Meeting of the Steering Committees of Barents Tuberculosis Programme and Barents HIV/AIDS Programme

Lappeenranta, December 12-13, 2013

Meeting minutes

1. Opening of the meeting

Dr. Viacheslav Zinkevich agreed to chair the meeting, as both HIV/AIDS SC Chair Evgenia Kotova and TB SC Chair Alevtina Grishko were unable to come to the meeting.

Ms Outi Karvonen, Barents HIV/AIDS Programme Coordinator, opened the meeting and welcomed everybody in Lappeenranta. Some Steering Committee members were not able to participate mostly due to time constraints. Special regards were sent by Gunilla Rådö who e-mailed about the Swedish reform in which the Swedish Institute for Communicable Disease Control will be merged with the Swedish National Institute of Public Health to become the Public Health Agency of Sweden in the beginning of January 2014.

Autumn 2013 has been full of events, and Ms Karvonen mentioned two major ones: seminar "Challenges and best practices in control of MDR TB and HIV+TB co-infection among vulnerable populations in Barents Region" in St. Petersburg on 15 November and Side Event of the NDPHS Partnership Annual Conference "Combating HIV and TB through a joint regional action" in Helsinki on 21 November. The NDPHS Statement on HIV and TB was endorsed by the meeting of ministers on the following day, 22 November.

Dr. Zaza Tsereteli, Barents TB Programme Coordinator, thanked for organising this common meeting in Lappeenranta. He reminded participants about the prime ministers meeting in Kirkenes last June when a new Declaration was published on the 20th Anniversary of the Barents Euro-Arctic Cooperation. In this Declaration health issues are pointed out in the following way:

> "With the continuous increases in contacts across borders and more integrated labour markets, cooperation and coordination between health institutions and authorities need to be

further strengthened. Special attention should be given to emergency preparedness, prevention and control of communicable and non-communicable diseases and securing social well-being for vulnerable groups and the general population."

The Joint Working Group on Health and Related Issues (JWGHS) has now new chairmanship for the next two years: Sweden together with Murmansk Region. The next meeting will be in March in Murmansk.

Zaza Tsereteli noted that it is very reasonable to have the both Steering Committees – on HIV/AIDS and on Tuberculosis – meeting together. According to the WHO Global Tuberculosis Report 2013, there were 1.1 million people living with HIV fallen ill with tuberculosis in 2012.

2. Adoption of the Agenda

The agenda was adopted.

3. Trends in MDR TB and HIV/TB co-infection in Northwest Russia, *Dr. Vladimir Galkin, St. Petersburg Tuberculosis Institute*

Dr. Galkin gave a profound analysis on development of TB situation in Northwest Russia NWR). TB notification rate (newly detected cases per 100,000 population) has been decreasing since 2008 in NW Russia and in whole Russian Federation (RF). The rates in 2012 were 52.1 in NWR and 68.1 in RF.

The TB statistics vary depending on data used for analysis. For MDR TB and the following data collection forms are used: Form no 33 and Form no 7-TB; for HIV/TB the forms used are no 33 and no 61. The differences between forms are the following: Form 33 covers information on registered and followed-up TB patients only among permanent residents, form 7 covers information on newly diagnosed TB cases, both new cases and relapses, for treatment (everyone who has started TB treatment), form 61 is used by AIDS centres and it covers everyone who has TB/HIV co-infection, including those in prison.

MDR TB has started slightly to decrease in Barents area and Leningrad and Kaliningrad regions, but not in Novgorod, Pskov, Vologda, St. Petersburg and several other parts of RF. MDR rates are rather high in Karelia and Komi Republics, Murmansk and Archangelsk regions. The share of XDR among MDR cases in NWR is highest in St. Petersburg and Leningrad Region. XDR is though increasing in whole Barents area.

