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REGIONAL OFFICE FOR **Europe**

**11th National TB
Programme Managers'
Meeting**

London, United Kingdom
2–3 July 2012

Meeting report



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Acronyms and abbreviations

CCM	Country Coordinating Mechanism (Global Fund)
DOTS	First component and pillar of the StopTB Strategy recommended to control tuberculosis
DRG	diagnosis-related group
ECDC	European Centre for Disease Prevention and Control
ELI	European TB Laboratory Initiative
GLC	Green Light Committee
GLC/Europe	Green Light Committee for the WHO European Region
GLI	Global Laboratory Initiative
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
KNCV	KNCV Tuberculosis Foundation, Netherlands
MDR-TB	multidrug-resistant tuberculosis
PR	Principal Recipient (Global Fund)
STAG-TB	WHO Strategic and Technical Advisory Group for Tuberculosis
TB	tuberculosis
The Union	International Union Against Tuberculosis and Lung Disease
USAID	United States Agency for International Development
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis

Acknowledgements

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Background

Over the past 15 years, regular meetings have been held between the managers of national tuberculosis programmes in the WHO European Region. These meetings have been organized by the WHO Regional Office for Europe in collaboration with various partners, including KNCV Tuberculosis Foundation (Wolfheze Workshops), the European Centre for Disease Prevention and Control (ECDC) and WHO headquarters. These meetings have witnessed the progressive merging of priorities for tuberculosis (TB) control intervention among all 53 Member States of the Region. Multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB are a growing challenge across the Region. This has led to a new interest in identifying and addressing the risk factors and social determinants of TB and greater focus on innovative approaches for TB prevention, diagnosis, treatment and care.

In October 2007, the endorsement of the Berlin Declaration on Tuberculosis renewed the political commitment to stop TB in the WHO European Region. The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011-2015, which was unanimously endorsed along with its accompanying resolution (EUR/R61/R7) by the 53 Member States of the WHO European Region at the 61st session of the Regional Committee for Europe, was launched in Moscow in October 2011 at the MDG-6 International Forum.

The WHO Regional Office for Europe is organizing the 11th national TB programme managers' meeting back-to-back with the 6th Conference of The Union Europe Region. The managers' meeting provides an excellent opportunity to discuss the challenges and opportunities shared by all countries in the Region to fulfil the above commitments, achieve Millennium Development Goal 6 by 2015 and discuss the post-2015 StopTB strategy.

Scope and purpose

The scope and purpose of the meeting are described in Annex 1.

Participants

The final list of participants may be found in Annex 2.

Welcome reception

An informal reception was organized on 2 July 2012, which was attended by Ms Roelofs, WHO goodwill ambassador and First Lady of Georgia.

Opening session

Speakers:

Dr Masoud Dara, Programme Manager, Tuberculosis and M/XDR-TB, WHO Regional Office for Europe
Dr Hans Kluge, Special Representative of the Regional Director to prevent and combat M/XDR-TB and Director of the Division of Health Systems and Public Health, WHO Regional Office for Europe
Virendra Sharma MP, Member of United Kingdom Parliament and Vice-Chair of the All-Party Parliamentary Group on Global Tuberculosis
Paul Thorn, patient representative and Vice-Chair of the StopTB Working Group on MDR-TB

Dr Masoud Dara, Programme Manager, Tuberculosis and M/XDR-TB, WHO Regional Office for Europe, welcomed participants to the meeting and showed an introductory video, "STAG-TB 2012: 12th Meeting of the WHO Strategic and Technical Advisory Group for TB". The Strategic and Technical Advisory Group for Tuberculosis (STAG-TB) is made up of 20 experts, representing ministries of health, national TB control programmes, academic and research institutions, civil society organizations, communities and patients affected by TB, and professional associations. STAG-TB provides objective, ongoing technical and strategic advice for WHO on TB care and control. STAG-TB's objectives are to provide the WHO Director-General, through the StopTB Department, with an independent evaluation of the strategic, scientific and technical aspects of WHO's TB activities, review progress and challenges in WHO's TB-related core functions, review and make recommendations on committees and working groups, and make recommendations on priorities in WHO's TB activities.

The video provided a retrospective view of the TB burden worldwide, then summarized global progress towards its control and management. Since 1995, 46 million people have been cured and 7 million lives saved through DOTS and the StopTB Strategy. Progress has been dramatic, and provides a clear indication that the world is on track to achieve the 50% mortality reduction target by 2015. Rapid technologies, such as GeneXpert, facilitate early detection of cases and have been rolled out to 47 countries, and the number of tests is doubling almost every quarter. Key recent events were summarized, highlighting the continued drive for further progress. The video served as a reminder that TB, a treatable and curable disease, is everybody's responsibility. WHO is keen to engage nongovernmental organizations and wider communities in TB control and care through in-country initiatives, for example through the organization of regional workshops and provision of technical support.

Key policies and guidelines published by WHO were described. In future, financing of TB control will be an important issue: the video emphasized that sharing costs will result in shared benefits. Overall, 85% of TB financing comes from domestic sources, but in low-income settings the figure is only 50%. Increasing funding and addressing funding gaps should be a priority, as should increasing TB case detection. In conclusion, the video stated that TB control is a marathon that must be run to the end.

