

**The Minimum Package for Cross-Border TB Control and Care
in the WHO European Region: a Wolfheze Consensus Statement**

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Summary

The World Health Organization (WHO) European Region estimates that more than 400,000 tuberculosis (TB) cases occur in Europe, a large proportion of them among migrants.

A coordinated public health mechanism to guarantee TB prevention, diagnosis, treatment and care across borders is not in place. A consensus paper describing the minimum package of cross-border TB control and care was prepared by a Task Force following a literature review and the inputs from the National TB Control Programme managers of the WHO European Region and the Wolfheze 2011 Conference.

A literature review focused on the subject of TB in migrants was carried out, selecting documents published during the eleven-year period 2001-2011.

Several issues were identified in cross-border TB control and care, varying from the limited access to early TB diagnosis, to the lack of continuity of care and information during migration, and the availability of, and access to, health services in the new country.

The recommended minimum package addresses the current shortcoming and intends to improve the situation by covering several areas: political commitment (including the implementation of a legal framework for TB cross-border collaboration), financial mechanisms, and adequate health service delivery (prevention, infection control, contact management, diagnosis and treatment, psychosocial support).

Word Count: 4,843

Introduction

Tuberculosis (TB), HIV/AIDS and malaria are important clinical and public health issues worldwide. The World Health Organization (WHO) estimates that 8.8 million new TB cases and 1.4 million deaths occurred in 198 countries due to TB in 2010 [1]. Of these numbers, 418,000 patients and 60,000 deaths due to TB are estimated in the WHO European Region, a large proportion of them among migrants [2]. Despite the wide difference in TB notification in the Region (from 2.8 to 123 per 100,000 population), TB is considered a public health problem in most countries particularly among the vulnerable populations (i.e., individuals at higher risk of exposure to discrimination, hostility, or economic adversity) frequently located in cities of low incidence countries [3,4]. The reported treatment success of patients in WHO European Region have been, aberrantly, the lowest among all WHO Regions with 68.7% and 47.6% for the 2009 cohorts of new and previously treated patients, respectively. During the same period, default rates were up to 6.4% and 11.3% among new and previously treated patients, respectively. Most patients moving from one country to another are lost to follow-up (defaulters, transfers out and unknown) with 11%, 17% and 22% among new, previously treated and MDR TB patients, respectively. [1,2]

Several factors have led to an increase of population mobility in the WHO European Region, including establishment of the European Union (EU) and free movement within the Newly Independent States (NIS), particularly for seasonal labour. The increased population mobility requires an effective and sustainable mechanism to coordinate interventions ensuring quality TB prevention and care, including early diagnosis, uninterrupted treatment and patient support across borders [5] (Figure 1).

Quality diagnosis and treatment of TB are both individual human rights (independent of legal or residential status of the patient) and public health pre-requisites to prevent further development of multidrug resistant TB (MDR-TB) and extensive drug resistant TB (XDR-TB). Given the alarming increase in prevalence of drug resistance in the WHO European Region, a specific regional effort was conducted [6] to complement the global efforts to eliminating TB by 2050 as set by the Stop TB Partnership [7] (Table 1).

The right to health and access to health care are, defined in Article 12 of the 1966 United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) ratified

by most of the countries in the world [8]. For health authorities, there is an internationally-agreed ethical obligation to provide universal access to TB and drug resistant TB care, which should include the use of quality drugs free of charge for all patients through culturally competent and gender sensitive services [9]. These services have to be tailored for those individuals who face increased risk of getting infected with TB and develop active TB, and for those with higher risk of defaulting treatment and having challenges of accessing and fully utilizing services, including refugees, asylum seekers, migrants and mobile populations [10]. For undocumented migrants, the International Union against Tuberculosis and Lung Disease specifically recommends to ensure the easy access to TB diagnosis and no deportation until the end of treatment [11]. In some countries, however, denial of entry of TB suspects is enforced and if vulnerable individuals, such as asylum seekers, or undocumented migrants, are diagnosed with TB, they may be extradited without ensuring continuity of TB treatment [11-14]. For TB patients crossing national borders, there is often lack of continuity of treatment due to lack of patient-centred approaches and/or availability of sound transfer mechanisms [12-14].

Under the Wolfheze's movement initiative, a Task Force (http://www.euro.who.int/__data/assets/pdf_file/0005/124466/E94368.pdf) of experts discussed the minimum package of cross border TB control and care [15]. A literature review was conducted and the concept paper was discussed and finalized with the inputs from the National TB Control Programme managers of the WHO European Region and Wolfheze 2011. This consensus paper defines the minimum package of cross border TB control and care in the WHO European Region.