HIV/TB co-infection cases have increased annually in Russia. In 2012, among 10.7% of new TB cases were detected HIV (in St. Petersburg even 17.4%; in Leningrad region every fourth newly detected TB patient is HIV-positive). In NWR HIV/TB rate per 100,000 is 8.1, but if prisoners are included then the rate is over 10. HIV/TB is increasing especially quickly in Karelia, Murmansk and Novgorod.

During 2012, there were 4329 MDR TB patients in dispensaries in NW Russia. From them 341 died of TB, and 239 died of other reasons. 662 of them became smear negative, i.e. 15.3%.

At the same period there were 227 MDR HIV/TB patients in 9 NW Russian regions (St. Petersburg figures are not included). From them 5 died of TB and 49 of other reasons, including HIV infection. During 2012, 25 of them became smear negative (11%). At present there is no information on how many of them receive ART.

Those Russian regions which implement DOTS, are more effective in treatment of MDR TB and have been able to decrease mortality. The problem with MDR TB statistics is that they do not include migrants, and e.g. in St. Petersburg every fourth newly detected TB case is registered among migrants.

4. Development of HIV situation in Northwest Russia, *Dr. Svetlana Ogurcova, Northwest District AIDS Centre, St. Petersburg*

In 2013 there were approximately13.5 million people living in NW Russia which is quite the same as in 2012. The HIV incidence rate (cases per 100,000 population) in NW Russia has slightly decreased since 2009 at the same time when this rate has increased in whole Russia; then in 2012 the rates became the same – 48.1 per 100,000.

In 2012, the HIV incidences were the following in NW Russia:

- 82 (per 100,000) in Leningrad Region
- 65,8 in St. Petersburg
- 60,7 in Novgorod Region
- 46,8 in Kaliningrad Region
- 44,5 in Murmansk Region
- 25 in the Republic of Karelia
- 22,6 in the Republic of Komi
- 16 in Vologda Region
- 10,2 in Pskov Region
- 7,9 in Archangelsk Region
- 4,7 in Nenets Autonomous District.

Compared with 2012, there has been strong increase in Novgorod Region – 59%. Some increase has been noted in Archangelsk Region (absolute no of cases – 92 in 2012 compared with 78 in 2011). Clear increase was detected in Karelia and Komi already in 2011, and the numbers stayed at high level in 2012.

Cumulative number of registered HIV cases in NW Russia was 96 160 in the end of 2012. As 14 901 HIV-infected people have died, there were 81 259 people living with HIV in NW Russia. In St. Petersburg and Leningrad Region HIV prevalence has reached 1% in 2013.

During 2012 testing on HIV among general population was slightly increased, but testing of risk groups has decreased since 2006 and stayed at lover level in 2012 (no additional decrease was noted). Testing of people who inject drugs (PWID) was decreased in Archangelsk, Pskov, Kaliningrad, St. Petersburg and Leningrad Region. On the other hand, testing of PWID was clearly increased in Karelia and Komi.

Even though only 2% of HIV cases are detected among MSM, it means that infections are increasing in this group at the same time, when there is decrease in all other groups. Incidence is decreasing also among migrants, even though testing has increased among them.

During 2012, 48.7% of HIV cases were transmitted through injecting drug use in NW Russia. According to National HIV meeting which was recently organised is Suzdal, there are 188 drug users per 100,000 population in NW Russia. From these drug users approx. 29% are HIV-infected.

During 2012 there were 1476 children born to HIV-positive mothers in whole Russia, from these children 57 contracted HIV from mother.

766 individuals died of AIDS in NW Russia during 2012.

5. Development of HIV and TB situation and related ongoing activities in Norway

Dr. Hans Blystad, Norwegian Institute for Public Health: HIV in Norway

Even though there is some decrease in HIV cases in Norway, the overall trend does not seem good.

