Report of the WHO European Region Interagency Coordinating Committee (ICC) – 3rd Meeting Focusing on Tuberculosis

Sinaia, Romania, 29–30 September 2004
ABSTRACT

TB is out of control in many countries in the WHO European Region. The number of cases reported is increasing, and this is accompanied by a frightening rise in the incidence of MDR-TB and TB/HIV. The problem is compounded by inadequate political commitment, inadequate infrastructure, inadequate implementation of effective TB control strategies in many countries, and inadequate financial support. The Interagency Coordinating Committee met for the third time in Sinaia, Romania, 29–30 September 2004, to discuss major challenges for TB control in the Region and identify coordinated response by WHO and international partner organizations and donors involved in TB control in EUR. The report provides information on major issues discussed, presents the meeting conclusions and recommendations.

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CONTENTS

Day 1, ICC – 3rd meeting focusing on tuberculosis................................. 1
  Opening session .......................................................................................................................... 1
  Overview of the TB situation and progress in DOTS expansion in the European Region.... 2
  Advocacy and communication on TB: changing situation in Ukraine ......................... 4
  Establishment of the European Partnership to Stop TB ........................................... 5
  Feedback on conclusions and recommendations from NTP and TAG meetings (27–29 September 2004) .......................................................... 6

Day 2, ICC – 3rd meeting focusing on tuberculosis................................. 8
  HIV/AIDS: 3 by 5 Initiative .................................................................................................. 8
  Plan of work and budget for the TB programme, 2004–2005 ........................................ 10
  GDF activities ..................................................................................................................... 12
  Discussion on collaboration and resources needed for TB activities in the European Region: feedback from partners .................................................. 13

Conclusions and recommendations of the meeting................................. 15
  Conclusions ......................................................................................................................... 15
  Recommendations ............................................................................................................. 16

Annex 1
  Programme ......................................................................................................................... 18

Annex 2
  List of Participants ICC – 3rd meeting focusing on tuberculosis ................................. 20
Day 1, ICC – 3rd meeting focusing on tuberculosis

The Interagency Coordinating Committee (ICC) met in Sinaia, Romania, 29–30 September 2004. The scope and purpose of the meeting were to:

- review the current tuberculosis (TB) situation and monitor the progress made in DOTS expansion in the WHO European Region (including addressing MDR-TB and TB/HIV), together with partner organizations and donors;
- review the plan of work and budget for the 2004–2005 biennium, and analyse gaps in human, technical and financial resources for DOTS expansion;
- review collaboration with the Global Drug Facility (GDF), Global Fund to Fight AIDS, TB and Malaria (GFATM), Green Light Committee (GLC) and HIV/AIDS programmes in implementation and expansion of DOTS and DOTS-Plus;
- review the current status of collaboration with technical and financial partners, and discuss future steps in strengthening TB control partnerships in the Region.

Opening session

Dr Håkan Sandbladh was elected to serve as Chair and Dr Alan Hinman served as Vice-Chair. Dr Yelena Yurasova was the Rapporteur. The programme is attached as Annex 1 and the final list of participants is attached as Annex 2.

Opening remarks from Dr Håkan Sandbladh, Chair

In recent years DOTS expansion in the Region has accelerated and more governments have strengthened their commitment to fighting TB, so more funds have become available for TB control. Discussions are taking place on MDR-TB management within the DOTS strategy, trends in TB surveillance, and the effective use of the increasingly available funds. The role of ICC is very important, since with the scaling up of DOTS expansion, quality is a vital concern. In 2002 ICC-TB decided to be separate from ICC-HIV/AIDS, but it is now time to consider whether these two fora should be united. Further efforts should be undertaken to manage the dual TB/HIV epidemic in the Region.

Opening remarks from Dr Gudjon Magnusson, Director, Division of Technical Support, Reducing Disease Burden, WHO EURO

Dr Magnusson welcomed the participants and made some opening remarks. He greeted participants on behalf of Dr Marc Danzon, Regional Director. In the last few years the WHO Regional Office for Europe has identified its priorities with the focus on support to Member States, promoting evidence based interventions in public health and providing “silent” evidence (e.g. progress in implementation of the resolution of the fifty-second session of the Regional Committee for Europe on TB and HIV). Currently, the constraint is not lack of funds or resources, but insufficient political commitment. Political commitment is the key to addressing the HIV epidemic, especially in eastern Europe, where it is only just beginning. There are as yet relatively few AIDS cases in the Region, but we can expect an increase in TB, as the number of AIDS cases grows. To treat 100 000 patients with antiretroviral therapy (ART) by 2005 is a “3 by 5” target for the WHO European Region.
There are many partners supporting WHO’s efforts in the Region; GFATM provides support to countries, and 10 Member States received GFATM funds for TB in the Region. However, the main concern is how Member States can increase their capacity to implement the activities planned and to make an impact on TB and HIV/AIDS. WHO recognizes that in addition to political commitment, the key word for today is PARTNERSHIP, and ICC-TB is a tool for improving the situation. Some progress has been made in TB control in the Region, with the result that notification rates on TB reported by the Russian Federation have decreased slightly, but the situation there, as well as in the other countries, is still of concern. WHO cannot push Member States to revise their health policies, but together with partners it can facilitate change.

There are 11 Global Health Priorities for WHO, and apart from fighting major diseases such as TB, HIV and malaria, there is a need to strengthen health systems. If this is not done, the fight against these major diseases will fail. There is also a need to involve NGOs in TB control and efforts are required to build this cooperation effectively.

**Overview of the TB situation and progress in DOTS expansion in the European Region**

Dr R. Zaleskis, Regional Adviser, TB Control, outlined the current TB situation in the WHO European Region and made reference to some of the recommendations from the 2nd ICC-TB meeting. He demonstrated progress in DOTS expansion at the regional and country levels, described achievements in TB control since the last ICC-TB, and highlighted the challenges and constraints. He emphasized the need for joint efforts by WHO and national and international partners to strengthen TB control in the WHO European Region in order to reach the World Health Assembly (WHA) Global Targets by 2005 as a step towards achieving the Millennium Development Goals by 2015.

