Report of the WHO programme review of the national TB control programme in Slovakia

11–14 March 2013
ABSTRACT

At the request of the government of Slovakia, the WHO Regional Office for Europe has recently conducted a review of the Slovakian national TB prevention and control strategies and activities. The particular focus was on moving towards the elimination of TB, improving childhood TB measures, improving TB prevention and control in other vulnerable groups and reviewing national policies and guidelines for TB prevention and control. The review has produced specific recommendations which will enable relevant country stakeholders to improve current TB prevention and control strategies and interventions.

Keywords

DELIVERY OF HEALTH CARE – organization and administration
GUIDELINES
HEALTH MANAGEMENT AND PLANNING
PROGRAM EVALUATION
TUBERCULOSIS, MULTIDRUG-RESISTANT – diagnosis – prevention and control
TUBERCULOSIS, PULMONARY – prevention and control

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# Abbreviations

<table>
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<th>Description</th>
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<tr>
<td>BCG</td>
<td>Bacille Calmette Guerin</td>
</tr>
<tr>
<td>ECDC</td>
<td>European Center for Disease Prevention and Control</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>LTBI</td>
<td>latent TB infection</td>
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<tr>
<td>MDR</td>
<td>multidrug-resistant</td>
</tr>
<tr>
<td>SMART</td>
<td>specific, measurable, attainable, relevant and time-bound</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
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Introduction

In January 2012, the government of Slovakia decided to stop obligatory Bacille Calmette Guerin (BCG) vaccinations in view of the low incidence and notification of TB in the country. Since then, there has been a major debate for and against this decision. This is of greater relevance in view of the increase in TB among children in specific subpopulations (particularly the Roma people), which is giving particular concern.

At the request of the Minister of Health of Slovakia and the WHO Regional Director for Europe, the Tuberculosis and Multidrug-Resistant programme of the WHO Regional Office for Europe has conducted an external review of the national TB control programme in Slovakia, paying specific attention to childhood TB and interventions aimed at the elimination of TB. At the request of the Regional Office, the European Center for Disease Prevention and Control (ECDC) participated in the review to bring the ECDC perspective. This was the first TB programme review in Slovakia.

Terms of reference

The terms of reference of the mission were to:

1. review existing policies, guidelines and plans for TB prevention, control and care at national level and interventions aimed at the elimination of TB, with an emphasis on vulnerable populations;
2. assess the attributed impact of BCG vaccination on TB epidemiology;
3. propose the risk groups and selection criteria for identifying the subpopulations of children benefiting from pro-active interventions for diagnosis and treatment of TB and latent TB infection (LTBI);
4. propose interventions and approaches for TB prevention and control among vulnerable groups, including children, and define the vaccination approach for selected subgroups of children;
5. recommend interventions and a regimen for prophylactic treatment of paediatric contacts of patients with pulmonary TB.

Process

With the assistance and coordination of the WHO country office, the mission was conducted from 11 to 14 March 2013. The members were:

- Dr Masoud Dara, Programme Manager, Tuberculosis and Multidrug-Resistant Tuberculosis, WHO Regional Office for Europe (team leader);
- Dr Marieke van der Werf, Head of TB Programme, ECDC;
- Dr Martin van den Boom, Technical Officer, Tuberculosis and Multidrug-Resistant Tuberculosis, WHO Regional Office for Europe;
- Dr Iveta Ozere, clinician and expert in childhood TB from Latvia and WHO temporary adviser.
The mission reviewed technical reports, surveillance data, national reports and epidemiological data, assessed the various aspects of the TB programme, interviewed health care staff in hospitals, ambulatory care units and TB laboratory services in the public and private sectors and participated in a round-table meeting with national experts.

In preparation for the visit, the mission received the following documents and information.

- Parallel report by the European Roma Rights Centre, Milana Šimečka Foundation and the Centre for the Research of Ethnicity and Culture (CVEK) concerning Slovakia to the Committee on the Elimination of Racial Discrimination, for consideration at the 82nd Session (11 February to 1 March 2013) (1).
- Solovič I, Švecová J. Epidemiological situation in TB in Slovakia (powerpoint presentation) (2).
- Metodické usmernenie hlavného odborníka Mz Sr pre odbor pneumológia a fitizeológia [Methodological guidance, main expert for the Ministry of Health, Department of Pneumology and Phthisiology] (in Slovakian) (3).
- Rimárová K. The health of the Roma people in central and eastern Europe (4).

