approached Dr. Derreck Ya [misspelled?] a fellow South African who at the time was the head of the Tobacco Free Initiative of the WHO to find out whether intercessional regional meetings might be considered. He said that they were possible but perhaps not really necessary given the fact that this was a broad based international negotiation. I begged to differ from my inside knowledge of our Africa meetings. And I asked whether the WHO would be prepared to pay for an intercessional meeting in South Africa if we could organize one. He said he would. I then phoned the South African Minister of Health, Dr. Tshabalala-Misimang who is with us here tonight, to talk the matter through with her. I shared my concerns and the concerns of my fellow African delegates. I told her of the conversation with Dr. Ya and asked whether she would be prepared to host a meeting on the basis that the WHO would pay for it. She agreed immediately.

In my opinion her decision and the Africa Tobacco Control Meeting in Johannesburg in March of 2001 was historic. It was historic for Africa and it was historic for the world. More than half of the Member States of the AFRO Region came. We spent five days informing ourselves thoroughly about the treaty making process and also about the elements of truly effective tobacco control measures. And we did this against

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the background of our unique situations, country by country. We listened attentively, as is the way in Africa, to the perspectives of all including the leaf growing countries and eventually we found a way to accommodate concerns about tobacco growing without weakening the overall desire for effective tobacco control measures.

We have a saying in South Africa that when we are in disagreement about something we should try to find one another. In Johannesburg we truly did. Our expectations going into the meeting were wobbly but overall high. But the achievement was nothing we could ever have imagined. We found ourselves so well that we were able to issue a joint declaration on the outcomes of the meetings. Some of us when we reached Geneva a few months later were concerned that because only half of the AFRO Member States had made it to the Johannesburg meeting, those who had not attended might take up different positions at the next round of negotiations in Geneva.

Our first regional meeting the day before the negotiations was delicate. We proceeded sensitively and cautiously. The tension was palpable. But once again we truly found one another. There and then on the night before the second round of negotiations were due to begin we took a momentous decision. We decided to speak through the negotiations with a single voice despite our differences.

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As the Chair of the Johannesburg meeting I was nominated to speak on behalf of the 46 Member States of The AFRO Region for the first meeting. It was a great honor. I will never forget the first intervention that Africa made from the floor at the opening session. In the negotiating room it was business as usual. Countries spoke one by one making general statements. Translation went through the headphones in the six official UN languages. There was the usual low hum of people conversing quietly in their delegations while others moved in and out of the room.

When our turn came South Africa was recognized by the chair and I took the floor. I began by announcing that I was not speaking only on behalf of South Africa but on behalf of the other 45 Member States of The AFRO Region. The room fell silent. No one was expecting it. We called for the strongest possible tobacco control measures to form the heart of the treaty. We did so on the basis that as a group of developing countries and African countries in particular, we were especially vulnerable to the machinations [misspelled?] of the transnational tobacco companies. We said that we were speaking up for our children and for their children too. We made the point that whereas tobacco consumption in Africa was still relatively minor, it had the potential to develop into a full blown epidemic and that the industry was moving swiftly to ensure that it did just that.

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We ended by saying that we believed it was our duty, our moral duty as Africa's representatives at the negotiations to ensure that we acted preventatively and with strength.

And so it came about that the AFRO Region harnessed its strength and moved forward decisively with determination supported by our governments at home. We had started out small, weak and poor but we were ready to take on the giants. The industry giants as well as the countries that were serving the profit making goals of an evil industry that knowingly continues to produce and market products that cause death and disease.

Africa led with this position from the start of the negotiations to the end. We did not flinch. We never wavered in our call for amongst other things, strong tax and price measures to constantly drive the price of tobacco products up. Because economists agree that the most effective way to reduce tobacco consumption is to ensure that cigarettes cost and other tobacco products cost a great deal of money. This is especially effective for people who are poor and for children, young people who may be considering smoking.

We called for a total ban on all forms of advertising, promotion and sponsorship. We called for packaging and labeling of tobacco products to be clear and effective and to include pictorial health warnings, pictures of diseased lungs, pictures of the results of smoking. We called for the

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protection of everyone from exposure to tobacco smoke and we called for measures to be introduced to control illicit trade.