Next followed a brief address by Dr Hans Kluge, Special Representative of the Regional Director for Europe to prevent and combat M/XDR-TB. It is well known that, despite the modest 2% annual decrease in TB incidence, MDR-TB and XDR-TB are a global problem. We have 5% of the global burden of disease in the WHO European Region, but 20% of the global burden of MDR-TB. To tackle this problem, the Regional Director established a special project to prevent and control M/XDR-TB, which is now a regional priority. The first and most important pillar of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011-2015 is the prevention of MDR-TB. In September 2011, after many months of consultation with Member States, partners, communities and civil society, the Action Plan was endorsed by the Regional Committee for Europe in resolution EUR/RC61/R7. In the last three years, significant progress has been made in TB control but, as made clear in the video, many challenges remain. We have to translate the regional Action Plan into national action plans. At the 2012 Regional Committee meeting in Malta, the Regional Director for Europe will present a new WHO European health policy, "Health 2020". This is an overarching health policy framework for the 53 Member States of the Region, aimed at tackling health inequalities between and within countries through a "whole-of-government" approach, acknowledging that the most powerful determinants of health lie outside the health sector. Health must be tackled at the highest level of government if much more progress is to be made in TB, but also in noncommunicable diseases which are closely linked with TB. With respect to the financial crisis, particularly in the European Region, this leads us to the topic of efficiency. It is possible to get money for health even in the current financial crisis, as long as it can be demonstrated that better health is returned for the money. The *World health report 2010*, entitled *Health systems financing: the path to universal coverage*, reported that in each country's health system there is between 20% and 40% wastage, so countries must get their own house in order first. In many countries, TB control is still very much institutionalized in the hospital system.

Varendra Sharma MP then addressed the audience in his capacity as Vice-Chair of the All-Party Parliamentary Group on Global Tuberculosis, which is an interest group recognized by the United Kingdom Parliament. The group, as the name suggests, works with all major political parties to promote effective interventions to tackle TB in the United Kingdom and across the world. TB rates and deaths globally are dropping, albeit slowly. There is a new TB diagnostic tool that reduces diagnosis time from weeks to hours, as well as vaccines and shorter drug regimens at the advanced trial stage. Significant progress has been made, yet the WHO European Region faces important challenges in its struggle against TB. The Region has high rates of MDR-TB, and every year there are 418 000 new TB patients and 60 000 deaths. The rapid growth of the HIV epidemic in eastern Europe has led to a sharp increase in HIV-related TB. There is still limited political and financial commitment to TB control and lack of advocacy, communication and social mobilization.

Turning to the Millennium Development Goals and the Global Fund to Fight AIDS, TB and Malaria, he said that discussions of health, education, water, sanitation and maternal health often return to the same issue: poverty. Addressing poverty more broadly is crucial to all development goals; that is why the Goals must be seen as a wider implementation of change. If the current progress is sustained, the world will be on track to achieve the MDG 6 targets relating to TB, which is to be welcomed. However, health must feature in the post-2015 development agenda and more aspirational targets for TB must be included. Discussions have just started with WHO and governments, so it is important to lobby and ask your own government to add its voice to the calls for universal health coverage to be a pillar of the post-2015 development agenda.

The All-Party Parliamentary Group on Global Tuberculosis will strongly support this critical aim. It goes without saying that the Global Fund to Fight AIDS, TB and Malaria is fundamental to combating TB, with programmes supported by the Fund providing anti-TB treatment for 8.6 million people. It is crucial that the Fund is protected and continues to receive adequate resources to sustain its legacy.

Clear and sustained political commitment is crucial if campaigns like the StopTB plan are to work. Fostering national and international partnership is essential for implementation of a long-term strategic action plan prepared by national TB control programmes. Sufficient funding is essential; currently resources are inadequate and further effort is required to mobilize additional resources from both domestic and international sources. What is needed for TB is long-term investment and research. With political leadership and political will, this can be achieved. It is the role of elected representatives to hold their government to account and question how much funding is awarded to MDG 6 and especially to TB.

Finally, Paul Thorn was introduced to talk about the patient perspective. A picture was displayed on the screen of Mr Thorn as a TB patient at the age of 25. When the picture was taken, he believed that he would die of TB. He spoke of his gratitude for his continued existence and for being able to get on with his life. He has been HIV-positive since 1990, and was infected with MDR-TB while a patient in a hospital HIV unit. He contracted the disease from an initially drug-sensitive Brazilian patient who had been continually lost to follow-up. By the time this patient arrived in London, his disease was multidrug-resistant. Mr Thorn was treated in a negative pressure isolation room for over three months. By the time he was discharged, he had lost his home, job and partner. He subsequently spent three years on treatment with terrible side-effects. He attributes his survival to living in a country able to provide excellent health care and access to high-quality treatment.

Session 1. Regional mechanisms for coordination and technical assistance and Post-2015 StopTB Strategy

Coordinators:	Dr Kristin Kremer, Dr Masoud Dara
Chairpersons:	Dr Hans Kluge, Professor Lee Reichman
Reporter:	Dr Kristin Kremer

Background

The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011-2015 was endorsed by the WHO Regional Committee for Europe at its 61st session in Baku, Azerbaijan in September 2011. In accordance with the Action Plan, a number of regional mechanisms were established to assist and coordinate the response of countries in preventing and controlling M/XDR-TB. WHO is initiating a consultation with its partners and Member States on the post-2015 StopTB strategy. In order to coordinate technical assistance and support for Member States, several platforms are provided. Pursuant to the decision of the 20th StopTB Partnership Coordinating Board meeting, the Green Light Committee for the WHO European Region (GLC/Europe) was established in July 2011, hosted by the WHO Regional Office for Europe. In response to the need to strengthen laboratory capacity for accurate diagnosis and early detection of anti-TB drug resistance, the Global TB Laboratory Initiative (GLI) and the Regional Office have established a European TB Laboratory Initiative (ELI). To renew coordination among partners, including civil society organizations, and to oversee the implementation of regional commitments, a regional interagency coordinating committee on TB control and care will be created by the end of 2012.

