
**12th WHO National TB
Programme Managers' Meeting**

and

16th Wolfheze Workshops

The Hague, Netherlands
29-31 May 2013

MEETING REPORT

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Acronyms and abbreviations

ACF	active case-finding
ACSM	advocacy, communication and social mobilization
BCG	bacille Calmette-Guerin vaccine
CSO	civil society organizations
CXR	chest X-ray
DOTS	the basic package that underpins the Stop TB Strategy
ECDC	European Centre for Disease Prevention and Control
EECA	Eastern Europe and Central Asia
EHRN	European Harm Reduction Network
EMRO	World Health Organization Eastern Mediterranean Region
EPTB	extrapulmonary tuberculosis
ERLN-TB	European Reference Laboratory Network for Tuberculosis
ERS	European Respiratory Society
ESTC	EU/EEA Standards for Tuberculosis Care
EU/EEA	European Union/European Economic Area
EURO	World Health Organization European Region
FEANTSA	European Federation of National Organisations working with the Homeless
GFATM	Global Fund to Fight Aids, TB and Malaria
HBC	high-burden country
IC	infection control
IDUs	injecting drug users
IGRA	interferon-gamma release assay
IPT	isoniazid preventive therapy
ISTC	International Standards of Tuberculosis Care
KAP	knowledge, attitude and practice
KNCV	KNCV Tuberculosis Foundation, Netherlands
M/XDR-TB	multidrug- and extensively drug-resistant tuberculosis
MAP	Consolidated Action Plan to Prevent and Combat M/XDR-TB
MDG	Millennium Development Goal
MOH	Ministry of Health
MOJ	Ministry of Justice
NTP	national TB programme
PTB	pulmonary tuberculosis
RICC-TB	Regional Interagency Collaborative Committee for TB Care and Control
SEARO	World Health Organization South-East Asia Region
TB	tuberculosis
TBEC	TB Europe Coalition
TUBIDU	TB Injecting Drug Users Initiative
WHO	World Health Organization

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and Mr Oluf Christoffersen for facilitating the webcasting, which made it possible for people not able to attend the meeting in person to follow the discussions.

Executive summary

The Wolfheze Workshops 2013 aims to strengthen tuberculosis (TB) control in the WHO European Region, with an emphasis on sharing experiences and discussing progress and plans for the development of Region-specific guidance documents based on a consensus-building approach.

During the three-day workshop, over 200 participants from 54 countries, including national TB programme managers; health authorities; laboratory experts; national TB surveillance correspondents; civil society organizations (CSO); and other partners discussed achievements, challenges and the way forward. The event was live-webcasted in English and Russian and was followed in more than 30 countries across the Region and beyond.

The three-day event reviewed progress made since the Berlin Declaration in 2007; the launch of the [ECDC Framework Action Plan to Fight Tuberculosis in the European Union in 2008](#); and the [Consolidated Action Plan](#) to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis (M/XDR-TB) in the WHO European Region 2011-2015 (MAP), published in 2011.

Among the many topics discussed, participants exchanged experiences from the laboratory network, on patient management and innovative models of care, on enhanced case-finding within high-risk settings; challenges in extrapulmonary TB, TB among vulnerable populations (including migrants and prisoners), childhood TB and the role of civil society.

Finally, the results of the working groups on urban TB and childhood TB were presented and discussed. On the basis of these discussions, three new working groups were proposed: (1) health financing in relation to TB control; (2) social determinants in relation to TB control; and (3) intensive case-finding, screening.

Presentations from the meeting are available on the KNCV Tuberculosis Foundation website in both English and Russian (www.kncvtbc.org/wolfheze-workshops-2013-presentations).

Background

Over the past 16 years, regular meetings have been held between the managers of national tuberculosis (TB) programmes in the WHO European Region. Since the 1990s, the WHO Regional Office for Europe and the KNCV Tuberculosis Foundation have organized regional meetings of national TB programme managers with various partners, including the European Centre for Disease Prevention and Control (ECDC) and WHO headquarters. These meetings have witnessed the progressive merging of priorities for tuberculosis control intervention among all 53 Member States of the Region. Multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB is 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 a 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, 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. A specific framework action plan for the European Union and European Economic Area (EU/EEA), the ECDC [Framework Action Plan to Fight Tuberculosis in the European Union](#), was launched in February 2008.

The 12th national TB programme managers' meeting was organized back-to-back with the 16th Wolfheze Workshops. The workshops provide a platform for national TB programme managers, health authorities, laboratory experts, national TB surveillance correspondents, CSO and other partners to discuss achievements, challenges and ways forward. The joint meeting of the national TB programme managers and the Wolfheze Workshops offered an excellent opportunity to discuss the challenges and opportunities shared by all countries in the Region to fulfill the above mentioned commitments, achieve Millennium Development Goal 6 by 2015 and discuss the post-2015 StopTB strategy.

The meeting was organized jointly by the World Health Organization Regional Office for Europe, the ECDC and the KNCV Tuberculosis Foundation (KNCV) in conjunction and in parallel with the joint [ECDC/WHO European TB Surveillance Network](#) annual meeting and the meeting of the ECDC-coordinated [European Reference Laboratory Network for Tuberculosis \(ERLN-TB\)](#).

Scope and purpose

The Wolfheze Workshops 2013 aim to strengthen TB control in the WHO European Region, with an emphasis on sharing experiences and discussing progress and plans for development of Region-specific guidance documents based on a consensus-building approach.

The programme of the Workshops focused on the progress made following the Berlin Declaration in 2007 and the launch of the Framework Action Plan in 2008 and the

Consolidated Action Plan in 2011. In addition, the event covered measures to improve the laboratory network; patient management and innovative models of care; enhanced case-finding within high-risk settings; extrapulmonary TB; TB among vulnerable populations including migrants and prisoners; childhood TB; and the role of civil society.

Opening session

Coordinators:	Dr Masoud Dara (WHO Regional Office for Europe), Dr Gerard de Vries (KNCV)
Speakers:	Mr van Aartsen (Mayor, The Hague), Mrs Sandra Elisabeth Roelof (First Lady of Georgia), Mrs Ilke van Engelen (ex-TB patient), Dr Hans Kluge (WHO Regional Office for Europe), Dr Marc Sprenger (ECDC), Mrs Gerdy Schippers (KNCV)

Mr van Aartsen, Mayor of The Hague, welcomed the participants to the meeting. He noted that, despite substantial progress in the fight against TB in Europe, the battle is far from over. With 385 000 new cases detected in the region every year, 44 000 lives lost, especially in the eastern part of the Region, and the increasing problem with MDR-TB, there are reasons to be concerned and to continue working together to fight TB. Mr van Aartsen highlighted the Netherlands' long history in the fight against TB, and ended his talk by emphasizing the necessity of exchanging knowledge in order to fight TB. He wished the participants a successful conference.

First Lady of Georgia and WHO Goodwill Ambassador, Mrs Sandra Elisabeth Roelofs, took the participants on a journey back to the establishment of the Netherlands TB foundation (KNCV Tuberculosis Foundation) and the developments in TB control in the Netherlands from the 1940s until the present. She described how strong Government commitment has contributed to current record low TB rates in the Netherlands, reduced from levels similar to what is seen in some Eastern European countries today. Despite the financial crisis, investing in TB control is both vital and cost-effective, an issue which, especially in times of austerity, should not be neglected. Mrs Roelofs ended her speech by stressing how important it is that diagnosis and treatment of TB should be accessible, affordable, and available to all and encouraged the participants to work together in the continued fight against TB.

Ms Ilke van Engelen, an ex-TB patient from the Netherlands, shared her very personal story as a recovered TB patient. She described how, in late 2011, a prolonged cold and cough, combined with symptoms of fatigue, were finally diagnosed as TB after more than six months and many visits to the family doctor and specialists. She shared her experiences with the Netherlands health-care system and her reaction when she was finally diagnosed. She also highlighted the essential role of her TB contact person in her recovery and her six months' fight to get back to her old self. Ms van Engelen stressed the importance of good communication in TB care, and how the relationship between the patient and health-care providers can make all the difference. She closed by wishing all participants a fruitful conference.

Dr Hans Kluge, WHO Regional Office for Europe, Director, Division of Health Systems and Public Health and Special Representative of the WHO Regional Director for Europe on M/XDR-TB, welcomed all participants to the meeting on behalf of the Regional Director. He reminded participants that, since the endorsement of the Consolidated Action Plan in Baku in 2011, many milestones have been achieved. However, treatment success is still low, partly because of the lack of effective medicines and inadequate TB control across borders. Although TB is mainly a problem in the east of the Region, Dr

Kluge noted how it is increasingly becoming a problem in big cities in the west as well. Dr Kluge closed by congratulating the Member States on their hard work and achievements and hoped for successful discussions during the meeting.

Dr Marc Sprenger, ECDC, likewise welcomed participants. Moved by the story of the ex-TB patient Ms Ilke van Engelen, he shared his own childhood experience of being infected with TB. Looking back, he is impressed with and grateful for having grown up in a health system that could detect TB and respond effectively. Without it, he would not be there today. Dr Sprenger described the involvement of ECDC in TB control and encouraged participants to continue sharing experiences and hard work. He ended his talk by emphasizing the importance of not forgetting the patients and civil society, and quoted the Director-General of WHO: "[We have to influence people at the top, but it is people at the bottom who matter most](#)".

Finally, Mrs Gerdy Schippers, Director of Finance, KNCV Tuberculosis Foundation, welcomed the participants on behalf of KNCV Tuberculosis Foundation. Starting with a short introduction to the history of the Wolfheze movement and the collaboration with WHO and ECDC, she reminded the participants that the essence of the Wolfheze movement is to work jointly to fight TB. This year's theme, the progress of implementation of the Consolidated Action Plan, is close to the heart of KNCV. She highlighted the importance of nongovernmental organizations and civil society in the fight against TB and of keeping the patient perspective in mind. Mrs Schippers ended the opening session by reminding the participants that we can eliminate TB from the world, but it requires partnerships to be taken to an even higher level and leadership beyond what we have seen before.

Session 1. Follow-up to Berlin Declaration 2007, the Consolidated Action Plan to Prevent and Combat M/XDR-TB in the WHO European Region 2011-2015 and the Framework Action Plan to Fight TB in the EU

Coordinators: Mrs Fanny Voitzwinkler (GHA), Dr Masoud Dara (WHO Regional Office for Europe), Dr Agnes Gebhard (KNVC), Dr Marieke J. van der Werf (ECDC)

Chairpersons: Dr Masoud Dara (WHO Regional Office for Europe), Dr Marieke J. van der Werf (ECDC)

Reporters: Dr Andreas Sandgren (ECDC), Dr Martin van der Boom (WHO Regional Office for Europe)

Background

In 2007, the WHO Ministerial Forum "All Against Tuberculosis" adopted the Berlin Declaration on Tuberculosis. In 2008, the Framework Action Plan was published by the ECDC, and in 2011 the Consolidated Action Plan and resolution EUR/R61/R7 were unanimously endorsed by the 53 Member States of the WHO European Region.

