



**Area Health
Education
Centers
Program**

University Tower Office
1123 S. University, Suite 400
Little Rock, AR 72204

(501) 686-2590 [Voice]
(501) 686-2585 [Fax]

October 30, 1998

The Honorable Hillary Rodham Clinton
The White House
Washington, DC 20500-2000

Dear Hillary:

I was delighted to learn yesterday of your recent meeting regarding tuberculosis, since we have undertaken one in Volgograd, Russia. With USAID support given to UAMS and the Volgograd Medical Academy by the American International Health Alliance, we have trained two young physicians from Volgograd and next week will participate in a conference there sponsored by the Academy. Dr. Joe Bates is the senior, distinguished member of our team. In his laboratory, Dr. Kathy Eisenach and Dr. Don Cave are international leaders in the molecular biology of tuberculosis. A description of our project accompanies this.

We look forward to your leadership with respect to the grave threat presented by tuberculosis and would welcome opportunities to discuss the matter with you.

Please let me add that Ruth Remmel, Maggie Garcia, and Mary all enjoyed seeing you a couple of weeks ago in Little Rock. We all remain solid supporters.

Sincerely,

James C. Wohlleb
Assistant Director

Enc.

**University of
Arkansas for
Medical Sciences**

Equal Opportunity Employer

file TB

VOLGOGRAD TUBERCULOSIS CONFERENCE, NOVEMBER 1998

Background

From Tuesday through Thursday, November 3 to 5, the tuberculosis conference of the Arkansas-Volgograd partnership (funded by AIHA) will take place at the Volgograd Medical Academy. Originally anticipated as a national conference, its scope was altered in June 1998 during the trip of the Arkansas team to Moscow and Volgograd. They discovered during conversations in Moscow that another national conference was planned at the Moscow Medical Academy in September. The Arkansas-Volgograd partners also concluded during discussions in Volgograd that focus on improving laboratory procedures in Volgograd might alone enhance cure rates through achieving more precise and reliable identification of specific strains of tuberculosis.

Further, the Arkansas team sensed that an opportunity to compare management of cases and their outcomes with open discussion might reveal why 10 per cent or more of therapies fail. This seems more appropriately conducted in a local rather than a national forum.

On the other hand, the stature of the lecturers recruited for the laboratory sessions is international. Desiring to continue the dialogue begun during our introductions in Moscow, the partners also believe that participation by the leaders there would be beneficial to long-term progress of aiding in the war against tuberculosis in Russia.

Contents of the conference

On Tuesday and Wednesday, the "consecutive case conference" proposed by Dr. Bates and accepted in Volgograd last June will occur. Dr. Karaduta and Dr. Kosolapov will describe approaches to tuberculosis control, procedures, and results that they have observed during their 6 months in Arkansas. Following their lectures, we propose to stop for a half-hour then begin presentations and discussions of 10 tuberculosis cases from Arkansas. This will require the remainder of the day. On Wednesday, cases from Volgograd will be given and discussed. The amount of time allotted might not be enough to hear all 10 cases from each Arkansas and Volgograd. Participants will proceed with as many as possible within the allotted periods of time.

Dr. Jennifer Dillaha, a fellow in infectious diseases at UAMS and the Veterans Administration Medical Center, prepared 2-page summaries of 10 consecutive cases who presented to clinics in Little Rock starting four years ago. Dr. Karaduta translated these into Russian and carried them back to Volgograd two weeks before the conference. Illustrations and graphs will be labeled in both English and Russian.

To provide the clinicians and laboratory staff with an overview of the laboratory's role in tuberculosis control, lectures will cover this in the afternoon on Wednesday. Thursday, the focus shifts to specific laboratory methodologies, which will be most informative to the technicians in tuberculosis laboratories. Following is the schedule for the conference.

<u>Sessions on Tuesday, November 3</u> 09:00 Introductions 09:15 TB Control in the US, Dr. Karaduta 10:00 US Lab Methods, Dr. Kosolapov 10:45 Break 11:15 Case Presentations 13:00 Lunch 14:00 Case Presentations 16:00 Summary and Discussion	<u>Sessions on Wednesday, November 4</u> 09:00 Case Presentations 10:45 Break 11:15 Case Presentations 13:15 Lunch 14:00 Role of the Laboratory in the Diagnosis of Tuberculosis, Dr. Eisenach 15:00 Molecular Epidemiology of TB, Dr. Cave 16:00 Summary and Discussion
<u>Lectures on Thursday, November 5</u> 09:00 Specimen Collection and Handling; Microscopy, Dr. Pfyffer 10:00 Discussion 10:30 Break 11:00 Specimen Processing and Culture Methods, Dr. Pfyffer 12:00 Discussion 12:30 Lunch	<u>Lectures on Thursday, November 5</u> 13:30 Identification and Drug Susceptibility Testing, Dr. Siddiqi 14:30 Discussion 15:00 Molecular Methods for Direct Detection and Drug Susceptibility Testing, Dr. Eisenach 16:00 Discussion 16:30 Summary and Conclusions
<u>Friday, November 6</u> Evaluation of conference Tours of laboratories	<u>Friday, November 6</u> Plan laboratory changes Other project plans

On Thursday, two family physicians from Arkansas -- the director of a residency program and another in private practice -- will lecture and discuss cases with faculty and residents of the new family medicine department of Volgograd Medical Academy.

As many laboratory staff as possible will attend from the laboratories of the academy as well as from those of the oblast and city of Volgograd. This includes people who collect and prepare specimens. Because the visiting experts will emphasize practical techniques for achieving reliable and precise results, their instruction will lead to improvements of laboratory performance during the next year as the partners continue communications.

This outcome of the conference is critically important to the future of the project in so far as it will lay the foundation for advances in laboratory development and, indirectly, clinical successes. The direction planned for the next year or more emphasizes the necessity and achievement of reliable and precise laboratory performance. Continuing education and monitoring operations will follow initial training. Studies of laboratory procedures in Arkansas by visiting faculty and staff from Volgograd will continue. These will stress quality control. With funds currently being sought, a new reference laboratory will be constructed in space already designated for this purpose by the academy. The educational activities in Volgograd and Arkansas will prepare staff for this reference laboratory.

The rationale for emphasis on laboratory performance is twofold. It rests on observations of last June that faculty of the Academy are more open to instruction and improvements in their laboratories than in their clinics. The other reason is the expectation that more precise and reliable laboratory methods will result more frequently in appropriate medications for patients and enhance the capacity for detecting ineffective treatments.

Because similar attitudes seemed to prevail in Moscow, and because effectiveness of treatment appeared to be approximately the same in Moscow as in Volgograd, the partners believe that involving leaders of tuberculosis clinics and laboratories of Moscow will benefit national progress against tuberculosis through dissemination of technology. An additional advantage to nationwide anti-tuberculosis actions will be increased exchange of information and solidarity among groups of experts.

Private sector support

Becton Dickinson (BD)-Europe has agreed to support the meeting by sending Dr. Gaby Pfyffer from the University of Zurich and Dr. Salman Siddiqi from the Maryland, USA offices of BD Biological Systems. Dr. Pfyffer, who consults internationally on laboratory methods, will lecture on collecting and processing specimens. Another expert on methods in tuberculosis laboratories, Dr. Siddiqi will describe drug susceptibility testing.

Dr. Andrey Pchelkin of the DINA firm in Moscow is invited to attend with a guest and to exhibit diagnostic kits sold by his firm for use in tuberculosis laboratories.

The partnership has submitted a request to BD for assistance with the construction of a new laboratory for tuberculosis. Its intended function is as a reference resource where technicians of the oblast will be trained, operations of other laboratories will be monitored, and research will be conducted (in addition to its routine service of laboratory clinics).

Invited guests

The Volgograd Medical Academy and the University of Arkansas for Medical Sciences invited the following tuberculosis leaders and officials (or their designated alternates) to the November conference in Volgograd. Due to relatively late invitations and prior commitments, however, most could not attend.

Alexander G. Khomenko, M.D., Director of the Central Tuberculosis Institute and member of the Russian Academy of Medical Sciences

Vitaliy I. Litvinov, M.D., Director of the Moscow Anti-TB Center and Corresponding Member of the Russian Academy of Medical Science (Formerly he headed the Immunology Department of the Central Tuberculosis Institute.)

Valentina I. Golyshevskaya, M.D., and Inna R. Dorozhkova, M.D., Institute for Phthisiopulmonology Research of the Moscow Sechenov Medical Academy

Farit A. Batyrov, M.D., Director of the Moscow Clinical Tuberculosis Hospital No. 7

Adalbert Laszlo, PhD, Consultant, WHO and IUATLD, Ottawa, Ontario, CANADA

Donald Enarson, M.D., Director of Scientific Activities, IUATLD, Paris, FRANCE

Natalia V. Voziianova, Project Management Specialist, Health Division;
George R. Oswald, Health Industry Specialist, Office of General Development; and
Nikita Yu. Afanasiev, M.D., M.P.H., Project Management Specialist for Health and Pharmaceuticals; USAID, Moscow, RUSSIA

Victor Boguslavsky, M.D., Director, AIHA/Moscow

Alex Goldfarb, Ph.D., Public Health Research Institute, New York, NY, USA

Rick O'Brien, M.D., Kenneth Castro, M.D., and Nancy J. Benkin, M.D., Tuberculosis Control Program, Centers for Disease Control and Prevention, Atlanta, GA, USA
(Unable to attend.)

Lee B. Reichman, M.D., M.P.H., Director, National Tuberculosis Center, Medical College of New Jersey, Newark, NJ, USA (Consultant to this project but unable to attend.)

file

**Tuberculosis Meeting
October 28, 1998**

Briefing Book

Table of Contents

- 1 - List of Participants
- 2 - Seating Chart
- 3 - Talking Points

U.S. Government Activities

- 4 - Department of Health and Human Services
- 5 - U.S. Agency for International Development
- 6 - Gore/Primakov Commission

NGO/International Organizations Activities

- 7 - OPEN Society Institute
- 8 - World Health Organization
- 9 - World Bank

Al D'Amato letter?

**TB Meeting
October 28, 1998**

List of Participants

World Health Organization

Dr. Gro Brundtland

Dr. David Heymann

*Executive Director for Communicable
Diseases*

Ambassador Jonas Store

Executive Director

Ambassador Thomas Loftus

World Bank

Dr. James Wolfensohn

President

Jan Piercy

U.S. Executive Director

Dr. David de Ferranti

*Vice President, Human Development
Network*

Chris Lovelace

Director, Human Development Sector

Open Society Institute

George Soros

Dr. Paul Edward Farmer

Dr. Alexander Goldfarb

Dr. Srdan Matic

Project 55 TB Initiative (Ralph Nader grp.)

Christoph Lee

AID

Administrator Brian Atwood

Duff Gillespie

*Deputy Assistant Administrator for
Population, Health and Nutrition*

HHS

Secretary Donna Shalala

Peggy Hamburg

Asst. Secretary for Planning and Evaluation

State

Frank Loy

Undersecretary of State for Global Affairs

Douglas Wake

Office of Assistance to the NIS

WH/NSC

Melanne Verveer

Marsha Berry

Ken Bernard

Andrew Weiss

Leon Furth

TB Meeting Seating Chart

October 28, 1998 -- The Map Room

David Heyman X	Amb. Jonas Store X	Amb. Thomas Loftus X	David de Ferranti X	Chris Lovelace X	Door
	George Soros X	Gro Brundtland X	James Wolfensohn X		

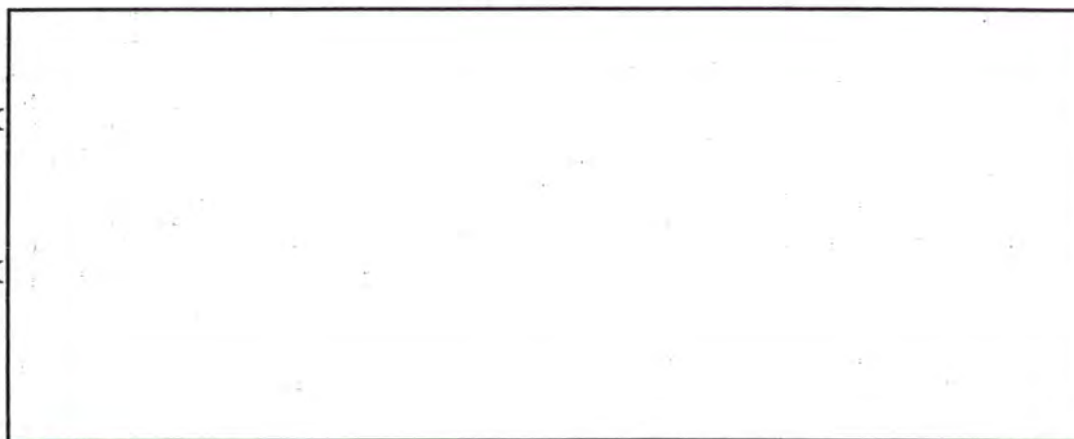
Srdan X
Matic

Alexander X
Goldfarb

Paul X
Farmer

Frank X
Loy

Leon X
Furth



X Jan
Piercy

X Melanne
Verveer

X Ken
Bernard

	X Brian Atwood	X HRC	X Donna Shalala	
X Duff Gillespie	X Andrew Weiss	X Douglas Wake	X Peggy Hamburg	X Chrisoph Lee
				X Marsha Berry

TUBERCULOSIS MEETING
OCTOBER 28, 1998
MAP ROOM

TALKING POINTS

OPENING REMARKS:

- I am pleased all of you could come to take part in this discussion of international tuberculosis control, one of the most critical and threatening global disease issues of our day. Looking around the room, it is clear that we have assembled the talent to help support a coordinated strategy to deal with TB worldwide.
- We all know the statistics concerning the resurgence of this age-old scourge: 8 million new cases per year over and over 2,000,000 deaths - that's over 5,000 deaths per day. As we enter the 21st century, TB remains the single largest infectious disease killer of adults. And most Americans still believe that TB is a disease of the past.
- We have recently been reminded again of how pressing this problem has become by George, who with his seemingly unlimited energy and commitment, has highlighted the TB epidemic in Russia and the other countries in the Newly Independent States.
- And the epidemic in Russia is raising a new issue - multi-drug resistant TB, which not only will make treatment far more expensive, but also poses a serious threat outside the region - a deadly form of disease that can cross borders as quickly as an international plane flight.
- There are no simple answers to the TB epidemic. This is not a disease that is easily treated with a single antibiotic prescription or injection. We must look at TB control in the context of development of quality health care at the community level. And we need high-level political commitment to ensure that a "best-practices" approach to control is seen as a high government priority.
- Obviously, funding is critically important to carry out these important control programs. Also important is the need to develop broad-based partnerships with other concerned nations, the private sector, academia, foundations and especially the

UN. With a global partnership under the expert leadership of Dr. Brundtland and W.H.O to carry out the needed TB control, we can, and will, move to control this killer.

Introduce other speakers:

- I would like to turn at this point to **Secretary Donna Shalala**, whose national and international leadership in health promotion and disease control need no elaboration for this group. She co-chairs the Health Committee of the Gore-Primakov Commission, and is passionate in her support of the new leadership of Gro Brundtland at W.H.O.

[Note: Secretary Shalala will likely speak on the components of international TB control as learned from our domestic experience. For Russia, she will emphasize the critical political commitment that can be developed through the work of the Health Committee of the Gore Commission. She will touch on countries building a rational national control strategies and the "Global Stop TB Initiative" of W.H.O.]

- Introduce **Brian Atwood**, Administrator, USAID

[Note: he will describe the USAID approach to TB internationally concentrating on broadening the issue to the NIS and other affected countries. He will note institutional investments, and may mention the mission of the Strategic Design Team leaving next month to set up "Demonstration Sites." in Russia.]

- Introduce **Dr. Gro Brundtland**, Director General, W.H.O.

[Note: She will discuss W.H.O.'s leadership in the "Global Stop TB Initiative" - including the complex constraints related to inadequate trained health personnel, inefficient drug procurement systems, poor political will, and problems of drug resistance. She will outline the W.H.O. actions.]

- Introduce James Wolfensohn, President, World Bank

[Note: He will outline the World Bank's interest in the problem, its past investments, and interests in working in Russia and other countries with significant TB problems.]

- Introduce George Soros.

[We are told that he will support W.H.O.'s lead in dealing with the global epidemic, and will offer his assistance in building a global consortium of major institutions and intergovernmental organizations (such as the EU) to raise the required funds.]

Discussion. open

CONCLUDING REMARKS:

- I am gratified to hear that we seem to have the same basic approach for dealing with the global TB epidemic. I won't recapitulate what was said, you all are better than I at representing your agencies and interests. We have much to do.
- With regards to Russia, I encourage the joint CDC/USAID/WHO Strategic Design Team to report back on what specific intervention plans will work best. We must help Russia and the other Newly Independent States develop rational and "do-able" national plans for TB control and treatment given their specific circumstances.
- Globally, we have an important task laid out before us. Each of us can contribute to our collective goal of controlling this epidemic - and doing so by doing what each agency or organization does best. But we should move forward quickly and resolutely - working together jointly with a common ideal of caring for and treating those who are infected, and stopping the spread of the disease through both community and international action.



AUG 28 1998

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Tuberculosis Epidemic in Russia

Because the tuberculosis (TB) epidemic in Russia is such an important health care issue, I am providing you with an update and background on its current status and the steps we are taking to address this significant, world-wide threat to the public health. Also, I have attached talking points and a brief background paper for your use should the opportunity arise during your visit to further our recent progress made in combating this deadly disease.

As you know, I have had the pleasure of serving as a co-chairperson, together with the Russian Minister of Health, on the Health Committee of the Gore-Chernomyrdin Commission. TB control is a key issue for the Health Committee and many resources of the Department of Health and Human Services, especially through the Centers for Disease Control and Prevention (CDC), and the USAID, Department of State have been mustered to assist the Russian government in fighting this disease. But urgent problems continue that need to be addressed.

First, although Russia has the relatively low-cost drugs that can be used to treat TB, there are often more TB patients in the prisons and sanatoria than can be treated with the drugs available. Also lacking is surveillance, laboratory support and the organizational systems and discipline to see treatments completed.

Second, when the inexpensive, simple antibiotic treatments for TB are not adhered to, are inadequate or unavailable, a Multi-Drug Resistant Tuberculosis (MDR-TB) may emerge that is treatment-resistant and requires much more expensive antibiotics. If these are unavailable or are used in a haphazard fashion, there is substantial risk of developing even more resistant strains of TB and spreading an airborne epidemic beyond Russia.

We have worked with our Russian colleagues to encourage them to adopt a treatment regimen, known as Directly Observed Therapeutic Strategy (DOTS), that has been advocated by the CDC and the World Health Organization (WHO). DOTS entails carefully monitoring patients to ensure that they take the full course of antibiotics prescribed to eliminate TB. This can be done in either an in-patient or out-patient setting, but the cost savings of out-patient treatment are substantial. It is an important world-wide strategy to treat TB that can improve the quality of care and reduce costs without the need for prolonged institutionalization.

However, some have argued that because DOTS does not require institutionalization, drug treatment compliance could be lower, which could lead to the emergence of MDR-TB. The official Russian policy on TB retains the traditional approach of treatment in sanatoria. This is especially true among local officials where the sanatoria system is a major source of employment.

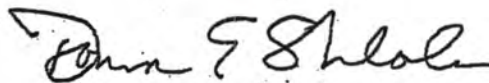
Seeing both sides of this issue, we have pushed hard, but respectfully, for reform in Russia. I am especially pleased that the Gore-Chernomyrdin Health Committee has given us a forum to convince the Minister of Health to adopt DOTS and to make the organizational changes necessary for its implementation. The cost of adequate treatment of TB in Russia, including transition to a system of DOTS, remains a challenge but HHS and the State Department are working with our Russian counterparts to develop a short- and long-term strategy.

One example of our success stems from our convincing the Ministry of Health to adopt DOTS which paved the way for Mr. George Soros and his grantees to implement DOTS demonstration projects in Russia. Under this effort, Mr. Soros' Open Society Institute is providing funding to the New York City-based Public Health Research Institute (PHRI) to implement DOTS pilot projects in Russia with a focus on the possible emergence of MDR-TB. I would note that the First Lady is keenly aware of the public health threat of MDR-TB and raised it during a meeting with Mr. Soros where he was explaining his initiative in Russia.

You should also be aware that Mr. Soros' grantee, PHRI, together with the Britain-based Medical Emergency Relief International and the Belgian-based Medecins Sans Frontieres (Medicine Without Frontiers) have sent an open letter to President Yeltsin urging that he do more to combat the spread of MDR-TB, warning that Russia has become the "world's incubator of the deadly disease." Some Russian conservatives consider these efforts to be a "plot" by western drug companies to sell Russia expensive pharmaceuticals.

We would suggest a less politically confrontational, more public health approach to this complicated issue. An approach based on the scientific evidence that DOTS can be a more effective and lower cost approach to the treatment of TB, especially with respect to the threat of MDR-TB. We hope that the progress that we have made with the Russian Ministry of Health, which has made it possible for the Mr. Soros' initiative to occur, can be continued.

As I mentioned above, I am making the attached talking points and briefing paper available to you should the opportunity arise to further our public health goals of reducing the incidence of TB, especially MDR-TB, among the Russian people. I have also attached an informative editorial by Harvard Professor, Howard Hiatt, who argues because of its airborne spread, resurgent tuberculosis, and MDR-TB in particular, are an even greater threat to society than the AIDS epidemic. Please let me know if you would like any additional information.



Donna E. Shalala

Enclosures

Tuberculosis Epidemic in Russia

Talking Points

- We share your concern about the increased incidence of tuberculosis (TB) in Russia, and especially the emergence of a particularly dangerous form of tuberculosis, multidrug-resistant TB (MDR-TB) that cannot be treated with conventional antibiotics.
- We understand that MDR-TB is now a particular challenge in the penal system of the Russian Federation. Prisoners released after even brief stays in crowded prisons may have acquired the disease and become the source of infection in the community at large.
- We in the U.S. have had our own unfortunate experience with drug-resistant tuberculosis. During late 1985 and early 1990's, we had outbreaks of MDR-TB in hospitals and prisons, much of which was associated with HIV/AIDS co-infection.
- We have committed a substantial level of effort and resources to bring the situation under control. Only after implementation of treatment methods, such as directly observed therapy, that are recommended by the World Health Organization and our own Centers for Disease Control and Prevention, were we able to make real progress in controlling this persistent disease.
- We are aware of the situation in Russia and applaud your recent efforts of the Russian Ministry of Health and the Chief Administration of Execution of Punishment to implement international standards of TB control.
- We also understand the difficulties you face, both economic and social, in restructuring the system of TB care.
- However, we also are aware that there are successful pilot projects underway in Ivanovo and Tomsk that are being carried out as part of multilateral and our own bilateral cooperation.
- Based on these experiences, we stand ready to provide technical assistance as you work towards a nationwide program of tuberculosis control in Russia.

Russia's Health Care System and Condition

Serious shortcomings in Russia's health system and disease profile threatens the country's ability to provide adequate public health services to the Russian people, and for some diseases, poses a cross-border threat to the health of other nations, including the United States. While many general health statistics have improved modestly in the last two years, including life expectancy, alarming increases are evident in rates of STDs, HIV and TB.

Between 1990 and 1997, the incidence of syphilis has increased from 5.4 per 100,000 to 216.9 per 100,000 -- an increase of nearly 5,000%. Gonorrhea is increasing rapidly as well, and what shocks health officials and local leaders is that many of those infected are under the age of 20. In 1987, Russia had 24 recorded cases of HIV. By the first half of 1998 there were close to 8,700 cases of HIV and 300 AIDS deaths reported. Outside estimates are much higher, but even the Russian Duma estimated that Russia can expect at least one million cases of HIV in the coming years, with which the health and economic system will be unable to cope. The rise in TB cases has been dramatic, with civilian notifiable cases increasing from 36 per 100,000 in 1992 to 75 per 100,000 in 1996; particularly worrisome is the level of multiple-drug resistant TB which is estimated at 7.3% of all civilian cases, posing a distinct threat beyond Russia's borders. The TB situation in prisons is far worse.

The health system suffers from low and underfunded health budgets, poor performance of the mandatory health insurance program in collecting premiums, and the lack of a legal framework for the private provision of health care despite survey findings indicating that upwards of 40% of health expenditures are out-of-pocket. The work of medical providers suffers from a lack of evidence-based medicine and quality improvement in all aspects of healthcare, especially diagnosis and treatment protocols.

Nonetheless, successful dialog between U.S. and Russian health experts through the bi-lateral commission initiated by Vice President Gore, and effective use of USAID foreign assistance contributions are evident. Since 1992, the U.S. has provided over \$95 million to address a broad range of health issues important to Russia such as immunization, women's reproductive health, pharmaceutical investment and quality control, environmental health, and health information and response activities. Approaches involving partnerships between U.S. and Russian organizations have been successful at the local level and, in one program's case, has led to U.S. private contributions of time and equipment estimated at \$45 million over the last four years. Attempts at strengthening the role of non-governmental organizations in the delivery of public health information and services health field requires more attention.

Tangible results are evident from the U.S.-Russian cooperation. For example, an estimated three million Russian couples now have access to safe and effective family planning services, and U.S. assistance has been credited with bringing down abortion rates. Yet, controversy about family planning has increased from the political right and from some religious groups. The Yeltsin administration wants to continue U.S.-Russian cooperating on reproductive health programs, and expand into improvements in maternal and neo-natal health. Russia is also working with the U.S. on a national initiative to improve the quality and access to health services, and a multi-year strategy aimed at STD/HIV prevention and control. A design effort for USG assistance in TB control is scheduled for Fall 1998.

More Deadly Than AIDS

Howard Hiatt

Washington Post

August 14, 1998

Many Americans think that with the discovery of streptomycin more than 50 years ago, the tuberculosis problem was solved. But a little-noticed (in the United States) TB epidemic now kills 3 million adults a year worldwide, more than AIDS or malaria. Even more threatening is the increasing appearance around the globe of forms of TB that are resistant to streptomycin and many other drugs that have been used to treat the disease.

Almost every person with the common variety of TB can be cured with two to four medications daily for at least six months at a total cost of about \$100. In recent years the World Health Organization, with support from the World Bank, has treated drug-sensitive TB in many countries with a very effective strategy that involves supervised administration of the drug over the prescribed period.

But when TB sufferers are treated inadequately, that is, when they don't have all the required drugs or don't take them long enough, mutant TB bacteria that are more resistant to the drugs grow. Patients may feel better temporarily, but what was a curable condition can become a death sentence. And their now multidrug-resistant (MDR) TB bacteria infect others.

MDR TB can often be cured, but at a cost eight to 80 times higher than that of treating ordinary TB. Until a few months ago that cost led to the view that treatment of MDR TB in resource-poor countries was not "cost-effective." But Paul Farmer and Jim Kim, two physician- anthropologists who divide their time between work at Harvard Medical School and Brigham and Women's Hospital, on the one hand, and the poorest areas of Haiti, Peru and Mexico, on the other, have changed that.

In the barrios of Lima, where they have been involved in community-building for five years, they recognized that treating only patients with drug-sensitive TB, the most prevalent kind, could encourage the spread of MDR TB.

Even more important, they regard treatment for MDR TB as the right of all its victims. Finally, they know well that infectious diseases respect no border and that their spread to the rest of the world is more than a threat. In fact, an American priest who recently died of MDR TB in Boston had come there from service in the barrios of Lima.

Therefore, they began treating almost 100 of the many desperately ill patients with MDR TB in Lima with five or more drugs daily over a period of two or more years.

More than 85 percent appear to have been cured. Farmer and Kim ascribe a large part of their success to their partnership with community members whom they have trained to ensure that every patient takes every dose of every medication every day. The cost has been great (although

much, much less than the cost in a U.S. hospital), but they have thus far succeeded in obtaining the needed drugs, partly by going into debt.

Earlier this year tuberculosis specialists from around the world gathered at the American Academy of Arts and Sciences and examined and then endorsed the preliminary Lima evidence. Subsequently, the World Health Organization decided to replicate the Lima experiment in a few other sites around the world that it has designated MDR TB "hot zones."

Thanks to the generosity of George Soros, the first such sites will be in Russia and Latvia, where MDR TB is prevalent and spreading rapidly. The Soros foundations have committed to pay for programs there. But if the worldwide epidemics are to be contained, many more groups must be mobilized. The World Bank, national governments -- particularly those of industrialized nations -- the pharmaceutical industry, other business leaders concerned with international trade, scientists and others all can play crucial roles in a program to wipe out all forms of TB.

The AIDS pandemic has appropriately aroused the concerns of people around the world. The tuberculosis pandemic requires no less. Because it is spread much more readily than AIDS -- through the air that everybody may breathe -- it represents an even greater threat.

The writer, a professor of medicine at Harvard, is director of the Initiatives for Children Program of the American Academy of Arts and Sciences.

© Copyright 1998 The Washington Post Company



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

MEMORANDUM

TO: WH/OFL, Melanne Verveer

FROM: Acting AA/ENI, Donald L. Pressley *[Signature]*

SUBJECT: Tuberculosis in the ENI Region

In response to my conversations with Mrs. Clinton during our recent trip to Eastern Europe, please find below a summary of USAID's tuberculosis activities in Europe and the New Independent States (ENI).

Following a general decline in the incidence of tuberculosis (TB) prior to 1991, rates have risen dramatically since then. With a continuing breakdown of the health systems in the troubled economies of the NIS, most countries continue to follow a very cost-inefficient TB control strategy involving active case-finding, regular chest X-rays, excessive skin testing and immunizations, and a well-entrenched, costly sanatoria network. USAID is assisting in reorienting the TB control effort in the region through: pilot efforts on the WHO recommended directly observed therapy, short course (DOTS); strengthening epidemiological monitoring and surveillance; more rational pharmaceutical management, including appropriate prescribing practices and pharmaceutical procurement; and strengthening health care delivery systems.

In addition, USAID awarded a first tranche of funding to the Department of Health and Human Services (DHHS) to create an ENI regional TB working group to include expertise from WHO, SOROS and other entities to address TB in the region. The working group will help define the barriers to acceptance and adoption of DOTS in the NIS and will recommend activities necessary to overcome the barriers.

A. TUBERCULOSIS IN RUSSIA

As you know, since the collapse of the ruble and the banking system in Russia, the State Department (S/NIS/C) and the NSC have been closely tracking the TB and pharmaceutical situation in Russia, and have discussed the possibility of humanitarian assistance to respond to particular needs. TB in Russia, however, is not responsive to short-term humanitarian assistance. The number of notifiable cases of TB in Russia has more than doubled over the past six years, from approximately 35/100,000 population in 1992 to approximately

75/100,000 population in 1998, according to the Ministry of Health (MOH) and WHO. Russia's TB rates are among the highest in Europe. Rampant TB rates in prisons continue to serve as a source of infection for the civilian population and multi-drug resistant forms of the disease are on the increase. These two factors have emerged as major threats to successful control of the epidemic. Mortality due to TB in the general population is about 17 per 100,000 population, while in the prison population it is estimated to be as high as 484 per 100,000 population.

Russia continues to follow outdated diagnostic and treatment practices. Efforts by the USG, Soros and other donors to modify those practices, are showing some positive results. But TB in Russia is a complex problem, for which there is no clear or short term fix. Progress towards adoption of modern methods is constrained by a range of difficult economic, political, institutional, psychological, ethical, social and logistical impediments.

In an effort to position itself to respond to the growing crisis, USAID/Moscow commissioned a study to examine the availability of and procurement methods for first-line TB drugs in Russia. The September 1998 report indicates that: a) the first-line anti-tuberculosis (TB) drugs are all available on the Russian market; b) that Russian drug manufacturers increased production of first-line TB drugs by 50% during 1997 and now claim to have sufficient production capacity to satisfy 100% of the country's need for these first-line TB drugs for 1998; but c) chronic shortages nevertheless exist due to perpetual problems with raw materials, procurement, distribution, affordability, and stock management. An emergency drop of TB pharmaceuticals is not needed now and would complicate or even worsen the situation, since the system is not prepared to properly handle a DOTS program. Nonetheless, USAID/Moscow will continue to monitor the situation.

Programs Underway

Because of the risk of promoting multi-drug resistant TB, there is a growing recognition that "doing DOTS badly is worse than doing nothing at all." It is absolutely critical that Russia have in place a sensible and comprehensive plan and adequate implementation capacity to support a DOTS program before drugs are distributed and treatment activities are initiated. USAID and the Centers for Disease Control (CDC) are moving quickly and responsibly to develop a plan to deal with the current crisis.

- With S/NIS assistance, USAID set aside in FY98 \$1.5 million of Freedom Support Act (FSA) funding for TB efforts in Russia. In November, USAID and CDC will begin a TB assessment and design effort to identify likely sites for a multi-year TB program. It is envisioned that the USAID/CDC program will support pilot, community-based activities which complement and build on the work supported by the Soros Foundation and other bilateral donors. Because of statutory limitations, USAID and CDC expects to focus on civilian (not prison) populations. The programs will

institute a "DOTS-Plus" strategy (including food supplements and other inputs besides TB drugs) while tracking the prevalence of multi-drug resistant TB.¹

- A one year hospital partnership (funded by USAID) between the University of Arkansas, School of Medical Sciences and the Volgograd State Medical Academy is initiating modern standards for tuberculosis diagnosis, treatment, and case management in a very limited way. All new health partnerships under the American International Health Alliance (AIHA) will explicitly include TB in the initial needs assessment.
- The American College of Physicians in collaboration with DHHS is working on a pilot effort to integrate TB into other quality and primary care initiatives..

For other donors working on TB programs in Russia, please see attached matrix, "Summary of Donors' Tuberculosis Programs in the Russian Federation as of October 1998."

B. TUBERCULOSIS IN CENTRAL ASIAN REPUBLICS (CAR)

Central Asia has seen a three to four fold increase in tuberculosis since the early 1990's. Although a number of other countries have TB rates higher than those found in CAR, the situation is still grave because of the often incurable form of the disease multi-drug resistant TB. USAID, Chevron and other donors, in a unique public-private partnership, are funding a TB initiative in CAR, and the results are just beginning to surface.

Programs Underway

Chevron Munaigas funded Project HOPE to introduce DOTS at pilot sites in Kazakhstan in 1994. Chevron also delivered a TB mobile clinic to Almaty Oblast, with transportation costs covered by the Department of State.

In 1997, USAID/CAR started its "TB Initiative", in collaboration with Chevron, building upon on-going health reform efforts. The implementing team includes Abt Associates, Project HOPE, and CDC — a collaborative public-private partnership which has worked extremely well in the region. Broad objectives have been to update the existing TB diagnostic, treatment and control practices in the region through demonstration pilot sites in Kazakhstan and Kyrgyzstan. Activities include: developing national TB education campaigns; training health care professionals; supporting and monitoring DOTS pilot projects in Almaty (81 patients) as a model for national expansion; strengthening TB epidemiology and surveillance; and analyzing the cost-effectiveness of DOTS.

¹ It should be noted, however, that Russian-Iran legislative directives, if enacted, will dramatically constrain the flexibility and scope of this program both at the federal and community levels.

Because of USAID's TB initiative, in May 1998, the President of Kazakhstan, Mr. Nazarbaev, signed a decree to implement DOTS nationwide. Some funding has been allocated and momentum is apparent in the MOH. Supported by all the donors in the region, a development plan for the National TB Control Program has been finalized to implement DOTS at limited pilot sites which will act as centers for training for the rest of the country.

Thus far, USAID has committed \$1,980,000 of FSA funding for the program. Through collaboration with the World Bank, TB activities will be expanded to additional oblasts in Kazakhstan and Kyrgyzstan over the next few years. In 1999, subject to availability of funding, elements of the program will be expanded to Tajikistan, Turkmenistan and Uzbekistan. Other organizations involved in or exploring TB-related activities in Central Asia include AMOCO, Lutheran Ministries, Medecins sans Frontiers-Luxenburg, Philip Morris, SOROS and the University of Wisconsin.

Although too early to measure impact, TB initiatives accomplishments in CAR to date include: training of 385 physicians and other health workers in DOTS therapy, laboratory methods, drug supply and logistics, and health surveillance; provision of modern laboratory equipment and supplies for smear microscopy to three demonstration sites; initiating an information campaign including two press conferences on TB in Kazakhstan and two TV videos which are shown on national and Almaty TV; and ongoing policy dialogue on costs and laws concerning TB prevention, diagnosis and treatment.

C. TUBERCULOSIS IN OTHER AREAS OF THE ENI

Caucasus: The Mission is currently revising their health strategy and will explore possible TB initiatives.

Ukraine: During the period 1990-1996, the TB rate in Ukraine increased by 45 percent and the MOH states that the country now has 45.8 people per 100,000 infected with TB. The Mission in Ukraine is exploring TB initiatives in conjunction with a future primary health care strategy.

Kosovo: USAID's Office of Disaster Assistance (OFDA) has provided about \$696,000 to Doctors of the World to provide food and hygiene parcels for TB patients and their families as incentives to increase treatment compliance in collaboration with a Swedish and multi-donor funded screening and treatment program in Kosovo. Over 4,000 TB patients have benefitted from this program. Initial results show a significant increase in the patient compliance rate. As peace plans begin to take effect, USAID will continue to review the status of TB in Kosovo especially when developments programs become more regular.

An Ancient Marauder Looms Again

■ **Tuberculosis:** The fight against it must be global as drug-resistant strains spread.

By RALPH NADER
and R. GORDON DOUGLAS

For the first time since the introduction of anti-tuberculosis drugs in the 1950s, the world faces the threat of incurable TB, a disease that destroys the lungs, dooming its victims to drown in their own blood. This deadly infection is airborne; it spreads like the common cold. Worst of all, highly resistant strains have been discovered in 34 countries by the Global Project on Anti-TB Drug Resistance.

If tuberculosis were a newly emerging disease rather than an ancient marauder, it would be making headlines almost daily. However, in the four years since the World Health Organization declared TB a global emergency, there has been little international alarm. Inexpensive, generic medications have long existed to cure tuberculosis, yet 3 million people die each year, making TB the greatest infectious killer worldwide, responsible for one-fourth of the world's preventable deaths.

In October, an unprecedented report released by top U.S. and international health agencies issued the ultimate warning: Multi-drug-resistant strains of tuberculosis (MDR-TB), which can be virtually untreatable, have emerged worldwide and threaten to overwhelm the public health systems of India, Russia, Latvia, Estonia, Argentina, Ivory Coast and the Dominican Republic. In these countries, poor TB

control programs misuse antibiotics and ineffectively treat patients, practices that foster drug-resistant strains. These MDR-TB "hot-zones" pose a grave threat to global health, as international travel and migration put all areas of the world in close contact.

Few people recognize the danger that MDR-TB poses to Americans. It is very difficult and expensive to contain, and the industrialized world is by no means immune. Since 1991, when these strains were found in only 13 states, MDR-TB has spread to 42 states and the District of Columbia. In September, a new strain of highly contagious TB that multiplies at 1,000 times the normal rate was identified along the Tennessee-Kentucky border.

Transmission of tuberculosis can occur anywhere, from planes to schools to neighborhood bars. In 1994, a South Korean woman with MDR-TB infected four Americans on a plane.

The importation of TB across international borders is very common. In this country, 37% of TB patients are foreign-born, 25% of them from one of four "hot zones": India, Korea, Vietnam and the Dominican Republic. In the Dominican Republic, where 9% of TB cases are MDR, one out of every seven residents has obtained a visa for travel to the U.S.

The U.S. learned a harsh lesson when the dismantling of TB control infrastructure in the 1980s led to sharp increases in tuberculosis. According to New York City's director of TB control, the explosion of MDR-TB required more than \$700 million between 1992 and 1996 to quell the outbreak.

