

**Global Health Working Session: Neglected Health Threats:
Silent Killers, Practical Responses
2006 Clinton Global Initiative Annual Meeting
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FEMALE SPEAKER: Ladies and gentlemen, please remain in your seats. Our next panel is about to begin. Thank you. Ladies and gentlemen, please take your seats. We are about to begin our next panel. Ladies and gentlemen, please take your seats, we are about to begin. Please be seated. Once again, please take your seats. We'd like to begin in 30 seconds. Please be seated. Ladies and gentlemen, may I have your attention please. Please welcome our next set of panelists, Lance Armstrong, Valentine Fuster, Srinath Reddy, and Nizal Sarraf Zadeگان.

[APPLAUSE]

And our moderator, once again, George Stephanopoulos.

[APPLAUSE]

GEORGE STEPHANOPOULOS: Thank you all. Can you all hear me? I think we have a lot of overlap from the last program, and this is really in many ways the flip side of what we were talking about just in the last hour and a half. Before we were talking about diseases, which now only exist in the developing and in the poor world that have been eradicated from the more developed world, but now we're going to focus on chronic diseases that we usually think are more prevalent, and are more prevalent in the developed world. Things like cancer, heart disease, respiratory disease, stroke and diabetes, but are increasingly becoming a tremendous problem for the developing world as well. In

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fact, they are now the number one cause of death in the developing world except for the AIDS ravaged nation of sub-Saharan Africa.

Let me just throw out a few numbers at the start. Seventy-percent of cancer deaths are now in the developing world. Eighty-percent of demand for tobacco comes from the developing world and the UN just reported for the first time ever, and this is something that really surprised me, there are now more people overweight than underweight in the developing world. By 2025, the World Health Organization expects that three-quarters of the diabetics are going to be coming from the Third World, and four out of five of the 17 million annual cardiovascular disease deaths took place in low- and middle-income countries, and it's starting to affect younger and younger citizens of those countries. Obviously, this is a huge health problem. It is killing people everyday. It's costing the global economy billions.

With that context, let me introduce our panel. You probably all know Lance Armstrong, seven times Tour de France winner.

[APPLAUSE]

You probably also know of his personal history overcoming cancer and of his tremendous work here in the United States now in trying to prevent cancer.

Next to him is Dr. Nizal Sarraf Zadehan, who is the

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director of the Cardiovascular Research Center in Isfahan, Iran. She started a healthy heart program and works with schools, businesses, and health professionals to promote healthy lifestyles. You're going to have to explain this later, but one of your major contributions is to adapt the Finnish model, which is the world standard for cardiovascular disease prevention to the realities of low and middle income countries.

We also have Dr. Valentin Fuster, who is the president of the World Health Foundation, and a professor of cardiology at Mount Sinai. He leads global efforts to have heart disease recognized as the major killer in both the developed and the developing worlds, and the WHF, under his leadership has pioneered development of new and innovative partnerships with corporations who share this goal.

Finally, to my right, Dr. Srinath Reddy, who is one of the first to warn of an impending epidemic of cardiovascular disease and diabetes in India, and has been one of the world's most proactive leaders in stemming the spread of chronic diseases. He is president of the Public Health Foundation of India, and professor of cardiology at the All India Institute of Medical Sciences.

Welcome to all the panelists, and Lance, let me begin with you. If you could just draw on your personal experience with the foundation here in the United States addressing

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cancer. What lessons do you draw from that that could be applicable to the developing world?

LANCE ARMSTRONG: Is this on? Obviously, cancer is a major killer in this country. Arguably the number one killer. There, I suppose, 15 or 20 years ago, there was a stigma around cancer. In this country, people didn't talk about it. They didn't share their stories if they were sick and they were getting chemotherapy, bald, and looked sick, they didn't go outside. I spent the last 15 years racing a bicycle in Europe, and I never saw somebody that was visibly undergoing chemotherapy. Sometimes they would come to the race and tell me their story, but just on the streets, very rarely.

Then I think as you move beyond Europe into Africa and Asia, again a stigma there. Also, a lot of misinformation, or no information, because people are a little bit clueless, but the facts are the facts. As the globe develops, habits continue to go south, which they have in America. Kids become more sedentary. Smoking on the increase. We know what that leads too. It leads to higher cancer rates and death rates. Tobacco is a big part of that. Just in this country alone, we know that tobacco could prevent 50-percent of all cancers. Look at a continent like Asia. Smoking is incredibly prevalent, and there are not a lot of controls there for that. Again, not a lot of

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information.

GEORGE STEPHANOPOULOS: Dr. Zadegan, let me have you follow up right there on the problem of tobacco and smoking. How do you deal with it in a culture like the Iranian culture, and across not only Asia, the Middle East, where there really hasn't been a stigma against the use of tobacco?

NIZAL SARRAF ZAEDGAN: Well, first I want to thank The Clinton Initiative for inviting me here and giving me this opportunity to talk about this really neglected issues and health issues everywhere around the world.

Regarding tobacco, I should say the most important market now is in Asia and in the Middle East area. Specifically for youth, the children. There is another emerging issue, which is the hubble bubble, [misspelled?] which is the water pike [misspelled?]. It's becoming very important and very popular. It was popular in some of these countries in the Middle East, but now it's becoming everywhere, and it's targeting women and youth as well. So it's a big problem, and how to work with this? How to combat with this? It's an issue not of education only, because it will not work. I think the problem should be solved comprehensively, its public education plus looking to the environment, having some environmental changes. You need policies. You need good policies. If you look to the FCTC

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with the major efforts that was done by WHO, and if you implement FCTC, that will be good.