Content of the session

1. Post-2015 StopTB strategy
2. Green Light Committee for the WHO European Region
3. European TB Laboratory Initiative
4. Regional interagency coordinating committee on TB control and care

Methodology

- Presentations
- Discussion in plenary

Objectives

- To inform participants about the organization and functions of newly established regional mechanisms for coordination and technical assistance related to TB and M/XDR-TB
- To discuss the draft proposed outlines of the post-2015 Stop TB strategy
- To obtain feedback from the participants about the above topics

Expected outputs

- Participants have understood how the established regional mechanisms are functioning and can be used for country support
- Participants have provided suggestions for optimal functioning of the regional mechanisms
- Participants have provided preliminary and informal inputs on the post-2015 Stop TB strategy

Format

09:30 – 09:45	Preliminary directions of the post-2015 StopTB targets	Dr Masoud Dara
09:45 – 10:00	Discussion in plenary	All participants
10:00 – 10:30	<i>Coffee break</i>	
10:30 – 10:45	European TB Laboratory Initiative	Dr Kristin Kremer
10:45 – 11:00	Discussion in plenary	All participants
11:00 – 11:15	GLC/Europe, TBTEAM and regional interagency coordinating committee on TB control and care	Dr Ogtay Gozalov
11:15 – 11:30	Discussion in plenary	All participants

Session 1 focused on regional mechanisms for coordination and technical assistance and the post-2015 Stop TB strategy. After a brief introduction by Professor Lee Reichman of the New Jersey Medical School Global Tuberculosis Institute (UMDNJ), United States of America, Dr Masoud Dara made the first presentation, entitled “Preliminary directions of the post-2015 StopTB targets”, in which he outlined the current burden of MDR-TB in the Region and the global and European response. In terms of the Millennium Development Goal target of halving TB mortality by 2015, the Region is on track, as there has been a 40% decrease since 1990. However, reducing incidence has proven trickier, with a decline of approximately 1.3% per year. Notification of MDR-TB is on the rise: between 2005 and 2010 notifications rose from approximately 4% among new cases to nearly 14% among new cases. TB-HIV coinfection is also on the rise, having increased by 20% over the last five years.

WHO Member States have called for the development of a new post-2015 strategy and targets for TB control and for consideration by the Sixty-seventh World Health Assembly in 2014. Key challenges will be: improved case detection; TB/HIV coinfection; MDR-TB; weak health policies, systems, financing and services; underengaged communities and

providers; and bottlenecks in financing of research and innovation. The way forward lies in innovation, with more and better DOTS, the StopTB Strategy and the post-2015 TB strategy. Three pillars of the strategy are proposed: innovative TB care; bold policies and supportive systems; and intensified research and innovation. These should be tailored to the country setting and should go beyond TB programmes to reach the whole health-care system. In terms of targets, the StopTB Partnership wants to see prevalence and death rates reduced by 50% by 2015 compared with 1990, and the global incidence of active TB cases reduced to <1 case per 1 million population per year by 2050 – translating to a rate of decline never yet observed at country level. These targets have other limitations. The 1990 baseline is not documented in most countries. DOTS programmes were generally introduced during the mid-to-late 1990s and pre-DOTS data in low- and middle-income countries are usually unreliable.

Activities for 2012 include a number of consultations at national TB programme manager meetings, regional technical advisory groups and other events; consultation with the TB civil society forum; a StopTB symposium in Kuala Lumpur, Malaysia for national TB programme managers and partners; and consultation at the Stop TB Partnership Coordinating Board. In 2013, there will be consultations with national TB programme managers, WHO regional offices, partners and the StopTB Partnership Coordinating Board; a presentation at STAG-TB for technical endorsement; consultations at regional events; and preparation of documents for discussion by the WHO Executive Board in 2014.

In the ensuing discussion, participants noted that Ukraine has had great success in reducing “classical” TB cases but has great problems with M/XDR-TB and TB-HIV coinfection. The latter cohort of patients includes drug users and contributes greatly to TB mortality. The participant from Uzbekistan stated that the goals that have been set are achievable with the necessary diagnostic tools and treatment. Uzbekistan has seen a huge reduction in mortality rates; however, the current challenge is universal coverage with second-line drugs. Outpatient treatment has been introduced in two regions of Uzbekistan, in a project managed by Médecins Sans Frontières with a 70% success rate, but it should be further promoted. The participant from Israel said that, with reference to the TB death reduction target, it is important to distinguish “death with TB” from “death due to TB”. Other participants said that while, future targets should be bolder, they should be also be more understandable for politicians and non-public-health professionals in order to secure more funding. A representative of the European Centre for Disease Prevention and Control (ECDC) pointed out that, although the 50% reduction in mortality is a suitable challenge at the global level, at the European Union level it will be extremely difficult to achieve, as the mortality rate is lower, and that the target may therefore not be motivating.

Dr Kristin Kremer (Tuberculosis and M/XDR-TB Control Programme, WHO Regional Office for Europe) made the second presentation on ELI, a new initiative to strengthen laboratory capacity. MDR-TB outcomes in Europe are the worst in the world. The Region has a treatment success rate of 68%, 9% mortality, 11% failure and 16.5% default, and the rates are even worse among previously treated cases. The treatment success rate fell from 74% to 68% in the period 2001–2009, while treatment failure and death rates have increased. The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011-2015 aims to decrease by 20% the proportion of cases of MDR-TB amongst previously treated patients, diagnose at least 85% of estimated MDR-TB cases, and treat 75% of patients notified as having MDR-TB successfully. To diagnose these cases, access to testing for susceptibility to first- and second-line anti-TB drugs, and HIV testing and counselling among TB patients will be scaled up. Milestones: by the end of 2012 all previously treated TB patients will have their TB isolates tested for resistance to first- and second-line drugs, and by the end of 2013 rapid molecular diagnostic tests will be available for all eligible patients.