The World Health Organization spends \$11 million annually on TB control, of

which the U.S. contributes only about \$500,000. WHO estimates that, in addition to commitments from developing countries, \$100 million more is needed annually to control the epidemic and prevent the spread of MDR-TB. Surely, Americans would be willing to foot some portion of that bill to prevent a disease that WHO's Richard Bumgarner called "Ebola with wings" from descending on our shores.

Congress has approved additional money for the Agency for International Development, which channels funds to WHO, to combat infectious diseases worldwide. If only the Clinton administration would follow through more comprehensively. Some of the proposed new funding for biomedical research and for the National Institutes of Health also should be channeled into TB research. Furthermore, the U.S. must pay its dues to the United Nations if WHO is to be effective in fighting TB and other such deadly diseases. Unless this funding is sustained over the long term, TB programs will be ineffective, treatment of patients will be incomplete and our temporary good intentions will only fuel the spread of drug-resistant strains.

The only way to protect Americans against multi-drug-resistant tuberculosis is to support effective treatment and control programs that prevent MDR-TB from developing. It is a war that must be fought internationally, before this country becomes a primary TB battleground.

Ralph Nader and Dr. R. Gordon Douglas are on the steering committee of the Princeton Project 55 Tuberculosis Initiative of Princeton University's Class of 1955.

21/oct/98

Health Committee

GORE - PRIMIKOV

IV TUBERCULOSIS

Summary of Situation

In Russia, as in much of the former Soviet Union, tuberculosis (TB) cases have increased dramatically in recent years. In addition, multi-drug resistant (MDR) TB which does not respond to conventional treatment has emerged. MDR-TB has spread in environments such as prisons and hospitals, and threatens TB control efforts since the costs for treating MDR-TB are 100 fold-higher than for treating non-resistant TB (\$3000/case versus \$30/case). The problems have emerged because of unstable drug supplies and reluctance of the medical establishment to use the simple, effective strategy known as DOTS that consists of five elements that include government commitment, appropriate methods of TB diagnosis, an adequate supply of quality drugs, supervised administration of these drugs, and careful monitoring of treatment outcomes. This approach is used in the U.S. as well in more than 100 other countries. Unless the TB problem in Russia is dealt with immediately, drug resistance due to poor treatment practices will continue to develop and spread in the community, making TB virtually untreatable.

U.S. Activities to Date

TB has been considered as an important disease by the Health Committee of the Gore-Primakov Commission. At the request of the Department of Health and Human Services, CDC has participated in the committee's TB activities, which until now have been limited because of availability of resources and resistance at the national level in Russia to institute meaningful changes in national TB policies. CDC activities to date have included a series of visits to Russia in which meetings were held with national counterparts for the purpose of discussing possible collaboration. In addition, CDC planned and hosted a U.S. study tour of TB experts from the leading TB institute in Russia in February 1997 to see the U.S. TB strategy in action in a variety of settings. Although CDC has been involved in a number of TB projects in the Central Asian Republics and the Baltics, direct involvement in Russia has been limited. Recently, however, USAID in Moscow has recognized the importance of the problem and is planning on providing mission funds for a three year period to CDC for the development of one or more pilot projects.

PHRI/Soros Activities

In September 1998 CDC staff conducted a joint visit with members of the Public Health Research Institute/Soros Steering Committee to examine their activities in the civilian and prison populations in the Tomsk Oblast and a TB prison in the Kemerovo Oblast.

Public Health Research Institute (PHRI) of New York City has received a \$12 million grant from the Soros Foundation (Open Society Institute, OSI) to undertake projects aimed at reform of tuberculosis control in the Russian Federation (RF). Dr Alex Goldfarb,

a senior scientist in PHRI, serves as the director of the project. After one year of operation, PHRI has joined DOTS demonstration projects in the civilian sectors in Iyonova (initially supported by WHO) and Tomsk (supported by the British NGO, MERLIN), strengthening laboratory capacity and entering into contracts with local authorities to achieve cost savings by reducing the number of TB hospital beds and of unproductive TB screening activities. For assistance in training, project monitoring, and surveillance/reporting, PHRI is working with the Central TB Research Institute (Prof Alexander Khomenko) in Moscow. PHRI is also supporting a DOTS project initiated by MSF/Belgium in a TB prison in Mariinsk (Kemerovo) and has begun DOTS projects in four other prisons (Tomsk, Iyonova, Mari-El, Vladimir and Nidzy-Novogograd). Based on information available to CDC, it appears that the DOTS projects in the civilian sectors, where rates of initial MDR-TB appear to be relatively low, are succeeding. However, failure rates as high as 40% have been found in the Mariinsk prison, likely because of an equivalent rate of MDR-TB in new patients beginning treatment. Clearly, in such a setting a DOTS-alone approach may be inadequate. As a next step, PHRI intends to implement a DOTS-plus project in Tomsk (both the civilian and prison sectors). With project funds now fully committed, PHRI is looking for other partners and funding sources to expand DOTS-plus programs in regions where it is working and extend DOTS implementation to other regions in RF.

U.S. Planned Activities

Beginning November 15, CDC will detail a public health advisor to Moscow for a 4 to 5 week period to assist the USAID Mission in the development of a TB in Russia Background/Strategy Document.

In late November, a joint CDC-AID team will visit Russia to perform an assessment of three areas to determine which area would be most suitable to serve as a demonstration site for CDC-guided TB control project activities. This multi-disciplinary team will consist of a senior epidemiologist, a TB laboratory specialist, a senior public health advisor and an experienced program management officer. One of the sites to be visited, the Kemerovo Oblast in Siberia, has expressed a strong interest in introducing the basic DOTS strategy in the civilian population (Medecins Sans Frontieres, Belgium is already working successfully in the main prison). The second site, the Ivanovo Oblast near Moscow has been used as a pilot area by the World Health Organization and has one of the two most developed DOTS programs in Russia. In this oblast, the U.S. contribution would be the development of a strategy to identify and cure the MDR-TB patients who are not cured by the routine DOTS approach. The third area under consideration is the Novgorod Oblast which is said to have a progressive governor and chief TB doctor, and has allegedly indicated it's willingness to provide an adequate supply of required TB drugs. If successful, a demonstration project would serve as model for other oblasts in the country. It is hoped that if success is demonstrated in various oblasts, the other oblasts

which are still expressing considerable reluctance to abandon old treatment strategies will be willing to change to the DOTS approach.

Major Obstacles

1. The amount of money that is being made available at the USAID mission is inadequate to fully support the proposed activities.
2. Current U.S. government restrictions on the ways in which money can be spent in Russia may limit the usefulness of available monies. At least part of the potentially available mission funds cannot be spent on activities benefitting the national, oblast, or local governments or on salary support for Russian nationals).
3. For these projects to be conducted successfully, USAID money must be spent (or other sources must be located) to pay for drugs. Although the need for the expensive MDR TB drugs may diminish over time if the program is successful, the need for basic TB drugs will remain, and it appears unlikely that the oblast or national governments will be able to bear these costs in the next several years.
4. Sustainability of efforts beyond the duration of the project may be difficult unless the financial situation of the country undergoes dramatic improvement.

Coordination Meeting on TB in Russia, 15 October, 1998

At a meeting convened last week (15 October, 1998) by the Office of the Coordinator for NIS Assistance, the group, including Drs. Hamburg and Eisenberg, explored several ideas that were later discussed with Dr. Helene Gayle at CDC. The demonstration projects described above will be most effective in the long run, if they are combined with the following initiatives:

1. The setting of a national framework and establishment of an environment for broader adoption of improved care patterns (especially if the demonstrations can show the effectiveness of "best practices"). This would likely be done with Russian TB leaders, oblast leaders, medical education and professional leaders, and political leaders. This should be linked with the American International Health Alliance (AIHA) and American College of Physicians (ACP) projects, and integrated with the Health Committee's quality and primary care initiatives.
2. The building of capacity to care for patients with TB outside sanatoria and prisons. This means upgrading the ability of hospitals and polyclinics to care for TB patients, especially once they have been successfully started on treatment and can be sent into community-based DOTS programs (more difficult, obviously, with

MDR-TB).. This can be done in conjunction with the ACP project, perhaps with other Health Committee efforts to help upgrade primary care and polyclinics.

3. The building of capacity in laboratories for testing TB sensitivities and for assisting clinicians in the selection of appropriate treatment, combined with laboratory support for a more extensive surveillance system to identify the disease burden and to characterize the epidemic better. Dr. Hamburg emphasized this as having been very important in New York City's success in reducing MDR-TB.
4. The identification of the Russian drug availability situation. Funds should be considered to assist the broader distribution and delivery of drugs, some of which are already in Russia but are not being used. A combination of the lack of money to buy pharmaceuticals, poor health sector organization for their distribution to the areas most in need, and the lack of knowledge or commitment to use the drugs appropriately, as well as other factors, contribute to this problem.

These efforts will be very expensive, but the Health Committee should take advantage of the attention this is getting to emphasize that one can't do demonstration projects without building reform of TB care into the public health infrastructure, improving the community-based care, and paying attention to quality of care. Depending on the intervention, these could be done either in the demonstration regions, in the nation as a whole, or as part of other donor and collaborative programs (eg, the Access to Quality Care Initiative, AIHA). It should also be linked with the Soros initiative, of course.

The challenge is how to do the demonstrations with the little money available to the Health Committee, and to have concrete and near-term products and achievements, yet offer a broader scope of ideas that focuses those who may direct more funds toward the program on the full spectrum of components of the initiative if it is to be long lasting.

V MATERNAL CHILD HEALTH

The USAID Women's Reproductive Health Project

This project has continued its roll-out and institutionalization activities. A team recently left Russia after developing a strategy for the next 3-4 years which will expand current work in the area of women's reproductive health to Women's and Children's Health. New efforts will include work in policy development, NGO development; research; and information, education, and communication activities.

1. To date, six of the eight roll-out sites have received contraceptive technology update trainings and four have received contraceptive shipments. Training in the

cc: Melanne

OPEN SOCIETY INSTITUTE

O S I

GEORGE SOROS
Chairman

ARYEH NEIER
President

20th August 1998

Mrs. Hillary Rodham Clinton
The White House
Washington D.C. 20500-2000

Dear Hillary,

You told me at our last meeting of your interest in the problem of tuberculosis in Russia. As you noted, explosive prison epidemics in Russia are fueling the larger national epidemic; these outbreaks are, of course, not contained by national boundaries. I am very pleased that Dr. Gro Brundtland of the World Health Organization has underlined the importance of U.S. leadership in addressing this global emergency.

We have started a program to address TB in Russia through the WHO-endorsed control strategy of directly observed therapy or "DOTS" which cures sensitive TB and prevents new multiple drug-resistant TB from developing. We have received requests to support programs from our foundations in such countries as Kazakhstan, Kyrgyzstan, and Azerbaijan which are currently under consideration.

Since we initiated this work a year ago, we have discovered that the problem is considerably worse and more difficult than we imagined. My concerns fall into two main areas: MDR-TB, and other impediments to the adoption of the DOTS approach.

First, the situation is greatly complicated by the multidrug-resistant strains of TB which are not effectively treated through the DOTS approach. The World Health Organization last month endorsed a "DOTS-Plus" strategy which addresses drug resistant treatment in circumstances such as those found in Russia. Since we met, I have directed our TB team to adopt this expanded approach in order to save lives and halt epidemics already underway.

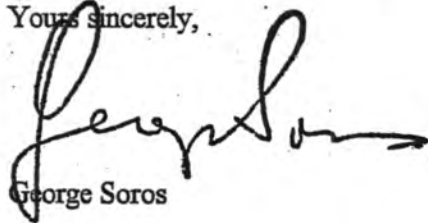
This enhanced approach is significantly more costly than the simpler "DOTS" approach. This expansion will require additional funding, though far less than the cost of ignoring these drug-resistant strains. While I am prepared to commit some additional funds to TB, I have become convinced that the problem can be addressed only with the coordinated and solid financial commitment of a wide range of international, bilateral and private donors.

Second, as our programs develop in Russia, we have encountered a range of economic, political, social, and logistical impediments to the adoption of the WHO/DOTS strategy. Similar impediments exist in other countries as well. We appreciate that failure to overcome these issues could jeopardize our investments in TB control, but simple solutions are not readily available. This is an issue you may want to raise in connection with your visit to Russia in September.

Hillary Rodham Clinton
20th August 1998
Page 2

I understand that the WHO is currently considering undertaking a global TB program. I have written Dr. Brundtland a similar letter, and would like to find ways to work with them. A handful of key players—yourself, Dr. Brundtland, Jim Wolfenson of the World Bank, for example—could make all the difference if we act promptly. It is my hope that we can join together in calling for the sustained international attention and funding that could contain outbreaks in the former Soviet Union and elsewhere. The United States has a critical and new role to play in confronting public health threats outside of its borders. I look forward to hearing from you on this important issue.

Yours sincerely,

A handwritten signature in black ink, appearing to read "George Soros", with a long, sweeping horizontal stroke at the end.

George Soros

OPEN SOCIETY INSTITUTE O S I

GEORGE SOROS
ChairmanARYEH NEIER
President

20th August 1998

Dr. Gro Brundtland
World Health Organization
Geneva, Switzerland

Dear Dr. Brundtland:

I understand that the WHO is currently considering undertaking a global program to address the problem of tuberculosis. As you may know, my foundations have started a program to address TB in Russia through a DOTS based approach. We have received requests to support programs from our foundations in such countries as Kazakhstan, Kyrgyzstan, and Azerbaijan which are currently under consideration.

Since we initiated this work a year ago, we have discovered that the problem is considerably worse and more difficult than we imagined. My concerns fall into two main areas: MDR-TB, and other impediments to the adoption of the DOTS approach.

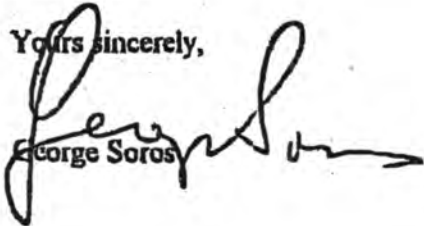
First, as you are well aware, the situation is greatly complicated by the multidrug-resistant strains of TB. We were very pleased to learn that the WHO last month endorsed a "DOTS-Plus" strategy addressing drug resistant treatment in circumstances such as those found in Russia. I have since directed our TB team to adopt this expanded approach in order to save lives and halt epidemics already underway.

Unfortunately, we realize that this enhanced approach is significantly more costly than the simpler "DOTS" approach, and will require additional funding, though far less than the cost of ignoring these drug-resistant strains. While I am prepared to commit some additional funds to TB, I have become convinced that the problem can be addressed only with the coordinated and solid financial commitment of a wide range of international, bilateral and private donors.

Second, as our programs develop in Russia, we have encountered a range of economic, political, ethical, and logistical impediments to the adoption of the DOTS strategy. Similar impediments exist in other countries as well. We appreciate that failure to overcome these issues could jeopardize our investments in TB control, but simple solutions are not readily available.

I am hopeful that the WHO will decide to undertake a global plan to control TB. I would like to find ways to work together in addressing this public health emergency. I have spoken with Hillary Clinton about this problem, and have written her a similar letter. A handful of key players--yourself, Hillary Clinton, Jim Wolfenson of the World Bank, for example--could make all the difference if we act promptly. I look forward to discussing this important matter with you in the near future.

Yours sincerely,


George Soros

OSI-LED INITIATIVE TO ERADICATE TB

AUGUST 1998

"The two largest TB NGOs, KNCV in The Netherlands, and the International Union Against TB and Lung Disease, have a combined budget for fighting TB of just over \$10 million. Last year, the Wellcome Trust announced it could provide over \$2 million to determine the complete sequence of the genome of the tubercle bacillus. Unfortunately, most of the largest foundations, such as Ford, Rockefeller, Kellogg and Pew, and the largest health and development NGOs, such as CARE, Save the Children and Oxfam, remain conspicuously absent in the battle against TB."

BASIC TENETS OF THE OSI-TB INITIATIVE

- Tuberculosis remains the single largest infectious contributor to adult mortality in the world today.
- Increasing globalization of economies demands a global response to the TB pandemic.
- An effective and concerted response demands not only the leadership of the medical and scientific communities, but also the full participation of the private sector, including international trade and finance.

JUSTIFICATION FOR OSI INVOLVEMENT IN GLOBAL TB CONTROL

- George Soros is the single largest individual donor to TB control in the world today.
- The regions in which the Network of Foundations is established— from the former Soviet Union to South Africa— are those in which TB is endemic or recrudescing; these regions are particularly hit hard by drug-resistant TB.
- The OSI brings two critical and previously missing components to TB control: a human-rights approach and new leadership from the business

sector, previously a minor player in the TB community. Furthermore, the geographical reach of the Network of Foundations is unparalleled and the OSI would bring significant experience to the containment of prison-related outbreaks.

JUSTIFICATION FOR CHOICE OF PARTNERING INSTITUTIONS AND COMPOSITION OF ADVISORY BOARD

The organizations identified as potential partners in an OSI-led TB eradication effort are the major participants in global TB control. The Advisory Board would bring together the leaders of these organizations, as well as key players in international public health. Others will no doubt be identified.

PROPOSED ORGANIZATIONS	PROPOSED ADVISORY BOARD REPRESENTATIVE
AMERICAN ACADEMY OF ARTS AND SCIENCES	<i>HOWARD HIATT</i>
CARTER CENTER	<i>WILLIAM FOEGE</i>
CENTERS FOR DISEASE CONTROL AND PREVENTION	<i>HELENE GAYLE</i>
HARVARD MEDICAL SCHOOL	<i>PAUL FARMER</i>
INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE	<i>NILS BILLO</i>
KNCV, HOLLAND	<i>KITTY LAMBRECHT</i>
LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE, UK	<i>JOHN PORTER</i>
MEDICAL RESEARCH COUNCIL, SOUTH AFRICA	<i>BERNARD FOURIE</i>
NATIONAL JEWISH MEDICAL AND RESEARCH CENTER	<i>MICHAEL ISEMAN</i>
NATIONAL TUBERCULOSIS CENTER & PUBLIC HEALTH RESEARCH INITIATIVE	<i>LEE REICHMAN</i>
RESEARCH INSTITUTE OF TUBERCULOSIS, KAZAKSTAN	<i>AMAN ZHANGIREEV</i>

PARTNERS IN HEALTH	<i>JIM YONG KIM</i>
ROCKEFELLER FOUNDATION AND THE HARVARD SCHOOL OF PUBLIC HEALTH	<i>LINCOLN CHEN</i>
UNIVERSITY OF ALABAMA	<i>MICHAEL KIMERLING</i>
WORLD HEALTH ORGANIZATION	<i>ARATA KOCHI</i>

WHAT ARE THE GOALS OF OSI-TB?

OSI-TB would not seek to replicate existing TB-control structures, nor would it seek to act alone in inaugurating new TB treatment and control efforts. Rather, OSI-TB would seek to fill in gaps:

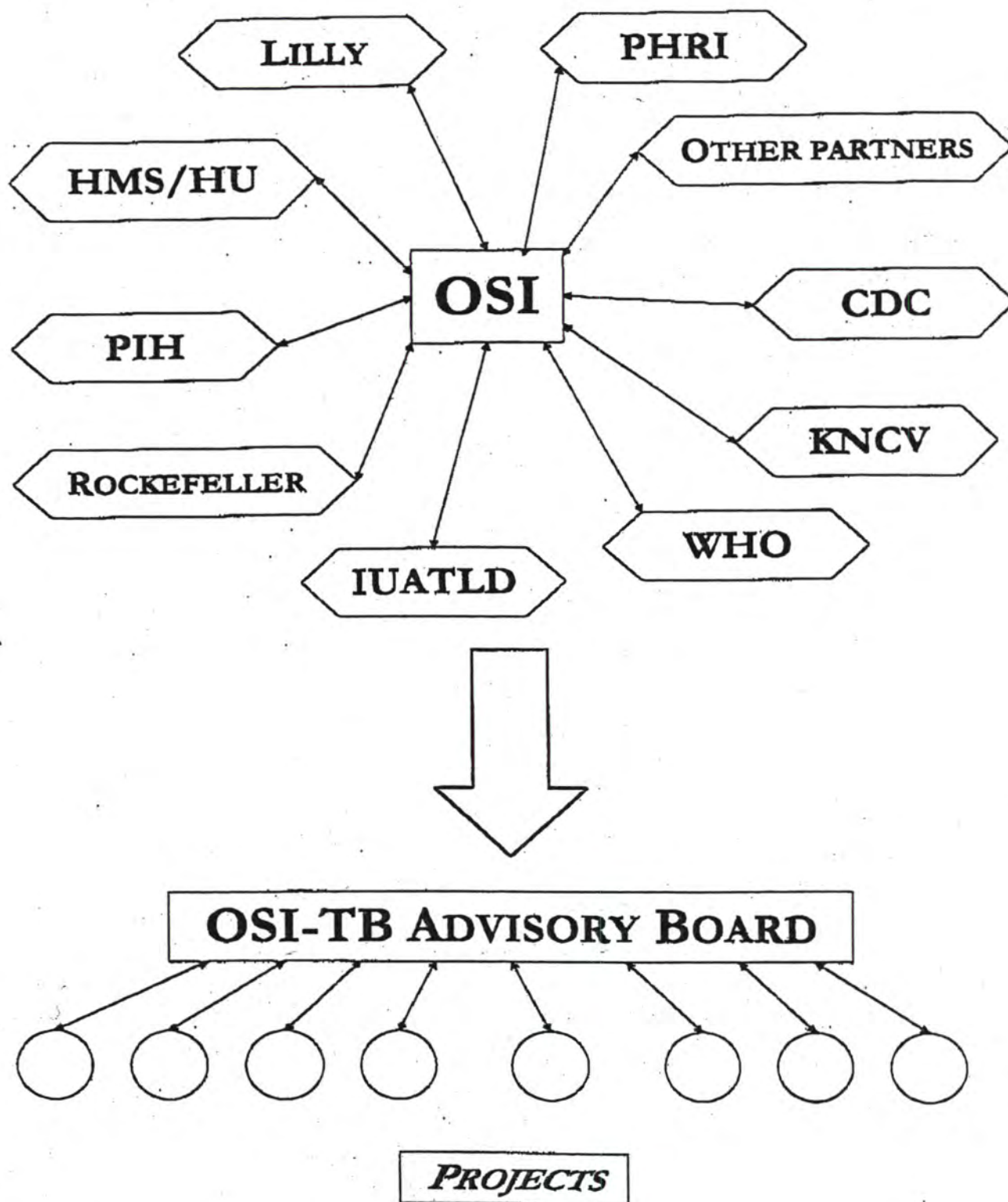
- *Leadership gaps* must be filled if truly global efforts are to progress. OSI-TB would have a special focus on leadership from business sectors, including international finance, the pharmaceutical industry, and philanthropies; the human-rights community would also be engaged.
- *Gaps in political will* must be filled if government support for national DOTS-based programs, including "DOTS-Plus," are to have real impact on the global TB pandemic.
- *Gaps internal to the TB community* have neglected critical developments—MDRTB and prison-centered outbreaks of TB— that threaten the hard-won gains of global TB control.
- *Funding gaps* will be filled not through direct OSI contributions, but rather through coalition building to channel new resources into priority TB-control efforts.

HOW WOULD OSI-TB WORK?

OSI-TB can make have an enduring impact on global TB control through a four-step process:

1. Forge a powerful consortium of actors and institutions, led by an expert Advisory Board.
2. Convene a meeting of Dr. Gro Brundtland (WHO), Jim Wolfensen (World Bank) George Soros, the U.S. Surgeon-General Satcher, and leaders of the global TB community to launch a worldwide campaign to bring new resources to TB control.
3. This campaign will have as its centerpiece a drive to secure an unprecedented commitment of public and private resources— the Global Trust for TB Control— targeted to Board-approved projects.

-
4. Identify TB "hot zones" where new public-private partnerships, funded through the Trust, can contain deadly epidemics and promote the primary goals of modern TB control.



**PROGRAM IN INFECTIOUS DISEASE AND SOCIAL CHANGE**

DEPARTMENT OF SOCIAL MEDICINE, HARVARD MEDICAL SCHOOL

641 HUNTINGTON AVENUE, BOSTON, MA 02115

PH. (617)432-3715, FAX: (617)432-2565

PAUL FARMER AND JIM YONG KIM, DIRECTORS**TO: ARYEH NEIER & GEORGE SOROS****OPEN SOCIETY INSTITUTE****FAX: 212-548-4608****FROM: PAUL FARMER, M.D., PH. D.****DATE: 17 SEPTEMBER 1998**

During the week of 6-11 September, I traveled with a fact-finding mission to investigate the state of tuberculosis (TB) control in Russia, with a particular interest in assessing the problem of TB in prisons. We also evaluated the OSI-funded TB control initiative conducted by the Public Health Research Institute (PHRI). Our team included representatives of the World Health Organization (WHO) and U.S. Centers for Disease Control, as well as clinical and research specialists in tuberculosis control. This group, which serves as the advisory committee to the PHRI projects, counts decades of experience in TB control and research. I myself acted as special consultant on TB epidemiology and treatment to the OSI.

For a number of reasons, we expected the TB situation in Russia to be grim. Several of us had previously visited regional TB facilities; all of us were familiar with reports, in the Russian and foreign popular press, describing large outbreaks of TB and high case-fatality rates. These outbreaks, in tandem with the dismantling of the public-health infrastructure, have led to a rapid rise in national case rates. In 1990, TB incidence in Moscow was estimated at 27 per 100,000 population; by 1993, it had almost doubled, to 50 per 100,000. The situation is significantly worse in Siberia, where incidence went from 43 to 94 per 100,000 during the same period. By March 24th, 1998, it was possible for the WHO to announce that TB incidence in Russia had risen another 50% between 1994 and 1996. About a quarter of a million new cases were detected in 1996 alone.

We were also concerned about multidrug-resistant tuberculosis (MDRTB). Most members of the committee had read the recent WHO/IUATLD report, which suggested decreased cure rates and significant levels of resistance to first-line antituberculous drugs in the region surveyed. Finally, we knew that the epidemic was particularly affecting, and amplified within, the prison system. In the space of the last few years, TB has become the leading cause of mortality among Russian prisoners and detainees, accounting for 40-80% of all prison deaths in some facilities. National TB mortality among Russian prisoners was recently pegged at 484 per 100,000— among the highest in the world.

In the light of these unwelcome trends, the OSI-funded initiatives were deemed particularly welcome both by many Russian officials and by the broader, global TB community. The PHRI has initiated work in both the civilian and prison populations of Tomsk, and has recently expanded its support of key reforms to the neighboring oblast, Kemerovo. Similar efforts are also underway in Vladimir, closer to Moscow.

I have visited all of these regions. On this most recent trip, however, the mission visited Siberian facilities only. What we found disturbed us greatly. A PHRI-led public-private coalition—linking foreign NGOs, including Médecins Sans Frontières (MSF) and MERLIN UK, with both prison and civilian health authorities—has already led to substantial improvements in aspects of TB control, ranging from case detection to the standardization of record-keeping and program evaluation. Furthermore, this coalition has been able to substantially reduce improper TB-control practices, which are the root cause of increased rates of treatment failure and increased rates of acquired resistance to the best and least expensive drugs. The committee was unanimous in deeming these reforms central to any effort designed to avert further disaster.

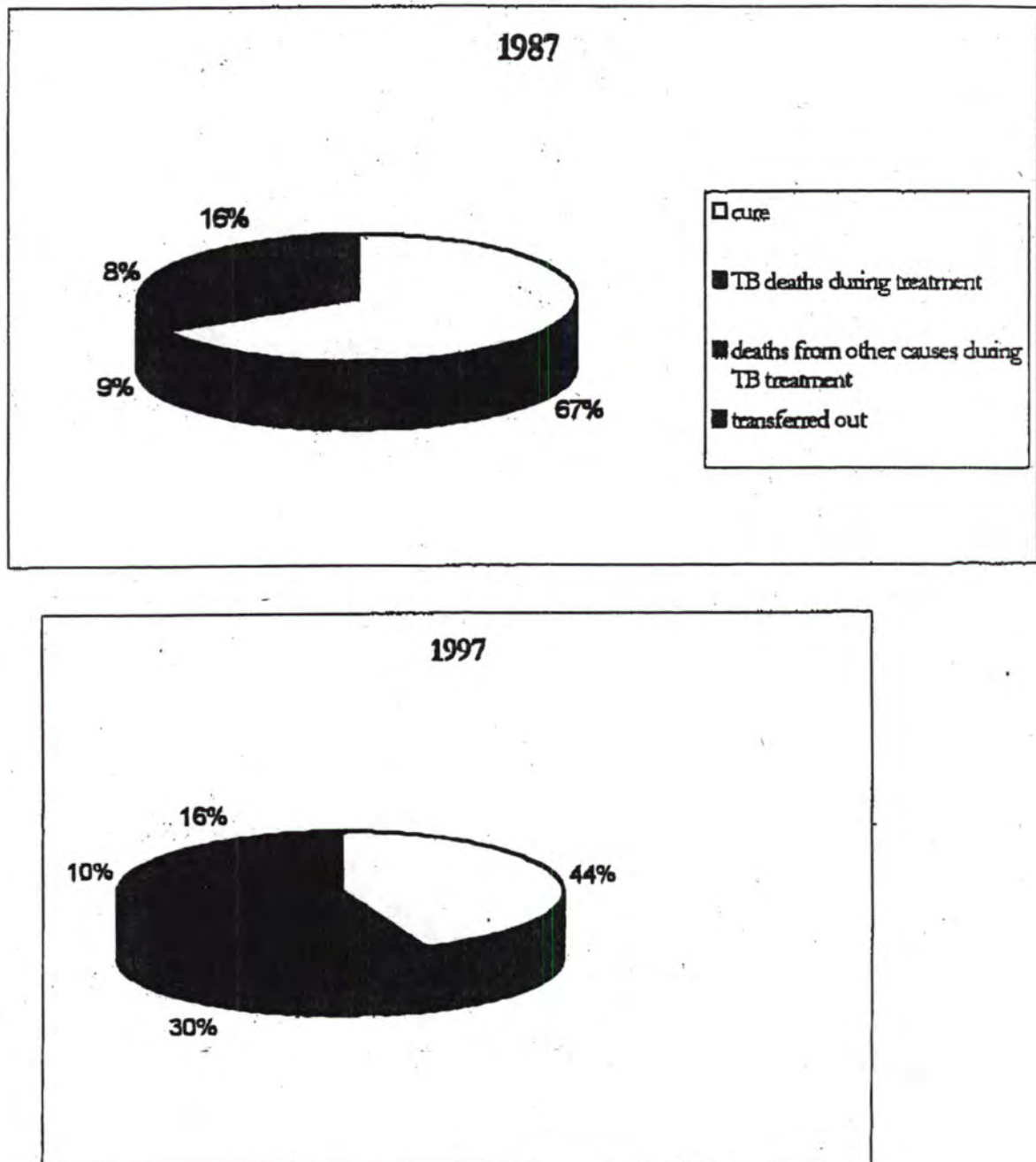
These reforms, however, come late. When the OSI-funded initiative was planned and funded, the contribution of drug resistance to low cure rates was unknown, but MDRTB was estimated to represent no more than 5% of incident cases. What we found, however, was a rate of MDRTB many times in excess of this estimate, and we suspect that drug resistance helps to explain the very low cure rates seen inside a number of the institutions in which standard TB-control practices have been implemented.

The case of Penal Colony 33, in Mariinsk, Kemerovo, gives an idea of both the gravity and extent of the problem. For the last few years, the Belgian branch of MSF has worked inside the Colony with close cooperation, obviously, from prison officials. Treatment has been standardized, and case detection, treatment protocols, and record-keeping are now in keeping with WHO-endorsed TB-control practices. And yet, preliminary cohort studies have revealed cure rates of less than 60% even though the standardized regimen has been bolstered by a fifth drug, and all doses are directly observed. Although complete drug-susceptibility data are not available, preliminary testing in Belgium suggests that a majority of treatment failures are due to drug resistance. Patients who fail therapy now constitute an increasingly large proportion of those detained in Colony 33; they are eventually isolated from other prisoners. Since Russian law does not permit indefinite detention, however, these prisoners, still infectious, are simply released into the community at the end of their term. A majority of the group—80% by some estimates—are lost to follow up after release, underscoring the need for close coordination of prison and civilian TB control.

Rapidly rising TB case rates elsewhere in Kemerovo Oblast are further proof of the relationship between prisons and the surrounding community, as is the fact that fully a third of all civilian TB diagnoses are made in those with a history of imprisonment. Finally, the highest extramural rates are registered among prison guards and others working in close association with TB-affected prisoners.

Equally disturbing, and again suggestive of the increasing contribution of drug resistance to poor outcomes, are data showing that, between 1987 and 1997, as rates of TB skyrocketed, cure rates went from an already-low 67% to a sobering 44%. (See Figure 1). Death rates among those treated also increased, from 9% to 30%. Note that rates of abandonment and death due to other causes during treatment remained constant.

Figure 1. Trends in TB treatment outcomes, 1987 and 1997
Kemerovo Oblast, civilian population



After meeting with both civilian and prison officials from Kemerovo, the fact-finding mission met with the state governor and leading health officials. We urged the governor to declare tuberculosis an "emergency," and he assured us of his strong and unconditional support for the institution of

WHO's Response to the Global Tuberculosis Emergency

1. In 1993, the World Health Organization declared TB a global emergency. It took this unprecedented step as TB was claiming the lives of 2-3 million people each year, making it the leading infectious killer of youth and adults. Increasingly, the disease was becoming resistant to currently available medicines because of careless TB treatment practices. (Drug resistance can develop when patients get the wrong drugs, drug supply is irregular or patients stop taking their medicines too soon because they feel better). And yet, in spite of these dangers, the world's response to the epidemic was minimal.
2. WHO defined the enormous size of the global TB problem through expanded monitoring and surveillance. For example, it determined that TB had become the leading cause of death among HIV positive people. The disease also orphans hundreds of thousands of children each year and is the single biggest killer of young women.
3. WHO also determined that TB is a major contributor to poverty. Eighty per cent of TB patients are in the most economically productive years of their lives. TB sends many self-sustaining families into poverty. If the breadwinner of a family is not properly diagnosed or treated, he or she will lose, on average, a full year of work.
4. WHO developed an effective TB control strategy known as DOTS. DOTS is the most effective strategy available for detecting and curing TB. It was developed from two decades of testing and best practices. DOTS requires direct observation of treatment to ensure that patients take the medicines; and it also requires government commitment, microscopy services, reliable drug supply and monitoring systems. DOTS can help any country -- rich or poor -- to achieve high cure rates. DOTS achieves cure rates as high as 95 per cent even in economically devastated or war-torn areas. Besides achieving high cure rates, DOTS has a number of important advantages:
 - The strategy can be integrated successfully within general health services to achieve widespread coverage.
 - DOTS does not require hospitalization or isolation. Patients can remain at home and return to work in a few short weeks.
 - DOTS is as effective in curing TB in both HIV-positive and HIV-negative people, and is one of the most affordable ways of extending the life of a HIV-positive person.
5. WHO and the World Bank determined the cost effectiveness of DOTS. DOTS helps prevent multidrug resistance, which is often fatal and up to 100 times more expensive to treat. The World Bank considers DOTS as one of the most cost-effective health strategies available. A six-month course of drugs for DOTS costs between \$10 to \$20 per patient in most developing countries. DOTS is a sound economic investment for any government. For example proper use of DOTS in Thailand could save the country \$2.3 billion over 20 years.
6. The Organization promoted the global implementation of DOTS. WHO developed the necessary tools, guidelines, training materials and policies to promote the implementation of DOTS. At the same time, WHO embarked on major advocacy and intensified technical assistance to over 50 countries, focusing on big countries with largest TB burdens. These efforts have made DOTS one of the fastest expanding health interventions of this decade. Today, nearly 2 million people are being cured with DOTS.

Indicator	1990	1998
Number of countries using DOTS	10	110
Percent of TB patients being treated by DOTS	Under 1 percent	15 percent
Drug costs per patient	\$40-60	\$10-20
External donor aid to TB control	\$16 million	\$70 million

WHO's Challenge Ahead

1. WHO has identified the main constraints that are preventing further progress against the TB epidemic. These are 1) lack of political commitment; 2) lack of human and financial resources; 3) unavailability of affordable and secure supplies of anti-TB drugs; 4) increased multiple-drug resistant TB (MDR-TB); and 5) the HIV epidemic, which is partly fueling the global TB epidemic. A global strategy is needed to address these constraints, particularly in high-burden countries.
2. WHO's new Director General - Dr Gro Harlem Brundtland - has identified TB as a priority concern for the "renewed" WHO.
3. Groundwork must now be established among global partners for a major initiative on TB. The Stop TB Initiative will lay out and prioritize the steps needed to overcome current constraints to action and provide the basis for a significant expansion of global efforts against TB.
4. The Stop TB Initiative will serve to command increased attention and resources for further implementation of DOTS; swiftly establish solutions to sustained global access to anti-TB drugs; identify cost effective options for addressing MDR-TB and frame a long term vision for a TB research and development agenda to include new tools - most importantly an effective vaccine.

THE GLOBAL TUBERCULOSIS EPIDEMIC

Burden of disease

- There were an estimated 8 million new cases of TB in 1997, including 3.6 million cases of infectious pulmonary disease, and 16.1 million existing cases of disease.
- An estimated 2.0 million people died of TB that year, about 1 in 4 cases. TB causes more deaths than any other single infectious agent.
- Roughly 1 in 3 people carry the *M. tuberculosis* bacterium (MTB), i.e. 1.8 billion people.
- Countries in South East Asia had the largest number of new cases (3.0 million) in 1997, but the rate per head was highest in sub-Saharan Africa (257/10⁵ persons).
- 22 countries had 80% of all incident cases. The leading five together accounted for over half the global total. They were all in Asia: India (1.9 million), China (1.4 million), Indonesia (583,000), Bangladesh (292,000) and Pakistan (261,000).
- 1 in every 500 people was infected with both TB and HIV. Three-quarters of a million TB cases (8%) were infected with HIV. The highest rates of co-infection (over 1 in 50 people) were in southern Africa, but India had the largest number of co-infected individuals (1.9 million) and the largest number of HIV-infected TB cases (190,000).
- Surveys suggest that about 1 in 10 TB cases is resistant to at least one drug; about 1 in 50 cases is multi-drug resistant (to at least isoniazid and rifampin).
- The huge scale of the problem is explained mainly by poor control and population growth in south Asia and sub-Saharan Africa, and high rates of MTB/HIV co-infection in some African countries.

Trends

- Without greater control effort, annual TB incidence is expected to increase from about 8 million cases/year in 1997 to 11 million cases/year by 2020.
- Reaching WHO targets of 70% case detection and 85% cure by year 2010 could save about 1 in 4 cases (approx. 50 million) over the next two decades.
- The incidence of disease is increasing most quickly in African countries that have high levels of HIV (e.g. Malawi, Kenya, Tanzania). It is also increasing quickly in countries where control programmes have broken down (e.g. Russian Federation).

Control

- Only about half of infectious cases are treated and cured. The cure rate in DOTS Programmes is much higher than average, typically about 80%.
- Approximately half of all countries have now adopted the WHO DOTS strategy. Twenty-one of the 22 highest-burden countries have DOTS Programmes, but most with low rates of case finding and cure.
- At present, about 1 in 10 infectious TB cases is cured in DOTS programmes
- Among high-incidence countries, the best control programmes are in Peru, Tanzania and Viet Nam, though programmes in Bangladesh and China have expanded rapidly during the 1990s.
- Progress in TB control is very slow in the majority of high-burden countries, notably India, Indonesia, Nigeria, Pakistan, Philippines and Russia.