These were assessed by the team members and the information provided in them was used in the development of the key findings, key challenges and recommendations set out below.

**Brief background**

**Epidemiology of TB in Slovakia**

In the last decade, the TB notification rate has decreased significantly from 23/100 000 population in 2000 to 6.4/100 000 population in 2012, with bacteriological verification (culture positivity) of 55.4% of all TB cases in 2012. During the same period, case detection improved from 83% to 89%. Similarly, between 1995 and 2010 the TB cure rate rose from 64% to 84%.

The geographical burden of TB appears to be spread fairly evenly across the country, although the TB notification rate was almost three times higher in the Presov region in the north-east (11.6/100 000) than in the Nitra region in the west (3.8/100 000) (2012 data).

Since 2010, there have been no known cases of TB/HIV co-infection. In 2012, a total of four multidrug-resistant (MDR)-TB cases were reported.
Of the 345 cases of TB notified in 2012, 76 (21.5%) were among the Roma population. This percentage has been steadily rising from less than 10% in 2000. The Roma people make up approximately 10% of the population.

**TB in children**

In 2012, the notification rate of TB in children and young people aged under 19 years was 2.3/100 000. In that year, 19 children were diagnosed with TB (6 of them aged under 5 years), all belonging to the Roma people. The proportion of children diagnosed with TB among the Roma increased from 46.7% in 2000 to 100% in 2012 and remains high. Despite the low overall notification rate of TB in children and young people aged under 19 years, 25% of all Roma TB patients in 2012 were in this age group. Since 2010, the total number of TB cases in children has been gradually increasing, with a predominance among Roma children of 82% in 2010 and 100% in 2012. There were seven culture-positive TB cases in 2012, including two sputum smear-positive pulmonary TB cases in children (two of them with mono-resistance to isoniazid). Of 19 children diagnosed with TB, 18 had received BCG vaccinations. No cases of TB meningitis were diagnosed during the last five years.

**Key findings, challenges and recommendations**

**Policies, guidelines and plans for TB prevention, control and care**

**Key findings and challenges**

TB is embedded as a chapter in the national Act on Protection, Support and Development of Public Health. There are sound and up-to-date national textbooks, guidelines on TB treatment, care and management (different for nurses and pulmonologists) and orientation material regarding TB treatment and care which are generally accessible to different audiences (for example, in the waiting rooms of general practitioners (GPs) and pulmonologists for patients and their family members). Material for patients is also translated into Roma.

Collaboration is excellent between the different stakeholders involved in TB control, whether public-private or public-public and at different levels of the health system. Patient referral and counter-referral practices between GPs, TB specialists and in- and outpatient facilities are comprehensively and systematically organized. Patient transfers are notified by telephone or standard mail and are often complemented by fax (using a semi-standardized referral form for mail and fax).

Medical education relating to TB is continuing and up to date. Conferences, meetings, workshops and case studies are jointly organized on an almost monthly basis by the TB centre, the Slovak Society of Respiratory Diseases and other academic institutions. These courses target GPs and nurses as well as specialized pulmonologists.

There are some good models of patient-centred TB care, particularly those with the goal of outreach to hard-to-reach subpopulations. This is reflected by the teaming of GPs with assistants from the Roma communities: the GPs ensure early referral and treatment follow-up, helped by the Roma assistants through their community links with hard-to-reach populations. This facilitates not only adherence to and follow-up after treatment, but also education about the
prevention of TB and investigation of contacts of people with TB. Unfortunately, limited funding means that this only happens in a few communities.

There is a lack of a specific diagnostic algorithm. At the national reference laboratory, several different solid and liquid culture methods (Löwenstein Jensen, Bactec, Ogawa, Middlebrook) are used simultaneously. At the time of the visit, no rapid diagnostic tests were available for initial diagnosis. A line probe assay was available for identification of second-line drug resistance.

Of the 266 new pulmonary TB cases reported in 2011, only 149 (56.0%) were laboratory-confirmed. A considerable number of TB cases have an A16 coded diagnosis. Since their diagnosis has not been bacteriologically confirmed there may be a certain risk of over-diagnosis. There is some deviation from the recommended standard TB treatment regimen and duration: cases have been assessed where it was found that the treatment duration was unnecessarily extended to nine months. Similarly, the mission found cases of ciprofloxacin being used for TB treatment and fluoroquinolones for drug-susceptible TB when resorting to a first-line drug alternative would have been possible.