GEORGE STEPHANOPOULOS: Why don't you explain what that is, the FCTC?

NIZAL SARRAF ZAEDGAN: FCTC. It's the Framework Convention Alliance for Tobacco Control that was done. It was a lot of effort and energy done by many, many countries with WHO, with many foundations, international foundations. NGOs, GOs, done for many years. It was ratified. It was signed and then ratified and I believe that the last country that ratified it was Ecuador. That was the 137th country that ratified it in July, last July. So it will become enforced when it is ratified by a country. There are many articles within FCTC dealing with everything, like education, smuggling.

GEORGE STEPHANOPOULOS: I'm sitting here looking at Donna Shalala in my eye line and it just makes me think about all of her efforts throughout the 1990s to work against and eventually with the tobacco companies to prevent them from targeting children with their advertisements. Is that a nonstarter in developing world, or have you had any efforts along those lines?

NIZAL SARRAF ZAEDGAN: There are some in force. There are many articles in FCTC dealing with this. Youth, selling to youth or dealing with youth. Passive smoking,

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secondhand smoking. All these things are dealing with youth, smoking with youth, and my ideas are to we need to reinforce these articles of FCTC. If it's done. If it's money toward, if it's evaluated to be well and properly implemented, we will have good success with tobacco control.

GEORGE STEPHANOPOULOS: I want to move to the optimistic side of this and hope, but first I'd like a little more discussion, Dr. Fuster, from you on the failures in preventing chronic disease in the developing world and what you've learned from them.

VALENTIN FUSTER: Well, I think we are first failing the developed world. It is the number one killer when you put cardiovascular disease and stroke, and now it's a plateau, but the disease appears six years later compared with three decades ago. So we have postponed, but the prevalence is very high. The problem in the developing countries is that they are becoming westernized. You talk about tobacco, but let me add lack of exercise, which leads to obesity. The foods that contain high carbohydrates are cheaper, so therefore you have now a conglomerate of tobacco; the companies are getting there, because I'm living from here. Then we have the lack of exercise and then we have these diet approach, which really has to change, so when you put all these three together, you can understand that 80-percent of the heart attacks that take place today, in 2005 -

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these are the statistics from the HMO, the last statistics are in developed countries - 80-percent of the heart attacks, and the prevalence and the incidence of the disease are really increasing.

So I feel very grateful, actually and very honored to be here this morning because this is a neglected problem, with a difference in comparison with the first panel. The great difference is economics. The first panel you didn't need much to have an action, and to have a benefit. In cardiovascular disease it's very expensive.

GEORGE STEPHANOPOULOS: Why is that?

VALENTIN FUSTER: To treat a heart attack, to prevent the next heart attack. The interventions that are coming in, it's very expensive. Therefore, it's a silent disease that we only become aware, we only stop smoking the moment we develop the first heart attack, and all has been silent. It's time to really pay attention, because in 10, 15 years from now, in developed countries, it will be absolutely impossible to afford what is coming up. This is basically why I feel this panel, particularly so important.

GEORGE STEPHANOPOULOS: Dr. Reddy, I want to come to you and talk about diabetes in just a second, but before we leave this subject, let me bring it back to Lance. I saw you nodding your head when Dr. Fuster was talking about the bad habits that are getting picked up in the developing world,

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lack of exercise, obesity. I just wondered it always surprises me to hear that. That it's happening both here and in the developing world, and how do you break through, particularly to younger people, and break those bad habits?

LANCE ARMSTRONG: I was nodding my head when he was becoming westernized because I have three little kids and we don't have an X-Box, and we don't have a PlayStation. I make my kids go out, fall down, scrape their knee, ride their bikes, swim in the pool, and do what we did as kids. The reality is that not only is the older population becoming lazier, but that trickles down to our children as well. Now I'm talking about exercise, but that also goes to food. We also talked about in racing, in terms of eating healthy. We wanted to eat close to the farm. Our country and our society is eating farther and farther away from the farm, which is also going to happen in other countries and other continents. It's all about convenience and it's all about cheap food and easy food.

All of this stuff adds up, so if you consider lack of exercise or sedentary lifestyle, poor diet, smoking, drinking, all of these bad habits, it's pretty clear what that leads to. Of course it starts here and as the world becomes modernized and westernized, they have those conveniences. That's going to lead to a global epidemic.

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GEORGE STEPHANOPOULOS: One of the things it leads to is diabetes. You've been dealing with that challenge in India. Talk to us about it.

SRINATH REDDY: Well, India is the world capital of diabetes. We currently have about 30 million people with diabetes, and it's expected that this number will double in the next 20 years. It's not just a matter of individual behaviors that determines who gets diabetes, who gets heart attacks, who gets blood pressure, or who takes to tobacco smoking. There are social determinates which can be modified by policy interventions. Professor said that heart disease is very expensive, indeed. All affairs of the heart are expensive, but we can actually have a fair amount of control by policy interventions, which help people access healthy foods, have physical activity and safe and pleasurable environments. Have a tobacco free public space, and have an advertisement ban on tobacco for example.

GEORGE STEPHANOPOULOS: So what are the policy interventions? What are we talking about specifically?

SRINATH REDDY: Well, let me talk about tobacco, advertising bans, raise taxes which increase prices and make it difficult for young people and poor people to purchase tobacco. We also require restrictions or a ban on access to young people. We need stronger health warnings. These are some of the measures that are shown to be very effective.