No. 2

Briefing Points for the Director-General's 28 October meeting at the White House With Mrs H Clinton, Mr J Wolfensohn and Mr G Soros

The Tuberculosis Problem

- Each year there are about 8 million new TB cases, with about 2 million deaths.
- Multidrug-resistant TB (MDR-TB) has emerged as a major threat to TB control in some countries, including Russia and the Baltic States.
- In 1997 an estimated 8% of TB cases were attributable to HIV, the burden falling mainly on sub-Saharan Africa and increasing in other regions, especially the Indian sub-continent.
- TB is the biggest single killer of women aged 15-44 world-wide, is the major cause of death among the HIV infected, and is a significant brake on socio-economic development in poor countries as it affects mostly young adults.
- The global response to TB has thus far been inadequate: many poor countries are failing to control it; rich countries are not doing enough to support TB control in the poor countries and, as a result, the prevalence of TB globally remains unacceptably high, and MDR TB is being created and spread internationally.

The Current Solution to the TB Problem

- The DOTS strategy has been shown by the WHO in collaboration with the World Bank to be one of the most cost effective health interventions.
- Proper case detection and cure of infectious cases are the cornerstone of the TB control strategy.
- Successful implementation of such strategy achieves high cure rates (e.g., 95% cure among a quarter of a million TB patients annually in China).

Existing Constraints to the Solution

- The DOTS strategy is labour intensive, requires direct observation of treatment and strict patient monitoring.
- Where the prevalence of MDR-TB is high or where HIV infection is widespread, control measures in addition to the DOTS strategy are necessary.
- Although 97 countries have adopted the DOTS strategy, only 15% of TB patients globally are treated under DOTS because only few countries have achieved full coverage.
- Governments of high prevalence countries have shown insufficient political will and leadership, and have not allocated adequate financial resources.
- There is a lack of trained human resources and of secure, quality controlled drugs.
- Inefficient drug procurement systems in most countries result in an increase in the cost of drugs and produce shortages of stocks.
- BCG vaccine is ineffective to prevent infectious forms of TB, thus it cannot interrupt TB transmission.

Recommended Actions

The current global TB control situation is similar to that of vaccine preventable diseases in the mid 1980s. EPI has successfully progressed to achieve the global targets in the early 1990s through global coalition building and country specific social mobilization. Even though TB control and the implementation of DOTS may be more complicated than EPI operations, through global coalition and country specific social mobilization, DOTS coverage can be expanded to allow achievement of the global targets of 70% case detection and 85% cure rate by 2010. Therefore, we recommend the following:

1. WHO, the World Bank and various US agencies and private charitable interests such as the Open Society Institute commit themselves to work together and combine efforts to analyse constraints, prepare, appraise and finance projects that provide solutions and assist countries with high quality technical implementation of TB control.
2. WHO, in partnership with the World Bank, various agencies throughout the world, and other private and public interests will establish a Stop TB Initiative which has the following four components:
 - A global charter for advocacy and commitment to TB control and elimination of MDR-TB.
 - A global action plan to coordinate interaction among international partners to ensure effective TB control.
 - A mechanism to swiftly establish global access to anti-TB drugs.
 - A global research agenda balancing short and long-term vision.
3. successful Initiative will ensure the following:
 - TB activities at WHO and worldwide are facilitated.
 - Expanded effective TB control in high burden priority countries.
 - Expanded global surveillance of drug resistance and new interventions to treat MDR-TB focusing on Russia and other high MDR-TB burden countries.
 - A global drug facility or direct drug funding to countries in need to ensure the sustained supply of quality, fixed-dose, combination TB drugs.
 - Coordinated approaches to the care and prevention of TB and HIV, especially in Sub-Saharan Africa.
 - Improved tools to deliver effective TB control services as an integral part of primary health care.
 - Development of new tools, such as rapid diagnostic tests, drugs and vaccines.

The World Bank's Current Activities in Tuberculosis Control

- The World Bank is fully committed to fighting the global tuberculosis epidemic. The World Bank's contribution is twofold: through the policy advice it provides to countries, and through country-specific lending.
- In pursuing TB control activities, the Bank collaborates closely with WHO, NGOs, bilateral and technical agencies. For example, a current Bank project in Latvia will be financing improved TB treatment and surveillance, with technical assistance provided by the U.S. Centers for Disease Control. The Bank is also working closely with partners regarding potential interventions for improved TB control in Russia.
- The Bank has provided nearly US\$ 300 million in financing for tuberculosis control programs since 1989, making it the largest single source of external funding for tuberculosis control in developing countries.
- About twenty countries are using World Bank financing to implement the WHO-recommended TB control strategy (DOTS). Several new projects are under preparation. Some projects are tuberculosis-specific, but a majority address TB control within broad health sector development and health sector reform projects.
- The two largest Bank-supported TB control projects are in China and India. These countries are home to more than one third of the world's estimated 8 million new TB cases each year.
- The project in China was initiated in 1992 and has demonstrated dramatic results with the DOTS strategy: half of the country's population is now covered, and over one million infectious cases have been cured to date. The challenge now is to expand this success to the rest of China and to achieve financial sustainability.
- In India, the TB control project, which began in 1997, has also achieved excellent results with DOTS in several pilot regions. It has established the foundation for the Revised National TB Control Program, and is providing the impetus for an 8-12 year process of extending the approach nationwide. Political commitment, assured drug supply, health worker training and supervision, patient education and motivation, and operational research are critical to the progress of these projects.
- The Bank is supporting implementation of the DOTS strategy in countries as diverse as Bangladesh, Cambodia, Cote d'Ivoire, Egypt, Haiti, Krygyzstan, Morocco, Niger, Philippines, Romania, and Vietnam. In some countries, tuberculosis control is intimately linked to prevention and control of HIV/AIDS, and the strengthening of collaborative interventions, education, and referral is critical.

71412

ALFONSE D'AMATO, NEW YORK, CHAIRMAN

CHRISTOPHER H. SMITH, NEW JERSEY, CO-CHAIRMAN

Ben Nighthorse Campbell, Colorado
Spencer Abraham, Michigan
Conrad Burns, Montana
Olympia J. Snowe, Maine
Frank R. Lautenberg, New Jersey
Harry Reid, Nevada
Bob Graham, Florida
Russell P. Feingold, Wisconsin

John Edward Porter, Illinois
Frank R. Wolf, Virginia
Matt Salmon, Arizona
Jon Christensen, Nebraska
Steny H. Hoyer, Maryland
Edward J. Markey, Massachusetts
Benjamin L. Cardin, Maryland
Louise McIntosh Slaughter, New York

**COMMISSION ON
SECURITY AND COOPERATION IN
EUROPE**

234 FORD HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6460
(202) 225-1901
FAX: (202) 226-4199
E-MAIL: CSCE@MAIL.HOUSE.GOV

EXECUTIVE BRANCH COMMISSIONERS

JOHN SHATTUCK, DEPARTMENT OF STATE
(Vacant), DEPARTMENT OF DEFENSE
(Vacant), DEPARTMENT OF COMMERCE

MICHAEL R. HATHAWAY, CHIEF OF STAFF
DOROTHY D. TAFT, DEPUTY CHIEF OF STAFF

October 9, 1998

To: K. BERNAL
FYI.

The Honorable Madeleine Albright
Secretary of State
Department of State
2201 C Street, NW
Washington, DC 20520

Dear Madame Secretary:

We are writing to focus your attention on the growing threat of Multiple Drug Resistant Tuberculosis (MDRTB) in the Russian Federation, as outlined in the attached information. We would appreciate learning what initiatives have been undertaken by the United States to help contain and defeat this biological threat. Like the Y2K problem, the MDTRE problem can become a crisis if not addressed in a timely and effective manner.

With easy international travel and limited means of protecting people from an airborne pathogen, the incubation and spread of MDRTB in Russia also poses a threat to the health of the U.S. population. Moreover, as the world has seen before in this century, the spread of disease, whether influenza after World War I or AIDS in Africa, can threaten and even upset social, political, and economic structures necessary for peace and security.

This medical threat must be addressed now, while it may still be possible to limit the consequences. Given Russia's economic troubles and political uncertainty, a concerted international effort to help the Russian authorities contain the spread of this disease and treat its victims appears to be urgently necessary. Currently, the Open Society Institute of the Soros Foundations is funding a \$12 million program to combat TB and MDRTB in Russia. Other NGOs, such as Doctors Without Borders, Medical Emergency Relief International, and the New York Health Research Institute, have already begun studying the issue and have raised the alarm. But the problem is genuinely global in scope and will require assistance from governments.

We understand that George Soros is planning in the near future to discuss this troubling matter with Mrs. Hillary Rodham Clinton and World Bank President James Wolfensohn, and to emphasize the necessity of governmental involvement. The United States should certainly take the lead in coordinating the activity of medical experts, foreign capitals, international organizations and NGOs to assess the risk and

PRINCETON PROJECT 55 INC.

Tuberculosis Initiative

file
TB

Ralph Nader
P.O. Box 19312
Washington, DC 20036

May 27, 1998

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear Mrs. Clinton,

In your recent speech before the World Health Assembly in Geneva, you provided an excellent account of the severity and urgency of many global health crises. We are particularly pleased by your emphasis on the prevention and treatment of infectious diseases like tuberculosis.

Major public addresses such as yours are exactly what is now required to revive this nation's awareness of these profoundly neglected health causes. TB is one of the most disproportionately unheeded pandemics, yet it is the world's number one infectious killer and the death toll is rising every year. Few people in this country are aware of the enormous burden TB exacts from the citizens of developing countries, and the clear and present threat that drug resistant strains pose to the health and national security of the United States. TB kills more women than all causes of maternal mortality combined, yet most Americans consider it a disease of the past. The *yearly* death toll from land mines is matched by TB *every single day*, however many journalists and even public officials believe we have won the war against tuberculosis.

You have the unique capacity to refocus America's attention on health issues of major global importance, and this speech was an exemplary first step. Now, as you said, "We must put our hearts, our minds, and our resources in action." In South America, you witnessed the unprecedented successes that can be achieved through the use of directly-observed treatment for tuberculosis patients. As you saw, the WHO-recommended regimen, Directly-Observed Treatment, Short-course (DOTS) is a very simple system, that the World Bank determined to be one of the world's most cost-effective health interventions. Successful application of DOTS has produced cure rates above 85% in places as diverse as New York, Peru, China, Tanzania, and Bangladesh. In most countries, the overall effect of DOTS on the primary health infrastructure and the incidence of infectious diseases has been remarkable.

For the health and stability of developing nations, and to protect Americans from multi-drug resistant TB (MDR-TB), it is time for the U.S. to make a significant investment in DOTS for the most severely affected nations of the world. USAID's new infectious disease initiative is a good beginning, but this pilot project must be expanded to other key regions of the world. MDR-TB is already threatening to overwhelm the public health systems of "hot-zones" such as Latvia, Estonia, Russia, the Dominican Republic, Argentina, and the Ivory Coast. Unless we ensure the rapid application of DOTS in these

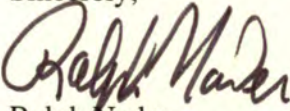
and other countries, epidemics of MDR-TB will become commonplace in many more countries.

A global assault on TB will also require significant commitments from the WHO, and from developing nations. The U.S. should make use of its diplomatic influence to encourage endemic nations to dedicate resources to the control of TB within their borders. Additionally, the U.S. should help to accelerate the introduction of WHO Secretary General-Elect Gro Harlem Brundtland's "Roll Back Malaria" and "Roll Back TB" initiatives. Currently the WHO Global TB Programme's total annual budget for the application of DOTS is a paltry \$11 million. Dr. Brundtlandt should be supported in significantly increasing funding for the TB program, in accordance with its prominence among causes of death globally.

Finally, with the introduction of the President's "Research Fund for the 21st Century," now is the time for the U.S. to make a meaningful investment in research on the infectious diseases of major global health importance identified by USAID's new initiative. DOTS can make a significant impact on the global disease burden, but without an effective TB vaccine, we will not be able to control TB over the long-term. Now that scientists have read the entire genetic code of the TB microbe, the potential for the development of new drugs, diagnostics, and vaccines has never been better. This March, a working group of TB and vaccine experts, convened by Secretary Shalala, met to formulate a national "Blueprint for a Tuberculosis Vaccine," which sets the course for accelerated development of a TB vaccine, but without new funding, this initiative cannot get under way.

Thank you, Mrs. Clinton, for your dedication to the health of the world's population. We hope that you will work with us to significantly increase U.S. commitments to global health.

Sincerely,

A handwritten signature in dark ink, appearing to read "Ralph Nader", written in a cursive style.

Ralph Nader
Steering Committee

Enclosures: informational packet

cc: Mr. Sidney Blumenthal, Dr. Laura Efros, Mr. Tom Friedman, Mr. Leon Fuerth, Mr. David Halperin, Mr. Chris Jennings, Dr. Donald Jordan, Dr. David W. Kampt, Mr. Peter Rundlet, Mr. Eric Schwartz, Mr. Michael Waldman, and Mr. Joel Wilson.

file TB

Shalala

- lessons from the US exp 'ce
- we can't deal w TB in US unless deal abroad
Cheaper to do in India than US.
- Can't be complacent -
waiting → more costs.
- need clear + measurable goals
- pol. will critical - takes
level of mobilization
- Russia: Diagnosis, etc -
real problems
time urgent prob.

THE WHITE HOUSE
WASHINGTON

move from jails + Sanatoria
to a DOT strategy. - "get it
at highest levels"

US:
\$ for research around the
world.
want to make progress in US.

Brian: prob- in R- money
to DOTs strategy. If don't
do well - (DOTs) could be
worse

Drug resistant - often due
DOTs misapplied

THE WHITE HOUSE
WASHINGTON

This issue affects all of
us directly in us

[This has to be overall
strategic approach - long
term - not ^{just} humanit'n

- accelerate dev. & a
global plan - policy &
resource
- surveillance systems
- Russia - ^{major} field demo
sites

It Kam CDC, WHO &
USAID

to Russia for
assessment for demo
model

THE WHITE HOUSE
WASHINGTON

Gro

WITO - can do little alone.

we can give gd advice

multi drug resist'ce -

weakness in strategy

nds surveill'ce of patients
for 6 mos. treatment

- nd countries to be
active.

- 22 countries w highest
incidence of TB (even
though adopted DOTS)

Now in Norway fear
TB + drug resist'ce from
R, not inside

THE WHITE HOUSE
WASHINGTON

nd to change mechanism
to affect new treatments &
may be new effort for vaccines

World Bank

- partnership w/ WHO.
- in dialogue w/ Pensions.

DOTS

DOTS-plus - not a special
strategy

prepared to increase funding
for Stop TB - They have to do
directly in countries.

Close relationship w/ AIDS.

THE WHITE HOUSE
WASHINGTON

Snos - got started in
Rumi - then realized
multi-drug resistⁿ
prob.

One showed interest in
issue at the same time.

- Request we form an
action plan

Steering group - under WHO.

need a donors conference
to mobilize political support

\$1b target probably too big.

Foundations linked to drug
welcome trust

THE WHITE HOUSE
WASHINGTON

in R - needs to be a
gov't request -
Ministry of Health - Can't
ask solely for TB - too
many other critical prob.
Ministry of Justice recog'd
as the biggest prob.

Saras - should be stronger
"treatment" -

action plan prob: DOTS
DOTS plus

ITAC - have to raise
public awareness as a
public health issue

THE WHITE HOUSE
WASHINGTON

Loy - Bring to atten. 9
ambassadors to meet
with pol. leaders + former
leaders.

Soros - Steering group to
focus on Russia

get assessment report to
everyone around the table.

- assessment should look
at Soros projects + 3 other
European projects
at least in Russia.

THE WHITE HOUSE
WASHINGTON

1000

Russia's effort deserves great
attention. within larger
context.

PRINCETON PROJECT 55 INC.

Tuberculosis Initiative

Project Managers

Celine Gounder

1600 20th Street NW
Washington, DC 20009
(202) 588-7748
fax: (202) 588-7798
tbidc@aol.com

Scott Regenbogen

Center for Civic Leadership
32 Nassau Street
Princeton, NJ 08542
(609) 921-7812
fax: (609) 921-2712
tbinj@aol.com

HOW IS PRINCETON PROJECT 55 FINANCED?

Princeton Project 55 is financed primarily by contributions from members of the class, their families and friends. Some funding has been obtained from grant making foundations.

Contributions to Princeton Project 55 are tax deductible. A copy of the 501(c)(3) ruling is available upon request.

HOW CAN I PARTICIPATE?

- If you are a member or spouse of the Princeton Class of 1955 and haven't already done so, JOIN PROJECT 55 NOW!
- Volunteer to work on one of our programs. You need not be a member of Project 55 to help on our projects — many of our best volunteers have no connection with Princeton or the Class of 1955.
- Propose and develop a project of your own.
- Make a tax deductible contribution to Princeton Project 55. We need your help.
- Join or help form a public service program with your own classmates, friends or alumni association. Call or write us for help or information.

A FINAL WORD

We are Democrats, Republicans, Independents and none of the above. We are liberals, conservatives and some of each. We are doctors, lawyers, businessmen, accountants, ministers, writers, educators and just about everything else. Whatever we are we have much in common:

- We came of age together.
- We are the beneficiaries of an exceptional education and opportunities in life that are not available to everyone. With this privilege goes responsibility.
- By virtue of knowledge and experience developed over many years, we have much to offer.
- We are in it together. There is much to be done.

Please join us.

PRINCETON PROJECT 55 and its CENTER FOR CIVIC LEADERSHIP

"Mobilizing Princeton alumni, students and others to strengthen national institutions and values, to provide civic leadership, and to implement solutions to critical national and global problems."

PRINCETON PROJECT 55
THE CENTER FOR CIVIC LEADERSHIP
32 Nassau Street
Princeton, New Jersey 08542

Phone (609) 921-8808
Fax (609) 921-2712

32 Nassau Street
Princeton, New Jersey 08542

Phone (609) 921-8808
Fax (609) 921-2712

PRINCETON PROJECT 55 is a non-partisan, nonprofit tax exempt organization established by the Princeton University Class of 1955 to provide an outlet for men and women of our generation to become more effectively involved in solving the problems facing our nation and to inspire our children's generation and others to join in that effort.

THE CENTER FOR CIVIC LEADERSHIP coordinates and supports public interest projects approved by Princeton Project 55. Its recently expanded office space and staff are available to assist other public interest projects on a shared cost basis. By locating in Princeton, the Center benefits from the intellectual resources of the University and its students and faculty.

* * * *

Princeton Project 55 was born of the realization that there is a vast untapped resource, available for the public good, among women and men of our generation. We are prepared to devote a larger share of our time and energy to preserving and improving a world from which we have received so much. We believe that the knowledge and experience we have accumulated can be used to find new solutions to difficult problems.

We believe that in a society that has recently been characterized by so much greed and self-interest, many of the young men and women who are now graduating from Princeton and other colleges and universities across the country are seeking guidance and opportunities to contribute to the public good. We believe we can respond to their needs.

Princeton Project 55 and its Center for Civic Leadership are our effort to transform these beliefs into reality.

* * * *

"You're going to be saying something that is profoundly relevant to American life at this moment. This is an era of non-commitment. You will be saying that commitment matters. This is an era of self-preoccupation. You will be saying that self-absorption is not enough. This is an era of disintegrating values. You will be saying that we do have shared values worthy of commitment, even sacrifice. You will be saying that shared effort to solve our problems is not a hopeless venture."

John W. Gardner
(Addressing Princeton Project 55)

WHAT IS PRINCETON PROJECT 55 DOING?

Princeton Project 55 focuses its efforts on strengthening civic organizations and initiating projects to find and test systemic solutions to critical problems affecting the public interest. To be considered by Project 55, a project must:

- address important societal issues
- focus on systemic change rather than treating symptoms
- hold promise of significant impact
- encourage and utilize community participation
- provide opportunities for substantial involvement by Princeton students and alumni
- be non-partisan

• **The Public Interest Internship Program** places Princeton students and recent graduates in summer internships and full-year Fellowships with public interest organizations across the country. Interns and Fellows work for groups selected by Project 55 for the quality of their work and their emphasis on finding systemic solutions to the problems they address. Project 55 members and other Princeton graduates serve as mentors, orienting Interns and Fellows to the communities where they work and meeting with them on a regular basis during their service.

The Public Interest Program has been hugely successful. The number of applicants and placements have increased dramatically since the program began in the summer of 1990. The program both helps the host organizations and introduces increasing numbers of Princeton graduates to public interest work. A significant number of participants have decided on a public service career as a result of their experience. Many more will be motivated to participate in public service on a volunteer basis while pursuing other careers. It is the goal of the Public Interest Program to provide a meaningful public interest experience to 10 percent of each Princeton graduating class by 1995.

• **Character Education** Princeton Project 55 took the lead in organizing The Character Education Partnership, a nonpartisan, nonprofit coalition of individuals and organizations, including prominent national education associations. The Partnership encourages schools throughout the United States to initiate or strengthen K-12 character education. By stressing such commonly held values as honesty, responsibility, perseverance and respect for self and others, character education has proved successful in (a) reducing student violence, pregnancy, substance abuse and disrespect, (b) improving academic performance, and (c) preparing young people to become responsible citizens.

• **Mentoring.** Project 55 has instituted highly regarded mentoring programs for at-risk inner city students in Trenton, New Jersey and Southern Connecticut, and Project members are in the process of organizing or supporting similar programs in other areas. Project 55's programs involve a greater commitment of time and effort on the part of both mentor and mentee than other programs, and as a result of the combined efforts of the mentoring and character education projects, the character education curriculum has been introduced or is under consideration in schools in both areas. The leaders of these programs see mentoring as a "foot in the door" for a variety of interventions designed to re-instill hope and accomplishment in the lives of our inner-city children.

• **Service Exchange Program.** The Service Exchange Program enables citizens in impoverished areas to provide needed services to each other on a barter basis. Every hour of service given by a participant entitles that participant to an hour of service in return. For example, a resident who does shopping for an elderly person who is incapacitated might receive babysitting services in return. All records are maintained in a central computer, and the program is administered by a local agency. The program not only provides needed services, it also rebuilds a sense of community among the participants. PP55 has organized three service credit programs in New Jersey and is working to establish another in Atlanta.

• **Outreach.** Project 55 has encouraged and assisted the formation of similar projects by other alumni groups both from Princeton and other colleges and universities. Representatives of over 50 other universities have attended PP55 conferences. The Princeton Club of Chicago has launched a major educational effort in an inner-city high school and co-sponsored a three-day seminar on urban problems. The Harvard Law School Class of 1958 has formed Project Appleseed to organize centers for public interest law. ReachOut 56 has been established by the Princeton Class of 1956, and Yale has formed its own Project 55.

• **Program Development.** Project 55's Program Development Committee evaluates additional program proposals against the criteria described above and in light of such factors as cost, practicality, and the presence of a "passionate leader" whose devotion and enthusiasm are essential to the success of any project. The committee also provides program development assistance and support.

Princeton Project 55 is not a grant-making foundation. Its resources are used to maintain the Center for Civic Leadership and provide coordination, assistance and seed money for its projects. With the exception of a small paid staff, the time devoted by members and associates to Princeton Project 55 programs is donated. Many projects will require additional funding from outside sources, and it is the responsibility of each project team to raise those funds from independent public or private sources.

file TB

October 6, 1997

Melanne Verveer, Chief of Staff
Office of the First Lady
The White House
Washington, D.C., 20500

Dear Melanne:

That was an encouraging telephone conversation we had about the First Lady possibly engaging the scourge of tuberculosis worldwide and its drug resistant strain. A number of Administration officials made the suggestion that Hillary Clinton could make a major contribution to raising the visibility of that challenge within the government and the general public. As I mentioned, the entire area of global infectious diseases and the increasing resistance that these organisms are displaying should become a new and major pillar of American foreign policy. Just TB and malaria are taking five and one half million lives a year. With more international travel, even nations with well developed public health systems are becoming more vulnerable, according to recent studies.

So, for starters, I am enclosing a very concise and readable collection of materials on TB prepared by Princeton Project 55 (also described herein) and the Project Managers--Celine Gounder here in Washington and Scott Regenbogen in Princeton, New Jersey. It would be useful if the First Lady were to spend a few minutes perusing these fact sheets.

Please let me know if any action is forthcoming or any interest is incubating. Her trip to Central Asia takes her to a region where TB is all too prevalent.

Sincerely


Ralph Nader

PO Box 19312
Washington, D.C., 20036

Enclosure--TB packet

Fighting TB: a second chance to do it right

But the foe now includes 'Ebola with wings'



LIZ OILBERT—SYGMA

The new campaign is aimed at curing millions of TB victims like this man in Somalia.

BY TIM ZIMMERMANN

Hollywood screenwriters might favor newer and more exotic bugs. But the infectious disease that ranks as the world's deadliest is very old and very familiar, a plague spread by mere coughing and sneezing. Hippocrates called it *phthisis* ("shriveling and wasting away"). Victorians called it consumption. In 1900, not long after people began calling it tuberculosis, it accounted for 1 in 7 deaths in America and Europe. But when a drug-based remedy emerged at mid-century, the scourge suddenly seemed doomed—only to bounce back.

Today, the TB microbe is harbored by up to 2 billion people, about a tenth of whom will become sick and infectious. Each year, TB claims nearly 3 million lives—which is more than all other infectious diseases combined. Worse, shoddy treatment has spawned drug-resistant strains that are virtually incurable. "It's a scary story," says John Crofton, an Edinburgh clinician who 40 years ago helped prove that a cure was at hand. "And what's so tragic is that it is preventable."

Last week, the World Health Organization urged the expansion of an anti-TB strategy that has the potential to cure nearly every person treated, except for those with the new superbugs. Known as DOTS—Directly Observed Treatment, Short-course—the approach relies upon the careful monitoring of patients for six to eight months as they take a daily dose of four different drugs. The hope is that 7 of every 10 TB victims will receive the treatment over the next decade and that 10 million lives thus will be saved.

DOTS isn't new. More than 70 nations have used it this decade, and data now show its effectiveness in places as different as New York City and Peru. But the approach is being used for only 1 in 10 TB sufferers worldwide. The WHO initiative targets 13 countries—including Russia, China, and Mexico—that harbor three fourths of the world's estimated 20 million active TB cases. The additional cost would be about \$100 million a year.

Lung wrecker. DOTS may be a therapeutic breakthrough, but the history of efforts to stamp out tuberculosis is a tale of hubris. The TB bacillus is insidious and

tough, lodging itself within the lung, where it is contained indefinitely by the body's immune system or, for an unlucky 10 percent, breaks out into active, infectious tuberculosis. With the drugs found at mid-century, TB mortality in developed countries dropped sharply. In the United States, TB deaths fell from almost 20,000 in 1953 to below 2,000 in the 1980s. Many richer nations, including America, considered TB defeated and began cutting research and treatment funds.

But the disease continued to thrive in the developing world, where incomplete treatments were common. From a public-health standpoint, faulty treatments—in which some patients would neither die nor be cured—turned out to be worse than no treatment at all. Statistically, if 10 people were left untreated, 5 died and 2 remained uncured and infectious (the other 3 were cured by their own natural defenses). But of every 10 on an incomplete drug regimen, only 2 died while 4 remained uncured and infectious. One infectious person typically would infect 10 to 15 additional people in a year. Thus inadequate treatments tended to double the rate of transmission. They also created drug-resistant strains. The calamity, says Dr. John Sbarbaro of the University of Colorado, has been "a global failure of politicians, a failure of public health, and a failure of physicians."

Today, the WHO estimates that 50 million people carry the extraordinarily durable form of tuberculosis known as MDR, or multidrug-resistant TB. The several million in the developing world who get active MDR-TB will be as good as dead. Elsewhere, even in good hospitals, MDR treatment can cost \$250,000 a patient, and still some 40 to 50 percent will die. "It's like Ebola with wings," warns Richard Bumgarner, deputy director of the WHO's Global TB Program. "And once that MDR epidemic is created outside our borders, there is no way to protect the U.S."

A brief resurgence of TB in the United States caused by the AIDS epidemic has been brought under control. But the Centers for Disease Control and Prevention says outbreaks of MDR continue.

If this were Greek tragedy, there would be no second chance. But decades after researchers developed the drugs necessary to treat tuberculosis, DOTS represents a cost-effective strategy to redress the policy failures of the past. Whether the strategy is widely implemented is a repeat test of global priorities for the politicians. Whether the right antibiotics to treat multidrug-resistant TB can be found is yet another test for the scientists. ■

The Washington Post

June 24, 1997

Controlling Infectious Diseases

David Brown ably chronicles specific progress made against infectious diseases such as leprosy and river blindness but overall paints too rosy a picture of the future [*"The Long March Toward Stamping Out Infectious Diseases,"* news story, June 2]. New evidence is beginning to sketch a truer and more frightening picture.

In the 1970s, with the eradication of smallpox and the discovery of the polio vaccine, it seemed that infectious diseases would be eliminated by the year 2000. Since then the medical world has identified some 30 new diseases, and multidrug-resistant forms of TB, malaria and other diseases once thought to be under control threaten to overwhelm fragile health systems in many countries. Infectious diseases today kill 17 million people each year. With 2 million people crossing international borders every day, stopping these microbial threats at our borders is not a realistic option.

The dangers these diseases pose to

the health and economic well-being of Americans is immense, but we are not doing nearly enough to control them. It is particularly appalling that there is no global system for surveillance and control of infectious disease outbreaks. The patchwork of uncoordinated agencies and programs should be linked with a global information network, and public health systems should be greatly bolstered in countries where potentially catastrophic diseases such as AIDS and the Ebola virus originate.

The government and the pharmaceutical industry need to work together. While firms such as Merck have donated drugs to fight river blindness, corporate generosity is not a substitute for creating the financial incentives for developing new drugs and building the local infrastructure for distributing them in needy countries.

PATRICK LEAHY

U.S. Senator (D-Vt.)

Washington

FINANCIAL TIMES

MONDAY MARCH 24 1997

Action on TB would bring big economic returns, says WHO

By Clive Cookson,
Science Editor

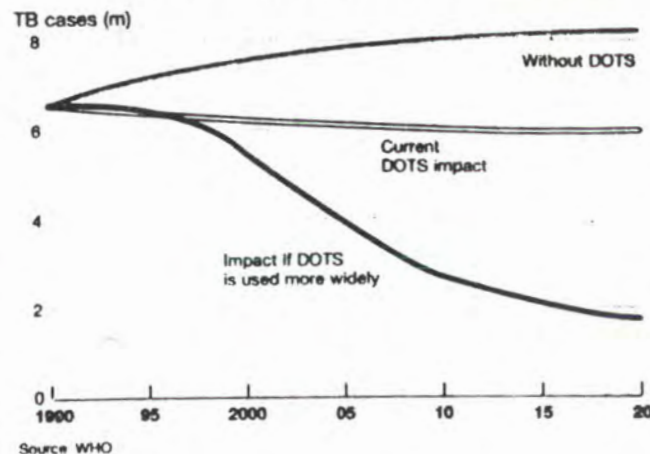
Effective tuberculosis control programmes would bring huge economic returns as well as health and social benefits, according to a report released by the World Health Organisation today, World TB day.

Tuberculosis kills an estimated 3m people a year - more than any other infectious illness.

The first detailed economic study of TB treatment has been carried out for WHO in India, where about 30 per cent of the world's tuberculosis cases occur. It shows that, if the Indian government spent \$200m a year on an effective control programme, the tangible benefits to the economy would be worth at least \$750m a year - and might be much greater.

Comparable benefits for the world as a whole would run to billions of dollars a year and could exceed \$20bn a year, says Dr Joel Almeida, medical officer at the WHO global TB programme, who

TB worldwide: DOTS can turn the tide



carried out the Indian study with Professor Ravindra Dholakia and colleagues at the Indian Institute of Management, Ahmedabad.

A similar study, soon to be published for Thailand, will show a larger benefit per patient there than in India because average income is higher, Dr Almeida says. The same would apply to other rapidly industrialising Asian countries such as China and Indonesia, which

account between them for over 40 per cent of the world's TB.

WHO's recommended control strategy is DOTS (directly observed treatment short-course). This requires each patient to take a combined dose of four powerful antibiotics every day (or on alternate days) for six to eight months.

The main feature of DOTS is that a health worker observes the patient swallow

every dose and monitors his or her progress until the disease is cured.

This strict supervision is a striking contrast to what happens today in India and many other developing countries: doctors prescribe antibiotics in a haphazard way and they make little effort to ensure that the patients take the whole course. As a result, people stop taking the drugs when they feel better but before the TB bacillus has been eliminated from their body.

Then, after a while, the disease returns - sometimes in a drug-resistant form more difficult to treat.

At present DOTS is used for no more than 10 per cent of the world's TB patients, although the latest WHO statistics show that it is far more effective than other approaches.

It typically achieves cure rates of 80 to 90 per cent, compared with about 40 per cent for unsupervised treatment.

Indeed Dr Arata Kochi, director of the WHO global TB programme, says there is

clear evidence even 10 per cent use of DOTS has led to a levelling off of the worldwide TB epidemic after decades of growth. "We now know that if we use DOTS more widely, we can send the epidemic into decline and can save many millions of lives in the next 10 years," he says.

The WHO's target is to raise the DOTS treatment rate from one in 10 to seven in 10 patients worldwide. That could halve the number total of new TB cases, Dr Kochi says.

The world's governments and aid agencies would need to spend an additional \$500m a year to achieve a 70 per cent DOTS treatment rate, says Dr Almeida - an insignificant amount compared with the projected economic gains from having millions of people working healthily instead of sickening or dying from TB. The Indian study shows economic benefits would justify spending as much as \$750m a year on TB control in India, assuming a "discount rate" as high as 16 per cent.

Herald INTERNATIONAL Tribune

PUBLISHED WITH THE NEW YORK TIMES AND THE WASHINGTON POST

TUESDAY, MARCH 18, 1997

Russian Prisons Breeding Drug-Resistant Tuberculosis, Officials Warn

By Barry James
International Herald Tribune

Russian prisons and labor camps have become incubators of virulent, drug-resistant tuberculosis that is spreading through the region as prisoners are released, officials in Moscow and at the World Health Organization said Monday.

The Moscow Center for Prison Reform said 2,481 of every 100,000 prisoners contract TB, but at some labor camps the question is almost not whether prisoners will catch the disease but when.

Russia has a prison population of more than one million.

The situation is even worse in some other regions of the Commonwealth of Independent States. The International Committee of the Red Cross, which administers a treatment program in Baku, Azerbaijan, reported recently that there were 4,667 cases of TB for every 100,000 prisoners — 50 times higher than in the general population — with a 25 percent mortality rate.

In Kazakhstan, the government last year released about 56,000 prisoners under an amnesty, many of them suffering from drug-resistant tuberculosis, according to the Global TB Education Fund in Washington.

The fact that prisoners are spreading the disease among the general population after their release is one reason — along with the collapse of medical services and general poverty — why TB rates are climbing back to levels of 20 years ago, spawning the highest mortality rates in Europe and taking the lives of those in their most productive years," according to the WHO's 1997 TB report,

which will be made public in Berlin on Wednesday.

"The recent dramatic increase in TB cases is a clear reflection of the economic turmoil and social upheaval in the Russian Federation since 1990," the report says.

Figures given by Alexander Khomenko, director of Russia's central research institute of tuberculosis, indicate that the rate of TB in the general population may almost have tripled between 1991 and 1996 to 70 cases for every 100,000 people in the Russian Federation.

This is between four and seven times higher than the figures reported in most Western countries, where the disease is largely controlled by multiple drug therapies but is nevertheless becoming an increasing public health hazard. In 1995, the last year for which figures are available, the United States reported 8.7 cases of TB per 100,000, a total of 22,860 cases, of which 4.1 percent were in correctional institutions.

Dr. Hans Kluge, Moscow coordinator for Doctors Without Borders, said that in some regions, 60 percent of TB patients were former prisoners.

"If we want to break the chain of transmission, we have to tackle the problem at the root, in the prisons," he said.

Nick Banatvala of Medical Emergency Relief in London, which operates a TB treatment program among the general population, said there was a "tremendous need" for good work in the prisons, where the disease was mostly affecting young male adults.

Valeri Sergeyev of the Moscow Center for Prison Reform said many prisoners can expect to contract TB, which is spread by an airborne bacillus, even be-

fore they are sentenced because of overcrowding, poor hygiene and lack of decent nutrition in holding prisons.

Dr. Kluge said that from a public health point of view it was better not to treat the infected prisoners and allow them to die, rather than give them partial drug treatment that built up resistance to the disease and spread it among the population.

Doctors Without Borders runs a treatment program at the Marensk special TB camp in central Siberia based on multiple drug therapy, but Dr. Kluge said sputum samples sent to Belgium for analysis indicated that some prisoners had acquired resistance to the entire panoply of drugs.

The Marensk program reaches only 400 of the 2,000 prisoners at Marensk, but Dr. Kluge said he was trying to persuade authorities to expand it to prevent continual reinfection. The camp, built for 700, is so overcrowded that prisoners sleep in shifts, and some rent out their beds by the hour. Nevertheless, prisoners consider they are better off there than in the labor camps and deliberately avoid taking medication or fake their sputum tests in order to avoid being sent back.

"It is a disaster," Dr. Kluge said. "In January and February this year, 115 patients died. It's a real cemetery."

He said that hundreds of TB victims were awaiting admission to Marensk, and in the meantime spreading the disease in other camps. The problem was compounded by homosexuality and promiscuity in the camps, he added.

A principal means of spreading the disease, Dr. Kluge said, were prison trains where detainees were crammed 30 into a compartment.

FRONTIER POST

Pakistan

Monday, March 24, 1997

World TB day being observed today **The scourge that kills 100,000 in Pakistan annually**

By Dr. KHABIR AHMAD

PESHAWAR — Tuberculosis — assumed by many as a disease of the past, poor and poets — has become the world's leading infectious killer, claiming nearly three million people in 1995 and likely to kill at least 30 million people in the next 10 years, if the current trends continue.

According to World Health Organisation (WHO), one-third the world's population — about 2 billion people — have already infected with tuberculosis.

"Someone is infected with TB every second. Left untreated, one person with active TB will in fact 10 to 15 people in a year's time. Like the common cold, TB spreads through air and by relatively casual contact," says WHO.

The World TB Day, being observed worldwide today reminds us the fact that more than 40 years after the discovery of drugs that can wipe out TB, the disease continue to kill more people than ever. It reminds us that the TB epidemic is still out of control. The day, according to Dr Arata Kochi, the WHO director of global TB programme, gives us an opportunity to help break this silence and stop the spread of tuberculosis.

This day is the anniversary of the discovery of the cause of TB in 1882. "Yet, over one hundred

years later, the effective tools and medicines discovered long ago for fighting TB, are not being put to proper use," he said.

This year, the core theme of the day is: "Use DOTS more widely." DOTS (Directly Observed Treatment Strategy) which was endorsed by the WHO in 1993 when it declared TB as a global emergency, involves health workers or family members watching patients take each dose of anti-TB drugs and monitor patients' progress until the patients are cured. This supervision must continue every day for the first two months and, ideally, for all six months of treatment.

Dr Kochi said that DOTS currently covered only about 10 per cent of the world's population.

"DOTS has doubled cure rates in Tanzania, China and New York City. Many other countries have also started adopting the DOTS strategy and are also achieving higher cure rates," he said, adding that the DOTS strategy was able to cure as much as 95 per cent of all TB patients — twice as many as any previous anti-TB strategy. TB medicines can cost as little as \$11.

DOTS strategy of the WHO has five main elements.

1- The first priority for every programme must be to DIRECT attention toward identifying sick,

infectious cases, so that they can be cured.

2- The patients must be OBSERVED and recorded swallowing each dose of their medicines by a health worker.

3- TB patients must be provided treatment within a system that ensures that they are being cured.

4- The correct dosage of anti-TB medicines — known as SHORT-COURSE chemotherapy — must be used for the right length of time.

5- Governments must support the DOTS strategy emphatically and make TB control a high priority.

As far as Pakistan is concerned, "TB is back with a vengeance, claiming 100,000 lives every year," says Dr M.A. Barzgar, WHO representative to Pakistan.