Methods

A review of the evidence relevant for the development of this document was performed. PubMed, EMBASE results and grey literature were evaluated in order to find articles dealing with the topic "TB and migration"; the selected publication period is January 2001-December 2011. In addition, all the abstracts published over the same period in the International Journal of Tuberculosis and Lung Diseases were checked.

Combinations of the following search terms were used: "tuberculosis", "multidrug-resistant tuberculosis", "extensively drug-resistant tuberculosis", "MDR", "XDR", "immigration", "migration", "migrants", "human rights", "asylum seekers", ethnic minorities and "Europe". The search was not restricted to publications in English. In addition, bibliographies of

retrieved articles were also hand-searched and relevant documents were provided by the National Delegates represented in Wolfheze workshops.

Citations were independently screened by three investigators (MD, AS and GBM) by examining titles and abstracts to identify potentially relevant studies, and differences were resolved by consensus.

The evidence collected was organised in the following sections: key challenges, relevant legal framework, international health regulations, and European experiences. On the basis of this evidence the Minimum Package for cross-border TB control and care was finally developed by the Task Force.

Definitions

Migrant is an individual who changes his/her nation of usual residence [3].

A *long-term migrant* is defined as a subject who moves to a nation other than that of his/her usual residence for ≥ 365 days (the country of destination becomes his/her new country of residence) [3].

A *short-term migrant* is defined as a subject moving to a country other than that of his/her usual residence for a period ranging from ≥ 3 months to < 12 months, except for holiday, visits to friends and relatives, business, medical assistance or pilgrimage [3].

Undocumented migrant is a person who, owing to unauthorized entry or the expiry of his/her visa, lacks legal status in a transit or host country. “Illegal” is not used because underlines a criminal connotation [3].

Refugee: according to the 1951 Refugee Convention a refugee is someone who, owing to a well-founded fear of being persecuted because of race, religion, nationality, politics, or membership of a particular social group, is outside his/her usual country of residence, and is unable to, or unwilling, to avail himself/herself of the protection of that country [3].

Asylum seeker is a person seeking security from persecution in a country other than his/her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, he/she may be expelled unless permission to stay is provided on humanitarian or other related grounds.

Migrant worker is a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national (*Art. 2(1), International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990*) [3].

Multidrug-resistant tuberculosis (MDR-TB): TB caused by mycobacterial strains showing *in vitro* resistance to at least isoniazid and rifampicin, the two most potent first-line drugs for TB treatment [1].

Extensively drug-resistant TB (XDR-TB): TB caused by mycobacterial strains showing *in vitro* resistance to isoniazid and rifampicin plus any fluoroquinolone and at least one of the injectable second-line drugs – amikacin, capreomycin or kanamycin [1].

Europe indicates the WHO European Region, composed of 53 Member States, if not specified differently [15].

EU indicates the European Union, composed of 27 Members States [16].

EEA indicates the European Economic Area.

Individuals crossing borders: for practical purposes, the current paper refers to all individuals who, for any reason, travel from one country to another for any period of time [3].

Wolfheze: a series of workshops named after a village in the Netherlands where KNCV Tuberculosis Foundation, WHO and other technical agencies jointly organized a series of workshops, known as the “Wolfheze Workshops”, for the National TB Programme (NTP) Managers of low TB prevalence countries in Western Europe. The aim of the workshops was to redefine TB control in the WHO European Region, with emphasis on formulating guidelines and standards based on a consensus-building approach. Consensus was attained through extensive consultations among TB control experts, national correspondents and representatives of health ministries. This group was later expanded to all countries of the Region.

Key challenges of cross-border TB control and care

Countries of WHO European Region face an array of challenges in cross-border TB control. These include limited access to early TB diagnosis, a lack of continuity of care for TB patients when they move to another country, and no or little information to the health

providers in the countries of transit, destination and return [15-17]. In addition, there is often lack of appropriate and/or adequate information for patients as to their rights, availability of health services, coverage entitlements and accessibility of services [11,16,18]. In some countries, there is no provision for the coverage of the costs of TB diagnosis and treatment, which mainly rely on individual payment. Accessing healthcare can be a special challenge for migrants [15,18]. These are further complicated by cultural and language barriers, stigma and fear of deportation.

The fear of discrimination and furthermore of deportation because of TB may cause to hide symptoms and delay diagnosis, to start self treatment or even to discontinue a treatment already started, which can eventually lead to development of (multi)drug-resistant TB [11]. Deporting migrants can cause the discontinuation of their treatment [17], even when deported to other European Union (EU) countries of the Schengen area¹.