Planned activities to strengthen the TB laboratory network are as follows.

- Collaboration between the supranational reference laboratories – these are the main contact points where capacity needs to be increased. WHO will expand its support for national reference laboratories.
- Preparation of a guide for accelerated quality-assured new diagnostics.
- TB laboratory development plans in place by 2013.
- Technical assistance for accelerated uptake of quality-assured diagnostics through new and existing funding mechanisms.
- Building of human resource capacity.
- Prioritization of funding for the introduction of new diagnostics.
- Quality assurance schemes and minimum biosafety requirements in place by 2013. This is an area of concern. Culture procedures should always be carried out in a biosafe environment, at least a level 2 laboratory.
- Ensure the availability of rapid tests so patients can be put on treatment quickly to prevent further spread of the disease.

Patients are often sent from the HIV centre to the TB centre for diagnosis and treatment, which may expose the patient to TB unnecessarily. Patients should be tested for TB at the HIV centre. Personnel involved in TB care in HIV centres, and those providing HIV care in TB centres, should receive more training. Active TB diagnosis should be available for all people living with HIV by the end of 2012.

In respect of current laboratory capacity in the Region, in 2010 35 countries reported that they had established in-country external quality assurance schemes. Unfortunately only 20% of smear microscopy laboratories and 21% of culture laboratories showed good performance. The percentage of culture-confirmed TB cases among pulmonary TB cases is as low as 40% in some areas of western Europe. The same is true of sputum smear positivity. This is a challenge for the near future as we implement the Xpert MTB/RIF tests for diagnosis of TB and detection of rifampicin resistance. Currently, some countries have a culture-confirmation rate of less than 40%, so doctors are diagnosing TB without laboratory confirmation. The doctors need to be convinced that the new test is reliable and that, if the test is positive for TB and rifampicin resistance, they should quickly initiate the appropriate treatment regimen.

With regard to the availability of laboratory services in the Region, culture, drug susceptibility testing and line probe assay tests for prediction of drug resistance are not as widely available in the non-European-Union States in the Region, and

microscopy services may be downgraded. ELI's mission is to strengthen laboratory capacity, particularly in the eastern part of the European Region. ELI is a network of national and supranational laboratories and international partners. It will be a regional platform to facilitate laboratory-related activities detailed in the Action Plan. This will give guidance on the most appropriate TB laboratory technologies and integration or coordination with other activities, including HIV testing. Fifty institutes have already signed up to ELI.

ELI's terms of reference include:

- implementing policy guidance, procedures and standards, for instance by providing translations into local languages (e.g. Russian);
- increasing the capacity of the laboratories;
- developing quality assurance standards and promoting accreditation.

In the general discussion, it was stated that, in some countries, changes to the law would be needed to amend the TB treatment regimen on the basis of a finding of rifampicin resistance alone. Uzbekistan has several GeneXpert machines, and has already detected rifampicin-resistant forms of TB. The country has had problems with training and with bringing the machines into the country owing to Customs restrictions. One participant noted that ELI has both English and Russian as its working languages in order to help countries that are lagging behind in the introduction of new laboratory techniques because of the language barrier. National policies are not always adapted to laboratory work.

The third presentation, made by Dr Ogtay Gozalov (Tuberculosis and M/XDR-TB Control Programme, WHO Regional Office for Europe), dealt with GLC/Europe, TBTEAM and the regional interagency coordinating committee on TB control and care. GLC/Europe is one year old and is very active in supporting countries in reviewing their national plans, which are being aligned with the regional plans. It develops guidelines based on the specific needs of each country: there are seven main areas of intervention and the focus is on prevention. It also deals with the consequences of delayed diagnosis or inadequate treatment. TBTEAM is the global technical assistance mechanism. In Europe, the partners are developing plans for submitting technical assistance requests. There are weekly meetings with the Global Fund¹ to discuss implementation and grant renewals, which improves communication and resolves bottlenecks. A Web site¹ is available where the status of projects can be checked. The third body, still in the process of development, is the regional interagency coordinating committee on TB control and care. The parties involved are governments, donors, WHO and other technical agencies, community organizations, faith-based organizations and TB patients and their relatives and friends. Only if all these organizations are part of TB control can the efforts succeed. The regional interagency coordinating committee on TB control and care ensures equitable access to appropriate diagnostics, treatment, care and follow-up.

In response to a question about the way the regional interagency coordinating committee on TB control and care will be funded and the associated timescale, it was stated that funding will depend on those present to make it a success. A committee to pursue this end will be formed soon. The participant from Uzbekistan noted that the various civil-society organizations in the country did not work well together. A network of TB-focused civil society organizations and their representative has now been created and is a member of the Global Fund's Country Coordinating Mechanism for Uzbekistan. A further comment was that other countries might usefully emulate the United Kingdom Parliament's cross-party advisory group on tuberculosis.

Next steps

- Suggestions and remarks about the post-2015 StopTB strategy will be forwarded to WHO headquarters and the strategy will be further discussed and presented for input at the various events mentioned above.
- The fact that national regulations (such as laws or decrees (*prikaz*)) sometimes hinder the import of laboratory reagents and/or equipment, and the obstacles which sometimes prevent a change to a more appropriate treatment regimen following the detection of rifampicin resistance require discussion at senior political levels.
- Countries will be informed about progress in the development of the regional interagency coordinating committee on TB control and care and further activities of regional mechanisms through the Regional Office newsletter and Web site and presentations at international meetings.

¹ <http://www.stoptb.org/countries/tbteam/default.asp>.