Talking to The Frontier Post by Telephone, Dr Barzgar said: "At least 1.5 million people are already infected with TB to which 400,000 new cases are added every year."

"If we don't take appropriate measures, the TB epidemic could only get worse," he warned.

According to Dr Barzgar, the day is aimed at generating public awareness that TB today is a problem that will not wait. The TB, he said, was frustrating killer and stressed the need for adopting the DOTS strategy.

The Indian Express

SATURDAY, APRIL 5, 1997

Tuberculosis time-bomb

Fight it globally, fight it at home

IT is tuberculosis more than any other disease that underlines John Donne's pragmatic observation that no man is an island. The time-bomb ticks, not just for some forgotten hill tribe, but for the residents of New York and London, Chennai and Dacca; not just for the refugee from regions that exist below the poverty line, but for the well-heeled and well-fed. Today this 19th century malady, that once went by the romantic term 'consumption', is killing more people in the world than ever before. What is worse, it has combined with late-20th century killers like AIDS to wreak further damage. A person afflicted by AIDS is ten times more likely to contract TB than others.

The roller-coaster ride of this centuries-old disease may appear strangely out of sync with the promise of modernity. The hopes raised by the identification of the TB bacillus by Robert Koch in 1882 and the discovery of rifampicin as an effective drug against the disease in the late 1960s seem to have been belied. There are three main reasons for this. The first, of course, is the highly contagious nature of the disease and the close proximity with which human beings live and work together in a world where an estimated one-third inhabitants carry the TB bacilli. The second, even more tragic, aspect is that the battle against the disease the world over has been an extremely half-hearted one. Time and again, once the obvious symptoms of the disease like bouts of coughing disappear, patients imagining they are cured give up medication pre-

maturely and get saddled with multi-drug-resistant TB. Thirdly, there has been a general failure of diagnosis. For this, both patients and medical personnel have to blame. Social prejudice has meant that those afflicted by TB present themselves to medical attention only in the later stages of the disease. Even then their condition could remain undetected because of tardy data-collection. A proper sputum examination is the only way to diagnose TB accurately, yet many doctors continue to depend on X-ray reports emanating from faulty equipment. Thus valuable time is lost, even as more people are exposed to the contagion.

The battle against the disease world-wide has to be waged particularly hard in this country, which has an estimated 14 million TB patients. Every year at least five lakh Indians die of it. It is an unrelenting epidemic that few speak about, an epidemic that hasn't been controlled in these 50 years of independence. The National Tuberculosis Control Programme and its recently revised version have often been a charade of simulated sputum samples, broken-down X-ray equipment and a severe shortage of medicines. If there is a glimmer of hope in all this it is the internationally recommended breakthrough in TB control known as Directly Observed Treatment Short-course or DOTS. The strategy here is to merge conventional multi-drug therapy with a new management system that ensures the monitoring of each TB patient until he, or she is certified as cured.

Herald Tribune

PUBLISHED WITH THE NEW YORK TIMES AND THE WASHINGTON POST

London, Thursday, March 20, 1997

WHO Hails Advance in Tuberculosis As Milestone

TB: World Health Organization Hails a Treatment That Could Save Millions of Lives

By Alan Cowell
New York Times Service

GENEVA — Claiming "the biggest health breakthrough of this decade," the World Health Organization forecast Wednesday that millions of lives could be saved over the next 10 years through a tuberculosis treatment that has been field-tested in such disparate places as New York City and rural Tanzania.

Researchers said the benefits of the system, known as Directly Observed Treatment Short-course, or DOTS, have become apparent only in the past few months as a mass of new data has shown dramatic increases in the numbers of people cured as a result of the regimen.

The new treatment and management regime is based on close monitoring of tuberculosis patients to ensure that they fully complete a course of powerful medication lasting six to eight months.

In the past, said Dr. Paul Nunn, the head of the World Health Organization Tuberculosis Research and Surveillance Unit here, patients who failed to complete such courses ended up generating drug-resistant and incurable strains of the disease.

The new system — in use in 70 of the world's 216 countries and territories — differs markedly from other forms of treatment where the therapy regimen is not standardized or where tuberculosis treatment centers on mass scanning of the population by X-ray and institutionalization of infected patients, researchers said.

The development was revealed simultaneously at the World Health Organization headquarters in Geneva and at the institute in Berlin named for Robert Koch, the German physician who announced his discovery of the bacilli causing tuberculosis on March 24, 1882.

Since then, the disease has killed untold millions of people, said Dr. Nunn, but "completely fell off the public

health radar screen" in the 1960s and 1970s amid widespread assumptions it was under control.

Only in the early 1990s, when "huge increases" in tuberculosis cases began to be identified in New York City, did health officials focus anew on the disease, Dr. Nunn said.

He added that tuberculosis claims 2 to 3 million deaths per year from a reported 6 to 8 million cases.

In an interview, Dr. Nunn said that several factors explained the worldwide upsurge in the ailment in the 1990s. These included the spread of the HIV virus resulting in reduced natural immunity, immigration from developing to developed countries and the breakdown of health-care systems in Russia and parts of Eastern Europe following the collapse of communism.

The epidemic "has been running unabated in most of the world's countries and has even begun to worsen in Eastern Europe and parts of Western Europe," said Jaap Broekmans, an official who helped in the development of the DOTS strategy. According to Mario Raviglione, a medical officer at the World Health Organization, recently compiled data from surveys of 98 percent of the global population show that the new treatment and management system produces cure rates of 77 percent, compared with 41 percent from other programs to combat tuberculosis.

The highest rate using the new system was recorded in the mid-1990s in China, Dr. Nunn said, in a project where 95 percent of 114,000 people infected with tuberculosis were cured.

Hiroshi Nakajima, the director-general of the World Health Organization, said in a statement that the new system was "the biggest health breakthrough of this decade, in terms of the lives we will be able to save."

Dr. Nakajima said the organization anticipated that "at least 10 million deaths" would be prevented in the next 10 years "with the introduction and extensive use" of the new strategy.

Tuberculosis is an infectious disease almost always transmitted through airborne bacteria from an infected person. It destroys the lungs, leading to bleeding

and asphyxiation. Patients also display wasting as muscle tissue is eaten away.

According to the World Health Organization, the disease dates back about 6,000 years and was once known as the "white plague."

It was so much part of the fabric of 19th century European society that it inspired poets and musicians in works including Puccini's opera "La Bohème."

In the early 20th century, richer patients were confined to sanatoriums such as the institution depicted in Thomas Mann's novel, "The Magic Mountain."

These days, Dr. Nunn said, tuberculosis claims more lives than AIDS. He said a full one third of people stricken with the HIV virus — and thus susceptible to infection — die from tuberculosis.

An assessment by the World Health Organization published Wednesday called the disease the "leading infectious killer of youths and adults" in the world, claiming most of its victims among economically active people predominantly in the Third World.

The DOTS program centers on the use of four established, low-cost tuberculosis drugs — isoniazid, rifampicin, parazinamide and either ethambutol or streptomycin — taken in conjunction. An advantage of the system, Dr. Nunn said, is that the full course of treatment can cost as little as \$11, much less than other cures.

Under the new system, health officers must physically witness a patient taking a full course of medication.

"The most important thing is to hold on to the patients," Dr. Nunn said. "People take drugs for a month and feel much better and think, 'Why should I go on seeing this health worker?'" In fact, by breaking off a course of treatment, Dr. Nunn said, patients encourage drug-resistant, incurable tuberculosis.

The DOTS program is billed by the World Health Organization as a breakthrough in part because other research has not so far produced a vaccine to prevent tuberculosis.

"Prevention lies in the cure," Dr. Nunn said. "If you cure patients, you prevent them from transmitting the disease."

Newsday

March 20, 1997

WORLD'S TB EPIDEMIC COULD HIT 9 MILLION

by Laurie Garrett, Staff Writer

The world's tuberculosis epidemic will top nine million active cases annually within 20 years if governments fail to swiftly change the way they handle the disease, according to a report released yesterday by the World Health Organization.

In countries using appropriate TB control measures — called Directly Observed Therapy — TB is leveling off and the incidences of drug-resistant forms are at manageable levels. Currently, there are 7.5 million active cases of TB worldwide.

But several countries refuse to use the labor-intensive DOT to treat what Richard Bumgarner, WHO's TB deputy director, calls "ebola with wings." The reference is to TB's airborne contagion and 50-percent lethality if untreated. The refusal seems part economic, part philosophic.

For example, Russian authorities insist that TB's spread is due to poverty and poor housing rather than to improper treatment. And, they say, the appropriate cure involves months or years of quarantine in sanatoriums, where patients are given a succession of antibiotic treatments.

"The patients are charged for everything, including the drugs. When they run out of money, they're kicked out of the institutions," Bumgarner said.

Under DOT, properly medicated patients can live at home because the medication renders them noncontagious. The DOT system of daily monitoring to ensure proper use of four antibiotics proved its worth in New York City. Through DOT, and at a cost of about \$1 billion, New York's early 1990's epidemic was controlled by 1994.

The incidence of TB in Russia in 1995 was 6 1/2 times that of the United States. Several other Eastern European countries have even higher rates. Latvia, Lithuania and Moldova report TB rates that are 7 1/2 times greater than in the United States and Romania's TB rate is nearly 12 times greater, according to WHO.

In the short run, Bumgarner said, persuading governments to switch to DOT could not only save lives, but prevent the otherwise inevitable spread of drug-resistant TB into Western Europe.

TB Weekly

April 1, 1996

Epidemiology TB Rates in U.S. Drop but Authorities Fear Complacency

The renewed fight against tuberculosis (TB) in the U.S. is yielding results, with the number of cases dropping for the third consecutive year, but experts said another lapse in complacency could be lethal.

According to statistics released by the U.S. Centers for Disease Control and Prevention (CDC), there were 22,812 new TB cases in 1995, a six percent drop from 1994. The rate per 100,000 people fell to 8.7 from 9.4.

The goal remains elimination — less than one case per 100,000. But several barriers remain, according to doctors and public health experts at a conference in Washington, D.C., marking World Tuberculosis Day.

Tuberculosis killed three million people and made eight million sick in 1995, the World Health Organization (WHO) said. WHO projected it would take \$500 million a year to bring the epidemic under control globally.

In an age of international travel and migration, no single country can wipe it out alone, experts from the CDC, American Lung Association and Pan-American Health Organization said.

Perception is part of the problem. Effective drugs have been available to fight TB for 50 years and health authorities had begun to think of the lung disease as a vanquished enemy, a problem of the past.

But as soon as they let their guard down, TB re-emerged as a serious health threat. The problem was exacerbated by the AIDS epidemic because AIDS patients are particularly vulnerable to TB.

"The 20 percent resurgence of TB in this country from 1985 to 1992 after more than three decades of steady decline clearly demonstrates the high price of complacency," Dr. Kenneth Castro of the CDC told a news conference. "To be successful in this battle we must refrain from premature declarations of victory, which lead to complacency."

Doctors are also alarmed that there are more strains of TB resistant to standard drugs and they fear that if lowered vigilance results in another surge of cases, drug resistance will be an even more treacherous problem the next time around.

INDIANAPOLIS STAR

Indianapolis, IN
Thursday, March 20, 1997

TB epidemic exploding in Russia

■ Global threat of disease leveling off due to better treatment, but Eastern Europe headed for 'crisis.'

By Paul Geitner
ASSOCIATED PRESS

BERLIN — Better treatment has stabilized the spread of tuberculosis worldwide for the first time in decades, but U.N. health officials said Wednesday that a growing TB epidemic in Russia is threatening Europe.

The global TB epidemic has leveled off because health care workers are being trained to make sure patients take the full, six-month course of medication, World Health Organization officials said at a news conference.

They said widespread use of the new "DOTS" — or Directly Observed Treatment, Short-course — method could cut the number of TB cases in half over the next decade, saving 10 million lives, as well as prevent the development of drug-resistant strains.

But the method is still not being used in Eastern Europe, and economic and social upheaval in Russia and other former Soviet bloc countries since the end of communism has contributed to a tubercu-

Return of tuberculosis

Tuberculosis claims as many as 3 million lives each year. Thirteen countries are home to nearly 75 percent of the world's TB cases.



Source: World Health Organization

Associated Press

losis explosion there.

Since 1991, Russia has seen a 70 percent rise in TB cases and a 90 percent jump in TB death rates, said Richard Bumgarner, deputy director of the WHO's Global TB Program.

Lethal drug-resistant strains account for 6 percent of the TB cases in the Baltic country of Latvia, 14 percent in Estonia and 18 percent in Lithuania, he said.

"Make no mistake," Bumgarner said, "Europe has been heading slowly but surely to another TB crisis."

Tuberculosis, the world's top infectious killer, is spread through coughing and sneezing and can be highly contagious.

Although effective and affordable drugs have been available since the 1950s, they generally must be taken for six to eight months. Many patients, especially in poorer countries, stop taking them as soon as they begin to feel better because of the inconvenience or to save money.

That allows the stronger TB germs that resisted the initial drug onslaught to reproduce, making it harder, if not impossible, to cure later.

Fully adopted in the United States and elsewhere since the early 1990s, the DOTS method involves better identification of TB cases and training of people to administer medication.

Foreign Operations Subcommittee Hearing “Combating Infectious Diseases” May 15, 1997

Witnesses

- Dr. Barry Bloom, Investigator, Howard Hughes Medical Institute; Professor of Microbiology and Immunology, Albert Einstein College of Medicine
- Dr. David Heymann, Director, Division of Emerging and Other Communicable Diseases Surveillance Control, WHO
- Dr. Nils Daulaire, Chief Health Policy Advisor, USAID
- Dr. Gordon Douglas, President, Merck Vaccines
- Dr. John Sbarbaro, Professor of Medicine and Preventive Medicine, University of Colorado Health Sciences Center

Dr. Barry Bloom discussed three major infectious diseases that he felt most needed to be addressed in developing countries: tuberculosis, AIDS, and malaria. Dr. Bloom suggested that three major WHO extrabudgetary programs be considered for increased financial support, including the WHO Global Program for Tuberculosis (GTB). In Africa, he noted, TB is the most common cause of death among those infected with HIV, killing 30% of AIDS patients there. In addition, multi-drug resistant strains of tuberculosis are now emerging, as seen recently in New York. Unless drug treatment is properly supervised, tuberculosis becomes rapidly resistant to the only drugs available. Directly observed treatment prevents emergence of resistance and leads to cures in over 85% of tuberculosis patients, rendering them non-infectious within a month. In the long-term, efforts should be made to develop an effective vaccine.

Dr. David Heymann outlined a global framework for surveillance and control of infectious diseases, which WHO is putting in place. Dr. Heymann noted that within a year, there have been 27 infectious disease outbreaks in addition to the heavy burden of underlying diseases. Included among these is TB, the spread of which is now facilitated by HIV infections. Dr. Heymann emphasized the need for strengthening public health infrastructure. He explained that WHO's programs should be empowered to help in strengthening national capacities to detect and control infectious diseases. He also stated that the WHO's existing infectious disease monitoring networks and computerized information systems should be expanded.

Dr. Nils Daulaire noted that in FY 1996, USAID devoted approximately \$320 million to infectious disease programs. USAID's approach to infectious diseases consists of four elements: basic prevention through changing the conditions that allow infectious diseases to spread and flourish; secondary prevention by improving health systems so that they can prevent and control infectious diseases; targeted prevention and control through specifically tailored programs that focus on high priority diseases; and, response to emergency situations. USAID's principal efforts, outside childhood BCG immunization (which provides modest protection against new TB infection), have been in support of programs aimed at developing a rational approach to managing TB among people with HIV infection. "It is clear that the resource needs of a truly global effort to address TB are enormous, in all likelihood dwarfing today's AIDS control efforts. This is unquestionably the biggest unmet need among infectious diseases today." Dr. Daulaire maintains that before a global TB program can be launched, greater efforts should be made to improve health infrastructures in developing countries.

Dr. Gordon Douglas explained that the US needs a comprehensive public policy that addresses issues ranging from research initiatives to health care delivery infrastructure, and whose implementation depends on strategic partnership efforts between government and other segments of society, such as the private sector. Dr. Douglas noted that the failure to use TB drugs appropriately has led to widespread emergence of TB strains that are resistant to existing antibiotics. Dr. Douglas also observed that the HIV/AIDS pandemic is further fueling emergence of multi-drug resistant tuberculosis. Dr. Douglas outlined barriers to increased involvement of the private sector in infectious disease control efforts: inadequate protection of intellectual property; parallel trade in patent-protected medicine (when different prices are set by governments among price-controlled markets); government price and profit controls; black market sales; lack of quality assurance and the willingness to compromise on quality to achieve cost savings; inadequate resources for countries to acquire effective therapies and newer vaccines; lack of epidemiological data; and the lack of health system infrastructures that can support rigorous treatment regimens.

Dr. John Sbarbaro began by saying, "I was asked to come up with a disease that exemplified all the points my colleagues have made. The obvious answer is tuberculosis." Dr. Sbarbaro noted that the WHO approach to TB, DOTS, is a highly effective approach to controlling tuberculosis. According to Dr. Sbarbaro, little advancement in health infrastructure is necessary to apply DOTS because all that is required is the participation of primary health care workers and village health workers. Dr. Sbarbaro believes that USAID should become a leader on global tuberculosis control by putting more money into WHO's DOT program. The WHO uses its funding as seed money to start programs that governments find so effective that they then fund it themselves. Dr. Sbarbaro also noted that WHO should be encouraged to make TB a higher priority, and that the World Bank should be encouraged to lend money for controlling TB.

Tuberculosis Fact Sheet

United States Statistics

- In 1996, a total of 21,337 cases of tuberculosis were reported to the CDC from the 50 states, the District of Columbia, and New York City (8.0 cases per 100,000 population). This represents a 6.7% decrease from 1995.
- During 1996, a total of 29 states reported fewer TB cases than in 1995, and 21 states and DC reported no change or more cases in 1996 than in 1995.
- Data indicates a decreased number of TB cases among U.S.-born persons and an increased number among foreign-born persons. During 1996, TB cases reported among persons born outside the U.S. accounted for 36.6% of total reported cases, compared with 34.7% in 1995. In 1996, the number of TB cases among foreign-born persons decreased 2.9%, representing the first decreases among foreign-born persons since 1986 (the first year such data were collected).
- Homeless populations in big cities are reservoirs for tuberculosis: some estimates show that as many as 30% of the homeless population of San Francisco may be infected with the TB bacillus.
- In 1990, it is estimated that \$700 million was spent to treat the 26,000 U.S. cases of TB that year.

SOURCE: CDC. (1996) "Tuberculosis Morbidity — United States, 1995." MMWR. 45: 365-370.

_____ (1997) "Tuberculosis Morbidity — United States, 1996." MMWR. 46: 695-700.

Global Tuberculosis Statistics

- In 1995, more people died of tuberculosis than in any other year in history.
- There are 8 million new TB cases annually. Of these, only 5 million receive any form of treatment at all, and only 500,000 receive DOTS.
- TB causes more deaths than any other infectious disease. It kills 3 million people every year. Of these, 1 million are women.
- The WHO estimates that 180 million children less than fifteen years of age were infected with tuberculosis as of 1995.
- In 1994, there were about 23 million refugees worldwide. As many as half of them may be infected with the tuberculosis bacillus, as refugee camps present prime conditions for the spread of tuberculosis.
- TB is the leading killer of HIV-positive people worldwide.
- The American Lung Association estimates that improvements in TB control could increase economic output in developing countries by more than \$24 billion annually.

SOURCE: WHO web site, <http://www.who.ch/programmes/gtb/tbrep-96/tbreport.htm>.

*Tuberculosis — Continued***TABLE 1. Number of reported tuberculosis cases, percentage change in number of cases, and case rates*, by state and year — United States, 1995–1996**

State	No. cases		% Change from 1995 to 1996	Case rate	
	1995	1996		1995	1996
Alabama	420	423	+ 0.7%	9.9	9.9
Alaska	81	96	+18.5%	13.4	15.8
Arizona	319	282	-11.6%	7.6	6.4
Arkansas	271	225	-17.0%	10.9	9.0
California	4,677	4,313	- 7.8%	14.8	13.5
Colorado	95	104	+ 9.5%	2.5	2.7
Connecticut	139	138	- 0.7%	4.2	4.2
Delaware	56	43	-23.2%	7.8	5.9
District of Columbia	102	139	+36.3%	18.4	25.6
Florida	1,556	1,417	- 8.9%	11.0	9.8
Georgia	746	790	+ 5.9%	10.4	10.7
Hawaii	193	200	+ 3.6%	16.3	16.9
Idaho	14	15	+ 7.1%	1.2	1.3
Illinois	1,024	1,060	+ 3.5%	8.7	8.9
Indiana	199	202	+ 1.5%	3.4	3.5
Iowa	72	70	- 2.8%	2.5	2.5
Kansas	89	74	-16.9%	3.5	2.9
Kentucky	327	259	-20.8%	8.5	6.7
Louisiana	476	420	-11.8%	11.0	9.7
Maine	28	21	-25.0%	2.3	1.7
Maryland	370	319	-13.8%	7.3	6.3
Massachusetts	330	262	-20.6%	5.4	4.3
Michigan	424	443	+ 4.5%	4.4	4.6
Minnesota	156	131	-16.0%	3.4	2.8
Mississippi	271	251	- 7.4%	10.0	9.2
Missouri	244	224	- 8.2%	4.6	4.2
Montana	21	19	- 9.5%	2.4	2.2
Nebraska	24	22	- 8.3%	1.5	1.3
Nevada	115	137	+19.1%	7.5	8.5
New Hampshire	23	21	- 8.7%	2.0	1.8
New Jersey	848	820	- 3.3%	10.7	10.3
New Mexico	85	89	+ 4.7%	5.0	5.2
New York	3,066	2,588	-15.6%	16.9	14.2
North Carolina	519	554	+ 6.7%	7.2	7.6
North Dakota	5	8	+60.0%	0.8	1.2
Ohio	280	301	+ 7.5%	2.5	2.7
Oklahoma	237	201	-15.2%	7.2	6.1
Oregon	156	190	+21.8%	5.0	5.9
Pennsylvania	674	583	-13.5%	5.6	4.8
Rhode Island	50	35	-30.0%	5.1	3.5
South Carolina	334	348	+ 4.2%	9.1	9.4
South Dakota	28	19	-32.1%	3.8	2.6
Tennessee	465	504	+ 8.4%	8.8	9.5
Texas	2,369	2,103	-11.2%	12.7	11.0
Utah	48	58	+20.8%	2.5	2.9
Vermont	4	4	—	0.7	0.7
Virginia	359	349	- 2.8%	5.4	5.2
Washington	278	285	+ 2.5%	5.1	5.2
West Virginia	71	57	-19.7%	3.9	3.1
Wisconsin	117	114	- 2.6%	2.3	2.2
Wyoming	5	7	+40.0%	1.0	1.5
Total	22,860	21,337	- 6.7%	8.7	8.0

* Per 100,000 population.

DOTS: A PROVEN STRATEGY

The most effective way to control TB is to stop its spread at the source — curing sick patients. The secret to treating TB is as simple as making certain that patients regularly swallow the right medicines until they are cured. This supervision is the cornerstone for the World Health Organization's (WHO) recommended TB control strategy: directly-observed treatment, short-course (DOTS).

DOTS is the only viable method for reducing TB transmission and death worldwide. It has been successful in such diverse locations as New York City, Tanzania, Peru, Guinea, Bangladesh, and China.

Short-Course Chemotherapy

Initial Phase of Treatment

(Daily for 2 months)

Isoniazid	300 mg
Rifampicin	600 mg
Pyrazinamide	2000 mg
Ethambutol	1200 mg

Continuation Phase of Treatment

(3 times a week, 4 months)

Isoniazid	600 mg
Rifampicin	600 mg

DOTS Is an Effective Cure & Prevents New Infections

DOTS is a strategy that provides a standardized combination of the most effective medicines; ensures through direct observation that these medicines are taken regularly until patients are cured; and monitors patients' overall progress. This three-pronged approach is key to saving lives and stopping the TB epidemic.

DOTS uses a specific combination of four anti-TB medicines — isoniazid, rifampicin, pyrazinamide, and ethambutol (or streptomycin) — in a treatment known as short-course chemotherapy. When patients take these drugs consistently for the required six months, they are more than 95% effective.

In addition to providing the right medicines, ensuring that patients regularly take all the drugs in their treatment is one of the most vital aspects of TB control. Direct observation of treatment is one of the most vital aspects of TB control. Direct observation of treatment is one important element of the DOTS strategy and is necessary because the most serious impediment to controlling TB is that patients often interrupt or stop their treatment, sometimes because they mistakenly believe they are cured or because the medicines cause side effects. In addition, in some countries, drugs are not available continually. The DOTS strategy addresses these problems by making it the responsibility of the health worker — not the patient — to ensure that treatment is complete and the patient's progress is monitored carefully.

DOTS Prevents Multi-Drug Resistant TB

The DOTS strategy also prevents TB from becoming multi-drug resistant. Many patients fail to take all their medicines consistently because of the extended treatment period or because they no longer have any of the outward symptoms of the disease. In addition, many doctors and health

workers prescribe the wrong drugs or the wrong combination of drugs. This inconsistent or partial treatment is the primary cause of multi-drug resistant TB.

By providing the right combination of medicines, supervision, careful evaluation and monitoring of a patient's progress, the DOTS approach successfully prevents multi-drug resistance by ensuring full treatment of a sick patient until they are proven cured.

DOTS Has Been Successful Around the World

Tanzania, China, Guinea, Peru, Bangladesh, Mpumalanga (South Africa), and New York City have used the DOTS approach and seen their cure rates skyrocket. For example in:

- **New York City:** Using the DOTS approach, New York City has achieved a 36% decrease in the number of TB cases between 1992 and 1995 and cut the MDR-TB rate by 75%.
- **Bangladesh:** In 1993, the government of Bangladesh adopted DOTS to cure its widespread TB cases. By 1995, as many as 80% of the TB patients treated were being completely cured in the parts of the country using the DOTS strategy.
- **China:** Since DOTS was implemented in 1991, the TB cure rate in participating provinces of China has improved dramatically from less than 50% to over 90% among new cases.
- **Peru:** From 1991-94, the treatment and cure of contagious cases is estimated to have prevented 1.5 million new infections.
- **South Africa:** DOTS is currently being tested in Mpumalanga District with good results. Over 80% of TB patients have been successfully treated in the Mpumalanga demonstration project.

Other countries who are just beginning to use the DOTS strategy are also witnessing significant results. In India, pilot projects in New Delhi, Gujarat, and Bombay are using the DOTS strategy and are tripling their previous cure rates.

But More Countries Need To Implement DOTS

The DOTS strategy needs to be put into effect in many countries plagued by TB. Of the 8 million people who develop active TB each year, only about 500,000 have access to a DOTS based approach. If the DOTS strategy were used consistently throughout a dozen large countries — such as Bangladesh, Brazil, China, Ethiopia, India, Indonesia, Mexico, Nigeria, Pakistan, Russia, South Africa, Zaire — nearly three-fourths of the world's TB cases could be cured. As of 1995, only five of these twelve countries had aggressively committed to establishing and expanding TB control based on the DOTS strategy.

The disease already is endemic globally. Russia and Eastern Europe have seen reports of TB cases surge upwards, with some regions experiencing high rates similar to those found in Africa. Industrialized countries are not exempt; cities such as Montreal, Milan, Amsterdam, Dallas, and Paris have seen TB rates rise in recent years.

Multi-Drug Resistant TB: An Incurable Disease?

Recent Outbreaks of MDR-TB

New York City
London
Milan
India
Thailand
South Africa
Estonia
Pakistan

Source: WHO Global TB Program

New, multi-drug resistant strains of tuberculosis are threatening to make TB incurable again, as it was before a cure was found in 1952. Multi-drug resistance is a man-made phenomena and is created by inconsistent or partial TB treatment. Multi-drug resistant strains of TB spread as quickly as regular TB and have emerged in cities all over the world.

Humans Are Breeding Multi-Drug Resistant TB

Inconsistent or partial TB treatment is the primary cause of multi-drug resistant strains of tuberculosis — it does not occur naturally. Many patients do not take their medicines for the entire six-month treatment period or stop treatment because they no longer have the outward symptoms of the disease.

In addition, many doctors and health workers prescribe the wrong combination of drugs. The World Health Organization estimates that nearly two-thirds of those who are prescribing TB medication are putting people at risk to drug-resistant TB.

A standardized four-drug regimen of anti-TB medicines taken consistently for six months offers a 95% cure rate for TB. But when treatment is inconsistent or not properly administered, some TB bacteria may not be killed. They will be weakened, but not dead. If treatment continues haphazardly, or is simply repeated when a patient begins to feel sick again, the bacteria could become resistant to some, or all, of the drugs. They can then multiply, creating millions of copies of themselves, all drug resistant.

Multi-Drug Resistant TB Is Too Costly to Cure

Strains of multi-drug resistant TB are just as contagious as the regular TB bacteria, but in many cases, they cannot be cured with available and affordable drugs. Multi-drug resistant TB can raise the cost of treating tuberculosis 100 times.

The mutant TB strains may be resistant to one, two, three, or even up to nine different anti-TB drugs, making treatment more difficult and costly to administer. In developing countries, people with multi-drug resistance usually die because effective treatment is impossible in a poor nation. In wealthy countries, approximately 50% of patients with MDR-TB die because of the difficulty of treating the disease.

Multi-Drug Resistant TB is Spreading

Researchers estimate that as many as 50 million people may already be infected with TB that is resistant to one or more common anti-TB drugs — and that number is growing.

Although no one knows exactly how far multi-drug resistant TB has spread, it exists in both the developing and industrialized world. A 1995 study of regions in Pakistan showed that 75% of TB patients were resistant to at least one drug, and over 40% were resistant to more than three drugs. In the United States, New York City has seen a 36% decrease in the number of TB cases reported between 1992 and 1995 — but, new drug resistant strains of TB persist. A new study documents the transmission of a TB bacteria resistant to seven drugs from New York to metropolitan areas in Florida, Nevada, Georgia, and Colorado. These cities have a combined population of 7.1 million and are hubs for air and auto travel.

DOTS Can Prevent Multi-Drug Resistant TB

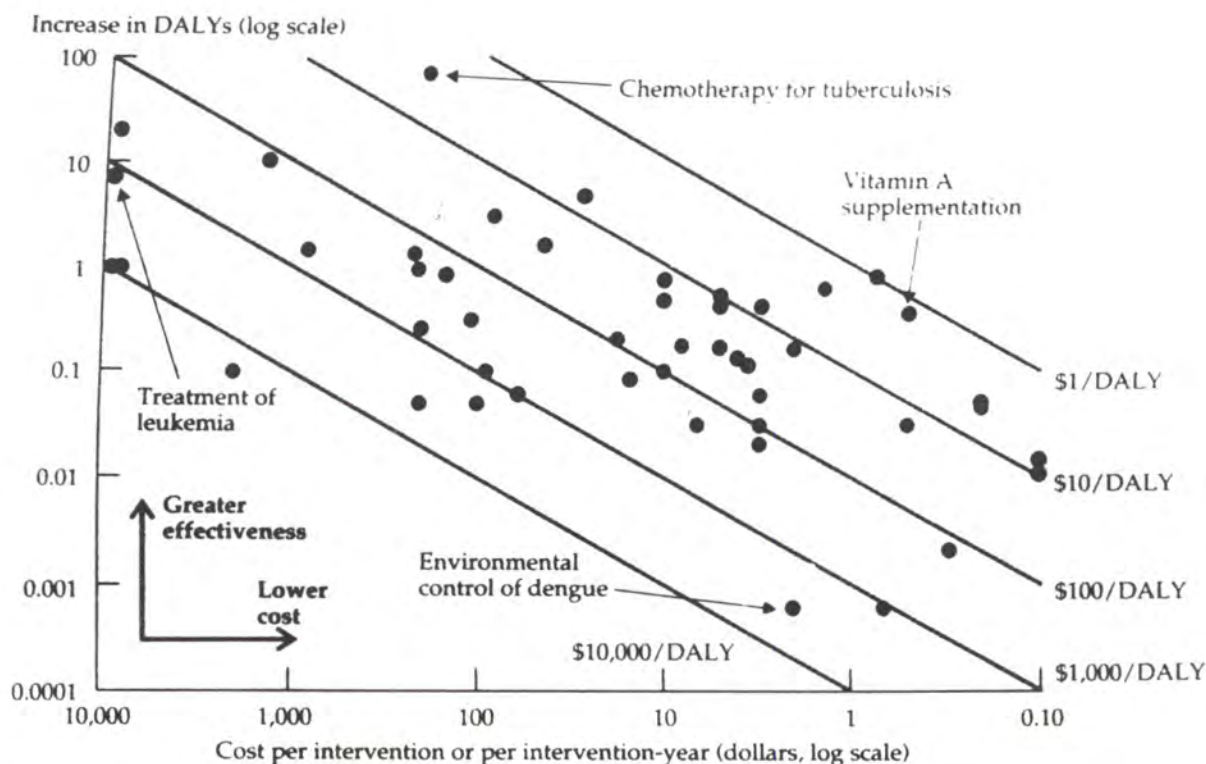
Failure to adhere consistently and completely to the standardized combination of anti-TB drugs can cause multi-drug resistance to an effective cure. Because of this phenomenon, the most vital aspect of TB control is not the choice of drugs available today, but the measures taken to ensure that patients regularly take all the drugs in their treatment.

The World Health Organization's recommended strategy of treatment — directly-observed treatment, short-course — meets that challenge. DOTS is a strategy that provides a standardized combination of the most effective medicines, ensures through direct observation that these medicines are taken regularly until patients are cured, and monitors patients to ensure their overall progress. This three-pronged approach is the key to saving lives and stopping the TB epidemic.

If adequate funds are spent to attack the TB problem at its source — in sick patients — we could cure more than 85% of those infected with TB in developing countries, stop the spread of the disease, and prevent the creation of MDR-TB in the first place.

The World Bank has called the DOTS strategy one of the “most cost-effective of all health interventions.”

Figure 3.2 Benefits and costs of forty-seven health interventions



Target:

- Children under age 15
- Adults age 15 or older^a

Note: DALY, disability-adjusted life year. Interventions are specific activities intended to reduce disease risks, treat illness, or palliate the consequences of disease and disability; an intervention-year is an intervention repeated throughout the year rather than provided only once.

a. Includes some interventions that benefit all age groups.

Source: Jamison and others forthcoming; World Bank data.

Projected Change in the Rank Order of Disease Burden for 15 Leading Causes, Worldwide 1990-2020

1990 Disease or injury	Rank Order	2020 Disease or injury
Lower respiratory infections	1	Ischemic heart disease
Diarrheal diseases	2	Unipolar major depression
Conditions arising during perinatal period	3	Road traffic accidents
Unipolar major depression	4	Cerebrovascular disease
Ischemic heart disease	5	Chronic obstructive pulmonary disease
Cerebrovascular disease	6	Lower respiratory infections
TUBERCULOSIS	7	TUBERCULOSIS
Measles	8	War
Road traffic accidents	9	Diarrheal diseases
Congenital anomalies	10	HIV
Malaria	11	Conditions arising during perinatal period
Chronic obstructive pulmonary disease	12	Violence
Falls	13	Congenital anomalies
Iron-deficiency anemia	14	Self-inflicted injuries
Protein-energy malnutrition	15	Cancers of trachea, larynx, and bronchus

NOTE: Disease burden is measured in disability-adjusted life years (DALYs), a measure that combines the impact on health of years lost due to premature death and years lived with a disability. One DALY is equivalent to one lost year of healthy life.

SOURCE: Murray, C. J. L., and Lopez, A. D. 1996. *Global Burden of Disease and Injury*, Vol. 1. Boston: Harvard University Press.

MEMORANDUM

DATE: October 2, 1997
TO: Eric Schwartz, Richard Ragan
National Security Council
FROM: Ralph Nader
Steering Committee, Princeton Project 55 Tuberculosis Initiative
RE: global tuberculosis control activities
ATTACHMENTS:

1. Princeton Project 55 brochure
2. Tuberculosis fact sheets
3. Media coverage of tuberculosis
4. Congressional interest in increasing funding for TB programs
5. Senate hearing on infectious diseases

The mission of the Princeton Project 55 Tuberculosis Initiative is to encourage United States leadership of effective and innovative tuberculosis prevention and treatment programs, and to raise public awareness about tuberculosis. We are a public service interest organization, and the steering committee of the PP55 Tuberculosis Initiative includes myself, Dr. Gordon Douglas (President of Merck Vaccines), Dr. Myron Freund, Bill Shafer, and Pete Milano, all members of Princeton's Class of 1955. The Project Managers of the Tuberculosis Initiative are Celine Gounder and Scott Regenbogen.

Tuberculosis is the single greatest infectious killer in the world, causing 8 million illnesses and 3 million deaths every year. Like the common cold, TB is spread through the air by casual contact. The primary cause of this epidemic is ineffective treatment and prevention strategies, which fail to identify infected individuals, and poorly address infectious cases. The HIV/AIDS epidemic is now fueling the TB epidemic and threatens an explosion of TB, especially in Asia, Eastern Europe, and the nations of the former USSR.

Yet an extremely cost-effective treatment and management system has proven to effectively control TB in all parts of the world. This strategy is known as DOTS (Directly Observed Therapy Short-course). DOTS ensures that each patient's treatment and cure is monitored and documented, and that action is taken if progress is not made. As part of the strategy, health workers watch their patients take their medication, and monitor them until they are cured. DOTS has achieved cure rates of greater than 85% in places as different as New York City, Peru, China, Tanzania and Bangladesh. The World Bank has called the DOTS strategy one of the "most cost-effective of all health interventions." This comprehensive therapy can cost as little as \$11 per patient in developing countries.

DOTS is essential because when patients do not take all of their medications, they produce strains of the bacteria that are resistant to anti-TB drugs. Some strains have become resistant to the whole arsenal of drugs, making them virtually incurable. These especially dangerous multi-drug resistant forms of tuberculosis (MDR-TB) can be prevented by ensuring that patients take their medicines.

MDR-TB is the most serious infectious disease threat for the early 21st century for three reasons: i) it is virtually incurable and highly fatal in the developing world; ii) it is transmitted by casual contact, through the air; and iii) it is already widespread, and is poised to break out of the "hot-zones" which have been identified as areas of particular danger.

The world stands at a crossroads for mobilizing international action. Effective TB control would protect US public health well into the next century. It is imperative that an effective program be installed, and that commitments be sustained.

Congressional Interest in Tuberculosis

The Princeton Project 55 Tuberculosis Initiative has been in contact with all senators and congressmen on the Foreign Operations subcommittees of the Appropriations committees. Both Foreign Operations subcommittees have discussed appropriations to USAID for the purpose of combating infectious diseases.

In the Senate subcommittee, Sen. Patrick Leahy (D-Vermont) has been a strong proponent of increasing funding to infectious disease programs. In May, the Foreign Operations subcommittee held a hearing — “Combating Infectious Diseases” — on behalf of Sen. Leahy. Sen. Daniel Inouye (R-Hawaii) is also interested in TB control because Hawaii has the second highest case rate of tuberculosis in the country. Others supportive of increased funding to tuberculosis programs include: Sen. Tom Harkin (D-Iowa), Sen. Frank Lautenberg (D-New Jersey), and Sen. Patty Murray (D-Washington). No senators expressed opposition to increasing funding available for tuberculosis control programs.

In the House subcommittee, Rep. Rodney Frelinghuysen (R-New Jersey), Rep. Nita Lowey (D-New York), Rep. Sidney Yates (D-Illinois), Rep. Nancy Pelosi (D-California), Rep. Esteban Torres (D-California), and Rep. David Obey (D-Wisconsin) are most strongly supportive of increasing funding to tuberculosis control programs. Rep. Frelinghuysen will be taking the lead during the conference committee on the Foreign Operations Appropriations bill to insert report language advocating funding of the Global Tuberculosis Initiative. No congressmen expressed opposition to increasing funding available for tuberculosis control programs.