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In terms of diet, we need healthier oils and healthier fats to be supplied through the food chain at affordable prices.

GEORGE STEPHANOPOULOS: Are they always more expensive?

SRINATH REDDY: Unfortunately, in developing countries they are. You look at the West, for example, now you have removed transfats from the food processing industry. Unfortunately, that's not so in developing countries. In Marishis [misspelled?], one simple policy change of substituting the ration [misspelled?] oil from palm oil, to soy oil, just by the price change mechanism, encourage people to take healthier oils, and that brought the blood cholesterol levels across the whole population. Similarly, in Poland, the liberalization of the import of fruit and vegetables, and the substitution of vegetable oils for animal fats in the mid '90s, dramatically reduced the heart attack rates in contrast to other countries of central and Eastern Europe. So the power that policymakers and businesses have in changing the destinies of these countries is tremendous.

GEORGE STEPHANOPOULOS: They did it with tax policy, you're saying.

SRINATH REDDY: Absolutely. Tax policy is required to make unhealthy products like tobacco and unhealthy foods costlier and healthy products cheaper. We do require those

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kinds of policy interventions in order to help people to make and maintain healthy choices. Even urban planning, for example. If you create urban conditions, in which people can't take a walk, or cycle, and here we have Lance Armstrong, the best example of what cycling can do, but you have, unfortunately, situations where you make it extraordinarily difficult for people to have physical exercise. It is a paradox of our culture of modernity, that previously people used to be paid for doing physical work, now we are to pay for doing physical work by going to gyms and paying a fee. [LAUGHTER]

GEORGE STEPHANOPOULOS: Exactly right. Dr. Fuster, you mentioned the crossover from the earlier program, and I wonder if one of the things that we learned in the last panel was that you could treat these neglected or treatable diseases in clusters. I assume the same lesson applies here.

VALENTIN FUSTER: I agree. I like to make a very strong point, actually. In that one thing is that the policy makers, and I think has been very well pointed out, the impact that they can have, but let me go into the community. We are too ambitious. What we should do is to go to the community, engage the community, make the government and authorities to back you up.

GEORGE STEPHANOPOULOS: At what level?

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VALENTIN FUSTER: Any community, especially the Island of Grenada, in the Caribbean, 100,000 people. I call that a community. You can be the community of a neighborhood. New York has about seven different communities with all their own roots and their own culture. That's the way to get at, and to understand that community. One of the things that we learned in the Island of Grenada, for example, is we are really preventing disease to go from diabetes into cardiovascular event, because that's the stage they are. We learned very rapidly, we didn't understand that culture, so we had to spend weeks to understand what is going on there. Now the point is, these people in the neighborhood help each other, so I'd like to finish this comment by saying to you the following.

Our vows [misspelled?] we do not change unless there is a law, unless there is a policy as was described on things that we can change we don't, but if we have our friends to support us and to go with us, that to me is extremely important for the future.

GEORGE STEPHANOPOULOS: Is that a difference, then, between what we're talking about here and what we're talking about before? Both you and Dr. Reddy have talked about policy intervention, and it seems like because these problems are on such a grand scale and have so many different causes,

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that governments are going to have to deal with it, not generally private foundations or corporations on their own.

VALENTIN FUSTER: I disagree. I'm sorry.

GEORGE STEPHANOPOULOS: You disagree?

VALENTIN FUSTER: I do.

GEORGE STEPHANOPOULOS: Go to it. [LAUGHTER] Let me hear. Both of you, I want to hear you both.

VALENTIN FUSTER: First of all, if we go to a community, the first thing I have to do, I have to talk to the governor, and the next thing I need is money. Who is going to give it to me? So you cannot say that you work in a community and you don't need the private enterprise. You just need it. You don't need the private enterprise to do a magnificent thing in a huge country, you need it there too. So I think we really have to come down to the reality and today, the partnership, whether you work on a neighborhood or whether you work on a community, and the authority in that community is absolutely essential to succeed.

SRINATH REDDY: We do need policy interventions from the government to create climate conducive to health behaviors, but who sets the agenda for the policy? Who actually allows the policy to be implemented successfully? Ultimately these are communities. It is the wish and the wisdom of the community that ultimately forces policy makers to implement health policies. If the community is also not

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mentally prepared to accept policy changes like for example, smoke free public places, you may enact laws but they will never succeed, so you do require both the top down regulatory approach as well as a bottom up community mobilization approach.

This is where the civil society organization need to be strengthened so they can actually activate and mobilize the strength of the communities. That is where all the people who are gathered here can strengthen NGO capacity so that right from schoolchildren to women in the communities to as well as other organized civil society groups, they can be strengthened in order to not only articulate the demand for health policies, but also to ensure the success once the policies are introduced as laws.

NIZAL SARRAF ZAEDGAN: I want to add that usually governments, it's not in low and middle countries only. It's in high-income countries too. In [inaudible] of countries. They are not interested that much with dealing chronic diseases prevention, because it takes a long time to prevent so you will see the outcomes a little late. You will achieve them very late, and also it needs more money, sustainable funds. So the problem is that they are more interested with infectious diseases, and if you see since yesterday, I was talking to my friends now, to Janet [inaudible], since yesterday, we are talking infectious diseases. All donations

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go to malaria, to tuberculosis, AIDS. I'm not against this. It's good, but we should look to the individualized as one individual.