The tobacco industry actually engages in illicit trade of tobacco products to avoid the taxation that they boast about providing for governments. And this has now been proven through documents which have been released to the public as a result of court action.

Perhaps two of the strongest measures in the treaty are principles that underline it. The treaty is not a buffet. No country that accedes to the treaty can make any reservations. It cannot pick and choose amongst the various articles that as a package make up effective tobacco control.

Whether we have succeed in bringing down the giant remains to be seen. I am deeply honored to be the one here tonight telling you Africa's story. It is not my story. It is the story of 46 countries and 46 teams of wonderful energetic and committed negotiators. My respect and admiration for my fellow African colleagues is unending. Each country negotiating in Geneva had its heroes at home. I acknowledge them all. But as a South African here tonight it would be remiss of me not to pay special tribute to South Africa's tobacco control heroes.

I will start with the other members of South Africa's negotiating team and I will name them. Daisy Mafubelu, our Health Attaché, Zenaliam Tembu [misspelled?] at the time the

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Head of Health Promotion in the Department of Health, Mr. Hopalone Sucobay [misspelled?], and Blanche Pitt. I'd also like to salute with gratitude the two successive Ministers of Health since our country first came to freedom in 1994 who have developed and implemented South Africa's tobacco control policy and the African National Congress, their party who first recognized the tremendous dangers of tobacco use. These are Dr. Nkosazana Dlamini-Zuma who developed the legislation and Dr. Manto Tshabalala-Misimang who implemented it and who is now overseeing amendments to that legislation to strengthen it greatly. Without their political will and their focused leadership the history of tobacco control in South Africa and perhaps also in Africa and the world may have been very different.

And finally from the South African side I'd like to salute our foremost nongovernmental organization in tobacco control. The National Council against Smoking magnificently led by Dr. Yussuf Saloojee the Council's help is always invaluable.

The FCTC, the idea of an international treaty and the substance for such a document did not appear by magic. People worked hard over many years to get to the point where negotiations could begin. So I would like also tonight to pay tribute to the host of international leaders from governments and civil society who as they became aware of the

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extraordinarily dangerous nature of tobacco products first spoke up with clarity and courage about the products themselves and about the transnational corporations that produce them.

I will name no names, to do so would be to risk leaving someone or some group out. So let me simply say this, to you we owe a debt of gratitude. What you have done individually and collectively benefits us all and more importantly what you have done benefits children today and will continue to benefit children for many years to come. A tobacco free world may be a long way off but it is no longer an impossibility and we are working collectively to achieve just that. Thank you.

[Applause]

YUSSUF SALOOJEE, PH.D.: Thank you Patricia for sharing your special insights into the negotiations on the Framework Convention. The picture you used to depict the negotiations was David and Goliath. The image that comes to my mind is slightly different. We in South Africa have a saying that when you strike a woman you strike a rock. The tobacco industry has been put on notice that when it takes on the women of Africa it will strike a rock. Thank you again Patricia. [Applause]

ASMA EL SONY, PH.D.: Now it's time for the Union Awards Ceremony and as you know the Union awards were established to recognize exceptional contributions in tuberculosis and lung diseases. May I call upon the Union Executive Director Dr. Nils Billo to come to the podium.

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NILS BILLO, M.D.: The Union Scientific Prize of \$2,000 U.S. is awarded to a researcher on the 45 years of age for work on tuberculosis on non TB lung disease during the past two years. Dr. Mardhukar Pai is a 37 years old physician from India currently working in Canada as an assistant professor of epidemiology at McGill University. He completed his medical training and community medicine residency in India. There he was involved in running the TB and Leprosy Control Programs at the Christian Medical College in Vellore and in 2004 he completed his PhD in epidemiology at the University of California Berkeley with a doctorate research focused on the evaluation of new tests for TB diagnosis.

In 2005 and 2006 he held a post doctoral fellowship at the University of California San Francisco where he worked on development of international standards for tuberculosis care. In 2006 Dr. Pai joined the epidemiology faculty of McGill University and became Assistant Director for Global Health Research at the Research Institute of the McGill University Health Center.