Progress in the implementation of the plans is reported in the joint Regional Office and ECDC report *Tuberculosis surveillance and monitoring in Europe 2012*. A report on progress in the implementation of the Consolidated Action Plan will be submitted to the 63rd session of the WHO Regional Committee for Europe in September 2013. The participants in the national TB programme (NTP) managers' meeting/Wolfheze Workshops, combined with members of the TB surveillance network in Europe and ERLN-TB, make an excellent group to assess progress and exchange experiences of the implementation these commitments and plans, and discuss what is needed to reach the targets and outputs defined in the plans.

Content of the session

1. Introductions followed by country presentations on achievements and current situation of TB control, taking the themes of "Diagnosis", "Treatment and care", "Infection control" and "Advocacy, partnerships and political commitment" in the context of the 2007 Berlin Declaration, the Consolidated Action Plan and the Framework Action Plan.
2. Discussion between policy-makers and professionals on progress and experiences regarding implementation of the Consolidated Action Plan and the Framework Action Plan, with a focus on political commitment, resource mobilization and monitoring and evaluation.
3. Presentation of European Union Standards for Tuberculosis Care (ESTC) and their implementation.

Methodology

- Plenary presentations
- Working group discussions
- Plenary discussion of the results of the group work

Objectives

- To follow up on implementation and monitoring of the Berlin Declaration, the Consolidated Action Plan and the Framework Action Plan
- To familiarize the participants with the content and status of implementation of the ESTC

Expected outputs

- Participants are informed about the progress of the implementation of the Berlin Declaration, the Consolidated Action Plan and Framework Action Plan
 - Examples of best practices, obstacles and next steps to reach the outputs and targets of the Consolidated Action Plan and Framework Action Plan are shared, discussed and documented
 - Participants have gained new ideas in implementation of the ESTC
 - Wolfheze working group(s) are proposed for establishment on themes/subject(s) which need to be further worked out, with concerted action
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Summary of session 1

The first part of the session was dedicated to an overview of the progress made with implementation of the TB prevention and control plans of the WHO European Region and the European Union at both regional and national levels.

Dr Masoud Dara, Manager, TB and M/XDR-TB Programme (TBM), WHO Regional Office for Europe reported on the progress of the Berlin Declaration and Consolidated Action Plan to Prevent and Combat M/XDR-TB. An update was given on the epidemiological situation of TB and MDR-TB in the European Region and progress made on the Consolidated Action Plan core indicators. Although many countries have shown good progress, the WHO European Region has the lowest treatment success rate worldwide. Substantial progress has been made in the recruitment of MDR-TB patients in treatment programmes. However, treatment success rates for MDR-TB are far below the threshold envisaged in the Consolidated Action Plan. Further, the full treatment regime is often not used and there are problems with stock-outs of second-line drugs, which poses challenges for TB control in most of the high MDR-TB burden countries in the Region. Several countries have been assisted and have revised their financing mechanisms. However, the cancellation of Round 11 funding by the Global Fund to Fight Aids, TB and Malaria (GFATM) and the world financial crisis pose challenges for many countries and result in budget cuts for TB control. Key next steps for WHO include providing close and continuous support for Member States in implementation of the Consolidated Action Plan; preparation of a compendium of best practices; identification of and addressing the social determinants of TB and M/XDR-TB; scaling-up of best practices and patient-centred ambulatory care; strengthening of country capacity in surveillance for producing reliable estimates of MDR-TB figures; rational use of new TB drugs; interventions to move toward TB elimination in low-TB-incidence countries; and defining the role of surgery in TB and M/XDR-TB.

Dr Marieke van der Werf, Head of TB programme, ECDC, reported on the progress of the Framework Action Plan. She provided an update on the epidemiological situation

in the European Union and EEA and went over the status of the four epidemiological and eight core operational indicators of the follow-up to the Framework Action Plan. In summary, Dr van der Werf showed that, at European Union level, only one out of four epidemiological targets was met (the five-year trend in TB case-notification rates has declined overall in the European Union over the period 2007-2011). Only one out of five measured core targets was met (the performance in external quality assurance schemes run by ERLN-TB showed that national TB reference laboratories provide good performance for all diagnostic methods). It was therefore concluded that, despite good progress, continued and strengthened efforts in implementation of the Framework Action Plan are urgently needed. One next step will be to improve the further analysis of underlying causes that have hampered the implementation of the Plan.

Following the presentations by WHO and ECDC, four high-priority countries and four low-incidence countries gave brief presentations on their progress in diagnosis; treatment and care; infection control; and advocacy, partnership and political commitment at national levels.

DIAGNOSIS

Dr Gulnoz Uzakova, Uzbekistan (high-priority country) described how Uzbekistan has shown strong political commitment to TB control and has a well-functioning TB programme based on the main pillars of WHO guidance on TB control. In addition, good partnerships have been established with international partners and technical agencies. New molecular tools have been adapted and are used, and quality assurance is good overall. At regional level, priority has been given to culturing on solid and liquid media, and in three regions GeneXpert devices have been installed. There is not yet an official strategy for the introduction of new tools for TB control, but a draft is in preparation at national level. The main challenges at this point include the rational use of resources, improved logistics, improved palliative care and further investigation of the situation of childhood TB.

Dr Daniella Cirillo, Italy (low-incidence country) described how Italy has achieved a well-functioning laboratory system with a good infrastructure of labs at all three levels. External quality assurance is implemented for both first-line and second-line drug susceptibility testing. In addition, a good system for regular training of laboratory staff, clinicians and other health-care workers has been established. Key challenges include strengthening of the surveillance system and data reporting within levels and from the regional level to the national level. Secondly, lack of funds for the implementation and support of the regional and national laboratory networks is a challenge for the further improvement of TB diagnosis in Italy.

TREATMENT AND CARE

Dr Armen Hayrapetyan, Armenia (high-priority country) described how TB case notification has steadily decreased since 2005, but with increases in the number of MDR-TB cases. Key achievements so far include new TB and MDR-TB and XDR-TB response plans; national guidelines for TB care; and newly developed infection control plans. Armenia has also introduced rapid testing tools including GeneXpert and there is

good availability of new drugs for treatment of M/XDR-TB patients. In addition, a programme for home-based TB care has been introduced. A key challenge is the continued low treatment success rate for MDR-TB, which since 2007 has remained at 53-55%, and there is also an increased number of TB/HIV coinfected patients. Additional challenges include the modernization of TB services and expansion of the training of physicians, nurses and TB specialists. Among next steps in treatment and care is the continued training of relevant health-care workers in TB (not just TB specialists); continued efforts to modernize TB services; and improving ambulatory treatment and care for TB patients.

Dr Gábor Kovács, Hungary (low-incidence country) described how a steady decline in TB cases and a current low level of MDR-TB (<3%) places Hungary in an overall favourable position. There is political commitment, and a new national TB control plan is under revision with implementation starting in 2015. Hungary has also revised the protocols for TB treatment and diagnostics in line with international recommendations. However, the country is facing problems with ensuring adequate human resource capacity in general and for TB specifically. DOTS¹ is implemented, but there are concerns about its continued financing. In addition, there is a need to improve the model of implementation of DOTS, by for example involving social services, nongovernmental organizations and churches to expand nonhospital care and to improve collaboration with CSO. Finally, the percentage of laboratory confirmed new TB cases needs to be raised from the current 51% to reach 75% by 2020. The treatment success rate must also be improved from the current 64% to reach 85% by 2020.

INFECTION CONTROL (IC)

Dr Nestan Tukvadze, Georgia (high-priority country) summarized how the WHO TB infection control guidelines from 2009² have been adopted and implemented. A basic risk assessment was conducted for all specialized TB service points and nearly 100% of the TB outpatient service points have been upgraded through renovation, with facility IC measures implemented and followed. In addition, all microscopy laboratories have been upgraded to meet the necessary biosafety level, and engineering control measures have been implemented. Currently, Georgia is working on expanding the “3Is for TB/HIV”³ training for health-care professionals and developing tools on IC standards for renovation and construction of health-care facilities. Key challenges include the monitoring and evaluation of the implementation and effect of IC measures, and procedures to ensure adequate maintenance of engineering control measures in future. Next steps for the country are to improve the initiatives and steps which have been taken in order to provide better IC, and to document best practices as well examples which have proved to work less well.

¹ DOTS: the basic treatment package that underpins the Stop TB Strategy.

² World Health Organization. *WHO policy on TB infection control in health-care facilities, congregate settings and households*. Geneva, 2009.

³ 3Is: Intensified case-finding, Isoniazid preventive therapy (IPT) and Infection control for TB.

Dr Karin Rønning, Norway (low-incidence country) presented Norway's comprehensive guidelines for TB care, prevention and control, which are well disseminated and accepted by health-care providers. A national IC guideline is available, although it does not include a separate TB-IC plan. Standards in health-care facilities are generally very high, with appropriated isolation capacity. A majority of new cases occur among individuals born in high-incidence countries, and elderly Norwegian-born people. The key challenge for Norway is the quick identification of TB, provision of high-quality care and further improvement of the TB contact investigation system to identify latently infected individuals.

ADVOCACY, PARTNERSHIP AND POLITICAL COMMITMENT

Mr Jonathan Stillo, Romania (high-priority country) summarized that although Romania has signed the Berlin Declaration and the Consolidated Action Plan, the TB situation is still critical. The incidence remains high, with high levels of MDR-TB and treatment success rates are below the targets, in particular for MDR-TB. Multiple changes of decision-makers in recent years have led to a lack of coherence and continuity in TB control. Thus there are serious challenges related to the financing and political commitment for TB control and the implementation of TB action plans. Steps towards strengthening advocacy and push for political commitment were taken with the formation of the Romanian STOP TB Partnership. With the presence of the international community through WHO, ECDC, US Embassy/US Department of Defense and the now limited financial support from GFATM, it is evermore important to build partnerships and push for political commitment. In conclusion, a lot has been achieved on advocacy, communication and social mobilization, but more needs to be done particularly with regards to mapping and identifying possible future resources, in order to not lose the momentum gained (i.e. if ultimately there will be no further GFATM financial support to the country).

Mr Simon Logan, United Kingdom (low-incidence country) presented the All-Party Parliamentary Group on Global Tuberculosis, which was established in the UK. The group works across political parties to address TB by arranging meetings in parliament, working through parliamentary procedures such as debates, oral and written questions and the publication of reports and research projects. Effective communication with politicians has proven to be essential. Partnerships among nongovernmental organizations, academics, civil servants and public health professionals are also key to building a strong and united approach. It is the experience that there is a need for a strong and coordinated strategy when engaging with the relevant ministers and their staff. Finally, it is important to not only communicate that TB is a problem, but also to offer solutions and to work to get the politicians to commit to TB control.

Working group discussions

The four topics (diagnosis, treatment and care, infection control, and advocacy, partnerships and political commitment) were further discussed in separate working groups. There was wide representation of participants in the joint meeting, and they were encouraged to take part in discussions outside their direct area of expertise in order to promote cross-fertilization between topic areas.

DIAGNOSIS

The group structured its discussions around six questions.