Session 2. Follow-up to Wolfheze Workshops 2011

Coordinators:	Dr Gerard de Vries, Dr Ogtay Gozalov
Chairpersons:	Dr Peter Gondrie, Dr Masoud Dara
Reporter:	Dr Andrei Dadu

Background

During the last Wolfheze meeting held at The Hague, Netherlands, on 25-27 May 2011, specific commitments were made for the finalization of two important documents after feedback from participants, namely the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region 2011-2015 and the Minimum Package for Cross-Border TB Control and Care in the WHO European Region: A Wolfheze Consensus Statement, which has just been published. Following the session on childhood TB at the previous national TB programme managers' meeting, the Regional Office established a Task Force on Childhood TB. The Task Force is currently conducting a survey on childhood TB prevention and control practices.

Content of the session

1. Minimum Package for Cross-Border TB Control and Care
2. Update on the progress of the childhood TB survey
3. The role of partnerships in TB control

Methodology

- Presentations
- Discussion in plenary

Objectives

- To update participants on the Minimum Package for Cross-Border TB Control and Care
- To present the activities of the Task Force on Childhood TB
- To discuss the above topics and receive feedback from participants

Expected outputs

- Participants are updated on the proposed measures for cross-border TB control and care and discuss implementation of these measures. Participants are aware of the process of the childhood TB survey
- Participants' awareness has been raised about the role of partnerships in TB control

Format

11:30 – 11:45	The role of partnerships in TB control	Ms Sandra Roelofs
11:45 – 12:00	Survey of practices on childhood TB	Dr Valiantsin Rusovich
12:00 – 12:15	Minimum Package for Cross-Border TB Control and Care	Dr Pierpaolo de Colombani
12:30 – 13:30	Lunch	

A video address was given by Ms Sandra Roelofs, a WHO goodwill ambassador. She noted that partnerships and well-equipped professionals are crucial for a successful fight against TB. Increasingly, the circumstances surrounding TB are aggravated by personal conditions and drug-resistant forms of the disease. To reach the most vulnerable groups, we need community-based alliances, support groups, faith-based organizations, psychologists, students, academics and researchers, as well as links with facilities that provide palliative care services promoted by nurses and social workers. The roles of relatives and friends of the patient should not be underestimated, as they facilitate and support prolonged adherence to treatment. In countries where health care is privatized, fighting TB is not a profitable exercise, and it is a conscious health-care choice to protect the population. TB patients can only be successfully treated if they change their behaviour, including physical exercise, healthier nutrition and other preventive measures on a daily basis, together with being a responsible and active member of society. Therefore, preventive measures and a healthy lifestyle are very important. International organizations can provide technical and strategic know-how, direction and assistance. Governments could take the fight against TB more seriously and invest in prevention, treatment and care, including primary health care and community-based initiatives. Nongovernmental organizations and other civil society members are happy to help in reaching out to patients and their families. We need to offer the best possible medical care, and particularly the information component, which is so decisive in preventing the spread of disease.

Dr Valiantsin Rusovich (WHO Country Office, Belarus) talked about a survey of practices relating to childhood TB and presented the preliminary results of the Task Force on Childhood TB. This work is a follow-up to the WHO national TB programme managers' meeting at The Hague. There is a need to address discrepancies in the policies on childhood TB in the Member States. One of the goals is to inform national TB programme members of progress by 2012. The main activities in 2012 were appointing chairpersons and subgroups and development, translation and piloting of the questionnaire. The next steps are sending out questionnaires, processing the data, reporting, preparing recommendations, implementing changes in TB policy and exploring the possibilities for training in childhood TB.

Dr Pierpaolo de Colombani (Tuberculosis and M/XDR-TB Control Programme, WHO Regional Office for Europe) talked on the Minimum Package for Cross-Border TB Control and Care in the European Region. This package was originally discussed at the meeting at The Hague in 2010, where there was a recommendation that a concept paper on cross-border

TB control should be developed. A working group was established to this end, which looked at the governance, financing, service delivery, surveillance and supportive environment required for the minimum package. A list of focal points that can be used for referral of patients between countries already exists under the International Health Regulations (2005). Some examples were given, and this practice was proposed for future expansion.

In the ensuing discussion, a question was asked about obtaining the list of focal points, with the comment that it is problematic to distribute confidential data via e-mail. It was made clear that the list of focal points is already available from the Ministry of Health in each country. The International Health Regulations mechanism can be used to establish initial contact between different TB providers, which will be followed by the exchange of confidential patient data by more secure means. The participant from Uzbekistan commented that the country has a migrant labour force with TB problems and asked whether a study on migrant workers and the possibility of providing TB services for them could be conducted. Another participant noted that, in most countries, the majority of migrants are not citizens of European Union Member States and therefore find it difficult to obtain TB care. The participant from Israel noted that migrant workers are treated at the expense of the State. There is an issue of deporting patients with TB back to countries where there is limited or no care. An associated issue is the willingness of the patient to be deported. One participant noted that the system of focal points established under the International Health Regulations (2005) is the best way to exchange information between countries.

Mr Mike Mandelbaum (Chief Executive of TB Alert) next gave a short presentation on TB in the United Kingdom, which has become more prevalent over the past 25 years. The TB programme integrates organizations working in the field of homelessness and other areas. The focus is on awareness-raising so that these groups can interact with other agencies effectively.

Next steps

- Facilitated by WHO/Europe, the Region-wide survey on TB care among children will be processed and reported back to the countries. These results will form the basis for policy change regarding childhood TB in the Member States of the European Region, as well as specific regional workplans for strengthening country capacity in childhood TB/MDR-TB and implementing those policies.
- Participants committed themselves to making joint efforts to implement
- the Minimum Package for Cross-Border TB Control and Care in the European Region. Region-wide implementation will be facilitated by the Regional Office.