He has been an active TB researcher for seven years focusing on the evaluation of novel T cell-based diagnostic tools TB infection [inaudible] of evidence on TB diagnostics, development of evidence based standards for TB care and control and [inaudible] TB and TB infection control in developing countries.

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He has published more than 50 articles on tuberculosis including 17 in the past two years. They appeared in journals such as *Lancet Infectious Diseases*, *JAMA*, *Annals of Internal Medicine*, and others. In 2006, he won a Millennium Research Award from McGill University and in 2007 he won the New Investigator Career Award from the Canadian Institutes of Health Research.

Dr. Pai has also been recognized as a gifted teacher winning an Outstanding Graduate Student Instructor Award with distinction while at Berkeley and the Teaching Excellence Award during his first year at McGill.

Dr. Pai is an associate editor of the *International Journal of Tuberculosis and Lung Disease* and is an active member of the Stop TB working Group on New Diagnostics. He also consults for the Foundation for Innovative New Diagnostics, FIND in Geneva.

A scientist who has clearly demonstrated his passion for TB research and control Dr. Pai is the winner of the 2007 Union Scientific Prize. Congratulations. [Applause]

MADHUKAR PAI, M.D.: This is such an honor for somebody who has come from India and moved on to work in the U.S. and Canada. I would like to thank the Union for this encouragement and for this honor. Although this is for my scientific research as all of you know none of us does research in isolation. We all work in teams therefore a lot of people have

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done research with me should share some of this credit including my mentors, my colleagues and my students. And also I'd like to finally thank many senior colleagues and mentors who are present here today who encouraged me to apply for this award and supported my nomination. Thank you. [Applause]

ASMA EL SONY, PH.D.: The Karel Styblo Public Health Prize is awarded to a health worker, lay person or physician for contribution to tuberculosis control or non tuberculosis disease. Lucy Cheshire's inspirational leadership has broken new ground in TB advocacy over the past decade. A clinical nutritionist from Eldoret Kenya she was 20 years old when Lucy was diagnosed with HIV. In 1997 she became the first female health professional in Kenya to publicly acknowledge having the disease. Three years later Lucy developed tuberculosis in her chest, lymph nodes and joints. She was hospitalized for seven months. But during this time she also began to receive the antiretroviral treatment for HIV that saved her life.

Since then Lucy became one of the most widely know TB/HIV activists. Lucy recently completed a term as Stop TB Coordinating Board's first ever patient representative. In this capacity she was instrumental in convincing African Ministers of Health and the World Health Organization AFRO Region to declare TB an regional emergency in Africa in 2005.

She visited Canada, the U.S. and U.K. to meet with government officials, the media and NGOs to raise support for

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tuberculosis and HIV. She continues to serve on Stop TB and WHO Committees as well as working with the Open Society Institute in Kenya.

Lucy is part of the Advocacy to Control TB Internationally, ACTION Project and was a founder of the United Civil Society Coalition Against HIV, AIDS, TB and Malaria. In 2005 she sent a letter to then the Prime Minister Tony Blair. Ms. Cheshire wrote, I am alive and healthy today thanks to the doctors treating TB and at the same time as managing my HIV infection but many thousands of others are not as fortunate. The lives of half a million Africans could be saved every year, right now if TB control and efforts to tackle TB/HIV co infection were given an urgent priority.

The Union ladies and gentlemen is pleased to have the opportunity to recognize Ms. Cheshire's achievements by awarding her the Karel Styblo Prize. [Applause] May I call upon Lucy Cheshire. [Applause]

LUCY CHESHIRE: Ladies and gentlemen, seven years ago I lay on my hospital bed just about to die. I didn't know that I would live to see this day. From death TB has basically turned my death into hope. And I just want to say thank you. More especially to all the TB and the TB/HIV patients around the world who have endured TB treatment which is many a times never easy and have actually joined the fight against TB.

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I want to say a special thank you to the TB/HIV Working Group who have nurtured me and mentored me in many ways. For all the efforts that they have put in I want to say thank you specifically to Dr. Getahun of the TB/HIV Sops TB Partnership for all his support and more specifically also to all the ACTION partners around the world.