The situation in 2013 was the following:

- Total 5138 (3460 men and1678 women) HIV notifications as of 1. January 2013
- Probably slight decrease in newly diagnosed in 2013
- Considerable increase in no. of cases infected in Norway during the last 10 years due to increase among men who have sex with men.
- Slight decrease last years among migrants (mostly from Africa) infected before arriving Norway
- Number of newly infected drug users remains low and stable
- Mother-to-child transmission is very rare in Norway
- Approx. 4500 people are living with HIV in Norway. Of these:
  - Ca. 40 % is heterosexuals, the great majority of migrant background
  - Ca. 40% is men who have sex with men
  - Ca. 10% is infected in other ways, primarily by drug use
- Approx. 30 - 40 children are living with HIV.

Migrants mostly contract HIV before arriving to Norway, so it is impossible to control this. The situation among MSM continues to be worrying. They are educated people and they know about HIV, still they take risks. Rapid testing has been increased among MSM.

Norway has a good strategy against HIV – it involves 8 ministries, but its implementation could be intensified. There are some hopes, because the new minister of health wishes to revitalize the HIV strategy plan.

Debates are going on concerning de-criminalization of HIV risk behavior; it seems that the legislation may be slightly liberalized.

Year 2013 is the first one when it is possible to combine registers on HIV and TB and to see the amount of HIV/TB co-infections. So far in 2013 there had been detected 35 cases of co-infections. It was latent TB in these cases, and majority of infected people were migrants.

Dr. Karin Rönning, Norwegian Institute for Public Health: TB in Norway

Mortality of TB has decreased close to zero in Norway. Morbidity of TB was at lowest in 1996, after that there has been increase together with the increase of migration.

When looking at the age distribution of TB cases, it can be noted that 20-40 years is the leading group among foreign born, and 80-89 years among Norwegian born.

There are quite few cases of MDR TB detected in Norway – 8 or less cases per year. These cases have been brought from other countries, no transmission of TB neither development into MDR has happened in Norway.

TB activities have been defined by National Tuberculosis Programme and guided by regulations e.g. on screening of immigrants.

Norway has the same problem as other Scandinavian countries: physicians so seldom see a TB patient that they do not recognize TB. This increases the need for guidance.

During last years, treatment of latent TB has been increased. This is a difficult field of work, as there is not so much knowledge and experience, yet. It is also complicated to get migrants to accept treatment of latent TB when they do not feel themselves ill. Anyhow, this is done in order to reach eradication of TB.

6. Presentation of the NDPHS Statement on HIV and Tuberculosis, further plans for NDPHS strategy 2014–2020.

Dr. Ali Arsalo, Chair of the NDPHS Expert Group on HIV/AIDS and Associated Infections

Ali Arsalo informed participants on the new NDPHS Statement “Impact of the HIV/AIDS and tuberculosis on people and economies of the Northern Dimension Countries – status quo and the way forward” which was approved by NDPHS Partnership Annual Conference on 22 November. The aim of the statement is that the governments of Northern Dimension countries recognise their responsibilities and renew their commitment to develop and support effective country and regional responses to further improve the current HIV and tuberculosis situations and reduce their impacts on human lives, economy and society.

The summary of the Statement includes the following:

“NDPHS Partners will be engaged to:

- Exchange information and experiences in the work against HIV, AIDS and TB and HIV/TB co-infection;
- Support multilateral actions combining primary health and social care, improving early diagnostics, treatment, psychological care and access to services;
- Support NGOs working with vulnerable populations;
- Further develop national efforts, joint platforms and new regional approaches;

- Support the NDPHS in facilitating cooperation through joint international activities;
- Strengthen prevention, control and reduction of harmful consequences of HIV, AIDS and TB as well as other associated infections."

The three challenges of the Statement are:

- How do we maintain our capacity for shared situational awareness?
- How do we maintain personal and institutional relationships in the future?
- How do we arrange future collaboration?

This Statement can be taken into account while preparing/revising the strategy on HIV/AIDS for the Barents region.

