

GLOBAL PARTNERSHIP TO STOP TB

# Highlights: First Stop TB Partners' Forum



22-23 OCTOBER 2001 • WASHINGTON, DC



The Global Partnership to Stop TB would like to express its appreciation to the partners that supported the first Stop TB Partners' Forum:



*American Thoracic Society*



*Canadian International Development Agency*



*Government of the Netherlands*



*Open Society Institute*



*Rockefeller Foundation*



*Task Force for Child Survival and Development*



*US Agency for International Development*



*US Centers for Disease Control and Prevention*



*World Bank*



*World Health Organization*

Available in English only in hard copy  
and on our Internet website at: [www.stoptb.org](http://www.stoptb.org)  
Printed December 2001

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# *Preface*

The World Bank's mission is to help create a world without poverty, and communicable disease control is among our top priorities.

Tuberculosis, malaria and HIV/AIDS inhibit poverty alleviation and development throughout the world. By hosting the first Stop TB Partners' Forum, we are sending a signal of our commitment to the partnership and to reversing the epidemic. We have a cure for tuberculosis and a cost-effective strategy to deliver that cure—DOTS.

Global partnerships can make a difference. The World Bank commends all partners for their dedication and success in expanding access to DOTS and fostering the discovery of more rapid means to stop TB.

Our work to date with high TB burden countries has shown that investment in TB control can make a difference in reducing suffering, death and disease transmission. Our partnerships with governments, technical agencies, NGOs and communities enable better use of the resources available and help overcome obstacles in our path.

The launch of the Global Plan to Stop TB at the first Partners' Forum represents a milestone. It provides a roadmap towards a TB-free world. The World Bank endorses this Plan and will contribute to it through investment and policy support for TB control and health systems worldwide. We are heartened by expanding investments made by many high burden countries, by wealthier countries and by private sources. We still have a long way to go, but the 2005 TB control targets are realistic if we continue to scale-up our efforts and innovate.



Mr James Wolfensohn  
President  
The World Bank

The Global Partnership to Stop TB is a pioneering effort. With its innovative approach to health and development, it has broken the mould—and done so in record time.

In fact, the first Stop TB Partners' Forum was convened in Washington, DC, in October 2001, just 18 months after the groundbreaking Amsterdam Declaration to Stop TB in March 2000.

In that short time, the fledgling partnership grew from six to over 120 organizations—key partners from governments, donors, bilateral and multilateral agencies, NGOs, scientists, health and community workers and civil society. One of its first initiatives, the Global Drug Facility, is already delivering life-saving anti-TB drugs to recipient countries.

Through the Global Plan to Stop TB, which sets out the strategies, priorities and resource needs through 2005, further investment is being encouraged as the next vital step on the road towards a TB-free world—and as an act of enlightened self-interest for rich and poor alike.

The partnership for better global health is both a responsibility and an opportunity to make a real difference. Stopping TB means a healthier and more prosperous world.

Dr Gro Harlem Brundtland  
Director-General  
World Health Organization



# Washington Commitment

## The first Stop TB Partners' Forum,

Involving ministerial representatives from high-burden countries comprising 80% of the global tuberculosis (TB) burden, heads of agencies and representatives of Stop TB partners, meeting in Washington, DC, at the World Bank, recognizing tuberculosis as a critical factor contributing to persistent entrapment by poverty, and as such being an impediment to economic development, herewith expresses its commitment to further operationalize the Amsterdam Declaration to Stop TB by:

- undertaking urgent and accelerated action against tuberculosis over the next 50 months;
- intensifying efforts to reach the global targets for tuberculosis control by 2005;
- detecting 70% of people with infectious tuberculosis, and successfully treating 85% of those detected; and
- mobilizing additional resources through increasingly coordinated efforts.

## The Partners' Forum participants hereby issue the following statement:

### I. We are encouraged by the progress made in implementing the Amsterdam Declaration:

- Tuberculosis is now increasingly recognized internationally as a social and economic—as well as a health—issue;
- The number of countries adopting DOTS has increased substantially;
- Several TB high-burden countries have rapidly expanded DOTS coverage;
- A growing number of TB high-burden countries have established national coordination mechanisms as partnerships to optimize support for control programmes; some have also initiated partnerships with the private sector;
- The Global Partnership to Stop TB is continually expanding and developing operational mechanisms to accelerate action;
- A Global Plan to Stop TB, comprehensively describing the actions, resources and partnerships that will accelerate progress towards TB elimination, has been developed;
- National and international resources invested in TB control and research have increased substantially;
- The Global Fund to Fight AIDS, TB and Malaria (GFATM) is being developed to channel additional resources to countries;
- A Global DOTS Expansion Plan, identifying the actions and resources needed to meet the global targets for TB control in the 22 high-burden countries, has been developed by countries and partners;
- The Global Drug Facility (GDF) has been launched and is already delivering TB drugs to countries in Africa, Asia and Eastern Europe, at considerably reduced prices;
- The DOTS-Plus Green Light Committee (GLC) for access to second-line drugs for the management of multidrug-resistant TB (MDR-TB) has approved projects that are currently benefiting from drug price reductions of up to 94%;
- The Global Alliance for Tuberculosis Drug Development (GATB) has been established and is funding research into new drugs;
- The Global Working Group on TB-HIV is promoting implementation of the range of interventions available to decrease the burden of TB-HIV;
- TB vaccines development has received renewed attention and reinforced support through coordination and resources;
- The TB Diagnostics Initiative has expanded to involve more partners.



# *to Stop TB*

## **II. Despite this welcome progress, there is no room for complacency. We note with grave concern that:**

The level of public awareness, as well as the degree of political and financial commitment, remains inadequate. As a result, the global TB epidemic continues to worsen, undermining the development of families, communities and thus national economies. It traps the world's poorest, stigmatizing individuals, marginalized and vulnerable groups (including prisoners, refugees, migrants and the homeless) in a vicious cycle of disease and poverty.

- Only one in four people with tuberculosis is treated with DOTS. The current rate of DOTS expansion is still far too slow to reach the global targets by 2005. Failure to reach these targets will condemn millions of people to disease and death;
- The TB epidemic continues to grow, and more people now die from tuberculosis than ever before—nearly two million every year;
- The tuberculosis epidemic increases ten per cent per year in Africa—largely due to HIV/AIDS. Thirteen million people around the world are dually infected with TB and HIV, the majority in Africa and Asia;
- Similar increases in rates of TB have been observed in the former Soviet Union, as a result of the severe socioeconomic difficulties of the last decade;
- Two of every three people stricken with tuberculosis are young adults in their most productive years—many also suffering from AIDS—who are cut down in the prime of their lives;
- Hundreds of thousands of people, many of whom are socially disadvantaged and have no access to effective treatment, have drug-resistant tuberculosis;
- The magnitude of suffering and death caused by the global tuberculosis pandemic is both alarming and unacceptable. Far more than just a health concern, this human tragedy demands urgent action on a global scale to address both the TB and HIV/AIDS epidemics and their repercussions on global development;
- Many countries continue to face serious constraints to TB control, with insufficient human and financial resources, and an inadequate health care infrastructure.

## **III. As representatives of the national governments of 18 of the highest TB burden countries, we recognize that urgent and specific action is needed over the next 50 months to accelerate progress against tuberculosis and to achieve the global targets, which are to detect 70% of infectious cases, and cure 85% of those detected. We commit to:**

- **Ensuring that all people with TB have access to effective care by:**
  1. Developing and implementing strategies for development of sufficient, sustainable, human and financial resources to meet the challenge of stopping tuberculosis;
  2. Expanding tuberculosis prevention and care programmes based on the DOTS strategy in all public health services, in line with internationally accepted standards and practices;
  3. Developing sustainable systems capacity to plan, implement, manage and evaluate TB programmes;
  4. Monitoring and evaluating national tuberculosis programmes to confront the disease and prevent the emergence of drug-resistant strains and effectively manage people with drug—resistant tuberculosis;
  5. Working in close public-private sector collaboration with other health service providers in the private sector, nongovernmental organizations (NGOs) and social security agencies;

*...endorsed  
at the first  
Partners'  
Forum on  
23 October  
2001*

6. Raising awareness and mobilizing society to undertake tuberculosis prevention and care;
  7. Promoting the development of national and sub-national partnerships with all stakeholders in society, including government departments and organizations, private health sector partners, industry, NGOs, social security agencies and the community.
- **Addressing the urgent issue of the tuberculosis and HIV/AIDS co-epidemic by:**
    1. Massively expanding DOTS coverage, to ensure that people with tuberculosis, irrespective of their HIV status, have access to effective care and support;
    2. Enhancing effective collaboration between tuberculosis and HIV/AIDS prevention and care programmes, promoting increased use of all appropriate interventions, including voluntary counselling and testing, and community-based initiatives in education, care and support;
    3. Building on lessons learnt from successful DOTS programmes in providing appropriate treatment, care and support for people with HIV/AIDS.
  - **Co-ordinating effective action by:**
    1. *Collaborating within the health sector.* The care of adults and children with tuberculosis is an integral part of primary health care and a major contributor to the overall development of national health systems;
    2. *Collaborating across sectors.* Confronting tuberculosis requires collaboration across government sectors and action across the entire spectrum of society. It is a complex socioeconomic problem that impedes human development, and cannot be controlled by the health sector acting alone;
    3. *Collaborating across borders.* Recognizing that TB respects no borders, and that other countries not represented in this Forum face many or all of the same problems, we call upon our colleagues around the world to join us and actively participate in building momentum against tuberculosis and for better health for all. TB control is a global public good and requires global action. The epidemic will continue to worsen unless we share resources, best practices and tools within and across borders.

**IV. As partners supporting high TB burden countries committed to achieving the global targets to stop TB within the next 50 months, we affirm our support for these efforts.**

While recognizing that it is first and foremost the responsibility of affected countries to initiate and sustain action against tuberculosis, we call attention to the fact that the problem is often greatest in the very countries which can least afford to take action. Because it is in the interest of the global community to support tuberculosis control worldwide:

- **We commit to sharing our resources by:**
  1. Providing technical assistance to support global, regional and national stop TB programmes and activities;



2. Mobilizing increased financial resources for countries and partners in support of the Global Plan to Stop TB, using existing mechanisms and new initiatives, such as the Global Fund to Fight AIDS, TB and Malaria;
  3. Establishing a mechanism for direct financing of the Stop TB Partnership.
- **We commit to working in partnership by:**
    1. Endorsing the Framework of the Global Partnership to Stop TB;
    2. Collaborating through Stop TB Working Groups and other operational structures established by the partnership to achieve the objectives of the Global Plan to Stop TB;
    3. Promoting and supporting the development of interagency coordinating committees, or similar mechanisms, at the national and regional level;
    4. Supporting the further development of the Global TB Drug Facility and other initiatives of the Global Partnership to Stop TB.

**V. Together, as national governments and partners, we commit to monitoring our progress, and undertaking the following specific actions:**

- ***Within the next 50 days—by the end of 2001:***
  - All high-burden countries will finalize national plans to achieve the global TB control targets;
  - All partners represented in this meeting will affirm their commitment to the Global Plan to Stop TB;
  - All partners will support the launch of the Global Fund to Fight AIDS, TB and Malaria.
- ***Within the next 50 weeks—by the end of 2002:***
  - We will achieve a global DOTS case detection rate of at least 35%;
  - All high-burden countries will establish interagency coordinating committees, or similar mechanisms, that will include tuberculosis control within the scope of their mandates;
  - The Global TB Drug Facility will provide drugs to treat at least one million additional patients.
- ***Within the next 50 months—by the end of 2005:***
  - We will achieve a global DOTS case detection rate of at least 70%, while maintaining a treatment success rate of at least 85%;
  - We will develop and scale up effective responses to TB-HIV and MDR-TB;
  - We will develop the Global Plan to Stop TB for the period 2006–2010.
- ***Within the next 50 years—by 2050:***
  - We will eliminate tuberculosis as a global public health problem.