Other senators and congressmen have a record of supporting tuberculosis programs:

Rep. James Walsh (R-New York) had tuberculosis himself, and is a strong supporter of increased funding to tuberculosis control programs.

Rep. John Dingell’s (D-Michigan) father had tuberculosis and the congressman is supportive of TB control initiatives. In 1995, he requested a report from the General Accounting Office on the incidence of tuberculosis in the United States.

In 1994, Sen. Frank Lautenberg (D-New Jersey) supported a measure allotting \$500,000 to support two demonstration projects whose focus was to be on collaborative approaches to controlling the spread of TB.

In 1994, Rep. Tony Hall (D-Ohio) called upon USAID to make tuberculosis a priority, and if it failed to do so, he called upon Congress to earmark funding for tuberculosis programs.

In 1992, Sen. Edward Kennedy (D-Massachusetts), Reps. Henry Waxman (D-California), and Edolphus Towns (D-New York) jointly requested a congressional Office of Technology Assessment report on the rise of tuberculosis cases in the United States. In 1994, Sen. Kennedy and Rep. Dingell requested a follow-up study.

In 1992, Rep. Waxman and Rep. Charles Schumer (D-New York) proposed that \$100 million be spent for special testing and drug programs to fight drug resistant tuberculosis.

In contrast, Rep. Lamar Smith (R-Texas) said in 1993 with regard to tuberculosis prevention, “You know, prevention is always best. But I look upon prevention a little bit differently. To me, prevention means that we have more border security, a better border patrol.”

PRINCETON PROJECT 55 INC.

Tuberculosis Initiative

file
TB

Ralph Nader
P.O. Box 19312
Washington, DC 20036

May 27, 1998

First Lady Hillary Rodham Clinton
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear Mrs. Clinton,

In your recent speech before the World Health Assembly in Geneva, you provided an excellent account of the severity and urgency of many global health crises. We are particularly pleased by your emphasis on the prevention and treatment of infectious diseases like tuberculosis.

Major public addresses such as yours are exactly what is now required to revive this nation's awareness of these profoundly neglected health causes. TB is one of the most disproportionately unheeded pandemics, yet it is the world's number one infectious killer and the death toll is rising every year. Few people in this country are aware of the enormous burden TB exacts from the citizens of developing countries, and the clear and present threat that drug resistant strains pose to the health and national security of the United States. TB kills more women than all causes of maternal mortality combined, yet most Americans consider it a disease of the past. The *yearly* death toll from land mines is matched by TB *every single day*, however many journalists and even public officials believe we have won the war against tuberculosis.

You have the unique capacity to refocus America's attention on health issues of major global importance, and this speech was an exemplary first step. Now, as you said, "We must put our hearts, our minds, and our resources in action." In South America, you witnessed the unprecedented successes that can be achieved through the use of directly-observed treatment for tuberculosis patients. As you saw, the WHO-recommended regimen, Directly-Observed Treatment, Short-course (DOTS) is a very simple system, that the World Bank determined to be one of the world's most cost-effective health interventions. Successful application of DOTS has produced cure rates above 85% in places as diverse as New York, Peru, China, Tanzania, and Bangladesh. In most countries, the overall effect of DOTS on the primary health infrastructure and the incidence of infectious diseases has been remarkable.

For the health and stability of developing nations, and to protect Americans from multi-drug resistant TB (MDR-TB), it is time for the U.S. to make a significant investment in DOTS for the most severely affected nations of the world. USAID's new infectious disease initiative is a good beginning, but this pilot project must be expanded to other key regions of the world. MDR-TB is already threatening to overwhelm the public health systems of "hot-zones" such as Latvia, Estonia, Russia, the Dominican Republic, Argentina, and the Ivory Coast. Unless we ensure the rapid application of DOTS in these

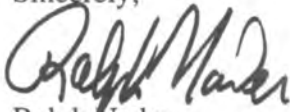
and other countries, epidemics of MDR-TB will become commonplace in many more countries.

A global assault on TB will also require significant commitments from the WHO, and from developing nations. The U.S. should make use of its diplomatic influence to encourage endemic nations to dedicate resources to the control of TB within their borders. Additionally, the U.S. should help to accelerate the introduction of WHO Secretary General-Elect Gro Harlem Brundtland's "Roll Back Malaria" and "Roll Back TB" initiatives. Currently the WHO Global TB Programme's total annual budget for the application of DOTS is a paltry \$11 million. Dr. Brundtlandt should be supported in significantly increasing funding for the TB program, in accordance with its prominence among causes of death globally.

Finally, with the introduction of the President's "Research Fund for the 21st Century," now is the time for the U.S. to make a meaningful investment in research on the infectious diseases of major global health importance identified by USAID's new initiative. DOTS can make a significant impact on the global disease burden, but without an effective TB vaccine, we will not be able to control TB over the long-term. Now that scientists have read the entire genetic code of the TB microbe, the potential for the development of new drugs, diagnostics, and vaccines has never been better. This March, a working group of TB and vaccine experts, convened by Secretary Shalala, met to formulate a national "Blueprint for a Tuberculosis Vaccine," which sets the course for accelerated development of a TB vaccine, but without new funding, this initiative cannot get under way.

Thank you, Mrs. Clinton, for your dedication to the health of the world's population. We hope that you will work with us to significantly increase U.S. commitments to global health.

Sincerely,



Ralph Nader
Steering Committee

Enclosures: informational packet

cc: Mr. Sidney Blumenthal, Dr. Laura Efros, Mr. Tom Friedman, Mr. Leon Fuerth, Mr. David Halperin, Mr. Chris Jennings, Dr. Donald Jordan, Dr. David W. Kampt, Mr. Peter Rundlet, Mr. Eric Schwartz, Mr. Michael Waldman, and Mr. Joel Wilson.

JB

cc: Melanne

FACSIMILE

WORLD HEALTH ORGANIZATION

CH-1211 Geneva 27 - Switzerland
Telegram: UNISANTE GENEVA
Telex: 415416



Tel: +41 (22) 791.2711
Fax: +41(22) 791.
Email: brundtlandg@who.ch
WWW: <http://www.who.ch>

Message No.:

Page 1 of 2 pages

Date: 5 November 1998

From: Office of the Director General
HQ Geneva

To: Office of the First Lady of the United States of
America

Fax No.: (1 202) 456 2883

Our ref.: GTB/T9-370-30

Subject: PERSONAL MESSAGE FROM THE
DIRECTOR-GENERAL FOR KIND
TRANSMISSION TO THE FIRST LADY,
MRS HILLARY RODHAM CLINTON

Dear Mrs Clinton,

Dear Hillary

Thank you for hosting the meeting on Tuberculosis at the White House on 28 October 1998.

I was strongly encouraged by the clear level of commitment among US agencies, the Open Society Institute and the World Bank to accelerating the fight against TB. Strong support and leadership from these institutions, including the National Institutes of Health (NIH), US Agency for International Development (USAID) and Centers for Disease Control and Prevention (CDC), and of course also a number of other partners, are critical to renewed global efforts to combat this preventable disease.

The situation of the present TB control effort is very similar to that of child immunization in the mid-1980s. Basically, technical knowledge existed, a critical mass of people were being trained to implement Expanded Programme on Immunization (EPI) and many countries, mainly small and mid-size, were making good progress. But the progress was very slow in large countries, resulting in a low global immunization coverage.

However, child immunization has achieved the global target in the early 1990s by adding coalition building at global level and country specific social mobilization to the ongoing effort. I believe we can drastically expand coverage of the directly observed treatment, short-course (DOTS) strategy, as well as pursuing new and innovative approaches, by following a similar path.

As we discussed during our meeting, WHO is prepared to give its fullest attention to a renewed attack on TB globally, including a special focus on the situation in the Russian Federation. I have instructed my staff to accelerate the careful preparation of a Stop TB Initiative which will serve to galvanize a broad global coalition of important partners, and to initiate social mobilization in the target countries. As such, WHO welcomes the opportunity to lead this effort. I am delighted that Mr Soros and Mr Wolfensohn have committed to participate in and support this Initiative.

cc: Mr George Soros, Soros Foundation, New York (Fax 1 212 974 0367)
Mr James Wolfensohn, World Bank, Washington (Fax 1 202 522 3031)



A critical first step is a meeting of potential Initiative partners on 28 November 1998 in Bangkok to begin planning for the expansion of the partner base in the fight against TB. This will be important in order to achieve the level of political and economic commitment needed to reverse the grip of this disease in the 22 countries which account for 80% of the world's TB. WHO staff will be working with representatives from the CDC, the World Bank and others to identify appropriate collaborators and secure expanded commitment to this Initiative.

In early 1999, a second meeting of partners is planned. This meeting will serve to build global consensus regarding strategy and direction of the Initiative.

I am confident that by working together through a Stop TB Initiative we will make a difference in mobilizing worldwide commitment required to adequately confront the global TB epidemic. I thank you again for hosting the important meeting last month, your continued interest in global health issues, and the particular support you are giving to WHO and to myself.

Yours sincerely,



Gro Harlem Brundtland, MD, MPH
Director-General

*file with TB*

63
Téléphone Central/Exchange: +41 (22) 791.2111
Direct: 791.2963
Direct fax: 791.4199
E-mail: nunnp@who.ch

In reply refer to: STB-T9/370/30
Prière de rappeler la référence:

Mrs Hillary Rodham Clinton
First Lady of the United States of
America
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500
USA

27 April 1999

Dear Hillary,

Further to our recent meeting and communications regarding the global tuberculosis epidemic, the STOP TB Initiative and specific efforts to assist the government of the Russian Federation to improve the TB control situation, I would like to brief you on the results of recent WHO activities in these areas.

Following our meeting at the White House in October 1998, WHO, on behalf of a growing coalition of partners, launched the STOP TB Initiative. Over the past few months, through generous support from USAID, CDC and others, a Secretariat based in Geneva consisting of staff seconded from WHO and various external partners has been laying the foundations of a global campaign to STOP TB. Its aims are to create greater public demand for action against TB and to stimulate the political leadership necessary to mount an effective response – with special focus on the 22 highest burden countries which account for 80% of the global burden of disease.

To build momentum and draw high level political attention to this campaign, a stream of activities is planned for 1999-2000. These events will serve to bring new partners, including donor agencies, foundations, industry and academia, into the Initiative, and in a stepwise fashion establish the foundation for expanded global action against TB. This includes a "Ministerial Conference to STOP TB" which will be co-organized by STOP TB and the Government of The Netherlands and will be held in The Netherlands in March 2000. This conference will bring together the Ministers of Health as well as Finance, Development or Planning from the highest burden countries to set the stage for expanded country action against TB across sectors of government and society.

An All Partners' Forum is slated for the spring of 2000 with the aim of bringing in a wider range of players into TB control and strengthening the co-ordination between the internal and external TB control organizations working in high TB prevalence countries.

I have welcomed the World Bank and the Soros Foundation as partners in this Initiative and have requested the support of Mr Wolfensohn and Mr Soros for several of these activities. In addition, I have invited the participation of Ms Carol Bellamy (UNICEF) and Mr James Gustave Speth (UNDP) in the STOP TB Initiative in order to ensure wider participation of UN system agencies in the fight against TB.

.../2

cc: Mr G. Soros, Open Society Institute, New York
Mr J. Wolfensohn, World Bank, Washington, D.C.

Our joint efforts to assist the Russian Federation have also progressed since we last met. In early March 1999, a WHO delegation, led by Dr David Heymann, Executive Director of Communicable Diseases, visited Moscow and met with officials at the Ministry of Health, the Russian Academy of Medical Science, the health committee of the DUMA and the Russian Red Cross. During these meetings, an agreement was reached to establish an interdisciplinary group, led by the Ministry of Health and WHO and comprised of Russian and international TB experts, with the objective of developing the best strategy for the control of TB in the Russian Federation.

I was particularly happy regarding this agreement, as it shows significant progress by the government of the Russian Federation in their concern for and political commitment to TB control. We have suggested that the USAID, CDC, the Soros Foundation's Open Society Institute, the World Bank, and other donors assisting the government of the Russian Federation in TB control be invited to join this working group. We are currently in the process of finalising the terms of reference with the Russian Ministry of Health.

I am confident that this working group will facilitate the improvement of TB control in the Russian Federation, make it more cost effective, more accessible to larger populations and provide recommendations on areas such as TB in prisons and the management of drug resistant forms of TB.

Regarding the issue of multiple drug resistance (MDR-TB) in the Russian Federation and other heavily impacted areas of the world, in January 1999 WHO convened a meeting to plan and coordinate a rational, evidence-based approach to this emerging issue. Meeting participants, which included USAID and CDC, agreed to strengthen collaboration on MDR-TB work between institutions and affected communities. WHO was called upon to serve as the coordinating institution to establish a global working group of experts and interested parties, and to serve as the negotiator to facilitate the implementation of pilot projects in settings where MDR-TB is firmly entrenched. It is anticipated that the results from these projects will provide the necessary evidence for policy recommendations to WHO member states facing this complicated health issue.

I thank you for your continued interest in and leadership on global health issues and look forward to communicating more progress on these and other important activities in the months to come.

Yours sincerely,

A handwritten signature in dark ink, appearing to read "Gro H. Brundtland". The signature is fluid and cursive, with the first name "Gro" and last name "Brundtland" clearly distinguishable.

Gro Harlem Brundtland, MD, MPH
Director-General

GEORGE SOROS
ChairmanARYEH NEIER
President

March 3, 1999

Mr. J. Brian Atwood
Administrator
Agency for International Development
1300 Pennsylvania Avenue, N.W.
Room 6.9
Washington, D.C. 20523

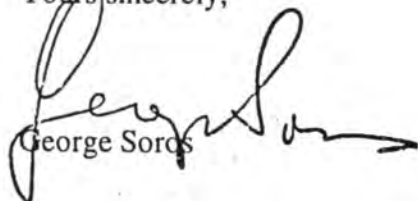
Dear Mr. Atwood,

I want to congratulate you on the decision of US AID to fund a DOTS-Plus pilot project on treatment of multi drug resistant TB in Russia, to be carried out by a team from the U.S. Centers of Disease Control and Prevention.

I was particularly pleased to learn that the city of Ivanovo was chosen as the project site. As you know, a TB control program of the Public Health Research Institute (PHRI), supported by OSI, has been operational in Ivanovo for nearly a year. PHRI has prepared the groundwork for the CDC project and will continue to maintain the infrastructure to support and interact with the CDC team, thus significantly increasing the chances for our joint success.

The complimentary effort by PHRI and CDC which is funded, respectively, by OSI and US AID is a perfect, albeit rare, example of public/private collaboration to address pressing issues of global public health. And it appears to be the first concrete outcome of the meeting that we had last October at the White House. I am looking forward to continued work with you.

Yours sincerely,


George Soros

CC: Hillary Clinton, Donna Shalala, Gro Brundtland, James Wolfensohn,
John Eisenberg, Margaret Hamburg

H 8542

CONGRESSIONAL RECORD—HOUSE

September 6, 1995

gentlemen, the government is beginning to govern and Congress has little, if any, control over the FBI, the ATF, and IRS.

Shame Congress. Clean hands? My assets.

WHAT I LEARNED ON SUMMER VACATION

(Mr. HAYWORTH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HAYWORTH. Mr. Speaker, we might entitle this, "What I Learned on Summer Vacation." The fact is, going back home, we reorient ourselves to the great and good common sense of the American people.

Did I hear uniformity among the constituents of the Sixth District of Arizona? Of course not. Good people can disagree, but overwhelmingly the people of the Sixth District of Arizona told me, "Stay the course, stick to your principles, work hard to reform this government."

Indeed, we have heard today already broad bipartisan consensus, and so in that spirit of bipartisanship, I extend my hand to my friends on this side of the aisle, saying the problems we confront are too great for politics as usual.

Let us get about the business of governing America.

FIRST LADY DESERVES OUR PRAISE

(Mr. RICHARDSON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. RICHARDSON. Mr. Speaker, the First Lady deserves credit, first for going to China, and second for speaking out so forcefully for human rights and women's rights.

The First Lady spoke out eloquently against forced abortions and forced sterilizations and other women's rights abuses common in other countries, such as rape, mutilation, and domestic violence. She also stressed the importance of women to families and the need for setting new standards for women's health, economic welfare, family planning, and the status of women in general.

Mr. Speaker, the First Lady showed guts and commitment in China, and she deserves our praise.

Mr. Speaker, the First Lady has worked continuously on issues related to women, children, and families for the past 25 years. This week she has combined her skills and experiences with the role of diplomat.

Amidst tenuous United States-Chinese relations, the First Lady has walked a fine line in Beijing—balancing the urgent need for women's rights and the administration's policy of constructive engagement with China.

Mrs. Clinton has successfully pointed out the need for a forum of openness of free speech in Beijing. Her remarks underscore the magnitude of the U.N. Women's Conference

and the need for responsible behavior by every member of the international community to confront the oppression that afflicts millions of women.

With the assistance of the U.S. Ambassador to the United Nations, Madeleine Albright, Mrs. Clinton has laid the important groundwork for continued dialog between Secretary of State Christopher and the Chinese Foreign Minister in their upcoming meeting.

Hillary Clinton deserves our gratitude for her efforts which engage China while steadfastly advocating the need for advances in human rights which are necessary for China's genuine integration in the international arena.

OUR COMMITMENT TO GET THE JOB DONE

(Mr. BASS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BASS. Mr. Speaker, I am proud to say that today the House Republicans are ready to finish the job we started 8 months ago. We are ready to balance the budget for the first time in a generation, to help save this country for our children and our grandchildren, and we are ready to pass a plan that will protect, preserve, and strengthen Medicare for our senior citizens.

We are willing to take the heat on this controversial issue to save a broken system that three, I repeat, three of President Clinton's own Cabinet secretaries say needs to be dealt with immediately. We are ready to pass a plan that will help end our country's welfare system that creates poverty, dependency, destitution, breaks up families, and discourages people from working.

We are committed to ending a system that has created debt and has rewarded inefficiency.

We are not afraid to take on the special interests and the status quo here in Washington. In fact, the only ones interested in preserving the old ways are the defenders of the old order who live and breathe inside Route 495 in Washington, DC, and if we learned anything during this August recess, it is that the American people want us to stay the course and continue with this revolution in 1995.

PROTECTING HUMAN RIGHTS OF ALL PEOPLE

(Mr. FRANK of Massachusetts asked and was given permission to address the House for 1 minute and to revise and extend his remarks and include extraneous material.)

Mr. FRANK of Massachusetts. Mr. Speaker, sadly, just before we left for recess, the President of Zimbabwe, Robert Mugabe, engaged in an unjustified wholly prejudicial attack on gay men and lesbian citizens of his country.

The attack was in sharp contrast to the leadership of, for instance, Nelson Mandela, who has included in the Constitution of South Africa, with the sup-

port of that country, protections against discrimination.

I am very pleased to say that at the request of myself and the gentlewoman from California (Ms. WATERS) about 70 Members of this House have joined in sending a letter to Mr. Mugabe objecting strenuously to his bigoted attack on people who simply have a different sexual orientation, noting that this kind of denunciation of people who are decent citizens is contrary to the respect for human rights that we had hoped Mr. Mugabe would show.

I am including at this point in the RECORD the letter and the list of signatures, as follows:

His Excellency ROBERT MUGABE,
President, Harare, Zimbabwe.

DEAR MR. PRESIDENT: We were distressed to read your attack on people who are gay and lesbian.

As Members of Congress dedicated to protecting the human rights of all people, we believe that you are gravely mistaken in your denunciation of people based on their sexual orientation and your assertion that they should be excluded from the protection of their "individual freedom and human rights."

When individuals are mistreated by government because of some basic characteristic of their nature, human rights are violated. Attacking decent individuals who are fully respectful of the rights of others, who are productive and responsible citizens, but who happen to be gay or lesbian is wrong. As strong supporters of the struggle of the people of South Africa against the oppressive, dehumanizing apartheid system, we welcomed the inclusion in the Constitution of South Africa of recognition that discrimination based on an individual's sexual orientation is wrong. We strongly urge you to re-examine this issue and to follow the example of the new government of South Africa in respecting the human rights of all people.

BARNEY FRANK,

Member of Congress.

MAXINE WATERS,

Member of Congress.

COSIGNERS OF THE LETTER TO PRESIDENT ROBERT MUGABE OF ZIMBABWE

Neil Abernethy, MC; Xavier Becerra, MC; George Brown, MC; Ronald Delums, MC; Lloyd Doggett, MC; Anna Eshoo, MC; Elizabeth Furse, MC; Steven Gunderson, MC; Alcee Hastings, MC; Steny Hoyer, MC; Patrick Kennedy, MC; Zoe Lofgren, MC; Edward Markey, MC; Marty Meehan, MC; George Miller, MC; Joseph Moakley, MC; Eleanor Holmes Norton, MC; Frank Pallone, MC; Jack Reed, MC; Martin Sabo, MC; Charles Schumer, MC; Gerry Studds, MC; Melvin Watt, MC; Sidney Yates, MC; Gary Ackerman, MC; Howard Berman, MC; William Clay, MC; Norman Dicks, MC; Richard Durbin, MC; Sam Farr, MC; Sam Gejdenson, MC; Luis Gubler, MC.

Shelia Jackson-Lee, MC; Tom Lantos, MC; Nita Lowey, MC; Jim McDermott, MC; Carrie Meek, MC; Norman Mineta, MC; James Moran, MC; John Oliver, MC; Nancy Pelosi, MC; Lucille Roybal-Allard, MC; Bernard Sanders, MC; David Skaggs, MC; Edolphus Towns, MC; Henry Waxman, MC; Thomas Barrett, MC; Sherwood Boehlert, MC; Peter DeFazio, MC; Julian Dixon, MC; Elliot Engel, MC; Thomas Foglietta, MC; Henry Gonzalez, MC; Jane Harman, MC; Maurice Hinchey, MC; Eddie

September 6, 1995

CONGRESSIONAL RECORD—HOUSE

H8549

Bernice Johnson, MC; John Lewis, MC; Carolyn Maloney, MC; Cynthia McKinney, MC; Kweisi Mfume, MC; Patsy Mink, MC; Jerrold Nadler, MC; Major Owens, MC; Charles Rangel, MC; Bobby Rush, MC; Patricia Schroeder, MC; Louise Slaughter, MC; Nydia Velázquez, MC; Lynn Woolsey, MC.

INTRODUCTION OF THE MOTOR SPORTS PROTECTION ACT

(Mr. FUNDERBURK asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. FUNDERBURK. Mr. Speaker, as you know, North Carolina is the home of professional auto racing and it is on behalf of thousands of North Carolinians and millions of NASCAR, NHRA, and INDY racing fans across America that I introduce the Motor Sports Protection Act today.

Mr. Speaker, Bill Clinton is waging war on the tobacco family. He has threatened the livelihood of thousands of tobacco farmers across the South and he is now on the verge of destroying professional automobile racing as we know it.

The Funderburk bill, which Richard Petty says all race fans can rally around, will stop Bill Clinton before he crosses the finish line. It prevents Big Brother agents from slapping advertising restrictions on the tobacco sponsors of pro racing. Mr. Speaker, each NASCAR alone pumps over \$2 billion into the southern economy. Racing fans are hard-working, law-abiding Americans. They deserve better than to be used as pawns in Bill Clinton's shell-game. Let's send him a message right now: Bill Clinton keep your hands off racing.

Support the Funderburk Motor Sports Protection Act

WOMEN STILL TREATED AS SECOND-CLASS CITIZENS

(Mrs. SCHROEDER asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. SCHROEDER. Mr. Speaker, the United Nations owes the women of the globe a great apology.

Every 10 years there is an international U.N. Women's meeting, and the United Nations could have cared less about what the host did to make this meeting as inconvenient and as awful as possible. In fact, the Secretary General of the United Nations could not even bother to come. He predicted he was going to have a fever all 12 days that this meeting was going to be going on.

Now, the message that sends to all countries is that the United Nations is putting this on only because it is politically correct, but they do not really care, and the Secretary General cannot really bother to come.

I find that tragic, and I am very grateful the First Lady went and tried

to put together anything that we could, because these issues are very, very critical.

There will not be another international meeting for 10 years, and to have allowed China to play with it this way is outrageous.

I think the House leadership owes American women also an apology, because the delegation sent from this body to the women's meeting could not have a woman chair. A woman could only be a cochair. They had to send a male along, too, and one who does not have a good record on women's issues.

I find that very troubling, and the message from all of this is, "Women, our time still has not come yet." When will we be treated as first-class rather than the second-class citizens the United Nations relegated us to as we see this meeting in Beijing proceed?

□ 1220

CAL RIPKEN, JR.'S MANY ACHIEVEMENTS

(Mr. EHRLICH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. EHRLICH. Mr. Speaker, today I rise in tribute to a constituent whose achievement is the talk of the Nation.

Tonight Cal Ripken, Jr., a native of Aberdeen, MD, will play his 2,131st consecutive game with the Baltimore Orioles, breaking a longstanding record held by the legendary Lou Gehrig. It is fitting that Cal is the only player ever to accomplish this feat, because he uniquely represents the qualities for which Lou Gehrig will always be remembered—sportsmanship, fair play, and sheer love of the game.

Fans across the Nation have started calling Cal the Iron Man. But endurance is only one aspect of his success. He was Rookie of the Year in 1982; MVP in 1983 and 1991; and played in 13 consecutive All-Star games. He has hit more home runs than any shortstop in major league history.

Despite his fame, Cal Ripken takes precious time before and after every game to sign autographs, pose for pictures, or simply to chat with his fans—the way Babe Ruth, Lou Gehrig, and Jackie Robinson once did. At a time when many fans are disillusioned by the big-business approach to baseball, Cal's sincere passion for the sport reminds us of a time when baseball was what it was always meant to be—a game.

I urge all my colleagues to join with me and the citizens of Maryland as we salute Cal Ripken, Jr. His accomplishment is a timely illustration of what is best about our national pastime.

NOW 71 PERCENT OF AMERICANS DO NOT TRUST REPUBLICANS TO HANDLE MEDICARE

(Ms. DELAURO asked and was given permission to address the House for 1

minute and to revise and extend her remarks.)

Ms. DELAURO. Mr. Speaker, over the August break, I had a chance to meet with my constituents to discuss the Republican plan to cut Medicare in order to finance a tax cut for the wealthy. The people I represent want me to bring a message back to the Republican leadership: Medicare is a trust fund, not a slush fund.

Now, I know that my Republican colleagues were also back home trying to sell themselves as the true protectors of Medicare. But, the American public isn't buying this GOP makeover. The public is skeptical about the sketchy GOP plan that claims private insurance companies will offer seniors more for less. With such fantastic claims, it's no wonder that a recent poll found 71 percent of Americans have little trust in the House Republicans to handle Medicare.

For 30 years Republicans have wanted to privatize Medicare. In fact, the current majority leader has said that he would have no part of Medicare in a free world. Does that sound like a party that wants to protect Medicare?

THERE IS MORE TO DO

(Mr. RADANOVICH asked and was given permission to address the House for 1 minute.)

Mr. RADANOVICH. Mr. Speaker, this 104th Congress now moves forward from the Contract With America. And, "move" must be the operative word.

The lesson learned in our August recess is that the public wants action not words. Everywhere I went, men and women said, "Congressman, we'd sooner have you moving ahead * * * even if the path is rough and you stumble occasionally * * * don't let Congress just stand there."

America bought in to our program. They approve our commitment to a balanced budget. They like outting back the bureaucracy. They commend term limits.

Most of this we delivered in this House. Yet, there is more to do here on the Hill, and I urge the Senate to heed the call.

Let us get down to business, but let us make sure it is dealing with unfinished business, not business as usual.

REPUBLICANS TAKING THE CARE OUT OF MEDICARE

(Mr. ENGEL asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. ENGEL. Mr. Speaker, I rise today on behalf of my mother, Seroy Engel, and the millions of mothers, fathers, sisters, and brothers throughout our Nation whose lives depend on Medicare. In the next few weeks this legislative body is going to have to make some tough decisions. The question will be will we let the Republicans take the care out of Medicare. I say, "No."

H8550

CONGRESSIONAL RECORD—HOUSE

September 6, 1995

bill. If we are going to vote, to put Congress first and make sure Congress does not have to shut down and take the same lumps that the rest of the Federal Government and the rest of the public does, at least give the public lobby reform. Let us vote on lobby reform today. It is very easy and it is very, very simple. Ban the trips, ban the gifts, ban the free meals.

Mr. Speaker, I have taken the lobby reform pledge. I have voluntarily taken on and agreed to abide by the provisions of the lobby reform package, even though it is not the law. This House can do the same thing today. Therefore, I would just call upon the Republican leadership and the Speaker, first of all, to schedule something else. Get some other bills moving that mean something to the public besides Congress' appropriation.

The second thing: If we are going to bring Congress' appropriation to the floor today, please put lobby reform on it. End the free trips, end the junkets, end the meals, end the guests, end the bad perception. Bring some reform to this Congress.

Finally, third, if I could just get time for one more, Mr. Speaker, could we do campaign finance reform? We have heard a lot of talk about it. There was a great handshake out there in New Hampshire 8 to 10 months ago; but how about real campaign finance reform to make it easier for challengers? I voluntarily agreed to limit the campaign spending that I do. I voluntarily take the voluntary campaign pledge that our Secretary of State in West Virginia issues every election season. Congress, though, ought to be willing to pass this for the entire country, and so make it easier for challengers, make it easier for the public, and make sure that the money chase ends.

Finally, Mr. Speaker, let me just urge the Members today, do not make the first thing Congress does when it comes back into session to pass its own bill for its own appropriation to feather its own nest. If we are going to do that, Mr. Speaker, I would urge, please let us have lobby reform: End the trips, end the junkets, end the free meals, and finally begin to restore some faith in this congressional system, and particularly, in this House of Representatives.

✓ COMMENDING HILLARY CLINTON AND MADELEINE ALBRIGHT FOR STRONG STATEMENTS ON HUMAN RIGHTS DURING THE U.N. FOURTH WORLD CONFERENCE ON WOMEN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Ms. PELOSI] is recognized for 5 minutes.

Ms. PELOSI. Mr. Speaker, I appreciate the opportunity to address the House on this very important day. I rise to commend First Lady Hillary Clinton and our Ambassador to the United Nations, Ambassador Madeleine Albright, for the strong statements

that they made at the U.N. Fourth World Conference on Women. Mr. Speaker, I rise as one who opposed Beijing as the venue for this important conference. I still think it was a most unfortunate choice.

I rise as one who does not think that the United Nations has been strong enough in enforcing its own rules in terms of open participation for women in the conference. The United Nations did not do enough, whether we are talking about the accreditation of women from Taiwan and Tibet, or women who are concerned about women's and human rights in those countries. The United Nations did not do enough in regard to people that the Chinese just did not want into that conference because their countries recognize Taiwan; for example, the representatives from Niger.

However, Mr. Speaker, what I really want to call to the attention of our colleagues are the strong statements made by the two leaders of our delegation. I strongly supported a high-powered delegation to the Beijing conference. I strenuously opposed the attendance by First Lady Hillary Rodham Clinton. I did so because I thought it was not possible for her to attend the conference and make the strong statement that she made.

Indeed, Hillary Rodham Clinton's statements, are the strongest statements made on human rights in China, in Asia, and in the world by this administration to date. I am very, very proud that the women of the Clinton administration are taking such a strong stand on this very important issue.

The First Lady, in Beijing, very courageously stood up and broke the silence on sterilization and forced abortions in a country where that is the policy. Therefore, I say in the spirit of commendation to the First Lady and to Ambassador Albright that when they said they would not mince words when they went to China, that they would make the statements that would be necessary, they, indeed, did. I commend them for that.

It is shameful, I think, that such an important conference on the rights of women and the economic future of women and families was held in a country with such an appalling human rights record. The strong statements of these members of the U.S. delegation made it clear that our Nation must not waiver from its commitment to personal and political freedom to equal rights and equal opportunity.

The First Lady, in her remarks, was eloquent in her defense of the principles of women's rights and human rights, and she spent a great deal of her time talking about how advancing women's rights would strengthen families throughout the world. She emphasized how that strengthening families, building families, was what was important in strengthening societies throughout the world.

The First Lady reaffirmed and supported the conference's main themes of economic and educational opportunity, health care, and protecting women against violence. Again, the First Lady and the Ambassador did not mince words of protest over repression, ignorance, abuse, and torture while the Chinese Government looked on. We have been told that the Chinese Government has not reported on the First Lady's speech, but we do know that the word will get out.

As one who has opposed the First Lady's attendance, I want to commend her for her outstanding courage for breaking the silence on human rights in China, for breaking the silence on sterilization and forced abortion in China. There are many in this body who opposed the conference itself. I do not include myself among them, because I believe that the conference is a very important one. I think that some of those who opposed the conference and opposed the First Lady's attendance did so because of China's forced abortion policy.

I look forward to working with those colleagues, as some of us have been working together in the Subcommittee on Foreign Relations of the Committee on Appropriations and in other committees of this House, to improve the lot of the women in the world by improving their health. The First Lady talked about women's health, she talked about violence against women, she talked about child survival, she talked about the spread of AIDS and how rapidly it is spreading among women in the developing countries.

I look forward to continuing my work with our colleagues on this subject, and certainly working with the Clinton administration on those areas where more common ground has now been laid by the First Lady, and where more opportunity has been presented by this very important conference which called attention to these issues.

With that, Mr. Speaker, I am very proud to place into the RECORD the two statements, by First Lady Hillary Rodham Clinton to the United Nations Fourth World Conference on Women, and the remarks before the World Health Organization, as well as the statement of our Ambassador to the United Nations, Ambassador Madeleine Albright. She was a great participant in the conference, she represented our country very excellently, as she always does. I am very pleased to put Ambassador Albright's very strong statement on human rights, indeed, basic freedoms for all people, men and women, in the RECORD of this Congress.

The material referred to follows:

AMBASSADOR MADELEINE K. ALBRIGHT, U.S. PERMANENT REPRESENTATIVE TO THE UNITED NATIONS—REMARKS TO THE FOURTH WORLD CONFERENCE ON WOMEN

BEIJING INTERNATIONAL CONVENTION CENTER, BEIJING, CHINA, SEPTEMBER 6, 1995

Honored guests, fellow delegates and observers, I am pleased and proud to address this historic conference on behalf of the United States of America.

September 6, 1995

CONGRESSIONAL RECORD—HOUSE

H8551

My government congratulates the thousands who have helped to organize the conference, to draft the Platform for Action, to inform the world about the subjects under discussion here and to encourage wide participation both by governments and NGOs.

We have come here from all over the world to carry forward an age-old struggle: the pursuit of economic and social progress for all people, based on respect for the dignity and value of each.

We are here to promote and protect human rights and to stress that women's rights are neither separable nor different from those of men.

We are here to stop sexual crimes and other violence against women; to protect refugees, so many of whom are women; and to end the despicable notion—in this era of conflicts—that rape is just another tactic of war.

We are here to empower women by enlarging their role in making economic and political decisions, an idea some find radical, but which my government believes is essential to economic and social progress around the world; because no country can develop if half its human resources are de-valued or repressed.

We are here because we want to strengthen families, the heart and soul of any society. We believe that girls must be valued to the same degree as boys. We believe, with Pope John Paul II, in the "equality of spouses with respect to family rights". We think women and men should be able to make informed judgments as they plan their families. And we want to see forces that weaken families—including pornography, domestic violence and the sexual exploitation of children—condemned and curtailed.

Finally, we have come to this conference to assure for women equal access to education and health care, to help women protect against infection by HIV, to recognize the special needs and strengths of women with disabilities, and to attack the root causes of poverty, in which so many women, children and men are entrapped.

We have come to Beijing to make further progress towards each of these goals. But real progress depend not on what we say here, but on what we do after we leave here. The Fourth World Conference for Women is not about conversations; it is about commitments.

For decades, my nation has led efforts to promote equal rights for women. Women in their varied roles—as mothers, farm laborers, factory workers, organizers and community leaders helped build America. My government is based on principles that recognize the right of every person to equal rights and equal opportunity. Our laws forbid discrimination on the basis of sex and we work hard to enforce those laws. A rich network of nongovernmental organizations has blossomed within our borders, reaching out to women and girls from all segments of society, educating, counseling and advocating change.

The United States is a leader, but leaders cannot stand still. Barriers to the equal participation of women persist in my country. The Clinton Administration is determined to bring those barriers down.

Today, in the spirit of this conference, and in the knowledge that concrete steps to advance the status of women are required in every nation, I am pleased to announce the new commitments my government will undertake:

First, President Clinton will establish a White House Council on Women to plan for the effective implementation within the United States of the Platform for Action. That Council will build on the commitments made today and will work every day with the nongovernmental community.

Second, in accordance with recently-approved law, the Department of Justice will launch a six-year, \$1.6 billion initiative to fight domestic violence and other crimes against women. Funds will be used for specialized police and prosecution units and to train police, prosecutors and judicial personnel.

Third, our Department of Health and Human Services will lead a comprehensive assault on threats to the health and security of women—promoting healthy behavior, increasing awareness about AIDS, discouraging the use of cigarettes, and striving to win the battle against breast cancer.

And, as Mrs. Clinton made clear yesterday, the United States remains firmly committed to the reproductive health rights gains made in Cairo.

Fourth, our Department of Labor will conduct a grassroots campaign to improve conditions for women in the workplace. The campaign will work with employers to develop more equitable pay and promotion policies and to help employees balance the twin responsibilities of family and work.

Fifth, our Department of the Treasury will take new steps to promote access to financial credit for women. Outstanding U.S. microenterprise lending organizations will be honored through special Presidential awards and we will improve coordination of federal efforts to encourage growth in this field of central importance to the economic empowerment of women.

Sixth, the Agency for International Development will continue to lead in promoting and recognizing the vital role of women in development. Today, we announce important initiatives to increase women's participation in political processes and to promote the enforcement of women's legal rights.

There is a seventh and final commitment my country is making today. We, the people and government of the United States of America, will continue to speak out openly and without hesitation on behalf of the human rights of all people.

My country is proud that, nearly, a half century ago, Eleanor Roosevelt, a former First Lady of the United States, helped draft the Universal Declaration of Human Rights. We are proud that, yesterday afternoon, in this very hall, our current First Lady—Hillary Rodham Clinton—re-stated with memorable eloquence our national commitment to that Declaration.

The Universal Declaration reflects spiritual and moral tenets which are central to all cultures, encompassing both the wondrous diversity that defines us and the common humanity that binds us. It obliges each government to strive in law and practice to protect the rights of those under its jurisdiction. Whether a government fulfills that obligation is a matter not simply of domestic, but of universal, concern. For it is a founding principle of the United Nations that no government can hide its human rights record from the world.

At the heart of the Universal Declaration is a fundamental distinction between coercion and choice.

No woman—whether in Birmingham, Bombay, Beirut or Beijing—should be forcibly sterilized or forced to have an abortion.

No mother should feel compelled to abandon her daughter because of a societal preference for males.

No woman should be forced to undergo genital mutilation, or to become a prostitute, or to enter into marriage or to have sex.

No one should be forced to remain silent for fear of religious or political persecution, arrest, abuse or torture.

All of us should be able to exercise control over the course of our own lives and be able to help shape the destiny of our communities and countries.

Let us be clear. Freedom to participate in the political process of our countries is the inalienable right of every woman and man. Deny that right, and you deny everything.

It is unconscionable, therefore, that the right to free expression has been called into question right here, at a conference conducted under the auspices of the UN and whose very purpose is the free and open discussion of women's rights.

And it is a challenge to us all that so many countries in so many parts of the world—north, south, west and east—fall far short of the noble objectives outlined in the Platform for Action.

Every nation, including my own, must do better and do more—to make equal rights a fundamental principle of law; to enforce those rights and to remove barriers to the exercise of those rights.