By 2003 DOTS had been implemented in 41 countries of the Region with 40% DOTS population coverage. The sessions of the WHO Regional Committee in September 2003 and September 2004 paid special attention to the TB control problem. To respond to the challenges in the Region, the National TB Programme Managers’ (NTP) meeting took place from 27 to 28 September 2004, and the European Technical Advisory Group (TAG) was established, with the first meeting taking place from 28 to 29 September 2004. Representatives of the Region actively contributed to the work of the Global Working Groups on DOTS expansion, MDR-TB and other topics.

Significant technical support was provided to the countries of the Region on drug-resistance surveillance, management of MDR-TB, collaboration with GDF and intensified support to high burden countries, such as the Russian Federation and Romania. The WHO Regional Office contributed to the development of human resources for TB control by organizing the annual WHO-KNCV TB management workshops, Warsaw, Poland; annual laboratory workshops, Warsaw, Poland; annual TB consultants’ courses, Sondalo, Italy; annual Tartu training courses on DOTS in collaboration with FILHA; meetings of the Collaborative for Training and Education for TB Control (twice per year); 3rd Congress of the IUATLD Europe Region, Moscow, Russian Federation (June 2004); and establishment of the WHO collaborating centre for training and research on MDR-TB, Riga, Latvia, 2004. Significant efforts were made to strengthen partnerships and social mobilization for TB control, as well as collaborative interventions in the field of TB/HIV, TB and PHC, TB in prisons, and the Practical Approach to Lung Health (PAL) strategy. Dr Zaleskis presented the achievements and priorities at
subregional and/or country level, 2003–2004, for the Russian Federation, the central Asian republics, Ukraine, the Balkan countries and the Caucasus. With the increased efforts, case detection rates in the WHO European Region have reached 39% over the past five years, while treatment success rates have reached 73–75% in DOTS areas.

Among the challenges and constraints to TB control and to achieving the Global Targets at the regional level are slow DOTS expansion (population coverage was 40% in 2002, 17% in 2001); low case detection and treatment success rates; high rates of MDR-TB; dual epidemic of TB/HIV; difficulties with organizing European TB surveillance, including drug-resistant TB; poor laboratory performance and lack of quality assurance; lack of resources in general for TB control in the Region for 2004–2005 and in particular for TB staff at the WHO Regional Office for Europe.

The fifty-fourth session of the Regional Committee for Europe (Copenhagen, 6–9 September 2004), followed up on the RC 52 resolution on TB control and suggested that quality DOTS expansion should become a top priority for governments to help them achieve full geographical coverage towards the Millennium Development Goals for TB (to have halved prevalence and mortality by 2015 and begun to reverse the incidence of TB). The sustainability of TB control depends largely on working with and mobilizing new partners to maximize and optimize efforts and resources.

Discussion

Dr J. Broekmans emphasized that TB in Europe is currently out of control and urgent measures are required to bring it under control.

Dr G. Magnusson suggested that to make TB control effective, it is not enough to have strong political commitment. Countries should have the capacity to bring TB under control, and partners should help governments to utilize funds for TB control properly.

Mr M. Luhan proposed that WHO should declare TB a Regional Health Emergency. This could help to advocate for stronger TB control in a number of countries of eastern Europe, raise the level of commitment and achieve proper allocation of resources.

Given that declaring TB a Global Health Emergency in 1993 became a turning point for global TB control, so declaring TB a Regional Health Emergency should help the Region to mobilize resources for TB. The task of all partners is to advocate for TB. International partners should tailor their activities to national TB programmes and visa versa. Major efforts are needed to gain the interest and support of the European Union (EU) for TB control in the Region. Its influence could also be used for negotiations with some countries, e.g. Ukraine.

According to Dr G. Magnusson, some of the difficulties encountered with the EU are the result of its lack of expertise in disease categories. Unfortunately, when applying for EU funds, WHO is competing with its Member States or other UN agencies. WHO should not compete with Member States for funds, as there should be a special agreement and funds for technical support by WHO. Secondly, if the EU declares a disease an emergency, some countries can apply for humanitarian assistance. WHO tries to hold regional meetings between WHO and the EU at least once a year, there is a senior level meeting twice a year, and TB will be on the agenda of the meeting in October 2005. The EU has become very committed to HIV/AIDS, and this could serve as an example for mobilizing resources for TB control.
Dr U. Weber suggested that coordination of donors is very important for GFATM. He also noted that the choice of activities at the country level was usually made after the announcement of a new round. In reality preparations should start considerably in advance, as it takes time to organize the process and request support, if necessary.

Dr G. Steenbergen agreed that apart from donor funds, increased political commitment was needed. At the moment TB is regarded by many governments as the concern of the donor community and not a national responsibility. The harder the international community looks for additional international resources, the less national authorities try to mobilize local resources. The aim is that TB should become primarily a national concern, instead of an international one. National governments should feel responsible for TB, but also accountable to their own people and to the international community which they respect. An additional strategy is needed on how to address an audience sensitive not to technical, but to political questions.

Dr L. Goguadze underlined the role of advocacy and suggested delivering a collective message at the big fora, e.g. ministerial conferences. He also expressed his concern regarding the decrease in resources available to WHO at a time when TB control efforts in the Region urgently needed to be scaled up.

Dr H. Sandbladh agreed that the international community had so far concentrated on technical issues; however, it should become more effective at advocacy, and WHO EURO should not be alone in this endeavour.

Dr Y. Yurasova noted the importance of human resource development for sustainable and effective TB control in the Region, an issue reiterated by the recent NTP meeting. With accelerated DOTS expansion and increased requests from Member States for assistance in strengthening and developing human resources for TB control, there are fewer funds available for WHO to provide technical assistance in this area. This problem should therefore be considered by ICC.

**Advocacy and communication on TB: changing situation in Ukraine**

*Dr K. Miskinis, WHO TB Medical Officer for Ukraine,* described the TB control situation in Ukraine and emphasized the achievements and challenges of promoting the WHO TB control strategy in the country.