***We mandate the Stop TB Partnership Secretariat to report annually to the Forum on progress in achieving these objectives.***

# Introduction

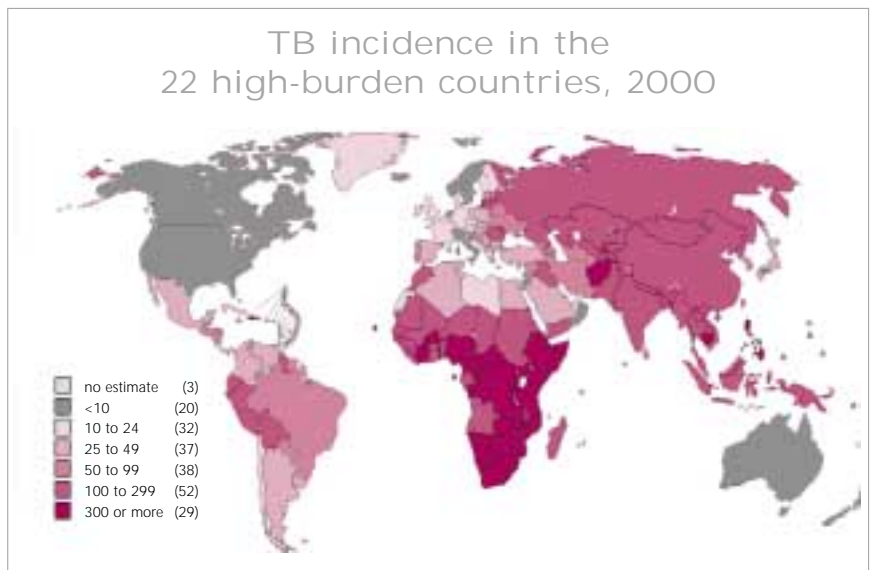
***“There is a tide in the affairs of men, which, taken at the flood, leads on to fortune...”***

*William Shakespeare*

Before turning to the specifics of this report, let us take a moment to look at the bigger picture, historically and geographically. When we do, it is overwhelmingly evident that we have reached a crucial threshold in the health-related history of civilization as a whole. After centuries in which infectious diseases—tuberculosis foremost among them—claimed countless lives, within the brief space of only 50 years, science and medical technology have placed unprecedented opportunities at our disposal. Since the 1950s, we have developed a regimen of multidrug chemotherapy that can fully cure TB and thus keep it from spreading, an undreamed-of achievement. With this breakthrough, we have reached that “floodtide” that could lead on to the “fortune” of a TB-free world. We have the means to relegate TB to “the dustbin of history.”

The opportunity is there. Are we using it? Yes. Optimally? *No*. Is the clock ticking? *Absolutely*.

*TB's 22 high-burden countries in March 2000 listed in descending order of incidence: India, China, Indonesia, Bangladesh, Pakistan, Nigeria, Philippines, South Africa, Russian Federation, Ethiopia, Viet Nam, Democratic Republic of the Congo, Brazil, United Republic of Tanzania, Kenya, Thailand, Myanmar, Afghanistan, Uganda, Peru, Zimbabwe and Cambodia.*



Take a look at the global map. It shows the 22 TB high-burden countries that, together, account for 80% of the world's TB cases. It is there—and now—that we must concentrate our efforts if we are to take the “floodtide of technology” before it passes. Even now, 5 000 people die needlessly each day of TB, a disease that is *curable* for as little as US\$ 10. Is there a moral imperative? *Undeniably*.

The Global Partnership to Stop TB was created out of this moral and medical imperative. The next 50 months are crucial. Do it now—or the tide of drug resistance, HIV/AIDS and other, as yet unforeseen, factors may turn and this shining opportunity be lost forever. We cannot let that happen.

Our vision is one of a TB-free world. This vision is attainable. We know exactly what it will take and what the price tag is: US\$ 9.3 billion over the five-year period 2001–2005. The global shortfall is less than US\$ 1 billion per year. Countries can spend more than that on wars in a single *day*. So, yes, our vision is well within reach. But visions also require “nuts and bolts” mechanisms and actions. That is what the Global Partnership to Stop TB and its first Partners’ Forum is all about.

***The global shortfall for TB control is less than US\$ 1 billion per year. Countries can spend more than that on wars in a single day.***

***The Forum was convened for two primary reasons:***

The following pages capture the highlights of the **first Stop TB Partners' Forum** convened in Washington, DC, from 22-23 October 2001. This meeting, a milestone in the chronicle of global TB control, brought together some 200 participants from around the world, in particular representatives from 18 of the 22 TB high-burden countries. This national presence shows the resolute commitment of hardest-hit countries to come to grips themselves with the TB crisis in their midst.

This Forum was convened for two primary reasons: endorsement and investment. First, in the true spirit of partnership, the Stop TB Partnership Framework, the Washington Commitment, and the Global Plan to Stop TB were endorsed by all participants. Second, through the Global Plan, which set out the strategies, priorities and resource needs until 2005, investment is being actively encouraged as the next and vital step on our road towards a TB-free world.

The **Washington Commitment** was the primary political outcome of the Forum. Coming just 18 months after the Amsterdam Declaration of March 2000, it marks the second milestone and provides further impetus to attain the 2005 TB control targets of 70% detection and 85% cure outlined in the report. With endorsement by national governments and non governmental actors, it models the essence of the Partnership's inclusive approach.

The Forum reported on progress since Amsterdam (March 2000) in expanding the DOTS strategy. It also dealt with "hot topics," such as the threats of multi-drug-resistant TB and the overlapping epidemics of TB and HIV/AIDS. Concrete steps towards reinforcing global efforts to Stop TB were presented, highlighting the work of the six working groups and task forces.

A series of three concurrent roundtables on the joint themes of finance and partnerships were staged to provide success stories and lessons learned from the national perspective. The were interspersed with a session on concrete opportunities to invest in the Stop TB initiative, featuring presentations by high-profile partners, such as WHO, the World Bank and the Chairman of the Open Society Institute.

The Forum had several specific outcomes, which will guide its next steps. Both the Washington Commitment and the **Stop TB Partnership Framework** were endorsed and, in fact, the Forum reflected this spirit of partnership, including not only TB-affected countries but also international development agencies, bilateral and multilateral partners, NGOs, foundations and the private sector. As Dr Brundtland noted, "partnerships are the way of the future."

As a concrete product, the **Global Plan to Stop TB** was also launched. It is noteworthy that, to date, TB is the only disease in history for which a global control and investment plan, complete with detailed resource needs, has been drawn up. This innovative plan, which is also attractive from an investment viewpoint, may well serve as a model for other diseases in future.

Finally, the presence and active endorsement of the Stop TB Partnership and Global Plan by high-profile advocates—World Bank President James Wolfensohn, WHO Director-General Gro Harlem Brundtland, and internationally known financier-philanthropist George Soros—in itself reflects the high level of global commitments to control TB throughout the world.

We hope that the forthcoming pages will provide you, the reader, with both the concrete information and the visionary inspiration to make you an (even more active) partner in our Global Partnership to Stop TB.

***The Washington Commitment was the primary political outcome of the Forum.***

***"Partnerships are the way of the future."***

*Gro Harlem Brundtland  
Director-General, WHO*

***...endorsement and investment.***

# 1. Progress since Amsterdam:

**The World Bank sees the Global Plan to Stop TB as a road map for a world free of TB. We will reinforce our role as a principal external financier of TB Control Programmes and health systems worldwide.**

*James Wolfensohn,  
President  
The World Bank Group*

## Taking TB control to scale



**World Bank President, Mr James Wolfensohn,** opened the Partners' Forum with the statement that the myth of two worlds is no more. "Globalization should benefit everyone, including the poor and the sick. We have the technology; we need stronger partnerships to take TB control to scale." TB offers a prime example of the huge benefits that derive from global cooperation and the perils of non-action. Developing countries must invest more in health, integrating DOTS for TB control into health systems development. Improving health will also reduce poverty, the Bank's ultimate aim.

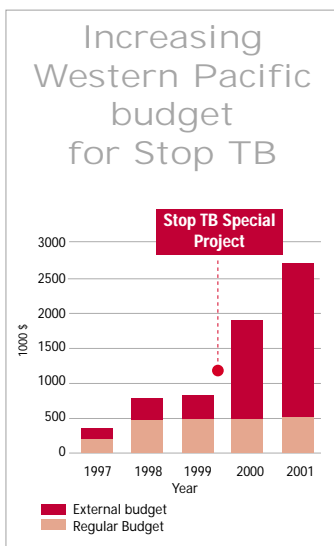
## Celebrating 50 years of successful TB treatment



**TB Pioneer, Sir John Crofton,** who was knighted in 1977 for his contribution to TB control in Scotland and who, at 90, is still actively involved, traced the success story of multidrug chemotherapy over the past half century. Examples from developed and developing countries alike verified his once radical, but now fully endorsed view that "a 100% cure of pulmonary TB is both a reasonable and achievable target." Despite recent setbacks due to the emergence of HIV/AIDS and multidrug-resistant TB, Sir Crofton declared that "we have the means to win, we must have the will."

## Getting the job done together

**WHO's Western Pacific Region: Regional Director, Dr Shigeru Omi,** said that his region had 25% of the world's TB burden but it had acted decisively in 1999, establishing Stop TB as a special project for the region and quadrupling the TB budget. A strong foundation has been built; WHO TB staff has increased from two to ten; the number of countries in the region implementing DOTS has increased from 18 to 22; and partner support has risen significantly since that time. Now the region aiming for 100% coverage—"DOTS for all by 2005"—in order to halve its TB burden by 2010.



**We must expand DOTS.**

There has been significant progress since Amsterdam—but not enough: only 23% of people with TB are treated in DOTS programmes. Our targets are to identify at least 70% of active TB infections and cure 85% of those detected. We can do it!

***We have made significant progress to Stop TB since the Amsterdam Declaration in March 2000...***

# Expanding DOTS

## Making TB a top priority in South-East Asia

**WHO's South-East Asia Region: Deputy Regional Director, Ms Poonam Khetrapal Singh**, said that SEARO accounted for 38% of the world's TB cases but that it was expanding DOTS to achieve nationwide coverage by 2005 or sooner. She singled out India, which alone accounts for 33% of the global TB burden, as the country making the most dramatic progress: 20-fold DOTS expansion and a 7-fold reduction in TB deaths since July 1998. In 2000, she estimated that India had accounted for over 50% of the global increase in DOTS coverage and that in 2001 it would be treating more patients with DOTS than any other country in the world.