1. Who is responsible for the quality of the TB laboratory network?
 - It was the general consensus of the group that national reference laboratories should play a role but that, in practice, some labs are not able to perform these functions.
2. Should we move to obligatory accreditation of all TB labs?
 - It was recommended that laboratories should be accredited/have a quality management system in accordance with national legislation and regulations, but the discussion illustrated that accreditation is a complex issue which differs in different jurisdictions/countries.
3. How do we define universal access to rapid diagnosis?
 - Universal access to rapid diagnosis was defined as equal access of TB patients (within in a country) to rapid TB diagnosis when needed.
 - The group also discussed the balance between universal access to rapid tests and high-quality rapid tests.
4. What are the obstacles preventing scaling-up of rapid diagnosis?
 - Diagnostic delay: lack of suspicion regarding TB, delay in taking action after rapid diagnosis and inappropriate testing – no role for interferon-gamma release assays (IGRA) in diagnosing active TB.
 - Cost: countries with the greatest financial problems are paying the highest prices for rapid assays. One reason for this is high distributor costs, so manufacturers should supervise their downstream distributors. Existing systems for rapid diagnosis are good but need to be improved. Development of new TB drugs is necessary to increase availability in countries where they are needed most and to reduce costs through increased competition.
 - Political will: the group expressed concern that political will may be blocked by administrative sclerosis, bureaucratic slowness and sometimes corruption, which affect availability and final cost. A broad lack of managerial capacity within overall programme and support services was also mentioned.
5. What are the causes of problems in second-line drug susceptibility testing capacity?
 - Priorities must be set – in the first instance, drug susceptibility testing should focus on fluoroquinolones and injectable drugs for rapid identification of XDR-TB cases. Then drug susceptibility testing for other/reserve drugs for proper treatment andmanagement.
 - Problems with reserve/third-line drugs – unavailability of substances, technical issues, clinical interpretation, lack of external quality assurance, cost, lack of standardization.
6. What are reasonable workloads for frequently used laboratory tests?
 - There was general consensus in the group that information on this is needed, but is not currently available. All we have to base our discussion on now is opinions rather than systemized experiences. The group agreed that mechanisms and test protocols should be developed and established to provide the necessary evidence.

TREATMENT AND CARE

The discussions of the group (22 countries) centred around three major topics:

1. Planning - to achieve universal access to TB treatment
 - Most of the countries have elaborated their plan or are in the process of doing so. Most countries have also achieved universal access to Second Line Drug treatment. The group reported that the Consolidated Action Plan had been very useful in this process
 - The challenges experienced during the planning process related to drug management, sustainability of financing and the quality of treatment were discussed
 - The group recommended increased government commitment. Health finance reform, implementation of eTB Manager, and technical assistance in planning could contribute to overcoming the challenges
2. Models of care for MDR-TB
 - Countries reported that models of ambulatory care are increasingly used, and that health financing based on actual number of TB patients had lead to a reduction in the number of hospital beds
 - The challenges for models of care primarily reported were: financing mechanism, insuring appropriate Infection Control (IC) measures, insuring adherence to treatment, and lack of social support
 - The group suggested that more technical guidance is developed
1. Drug management
 - Many countries reported uninterrupted supply, some have already implemented eTB software, and some countries have strengthened drug regularity authorities
 - The challenges experienced in the group related to proper drug registration; decentralized procurement; quality assurance of drugs; insecure budgets; lack of quality assured PPD and BCG
 - The group proposed that intensified technical assistance and direct procurement from GDF could help overcome the challenges

INFECTION CONTROL

The working group facilitators briefly outlined the objective of the working group discussions. This was followed by country presentations from Azerbaijan (focus on penitentiary system) and Armenia (focus on civilian sectors).

In order to obtain tangible results responding to the epidemiological heterogeneity of the WHO European Region the group divided into two groups: one group consisted of representatives from the WHO Eastern European countries and the other of the WHO Western European countries. Participants in each group discussed main points of IC such as status of national TB IC guidelines and strategic plans; possible funding and other organizational mechanisms supporting further out-patient treatment and care;

development of TB IC plans at facility levels; human resources capacity building; monitoring and evaluation of TB IC activities; rapid diagnosis; patients' triage; application of ventilation and UVGI fixtures; respiratory programmes; etc. Each group formulated existing gaps in TB IC and next steps to improve the situation in the region. Main conclusions were that there has been a lot of progress in infection control in both socio-economically well-off countries with a lower TB burden and in higher TB burden countries with often lower GDPs, and that countries should focus on best possible (cost)-effectiveness in their respective contexts.

Key recommendations are summarized as follows:

1. Improve funding mechanisms in TB services through country targeted advocacy, i.e. by more clearly including and highlighting IC benefits in national strategic plans for TB prevention and control
2. Update more regularly existing norms and regulations in TB IC, covering both the civilian and penitentiary systems/sectors
3. Standardize TB IC training modules taking the country specifics into account
4. Advocate for and develop plans/projects for TB IC inclusion into operational research, particularly at facility levels, covering all aspects of infection control, in order to create more robust evidence on effective IC models
5. Develop country-adapted standardized specifications for ventilations systems, measuring equipment, UVGI fixtures
6. Develop country-specific procurement processes for IC equipment and individual protection measures.

ADVOCACY, PARTNERSHIP and POLITICAL COMMITMENT

The group's discussions revolved around the challenges in advocacy work and recommendations on how to overcome these challenges.

Main challenges to advocacy:

- There is a lack of involvement of all stakeholders and a lack of coordinators for NTP-CSO relation. Advocacy is often regarded as the task of CSO
- There is a lack of advocacy tools adapted to national contexts and languages
- Funds are limited for advocacy activities. Priority is given on drugs and there is no budget line for TB ACSM and few places to apply for support for advocacy activities
- There is a lack of capacity building for TB nongovernmental organizations (in comparison with HIV nongovernmental organizations)
- There is a lack of understanding of the impact of advocacy for TB control
- TB affects vulnerable groups who are not popular with the decision makers
- Lack of understanding and evidence of the impact and effectiveness of advocacy is
- There is a need to exchange best practices in advocacy across the region

Recommendations from the group:

Capacity building

- Build advocacy capacity of nongovernmental organizations and CSO

- Find appropriate ways of talking about TB and adapting discourse to the context
- Offer more training for national TB stakeholders in advocacy in national languages

Coordination/partnership

- Create national platforms on TB (e.g. STOP-TB partnerships)
- Create integrated coalition and partnerships with HIV nongovernmental organizations and learn from their experiences
- Create NTP-CSOs relations and develop a legal framework for their cooperation
- Make sure that community involvement is part of NTP
- Make sure that ACSM strategy is aligned with NTP

Monitoring and Evaluation

- Strengthen awareness of the Berlin Declaration's MandE framework indicators on member states involvement of CSO – MAP indications on advocacy
- Create a pool of evidence showing effectiveness of advocacy
- Develop indicators of community involvement
- Give the community tools to evaluate community projects

Political Advocacy

- Raise awareness about TB among decision-makers
- Advocate for poverty reduction and social determinants of TB, stigma around vulnerable groups
- Adapt advocacy to context and messaging to current economic context

Funding

- Explore private sector funding possibilities and push for GFATM funding for ACSM

Dr Andreas Sandgren, ECDC gave the last plenary presentation of the day, which focused on the European Union Standards of Tuberculosis Care (ESTC) and a discussion of their implementation. The International Standards of Tuberculosis Care (ISTC), launched in 2006 and updated in 2009, describe a widely accepted level of TB care. However, they are not always adapted to the European situation and practices, which has lead to poor implementation in the EU. The results of a survey on TB patient management highlighted several serious deviations from the international standards, even in clinical reference centres in the EU. Combined with the to some extent better resources available in the EU which puts them in a good position to raise the standards of TB care compared to that of the ISTC this finding justified the development of new standards specifically tailored to the EU context. Dr Sandgren covered how the ESTC were developed by the ECDC and European Respiratory Society. He presented examples of the EU adapted standards and referred to the April 1, 2012 issue of European Respiratory Journal (first author: GB Migliori) for more information. The implementation of the ESTC depends on the wide dissemination and adoption of them by the EU countries. It was concluded that the wider dissemination and advocating for the significance and potentially added benefit for the ESTC will bring more benefit for patient humanity and equity in the long run.

Session 2. Intensified TB case-finding: yield and impact on TB epidemiology

Coordinators: Dr Knut Lönnroth (WHO)/ Dr Ellen M.H. Mitchell (KNCV) / Mr Dmitry Pashkevich (WHO Russia)

Chairpersons: Dr Masoud Dara (WHO Regional Office for Europe), Dr Gerard de Vries (KNCV)

Reporter: Dr Maria Idrissova (KNCV)

Background

Global surveillance reports show progress toward the Millennium Development Goals for 2015 in terms of declining TB incidence, prevalence and mortality. In many countries however, case detection rates are still lagging. Active case-finding is often advocated as a method to improve case-finding especially in hard-to-reach populations. The epidemiological impact of active case-finding is much debated. In 2011 WHO commissioned systematic reviews to assess the effect of active case-finding interventions and to assess the accuracy of different screened tests and approaches. Guidelines for contact investigation were published in 2012. Guidelines for active case-finding in high-risk groups were published in 2013.

Content/scope of the session

The focus of this session will be on how to translate the guidelines into effective country strategies in order to optimize yield of active case-finding in high-risk groups, while avoiding indiscriminate and costly interventions.

Methodology

- Plenary presentations, Country presentations
- Discussion in working groups and reporting of the working group in the plenary

Objectives

1. To discuss WHO guidelines on active case-finding
2. Discuss possibilities to rationalize the use of TB screening through a discussion of the pros and cons and implications of prioritizing different risk groups and algorithms
3. To discuss ethical issues of active case-finding

Expected outputs

- Participants are informed on scientific evidence for the effectiveness of active case-finding, and international recommendations based on available evidence
- Participants have provided inputs on identification of high-risk groups and effective strategies for intensified case-finding, including the pros and cons and (ethical) prerequisites for implementation

Summary of session 2

Dr Anja van't Hoog from Amsterdam Institute for Global Health and Development demonstrated the results of a systematic review, meta-analysis and modeling exercise on tools for tuberculosis screening in low and medium incidence settings. The review showed that CXR (Chest X-Ray) screening has higher sensitivity and greater accuracy compared to symptom screening. The review was however faced with a number of

limitations, including the small number of studies included, most with verification bias and different definitions of index test and reference standards across the studies. Guidance on how to choose between diagnostics algorithms in different settings was provided during discussion.

Dr Knut Lönnroth, WHO/STB/PSI expert, presented the newly published WHO guidelines on systematic screening for active tuberculosis. Dr Lönnroth introduced the key principles and definitions of intensive case-finding, different diagnostic algorithm options, summarized the systematic review findings, and gave recommendations for which risk groups to focus screening on. Key principles are: 1) Basic conditions for TB care are met, baseline assessment suggests that benefits outweigh harm and cost is reasonable and likely cost-effectiveness compared to other possible interventions; 2) Prioritization of risk groups for screening; 3) The screening is acceptable to the target group. Advice on how to obtain informed consents and disclose information about results was also given. The cost-effectiveness of screening interventions in populations with an annual TB incidence of less than 1% is generally unfavorable. The need for screening tools and operational guidelines were mentioned as very important for systematic screening for active TB. During the discussions questions were asked regarding the screening of migrants. Dr Lönnroth responded that the issue of immigrants has not been dealt with separately in the guidelines, partly because the systematic review identified no studies on the impact of screening of migrant groups. However, migrants are indirectly covered under risk groups. In this regard Dr Lönnroth stressed the importance of assessing whether specific groups actually constitute risk groups before initiating screening programmes.