Division into two groups:

1) **Barents HIV/AIDS Programme Steering Committee**
   - Strategy issues (see Annex 1)
2) **Barents Tuberculosis Programme Steering Committee**
   - Discussions on WHO post 2015 TB strategy draft and project development (see Annex 2).

7. Development of HIV situation and related ongoing activities in Finland

Marja Anttila, National Institute for Health and Welfare (THL), Finland

The statistic data in Finland comes from National Infectious Diseases Register and some prevalence studies among populations at most risk. Information to the register comes from both physicians and laboratories, and they are linked with the help of the identification code of a person.

Incidence was 2.9/100 000 in 2012.

By 8.12.2013 the total number of registered HIV cases was 3205. Transmission routes among the cumulative number were the following:

- heterosexuals accounted for around 40 % of the cases
- men having sex with men around 30 %
- injecting drug users around 10 %

New national HIV strategy for 2013–2016 was published in December 2012. As the general prevalence in Finland is very low (estimated 0,1% among adults), the strategy concentrates on most at risk groups which are: people living with HIV, men having sex with men, people from high prevalence countries, travellers, injecting drug users, sex workers and prisoners.

HIV continues to spread among MSM. Most of the cases are among Finns, and most often the infection has been contracted in Finland. Two prevalence studies have been implemented among MSM. The prevalence is approx. 20 higher than among general population.

The number of heterosexual infections has been steadily growing, among both foreigners and Finns. Often the infection has been contracted abroad, most often in Thailand, Estonia or Russia.

Migrants represent about 5% of the population in Finland, but at the same time approx. 50% of new HIV-infections are detected among them. Most often transmission route is heterosexual and the infection has been contracted in the country of departure (Sub-Saharan Africa being the first, during 2008–2012 altogether more than 60 countries of origin). In a survey conducted by THL, knowledge about prevention and transmission routes among migrants was found to be very low.

After the epidemic among people who inject drugs (1998-1999), a wide network of Low Threshold Health Service Centres which offer needle exchange has been established around Finland (approx. 30 centres). The *Act on Communicable Diseases* from 2004 obligates municipalities to provide health counselling for PWID in their area, including exchange of injecting equipment. Currently the HIV prevalence among people who inject drugs is around 1%.

The challenges in the HIV response in Finland are e.g. access to treatment for non-resident foreigners and late diagnosis among all detected cases. Testing should be increased.

8. **Development of TB situation and experiences from an epidemic in the city of Turku**, *Hanna Soini, THL*

TB situation in Finland is quite similar as in Norway. Nowadays there are approximately 300 cases of TB detected annually (275 in 2012, i.e. incidence was 5/100 000).

BCG vaccination was taken away from the general vaccination programme in 2006, and after that only newborn from risk families have been vaccinated. Risk means that a parent comes from high-endemic country or a parent is ill with TB.

In 2007 Finland started to use EU case definition according to which also clinical cases which have not been confirmed by laboratory are being registered.

In 2012 most of the newly detected cases were pulmonary (71%). About half of the new cases were detected among elderly people.

In 2012 there were 6 cases of HIV/TB co-infection. Every TB patient is recommended to have an HIV test.

There are quite few MDR TB cases – last year 3 cases; and one of them was XDR. Mostly MDR cases are detected among migrants.

National Advisory Group for tuberculosis treatment has been established by the Ministry of Social Affairs and Health in 2007. Chairperson and secretary of the group are located in Filha. The group collects information from complicated cases, and each MDR and XDR case is reported to the Group. The Group gives advice and supervision to the treatment. The national TB reference laboratory is located in THL.

Molecular epidemiology of TB in Finland has been studied:
- 4-year population-based study (2008-2011)
- Analysis of 1048 *M. tuberculosis* isolates by genotyping
- Main results:

- 70% of TB cases were Finnish-born
- Mean age of diagnosis was 62
- Distinct TB genotypes were found among
    - foreign-born
    - young Finnish
    - old Finnish cases
- Only 10% of clusters comprised of foreign- and Finnish-born cases – transmission between the groups is rare
- Young Finns were more likely to be clustered and have smear positive pulmonary TB – more likely to transmit TB than elderly cases.