I would want to make one plea and that is we cannot win the fight against TB unless we get the HIV community fully on board. There's a lot that needs to be done in relation to diagnostics, to vaccines, to better drugs for TB, for there are many vulnerable people who are dying out there from a disease that is preventable and treatable. For all those who supported my nomination I want to say thank you and let's continue working together to ensure that this world is free from TB. Thank you all. [Applause] [Audience singing]

ASMA EL SONY, PH.D.: May I call upon Dr. Nobu Ishikawa for the Princess Chichibu Global TB Memorial Award. Dr.

NOBUKATSU ISHIKAWA, M.D.: The Princess Chichibu Memorial TB Global Award has been given yearly since 1998 by Japan Anti-Tuberculosis Association in collaboration with the IUATLD in recognition of the distinguished achievements of a selected individual when who has made a great contribution to international anti-tuberculosis research and activities. The selection is made by the recommendation of the award committee of the Union.

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The late Princess Chichibu lost her husband Prince Chichibu due to tuberculosis at the age of 30 when no modern TB medicine was yet available. Her sorrow and grief moved her to dedicate herself throughout her life to the promotion of TB control both domestically and globally. As the Patroness of Japan Anti-Tuberculosis Association for 55 years since its foundation she inaugurates the Global Conference of IUAT which was held in Tokyo in 1974.

This award is established based on her will to make this world free of TB so that nobody should suffer from TB or lose his or her life due to this disease.

The winner of the award for 2007 is Dr. Jaap Franz Broekmans for his outstanding contribution in promoting global combat against tuberculosis. [Applause]

Dr. Broekmans based at KNCV Tuberculosis Foundation has played a major role in the development and dissemination of the DOTS strategy. He also took a substantial leadership in the Union and also in the Foundation of Stop TB Partnership. He has held chairs of various important international committees which I no need to mention further more.

I on behalf of our Imperial Highness Princess Akishino successor Princess and the Patroness of Japan Anti-Tuberculosis Association would like to invite Dr. Broekmans to receive this award. Dr. Broekmans. [Applause] This is the kind of

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[inaudible] we use for the campaign of the [inaudible]
fundraising in Japan.

JAAP FRANS BROEKMANS, M.D.: Thank you very much Dr. Ishikawa. And when I speak to you of course I see Dr. Morti [misspelled?], Dr. Alki [misspelled?] and Dr. Shimow [misspelled?] with whom I have worked in your same position over the years. Thank you very much for this honor.

Princess Chichibu and her husband were not only patrons of global tuberculosis and the fight against tuberculosis but also great patrons of the arts. That's why I have chosen this exquisite 19th century wood block print by one of Japanese, Japan's great master Hiroshige in return.

And let me start with a small anecdote. [Inaudible] Blaker [misspelled?] my predecessor at KNCV and [inaudible] Nils Billo predecessor had the privilege to have an audience with Princess Chichibu at the TSRU meeting in 1987. As a present they brought delicately wrapped maron glace from France. And at the end of the audience Princess Chichibu asked [inaudible] Blaker [misspelled?] kindly to convey her best wishes to the children of Queen Beatrix. Such were the times.

I'm very honored to receive this award and I'd like to accept the prize on behalf of my colleagues and coworkers at KNCV, at the Union, at CVC at ATS and last but not least at WHO. Not so long ago we were a small band of entrepreneurs that together jump started the Stop TB Initiative, adopted the

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recommendations of the Londenette Hawk [misspelled?] Committee organized the Amsterdam Ministerial Conference that matured into the Stop TB Partnership as we know it today. And we all feel and could feel yesterday the tremendous force of that movement in this audience.

Wendy can I have the next? The greatest of Japanese artists Hokusai depicted Mount Fuji 36 times from different locations. He made them when he was 70 years old. This one is from 1830 and is called Red Fuji.

I'd also like to accept this prize on behalf of many colleagues and coworkers in the countries where I've worked, Tanzania, Vietnam, China and Indonesia in the early days of DOTS expansion. Many of you are in the audience today and I greet you from here. And I'm especially proud to see Dr. Sau VanChang [misspelled?] on the first row, Wendy next.