The shortcomings of TB care across the borders stem from lack of coordination between the Member States of the WHO Europe Region, inadequate legal framework and insufficiencies of health systems to deal with cross border TB control and care, including accurate and adequate data collection. [16-18]. For example geographic origin of patients is reported in 98.3% of cases in EU/EEA countries, but in only 51.2% of cases in non EU/EEA countries [2]

Relevant legal and policy framework for cross border TB control and care

The legal framework applied in the WHO European Region for cross border TB control and care is quite different among countries. While in some countries free TB diagnosis and treatment is provided to all residents irrespective of their nationality or status (e.g. Norway and Kazakhstan), in others a legal framework allowing free access to health services does not exist, is not fully developed, or is not applied in practice. In some countries, health professionals and social workers are prevented by law to report TB cases to police/immigration authorities, while in others the health professionals and social workers are required to do so, regardless of the their professional oath.

¹ The Schengen Area currently consists of twenty-six states (Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland) all but four of which are members of the European Union (Iceland, Norway, Switzerland, Liechtenstein)

In the EU countries, the European Council Regulation 343 of February 2003, known as “Dublin II Regulation” [19], has established the criteria and mechanisms for determining the country responsible for examining asylum applications by a third-country national (TCN). This regulation was issued to limit the “asylum shopping” and to ensure that each asylum applicant’s case is processed by one country only. It is usually the country where the application was deposited first which has the responsibility to provide asylum (even if on a temporary basis), including provision of access to health care. Consequently, a country diagnosing TB in an asylum seeker may elect to transfer this patient to the country where the application for asylum was first deposited, even if TB treatment is still going on.

More recently, the European Council approved the Directive 2011/24/EU on patients' rights in cross-border healthcare, as an attempt to regulate cross-border health care in the EU’s free mobility context by mandating that patients are treated equitably on the basis of their needs rather than on the basis of their Member State affiliation [20]. It requires that information is provided to the patients via national contact points for cross-border healthcare, which need to be set up. National health services will need also to have access to a repository of information from European Reference Networks, where the protection of individual data will be provisioned by the European Council Directive 95/46/EC [21] and the Directive 2002/58/EC [22] concerning the processing and protection of personal data in the electronic communications. The Directive, however, is applicable only to insured EU citizens and regularly residing TCN and remains to be fully implemented.

In March 2011, the European Parliament approved the Resolution on “Reducing health inequalities in the EU” calling on Member States and the EU institutions for universal, equitable and affordable access to healthcare for all, especially for undocumented migrants including access to quality legal advice and information about their individual rights [23].

In non-EU countries of the WHO European Region, related legal frameworks are rather vague or non-existent [24,25]. Diverse national legislations consider cross-border TB control and care. Some of them ensure free diagnosis and treatment of TB for all residents irrespective of their nationalities or legal status. Others are much vaguer and some countries do not have any specific framework. Those countries, however, are signatories to commitments to uphold the right to health for all [8] and to the WHO World Health Assembly Resolution 61.17 on “Health of migrants” [26,27]. In November 2011 the Committee of Ministers of the Council of Europe (47 Member States) adopted the Recommendations on mobility, migration

and the access to health care further outlining and detailing necessary action at national level as well as collaboration between States [27].

International Health Regulations

Since 15 June 2007, the revised International Health Regulations (IHR) are being implemented by all countries world-wide [28]. The full implementation of this legally-binding agreement will significantly contribute to global public health security by providing a framework for coordinated management of events that may constitute a public health emergency of international concern, and by promoting the capacity of all countries to detect, assess, notify and respond to public health threats. Although TB is not listed among the group of diseases which constitute a public health emergency, the network developed for IHR could be used in promoting the continuum of care of TB patients. IHR is generally applicable to transnational TB transmission, thus notification of TB to WHO could be considered if the episode raises an important concern to international public health.

Additional details are provided in the online Annex.

European experiences on cross-border TB control

In spite of the information available on TB cases notified among migrants in Europe (both in terms of absolute numbers and proportions) obtained through country surveillance (Table 1), and on the net migration rate in Europe (difference between the number of persons entering and leaving a country during the year per 1,000 persons, Figure 1) not much is known on cross-border TB control.

Although several projects aimed at creating a framework of collaboration on epidemiological issues in order to improve communicable diseases surveillance, communication and training across countries have been implemented in Europe, academic publications on the topic are scanty and much remains to be achieved in practice. Examples of such work include the EpiSouth project [29] for the Mediterranean and the Balkans and the International Circumpolar Surveillance [30] and the EpiNorth initiative [31]. Other projects undertook a situational analysis at the new EU borders and identified needs for systematic monitoring and provision of adequate health care as well as for cross-sectoral and cross-border collaboration, in view of gaps of continuity of care for asylum seekers and migrants held in places of detention [32].