It appears that the successes of the pilot project on DOTS implemented by WHO in cooperation with the Donetsk regional authorities have not been fully recognized by the national health authorities. Political commitment to effective TB control in accordance with internationally approved principles is still lacking in Ukraine. The efforts of WHO and international partners, the high-level mission by WHO and USAID officials, and the establishment of the WHO TB Office in Kiev have had limited results. The Ministry of Health (MOH) of Ukraine has agreed to establish a High-Level Working Group (HLWG) on TB in Ukraine, but practical progress in this direction is very slow. The levels of HIV infection and MDR-TB in the country require an urgent response from WHO and the international community.

**Discussion**

Dr L. Goguadze informed that the IFRC representative in Ukraine was experienced in advocacy and information activities and could contribute to TB advocacy in the country. He also suggested that 300 Red Cross nurses funded by the government could be involved in TB control to support
WHO’s efforts.

Dr K. Miskinis mentioned that advocacy activities had been implemented as a limited part of the DOTS pilot project in Donetsk, and laboratories were prepared to handle more examinations for TB suspects. However, although the local authorities did not object to advocacy as such, they did not provide any support for it. It was also important to have all information materials printed in both Russian and Ukrainian.

Dr G. Magnusson suggested that there was an excellent opportunity for Ukraine to move from a WHO pilot project to broader cooperation with the NGO movement in the country. WHO started alone, but today such agencies as KNCV, PATH and IFRC, as well as NGOs for HIV/AIDS are active in the country.

Dr J. Veen pointed out the problem of NGOs developing their own materials, driven by their organizational priorities and the wishes of donors. When talking to donors, all organizations should use the same materials within the country and should not develop their own ones.

Dr A. Hinman agreed with the above concerns and suggested that an exchange of information on existing training and information materials for TB control and the development of new ones should be led by WHO EURO or the Stop TB Partnership.

Dr Y. Yurasova informed ICC that the Collaborative for Training and Education for TB Control in the countries of the former Soviet Union was established in 2000 by the agencies involved in such activities in the targeted region in order to coordinate their efforts and avoid duplication. The Collaborative meets twice a year to exchange information and materials. The TB library hosted by WHO Moscow collects training and information materials on TB control that have been developed for the targeted countries. New partners who are active in the Region are welcome to participate in the meetings of the Collaborative. Discussions are going on about broadening the geographical area targeted by the Collaborative.

As the majority of partners present at the ICC meeting were aware of or had participated in the work of the Collaborative, Dr H. Sandbladh suggested building further activities on the existing platform and promoting it for the whole European Region.

Dr A. Trusov shared information on the Project HOPE (Kazakhstan) training course for journalists. Dr W. Jakubowiak mentioned the example of a TACIS grant for North-West Russia for an information and advocacy campaign, which did not take into account the experience already existing in the country. Late efforts to coordinate activities prevented the effective use of funds. The EU should be specifically approached with advice to ensure the coordination of EU-funded projects with activities in the countries, as well as more active cooperation with other partners.

Establishment of the European Partnership to Stop TB

Dr G. Steenbergen, Stop TB Partnership Secretariat, described the goals and historical steps in the development of the Global Stop TB Partnership and Global TB Drug Facility. The principles of the Partnership are to expand the support base for TB control for greater sustainability; to gain political recognition; to involve all national and international stakeholders; to respect each partner’s autonomy; to share responsibilities and synergize resources. The Partnership’s
activities include mobilization of additional national and international resources; political advocacy; social mobilization; increasing public awareness; professionalizing activities that are not core NTP tasks. The coordination and partnership mechanisms were described, as well as the principles of organization. Building the Partnership at subregional level can be of added value, as countries in a (sub)region share similar constraints and challenges; NTPs can benefit from international and (sub)regional exposure; it is easier to achieve a higher political profile and to start cross-border initiatives; it could lead to greater efficiency; and new resources can be tapped. The Global Partnership Secretariat can assist in the development of a partnership with specific products for advocacy and communication, resource mobilization, information technology, drug procurement and management, and technical assistance and training.

Discussion
Dr H. Sandbladh emphasized the importance of clarifying the terms of reference of ICC-TB with regard to advocacy and exchange of information, etc., as ICC had not been effective in this area so far. In order to get people to work more effectively, we need to strengthen the broad partnership and to bring together civil society, the private sector, UN agencies, NGOs, churches and universities, etc. He suggested that the experience of IFRC should serve as a model for such a consortium for TB in the WHO European Region. He also acknowledged the difficulties with EU commitment and suggested that ICC-TB should be a catalyst for such cooperation and scaling up of quality control, MDR-TB interventions and HIV/TB cooperation.

Dr A. Trusov informed participants that Project HOPE recently got a grant for TB programmes in the central Asian republics for five years in cooperation with five partners, including the New Jersey Medical School National Tuberculosis Center. They have initiated HLWG and Thematic Working Group activities and started discussions with the MOHs of three countries. It would be very helpful if WHO Moscow and WHO EURO could provide them with an official statement and assistance with methodologies. As these countries have similar problems with TB, there are plans to establish a subregional HLWG. Dr Trusov also emphasized that TB programme activities for the penal sector and the civil population should be integrated. As a result of Project’s HOPE activities in Karaganda, a number of TB ex-prisoners registered with the civil services to continue their treatment after their release increased from 8% to more than 60%.

Feedback on conclusions and recommendations from NTP and TAG meetings (27–29 September 2004)

Dr K. Vink presented the draft recommendations developed by the TAG meeting, 28 September 2004. The terms of reference of TAG were discussed and agreed upon. During the first meeting a number of recommendations to WHO were developed, addressing the issues of TB control status, laboratory strengthening, drug management, surveillance and monitoring, multidrug-resistant TB, TB/HIV, operational research, and TB and foreign-born persons. The full recommendations will be available in the report on the TAG meeting.

Discussion
Dr H. Sandbladh mentioned the need to distinguish the terms of reference of ICC-TB and TAG. Probably, ICC-TB will deal more with advocacy and resource mobilization.