There are no fixed-dose TB drug combinations or paediatric drug formulations.

In some cases, GPs and pulmonologists have been over-prescribing fluoroquinolones for infectious respiratory diseases other than TB, where resort to penicillin or early generation cephalosporine would have been better so as to keep a drug in reserve for treating MDR-TB and avoiding resistance to fluoroquinolones.

It was found that in many cases TB patients remained hospitalized for at least two months of the initial phase of their treatment, and in some cases beyond sputum smear conversion.

Following discharge from hospital, TB patients normally receive their TB drugs once a month from the pulmonologist. Between visits to the pulmonologist they receive no specific support. Hospitalization is used to ensure adherence to treatment. Once they are cured, patients are seen every three months for one year and then every six months for an additional two-year period, in line with national guidelines on long-term follow-up of patients with TB.

Funding for TB control is provided through the insurance companies and is mainly patient-based. The Ministry of Health provides limited funding for TB surveillance. No specific funding is available for the national reference laboratory.

There is no national plan for TB prevention and control, which could provide clearly defined guidance and orientation towards specific, measurable, attainable, relevant and time-bound (SMART) goals and objectives, particularly taking into account the limited resources and the overall goal of TB elimination. The Ministry of Health has, however, produced the above-mentioned Methodological guidance (3).

TB care is fully reimbursed from public funds. There are, however, technology- and inflation-related increases in TB-related costs for the health care system. Such increased financial demands need to be fully matched and covered by increased contributions from the national health insurance companies in future, in order to keep up the achievements made in TB control so far.
Outreach models of care are limited in quantity and quality and do not yet sufficiently cover hard-to-reach subpopulations. The chain of TB transmission must be interrupted even earlier to reduce the burden of TB. A majority of such models (such as that of Roma assistants affiliated to GP practices) are funded by the European Union.

It is difficult to counteract the over-prescription of fluoroquinolones in general practice for non-TB respiratory infections, both from the point of view of legislation and of changing the mentality of health care providers.

Physicians in some western parts of the country and in the capital, where the burden of TB is lower, are less aware of TB as public health threat. Overall, the general population is insufficiently aware of TB.

A particular challenge is the stigmatization of TB and its association with other stigmas, such as those attached to socially disadvantaged groups.

**Recommendations**

National policies and guidelines for TB control should be regularly reviewed and updated to take account of scientifically-based international recommendations and to ensure the cost-effective use of resources.

A SMART national TB elimination plan should be developed to help guide, orient, plan for, consolidate and further improve TB prevention and control efforts with the ultimate aim of eliminating TB.

Outreach models of care (such as those using community nurses) should be refined and expanded so as to improve the detection of cases of TB, provide home-based treatment and care, prevent transmission and improve follow-up treatment so as to increase the chances of its success.

The option for outpatient treatment of TB during the intensive phase after sputum smear conversion should be ensured.

Feasible strategies should be developed to reduce the stigma of TB using, for example, targeted public health education and campaigns with celebrities affected by TB and scaling up the involvement of community representatives.

**Attributed impact of BCG vaccination on TB epidemiology**

**Key findings and challenges**

In line with the low incidence/notification rate of TB, mandatory and universal BCG vaccination (coverage of an estimated 98%) was stopped on 1 January 2012. That year, 19 cases of childhood TB were notified, of whom 18 had been BCG-vaccinated. None had developed disseminated TB or TB meningitis. All were found in the Roma population. Currently, children who are contacts of sputum smear pulmonary TB patients are the only group selected for BCG vaccination. Epidemiologically, it is thus too soon to assess any potential impact from the discontinuation of mandatory BCG vaccination.
Recommendation

In order to assess the epidemiological impact of discontinued mandatory and universal BCG vaccination, monitoring and documentation should be carried out of notified cases of TB (including severe forms of TB) among BCG-vaccinated and non-vaccinated children aged up to 14 years, as well as in paediatric subpopulations living in settings with an incidence higher than the national average.