## Opening the window of opportunity wider

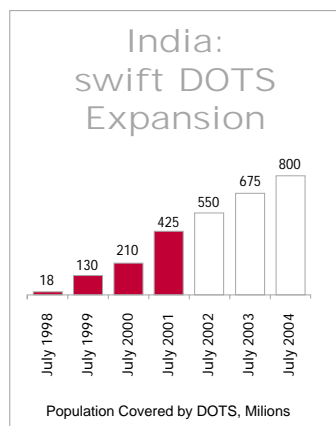
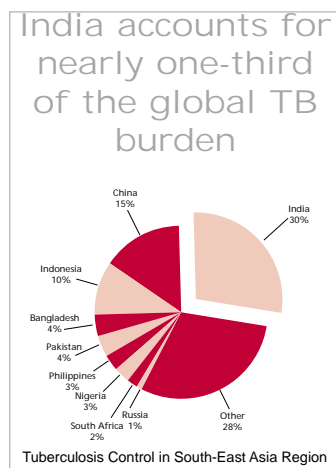
**USAID's Director of the Center for Population, Health and Nutrition, Dr Duff Gillespie**, said that USAID had becoming increasingly involved in global TB control since 1998, providing support for a diversity of activities, including DOTS expansion through surveillance, training and new tools, and improving implementation of community-based care and ProTEST. USAID had also spearheaded the development of the TB Coalition for Technical Assistance (TBCTA). Now it would be crucial to "keep the window of opportunity from closing... to open it even wider." Partners should do more to document their successes and advocate in an expanded arena.

## Generating political support

**The Pan American Health Organization's Regional Director, Sir George Alleyne**, said that the challenges in this region were similar but on a smaller scale and that Peru had made remarkable progress in graduating out of the group of 22 TB high-burden countries. "We should see the glass as half full, not half empty," he said, adding that PAHO was striving for a 90% DOTS coverage rate by 2003, ahead of target.

Overall, additional resources would be essential to ensure that all aspects of the Amsterdam Declaration were implemented and the rate of DOTS expansion increased. He said that the public needed more information on TB, especially in high-burden countries, and that issues such as gender discrimination and stigma must be tackled; more DOTS-trained health care professionals were needed, both in clinical and home-care settings.

Regarding political support, Dr Alleyne said that, in fact, it was "available and increasing." He concluded by citing the lyrics of a Mahalia Jackson gospel song that ended, "Good Lord, don't move the mountain, just give me the strength to climb."



TB control international development targets for 2005:

- Identify at least 70% of all active TB cases;
- Cure at least 85% of those detected and properly treated.

*... but much remains to be done and time is running out.*

# 2. Combating new threats

**HIV infection is the most potent risk factor for converting latent TB into active TB. In parts of sub-Saharan Africa, two-thirds of TB patients are co-infected with HIV.**

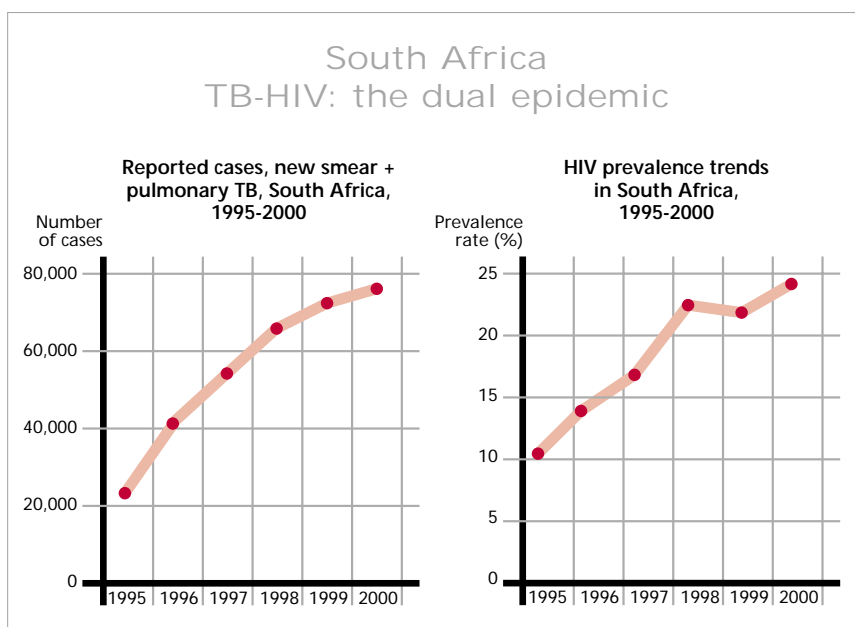
## Overcoming obstacles: TB-HIV

WHO's Regional Director for Africa, *Dr Ebrahim Samba*, and Director of Public Health (RIVM, Netherlands), *Dr Gijs Elzinga*, co-chaired Session Two. Dr Samba began by pointing out that, although India had the highest TB incidence, Africa had the highest per capita disease rate. In many sub-Saharan African countries badly affected by HIV/AIDS, at least two-thirds of TB patients are co-infected with HIV; for the continent as a whole, the percentage is 40%. Describing the combination of TB, HIV and poverty as "dynamite waiting to explode," he stressed that adequate resources, plus the ability to shift them in keeping with quickly changing needs, would be paramount in combating these overlapping epidemics.

## Optimizing opportunities: stepping up TB control

**South Africa: Executive Council for Health, Mr Sello Moloto**, presented his country as a case in point. Burdened by one of the world's worst TB epidemics, South Africa is also one of the countries most severely affected by HIV/AIDS. With TB increasing due to high HIV prevalence, collaboration is imperative.

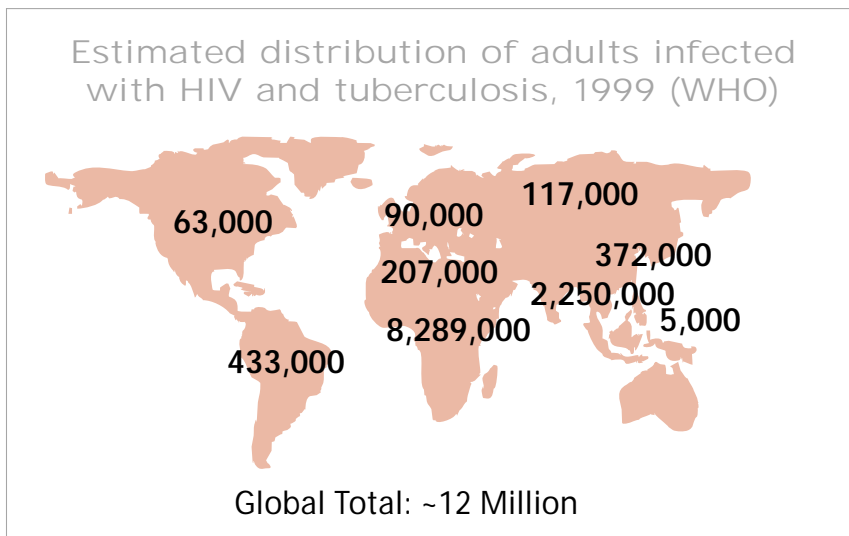
"These statistics have brought home the fact that treating HIV/AIDS means stepping up TB control," said Moloto. Working in tandem, South Africa's public sector TB and HIV/AIDS departments have merged to facilitate funding and programme support. Four collaborative TB-HIV pilot projects have been started since 1999. Key activities include: more voluntary counselling and testing (VCT), tandem TB and HIV/AIDS training for health care workers and improved prevention and management of opportunistic infections.



**We are moving against the overlapping TB-HIV epidemics...**

We must confront—and conquer—new TB threats like HIV/AIDS. It threatens to undermine the progress in TB control. HIV has dramatically fuelled the TB epidemic, especially in sub-Saharan Africa—and yet TB is treatable and curable, even in people living with HIV/AIDS. We must develop our complementary response to the overlapping TB-HIV epidemic.

Centers for Disease Control and Prevention/Global AIDS Programme: *Dr Harold Jaffe, Acting Director, National Center for HIV/STD/TB Prevention*, began by citing the somber statistics: world-wide, over 40 million people estimated to be infected with HIV/AIDS, 12 million of whom are co-infected with TB. The co-infection picture is shown below.



Jaffe stressed that the convergence of these two diseases demanded a complementary response that carefully balanced resources to minimize the threat of overburdened budgets and infrastructures in hard-hit countries, and to maximize the opportunities for integrated prevention and care.

Synergy works both ways, he said; the treatment of one disease helped mitigate the other. CDC’s Global AIDS Program (GAP) also works in synergy with WHO, UNAIDS and the public health sectors of severely affected countries, assisting with infrastructure development, capacity building, and HIV prevention, treatment and care. Of GAP’s 24 countries, 14 are also WHO TB high-burden countries. GAP is currently promoting active collaboration between TB and HIV/AIDS programmes in four African countries: Botswana, Côte d’Ivoire, Kenya and Uganda.

***Collaboration: between the CDC and Tanzania: “Since the beginning of this year, we’ve been flooded with HIV screening kits from the CDC... this means we don’t have to worry about running out. We can now test all TB patients who agree to it for HIV as well.”***

*Ali Mzige  
Director, Prevention Services  
UR Tanzania*

***We now need to optimize opportunities by developing a complementary response to TB and HIV/AIDS.***

# 3. Reinforcing global efforts

We must reinforce global efforts against TB. The Global Partnership expands, adapts, improves and strengthens efforts to Stop TB. Supporting the Working Groups and Task Forces will empower each of these efforts. Endorsing the Partnership Framework and the Global Plan to Stop TB are key next steps.

## Creating a climate for action

**Session 3: Reinforcing Global Efforts to Stop TB: Professor Francis Omaswa (Uganda)** opened the session by reminding participants of Sir John Crofton's prophetic observation that "nothing happens until the climate of opinion is right," adding that the Forum and its follow-up must create this prerequisite climate.

## Building the partnership

**Status of the Partnership: Dr Jacob Kumaresan (WHO)**, Executive Secretary of the Stop TB Partnership Secretariat, presented a comprehensive update on its current status. Created only in 1998, it had grown from 6 to over 120 members—in just three years and continues to expand. At the same time, it had also developed the Partnership Framework and the Global Plan to Stop TB.

Dr Kumaresan said that the Partnership's mission reflected the "human dimension of TB": to ensure that every TB patient has access to effective diagnosis, treatment and cure; to stop TB transmission; to reduce the inequitable social and economic toll of TB; and to develop new preventive, diagnostic and therapeutic tools and strategies to stop TB. The Partnership's structure is shown below.



*The Global Partnership to Stop TB is growing...*



# to stop TB

Dr Kumaresan pointed out that the Partnership had responded swiftly and effectively to the calls expressed at the signing of its Amsterdam Declaration to Stop TB in March 2000, creating and putting in place new plans and innovative mechanisms within a very short timespan:

Progress since Amsterdam	
<i>The call</i>	<i>The response</i>
National plans	Global DOTS Expansion Plan
Access to drugs	Global Drug Facility
Research	Global Alliance for TB Drug Development
Funds	Global Fund to Fight AIDS, TB and Malaria



## Introducing innovative approaches

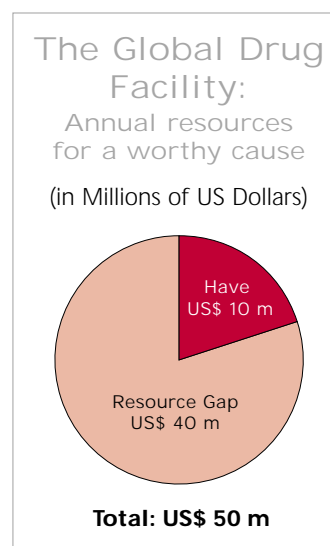
**The Global Drug Facility:** *Dr Jacob Kumaresan (WHO)* provided a more in-depth introduction to the Global Drug Facility (GDF), which he described as an “innovative approach to securing access to high quality TB drugs”. A Partnership initiative, he said that the GDF was being managed by a small staff within the Stop TB Secretariat at WHO’s Geneva headquarters. After its endorsement in Amsterdam, it became operational in record time, as shown in the illustration below.