TB incidence is low, but sometimes there are mini-epidemics. Recently in the city of Turku a 17-years old boy has been found with active TB and a big amount of contacts (14 of them detected with TB). Contact tracing covered altogether 600 people, and they all were screened by x-ray and IGRA. 35 people received treatment for latent TB.

The main conclusions on TB situation in Finland are the following:

- TB incidence in Finland has stabilized;
- Patients are younger;
- Number of foreign-born patients is increasing;
- Younger patients are more likely to transmit TB;
- Education for health-care personnel is needed.

9. New TB Programme and related projects in Finland

Rauni Ruohonen, Filha

It took 1.5 years to prepare the new Tuberculosis Programme for Finland. This work was done by FILHA together with THL. The working group included 15 specialists, and 23 different parties were consulted.

The new Programme pays more attention to:

- the roles of primary health care and occupational health care in TB control;
- challenges posed by patients with immigrant background;
- improving the efficiency of treatment in all patient groups, introduction of DOT to all patients;
- treatment of LTBI in certain groups;
- strengthening early detection of TB disease and LTBI – new contact tracing guidelines;
- increasing training and research.

According to the Programme, LTBI treatment should be offered to those who have recent infection and increased risk to develop active TB:

- For all with clearly decreased immunity and persons < 16 years
- Pending on risk assessment for persons < 35 years.

The most typical risk group for TB in Finland are elderly Finns >75 years of age and men aged 45-64 years who mostly are homeless alcoholics.

The problem in health care is that TB knowledge is located in central hospitals, but the TB patients mostly come to primary health care, elderly care, occupational health services, prisons etc. A wide training program has been started in 2013. Training courses are organised in specific topics, like DOT and contact tracing. Open web training packages has been created for professionals and students.

Two pilots in training institutions of social care and nursing were implemented – one in Tampere and another one in Helsinki. In Tampere the group of trainees included nurse students, in Helsinki also social work students. Training in Tampere concentrated on clinical TB and treatment of TB. Topics in Helsinki were: TB as infection and disease, transmission of TB and the measures to prevent transmission, early detection, contact tracing, communicating with patients. Training in Tampere was mostly web-based; in Helsinki it included more face-to-face periods and also practical work period. Both pilots got positive assessment, but the Helsinki pilot seemed to be more interesting as it also lead into mini-interventions at work places when older nurses started to inform others on TB.

Other projects related to the TB Programme include an EU funded project "Prevention and early detection of TB and HIV among young asylum seekers", piloting symptom based screenings in homeless shelters in Helsinki and introducing a new web site www.tuberkuloosi.fi.

10. Plans for 2014

The HIV/AIDS Coordinator informed about an application submitted for Finland about continuation of the project "Promotion of good practices in the work against HIV and tuberculosis in the Barents region". The expected results of the project are:

a. Networking and exchange of information improved between HIV and TB specialists in the Barents region
b. Provision of support to strengthened exchange of best practices and experiences with comprehensive and realistic approaches in the Barents region
c. Provision of support to NGOs working with vulnerable groups of people in the Barents region
d. Advocacy work done in order to bring the understanding of the complexity of the HIV and TB situation to authorities of the Barents region

The main planned activity under the networking component is planned to be ***a joint meeting of the Steering Committees of the Barents HIV/AIDS Programme and the Barents Tuberculosis Programme***. It could be organized in Murmansk or Archangelsk with specific focus on collaboration between HIV and TB services, as well as narcology institutions.