During the **working group discussions** a variety of questions were raised relating to

- a) The epidemiological justification for certain types of screening;
- b) The operational issues that screening implies; and
- c) The evolution of screening programmes over time

A topic that was much discussed was the identification of risk groups. Many countries reported that the method for selecting risk groups is not always clear and often have more historical than contemporary value. Few countries reported to have stable estimates of TB prevalence in all sub-populations upon which to base their choices. In Netherlands, Romania, Slovakia and Latvia the definition of a risk group is a population with a TB prevalence above 50/100 000. In Hungary the threshold is 20/100 000. However, with TB prevalence unknown for many sub-populations these definitions are often not useful in practice. Some atypical populations were mentioned as "risk groups" in the European context including dairy farmers, school teachers, adolescents, women of reproductive age, and people applying for marriage licenses. The justification for selection of these groups is largely based on risk to others, rather than risks to the individuals.

The role of politics and financing of TB screening programmes was discussed. In some countries screening enjoys strong political support. Due to its visible nature screening can serve political as well as public health ends. This was mentioned as both an advantage and a disadvantage. Some members worried that dismantling low yield

occupational and screening programmes would result in detrimental budget cuts to the overall TB programme, since the funds would not necessarily be reprogrammed for other TB needs. Others saw support for costly screening of limited value as a trade off, preventing investment in other TB priority areas. In other contexts financial considerations (affordability) drove the closing of screening programmes. For example in Romania, Slovakia and Latvia the decision made in 1990s to cease screening in populations below 50/100 000 depended very much on financial considerations. Other countries mentioned cost-effectiveness; Health System considerations, namely availability of primary health-care services; TB care for all population groups; and epidemiological considerations as the main drivers of change.

Main conclusions

- Active case-finding (ACF) needs political commitment and funding over the long term (approx. 10 years) to ensure highest likelihood of saturation
- If ACF is done as a response to an outbreak, prompt funding is needed
- Do not start screening unless full support systems are in place to cope with increased demand
- How to best encourage uptake amongst target group and ethical and practical issues must be addressed in advance
- ACF screening activities should be integrated in existing programmes/services
- CSO have an important role to play in raising awareness before screening starts, providing referrals and peer support to patients who receive a positive result and also during an exit strategy to continue health education amongst risk groups
- Screening programmes are interventions on both individual and public health level. There is a need to build-in support post testing (from CSO and others) in maintaining health and not starting unhealthy behavior

Recommendations of the group

1. Create a new Wolfheze working group on screening in the European Region
2. WHO Regional Office for Europe and technical partners should develop simple monitoring tools for active screening
3. An advocacy tool for the dialogue with Ministers and NTP programmes in the regions still using the population-screening model to convince governments to move to the risk group approach is needed
4. Main criteria for prioritization of risk groups should be developed
5. Diagnostic algorithm should be revised in terms of screening steps used
6. Increasing TB awareness among risk groups and highlighting the index of suspicion among key medical specialists should be considered as complementary approaches
7. Advice is needed on how to obtain informed consent and disclose results
8. Diagnostics algorithm should be revised in terms of steps in the screening process
9. There is an urgent need for rigorous outcome evaluation and benchmarks. Operational research is needed to evaluate effectiveness and cost-effectiveness of population screening in order to get recommendations for shifting the system of TB screening in the programmes.
10. More data on screening algorithms especially to learn how the roll-out of GeneXpert changes the yield from screening is needed.

Session 3. Role of civil society in TB control

Coordinators:	Mrs Fanny Voitzwinkler (Global Health Advocates)/ Mrs Ieva Leimane (KNCV) /Dr Agnes Gebhard (KNCV)
Chairpersons:	Mr Paul Sommerfeld and Mr Zahedul Islam (TB Europe Coalition) and Dr Martin van den Boom (WHO Regional Office for Europe)
Reporter:	Mrs Ieva Leimane (KNCV)

Background

The role of civil society is key in the fight against TB. It is well established that CSO that work close to affected communities, understand well their challenges and can be great drivers of change in society. The European region is lagging behind in reaching the Millennium Development Goals (MDGs) for TB, especially when it comes to drug-resistant TB. Better results in the fight against the MDR-TB epidemic can be catalyzed by more effective involvement of CSOs and other stakeholders in TB control and care. Presently, there are few CSOs working solely on TB in high-burden countries (HBCs) of the WHO EURO region. This session will give an overview of CSO networks in the region that link and strengthen CSOs working in TB control. It will showcase country examples of CSO involvement in TB control and the opportunities and obstacles for further involvement. This will be shown from the perspective of NTPs and CSOs in small and large, high and low prevalence countries and from the perspective of HIV/TB/IDU care collaboration.

Objectives of the session

At the end of the session participants should be able to:

1. Recognize the importance of civil society in TB control and care in the region, and collaboration with HIV, TB and IDU partner organizations
2. Have knowledge on CSO networks and their activities in the region
3. Identify opportunities for greater engagement with CSOs and scale up of the activities

Content of the session

- Country presentations on the role of CSOs and affected communities for TB control and care
- Examples of collaboration with HIV, IDU and TB partners in TB control and care
- Role and activities of CSO networks in the region
- Plenary discussion
 - o Identifying opportunities and obstacles for CSO involvement in TB control and care in the region
 - o Formulating the future role of CSOs in Wolfheze

Methodology

- Plenary presentations and discussions with NTPs and CSO representatives

Expected output

- Participants have increased their understanding of the CSO landscape in the EURO region in support of TB control
- Summary of identified opportunities and obstacles for CSO involvement in TB control
- Formulation of the future role of CSOs in the European region in the Wolfheze context

Summary of session 3

As an introduction to the topic of CSO, **Mr Paul Sommerfeld from TB Coalition Europe and TB Alert** briefly presented some basic concepts of CSOs (and similar organisations) and their role in the WHO EURO Region in TB prevention, care and control. Strengths of CSOs and the importance of regarding them as equal partners in advocacy for TB control was emphasized as well as their added value at the service delivery level and their role in MDR-TB control. Differences in the cooperation among National TB programmes and CSOs in the eastern and western part of the region were noted, and attention drawn to the fact that the paradigm of involvement and partnerships are shifting also in the eastern countries. Patients' organizations are however still rare. There is an urgent need for advocacy from CSOs to get governments to accept that they must increase domestic funding to TB control and to have the EU accept their responsibility in contributing to the fight of TB in its poorer neighbouring countries. A number of networks in the region were listed, including TB Europe Coalition (TBEC); European Harm Reduction Network (EHRN); TB Injecting Drug Users Initiative (TUBIDU); and the Regional Interagency Collaborative Committee for TB Care and Control (RICC-TB).

Mrs M. Tvaradze, EHRN presented examples of integrated TB services for injecting drug users (IDUs) with HIV and TB in high-burden countries. A major barrier in providing diagnosis and treatment for drug users in the Eastern Europe and Central Asia (EECA) region is a lack of contact with the target group. In addition, lack of incentives for IDUs to receive treatment and negative experiences prevents the provision of proper care to this group of patients. The concept of harm reduction can be an entry point for improving TB services to IDUs. This includes: 1) the possibility to get examination and receive treatment in the most convenient way for the client; 2) an integrated approach to addressing problems related to HIV, TB and substance dependency; 3) continuity between in-patient and out-patient treatment stages; and 4) involving harm reduction programme staff into provision of TB care.

Following the general presentations three countries presented their experiences with involving CSOs in TB care and control.

From **Macedonia** (low-burden country), **Mr D. Iliev** shared the experiences of the national nongovernmental organization **MERC** in raising awareness of TB among patients, their families and general practitioners. The aim is to improve knowledge and compliance, ensure better support to the families, reduce stigma and promote patient rights. Experiences of the project have showed that:

- Medical staff needs to be specialized in TB and have good communication skills
- Patient education sessions should be short, clear and provided in the patient's preferred language
- Support with package (hygiene supply, food)
- Monitoring and evaluation and feedback of performance is crucial
- Communication materials need to be developed based on the health literacy principles
- Main obstacles for high-quality TB care and good collaboration for service delivery include low awareness of TB among patients, health-care workers and institutions

From **Ukraine** (high-burden country), **Mr Z. Islam**, shared the experience of **Alliance Ukraine** on collaboration between TB/HIV CSOs and TB/HIV programmes. It was emphasized that the participation of CSOs in TB and TB/HIV activities is crucial to successful implementation of TB programmes. In addition, the importance of approaching the CSOs involvement in a holistic way and making sure that CSOs support the government programmes in their plans and activities was noted. It was noted that it is important to have a patient-oriented approach; that CSO staff are trained in TB; and that services are integrated. Stigma and discrimination along with the lack of financing for both governmental TB services and CSOs are key challenges for enhanced cooperation between CSOs and government institutions.

Also from **Ukraine**, **Mr D. Denisenko** talked about public health measures and involvement of private organizations. What are the needs to advocate for state funds for TB and what needs to be done to be heard by decision-makers.

Finally, from **Bulgaria**, **Mrs N. Ivanova (association “Dose of love”)** presented examples from the grass root level on the necessity of political commitment to TB control in order to sustain initiatives and activities when funding from external donors runs out. Some of Bulgaria's main challenges in TB relate to the old conception of TB as a purely medical problem. The result is lack of awareness and understanding on how CSOs can support the Government in delivering care to those who are violated, discriminated and from specific vulnerable populations. The CSOs in Bulgaria are still weak and not unified. There is a need for CSOs to update their technical knowledge on TB and strengthen their capabilities to apply for external funds and advocate for Government involvement at all levels.

Main conclusions and recommendations

After the presentations the floor opened for questions and discussions. There was general consensus that it is necessary to improve CSOs medical knowledge in order for them to deliver better services and to contribute to the much needed advocacy work. There is a need to organize CSOs better and for them to be able to coordinate and share experiences. In addition, CSOs should be better at documenting their impact on TB control. The suggested next steps were therefore:

1. Collaborate with medical services for development of technical knowledge and skills of CSOs staff
2. Develop CSOs consortiums at country level to be able to apply for the upcoming grants and have a Memorandum of Understanding with the Ministry of Health
3. Share ‘best practices’ on CSO involvement with WHO Regional Office for Europe in a compendium
4. During the Wolfheze workshops in 2015 organize a discussion among NTPs and CSOs and integrate the role of CSOs in all technical sessions and not as a stand alone component of TB control

Session 4. Extrapulmonary TB - Situation analysis and challenges

Coordinators:	Dr Marieke van der Werf (ECDC) / Dr Kristin Kremer (WHO Regional Office for Europe) / Dr Barbara Hauer (RKI)
Chairpersons:	Dr Lena Fiebig (RKI) and Dr Tillyashaykhov (Center of Phtisiatry and Pulmonology)
Reporter:	Dr Kristin Kremer (WHO Regional Office for Europe)

Background

- Bacteriological confirmed pulmonary TB has long been the focus of TB control. New global and European strategic plans cover all TB cases, including those with extrapulmonary TB
- European countries have submitted surveillance data on pulmonary and extrapulmonary TB since 1997. These data show a large variation among countries in the percentage of extrapulmonary TB cases among all TB patients. EU/EEA countries also submit information about the site of extrapulmonary TB since 2001.
- Extrapulmonary TB can present with many different signs and symptoms and therefore poses a challenge to diagnosis
- Since patients with both pulmonary and extrapulmonary TB are classified as pulmonary TB cases the real burden of extrapulmonary TB is unknown