If you remember the picture of the lady yesterday, Mrs. Laura Bush, she showed a picture of a lady who was happy of having, she was HIV-positive, and she would not get the disease and she was happy with that. She was obese. I was thinking that, she is, she will not get the disease, yes, that's right, but she's obese. She will get diabetes in the future, cardiovascular disease, because this is the real neglected part, which is the most important reason for mortality everywhere in the world. Governments are not interested with that, so in our situation, in the Middle East area, we need some demonstration projects. We need some practical models, evidence to show to the government, and then to get their attention to pay or to invest to do something for prevention.

GEORGE STEPHANOPOULOS: You talk about the resistance at the government level. Do you find much cultural resistance?

NIZAL SARRAF ZAEDGAN: It's everywhere. If you want to start something to plan for a community-based prevention, you need to think about all levels of prevention. In order to go and get good results, so it's primary, it can do all these levels of prevention. You need to do a good situation

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analysis to study what is going to go on in the community. What are the social determinates, cultural determinates? Whether they are in favor of your interventions? What are against your interventions? In terms of everything.

People believe policies, legislations, environment, everything, is not when we go with WHO like we have some training courses, like with some other countries. We talk to the people. They say the situation analysis is to look for the prevalence of the risk factors. What's the percentage of the people who are smokers, obese, having diabetes, cardiovascular disease, that's it? It's not the case. You need to think about why? What are the reasons? What's the environment? What are the policies? All these things, and to plan for a community based initiative or interventions strategies, based on all these points and issues, and then you will get better results.

GEORGE STEPHANOPOULOS: Lance, you thought a lot about this as it applies to cancer, and obviously - and I know you focus especially on prevention. We all know, you don't smoke you're less likely to get cancer. You don't go in the sun, you're less likely to get cancer. What are the other rules that you've learned in your work?

LANCE ARMSTRONG: I just want to say one thing about the smoking part.

GEORGE STEPHANOPOULOS: Okay.

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LANCE ARMSTRONG: Because I think in this country there are certain cities like Austin, Texas, where we live smoke free, the city is smoke free, but then it took away a little bit city by city. Then you look at a country like Ireland, which – any Irish people here? Start drinking Guinness when they walk. [LAUGHTER] Yet that whole country mandates smoke free. I think that's an amazing policy, and obviously that comes from the top down.

I think that this country should do something like that too, for something that's clearly so devastating and so strongly linked to a lot of problems, not just cancer but heart disease. All of the things that we just discussed. Outside of that, you asked me what else we've come to know. It's simply, of course, some people are just predisposed and that's bad luck, but a lot of times prevention and awareness is so strong and so obvious in terms of not smoking healthy lifestyle. It's all about lifestyle. It's what you do when you wake up 'til when you go to bed.

Then the other thing I suppose we haven't talked about is, which is probably bigger in this country than some other places, is stress. As we know, stress in this country, running around and trying to live the life that you want to live, is tough sometimes as opposed to other places where life is simpler.

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GEORGE STEPHANOPOULOS: Simpler, but a little hard to get around. Harder to get around, but Dr. Reddy, if you could talk about the resistance you've gotten at the government level. The kinds of interventions that you think are necessary, and what you learned about how to overcome them.

SRINATH REDDY: Firstly, there has been a reluctance on part of most governments in the developing countries, just as it is there in government partners and donor communities internationally. To recognize that chronic diseases are a major threat to people in the developing countries. There is also a prior prejudice that this affects only the rich, it does not. The poor people are increasingly affected and that most vulnerable victims as the epidemics advance. Even now in India, we have clear evidence that a person with a low income is about one and a half more likely to get a heart attack. A person with low educational status is twice as more likely to get a heart attack, and this is true of developing countries as well. The poor not only are more at risk, but they are also more vulnerable, because they have less access to health services and affordable technologies, but now that the governments have begun to recognize that this is a problem and this needs to be tackled, there are policies that are being set in motion but they need to be strengthened. As I said, even for getting policies into

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place, you need to mobilize the community. In India, for example, we managed in terms of the tobacco legislation to mobilize young people by involving them in policy discussions related to the health of their generation, both currently and in the future. Based on this policy discussions, 25,000 school students went to the prime minister of India, and sent them in 1988 and said, the health of our generation is at stake, we would like you to protect it by having a comprehensive ban on tobacco advertising and then subsequently bringing about a tobacco law. By 2001, the Indian parliament had a law introduced and by 2003, the law was passed. This is the same parliament in 1995 said that tobacco economics suggest that India should not have a tobacco control policy, but in 2003, the parliament passed a law unanimously so you do require to mobilize people especially the young people. Make them stakeholders in the future and then enable them to actually bring about policies.

GEORGE STEPHANOPOULOS: Dr. Fuster, if you could pick one problem to focus on, would it be tobacco?

VALENTIN FUSTER: No. The problem I see is that we do not advocate our children properly. In other words, the key should mean the age between 5 and 10 - as we have learned from "Sesame Street," which I'm working with - this is the age where you can really model your behavior of the future. We should tell children what is good about preserving health.

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We should not be negative. We should be very positive. I can tell our first experience in a project in Columbia is to have more influence on the parents to stop smoking, than the other way around. So I think we have to learn [inaudible] we need loss. We need support from our friends, and then we change behavior.

GEORGE STEPHANOPOULOS: Could you talk a little bit more about that? Because I just assume intuitively that kids pay attention to what their parents do, not to what they say.