Children benefiting from pro-active interventions

Key findings and challenges

There appears to be no specific algorithm in place for the prophylactic treatment of LTBI. Treatment of LTBI as recommended by WHO through six months of isoniazid is sometimes prolonged to nine months or conducted through double therapy of three months of isoniazid complemented by rifampicin, or four months of rifampicin.

Approximately 120 immigrants arrive in Slovakia each quarter. They are screened for TB using chest X-ray and tuberculin skin test and are prescribed prophylactic treatment if they are diagnosed with LTBI.

All kinds of prophylactic treatment are self-administered. The dose of isoniazid for treatment of LTBI in children is lower than that recommended by WHO (5–8 mg/kg/day as against 10–15 mg/kg/day). WHO’s Rapid advice. Treatment of tuberculosis in children (6) is frequently used as reference material on this issue.

Of the 25 children currently being treated in the Scrobars Institute for Paediatric TB and Lung Diseases, 9 have received prophylactic treatment with isoniazid. The hospitalization of children for prophylactic treatment has been justified by social conditions and the need for supervision of the treatment available in the hospital.

Children who are contacts of TB patients are currently the only group of children targeted for diagnosis and treatment of active TB and LTBI.

Children are sometimes hospitalized for prophylactic treatment for LTBI.

Recommendations

The more efficient use of resources in the treatment, prevention and care of TB (including the choice of drugs, duration of treatment, inpatient versus ambulatory treatment, contact-screening, BCG vaccination and treatment of LTBI) will be enhanced through standardization and rationalization. There needs to be a careful and consensual discussion of this issue and decisions taken among all national stakeholders to ensure the best possible “buy-in” and adherence by the highest number of stakeholders and health care providers involved.

Taking into consideration country-specific conditions, selection criteria should be defined to identify the subpopulations benefiting from pro-active interventions for diagnosis and treatment of active TB and LTBI, including risk groups for TB and individuals with internationally recognized risk factors associated with an increased risk for progression to TB (6–12).
When individuals are diagnosed with LTBI, active TB should be ruled out and chemoprophylaxis started according to the latest WHO recommendations (six months of isoniazid).

WHO’s recommended dosages of isoniazid should be used for prophylactic treatment in children (10–15 mg/kg/day) (6,13).

**Interventions and approaches for TB prevention and control among vulnerable groups**

**Key findings and challenges**
Contacts of people with TB, immigrants, military recruits and medical staff are considered vulnerable groups for the purposes of TB prevention and control. Medical staff are screened by chest X-ray every two years. Contacts of people with TB, immigrants and recruits are screened by tuberculin skin test, chest X-ray and sputum examination (if indicated).

**Recommendations**
Vulnerable groups of children and adults should be identified for TB disease and LTBI (6–12). WHO is available to support the development and/or adoption of national guidelines, if required.

Targeted identification, diagnosis and treatment of TB disease and LTBI should be enhanced in vulnerable groups, with the best possible use made of existing mechanisms and according to the latest WHO recommendations (6,7,9,10,12–15). Provider-initiated BCG vaccination should be offered free (with the possibility of opting out) to:
- children born in settings with a TB incidence higher than the national average
- children born of parents coming from high-incidence countries
- children travelling to settings with a high incidence of TB
- children moving to an area with a high incidence of TB (11,16–18).

BCG vaccine should be made available to the target populations mentioned above. The procurement and supply mechanism needs to be worked out. One option would be to provide BGC in several provinces or districts with higher rates of TB and arrange for vaccines to be transported to other districts.

**Recommended Interventions and a regimen for prophylactic treatment of paediatric contacts of patients with pulmonary TB**

**Key findings and challenges**
Contact identification and investigation is functioning well. In the Presov region, which has the highest TB notification rate of 11.6/100 000 population, no TB cases were identified among the Roma people in 2012. Good contact-tracing practices have contributed to this. TB cases were diagnosed in the Roma subpopulation and all secondary TB cases were identified and cured, with between 10 and 1400 contacts investigated per TB patient diagnosed. In 2006, of more than 1000 contacts investigated in Spišská Nová Ves, 15 TB patients were identified. If infectious source cases cannot be identified, all inhabitants of a setting are evaluated for TB in that region. In Kežmarok, 66 adults and 18 children aged over 12 years were examined in relation to one TB patient.
Family members of TB patients are asked to identify all the patients’ contacts. Identified contacts are invited to consult the regional pulmonologist. GPs and pulmonologists routinely provide cross-checks regarding examinations of contacts. About 95% of identified contacts undergo examination for TB. If the first screening is negative, family contacts are checked again after six months. Contacts are examined using tuberculin skin test, chest X-ray and sputum sample examination. Induration of tuberculin skin test >10 mm is considered positive for infection with *M. tuberculosis*; those individuals are prescribed prophylactic treatment for LTBI. Interferon-gamma release assays are available and are used, if necessary, in addition to the tuberculin skin test.