Session 3. Efficient financing of TB services

Coordinators:	Dr Juan Tello, Dr Pierpaolo de Colombani
Chairpersons:	Dr Malgorzata Grzemska, Dr Nicolas Cantau
Reporter:	Dr Pierpaolo de Colombani

Background

TB and M/XDR-TB are partly the result of weak health systems: the absence of TB on the political agenda, fragmented public health management, perverse financing mechanisms discouraging outpatient care, poor planning of human resources, laboratory networks unable to diagnose TB quickly and provide reliable information on resistance to TB drugs, poor health infrastructures and airborne infection control, lack of patient support, inadequate involvement of primary health care and other potential TB providers, immature systems of drug management and supply, misleading surveillance systems. Most of the high TB priority countries of the Region are already engaged in reforming their health systems and financial mechanisms to increase sustainability, efficiency, effectiveness and accountability. This is an opportunity for national TB programmes to convert hospital services into more cost-effective and patient-centred outpatient services.

Content of the session

1. Overview of the international experience of purchasing health services
2. Guiding principles on purchasing health services, including TB services
3. Analysis of current problems and potential reforms in countries of the European Region

Methodology

- Presentations
- Group work
- Discussion in plenary

Objectives

- To inform participants about the evolution of payment mechanisms with a view to creating incentives for high service quality, efficiency and responsiveness to patients' needs
- To discuss specific incentives that health financing policy should set for TB services
- To identify priority areas for reforms in the way TB services are purchased in the European Region

Expected outputs

- Participants have a better understanding of alternative purchasing mechanisms for inpatient and outpatient TB care
- Reflections on the current situation in countries and on potential improvements in health financing
- An understanding of the limitations of health financing policy to drive changes in clinical behaviour

Format

13:30 – 14:00	The evolution of provider payment mechanisms for health services and specific principles for paying for TB services	Ms Nora Markova
14:00 – 14:30	Discussions in plenary	All participants
14:30 – 14:40	Introduction to the working groups	Dr Juan Tello
14:40 – 15:00	<i>Coffee break</i>	
15:00 – 16:30	Discussion in working groups Group A: Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan Group B: Bosnia and Herzegovina, Georgia, Kosovo, ¹ Latvia, Republic of Moldova, Romania, Serbia, Turkey Group C: Other countries	Dr Masoud Dara Ms Nora Markova Dr Juan Tello Dr Pierpaolo de Colombani Dr Ibrahim Abubaker Dr Gerard de Vries
16:30 – 17:30	Group reporting Discussion in plenary	Group reporters All participants
17:30 – 17:45	Closing remarks	Dr Hans Kluge Dr Masoud Dara

Session 3 focused on the efficient financing of TB services. The first presentation was entitled "The evolution of payment mechanisms and thoughts on paying for TB services" and was presented by Ms Nora Markova of the WHO Barcelona Office for Health Systems Strengthening.

Payment mechanisms have evolved over the years from input-oriented to outcome-oriented:

- input: historical budgets based on beds, staff, infrastructure
- output: fee-for-service, per diem (fee for each day spent by patients in a facility), case-based payment

¹ In accordance with UN Security Council Resolution 1244 (1999).

- outcome: bonus for targets, pay-for-performance.

Purchasing instruments include payment methods (which should be consistent across the health system and favour cost-effective services), contracting (a certain volume and mix of services according to need) and performance measurement (process, output, outcome). Purchasing should move from “passive” to “strategic”, i.e. we should not just act as cashiers allocating resources in obedience to set norms, but we should influence service providers’ actions, i.e. performance-based payments, selective contracting and quality improvement and rewards. As such, the financial risk increasingly shifts to the provider, i.e. there is a move from allocation of historical budget inputs (beds, staff, infrastructure) to purchasing providers’ outputs (fee-for-service, per-diem and case-based payment through diagnosis-related groups), to purchasing providers’ outcomes (bonus for targets and pay for performance). The dominant payment methods are: capitation in primary care; fee-for-service in outpatient specialist care; and case-based payment in inpatient care. All these methods have their limitations. Under fee-for-service, the purchaser bears all the risks, there is an incentive to increase the volume of services unnecessarily (e.g. supplier-induced demand generating overtreatment) and administration costs are high. With per-diem payment, some risks are shared between purchaser and provider, but hospital care increases and quality of care decreases. In these cases, hospital admission should be adjusted according to the severity of the disease and the actual cost per day of hospitalization. A fair approach is to consider per-case payments based on average cost within diagnosis-related groups (DRGs) or case-mix-adjusted payments which allocate more resources for sicker patients. The next type of payment method is the global budget, which covers all services provided in a given time period, based on history plus trends. If this is to work, it requires fixed ceilings and floors for expenditure, standardized protocols described in national guidelines and effective incentives for compliance with implementation.

Things to consider, then, are: who bears the financial risk? What are the incentives of the payment method?

So, how do we move from passive to strategic purchasing? First, you must know what you are paying for by measuring outputs. Based on this thinking, the Regional Office Division of Health Systems and Public Health approach to health systems strengthening has a three-pillar strategy: have clear expected health gains, identify core services required to achieve these gains; identify and remove systemic bottlenecks to scale up coverage of core services.

With particular regard to TB financing, we need to know what a good health financing system for TB services should look like. What are the specific objectives of delivering TB services that should be supported, and which are the essential services which should be delivered even if resources are scarce? The StopTB Strategy does indeed have some key objectives to consider: early detection of TB cases; rapid and accurate diagnosis (in particular for MDR-TB); maximize outpatient treatment and minimize hospital admissions; effective infection control in hospitals; minimize length of hospital stay; create incentives for patients to comply with treatment. Alongside these objectives, there are service delivery objectives: limit hospitalization for the purposes of diagnosis; treat most non-MDR-TB cases in the community, especially sputum-negative and nonpulmonary TB cases; reduce number of hospital beds; build a strong primary care system to strengthen case-finding and directly-observed treatment. However, throughout the European Region, current payment methods encourage hospitalization and often excessively long hospital stays.