VALENTIN FUSTER: No, the kids pay – the experience we have is the kids the role model in terms of telling them what to do, are the 15- to the 20-year-olds. They have an incredible influence. What we are doing now, in a meeting that is coming out in India, you are involved, is we are going to teach the 15- to the 20-year-olds who come in from Latin America, a large number of people, to develop a network that will teach the children in the school systems at 5 to 10 years of age, the importance of health for their lives. That to me, that's what we have to do, are projects, demonstration projects.

I'm not telling you that this is the answer we have to see in a few years, but that demonstration projects like these where we should aim at, and this is one of the projects that we are very, very involved, and is exciting.

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GEORGE STEPHANOPOULOS: I guess if that's right it would also lead you to think of things like trying hard not to see 18 year old girls smoke in movies, because of the examples they set.

VALENTIN FUSTER: I'd like to capture your question, and I'm sorry I didn't capture it.

GEORGE STEPHANOPOULOS: No, I'm just saying if you try and think of the broader culture as well, if these 15- to 20-year-olds are the role models, you might want to, again there is the issue of censorship of getting to the issue, but try to convince television production companies, movie companies, I see you want to address this question, to make sure you are not seeing girls and boys that age smoking.

VALENTIN FUSTER: I agree, I mean - but, you see, you are touching into the [inaudible] that are many items being discussed this morning. Each of them is a project. This is what I'm trying to say. We cannot just give an answer to a huge problem like this, we have to take it in part, and this is basically -

NIZAL SARRAF ZAEDGAN: Yes, I would like to add to the role models, this is very important, strategy. We use this even in our schools, so the children, we did the education for the teachers, the schoolchildren, the parents for non-communicable diseases, let me say, because I don't agree with non-communicable, because in my idea as I

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discussed with my friends, communicable diseases are diseases which are transmitted between individuals but chronic disease, it's sort of communicable. That's transmitted by westernization and globalization between countries and population.

GEORGE STEPHANOPOULOS: By example.

NIZAL SARRAF ZAEDGAN: This is what I believe, so chronic diseases are, we use the role models, not only in the schools, but in the work sites, for women, for NGOs, and it was very good. It was very good strategy. We did the International Quit and Win contest that was done by KTL in Finland, started in 1994. A very good contest for tobacco control, more than 100 countries in the world, they participated in that. When we distributed the announcement for participation of smokers, and we did the lottery, eight of ten of the winners, they said we got the message from our children, and we stopped smoking. So there are models, the children, it's not for them only. It's for transmission or transmitting the message to their parents or their family at all.

GEORGE STEPHANOPOULOS: We've run a little bit over. Let me bring Dan Stone back up, because we're going to go to the table top exercises. Thank you.

DANIEL STONE: Okay, so we're now ready to turn the conversation over to you folks. We recognize universally how

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expensive it is to treat sick people. We also widely recognize that the fundamental key to chronically ill populations is prevention. So we have a two-part question that we'd like to consider at your tables.

First of all, recognizing the insufficiencies of resources to manage all chronically ill patients, how can we more efficiently encourage prevention oriented initiatives? Then, if prevention doesn't work or where it doesn't work, what are some innovative and efficient ways of providing needed treatment for the increasing number of people with chronic diseases? You've got 25 minutes for this conversation and we'll be back up later.

[END RECORDING - PART 2]

[START RECORDING - PART 3]

FEMALE SPEAKER: Our moderator and panelists are now rejoining us.

GEORGE STEPHANOPOULOS: Okay, we're ready for the next phase. And I'd like to start out with a *mea culpa* for Dr. Fuster. I was told you were head of the World Health Foundation, but now I've been told that it's the World Heart Federation, so excuse me for that.

Let me begin by starting with the questions from the audience, one for you. One audience member wants you to explain the benefits of the polypill and how that has simplified treatment and we were talking off stage. I also

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want you to take the opportunity to talk about what you consider a big gap in the UN millennium challenges.

VALENTIN FUSTER: Yeah, why a polypill? Following a heart attack, people have to take three pills. Aspirin, what we call an ace inhibitor, and what we call a statin. If they do that, the incidence of an occurrence of a heart attack decreases by 60-percent. Problem, people don't take three pills a day. After a year, only 15-percent of the people take the three pills. Second, it's very expensive. So here is the issue. We always have to change behavior, but here is one situation that pills help. With the World Heart Federation - which, by the way to define it, involves almost 200 cardiovascular communities, and foundations or hundred countries around the world - we have the purpose of preventing and controlling heart disease in middle- and low-income countries. So here we come into middle- and low-income country with a disease that is very expensive and you need to take the pill.

What can we do? Let's develop a single pill. A single pill that people will take. Will be more compliance, it is easier to take than to take three pills a day, and lets make it much cheaper. With the National Heart, Lung and Blood Institute in Spain, which I am the director, the scientific director, and the World Heart Federation, we partner and then we are now going into the private enterprise

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and we are in the process of developing a polypill. A polypill that will be used following a heart attack and is now aiming to grow to middle countries in terms of results is the very low-income countries. There are other issues that have to be approached. We are now in the process and we think this polypill will be probably available by late 2009, 2010. The cost, it is predicted, it will be 75-percent lower than the cost of the three pills that they have been taking today, that you should take, and actually people are not taking them.

GEORGE STEPHANOPOULOS: Lance, there is one here for you. They want to know how can we get a coalition of sports and players to take a more proactive role to energize their fans to be more personally responsible and to support public policies that would help prevent these diseases.