Japanese foot prints were an important influence on the development of modern art in Europe. Monet, Van Gogh, Rodin all had many works in their collections. This print by Hiroshige is very famous for the unique way he depicts rainfall. We are fortunate to live in times of strong global political commitment and funding for tuberculosis. I have seen different times. The only way to maintain our current momentum is to keep our focus and to show results, more patients detected, more patients cured and to eventually demonstrate the epidemiological impact of our work. Only on that basis of

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tangible measured results can we hope that the political commitment and funding that we enjoy today will remain. Success is possible but we will have to fight for it.

My last slide most probably is familiar to you all. The Great Wave and the fisherman struggling to be bring the fish caught at high seas to the shore. And you can see in the distance Mount Fuji. Thank you very much. [Applause]

ASMA EL SONY, PH.D.: May I ask Dr. Marcos Espinal from the World Health Organization to come to the podium please for the Kochon Prize?

MARCOS ESPINAL, M.D.: Good afternoon from the Stop TB Partnership. I'm pleased to announce today the Kochon Stop TB Partnership Award for the second year in a row. The award is given by the Partnership to those who are contributing majorly to stopping TB. And without further delay I will call up Chairman Doo-Hyun Kim of the Kochon Foundation who would like to say a few words before we call onto the [inaudible]. Thank you. Chairman.

DOO-HYUN KIM: Executive Directors, distinguished guests, ladies and gentlemen. The Kochon Foundation is proud to partner with the Sop TB Partnership in awarding this prize. The Stop TB Partnership Kochon Prize is a way of recognizing and rewarding individuals or organizations who have contributed in an extraordinary way to fighting tuberculosis.

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The prize is given in memory of Chong-Kun Lee who established a pharmaceutical company in South Korea and was one of the first people in the country to produce life saving anti-TB drugs. The late Chairman Lee bequeathed his partner assets to the Kochon Foundation to fund scholarships and research and to ensure a humanitarian spirit is nurtured.

The Kochon Prize is a humble attempt to recognize agencies who work tirelessly everyday in the communities in laboratories, in Ministries of Health and beyond to bring the dream of a TB free world as step closer.

We hope the prize not only recognizes success of the winners but enables them to continue to be fully engaged and part of a global family working to implement a global plan to stop TB. It is clear that TB affects us all but the real credit for fighting this disease should go to those who are on the front lines.

With this in mind I am delighted to give the award to Dr. Marcos Espinal, Executive Secretary of the Stop TB Partnership for the announcement of the winners of 2007 Stop TB Partnership Korea Kochon Prize. Thank you. [Applause]

MARCOS ESPINAL, M.D.: Thank you. The Stop TB Partnership Kochon Foundation Award consisting of a medal, certificate and \$65,000. The board decided to split it this year between two outstanding institutions. The award will go to the Ministry of Health of China for its efforts in expanding TB

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control in China. And it will go to also to the Bangladesh Rural Advancement Committee for its work in Bangladesh.

For the Ministry of Health of China we are pleased to recognize the outstanding work of two important persons in the expansion of the DOTS strategy in China.

Professor Zhao Fengzeng graduated in 1962 from Shanghai Medical University. After graduation Dr. Zhao worked at the TB Thoracic Tumor Research Institute in Beijing. In the 1960's Dr. Zhao worked intensively in the field, government offices, factories, mines and farms on active case finding diagnosis of TB.

In the 1970's he began research on TB epidemiology and was involved in the first nationwide random survey for epidemiology of tuberculosis in 1979. Based on that experience, Dr. Zhao developed and led nationwide tuberculosis random surveys in 1984, 1990, and 2000. In 1982 Dr. Zhao was appointed Deputy Director and then Director of the TB Control Intervention Center in Beijing where he was responsible for developing and implementing the National TB Program.

In the early 1990's Dr. Zhao cooperated with WHO and actually with the Union Professor Karel Styblo for the development of the China TB Control Project supported by a World Bank loan. Dr. Zhao was in charge of technical implementation of the project. Once again he went to the field where he motivated and trained village doctors in DOTS

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implementation. Dr. Zhao's work resulted in the expansion of DOTS strategy to cover 650 million people in China leading to an increase in the TB treatment rate from 50-percent to over 80-percent of the population.