That is why President Clinton has made favorable action on the Convention to Eliminate Discrimination Against Women a top priority. The United States should be a party to that Convention.

And it is why we will continue to seek a dialogue with governments—here and elsewhere—that deny to their citizens the rights enumerated in the Universal Declaration.

In preparing for this conference, I came across an old Chinese poem that is worth recalling, especially today, as we observe the Day of the Girl-Child. In the poem, a father says to his daughter:

We keep a dog to watch the house,

A pig is useful, too.

We keep a cat to catch a mouse.

But what can we do with a girl like you?

Fellow delegates, let us make sure that question never needs to be asked again—in China or anywhere else around the world.

Let us strive for the day when every young girl, in every village and metropolis, can look ahead with confidence that their lives will be valued, their individually recognized, their rights protected and their futures determined by their own abilities and character.

Let us reject outright the forces of repression and ignorance that have held us back; and act with the strength and optimism unity can provide.

Let us honor the legacy of the heroines, famous and unknown who struggled in years past to build the platform upon which we now stand.

And let us heed the instruction of our own lives. Look around this hall, and you will see women who have reached positions of power and authority. Go to Hualou, and you will see an explosion of energy and intelligence devoted to every phase of struggle. Enter any community in any country, and you will find women insisting—often at great risk—on their right to an equal voice and equal access to the levers of power.

This past week, on video at the NGO Forum, Aung San Sun Kyi, said that "it is time to apply in the arena of the world the wisdom and experience" women have gained.

Let us all agree; it is time. It is time to turn bold talk into concrete action.

It is time to unleash the full capacity for production, accomplishment and the enrichment of life that is inherent to us—the women of the world.

Thank you very much.

FIRST LADY HILLARY RODHAM CLINTON—REMARKS FOR THE WORLD HEALTH ORGANIZATION FORUM ON WOMEN AND HEALTH SECURITY

BEIJING, CHINA, SEPTEMBER 5, 1995

Thank you, Dr. Nakajima.

Dr. Nakajima, Dr. Sadik, Gertrude Mongella, delegates to the Fourth U.N. Conference on Women, and guests from all corners of the world, I am honored to be here

H8552

CONGRESSIONAL RECORD—HOUSE

September 6, 1995

this morning among women and men who are committed to improving the health of women and girls everywhere.

I commend the World Health Organization for making women's health a top priority and for establishing the Global Commission on Women's Health.

I am proud that in the preparatory meeting for this Fourth World Conference on Women, the United States took the lead in highlighting the importance of a comprehensive approach to women's health. That approach builds on actions taken at previous women's conferences and the recent conferences at Cairo and Copenhagen, whose goals to promote the health and well-being of all people were endorsed by 180 nations.

Cairo was particularly significant as governmental and non-governmental participants worked together to craft a Program for Action which, among other things, calls for universal access to good quality reproductive health care services, including safe, effective, voluntary family planning; greater access to education and health care; more responsibility on the part of men in sexual and reproductive health and childbearing; and reduction of wasteful resource consumption.

Here at this conference, improving girls and women's health is a priority of the draft Platform for Action. It includes such goals as: Access to universal primary health care for all people—a goal not yet achieved in many countries, including my own. The promotion of breast feeding. The provision of safe drinking water and sanitation. Research in and attention to women's health issues, including: environmental hazards, prevention of HIV/AIDS and other sexually transmitted diseases, encouragement for adolescents to postpone sexual activity and childbearing, and discouragement of cultural traditions and customs that deny food and health care to girls and women.

Goals such as these illustrate a new commitment to the well-being of girls and women and a belief in their rights to live up to their own God-given potentials.

At long last, people and their governments everywhere are beginning to understand that investing in the health of women and girls is as important to the prosperity of nations as investing in the development of open markets and trade. The health of women and girls cannot be divorced from progress on other economic and social issues.

Scientists, doctors, nurses, community leaders and women themselves are working to improve and safeguard the health of women and families all over the world. If we join together as a global community, we can lift up the health and dignity of all women and their families in the remaining years of the 20th century and on into the next millennium.

Yet, for all the promise the future holds, we also know that many barriers lie in our way. For too long, women have been denied access to health care, education, economic opportunities, legal protection and human rights—all of which are used as building blocks for a healthy and productive life.

In too many places today, the health of women and families is compromised by inadequate, inaccessible and unaffordable medical care, lack of sanitation, unsafe drinking water, poor nutrition, insufficient research and education about women's health issues, and coercive and abusive sexual practices.

In too many places, the status of woman's health is a picture of human suffering and pain. The faces in that picture are of girls and women who, but for the grace of God or the accident of birth, could be us or one of our sisters, mothers or daughters.

Today, at least fifteen percent of pregnant women suffer life threatening complications and more than one-half million women

around the world die in childbirth. Most of those deaths could be prevented with basic primary, reproductive and emergency obstetric health care. In some places, there are 175,000 motherless children for every one million families. Many of those children don't survive. And of those who do, many are recruited into a life of exploitation on the streets of our world's cities, subjected daily to abuse, indignity, disease, and the specter of early death.

There must be a renewed commitment to improving maternal health. The WHO launched in 1987 a Safe Motherhood Initiative to halve maternal mortality by the year 2000. To reach that goal, more attention must be paid to emergency medical care as well as primary prenatal care. Providing emergency obstetric care is a relatively cheap way of saving lives—and along with family planning services is among the most cost effective interventions in even the poorest of countries.

The commitment of the WHO and its Global Commission on Women's Health to make childbearing and childbirth a safe and healthy period of every woman's life deserves action on the part of every nation represented here.

One hundred million women cannot obtain or are not using family planning services because they are poor, uneducated or lack access to care. Twenty million of these women will seek unsafe abortions—some will die, some will be disabled for life. A growing number of unwanted pregnancies are occurring among young women, barely beyond childhood themselves. As we know, when children have children, the chances of schooling, jobs, and good health is reduced for both parent and child. And our progress as a human family takes another step back.

The Cairo document recognizes "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so." Women should have the right to health care that will enable them to go safely through pregnancy and childbirth and provide them with the best chance of having a healthy infant.

Women and men must also have the right to make those most intimate of all decisions free of discrimination, coercion and violence, particularly any coercive practices that force women into abortions or sterilizations.

On these issues, the US supports the provisions in the Beijing Platform for Action that reaffirm consensus language that was agreed to at the Cairo Conference about a year ago. It declared that "in no case should abortion be promoted as a method of family planning." The Platform asks governments "to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services."

Violence against women remains a leading cause of death among girls and women between the ages of 14 and 44—violence from ethnic and religious conflicts, crime in the streets and brutality in the home. For women who survive the violence, what often awaits them is a life of unrelenting physical and emotional pain that destroys their capacity for mothering, homemaking or working and can lead to substance abuse, and even suicide.

Violence against girls and women goes beyond the beatings, rape, killings and forced prostitution that arise from poverty, wars and domestic conflicts. Every day, more than 5,000 young girls are forced to endure the brutal practice of genital mutilation. The procedure is painful and life-threatening. It is degrading. And it is a violation of

the physical integrity of a woman's body, leaving a lifetime of physical and emotional scars.

HIV, AIDS, and sexually transmitted diseases threaten more and more women—and experts predict that by the end of this decade more than half of the people in the world with HIV will be women. AIDS, which threatens whole families and regions, demands the strongest possible response. Governments and the international community must address head-on the growing number of women who are being infected.

More than 700,000 women worldwide face breast cancer each year—and over 300,000 die of it. It's the leading cause of death for women in their prime in the developed world. In the time I speak to you today, 26 women around the world will die of breast cancer. In my own country, it is hard to find a family, an office, or a neighborhood that has not been touched by this disease. My mother-in-law struggled against breast cancer for four years before losing her battle.

Tobacco use is the number one preventable cause of death. Ninety percent of women who smoke began to smoke as adolescents—leading to high rates of heart disease, cancer, and chronic lung disease later in life.

As the WHO points out, we also need to recognize and effectively address the fact that women are far more likely to be exposed to work-related and environmental health hazards. Policies to alleviate and eliminate such health hazards associated with work in the home and in the workplace demand action.

Research also indicates that certain communicable diseases affect women in greater numbers. Tuberculosis, for example, is responsible for the deaths of one million women each year and those in their early and reproductive years are most vulnerable.

When health care systems around the world don't work for women: when our mothers, daughters, sisters, friends and coworkers are denied access to quality care because they are poor, do not have health insurance, or simply because they are women, it is not just their health that is put at risk. It is the health of their families and communities as well.

Like many nations, the United States brings to this conference a serious commitment to improving women's health. We bring with us a series of initiatives which represent the first steps to carrying out this Conference's Platform for Action.

We are continuing to work for health care reform to ensure that every citizen has access to affordable, quality care.

We are proposing a comprehensive and coordinated plan to reduce smoking by children and adolescents by 50 percent.

We are working to address the many factors that contribute to teenage pregnancy, our most serious social problems, by encouraging abstinence and personal responsibility on the part of young men and women; improving access to health care and family planning services; and supporting health education in our schools.

We are pursuing a public policy agenda on HIV/AIDS that is specific to women, adolescents, and children.

We are continuing to fund and conduct contraceptive research and development.

We are addressing the health needs of women through initiatives such as:

The National Action Plan on Breast Cancer—a public, private partnership working with all agencies of government, the media, scientific organizations, advocacy groups and industry to advance breast health and eradicate breast cancer as a threat to the lives of American women.

An Expansion of the National Breast and Cervical Cancer Early Detection Program—

September 6, 1995

CONGRESSIONAL RECORD — HOUSE

H8553

which will ensure that women who need regular screening and detection services have access to them, and that those services meet quality standards.

The inclusion of women in clinical trials for research and testing of drugs or other interventions that probe specific differences between men and women in patterns of disease and reactions to therapy.

The special health needs of older women will be addressed through educational campaigns about osteoporosis, cancer and other diseases.

And the US is conducting the largest clinical research study ever undertaken to examine the major causes of death, disability and frailty in post-menopausal women.

Women's health security must be a priority of all people and governments working together. Without good health, a woman's God-given potential can never be realized. And without healthy women, the world's potential can never be realized.

So let us join together to ensure that every little boy and girl that comes into our world is healthy and wanted, that every young woman has the education and economic opportunity to live a healthy life; and that every woman has access to the health care she needs throughout her life to fulfill her potential in her family, her work, and her community.

If we care about the futures of our daughters, our sons, and the generations that will follow them, we can do nothing less.

Thank you for the work you do every day to bring better health to the women, children, and families of this world. Thank you for helping governments and citizens around the world understand that we cannot talk about equality and social development without also talking about health care.

Most of all, thank you for being part of this historic and vital discussion, which holds so much promise for our future.

FIRST LADY HILLARY RODHAM CLINTON—REMARKS FOR THE UNITED NATIONS FOURTH WORLD CONFERENCE ON WOMEN

BEIJING, CHINA, SEPTEMBER 5, 1995

Mrs. Mongella, distinguished delegates and guests:

I would like to thank the Secretary General of the United Nations for inviting me to be part of the United Nations Fourth World Conference on Women. This is truly a celebration—a celebration of the contributions women make in every aspect of life: in the home, on the job, in their communities, as mothers, wives, sisters, daughters, learners, workers, citizens and leaders.

It is also a coming together, much the way women come together every day in every country.

We come together in fields and in factories, in village markets and supermarkets, in living rooms and board rooms.

Whether it is while playing with our children in the park, or washing clothes in a river, or taking a break at the office water cooler, we come together and talk about our aspirations and concerns. And time and again, our talk turns to our children and our families.

However different we may be, there is far more that unites us than divides us. We share a common future. And we are here to find common ground so that we may help bring new dignity and respect to women and girls all over the world—and in so doing, bring new strength and stability to families as well.

By gathering in Beijing, we are focusing world attention on issues that matter most in the lives of women and their families: access to education, health care, jobs, and credit, the chance to enjoy basic legal and

human rights and participate fully in the political life of their countries.

There are some who question the reason for this conference. Let them listen to the voices of women in their homes, neighborhoods, and workplaces.

There are some who wonder whether the lives of women and girls matter to economic and political progress around the globe. Let them look at the women gathered here and at Helrou... the home-makers, nurses, teachers, lawyers, policy-makers, and women who run their own businesses.

It is conferences like this that compel governments and peoples everywhere to listen, look and face the world's most pressing problems.

Wasn't it after the women's conference in Nairobi ten years ago that the world focused for the first time on the crisis of domestic violence?

Earlier today, I participated in a World Health Organization forum, where government officials, NGOs, and individual citizens are working on ways to address the health problems of women and girls.

Tomorrow, I will attend a gathering of the United Nations Development Fund for Women. There, the discussion will focus on local—and highly successful—programs that give hard-working women access to credit so they can improve their own lives and the lives of their families.

What we are learning around the world is that, if women are healthy and educated, their families will flourish. If women are free from violence, their families will flourish. If women have a chance to work and earn as full and equal partners in society, their families will flourish.

And when families flourish, communities and nations will flourish.

That is why every woman, every man, every child, every family, and every nation on our planet has a stake in the discussion that takes place here.

Over the past 25 years, I have worked persistently on issues relating to women, children and families. Over the past two-and-a-half years, I have had the opportunity to learn more about the challenges facing women in my own country and around the world.

I have met new mothers in Jakarta, Indonesia, who come together regularly in their village to discuss nutrition, family planning, and baby care.

I have met working parents in Denmark who talk about the comfort they feel in knowing that their children can be cared for in creative, safe, and nurturing after-school centers.

I have met women in South Africa who helped lead the struggle to end apartheid and are now helping build a new democracy.

I have met with the leading women of the Western Hemisphere who are working every day to promote literacy and better health care for the children of their countries.

I have met women in India and Bangladesh who are taking out small loans to buy milk cows, rickshaws, thread and other materials to create a livelihood for themselves and their families.

I have met doctors and nurses in Belarus and Ukraine who are trying to keep children alive in the aftermath of Chernobyl.

The great challenge of this conference is to give voice to women everywhere whose experiences go unnoticed, whose words go unheard.

Women comprise more than half the world's population. Women are 70 percent of the world's poor, and two-thirds of those who are not taught to read and write.

Women are the primary caretakers for most of the world's children and elderly. Yet

much of the work we do is not valued—not by economists, not by historians, not by popular culture, not by government leaders.

At this very moment, as we sit here, women around the world are giving birth, raising children, cooking meals, washing clothes, cleaning houses, planting crops, working on assembly lines, running companies, and running countries.

Women also are dying from diseases that should have been prevented or treated; they are watching their children succumb to malnutrition caused by poverty and economic deprivation; they are being denied the right to go to school by their own fathers and brothers; they are being forced into prostitution, and they are being barred from the ballot box and the bank lending office.

Those of us who have the opportunity to be here have the responsibility to speak for those who could not.

As an American, I want to speak up for women in my own country—women who are raising children on the minimum wage, women who can't afford health care or child care, women whose lives are threatened by violence, including violence in their own homes.

I want to speak up for mothers who are fighting for good schools, safe neighborhoods, clean air and clean airwaves... for older women, some of them widows, who have raised their families and now find that their skills and life experiences are not valued in the workplace... for women who are working all night as nurses, hotel clerks, and fast food chefs so that they can be at home during the day with their kids... and for women everywhere who simply don't have time to do everything they are called upon to do each day.

Speaking to you today, I speak for them, just as each of us speaks for women around the world who are denied the chance to go to school, or see a doctor, or own property, or have a say about the direction of their lives, simply because they are women.

The truth is that most women around the world work both inside and outside the home, usually by necessity.

We need to understand that there is no formula for how women should lead their lives. That is why we must respect the choices that each woman makes for herself and her family. Every woman deserves the chance to realize her God-given potential.

We also must recognize that women will never gain full dignity until their human rights are respected and protected.

Our goals for this conference, to strengthen families and societies by empowering women to take greater control over their own destinies, cannot be fully achieved unless all governments—here and around the world—accept their responsibility to protect and promote internationally recognized human rights.

The international community has long acknowledged—and recently affirmed at Vienna—that both women and men are entitled to a range of protections and personal freedoms, from the right of personal security to the right to determine freely the number and spacing of the children they bear.

No one should be forced to remain silent for fear of religious or political persecution, arrest, abuse or torture.

Tragically, women are most often the ones whose human rights are violated. Even in the late 20th century, the rape of women continues to be used as an instrument of armed conflict. Women and children make up a large majority of the world's refugees. And when women are excluded from the political process, they become even more vulnerable to abuse.

I believe that, on the eve of a new millennium, it is time to break our silence. It is

H 8554

CONGRESSIONAL RECORD—HOUSE

September 6, 1995

time for us to say here in Beijing, and the world to hear, that it is no longer acceptable to discuss women's rights as separate from human rights.

These abuses have continued because, for too long, the history of women has been a history of silence. Even today, there are those who are trying to silence our words.

The voices of this conference and of the women at Hailou must be heard loud and clear:

It is a violation of human rights when babies are denied food, or drowned, or suffocated, or their spines broken, simply because they are born girls.

It is a violation of human rights when women and girls are sold into the slavery of prostitution.

It is a violation of human rights when women are doused with gasoline, set on fire and burned to death because their marriage dowries are deemed too small.

It is a violation of human rights when individual women are raped in their own communities and when thousands of women are subjected to rape as a tactic or prize of war.

It is a violation of human rights when a leading cause of death worldwide among women ages 14 to 44 is the violence they are subjected to in their own homes.

It is a violation of human rights when young girls are brutalized by the painful and degrading practice of genital mutilation.

It is a violation of human rights when women are denied the rights to plan their own families, and that includes being forced to have abortions or being sterilized against their will.

If there is one message that echoes forth from this conference, it is that human rights are women's rights. . . . And women's rights are human rights.

Let us not forget that among those rights are the right to speak freely. And the right to be heard.

Women must enjoy the right to participate fully in the social and political lives of their countries if we want freedom and democracy to thrive and endure.

It is indefensible that many women in non-governmental organizations who wished to participate in this conference have not been able to attend—or have been prohibited from fully taking part.

Let me be clear. Freedom means the right of people to assemble, organize, and debate openly. It means respecting the views of those who may disagree with the views of their governments. It means not taking citizens away from their loved ones and jailing them, mistreating them, or denying them their freedom or dignity because of the peaceful expression of their ideas and opinions.

In my country, we recently celebrated the 75th anniversary of women's suffrage. It took 150 years after the signing of our Declaration of Independence for women to win the right to vote. It took 72 years of organized struggle on the part of many courageous women and men.

It was one of America's most divisive philosophical wars. But it was also a bloodless war. Suffrage was achieved without a shot fired.

We have also been reminded, in V-J Day observances last weekend, of the good that comes when men and women join together to combat the forces of tyranny and build a better world.

We have seen peace prevail in most places for a half century. We have avoided another world war.

But we have not solved older, deeply-rooted problems that continue to diminish the potential of half the world's population.

Now it is time to act on behalf of women everywhere.

If we take bold steps to better the lives of women we will be taking bold steps to better the lives of children and families too. Families rely on mothers and wives for emotional support and care; families rely on women for labor in the home; and increasingly, families rely on women for income needed to raise healthy children and care for other relatives.

As long as discrimination and inequities remain so commonplace around the world—as long as girls and women are valued less, fed less, fed last, overworked, underpaid, not schooled and subjected to violence in and out of their homes—the potential of the human family to create a peaceful, prosperous world will not be realized.

Let this conference be our—and the world's—call to action.

And let us heed the call so that we can create a world in which every woman is treated with respect and dignity, every boy and girl is loved and cared for equally, and every family has the hope of a strong and stable future.

Thank you very much.

God's blessing on you, your work and all who will benefit from it.

THE B-2 BOMBER AND AMERICA'S READINESS

The SPEAKER pro tempore (Mr. EVERETT). Under a previous order of the House, the gentleman from Washington [Mr. DICKS] is recognized for 5 minutes.

Mr. DICKS. Mr. Speaker, today I want to address the House of Representatives in this special order on a very important issue that will come before the House tomorrow morning, tomorrow afternoon, when we consider the defense appropriations bill. Since 1980, I have been a strong supporter of the policy of former President Carter and Secretary of Defense Harold Brown in initiating the stealth bomber, the B-2 program.

In the Gulf war, we saw with vivid evidence the effectiveness of stealth technology when it was decided to use the F-117's against the most heavily defended targets inside Saddam Hussein's Iraq. The F-117's, without the requirement for jammers and other support aircraft, were able to go in and attack the most heavily defended targets, using 2,000 pound precision-guided munitions. They were able to knock out those radars and surface to air missiles almost instantly, and come back without our pilots being shot down.

I believe that the B-2 bomber is just a bigger and better version of the F-117. It allows us to go five times as far and carry eight times as much conventional munitions and submunitions. With those same 2,000 pounds, it could carry 16, each of which would be independently targetable.

I think the most revolutionary thing about stealth technology is its capability against mobile targets. In a B-2 study that was done by Rand back in 1991, a simulation was used of Saddam Hussein's division, moving from Saudi Arabia into Kuwait. The B-2 was loaded up with sensor-fused weapons. Each B-2 could carry about 1,400 of these submunitions that look like a puck with a parachute on top when dispensed. With Saddam's division coming

into Kuwait, three B-2's interdicted it, dropped the sensor-fused weapons, and were able to knock out 46 percent of the mechanized vehicles including tanks in that division. That, Mr. Speaker, is a revolutionary conventional capability.

The problem is that every study that has been done on the B-2 indicates that having only 16 of them is simply not enough. The Rand study and the study that was done by Gen. Jasper Welch, stated that somewhere between 40 and 60 are needed. I in fact asked General Powell what he recommended to Dick Cheney, and he said, "I recommended 50."

In my judgment, this is the most important defense decision we will be making in this decade. Seven former Secretaries of Defense wrote President Clinton urging him to procure additional B-2's. We have spent \$44.4 billion to develop the technology for the B-2 bomber. We are now able to get an additional 20 B-2's for about \$15.3 billion. In my mind, that is affordable. If we shut down the line, and if we come back to it in 5 or 10 years and say, "My gosh, we do not have the bombers we need for the future," it will cost \$10 billion just to open the line and we get nothing.

My judgment is that there is another important issue that has been missed by the press. That is the cost of the munitions on these planes. If we have standoff weapons, which the administration supports, on the B-52's and the B-1-B's, first of all, they have no utility against mobile targets. No. 2, is that they cost \$1.2 million per missile, because you have to have long-range missiles. They also cost about \$15 to \$20 billion for a load of them.

The cost of the weapons in the B-2 J-DAMS weapon is \$320,000 for 16 of them, and in my judgment, that is a major difference, one-fourth the cost of one cruise missile and a fraction of the cost of a load of missiles. In a few days of a major conflict, you could pay for the B-2 simply by having these less expensive weapons, either the sensor-fused weapon or the J-DAMS. I think that is a major difference. I also believe, if we had enough B-2's, the potential someday for a conventional deterrent.

What if we had been able to show Saddam that we had this capability and we could have avoided the Gulf war? It cost us \$10 billion to move all our forces out to the Gulf. Then it cost \$60 billion to prosecute the war, \$70 billion was expended.

□ 1330

The cold war is over, yet we still have threats out there. People say there are no threats. Saddam still exists. We have problems with Iran, we have problems with North Korea. And in each of those scenarios, there could be military divisions coming across the borders into a neighboring country.

In my judgment, having this long-range stealth bomber capability that can go in without any other support

PRIORITY

UNCLASSIFIED

file TB

WHITE HOUSE SITUATION ROOM

PAGE 01 OF 07

PRT: FIRSTLADY

SIT: BERNARD

SIT: NSC

<PREC> PRIORITY <CLAS> UNCLASSIFIED <DTG> 121529Z JUL 99

FM USMISSION GENEVA

TO RUEHC/SECSTATE WASHDC PRIORITY 6961
INFO RUCNDT/USMISSION USUN NEW YORK 5220
RUEHAT/AMCONSUL AMSTERDAM 0015
RUEHPH/CDC ATLANTA GA
UNCLAS SECTION 01 OF 04 GENEVA 005322

DEPT FOR IO

PASS TO HHS FOR OS, OPHS (LURI), OIRH, CDC, NIH, FDA

PASS TO USAID FOR GLOBAL BUREAU, AFR, PPC

PASS TO NSC WHITE HOUSE FOR DR. BERNARD

E.O. 12958: N/A

TAGS: TPHY, TBIO, WHO

SUBJECT: W.H.O. - INVITATION TO MRS. CLINTON TO
PARTICIPATE IN YEAR 2000 STOP TB CONFERENCE

1. THIS IS AN ACTION MESSAGE FOR THE DEPT. SEE PARA 15.

2. SUMMARY: DR. GRO HARLEM BRUNDTLAND, DIRECTOR GENERAL,
W.H.O. HAS INVITED THE FIRST LADY TO PARTICIPATE IN A
MARCH 2000 CONFERENCE IN AMSTERDAM ON TUBERCULOSIS
CONTROL AND THE HIGHEST BURDEN COUNTRIES. THIS MESSAGE
REVIEWS OUR UNDERSTANDING OF THE OBJECTIVES, FORMAT, AND
AGENDA OF THE CONFERENCE. END SUMMARY.

INVITATION TO MRS CLINTON

3. MISSION HAS RECEIVED A COPY OF A LETTER DATED JUNE 14
SENT TO THE FIRST LADY, HILLARY RODHAM CLINTON, FROM DR.
GRO HARLEM BRUNDTLAND, DIRECTOR-GENERAL, WORLD HEALTH
ORGANIZATION (W.H.O.) INVITING MRS. CLINTON TO
PARTICIPATE IN A MINISTERIAL CONFERENCE TO STOP TB, TO BE
HELD IN THE NETHERLANDS, MARCH 21-23, 2000. TEXT
FOLLOWS:

UNCLASSIFIED

PRIORITY

UNCLASSIFIED

WHITE HOUSE SITUATION ROOM

PAGE 02 OF 07

DEAR HILLARY,

FURTHER TO MY RECENT LETTER OF 27 APRIL 1999 REGARDING THE TUBERCULOSIS EPIDEMIC AND THE STOP TB INITIATIVE, I WOULD LIKE TO ENQUIRE ABOUT YOUR AVAILABILITY TO PARTICIPATE IN A MINISTERIAL CONFERENCE TO STOP TB. THIS CONFERENCE IS TENTATIVELY SCHEDULED FOR 21-23 MARCH 2000 AND WOULD BE CO-SPONSORED BY W.H.O., AND THE GOVERNMENT OF THE NETHERLANDS WHICH WOULD HOST THE MEETING. THERE, FOR THE FIRST TIME, THE SOCIAL, HEALTH AND ECONOMIC DEVELOPMENT CONSEQUENCES OF THE EPIDEMIC WOULD BE CLEARLY ENUNCIATED TO MINISTERS OF HEALTH AS WELL AS MINISTERS OF FINANCE, DEVELOPMENT OR PLANNING FROM THE WORLD'S HIGHEST BURDEN COUNTRIES. WE KNOW THAT COMBATING TB REQUIRES SUSTAINED SUPPORT ACROSS SECTORS OF GOVERNMENT AND SOCIETY. THE MINISTERIAL EVENT WOULD SET THE STAGE FOR WIDENING THE RANGE OF ACTORS INVOLVED IN TB CONTROL AT COUNTRY LEVEL.

FOLLOWING FORMAL AGREEMENT, WHICH WE ANTICIPATE SOON, FROM THE GOVERNMENT OF THE NETHERLANDS, YOU WILL BE INVITED TO JOIN ME AT THE MINISTERIAL CONFERENCE ON THE EVENING OF 22 MARCH AND MORNING OF 23 MARCH. YOUR PRESENCE AND COMMITMENT TO ISSUES SUCH AS TB WOULD LEND STRONG CREDIBILITY TO THE PROCEEDINGS.

I LOOK FORWARD TO OUR CONTINUED COOPERATION AS PARTNERS IN THE STOP TB INITIATIVE, AND TO A SUCCESSFUL MINISTERIAL CONFERENCE TO STOP TB.

YOURS SINCERELY,
GRO HARLEM BRUNDTLAND, MD, MPH
DIRECTOR-GENERAL

END LETTER

OBJECTIVES/OVERALL PURPOSE

4. MISSION'S HEALTH ATTACHE DISCUSSED PLANS FOR THE CONFERENCE WITH DR. MAARTEN BOSMAN OF THE STOP TB INITIATIVE. THE FOLLOWING MAY BE HELPFUL TO THE WHITE HOUSE IN DECIDING WHETHER TO ACCEPT THIS INVITATION:

A. THE OVERALL OBJECTIVE OF THE CONFERENCE IS TO BUILD, ENHANCE AND SUSTAIN THE POLITICAL WILL OF GOVERNMENTS TO COMMIT TO INVESTING IN AND SUSTAINING EFFECTIVE TB CONTROL AS PART OF OVERALL HEALTH SECTOR DEVELOPMENT.

UNCLASSIFIED

PRIORITY

UNCLASSIFIED

WHITE HOUSE SITUATION ROOM

PAGE 03 OF 07

B. THE CONFERENCE WILL ADDRESS TB AS A MAJOR CONSTRAINT ON SOCIO-ECONOMIC DEVELOPMENT. IT WILL PRESENT TB AS A MAJOR CAUSE OF HUMAN SUFFERING, AFFECTING PARTICULARLY THE POOR, WOMEN AND CHILDREN, AND EMPHASIZE THE NEED FOR GOOD TB CONTROL SERVICES AS AN INTEGRAL COMPONENT OF EXPANDED AND STRENGTHENED HEALTH SERVICES WHICH CAN ACCELERATE ECONOMIC GROWTH AND SOCIAL DEVELOPMENT.

UNCLAS SECTION 02 OF 04 GENEVA 005322

DEPT FOR IO

PASS TO HHS FOR OS, OPHS (LURI), OIRH, CDC, NIH, FDA

PASS TO USAID FOR GLOBAL BUREAU, AFR, PPC

PASS TO NSC WHITE HOUSE FOR DR. BERNARD

E.O. 12958: N/A

TAGS: TPHY, TBIO, WHO

SUBJECT: W.H.O. - INVITATION TO MRS. CLINTON TO PARTICIPATE IN YEAR 2000 STOP TB CONFERENCE

C. TWO POSITION PAPERS WILL BE PRESENTED ADDRESSING THE OVERRIDING ISSUE OF BUILDING AND SUSTAINING POLITICAL WILL AND INVESTING IN AND SUSTAINING EFFECTIVE TB CONTROL AS PART OF OVERALL HEALTH SECTOR DEVELOPMENT.

D. THE CONFERENCE AIMS TO ACHIEVE ITS OBJECTIVES THROUGH THE FOLLOWING:

--DISCUSSING THE IMPACT OF THE TB PROBLEM ON THE ECONOMY AND SOCIETY AND THE SOCIETAL AND ECONOMIC GAINS THAT CAN BE DERIVED FROM INVESTING IN TB CONTROL;

--STIMULATING INCREASED AWARENESS OF THE GLOBAL TUBERCULOSIS PROBLEM, THE STALLED PROGRESS IN IMPLEMENTING EFFECTIVE TB CONTROL IN MANY OF THE MOST AFFECTED COUNTRIES AND THE FACT THAT NEARLY 85 PERCENT OF THE WORLD'S POPULATION LACKS ACCESS TO THE MOST COST EFFECTIVE CURE STRATEGY;

-- ANALYZING EXPERIENCES, LESSONS LEARNED AND CHALLENGES TO TB CONTROL IN THE MAJOR HIGH BURDEN COUNTRIES;

-- DISCUSSING AND ADOPTING NEW APPROACHES TO APPLICATION OF DOTS (DIRECTLY OBSERVED THERAPY, SHORT COURSE) IN THE CONTEXT OF SOCIETY AND THE HEALTH SECTOR AT LARGE, INCLUDING SECTOR DEVELOPMENT APPROACHES.

UNCLASSIFIED

PRIORITY

UNCLASSIFIED

WHITE HOUSE SITUATION ROOM

PAGE 04 OF 07

EXPECTED RESULTS

5. W.H.O. HOPES THAT THE CONFERENCE WILL YIELD A RESOLUTION, ENDORSED BY MINISTERIAL PARTICIPANTS, STATING THEIR COMMITMENT TO REVIEW THEIR GOVERNMENTS' CURRENT INVESTMENTS IN TB CONTROL, REDIRECT COMMITMENT TO REVIEW THEIR GOVERNMENTS' CURRENT INVESTMENTS IN TB CONTROL, REDIRECT THESE RESOURCES TO MORE EFFECTIVE TB ACTIVITIES, WHERE APPROPRIATE RAISE PUBLIC AWARENESS OF TB AND SEEK INCREASED INVESTMENTS IN TB CONTROL TO SUPPORT SECTOR-WIDE DEVELOPMENT.

6. COMMITMENT TO THE STOP TB INITIATIVE INCLUDING OWNERSHIP OF THE DEVELOPMENT PROCESS FOR THE GLOBAL ACTION PLAN AND THE GLOBAL CHARTER.

FORM AND PARTICIPATION

7. THE CONFERENCE WILL INCLUDE PANEL PRESENTATIONS AND FACILITATE DISCUSSION OF KEY ISSUES FACED BY THE HIGHEST BURDEN COUNTRIES. COUNTRY EXPERIENCES ON SIGNIFICANT CONSTRAINTS TO ACTION WILL BE PRESENTED BY PARTICIPATING DELEGATES. A CONFERENCE REPORT REFLECTING THE MAJOR OUTCOMES OF DISCUSSIONS WILL BE PREPARED FOR ENDORSEMENT DURING THE FINAL SESSION.

8. THE CONFERENCE WILL HAVE APPROXIMATELY 130 PARTICIPANTS, WITH AN ESTIMATED 66 OF THESE FROM HIGH BURDEN COUNTRIES, ONE REPRESENTATIVE FROM EACH OF THE SIX W.H.O. REGIONAL OFFICES, FIVE CHAIRS AND SPEAKERS, THE W.H.O. TB INITIATIVE STEERING GROUP, DUTCH GOVERNMENT DELEGATIONS.

9. COUNTRIES BEING INVITED ARE: BANGLADESH, BRAZIL, CAMBODIA, CHINA, DR CONGO, ETHIOPIA, INDIA, INDONESIA, KENYA, NIGERIA, PAKISTAN, PERU, PHILIPPINES, RUSSIA, SOUTH AFRICA, TANZANIA, THAILAND, UGANDA, VIETNAM, ZIMBABWE. WE UNDERSTAND THAT THEIR MINISTERS OF HEALTH ARE EXPECTED TO PARTICIPATE.

10. THE OFFICIAL LANGUAGE OF THE CONFERENCE WILL BE ENGLISH. TRANSLATION INTO RUSSIA, CHINESE, FRENCH, PORTUGUESE AND SPANISH IS PLANNED FOR THE TECHNICAL SESSIONS, PANEL DISCUSSION AND FINAL SESSION.

11. THE GOVERNMENT OF THE NETHERLANDS IS THE ACTUAL HOST OF THE CONFERENCE, BUT IS ENTERING INTO A CONTRACT WITH

UNCLASSIFIED

PRIORITY

UNCLASSIFIED
WHITE HOUSE SITUATION ROOM

PAGE 05 OF 07

W.H.O. FOR ORGANIZATION AND IMPLEMENTATION.

PROPOSED AGENDA

UNCLAS SECTION 03 OF 04 GENEVA 005322

DEPT FOR IO

PASS TO HHS FOR OS, OPHS (LURI), OIRH, CDC, NIH, FDA

PASS TO USAID FOR GLOBAL BUREAU, AFR, PPC

PASS TO NSC WHITE HOUSE FOR DR. BERNARD

E.O. 12958: N/A

TAGS: TPHY, TBIO, WHO

SUBJECT: W.H.O. - INVITATION TO MRS. CLINTON TO
PARTICIPATE IN YEAR 2000 STOP TB CONFERENCE

12. THE CONFERENCE WILL BE DIVIDED INTO TWO PARTS. THE FIRST ONE AND ONE-HALF DAYS WILL BE FOCUSED ON ACTIVE INVOLVEMENT OF THE PARTICIPANTS THROUGH COUNTRY PRESENTATIONS AND PANEL DISCUSSIONS. A DRAFTING GROUP WILL SUMMARIZE THE RECOMMENDATION FORMULATED DURING THE PANEL DISCUSSIONS INTO A DRAFT CONFERENCE RESOLUTION. DURING THE FINAL HALF DAY OF THE CONFERENCE DR. BRUNDTLAND AND WORLD BANK, PRESIDENT WOLFENSON, OR HIS DESIGNEE WILL ADDRESS THE PARTICIPANTS. IT WILL END WITH A PLENARY SESSION TO DISCUSS AND ENDORSE THE CONFERENCE RESOLUTION.

13. PROVISIONAL AGENDA FOLLOWS:

A. DAY ONE: BEGINS AT 1400 HRS.

WELCOMING STATEMENT: MINISTER A (TO BE DETERMINED)

INTRODUCTION TO THE STOP TB INITIATIVE - DR. DAVID HEYMANN

SUMMARY REPORT OF PRE-CONFERENCE REGIONAL AND COUNTRY WORKSHOP RESULTS AND RECOMMENDATION

SUMMARY OF POSITION PAPERS ON THE ECONOMIC IMPACT OF TB AND HEALTH SECTOR DEVELOPMENT AND TB

PANEL DISCUSSION: INVESTING IN TB CONTROL WORKS
---THE W.H.O. RECOMMENDED TB CONTROL STRATEGY

UNCLASSIFIED

PRIORITY

UNCLASSIFIED
WHITE HOUSE SITUATION ROOM

PAGE 06 OF 07

---PANEL PRESENTATIONS: KENYA, VIETNAM, PERU

--- DISCUSSION ON THE PROPOSITION: "A COST-EFFECTIVE
STRATEGY FOR DIAGNOSING AND TREATING TUBERCULOSIS
PATIENTS IS AVAILABLE"

DRAFTING GROUP SESSION

DINNER

B. DAY TWO

PROGRESS MADE AND LESSONS LEARNED IN IMPLEMENTING
EFFECTIVE TB CONTROL

-- PANEL DISCUSSION: CHANGING ECONOMICS AND THE
EFFICIENCY OF GOVERNMENT IN DELIVERING TB CONTROL

-- PANEL DISCUSSION: HEALTH SECTOR DEVELOPMENT AND TB
CONTROL

-- PANEL DISCUSSION: PARTNERSHIPS AND PRIVATE/PUBLIC MIX
APPROACHES FOR TB CONTROL

-- PANEL DISCUSSION; COPING WITH THE TB/HIV CO-EPIDEMIC

DINNER AND SOCIAL EVENT

C. DAY THREE

FINAL SESSION: RESPONDING TO THE GLOBAL TB EPIDEMIC IN
THE NEW MILLENNIUM

-- WELCOMING STATEMENT: MINISTER B (TO BE DETERMINED)

-- ADDRESS: DG W.H.O. - THE STOP TB INITIATIVE

-- KEYNOTE ADDRESS: "THE IMPORTANCE OF INVESTING IN TB
CONTROL" MR. JAMES WOLFHENSON, PRESIDENT, WORLD BANK (OR
HIS REPRESENTATIVE)

-- PLENARY: "THE AGENDA FOR INTERNATIONAL ACTION AGAINST
TB" DISCUSSION AND ENDORSEMENT OF CONFERENCE RESOLUTION

CLOSING CEREMONY.

