Wolfheze 2010

20 Year Jubilee
Bridging the gaps, where do we stand after 20 years?

9th National TB Programme Managers’ Meeting of WHO European Region/14th Wolfheze Workshops

Jointly organized by

World Health Organization Regional Office for Europe and KNCV Tuberculosis Foundation

31 May–3 June 2010
The Hague, the Netherlands
Bilderberg Europa Hotel Scheveningen

Consolidated Report

by
Dr Masoud Dara
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Acronyms and abbreviations

DOTS  First component and pillar of the Stop TB Strategy recommended to control tuberculosis
DSM  Direct Sputum Microscopy examination (for mycobacterium tuberculosis)
DST  Drug Susceptibility Testing
ECDC  European Centre for Disease Prevention and Control
EEA  European Economic Area
EFTA  European Free Trade Association
EU  European Union
GLC  Green Light Committee
GFATM  Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV  Human Immunodeficiency Virus
ICRC  International Committee of Red Cross
IFRC  International Federation of Red Cross and Red Crescent
IGRA  Interferon Gamma Release Assay
IUATLD  International Union Against Tuberculosis and Lung Disease
KIT  Royal Tropical Institute, the Netherlands
KNCV  KNCV Tuberculosis Foundation
LPA  Line Probe Assay
LTBI  Latent Tuberculosis Infection
MDR-TB  Multidrug-resistant Tuberculosis
NGO  Nongovernmental Organization
NRL  National (Mycobacteriology) Reference Laboratory
NTP  National Tuberculosis Programme
PHC  Primary Health Care
RIVM  The National Institute for Public Health and the Environment, the Netherlands
TB  Tuberculosis
TB CAP  Tuberculosis Control Assistance Program
TBCTA  Tuberculosis Coalition for Technical Assistance
USAID  United States Agency for International Development
WHO  World Health Organization
WHO Europe  World Health Organization Regional Office for Europe
WPC  Wolfheze Programme Committee
XDR-TB  Extensively Drug-resistant Tuberculosis
Acknowledgements

The Wolfheze organizing committee would like to express its deepest gratitude to Ms Valérie de Meyer, KNCV Programme Assistant, for her dedication, enthusiasm and excellent coordination of the logistics of the event.

Ms Elizabeth Neville, WHO Programme Assistant, and Ms Brenda de Jager Reyes-Munoz have equally been instrumental in the successful organization of the Wolfheze Workshops.

Ms Lyudmila Yurastova and Ms Nina Volkova provided outstanding written Russian-English and reverse translation and interpretation of plenary and working group sessions.

The members of Wolfheze programme committee and session coordinators helped develop the programme of the event in order to address the challenges of TB control in Europe.

Special thanks is extended to facilitators, speakers and reporters of the Wolfheze sessions.

Finally, thanks is due to Ms Anne Paret (www.vertalenenvertellen.nl), for editing this consolidated report.
Introduction

Since 1990, the KNCV Tuberculosis Foundation, WHO headquarters and the WHO Regional Office for Europe, the International Union Against Tuberculosis and Lung Disease (IUATLD) and EuroTB/ European Centre for Disease Prevention and Control (ECDC) have jointly organized a series of workshops, known as the "Wolfheze Workshops", named after a village in the Netherlands where the first meetings took place for the National TB Programme (NTP) Managers of low TB prevalence countries in Western Europe. The aim of the workshops was to redefine tuberculosis control in the WHO European Region, with emphasis on formulating guidelines and standards based on a consensus-building approach. Consensus was attained through extensive consultations among tuberculosis control experts, national correspondents of EuroTB, and representatives of health ministries. This has resulted in several publications of consensus documents and position papers. Since 2002, the workshops have been organized in conjunction with the WHO European NTP Managers’ Meeting, which focuses on management and coordination of TB control efforts in high TB priority countries in Europe.

In October 2007, at the Ministerial Forum jointly organized in Berlin by the WHO and the Ministry of Health of Germany, The Berlin Declaration on Tuberculosis was endorsed as a statement of renewed political commitment on the part of all countries in the WHO European Region. This political commitment should become operational through implementation of the Plan to Stop TB in 18 High-priority Countries in the WHO European Region, 2007-2015, and the Framework Action Plan to Fight TB in the European Union launched by the ECDC on 17 March 2008.

2010 marked the 20 year jubilee of the Wolfheze Workshops offering WHO Member States an opportunity to review the achievements and challenges of the movement and to share and discuss their own experiences. The aim of Wolfheze 2010 was to assess progress made following the Berlin Declaration towards achieving Millennium Development Goal No. 6 (MDG 6) by 2015. MDG 6 involves programmatic management of MDR/XDR-TB contributing to development of regional MDR-TB Action Plan, enhanced case-finding within high risk settings and improved case management across borders, while safeguarding the human rights principles and rights of TB patients.

Scope and purpose of Wolfheze 2010

1. to review the achievements and challenges of the Wolfheze movement in the last 20 years and discuss future plans;
2. to discuss measures to accelerate prevention and control of MDR/XDR-TB in the region and provide recommendations to the WHO and partners in preparation for a regional MDR-TB Action Plan;
3. to review progress made in TB control in the Member States following the Berlin Declaration and the status of implementation of the Plan to Stop TB and the European Framework Action Plan;
4. to present the latest evidence for the development of effective TB control policies; and
5. to bridge technical gaps by exchanging information in specific areas related to TB control in high TB priority countries and low and medium TB burden countries.

Preparatory steps

At its annual meeting in Dubrovnik on 29 May 2009, WPC agreed to hold the next Wolfheze Workshops from 31 May - 3 June 2010. The WPC members proposed the main themes for Wolfheze 2010. The first announcement was sent out on behalf of the organizing committee (WHO and KNCV) on 16 October 2009 to WHO Member States, technical partners, civil society organizations and other stakeholders involved in TB control in Europe.

Participants

The workshops drew a total of 113 participants including national TB control programme managers, civil society representatives (18) and Ministry of Justice representatives (3) from 39 countries. For the full list of participants, please refer to annex 1.
Welcome reception & exposé on the history of Wolfheze

On Monday 31 May 2010, after participants’ registration (15:00-18:00 hrs), a welcome reception was hosted with a special exposé to celebrate the 20 year jubilee of the Wolfheze movement. Pictures of 1990 and first meetings in Wolfheze along with anecdotes and memories of Wolfheze members were exhibited. Dr Jaap Broekmans made a brief, touching speech, illustrating the ambiance of the first Wolfheze Workshops in the village of Wolfheze near Arnhem. KNCV staff who assisted in organizing the first Wolfheze Workshops 20 years ago also attended the welcome reception.

Dr Jaap Broekmans sharing his memories of the first Wolfheze Workshops in 1990 (with Ms Nina Volkova translating into Russian for Russian speaking guests)

Exposé presented a flashback of the first Wolfheze Workshops with pictures and anecdotes
Tuesday, 1 June 2010
9:00–9:45

Opening session (session 1)

Chairperson: Jeroen van Gorkom/Masoud Dara

Welcome note
Jeroen van Gorkom (on behalf of Peter Gondrie),
KNCV Tuberculosis Foundation

Special address
Philip van Dalen, Ministry of Health, Welfare and Sport, the Netherlands

Wolfheze award ceremony
On behalf of the Wolfheze Programme Committee

Scope and purpose of the workshops
Richard Zaleskis, WHO/EURO

Narrative

During the official opening ceremony, after a short greeting by Dr Jeroen van Gorkom, Head of the International Unit of the KNCV Tuberculosis Foundation (on behalf of Dr Peter Gondrie), the representative of the Ministry of Health, Welfare and Sport of the Netherlands, Dr Philip van Dalen, welcomed participants in a key note speech. Dr van Dalen emphasized that there is a need for continuous commitment to improve TB control, particularly in countries with low TB incidence like the Netherlands. "A downward trend still necessitates a proactive tuberculosis control policy." Dr van Dalen named the following areas as specific challenges: ensuring health care staff’s expertise and laboratory proficiency to diagnose TB as early as possible and improving access to health services for hard-to-reach populations (migrants and other risk groups). He added that the emergence of multidrug-resistant tuberculosis poses a serious threat to public health throughout the region and also to countries with a low TB burden like the Netherlands. Dr van Dalen regretted the fact that the WHO European Region is not on track to achieve the Millennium Development Goals, while sufficient funds are already available. He highlighted the role of Dutch expertise, particularly KNCV as well as RIVM and KIT, and the contribution of the Dutch government to TB control via GFATM, WHO partnership and Stop TB Partnership among others. Dr van Dalen mentioned that the Netherlands has organized an external review of its TB control programme in 2003 and 2008 in order to improve the quality of services on a continuous basis. He pointed out that it is open to learn from the experiences of other countries. He underlined the importance of the Wolfheze Workshops in strengthening cross-border collaboration and sharing best practices in TB control. He wished participants a pleasant stay in the Netherlands and a successful workshop.