Dr A. Hinman suggested that ICC could be transformed into a European Stop TB Partnership, with TAG covering technical issues.

Dr G. Steenbergen noted that ICC-TB should define the activities to be carried out, as it will be more action oriented and not just a coordinating body. This should be very carefully evaluated.
The importance of involving advocacy specialists and TB patients (activists) was mentioned by several participants. Unlike HIV/AIDS, there are not many NGOs working with TB, so the Red Cross could serve as an example and a catalyst for other NGOs to address TB control. The issue of stigma should be addressed very strongly.

Human resource development for TB control has been acknowledged to be of crucial importance for effective and sustainable TB control.

Dr U. Weber noted that GFATM is determined to achieve results in fighting TB, so whatever technical support is needed for countries, it can be included in their applications to GFATM, including training. However, the recipient should have a Country Coordinating Mechanism (CCM) in place. Training at national and international levels can accompany other activities, such as drug supplies and management, and funding can come from GFATM. Advocacy can also be included. It is very important to have advocacy and communication included in applications to GFATM, but the Global Fund is a reactive body. If a technically sound proposal does not have an advocacy component, there will be no funding for advocacy (since the country has not requested it). A CCM is a national group of stakeholders, and GFATM does not prescribe who sits there, e.g. whether there is an advocacy person.

Dr A. Hinman suggested that ICC-TB could recommend that countries which plan to apply to GFATM should have a focal point for advocacy for TB control within the CCM.

Dr G. Steenbergen mentioned that many countries needed technical assistance with preparing their applications to GFATM, but there were no funds available for such support. Partners should therefore mobilize resources for technical assistance, including assistance by WHO. It is important to have clear instructions from the very beginning on how to develop a correct application and how to encourage donors to support this process.

Dr L. Blanc shared WHO’s experience in providing technical assistance with developing GFATM proposals during the first four rounds. An analysis of success according to the support received showed that with support of one week or less, the quality of a proposal was not good and had a low success rate. Support for two or three weeks or more equated with a higher success rate. The problem is that if a proposal is good, it is difficult to incorporate technical assistance, since some countries think they have the necessary competency. The development of a proposal is the first step, but the implementation and development of a two-year plan is crucial, as the country will be judged on its performance.

Dr P. Reff suggested that a country’s capacity for implementation and absorption of resources should be taken into account. Even if a good proposal is developed, there may be no implementation capacity in the country when the money arrives.

Dr C. Hennig mentioned the Back-up Initiative by GTZ, which provides resources to enable WHO EURO to assist Member States in developing applications to GFATM. It is an ongoing positive process.

According to Dr U. Weber, GFATM was initially perceived as funding for HIV programmes, so the majority of funds in the first rounds went to HIV. However, 15% of the grants are underperforming and funding for them will be not continued, 10% of the grants will be
reprogrammed, and the rest are performing well. Romania is a positive example; it had its application approved in Round 2 and has started implementation very effectively.

Many countries which have applied to GFATM have weak health systems and need good partners. In some countries CCM is not very effective and needs to be supported.

Dr J. Veen suggested that there was a need to provide more continuous technical assistance with the implementation of GFATM proposals.

Dr G. Magnusson noted that for both TB and HIV there was a need to build capacity at the subregional level and at the country level. WHO cannot form partnerships alone, but it can start the process. Since effective fundraising for WHO takes place at the country level, it is important to build up the WHO country offices. Partnerships should be built at both the regional and the national levels.

**Day 2, ICC – 3rd meeting focusing on tuberculosis**

**HIV/AIDS: 3 by 5 Initiative**

*Dr A. Braye, WHO Country Officer, 3 by 5, Ukraine,* described the TB/HIV epidemic globally and in the WHO European Region. According to WHO/UNAIDS estimates, by the end of 2003 there were 1,950,000 (0.95–3.19m) people living with HIV/AIDS (PLWHA), which means 0.6% prevalence. The total number of reported HIV cases was 800,734; the total number of reported AIDS cases was 287,346, and the total number of reported deaths from AIDS was 165,121. The features of the epidemic in Europe were presented, emphasizing that about 75–85% of all HIV cases in Europe are male. 30–70% of all HIV infections are among persons younger than 25 years; among those vulnerable to HIV are IDUs, migrants, ethnic minorities, prisoners and sex workers. The main means of HIV transmission in Europe is IDU-related, and up to 30% of HIV-infected females are IDUs, while 50% are partners of IDUs. Risk groups for HIV in Europe are similar to TB patterns: mostly males, younger in the East, older in the West, immigrants and prisoners.

The 3 by 5 Initiative was described as a shared global target to provide ART to three million people with HIV/AIDS by the end of 2005, with the goal of achieving universal access. WHO cannot do this alone, so partnerships with all interested parties are vital. Major components of the “3 by 5” strategic framework include: global leadership, strong partnerships and advocacy; urgent, sustained country support; simplified and standardized tools to deliver ART; effective, reliable supply of medicines and diagnostics; and rapid identification and reapplication of new knowledge and successes.

Specific responses in WHO EURO include the development of the European framework to decrease the burden of TB/HIV in Europe; national recommendations on TB/HIV (Russian Federation); clinical protocols for HIV/AIDS care and treatment (NIS countries); clinical guidelines for TB/HIV management (Ukraine); TB/HIV training activities, pilot projects and partnership development; focus on “3 by 5” countries (Russian Federation, Ukraine, central Asia, Caucasus).
Discussion
The European TB/HIV network addresses collaboration between TB and HIV programmes in the countries. There is a need to raise interest in TB specialists on HIV and interest in HIV specialists on TB, which can be done through joint training courses.

Dr J. Veen highlighted one of the obstacles for cooperation between TB and HIV specialists. TB specialists in eastern Europe are mainly elderly people, dealing with an “old” disease with limited resources available, and they do not see the impact of the HIV epidemic. HIV is a “new” disease, involving younger people, with significant funds available. Special measures are needed to bring these two professional groups together.