ROLE FOR FIRST LADY

UNCLASSIFIED

PRIORITY

UNCLASSIFIED
WHITE HOUSE SITUATION ROOM

PAGE 07 OF 07

14. ACCORDING TO DR. BOSMAN SHOULD MRS. CLINTON DECIDE TO ACCEPT DR. BRUNDTLAND'S INVITATION, A UNIQUE ROLE WOULD BE CREATED FOR HER. SHE WOULD BE ACCORDED UNCLAS SECTION 04 OF 04 GENEVA 005322

DEPT FOR IO

PASS TO HHS FOR OS, OPHS (LURI), OIRH, CDC, NIH, FDA

PASS TO USAID FOR GLOBAL BUREAU, AFR, PPC

PASS TO NSC WHITE HOUSE FOR DR. BERNARD

E.O. 12958: N/A

TAGS: TPHY, TBIO, WHO

SUBJECT: W.H.O. - INVITATION TO MRS. CLINTON TO PARTICIPATE IN YEAR 2000 STOP TB CONFERENCE

RECOGNITION IN HER OWN RIGHT FOR HER LEADERSHIP IN THE HEALTH SECTOR AND THE SPECIAL INTEREST SHE HAS SHOWN, PARTICULARLY IN PRIOR DISCUSSIONS WITH DR. BRUNDTLAND, IN TUBERCULOSIS.

15. ACTION REQUEST: MISSION WOULD APPRECIATE BEING ADVISED OF MRS. CLINTON'S ACCEPTS DR. BRUNDTLAND'S INVITATION AND WHETHER SHE WOULD LIKE US TO PLAY A ROLE IN ARRANGING HER PARTICIPATION.

MOOSE

<^SECT>SECTION: 01 OF 04

<^SSN>5322

<MSGID> M3955114

UNCLASSIFIED

**Tuberculosis Meeting
October 28, 1998**

Briefing Book

file TB

Table of Contents

- 1 - List of Participants
- 2 - Seating Chart
- 3 - Talking Points

U.S. Government Activities

- 4 - Department of Health and Human Services
- 5 - U.S. Agency for International Development
- 6 - Gore/Primakov Commission

NGO/International Organizations Activities

- 7 - OPEN Society Institute
- 8 - World Health Organization
- 9 - World Bank

Al D'Amato letter?

**TB Meeting
October 28, 1998**

List of Participants

World Health Organization

Dr. Gro Brundtland

Dr. David Heymann

*Executive Director for Communicable
Diseases*

Ambassador Jonas Store

Executive Director

Ambassador Thomas Loftus

World Bank

Dr. James Wolfensohn

President

Jan Piercy

U.S. Executive Director

Dr. David de Ferranti

*Vice President, Human Development
Network*

Chris Lovelace

Director, Human Development Sector

Open Society Institute

George Soros

Dr. Paul Edward Farmer

Dr. Alexander Goldfarb

Dr. Srdan Matic

Project 55 TB Initiative (Ralph Nader grp.)

Christoph Lee

AID

Administrator Brian Atwood

Duff Gillespie

*Deputy Assistant Administrator for
Population, Health and Nutrition*

HHS

Secretary Donna Shalala

Peggy Hamburg

Asst. Secretary for Planning and Evaluation

State

Frank Loy

Undersecretary of State for Global Affairs

Douglas Wake

Office of Assistance to the NIS

WH/NSC

Melanne Verveer

Marsha Berry

Ken Bernard

Andrew Weiss

Leon Furth

TUBERCULOSIS MEETING
OCTOBER 28, 1998
MAP ROOM

TALKING POINTS

OPENING REMARKS:

- I am pleased all of you could come to take part in this discussion of international tuberculosis control, one of the most critical and threatening global disease issues of our day. Looking around the room, it is clear that we have assembled the talent to help support a coordinated strategy to deal with TB worldwide.
- We all know the statistics concerning the resurgence of this age-old scourge: 8 million new cases per year over and over 2,000,000 deaths - that's over 5,000 deaths per day. As we enter the 21st century, TB remains the single largest infectious disease killer of adults. And most Americans still believe that TB is a disease of the past.
- We have recently been reminded again of how pressing this problem has become by George, who with his seemingly unlimited energy and commitment, has highlighted the TB epidemic in Russia and the other countries in the Newly Independent States.
- And the epidemic in Russia is raising a new issue - multi-drug resistant TB, which not only will make treatment far more expensive, but also poses a serious threat outside the region - a deadly form of disease that can cross borders as quickly as an international plane flight.
- There are no simple answers to the TB epidemic. This is not a disease that is easily treated with a single antibiotic prescription or injection. We must look at TB control in the context of development of quality health care at the community level. And we need high-level political commitment to ensure that a "best-practices" approach to control is seen as a high government priority.
- Obviously, funding is critically important to carry out these important control programs. Also important is the need to develop broad-based partnerships with other concerned nations, the private sector, academia, foundations and especially the

UN. With a global partnership under the expert leadership of Dr. Brundtland and W.H.O to carry out the needed TB control, we can, and will, move to control this killer.

Introduce other speakers:

- I would like to turn at this point to **Secretary Donna Shalala**, whose national and international leadership in health promotion and disease control need no elaboration for this group. She co-chairs the Health Committee of the Gore-Primakov Commission, and is passionate in her support of the new leadership of Gro Brundtland at W.H.O.

[Note: Secretary Shalala will likely speak on the components of international TB control as learned from our domestic experience. For Russia, she will emphasize the critical political commitment that can be developed through the work of the Health Committee of the Gore Commission. She will touch on countries building a rational national control strategies and the "Global Stop TB Initiative" of W.H.O.]

- Introduce **Brian Atwood**, Administrator, USAID

[Note: he will describe the USAID approach to TB internationally concentrating on broadening the issue to the NIS and other affected countries. He will note institutional investments, and may mention the mission of the Strategic Design Team leaving next month to set up "Demonstration Sites." in Russia.]

- Introduce **Dr. Gro Brundtland**, Director General, W.H.O.

[Note: She will discuss W.H.O.'s leadership in the "Global Stop TB Initiative" - including the complex constraints related to inadequate trained health personnel, inefficient drug procurement systems, poor political will, and problems of drug resistance. She will outline the W.H.O. actions.]

- Introduce **James Wolfensohn**, President, World Bank

[Note: He will outline the World Bank's interest in the problem, its past investments, and interests in working in Russia and other countries with significant TB problems.]

- Introduce **George Soros**.

[We are told that he will support W.H.O.'s lead in dealing with the global epidemic, and will offer his assistance in building a global consortium of major institutions and intergovernmental organizations (such as the EU) to raise the required funds.]

Discussion. open

CONCLUDING REMARKS:

- I am gratified to hear that we seem to have the same basic approach for dealing with the global TB epidemic. I won't recapitulate what was said, you all are better than I at representing your agencies and interests. We have much to do.
- With regards to Russia, I encourage the joint CDC/USAID/WHO Strategic Design Team to report back on what specific intervention plans will work best. We must help Russia and the other Newly Independent States develop rational and "do-able" national plans for TB control and treatment given their specific circumstances.
- Globally, we have an important task laid out before us. Each of us can contribute to our collective goal of controlling this epidemic - and doing so by doing what each agency or organization does best. But we should move forward quickly and resolutely - working together jointly with a common ideal of caring for and treating those who are infected, and stopping the spread of the disease through both community and international action.



AUG 28 1998

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Tuberculosis Epidemic in Russia

Because the tuberculosis (TB) epidemic in Russia is such an important health care issue, I am providing you with an update and background on its current status and the steps we are taking to address this significant, world-wide threat to the public health. Also, I have attached talking points and a brief background paper for your use should the opportunity arise during your visit to further our recent progress made in combating this deadly disease.

As you know, I have had the pleasure of serving as a co-chairperson, together with the Russian Minister of Health, on the Health Committee of the Gore-Chernomyrdin Commission. TB control is a key issue for the Health Committee and many resources of the Department of Health and Human Services, especially through the Centers for Disease Control and Prevention (CDC), and the USAID, Department of State have been mustered to assist the Russian government in fighting this disease. But urgent problems continue that need to be addressed.

First, although Russia has the relatively low-cost drugs that can be used to treat TB, there are often more TB patients in the prisons and sanatoria than can be treated with the drugs available. Also lacking is surveillance, laboratory support and the organizational systems and discipline to see treatments completed.

Second, when the inexpensive, simple antibiotic treatments for TB are not adhered to, are inadequate or unavailable, a Multi-Drug Resistant Tuberculosis (MDR-TB) may emerge that is treatment-resistant and requires much more expensive antibiotics. If these are unavailable or are used in a haphazard fashion, there is substantial risk of developing even more resistant strains of TB and spreading an airborne epidemic beyond Russia.

We have worked with our Russian colleagues to encourage them to adopt a treatment regimen, known as Directly Observed Therapeutic Strategy (DOTS), that has been advocated by the CDC and the World Health Organization (WHO). DOTS entails carefully monitoring patients to ensure that they take the full course of antibiotics prescribed to eliminate TB. This can be done in either an in-patient or out-patient setting, but the cost savings of out-patient treatment are substantial. It is an important world-wide strategy to treat TB that can improve the quality of care and reduce costs without the need for prolonged institutionalization.

However, some have argued that because DOTS does not require institutionalization, drug treatment compliance could be lower, which could lead to the emergence of MDR-TB. The official Russian policy on TB retains the traditional approach of treatment in sanatoria. This is especially true among local officials where the sanatoria system is a major source of employment.

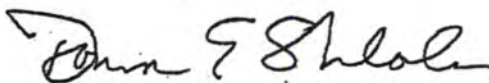
Seeing both sides of this issue, we have pushed hard, but respectfully, for reform in Russia. I am especially pleased that the Gore-Chernomyrdin Health Committee has given us a forum to convince the Minister of Health to adopt DOTS and to make the organizational changes necessary for its implementation. The cost of adequate treatment of TB in Russia, including transition to a system of DOTS, remains a challenge but HHS and the State Department are working with our Russian counterparts to develop a short- and long-term strategy.

One example of our success stems from our convincing the Ministry of Health to adopt DOTS which paved the way for Mr. George Soros and his grantees to implement DOTS demonstration projects in Russia. Under this effort, Mr. Soros' Open Society Institute is providing funding to the New York City-based Public Health Research Institute (PHRI) to implement DOTS pilot projects in Russia with a focus on the possible emergence of MDR-TB. I would note that the First Lady is keenly aware of the public health threat of MDR-TB and raised it during a meeting with Mr. Soros where he was explaining his initiative in Russia.

You should also be aware that Mr. Soros' grantee, PHRI, together with the Britain-based Medical Emergency Relief International and the Belgian-based Medecins Sans Frontieres (Medicine Without Frontiers) have sent an open letter to President Yeltsin urging that he do more to combat the spread of MDR-TB, warning that Russia has become the "world's incubator of the deadly disease." Some Russian conservatives consider these efforts to be a "plot" by western drug companies to sell Russia expensive pharmaceuticals.

We would suggest a less politically confrontational, more public health approach to this complicated issue. An approach based on the scientific evidence that DOTS can be a more effective and lower cost approach to the treatment of TB, especially with respect to the threat of MDR-TB. We hope that the progress that we have made with the Russian Ministry of Health, which has made it possible for the Mr. Soros' initiative to occur, can be continued.

As I mentioned above, I am making the attached talking points and briefing paper available to you should the opportunity arise to further our public health goals of reducing the incidence of TB, especially MDR-TB, among the Russian people. I have also attached an informative editorial by Harvard Professor, Howard Hiatt, who argues because of its airborne spread, resurgent tuberculosis, and MDR-TB in particular, are an even greater threat to society than the AIDS epidemic. Please let me know if you would like any additional information.



Donna E. Shalala

Enclosures

Tuberculosis Epidemic in Russia

Talking Points

- We share your concern about the increased incidence of tuberculosis (TB) in Russia, and especially the emergence of a particularly dangerous form of tuberculosis, multidrug-resistant TB (MDR-TB) that cannot be treated with conventional antibiotics.
- We understand that MDR-TB is now a particular challenge in the penal system of the Russian Federation. Prisoners released after even brief stays in crowded prisons may have acquired the disease and become the source of infection in the community at large.
- We in the U.S. have had our own unfortunate experience with drug-resistant tuberculosis. During late 1985 and early 1990's, we had outbreaks of MDR-TB in hospitals and prisons, much of which was associated with HIV/AIDS co-infection.
- We have committed a substantial level of effort and resources to bring the situation under control. Only after implementation of treatment methods, such as directly observed therapy, that are recommended by the World Health Organization and our own Centers for Disease Control and Prevention, were we able to make real progress in controlling this persistent disease.
- We are aware of the situation in Russia and applaud your recent efforts of the Russian Ministry of Health and the Chief Administration of Execution of Punishment to implement international standards of TB control.
- We also understand the difficulties you face, both economic and social, in restructuring the system of TB care.
- However, we also are aware that there are successful pilot projects underway in Ivanovo and Tomsk that are being carried out as part of multilateral and our own bilateral cooperation.
- Based on these experiences, we stand ready to provide technical assistance as you work towards a nationwide program of tuberculosis control in Russia.

Russia's Health Care System and Condition

Serious shortcomings in Russia's health system and disease profile threatens the country's ability to provide adequate public health services to the Russian people, and for some diseases, poses a cross-border threat to the health of other nations, including the United States. While many general health statistics have improved modestly in the last two years, including life expectancy, alarming increases are evident in rates of STDs, HIV and TB.

Between 1990 and 1997, the incidence of syphilis has increased from 5.4 per 100,000 to 216.9 per 100,000 -- an increase of nearly 5,000%. Gonorrhea is increasing rapidly as well, and what shocks health officials and local leaders is that many of those infected are under the age of 20. In 1987, Russia had 24 recorded cases of HIV. By the first half of 1998 there were close to 8,700 cases of HIV and 300 AIDS deaths reported. Outside estimates are much higher, but even the Russian Duma estimated that Russia can expect at least one million cases of HIV in the coming years, with which the health and economic system will be unable to cope. The rise in TB cases has been dramatic, with civilian notifiable cases increasing from 36 per 100,000 in 1992 to 75 per 100,000 in 1996; particularly worrisome is the level of multiple-drug resistant TB which is estimated at 7.3% of all civilian cases, posing a distinct threat beyond Russia's borders. The TB situation in prisons is far worse.

The health system suffers from low and underfunded health budgets, poor performance of the mandatory health insurance program in collecting premiums, and the lack of a legal framework for the private provision of health care despite survey findings indicating that upwards of 40% of health expenditures are out-of-pocket. The work of medical providers suffers from a lack of evidence-based medicine and quality improvement in all aspects of healthcare, especially diagnosis and treatment protocols.

Nonetheless, successful dialog between U.S. and Russian health experts through the bi-lateral commission initiated by Vice President Gore, and effective use of USAID foreign assistance contributions are evident. Since 1992, the U.S. has provided over \$95 million to address a broad range of health issues important to Russia such as immunization, women's reproductive health, pharmaceutical investment and quality control, environmental health, and health information and response activities. Approaches involving partnerships between U.S. and Russian organizations have been successful at the local level and, in one program's case, has led to U.S. private contributions of time and equipment estimated at \$45 million over the last four years. Attempts at strengthening the role of non-governmental organizations in the delivery of public health information and services health field requires more attention.

Tangible results are evident from the U.S.-Russian cooperation. For example, an estimated three million Russian couples now have access to safe and effective family planning services, and U.S. assistance has been credited with bringing down abortion rates. Yet, controversy about family planning has increased from the political right and from some religious groups. The Yeltsin administration wants to continue U.S.-Russian cooperating on reproductive health programs, and expand into improvements in maternal and neo-natal health. Russia is also working with the U.S. on a national initiative to improve the quality and access to health services, and a multi-year strategy aimed at STD/HIV prevention and control. A design effort for USG assistance in TB control is scheduled for Fall 1998.

More Deadly Than AIDS

Howard Hiatt

Washington Post

August 14, 1998

Many Americans think that with the discovery of streptomycin more than 50 years ago, the tuberculosis problem was solved. But a little-noticed (in the United States) TB epidemic now kills 3 million adults a year worldwide, more than AIDS or malaria. Even more threatening is the increasing appearance around the globe of forms of TB that are resistant to streptomycin and many other drugs that have been used to treat the disease.

Almost every person with the common variety of TB can be cured with two to four medications daily for at least six months at a total cost of about \$100. In recent years the World Health Organization, with support from the World Bank, has treated drug-sensitive TB in many countries with a very effective strategy that involves supervised administration of the drug over the prescribed period.

But when TB sufferers are treated inadequately, that is, when they don't have all the required drugs or don't take them long enough, mutant TB bacteria that are more resistant to the drugs grow. Patients may feel better temporarily, but what was a curable condition can become a death sentence. And their now multidrug-resistant (MDR) TB bacteria infect others.

MDR TB can often be cured, but at a cost eight to 80 times higher than that of treating ordinary TB. Until a few months ago that cost led to the view that treatment of MDR TB in resource-poor countries was not "cost-effective." But Paul Farmer and Jim Kim, two physician- anthropologists who divide their time between work at Harvard Medical School and Brigham and Women's Hospital, on the one hand, and the poorest areas of Haiti, Peru and Mexico, on the other, have changed that.

In the barrios of Lima, where they have been involved in community-building for five years, they recognized that treating only patients with drug-sensitive TB, the most prevalent kind, could encourage the spread of MDR TB.

Even more important, they regard treatment for MDR TB as the right of all its victims. Finally, they know well that infectious diseases respect no border and that their spread to the rest of the world is more than a threat. In fact, an American priest who recently died of MDR TB in Boston had come there from service in the barrios of Lima.

Therefore, they began treating almost 100 of the many desperately ill patients with MDR TB in Lima with five or more drugs daily over a period of two or more years.

More than 85 percent appear to have been cured. Farmer and Kim ascribe a large part of their success to their partnership with community members whom they have trained to ensure that every patient takes every dose of every medication every day. The cost has been great (although

much, much less than the cost in a U.S. hospital), but they have thus far succeeded in obtaining the needed drugs, partly by going into debt.

Earlier this year tuberculosis specialists from around the world gathered at the American Academy of Arts and Sciences and examined and then endorsed the preliminary Lima evidence. Subsequently, the World Health Organization decided to replicate the Lima experiment in a few other sites around the world that it has designated MDR TB "hot zones."

Thanks to the generosity of George Soros, the first such sites will be in Russia and Latvia, where MDR TB is prevalent and spreading rapidly. The Soros foundations have committed to pay for programs there. But if the worldwide epidemics are to be contained, many more groups must be mobilized. The World Bank, national governments -- particularly those of industrialized nations -- the pharmaceutical industry, other business leaders concerned with international trade, scientists and others all can play crucial roles in a program to wipe out all forms of TB.

The AIDS pandemic has appropriately aroused the concerns of people around the world. The tuberculosis pandemic requires no less. Because it is spread much more readily than AIDS -- through the air that everybody may breathe -- it represents an even greater threat.

The writer, a professor of medicine at Harvard, is director of the Initiatives for Children Program of the American Academy of Arts and Sciences.

© Copyright 1998 The Washington Post Company



U. S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

MEMORANDUM

TO: WH/OFL, Melanne Verveer
FROM: Acting AA/ENI, Donald L. Pressley *DL Pressley*
SUBJECT: Tuberculosis in the ENI Region

In response to my conversations with Mrs. Clinton during our recent trip to Eastern Europe, please find below a summary of USAID's tuberculosis activities in Europe and the New Independent States (ENI).

Following a general decline in the incidence of tuberculosis (TB) prior to 1991, rates have risen dramatically since then. With a continuing breakdown of the health systems in the troubled economies of the NIS, most countries continue to follow a very cost-inefficient TB control strategy involving active case-finding, regular chest X-rays, excessive skin testing and immunizations, and a well-entrenched, costly sanatoria network. USAID is assisting in reorienting the TB control effort in the region through: pilot efforts on the WHO recommended directly observed therapy, short course (DOTS); strengthening epidemiological monitoring and surveillance; more rational pharmaceutical management, including appropriate prescribing practices and pharmaceutical procurement; and strengthening health care delivery systems.

In addition, USAID awarded a first tranche of funding to the Department of Health and Human Services (DHHS) to create an ENI regional TB working group to include expertise from WHO, SOROS and other entities to address TB in the region. The working group will help define the barriers to acceptance and adoption of DOTS in the NIS and will recommend activities necessary to overcome the barriers.

A. TUBERCULOSIS IN RUSSIA

As you know, since the collapse of the ruble and the banking system in Russia, the State Department (S/NIS/C) and the NSC have been closely tracking the TB and pharmaceutical situation in Russia, and have discussed the possibility of humanitarian assistance to respond to particular needs. TB in Russia, however, is not responsive to short-term humanitarian assistance. The number of notifiable cases of TB in Russia has more than doubled over the past six years, from approximately 35/100,000 population in 1992 to approximately

75/100,000 population in 1998, according to the Ministry of Health (MOH) and WHO. Russia's TB rates are among the highest in Europe. Rampant TB rates in prisons continue to serve as a source of infection for the civilian population and multi-drug resistant forms of the disease are on the increase. These two factors have emerged as major threats to successful control of the epidemic. Mortality due to TB in the general population is about 17 per 100,000 population, while in the prison population it is estimated to be as high as 484 per 100,000 population.

Russia continues to follow outdated diagnostic and treatment practices. Efforts by the USG, Soros and other donors to modify those practices, are showing some positive results. But TB in Russia is a complex problem, for which there is no clear or short term fix. Progress towards adoption of modern methods is constrained by a range of difficult economic, political, institutional, psychological, ethical, social and logistical impediments.

In an effort to position itself to respond to the growing crisis, USAID/Moscow commissioned a study to examine the availability of and procurement methods for first-line TB drugs in Russia. The September 1998 report indicates that: a) the first-line anti-tuberculosis (TB) drugs are all available on the Russian market; b) that Russian drug manufacturers increased production of first-line TB drugs by 50% during 1997 and now claim to have sufficient production capacity to satisfy 100% of the country's need for these first-line TB drugs for 1998; but c) chronic shortages nevertheless exist due to perpetual problems with raw materials, procurement, distribution, affordability, and stock management. An emergency drop of TB pharmaceuticals is not needed now and would complicate or even worsen the situation, since the system is not prepared to properly handle a DOTS program. Nonetheless, USAID/Moscow will continue to monitor the situation.

Programs Underway

Because of the risk of promoting multi-drug resistant TB, there is a growing recognition that "doing DOTS badly is worse than doing nothing at all." It is absolutely critical that Russia have in place a sensible and comprehensive plan and adequate implementation capacity to support a DOTS program before drugs are distributed and treatment activities are initiated. USAID and the Centers for Disease Control (CDC) are moving quickly and responsibly to develop a plan to deal with the current crisis.

- With S/NIS assistance, USAID set aside in FY98 \$1.5 million of Freedom Support Act (FSA) funding for TB efforts in Russia. In November, USAID and CDC will begin a TB assessment and design effort to identify likely sites for a multi-year TB program. It is envisioned that the USAID/CDC program will support pilot, community-based activities which complement and build on the work supported by the Soros Foundation and other bilateral donors. Because of statutory limitations, USAID and CDC expects to focus on civilian (not prison) populations. The programs will

institute a "DOTS-Plus" strategy (including food supplements and other inputs besides TB drugs) while tracking the prevalence of multi-drug resistant TB.¹

- A one year hospital partnership (funded by USAID) between the University of Arkansas, School of Medical Sciences and the Volgograd State Medical Academy is initiating modern standards for tuberculosis diagnosis, treatment, and case management in a very limited way. All new health partnerships under the American International Health Alliance (AIHA) will explicitly include TB in the initial needs assessment.
- The American College of Physicians in collaboration with DHHS is working on a pilot effort to integrate TB into other quality and primary care initiatives..

For other donors working on TB programs in Russia, please see attached matrix, "Summary of Donors' Tuberculosis Programs in the Russian Federation as of October 1998."

B. TUBERCULOSIS IN CENTRAL ASIAN REPUBLICS (CAR)

Central Asia has seen a three to four fold increase in tuberculosis since the early 1990's. Although a number of other countries have TB rates higher than those found in CAR, the situation is still grave because of the often incurable form of the disease multi-drug resistant TB. USAID, Chevron and other donors, in a unique public-private partnership, are funding a TB initiative in CAR, and the results are just beginning to surface.

Programs Underway

Chevron Munaigas funded Project HOPE to introduce DOTS at pilot sites in Kazakhstan in 1994. Chevron also delivered a TB mobile clinic to Almaty Oblast, with transportation costs covered by the Department of State.

In 1997, USAID/CAR started its "TB Initiative", in collaboration with Chevron, building upon on-going health reform efforts. The implementing team includes Abt Associates, Project HOPE, and CDC -- a collaborative public-private partnership which has worked extremely well in the region. Broad objectives have been to update the existing TB diagnostic, treatment and control practices in the region through demonstration pilot sites in Kazakhstan and Kyrgyzstan. Activities include: developing national TB education campaigns; training health care professionals; supporting and monitoring DOTS pilot projects in Almaty (81 patients) as a model for national expansion; strengthening TB epidemiology and surveillance; and analyzing the cost-effectiveness of DOTS.

¹ It should be noted, however, that Russian-Iran legislative directives, if enacted, will dramatically constrain the flexibility and scope of this program both at the federal and community levels.

Because of USAID's TB initiative, in May 1998, the President of Kazakhstan, Mr. Nazarbaev, signed a decree to implement DOTS nationwide. Some funding has been allocated and momentum is apparent in the MOH. Supported by all the donors in the region, a development plan for the National TB Control Program has been finalized to implement DOTS at limited pilot sites which will act as centers for training for the rest of the country.

Thus far, USAID has committed \$1,980,000 of FSA funding for the program. Through collaboration with the World Bank, TB activities will be expanded to additional oblasts in Kazakhstan and Kyrgyzstan over the next few years. In 1999, subject to availability of funding, elements of the program will be expanded to Tajikistan, Turkmenistan and Uzbekistan. Other organizations involved in or exploring TB-related activities in Central Asia include AMOCO, Lutheran Ministries, Medecins sans Frontiers-Luxenburg, Philip Morris, SOROS and the University of Wisconsin.

Although too early to measure impact, TB initiatives accomplishments in CAR to date include: training of 385 physicians and other health workers in DOTS therapy, laboratory methods, drug supply and logistics, and health surveillance; provision of modern laboratory equipment and supplies for smear microscopy to three demonstration sites; initiating an information campaign including two press conferences on TB in Kazakhstan and two TV videos which are shown on national and Almaty TV; and ongoing policy dialogue on costs and laws concerning TB prevention, diagnosis and treatment.

C. TUBERCULOSIS IN OTHER AREAS OF THE ENI

Caucasus: The Mission is currently revising their health strategy and will explore possible TB initiatives.

Ukraine: During the period 1990-1996, the TB rate in Ukraine increased by 45 percent and the MOH states that the country now has 45.8 people per 100,000 infected with TB. The Mission in Ukraine is exploring TB initiatives in conjunction with a future primary health care strategy.

Kosovo: USAID's Office of Disaster Assistance (OFDA) has provided about \$696,000 to Doctors of the World to provide food and hygiene parcels for TB patients and their families as incentives to increase treatment compliance in collaboration with a Swedish and multi-donor funded screening and treatment program in Kosovo. Over 4,000 TB patients have benefitted from this program. Initial results show a significant increase in the patient compliance rate. As peace plans begin to take effect, USAID will continue to review the status of TB in Kosovo especially when developments programs become more regular.

An Ancient Marauder Looms Again

■ **Tuberculosis:** The fight against it must be global as drug-resistant strains spread.

By RALPH NADER
and R. GORDON DOUGLAS

For the first time since the introduction of anti-tuberculosis drugs in the 1950s, the world faces the threat of incurable TB, a disease that destroys the lungs, dooming its victims to drown in their own blood. This deadly infection is airborne; it spreads like the common cold. Worst of all, highly resistant strains have been discovered in 34 countries by the Global Project on Anti-TB Drug Resistance.

If tuberculosis were a newly emerging disease rather than an ancient marauder, it would be making headlines almost daily. However, in the four years since the World Health Organization declared TB a global emergency, there has been little international alarm. Inexpensive, generic medications have long existed to cure tuberculosis, yet 3 million people die each year, making TB the greatest infectious killer worldwide, responsible for one-fourth of the world's preventable deaths.

In October, an unprecedented report released by top U.S. and international health agencies issued the ultimate warning: Multi-drug-resistant strains of tuberculosis (MDR-TB), which can be virtually untreatable, have emerged worldwide and threaten to overwhelm the public health systems of India, Russia, Latvia, Estonia, Argentina, Ivory Coast and the Dominican Republic. In these countries, poor TB

control programs misuse antibiotics and ineffectively treat patients, practices that foster drug-resistant strains. These MDR-TB "hot-zones" pose a grave threat to global health, as international travel and migration put all areas of the world in close contact.

Few people recognize the danger that MDR-TB poses to Americans. It is very difficult and expensive to contain, and the industrialized world is by no means immune. Since 1991, when these strains were found in only 13 states, MDR-TB has spread to 42 states and the District of Columbia. In September, a new strain of highly contagious TB that multiplies at 1,000 times the normal rate was identified along the Tennessee-Kentucky border.

Transmission of tuberculosis can occur anywhere, from planes to schools to neighborhood bars. In 1994, a South Korean woman with MDR-TB infected four Americans on a plane.

The importation of TB across international borders is very common. In this country, 37% of TB patients are foreign-born, 25% of them from one of four "hot zones": India, Korea, Vietnam and the Dominican Republic. In the Dominican Republic, where 9% of TB cases are MDR, one out of every seven residents has obtained a visa for travel to the U.S.

The U.S. learned a harsh lesson when the dismantling of TB control infrastructure in the 1980s led to sharp increases in tuberculosis. According to New York City's director of TB control, the explosion of MDR-TB required more than \$700 million between 1992 and 1996 to quell the outbreak.

The World Health Organization spends \$11 million annually on TB control, of

which the U.S. contributes only about \$500,000. WHO estimates that, in addition to commitments from developing countries, \$100 million more is needed annually to control the epidemic and prevent the spread of MDR-TB. Surely, Americans would be willing to foot some portion of that bill to prevent a disease that WHO's Richard Bumgarner called "Ebola with wings" from descending on our shores.

Congress has approved additional money for the Agency for International Development, which channels funds to WHO, to combat infectious diseases worldwide. If only the Clinton administration would follow through more comprehensively. Some of the proposed new funding for biomedical research and for the National Institutes of Health also should be channeled into TB research. Furthermore, the U.S. must pay its dues to the United Nations if WHO is to be effective in fighting TB and other such deadly diseases. Unless this funding is sustained over the long term, TB programs will be ineffective, treatment of patients will be incomplete and our temporary good intentions will only fuel the spread of drug-resistant strains.

The only way to protect Americans against multi-drug-resistant tuberculosis is to support effective treatment and control programs that prevent MDR-TB from developing. It is a war that must be fought internationally, before this country becomes a primary TB battleground.

Ralph Nader and Dr. R. Gordon Douglas are on the steering committee of the Princeton Project 55 Tuberculosis Initiative of Princeton University's Class of 1955.

21/04/98

Health
Committee

GORE - PRIMKOV

IV TUBERCULOSIS

Summary of Situation

In Russia, as in much of the former Soviet Union, tuberculosis (TB) cases have increased dramatically in recent years. In addition, multi-drug resistant (MDR) TB which does not respond to conventional treatment has emerged. MDR-TB has spread in environments such as prisons and hospitals, and threatens TB control efforts since the costs for treating MDR-TB are 100 fold-higher than for treating non-resistant TB (\$3000/case versus \$30/case). The problems have emerged because of unstable drug supplies and reluctance of the medical establishment to use the simple, effective strategy known as DOTS that consists of five elements that include government commitment, appropriate methods of TB diagnosis, an adequate supply of quality drugs, supervised administration of these drugs, and careful monitoring of treatment outcomes. This approach is used in the U.S. as well in more than 100 other countries. Unless the TB problem in Russia is dealt with immediately, drug resistance due to poor treatment practices will continue to develop and spread in the community, making TB virtually untreatable.

U.S. Activities to Date

TB has been considered as an important disease by the Health Committee of the Gore-Primakov Commission. At the request of the Department of Health and Human Services, CDC has participated in the committee's TB activities, which until now have been limited because of availability of resources and resistance at the national level in Russia to institute meaningful changes in national TB policies. CDC activities to date have included a series of visits to Russia in which meetings were held with national counterparts for the purpose of discussing possible collaboration. In addition, CDC planned and hosted a U.S. study tour of TB experts from the leading TB institute in Russia in February 1997 to see the U.S. TB strategy in action in a variety of settings. Although CDC has been involved in a number of TB projects in the Central Asian Republics and the Baltics, direct involvement in Russia has been limited. Recently, however, USAID in Moscow has recognized the importance of the problem and is planning on providing mission funds for a three year period to CDC for the development of one or more pilot projects.

PHRI/Soros Activities

In September 1998 CDC staff conducted a joint visit with members of the Public Health Research Institute/Soros Steering Committee to examine their activities in the civilian and prison populations in the Tomsk Oblast and a TB prison in the Kemerovo Oblast.

Public Health Research Institute (PHRI) of New York City has received a \$12 million grant from the Soros Foundation (Open Society Institute, OSI) to undertake projects aimed at reform of tuberculosis control in the Russian Federation (RF). Dr Alex Goldfarb,

a senior scientist in PHRI, serves as the director of the project. After one year of operation, PHRI has joined DOTS demonstration projects in the civilian sectors in Iyonova (initially supported by WHO) and Tomsk (supported by the British NGO, MERLIN), strengthening laboratory capacity and entering into contracts with local authorities to achieve cost savings by reducing the number of TB hospital beds and of unproductive TB screening activities. For assistance in training, project monitoring, and surveillance/reporting, PHRI is working with the Central TB Research Institute (Prof Alexander Khomenko) in Moscow. PHRI is also supporting a DOTS project initiated by MSF/Belgium in a TB prison in Mariinsk (Kemerovo) and has begun DOTS projects in four other prisons (Tomsk, Iyonova, Mari-El, Vladimir and Nidzy-Novgograd). Based on information available to CDC, it appears that the DOTS projects in the civilian sectors, where rates of initial MDR-TB appear to be relatively low, are succeeding. However, failure rates as high as 40% have been found in the Mariinsk prison, likely because of an equivalent rate of MDR-TB in new patients beginning treatment. Clearly, in such a setting a DOTS-alone approach may be inadequate. As a next step, PHRI intends to implement a DOTS-plus project in Tomsk (both the civilian and prison sectors). With project funds now fully committed, PHRI is looking for other partners and funding sources to expand DOTS-plus programs in regions where it is working and extend DOTS implementation to other regions in RF.

U.S. Planned Activities

Beginning November 15, CDC will detail a public health advisor to Moscow for a 4 to 5 week period to assist the USAID Mission in the development of a TB in Russia Background/Strategy Document.

In late November, a joint CDC-AID team will visit Russia to perform an assessment of three areas to determine which area would be most suitable to serve as a demonstration site for CDC-guided TB control project activities. This multi-disciplinary team will consist of a senior epidemiologist, a TB laboratory specialist, a senior public health advisor and an experienced program management officer. One of the sites to be visited, the Kemerovo Oblast in Siberia, has expressed a strong interest in introducing the basic DOTS strategy in the civilian population (Medecins Sans Frontieres, Belgium is already working successfully in the main prison). The second site, the Ivanovo Oblast near Moscow has been used as a pilot area by the World Health Organization and has one of the two most developed DOTS programs in Russia. In this oblast, the U.S. contribution would be the development of a strategy to identify and cure the MDR-TB patients who are not cured by the routine DOTS approach. The third area under consideration is the Novgorod Oblast which is said to have a progressive governor and chief TB doctor, and has allegedly indicated it's willingness to provide an adequate supply of required TB drugs. If successful, a demonstration project would serve as model for other oblasts in the country. It is hoped that if success is demonstrated in various oblasts, the other oblasts

which are still expressing considerable reluctance to abandon old treatment strategies will be willing to change to the DOTS approach.

Major Obstacles

1. The amount of money that is being made available at the USAID mission is inadequate to fully support the proposed activities.
2. Current U.S. government restrictions on the ways in which money can be spent in Russia may limit the usefulness of available monies. At least part of the potentially available mission funds cannot be spent on activities benefitting the national, oblast, or local governments or on salary support for Russian nationals).
3. For these projects to be conducted successfully, USAID money must be spent (or other sources must be located) to pay for drugs. Although the need for the expensive MDR TB drugs may diminish over time if the program is successful, the need for basic TB drugs will remain, and it appears unlikely that the oblast or national governments will be able to bear these costs in the next several years.
4. Sustainability of efforts beyond the duration of the project may be difficult unless the financial situation of the country undergoes dramatic improvement.

Coordination Meeting on TB in Russia, 15 October, 1998

At a meeting convened last week (15 October, 1998) by the Office of the Coordinator for NIS Assistance, the group, including Drs. Hamburg and Eisenberg, explored several ideas that were later discussed with Dr. Helene Gayle at CDC. The demonstration projects described above will be most effective in the long run, if they are combined with the following initiatives:

1. The setting of a national framework and establishment of an environment for broader adoption of improved care patterns (especially if the demonstrations can show the effectiveness of "best practices"). This would likely be done with Russian TB leaders, oblast leaders, medical education and professional leaders, and political leaders. This should be linked with the American International Health Alliance (AIHA) and American College of Physicians (ACP) projects, and integrated with the Health Committee's quality and primary care initiatives.
2. The building of capacity to care for patients with TB outside sanatoria and prisons. This means upgrading the ability of hospitals and polyclinics to care for TB patients, especially once they have been successfully started on treatment and can be sent into community-based DOTS programs (more difficult, obviously, with

MDR-TB).. This can be done in conjunction with the ACP project, perhaps with other Health Committee efforts to help upgrade primary care and polyclinics.

3. The building of capacity in laboratories for testing TB sensitivities and for assisting clinicians in the selection of appropriate treatment, combined with laboratory support for a more extensive surveillance system to identify the disease burden and to characterize the epidemic better. Dr. Hamburg emphasized this as having been very important in New York City's success in reducing MDR-TB.
4. The identification of the Russian drug availability situation. Funds should be considered to assist the broader distribution and delivery of drugs, some of which are already in Russia but are not being used. A combination of the lack of money to buy pharmaceuticals, poor health sector organization for their distribution to the areas most in need, and the lack of knowledge or commitment to use the drugs appropriately, as well as other factors, contribute to this problem.

These efforts will be very expensive, but the Health Committee should take advantage of the attention this is getting to emphasize that one can't do demonstration projects without building reform of TB care into the public health infrastructure, improving the community-based care, and paying attention to quality of care. Depending on the intervention, these could be done either in the demonstration regions, in the nation as a whole, or as part of other donor and collaborative programs (eg, the Access to Quality Care Initiative, AIHA). It should also be linked with the Soros initiative, of course.

The challenge is how to do the demonstrations with the little money available to the Health Committee, and to have concrete and near-term products and achievements, yet offer a broader scope of ideas that focuses those who may direct more funds toward the program on the full spectrum of components of the initiative if it is to be long lasting.

V MATERNAL CHILD HEALTH

The USAID Women's Reproductive Health Project

This project has continued its roll-out and institutionalization activities. A team recently left Russia after developing a strategy for the next 3-4 years which will expand current work in the area of women's reproductive health to Women's and Children's Health. New efforts will include work in policy development, NGO development; research; and information, education, and communication activities.

1. To date, six of the eight roll-out sites have received contraceptive technology update trainings and four have received contraceptive shipments. Training in the

cc: Melanne

OPEN SOCIETY INSTITUTE

O S I

GEORGE SOROS
Chairman

ARYEH NEIER
President

20th August 1998

Mrs. Hillary Rodham Clinton
The White House
Washington D.C. 20500-2000

Dear Hillary,

You told me at our last meeting of your interest in the problem of tuberculosis in Russia. As you noted, explosive prison epidemics in Russia are fueling the larger national epidemic; these outbreaks are, of course, not contained by national boundaries. I am very pleased that Dr. Gro Brundtland of the World Health Organization has underlined the importance of U.S. leadership in addressing this global emergency.