Content / scope of the session

1. Overview of extrapulmonary TB situation in the EU/EEA countries
2. Country presentations on challenges in diagnosis and analysis of surveillance data from a variety of settings
3. Plenary discussion

Methodology

- Plenary presentations and discussion

Objectives

1. Provide an overview of the extrapulmonary TB situation in EU/EEA countries
2. Present country experiences with diagnosis of extrapulmonary TB and analysis of surveillance data
3. Generate discussion on how TB programmes can improve awareness and ensure timely and adequate diagnosis
4. Generate discussion on improving surveillance of extrapulmonary TB

Expected deliverables

1. Increased awareness of extrapulmonary TB among the participants
2. Suggestions on how to improve surveillance data on extrapulmonary TB

Summary of session 4

Dr Marieke J. Van der Werf, ECDC reported on the epidemiological situation of extrapulmonary TB (EPTB) in the EU/EEA over the last 10 years (2002-2011). As

opposed to pulmonary TB (PTB), the incidence of EPTB has remained stable in the EU/EEA. In the time period 2002-2011 a total of 868,726 TB cases were identified and 167,652 (19.3%) extrapulmonary TB cases. In 2011, the overall proportion of EPTB cases in the EU/EEA was 22.3%, ranging between 3.9% and 66.7% in different EU/EEA countries. Especially in the Northern part of Europe a higher proportion of cases is diagnosed with EPTB. Data show that EPTB is more frequent in females and in children (0-14 year age group) and among more among HIV+ individuals. EPTB was also reported to be more frequent in individuals of foreign origin. The majority of the cases of EPTB are lymphatic and pleural, however often the site is not specified in the reporting. During the discussion it was stressed that it is unknown how the confirmation of EPTB was done for most cases because only 40% of EPTB cases were confirmed by culture. Furthermore, it was suggested to look at the age distribution of the patients and to identify the possible reasons for why EPTB is not decreasing.

Mr Ivan Solovic, Slovakia presented the findings of a survey on the diagnosis and challenges in diagnosing and treating EPTB in the EU. The study, which included data from Austria, Czech Republic, Germany, Malta, Netherlands, Poland, Romania, Slovakia, Slovenia, Sweden, and United Kingdom, found that in the majority of the participating EU countries EPTB is diagnosed and treated by a pulmonologist. Paediatricians are involved in the treatment of EPTB in children. Guidelines for the diagnosis of EPTB exist in 8 of the 11 countries. In most countries a medical history and examination is followed by invasive procedures to collect material for confirmation. A specific challenge in the diagnosis of EPTB is diagnostic delays, due to the fact that very often EPTB is not considered because it is a rare disease and that most medical professionals do not have experience in diagnosing it. In addition, diversity of symptoms that may mimic symptoms of other pathologies poses a challenge in diagnosis. Finally, obtaining an appropriate sample for confirmation of EPTB is a frequently mentioned challenge. Dr Solovic concluded that awareness raising among non-pulmonary physicians about EPTB and guidelines for diagnosis and treatment of EPTB may result in more timely and adequate diagnosis.

Dr Alena Skrahina, Belarus reported on the EPTB situation in Belarus. It was shown how TB and EPTB have gradually decreased in the period 2002-2012. The incidence of EPTB has been stable over the last couple of years and was in 2012 4.1 per 100 000 population, equal to about 10% of all new TB cases. Bacteriological confirmation of TB increased from 46-64%, confirmation of EPTB remained stable at around 10%. As is the case with pulmonary TB the proportion of MDR-TB among bacteriologically confirmed cases is increasing (in 2012 it was 18.1%). In contrast to the general trend in the region, EPTB in Belarus is most commonly found in bones and the urogenital system. This might be due to both over and under diagnosis. Compared to PTB, better success rates are recorded for EPTB, especially fewer failures occur among EPTB cases. This finding might be explained by a high level of compliance among EPTB, due to social advantages in complying to treatment such as disability compensation, whereas PTB patients do not receive this support. Main challenges include absence of national EPTB guidelines and a lack of collaboration between TB specialists and other specialists. Another challenge is the low level of bacteriological confirmation.

Ms Tanja Ducombe, from the Robert Koch Institute, Germany reported on TB

surveillance in Germany 2002-2009 with a special focus on meningitis. The study shows that EPTB manifestations in Germany, including often-fatal meningitis, occur more frequently than so far reflected by routine analyses. Analyzing only by main site ignored 1/3 of EPTB manifestations. Meningitis TB was found in 9% of all TB cases affected, however the case fatality is high (25%) and the patients have very long hospital stays. It was also found to be more common in young female cases and those born in WHO SEARO and WHO EMRO regions. Based on the study it is recommended: 1) to monitor severe disease using all information on disease manifestation and severity available from surveillance data; and 2) to transfer the gained knowledge to TB case management.

During the subsequent **discussions** the need to objectify diagnosis on EPTB was raised and it was suggested that there is a need for WHO guidelines on diagnosis of EPTB. This is especially the case in a situation where doctors are becoming less and less aware and have limited experience with EPTB.

Main conclusions and recommendations

- A significant percentage of the notified TB cases in the EU are diagnosed with EPTB and in contrast to PTB the EPTB notification rates are not decreasing
- There is need for WHO guidelines on diagnosis and treatment of EPTB cases and better collaboration between non-pulmonary physicians and experts in EPTB
- Challenges in the diagnosis of EPTB include the diversity of symptoms with which EPTB may present; the low level of suspicion among clinicians; the difficulty in obtaining an adequate sample for confirmation; and the lack of request for microbiological investigation. Consequently there is differential diagnosis, late diagnosis, under diagnosis, over diagnosis and accidental diagnosis
- Because of the low culture-confirmation rate of EPTB cases drug susceptibility test results are often not available, which leads to inappropriate treatment of such cases

Session 5. TB in vulnerable populations (migrants and prisoners)

Coordinators:	Dr Pierpaolo de Colombani (WHO Regional Office for Europe), Dr Svetlana Pak (KNCV), Dr Agnes Gebhard (KNCV)
Chairpersons:	Dr Pierpaolo de Colombani, Prof. Anton van Kalmthout (Tilburg University, Netherlands)
Reporter:	Dr Agnes Gebhard (KNCV)

Background

Cross-border TB control and care has long been recognized as a challenge in TB control in the Central Asian sub-region. In November 2011, KNCV Tuberculosis Foundation and WHO Regional Office for Europe organized a high-level meeting on “Migration and TB: cross border TB control and care in Central Asian Region” in Almaty, Kazakhstan. The meeting was followed by a letter by the WHO Regional Director calling the Ministers of Health of Kazakhstan, Kyrgyzstan, Russian Federation, Tajikistan and Uzbekistan to strengthen cooperation and coordination of approaches in the field of tuberculosis control in migrants, regardless of their legal and residential status. In November 2012, the “Minimum package for cross-border TB control and care in the WHO European Region: A Wolfheze consensus statement” was published. In 2013, the European Respiratory Society and WHO Regional Office for Europe will launch an e-mail based platform for consultation on MDR-TB, which may be used to facilitate the referral of patients between countries.

Prevention and control of MDR-TB in prisons is improving in many countries of the Region due to the strong commitment of the penitentiary authorities and the support from The Global Fund. Despite this still too many TB patients stop their treatment after their release from prisons and entering in the civilian health system. Some good practices can be identified and promoted.

Content / scope of the session

- Presentation of some of the current efforts on cross-border TB control and care and holding of TB patients released from prisons
- Discussion among the participants

Methodology

- Presentations and discussion in plenary

Objectives

1. To inform participants about current efforts on cross-border TB control and care and holding of TB patients released from prisons.
2. To discuss how to expand the current efforts.

Summary of session 5

Mr O.I. Bobokhoja, Director of the National TB Centre in Tajikistan presented the results of a study of knowledge, attitude, practice (KAP) and behavior in relation to TB and access to TB services among 503 (labor) Tajik migrants. Among those with TB, the obstacles to access health services in the country of employment (mostly Russian

Federation) and in Tajikistan were studied. The study shows that many migrants' awareness of TB symptoms and knowledge of what causes TB is limited. Most often the migrants' symptoms occur when they are in their host country, and that high cost of treatment is the main reason for returning to Tajikistan. Some are deported back to Tajikistan, when diagnosed with TB. Recommendations from the study are to ensure access to good quality, free of charge treatment by updating the regulatory framework in countries and ensuring adequate exchange of information. The results of the survey will be shared in the CAR sub-regional Thematic Working Group on Cross Border TB Control as evidence for further policy development. Reportedly, the regional discussions started years ago have already resulted in better transfer of information on TB in migrant patients returning to Tajikistan from the Russian Federation. The participants applauded the study, which adds further information to other studies of this kind in the region, while commenting that more research is needed also regarding other vulnerable groups. A particularly vulnerable and as yet not studied group in Western Europe is migrants kept in migration-detention centres.

Dr Pierpaolo de Colombani, WHO Regional Office for Europe presented a E-consultation platform recently developed by The European Respiratory Society (ERS). The platform facilitates consultation of M/XDR-TB cases between physicians across the WHO European Region while preserving patients confidentiality of their clinical data. The platform is managed by ERS in collaboration with WHO Regional Office for Europe and ECDC. The purpose is to allow a European clinician, free of charge, to load a patient's data and within one working day to receive suggestions by two experts on how to manage a difficult-to-treat TB case. In addition, the platform will help to support follow-up of TB patients travelling within Europe. The use of the platform was demonstrated to the participants. The platform will be further expanded to enable the exchange of information between physicians working in different countries and dealing with TB patients who are migrating or have migrated. Some participants expressed concern about the use of this tool in relation to the network under the International Health Regulations. While this network is successfully used also for M/XDR-TB in some countries, it is strictly inappropriate (X/MDR-TB is not a condition to report under the International Health Regulations) and of cumbersome use in many other countries. Once properly developed, the expansion of the E-Consultation Platform seems an appropriate mechanism of TB cross-border communication. More discussion is needed when the expansion of the E-Consultation Platform is developed. To access the platform (in both English and Russian) please refer to: www.tbconsilium.org.

Ms Lilian Severin, Director of the nongovernmental organization Act For Involvement (AFI) in Moldova showed how problems of interruptions of TB treatment after release from prison are overcome in the Republic of Moldova. Essential components of the strategy include the careful preparation of referral before the release from prison (proper planning, individual patient counselling); involvement of CSOs in contacting prisoners; establishment of trust; and ensuring correct information on the prisoner's residence and other needs after release. Post-release follow up includes strengthening monitoring and recording/reporting; inter-sectorial collaboration for patients support; as well as individual counselling by former prisoners. Main challenges are the poor attitude and communication of civilian health workers towards former prisoners, and a lack of opportunities of social re-integration after prison release.

Dr Emanuele Pontali from the Italian Society for Prison Medicine reported on Italian experiences with transferring prison health services from the prison administration under the Ministry of Justice (MOJ) to the Ministry of Health's (MOH) regional authorities. The law was issued in 1999, but the actual implementation order was passed only in 2008. Challenges were the different standards of healthcare between prisons and the civilian health services at the moment of transfer, as well as a lack of funds from the prison side for health care. Differences in cultures and priorities between prison staff and health staff sometimes complicate the collaboration. Transferring health-care services is a complicated process, which requires sustained political commitment, motivation and endurance from the parties involved. Although the transfer itself was successful and had a positive effect on the quality of health-care services for prisoners, the discussion revealed much dependence of the system on the personal goodwill of individual civilian health staff members. A remaining challenge remains the provision of health care to undocumented migrants in detention centres.