Paediatric contact-tracing and investigation have improved significantly in the last decade: infectious source cases were identified in all 19 children diagnosed with TB in 2012.

**Comparison of TB identification in children 1986—2001 and 2012**

Table 1 gives a comparison of the identification of TB in children between 1986–2001 and 2012.

<table>
<thead>
<tr>
<th>Identification of TB</th>
<th>1986–2001 (%)</th>
<th>2012 (%)</th>
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<tbody>
<tr>
<td>Contact investigation</td>
<td>34.9</td>
<td>74 (N=14)</td>
</tr>
<tr>
<td>Clinical symptoms consistent with TB</td>
<td>43.4</td>
<td>26 (N=5)</td>
</tr>
<tr>
<td>Positive Mantoux test &gt;15 mm (performed at age 11 years before BCG revaccination)</td>
<td>20.7</td>
<td>NA</td>
</tr>
<tr>
<td>Infectious source case(s) identified</td>
<td>NA</td>
<td>100 (N=19)</td>
</tr>
<tr>
<td>Infectious source case not identified</td>
<td>45.8</td>
<td>0</td>
</tr>
<tr>
<td>Other (not specified)</td>
<td>1</td>
<td>0</td>
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</table>

The investigation of contacts is not always given priority in clinical practice.

**Recommendation**

Contact-tracing should be continued, rationalized and intensified, based on a national consensus and in accordance with the latest internationally recognized recommendations (9,19–22).

**Summary of recommendations**

The following is a summary of the mission’s recommendations.

1. The Ministry of Health and its appointed institute should regularly review and update (at least every two years) national policies and guidelines on TB control to take into account scientifically-founded modifications of previous international recommendations.

2. A SMART national TB elimination plan should be developed to help guide, orient, plan for, consolidate and further improve TB prevention and control efforts, with the aim of ultimately eliminating TB.

3. Monitoring should be carried out of TB notifications and severe forms of TB among BCG-vaccinated and non-vaccinated children (up to the age of 14 years) in the next few years, so
as to assess the epidemiological impact of stopping the mandatory universal BCG vaccinations.

4. Selection criteria should be defined to identify the subpopulation of children benefiting from pro-active interventions for diagnosis and treatment of TB and LTBI. These should include close contacts of TB patients, persons who have immigrated from high-incidence settings and persons working or living in multi-occupancy facilities with people who are at high risk of TB (such as prisons, refugee camps, mental institutes and homeless shelters), taking into account other internationally recognized risk factors such as the presence of diabetes and immunosuppression.

5. Children at risk for LTBI and TB disease should be identified and regularly followed up for LTBI and TB, with the best possible use made of existing mechanisms.

6. Contact-tracing should be continued, rationalized and intensified, based on a national consensus. Active TB should be ruled out and chemoprophylaxis commenced according to the latest WHO recommendations (six months of isoniazid).

7. Provider-initiated BCG vaccinations should be offered free (with the possibility of opting out) to:
   - children born in settings with a TB incidence higher than the national average
   - children born to parents coming from high-incidence countries
   - children travelling to settings with a high incidence of TB
   - children moving to an area with a high incidence of TB.

8. Outreach models of care should be refined and expanded so as to improve the detection of cases of TB, provide home-based treatment and care, prevent transmission and follow up treatment better in order to increase the chances of its success.

9. Feasible strategies should be developed to reduce the stigma of TB.

References

1. Parallel report by the European Roma Rights Centre, Milana Šimečka Foundation and the Centre for the Research of Ethnicity and Culture (CVEK) concerning Slovakia to the Committee on the Elimination of Racial Discrimination, for consideration at the 82nd Session (11 February to 1 March 2013). Budapest, European Roma Rights Centre, 2013 (http://www2.ohchr.org/English/bodies/cerd/docs/ngos/europeanromarightscentre_Slovakia_CERD82.pdf, accessed 9 July 2013).