Dr U. Weber informed that in the next round GFATM will encourage TB proposals to include an HIV component and HIV proposals to include a TB component in order to ensure proper collaboration.

Dr K. Miskinis mentioned the problems and progress in cooperation between vertical TB and HIV programmes in Ukraine.

Regarding Professor S. Hoffner’s question about the danger of ART drug resistance, Dr Braye brought up the example of Africa. Many experts thought that ART drugs should not be available in Africa, as treatment adherence could not be achieved. However, published studies show that ART resistance rates are not higher than in Europe and are lower than in the USA. Therefore, currently there are no reasons to think that ART resistance will be higher in eastern Europe than in the rest of the world.

Dr L. Blanc suggested involving young active HIV specialists in TB control to stimulate TB specialists. He motioned that at the global level the TB/HIV problem had not been well managed until recently, and only now is there a Task Force for TB/HIV at WHO HQ, which includes both TB and HIV specialists.

The specific feature of the TB epidemic in Europe is MDR-TB. If the HIV epidemic joins MDR-TB, there will be a rise in primary MDR-TB, as US experience shows.

Regarding Dr E. Petrescu’s question about the rationale behind the “3 by 5” target for Europe, Dr Braye explained that WHO looked at the coverage in western Europe (above 80%) and used this indicator as a target for other European countries: to achieve coverage with ART above 80% in two years. This target is very ambitious, and WHO officers in the countries implementing the 3 by 5 Initiative have just been recruited.

Dr W. Jakubowiak mentioned that discussions on GFATM proposals had allowed collaboration between TB and HIV programmes to start in the countries. In the Russian Federation national guidelines on TB/HIV had been drafted and TB/HIV focal points had been nominated in all regions of the country. As a result of the distribution of responsibilities, a national coordination body would be established in December 2004. The lesson learnt is therefore to start with activities at the regional level, and this in turn will motivate the national level.

Dr Braye described the HIV epidemic in Ukraine as a concentrated epidemic moving towards a generalized one, with IDUs being the major group of concern. Treatment provided within the 3 by 5 Initiative will mainly address this group of people, so it will be a big challenge.
Ms D. Barry expressed her concerns with regard to concentrating all efforts on IDUs, as sex transmission has been neglected, and this large population group should be addressed.

**Plan of work and budget for the TB programme, 2004–2005**

*Dr P. de Colombani, Medical Officer, WHO EURO,* described the process of developing the workplan for WHO TB control activities for 2004–2005 with regard to needs assessment, defining the priorities and finalizing the Biennial Collaboration Agreements and Intercountry Programmes.

Dr de Colombani presented the budget for the WHO EURO TB control programme, 2004–2005, according to the source of funding, planned and actual costs with funding gaps, subregional and country specifics. In 2004–2005 due to the increased needs for TB control interventions, the estimated costs were US$ 14 130 000 with a working budget (money available) of US$ 10 183 000. 96.1% of the working budget was represented by voluntary donations and 3.9% by the WHO regular budget. The total funding gap is about US$ 4 million.

USAID/OSI, GTZ and WHO HQ provide the main part of the budget. Major funding gaps are for the Russian Federation (support to implementation of the TB/HIV World bank project), the Balkan countries (technical support to Croatia and Romania), the central Asian republics (technical support for Uzbekistan) and the Regional Office (technical assistance to the countries, regional training activities, and salaries for regional TB programme staff).

**Discussion**

Mr J. Scholten explained that supervision of the WHO country and subregional offices takes place at regional level, involving regional secretarial and administrative resources. For example, funds provided for Moldova were for laboratory strengthening and no expenditures for the Regional Office were envisaged.

Dr J. Broekmans expressed his concern that WHO EURO activities depended heavily on funds provided by the USA. This fact is very important in identifying political commitment, as the international community is looking for political commitment in eastern European countries, but it also needs to approach western Europe and the EU. Europe should start solving its own problems.

Dr H. Sandbladh commented that the last ICC-TB meeting had already made such a recommendation, and it had also asked Dr Marc Danzon, WHO Regional Director, to visit the EU and advocate for TB in Europe. However, there was no information on such a visit. EU representatives had been invited to attend the current ICC meeting, but were not able to do so.

Dr G. Steenbergen suggested that ICC-TB should reconsider its role, and signs of urgency must be reflected and communicated. Advocacy should take place at a higher level – the Council of Europe. If ICC-TB were to be transformed into a regional body, a high level of political commitment could be generated.

Dr P. de Colombani commented on the difference between the planned costs and the working budget for 2004–2005, which is about US$ 4 million. In the 2002–2003 biennium the financial gap was US$ 2 million. The WHO budget and financial gap increased, as WHO planned for more activities, but got less money.
Several participants expressed the overall recognition of a need to scale up the volume and the quality of DOTS expansion, and to target countries lacking political commitment to effective TB control, such as Ukraine, with such problems as TB/HIV, MDR-TB, etc. At the same time they expressed concern that along with the need to scale up action, the resources available to the WHO Regional Office for Europe had decreased, preventing implementation of the action required. This is another strong reason to apply to the EU. The international community knows what steps are needed, but additional resources are required. Activities which will be cancelled in 2005–2006 by WHO due to lack of funds (training, human resource development, etc.) in fact mostly need to be scaled up.

Dr L. Ditiu emphasized that WHO gets requests from MOHs to help scale up TB control actions, but WHO cannot respond adequately due to lack of resources. Sometimes there are funds available for activities in the countries, but there are no funds for staff to implement these activities.

Dr U. Weber suggested that the Global Stop TB Partnership has established effective advocacy with USAID, DFID and Sida, with legal and advocacy expertise. However, there is no mechanism to influence the EU. There is an urgent need to establish a Regional Stop TB Partnership as the only way to develop advocacy with the EU in Brussels.

It was mentioned that partners from EU countries should take this message back and try to raise the issue of TB control on the EU agenda. The interested countries, such as Germany, Netherlands, Italy and the Scandinavian countries should help with this.