In the short space of 18 months, the GDF has responded rapidly to the demand for TB drugs. Already it has:

- processed applications from 25 countries;
- approved applications from 12 eligible countries;
- begun drug delivery to 5 of them;
- brought TB drug prices down by 30%; and
- acted as a catalyst for introduction and expansion of DOTS.

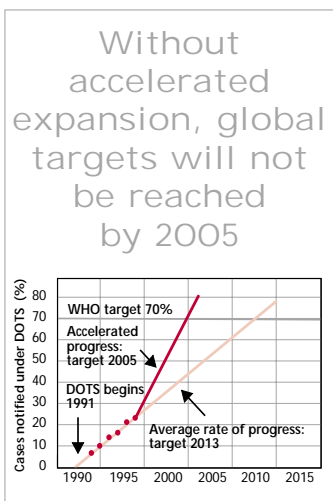
Looking forward, Dr Kumaresan said that, by 2005, the Global Drug Facility aimed to provide drugs for ten million TB patients. Launched with a grant from the Canadian Government, the GDF would need some US\$ 50 million a year over the next five years to continue and expand its work.

The Global Partnership to Stop TB was prepared, and its framework endorsed, as part of this partnership effort at the national level. Now, building on this momentum, the next steps would be to ensure follow-up activities at the regional, national and local levels.



*...Now we must further expand, adapt, improve and strengthen our efforts in TB control.*

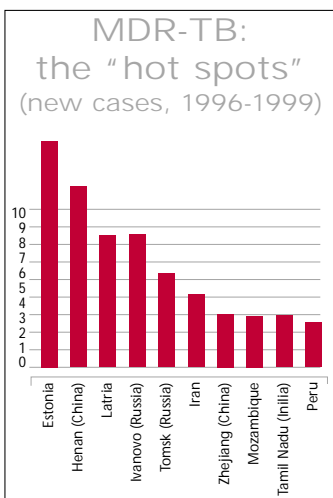
# Reporting from the Stop TB



**Session 3 Roundtable: Mr Ernest Loevinsohn (World Bank) and Professor Francis Omaswa (Uganda)**, co-chairs of the session, introduced the presenters for each of the six Working Groups.

## Expanding DOTS

**DOTS Expansion Working Group: Dr Tang Eang Mao (NTP, Cambodia)** said that studies suggested that, at current rates, global TB control targets would not be achieved before the year 2013. He stressed the importance of continuing with the post-Amsterdam process of accelerated DOTS expansion at both the national and international levels, including the development of the Global DOTS Expansion Plan (GDEP). Within the first year, four of WHO's six regions, as well as 14 of the 22 TB high-burden countries (HBCs), had already developed plans; Interagency Coordination committees (ICC) were operational in five regions and nine HBCs; and a global report had been published. A sizeable funding gap remained even though governments of the 22 HBCs were contributing more than half of the overall resources (US\$ 689 million out of US\$ 1 159 billion total).



## Adapting to MDR-TB

**MDR-TB Working Group: Dr Jim Kim, Executive Director of Partners in Health (PIH)**, a Boston-based NGO within the Harvard Medical School, pointed out the world's MDR-TB "hot spots" and went on to describe the DOTS-Plus strategy and the "Green Light Committee" (GLC), a globally pooled, competitive procurement mechanism that dramatically reduced prices for second-line TB drugs and, in acting as gatekeeper for eligible countries, also ensured responsible use. It has already approved six pilot projects that are currently being implementing.

Citing early accomplishments, he said that DOTS-Plus was being implemented, under the umbrella of the priority DOTS strategy, according to new guidelines in these "hot spots." The market for second-line drugs had already responded by becoming up to 94% cheaper. Six DOTS-Plus projects, serving some 1 500 patients, were already operational and benefiting from substantive drug price reductions while effective advocacy was keeping MDR-TB high on the public health agenda.

## Improving collaboration

**TB-HIV Working Group: Professor Francis Omaswa, Director General of Health Service, Ugandan Ministry of Health**, said that 60% of Ugandan TB patients were also HIV-positive and that TB could learn from NGO successes in dealing with HIV/AIDS in Uganda. Under-scoring points brought out in Session 2, he said that the goal of this working group was to "reduce the socioeconomic burden of TB in high HIV prevalence populations." To improve collaboration, Prof. Omaswa pointed out that the global working group had endorsed the strategic framework to control TB-HIV, set up a scientific panel to develop

*An investment of US\$ 180-210 million...*

# Working Groups

collaborative implementation guidelines, and established pilot sites in several countries. He stressed that the future lay in effective collaboration between TB and HIV programmes to support the delivery of interventions at all levels of the health system, including a strong community base. These would require additional financial and technical assistance in future.

## Strengthening tools

**New TB Drugs Working Group: Dr Giorgio Roscigno, Deputy Chief, Global Alliance for TB Drug Development (GATB)** reported that “TB epidemiology is deteriorating” due to the confluence of the TB and HIV/AIDS epidemics, the rise of MDR-TB, and constraints to DOTS expansion. New drugs were urgently needed, he said, to shorten treatment duration to less than three months, treat drug-resistant TB strains and preclude progression from latent to active TB disease.

Although no new TB drugs had entered the market in the last 30 years, the time was now ripe, thanks to new scientific potential and an environment more conducive to investment in TB control. GATB had already brought together some 30 public, private and non-profit sector partners to “ensure that TB control efforts were sustainable by developing new, effective and affordable anti-TB drugs.” Making collaborative use of the best features of the public and private sectors, the prognosis was good. There was a blueprint for action; the drug pipeline was promising; and developing countries themselves were involved. The goal was to have at least one new drug registered by 2010 and available in high-burden settings by 2012. An investment of US\$ 180-210 million would be needed to realize this “unprecedented opportunity.”

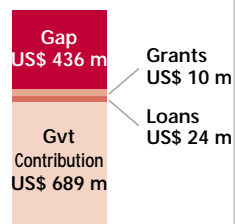
**New TB Diagnostics Working Group: Dr Mark Perkins (WHO)** presented on behalf of Dr Narayanan (India), said it was unacceptable that TB detection still relied on a century old discovery, sputum microscopy, and that TB goals could not be met with existing diagnostics. This dramatized the urgent need for new diagnostics tools to better deal with case detection, drug resistance and latent TB infection. He reported that there were now over 50 private sector enterprises involved in developing new diagnostics. Like GATB (above), they functioned as a “virtual shop” and would serve as a strategic catalyst for the private sector to do the work.

**New TB Vaccines Working Group: Dr Ann Ginsberg, NIAID, National Institutes of Health (USA)** began by reminding participants that, although a vaccine already existed, “if the BCG (vaccine) were working as it should, we wouldn’t have the epidemic that we have today, the one we are here to stop.” A replacement for the BCG was needed. Working hand-in-hand with DOTS Expansion and high-burden countries, this 13-member working group, first convened in June 2001, was targeting “at least one new vaccine registered and available in TB high-burden countries by 2020.”

## DOTS Expansion:

Governments of high-burden countries contribute more than half the financial needs  
(In millions of US\$)

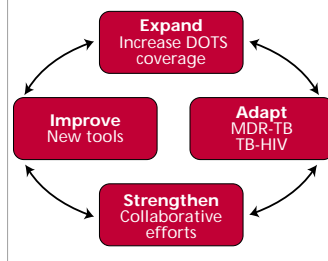
US\$ 1 159 m



22 High-Burden Countries

## The Global Drug Facility:

annual resources for a worthy cause

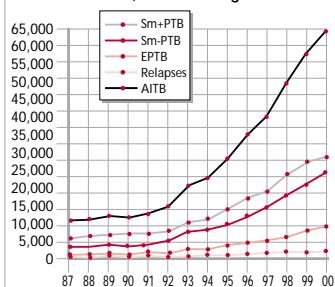


*...could enable development of a new anti-TB drug by 2010.*

# 4. Channeling resources for

## Kenya: channeling TB control resources

NLTP KENYA, TB Casefinding: 1987-2000



- High Burden TB country
- On average annual increase of 18%
- DOTS started in 1993 and achieved national coverage in 1997
- Treatment success rate of 78%

**Session 4: Finance Track: Dr Adam Wanner, American Thoracic Society**, chaired this track devoted to profiling concrete examples of proven channels for delivery of financial resources to TB high-burden countries.

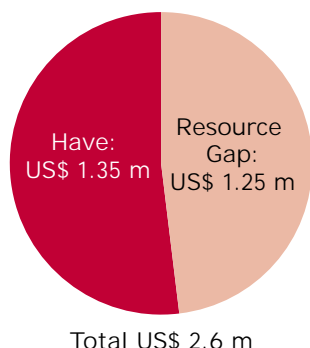
## Cultivating a new donor support base

**Kenya: Dr Grace Gakiria, Ministry of Health**, positioned Kenya from the outset as one of the 22 TB high-burden countries in need of additional external resources to address the 18% average annual increase in TB incidence.

Although there had been only one bilateral donor until 2001, now a new support base is emerging which is enabling Kenya to sustain DOTS. It includes the World Bank and the Global Drug Facility for drug procurement, as well as the World Bank, CDC, a number of NGOs and private sector partners to assist in implementing DOTS. Still, there is a funding gap to the year 2005 for other needs, such as the expansion of diagnostic centres, MDR surveillance, DOTS-Plus, operational research, and special strategies for high-risk groups.

## Myanmar: closing the resource gap

(in Millions of US Dollars)



## Benefitting from the Global Drug Facility

**Myanmar: Dr Wann Maung, Ministry of Health**, highlighted his country's positive experience with the Global Drug Facility, which had responded quickly to Myanmar's application for drugs and is crucial to realizing its target of 100% DOTS coverage by 2003. In order to realize future plans and meet major challenges, including lack of transport facilities, topographical and linguistic barriers, TB-HIV and MDR-TB-related problems, and cross-border and transient populations, Myanmar would need external assistance to fill a projected resource gap of US\$ 1.35 million in 2002 alone.

## Making international donor collaboration "pro-poor"

**UK Department for International Development (DFID):**

**Dr Julian Lob-Levyt** began by saying that globalization could be managed to benefit the health and well-being of the poor and that global health opportunities such as the Global Partnership to Stop TB and the Global Drug Facility should be seen as "a shared interest."

The newly created Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) was cited as another powerful mechanism which, making use of existing international mechanisms like Stop TB, could channel significant investments into tools for TB diagnosis and treatment. He said that should also lend technical advice and support to GFATM as there was a natural synergy.

*We are creating mechanisms to channel existing resources...*

# TB control

## Swapping defense for health spending

**Peru:** *Dr Manuel Quimper Herrera, Vice-Minister of Health*, presented his country's remarkable success story in bringing rampant TB under control through a mixture of top level political and technical support and innovative resource mobilization to increase the range of health services and expand DOTS throughout this poverty-afflicted Andean nation.