Component on exchange of best practices and experiences includes organization of a ***training seminar/workshop*** with the following objectives:

- To establish and strengthen the mechanisms of collaboration and joint management between HIV programmes and TB-control programmes for delivering improved and integrated TB and HIV services, as recommended by the Barents Tuberculosis Programme;
- To develop closer interaction between the civilian and penitentiary healthcare services;
- To exchange actual information between key experts from Norway, Sweden, Finland and Russian Barents regions.

In the application some possible themes for the seminar are mentioned to be:

- prevention and early case finding of TB among HIV-infected persons
- testing of HIV and TB screening among vulnerable populations
- improvement of TB and HIV infection control in organisations working with vulnerable populations
- prevention and treatment of MDR TB.

The themes above can be changed and modified according to the needs. The venue for the seminar is planned to be Archangelsk, Murmansk or another suitable location.

Silje Hagerup informed about a ***Norwegian-Russian application*** which includes organization of ***a three-day seminar in Archangelsk to sum up 15 years of experience in TB control***. One of the themes in the seminar is HIV/TB co-infection. After vivid discussions it was concluded that it would be reasonable to combine the common meeting of Steering Committees with this seminar, in case that both projects will receive financing. A good time could be in the second half of May.

The training seminar with Finnish financing could be organized later, probably in autumn. St. Petersburg Tuberculosis Institute has expressed a wish that this seminar should be combined with some big national conference.

Additionally, both Steering Committees should have separate meetings. The meeting of the Barents HIV/AIDS Programme should be dedicated to renewal of the strategy. This meeting could be organized earlier in spring, e.g. in April.

11. Any other business
Conclusions of the meeting

No other business was discussed. Chair thanked organisers and participants for the meeting.

Annexes

Annex 1 Barents HIV/AIDS Programme Steering Committee session
Annex 2 Barents Tuberculosis Programme Steering Committee session
Annex 3 List of participants

Annex 1

Division into two groups:

1) **Barents HIV/AIDS Programme Steering Committee** (present: Svetlana Ogurcova, Vjacheslav Zinkevich, Elena Popova, Inna Rozhkova, Hans Blystad, Janicke Fischer, Marja Anttila, Ali Arsalo, Outi Karvonen and Anelma Lammi (interpreting)

Leadership of the Steering Committee

The group discussed the leadership issues of the Barents HIV/AIDS Programme Steering Committee. The chairperson has not been able to participate at meetings for a long while, and after resigning of Harald Siem there is no vice-chair. It was decided that the Coordinator will contact the chairperson to ask about her willingness to continue. Depending on her answer, Ministry of Health of Murmansk will be contacted concerning chairmanship/vice-chairmanship.

Strategy issues

The strategy of the Programme was planned in 2004, and has not been revised since that. Situation has changed quite a lot during these years, and it is reasonable to renew the strategy. Norway is willing to give some financing for this work, and Zaza Tsereteli has agreed to work as a consultant to implement this mission. This is very appropriate, because he did the planning work in 2004 under guidance of Ali Arsalo.

Participants considered what should be the starting point for the strategy work. The NDPHS Expert Group on HIV/AIDS and Associated Infections has done a very extensive analysis and internal strategy. Some major aspects can be taken from this strategy, but it cannot be used directly. Neither does it make sense to take the old Barents HIV/AIDS strategy and start to look at it point by point. Ali Arsalo proposed that it is better to start from the clean table by asking each region and country to name 3-7 top priority problems/needs in the field of HIV/AIDS where this collaboration could bring added value. Marja Anttila recommended also reading the evaluation report of Pauli Leinikki from 2011. The participants decided to start collecting priority problems. Below are the ones listed at the session.