Dr R. Zaleskis described the difficulties in supporting the WHO TB Office for the central Asian republics, which provides support for the five countries with the highest level of MDR-TB in the world, the highest level of TB notification in the WHO European Region and the problem of TB/HIV. However, as of 2005, WHO would need to close the office because of a lack of commitment from donors to continue support for this office. There was a verbal commitment from USAID, but all five WHO regional and subregional/country offices depend on USAID funds with the exception of the Caucasus where support is shared by GTZ and OSI. There is a problem with retaining TB staff at the Regional Office, since there are no funds for contracts. Only two people in WHO EURO are paid from the regular budget, while the salaries of the rest depend on voluntary donations. There are no funds to continue the contracts of four Professional staff and two General Service staff. Support from WHO HQ is very generous, but the situation must be stable to allow effective work and planning.

Dr H. Sandbladh suggested that ICC should strongly recommend that WHO EURO declare TB an Emergency in the Region. The international community should become aware of the possible consequences; WHO and technical agencies cannot operate effectively and take new steps in TB control without proper resources. Declaring TB a Regional Emergency could provide access to EU emergency funds.

Dr A. Hinman agreed with the suggestion and emphasized that there were enough data to support the declaration of an emergency, since TB was out of control in Europe. MDR and the TB/HIV situation had already been mentioned; statistics proved that action was urgently needed and if the necessary resources were not forthcoming, the situation would only get worse.

Dr C. Hennig noted that the above point should be taken up at a higher level. GTZ would strongly support this idea in order to gain support.
Dr P. de Colombani underlined the importance for Member States of requesting WHO more strongly to prioritize TB on its agenda, as well as proposing it as one of the health priorities for the EU. Countries should approach the EU or other agencies through their representatives to advocate that WHO should be provided with support for TB control.

GDF activities

Dr A. Zagorskiy, MSH, reminded the participants of the GDF mandate to deliver cost-effective high quality standardized TB medicines to the border of the recipient countries (at no cost or at highly competitive prices). Partners are expected to assist with initial TB surveys and monitoring missions; provide technical assistance to the recipient countries in streamlining the distribution network; provide technical assistance in streamlining and expanding DOTS; and develop the local drug management capacity: selection, procurement, distribution, use, management and quality assurance. Among future challenges the speaker mentioned the trend of using other procurement mechanisms instead of GDF grants, which may have a potentially negative impact on the effectiveness of TB control; the increase in monitoring work/technical assistance and in-country drug management requiring increased resources for consultants from GDF; low detection rates and use of anti-TB drugs of questionable quality from other sources of supply.

The potential role of partners and ICC would be to promote GDF as a source of cost-effective quality assured drugs, to encourage countries to apply for GDF grants or procure drugs from GDF, and to include the need to procure drugs from GDF in GFATM proposals.

Discussion

Dr P. Reff mentioned the problems of procuring TB drugs through GDF, as it was very difficult to persuade countries to use GDF, and there were vested interests in using GDF facilities. The wording by GFATM encouraging countries to procure drugs through GDF is too vague; this may need to be imposed, if it is possible from a legal point of view.

Dr U. Weber stated that the above suggestion was not possible for GFATM.

Dr A. Zagorskiy suggested that GFATM should insist on procurement of TB drugs according to international standards, i.e. from GMP enterprises that have been properly checked.

Dr H. Sandbladh noted that there was a clear switch from procurement through GDF to procurement from local sources using GFATM funds. Many countries would like to support and develop their own capacity to produce drugs and they need help with this.

Dr G. Steenbergen argued that GDF was not a procurement agency. GDF sets standards to ensure that the best quality drugs are available in the right dosages and in the right combinations. GDF has developed fixed-dose combinations. Using GDF is an advantage in countries where procurement and quality insurance systems are not in place. When they have them, countries can procure drugs locally. However, if this is not possible, they should use GDF.

Dr U. Weber emphasized that GFATM did not prescribe a mechanism to procure drugs, except for drugs for MDR-TB to be procured through GLC, due to the danger of MDR-TB. However, GFATM assesses a country’s capacity for procurement, and only if the country passes the procurement test does it receive money from GFATM for procurement. GDF should have enough strong points to be able to convince countries.
Professor L. Reichman and Dr H. Sandbladh stressed that GFATM should contribute to the prevention of MDR-TB caused by bad procurement mechanisms and poor quality drugs. Procuring TB drugs from WHO pre-qualified producers might be considered.

Mr M. Luhan pointed out that from an advocacy perspective, the TB community must speak with one voice in order to be effective, as the HIV community did. GDF should be promoted in order to avoid resistance to first-line drugs. This should be brought to the attention of the GFATM Board.

**Discussion on collaboration and resources needed for TB activities in the European Region: feedback from partners**

Dr G. Steenbergen initiated discussions on how to transform ICC-TB into a more operational, more effective body with a stronger advocacy role and able to bring TB issues to a higher level. NTP meetings, TAG and ICC-TB exist at the regional level. A Regional Stop TB Partnership would be an umbrella organization with representatives of countries and agencies on the Board. It is important for countries to be represented by ministers of health, not national TB programme managers. There should be a Secretariat to actively follow up the recommendations made by the Stop TB Board, and an action plan should be drawn up. The Secretariat would be a fully dedicated body located at an agreed agency.

In order to have ICC recommendations implemented, the current coordination mechanism should be changed. The Coordination Board does not represent a specific agency. It needs to be recognized politically as a collective body representing all concerned with TB in the WHO European Region. The Stop TB Board would enable joint forces to be brought together. The Secretariat would follow the decisions on a day-by-day basis.

Dr R. Zaleskis noted that if partners agreed to establish a Stop TB Partnership for Europe, there would be no role for ICC, but NTP and TAG would remain. It would be logical to transform ICC-TB into a Stop TB Partnership.

Dr A. Hinman raised the problem of resources for the Secretariat. So far WHO EURO has been the Secretariat for NTP meetings, TAG and ICC, so they have been part of WHO. The Stop TB Secretariat should be separate, but it should be funded.