At country level several recent examples are emerging:

In *Norway*, undocumented migrants in principle have free access to TB diagnosis. TB suspects may go to the municipal 24-hour emergency clinic in the capital, although fear of police may still create a hindrance. Since 2009, several Non Governmental Organizations (Church City Mission and Norwegian Red Cross) are running a low-profile, low-threshold health centre for undocumented migrants in the capital City, Oslo. Once suspected of being affected by TB, the patients can apply to the Migration authorities for temporary permission to stay in the country. Commonly, this permission is granted, in accordance with the 2009 revised immigration regulations [33] stating that foreigners who are under investigation of (or in treatment for) TB, should not be forced to leave the country before the suspicion of disease has been discarded, or the treatment has been completed. This regulation formalized the practice established in recent years. Exceptions can be made in special cases, justifiable from a health perspective, if there are possibilities for continuum of care, or other special reasons. Currently, the practice is not to deport TB patients during treatment including the so-called "Dublin countries". There are presently no indications that this policy has attracted patients to Norway.

Switzerland has implemented a system of TB screening among asylum seekers and refugees at the border. The system detects some cases of TB every year [34]. A larger group of migrants affected by TB are detected during their stay in the country, while waiting for a legal decision or after a decision has been taken. If a case of TB is detected during this period, asylum seekers have the right to stay in Switzerland until the completion of TB treatment, whatever the final decision will be (granted refugee status or rejected). However, a migrant belonging to the Dublin Declaration has to leave Switzerland and turn back to the European Country where the application for asylum was first deposited. If the delay for transfer back allows, the treatment may be completed in Switzerland. If the delay for transfer back is too short (i.e. diagnosis of TB shortly before the deadline for transfer back), the treatment may have to be completed in another European country. The migration authorities (Swiss Office for Migrations) offer help and assistance for organizing the further treatment at an appropriate service in the country of transfer. Differently from asylum seekers and refugees, undocumented migrants with TB have no legal right to stay in the country and are threatened with rejection and deportation at any time. Furthermore, they usually have no health insurance which can cover the costs for TB treatment, except in some cities. In practice, it is rather easy to postpone rejection, even for undocumented migrants, until the treatment of TB is

completed, while the financial burden of the TB treatment is the main problem and has to rely on private or charitable funding.

The Russian Federation is a destination country for thousands of new migrants from many countries of the former Soviet Union, including undocumented labour-migrants and, refugees. By law and linked to the work and residence permit, they have to be screened for infectious diseases, including TB, at their own expenses. TB is a condition which can justify deportation within 15 days from diagnosis. In March 2009, a survey was conducted jointly by *The International Organization for Migration* (IOM) and WHO among labour migrants in Tajikistan to elucidate key factors influencing access to TB diagnosis and treatment both in their labour destination country (largely the Russian Federation) and at home. The study showed that migrants have increased vulnerability to TB due to the working and living conditions in the destination country and that access to health services is limited due to their legal status or the high cost of health services abroad [35]. The preliminary results of the survey were presented in a round table in Moscow in July 2009 and possible interventions were identified jointly by the Tajikistan and Russian participants.

The Netherlands has changed the Migration Act in the end of 2009 [36]. Since then it is legally arranged that it is not allowed to deport migrants to another country while they are suspected to be affected by TB. This includes also the asylum seekers belonging to the Dublin Regulation. In the Migration Act is also laid down that when migrants (including undocumented migrants, asylum seekers, and foreigners with a temporary permit) are diagnosed with TB, they have the right to stay legally in the Netherlands for the overall treatment duration. Unfortunately, the Migration Act does not allow the asylum seekers belonging to the Dublin Regulation to stay in the country till the completion of treatment (unless they are still sputum smear positive). However relevant efforts have been taken to ensure continuation of their treatment in the country of destination. But this is often very hard to do and no good follow up is possible. In 2008, five cases on TB treatment were reported to have been transferred outside the Netherlands, but it was not clear whether these transfers were due to the Dublin Regulation and research had to be started to retrieve more information about this patient group.