To turn this around, Kyrgyzstan has based its system on DRGs using case classification and directly observed therapy groups. Cost accounting is weighted by group. The TB hospital budget is therefore based on the expected number of cases multiplied by the relative weight of each case type. The hospital has to manage within this budget. Many countries use the capitation payment approach for primary health care providers. To create incentives for proper care, there should be some payment related to provider workload, i.e. a difference in payment between TB and MDR-TB patients. Bonus payments may be made on successful completion of treatment to ensure close supervision. It is also worth considering paying patients directly, as they need to continue treatment even after they start to feel better.

Ideas for paying for TB services are as follows:

- pay a bonus for active case-finding
- pay primary providers based on case-load and complexity and with a bonus for treatment completion
- pay modest cash amounts to patients upon treatment completion
- do not pay for hospital admission for diagnostic testing
- do not pay for hospitalization of nonsevere smear-negative patients/nonpulmonary TB
- pay for hospitalization only until patients are sputum-smear-converted (i.e. no longer infectious).

In the general discussion, it was pointed out that overhospitalization of TB patients is not only inefficient but leads to further development of MDR-TB because of poor infection control. Many patients go through multiple levels of care – can we create incentives for the patient-centred approach across all these levels? Hospitalization of sputum-negative patients/nonpulmonary patients should be considered when they have severe clinical conditions. Also, instead of paying until smear conversion, the patients should be discharged as soon as possible, as they often become noninfectious even prior to smear conversion. When thinking of modest cash payments to patients, could these be made not on treatment completion, but on successful transfer to the next care level?

The second presentation by Dr Juan Tello (Health Governance Programme, WHO Regional Office for Europe) introduced the group exercise. The three working groups were requested to answer the following question:

If you need to shift from hospital to primary care in order to achieve more cost-effective and patient-centred services, which financing options will you put in place in your country?

Possible lines of discussion include: identifying key actors, the expected improvements desired, and the financing options that would create incentives for these changes. Disincentives in one area must be balanced out by incentives in another.

The participants split into three groups (A, B and C) and the results of each group’s discussions were presented by the group reporter in plenary.

Group A: Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan

The main topic of discussion was “Moving towards an integrated approach in financing TB services”. The conclusion was that, whatever financing mechanism is introduced, it is important not to reduce the total financing available for TB. In the revision of financing mechanisms, the health-care system in general should not be forgotten, as TB care is carried out at multiple levels of care. An integrated approach should be taken that does not solely focus on TB. Rationalization of the number of hospital beds should be attempted. Multisectoral working groups should be formed within countries. Overall, salaries of TB specialists should be increased. Finally, provider incentives are very important and should be combined with patient incentives, where appropriate, to increase adherence to TB treatment. At present, these approaches would be very expensive and are mainly implemented through donor-funded projects of questionable sustainability. Consequently it is suggested that pilot projects are implemented to test provider-centred and patient-centred incentives and present the results to the government. Whichever patient incentives are put in place, the emphasis should not be solely on MDR-TB patients but also on regular TB patients, whose motivation is just as important. Countries should revise their hospitalization and discharge criteria to provide the most effective and cost-effective care possible for the patient. It was agreed that performance-based models of payment should be introduced in both hospital and ambulatory care settings and that costing studies are necessary and required in all countries.

Group B: Bosnia and Herzegovina, Georgia, Kosovo,¹ Latvia, Republic of Moldova, Romania, Serbia, Turkey

The members of Group B presented their current financing models, country by country, which vary considerably; most of them have recently been, or are soon to be, reformed. Serbia uses historical budgets (but is soon moving to DRG for hospital care and fee-for-service in primary health care), as do Kosovo and Bosnia and Herzegovina. Latvia has fees-for-service for both hospital and outpatient care and is planning to introduce DRG for hospital care and a quality bonus system for outpatient care. Romania has mixed financing, based on historical budgeting for medicines by the Ministry of Health and health insurance which pays for hospital per-diem and per-service outpatient services for TB. Turkey has a national health insurance system providing per-diem payments for hospitals and fees-for-service (capitation) for family doctors, who also receive bonuses according to their performance. The Republic of Moldova has a similar practice. In Georgia, all TB services have been privatized and are purchased by private health insurance providers, based on per-diem hospital care and case-based outpatient care; TB diagnosis is financed directly from the Ministry of Health budget.

Some general issues came out of the group discussion:

- the importance of providing TB diagnosis and treatment free of charge, which is widely done;
- the difficulty of co-opting primary health care providers, who are not motivated to take on TB patients;
- the limited provision of effective patient support outside the implementation of Global Fund grants;
- the limited provision of incentives for providers, which in any case are dependent on Global Fund grants (with the exception of Turkey);
- the very limited involvement of the private sector (with the exception of Georgia).

Group C: Belgium, Germany, Israel, Netherlands, Slovakia, Switzerland, United Kingdom

The group first discussed current financial models in their respective countries before moving on to the exercise. The key points agreed upon were as follows:

- free TB treatment should be advocated
- financing through diagnosis-related groups allows for some control
- stop per-diem payment
- fee-for-service payments for doctors
- to encourage outpatient care, a network of specialist TB nurses in the community may be considered
- move some funding from hospitalization to preventive services
- MDR-TB may require specialist ambulatory care.