With regard to reporting by the Stop TB Board, Dr G. Steenbergen shared the experience of the Global Stop TB Partnership. Globally, above the Stop TB Board there is the Stop TB Forum, which meets once every two years. Similarly, in the European Region partners could organize an event where all partners from all regions are invited. Alternatively, the Board could provide feedback. TAG advises WHO and the Stop TB Board. The Chairs of the Working Groups are members of the Coordinating Board.

ICC-TB members should nominate the HIV programme representatives who would participate in the Board, since such representation exists at the global level. At the country level it depends on the situation. The Stop TB Board must be action oriented. Some issues are beyond NTP and TAG responsibilities and cannot be solved by these bodies alone. The Stop TB Partnership could address the problems at a higher level.
Dr A. Hinman stressed that ICC-TB members should decide if a European Stop TB Partnership should be established, while the structure and extent could be discussed later. There should be an evolutionary process. The outcome of the meeting should be a decision on principle, i.e. if this concept is to be recommended and who should develop the draft.

Professor L. Reichman acknowledged the success of the Global Stop TB Partnership and Working Groups. However, the Global Working Groups do not address regional issues. A European Partners’ Forum should complement, but not duplicate the Global Forum.

Dr L. Blanc stressed the importance of defining the role of each body. The NTP meeting and TAG have their clear terms of reference (TOR). The Stop TB Partners’ Board should also have clear TORs. At the regional level activities must be clearly linked to the emergency plan. With too many people involved, the Forum would be very difficult to manage and would require additional funds, while there are not enough funds for technical support. There should be a limited number of very committed members.

Dr H. Sandbladh suggested appointing a group of experts to draft the concept of the Stop TB Partnership, which would then be circulated among partners for discussion. The resources and organization of the Secretariat would be another problem to be addressed.

Mr M. Luhan reminded the meeting that secondment of staff was one of the resources used by the Global Stop TB Partnership. It had proven to be very effective, and it also brings in expertise and decreases costs.

Dr G. Steenbergen underlined the need to formulate the products that the Regional Stop TB Partnership should deliver, which cannot be delivered in any other way. Political advocacy should be the main tool for raising commitment in the countries and the Region as a whole, as well as for raising funds.

Dr R. Zaleskis appreciated the above idea, as so far there was no real body in the Region to address political advocacy, social mobilization and strengthening of partnerships. With the establishment of TAG, these issues were considered ICC tasks. Transforming ICC-TB into a Stop TB Partnership would be very interesting, but there should be clear TORs, resources and Secretariat. WHO EURO has no resources for this. Today it is time to address emergency issues for TB control at the level of political decision-makers. The high-level mission to Kazakhstan could be an example of targeting TB at both political and social levels.

Dr G. Steenbergen reminded ICC members that EURO had a seat on the Global Stop TB Partnership. The Global Coordinating Board could decide to allocate additional funds to help EURO set up a Regional Partnership (so called “seed” funds). The Global Secretariat could also help to set up a regional one and to assist with starting advocacy work. Dr J. Broekmans is the European representative of Global Stop TB, so he could bring the issues discussed to the Global Stop TB Board.
Conclusions and recommendations of the meeting

Conclusions

1. The ICC met at the International Hotel, Sinaia, Romania, 29–30 September 2004. Dr Håkan Sandbladh chaired the meeting and Dr Alan Hinman served as Vice-Chair. Dr Yelena Yurasova was the Rapporteur.

2. In opening the meeting, Dr Sandbladh highlighted some of the issues that ICC would need to address, including the availability of new funds (largely from the Global Fund to Fight AIDS, Tuberculosis and Malaria [GFATM]), which is overwhelming the capacity of some countries to use funds appropriately, the increasing need to merge DOTS and DOTS-Plus activities, the general relationship between AIDS and TB programmes, and the need to redefine the role of ICC, given the formation of a TB Technical Advisory Group (TAG), which had just completed its first meeting.

3. Dr G. Magnusson, Director of the Division of Technical Support, Reducing Disease Burden, WHO EURO, outlined the three priorities of the Regional Office – country presence, evidence base for interventions and the “silent” epidemics (AIDS, TB and malaria). He pointed out that 18 countries in the Region had received support from GFATM for HIV/AIDS and 10 for TB. He stressed that capacity building was a major issue and that political commitment and developing partnerships were the key to addressing the problems. He also pointed out that “categorical” programmes would only be successful, if they strengthened the overall health system.

4. Dr R. Zaleskis, Regional Adviser, TB Control, summarized the situation in the Region, including the fact that the reported number of TB cases was 373 497 in 2002, the highest figure in two decades, and that there had been a dramatic increase in HIV infections and MDR-TB, particularly in eastern Europe. The DOTS strategy has been implemented in 41 out of 52 countries, but only covers approximately 40% of the population in the Region. The case detection rate is 39% and treatment success rates are 75%, both below the 2005 targets. Laboratory performance and quality assurance are suboptimal. There is an increasing need for collaboration between TB and HIV programmes and between TB programmes in the civil and prison sectors.

5. Other presentations described the Global Stop TB Partnership, the difficulties in establishing effective advocacy/communication programmes, the global effort to get 3 million HIV-positive persons on antiretroviral therapy (ART) by 2005 (100 000 in the WHO European Region), and the proposed WHO EURO TB plan of work and budget for 2004–2005.

6. In discussion, among other things, it was pointed out that although some progress had been made, TB is out of control in many parts of Europe and there is still not the sense of urgency that the situation demands. The need for partners to develop a means of exerting their collective influence in accelerating progress was a major topic of discussion.

7. There is a funding gap of approximately US$ 4 million for the 2004–2005 biennium. Approximately half of this gap is for activities in the Russian Federation and it appears that it may be met. Similarly, the funding gap for activities in the central Asian republics may be covered. However, the funding gap in the Balkans is severe and potential donors have not yet been identified to fill the gap. There is also a severe gap in funding for activities
and salaries at the regional level. The largest single donor for TB activities in the European Region is USAID.