In 2002 China received a second loan from the World Bank which allowed the number of provinces involved to increase from 12 to 16. Under the leadership and support of the Chinese government the policy of free diagnosis and treatment was implemented in the entire country.

In 2005 China achieved 100-percent DOTS coverage, 70-percent case detection and 85-percent cure rate. Dr. Zhao is the Vice Chairman of TB Consult Committee of the Ministry of Health. He also consults for UITLD, Liverpool University, KNCV and WHO to coordinate domestic and international TB control projects. Ladies and gentlemen, Professor Zhao Fengzeng.

[Applause]

ZHAO FENGZENG: Ladies and gentlemen I'm truly honored to accept the 2007 Stop TB Partnership Kochon Prize on behalf of Ministry of Public Health in China. As I accept this extraordinary honor, I want to say thanks to the Stop TB Partnership and the Kochon Foundation for their very stringent commitment of fighting TB around the globe. I want to thank my government and [inaudible] officers for supporting me. And especially I want to say thanks my friends and my colleagues for their contribution and helped me to do the more the work.

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And last one I want to thank my family for understanding and support. Stop TB is a long hard fought campaign. I'm willing to make it my life long commitment. Thank you very much.

[Applause]

MARCOS ESPINAL, M.D.: Thank you. Dr. Wang Longde graduated from Lanzhou Medical College in 1969 and received his master's degree from the Chinese Academy of Medical Science in 1978. In 1980 he studied at the Mount Sinai School of Medicine, New York University as an exchange scholar for two years and received a national award on his return.

In 1982, Dr. Wang served as the head of the Scientific and Educational Department in Gansu Health Bureau and as the chief of the bureau from 1991 till 1995. From 1995 to 2007 he served as the Vice Health Minister of China. Dr. Wang has also served as a tutor at the Public Health College of Union Medical University and devoted himself to the study of epidemiology and public health. He has published over 40 papers in Chinese and internationally recognized journals and has contributed to or edited a variety of professional texts including tuberculosis control.

He has received the Science and Technology Award from Gansu Health Bureau in 1981 and Science and Technology Award of Gansu Province from the scientific committee of Gansu Province in 1993. He has also received the third award of Science and Technology from the Beijing Municipal Government. He has also

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received the second award of Science and Technology from the state council for the series of book he has published.

Dr. Wang has served as the Vice Minister of Health and has served also in the coordinating board of the Stop TB Partnership and has played a major role behind the policy at implementing the Stop TB Strategy in China. And today China has a full coverage of TB control to the DOTS [inaudible] in thanks to the leadership of Dr. Wang.

Ladies and gentlemen, Vice Minister Wang Longde from the Peoples Republic of China.

VICE MINISTER WANG LONGDE, M.D.: Respected Dr. Marcos Espinal, distinguished guests, ladies and gentlemen. Good evening. First of all my thanks go to the selection committee of the Stop TB Partnership Kochon Prize for their recognition of the TB prevention and control achievements in China and of the efforts made by me and Professor Zhao Fengzeng [inaudible] fight against tuberculosis.

The prize entitled to the Ministry of Health of China [inaudible] to the importance Chinese government attaches to tuberculosis prevention and control. The Chinese government promote the DOTS recommended by WHO. After years of enduring efforts a modern TB control strategy is formulated fit in into Chinese national situations. Only in this sound policy environment can we play our activities and make our humble contribution to TB control and detection.

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Furthermore we have two points to share with you. First to integrate medical institutions into TB prevention and the control system is the structural guarantee to realize TB control initial objective.

Second web-based direct reporting of TB cases by medical institutions together with CDC tracing and screening is technical guarantee to improving detection rates of TB cases. Ladies and gentlemen TB control is a social systematic work which needs joint efforts of all parties concerned and needs participation of all society.

For years TB control in China received extensive support and assistance from the international community. On behalf of the Ministry of Health of China I'd like to express my sincere thanks to those organizations, groups and individuals contributing to TB control in China. In the future I will continue devoting to the work of TB prevention and achievement and make contribution to the containment of TB epidemic in China and elimination the TB all over the world. Thank you for your attention. [Applause]

MARCOS ESPINAL, M.D.: Thank you, Vice Minister. With a vision of just enlightenment, healthy and democratic Bangladesh free from hunger, poverty, environmental degradation and different forms of exploitation based on age, sex, religion and ethnicity BRAC started as an almost entirely donor funded. A small scale relief and rehabilitation project to help the

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country overcome the devastation and trauma of the Liberation War.