Murmansk Region

- Organising of volunteer work in prevention of HIV is necessary. This work has been very active earlier, and there are only few infections among teenagers nowadays.
- IDU transmission is most common still in such cities like Murmansk, Monchegorsk and Apatity.
- Vertical transmission has reduced until 5.3% which is lower than elsewhere in Russia but looking at results in western countries, this could still be improved.
- Increasing no of AIDS patients with other medical problems, who are in the need for medical assistance, patient beds, palliative care etc.
- In cities like Kantalahti, Monchegorsk and Apatity there are practically no places for patients having HIV, and small hospitals cannot buy enough drugs. This situation is leading to increasing problem of opportunistic infections. There is the need for a more centralized system.

- Psychological support is needed for patients; e.g. a mobile unit for providing home support
- MSM are hard to reach in Murmansk Region.
- More effort needed in work with sex workers.

Archangelsk Region

- HIV cases are now detected in older age groups – among over 30 and even over 50 years;
- 40% of HIV-infected are people who are at work. Working population is difficult to reach in prevention, employers are not willing to collaborate;
- Mass media is not willing to deal with the issue of unemployment of HIV-infected (30% of HIV-infected persons are not working);
- Difficulties to reach sex workers. There probably are not so many sex workers as in Murmansk, but it would be good to reach them.
- MSM are an important group to work with – luckily there is a NGO with which this can be done successfully.

Republic of Karelia

- Primary health care personnel are not interested to detect HIV. Work has been done with maternal clinics, but general practitioners would need some stimulus;
- Treatment has been organized, but prevention lacks financing;
- It is difficult to contact employers in HIV prevention issues;
- Mass media demands efforts from experts to make media representatives to understand this field;
- Knowledge level of general population concerning HIV has got lower;
- There are some NGOs working with MSM, but it is very difficult to gain changes in risk behaviour. Also the new legislation makes this work more difficult;
- Amphetamine has become popular in Karelia, and it takes several years before its users visit health care institutions;
- Legal medical products from which new drugs are being made at home are a problem. Powders are being dissolved in liquid and this is then being injected together in a group;
- Drug users often quit treatment, and ARV drug resistance increases;
- Drug users have very few places for rehabilitation.

Additionally it was noted that migrants should not be forgotten as their amount is increasing in many regions.

Also Sweden, Norway and Finland should analyse priority problems. There are e.g. new issues connected with aging of HIV-infected people. Collaboration between infectious disease specialists and other physicians needs to be improved.

It was proposed that if Norway will find financing, there could be a workshop on strategy issues organised during spring.

On basis of this new situation analysis it could be decided what should be done during next 2-4 years. Also differences between regions should be taken into account.

Annex 2

2) **Barents TB Programme Steering Committee** (present: Zaza Tsereteli (chairing and interpreting), Vladimir Galkin, Anna Kondakova, Karin Rönning, Silje Hagerup, Hanna Soini and Rauni Ruohonen)

WHO post-2015 TB strategy

Hanna Soini presented the WHO draft on the new TB strategy after 2015. WHO has stated that the 2015 MDG target of halting and beginning to reverse TB incidence has been achieved. The goal for post 2015 strategy will be to end the TB epidemic. In global TB incidence less than 55 / 100 000 should be achieved in 2025 and less than 10/ 100 000 in 2035. This will be achieved with intensified integrated, patient-centered care and prevention; bold policies and supportive system; and intensified research and innovation.

The WHO Executive Board meeting will discuss in January 2014 and the World Health Assembly later in 2014.

In the discussion the new draft was considered as very ambitious including many risk factors taking especially the economical developments into account.

Project development

Silje Hagerup presented a project proposal “Stop tuberculosis in the North-West Russia in our lifetime”. This proposal was prepared for the submission to the Norwegian Ministry of Health and Care Services, for the possible funding, under the Co-operation projects in the Health and Social Sector between Norway and Russia.

The application is defined as a program that will involve 6 projects in different phases of a 5 year plan:

1 - Conference on the experience of collaboration in TB Control in the Arkhangelsk Region 2 - Monitoring of the TB contacts in the penitentiary system who received food support with the funding from NDPHS/HOD in 2012.

3 -Training in Health Communication at the AIDS center, and the development of Booklet on TB/HIV.