Dr Richard Zaleskis presented the scope and purpose of the Wolfheze Workshops (please refer to page 4 of this report for an overview of the scope and purpose of workshops).
Wolfheze award ceremony

Based on suggestion of Wolfheze Programme Committee (WPC), and on the occasion of the 20 year jubilee of Wolfheze, three members of the Wolfheze movement were nominated to be awarded with the certificate of appreciation.

On behalf of WPC, Dr Masoud Dara handed over the certificates of appreciation to the following individuals for their dedication and contribution to Wolfheze movement:

- Dr Mario Raviglione
- Dr Jaap Veen
- Professor Umrinisso Sirojiddinova (from Tajikistan)

Due to health problems, Professor Sirojiddinova could not participate in the workshops and therefore Professor Kurbonkhon Zakirova accepted the award on her behalf. With the assistance of UNDP in Tajikistan, a Skype® call was organized during the plenary session and professor Sirojiddinova reflected her vision on the role of Wolfheze in consensus-building and adoption of modern TB control policies in her country.
Tuesday, 1 June 2010
9:45-11:00

Follow-up to the Berlin Declaration (session 2)

Coordinators: Peter Gondrie and Richard Zaleskis
Chairperson: Masoud Dara
Reporter: Nonna Turusbekova

Background

The WHO European Ministerial Forum “All against Tuberculosis” hosted by the German Ministry of Health was held on 22 October 2007 in Berlin, Germany, to accelerate progress towards achieving the global targets for tuberculosis control in the WHO European Region. Over 300 participants attended the forum, including 20 health ministers and high-level decision-makers from 49 of the 53 Member States in the WHO European Region, along with representatives of other United Nations bodies, intergovernmental agencies, nongovernmental organizations and civil society. The most important outcome of the forum was the endorsement of The Berlin Declaration by all Member States who participated at the forum. The forum agreed to monitor the progress of implementation of the declaration every other year.

Content of the session

1. Regional achievements and challenges for follow-up to the Berlin Declaration;
2. Latest achievements in TB control following the Berlin Declaration in high-priority and low-incidence countries (presentations from two countries);

Methodology

1. Slide presentation
2. Questions and answers in the plenary

Objectives

1. To review the latest development in TB control at regional and country level following the Berlin Declaration;
2. To review the main challenges in TB control in order to reach the MDG targets;
3. To inform participants on preparations for the regional MDR-TB response plan.

Expected outputs

- Participants are aware of the latest situation in TB control following the Berlin Declaration at regional and country level;
- Challenges and possible solutions for future TB control are identified and discussed;
- Participants are aware of the process of development of the regional MDR-TB response plan.

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<tr>
<th>Time</th>
<th>Title of talk</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>9:45-10:00</td>
<td>Monitoring and follow-up to the Berlin Declaration in the WHO European Region</td>
<td>Richard Zaleskis</td>
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<tr>
<td>10:00-10:15</td>
<td>Follow-up on the Action Plan to Fight TB in the European Union</td>
<td>Davide Manissero</td>
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<td>10:15-10:30</td>
<td>Latest achievements in TB control in Ukraine following the Berlin Declaration</td>
<td>Olena Pavlenko</td>
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<tr>
<td>10:30-10:45</td>
<td>Latest achievements in TB control in Germany following the Berlin Declaration</td>
<td>Barbara Hauer</td>
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<tr>
<td>10:45-11:00</td>
<td>Regional MDR-TB response plan</td>
<td>Hans Kluge</td>
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**Narrative**

WHO and ECDC representatives made presentations on the latest development and progress of implementation of the Berlin Declaration, followed by country presentations (Ukraine and Germany) followed by Dr Hans Klüge’s talk on new developments at WHO Regional Office to address MDR/XDR-TB and preparation of a regional MDR-TB response plan.

Dr Zaleskis provided a summary of the Berlin Declaration, strategic actions for the follow-up on the declaration and main recommendations for follow-up of implementation. Twelve main milestones in follow-up were identified. He stated that the main challenges for TB control are economic recession and poverty, poorly developed health systems, MDR/XDR-TB, HIV epidemic, TB in prisons and migration. Dr Zaleskis added that TB incidence in the region is stabilized and even declined, which may be seen as an indication that one of the MDGs (No. 6) is within reach. In the near future however, we cannot achieve the targets in terms of reducing prevalence and TB mortality. Regarding treatment outcomes and treatment success rate, high death rates and high default rates remain major concerns. 15 out of 27 high MDR-TB burden countries are in the WHO European region. Other concerns are rising HIV prevalence and TB-HIV co-infection, together with a low detection rate of TB-HIV cases (48%). Next steps to follow up on the Berlin Declaration include monitoring by means of guidance and review missions at country level, adherence to STOP TB Strategy within health systems, strengthening, mainstreaming and maximizing synergy of different TB related interventions and promoting multi-sectoral approaches. Last, but not least, Member States and international partners are expected to allocate more resources, in line with their commitment to the Berlin Declaration, addressing urgent needs in the countries concerned.

Dr Davide Manissero from the European Centre for Disease Prevention and Control (ECDC) made the second presentation of the session under the title of “A Follow-up to the Framework Action Plan to Fight Tuberculosis in the EU.” The presentation focused on updating on EU/EEA and ECDC initiatives since the launch of the Framework Action Plan, informing participants of the Commission’s request for a monitoring framework to the Action Plan and the world TB day message on poor treatment outcome. Trends and rates on the EU and EEA/EFTA were analysed. Dr Manissero reviewed the Action Plan to Fight TB in the EU, which is based on four pillars: strengthening health systems, ensuring prompt and good quality TB care for all, developing and assessing new tools and building partnerships and international collaboration. The role of molecular surveillance was highlighted. Dr Manissero informed participants on the recent launch of the European Reference Laboratory Network for TB, addressing the need to improve culture coverage in the EU. Activities related to country support and outbreak response were explained, along with new tools and practices. He added that follow-up to the action plan involves developing a monitoring framework for the TB action plan, including the development of epidemiological outcome and process indicators. Dr Manissero announced that the draft monitoring framework will be shared with Wolfheze members for input in the coming weeks. He concluded that engagement of EU/EEA Member States in TB control within the EU/EEA borders is promising. Laboratory and surveillance initiatives catalyse efforts and enthusiasm for the implementation of the plan. There is a need to address sub-optimal treatment outcome and MDR-TB and the monitoring framework requires improvement.

The third presentation of the session was by Dr Olena Pavlenko from the Ministry of Health of Ukraine. Dr Pavlenko presented achievements of Ukraine following the Berlin Declaration. She added that the TB epidemic in Ukraine is largely due to economic decline and migration. As of 2006, incidence and mortality are slowly declining. However the MDR-TB rate is alarming (16% of new cases are MDR-TB). A multidrug-resistance survey has been conducted only recently. TB remains the main mortality factor in HIV-infected individuals. Dr Pavlenko mentioned recent decline is mainly due to political and financial support at the central and regional levels and implementation of the Stop TB Strategy. There is 100% availability of first-line drugs to the programme, but only 20-40% of second-line drugs. For the last few years, Ukraine has made progress by introducing international regulations on TB control. Quality implementation of the new regulations requires external technical support and resources (e.g. GFATM) and improvement of TB service depends on further health care reforms.

During the question and answer session, the issue of enforced hospitalization and isolation of patients in Ukraine was discussed. The new intervention in Ukraine requires establishing guarded wards under control of the persecutor’s office, which receives defaulters’ lists. In each region it is envisioned to create such wards. So far, only one region has done so. Moderators suggested ensuring the system adapts to patients needs and emphasized patients’ rights and responsibilities.