Further to its broader work in continued advocacy for upholding the right to health for migrants regardless of status and for migrant sensitive health systems, the IOM is performing health assessment among migrants, as well as for refugees within the framework of their resettlement to UK, France, Germany, Norway, Sweden, Finland and several other European

countries. The health assessment protocols significantly vary by country but most of them do include TB screening. The major Health Assessment project in relation to the European countries is the United Kingdom TB Detection Programme in eight high-prevalence countries, where IOM assessed around 482,000 United Kingdom visa applicants between October 2005 and December 2010. In several locations, IOM offers treatment to visa applicants diagnosed with TB, as well as, increasingly, health education.

The Minimum Package for cross border TB control and care

The Minimum Package presented here represents the minimum standards agreed upon among the Wolfheze group of experts and the National TB Programme managers to ensure cross-border TB control and care (Table 2). The recommended minimum package aims to break down the key barriers to diagnosis and treatment and data exchange for migrants and other cross border travellers with TB.

Governance

The countries shall ensure full commitment to cross-border TB control and care. A legal framework for TB cross-border collaboration has to be created in non-EU and EU countries as well as between EU countries and non-EU countries of the WHO European Region to ensure the right to health and the continuum of TB care for all patients regardless of their legal or residential status. Continuity of care can be improved by implementing a few simple activities:

- The current list of TB services within each Member State of the WHO European Region, mentioning one or more “reference centre(s)” per Country specifically identified for this task. Treating physician will have a useful instrument to refer their patients in case of need.
This list should be ideally kept online (with restricted access) and regularly updated. The responsibility of updating the e-mail addresses in the list would lie with each country.
- The list of national or sub-national focal persons (updated under care of the WHO Regional Office for Europe) if timely provided to physicians will further facilitate coordination to hopefully ensure continuity of care. Consensus was reached to indicate in three working days the maximum time necessary to share information on the patient moving from a country to another.

Finance

In the interest of patients' and public health, health authorities and providers should have ensured/at their disposal, by the governments funds and the health insurance organizations enough resources to provide diagnosis and treatment of any patient, irrespective of their nationality and legal status, in their country or if moved across the border. Special funds and treaties need to be established within EU or WHO Europe Region Member States to ensure reciprocity and cover the costs incurred for treating patients coming from other Countries. A possible common regional fund (Regional Health Insurance) dedicated for diagnosis and treatment of patients is strongly suggested especially for undocumented migrants, seasonal workers and international students.

Service delivery

All services should be culturally competent, respectful of patients rights and not be at the charge of the patient [9,12-14,37]. These services shall be provided without any interruption and designed via participatory consultative approaches, involving patients' organizations, cross-border and migrant communities and associations as well as those representing staff and professionals who are directly involved.

- *Prevention:* All people who are crossing a border should have the possibility of accessing preventive measures including diagnosis and treatment of latent TB infection as applicable, in the transit, host and return country [12-14,38].
- *TB infection control:* Administrative and environmental measures and respiratory protection shall be provided in diagnostic and treatment centres as well as during the process of transferring patients to another country [12-14,39,40].
- *Contact management:* All relevant family members and contacts need to be examined for TB and provided treatment if necessary [41].
- *Diagnosis:* All people crossing a border for any reason should be provided free of charge diagnosis of TB infection and disease [11,17] and drug resistant TB. The diagnosis services shall be provided in the previously identified "Reference centres". The location of these services shall be decided based on each country's health system. Early diagnosis is crucial to improve treatment outcome and break the transmission in the community.

- *Treatment:* Treatment of TB shall promptly be provided by the first point of contact, irrespective of patients' legal status. Treatment of drug resistant TB and TB/HIV co-infection need to be ensured [42].

Undocumented migrants should not be deported while on treatment [11,17]. If they are deported anyway, at least all pulmonary TB patients subject/subjected to holding/detention shall receive treatment until they are smear or culture negative and only after that may an individual be deemed fit for travel.

- *Continuity of care:* Patients who are diagnosed with TB shall be provided quality treatment [12-14] within the country and beyond the borders. The availability of necessary anti-TB drugs for continuation of treatment should be verified and ensured before the patient is transferred to another country [43]. Most effective for continuity of TB care of undocumented migrants is not deporting them while on treatment. The continuation of treatment shall be ensured between the health services of the country sending and the one receiving the patient.
- *Confidentiality:* All health workers are ethically bound and shall respect and be protected in doing so, their oath in maintaining confidentiality and not reporting TB patients, including undocumented migrants to regulatory authorities for possible deportation. The exception is the patient who rejects treatment and poses danger to public health, then only after appropriate counselling and psychosocial care; if the patient still refuses to receive treatment, he/she may be reported to the regulatory authorities for involuntary medical isolation. Practising involuntary isolation of patients shall be only exercised in rare cases and if all other attempts to treat patient fail.