Main conclusions and recommendations

The session concluded that in a majority of countries in the region the minimum package for cross-border TB control and care in the WHO European Region as laid down in the Wolfheze consensus statement published in November 2012 has not yet been implemented. There is a significant lack of information on the actual TB situation among vulnerable groups and especially migrants, emphasizing the need for studies like the one presented from Tajikistan, covering more vulnerable groups. It was encouraging to see best practice examples to guide improvements in TB control in prisons; especially for improving treatment outcomes by improving continuation of treatment after release, significantly with civil sector and nongovernmental organization involvement.

Session 6. Childhood TB

Coordinators: Dr Connie Erkens (KNCV), Dr Valentin Rusovich (WHO Belarus)
Chairpersons: Dr Malgosia Grzemska (WHO Headquarter), Dr Andreas Sandgren (ECDC)
Reporter: Dr Valentin Rusovich (WHO Belarus)

Background

Worldwide, at least 1 million TB cases occur each year in children under 15 years of age. Child friendly diagnostic tools and drugs are lacking. In many instances in the NIS countries prevention policies for childhood TB are still based on out-dated approaches entailing inefficient ill-focused mass screening programmes using tuberculin skin test and BCG re-vaccination practices that are not supported by WHO. The appearance of new diagnostics tools such as IGRA, a need for more focused screening of TB among risk groups including rigorous contact tracing, approaches to preventive treatment of childhood MDR-TB contacts require broad discussion and more unified approaches. Recording and reporting systems are not sufficient, surveillance data is missing. Children with TB represent the reservoir of TB disease in future. Despite policy guidelines the implementation of contact tracing and delivery of isoniazid preventative therapy (IPT) to young and HIV infected children is often neglected by public health programmes. Regulations in the countries in the region in many cases prevent non-infectious children with TB to go to school while on long term anti-TB treatment resulting in prolonged hospitalization and contribute to stigma and disruption of family life. Children are rarely included in clinical trials of new diagnostics, drugs and/or preventative strategies.

The above-mentioned issues were discussed in a special Childhood TB session during Wolfheze 2011. The following conclusions and recommendations were agreed upon:

- Advocacy is needed
- Diagnostic tools should be improved, new tools should be implemented
- Proper, systematic data collection and management should be ensured
- Children friendly drug formulations should be available
- Operational research and guidelines on such topics as role of vaccination and revaccination, preventive treatment of X/MDR-TB, drug toxicity etc. is needed
- Out-dated policies in childhood TB revaccination not consistent with WHO recommendations should be revised in the countries

A Task Force to develop a Framework for Follow-up of NTP managers meeting on Childhood Tuberculosis was established after this meeting. This session will review the activities of the task force, and the progress made by countries and partner organizations in TB control to address the challenges.

Objectives

1. Provide countries with latest updates on Childhood TB epidemiology, diagnostics and treatment (global perspective)
2. Share experience, best strategies and achievements on introduction of new policies in TB prevention, vaccination, contact tracing and IPT (countries perspective)

Content of the session

1. WW/WHO situation analysis of Childhood TB in European Region
2. ECDC project on management of Outbreaks in childhood TB
3. Sharing best practices and challenges
4. Patient perspective in management childhood TB

Methodology

1. Presentation and discussions in plenary

Expected outputs

1. Childhood TB will be addressed in the National TB programmes strategic plans
 2. Countries' programme and technical capacity will be built on Childhood TB prevention (BCG policies), contact tracing, diagnostics, treatment and care
 3. WHO guidelines on childhood TB will be adapted for country needs
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Summary of session 6

Dr Valentin Rusovich, WHO Belarus presented key findings of the survey “Current practices on TB prevention, laboratory diagnosis, TB treatment and ACSM activities in children 0-14 years in the Member States of the WHO European Region”. 30 countries participated in the survey, which revealed large differences in current policies on BCG vaccination. Most countries provide BCG at birth. In a few countries a risk-group-only-policy is in place and in a handful of countries BCG is currently abandoned all together. Although not recommended by WHO, revaccination at the age of 6-7 years is still practiced in a few countries in Eastern Europe and in some regions of Russia a second revaccination with BCG at the age of 14 years is also provided. The findings demonstrate that these countries need to revisit their policies to follow WHO recommendations. The use of IGRA in situations where a child is in contact with a TB infectious patient was also surveyed. IGRA is used in 9 countries to define the indication for prescribing isoniazid preventive therapy after ruling out of active TB in children. Other countries use the Diaskin test in all children with a sensitivity comparable to tuberculin skin test. It's concluded that guidance is needed for interpretation of the results of TST, risk groups for TST testing, and the use of IGRA/Diaskin. In implementing isoniazid preventive treatment differences among the countries in the dosage of isoniazid is observed and there is a need for harmonization. With respect to MDR-TB, contact recommendations are often absent, and careful clinical follow-up is required as well as research into possibilities of preventive treatment. With respect to the treatment policies, almost all countries report using WHO guidelines 2006 or 2010. Out-patient models of care are preferable for children with non-infectious TB, however some countries admit children into hospital for the entire period of TB treatment. Finally, the survey reveals that childhood TB formulations are generally absent in the Region, and that dosages of treatment for TB should be updated. ACSM strategies and plans could be useful tools in advocating and communicating changes in policies.

Dr Andreas Sandgren, ECDC presented progress made on the development of the EU guidance on “Investigation and control of TB incidents and outbreaks affecting children in congregate settings”. It is the intention that the ECDC guidance documents will assist EU countries in reviewing and developing national policies and guidelines on TB in children. Through a systematic review, evidence was collected to estimate the impact of TB outbreaks affecting children on the overall epidemiology of paediatric TB and to assess how outbreaks were managed. Generic national guidelines exist in many countries, but are often not comprehensive or setting/population specific. Topics in the guidance document will include trigger, incident and setting definitions; preparedness and plans; roles and responsibilities; essential steps of the investigation and control; prioritisation of children to be screened; management of LTBI and TB cases; key requirements for communication; and surveillance, monitoring and evaluation. It is expected that the guideline document will be finalised and available by the end of 2013.

Dr Martin van den Boom, WHO Regional Office for Europe provided updated information on the new approaches in WHO guidelines relevant for childhood-TB. Barriers to proper reporting of TB among children include:

- Lack of accurate, reliable diagnostic tools
- Traditional focus on smear-positive cases (mostly adults)
- Hospitals and private providers not linked
- Lack of recognition of the importance of childhood TB within existing child health programmes
- Lack of country guidelines and training material on childhood TB
- Lack of advocacy on behalf of children with TB

International leadership and guidelines in childhood TB has increased over the last years. In 2003 the Childhood TB subgroup within the STOP TB partnership was created and from 2006–12 several international policy guidelines⁴ have been issued. A 2nd Edition of WHO Guidance on Management of Childhood TB is to be published in 2013. The new updates will include developments in diagnostics (incl. use of new rapid molecular diagnostic tools), treatment; contact investigation; TB/HIV; and BCG. It was highlighted that negative Xpert test does not exclude TB in children and clinical decision should be made in all such cases.

Dr Kagaz Serikbayeva, National coordinator on childhood TB management in **Kazakhstan** presented the latest development on childhood TB management in Kazakhstan. The TB incidence rate in children has decreased from 57.6 in 1999 to 14.1 per 100 000 in 2012. Currently, Kazakhstan’s policy on BCG includes BCG vaccination at birth and at the age of 6-7 years to children who are tuberculin skin test negative after TST screening. In response to a high adverse reaction rate with the previous BCG vaccine a new Japanese BCG vaccine was introduced in 2007. The country has also experienced an episode of vaccine shortage from March 2005 to 2006, which resulted in 99 (0.05%) children of those non-vaccinated at birth developing TB, of which 13 (13.1%) died. The main source of TB detection in children is through screening of Mantoux. MDR-TB diagnostics include drug susceptibility testing to

⁴ WHO Guidance for national TB programmes on the management of TB in children; WHO recommendation on recording and reporting in two age groups for children (0-4 years and 5-14 years); WHO Rapid Advice on treatment of tuberculosis in children; WHO/IUATLD Guidance for national TB and HIV programmes on the management of TB in HIV-infected children; IUATLD Desk guide for diagnosis and management of TB in children and Sentinel project: management of multidrug resistant tuberculosis in children: a Field Guide

first and second-line drugs and implementation of the rapid diagnostic tests such as Hain test and GeneXpert MTB/Rif. There is also the system of contact identification with a known MDR-TB patient within or outside the family. Treatment of TB is performed in accordance with the WHO guidelines of 2010. Ambulatory model of care is implemented for TB cases with newly detected localized and not complicated processes.

Prof. Henadz Hurevich, NTP manager in Belarus presented recent policy changes in childhood TB prevention in Belarus. The driving forces behind the changes were: 1) the need to implement WHO recommendations on BCG vaccination and isoniazid preventive treatment; 2) appearance of the new diagnostic tools including IGRA and Diaskin test; and 3) a will to enhance contact investigation procedures in adults and children. Major changes include abandoning re-vaccination at the age of 14 years of age and step-wise approach to abandon the first BCG re-vaccination at the age of 6-7 years of age. Due to resistance among paediatricians it was decided to limit revaccination to risk groups only with the prospect of complete elimination of BCG re-vaccination in the near future. From 2012 the total annual tuberculin skin test screening in all children from 1 to 16 years of age was replaced by focused TST screening in risk groups. In addition, plans to develop new national guidelines on contact investigation and isoniazid preventive treatment in Belarus is underway.

Finally, **Dr Connie Erkens, TB consultant from Netherlands**, gave an update on the challenges of childhood TB in low prevalence countries. Netherlands is approaching TB elimination in native Dutch children with the incidence of 1.5 per 100 000 in 2011. The occurrence of TB in foreign-born population is 27 times higher. The occurrence of TB in second-generation immigrant population is three times higher than in native Dutch population. The absolute number of children with TB decreased from 106 in 1993 to 50 in 2012 with a corresponding incidence of 3.8 and 1.7 per 100 000 population. 2/3 of children with TB are diagnosed and treated by TB control units and the large majority is detected through contact investigation. Treatment success is high: overall 94% treatment completion is registered, yet in the period 2005-2010 two children < 5 years died of TB and one of other causes. In 2007, IGRA was introduced in Netherlands and the number of ethnic Dutch children with LTBI has decreased considerably since introduction of IGRA test. There is still room for improvement for the coverage BCG-vaccination in TB risk groups, detection and treatment of TB infection on entry in the Netherlands; and detection and treatment of TB infection among foreign-born TB contacts.

During the **discussions** it was suggested to collect more evidence on the results of implementing the Diaskin test supported by the international publications. Based on the experiences of some countries with adverse reaction (e.g. lymphadenitis) to BCG vaccinations it was noted that no recommendations on BCG management are available. It was therefore requested that consensus policy in addressing BCG adverse reactions in the region is developed. Dr Masoud Dara, WHO Regional Office for Europe announced that a BCG policy brief is under preparation at the WHO regional office for Europe based on the inputs of the childhood TB Task force. The policy brief is expected published in the near future.