Today BRAC has emerged as an independent virtually self financing paradigm in sustainable human development. It is the largest in the world employing 97,000 people. With the twin objectives of poverty alleviation and empowerment of the poor. Through experiential learning BRAC today provides and protects livelihoods of around 100 million people in Bangladesh. Diagnosing poverty in human terms and recognizing its multidimensional nature BRAC approaches poverty alleviation with a holistic approach. BRAC's outreach covers all 64 districts of the country and furthermore has been called upon to assist a number of countries including Afghanistan and Sri Lanka.

From the time of its modest inception in 1972 BRAC recognized women as the primary caregivers who would ensure the education of the children and the subsequent intergenerational sustainability of the families and households. Its comprehensive approach combines Microfinance under BRAC's Economic Development Program with health, education and other social development programs, linking all the programs strategically to counter poverty through livelihood generation and protection.

The Stop TB Partnership [inaudible] would like to acknowledge civil society and all the NGOs that are a part of

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the Stop TB Partnership by recognizing this year BRAC. Ladies and gentlemen Mr. Faruqe Ahmed will receive on behalf of BRAC Chair who is unable to attend today. Faruque. [Applause]

FARUQUE AHMED: Thank you and good evening ladies and gentlemen. On behalf of BRAC's Founder and Chairperson Mr. Fazle Hasan Abed, 68,000 community health volunteers, the entire health team, and 100,000 BRAC staff both in Bangladesh and abroad I extend our sincere thanks for honoring our TB Program with the Stop TB Partnership Kochon Prize.

It would seem strange that a development agency known for having 6 million Microfinance credit borrowers, 52,000 [inaudible] schools for 1.5 million children and [inaudible] healthcare program for 80 million population, enterprises in fisheries, silk, dairy, poultry for development should be selected for its excellence in TB program. The [inaudible] about BRAC working in a country of 140 million is the importance of going to scale. Whatever you do we must do it for millions and at a price affordable for the poorest. The same is true for the TB Program and may very well be the reason for its [inaudible].

Twenty five years ago we recognized TB as a major health program for adults in our country, an important impediment to develop and [inaudible] poverty. Till then TB was a doctor's disease, diagnosed, managed and treated only by the doctors. Few realized they had TB until too late when the

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disease reached advanced stages. Our poor clientele could not afford to attend doctors for treatment, far less for follow up. The traditional diagnosis and treatment was [inaudible] for our people.

For TB we learned that our women volunteers going house to house could also find those with cough and [inaudible] examination for diagnosis. The woman for to collect the medicine and patient treatment cards returned to village to oversee the daily [inaudible] of medicines, record a [inaudible] on the treatment card and educate the patient, the family and neighbors.

To reinforce the importance of treatment we insisted that each patient pay a community volunteer with a sum of [inaudible] 200, which is about three and half dollars, which is four days of wage labor. And sign an agreement with the families that when all the medicines are successfully taken, a dollar [inaudible] would be returned to the patient and the balance would be taken by the volunteer.

You can't imagine how important this incentive became to both patient and to the worker to [inaudible] results. In case of dire poverty the village leaders were approached to put up the money in the interest of the community. Imagine the social pressure to complete the treatment in this scenario.

As for the overall structure of the TB Program, we followed the model of our other development efforts. There is

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a supervisor for every trained volunteer who reports to a District Health Manager at the level of the sub district [inaudible] and TB drug supplies who manages the health activities in addition to the TB Control Program. The sub district managers are supported by the district [inaudible].

After a few years of high compliance in the TB Program we were asked by the government to expand the program. In collaboration with the government and financial support from global funds along with other NGOs we happily expanded the community based DOTS in the entire country. BRAC alone does [inaudible] the country.