Surveillance and Monitoring

Before the patient is transferred to another country, the complete medical records shall be entrusted to the patient and also shared with the health care provider in the recipient country; receipt of information and feedback need to be sent back to the health care provider sending the patient. The information should be transmitted in a mode strictly respecting confidentiality and data protection.

Examples of core indicators for monitoring the cross-border TB control and care to be adopted with consistency in all countries, include: number of TB patients who were diagnosed as having TB before or after moving to another country, number of TB patients who crossed the border and successfully completed their treatment.

Supportive environment

Counselling and advice on treatment adherence shall be an indispensable part of the Minimum Package for cross-border TB control and care. Psychosocial support and provision of enablers and incentives can play a crucial role for promoting treatment adherence and should be considered a priority intervention.

There is a need to engage the civil society organizations, particularly those who can work across the borders and secure treatment of the patients.

Advocacy-communication-social mobilization (ACSM) should be pursued at national and international levels and in line with recommendation for provision of migrant sensitive services to make this information known to both health providers and migrant communities and their leaders.

The progress and performance of mechanisms of collaboration between countries need to be carefully monitored.

Conclusions

Intensified actions are needed to address the current gaps in providing TB and drug resistant TB control and care across the borders. A legal framework for TB cross-border collaboration has to be created within the EU, in non-EU countries and between EU and non-EU countries of the WHO European Region to ensure the right to health and the continuum of TB care for all patients regardless of their legal or residential status.

In EU countries, an amendment to the Dublin II Regulation on asylum applications is recommended to foster and safeguard the continuity of TB care for asylum seekers.

Continuum of TB care between countries should be done through a shared updated list of TB services and national focal points for effective and timely communication regarding transferred TB patients.

A Minimum Package for cross-border TB control and care has been developed by a Wolfheze Task Force including known experts and the National TB Programme managers of the WHO European Region. National health authorities are called to adopt it. For its successful implementation, a supportive environment is needed and represented by effective patient support and cross-border health insurance schemes and funds, engagement of civil society organizations, advocacy-communication-social mobilization and cross-border monitoring mechanisms.

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(http://www.euro.who.int/_data/assets/pdf_file/0005/124466/E94368.pdf).

Table 1. Tuberculosis reported new cases by geographic origin in WHO European Region, 2010.