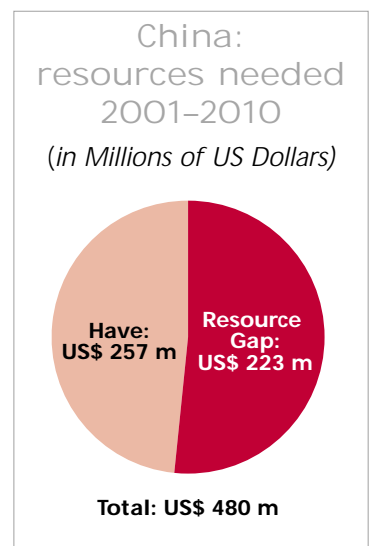
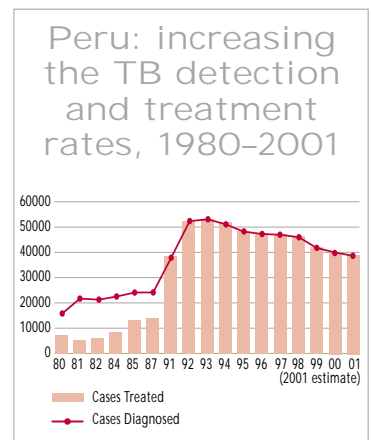
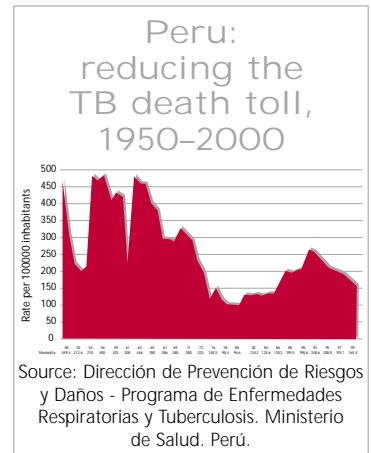
In Peru, as elsewhere, death is a "fact of life"; but in Peru between 1993 and 1998, it was particularly disturbing that 25,000 deaths were attributable to terrorism and 30,000 to TB. It was decided to launch a counter-offensive against TB and free Peru of the stigma of being one of the world's 22 highest burden countries—one of only two in Latin America.

The country's impressive results are being carried forward by the new administration's priorities, foremost among them a commitment to serve the poor and to re-design the Government's social and economic policies to reduce inequities and social exclusion. Improved TB detection and treatment, as well as HIV testing of all TB patients, are a priority. In resource terms, this has meant shifts in funding: 20% less for defense, 56% more for health and a 2002 TB control budget that amounts to some US\$ 23 million. It should also be noted that the lion's share of funds to treat TB patients—79% in 1999—came from civil society, while rich investors (e.g. gold mining) were increasingly "diverting funds to pay their social obligations."

## Investing in DOTS

**China:** *Mr Jin Xiaoming, Embassy of the People's Republic of China*, spoke on behalf of the Health Minister Zhang Wenkang. Recalling that China alone accounted for 15% of the world's TB burden and that TB and poverty were closely linked, he noted that TB control was a daunting task, given the large number of cases and limited resources. Still, China had taken its commitment to the Amsterdam Declaration very seriously and had followed up. He extolled the virtues of having invested in DOTS expansion over the past ten years, notably as a component of debt relief packages and in partnership with the World Bank, DFID, the Government of Japan and others.

"China is fully prepared to plunge into the global battle against TB," the spokesman said. The newly approved NPT 2001-1200 establishes a multisectoral TB prevention and control mechanism that will strive to achieve 90% DOTS coverage by 2005 and over 95% by 2010 and to treat two million infectious TB cases by 2005 and four million by 2010 with an 85% cure rate. Although a total of 2.14 billion yuan (US\$ 480 million) are available, some 4 billion yuan (US\$ 257 million) are still needed for this ten-year period. Efforts are currently underway to mobilize external funding to fill this resource gap.

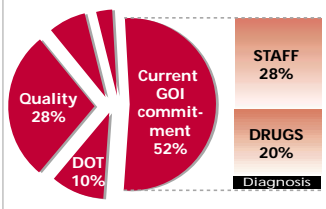


... and to mobilize new resources to Stop TB.

# 5. Strengthening health

DOTS and health sectors are mutually reinforcing: each strengthens the other. Sector-wide approaches can expand the reach of health sectors across a broader spectrum. Promoting synergies (e.g. TB-HIV) will also reduce the negative impacts on TB control.

Indonesia:  
requirements for  
effective DOTS  
implementation



Session 5, Finance Track: *Dr Paul Ehmer*, Head of the Transitional Secretariat for the newly created Global Fund to Fight AIDS, TB and Malaria (GFATM) chaired this session devoted to presentations on diverse approaches to health sector reform from Africa and Asia.

## Phasing in sector-wide approaches

UR Tanzania: *Dr Ali Mzige*, Director of Preventive Services, Ministry of Health, focused on his country's use of sector-wide approaches (SWAps) for health sector reform and lessons learned for the TB control programme. SWAps was introduced, based on the "basket funding principle," in 1997-1998. Unearmarked funds had allowed better advance planning and prioritized resource allocation for NTPs. As for SWAps lessons learned, he said that NTPs should be gradually phased-in with adequate management capacity; that TB control should be part of the essential national health package; that financial disbursements must be timely and transparent; that SWAps partner/donors must honour their pledges and timeframe; and that SWAps funds might not cover all TB activities.

## Decentralizing health care

Indonesia: *Dr Haikin Rachmat*, Ministry of Health, presented his country's experience in effective budgeting using a decentralized model, pointing out that this could affect traditionally vertical NTPs both positively and negatively. For Indonesia, decentralization meant the break-up of its NTP and the current necessity to seek separate funding from 30 provincial and 343 district governments—meaning that many district TB programmes were left empty-handed in 2001.

The key component, Dr. Rachmat said, was the development of a comprehensive advocacy strategy to enable local programme managers to negotiate effectively during budget discussions.

## Reforming the health sector

Cambodia: *Dr Mam Bun Heng*, Ministry of Health, cited milestones in his country's health sector reform (e.g. stable drug supply since 1994, TB cure rate rising from 85% in 1995 to 91% in 2001) and noted that demography/geography-based health sector reform begun in 1995 had reduced the number of administrative levels from four to three. Political commitment had resulted in the Prime Minister's establishment of a National TB Control Committee with provincial committees headed by their governors and salary supplements to TB staff. Additional human and financial resources were still needed but Cambodia was moving in the right direction.

*We are reforming health systems as one of keys to effective DOTS delivery...*

# *systems and resources*

**Session 4: Promoting Partnerships: Dr Jaap Broekmans, Royal Netherlands Tuberculosis Associations (KNCV)** chaired this session which, together with the other two in this track, featured presentations on the theme of partnership, illustrating how innovative alliances could be formed beyond the traditional medical-public health model.

## **Endorsing the government's role**

**Russian Federation: Professor Michail Perelman, Thoracic Surgeon and Chief TB Specialist, Ministry of Health**, spoke out for tradition, expressing the strong conviction that it was the government, rather than private practitioners or the private sector, that was responsible for across-the-board health service delivery. However, he noted that many contacts with TB control agencies abroad had been interrupted after the Cold War and that these needed to be restored in order to improve coordination efforts. He said Russia's goal was to "stop TB epidemics" and that there had been significant improvements over the past two years. Russia now worked through WHO, which should serve as a "powerful integrator".

## **Adapting to emergencies**

**Pakistan: H.E. Professor Mahoud Ahmed Choudry, Punjab Minister of Health and Population Welfare**, led with reference to the plight of the rising tide of Afghan refugees in his country since Pakistan was currently "a frontline country in the war against terrorism." He said that poor health delivery at the grassroots level was thwarting efforts at TB control and stressed the need for more public-private partnerships and the strengthening of services at the district level to meet the challenges posed by the current situation. Pakistan had adopted its own Islamabad Declaration as part of its commitment to DOTS and TB control. But he noted that it was caught in a series of unforeseen, rapidly unfolding circumstances to which it was difficult, but necessary, to respond. "Wisdom comes in retrospect; but we must live in prospect."

***Wisdom comes in retrospect; but we must live in prospect.***

## **Bringing in the private sector**

**Nigeria: Dr Edugie Abebe, Director General, Ministry of Health**, first described her "young democracy's" experience in hosting the two Abuja Summits (2000, 2001) and the process of bringing together Africa's Health Ministers and the endorsement of the Abuja Declaration to Stop TB and Leprosy in Africa on 9 October 2001. Now, she said, "we need to expand the number of partners and funding on a state level in order to increase the sustainability and expansion of TB programme." Currently there are negotiations with some of the oil companies in Nigeria to assist in TB programmes. "Partnerships are good, but they can be very delicate and fragile," she said, maintaining that, "in order to work, there must be clear roles and responsibilities within the partnerships."

***... and building our resource base through partnerships.***

# 6. *Building partnerships*

We must promote more and better partnerships at all levels. Today governments are vital actors—but they cannot succeed alone. Dynamic, cross-sectoral partnerships are the key to expanding outreach. The private sector, NGOs, academia and the media must all be engaged.

**Session 8: New Partnerships:** *Dr Fran du Melle, Executive Vice-President, American Lung Association*, invited ideas on how to involve new and non-traditional partners in the implementation of the Global Plan.

## Mobilizing new partners

**Viet Nam:** *Professor Le Ngoc Trong, Vice-Minister of Health*, shared his country's experiences in mobilizing new Stop TB partners. Beginning with only two Dutch NGOs, Viet Nam today had a wealth of partners, including the World Bank, CDC and the Dutch Government, as well as local "People's Committees" and "Peasants' Unions". Comparing the advantages and limitations of NGOs, bilaterals and multilaterals as partners, he said that TB control activities would require greater financial capacity with extended World Bank assistance and new partnerships with HIV/AIDS programmes, the private sector and academia.

## Providing incentives

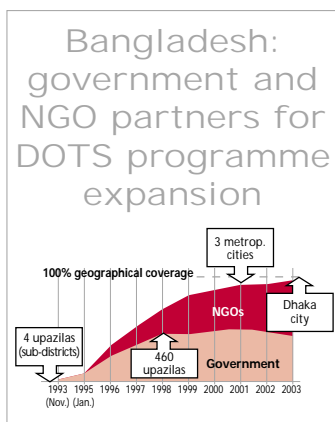
**Bangladesh:** *Mr Fazlur Rahman, Secretary, Ministry of Health and Family Welfare*, said that, thanks in large part to the Government's Memorandum of Understanding with both national and international NGOs (e.g. BRAC, Damien Foundation), 95% of the country's 129 million people were now covered by DOTS. Private businesses (e.g. Finlay Tea Estate) and international organizations like the World Food Programme were also active partners, the latter providing incentives in the form of food packages to reduce drop out rates.

## Engaging civil society

**PhilCAT:** *Dr Rodrigo Romulo, Chairman, Philippine Coalition against Tuberculosis*, said that his NGO, organized in 1994 to engage civil society in the battle against TB, now coordinated activities of about fifty entities, ranging from NGOs to religious groups to pharmaceutical companies. "Finding new partners is not a problem," he said, "they are approaching us. The main constraint is our own capacity to provide enough projects and plans for these new partners."

## Creating demand

**UNICEF:** *Dr Yves Bergevin, Chief of Health*, who has been active in the development of the Global Alliance for Vaccines and Immunization (GAVI) began the final session by saying, "If there's one message from this Forum, it is that business as usual won't do." Drawing from his lessons learned in Polio programmes and GAVI, he said that, besides national ownership, social mobilization should be used to create a bottom-up demand for TB services. There should also be a marketing plan using corporate sponsors, media and major NGOs to get the message out. Once underway, "success breeds success," he concluded.