**Recommendations**

1. **TB is out of control in many countries in the Region.** The number of cases reported is increasing, and this is accompanied by a frightening rise in the incidence of MDR-TB and TB/HIV. The problem is compounded by inadequate political commitment, inadequate infrastructure, inadequate implementation of effective TB control strategies in many countries, and inadequate financial support. A comprehensive TB programme must address MDR-TB and TB/HIV, as well as “traditional” TB. TB should be declared a Regional Emergency. In addition to reflecting reality, such a declaration will help galvanize support from countries within the Region, as well as from the EU and external donors. Particular emphasis should be placed on the highest burden countries.

2. **There is an urgent need to scale up both the extent and the quality of TB control efforts.** The Regional Director should convene a regional summit to develop a plan of action to combat the emergency. The summit should include ministers of health and finance as well as representatives of the EU and external partners.

3. **There is an increasing need for productive interaction between TB and HIV programmes.** HIV programme representatives should be major participants in TB meetings and TB programme representatives should be major participants in HIV meetings at global, regional and national levels. Closer interaction will be critical, if the Region is to meet its target of putting 100 000 new patients on ART by 2005.

4. **Applications to GFATM for TB programmes should include links to HIV programmes, and applications for HIV programmes should include links to TB programmes.**

5. **TB patients should be offered voluntary counselling and testing for HIV.** By the same token, persons undergoing HIV counselling and testing should be assessed for TB risk. GFATM applications should reflect these activities.

6. **GFATM provides a major opportunity for funding effective TB control programmes.** All partners must participate to ensure that applications to GFATM are of good quality and that, if awarded, GFATM funds are used effectively. The current absorptive capacity of many countries is quite limited, and extensive technical assistance over prolonged periods will be required to ensure effective implementation in many countries. Obtaining funding for technical assistance through GFATM grants is an extremely cumbersome bureaucratic system and as such should not be recommended. Instead, GFATM should be encouraged to “set aside” funds for technical assistance that could be utilized in a timelier manner.

7. **Communication and advocacy are critical components of TB control and HIV control programmes.** Applications to GFATM commonly lack appropriate attention to communication and advocacy. Each Country Coordinating Mechanism (CCM) should include expertise in this area (whether from national or external sources), and each application should address how communication and advocacy will be carried out. The Regional Office should increase its own capacity in communication and advocacy.

8. **GFATM should insist on procurement only of quality-assured drugs, such as through GDF.** This will be an important means of preventing the emergence of drug-resistant strains. ICC asks that the Regional Director of WHO (as well as the Director-General of WHO) make this request to GFATM. Countries receiving support from GFATM should use GDF for
procurement of drugs, unless they have well established and properly functioning procurement mechanisms that assure the quality of drugs. External donors should strongly encourage the use of GDF.

9. A Regional Stop TB Partnership should be formed to strengthen and transform the coordination of TB activities in the Region, provide increased advocacy, and attract increased support for TB control. This may result in the dissolution of ICC as such. Further exploration is required to arrive at a clear delineation of objectives, roles and responsibilities of component elements of the Partnership. The structure of the Global Stop TB Partnership may serve as an initial guide.

10. Stop TB Partnerships should be formed at country (or subregional) levels to ensure the necessary technical, financial and political support for programmes. The High-Level Working Group (HLWG) established in the Russian Federation is a mechanism that could well be applied elsewhere, such as in the central Asian republics, Ukraine and other countries.

11. WHO EURO should adopt as a major priority the formation of national and subregional Stop TB Partnerships.

12. There is a particular problem in implementing effective TB control in Ukraine. All partners are urged to work together to provide the necessary technical and political assistance to Ukraine to improve the situation. The formation of a HLWG should be a high priority.

13. EURO’s assignment of technical staff to regional, subregional or country offices is an important step towards providing the technical assistance needed to maintain and accelerate progress in the countries of the Region. Funding to continue this support must be identified from existing or new sources.

14. The regional workplan provides an outline for scaling up activities to bring TB under control in the Region. However, there is a severe funding gap (US$ 4 million for WHO EURO activities in addition to shortages within countries). Many technical assistance partners are also facing funding shortages. Urgent efforts are required to define the full extent of the funding gap and to find the funds to ensure further progress in the Region. Western European countries and the European Union must provide greater support to permit scaling up of control activities.
Annex 1

Interagency Coordinating Committee (ICC) – 3rd meeting focusing on tuberculosis

Sinaia, Romania, 29–30 September 2004

PROGRAMME

29 September 2004

14:00–14:15 Opening of the meeting

_Håkan Sandbladh, Chairman of ICC-TB_

_G. Magnusson, Director, Division of Technical Support, Reducing Disease Burden, WHO EURO_

14:15–14:30 Feedback on conclusions and recommendations from NTP and TAG meetings (27–29 September 2004)

_J. Scholten_

14:30–15:00 Overview of the TB situation and progress in DOTS expansion in the European Region

_R. Zaleskis_

15:00–15:15 Advocacy and communication on TB: changing situation in Ukraine

_K. Miskinis_

15:15–15:30 Establishment of the European Partnership to Stop TB

_G. Steenbergen_

15:30–16:00 Tea/coffee break

16:00–18:00 Discussion on coordination and partnership in Europe

18:00 Closure for the day
30 September 2004

09:00–09:15 HIV/AIDS: 3 by 5 Initiative
   A. Braye

09:15–09:45 Discussion

09:45–10:15 Plan of work and budget for the TB programme, 2004–2005
   P. de Colombani

10:15–10:30 Questions and answers

10:30–11:00 Tea/coffee break

11:00–12:30 Discussion on collaboration and resources needed for TB activities in the European Region: feedback from partners

12:30–14:00 Lunch

14:00–15:00 Discussion on collaboration and resources needed for TB activities in the European Region: feedback from partners (continuation)

15:00–16:00 Conclusions and recommendations of the meeting

16:00 Closure of the meeting
Annex 2

LIST OF PARTICIPANTS
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Sinaia, Romania, 29–30 September 2004

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Vice-Chairman
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