Fourth speaker Dr Barbara Hauer from the Robert Koch Institute in Germany presented the latest achievements in TB control in Germany following the Berlin Declaration. Dr Hauer presented TB control activities in Germany and mentioned quality TB surveillance data as one of the cornerstones of TB control. She added that the incidence of TB has been declining, however recently the decline seems to be slower. Economic and migration factors have major influence in Germany. There are different age peaks among the migrant population, but two thirds of cases still occur among the indigenous population. Activities
addressing TB in vulnerable populations were listed. A real challenge is availability of data on TB-HIV co-infection rate, due to information protection laws. MDR and XDR-TB are largely among foreign-born population, mainly originating from the former Soviet Union. Since 1995 all MRD TB strains are typed by the national reference laboratory. In conclusion, Dr Hauer mentioned that despite its low and declining TB incidence, Germany is facing many of the specific problems mentioned in the Berlin Declaration on Tuberculosis and recognizes the need for adequate and global solutions. Sustaining and further improvement of TB surveillance and epidemiological research projects are essential for effective TB control and further commitment and response at the political level.

During the question and answer session, survey tools like molecular typing and clustering as well as epidemiologic intervention were discussed. The financial costs of such tools are an issue of concern. External review as performed in the Netherlands could be a good tool for evaluating a TB control programme and improve services.

Dr Hans Kluge WHO Regional Director’s Special Representative to Combat MDR/XDR-TB presented the proposed process to develop an Action Plan to Fight MDR/XDR-TB in the WHO European Region 2010-2015. Dr Kluge presented the facts and figures about MDR-TB in the WHO European Region (only 21% DST coverage and 22.7% MDR-TB case detection rate in 2008) and why addressing MDR/XDR-TB is such a high priority. He mentioned that services for MDR-TB will be improved and built into the health systems. Socially vulnerable groups which are at higher risk of MDR/XDR-TB should be reached by TB services and social determinants should be addressed, with special attention to ethical values and human rights. Dr Kluge referred to the World Health Assembly, 62nd session (22 May 2009) Executive Board (EB126, 18-23 January 2010) and World Health Assembly, 63rd session (22 May 2010) with the resolution “Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis.”

Dr Kluge added that achievements have been mentioned, such as the work facilitated by the Green Light Committee (GLC), development of the regional plan and the renewed commitment from the WHO European Region towards (MDR)-TB control, which is translated in a number of tangible activities. The Action Plan to Fight MDR/XDR-TB in the WHO European Region includes scaling up response in all 53 Member States, situational assessment, endorsement by the Regional Committee in 2011 and building monitoring and evaluation system. The preliminary process includes brainstorming at the Wolfheze Workshops 2010 as the first step along with a number of other steps leading to finalization of the plan and its endorsement by the WHO Regional Committee in September 2011.

During the question and answer session, Dr Kluge reiterated that we should also highlight the results of monitoring of the programmes and address them at the proper EU levels, because some of the data is really shocking and must be brought to the attention of politicians. We should go beyond the level of TB control programmes and technical managers and address the political leaders and various commissions of EU. Having the MDR-TB plan, we need to raise the issue at ministerial level (MoF). It was also announced that a partnership agreement between the EU and the WHO will be signed in September 2010 in Moscow and in 2011; a more technical document including MDR/XDR issues will be signed.
Tuesday, 1 June 2010
11:30–13:00

20 years of Wolfheze movement (session 3)

Coordinators: Masoud Dara, John Watson
Chairpersons: Mario Raviglione, John Watson
Reporter: Nonna Turusbekova

Background
Wolfheze Workshops 2010 marks its 20 year jubilee with an opportunity to review the achievements and challenges of the movement. This session presents a review of three periods of the Wolfheze movement and enables participants to discuss the future of the Wolfheze Workshops.

Content
1. Presentation of achievements and challenges of the Wolfheze Workshops
2. Discussion on the future of Wolfheze movement

Methodology
1. Slide presentation
2. Questions and answers in the plenary

Objectives
1. To provide participants with an overview of origin, milestones and evolution of the Wolfheze movement
2. To present and discuss future direction of the movement

Expected outputs
• Participants are aware of Wolfheze achievements and challenges
• Participants have discussed the possible directions of the movement

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<tr>
<th>Time</th>
<th>Title of talk</th>
<th>Speaker</th>
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<tr>
<td>12:15-12:30</td>
<td>Period 3: 2006 onwards, separate and interlinked tracks for low/medium and high-incidence countries</td>
<td>Masoud Dara</td>
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<tr>
<td>12:30-13:00</td>
<td>Discussion in the plenary</td>
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Narrative

After a brief introduction by Dr Mario Raviglione and Professor John Watson, Dr Jaap Veen presented the first period in the history of the Wolfheze Workshops, covering the period from 1990 to 1995. In his talk, he revisited the topics discussed during the first workshop, including reflections on basic research, epidemiology and strategies to eliminate TB. The speaker praised the critical analysis exhibited during the workshop. The second Wolfheze Workshop in 1994 addressed two important issues: migration and surveillance. An important outcome was the establishment of a European Platform on TB Control for low-incidence countries, later to be expanded to a wider European region. Dr Jaap Veen concluded that the Wolfheze Workshops are a legacy for future generations to realize the power and effectiveness of a coordinated multinational approach to global health problems.

Dr Zaleskis presented the second period: 1996-2005 with multifaceted strategies for low, medium and high-incidence countries. During this period, establishment of a unified European TB surveillance was given priority. The number of countries reporting to the WHO increased significantly during this period. WHO NTP managers’ meetings marked the revival of stronger commitment to TB control in the WHO European Region, with DOTS implementation in high-priority countries. By 2006, 35 of the 53 countries in the region reported that over 95% of their populations had access to DOTS, but quality improvement of DOTS remained a major concern. Programme performance remained unsatisfactory. Dr Zaleskis concluded that the Wolfheze movement contributed to policy dialogue for TB elimination in low-incidence countries, management and control of drug-resistant TB, TB/HIV co-infection, TB in prisons and TB and migration.

Dr Dara presented the third period of the Wolfheze movement (2006 onwards). He highlighted the background of the establishment of two separate but interlinked tracks for high and low/medium-incidence countries. The aim of his talk was to offer more in-depth discussion and specific work on the bottlenecks relevant to each track while ensuring the link between the two. Dr Dara reviewed achievements, challenges and contributions of the third period of the Wolfheze movement. Wolfheze Workshops played a key role in overcoming longstanding controversies leading to a dynamic movement to harmonize TB control policies in Europe. He added that the movement is functioning as a think-tank and a platform for the ongoing exchange of experiences and the promotion of common approaches in order to improve TB control in Europe. Dr Dara elaborated on the role of the Wolfheze Programme Committee (WPC) and processes to improve knowledge management. One of them is the creation of a website whereby materials developed and work accomplished or underway by the Wolfheze movement may be shared with national and international stakeholders. Dr Dara suggested several topics for the plenary discussion of the next Wolfheze Workshops such as the development and finalization of the regional MDR-TB response plan, follow-up and implementation of the Berlin Declaration, cross-border TB control, TB in big cities, TB, ethics and human rights and actions to address social determinants.

During the plenary session, participants expressed their views on the role of Wolfheze and the importance of keeping the movement alive between the annual or biennial events. Dr Raviglione solicited suggestions from the audience on the areas to address via the Wolfheze movement.
Some participants suggested that the current setting of the Wolfheze Workshops with a plenary-working group is useful and more time needs to be devoted to round table discussion. The audience emphasized the importance of improving treatment adherence, strengthening quality of DOTS and TB services and sharing experiences among countries on most effective care models. The Wolfheze movement provides a good opportunity for representatives of the 53 Member States to get together as most issues are cross-cutting and cross-border. Wolfheze is a friendly forum and the documents that it issues are well-received in the countries. Wolfheze can make a large impact on increasing the basic anti-TB activities, as well as influence other groups such as surveillance and laboratory specialists who can improve the outcomes of discussions as demonstrated in the past. The role of civil society is paramount and it must be kept involved. The issue of human resources is important, but has not been addressed so far. Wolfheze could draw attention to the problems related to human resources and propose solutions.
Tuesday, 1 June 2010  
14:00–17:30

Consolidated Action to Prevent and Address MDR/XDR-TB in Europe (session 4)