*We are promoting partnerships from the top down...*



# at all levels of society

**Social Mobilization Partnership Track: Dr Mark Rosenberg, Executive Director, Task Force for Child Survival and Development, and Ms Joanne Carter, Legislative Director, Results International,** chaired this session which dealt with how to mobilize social will. While Mr. Carter noted that it was persistent advocacy that finally got the US Congress to commit to global level TB control, Dr. Rosenberg likened partnerships to a marriage, saying, "It's easier to find a good looking partner than to make the partnership work!"

## Using education to raise awareness

**Zimbabwe: Dr Stanley Midzi, Acting Deputy Director, Disease Prevention and Control, Ministry of Health and Child Welfare,** cited education as a key to effective social mobilization. By educating school children about TB, they could then become partners, helping to identify TB cases, encouraging timely health-seeking behaviour, even becoming DOTS observers for family members. He also said that the integration of the HIV/STI and TB units at the ministry level in his country was essential to improve coordination of services and ensure that funds were available for joint activities since in the past many donors had contributed significantly more to HIV/AIDS programs to the detriment of TB control.

## Making TB control a national priority

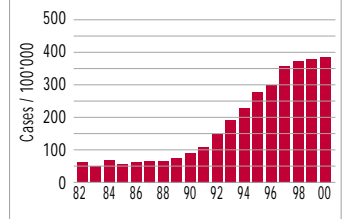
**Brazil: Dr Claudio Duarte da Fonseca, Secretary for Health Policy, Ministry of Health,** observed that in the past ten years political support for TB had been lost and needed to be regained. He hoped that a meeting in November, chaired by the Ministry of Health, would help to put TB back on the map as a national priority. At the local level, he noted that recent decentralization of programmes towards greater community involvement and more private sector support had helped in DOTS expansion to reach a 77% detection rate. He concluded that a joint approach at every level was required, especially for sustainability.

## Mobilizing the media

**Doctors of the World: Mr Robert Kushen, Executive Director,** described how partnerships with the media in Kosovo help social mobilization efforts to raise awareness about TB, its symptoms and treatment and at the same time reduce stigma, encourage referrals and increase compliance rates. Locally produced videos, aimed at different target audiences, had raised TB awareness. But he stressed the importance of specialized NGOs to reach groups such as Roma populations or intravenous drug-users. He also described how peer education programmes in which patients educated fellow patients, could increase patients' involvement in their treatment regimens, provide psychosocial support and to reduce drop-out rates.

### Social mobilization in Zimbabwe

The magnitude of the TB burden  
Incidence of TB in Zimbabwe

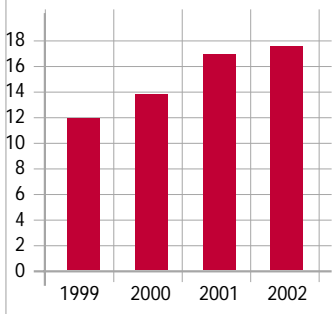


... and social movements from the bottom up.

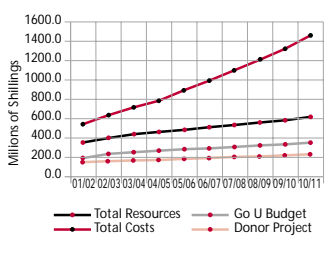
# 7. Creating sound investment

We must develop concrete, effective means of financing and evaluating results. New resources and activities are needed. The Global Plan profiles concrete opportunities to invest in Stop TB.

Philippines:  
opportunities to  
invest in Stop TB  
TB drug budget  
as proportion of total  
public Health Budget  
1999–2002



Uganda:  
the big gap  
between  
resources needed  
and available



**Session 6: Opportunities to Invest in Stop TB: Sir John Crofton and Mr Paul Mayho** introduced the session with a video on Stopping TB and foreshadowed introduction of the Global Plan to Stop TB, emphasizing that TB was one of the focal points of the new Global Fund to Fight AIDS, TB and Malaria. The session concluded with a video on the Global Drug Facility.

## Giving TB top priority

**Philippines: Dr Manuel Dayrit, Secretary of Health**, began by saying that his country, which ranks 15th on the list of 22 TB high-burden countries, is increasing government allocations for TB control and has increased its TB drug budget from 12% to 18% of the total public health budget. "TB gets top priority. Not only do we advocate for as much government money as possible; if another programme does not deliver results, we demand that the money be transferred to TB because our programmes are based on a Global Plan that guarantees results."

## Linking TB and HIV investment strategies

**Uganda: Captain Mike Mukula, Minister of State for Health**, focused on his country's experience with TB-HIV and the resources needed for their joint control. Pointing out that over half of Ugandan TB patients were co-infected with HIV, he said that both diseases shared some common control strategies; namely, information, education and communication (IEC), social mobilization and community-directed management. HIV/AIDS control should not be done in isolation from TB control. Uganda has already adopted an integrated approach with planning and resource mobilization for both conditions interlinked.

**Session 6: Panel Discussion: The Global Plan and Investments to Stop TB:** Featuring financier philanthropist George Soros, WHO Director General Gro Harlem Brundtland and Jo Ritzen on behalf of James Wolfensohn, President of the World Bank, this panel discussion was followed by a press conference open to all accredited media representatives. Below are excerpts from both.

## Improving health, reducing poverty



**Dr Gro Harlem Brundtland, WHO Director-General:**

"Improving health is a concrete, measurable way of reducing poverty and inequity—both at country and global level. Investments in health are investments in human potential. And human potential is the greatest resource for development. (Besides the) more than five thousand people dying daily from TB, despite a cure for the disease, TB takes an annual

*There are opportunities to invest in Stop TB...*

# opportunities

*estimated economic toll equivalent to US\$ 12 billion from the incomes of poor communities. Our collective response to these threats is critical. It holds the key to the economic and physical security, not just for individuals and communities, but for nations and continents. The 22 most-affected countries will provide their share, but it is clear that a major injection of development aid is needed to achieve our goals. With TB on the increase also in industrialized countries, this is not only the right thing to do—it is also an act of enlightened self-interest."*

The Global Plan to Stop TB aims to detect 70% of active TB cases worldwide and to treat 85% of those successfully by 2005. The five-year TB control price tag is estimated at US\$ 9.3 billion, about half of which has been raised to date. Investments are sought.

## Investing to achieve a TB-free future



**Mr George Soros, Chairman, Open Society Institute:**

*"The Open Society Institute is pleased to be a sponsor and catalyst of the Global Plan to Stop TB. We see this as a starting point towards a TB-free world. What gives me the greatest satisfaction is that TB and business experts are thinking seriously about developing successful business models and public-private partnerships. The market alone has failed to provide needed vaccines, diagnostics and drugs at affordable prices.*

*The Stop TB Partnership is valuable, not only in its own right, but also because it presents an excellent model of providing international assistance. For a total of US\$ 9.3 billion, we can double the number of people receiving effective therapy, curing six million more patients worldwide by 2005 than would otherwise have been cured. And with US\$ 4.5 billion already allocated by national governments and hundreds of millions more committed by private, national and multilateral programmes, closing that gap is within our grasp."*

## Increasing development assistance



**Mr Jo Ritzen, World Bank:**

*"Poverty undermines not only health, but also peace. Witness the events of September 11th that have forever changed the world and the way we live. One of the messages is that we must increase overseas development assistance and investments in plans that work.*

*Stopping TB is key to poverty reduction strategies at the heart of the World Bank's development agenda. We will have to triple our efforts over the next five years. It can be done. The Global Plan is a good fit for World Bank lending, both in terms of human health and development policy and in terms of sound economic investment. We are giving both the Partnership Framework and the Global Plan to Stop TB our full support."*

*...that promise high returns for donor and recipient alike.*

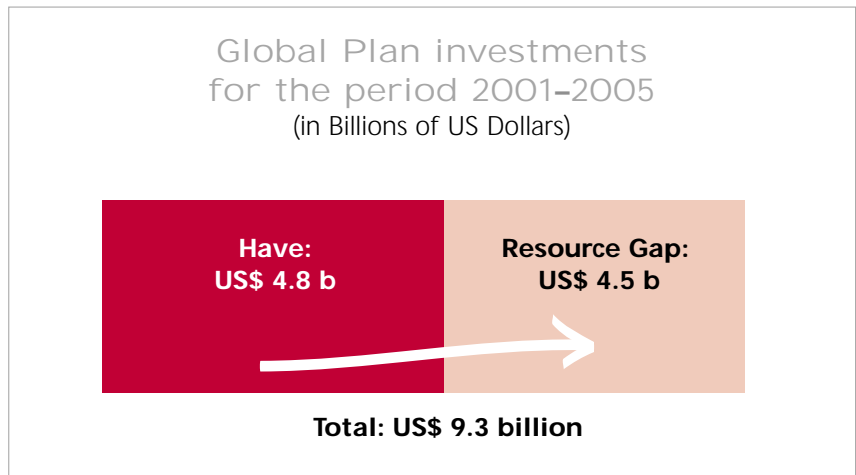
# 8. Global Plan to Stop TB

We must channel new resources to control TB.  
Over the period 2001–2005, we need a total of US\$ 9.3 billion  
to fund the Global Plan; US\$ 4.8 billion are available;  
we need another US\$ 4.5 billion to bridge the resource gap.

## Mobilizing resources, developing skills

As Mr Christopher Lovelace, Director of Health, Nutrition and Population at the World Bank, summed up, “a significant funding gap faces many of our TB high-burden countries. Nations must mobilize domestic resources and develop skills to use available resources more efficiently and effectively. We also need more public-private sector investment in public health. The Global Plan is a good vehicle... and resource mobilization skills are the need of the hour.”

***With less than  
US\$ 1 billion a year,  
we can relegate  
tuberculosis to the  
“dustbin of history.”***



## Creating a ripple effect

In closing, Sir John Crofton said that this first Partners' Forum provided a unique opportunity to widen the range of partners and increase its level of commitment. The most important thing, in his opinion, was “the enormous amount of support from top international people and bodies, including very powerful and influential politicians. The other remarkable achievement has been getting all these partners together. This conference is an outstanding jump forward... it has built up the climate of opinion globally and had a major ripple effect, shifting TB away from being just the business of a small, devoted elite.”

***We invite you to join in on...***

# Testimonials

In any partnership to Stop TB, it is people, especially the patients, who must be at the center. Below are the testimonials of current and former TB patients who spoke at the Forum.

## Ram Khadka (Nepal): From tragedy to triumph



Both Ram's parents contracted TB. "My father had simple TB," Ram recounted, "but my mother developed multidrug-resistant TB. She was hospitalized and it was while I was searching for her in the hospitals of Nepal that I got TB myself." But both Ram and his brother took advantage of DOTS and, after a stringent nine-month regimen, Ram was completely cured. "I owe my life today to DOTS," he said. Now Ram has launched a Nepal-based NGO, *Fight against TB and HIV/AIDS*, dedicated to changing attitudes and strengthening social and governmental commitment to TB control throughout the world. "I am a realist. I had TB and I survived. But more than 8,000 people die of TB each year in Nepal—it is one of our burning problems. We need help—socially, politically, technically—to form an international team to work for the alleviation of TB."