4 - "Forewarned is forearmed" - Information campaign on TB and its symptoms

5 - Activities for children and their parents at the sanatory in Archangelsk.

6 - Skill training for TB patients at the TB Dispensary in Archangelsk – Patient empowerment..

The overall objective of the program is to contribute to awareness rising of the general population on the issues of tuberculosis, improving the life of populations at risk and consequently, prevent the spread of TB and continue improving the treatment results for TB

in the Archangelsk Region and the Barents region. Expected outcome is improved control of tuberculosis, MDR TB, XDR TB and TB/HIV in the Arkhangelsk Region and the Barents Region.

The project was discussed in detail and recommendations to improve the project document were made. It was suggested to rethink and re-design project proposals related to the Skill training for TB patients and activities for children and their families. Since the project aims at having influence in the whole Barents area, and in current version, only Archangelsk Region was presented, the meeting recommended LHL to contact and involve representatives from the other parts of the Barents region in proposed project activities. In order to facilitate this process and increase the involvement of the Russian regions, it was decided that Project proposal would be translated into the Russian and shared with the SC chairman and other Regions for their inputs.

Steering Committee meeting of the Barents TB and Barents HIV/AIDS Programmes, December 12-13, 2013

List of participants for registration

Name and e-mail	Position and place of work	E-mail
1. Ms Svetlana **Ogurtsova**	Epidemiologist, St. Petersburg Pasteur Institute	nwaids@pasteurorg.ru
2. Mr Vladimir **Galkin**	Laboratory Head, Federal Research Institute for TB and Lung diseases, St. Petersburg	monitor_tbnw@yahoo.com
3. Mr Vjacheslav **Zinkevich**	Head Physician, AIDS Centre of Murmansk Region	zvk53@mail.ru
4. Ms Elena **Popova**	Head Physician, AIDS Centre of Arkhangelsk Region	arhaids@atnet.ru
5. Ms Anna **Kondakova**	Manager, Charity Fund of Aid to Lung and Heart Patients "Easy Breathing", Arkhangelsk	Found.help.tb@mail.ru annakondakova1@yandex.ru
6. Ms Inna **Rozhkova**	Head of Epidemiology and prevention unit, Republican AIDS Centre, Petrozavodsk	fwaids@yandex.ru aidscentr@onego.ru
7. Ms Rauni **Ruohonen**	Chief TB physician, Finnish Lung Health Association FILHA	rauni.ruohonen@filha.fi
8. Mr Ali **Arsalo**	Expert Group's Chairperson, NDPHS EG on HIV/AIDS&AI	ali.arsalo@kevicon.fi
9. Ms Outi **Karvonen**	Programme Coordinator, Barents HIV/AIDS Programme	outi.karvonen@thl.fi
10. Ms Marja **Anttila**	Senior Expert, National Institute for Health and Welfare THL	marja.anttila@thl.fi
11. Ms Hanna **Soini**	Laboratory Head, National Institute for Health and Welfare THL	hanna.soini@thl.fi
12. Ms Anelma **Lammi**	Project Planner, Finnish Lung Health Association FILHA	anelma.lammi@filha.fi
13. Ms. Karin **Rønning**	Department director, Department for infectious diseases surveillance, Norwegian Institute of Public Health	karin.ronning@fhi.no
14. Mr Hans **Blystad**	Deputy director, Department for Infectious Diseases Surveillance, Norwegian Institute of Public Health	hans.blystad@fhi.no
15. Ms. Silje **Hagerup**	Advisor tuberculosis, LHL International	sh@lhl.no
16. Ms Janicke **Fischer**	Senior Adviser, Norwegian Directorate of Health	Janicke.fischer@helsedir.no
17. Mr. Zaza **Tsereteli**	Barents TB Programme Coordinator, Norwegian Ministry of Health and Care Services	zazats64@yahoo.com