We thank the Ministry of Health, NGO partners, international donor, and [inaudible] agencies for their contribution and trust in our effort. Some 87,000 TB patients were diagnosed last year with 92-percent cure rate in BRAC areas. The only doctors that are involved in the government system at the district and sub district levels for technical supervision. For those who denigrate this non medical model we invite them to examine the results.

While BRAC manages scale of the TB Program. The real heroes are the 68,000 women community health volunteers. Ladies and gentlemen it is to those women that we dedicate this prize. The recognition is deservedly theirs. Their work is the unsung [inaudible] that brings health to all the people living in the community. Be it [inaudible] or distant village.

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I thank you all on behalf of each of them. Thank you.

[Applause]

MARCOS ESPINAL, M.D.: Thank you very much. This ends the Stop TB Partnership Kochon Foundation Awards. And now I'm pleased to introduce and Anna Cataldi. Anna has been appointed a Stop TB Ambassador in September 2007. She is from Italy. Anna Cataldi has a role to raise awareness world wide about the inferred burden of TB on refugees, migrants, people living in poverty and other disadvantaged groups.

Ms. Cataldi was appointed UN Messenger of Peace by former Secretary General Kofi Annan in 1998 and served in that role until 2007, has a long and accomplished record as a human rights advocate, she's the author of "Letters from Sarajevo" which chronicles the impact of war on Bosnia childrens. She is also traveled in Somalia, Rwanda and Afghanistan bringing support and encouragement to those caught in the dangerous conflicts of those countries.

In 1998 to mark the 50th Anniversary of the Universal Declaration of Human Rights, she initiated a project to create and distribute a passport sized pamphlet version of the Universal Declaration of Human Rights for Children. In March 2007 she conceived and helped organize a photo exhibit focusing on TB at the UN headquarters that was viewed by more than 100,000 people.

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Ladies and gentlemen, I'll give you Anna Cataldi, Anna please. [Applause]

ANNA CATALDI: Hello my name is Anna Cataldi. I am Italian and I'm a Stop TB Ambassador. And in the past 15 years as a war correspondent first and then as a Messenger of Peace I've been traveling in world. I've been witnessed first hand conflicts and I saw and I witnessed human beings inflicting pain, death to other human beings. Now as a TB Ambassador I see, I witness another battle but I see an army of people they fight not to inflict pain but to avoid pain to make relief from suffering other human beings. This is a very strong battle is the battle against the deadly bacterium. A bacterium for as long as the man was living was causing suffering and death.

In the past 126 years since Robert Koch discovered the enemy, the bacterium a lot of scientists they find the way to fight and they succeed in curing the TB but and what I would like to say by announcing the Stop TB Campaign for 2008 which is, the team is going I've stopped TB but now everybody is called to join the army of people of fight to stop TB. Because the bacterium is not easily defeated, this mycobacterium is clever, is smart, is elusive, is very sophisticated. The men succeed in finding medicine to fight and the bacterium change, become different. And there's a race to find new medicine, new medicine that don't exist so a new way to treat it and way to control and diagnosis it. So the Stop TB Campaign 2008 which

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is the theme is, I've stopped TB, is calling everybody, they can be health worker, patient civil society people, nurse, media, media they can have a huge role to fight to join this army this global army to fight TB. This is going to be a battle we never relax we have to keep being on guard and we keep going in order to save people from unnecessary death, unnecessary suffering. Thank you. [Applause]

MARCOS ESPINAL, M.D.: Thank you, Anna. And we're going to show a short video of Anna's latest visit to Afghanistan where you can see the suffering of the people of Afghanistan's in TB. Please the video.

[START VIDEO] [END VIDEO][Applause]

ASMA EL SONY, PH.D.: [Inaudible] Just as you know the Union is undergoing strategic planning and realigning its sections to match its activities and better carry them out. So please ensure that you sign up for one of the new sections and participate in their meetings on Sunday November 11th, at 18:30, at 6:30. Again the Union has started an HIV section. For those who are interested make sure that you sign up as well. You can see that the rooms are over there.

Ladies and gentlemen you are welcome once more to the Union's 38th World Conference; you are welcome to the inaugural cocktail at the ballroom. I declare this conference open and thank you very much and thank to The Minister and to our speakers. Thank you. [Applause]

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[END RECORDING]