LANCE ARMSTRONG: I don't know. There are a handful of athletes who are really out there on issues like that. I've tried to be out there because it affected me personally, and it's now become a new sort of competition for me, because I need that in my life for whatever reason. [LAUGHTER] But I think that obviously if other athletes are affected personally or a family member or somebody that, whatever the problem may be, it's accepting that - I always talk about this thing called the obligation of the cured, which my doctor has told me about when I left the hospital. They said

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listen, you can accept it or not, both are fine answers. But I accepted this obligation, and I went out and shared my story, and tried to make a difference. So it's just a question of whether or not athletes or sports stars or anybody in the public eye wants to take that on.

But certainly, when you talk about role models and you talk about how that trickles down to the youth of the world, that's a powerful group of people. We were talking about young women and who they look up to. I mean, I have 5-year-old twin girls, and I can only imagine when they're 12 who they're going to be looking up to. It's a little scary, but it's a powerful notion and one that we certainly should look at.

GEORGE STEPHANOPOULOS: Dr. Zaedgan, you were talking earlier that you don't really accept the distinction between chronic and infectious diseases. One of the questions here is, are there ways to address these two sets of diseases simultaneously or do we need different strategies for these what the audience thinks is different kinds of diseases?

NIZAL SARRAF ZAEDGAN: Usually, what currently is existing everywhere in the world is there is a good surveillance and monitoring system for infectious diseases everywhere, which is integrated with the primary health care system or public health centers. There is nothing about

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chronic diseases to be integrated within the primary health care system. So there are no preventive actions, activities.

GEORGE STEPHANOPOULOS: Why is that?

NIZAL SARRAF ZAEDGAN: That's because it's neglected diseases. This is what we said. It's not priority for governments. There are many obstacles, even the physicians, the health professionals, we need to work with everybody to increase awareness, to improve the awareness level, to pay attention to this priority. It's the [inaudible] killer, everybody knows that, and I like very much this Oxford Health Alliance theme which is three risk factors, that is nutrition, lack of physical activity, tobacco, leading to four diseases, which is cardiovascular disease, diabetes, cancers, COPDs, leading to more than 50-percent of the mortality in the world.

So this is a very nice, small and short theme, and everybody knows this, but in reality, nothing. There was even a study done by the World Health Organization. They asked the six regions of the world, "Do you have any policy at the national level for tobacco, for diabetes, for cardiovascular disease?" and many of the countries they said, "Yes." But who monitors this? Is there existing really policies for these things or not?

Now, coming back to your question, is this possible to integrate communicable and non-communicable disease

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together? In my idea, yes, we did that. In our demonstration project, what we did, we went to the health centers in the cities, the health houses in the rural area who were taking care of infectious disease, reporting and monitoring them, and we just asked few questions in the monitoring. We added some questions in the monitoring sheets, and we asked the people, the health workers, the people, and the volunteers who were working there to give three or four messages. It's not highly sophisticated to do intervention for NCDs. It started from this going up to do many interventional strategies. Yes, it could be done, but it needs different strategies.

GEORGE STEPHANOPOULOS: Dr. Reddy, you were talking earlier about the tax policies that were used to improve nutrition, but one of the questions here is what are the incentives for food companies to play a role in heart disease and diabetes in developing countries, or how would you create these incentives?

SRINATH REDDY: Certainly, we ought to create market conditions in which healthier food products can be sold and plenty at affordable rates for people. Simultaneously build consumer consciousness so that they'll opt for these healthy choices when available. So it requires both working with the food industry as well as incentivizing the production of healthier food products through some economic incentives, but

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it also requires a fair amount of consumer mobilization in order to provide the market for this.

GEORGE STEPHANOPOULOS: Have you had any experience with that in India?

SRINATH REDDY: Not yet, but there is in the urban areas of India, an increasing preference now for some of the healthier oils, as well as for the processed foods, which are lower in salt content as well as relatively free of trans fats and saturated fats. But again, this requires some additional competence, like price mechanisms to be introduced through incentives.

But if I may just stick on the earlier question that you posed to Nizal. In terms of the way which we can actually deal with both infectious as well as chronic diseases together, this whole business is an artificial divide. We are really looking at dealing with communicable, as well as chronic diseases together. It's an "and," not an "of," and this is simple, because if you are trying to save a child under the age of 15 years from dying of a diarrhea disease, you don't want that same child to die at the age of 20 or 35 of a heart attack prematurely. You are investing in the life of human beings.

Secondly, you refer to sub-Saharan Africa as an area where chronic diseases are probably not as much of a problem. It's only relative magnitude compared to infectious diseases.

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For example, in Tanzania, the stroke mortality rates because of paralysis [misspelled?] attacks in the age groups of 15 to 59, in Tanzania, are three to four times more than that of the United Kingdom in the same age group. So if you are really worried about the child who has lost parents because of AIDS epidemic, and the child of Tanzania is under the care of a 55-year-old grandmother, and that's the sole custodian and caretaker of that child in sub-Saharan Africa, you wouldn't want that lady to have a stroke because of undiagnosed and untreated high blood pressure. So you are actually investing in both infectious as well as non-infectious diseases.

Even ideologically, in terms of causation, healthy diets like fruit and vegetables prevent infections by building up immunity to prevent chronic diseases. Similarly, we now know that smoking is the cause of tuberculosis. It increases the risk of people getting tuberculosis. So it is time that we stop thinking in terms of barriers, and we really start thinking in terms of addressing all of these neglected diseases together through community-based demonstration projects.