**Bibliography**


Annex 1

PEOPLE AND ORGANIZATIONS CONTACTED

Bardejov St Jacob Regional Hospital
Dr Helena Lescisinova, Regional Pulmonologist
Dr Marian Petko, Director
Dr Martina Šuchova, Vice-Director

Spisska Nova Ves, private pneumological ambulatorium
Dr Slavomir Hrebenár, Regional Pulmonologist

Kežmarok, private pneumological ambulatorium
Dr Kristina Bartková, GP ambulatorium, Regional Pulmonologist
Dr Peter Marko, GP
Ms Martina Siskova, Roma assistant

National Institute for TB, Lung Diseases and Thoracic Surgery, Vysne Hagy
Mr Jozef Porac, General Director
Dr Alena Gallova, Vice-Director
Dr Jana Švecová, Vice-Director
Dr Ivan Solovic, Head, TB Department and head of national TB register
Dr Monika Polanová, Head, National Reference Laboratory

Srobars Institute for Children’s TB and Lung Diseases, Vysne Hagy, Kežmarok, Bardejov
Ms Miroslava Kolcunová, General Director
Dr Jaroslav Fabry, Vice-Director
Dr Martina Miskovska, Head, Children’s TB Department
Dr Jan Melter, Head, Microbiology Laboratory

Round-table meeting, Dolny Smokovec
Dr Marta Hajkova, Ministry of Health, Chief Specialist for TB and Lung Diseases
Dr Martina Brezina, Ministry of Health, Chief Specialist for Children’s TB and Lung Diseases
Dr Klara Frescerova, Consultant
Dr Henrieta Hudecková, Chief Epidemiologist, Ministry of Health

Meeting, Ministry of Health
Dr Viliam Cislak, Secretary of State
Dr Mario Miklosi, Director-General, Health Section
Dr Rastislav Gaspar, Director, Health Care Department
Mrs Sarka Kovacsova, Director, European Affairs and International Relations Department
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Dr Marta Hajkova, Chief Specialist for TB and Lung Diseases
Dr Klara Frescerová, consultant
Dr Ivan Solovic
Dr Jan Mikas, Public Health Authority
Dr Darina Sedlakova
Annex 2

PROGRAMME OF THE VISIT

Tuesday 12 March

09.00  Bardejov Hospital, TB and lung ambulatorium working with TB patients at the regional level with a high incidence of TB. Dr Lescisinova, Regional Pulmonologist, and Dr Marian Petko, Director of the regional hospital.

13.00  Dr Hrebenár, Regional Pulmonologist, Spisska Nova Ves, working with TB patients at the regional level with a high incidence of TB.

14.00  Dr Bartková, Regional Pulmonologist, Kežmarok, working with TB patients at the regional level with a high incidence of TB.

15.00  Dr Marko, GP, Kežmarok, working with TB patients at the regional level with a high incidence of TB, and with Roma assistant. Presentation of anti-TB programmes, including the integration of Roma assistants. Dr Marko, practical demonstration of cooperation.

16.00–19.00  Visit to the National Institute of Tuberculosis, Lung Diseases and Thoracic Surgery, Vysne Havy. General Director Porac, Dr Gallova, Vice-Director and Dr Švecová, Vice-Director. See the work of the national TB register, centre for the treatment of MDR-TB, with Assistant Professor Solovič, Dr Polanová, Head, National Reference Laboratory for Mycobacteria, and Dr Švecová, responsible for the national TB register.

Wednesday 13 March

09.00  Srobars Institute for Children’s TB and Lung Diseases, Dolny Smokovec. Children’s TB and lung diseases specialist Hospital. Ms Kolcunová, Director-General. Visit to children’s institute focusing on the countrywide treatment of TB.

10.00  Discussion with experts on child TB: Assistant Professor Solovic, Assistant Professor Hajkova, Assistant Professor Brezina (TB specialist at the Ministry of Health), Professor Hudečková (Chief Epidemiologist), Dr Fregerová (consultant).

14.00  Press conference in Dolny Smokovec.

Thursday 14 March

09.00  Ministry of Health, meeting with the Deputy Minister of Health, General Director of the Health Section and Director of the Public Health Institute.