**Coordinators:**  
Pier Paolo de Colombani, Agnes Gebhard

**Chairperson:**  
Hans Kluge, Richard Zaleskis

**Reporters:**  
Pier Paolo de Colombani, Masoud Dara

**Background**

Despite the heterogeneous context of countries in the WHO European Region, multidrug-resistant tuberculosis (MDR-TB) is a major public health problem in this part of the world. 15 of the 27 high-burden MDR-TB countries in the world are in Europe. The top nine countries in the world with MDR-TB exceeding 12% among new TB cases and the top six exceeding 50% among previously-treated TB cases are in this region. North-western Russia reports 28% of new TB cases with MDR-TB, the highest proportion ever recorded in the world. High correlation of MDR-TB among HIV-positive patients has been documented in some countries, as well as its linkage with proximate risk factors and social determinants, which also influence the TB epidemiology in high-income countries. Most of the countries in Europe with high MDR-TB have applied to the GLC for concessially priced quality assured drugs and have scaled up their national response. Major gaps still prevail however in universal access to early/rapid detection of drug resistance, effective treatment and programmatic management of drug-resistant TB. The Berlin Declaration and the Beijing Call for Action on TB engage all 53 Member States of the WHO European Region to address MDR/XDR-TB and to achieve the global targets of TB control by 2015 and TB elimination by 2050. The WHO Regional Office for Europe is planning to develop a consolidated Regional Action Plan to prevent and address MDR/XDR-TB in the region in collaboration with the 53 Member States in the WHO European Region and the partners.

**Content**

1. Planning and implementation of an adequate MDR-TB response in countries and in the region

**Methodology**

1. Introduction to working group discussion
2. Structured discussion in working groups
3. Presentation and questions and answers in the plenary

**Objectives**

1. To obtain input from country representatives on challenges and bottlenecks in preventing and addressing MDR/XDR-TB, including health system constraints
2. To solicit suggestions and expertise views on measures to take to prevent and control MDR-/XDR-TB in the region and scale up programmatic management of drug resistant TB (PMDT)
3. To discuss how a regional plan may be used at country and regional levels for further consolidated action to control MDR-TB/XDR-TB?

**Expected outputs**

- Bottlenecks in scaling-up MDR-TB interventions are identified and discussed
- Measures to accelerate prevention and control of MDR/XDR-TB in the region are identified
- Recommendations are provided to the WHO and partners to guide in preparation of regional MDR-TB/XDR-TB Action Plan
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<tr>
<td>14:00-14:15</td>
<td>Introduction to working group discussion</td>
<td>Hans Kluge</td>
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<tr>
<td>14:15-15:45</td>
<td>National response to MDR/XDR-TB: progress in planning and implementation: are we doing enough (countries and partners)?</td>
<td>3 working groups (HBC, MBC, LBC)</td>
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<td>Moderators:</td>
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<td>- Richard Zaleskis</td>
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<td>- Pierpaolo de Colombani</td>
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<td>- Agnes Gebhard</td>
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<td></td>
<td>GDF access to quality assured second-line drugs</td>
<td>Kaspars Lunte (GDF)</td>
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<td>Rapporteurs from participants</td>
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<td>15:45-16:15</td>
<td>Coffee break</td>
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<tr>
<td>16:15-17:30</td>
<td>Working groups report back to the plenary session</td>
<td>Rapporteurs of the working groups</td>
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</table>

**Narrative**

**Summary presentation**

This session involved only one presentation, allowing participants to dedicate most of their time to discussion in working groups. Dr Hans Kluge recalled his presentation during session 2 on the “Action Plan to Fight MDR/XDR-TB in the WHO European Region, 2010-2015.” He briefed participants on the work expected from the three working groups and presented two questions for discussion:

1) What must be done in the WHO European Region to fight MDR/XDR-TB in terms of:
   a) prevention and control
   b) strengthening of health systems

2) What should be the priorities for WHO support to countries in their fight against MDR/XDR-TB in the next five years?

**Summary of the discussion**

Participants from high, medium and low TB burden countries worked in three groups. Dr Kaspars Lunte provided the high TB burden countries group with a brief update on constraints in the supply of second-line anti-TB drugs and on recent actions undertaken by the GDF and the GLC to overcome these constraints.
Working groups

High TB priority countries group

The group discussed the actions which need to be taken: strengthening DOTS to prevent further development of MDR-TB; community awareness to enhance TB case finding; strengthening laboratories for rapid diagnosis of MDR-TB e.g. using Line Probe Assay (LPA); infection control to prevent transmission in health care services and congregate settings; promoting ambulatory treatment at community level; improved inter-sectoral collaboration for TB control; uninterrupted supply of quality assured drugs; training and funding for operational research; national planning to implement policies and guidelines; improved governance and ensure access of all population groups to TB care; integration of TB services at Primary Health Care (PHC) level; management and re-allocation of human resources; social support to patients, specific approaches to increase treatment adherence among risk groups (e.g. alcohol and drug abuse); facilitation of patients’ active participation in decision-making, programme planning and improving services geared towards patient-centered approaches.

The priorities for WHO support were listed as follows: follow-up to the Berlin Declaration at ministerial level; access to updated information and guidelines (infection control, treatment guidelines); increase motivation of TB care workers (recommendation on financial incentives); build human resource capacity (needs-based, quality training); develop guidance on involuntary treatment while respecting human rights; strengthening TB control in prisons (experience exchange, continuity of care outside prisons); integrate TB services at PHC level; facilitate uninterrupted supply of quality-assured drugs (advocacy with MOH, WHO prequalification); adjust international policies and guidelines to country specifics; advocate for revising GFATM eligibility criteria; develop effective systems and tools for TB control among migrants; promote cost-effective interventions and advocacy towards MOH to ensure adequate funding despite global financial crisis).

Medium TB burden working group

The working group was composed of representatives from Bulgaria, the Former Yugoslav Republic of Macedonia, Poland, Romania, Serbia, Slovakia and Turkey. The required actions were identified as follows: strengthen laboratory for TB drug susceptibility testing (quality-assured testing for all pulmonary positive cases, including of second-line TB drugs); facilitate procurement of TB drugs in the framework of the GLC mechanism (increase transparency of procedures, improve communication with the International Dispensary Association (IDA)and advocate for revising GFATM eligibility criteria) and outside the GLC mechanism to overcome the global shortage of TB drugs, the problem of registration of imported drugs and high shipping costs; address the problem of TB control in migrant populations (screening policies, medical tourism).

The priorities for WHO support were identified as follows: assisting countries in strengthening DOTS to prevent MDR-TB; ensure quality DST; enhance integration of TB services at PHC level; ensure drug supply outside the GLC mechanism; strengthen TB control among migrants; strengthen TB/HIV programmatic and clinical management; adopt legislation related to human rights and ethical values.

Low TB burden working group

Participants included mainly countries of Western Europe. Several actions were identified: to increase knowledge in countries where MDR-TB is rare (creating a European network of MDR-TB centres of excellence, training of medical professionals, establishing an international MDR-TB expert group); advocacy for MDR-TB control (cost impact and cost effective interventions); strengthen laboratory for timely MDR/XDR-TB diagnosis (development of laboratory minimum standards and diagnostic algorithms, closer collaboration between WHO and national TB reference laboratories); avoid mismanagement of TB cases (wider distribution and use of international guidelines, development of diagnostic, treatment and care standards); improve management of MDR-TB contacts (operational research); document evidence on effectiveness of XDR-TB treatment; provide access to GLC drugs also for low TB burden countries; organize proper isolation for TB infection control in hospitals and at home; ensure adequate TB legislation and services for migrants (regulation for undocumented migrants, European health insurance fund, cross-border collaboration); improve MDR-TB surveillance data (national and regional registration, strict notification of MDR/XDR-TB cases).
The priorities for WHO support were listed as follows: advocate activities to enhance political commitment for MDR-TB control by reviewing and monitoring national TB programmes; maintain and strengthen existing public health TB structures; promote application of updated treatment guidelines, improving programme monitoring, advise on limiting availability of TB drugs in order to prevent further development of MDR/XDR-TB, strengthen laboratories through support from high TB burden countries; focus on home treatment which is more patient-friendly, reduces the risk of nosocomial transmission and is less expensive.

**Next steps/recommendations**

All participants welcomed the initiative of the WHO Regional Office for Europe to develop an "Action Plan to Fight MDR/XDR-TB in the WHO European Region, 2010-2015" and shared their different perspectives and expectations during the discussion in the working groups. This is the first technical feedback that the WHO Regional Office for Europe has received from the Member States, to be expanded by means of a questionnaire sent to MOHs and ad hoc visits in selected countries. The first draft of the plan is expected by the end of September 2010.