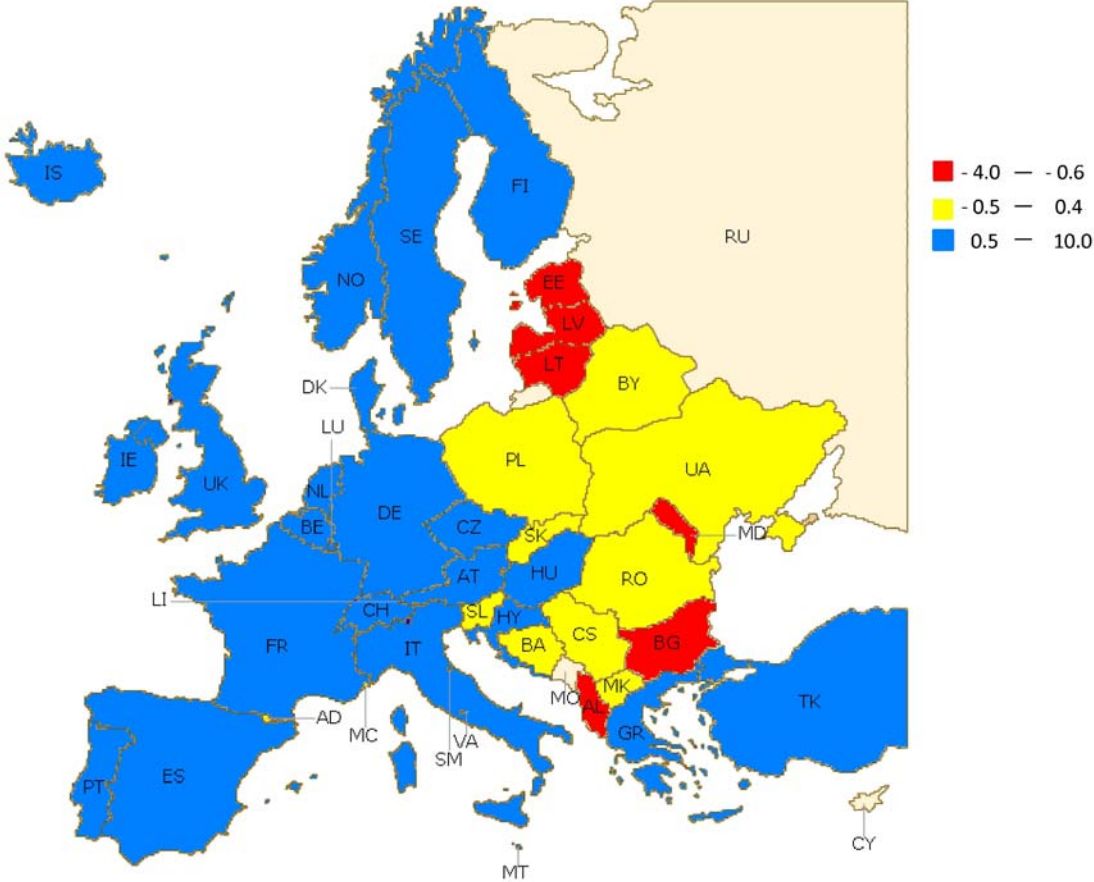
Country	Criteria for origin	Native N (%)	Foreign N (%)	Unknown N (%)	Total N
EU/EEA					
<i>Austria</i>	Citizenship	385 (56.0)	299 (43.5)	4 (0.6)	688
<i>Belgium</i>	Citizenship	506 (45.4)	609 (54.6)	0 (0.0)	1,115
<i>Bulgaria</i>	Birthplace	2,647 (99.9)	2 (0.1)	0 (0.0)	2,649
<i>Cyprus</i>	Birthplace	11 (18.0)	50 (82.0)	0 (0.0)	61
<i>Czech Republic</i>	Birthplace	561 (82.7)	117 (17.3)	0 (0.0)	678
<i>Denmark</i> ^(c)	Birthplace	143 (39.8)	216 (60.2)	0 (0.0)	359
<i>Estonia</i>	Birthplace	271 (82.4)	58 (17.6)	0 (0.0)	329
<i>Finland</i>	Birthplace	217 (66.4)	105 (32.1)	5 (1.5)	327
<i>France</i>	Birthplace	2,264 (44.3)	2,469 (48.3)	383 (7.5)	5,116
<i>Germany</i>	Birthplace	2,213 (51.1)	1,978 (45.7)	139 (3.2)	4,330
<i>Greece</i>	Birthplace	258 (52.8)	231 (47.2)	0 (0.0)	489
<i>Hungary</i>	Citizenship	1,720 (98.8)	21 (1.2)	0 (0.0)	1,741
<i>Iceland</i>	Birthplace	6 (27.3)	16 (72.7)	0 (0.0)	22
<i>Ireland</i>	Birthplace	243 (56.9)	171 (40.0)	13 (3.0)	427
<i>Italy</i>	Birthplace	1,418 (43.6)	1,809 (55.7)	22 (0.7)	3,249
<i>Latvia</i>	Birthplace	872 (93.4)	62 (6.6)	0 (0.0)	934
<i>Lithuania</i>	Birthplace	1,891 (97.6)	47 (2.4)	0 (0.0)	1,938
<i>Luxembourg</i>	Birthplace	12 (41.4)	17 (58.6)	0 (0.0)	29
<i>Malta</i>	Birthplace	7 (21.9)	25 (78.1)	0 (0.0)	32
<i>Netherlands</i>	Birthplace	275 (25.6)	789 (73.5)	9 (0.8)	1,073
<i>Norway</i>	Birthplace	50 (14.7)	289 (85.3)	0 (0.0)	339
<i>Poland</i>	Citizenship	7,463 (99.4)	46 (0.6)	0 (0.0)	7,509
<i>Portugal</i>	Birthplace	2,197 (83.7)	425 (16.2)	4 (0.2)	2,626
<i>Romania</i>	Birthplace	21,040 (99.8)	38 (0.2)	0 (0.0)	21,078
<i>Slovakia</i>	Birthplace	431 (98.2)	8 (1.8)	0 (0.0)	439
<i>Slovenia</i>	Birthplace	131 (76.2)	41 (23.8)	0 (0.0)	172
<i>Spain</i>	Birthplace	4,652 (65.6)	2,268 (32.0)	169 (2.4)	7,089
<i>Sweden</i>	Birthplace	96 (14.2)	579 (85.8)	0 (0.0)	675
<i>United Kingdom</i>	Birthplace	2,131 (25.1)	5,816 (68.6)	536 (6.3)	8,483
Subtotal EU/EEA		54,111 (73.1)	18,601 (25.1)	1,284 (1.7)	73,996
Non- EU/EEA					
<i>Albania</i>	Citizenship	444 (99.8)	1 (0.2)	0 (0.0)	445
<i>Andorra</i>	Citizenship	7 (100.0)	0 (0.0)	0 (0.0)	7
<i>Armenia</i>	Citizenship	1,779 (99.9)	1 (0.1)	0 (0.0)	1,780
<i>Azerbaijan</i>	Citizenship	-	-	8,394 (100.0)	8,394
<i>Belarus</i>	Citizenship	5,153 (92.8)	0 (0.0)	401 (7.2)	5,554
<i>Bosnia and Herzegovina</i>	Citizenship	1,390 (100.0)	0 (0.0)	0 (0.0)	1,390
<i>Croatia</i>	Birthplace	691 (99.4)	4 (0.6)	0 (0.0)	695
<i>Georgia</i>	Citizenship	5,796 (100.0)	0 (0.0)	0 (0.0)	5,796