GEORGE STEPHANOPOULOS: And with that, I want to bring the results of the tabletop discussions first, but we'll come back to you after we hear from Chris Jennings. Actually, no? I'm being told go ahead.

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VALENTIN FUSTER: You asked a second question that I didn't answer and that is, what is the millennium? I think it fits with everything we are discussing here. The United Nations millennium development goals in the year 2000 were to have eight achievements in the year 2015. One of them relates to disease in terms of malaria, HIV and other diseases. Chronic diseases that we are discussing today, cancer, cardiovascular disease, respiratory disease which are really growing very rapidly and will have a tremendous economic impact are not part of the millennium, have been completely ignored. If I have to say a single thing this morning, to me it would be, please, let's make chronic diseases, not just cardiovascular diseases and stroke, chronic disease part of the millennium.

GEORGE STEPHANOPOULOS: Why was it left out?

VALENTIN FUSTER: How this is done? There are some people here who are very influential. This is an issue of advocacy. This is an issue of awareness. When you look at the economics of what we are discussing here this morning, the impact in 10, 15 years from now, I can assure you the millennium has to take care of HIV. It has to take care of malaria. It has to take care of tuberculosis, absolutely, but please lets be sure that we aware of what is coming up here, which economically is going to be devastating. So it's

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a plea, I would say, on behalf of all of us who are dealing with chronic diseases.

GEORGE STEPHANOPOULOS: One more minute. I guess they are still not ready. You guys must have had a lot of ideas on there, but I did ask a slightly different question and I want to pose it to you. I don't understand why this cluster of diseases was left out of the millennium challenges. They're must have been a reason. They're must have been forces arrayed against, and I was just wondering if you had any theory on that, or if any of you do?

SRINATH REDDY: I think the issue is clear. We all are reactive in this world. We react to what is coming out that is important, HIV, malaria, it's extremely important. What happens is we don't pay enough attention what is coming. That's the problem, and I think it's quite human what has occurred, but we are here to just say please, let's just think what is happening. This is at least my view of what -

NIZAL SARRAF ZAEDGAN: When I think there are other issues that should be addressed, first we are doctors and we know what is the medical curriculum. There is nothing or there are few things mentioned within the medical curriculum about our role in prevention. So this is the first issue that we need to include or emphasize more on the medical curriculum for the physicians and health professionals. The other thing is that controlling infectious diseases is much

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more easier than I said before. Where there is outbreak of SARS or whatever else, like two or three cases, everything will be arranged, the government will take care, the regional office of WHO, WHO everywhere, they will take care to control this, but think about the huge numbers of diabetic patients or cardiovascular patients who die every day, and nobody pays attention. I mean, much more less than infectious diseases. Why? Because it's not very easy to get a vaccine and then control diabetes, control cardiovascular disease. It needs, what I said, a comprehensive approach. It needs public education, health professional education, training trainers, policy changes, environmental changes, and you have on the other side, you have Phillip Morris for tobacco. You have McDonald's. You have fast foods. You have all these things that attract many people specifically children, youth.

So the epidemic is increasing, obesity is increasing everywhere around the world, you, I mean the Western people, when we visit, or when we discuss, they said that usually the idea that they have in mind, do you have cardiovascular disease, you have chronic disease in Asia? Yes, we have. Come and see the Asian countries. See how much McDonald's are available over there. How much advertisement for tobacco? We're lucky in Iran, we don't have any advertisements for tobacco, but in Asian countries and Middle East countries, the advertisement is huge. So you need to

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tackle all these things. It's not that much easy, so governments are interested with infectious disease, because it's easier to control. It's not that it's neglected. Nobody was thinking about it. It's much more complex to do this with all these things that I mentioned.

GEORGE STEPHANOPOULOS: We're going to find out the solutions this group came up with right now. Chris Jennings is ready.

CHRIS JENNINGS: Thank you, George. I'm sorry I wasn't as fast as you wanted me to be, George, but there are too many ideas. The themes and the nuggets were definitely substantial and very complementary, so I'll quickly go through them so you have some time to discuss them.

Many were oriented towards prevention at the very beginning. Teaching healthy behaviors, but through existing communities and ceremonies and institutions, much like many of the panelists have suggested. There was an interesting couple of ideas about funding the distribution of HPV vaccines to prevent cervical cancer in develop countries. To reinforce the need for primary care. Hopefully catching disease early obviously, so you can deal with the overwhelming cost of dealing with it later. Managing the growth of cities to foster walking, biking, with public exercise facilities. This was stated quite a bit and there were some concerns raised in certain developing countries

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that they are actually building roads but dropping the bicycle access points, just as an example of not being able to, actually pushing down any type of incentives to exercise. This was the last point and I think it was important, which is prevention absolutely is key, but we have people who are sick today and we do not manage care very well. We can do a much better job, and we can do so efficiently.

As for the nuggets, there was a very definite belief that we can do much more interventions, specifically removing vending machines as has been the case. The Clinton Foundation has been doing work with Pepsi and others. Accelerating development of tobacco vaccine, which is now underway to a small degree. There was an interest in developing a code of conduct amongst the food companies, and it did not necessarily have to be regulatory or statutory, but definitely it had to happen. Re-brand chronic diseases was a similar theme, than we had neglected disease, find a new name. In this context, the suggestion was avoidable but I'll let you respond to that. Corporations should fund healthy employee programs because it is in their interest so to do for productivity.