**Tuesday, 1 June 2010**

17:30-18:30 Wolfheze Programme Committee meeting (WPC members),
(minutes are available upon request)
Wednesday, 2 June 2010
9:00–11:15

Social determinants of tuberculosis (session 5)

Coordinators: Pierpaolo de Colombani, Masoud Dara
Chairpersons: Masoud Dara, Pierpaolo de Colombani
Reporter: Pierpaolo de Colombani

Background
Tuberculosis is one of the diseases which is strongly influenced by social determinants. Social determinants of TB include a wide variety of factors impacting the transmission of TB, risk of progression from infection to disease, access to quality treatment and adherence to treatment. Examples of social determinants include migration, poverty, poor living conditions, homelessness, alcoholism and imprisonment.

Content
1. Social determinants of TB: towards interventions
2. Particular attention to TB control in prisons

Methodology
1. Slide presentation
2. Working group discussion
3. Questions and answers in the plenary

Objectives
1. To discuss priority actions to address the social determinants of TB in Europe
2. To discuss achievements and challenges in TB control in prisons in the region

Expected outputs:
- Participants have improved awareness of social determinants of TB and different causal pathways.
- Participants have discussed a set of recommendations to tackle the social determinants of TB and TB control in prisons and congregate settings including investment in prevention.

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<tr>
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<tr>
<td>9:00-9:15</td>
<td>Social determinants of TB: towards interventions</td>
<td>Knut Lönnroth</td>
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<tr>
<td>9:20-9:35</td>
<td>Latest recommendations of TB control in prisons</td>
<td>Masoud Dara</td>
</tr>
<tr>
<td>9:40-10:30</td>
<td>Working group discussion</td>
<td>Herman Reyes/Sylvia Wüst Knut Lönnroth Pierparolo de Colombani</td>
</tr>
<tr>
<td>10:30-11:15</td>
<td>Reporting back in the plenary and discussion</td>
<td>Rapporteurs of the working groups</td>
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Narrative

Summary of presentations
Two presentations were provided to facilitate the discussion. Dr Knut Lönnroth provided an update on the social determinants of TB playing a major role in the WHO European Region, the rationale for NTPs to address them and examples of actions (dealing with alcohol abuse, living conditions, migration). In Europe, investing in action to deal with social determinants leads to economic gains. Dr Masoud Dara presented the latest guidelines for control of TB in prisons, which were developed and published by the TB
Coalition for Technical Assistance and ICRC under USAID/TBCTA support. The guidelines are built upon acquired international experience and feature new chapters such as TB/HIV, infection control, MDR-TB, advocacy, organization and management of TB control in prisons.

**Summary of the discussion**

Participants split into three working groups discussing TB in relation to the following subjects: alcohol abuse, living conditions and detention in prison.

**Alcohol abuse**

In some settings 10-40% of TB patients referring to health care are alcoholics and have higher treatment defaulting rates. Few studies have tried to measure the problem and no systematic approaches have been developed for risk groups. There is a general reservation to recognize an association between alcohol abuse and TB. Possible interventions to consider are: linking TB programmes with other services (assistance with substance abuse, psychiatric care); organizing specific patient support in TB services (narcologist, psychiatrist); establishing a regional network for countries facing the same problems; early identification of alcohol abuse among TB patients; prolonged, even forced hospitalization; using DOT and incentives/enablers during outpatient treatment; strengthening outreach efforts to trace treatment defaulters.

**Poor living conditions**

Poor living conditions are common among population groups at higher risk of TB, such as asylum seekers (immigration centres), poor people, homeless and Roma communities. Different experiences and proposed solutions were shared among the group participants from Belgium, Malta, Moldova, Slovakia, Spain and Japan (observer). Possible interventions to consider are: establishing a national advisory committee to develop updated TB guidelines and monitor conditions in asylum seekers centres; educating employers on improving employees' living conditions; ensuring affordable health insurance; employing social nurses; create community workers among Roma population for education and support; TB screening of homeless. The WHO should put pressure on countries with a moral obligation to improve living conditions in settings such as prisons and immigration centres and promote collaboration between governmental institutions and nongovernmental organizations.

**Detention in prison**

The participants of this group were mainly from Russian speaking countries. Dr Hernan Reyes and Ms Sylvia Wüst shared ICRC experience in TB control in prison. Ms Wüst presented the lessons learned and challenges experienced by ICRC in Azerbaijan, including the problem of prisoners who refuse MDR-TB treatment and the ICRC approach to health education. The working group discussed possible interventions at the level of NTP, health system and beyond. NTPs and ministries of justice should work together in order to increase political commitment, adopt same TB guidelines and standards, share laboratory services, ensure entry and periodic TB screening in prisons, ensure one-stop service for complicated TB cases, integrate human resources management including training and supervision, ensure follow-up treatment after prison release and develop and maintain a national database that includes imprisonment status. Beyond the health system, cooperation should be established with other ministries and a medical commission set-up at parliamentary level to harmonize national financial support.

**Next steps/recommendations**

The importance of social determinants in creating and maintaining vulnerability to TB infection and disease is increasingly recognized. Prevention and management of MDR-TB among risk groups can be effective only by recognizing the role played by down and upstream determinants and addressing them within and beyond NTPs. WHO and international partners should promote and facilitate the undertaking of specific interventions complementing the implementation of the Stop TB Strategy.
Round table discussion in the parallel working group discussion
**Background**

With increasing population movement and in a highly globalized context which certainly affects the WHO European Region (from labour migrants in central Asia to free movement across EU), there is a need for more concerted action in order to provide quality TB care and sound treatment follow-up. Several challenges exist in the field of patient management. There is no clear picture however of existing inter-country initiatives in this respect. In particular, there is a need to collect information on practices in cross-border assurance of continuation of care, international contact tracing and data collection.

**Content**

1. Identification of challenges in cross-border TB control
2. Identification of minimum standards of TB care across borders
3. Recording and reporting related to TB care across borders

**Methodology**

1. Slide presentation
2. Working groups follow a structured set of questions
3. Reporting back from the working groups

**Objectives**

1. To identify key challenges in cross-border management of TB patients and their contacts
2. To identify the minimum standards package for cross-border TB control
3. To develop a Wolfheze concept paper on cross-border TB case management in the European Region

**Expected output**

- Draft concept paper for minimum package of TB care, recording and reporting across borders

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<tr>
<td>11:30-11:45</td>
<td>Challenges in cross-border TB patient care and management. Case studies from the field</td>
<td>Jean-Pierre Zellweger</td>
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<tr>
<td>11:45-12:00</td>
<td>Addressing TB control among migrants</td>
<td>Pierpaolo de Colombani</td>
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<tr>
<td>12:00-12:10</td>
<td>Objectives of the working group</td>
<td>Masoud Dara/Davide Manissero</td>
</tr>
<tr>
<td>12:10-13:00</td>
<td>Working groups</td>
<td>Davide Manissero Pierpaolo de Colombani Masoud Dara</td>
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<tr>
<td>13:00-13:30</td>
<td>Reporting back to plenary and discussion</td>
<td>Rapporteurs of the working groups</td>
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Narrative

Summary of presentations

In his keynote speech, Dr Jean-Pierre Zellweger shared his field experience of existing challenges in cross-border TB care and management in Switzerland. He highlighted that migrants may bring along numerous health problems which may be pre-existing or discovered after arrival and that some long-term diseases may require further treatment in another country. The continuity of care is a key problem when dealing with these patients who are often are lost to follow-up. The conflict between medical needs and legal status as well as confidentiality problems are among main obstacles to overcome in order to provide satisfactory care for this vulnerable population.

The second presentation was by Dr Pierpaolo de Colombani and addressed the situation of migration and TB in former Soviet Union countries, an important problem which is still insufficiently documented. A study in Russia by Dr N. Frolova showed that 68% of 3058 identified TB cases among labor migrants in 2007 were lost to follow-up and 12% were deported, thus only 20% of these cases were hospitalized for treatment. A survey conducted jointly by the International Organization for Migration (IOM) and the WHO in 2009 among Tajik seasonal workers in Russia, found high vulnerability for TB, misconceptions regarding TB transmission and treatment and limited access to TB services. The World Health Assembly Resolution 61.17 calls for attention to migrant health, which has been reinforced by the WHO/IOM Consultation on Migrant Health held in Madrid in March 2010. National TB programme managers are urged to tackle TB among migrants at the three levels of programme, health system and beyond, where migration plays its role of upstream social determinant of health.