<i>Israel</i>	Birthplace	51 (14.9)	292 (85.1)	0 (0.0)	343
<i>Kazakhstan</i>	Birthplace	24,847 (87.0)	0 (0.0)	3,703 (13.0)	28,550
<i>Kyrgyzstan</i>	Birthplace	5,308 (84.3)	0 (0.0)	987 (15.7)	6,295
<i>Macedonia, the former Yugoslav Republic of</i>	Birthplace	0 (0.0)	0 (0.0)	420 (100.0)	420
<i>Moldova</i>	Citizenship	5,416 (99.4)	31 (0.6)	0 (0.0)	5,447
<i>Monaco</i>	Birthplace	0 (0.0)	1 (100.0)	0 (0.0)	1
<i>Montenegro</i>	Citizenship	113 (99.1)	1 (0.9)	0 (0.0)	114
<i>Russia</i>	Citizenship	107,794 (66.3)	2,110 (1.3)	52,649 (32.4)	162,553
<i>San Marino</i>	-	-	-	-	-
<i>Serbia</i>	-	-	-	2,385 (100.0)	2,385
<i>Serbia excluding UN Administered Province of Kosovo</i>	Citizenship	-	-	1,501 (100.0)	1,501
<i>UN Administered Province of Kosovo</i>	Birthplace	884 (100.0)	0 (0.0)	0 (0.0)	884
<i>Switzerland</i>	Birthplace	150 (27.3)-	377 (68.7)-	22 (4)	549
<i>Tajikistan</i>	Birthplace	-	-	7,641 (100.0)	7,641
<i>Turkey</i>	Birthplace	-	-	16,551 (100.0)	16,551
<i>Turkmenistan</i>	Citizenship	-	-	3,230 (100.0)	3,230
<i>Ukraine</i>	Citizenship	-	-	36,409 (100.0)	36,409
<i>Uzbekistan</i>	Birthplace	-	-	20,330 (100.0)	20,330
Subtotal Non-EU/EEA		158,789 (50.4)	2,441 (0.8)	153,649 (48.8)	314,879
<i>Total</i>		212,900 (54.7)	21,042 (5.4)	154,933 (39.8)	388,875
Subtotal 18 HPC		182,814 (54.2)	2,349 (0.7)	150,295 (44.8)	335,458

Table 2. The Minimum Package for cross-border TB control and care.

Management , Human rights & Finance	Governance	Legal framework	Commitment to cross border TB control and care Ensure legal basis for cross border TB control and care within EU and non EU and between EU and non-EU
		Funding	Ensure funding from Government resources, health insurance and/or bilateral and multilateral funding mechanisms
		Intercountry correspondence	Create and maintain a live list of TB service providers in the Region
	Service Delivery	Prevention	Diagnosis and treatment of LTBI
		TB infection control	Administrative measures, Environmental measures and personal protection
		Diagnosis	Early diagnosis including drug resistant TB
		Treatment	Prompt and effective treatment
		Continuity of care	No deportation before the end of treatment or at least till the end of intensive phase and ensuring continuation phase treatment will be followed
	Surveillance & monitoring	Individual patient data	Effective transfer of patient's record
			Feedback to the centre sending patients
		Programme performance	Relevant indicators at country and Regional level measure the progress
	Supportive environment	Enablers and incentives	Counselling Psycho-social support to patients
		Advocacy communication and social mobilization	Empower communities for providing migrant –sensitive services Improve communication with migrant communities Advocate for full engagement of health authorities and stakeholders

Figure 1. Net migration rate in Europe (difference between the number of persons entering and leaving a country during the year per 1,000 persons)*.



* (http://globalgeography.aag.org/Migration1e/CaseStudy1_Europe_July09/CaseStudy1_Europe_July093.html, accessed on 24 February 2012)

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