Lastly, find the kids where the kids are. They are watching MTV, they're doing iPods, and other kids' access points that are culturally sensitive, but that get to the

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education of those children early when they are most impacted by it. With that, I'll turn it back over.

GEORGE STEPHANOPOULOS: Lots of practical and very specific solutions. Dr. Reddy, what struck you about them?

SRINATH REDDY: I think all of these are collectively excellent suggestions, and if they are implemented, then surely there can be a tremendous amount of difference made in a number of countries, but the results are going to require resourcing. We cannot push the responsibility entirely onto the governments. The governments need to act. We need to do a lot of things with the communities themselves, which means that we ought to be able to provide facilities in the communities for greater health awareness as well as greater adoption of healthier behaviors, and for this we need demonstration projects, which are aided by civil society organizations, so that we can show that change can be made and the change is quite effective. Once that change is demonstrated, then both the communities themselves as well as the governments are much more likely to take it up and replicate it on a wider scale.

GEORGE STEPHANOPOULOS: When you talk about demonstration projects, of the ones your working with now, which is the project that excites you the most?

SRINATH REDDY: There are two projects I am working on currently in India, and both are effective, but the one

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that excites me most is the one that I work with schoolchildren. Both in terms of awareness of the younger age group between class six to eight where we say it is learning the fact where there is health awareness of the school level, and home outreach programs. With the high school children, we call it learning to act. Based on the information learned earlier, they become change agents in the school, in the families, in the wider community. They become the change agents for disseminating health information, but they also undertake media advocacy and policy maker advocacy. They take ownership of the programs and that is what really excites me because this is the generation that requires to be given the greatest protection against chronic diseases and now they are taking ownership of that program.

The second, of course, is we have a very wide, country wide worksite program in which the employees, as well as their families are provided health education as well as risk factor screening, so that they are prevented from getting these diseases by early intervention on risk factors, and that's another effective way of handling things.

Just to sum up, the question about millennium development goals, the reason why people did not include chronic diseases in millennium development goals was because of the misimpression that this has no relation to poverty. But if a 40-year-old foreman in a factory collapses and dies

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in India of a sudden cardiac death, not only is he deprived of his life, but his children and his family will be pushed into the poverty cycle. It's been shown in Bangladesh that when somebody loses a parent in midlife years, the family is more likely to have children to have 12 times greater poverty levels, sometimes greater likelihood of getting into poverty cycle. You want to really insure of removal of poverty from the world. You cannot ignore chronic diseases.

GEORGE STEPHANOPOULOS: Dr. Fuster, I wonder if you could pick up on this question of a tobacco vaccine. How realistic is it and how effective could it be?

VALENTIN FUSTER: It would be excellent. [LAUGHTER] If this is available, but let me tell you if we just concentrate on tobacco, we are missing the game here. This is much more complicated. One of the things that I learned from the American Heart Association is how you have to attack all the issues and look at them individually, and then try to go for them. I would say to you, this summary is excellent because in fact it portrays what has been discussed this morning. We believe in demonstration projects, and we have one that puts it all together, which is rheumatic fever in Africa.

The World Heart Federation started with a program on rheumatic fever about two years ago, and now it is going into Egypt, Ethiopia. It's going into South Africa, and Ghana,

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and basically this is a disease that these infectious disease and chronic disease. It starts with a sore throat, and it goes into the heart. You develop a valve that gets narrow or too open and the patient needs surgery years afterwards. So here is a clear example of acute infectious disease and chronic. How many people? 50 million people have rheumatic fever. Two-thirds are in Africa at this moment. Now, what to do?

Look, penicillin. One of the cheapest drugs available. At the moment of truth, sore throat and so forth. How we approach the problem, education to the community. The governments of these countries are involved. We go the community, and we are now looking also for private enterprise to help, but it's an educational issue, and it actually puts together all the things that are being discussed here. The importance of the community, and the only thing we can do there is to teach them. Then they take care of themselves and rheumatic fever and rheumatic heart disease is a clear example of how the demonstration project, community driven with the local authorities being involved, can be quite successful. I prefer to talk about this than just going into the vaccine about tobacco.

GEORGE STEPHANOPOULOS: Dr. Zaedgan, you get that last word.

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NIZAL SARRAF ZAEDGAN: That was excellent, that you mentioned the demonstration project, because this is what I believe. I usually believe in not to go to the government to start something to do, to say, well, I want to do that, give me the money, I want to start a plan to control chronic diseases, diabetes, cardiovascular. This is not easy to do. I believe in doing from bottom to top and top to bottom, together. So you need a demonstration, a practical model to show it to the government and to do that, and we have a demonstration project as well, and we did many strategies like community participation and mobilization beside this, and education every where else. We had a very strong private, public collaboration. We involved the decision makers and the stakeholders to be involved in planning, implementing and evaluating the interventions. They feel it on its own. That will make you sure that this intervention will be more sustainable when you stop your monitoring or your work, because they feel it's their own. It's embedded within their systems. The stakeholders, decision-makers to be involved is a very important point.

GEORGE STEPHANOPOULOS: That is the last word. Thank you all very much. We had two terrific sessions. Please give them a hand. If nothing else, we're going to have to re-brand these sessions for next year to make sure we do treatable and avoidable diseases, but there really were so

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many good ideas generated here, and I hope all of you will return this afternoon for session three, which is about healthy workers and productive businesses. Thanks very much.

[END RECORDING - PART 3]