Summary of the discussion

Three working groups discussed the main barriers and possible solutions and next steps for Wolfheze.

Concepts

Key concepts identified during the workshop discussions were: the overarching principle of universal access to care for patients, including those that are moving across borders; the public health aspects to avoid further transmission, improve treatment outcome and avoid development of drug resistance; protection of labor migration; and finally, ensuring the individual rights of the patients.

Barriers

The core barriers towards ensuring adequate care for cross-border patients were discussed. These had to do mainly with legal issues of migration; the definition of migrants and the existence of different legislations for different types of migrants (asylum seekers versus labor or study migrants); different national legislations on deportation and differences in policies on whether to ensure stay in the country until treatment completion or not. To this effect, the Dublin Regulation\(^1\) and its implications for providing adequate health care to asylum seekers were discussed extensively. The concrete case was brought up of an MDR patient originating from Russia, claiming asylum in Switzerland, who was refused refugee status and whose treatment was interrupted because she had already lodged an asylum application in France. Her case pointed out the consequences of conflicts between legal status and medical needs.

The second core barrier identified was the financial issue, often a subordinate function to the legal issues and lack of cross-country agreements, the main obstacle being to clarify who is responsible for covering the cost of lengthy and expensive TB treatment. Both the legal and the financial aspects are highly relevant in developing policies on whether or not to take care of all incoming patients for the entire treatment period.

Other barriers concern health care management, such as lack of guidance on where to report patient data after starting treatment of migrants, the lack of coordination within and between countries in managing cross-border patients and sometimes lack of knowledge about these population groups and how to reach them. All these factors influence the chance of detection of TB cases, the quality of the treatment provided and the follow-up of patients belonging to this diverse population.

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\(^1\) The Council of the European Union regulation (EC) No. 343/2003, establishing the criteria and mechanisms for determining the Member State responsible for examining an asylum application lodged in one of the Member States by a third-country national.
Interventions

The discussion on possible interventions to overcome the identified barriers focused on cross-country agreements and on creating a comprehensive information infrastructure that should promote international cooperation and coordination, while taking into account individual patient rights and confidentiality.

Towards cross-country agreements it was suggested to investigate the feasibility of amendments to the Dublin Regulation to resolve issues on infectious disease treatment arising from its implementation. In addressing the financial issues, it was suggested to develop an international/supranational insurance mechanism to cover all health care costs related to cross-border TB treatment.

The information infrastructure would be organized around different components. Some of the suggestions brought forward were the creation of information hubs or national focal points where information on patients can be retrieved. Implementation of individual TB patient cards that the countries have agreed on, or even complete packages of patient documents with patient information and treatment history for sharing between countries were also proposed.

In terms of health care management, ideas were put forward on how to strengthen knowledge among health professionals on TB risks in source-countries. All behavioral and psychological aspects must be considered when informing TB cases among vulnerable populations, in particular asylum seekers.

Next steps/recommendations

The workshop was successful in terms of gathering a group of highly motivated people to define the minimum standards of TB care and management across the borders for migrants. This group will be undertaking a systematic literature review of migration and TB care. Together with the insights provided through this Wolfheze Workshop, it will serve as a basis for the formulation of a concept paper on the cross-border TB issue. The paper will further push for the development of a package for best practices and minimum standards for care and management of these vulnerable TB cases.
Tuberculosis, ethics and human rights (session 7)

**Coordinators:** Andreas Reis, Diana Weil
**Chairpersons:** Pierpaolo de Colombani, Masoud Dara
**Reporter:** Connie Erkens

**Background**
MDR and XDR-TB accentuate the ethical dilemmas and human rights concerns in TB control, TB treatment and prevention. The WHO established a task force on ethical issues in TB care and control and is finalizing guidance documents in this area, covering important issues such as equal access to diagnosis and treatment, involuntary isolation, screening and other public health measures, like cross-border issues, obligations and rights of TB patients, health care workers and communities and epidemiological and clinical research for poor and marginalized populations. Also, the WHO, UNAIDS and the Stop TB Partnership are establishing a task force on TB and human rights to develop a policy framework and strategic agenda for action in related areas. Means to use the global WHO guidance document will be discussed and participants will discuss and propose next steps for collaborative action on ethics and human rights concerns in the European context.

**Content**
1. WHO guidance document on ethics and planned partnership work on human rights
2. Specific issues in the European context including treatment adherence, involuntary detention regulations, infection control and MDR/XDR-TB surveillance

**Methodology**
1. Introductory presentation
2. Discussion of key issues in working groups

**Objectives**
1. To review ethical and human rights issues in TB control in the European region
2. To discuss use of new guidance in the European context and priorities for action

**Expected outputs**
- Participants are aware of ethical and human rights issues
- Problems and their solutions are identified and discussed
- Discussion note and suggested next steps

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<th>Title of talk</th>
<th>Speaker/Moderators</th>
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<tr>
<td>14:30-14:45</td>
<td><strong>WHO guidance documents on ethics</strong> Discussion</td>
<td>Andreas Reis</td>
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<tr>
<td>14:45-15:00</td>
<td><strong>Planned work of Stop TB Task Force on human rights, including policy and action framework</strong></td>
<td>Diana Weil</td>
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<td>15:00-15:15</td>
<td><strong>Feedback from the meeting on ethics and social determinants in Athens</strong></td>
<td>Victor Botnaru</td>
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<td>15:15-15:45</td>
<td><strong>Structured discussion in 3 groups</strong> Next steps on selected challenges: 1) Access to care for specific vulnerable populations 2) Promoting patient support and issues of involuntary detention 3) Ethical issues related to TB Surveillance</td>
<td>Diana Weil, Malgosia Grzemska, Andreas Reis</td>
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<tr>
<td>15:45-16:00</td>
<td><strong>Coffee break</strong></td>
<td>Rapporteurs of the working groups</td>
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<td>16:15-17:00</td>
<td><strong>Reporting back to plenary and discussion</strong></td>
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Narrative

Summary of presentations

As an introduction to the topic of ethics and human rights in TB control, two presentations were held on the work that is being done by the WHO Department of Ethics, Equity, Trade and Human Rights and the Stop TB Task Force on ethics to develop and implement a policy framework for a rights-based approach to TB prevention, care and control. The first presentation by Dr Andreas Reis of the WHO Department of Ethics, Equity, Trade and Human Rights, explained the need for ethical guidance to help countries solve problems related to poverty and issues of social and global justice and social determinants, conflicts of interest between public health measures aimed at TB control and rights and liberties of the individual and issues of stigmatization and discrimination. TB has so far received comparatively little attention by bioethics and human rights, but ethical issues have been highlighted by the emergence and spread of MDR/XDR-TB. In 2008, the WHO established a Task Force on Ethical Issues in TB Care and Control to identify key ethical questions that arise in TB programmes and potential solutions and to advise the WHO on the broad range of ethical issues related to TB care and control, with the ultimate goal of developing guidance for national TB programmes. Four discussion papers were developed by the Task Force covering the main areas where ethical issues need to be addressed:

- Diagnosis and treatment
- Obligations and rights of health care workers
- Patients and communities
- Public health measures (e.g. isolation, surveillance) and TB research

Key points in the WHO Guidance document on Ethics of TB Care and Control are:

- Overarching goals and ethical values (i.e. social justice/equity, solidarity, reciprocity, subsidiarity);
- The obligation to provide universal access to TB services;
- Information, counseling and the role of consent;
- Supporting adherence to TB treatment;
- The gap between the availability of drug susceptibility testing and access to MDR/XDR-TB treatment;
- Health care workers’ rights and obligations, including training, protection and duty to provide care;
- Involuntary isolation and detention as last-resort measures only after other all other means have failed;
- Research on TB care and control governed by internationally recognized guidelines.

The guidance document is now being discussed in different fora and will soon be circulated through the Wolfheze Workshops network.