Summing up, Ms Nora Markova (WHO Barcelona Office for Health Systems Strengthening) stressed that changing financial mechanisms involves weighing up the cost of inefficiency versus first-time successful treatment. In the long term, the latter is more cost-effective. Reducing inefficiencies, e.g. overhospitalization, can free up funds which can be used elsewhere. It is important to weigh up government versus donor funding in terms of innovation and sustainability. Objectives must be the focus in any health system, and whichever payment methods are chosen, they must be used in combination, as single changes often do not work. The TB sector does not exist in isolation, and broader systemic changes may be necessary in the move towards an outpatient-based system.

Dr Nicolas Cantau (Global Fund to Fight AIDS, Tuberculosis and Malaria) then spoke briefly from the perspective of the Global Fund Secretariat. The Global Fund has approved funding of US\$ 575 million for TB control in the European Region, and the vast majority of funds have already been disbursed to the relevant countries. Money is available, but goals are not being reached. It seems that TB reform and financing can be used as a proxy for broader health reform in the Region. It is extremely important that, in the long term, funds are used for diagnostics, treatment and support for MDR-TB patients. We are seeing a trend of lower treatment success among TB patients on DOTS, as they receive hardly any support. Although there has been some progress, there is still not enough community support or involvement. A great deal is said about HIV treatment literacy, but hardly anything about patient education in TB. The Global Fund can be used to enhance work done in the community and for the patient.

¹ In accordance with United Nations Security Council Resolution 1244 (1999).

Next steps

- Country-specific operational cost-effectiveness or other assessments should be undertaken to support revised models of care outside hospitals, including incentives for providers and patients and strengthening of TB and MDR-TB case-holding.
- The great differences in TB financing across the WHO European Region call for pilot projects that can test the most appropriate mechanism in a particular country. Global Fund grants offer opportunities to identify and promote more sustainable TB service delivery that can more easily be taken over by the Ministry of Health when the grant comes to an end.

Closure of the meeting

Dr Masoud Dara and Dr Hans Kluge officially brought the meeting to a close, raising the following points.

- **Outstanding questions:** What are the health system barriers to TB and MDR-TB control?
- **Health system delivery and financing:** A group of 10 experts will be looking at different frameworks and concepts of health service delivery at the London School of Hygiene and Tropical Medicine shortly after the current meeting. The output will be a concept paper, which will be circulated to Member States for consultation.
- **Forthcoming events:** A follow-up meeting to the 2009 Oslo Ministerial Meeting “Health in times of global economic crisis: the situation in the WHO European Region” will be held, also in Oslo, Norway, in April 2013. The meeting will revisit the 12 recommendations made at the 2009 meeting and share evidence on the way countries replied in terms of health policy responses. The fifth anniversary of the Tallinn Charter: Health Systems Strengthening for Health and Wealth, which includes a section on health financing, also falls in 2013.
- **Future activities:** Work is under way on a “quick scan” device for TB. A regional interagency coordinating committee on TB control and care is to be established. Participants are asked to provide comments and suggestions on the first draft of the conceptual framework for the post-2015 StopTB strategy. A meeting will be held in October 2012, probably in the Republic of Moldova, to discuss national TB strategic plans.
- **Outreach to non-health-sector actors:** We had an inspiring morning, starting with the patient perspective. The First Lady of Georgia addressed us on the role of partnerships and civil society. It is important to continue engaging Members of Parliament in TB control. The WHO Office in Brussels will raise awareness among Members of the European Parliament. Another step would be to look at the most valuable experiences of working with your local parliamentarians and share them across the Region.
- **Food for thought:** We need to concentrate on the most vulnerable members of the population. A lot of emphasis is placed on cost containment, but not always enough on the social aspects. We need new research on vaccines and drugs. It was noted that external programme reviews have become very important.
- **Meeting logistics:** Feedback from country colleagues indicated that they found the Webcasting of the event useful.

Annex 1. Scope and purpose

1. Present and discuss newly-established regional mechanisms for coordination and collaboration in TB control.
2. Provide a follow-up on specific issues raised during the last national TB programme managers' meeting, held at The Hague, Netherlands in 2011.
3. Provide an update on progress made in implementing the Berlin Declaration on Tuberculosis of 2007 and the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015.
4. Discuss the preliminary outline of the post-2015 StopTB strategy.
5. Discuss efficient financing of TB services.

Annex 2. List of participants

Member States

Armenia

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Azerbaijan

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Belarus

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Belgium

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Dr Maryse Wanlin
Medical Director, Belgian Lung and TB Association (BELTA)

Bosnia and Herzegovina

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Clinic for Lung Diseases of the Republika Srpska
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Latvia

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Netherlands

Dr Gerard de Vries
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United Kingdom of Great Britain and Northern Ireland

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House of Commons
Dr Ibrahim Abubakar
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European Centre for Disease Control

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Dr Sai Kumar Pothapregada

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Principal Recipient (PR) Global Fund Armenia

Dr Hasmik Harutyunyan

PR Global Fund Belarus

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PR Global Fund Bosnia & Herzegovina

Dr Rankica Bahtijarevic

PR Global Fund Georgia

Dr Maya Kavtaradze
Dr Nino Lomtadze

PR Global Fund Kazakhstan

Prof Shakhimurat Ismailov

PR Global Fund Serbia

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PR Global Fund Turkmenistan

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PR Global Fund Ukraine

Ms Tetyana Bilyk

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Results UK

Ms Jessica Khehne

TB Alert

Mr Mike Mandelbaum

Mr Paul Sommerfeld

Tuberculosis Survival Project

Mr Paul Thorn

United States Agency for International Development (USAID), Washington, DC

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HE Ms Sandra Roelofs, First Lady of Georgia

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme, each geared to the particular health conditions of the countries it serves.

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