The importance of screening children for HIV before performing the BCG vaccination was discussed. In addition, the optimal mode of the isoniazid prevention treatment was

discussed. It was clarified that the most common mode of organizing treatment is that the responsible parent supervise the treatment. It was also clarified that IPT should be prescribed by a TB specialist after ruling out of active TB. However, if the child is HIV-positive the most convenient way of supplying the patient with isoniazid is through the infectious disease specialist in one package with the anti-retroviral drugs.

Main conclusions and recommendations

- Although not recommended by WHO, BCG re-vaccination policies still exist in some countries. Countries are therefore encouraged to update their policies in TB prevention (including BCG policies and application of isoniazid prevention treatment), early TB detection (contact tracing) and TB/MDR-TB treatment (including models of out-patient treatment) using the latest WHO guidelines and experience from the countries in their implementation
- Guidance is needed for interpretation of the results of TST, risk groups for TST testing, use of IGRA/DIASKIN. More evidence needed for DIASKIN test practices
- Isoniazid preventive treatment, dosages of treatment of TB varies between countries and not always in line with the latest WHO recommendations
- The policies for the contacts for MDR-TB infectious index case will be further explored. The current most prevalent management is a careful follow-up without the preventive treatment prescriptions. Research in the possibilities of preventive treatment is needed. Please see also the recently published ECDC guidance document Management of contacts of MDR-TB and XDR-TB patients,
www.ecdc.europa.eu/en/publications/publications/201203-guidance-mdr-tb-contacts.pdf
- Out-patient model of care is preferable for children with non-infectious TB
- Obsolete National regulations on entry to schools/kindergartens could be a barrier to introduction of ambulatory model of care in children
- Childhood TB formulations are generally absent in the Region, dosages of treatment for TB should be updated
- Recommendations on the guidelines/policy paper on management of adverse events of BCG vaccination are needed
- ECDC guidance “Investigation and control of TB incidents and outbreaks affecting children in congregate settings” is expected for publication by the end of 2013
- New WHO guidelines on childhood TB are expected published by the end of 2013
- EU childhood TB care standards expected in 2014 will be another reference document for updating the childhood TB policies at country level and will be distributed among the childhood TB specialists in the countries

Session 7. WW working groups – reporting back, past and future targets

Coordinators: Dr Masoud Dara (WHO Regional Office for Europe), Dr Connie Erkens (KNCV)
Chairpersons: Dr Masoud Dara (WHO Regional Office for Europe), Dr Connie Erkens (KNCV)

Background

The Wolfheze Workshops offers an opportunity to stakeholders in national TB programmes to meet with policy-makers in WHO and ECDC and to share experience between Western and Eastern Europe and Central Asia. The workshops focus on management and coordination of TB control efforts in European countries. During the previous sessions participants have exchanged experiences and identified priorities for action and coordination of efforts in existing or newly formed Wolfheze Working Groups. In the coming period, these working groups will prepare consensus policy documents on specific topics in TB control, based on available scientific evidence and expert opinion, to be discussed and modified during the upcoming meetings and the next pan European conference in 2015.

Content

1. Reporting back from WW working group Urban TB control
2. (New) WW working groups: ToR, deliverables and planning

Methodology

- Presentation in plenary and discussions

Objectives

- To update participants on products and achievements of WW working group Urban TB control
- To agree on terms of reference and work plan of existing and new Wolfheze Working groups
- To agree on priorities for further collaboration and coordination

Expected output

- Participants updated on policy papers and coordination mechanisms in the context of TB control in urban settings in European Region
- Participants agree on priorities for future collaboration and coordination
- Participants have provided inputs on terms of reference, desired outputs and work plan of new and existing working groups

Summary of the session

Dr Gerard de Vries, the Netherlands opened the session with a report from the WW working group on Urban TB control. Summing up the history of the work on urban TB since 2010 de Vries went on to report on the main activities and achievements of the working group. This include the formation of a strong informal collaborative network of EU Big City TB controllers; several advocacy activities (ECDC World TB Day theme 2012, Union European Region Conference 2012); and the completion of a number of scientific papers on the epidemiology of TB in big cities and a consensus paper suggesting nine areas of possible

interventions. Next steps include an event in Brussels (possibly in EU Parliament) at the time of the publication of the two papers; focused activities and new projects, e.g. research projects; and formation of new alliances with other organisations (e.g. Union, FEANTSA, Eurocities network). New members were encouraged joining the group.

Ellen Mitchell provided a short follow-up on the active case-finding session. In general there was satisfaction with the WHO guidelines on active case-finding, however there was a call for some clarification specific to the European region. This included a need for guidance on how to secure funding for screening without having budget cuts in other TB activities and vice versa. It was mentioned how it is difficult to dismantle initiatives that have a lot of political support but are not evidence based, creating a fear that dismantling activities will allocate funds to other areas (outside TB). In addition, there was a strong call for operational research and better M&E on obtaining prevalence estimates for high-risk groups in the region. Finally, the importance of CSOs and guidance on which advocates and members of risk groups that should be involved in the screening programmes was requested.

In order to agree on the establishment of new WW working group a list of suggestions was complied, with the aim of establishing three new groups. It was stressed that when establishing working group it is important to have a concrete product to work towards and to include follow-up activities for the product.

Based on informal voting the below three highlighted themes were chosen for establishment of new WW working groups:

- **Health financing in relation to TB control**
- **Social Determinants**
- **Intensive case-finding, screening**
- Models of Care
- New diagnostic test and algorithms
- Operational research
- SLD surveillance
- Management of TB in autoimmune and immunodeficiency (other than HIV)
- Diagnosis and treatment of LTBI (ECDC surveillance network)
- MDR-TB contacts
- Cross-border TB control (access to TB control for migrants)
- Palliative care / management of XDR TB patients
- Procurement of (2nd-line) TB-drugs, pediatric formulations, diagnostic reagents (PPD), and BCG in low incidence / low MDR-TB burden countries (in cooperation with pharmacists / GDF / international medicine agency?)

Next steps for the new working groups include: 1) To agree on an outline for the background of the working group, 2) describe objectives of the group and 3) develop expected outcomes. Dr Connie Erkens (KNCV Tuberculosis Foundation) will follow-up on the group for Intensive case-finding; Dr Pierpaolo de Colombani (WHO Regional Office for Europe) will follow-up on the group on Social determinants and Dr Masoud Dara (WHO Regional Office for Europe) and Mr Szabolcs Szigeti will follow-up on the group of health financing.

Session 8. Closing of the meeting

Dr Dara Masoud (WHO Regional Office for Europe), Dr Marieke van der Werf (ECDC) and Dr Gerard de Vries (KNCV Tuberculosis Foundation) closed the meeting.

All three thanked the participants for their lively and interactive participation both during the sessions and in the informal discussions between sessions. It was noted that the informal interactions play an essential role in exchanging experiences and it was suggested to allow time for more informal discussion in future meetings.

All objectives of the meeting were met and it was appreciated that it had been possible to put together a programme that was of interest to both high priority countries and low incidence countries.

It was noted that all presentations will be available on the KNCV Tuberculosis Foundation's website (www.kncvtbc.org/wolfheze-workshops-2013-presentations) and the participants were encouraged also to refer to social media, e.g. Twitter, which during the course of the meeting had been used to reach out to people not present at the workshop.

Special mention and thanks was given to the colleagues who made webcasting possible, to the excellent translators and to presenters, conference coordinators, session chairs and reporters.

With the hope that the three interactive days of presentations and discussions will contribute to improving TB control in the region the National TB Programme managers' meeting/2013 Wolfheze Workshops was closed.

Annex 1 – List of participants

Member States

Armenia

Dr Hayk Davtyan
TB Data Specialist, National TB Control Office, Ministry of Health

Dr Armen Hayrapetyan
Director, National TB Control Office, Ministry of Health

Austria

Dr Jean-Paul Klein
Head, Department HIV/AIDS, TBC and Immunization, Ministry of Health

Dr Beatrix Schmidgruber
Leader of TB Department, Vienna Public Health Service

Azerbaijan

Dr Natavan Alikhanova
Head of M&E Department, Scientific Research Institute of Lung Diseases

Dr Rafail Mehdiyev
Head, Main Medical Department, Ministry of Justice

Belarus

Dr Henadz Hurevich
Director, Republic Scientific and Practical Centre for Pulmonology and TB

Dr Alena Skrahina
Republican Scientific and Practical Centre for Pulmonology and TB

Belgium

Dr Wouter Arrazola de Oñate
Medical Director, Belgian Lung and TB Association

Dr Maryse Wanlin
Medical Director, Belgian Lung and TB Association

Bosnia and Herzegovina

Dr Mladen Duronjic
National TB Manager, Clinic for Lung Diseases of the Republika Srpska

Dr Hasan Zutic
Expert Manager of TB and Lung Diseases, Clinic of Pulmonary Diseases and Tuberculosis ‘Podhrastovi’, Clinical Centre, University of Sarajevo

Croatia

Dr Aleksandar Simunovic
TB Manager, Croatian National Institute of Public Health

Denmark

Dr Flemming Kleist Stenz
Chief Medical Officer, National Board of Health, Greenland

France

Dr Thierry Comolet
TB Programme Coordinator, Ministry of Health

Dr Delphine Antoine
TB Epidemiologist, Institut de Veille Sanitaire

Georgia

Dr Marine Janjgava
Head of TB Control and Management Service, National Centre for Tuberculosis

and
Lung Diseases

Dr Nestani Tukvadze
Head of Research Unit, National Centre
for Tuberculosis and Lung Diseases

Germany
Dr Lena Fiebig
Robert Koch Institute

Dr Tanja Ducombe
EPIET Fellow, Robert Koch Institute

Hungary
Dr Gabor Kovacs
Chief Pulmonologist, Koranyi National
Institute of TB and Pulmonology

Israel
Dr Daniel Chemtob
National TB Programme Manager and
Director, Department of TB and AIDS

Italy
Dr Emanuele Pontali
Senior Consultant and Regional Delegate,
Galliera Hospital

Kazakhstan
Dr Tleukhan Abildayev
Director, National Centre of TB Problems
of the Ministry of Public Health

Dr Kagaz Serikbayeva
National Coordinator, National Centre of
TB Problems of the Ministry of Public
Health

Kyrgyzstan
Dr Abdullat Kadyrov
Acting Director General, National Centre
of Phthisiology

Dr Ainura Koshoeva
Head of M&E Unit, National Centre of
Phthisiology

Latvia
Dr Vija Riekstina
Head of National MDR-TB Registry, Riga
East University Hospital

Lithuania
Dr Edita Davidaviciene
Chief, National Tuberculosis and
Infectious Diseases University Hospital

Netherlands
Dr Rob Riesmeijer
Strategic Adviser, Centre for Infectious
Disease Control

Professor Anton van Kalmthout
Tilburg University

Norway
Dr Trude Margrete Arnesen
Senior Medical Officer, Norwegian
Institute of Public Health

Dr Karin Rønning
Head of Department of Infectious
Diseases Surveillance, Norwegian Institute
of Public Health

Portugal
Dr Raquel Duarte Bessa Melo
Assistant Coordinator of National TB
Programme, General Directorate of
Health

Republic of Moldova
Dr Liliana Domente
Director, Institute of Phthisiopneumology
“Chiril Draganici”