Dr Diana Weil from the WHO Stop TB department presented the objectives and next steps for a new Stop TB Task Force on TB and Human Rights. One of the objectives of the Stop TB strategy is to protect and promote human rights in TB prevention, care and control. Vulnerable groups face inter-related risk factors for TB and poor access to services. Ethics are norms of conduct for individuals and for societies, deriving from diverse sources. Human rights refer to a set of principles and norms which have been internationally agreed upon and are embodied in international legal instruments. Ethics and human rights are complementary approaches for the WHO.

The objectives of the Task Force for 2010-2011 are:

1. Develop a policy framework for a rights-based approach to TB prevention, care and control;
2. Develop and implement a strategic agenda to pursue a rights-based approach through a wide range of stakeholders;
3. Mainstream human rights approach in Stop TB Strategy, Global Plan and Stop TB efforts;
4. Advocate for adoption by other constituencies beyond TB;
5. Mobilize resources;
6. Monitor and evaluate first actions.

The Task Force will comprise of representatives of major stakeholder constituencies: from affected communities and risk groups to UN agencies, human rights organizations, civil society organizations, health and human rights experts and development partners.

Professor Victor Botnaru (new NTP manager of Moldova) provided feedback on the main outcomes of the meeting on ethics and social determinants of Health (SDH) held in Athens, Greece 10-12 May 2010. This was the first meeting in its kind. Main conclusions of workshops were:

- There is a need for the WHO to provide countries in issued related to ethics and SDH;
- WHO assistance is needed in developing laws and regulations related to infectious diseases;
- It is important that countries work with vulnerable groups, in particular migrants, to improve TB control;
- There is a potential need to integrate programmes, such as TB control and alcohol abuse.
Summary of the discussion

Three working groups discussed the following issues:
(1) Access to care for specific vulnerable populations
(2) Promoting patient support and issues of involuntary detention and
(3) Ethical issues related to TB surveillance.

(1) Access to care for specific vulnerable populations

The working group discussed the following action points to address limited access to care for specific vulnerable populations such as elderly persons, illegal migrants, Roma and sex-workers, keeping in mind the role of underlying social determinants:

Where can WE act?
• Reducing default rate through adjusted working hours, provision of free diagnosis and treatment, free transport, health education among others;
• Address hard-to-reach services rather than hard-to-reach patients (adapting services to patients’ needs);
• Promote success stories!

Where can WE not act directly?
• Economic issues
• Legal issues

Where WE can collaborate to address other concerns
• NGOs reaching special groups (e.g. Red Cross and other civil society organizations)
• Other government entities, e.g. insurance schemes, legal schemes
• Providing access to incentives, enablers, legal documentation for vulnerable populations
• Advocacy for involvement of further partners
• Promote success stories!

(2) Promoting patient support and issues of involuntary detention

This group discussed the duties of the state and the definition of preconditions to isolation.

The duties of the state are to:
• Provide comprehensive diagnosis and treatment to all residents;
• Ensure that patients are well informed on their rights and responsibilities (patients’ charter) (diagnosis, treatment and protection of others);
• Provide care based on a patient-centered approach and seek agreement between the patient and the care provider (e.g. possibility of hospital, ambulatory or home treatment among others);
• Ensure appropriate living conditions and adequate nutrition in the isolation facility with infection control in place;
• Consider involuntary isolation as the last resort;
• Ensure confidentiality;
• Find a balance between patients’ rights and public health rights

What conditions are needed before a patient is put in isolation?
• Ensure quality diagnosis (DSM, culture, DST, LPA)
• Provide sound (adherence) counseling and health education to the patient and the family
• Provide a choice of feasible care models
• Screening of family and close ones for LTBI or active disease and appropriate treatment of both
• Consider social support
• Consider home isolation
• Respect the human dignity of the patient
• Ensure treatment is available (at least palliative)

Key messages
• Work with the patients (improve communication and support)
• Improve models of care (health system)
• Resort to involuntary detention only in last instance

(3) Ethical issues related to TB Surveillance

The discussion in this group started with a case study concerning a prevalence survey of TB drug resistance. Survey is generally regarded as the first step: to collect information on how big the problem of
drug resistance is, before appropriate measures can be taken. Ethical approval should be sought for such a surveillance system/survey (as for research); however this may be done on an aggregated level, and does not necessarily require informed consent of the patients. Generally, it can be stated that the need to seek ethical approval for surveillance depends on whether data are:

- Routine-generated or specifically collected
- Anonymous or nominal
- Intended for public health purpose or for operational research
- Collected through information only or via invasive specimen collection methods
- Non-sensitive or sensitive (HIV)

Whether surveillance data are collected nominally or not, the main point agreed upon is that the confidentiality of surveillance data needs to be maintained and safeguarded. It was stated that the programmes shall identify treatment for patients as early as possible.

**Next steps/recommendations**

A new Stop TB Task Force on TB and Human Rights will be established and the WHO Guidance Document on Ethics and TB control will be circulated through the Wolfheze workshop network. Countries should take the lead in advocating human rights and ethics and should use the WHO guidance document to critically appraise TB programmes. Countries may need to involve the patient community more in their policy making. They should strive for humane conditions and look for possibilities of continuing treatment beyond hospital care, taking into account appropriate infection control measures (such as treatment hotels/clinics/home isolation). TB control efforts should always consider the patient perspective as well as the public health perspective.

**Social event**

On Wednesday, 2 June 2010, a social event for participants was organized from 18:30-22:00 with a visit to Madurodam [http://www.madurodam.nl/?lang=1](http://www.madurodam.nl/?lang=1).
Thursday, 3 June 2010
9:00–12:30

Intensified TB case-finding and TB control in big cities (session8)

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<th>Ibrahim Abubakar, Gerard de Vries</th>
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<td>Ibrahim Abubakar</td>
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<td>Reporters:</td>
<td>Delphine Antoine, Rob van Hest, Barbara Hauer</td>
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Background

The changing epidemiology of tuberculosis (TB) across Europe is characterized by a concentration of disease in certain sub-groups of the metropolitan population, resulting in an urban TB incidence 3–5 times higher than in rural areas. Large cities harbour a disproportionate number of inhabitants belonging to risk groups for TB, specifically legal and undocumented migrants from countries with a high incidence of TB, homeless persons, illicit drug users, alcoholics, street dwellers with psychiatric co-morbidities and persons with a history of imprisonment. Some of these risk factors commonly overlap. The prevention and control of TB among these risk groups is complicated by delayed diagnosis, onward transmission and poor treatment adherence. TB services that are not geared towards the needs of urban risk groups carry a continuing risk of higher rates of TB and drug-resistant strains. The past ten years have seen various, often local, activities in European big cities such as application of molecular epidemiology, mobile X-ray screening, employment of peer educators or laptop webcam-assisted DOT. There is an urgent need for the implementation of innovative approaches and tools for improved case-finding and more accessible and flexible TB services with the capacity to proactively engage those most at risk for better case-holding. Exchange of experiences of different urban TB control programmes should be encouraged and facilitated.

Content

1. Epidemiology of tuberculosis in big cities
2. Specific TB control efforts in big cities
3. Innovative approaches such as molecular epidemiology

Methodology

1. Presentation
2. Group discussion in three groups
3. Reporting back

Objectives

1. To review the latest updates on urban TB epidemiology and control: what has been done, what has been achieved, why are achievements not implemented elsewhere and which tools and interventions can been added;
2. To elaborate on innovative approaches (tools and interventions for enhanced TB control efforts in big cities), resulting in a list of ideas of recommendations;
3. To elaborate on establishment of an urban TB expert working group with representatives of big cities of the Member States;
4. To elaborate on future urban TB research priorities;
5. To elaborate on sources of funding for a European urban TB working group and research activities; European or from Member States/national programmes.
Expected outputs

- Participants are aware of urban TB epidemiology and innovative tools and interventions for enhanced TB control efforts in big cities in Europe;
- Formulating draft recommendations for tools and interventions for enhanced TB control in big cities.
- Formulating draft recommendations for TB research in big cities;
- Establishment of a working group of experts in urban TB control from big cities in the Member States, through their national TB programme managers, and appointment of a (provisional) secretariat;
- Formulating suggestions for sources of funding for a European urban TB working group and research activities.