## Johannes Linn (USA, World Bank): TB from World War II to today

Only seven when he contracted TB in post-World War II Germany, Linn attributed his susceptibility to the overall conditions of deprivation, malnutrition and poor health. As was the treatment in those days, he spent the next 4-5 months in a sanatorium and in 1954 underwent major—and successful—lung surgery. Linn said, "Today, once again, TB is widespread in Germany. We thought it was a disease of the past but that's not true. It is an aggressive disease. I am glad to see that the World Bank has taken on the TB cause worldwide. Now we are all more aware. We are coming together to take up the battle. It is a terribly important cause for all humanity. And, not to be forgotten, TB is an issue, even here in Washington, DC."

## Paul Mayho (UK): Defeating "the Devil's Alliance" of TB and HIV



A former health care worker in the UK, Paul tested positive for HIV at the age of 19 and then, five years later, came down with multidrug-resistant TB. Not only was his total isolation a "lonely experience in a faceless environment," he knew that this "devil's alliance" of diseases can prove fatal within a few months. Fortunately, Paul's case became a (qualified) success story. For, while HIV is not yet curable, TB—even MDR-TB—is. After three tenacious years of treatment, Paul was cured of TB and began a new life that "really couldn't be better...I have been given a second chance." In his book for TB patients, he says, "My message is a simple one: *keep taking the pills!* There is life beyond this."

... *the Global Plan to Stop TB.*

# Partners' Forum Agenda

## Sunday 21 October: OPENING

Venue: Omni Shoreham Hotel, Ambassador Ballroom  
17:00-19:00 **Registration**

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19:00–20:30 **Welcome Reception**  
**OPENING: THE HUMAN FACE OF TB**  
Facilitators: *Adam Wanner & Petra Heitkamp*  
Personal statements: *Ram Khadka (Nepal), Johannes Linn (World Bank/video), Paul Mayho (UK)*

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## Monday 22 October: STOP TB PARTNERS' FORUM

Venue: World Bank, Preston Room

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**SESSION 1: PROGRESS SINCE AMSTERDAM—EXPANDING DOTS**  
Chairs: *Jo Ritzen & George Alleyne*  
08:45-09:15 **Introduction**  
*Welcome Address: James Wolfensohn*  
*Celebrating 50 years of TB treatment: Sir John Crofton*  
09:15-10:15 **Progress and challenges in DOTS Expansion**  
*Roundtable Presentations: Western Pacific Region, South East Asia Region, USAID*

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**SESSION 2: NEW THREATS: OVERLAPPING EPIDEMICS OF TB and HIV**  
Chairs: *Ebrahim Samba & Gijs Elzinga*  
10:45-11:00 **Introduction:** *Video: TB and HIV*  
11:00-11:45 **Overcoming Obstacles, Optimizing Opportunities**  
*Roundtable Presentations: Thailand, South Africa, CDC/Global AIDS Program*

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**SESSION 3: REINFORCING GLOBAL EFFORTS TO STOP TB**  
Chairs: *Francis Omaswa & Ernest Loevinsohn*  
11:45-12:00 **The Global Partnership to Stop TB**  
*Status of the Partnership: Jacob Kumaresan*  
12:00-12:30 **Expand/Adapt/Improve – Stop TB Working Groups**  
*Roundtable Presentations: DOTS Expansion, MDR-TB, TB-HIV, New TB Drugs, New TB, Diagnostics, New TB Vaccines*  
12:30—13:00 **Discussion**

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**SESSION 4: CONCURRENT ROUNDTABLES—FIRST ROUND**  
**Finance Track: Mechanisms for Channeling Resources**  
Chair: *Adam Wanner*  
*Roundtable Presentations: Kenya, Myanmar, DFID*  
**Partnership Track: Promoting Partnerships**  
Chair: *Jaap Broekmans*  
*Roundtable Presentations: Russian Federation, Pakistan, Nigeria*

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Washington, DC

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**SESSION 5: CONCURRENT ROUNDTABLES—SECOND ROUND**  
**Finance: Health Sector Reform**  
Chair: *Paul Ehmer*  
Roundtable Presentations: *UR Tanzania, Indonesia, Cambodia*

**Partnership: Social Mobilization**  
Chairs: *Mark Rosenberg & Joanne Carter*  
Roundtable Presentations: *Zimbabwe, Brazil, Doctors of the World*

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17:30–18:30 Convening writing committee: *The Washington Commitment*  
18:00–19:30 Reception hosted by *Stop TB Partnership, World Bank,*

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## Tuesday, 23 October: MINISTERIAL PLANNING FORUM

Venue: World Bank, Preston Room

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**SESSION 6: OPPORTUNITIES TO INVEST TO STOP TB**  
Chair: *Paul Mayho & John Crofton*  
08:45–09:00 **Introduction**  
*Video: “Stopping TB”*

08:45–09:45 **Lessons learned on investing in TB**  
Roundtable Presentations: *Philippines, Uganda, Global TB Drug Facility*

09:45–11:00 **Global Plan and Investments to Stop TB**  
Keynote Presentations: *George Soros, Jo Ritzen, Gro Harlem Brundtland*

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11:00–11:30 **Press Conference and Launch of Global Plan to Stop TB**  
*George Soros, Jo Ritzen, Gro Harlem Brundtland*

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**SESSION 7: WASHINGTON COMMITMENT**  
Chair: *David Heymann*  
11:30–12:30 **Washington Commitment:** Presentation and discussion on the draft  
12:30–13:00 **Endorsement of the Washington Commitment**

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**SESSION 8: CONCURRENT ROUNDTABLES—THIRD ROUND**  
**Finance: Mobilizing New Resources**  
Chairs: *Christopher Lovelace & Nils Billo*  
Roundtable Presentations: *Peru, China, DR Congo*

**Partnership: New Partnerships**  
Chair: *Fran du Melle*  
Presentations: *Viet Nam, Bangladesh, PhilCAT, UNICEF*

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**CLOSING SESSION: STOP TB PARTNERSHIP: MOVING AHEAD**

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*21–23 October 2001*

# List of Participants

## GOVERNMENT DELEGATIONS

### Bangladesh

Mr Fazlur Rahman, Secretary, Ministry of Health & Family Welfare

H.E. Mr Ahmed Tariq Karim, Ambassador of Bangladesh to the USA

M. Shahidul Islam, Counsellor  
Embassy of the People's Republic  
of Bangladesh

Mr Fakrul Ahsan, Counsellor (Economic),  
Embassy of the People's Republic of Bangladesh

### Belgium

Dr Maryse Wanlin, Director, Fondation Contre les Affections, Respiratoires et pour l'Education à la Santé (FARES)

Dr Paul Cartier, Attaché Coopération  
Internationale, Belgian Embassy

### Brazil

Dr Claudio Duarte, Secretary of Health Policy

Dr Miguel Aiub Hijjar, Director, Centro de Referencia, Prof. Hélio Fraga

### Cambodia

Dr Mam Bun Heng, Secretary of State, Ministry of Health

Dr Tang Eang Mao, Director, National Center for TB & Leprosy Control, Ministry of Health

### Canada

Mr Ernest R. Loevinsohn Director General, Food Aid Centre & Multilateral Policy, Canadian International Development Agency (CIDA)

### China

Mr Jin Xiaoming, Minister Counselor, Embassy of the People's Republic of China in the USA

Mr Ya-fei He, Embassy of the People's Republic of China in the USA

Mr Xu Jie, Counsellor for Scientific and Technological Affairs, Embassy of the People's Republic of China in the USA

Mr Zhang Jian-ping, First Secretary for Economic Affairs, Embassy of the People's Republic of China in the USA

### DR Congo

Dr Constantin Miaka Mia Bilenge, Secrétaire General, Ministère de la Santé

### France

Dr Catherine Bilger, Official Representative, Ministry of Health

### Indonesia

Pr Umar Fahmi Achmadi, Director General CDC & EH, Ministry of Health

Dr Djunaedi Hadisumarto, Adviser of State Minister of National Development-Planning, Chairman of Bappenas

Dr Haikin Rachmat, Director of Direct Transmitted Diseases, Directorate-General of CDC & EH, Ministry of Health

### Japan

Dr Koji Okamoto, Director, Office of International Cooperation, International Affairs Planning Division, Minister's Secretariat, Ministry of Health, Labour and Welfare

### Kenya

Dr Grace Gakiria, NLT, Ministry of Health

### Mexico

Dr Elizabeth Ferreira, Director of Tuberculosis, Program in Mexico

### Myanmar

Dr Wann Maung, Director General, Department of Health, Ministry of Health

Dr Aye Htun, Programme Manager, Department of Health, Ministry of Health

### Netherlands

Dr Harry van Schooten, Senior Health Adviser, Ministry of Foreign Affairs

### Nigeria

Dr Edugie Abebe, Director Primary Health Care and Disease Control, Federal Ministry of Health

### Norway

Mr Tharald Hetland, Senior Adviser, Ministry of Health and Social Affairs

### Pakistan

Mr Ejaz Rahim  
Federal Secretary of Health  
Ministry of Health

H.E. Prof Mahoud Ahmed Choudry, Punjab Minister of Health

Dr Syed Karam Shah, National Programme Manager, Government TB Centre

### Peru

Dr Carlos Manuel Quimper Herrera, Vice Ministro de la Salud, Ministerio de Salud

Dr Roberto Alphonso Accinelli Tanaka, Responsable del Area de Tuberculosis, Ministerio de Salud

### Philippines

Dr Manuel Dayrit, Secretary of Health, Department of Health

Dr Myrna Cabotaje, Director III/Officer-in-Charge, National Center for Disease Prevention & Control (NCDPC)

### Russian Federation

Prof Tatiana Stukolova, Deputy Minister of Health

Prof Mikhail I. Perelman, Director, Russian Research Institute of Phthysiopulmonology

Mr Nikolay Barinov, Major-General, First Deputy of Head of GUIN, Ministry of Justice

Dr Alexander Pisarev, Chief Medical Officer, Ministry of Health

Dr Marina Budeyeva, Senior Technical Adviser, Quality Assurance Project, University Research Co., LLC

### South Africa

Mr Joel Ramokatsé Mokonoto  
Assistant Director, National TB Control Programme

Mr Sello Moloto, Member of Executive Council for Health, Northern Province

### Switzerland

Mr Niklaus Zingg, Representative of the Government of Switzerland at the World Bank

### UR Tanzania

Dr Said Egwaga  
Programme Manager  
National TB Leprosy Control  
Ministry of Health

Dr Ali A. Mzige  
Director  
Preventive Services  
Ministry of Health

### Uganda

H.E. Mr Miwesigwa Rukutana, Minister of State for Finance, Planning, and Economic Development, Ministry of Finance

Honourable Capt. G. Mike Mukula (M.P.),  
Minister of State for Health, Ministry of Health

Prof Dr Francis Omaswa, Director-General, Health Services, Ministry of Health

Mr David Nsubuga Serwawudde, Economic Adviser to the Minister, Ministry of Finance, Planning & Economic Development

### United States of America

#### Department of State

Dr Jack C. Chow, Deputy Assistant Secretary of State, International Health & Sciences, Bureau of Oceans & International Environmental and Scientific Affairs

Ms Judith Kaufman, Office of International Health Affairs, Bureau of Oceans & International Environmental and Scientific Affairs

#### Department of Health and Human Services

Ms Erika Elvander, International Program Officer, Office of Asia and the Pacific, Office of International and Refugee Health