Dr Svetlana Doltu
Head of Health Division, Department of
Penitentiary Institutions

Russian Federation
Dr Terreza Kasaeva

Deputy Director, Department of Specialized Medical Care and Medical Rehabilitation

Slovakia

Dr Ivan Solovic

Head of TB Department, National Institute for TB, Lung Diseases and Thoracic Surgery

Slovenia

Dr Petra Svetina Sorli

Register for TB, Ministry of Health

Spain

Dr Angels Orcau

Epidemiologist, Agencia de Salut Publica de Barcelona

Dr Ana Rodes

TBC Programme, Catalan Public Health Programme

Dr Elena Rodríguez Valín

Research epidemiologist, Instituto de Salud Carlos III

Sweden

Dr Jerker Jonsson

TB surveillance MD/epidemiologist, Swedish Institute for Infectious Disease Control

Switzerland

Dr Peter Helbling

National TB Manager, Federal Office of Public Health

Tajikistan

Dr Oktam Bobokhojaev

Director, Republican TB Centre

The former Yugoslav Republic of Macedonia

Dr Stefan Talevski

National TB Programme Manager, Institute for Lung Diseases and Tuberculosis

Turkmenistan

Dr Aysoltan Charyyeva

Head, Centre of TB Prevention and Control

Ukraine

Dr Olga Sakalska

Head, TB Control Department, State Service of Ukraine on HIV/AIDS and Other Socially Dangerous Diseases

United Kingdom of Great Britain and Northern Ireland

Dr Lucy Thomas

Head of TB Surveillance, Public Health England

Uzbekistan

Dr Doniyor Mirazimov

Head of Department of Treatment and Prevention, Ministry of Health

Dr Narghiza Parpieva

Chief TB Specialist, Ministry of Health

Dr Mirzagaleb Tillyashaykhov

Director, Republican Specialized Scientific Centre of Phthisiology

Dr Dilrabo Ulmasova

Director, Republican DOTS Centre

Representatives of other organizations

Health Development Centre “AFI”, Republic of Moldova

Dr Lilian Severin

Director

Amsterdam Institute for Global Health and Development (AIGHD)

Ms Anja van't Hoog

Dose of Love, Bulgaria Dr Nela Ivanova Executive Director	Dr Diana Petrosyan TB Coordinator, Global Fund Projects Coordinating Team
German Central Committee against Tuberculosis (DZK) Dr Ralf Otto-Knapp	Global Fund PR, Belarus Dr Ina Niakrasava Senior TB Adviser
European Respiratory Society Dr Stephane Dupasquier Head of IT	Global Fund PR, Georgia Dr Maia Kavtaradze TB Programme Director, Global Fund Projects Implementation Centre
Eurasian Harm Reduction Network Dr Maria Tvaradze Consultant, Technical Support Programme	Dr Maia Kipiani Training Coordinator, Global Fund Projects
European Centre for Disease Prevention and Control (ECDC) Dr Andreas Sandgren Expert in Tuberculosis, Surveillance and Response Support Unit	Dr Akaki Lochoshvili Executive Director, Global Fund Projects Implementation Centre
Dr Marieke van der Werf Senior Expert, Head of Tuberculosis Programme	Dr Nino Lomtadze Coordinator, Global Fund Projects
Global Fund to Fight AIDS, Tuberculosis and Malaria Dr Artashes Mirzoyan Senior Fund Portfolio Manager	Global Fund PR, Kazakhstan Professor Shakhimurat Ismailov
Country Coordinating Mechanism (CCM) Global Fund, Azerbaijan Dr Soltan Mammadov Vice Chair	Global Fund PR, Uzbekistan Dr Gulnoz Uzakova Manager
Country Coordinating Mechanism (CCM) Global Fund, Georgia Dr Ekaterina Iashvili TB consultant	Global Health Advocates Mr Patrick Bertrand Director
Global Fund Principal Recipient (PR), Armenia Dr Hasmik Harutyunyan Manager, Global Fund Projects Coordinating Team	KNCV Tuberculosis Foundation Dr Gerard de Vries Head Regional Office The Netherlands and Europe
	Dr Connie Erkens Senior TB Consultant
	Dr Vladislav Furman Regional TB IC Officer
	Dr Agnes Gebhard Senior TB Consultant

Dr Peter Gondrie
Executive Director
Ms Niesje Jansen
Senior Nurse Consultant

Dr Marija Idrissova
Senior Regional TB Adviser

Ms Helen McClimon
Secretary

Ms Ellen Mitchell
Senior Epidemiologist

Ms Beatrijs Stikkers
Executive Secretary

Ms Rianne van Hunen
Senior Consultant Nurse Surveillance

Mr Job van Rest
Head Datamanagement

Ms Marianne Wieser
Secretary

International HIV/AIDS Alliance in Ukraine
Dr Zahedul Islam
Director, TPSM

Medical Ecological and Research Centre, Macedonia
Dr Darko Iliev
Executive Director

Dr Kiril Soleski
Chief Executive Officer

National Research Institute of Tuberculosis and Lung Diseases, Islamic Republic of Iran
Dr Negin Ahmadi
Dr Marzieh Farnia
Dr Zahra Vaezi

Project HOPE
Dr Marija Joncevska
Laboratory Adviser

Dr Mariam Sianozova
Regional Director for Europe/Asia

Dr Alexander Trusov
Senior Programme Manager

Dr Christine Whalen
Senior Technical Adviser, Infectious Diseases

Results UK
Mr Bruce Warwick
Health Advocacy Assistant

Stop TB Partnership, Romania
Mr Jonathan Stillo

TB Alert
Ms Rachel Dukes
UK Programme Director

Mr Paul Sommerfeld
Chair

TB Europe Coalition
Ms Fanny Voitzwinkler
Coordinator

United States Agency for International Development (USAID)
Dr Sevim Ahmedov
Senior TB Technical Adviser

Dr Khorlan Izmailova
Regional HIV Adviser, Central Asia

Dr Yelena Samarkina
Senior Public Health Specialist, Central Asia

Verein Heilanstalt Alland, Austria
Dr Thomas Hirtl
Pneumologist

WHO Goodwill Ambassador for Health-Related United Nations Millennium Development Goals

Ms Sandra Roelofs

Observers

Mr Simon Logan
Policy Adviser, All-Party Parliamentary Group on Global Tuberculosis, United Kingdom

Dr Rukije Mehmeti
National TB Programme Manager, Ministry of Health, United Nations Administered Province of Kosovo, Serbia

Ms Sophie Toumanian
Municipal Health Service, Netherlands

Ms Nonna Turusbekova
Independent consultant

Ms Janine van den Brink
TB Control Bestrijding, Netherlands

Ms Oda van den Waarsenburg
TB Control Commission, Netherlands

Mr Dennis van Kraaijenoord
Municipal Health Service, Netherlands

Ms Natasha van't Boveneind
Netherlands School of Occupational Health

World Health Organization

WHO headquarters

Ms Inés Garcia Baena
Technical Officer, Tuberculosis Monitoring and Evaluation/Economics

Dr Dennis Falzon

Scientist, Laboratories, Diagnostics and Drug-Resistance
Stop TB

Dr Malgosia Grzemska
Coordinator, Technical Support Coordination

Ms Soleil Labelle
Technical Officer, Technical Support Coordination

Dr Knut Lönnroth
Medical Officer, Policy, Strategy and Innovations

Regional Office for Europe

Ms Colleen Acosta
Intern, Tuberculosis & M/XDR-TB

Mr Oluf Christoffersen
Supervisor, Printing and Conference Services

Dr Andrei Dadu
Technical Officer, Tuberculosis & M/XDR-TB

Dr Masoud Dara
Programme Manager, Tuberculosis & M/XDR-TB

Mr Sasa Delic
Conference Assistant, Printing and Conference Services

Dr Hans Kluge
Director, Health Systems and Public Health and Regional Director's Special Representative for M/XDR-TB in the WHO European Region

Dr Kristin Kremer
Scientist, Tuberculosis & M/XDR-TB

Ms Elizabeth Neville

Programme Assistant, Tuberculosis &
M/XDR-TB

Ms Nina Volkova
Ms Lyudmila Yurastova

WHO country offices

Dr Gayane Ghukasyan
National Professional Officer, WHO
Country Office, Armenia

Rapporteur

Ms Nina Bjerglund Andersen

Dr Javahir Suleymanova
National Professional Officer, WHO
Country Office, Azerbaijan

Dr Valentin Rusovich
National Professional Officer, WHO
Country Office, Belarus

Dr Nino Mamuashvili
National Professional Officer, WHO
Country Office, Georgia

Mr Szabolcs Szigeti
National Professional Officer, WHO
Country Office, Hungary

Ms Saliya Karymbaeva
Country Programme Officer, WHO
Country Office, Kyrgyzstan

Dr Dmitry Pashkevich
National Professional Officer, WHO
Country Office, Russian Federation

Dr Sayohat Hasanova
National Professional Officer, WHO
Country Office, Tajikistan

Dr Bogdana Shcherbak-Verlan
Technical Officer, Communicable
Diseases, WHO Country Office, Ukraine

Dr Jamshid Gadoev
National Professional Officer, WHO
Country Office, Uzbekistan

Interpreters

Annex 2 – Programme

Programme Wolfheze Workshops		
Tuesday 28 May	18:00-19:00	Welcome reception Wolfheze Workshops 2013 and farewell reception Dr. Peter Gondrie, Director KNCV TF
		Joint meeting day of Wolfheze Workshops for NTP managers, TB experts and officials Wolfheze movement, European Reference Laboratory Network for Tuberculosis (ERLN-TB) and Joint ECDC/WHO European Tuberculosis Surveillance Network
9:00-9:30		Opening session
		Follow-up of Berlin Declaration 2007, the Consolidated Action Plan to Prevent and Combat M/XDR-TB in WHO European Region 2011-2015, and the Framework Action Plan to fight tuberculosis in the European Union
9:30 – 09:50		Follow-up Berlin declaration and Consolidated Action Plan to prevent and combat M/XDR-TB 2011-2015
9:50 – 10:10		Follow-up of the Framework Action Plan to fight tuberculosis in the European Union
Wednesday 29 May	10:10 –11:50	Country presentations on progress with diagnosis, treatment, infection control and advocacy, partnerships and political commitment in high and low priority countries
11:50–12:00		Introduction working groups
12:00–13:00		Working Groups, themes: Diagnosis Treatment and care Infection control Advocacy, partnerships and political commitment
13:00–14:00		Lunch break
14:00–16:00		Working Groups
16:00–17:00		Plenary
17:00–17:30		Presentation of European Union Standards of Tuberculosis Care and discussion on implementation
Wolfheze Workshops for NTP managers, TB experts and officials Wolfheze movement		
Challenges and new strategies in TB control		
Thursday 30 May	9:00 -11:00	Intensified case finding
11:15 -13:00		Role of civic society in TB control
14:00 -15:15		Extrapulmonary TB: situation analysis and challenges
15:30 -17:00		TB in vulnerable populations (migrants / prisoners)
Wolfheze working groups: reporting back, past and future targets		
9:00-11:00		Childhood TB
11:15-12:45		Reporting back from WW working group Urban TB control (New) WW working groups: terms of reference, deliverables and planning
Friday 31 May	12:45 - 13:00	Closing