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<td>TB Control in Tashkent</td>
<td>Dilrabo Ulmasova</td>
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<td>09:15–09:30</td>
<td>Factors contributing to the high TB case rate in an urban area</td>
<td>Gerard de Vries</td>
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<td>09:30–10:30</td>
<td>Parallel sessions in working groups:</td>
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<td>1: Epidemiology of TB in big cities</td>
<td>Delphine Antoine</td>
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<td>2: Specific TB control efforts in big cities</td>
<td>Rob van Hest</td>
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<td>3: Innovative approaches</td>
<td>Barbara Hauer</td>
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<td>10:30–11:00</td>
<td>Coffee break</td>
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<td>11:00–12:30</td>
<td>Reporting back to plenary and discussion</td>
<td>Rapporteurs of the working groups/ Ibrahim Abubakar</td>
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Narrative

Following two presentations, one on illustrating the control of tuberculosis in a Western European city (Dr de Vries, Rotterdam, the Netherlands) and another on tuberculosis control in an Eastern European capital (Dr Ulmasova, Tashkent, Uzbekistan), participants were asked to work in three groups:

1. **Epidemiology (Chair: Delphine Antoine; rapporteur: Michelle Kruijshaar)**

   In Western Europe, information is widely available on the epidemiology of tuberculosis in urban areas showing higher incidence rates compared to rural areas, and documenting risk groups. In contrast, data from Eastern Europe is more limited. Evidence available suggests that the observed pattern in the West is not necessarily replicated in the East, with some large cities, for example Belgrade in Serbia, having lower rates of TB than rural areas. Furthermore in some countries, no differences may be found due to underreporting, e.g. of undocumented migrants and internal migrants.

   It was largely agreed that, in Western European cities, a key factor explaining higher incidence is immigration. In addition, in some cities higher rates may be explained by the presence of particular risk groups such as homeless and drug users. It is important, however, to note that the risk factors may differ per city. In Tokyo for example, urban poverty is found to be a risk factor, whereas in Hanoi, internal migrants form the risk.

   A number of outstanding epidemiological questions for urban TB epidemiology were identified, including importantly the need to agree on what constitutes a city (i.e. should this be defined in terms of population numbers or population density). The working group felt that national surveillance systems or ad hoc surveys should collect and analyse data on the geographical distribution of TB cases and particular characteristics that will allow an understanding of the epidemiology. These include: place of birth, time since entry, socioeconomic status, homelessness, injecting drug use and other risk factors.

2. **Specific control efforts in big cities (Chair: Rob van Hest; rapporteur: Wouter Arrazola de Onate)**
There was a clear recognition that the experiences and problems of many cities, especially in Western Europe were the same. In new EU countries and in Eastern Europe, the problems were of a different scale and TB is not always concentrated in big cities. Rural areas still have a high incidence of TB. Important issues around infrastructure, accessibility to health care and poverty remain. There was, however, recognition of the need for all parts of Europe to learn from each other.

A number of important interventions, which have been shown to be effective and are widely used in some cities, were discussed. These include active approach towards risk groups or hard-to-reach populations, use of legislation and the application of TB dispensary care models. It was recognized however, that finances and funding differ from country to country and that laws and by-laws on screening risk groups also differ.

There was general consensus on the need to make the problem visible. Suggested approaches included the use of DNA fingerprinting to highlight local transmission, the documentation of trends, actively publishing TB epidemiological information and control activity, advocacy and seeking funding.

In general, it was agreed that the way forward must include recognition of the fact that risk groups are not a national problem but an international, pan-European problem. A key example cited to illustrate this includes the Dublin claim asylum seekers and healthcare-driven migration.

3. **Innovative approaches (Chair: Barbara Hauer; rapporteur: Tefanie Castell)**

The approaches were grouped into information/educational interventions, screening, access to health care and monitoring, case-holding and treatment adherence.

Information/education: this was felt to be particularly relevant to special groups. An example cited was addressing the need of the Somali community in Stockholm, where different and innovative measures are being applied. Other specific measures discussed include the distribution of information among professionals/health services involved in care of risk groups (Sweden) and the use of new media (e-learning).

Screening: an example was reported from Switzerland where a simple computer questionnaire has been used successfully to assess asylum seekers. This tool has been translated into more than 30 languages. Screening for latent TB was felt to be another area where there are opportunities for innovative work including how IGRAs should be implemented in practice, the risk of re-infection which possibly varies among cities (home travel, infection after immigration), the identification of optimal preventive treatment regimen and acceptance and adherence to latent TB treatment.

Access to health care and monitoring: this was identified as a key issue. In particular, flexibility in office hours is required in order to cater for the needs of clientele who are only able to access care outside working hours. Other innovative approaches that have been tried include the use of webcam or mobile phone contact to implement DOT. These were perceived to be cost-effective given the consequences of treatment failure. The use of a service package, e.g. for those co-infected with HIV, which includes the provision of social, medical and legal support in a joint and coordinated manner, was felt to be important.

Case-holding and treatment adherence: innovative approaches here include the involvement of the community: e.g. family members (controversial), health care workers pharmacists, the effective use of translators to explain everything to the patient (Malta), the use of a variety of incentives: e.g. minutes on mobile phone, the provision of "treatment hotels" for the homeless after discharge from hospital and the importance of individualized approaches. A number of research priorities were identified including:

- The public health application of molecular typing. It was felt that while this is useful, it should only be a priority depending on resources and TB burden. Its relevance should always be assessed based on the opportunity for action and specific consequent interventions.
- Further research into the demographics of TB cases in cities (including issues such as international as well as internal migration);
- The use of qualitative/participatory research methods to reach high risk subgroups of the population;
- Use of IGRAs and cost-effectiveness within the context of city TB control programmes;
- Research into the issue of treating latent TB in people from countries with high proportion of drug resistant TB and how that affects TB control effort in countries where the burden of TB in cities is among immigrants;
- An evaluation of the role of selective BCG vaccination of children at risk (second or third migrant generation) including its effectiveness and cost-effectiveness;
- New ways of drug application (e.g. ports or depot injections);
• Operational/public health research should take into account the way the health system is organized and how this may enhance interventions.

**Next steps/recommendations**

There was general consensus that it is important to set up a working group, while recognizing existing initiatives and collaborations such as those through the IUATLD, ECDC, TBNET, TB PAN-NET and the Rotterdam-London exchange of mobile screening unit. The particular niche identified for this group relates to the development of policy and the use of interventions that have been evaluated in specific studies as part of a complex public health measure to improve control. So, for example, it would not be sensible to replicate the molecular epidemiology work undertaken by TB PAN-NET but rather take the next step and assess how DNA fingerprinting combined with other public health measures can contribute to the control of TB in cities.

There was consensus for the need to create a “recipient” group for funding which brings experts together covering all relevant fields (ECDC, WHO Europe). This group will be key to any attempt to leverage funding. Possible mechanisms were discussed including the use of "umbrella" organizations such as IUATLD and ERS. It was felt that a statement of support from ECDC/WHO Europe will go a long way in furthering this agenda and that bi- or trilateral cooperation between cities should be encouraged. It was recognized that some informal networking has started prior to and within this meeting. Any working group constituted should include colleagues with affinity for TB in big cities / risk groups. This will be enhanced by the production of a contact list (possibly not just the NTP manager), perhaps starting with the list of attendees at this meeting. Such a network with an informal secretariat will enhance the exchange of best practices, serve as a source of advice and support cross-border individual case management.

A programme of work has been agreed which will include:

- The need to improve knowledge on urban TB epidemiology and innovative tools and interventions for enhanced TB control efforts in big cities in Europe;
- The development of recommendations for tools and interventions for enhanced TB control in big cities to be published in a peer reviewed policy paper based on the findings of this workshop;
- The promotion of the research priorities identified in the session and the development of a research proposal for external funding;
- The establishment of a working group of experts in urban TB control and appointment of a (provisional) secretariat.

As a result of this session, an expert group meeting with participants from big cities in a number of low- incidence EU countries has already been agreed to take place in Stockholm, Sweden in December 2010.

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**Thursday, 3 June 2010**

**12:30–13:00**

**Closing session (session 9)**

During the closing ceremony, Dr Davide Manissero on behalf of ECDC, Dr Richard Zaleskis (on behalf of WHO), Dr Masoud Dara and Dr Connie Erkens (on behalf of KNCV) thanked participants and speakers. On behalf of the organizing committee, Dr Masoud Dara expressed gratitude to interpreters, logisticians and the WHO and KNCV assistants for their excellent support.
### Annex: list of participants and speakers

This list has been updated after participants checked the spelling of their names and email addresses submitted for registration.

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