#### USAID

Dr Duff Gillespie, Director of the Center for Population, Health, and Nutrition,

Ms Betsy Brown, Director of the Office of Health and Nutrition  
Mr Richard Greene, Acting Deputy Director

Dr Amy Bloom, Global Programme for Health



Dr Clydette Powell, Senior Technical Adviser for TB, Global Bureau

Dr Andrew Clements, Senior Technical Adviser for Infectious Diseases, Asia and Near East Bureau

Dr Deborah Lans, Global Program for Health

Dr Tim Clary, Technical Adviser, Europe and Eurasia Bureau

Dr Michael E. Zeilinger, DPM, Infectious Disease Team Leader

Dr Susan Bacheller, Senior Infectious Disease Adviser, Latin America and Caribbean Bureau

#### **United Kingdom**

Dr Julian Lob-Levyt, Chief Health and Population Adviser

Department for International Development (DFID)

Dr Alastair Robb, Senior Public Health Specialist

#### **Viet Nam**

Prof Le Ngoc Trong, Vice Minister, Ministry of Health

Dr Duc Duong Bui, Deputy Director, National Institute of TB & Respiratory Diseases

Ms Le Thi Thu Ha, Deputy Director, International Cooperation, Ministry of Health

Mr Minh Chien Ho, Deputy Director of Department for Labour, Culture and Social, Ministry of Planning and Investment

#### **Zimbabwe**

Dr Stanley Munyaradzi Midzi, Deputy Director, Disease Prevention and Control, Ministry of Health & Child Welfare

## **ORGANIZATIONS**

#### **American Lung Association (ALA)**

Dr Fran du Melle, Executive Vice President

#### **American Thoracic Society (ATS)**

Dr Adam Wanner, President  
Dr Carl Booberg  
Dr Philip Hopewell

#### **Center for TB in Children,**

Dr Tina Leticia, President

#### **Centers for Disease Control and Prevention (CDC)**

Dr Harold Jaffe, Acting Director  
Dr Kenneth Castro, Director  
Mr Paul Poppe, Deputy Director  
Dr Bess Miller, Associate Director  
Dr Michael Iademarco, Associate Director for Science  
Ms Wanda Walton, Chief, Communications and Education Branch  
Mr Michael Qualls, Deputy Branch Chief, International Activities

**Community Health Tuberculosis (CHATA)**,  
Mr Michael Levy, Associate Professor

**Development Communication Associates**,  
Dr William Walsh  
Dr Paul Zinti

#### **Doctors of the World**

Mr Robert Kushen

#### **Eurasian Medical Education Program**

Dr Harvey I. Sloane

#### **European Commission**

Mr Geert Heikens, Development Counsellor, Europe Aid Cooperation Office  
Ms Vlassia Vassikeri, Special Assistant for Development

#### **Fairfax County Health Department,**

Dr Fe' Mendiola Gutierrez, Assistant Health Director

#### **Family Health International (FHI)**

Dr Ya Diul Mukadi, MPH, Senior Technical Officer

#### **Global Fund to Fight AIDS, TB and Malaria,**

Dr Paul Ehmer, Head Transitional Secretariat

#### **Global Alliance for TB Drug Development,**

Dr Maria Freire, CEO  
Dr Giorgio Roscigno, Senior Adviser, Director of Strategic Development  
Ms Joelle Tanguy

#### **Global Health Council**

Ms Colleen Murphy, Research Associate

#### **Gorgas Memorial Institute Tuberculosis Initiative (UAB)**

Dr Michael Kimerling, Director

#### **Health Development Network,**

Ms Louise Berry  
Mr Bobby Ramakant  
Ms Mia Malan

#### **IDA Foundation**

Mr Guido Bakker, External Relations

#### **IUATLD**

Dr Nils Billo, Executive Director

#### **Infectious Diseases Society of America (IDSA)**

Dr Henry M. Blumberg, Associate Professor of Medicine, Programe Director, Division of Infectious Diseases, Emory University School of Medicine

#### **International Organization of Migration**

Dr Danielle Grondin, Director

#### **John Snow, Inc.**

Mr Jim Bates, Senior Technical Adviser

#### **J.R. Garrison and Associates Consulting Company**

Mr John Garrison, President

#### **KNCV – Royal Netherlands Tuberculosis Association**

Dr Jaap F. Broekmans, Director

#### **LHL – Norwegian Heart & Lung Association,**

Dr Svein Erik Myrseth, President  
Ms Mette Klouman, Manager, International Cooperation

#### **London School of Hygiene and Tropical Medicine (LSHTM)**

Dr Peter Godfrey-Faussett

#### **Management Sciences for Health (MSH)**

Dr Jim Rankin, Director  
Dr Malcolm Bryant, Director

#### **Merlin**

Dr Timothy Healing, Health Adviser

#### **National Institute of Allergy and Infectious Diseases (NIAID)**

Dr Ann Ginsberg  
Dr Barbara Laughon, Program Officer, Opportunistic Infections, Division of AIDS

#### **New Jersey Medical School National TB Center**

Dr Lee Reichman, Executive Director

#### **Open Society Institute**

Mr George Soros, Chairman  
Ms Nina Schwalbe, Director, Public Health Programs  
Ms Persephone Harrington, Network Public Health Program

#### **Partners in Health (PIH)**

Dr Jim Kim, Program Director  
Dr Arachu Castro, Instructor in Medical Anthropology, Department of Social Medicine  
Dr Michael Rich, Clinical Consultant  
Mr Olivier Appaix, Economist  
Mr Joel G. Brenner

#### **Philippine Coalition Against TB (PhiCAT)**

Dr Rodrigo Romulo, Chairman

#### **Princeton Project 55**

Dr Alan Riley, Program Manager

#### **Project HOPE**

Dr Robert Northrup, Senior Technical Adviser

#### **Research Institute for Tuberculosis (RIT)**

Dr Toru Mori, Japan Anti-Tuberculosis Association

#### **Results International**

Ms Joanne Carter, Legislative Director  
Ms Sue Perez, Researcher

#### **RIVM (National Institute of Public Health and Environmental Protection)**

Dr Gijs Elzinga

#### **Rockefeller Foundation - Health Equity**

Mr Richard Bumgarner, Consultant

#### **Ryder-Cheshire**

Mr Alastair Burt, Director

#### **Sequella Global Tuberculosis Foundation,**

Dr William McLin, Executive Director  
Dr Lewellyn Barker, Chief Medical Officer

**Speakers (without affiliation)**

Sr John Crofton  
Mr Ram Khadka  
Mr Paul Mayo

**Stop TB Canada**

Dr Anne Fanning, MD, FRCPC, Division of Infectious Diseases, Department of Medicine

**Task Force for Child Survival and Development**

Dr Mark Rosenberg, Executive Director  
Dr Alan R. Hinman, Coordinator  
Ms Laura Ross, Communications Specialist

**TB Alert**

Dr Paul Sommerfeld, Chair of Trustees

**Treatment Action Group**

Dr Michael Marco

**UNAIDS**

Dr Desmond Johns

**UNDP/IAPSO**

Mr Jack Gottling, Manager, Procurement & Consulting Services  
Mr Johan Van de Gronden, Director

**UNICEF**

Dr Yves Bergevin, Chief, Health, Programme Division

**University of São Paulo, Brazil,**

Dr Joao Yunes, Director of the School of Public Health

**World Food Programme**

Mr Werner Kiene, Representative to the Bretton Woods Institutions  
Mr Martin Koran, Assistant to the Representative to the Bretton Woods Institutions

**World Bank**

Mr James D. Wolfensohn, President  
Mr Jo Ritzen, Vice President, Human Development Network

Mr Christopher Lovelace, Director, Health, Nutrition and Population, Human Development Network

Dr Armin Fidler, Sector manager, health, Nutrition and Population, Europe & Central Asia Region

Dr Ok Pannenberg, Sector Leader for Health, Nutrition & Population, Africa Region  
Dr Salim Habayeb, Lead Public Health Specialist, South Asia Region

Ms Diana Weil, Senior Public Health Specialist, Health, Nutrition and Population  
Dr Enis Baris, Senior Public Health Specialist, East Asia and Pacific Region

Mr Phillip Hay, Senior Communication Officer, Human Development Network  
Rasul Bagirov, Operations Officer  
Ms Vivian Jackson, Communications Associate, Human Development Network  
Ms Christy Hanson, Consultant, TB & Immunizations, Africa Region

**World Health Organization (WHO),**

Dr Gro Harlem Brundtland, Director-General  
Dr David L. Heymann, Executive Director Communicable Diseases Cluster (CDS)  
Dr J.W. Lee, Director, Stop TB Communicable Diseases Cluster (CDS)  
Mr John Liden, DGO  
Dr Charles Gilks, HIV Department  
Dr Mario Raviglione, Coordinator, TB Strategy and Operations  
Dr Mark Perkins, Medical Officer  
Dr Paul Nunn, Medical Officer  
Dr Marcos Espinal, Medical Officer  
Dr Leopold Blanc, Medical Officer  
Dr Dermot Maher, Medical Officer  
Dr Chris Dye, Scientist

**WHO Liaison Office in Washington**

Dr Tom Loftus, Special Adviser to the Director-General  
Dr Nelle Temple Brown, WDC

**WHO/Regional Office for Africa**

Dr Ebrahim Samba, Regional Director  
Dr Eugene A. Nyarko, Regional Adviser, Tuberculosis

Mr Samuel Ajibola  
Dr Naomi Nhiwatiwa

**WHO/Regional Office for the Americas**

Sir George Alleyne, Regional Director  
Dr R. Rodriguez Cruz, Regional Adviser, Tuberculosis

**WHO/Regional Office for the Eastern Mediterranean**

Dr Akihiro Seitla, Regional Adviser, Tuberculosis, Communicable Disease Control  
Ms Paige Best, Information and Advocacy Officer  
Division of Communicable Diseases

**WHO/Regional Office for Europe**

Dr Richard Zaleskis, Regional Adviser, Tuberculosis  
Dr Wieslaw Jakubowiak, TB Co-ordinator  
Office of Special Representative of the Director General in Moscow

**WHO/Regional Office for South-East Asia**

Ms Poonam Khetrpal Singh, Deputy Regional Director, Director Programme Management  
Dr Nair Nani, Medical Officer, Tuberculosis

**WHO/Regional Office for the Western Pacific**

Dr Shigeru Omi, Regional Director  
Dr Dong Il Ahn, Regional Adviser, Tuberculosis  
Stop TB and Leprosy Elimination

**WHO/Stop TB Partnership Secretariat**

Dr Jacob Kumaresan, Executive Secretary  
Dr Sarah England, Technical Officer  
Ms Petra Heitkamp, Technical Officer  
Ms Jeannette Sanchez, Communications Officer  
Dr Ian Smith, Medical Officer  
Dr Ger Steenbergen, Medical Officer  
Ms Adrea Mach, Meeting Rapporteur

**Wyeth Whitehall Export GmbH**

Ms Suzie Demmer, Commercial Director CIS



## GLOBAL PARTNERSHIP TO STOP TB

### Major achievements in the first 50 days since the Partners' Forum

- Launch and endorsement of the Global Plan to Stop TB
- Endorsement of the Stop TB Partnership Framework
- Endorsement of the Washington Commitment to Stop TB
- Signing of the Memorandum of Understanding for the Global Drug Facility
- Extensive international media coverage



The Stop TB Partnership is hosted by the  
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