We have started a program to address TB in Russia through the WHO-endorsed control strategy of directly observed therapy or "DOTS" which cures sensitive TB and prevents new multiple drug-resistant TB from developing. We have received requests to support programs from our foundations in such countries as Kazakhstan, Kyrgyzstan, and Azerbaijan which are currently under consideration.

Since we initiated this work a year ago, we have discovered that the problem is considerably worse and more difficult than we imagined. My concerns fall into two main areas: MDR-TB, and other impediments to the adoption of the DOTS approach.

First, the situation is greatly complicated by the multidrug-resistant strains of TB which are not effectively treated through the DOTS approach. The World Health Organization last month endorsed a "DOTS-Plus" strategy which addresses drug resistant treatment in circumstances such as those found in Russia. Since we met, I have directed our TB team to adopt this expanded approach in order to save lives and halt epidemics already underway.

This enhanced approach is significantly more costly than the simpler "DOTS" approach. This expansion will require additional funding, though far less than the cost of ignoring these drug-resistant strains. While I am prepared to commit some additional funds to TB, I have become convinced that the problem can be addressed only with the coordinated and solid financial commitment of a wide range of international, bilateral and private donors.

Second, as our programs develop in Russia, we have encountered a range of economic, political, social, and logistical impediments to the adoption of the WHO/DOTS strategy. Similar impediments exist in other countries as well. We appreciate that failure to overcome these issues could jeopardize our investments in TB control, but simple solutions are not readily available. This is an issue you may want to raise in connection with your visit to Russia in September.

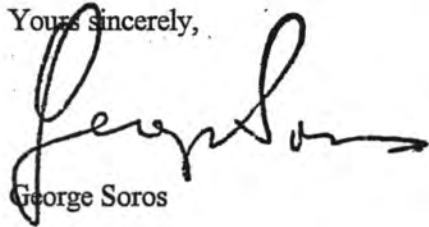
Hillary Rodham Clinton

20th August 1998

Page 2

I understand that the WHO is currently considering undertaking a global TB program. I have written Dr. Brundtland a similar letter, and would like to find ways to work with them. A handful of key players--yourself, Dr. Brundtland, Jim Wolfenson of the World Bank, for example--could make all the difference if we act promptly. It is my hope that we can join together in calling for the sustained international attention and funding that could contain outbreaks in the former Soviet Union and elsewhere. The United States has a critical and new role to play in confronting public health threats outside of its borders. I look forward to hearing from you on this important issue.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'George Soros', with a long horizontal stroke extending to the right.

George Soros

OPEN SOCIETY INSTITUTE O S I

20th August 1998

GEORGE SOROS
ChairmanARYEH NEIER
PresidentDr. Gro Brundtland
World Health Organization
Geneva, Switzerland

Dear Dr. Brundtland:

I understand that the WHO is currently considering undertaking a global program to address the problem of tuberculosis. As you may know, my foundations have started a program to address TB in Russia through a DOTS based approach. We have received requests to support programs from our foundations in such countries as Kazakhstan, Kyrgyzstan, and Azerbaijan which are currently under consideration.

Since we initiated this work a year ago, we have discovered that the problem is considerably worse and more difficult than we imagined. My concerns fall into two main areas: MDR-TB, and other impediments to the adoption of the DOTS approach.

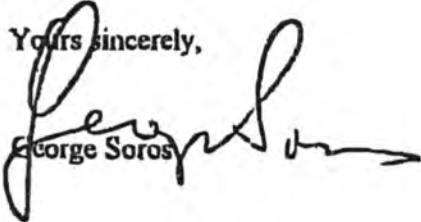
First, as you are well aware, the situation is greatly complicated by the multidrug-resistant strains of TB. We were very pleased to learn that the WHO last month endorsed a "DOTS-Plus" strategy addressing drug resistant treatment in circumstances such as those found in Russia. I have since directed our TB team to adopt this expanded approach in order to save lives and halt epidemics already underway.

Unfortunately, we realize that this enhanced approach is significantly more costly than the simpler "DOTS" approach, and will require additional funding, though far less than the cost of ignoring these drug-resistant strains. While I am prepared to commit some additional funds to TB, I have become convinced that the problem can be addressed only with the coordinated and solid financial commitment of a wide range of international, bilateral and private donors.

Second, as our programs develop in Russia, we have encountered a range of economic, political, ethical, and logistical impediments to the adoption of the DOTS strategy. Similar impediments exist in other countries as well. We appreciate that failure to overcome these issues could jeopardize our investments in TB control, but simple solutions are not readily available.

I am hopeful that the WHO will decide to undertake a global plan to control TB. I would like to find ways to work together in addressing this public health emergency. I have spoken with Hillary Clinton about this problem, and have written her a similar letter. A handful of key players--yourself, Hillary Clinton, Jim Wolfenson of the World Bank, for example--could make all the difference if we act promptly. I look forward to discussing this important matter with you in the near future.

Yours sincerely,


George Soros

OSI-LED INITIATIVE TO ERADICATE TB

AUGUST 1998

"The two largest TB NGOs, KNCV in The Netherlands, and the International Union Against TB and Lung Disease, have a combined budget for fighting TB of just over \$10 million. Last year, the Wellcome Trust announced it could provide over \$2 million to determine the complete sequence of the genome of the tubercle bacillus. Unfortunately, most of the largest foundations, such as Ford, Rockefeller, Kellogg and Pew, and the largest health and development NGOs, such as CARE, Save the Children and Oxfam, remain conspicuously absent in the battle against TB."

BASIC TENETS OF THE OSI-TB INITIATIVE

- Tuberculosis remains the single largest infectious contributor to adult mortality in the world today.
- Increasing globalization of economies demands a global response to the TB pandemic.
- An effective and concerted response demands not only the leadership of the medical and scientific communities, but also the full participation of the private sector, including international trade and finance.

JUSTIFICATION FOR OSI INVOLVEMENT IN GLOBAL TB CONTROL

- George Soros is the single largest individual donor to TB control in the world today.
- The regions in which the Network of Foundations is established— from the former Soviet Union to South Africa— are those in which TB is endemic or recrudescant; these regions are particularly hit hard by drug-resistant TB.
- The OSI brings two critical and previously missing components to TB control: a human-rights approach and new leadership from the business

sector, previously a minor player in the TB community. Furthermore, the geographical reach of the Network of Foundations is unparalleled and the OSI would bring significant experience to the containment of prison-related outbreaks.

JUSTIFICATION FOR CHOICE OF PARTNERING INSTITUTIONS AND COMPOSITION OF ADVISORY BOARD

The organizations identified as potential partners in an OSI-led TB eradication effort are the major participants in global TB control. The Advisory Board would bring together the leaders of these organizations, as well as key players in international public health. Others will no doubt be identified.

PROPOSED ORGANIZATIONS	PROPOSED ADVISORY BOARD REPRESENTATIVE
AMERICAN ACADEMY OF ARTS AND SCIENCES	<i>HOWARD HIATT</i>
CARTER CENTER	<i>WILLIAM FOEGE</i>
CENTERS FOR DISEASE CONTROL AND PREVENTION	<i>HELENE GAYLE</i>
HARVARD MEDICAL SCHOOL	<i>PAUL FARMER</i>
INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE	<i>NILS BILLO</i>
KNCV, HOLLAND	<i>KITTY LAMBRECHT</i>
LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE, UK	<i>JOHN PORTER</i>
MEDICAL RESEARCH COUNCIL, SOUTH AFRICA	<i>BERNARD FOURIE</i>
NATIONAL JEWISH MEDICAL AND RESEARCH CENTER	<i>MICHAEL ISEMAN</i>
NATIONAL TUBERCULOSIS CENTER & PUBLIC HEALTH RESEARCH INITIATIVE	<i>LEE REICHMAN</i>
RESEARCH INSTITUTE OF TUBERCULOSIS, KAZAKSTAN	<i>AMAN ZHANGIREEV</i>

PARTNERS IN HEALTH	<i>JIM YONG KIM</i>
ROCKEFELLER FOUNDATION AND THE HARVARD SCHOOL OF PUBLIC HEALTH	<i>LINCOLN CHEN</i>
UNIVERSITY OF ALABAMA	<i>MICHAEL KIMERLING</i>
WORLD HEALTH ORGANIZATION	<i>ARATA KOCHI</i>

WHAT ARE THE GOALS OF OSI-TB?

OSI-TB would not seek to replicate existing TB-control structures, nor would it seek to act alone in inaugurating new TB treatment and control efforts. Rather, OSI-TB would seek to fill in gaps:

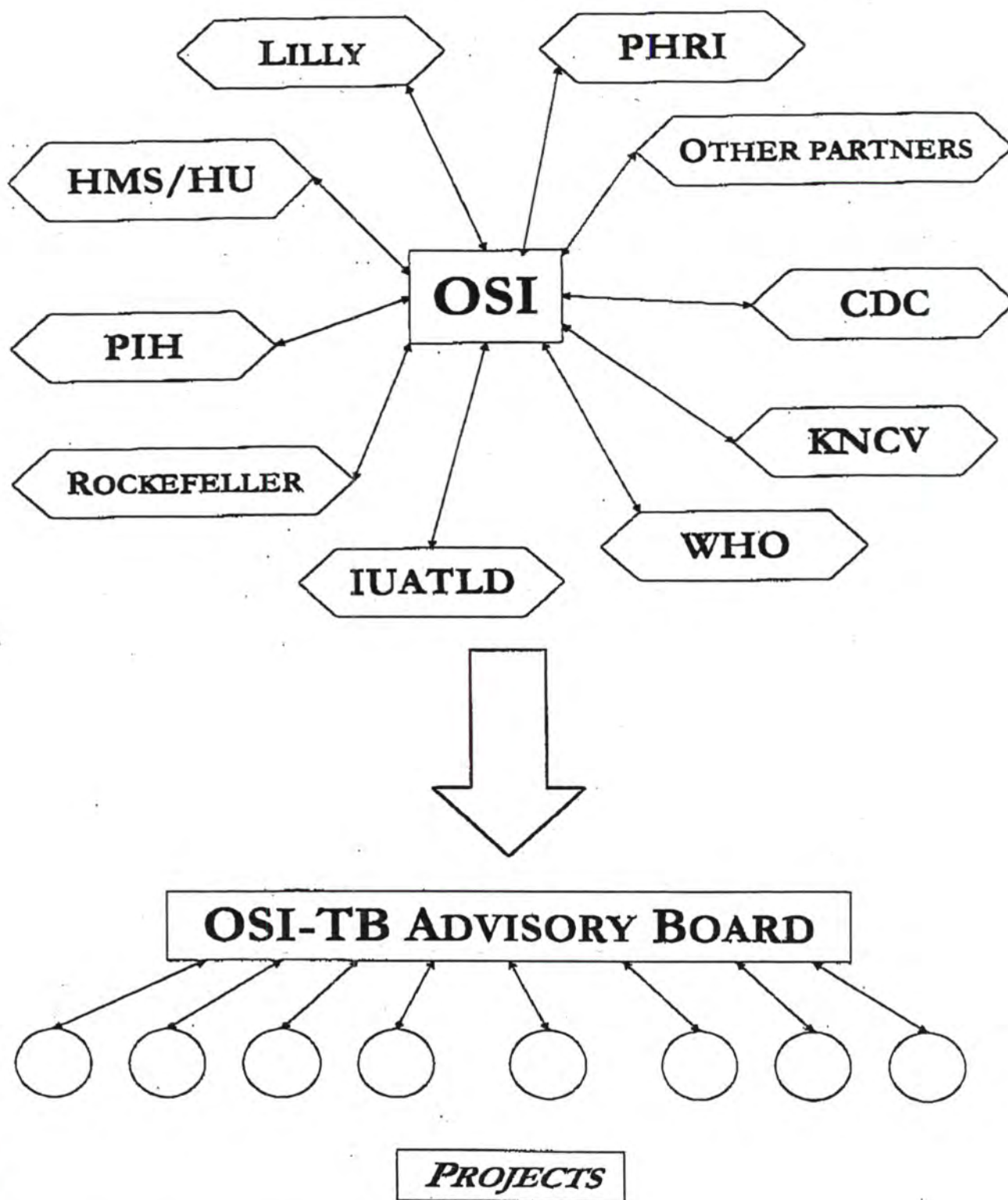
- *Leadership gaps* must be filled if truly global efforts are to progress. OSI-TB would have a special focus on leadership from business sectors, including international finance, the pharmaceutical industry, and philanthropies; the human-rights community would also be engaged.
- *Gaps in political will* must be filled if government support for national DOTS-based programs, including "DOTS-Plus," are to have real impact on the global TB pandemic.
- *Gaps internal to the TB community* have neglected critical developments—MDRTB and prison-centered outbreaks of TB— that threaten the hard-won gains of global TB control.
- *Funding gaps* will be filled not through direct OSI contributions, but rather through coalition building to channel new resources into priority TB-control efforts.

HOW WOULD OSI-TB WORK?

OSI-TB can make have an enduring impact on global TB control through a four-step process:

1. Forge a powerful consortium of actors and institutions, led by an expert Advisory Board.
2. Convene a meeting of Dr. Gro Brundtland (WHO), Jim Wolfensen (World Bank) George Soros, the U.S. Surgeon-General Satcher, and leaders of the global TB community to launch a worldwide campaign to bring new resources to TB control.
3. This campaign will have as its centerpiece a drive to secure an unprecedented commitment of public and private resources— the Global Trust for TB Control— targeted to Board-approved projects.

-
4. Identify TB "hot zones" where new public-private partnerships, funded through the Trust, can contain deadly epidemics and promote the primary goals of modern TB control.



**PROGRAM IN INFECTIOUS DISEASE AND SOCIAL CHANGE**

DEPARTMENT OF SOCIAL MEDICINE, HARVARD MEDICAL SCHOOL

641 HUNTINGTON AVENUE, BOSTON, MA 02115

PH. (617)432-3715, FAX: (617)432-2565

PAUL FARMER AND JIM YONG KIM, DIRECTORS**TO: ARYEH NEIER & GEORGE SOROS****OPEN SOCIETY INSTITUTE****FAX: 212-548-4608****FROM: PAUL FARMER, M.D., PH. D.****DATE: 17 SEPTEMBER 1998**

During the week of 6-11 September, I traveled with a fact-finding mission to investigate the state of tuberculosis (TB) control in Russia, with a particular interest in assessing the problem of TB in prisons. We also evaluated the OSI-funded TB control initiative conducted by the Public Health Research Institute (PHRI). Our team included representatives of the World Health Organization (WHO) and U.S. Centers for Disease Control, as well as clinical and research specialists in tuberculosis control. This group, which serves as the advisory committee to the PHRI projects, counts decades of experience in TB control and research. I myself acted as special consultant on TB epidemiology and treatment to the OSI.

For a number of reasons, we expected the TB situation in Russia to be grim. Several of us had previously visited regional TB facilities; all of us were familiar with reports, in the Russian and foreign popular press, describing large outbreaks of TB and high case-fatality rates. These outbreaks, in tandem with the dismantling of the public-health infrastructure, have led to a rapid rise in national case rates. In 1990, TB incidence in Moscow was estimated at 27 per 100,000 population; by 1993, it had almost doubled, to 50 per 100,000. The situation is significantly worse in Siberia, where incidence went from 43 to 94 per 100,000 during the same period. By March 24th, 1998, it was possible for the WHO to announce that TB incidence in Russia had risen another 50% between 1994 and 1996. About a quarter of a million new cases were detected in 1996 alone.

We were also concerned about multidrug-resistant tuberculosis (MDRTB). Most members of the committee had read the recent WHO/IUATLD report, which suggested decreased cure rates and significant levels of resistance to first-line antituberculous drugs in the region surveyed. Finally, we knew that the epidemic was particularly affecting, and amplified within, the prison system. In the space of the last few years, TB has become the leading cause of mortality among Russian prisoners and detainees, accounting for 40-80% of all prison deaths in some facilities. National TB mortality among Russian prisoners was recently pegged at 484 per 100,000— among the highest in the world.

In the light of these unwelcome trends, the OSI-funded initiatives were deemed particularly welcome both by many Russian officials and by the broader, global TB community. The PHRI has initiated work in both the civilian and prison populations of Tomsk, and has recently expanded its support of key reforms to the neighboring oblast, Kemerovo. Similar efforts are also underway in Vladimir, closer to Moscow.

I have visited all of these regions. On this most recent trip, however, the mission visited Siberian facilities only. What we found disturbed us greatly. A PHRI-led public-private coalition—linking foreign NGOs, including Médecins Sans Frontières (MSF) and MERLIN UK, with both prison and civilian health authorities—has already led to substantial improvements in aspects of TB control, ranging from case detection to the standardization of record-keeping and program evaluation. Furthermore, this coalition has been able to substantially reduce improper TB-control practices, which are the root cause of increased rates of treatment failure and increased rates of acquired resistance to the best and least expensive drugs. The committee was unanimous in deeming these reforms central to any effort designed to avert further disaster.

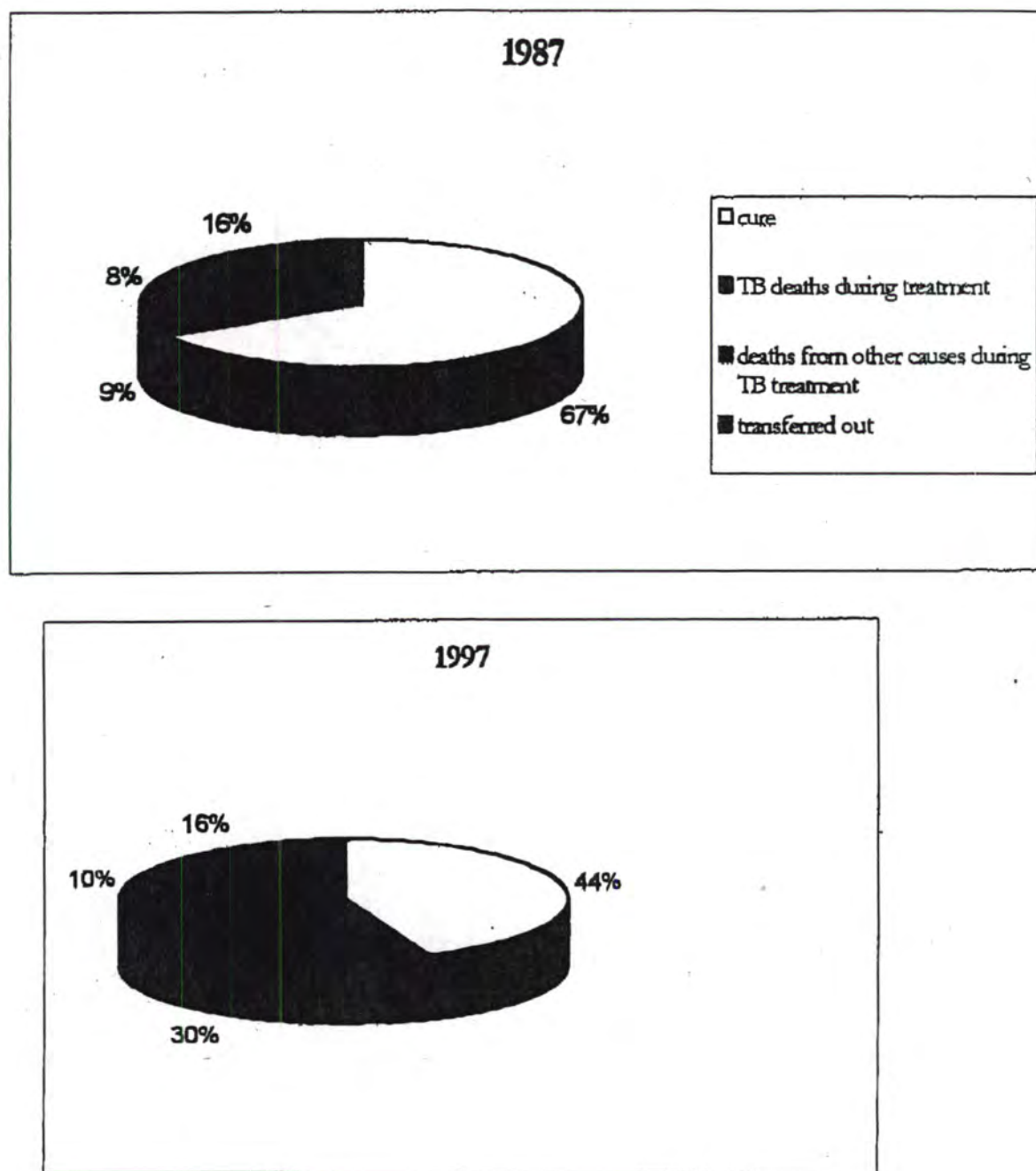
These reforms, however, come late. When the OSI-funded initiative was planned and funded, the contribution of drug resistance to low cure rates was unknown, but MDRTB was estimated to represent no more than 5% of incident cases. What we found, however, was a rate of MDRTB many times in excess of this estimate, and we suspect that drug resistance helps to explain the very low cure rates seen inside a number of the institutions in which standard TB-control practices have been implemented.

The case of Penal Colony 33, in Mariinsk, Kemerovo, gives an idea of both the gravity and extent of the problem. For the last few years, the Belgian branch of MSF has worked inside the Colony with close cooperation, obviously, from prison officials. Treatment has been standardized, and case detection, treatment protocols, and record-keeping are now in keeping with WHO-endorsed TB-control practices. And yet, preliminary cohort studies have revealed cure rates of less than 60% even though the standardized regimen has been bolstered by a fifth drug, and all doses are directly observed. Although complete drug-susceptibility data are not available, preliminary testing in Belgium suggests that a majority of treatment failures are due to drug resistance. Patients who fail therapy now constitute an increasingly large proportion of those detained in Colony 33; they are eventually isolated from other prisoners. Since Russian law does not permit indefinite detention, however, these prisoners, still infectious, are simply released into the community at the end of their term. A majority of the group—80% by some estimates—are lost to follow up after release, underscoring the need for close coordination of prison and civilian TB control.

Rapidly rising TB case rates elsewhere in Kemerovo Oblast are further proof of the relationship between prisons and the surrounding community, as is the fact that fully a third of all civilian TB diagnoses are made in those with a history of imprisonment. Finally, the highest extramural rates are registered among prison guards and others working in close association with TB-affected prisoners.

Equally disturbing, and again suggestive of the increasing contribution of drug resistance to poor outcomes, are data showing that, between 1987 and 1997, as rates of TB skyrocketed, cure rates went from an already-low 67% to a sobering 44 %. (See Figure 1). Death rates among those treated also increased, from 9% to 30%. Note that rates of abandonment and death due to other causes during treatment remained constant.

Figure 1. Trends in TB treatment outcomes, 1987 and 1997
Kemerovo Oblast, civilian population



After meeting with both civilian and prison officials from Kemerovo, the fact-finding mission met with the state governor and leading health officials. We urged the governor to declare tuberculosis an "emergency," and he assured us of his strong and unconditional support for the institution of

WHO's Response to the Global Tuberculosis Emergency

1. In 1993, the World Health Organization declared TB a global emergency. It took this unprecedented step as TB was claiming the lives of 2-3 million people each year, making it the leading infectious killer of youth and adults. Increasingly, the disease was becoming resistant to currently available medicines because of careless TB treatment practices. (Drug resistance can develop when patients get the wrong drugs, drug supply is irregular or patients stop taking their medicines too soon because they feel better). And yet, in spite of these dangers, the world's response to the epidemic was minimal.
2. WHO defined the enormous size of the global TB problem through expanded monitoring and surveillance. For example, it determined that TB had become the leading cause of death among HIV positive people. The disease also orphans hundreds of thousands of children each year and is the single biggest killer of young women.
3. WHO also determined that TB is a major contributor to poverty. Eighty per cent of TB patients are in the most economically productive years of their lives. TB sends many self-sustaining families into poverty. If the breadwinner of a family is not properly diagnosed or treated, he or she will lose, on average, a full year of work.
4. WHO developed an effective TB control strategy known as DOTS. DOTS is the most effective strategy available for detecting and curing TB. It was developed from two decades of testing and best practices. DOTS requires direct observation of treatment to ensure that patients take the medicines; and it also requires government commitment, microscopy services, reliable drug supply and monitoring systems. DOTS can help any country -- rich or poor -- to achieve high cure rates. DOTS achieves cure rates as high as 95 per cent even in economically devastated or war-torn areas. Besides achieving high cure rates, DOTS has a number of important advantages:
 - The strategy can be integrated successfully within general health services to achieve widespread coverage.
 - DOTS does not require hospitalization or isolation. Patients can remain at home and return to work in a few short weeks.
 - DOTS is as effective in curing TB in both HIV-positive and HIV-negative people, and is one of the most affordable ways of extending the life of a HIV-positive person.
5. WHO and the World Bank determined the cost effectiveness of DOTS. DOTS helps prevent multidrug resistance, which is often fatal and up to 100 times more expensive to treat. The World Bank considers DOTS as one of the most cost-effective health strategies available. A six-month course of drugs for DOTS costs between \$10 to \$20 per patient in most developing countries. DOTS is a sound economic investment for any government. For example proper use of DOTS in Thailand could save the country \$2.3 billion over 20 years.
6. The Organization promoted the global implementation of DOTS. WHO developed the necessary tools, guidelines, training materials and policies to promote the implementation of DOTS. At the same time, WHO embarked on major advocacy and intensified technical assistance to over 50 countries, focusing on big countries with largest TB burdens. These efforts have made DOTS one of the fastest expanding health interventions of this decade. Today, nearly 2 million people are being cured with DOTS.

Indicator	1990	1998
Number of countries using DOTS	10	110
Percent of TB patients being treated by DOTS	Under 1 percent	15 percent
Drug costs per patient	\$40-60	\$10-20
External donor aid to TB control	\$16 million	\$70 million

WHO's Challenge Ahead

1. WHO has identified the main constraints that are preventing further progress against the TB epidemic. These are 1) lack of political commitment; 2) lack of human and financial resources; 3) unavailability of affordable and secure supplies of anti-TB drugs; 4) increased multiple-drug resistant TB (MDR-TB); and 5) the HIV epidemic, which is partly fueling the global TB epidemic. A global strategy is needed to address these constraints, particularly in high-burden countries.
2. WHO's new Director General - Dr Gro Harlem Brundtland - has identified TB as a priority concern for the "renewed" WHO.
3. A groundwork must now be established among global partners for a major initiative on TB. The Stop TB Initiative will lay out and prioritize the steps needed to overcome current constraints to action and provide the basis for a significant expansion of global efforts against TB.
4. The Stop TB Initiative will serve to command increased attention and resources for further implementation of DOTS; swiftly establish solutions to sustained global access to anti-TB drugs; identify cost effective options for addressing MDR-TB and frame a long term vision for a TB research and development agenda to include new tools - most importantly an effective vaccine.

THE GLOBAL TUBERCULOSIS EPIDEMIC

Burden of disease

- There were an estimated 8 million new cases of TB in 1997, including 3.6 million cases of infectious pulmonary disease, and 16.1 million existing cases of disease.
- An estimated 2.0 million people died of TB that year, about 1 in 4 cases. TB causes more deaths than any other single infectious agent.
- Roughly 1 in 3 people carry the *M. tuberculosis* bacterium (MTB), i.e. 1.8 billion people.
- Countries in South East Asia had the largest number of new cases (3.0 million) in 1997, but the rate per head was highest in sub-Saharan Africa (257/10⁵ persons).
- 22 countries had 80% of all incident cases. The leading five together accounted for over half the global total. They were all in Asia: India (1.9 million), China (1.4 million), Indonesia (583,000), Bangladesh (292,000) and Pakistan (261,000).
- 1 in every 500 people was infected with both TB and HIV. Three-quarters of a million TB cases (8%) were infected with HIV. The highest rates of co-infection (over 1 in 50 people) were in southern Africa, but India had the largest number of co-infected individuals (1.9 million) and the largest number of HIV-infected TB cases (190,000).
- Surveys suggest that about 1 in 10 TB cases is resistant to at least one drug; about 1 in 50 cases is multi-drug resistant (to at least isoniazid and rifampin).
- The huge scale of the problem is explained mainly by poor control and population growth in south Asia and sub-Saharan Africa, and high rates of MTB/HIV co-infection in some African countries.

Trends

- Without greater control effort, annual TB incidence is expected to increase from about 8 million cases/year in 1997 to 11 million cases/year by 2020.
- Reaching WHO targets of 70% case detection and 85% cure by year 2010 could save about 1 in 4 cases (approx. 50 million) over the next two decades.
- The incidence of disease is increasing most quickly in African countries that have high levels of HIV (e.g. Malawi, Kenya, Tanzania). It is also increasing quickly in countries where control programmes have broken down (e.g. Russian Federation).

Control

- Only about half of infectious cases are treated and cured. The cure rate in DOTS Programmes is much higher than average, typically about 80%.
- Approximately half of all countries have now adopted the WHO DOTS strategy. Twenty-one of the 22 highest-burden countries have DOTS Programmes, but most with low rates of case finding and cure.
- At present, about 1 in 10 infectious TB cases is cured in DOTS programmes
- Among high-incidence countries, the best control programmes are in Peru, Tanzania and Viet Nam, though programmes in Bangladesh and China have expanded rapidly during the 1990s.
- Progress in TB control is very slow in the majority of high-burden countries, notably India, Indonesia, Nigeria, Pakistan, Philippines and Russia.

No. 2

Briefing Points for the Director-General's 28 October meeting at the White House With Mrs H Clinton, Mr J Wolfensohn and Mr G Soros**The Tuberculosis Problem**

- Each year there are about 8 million new TB cases, with about 2 million deaths.
- Multidrug-resistant TB (MDR-TB) has emerged as a major threat to TB control in some countries, including Russia and the Baltic States.
- In 1997 an estimated 8% of TB cases were attributable to HIV, the burden falling mainly on sub-Saharan Africa and increasing in other regions, especially the Indian sub-continent.
- TB is the biggest single killer of women aged 15-44 world-wide, is the major cause of death among the HIV infected, and is a significant brake on socio-economic development in poor countries as it affects mostly young adults.
- The global response to TB has thus far been inadequate: many poor countries are failing to control it; rich countries are not doing enough to support TB control in the poor countries and, as a result, the prevalence of TB globally remains unacceptably high, and MDR TB is being created and spread internationally.

The Current Solution to the TB Problem

- The DOTS strategy has been shown by the WHO in collaboration with the World Bank to be one of the most cost effective health interventions.
- Proper case detection and cure of infectious cases are the cornerstone of the TB control strategy.
- Successful implementation of such strategy achieves high cure rates (e.g., 95% cure among a quarter of a million TB patients annually in China).

Existing Constraints to the Solution

- The DOTS strategy is labour intensive, requires direct observation of treatment and strict patient monitoring.
- Where the prevalence of MDR-TB is high or where HIV infection is widespread, control measures in addition to the DOTS strategy are necessary.
- Although 97 countries have adopted the DOTS strategy, only 15% of TB patients globally are treated under DOTS because only few countries have achieved full coverage.
- Governments of high prevalence countries have shown insufficient political will and leadership, and have not allocated adequate financial resources.
- There is a lack of trained human resources and of secure, quality controlled drugs.
- Inefficient drug procurement systems in most countries result in an increase in the cost of drugs and produce shortages of stocks.
- BCG vaccine is ineffective to prevent infectious forms of TB, thus it cannot interrupt TB transmission.

Recommended Actions

The current global TB control situation is similar to that of vaccine preventable diseases in the mid 1980s. EPI has successfully progressed to achieve the global targets in the early 1990s through global coalition building and country specific social mobilization. Even though TB control and the implementation of DOTS may be more complicated than EPI operations, through global coalition and country specific social mobilization, DOTS coverage can be expanded to allow achievement of the global targets of 70% case detection and 85% cure rate by 2010. Therefore, we recommend the following:

1. WHO, the World Bank and various US agencies and private charitable interests such as the Open Society Institute commit themselves to work together and combine efforts to analyse constraints, prepare, appraise and finance projects that provide solutions and assist countries with high quality technical implementation of TB control.
2. WHO, in partnership with the World Bank, various agencies throughout the world, and other private and public interests will establish a Stop TB Initiative which has the following four components:
 - " A global charter for advocacy and commitment to TB control and elimination of MDR-TB.
 - " A global action plan to coordinate interaction among international partners to ensure effective TB control.
 - " A mechanism to swiftly establish global access to anti-TB drugs.
 - " A global research agenda balancing short and long-term vision.
3. Successful Initiative will ensure the following:
 - " TB activities at WHO and worldwide are facilitated.
 - " Expanded effective TB control in high burden priority countries.
 - " Expanded global surveillance of drug resistance and new interventions to treat MDR-TB focusing on Russia and other high MDR-TB burden countries.
 - " A global drug facility or direct drug funding to countries in need to ensure the sustained supply of quality, fixed-dose, combination TB drugs.
 - " Coordinated approaches to the care and prevention of TB and HIV, especially in Sub-Saharan Africa.
 - " Improved tools to deliver effective TB control services as an integral part of primary health care.
 - " Development of new tools, such as rapid diagnostic tests, drugs and vaccines.

The World Bank's Current Activities in Tuberculosis Control

- The World Bank is fully committed to fighting the global tuberculosis epidemic. The World Bank's contribution is twofold: through the policy advice it provides to countries, and through country-specific lending.
- In pursuing TB control activities, the Bank collaborates closely with WHO, NGOs, bilateral and technical agencies. For example, a current Bank project in Latvia will be financing improved TB treatment and surveillance, with technical assistance provided by the U.S. Centers for Disease Control. The Bank is also working closely with partners regarding potential interventions for improved TB control in Russia.
- The Bank has provided nearly US\$ 300 million in financing for tuberculosis control programs since 1989, making it the largest single source of external funding for tuberculosis control in developing countries.
- About twenty countries are using World Bank financing to implement the WHO-recommended TB control strategy (DOTS). Several new projects are under preparation. Some projects are tuberculosis-specific, but a majority address TB control within broad health sector development and health sector reform projects.
- The two largest Bank-supported TB control projects are in China and India. These countries are home to more than one third of the world's estimated 8 million new TB cases each year.
- The project in China was initiated in 1992 and has demonstrated dramatic results with the DOTS strategy: half of the country's population is now covered, and over one million infectious cases have been cured to date. The challenge now is to expand this success to the rest of China and to achieve financial sustainability.
- In India, the TB control project, which began in 1997, has also achieved excellent results with DOTS in several pilot regions. It has established the foundation for the Revised National TB Control Program, and is providing the impetus for an 8-12 year process of extending the approach nationwide. Political commitment, assured drug supply, health worker training and supervision, patient education and motivation, and operational research are critical to the progress of these projects.
- The Bank is supporting implementation of the DOTS strategy in countries as diverse as Bangladesh, Cambodia, Cote d'Ivoire, Egypt, Haiti, Krygyzstan, Morocco, Niger, Philippines, Romania, and Vietnam. In some countries, tuberculosis control is intimately linked to prevention and control of HIV/AIDS, and the strengthening of collaborative interventions, education, and referral is critical.

7142

ALFONSE D'AMATO, NEW YORK, CHAIRMAN

CHRISTOPHER H. SMITH, NEW JERSEY, CO-CHAIRMAN

Ben Nighthorse Campbell, Colorado
Spencer Abraham, Michigan
Conrad Burns, Montana
Olympia J. Snowe, Maine
Frank R. Lautenberg, New Jersey
Harry Reid, Nevada
Bob Graham, Florida
Russell P. Feingold, Wisconsin

John Edward Porter, Illinois
Frank R. Wolf, Virginia
Matt Salmon, Arizona
Jon Christensen, Nebraska
Steny H. Hoyer, Maryland
Edward J. Markey, Massachusetts
Benjamin L. Cardin, Maryland
Louise McIntosh Slaughter, New York

EXECUTIVE BRANCH COMMISSIONERS

JOHN SHATTUCK, DEPARTMENT OF STATE
(Vacant), DEPARTMENT OF DEFENSE
(Vacant), DEPARTMENT OF COMMERCE

MICHAEL R. HATHAWAY, CHIEF OF STAFF
DOROTHY D. TAFT, DEPUTY CHIEF OF STAFF

The Honorable Madeleine Albright
Secretary of State
Department of State
2201 C Street, NW
Washington, DC 20520

COMMISSION ON
SECURITY AND COOPERATION IN
EUROPE

234 FORD HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6460
(202) 225-1901
FAX: (202) 226-4199
E-MAIL: CSCE@MAIL.HOUSE.GOV

October 9, 1998

TO : K. BERNARD
FYI.

Dear Madame Secretary:

We are writing to focus your attention on the growing threat of Multiple Drug Resistant Tuberculosis (MDRTB) in the Russian Federation, as outlined in the attached information. We would appreciate learning what initiatives have been undertaken by the United States to help contain and defeat this biological threat. Like the Y2K problem, the MDTRE problem can become a crisis if not addressed in a timely and effective manner.

With easy international travel and limited means of protecting people from an airborne pathogen, the incubation and spread of MDRTB in Russia also poses a threat to the health of the U.S. population. Moreover, as the world has seen before in this century, the spread of disease, whether influenza after World War I or AIDS in Africa, can threaten and even upset social, political, and economic structures necessary for peace and security.

This medical threat must be addressed now, while it may still be possible to limit the consequences. Given Russia's economic troubles and political uncertainty, a concerted international effort to help the Russian authorities contain the spread of this disease and treat its victims appears to be urgently necessary. Currently, the Open Society Institute of the Soros Foundations is funding a \$12 million program to combat TB and MDRTB in Russia. Other NGOs, such as Doctors Without Borders, Medical Emergency Relief International, and the New York Health Research Institute, have already begun studying the issue and have raised the alarm. But the problem is genuinely global in scope and will require assistance from governments.

We understand that George Soros is planning in the near future to discuss this troubling matter with Mrs. Hillary Rodham Clinton and World Bank President James Wolfensohn, and to emphasize the necessity of governmental involvement. The United States should certainly take the lead in coordinating the activity of medical experts, foreign capitals, international organizations and NGOs to assess the risk and

Secretary Albright

October 8, 1998

Page 2

work out a plan of action. Perhaps the State Department could convene a conference, along with NIH or CDC, to look at this problem from both the Russian and U.S. ends, i.e., the potential public health impact on the United States, as well as the economic and political impact on the Russian Federation. Perhaps such a conference can identify what exactly the United States can do to help combat this disease.

We are sure you share our concern about this global threat, and we in Congress would like to work with you in averting a crisis. We look forward to hearing from you at your earliest convenience and learning what the Department is doing to address this important issue.

Sincerely,



CHRISTOPHER H. SMITH, M.C.
Co-Chairman



ALFONSE D'AMATO, U.S.S.
Chairman

cc: Mr. Samuel R. Berger
Asst. to the Pres. For Nat'l. Sec. Aff.

Enclosure

**TB Meeting
October 28, 1998**

file TB

List of Participants

World Health Organization

Dr. Gro Brundtland

Dr. David Heymann

*Executive Director for Communicable
Diseases*

Ambassador Jonas Store

Executive Director

Ambassador Thomas Loftus

World Bank

Dr. James Wolfensohn

President

Jan Piercy

U.S. Executive Director

Dr. David de Ferranti

*Vice President, Human Development
Network*

Chris Lovelace

Director, Human Development Sector

Open Society Institute

George Soros

Dr. Paul Edward Farmer

Dr. Alexander Goldfarb

Dr. Srdan Matic

Project 55 TB Initiative (Ralph Nader grp.)

Christoph Lee

AID

Administrator Brian Atwood

Duff Gillespie

*Deputy Assistant Administrator for
Population, Health and Nutrition*

HHS

Secretary Donna Shalala

Peggy Hamburg

Asst. Secretary for Planning and Evaluation

State

Frank Loy

Undersecretary of State for Global Affairs

Melinda Kimble

Douglas Wake

Office of Assistance to the NIS

WH/NSC

Melanne Verveer

Marsha Berry

Ken Bernard

Andrew Weiss

Leon Furth